

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	/	



ADMISSION SLIP

Admitting Doctor: Dr. Gnanavelu

Speciality: Cardio

Advised Date & Time: 11/1/2024 & 12:30 AM

Provisional Diagnosis:

DVD - CAD -

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 + PCI / Chest Angio

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

Expected Duration of Stay: 2-3 Days

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

Payer: ☒ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Send ECG report - 1 . CBC / Urea / Creatinine

Any other Instructions (if any):

Doctor's Signature



Name

Dr. Vel

Reg. No.

95268

Date

12/1/24

Time

12:30 AM

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

12/01/2024

01.16 AM

12/01/2024

01.16 AM

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

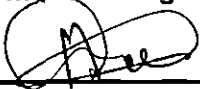
Front office Staff Signature

Name

Emp. No.

Date

Time



Alakh.

169

12/1/24

01.16 AM-



ADMISSION FORM

Marital Status M	Full Address : NO: 32 BURMA COLONY, KAMARAJ NAGAR NEW WASHIERMIZNPET, TONDIVARPET CHENNAI - 81		Telephone Number 8838394670 9003220589 9884894748
Occupation 101			
Referred from Dr. V. V.	Date of Time of Admission 12/01/24 - 01.16	Date & Time of Discharge 14/1/24	Total No. of Days 3 days
UNIT card.	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
CAD-EVOLVED IAMI-CAG-DOUBLE VESSEL			I25.4
DISEASE OF LCX & LAD (09/1/24) MILD LV			I25.2
DYSFUNCTION SYSTEMIC HYPERTENSION			I50.1
			I10
DATE	OPERATION / PROCEDURES		ICPM Code
12/1/24	SUCCESSFUL PTCA+STENT TO DISTAL LCX DONE USING 2.5X22 MM ONYX TRUCOR DES & PROXIMAL LCX USING 2.5X12MM ONYX TRUCOR DES & PTCA+STENT TO LAD DONE USING 2.25X18 MM ONYX TRUCOR DES DONE ON (12/01/24)		00.66
DATE	TYPE OF ANESTHESIA		
12/1/24	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL		
DISCHARGE STATUS			
<input type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input checked="" type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Dr. G. GNANAVELU Reg. No. 89469 Signature of the Consultant		Signature of Medical Records Officer	

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staff of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient..... 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 their attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

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

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 செலவுக்கான 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 தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

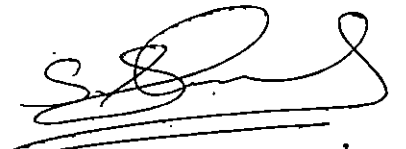

செவிலியர் கையொப்பம்

Signature of Admitting Nurse

தேதி 12/01/2024

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Date 01.16 AM - Signature of the Patient / Relative / Gurdian

For 
உறவுமுறை
Nature of Relationship

GENERAL CONSENT FOR ADMISSION



I, Mr. Kannan Govindhan the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

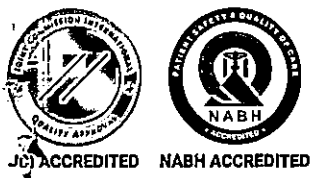
☐ Been explained this consent form in English, which I fully understand.

- 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			12/01/24	01.16
Surrogate/Guardian (if applicable #)		 (Write name and relationship with patient)	12/11/24	01.16
Reason for surrogate consent	Patient is unable to give consent because:			
Witness			12/11/24	01.16
Interpreter (if applicable)				

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



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DISCHARGE SUMMARY

IP No.	IPH2024000099	D.O.A	: 12/01/2024
UHID	MHI202381768	D.O.P	: 12/01/2024
Name	Mr. KANNAN GOVINDHAN	Room No.	: 110
Age / Gender	44 Years / MALE		
Consultant	Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 14/01/2024

DIAGNOSIS:

CAD – EVOLVED IWMI

CAG – DOUBLE VESSEL DISEASE OF LCX & LAD (09.01.2024)

MILD LV DYSFUNCTION

SYSTEMIC HYPERTENSION

PROCEDURE:

SUCCESSFUL PTCA + STENT TO DISTAL LCX DONE USING 2.5 X 22 MM ONYX TRUCOR DES & PROXIMAL LCX USING 2.5 X12MM ONYX TRUCOR DES & PTCA + STENT TO LAD DONE USING 2.25 X18 MM ONYX TRUCOR DES DONE ON 12.01.2024.

BRIEF HISTORY:

Mr. Kannan Govindhan, 44years old male, presented with complaints of compressive type chest pain radiating to left arm. He was evaluated in Govt Stanley hospital, diagnosed as ACS – evolved IWMI on 04.01.2024 and advised Coronary angiogram which revealed **DOUBLE VESSEL DISEASE OF LCX & LAD on 09.01.2024 and further advised for PTCA to LCX.** He came to Medway heart institute for PTCA for which he has been admitted.

No H/O fever, vomiting, diarrhea.

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

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

P I C C L E	-	NIL
HR	-	84bpm
BP	-	130/80 mmHg
SPO ₂	-	96% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft

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

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PATIENT
HELPLINE
94557 94557
1800 572 3003

Medway Group of Hospitals

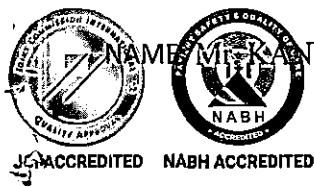
Kodambakkam	Mogappair	Chengalpattu	Villupuram	Kumbakonam	Kakinada
044-2473 4455	044-26530011	044-27426829	04146-242000	044-2473 4455	0884-2333367

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

Medway Centre of Excellence (Chennai)

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

MHI/HOSP/2022/118



NAME: MR. KANNAN GOVINDHAN UHID: MHI202381768



INVESTIGATIONS :

BLOOD: Hb- 14.6gm/dl, TWBC – 12380cells /cumm, PLT – 292000cells/cumm, Urea – 26mg/dl, Creatinine – 0.76mg/dl, Sodium – 139mg/dl, Potassium – 4.35 mg/dl.

ECG: sinus rhythm, HR – 84 bpm, evolved IWMI changes.

ECHO(12.01.2024): Mild concentric LVH. All chambers normal sized. RWMA (+)basal and mid infero septum, mid infero lateral, apical lateral hypokinetic. Mild LV systolic dysfunction. EF – 45%. Grade I diastolic dysfunction. Normal RV systolic function. IAS /IVS intact. All valves are structurally normal. Trivial MR. Trivial TR, No PAH. IVC normal in size and collapsing. Trace pericardial effusion postero lateral to LV, Behind RA. No clot / vegetation / pleural effusion.

POST PCI INVESTIGATIONS:

BLOOD(13.01.2024) :

Test Name	Result	Reference Value	Units
UREA	29	14 - 40	mg/dl
CREATININE	0.89	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mg/dl

ECG : sinus rhythm, HR – 79 bpm, no fresh ST-T changes

SCREENING ECHO(13.01.2024) : S/P PTCA. No pericardial / pleural effusion. RWMA – basal & mid inferior, basal infero – septum hypokinesia. Mild LV systolic dysfunction. EF – 45%. Normal RV systolic function. All valves are normal. IAS / IVS intact. Trivial MR. Trivial TR. No PAH. No clot / vegetation.

COURSE IN THE HOSPITAL:

Mr. Kannan Govindhan, 44years old male, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, he underwent **SUCCESSFUL PTCA + STENT TO DISTAL LCX DONE USING 2.5 X 22 MM ONYX TRUCOR DES & PROXIMAL LCX USING 2.5 X12MM ONYX TRUCOR DES & PTCA + STENT TO LAD DONE USING 2.25 X18 MM ONYX TRUCOR DES DONE ON 12.01.2024** by Right radial 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, beta blockers 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.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS - 15/15

Temp - 98.6°F

BP - 130/80mmHg

PR - 80/min

SPO2 - 96% in room air

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PATIENT
HELPLINE
94557 94557
1800 572 3003

Medway Group of Hospitals

Kodambakkam | Mogappair | Chengalpattu | Villupuram | Kumbakonam | Kakinada
044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367

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

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

MHI/HOSP/2022/118



NAME: MR. K. G. GNAN GOVINDHAN UHID: MHI202381768



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ADVICE MEDICATIONS:

SL. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. AX CER (TICAGRELOR)	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. AZTOR (ATORVASTATIN)	80 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. MET XL (METOPROLOL)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. ALPRAX (ALPRAZOLAM)	0.5 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. VALENT (VALSARTAN)	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
9.	TAB. PERINORM (METOCLOPRAMIDE)	10 MG	½	0	½	ORAL	AFTER FOOD	X 1 WEEK
10.	TAB. NIKORAN (NIKORANDIAL)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11.	TAB. PAN (PANTAPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
12.	SYP. CREMAFFIN (LIQUID PARAFFIN)	15 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE

DIET	LOW FAT 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.

K. Kavitha
"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.

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

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94557 94557
1800 572 3003

Medway Group of Hospitals

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Medway Centre of Excellence (Chennai)

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

MHI/HOSP/2022/118

INPATIENT INITIAL ASSESSMENT

Date: 12/1/24

Time of arrival in ward: 2:00

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 84 (beats/min) | BP: 180/80 (mmHg)

Respiration: 18 (breaths/min) | SpO₂: 96 (%) | Height: 160 (cms) | Weight: 65.5 (kgs) | BMI: 23.6 kg/m²

Pain: ☒ Yes ☐ No. If Yes, Score: 4/10

Pain Scale Used: ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: 1 day Location: chest

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

44y/o m came with H/O chest pain on & off x 1 day. H/O vomiting 3 episodes since yesterday morning. Patient was apparently normal before 1 day, then he developed chest pain which is intermittent in nature associated with giddiness. H/O vomiting 3 episodes vomitus contain food particles associated with mild giddiness. Then he went nearby hospital & CPOT was done on 09.1.24 else where. now, he got admitted for further evaluation.

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☐ Yes ☒ No. If Yes, duration: Hypertension: ☒ Yes ☐ No. If Yes, duration: 2 yrs

Others:

Past Surgical History:

H/O CABG done on 09.1.24 showed double vessel disease of LCA & LAD.

Present Medication (for Medication Reconciliation):

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History:**Personal / Social History (Tick whichever is applicable)**Lifestyle: ☐ Sedentary ☐ Active Occupation: _____Smoking: ☐ Yes ☒ NoAlcohol: ☐ Yes ☒ NoRecreational Drug Use: ☐ Yes ☒ No

Others: _____

Menstrual and Obstetric History (to be filled up for female patients):**General Physical Examination:**Pallor: ☐ Yes ☒ NoIcterus: ☐ Yes ☒ NoClubbing: ☐ Yes ☒ NoEdema: ☐ Yes ☒ NoLymphadenopathy: ☐ Yes ☒ No

SYSTEMIC EXAMINATION

CVS:

S162 ⊕

Respiratory System:

BAE ⊕

Gastrointestinal System:

soft, non-tender

Central Nervous System:

NPOD

GCS - 15/15

Urinary / Reproductive / Locomotor System:

normal

Skin / Ophthalmic / ENT

normal

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:

CAD - DVD

Recently decompensated

ACS - Evolved IWM

STEMI

mild LV dysfunction EF - 45%

Plan of Care:

Admit ↓ Dr. Ananuel

- Postoperative preparation

Plan. check CAG ± PTCA tomorrow

- Shift to Cath lab on call

- NPO from 8am tomorrow

- Consent

Investigations Advised:CBC, RBS, US, CR, Na⁺, K⁺**Diet Advice:**

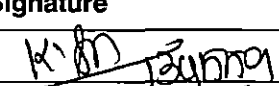
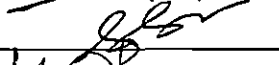

- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: Low salt, Low fat

Early Discharge Planning (fill in those which are appropriate at this stage):

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		DR. ANUSUYA	134559	12.1.24	2:00
Consultant		Dr. Ananavelu	39469	13/1/24	09:45
Patient Attendant		Relationship K. Sanyal	—	12/1/24	2:00

CONSENT FORM FOR CRITICAL CARE (ICU)

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

☐ Read

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

☐ Been explained this consent form in English / 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
- Arrhythmia
- 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 re inflated 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): _____

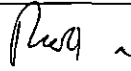

Possible alternatives:

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 procedure 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.

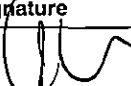
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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 #)		DAMES H (Write name and relationship with patient)	12/1/24	16:00
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		SHYAM	12/1/24	16:00
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		Dr. H. Arshad	9000	12/1/24	16:00

உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

என்ற பெயர் கொண்ட ட நோயாளியான அல்லது ட 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 சிகிச்சையளிக்கும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சுவாச வழிமுறை, மத்திய சிரை அணுகுவசதி இதய தமனி தமனிக்குழல்கள் உட்பட முச்சுப் பெருங்குழல்களுக்கு 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 கதிட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

ஒரு மைய சிரை கதிட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், 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 கதிட்டரை தாங்கும் என்பதால், நீண்ட காலஅளவிற்கு IV மருந்துகளை வழங்குவதற்காக. ஆன்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நயர் 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.
- பரிசோதனைகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிகுத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வைக்க செய்கிறது.
- லாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- புறவெளி லைன் வழியாக வாசோபிரெஸ்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெஸ்ஸ்களை (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 கதிட்டரைப் பொருத்தும் நேரத்தில் அதனை உட்செலுத்துகின்ற நேரத்தில் அசௌகரியம் ஏற்படக்கூடும்.
- இரத்தக்கசிவு: கதிட்டர் உட்செலுத்தப்படும் நேரத்தில் இரத்தக்கசிவு நிகழக்கூடும். இந்த இரத்தக்கசிவு வழக்கமாக மிகச்சிறிய அளவில் லேசாக இருக்கும் மற்றும் அது தானாகவே நின்றுவிடும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதிட்டர்), சருமத்திலிருந்து பாக்கிரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதிட்டர் பொருத்தப்படும் இடத்தை தாய்மைப்படுத்துவது மற்றும் பேண்ட்ஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉறைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுரையீரல் உறைக்காற்று நோய் (நுரையீரல் துவண்டு மடிதல்): மார்பு பகுதியில் ஒரு மைய சிரைகதிட்டர் பொருத்தப்படும்போது ஊசி சிரை / நாளத்தின் வழியாக கடந்து செல்லுமானால் அல்லது அதை தவறவிடுமானால் அந்த ஊசி நுரையீரலுக்குள் ஊடுருவி, நுரையீரல் துவண்டு மடிவதை விளைவிக்கும். இது நிகழமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காரணை அகற்றுவதற்கு விவாக்கங்களுக்கு 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 வாசோபிரெஸ்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தஓட்டத்தை

சிகிச்சையின் மாற்று வழிமுறை விடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

முச்சப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

முச்சப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை முச்சப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் முச்சத்திணை நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவு, உங்களது / உங்களது நோயாளியின் முச்சக்குழலுக்குள் ஒரு நெகிழ்வுத்திரன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. முச்சக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த முச்சக்குழல், 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. முச்சக்குழாய், குரல்வலைக்கு சுற்றுக்கீழே தொடங்குகிறது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு முச்சக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான முச்ச சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த முச்ச சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. முச்சக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திச ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது முச்சக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. முச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. முச்சப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் முச்சப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது முச்ச / 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 முச்சப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது / உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது
- சுவாசிக்க உதவு:
- 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 முச்சக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறுதிச் செவ்வியுழத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

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

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடையத் 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 நிகழுகின்ற நேரவில், 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 நோயாளியை / 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.

நோயாளி	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
பதிலாளர் / பாதுகாவலர் (பொருத்தமானால் ¹)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)		
பதிலாளர் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்லை; ஏனெனில்:			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருத்தமானால்)				

*ஆண்டுகளுக்கு 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, கிடைக்கும் என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பின் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அல்ல, இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

மருத்துவர்	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்



Every heart beat counts

DATE	NOTES
Mr. Vamnam 45/M	
12/1/24. 12:45 AM.	G/B Dr. Salai Sudhan (Cardio).
	CAD / Evolved Dwm. (4/1/24) / STAN.
	Now c/o chest pain since morning Settled now.
CAG - 109. HIV/HBsAg / HCV → -ve in Stanley.	NO H/O SOB / ^{gallop} palpitations - H/O 1 episode palpitation today morning O/E = Conscious, oriented.
ECG - Sinus rhythm. - LAD - TAV to ^{to} amp	CAG (4/1/24) - Stanley LAD - distal LAD 80-90% stenosis LAX - OM ₃ thrombus in total occlusion RCA - mid RCA 50% stenosis
Genomig Echo	PR - 86/min, BP - 102/79 (87)
- Hypokalaemia Iw/II/IS Basal & mid. & apical SW.	SpO ₂ 97% RA CNS = S, A, P RL = RAE ⊕
- EF - 45%, LVID - 42/33mm.	Imp: CAD / Evolved Dwm. / Post infarct angina / Mild W dysfunction / EF - 45% / STAN.
- Concentric LVT.	D/w Dr. Gnanavelu Sr.
- Gr I LVD	Admit in ward
- ⊕ Values.	- Dig: Fondezet 2.5mg S/c 0-0-1
- TAPSE - 17mm ⊕ Rv function	- T. Ecosprin 75mg 0-1-0
- No PAM/PE/dot.	- T. Axcos 90mg 1-0-1
to do - CBC, RBS W/Cr/Na/K..	- T. Met 80mg 0-0-1
check Plan CAG ± PTCA tomorrow	- T. Qvaly PAN D 1-0-1 (B/F)
	- T. MET XL 25mg 1-0-0
	- T. Nitrocontin 2.6mg 1-0-1

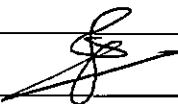
1724

DATE	NOTES
12/1/24 09:15	<u>Spr. Dr Gr-Gota</u>
	No clt pa.
	n sur
	vstcl stable
Bx-13dps A ₂ 96m	Cover S.S. ^(C) n istion
	L _o
	NPO from 7-30a
	Plan extra today
	\$
	9380

DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/1/24 18:30	<p>Ⓡ Radial PLS to LVP + LAR</p> <p>↓ SVP RRA Cannulated + BP stable after</p> <p>Lead engaged @ 3.5 EBU GR GR</p> <p>Lead wound @ whisper BS 0.014 GW</p> <p>Distal Lead line predicted @ 2x10 SC @ 10cm from</p> <p>Distal Lead @ 25x22 DBS onyx tissue</p> <p>Proximal Edge of stent lazy.</p> <p>proximal Edge of stent again overlapped &</p> <p>stent @ 2.5x12 DBS onyx tissue @ 18cm from</p> <p>stent line post distal @ 25x8 NC @ 18cm from</p> <p>Lead wound @ 0.014 18cm + pulled distally</p> <p>BW GW</p> <p>Lead line predicted @ 2x10 SC @ 10cm from</p> <p>Lead line stent @ 2.25x18 DBS onyx tissue</p> <p>@ 18cm for 15 sec. stent line post distal</p> <p>@ 25x8 DBS NC @ 18cm for 10 sec</p> <p>Ⓡ</p> <p>Ⓡ Progress 7ml/hour -</p> <p>for 10 hours</p> <p>Ⓡ Cath drugs as per</p>
<p>Medtronic Onyx TruCor™ 2.5 mm x 12 mm REF TRCR25012X LOT 0011402070 2025-09-12</p>	
<p>Medtronic Onyx TruCor™ 2.25 mm x 18 mm REF TRCR22518X LOT 0011791142 2026-05-22</p>	<p>Medtronic Onyx TruCor™ 2.5 mm x 22 mm REF TRCR25022X LOT 0011862435 2026-07-11</p>

9/30/24

DATE	NOTES
<div data-bbox="82 327 261 463" data-label="Text"> <p>12/1/24</p> </div>	
<div data-bbox="82 463 228 525" data-label="Text"> <p>530pm</p> </div>	<div data-bbox="433 376 1224 634" data-label="Text"> <p>pt had chf pain post P&B pt taken up for chemo good distal TIRU - 3 flow is in <u>Leio Hian</u></p> </div>
	<div data-bbox="492 687 1521 793" data-label="Text"> <p>INUS to Lev direct good approx of pt is preserved Distal Edge of gtt Post distal is 2.75 x 10 NR <u>Rs</u></p> </div>
	<div data-bbox="855 868 1050 910" data-label="Text"> <p>@ 14 am</p> </div>
	<div data-bbox="865 923 1427 1210" data-label="Text"> <p>James D. Wilshire 48mg in 48ml NS @ 4mg/hour w/ hypotension</p> </div>
	<div data-bbox="909 1253 1537 1455" data-label="Text"> <p>② D. Home ob sc bag to start 6 hours after shell removal</p> </div>
	<div data-bbox="917 1489 1581 1583" data-label="Text"> <p>③ Cont. By Dr. Nguyen for when</p> </div>
	<div data-bbox="945 1610 1500 1727" data-label="Text"> <p>④ (R) removed shell care</p> </div>
	<div data-bbox="1015 1759 1192 1910" data-label="Text"> <p> 93077</p> </div>



DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/1/24 7:40pm	<p>C/O / B: A-G-A-E-H-</p> <p>Can Round Run Cath lab.</p> <p>CAS pt developed severe chest pain not responding to 2 Morphine shifted back to Cath lab for check again.</p> <p>S/P PCZ to LCP & LAD down body.</p> <p>HR = 85/min</p> <p>SpO₂ = 96% - JNC -</p> <p>BP = 126/82</p> <p>S/P on: SLS @</p> <p>PS - BGR @</p> <p>PIC - SFT -</p> <p>CM - MMS.</p> <p>MC = 11/12</p> <p>Li.</p> <p>- Drug on per chart.</p> <p>- TPO chart.</p> <p>- vitals Monitory</p> <p>- w/f bleeding / Haemolysis</p> <p>- To do ECG & wear P-creat.</p> <p>to monitor</p>



Date: 12/1/24

ICU PROGRESS NOTES

Time: 9pm

Doctor's Name: Dr. Velupillay P.

ICU SCORES
(as Appropriate)

CLIF ACLF / AD score:
SOFA score:

MELD score:
SAPS II score:

AARC score:
APACHE II score:

ICU Day - 1
Background

yo AC - DVD

Issues last 24 hours

- post PTA

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M

Pain score

Pupils

Drains

Cardiovascular system

HR - 86/min Rhythm - NJA Cardiac Output -

BP - 110/80 CVP -

Cardiac Medications:

Respiratory system

Oxygen supplementation - 2L/min

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 :

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1. none

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1. -

2.

3.

Labs

Hb

Arterial TE

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 checks

• Urinal creatinine at Jan

• ECG at Jan

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. vel	95468	12/1/24	10m



Date : 13/1/24

Time : 9.00

Doctor's Name : Dr. Karthi

ICU PROGRESS NOTES

ICU SCORES
(as Appropriate)

CLIF ACLF / AD score:
SOFA score:

MELD score:
SAPS II score:

AARC score:
APACHE II score:

ICU Day
Background

CTE ASG
DWD.
post PTCA

Issues last 24 hours

8

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M 15/15 Pupils 3'

Pain score

Drains

Cardiovascular system

HR - 86 Rhythm *sin* Cardiac Output -

BP - 130/80 CVP -

Cardiac Medications:

Respiratory system

Oxygen supplementation -

Saturation / PaO₂ -

Ventilator : Spontaneous / Controlled

DATE
SAR: 984



Last C x R -
Drains -

GIT

P/A

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

Only feeds.

Microbiology

Invasive lines

1.

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

sepsis

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

Adh

Days as dated


no chit

manfor v. 1883

• Case - NIKONAR Agreem.

hi
8581

13

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Pruthi	8581	15/12/19	9:00





Medway
Heart
Institute

Every heart beat counts

DATE	NOTES
13/1/89 9 AM	<p><u>S/B Dr. Gnanavelu team.</u></p> <p>pt reexamined</p> <p>c/o atypical chest pain & abd. pain</p> <p>O/E: Conscious, oriented</p> <p>PR - 74/hr, BP - 136/83</p> <p>SpO₂ 97%, RA</p> <p>Cus = S₆ (P)</p> <p>RI = BAE (P)</p> <p>- Rt radial & femoral pulses well felt.</p> <p>- No puncture site issues</p> <p><u>Adv</u></p> <p>- Cont the same</p> <p>- Handshift to ward after completing Nikorandil infusion</p> <p>- Observation.</p> <p>97211</p>
<p>GRA</p> <p>- Simultaneous</p> <p>- LAD</p> <p>- P, H, E, AUF, V6</p> <p>- No further changes</p> <p>I 11658</p> <p>O 1350</p> <p>Urt/Cr - 29/0.89</p> <p>CCs - 121</p>	<p>Screwing Echo</p>

DOCTOR'S NOTES

Mr. KANNAN GOVINDHAN

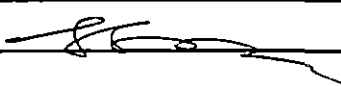
44/Male/MHI202481768

12/01/2024/1PH2024000099

Dr. G. GNANAVELU



PRE/POST OPERATIVE ECHO

Date & Time	S/L Dr. G. Gnanavelu	
13/1/2024		
9:30	Imp pair as chest & abdo	
	Hemodialysis	
	P 77 Jol 145/96	
	as @	
	Nely	
	for En 145 let out	
	Ecgs Rwna 25494	Add Eucledol
		gel 2-2-24
		T. Perann 1/2 - 1/2 34
		T. Nitkorant 1 - p
	Work output 40M	T Per way 1 - 0 - 1 hr
		T. Valnear way 1 - p
		



DOCTOR'S PROGRESS NOTES

DATE	NOTES
13/1/24	S/S Dr. V. S. S. P. / C
14 pm	At risk of not new onset
	Adv shift forward
✓ 15 pm	S/S Dr. Mohamed Hossain.
13/1/24	S/P PCI to LCX + LAD.
10 pm	Patient anxious oriented. afebrile.
	CVS → S1S2 ⊕.
	NS → BA ⊕
	P/A → soft, NT.
	Adv - monitor vitals
	- follow up chart
	- Plan 2 D/c tomorrow

(16/01/24)



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It counts

DATE	NOTES
17/11/29 10:00'	Spr GA & Tans do headaches an episode of fever last night from 2-10P 3R No do chest pain / SOB. 6 $\frac{1}{2}$ coming R 20/min Sa 136/80 SpO ₂ - 98% Cv, A/Mn (Beer) Remove wongkon T. Nolo Gray oral Antibiotics (I. Argemone) Gray 2. 7(3) day Stop F. M. ...
	B 12/4"

DATE	NOTES
14/1/24	S/B Dr. G. Lakshmi
10:30AM	pt reviewed,
	c/o headache.
	H/o fever - 100.3°F @ 4am
	Inj. Parac 1g iv stat given
	O/E. Conscious
	oriented vitals stable
	afebrile
	S/E. CUS-S, S ₂ +
	RS - BAET
	PA Soft
	CNS - NFND
	Adv.
	Remove peripheral line
	follow drug card
	N/F fever spikes
	Today plan a/c
	12/06/24

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

BLOOD GROUP

INVESTIGATION SHEET

Mr. KANNAN GOVINDHAN
A 44/Male/MHI202481768
U. 12/01/2024/IPH2024000099
Dr. G. GNANAVELU

Date	12/1/24	13/1/24				
HAEMATOLOGY						
Hb	14.6					
P.C.V	43.3					
Platelets	292000					
TLC	12380					
Polymorphs	78.4					
Lymphocytes	15.9					
Eosinophils	1.4					
Mono / Basophils	4.2 / 0.1					
E.S.R						
BIO-CHEMISTRY						
Urea	26	29.				
Creatinine	0.76	0.89.				
Sodium	139					
Potassium	4.35					
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]



Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

MR. KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr.G. GNANAVELU



MHI/IP/2022/074



Every heart beat counts.

VITAL INFORMATION SHEET

BLOOD GROUP

ON ADMISSION

Height in CM

Weight in Kg.

160cm

65-5 Key

Diagnosis: em - DDD, HTN

Procedure: PTC A To LAD & LEX + CAG

NO. OF DAYS	DOA	DAY-2	DAY-3
DATE	12/1/24	13/1/24	14/01/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10
40.5°			
40°			
39.5°			
39°			
38.5°			
38°			
37.5°			
37°			
36.5°			
36°			
PULSE	84 88 76 93 90		
RESP	20 20 22 20 20		
B.P.	120/80 123/78 121/67 128/68 130/80		
SPO2	96 96 96 97 97		
DAILY WEIGHT	65.5 kg 65.5 kg		
24 HRS INTAKE	1658 ml 1200 ml		
24 HRS OUTPUT	1352 ml 1650 ml		
BALANCE	+308 ml +50 ml		
MOTION	x	✓	

Mr.KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr.G. GNANAVELU



Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex: _____

Patient Id No: _____

NEWS key		DATE	TIME	DATE	TIME
0	1	2	3		
A+B Respirations Breath/ min					
A+B SpO2 Scale 1 Oxygen Saturation (%)					
SpO2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % in hypercapnic respiratory failure only scale 2 under the supervision of qualified person					
Air or Oxygen ?					
C Blood Pressure					
D Systolic BP					
E Heart rate / min					
F Consciousness Score for New onset of confusion (no score if chronic)					
G Temperature Degree Celsius					
NEWS Total					
Monitoring Frequency					
Escalation of Care Y/N					
Initials by RN					
Initials by Sr. RN					

Note: Nurses are trained 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 2 nd Hourly
	2	Every 4 th Hourly

[illegible]



Abstract



Every heart beat counts

[illegible]

[illegible]

[illegible]

[illegible]

PRE/POST OPERATIVE ECHO**Mr. KANNAN GOVINDHAN**

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr. G. GNANAVELU



Screening Echo

Date & Time	
13/01/2024	S/P PTCA
9:06am	<ul style="list-style-type: none"> No pericardial / pleural effusion RvMA - Basal & mid inferior Basal infu-septum hypokinesis Mid LV systolic dysfunction Normal RV systolic function All values are normal IAS/IS intact Trivial MR Trivial TR. NO PAH NO clot/vegetation
	<div> <div>WIDD: 48</div> <div>WIDS: 37</div> <div>EF: 45%</div> <div>EDV: 104ml</div> <div>EM: 52mm</div> <div>EF: 49%</div> </div> <div> <div>TRPS: 10</div> <div>RvSP: 20</div> <div>EVA: 1.26</div> <div>Med ELE: 11-9.5</div> <div>Lat ELE: 8.57</div> </div>
	HR: 76bpm
	Done by: Zibian (PA, RLS)
	MHI/0053

MHI2023/1768

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Affix Label here)
Name: **MR. IKARWAN LOONSHAN**
UHID: **12024000099**
DOB: **14/1/2000** Sex: **MALE**
DOA: **12/1/24**
Consultant: **Dr. GRANTWENT**

Diagnosis: **CAD - EUCARDIOMY / CAD - DUD 1 HCN / PTUA / EF-45 /**

Height: **160** cms Weight: **65.5** Kgs Food allergies: Yes/ No: if yes, specify.....

Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain



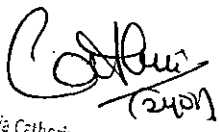
Diet Prescription: **600 calories, low fat, low salt, 200ml fluid restricted diet.**

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/ gain	<5%	5-10%	10-15%	>15%
2) Dietary Intake				
Duration: <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5				
Oral	No change	Sub-optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo-caloric liquid diet
Enteral / Parenteral Nutrition	Adequate / Excessive	Sub-optimal	Inadequate	Typo-caloric feeds
3) Gastrointestinal Symptoms Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4) Functional Capacity (Nutrition related functional impairment) Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
2) Sign of muscle wasting				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
Total Score = Sum of above 7 components				
Nutritional Status: Based on this patient is				
<input checked="" type="checkbox"/> Well Nourished (17 to 14)				
<input type="checkbox"/> Moderately Malnourished (15 to 18)				
<input type="checkbox"/> Severely Malnourished (19 to 35)				
Nutrition Intervention:				
<input checked="" type="checkbox"/> Oral <input type="checkbox"/> Enteral <input type="checkbox"/> Parenteral				
Diet counselling provided: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Frequency of re-assessment: <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Fort-night <input type="checkbox"/> Monthly				
Enteral / Parenteral <input type="checkbox"/> Daily <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes				

Dietitian Signature / Name / Date / Time:

Catherine 12/1/24, 12:40
Maria Catherine John (PYP)
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
12/1/24, 17:45	<p>A 44 year old male came to dietitian was assessed to be well nourished as evident by SGA.</p> <p>labs - Hb / D/D / Evaluated HbM</p> <p>Patient <u>refused</u> to Catheter for procedure (Perc) and kept on NPO. Patient <u>void</u> 6 w. NPO over. Patient <u>seated</u> <u>void</u> diet. Can initiate on soft solid diet.</p>	 Maria Catherine John Senior Dietitian
13/1/24, 14:00	<p>Patient <u>void</u> to ward. Reupped on the diet restriction. Motivated to eat well.</p>	 Maria Catherine John Senior Dietitian
14/1/24, 10:00	<p>Oral intake is good. Educated the patient and family on 1600 calories, no fat, no salt, no more fluid restricted diet <u>on discharge</u>. Supplied a meal list meal. Diet modification and clarification done. <u>Diet chart</u> given on discharge.</p>	 Maria Catherine John Senior Dietitian

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD - DVO / SHIV Allergies if any: NKA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
<u>ICU</u>	<u>Cathlab</u>	<u>12/1/24</u>	<u>15:35</u>	<u>CAC</u>

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):


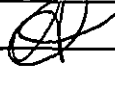
Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
<u>98.4</u>	<u>21</u>	<u>99</u>	<u>97</u>	<u>120/80</u>	<u>0</u>

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: tyl. morphine (2mg) . Ij. Emeret (6mg)

Any critical information: _____

Any specific recommendation: _____

	Signature	Name	Emp. No.	Date	Time
Handover by		<u>Nathiga</u>	<u>0240</u>	<u>12/1/24</u>	<u>17:14</u>
Handed over to		<u>V. Abinaya</u>	<u>0202</u>	<u>12/1/24</u>	<u>17:14</u>

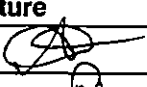

After Procedure:

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
<u>98.6</u>	<u>22</u>	<u>84</u>	<u>100</u>	<u>123/86/96</u>	<u>4/10</u>

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		<u>Nathiga</u>	<u>0240</u>	<u>12/1/24</u>	<u>18:05</u>
Handed over to		<u>Nathiga</u>	<u>0240</u>	<u>12/1/24</u>	<u>18:05</u>

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

Mr. KANNAN GOVINDHAN 44/Male/MHI202481768 12/01/2024/1PH2024000099 Dr. G. GNANAVELU 	Age: Sex: M/F Ward & Bed No: UHID
--	--------------------------------------

Dr. 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 blood. 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:


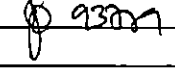
Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe 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 puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I acknowledge that Dr. 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 concerns 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				
witness		S. SAMAN (Brother)	12/1/24	17:00
Doctor		DR. KARTHI	12/1/24	17:00
Interpreter				

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

நிலை மற்றும் செயல்முறை

பின்வரும் ஆழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இருமல் குழாய்களில் துருபிழப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாறடையினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு ஹோக்கல் அளவீட்டிற்கு (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவட்டை/கையினுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டிருள்ள காண்ட்ராஸ்ட் மீடியத்தினை (என்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த காண்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புணர் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கிடைக்கக்கூடிய 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) மாறடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டைட்) 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 அளவிடான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிடான 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 விசுவத் 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 கிரத்தமேற்றது. ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். கிச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எந்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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



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

TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

Patient name	MR. KANNAN GOVINDHAN	ID	MHI202481768
Age/Gender	44 M	IP No.	IPH2024000099
Cath No.	3599	D.O.P.	12.01.2024

Done by Dr. G.Gnanavelu

Technician : Mr. Prathap

Scrub nurse : Ms. Sharmila

DIAGNOSIS : CAD –EVOLVED IWMi; MILD LV DYSFUNCTION, SHTN;

CAG: DOUBLE VESSEL DISEASE OF LCX & LAD.

APPROACH : Right radial artery

EXPOSURE TIME: 1390 sec

HARDWARE : 6F hemostatic sheath, 6 F EBU 3.5 guide

RAK: 220 mGy

CONTRAST : OMNIPAQUE 200 ml

DAP : 109Gy.cm2

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 8500 IU IA;

HEMODYNAMIC DATA: ABP 114/70 (84) PULSE 91 bpm SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
DISTAL LCX	TOTAL OCCLUSION OF DISTAL LCX	WHISPER	2 X 10 SC Balloon 10 atms	ONYX TRUCOR 2.5 X 22mm & 2.5 X 12mm 18 atms 15 s	2.5 x 8 NC balloon 18 atms	TIMI III FLOW
DISTAL LAD	80-90% STENOSIS	BMW	2 X 10 SC Balloon 10 atms	ONYX TRUCOR 2.25 X 18mm 16 atms 15 s	2.5 x 8 NC balloon 18 atms	TIMI III FLOW

REMARKS: Patient had chest pain after stenting of distal LCX. There was suspicious dissection of proximal edge of stent. Hence another overlapping was deployed. Inj Tirofuse 14 ml bolus was given and infusion at 8 ml started. Unj Nikorandil 2mg and aliquots of 50 mcg of Inj Sodium nitroprusside. Post procedure, patient developed severe chest pain in ICU. Check angio was done, which showed patent stents. IVUS was used to assess LCx stent. There was stent underexpansion distally. Hence postdilated with 2.75 x 8 balloon. Pain settled. ACT was 303 s.

RESULT: SUCCESSFUL PTCA X LAD & LCX.

Dr. G. GNANAVELU, MD, DM

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

Advisor & Mentor

Chief Cardiologist

Reg. No. 0046

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

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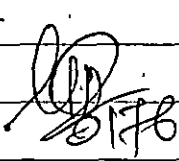
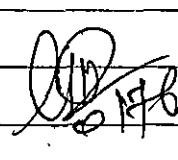
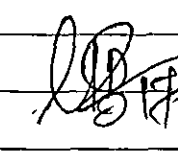
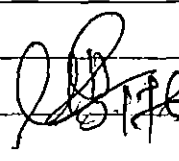
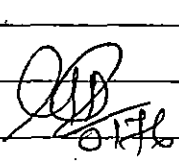
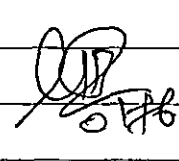
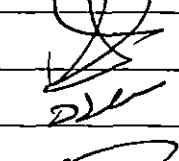
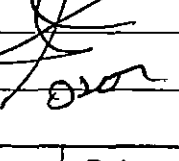
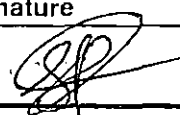
Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4451

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

MHI/HOSP/2022/118

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12/1/24 13:30	⇒ patient arrived 1 st floor to cath lab pt conscious & oriented pt vital stable pt on line patient.	
13:40	⇒ sterile drapping done under the local anaesthesia.	 0176
13:55	⇒ CAGI procedure started Rt radial artery approach.	 0176
13:55	⇒ INJ: NTG 200 mcg + INJ: Heparin 5000 IU given (o/b Dr. G. Gnana Velu) (sir)	 0176
14:00	⇒ HR: 89 bpm Bp: 12/87 (94) mmHg SpO2: 100% vital stable	
14:10	⇒ CAGI procedure done followed by PTCA to LAD and REX.	
14:10	PTCA Consent taken.	
14:15	⇒ INJ: NTG 200 mcg + INJ: Heparin 5000 IU given o/b Dr. G. Gnana Velu (sir)	 0176
14:15	⇒ INJ: Fentanyl 25 mcg + INJ: esmolol 4mg IV given o/b Dr. G. Gnana Velu (sir)	 0176
14:20	⇒ BP: 116/88 (99) mmHg, HR: 89 bpm SpO2: 100% vitals stable.	
14:25	⇒ INJ: Tirofiban 18ml Bolus IV given o/b Dr. G. Gnana Velu (sir)	 0176
14:45	⇒ JBP: 127/94/106 mmHg, HR: 88 bpm SpO2: 100% vitals stable.	
14:50	⇒ INJ: Midazolam 1mg IV given (o/b Dr. G. Gnana Velu) (sir)	 0176
15:15	⇒ INJ: Midazolam 1mg IV given (o/b Dr. G. Gnana Velu) (sir)	 0176
15:20	⇒ INJ: Heparin 1500 IU ⇒ ACT ⇒ 205 secs	
Document endorsed by	Signature 	Name <u>Ganapathy</u>
	Emp. No. <u>0016</u>	Date <u>12/1/24</u> Time <u>15:40</u>

NURSES PROGRESS NOTES

[illegible]

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086



Mr. KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/1PH2024000099

Dr. G. GNANAVELU



Name of the Procedure : PTCA Location : Cath Lab Date & Time : 12/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN Before Induction of Procedural Sedation (Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		TIME OUT <u>14:15</u> After procedural Sedation and before procedure (Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)		SIGN OUT <u>15:30</u> When Doctor indicates that the Procedure is completed	
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	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <u>PTCA</u> <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> RT <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side	<input checked="" type="checkbox"/> RT <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input checked="" type="checkbox"/> Yes	Position	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify : <u>Obscure</u>	
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify <u>ECG</u>	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Name of the Antibiotic given	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :	
		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
		Anticipated blood loss briefed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes		
		For procedural sedation cases		Corrective action : <u>I</u>	
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycaemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation <u>I</u>	Doctor performing the Procedure : <u>893719</u>	Nurse : <u>SN Sathya</u>	Technician : <u>pandey 2507</u>	Others Please Specify :
Date : <u>12/1/24</u> Time : <u>15:45</u>	Date : <u>12/1/24</u> Time : <u>15:45</u>	Date : <u>12/1/24</u> Time : <u>15:45</u>	Date : <u>12/1/24</u> Time : <u>15:45</u>	Date : <u>I</u> Time : <u>I</u>

Mr.KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

Patient Name

Dr.G. GNANAVELU

Consultant:**GIORAM / CORONARY ANGIOPLASTY****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 blood. 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:


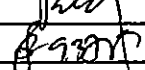
Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe 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 puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I 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 concerns 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				
witness		RAMESH	12/1/24	14:10
Doctor		Dr. G. Gnanavelu	12/1/24	14:10
Interpreter				

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஐஐசிஐடி (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 சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு ஹோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின்கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (எக்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புளாஸ் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கீச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கிடைக்கக்கூடிய 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 கான்ட்ராஸ்ட் மீடியத்தின் (டைட்) 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) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவினான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவினான சிராய்ப்பு

நோயாளி ஒப்புதல்

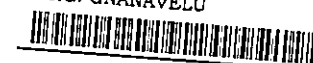
மருத்துவர் அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள 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. அளாதாரமான சூழலில், எனக்கு இரத்தமேற்றாதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார், கீச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எந்தெந்த உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Ev Mr. KANNAN GOVINDHAN
44/Male/MHI202481768
12/01/2024/IPH2024000099
Dr. G. GNANAVELU



Name of the Procedure : CAG Location : Cath lab Date & Time : 12/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN Before Induction of Procedural Sedation		TIME OUT After procedural Sedation and before procedure		SIGN OUT 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	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations confirms labeling and sent to lab <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		
Consent	<input checked="" type="checkbox"/> Yes	Position	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify : <u>Observation</u>	
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Essential Imaging displayed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify <u>ELG</u>	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :	
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Name of the Antibiotic given	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Corrective action : <u>I</u>	
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Anticipated duration briefed	<input type="checkbox"/> Yes		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes		
		For procedural sedation cases			
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation

Date :
Time :

Doctor performing the Procedure :

Date :
Time :

Nurse

Date :
Time :

Technician :

Date :
Time :

Others Please Specify :

Date :
Time :


Medway Hospitals®

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


Every heart beat counts

Procedure Monitoring Sheet (Cath Lab)

 Patient Name: **Mr. KANNAN GOVINDHAN**
 44/Male/MHI202481768
 12/01/2024/1PH2024000099
 UHID / IP : **Dr. G. GNANAVELU**
 Consultant :

 Age / Sex : **44y IM.**
 Ward Unit : **Ist floor**
 Diagnosis : **CAD - DxD**

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 130/80 Temp: 98.6 Pulse: 98 RR: 20 SPO2: 98			
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) not known		✓	
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse :	Date & Time : 12/01/2024 13:00		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
13:55	83b/min	22b/min	121/87(94)	100%	—	
14:15	83b/min	22b/min	101/87(95)	100%	—	
14:30	85b/min	22b/min	116/88(99)	100%	—	
14:45	87b/min	22b/min	127/94(106)	100%	—	
15:00	87b/min	20b/min	120/86(104)	100%	—	
15:30	89b/min	22b/min	127/72(102)	100%	—	
			procedure got over			

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

Time : 14:30 Route : RT Radial artery

Complication : Nil approx

BP : 124/86(94) mmHg, HR : 84b/min, RR : 22b/min SpO2 : 100%

Distal Pulse : felt, Puncture Site : no oozing no haematom

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 4 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in RT Radial artery.
- ◆ 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 dressing on 13/1/24 at 13:50 AM / PM after informing to the consultant.
- ◆ Special instruction if any: Nil

[Signature]
Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
<u>12/1/24 15:55</u>	<u>120/94</u>	<u>86</u>	<u>22</u>	<u>100%</u>	<u>no oozing no haem</u>	<u>good</u>	<u>-</u>	<u>[Signature]</u>

Nurses Notes :

CHA + PTCA procedure done RT Radial artery
sheath removed tight pressure bandage applied
no oozing no haematom cath int

Condition at the end of procedure : ☒ Stable ☐ Critical
 Patient shift to : ☐ Recovery Room ☐ Patient Room ☐ CCU ☐ Other CCU
 Name & Signature of the Nurse : [Signature] Date & Time : 12/1/24 15:55

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD-DVD Allergies if any: NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
1 st floor	Cathlab	12/1/24	13-25	CAG + PCI

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
97.6°	20 b/min	90 b/min	98%	130/70	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: Nil

Any critical information: Nil

Any specific recommendation: Nil

	Signature	Name	Emp. No.	Date	Time
Handover by		A. Nambhini	0170	12/1/24	13-25
Handed over to		V. Shrinaya	0202	12/1/24	13-25



After Procedure:

Procedure completed: ☒ Yes ☐ No 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 b/min	87 b/min	100%	134/80 (99)	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		V. Shrinaya	0202	12/1/24	16-00
Handed over to		A. Nambhini	0240	12/1/24	16-00

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

Patient Name	Mr. KANNAN GOVINDHAN 44 / Male / MHI202481763 12/01/2024 / IPH2024000099	Sex: M/F
Consultant:	Dr. G. GNANAVELU 	UHID

CONDITION AND PI

Dr. ~~G. 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 blood. 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

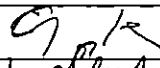
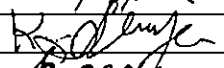
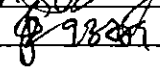
These are some of the more serious risks that can happen, but are not the only risks:

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 puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I acknowledge that Dr. ~~G. 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 concerns 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		Mr. Kannan	12.1.24	12.50
witness		K. Laxmo	12.1.24	12.50
Doctor		DR - KARTHI	12.1.24	12.50
Interpreter				

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

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இருமல் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு ஹோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவடை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (என்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர் சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (பூண்டு வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

- (i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கிடைக்கக்கூடிய மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கத்தீஸ்சின் 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 கான்ட்ராஸ்ட் மீடியத்தின் (டைட்) 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 கவடை பகுதியில் அறுவை சிகிச்சை சரியாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிடான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிடான 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 கிரத்தமேற்றதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். கிச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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

Procedure Monitoring Sheet (Cath Lab)

Every heart beat counts

Patient Name : **Mr.KANNAN GOVINDHAN**
44/Male/MHI202481768
12/01/2024/IPH2024000099
UHID / IP : **Dr.G. GNANAVELU**
Consultant :

Age / Sex :

Ward Unit :

Diagnosis :

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 123/78 Temp: 98.6 Pulse: 81 RR: 20 SPO2: 95			
Urine voided		✓	
Bowel preparation	✓		
Pre-procedure medication administered	✓		
Procedure site marked	✓		
Skin preparation done	✓		
NPO	✓		
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 : <i>[Signature]</i>	Date & Time : 12/1/24 @ 10:30		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
17:35	89b/min	22b/min	117/86(94)	100%	—	<i>[Signature]</i>
17:45	89b/min	22b/min	118/90(102)	100%	—	<i>[Signature]</i>
					procedure got over	

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

Time : 18.10 Route : RT femoral artery approach

Complication : Nil

BP : 117/86 (95) mmHg, HR : 89b/min, RR : 22b/min, SpO2 : 100%

Distal Pulse : felt, Puncture Site : no oozing no haematom

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 4 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in RT femoral artery.
- ◆ 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 femoral dressing on 13/1/24 at 17.15 AM / PM after informing to the consultant.

- ◆ Special instruction if any:

Nil

[Signature]
Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes :

RT femoral artery sheath secured keep in position secured with suture plaster bandage applied no oozing no haematom seen

Condition at the end of procedure : ☒ Stable

☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☒ CCU ☐ Other CCU

Name & Signature of the Nurse

[Signature]

Date & Time : 12/1/24 18.25



NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 12/1/24 Time of Arrival: 9:30 Mode of Admission: ☐ Walking ☒ Wheelchair ☐ Stretcher

Accompanied by Relative: ☐ Yes ☐ No If Yes, Name of the Relative: Mr. Meena

Relationship with Patient: Amma Contact Person's Name: _____ Relationship: _____

Contact No.: 883834673 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 : Angina 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	<u>0</u>	1	2	3	<u>0</u>
2. Feeling down, depressed, or hopeless	<u>0</u>	1	2	3	<u>0</u>

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: 84 (beats/min) | BP: 120/80 (mmHg)

Respiration: 20 (breaths/min) | SpO₂: 94 (%) | CBG: 112 (mg/dl) | Height: 160 (cms) | Weight: 65.5 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☒ No ☐ Medication ☐ Blood Transfusion ☐ Food ☐ Not known

If Yes, specify: _____

Pain: ☒ Yes ☐ No. If Yes, Score: 10 Pain Scale Used: ☐ NRS (>12 years) ☐ CPOT (ventilator / comatose)

Location: on left Location: chest

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: Normal diet

Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: Ms. Catherine Time: 2:30

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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Hearing Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Chewing Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Walking Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Daily Activity Of Living:

Activity	Independent	Assisted	Dependent
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: 27 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, immunosuppressant 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)

- ☒ 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
- ☐ 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		<input checked="" type="checkbox"/>	
Patients with intense chronic pain		<input checked="" type="checkbox"/>	
Woman in labor or experiencing termination of pregnancy		<input checked="" type="checkbox"/>	
Patients with emotional or psychological distress		<input checked="" type="checkbox"/>	
Patient suspected of drug or alcohol dependency		<input checked="" type="checkbox"/>	
Victims of abuse and neglect		<input checked="" type="checkbox"/>	
Patients whose immune system is compromised		<input checked="" type="checkbox"/>	
Patient with infections and communicable diseases		<input checked="" type="checkbox"/>	
Does the patient have implants		<input checked="" type="checkbox"/>	
Has tracheotomy been done		<input checked="" type="checkbox"/>	
Has colostomy been done		<input checked="" type="checkbox"/>	
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)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
2	Bedridden recently >3 days or major surgery within four weeks	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5	Entire leg swollen (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
6	Localized tenderness along the deep venous system (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
9	Previously documented DVT (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Risk Score Interpretation (Probability of DVT):

Final Score

Tick the score obtained (✓)

Action Taken

Date

Time

Low Risk

-2 to 0

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	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both <input checked="" type="checkbox"/> Nil				
Hearing Aid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Nil				
Eye glasses / Contact lens	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Jewellery	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Other valuables (specify)					

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
		RAMESH	Relationship Brother	12/1/24	2:00
Nurse		A. mony k.	0121	12/1/24	2:00
Unit In-Charge		Dhananav.	005	12/01/24	10:00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:

12/1/24

Shift:

☐ Morning

☒ Evening

☒ Night

S

SITUATION

Diagnosis: CAD - DIED

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: 6/15

POD: -

Central line days: -

VIP Score: -

B

BACKGROUND

Type of surgery: -

Date of surgery: -

Allergies if any: not known

On room air / oxygen: on room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 96 (%) | Height: 160 (cms) | Weight: 65 (kgs) | BMI: 23.6 kg/m²

Others: -

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

Fall Risk Score: 20 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: -

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		A. Manoharan	0170	12/1/24	7:00
Handover taken by		S. Nalin	0024	12/1/24	7:00
Document endorsed		S. Nalin	0024	12/1/24	8:00

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - IOWD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: ☒ Left: ☒

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: -

Central line days:

VIP Score: 0/5

B

BACKGROUND

Type of surgery:

Allergies if any: N/A

On room air / oxygen: on Room Air

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp 97.4°F | Pulse / HR: 72 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/70 (mmHg) | SpO₂: 97% | Height: 160 (cms) | Weight: 65.5 (kgs) | BMI: 23.6 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:

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:

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Nandhini	0170	12/1/24	13.40
Handover taken by		G. Gnanavelu	0202	12/1/24	13.50
Document endorsed		Jayaraman	0000	12/1/24	13.50

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - D.V.D.

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: ☒ Left: ☐

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: ☐

Day: ☐

Day: ☐

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0-15

B

BACKGROUND

Type of surgery: Pre-CA to IAD & Lx

Allergies if any: N/A

On room air / oxygen: RA

Complaints / New Symptoms in last shift:

Date of surgery: 12/1/24

IV fluids on flow: 5% NS + 30cc/h

A

ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 88 (beats/min) | Respiration: 11 (breaths/min)

BP: 110/72 (mmHg) | SpO₂: 96 (%) | Height: 168 (cms) | Weight: 65 (kgs) | BMI: 23.6 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 ☐ N/A Wound Dressing done: ☐ Yes ☒ No ☐ N/A

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:

	Signature	Name	Emp. No.	Date	Time
Handover given by		Natriya	0240	12/1/24	9:30
Handover taken by		SUMA MATHEWAR	024	12/1/24	19:30
Document endorsed		JAYARAMAN	0002	12/1/24	19:30

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/12/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - DTD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

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: NEDA

On room air / oxygen: Room air

Complaints / New Symptoms in last shift: -

Date of surgery: 12/1/23

IV fluids on flow: NF NS - 30cc/hr

A

ASSESSMENT

Vital Signs: Temp: 98°F | Pulse / HR: 80 (beats/min) | Respiration: 23 (breaths/min)

BP: 120/83 (mmHg) | SpO₂: 98 (%) | Height: 166 (cms) | Weight: 655 (kgs) | BMI: 23.6 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:

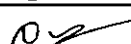
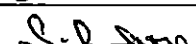
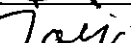
Pending lab reports / Investigations:

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		UMA MAHESWARI	0202	12/1/24	7:50
Handover taken by		S. Rave	0211	12/1/24	7:50
Document endorsed		JAY	0202	12/1/24	7:30

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24 Shift: ☒ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: not coupled, subcut

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD:

Central line days:

VIP Score: 0/5

B

BACKGROUND

Type of surgery: PCI to LAD & LEX

Allergies if any: NKDA

On room air / oxygen: Pt on Room Air

Complaints / New Symptoms in last shift:

Date of surgery: 12/01/24

IV fluids on flow: WF 30cc/hr on flow

A

ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 71 (beats/min) | Respiration: 20 (breaths/min)

BP: 112/62 (mmHg) | SpO₂: 99 (%) | Height: 160 (cms) | Weight: 65.5 (kgs) | BMI: 23.6 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:

Pending lab reports / Investigations:

Critical value alert and its corrections:


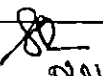


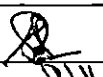

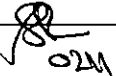

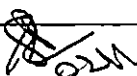


Changes in nursing care plan: ☐ Yes ☐ No. If Yes, modified care plan date:

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>S. P. Sore</i>	<i>S. P. Sore</i>	0211	13/1/24	16:20
Handover taken by	<i>S. P. Sore</i>	<i>M. D. Sore</i>	0022	13/1/24	16:30
Document endorsed	<i>S. P. Sore</i>	<i>S. P. Sore</i>	0022	13/1/24	16:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
12/01/21	<u>Morning Duty Notes</u>				
@ 7:30	⇒ Pt taken over from night duty Staff - Pt is conscious & oriented. Pt hemodynamically stable & recorded.	 0211			
7:40	⇒ T-98°F, P-70 bpm, R-20b/min; BP-119/72 mmHg, SpO2-98%.	 0211			
7:50	⇒ Pt lt cubital & ulnar/axillary line present & Patent. Inj. Nikomandil 1ml/hr infusion.	 0211			
8:00	⇒ Pt yesterday PCT to LAD & Lx done Pt radial approach no oozing & hematoma pressure bandage present.	 0211			
8:20	⇒ Pt had diet. no other complaints. Pt Medication given as per drug chart ⇒ Pt hourly I/O Chart maintained & recorded.	 0211			
9:30	⇒ Dr. Gnanavelu Sir seen the Pt afternoon ward shifting & T. Nicolson & T. Robinson and Pan Yong, Valentia	 0211			
11:00	⇒ Pt provide comfortable position. & Screaming Pains done. ⇒ Pt had diet. no other complaints. ⇒ Pt Medication given as per drug chart	 0211			
15:00	⇒ Pt one episode of fever informed to Dr. Valmusegen Sir advised to T. Dols bring to give. Advised to Pt shifted to ward.	 0211			
16:30	⇒ Pt shifted to ward Pt file reports. hand over to day staff.	 0211			
	<u>Recurred notes</u>				
16:45	⇒ patient received by car. Pt is stable.				
Document endorsed by	Signature	Name	Emp. No.	Date	Time
		J. J. J. J. J.	000	12/01/21	16:45



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/01/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: 0

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: PCI to LADP LCA

Date of surgery: 12/1/24

Allergies if any: NKDA

On room air / oxygen: RA

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 96.5°F | Pulse / HR: 76 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/60 (mmHg) | SpO₂: 97% | Height: 160 (cms) | Weight: 65.5 (kgs) | BMI: 23.6 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:

Drains: -

Normal diet

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:

Tomorrow plan discharge

	Signature	Name	Emp. No.	Date	Time
Handover given by	M. Revathi	M. Revathi	0225	12/1/24	7.30
Handover taken by	M. Revathi	M. Revathi	0225	14/1/24	7.30
Document endorsed	S. Nal PNP	S. Nal PNP	0024	14/1/24	18.20

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD < DVD

NEWS / PEWS Score: 0

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 CAD & LCA

Allergies if any: NKDA

On room air / oxygen: on RA

Complaints / New Symptoms in last shift: -

Date of surgery: 12/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 37.2 (°C) | Pulse / HR: 84/min (beats/min) | Respiration: 20/min (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 92 (%) | Height: 160 (cms) | Weight: 65.5 (kgs) | BMI: 23.6 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: (N) 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: Today: plan d/c

	Signature	Name	Emp. No.	Date	Time
Handover given by		B. Vanisi	0195	14/1/24	12.30
Handover taken by		S. Nalpan	0004	14/1/24	10.00
Document endorsed		S. Nalpan	0004	14/1/24	10.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
11/1/24	<u>Morning duty</u> <u>S/N Report</u>	
7.30	⇒ pt is taken over from night duty staff. ⇒ pt is conscious & oriented vitals are checked. ⇒ pt also Headache	<u>Chaf</u> <u>21/25</u>
9.00	S/B Dr. Siva Sir o/B to Add T. Dolo 600mg oral stat given. pt had a fever ⇒ Discharge medication was given as per doctor order. ⇒ pt Condition stable also any other Complaints. ⇒ pt Today Plan Discharge Billing closed. ⇒ patient handing over to Evening duty Staff Nurse	<u>Chaf</u> <u>21/25</u> <u>13/70</u>
	<u>Discharge Notes</u>	
11.00.	⇒ patient today discharge ⇒ patient conscious & oriented ⇒ patient IV Line Removal ⇒ patient all reports handing over to patient and patient attender	<u>Chaf</u> <u>21/25</u> <u>13/70</u>
12.30		
Document endorsed by:	Signature <u>Nice</u>	Name <u>S. V. P. N. P.</u>
		Emp. No. <u>2024</u>
		Date <u>11/1/24</u>
		Time <u>12.30</u>

ADULT NURSING CARE PLAN

Mr. KANNAN GOVINDHAN
44/Male/MHI202481768
12/01/2024/IPH2024000099
Dr. G. GNANAVELU

MHI/NUR/2022/044


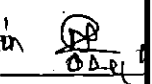


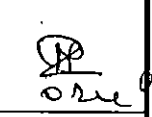
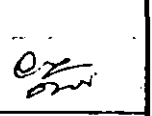
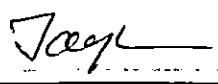


Every heart beat counts

Initial Date: 12/1/24 Time: 8:00		Modified Date: Time:	
Reason for Modification:		Diagnosis: COPD - DIED	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Patient had NPO E pt had @ diet N pt had @ diet
OXYGENATION <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Patient on Room Air E pt on Room Air N pt on room air
FLUID & ELECTROLYTES <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M I/O Chart Monitor E IVP NS - 30cc/hr N IVP NS - 30cc/hr

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input checked="" type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell. <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Good communication E verbal communication N pt vitals checked & record	  
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input checked="" type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Medication given as per drug chart E medicine given as per drug chart N medication given as per chart	  
Endorsed by	Signature	Name	Emp. ID	Date	Time
		JALADES	000	3/1/24	10:20

ADULT NURSING CARE PLAN

Mr. KANNAN GOVINDHAN

44 / Male / MHI202481768

12/01/2024 / IPH2024000099

Dr. G. GNANAVELU



MHI/NUR/2022/044









Every heart beat counts

Initial Date: 12/1/24		Time: 12:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD - DUD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M				
			E pt had				
			N/A had diet	[Signature]			
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M				
			E				
			N SpO ₂ - 98%	[Signature]			
FLUID & ELECTROLYTES <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M				
			E				
			N 2/0 chest cry monitored	[Signature]			


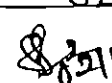
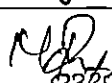
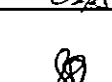
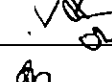
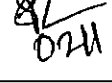
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E N pt mobilized well	
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input checked="" type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continnence or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M E N @ 12:00 AM putten @	
SKIN INTEGRITY <input type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M E N	

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Signature & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver to the patient <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M E N pt communicated well	[Signature] [Initials]
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M E N	[Signature] [Initials]
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	C. Nalini	0024	12/11/24	9:00

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt on bed mobilized	
			E patient was bed mobilized	
			N Pt slowly mobilized	M.D. 05/25
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenc / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Pt @ elimination pattern	
			E elimination pattern was normal	
			N Normal Elimination Pattern	M.D. 05/25
SKIN INTEGRITY <input type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Pt maintain @ skin integrity	
			E Maintained skin integrity	
			N maintain normal skin intact	M.D. 05/25

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M Pt Clean & well groomed	Don
			E patient stay cleaned	Don
			N Pt good hygiene	MD 02/11
SAFETY <input checked="" type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV <input type="checkbox"/> CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M Pt IDband Present	Don
			E No band (+)	Don
			N ID Band present	MD 02/11
COMFORT AND SLEEP <input checked="" type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input checked="" type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M Pt Provide comfortable position	Don
			E provided privacy	Don
			N provide comfort position	MD 02/11
OBSERVATION <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M Pt V/S checked & recorded	Don
			E vitals stable	Don
			N vital signs checked & recorded	MD 02/11
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input checked="" type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M Provide Psychological Support	Don
			E provided Psychological support	Don
			N	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt Communication well E maintained good rapport N Pt 4000 communication	  
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Pt Medication given as per chart E medication given as per chart N Medication given as per chart	  
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Jay	JANARDAN	0000	12/1/24	1000

ADULT NURSING CARE PLAN

Mr. KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr. G. GNANAVELU



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 14/1/24		Time: 8.00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD-DVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M pt on N Diet E N	[Signature] [Initials]			
OXYGENATION <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on Room Air E N	[Signature] [Initials]			
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M I/O chart maintained E N	[Signature] [Initials]			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Bedridden / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Emboic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M <i>pt well mobilized</i> E N	<i>Ch</i> <i>01/05</i>
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input checked="" type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M <i>pt self voided</i> E N	<i>Ch</i> <i>01/05</i>
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M <i>Maintain (N) skin intact</i> E N	<i>Ch</i> <i>01/05</i>

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M pt verbal communicated E N	[Signature] 2/15
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Due medication given E N	[Signature] 2/15
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	S. ual/NP	0024	1/11/24	1620



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully 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			4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours			4
MOBILITY ability to change and control body position	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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation			4
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum 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		23
					Initial & Emp. No. of Staff Nurse:		101
					Initial & Emp. No. of Sr. Staff Nurse:		101

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully 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. Barely Moist Skin is usually dry, linen only requires changing at routine intervals	4	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	4	4	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	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy 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, dairy 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 dairy 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	19	17
Initial & Emp. No. of Staff Nurse:					12/1/24	12/1/24	12/1/24
Initial & Emp. No. of Sr. Staff Nurse:					12/1/24	12/1/24	12/1/24

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



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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	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	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	2	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 dairy 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, dairy 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 dairy 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	18	18
Initial & Emp. No. of Staff Nurse:					[Signature]		
Initial & Emp. No. of Sr. Staff Nurse:					[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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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	3	1	24
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	1	24
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	1	24
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	1	24
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 IVs 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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation	3	1	24
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	1	24
					TOTAL SCORE	92	
					Initial & Emp. No. of Staff Nurse:	200	
					Initial & Emp. No. of Sr. Staff Nurse:	200	

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

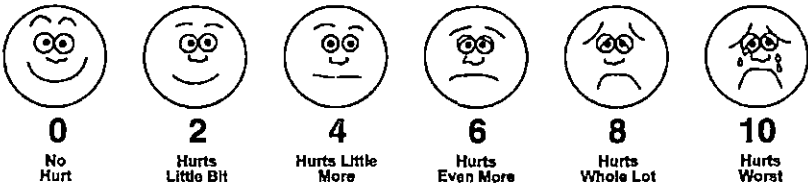
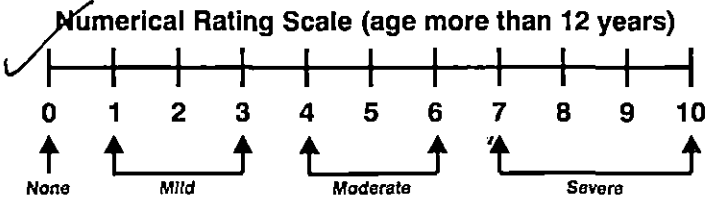


PAIN RE-ASSESSMENT & MONITORING CHART

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.
12:00	0/10	No pain	-	-	-	[Signature] 0220	Nar 0220
6:00	0/10	No pain	-	-	-	[Signature] 0220	Nar 0220
10:00	0/10	No pain	-	-	-	[Signature] 0220	Nar 0220
PT Received from ICU @ 16:00							
16:00	0/10	No pain	-	-	-	[Signature] 0220	Jay 0220
17:00	0/10	No pain	-	-	-	[Signature] 0220	Jay 0220
18:00	0/10	No pain	-	-	-	[Signature] 0220	Jay 0220
19:00	0/10	No pain	-	-	-	[Signature] 0220	Jay 0220
20:00	0/10	No pain	-	-	-	[Signature] 0220	Jay 0220

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.
9:00	0/10	No pain	-	-	-	Q 6208	Jay 6000
22:00	0/10	No pain	-	-	-	Q 6208	Jay 6000
23:00	0/10	No pain	-	-	-	Q 6208	Jay 6000
00:00	0/10	No pain	-	-	-	Q 6208	Jay 6000





PAIN SCALES

PIPPS (28 weeks to \leq 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological 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)		Numerical Rating Scale (age more than 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-conductive 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 - Interferential therapy Psycho-social therapy/counseling: K - Individual Counseling; L - Family counseling	


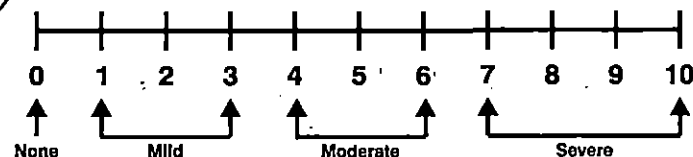
Pharmacological Interventions as per doctor's prescription

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.
12/1/24 01:00	0/10	No pain	-	-	-	one	Jay 200
02:00	0/10	No pain	-	-	-	one	Jay 200
03:00	0/10	No pain	-	-	-	one	Jay 200
04:00	0/10	No pain	-	-	-	one	Jay 200
4:30	2/10	Achy	30 mins	Heret Back side	on pharmacological action	one	Jay 200
05:00	1/10	Dull	30 mins	if	on pharmacological action	one	Jay 200
06:00	0/10	No pain	-	-	-	one	Jay 200
07:00	0/10	No pain	-	-	-	one	Jay 200
08:00	0/10	No Pain	-	-	-	one	Jay 200

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 9:00	0/10	No pain	—	—	—	 0241	Jag 0241
10:00	0/10	No pain	—	—	—	 0241	Jag 0241
11:00	0/10	No pain	—	—	—	 0241	Jag 0241
12:00	0/10	No pain	—	—	—	 0241	Jag 0241

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 - Pharmacological 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)	 <div> Numerical Rating Scale (age more than 12 years)  </div>
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 - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling

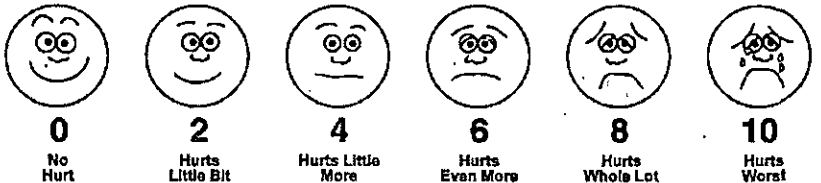
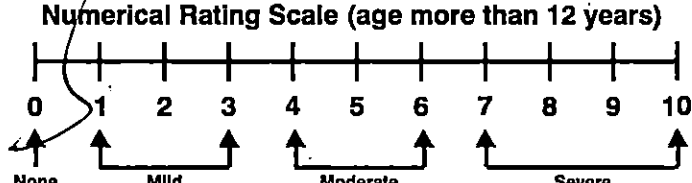
Pharmacological Interventions as per doctor's prescription

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 13:00	0/10	no pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu
14:00	0/10	No pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu
15:00	0/10	No pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu
16:00	0/10	No Pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu
20:00	0/10	NO Pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu
21/1/24 00:00				Patient sleep & happy			
7:00	0/10	NO Pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu
8:00	0/10	no pain	—	—	—	Dr. G. Gnanavelu	Dr. G. Gnanavelu

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



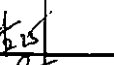
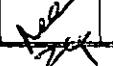
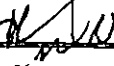
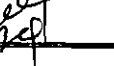
PIPPS (28 weeks to \leq 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention					
CRIES (38 weeks - 2 months)	The CRIES scale is used for Infants > than or = 38 weeks of gestation. A maximal score of 10 is 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)						Numerical Rating Scale (age more than 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 - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling					

Pharmacological Interventions as per doctor's prescription



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	Time					
		12/1/24	2:20	8:00	7:00			
S. No.	PARAMETERS							
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 ESKD / 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		<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								



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Mr. KANNAN GOVINDHAN
Patient 44/Male/MHI202481768
Name 12/01/2024/IPH2024000099
UHD Dr. G. GNANAVELU
DOB: [Barcode]

MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	12/1/24	12/1/24	12/1/24	12/1/24	13/1/24	13/1/24	13/1/24	14/1/24	
	Time	2:00	2:00	16:00	20:00	8:00	18:00	20:00	8:00	
History of falling (immediate or within 6 months)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	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		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	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		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0
Yes	15	15	15	15	15	15	15	15	15	15
Total Score		30	35	50	45	50	50	50	50	
Low Risk (0 - 24)										
Medium Risk (25 - 44)		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>							
High Risk (45 or above)				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Signature & Emp. No. of RN		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Signature & Emp. No. of Sr. RN		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	

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

[illegible]

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions

Completed By : Date 21/12/24 Time 2:00 Nurse Signature : [Signature]

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Disease	21/12/24				13/1/25				14/1/25				Doctor
<input checked="" type="checkbox"/> Information on Disease / Diagnostics													[Signature]
<input checked="" type="checkbox"/> Treatment													
Medications													Doctor / Nurse
<input checked="" type="checkbox"/> Information on Safe and Effective use of medicines													[Signature]
<input type="checkbox"/> Information on drug / drug and drug / food interactions													
<input type="checkbox"/> Discharge Medications													
Surgical Instructions													Nurse
<input checked="" type="checkbox"/> Pre - Operative Instructions													[Signature]
<input type="checkbox"/> Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
<input checked="" type="checkbox"/> Reporting of pain													
<input checked="" type="checkbox"/> Pain Management													[Signature]
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment													
Rehabilitation Techniques													[Signature]

Pr: [Signature]

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
<input checked="" type="checkbox"/> Diet Instruction for patients at Nutritional risk			NA			P	NA			P	NA		<i>[Signature]</i>
<input type="checkbox"/> Diet advice for home													Nurse
Discharge Planning													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													
<input type="checkbox"/> Smoking Cessation													Doctor
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> 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)

- K. Kavitha

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	<input checked="" type="checkbox"/>			Diet Advice	<input checked="" type="checkbox"/>		
ECG Report	<input checked="" type="checkbox"/>			CT Scan Report			
Doppler Report				CT Scan Film			
X-Ray Report				ECHO Report	<input checked="" type="checkbox"/>		
X-Ray Film				Ultrasound Report			
Compact Disk	<input checked="" type="checkbox"/>			Any Other Report			

Name of Attendant / Patient : K. Kavitha Signature : K. Kavitha

Name of Discharge Nurse M. Devita Signature : *[Signature]*



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Mr. KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/1PH2024000099

Dr.G. GNANAVELU



MHI/ICU/2022/056



Every heart beat counts

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 12/1/24 Time: 02:00

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. ANUSUYA	184559	2/1/24	2:00
Nursing Staff		A. monisha	5161	2/1/24	2:00
Dietician		Maria Colomin	2407	12/1/24	16:00
Physiotherapist					
Patient Care Service Staff					



IN-HOUSE TRANSFER FORM

Part A (to be filled by Nurses)

Date of Transfer: 13/1/24 Time: 4pm Transferred from: CW To: Ward

Diagnosis: CAD / DVT / SOB

Vital Signs: Temp: 98.6°F | Pulse / HR: 91 (beats/min) | BP: 139/90 (mmHg) | Respiration: 18 (breaths/min)

Part B (to be filled by Physicians)

Any Critical Investigations: _____

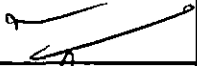

Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	<input checked="" type="checkbox"/> Clear <input type="checkbox"/> Crepitation <input type="checkbox"/> Rhonchi <input type="checkbox"/> Others: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdomen	<input checked="" type="checkbox"/> Soft <input type="checkbox"/> Tender <input type="checkbox"/> Distended <input type="checkbox"/> Others: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Sound	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Feeble <input type="checkbox"/> Loud <input type="checkbox"/> Others: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
CNS	<input checked="" type="checkbox"/> Conscious <input type="checkbox"/> Oriented GCS Score: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Surgical Patients (if applicable)	Surgical Site: <input type="checkbox"/> Healthy <input type="checkbox"/> Soakage <input type="checkbox"/> Others: _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	Tib. Escapkin	7mg	p/o	OD	Today	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	As - Axxon	9mg	p/c	BD	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Axxon	8mg	"	"	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Quat par MD	1kg	"	"	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	TAL - MET XL	2mg	p/o	OD	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	TAL - MET XL	2mg	"	BD	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Axxon - M	3mg	"	OD	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Axxon	0.5mg	"	HS	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Axxon	10mg	"	Wash	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Nicodine	5mg	p/o	BD	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
	As - Ureter	0.5mg	SL	BD	"	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details (if any):

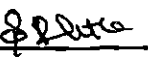

Patient Condition: ☒ Stable ☐ Sick-need urgent care ☐ Others: _____

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		Dr. Venu	95465	13/1/24	4m.
Receiving Doctor		Dr. Anusuya	134559	13/1/24	16:30


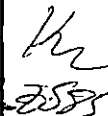
Part C (to be filled by Nurses)

Check for	Transferring Nurse	Receiving Nurse
Drains	<input type="checkbox"/> Chest <input type="checkbox"/> Abdominal <input checked="" type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	Air Way Type: <input type="checkbox"/> Patent <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others: _____ Oxygen Therapy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes via: _____ Rate: _____ li/min	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
NG Tube / Oral	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> For Feeding <input type="checkbox"/> Gastric Suction <input type="checkbox"/> Fluid Restriction	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Foley's Catheter	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Intravenous Access	<input checked="" type="checkbox"/> Peripheral Line <input type="checkbox"/> Central Venous Line <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pressure Injury	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Score	Fall Risk: 50 WELLS: _____ NEWS / PEWS: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Belongings	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Handover Details	Medication Administration Record explained: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Lab & Diagnostic Reports handed over: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Attendant Informed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		S. Puemalatha	0211	13/01/24	16:30
Receiving Nurse		R. Susha	0801	13/1/24	16:30

FAMILY COUNSELLING FORM

CONSULTANT- DR. Gnanavelu			DIAGNOSIS-			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
12/11/24	Doctor		family updated	-	Per	 2010
13/11/24	Doctor	Doctor	family updated	-	Brake	 2555

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : **Mr.KANNAN GOVINDHAN**

IP No. / UHID No

44/Male/MHI202481768

AGE / SEX :

12/01/2024/IPH2024000099

Ward / Bed No. *C-20 (2)*

Dr.G. GNANAVELU



BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
<i>11/1/24</i>							
	<i>20:00</i>	<i>LT cubital</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>followed</i>	<i>[Signature]</i>
<i>12/1/24</i>	<i>8:00</i>	<i>LT cubital</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>followed</i>	<i>[Signature]</i>
	<i>14:00</i>	<i>LT cubital</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
	<i>20:30</i>	<i>LT cubital</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>followed</i>	<i>[Signature]</i>
<i>13/01/24</i>	<i>8:00</i>	<i>LT cubital</i>	<i>0/5</i>	<i>Patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
	<i>14:00</i>	<i>LT cubital</i>	<i>0/5</i>	<i>Patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
		<i>LT cubital</i>		<i>line removed</i>			
<i>12/1/24</i>	<i>14:00</i>	<i>LT metacarpal</i>	<i>0/5</i>	<i>Patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
	<i>20:30</i>	<i>LT metacarpal</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
<i>13/01/24</i>	<i>8:00</i>	<i>LT metacarpal</i>	<i>0/5</i>	<i>Patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
	<i>14:00</i>	<i>LT metacarpal</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
	<i>20:00</i>	<i>LT metacarpal</i>	<i>0/5</i>	<i>patent</i>	<i>flushed</i>	<i>followed</i>	<i>[Signature]</i>
	<i>2:00</i>	<i>LT metacarpal</i>	<i>0/5</i>	<i>Patent</i>	<i>flushed</i>	<i>Followed</i>	<i>[Signature]</i>
<i>14/1/24</i>				<i>line removed</i>			



REQUISITION FOR MEDICINE

IP No. :

DOA :

UHID No. :

Room No. :

[illegible]**Pharm Bill & Name**



REQUISITION FOR MEDICINE

IP No. :

DOA :

UHID No. :

Room No. :

[illegible]

Nurse Name

Pharm Bill & Name


Medway Hospitals®
The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)


Where heart beat never stops...
REQUISITION FOR MEDICINE

IP No. :

DOA :

UHID No. :

Room No. :

150

Name of Patient :

Age / Sex :

Consultant Name :

S.No.	Date	Medicine Name	Qty.
1	10/10/2022	1. Amoxicillin	1
2	"	2. Paracetamol	2
3	"	3. Metformin	3
4	"	4. Clopidogrel	3
5	"	5. Aspirin	1
6	"	6. Atorvastatin	5
7	"	7. Lisinopril	2
8	"	8. Folic Acid	2
9	"	9. Vitamin B12	1
10	"	10. Calcium	1

Nurse Name

Pharm Bill & Name



MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1

Height (cms): 160cm

Weight (kg): 68.5kg

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

Drug Details

Description of Allergy

Doctor's Sign:

NKDA

Not known

Name: DR. ANUSUYA

Reg. No. 134559

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: Q24hly: 10:00hrs, Q12hly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hly: 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
21/12/24	13:55	INJ: NTG	200mcg	IV	[Signature]	93729	[Signature]	0202	13:55
21/12/24	13:55	INJ: HEPARIN *	2500	IV	[Signature]	93729	[Signature]	0202	13:55
21/12/24	14:15	INJ: FENTANYL *	25mcg	IV	[Signature]	93729	[Signature]	0202	14:15
21/12/24	14:15	INJ: EMESET	4mg	IV	[Signature]	93729	[Signature]	0202	14:15
21/12/24	14:15	INJ: HEPARIN *	5000	IV	[Signature]	93729	[Signature]	0202	14:15
21/12/24	14:25	INJ: TIROFIBAN *	100mg	IV	[Signature]	93729	[Signature]	0202	14:25
21/12/24	14:35	INJ: MIDAZOLAM	1mg	IV	[Signature]	93729	[Signature]	0202	14:35
21/12/24	15:15	INJ: MIDAZOLAM	1mg	IV	[Signature]	93729	[Signature]	0202	15:15
21/12/24	15:20	INJ: HEPARIN	1500	IV	[Signature]	93729	[Signature]	0202	15:20
21/12/24	15:30	TAB: SORBITRATE	5mg	ORAL	[Signature]	93729	[Signature]	0202	15:30
21/12/24	15:30	TAB: SORBITRATE	5mg	ORAL	[Signature]	93729	[Signature]	0202	15:40
21/12/24	15:45	INJ: PANTOPRAZOLE	40mg	IV	[Signature]	93729	[Signature]	0202	15:45
21/12/24	17:35	INJ: HEPARIN	1000	IV	[Signature]	93729	[Signature]	0202	
21/12/24	17:55	INJ: HEPARIN	1000	IV	[Signature]	93729	[Signature]	0202	

ANTIMICROBIALS
To be filled in by Doctors only

Date → To be filled by Nursing Staff only. Sign and time given

Time ↓

DRUG NAME

T. METXL

Dose

25MG

Route

P/O

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

K.M

134579

Start Date & Time

12-01-24 20:00

Stop Date & Time

Additional Info:

DRUG NAME

T. NETRO CONTIN

Dose

2.6MG

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K.M

134579

Start Date & Time

12-01-24 2:00

Stop Date & Time

Additional Info:

DRUG NAME

T. FLAVEDON MR

Dose

85MG

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K.M

134579

Start Date & Time

12-01-24

Stop Date & Time

Additional Info:

DRUG NAME

T. ALPRAX

Dose

0.5MG

Route

P/O

Frequency

0-0-1

Dr. Sign & Reg. No. / Seal

K.M

134579

Start Date & Time

12-01-24 21:00

Stop Date & Time

Additional Info:

DRUG NAME

SYP. CREMOPREDN

Dose

15ML

Route

P/O

Frequency

0-0-1

Dr. Sign & Reg. No. / Seal

K.M

134579

Start Date & Time

12-01-24 21:00

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

Uad

Uad

Uad

Uad

Uad

Uad

Uad

Uad

Uad

Uad

Uad

ANTIMICROBIALS
To be filled in by Doctors only

Date → To be filled by Nursing Staff only. Sign and time given

Time ↓

DRUG NAME

T. NICODUCE

Dose

5mg

Route

P.O

Frequency

1-2

Dr. Sign & Reg. No. / Seal

[Signature]
9322

Start Date & Time

12/1/24 8pm

Stop Date & Time

Additional Info:

8:00

20:00

DRUG NAME

Dr. GEMME

Dose

0.6ml

Route

S.C

Frequency

3x

Dr. Sign & Reg. No. / Seal

[Signature]
4007

Start Date & Time

13/1/24 @ 5:30

Stop Date & Time

Additional Info:

1

5:30

5:30

17:30

DRUG NAME

T. PEF. NORM

Dose

10g

Route

P.O

Frequency

4-0-6

Dr. Sign & Reg. No. / Seal

[Signature]
85851

Start Date & Time

13/1/24 @ 09:00

Stop Date & Time

Additional Info:

8:00

20:00

DRUG NAME

T. NIKORAN

Dose

5g

Route

P.O

Frequency

1-2

Dr. Sign & Reg. No. / Seal

[Signature]
85851

Start Date & Time

13/1/24 @ 9:00

Stop Date & Time

13/1/24 @ 14:00

Additional Info:

8:00

20:00

DRUG NAME

T-PAN

Dose

40g

Route

P.O

Frequency

1-2

Dr. Sign & Reg. No. / Seal

[Signature]
1381

Start Date & Time

13/1/24 @ 9:00

Stop Date & Time

Additional Info:

7:00

19:00

Area In-charge

Nurse Signature:

[Signature]
[Signature]
[Signature]

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

AS REQUIRED PRESCRIPTIONS

Date →

To be filled by Nursing Staff only. Sign and time given

Time ↓

13/11/14/01

DRUG NAME

T. VALZAMIDE

Dose

100

Route

PO

Frequency

Q-7

Dr. Sign & Reg. No. / Seal

12/11/24 @ 9:00

Start Date & Time

Stop Date & Time

20:00

20:00

Additional Info:

DRUG NAME

INTJ. PARA

Dose

1g

Route

IV

Frequency

SOS

Dr. Sign & Reg. No. / Seal

14/11/23 @ 4:00

Start Date & Time

Stop Date & Time

4:00

4:00

Additional Info:

DRUG NAME

SYMP. SUCROFATE

Dose

250

Route

PO

Frequency

1-2-7

Dr. Sign & Reg. No. / Seal

14/11/23

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:

12/11/24

INJECTION PRESCRIPTION AND ADMINISTRATION

[illegible]

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
12-1-24	2:00	Low salt, low fat	KM	134559					
12-1-24	8:00	NPO	KMD	134559					
12/1/24	16:00	Normal diet	ES	71810					
13/1/24	8:00	Normal diet	Kr	35851					
14/1/24	8:00	Normal diet	KMD	134559					

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			
	Evening					Evening			
12/1/24	Night	A. Jony Le.	0141	A		Night			
12/1/24	Morning	A. Manthir	0142	A		Morning			
12/1/24	Evening	A. Manthir	0240	A		Evening			
12/1/24	Night	UMA MANGSWARI	0208	S.		Night			
13/1/24	Morning	S. Premadevna	0211	S		Morning			
13/1/24	Evening	S. Premadevna	0211	S		Evening			
13/1/24	Night	E. Catherine	0807	E-C		Night			
14/1/24	Morning	B. Varian	0195	B		Morning			
	Evening					Evening			
	Night					Night			

MR.KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/1PH2024000099

Dr.G. GNANAVELU



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Stat / Once Only / Premedication Drugs

[illegible]



A

UHID NO : 202481768 AGE : 444 SEX : M

SURGICAL PROCEDURE: PTCA to LAD & LCx

POSTOP DAY : 21

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.		
8:00	300	300					300					150	150	150	150
9:00	-	300					300					-	150	150	150
10:00	-	300					300					-	150	150	150
11:00	-	300					300					100	250	250	50
12:00	-	300					300					-	250	250	50
13:00	200	500					500					-	250	250	250
14:00	-	500					500					50	300	300	200
15:00	500	1000					1000					100	400	400	600
16:00	-	1000					1000					-	400	400	600
SPECIFIC OBSERVATIONS/REMARKS								MEDICATION / DRUGS							

MH1/ICU/2022/064



MR. KANNAN GOVINDHAN

44/Malc/MH1202481768

12/01/2024/IPH2024000099

NAME : Dr.G. GNANAVELU

UHID NO :

AGE : 44y

SEX : M

SURGICAL PROCEDURE: PTCA + OLCA + LAD

POSTOP DAY : 1

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.	IVF	INJ	INJ	H.T.	H.T.	G.T.		
						450	30	7	4				600		
12/1/24															
16:00	-	-				450	30	7	4		100	100	715	287	
17:00	-	-				450	30	7	4		-	-	717	324	
18:00	-	-				450	30	7	4		-	-	821	361	
19:00	-	-				450	30	7	4		100	200	952	502	
20:00	-	-				450	30	7	4		100	300	1063	613	
21:00	-	-				450	30	7	4			300	1104	654	
22:00	-	-				450	30	7	4			300	1145	695	
23:00	100	100				550	30	7	4			300	1186	636	
00:00	-	100				550	30	21C	4		-	300	1220	670	
01:00	-	100				550	30		4		100	400	1354	804	
02:00	-	100				550	30		4		-	400	1388	838	
03:00	-	100				550	30		4		-	400	1422	872	
04:00	800	900				1350	30		4		-	400	1456	106	
05:00	-	900				1350	30	21 PARA 100ml	4		-	400	1590	240	
06:00	-	900				1350	30		4		-	400	1624	274	
07:00	-	900				1350	30		4		-	400	1658	308	
SPECIFIC OBSERVATIONS/REMARKS							MEDICATION / DRUGS								

MHI/ICU/2022/064



Medway
Heart
Institute

Every heart beat counts