

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



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Pat: Mrs.UMA P
Na: 56/Female/MHI202381+95
UH: 10/01/2024/IPH2024000083
DD: Dr.G. GNANAVELU
DO:
Con:

MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Benaravdu Speciality: Cardiologist

Advised Date & Time: 10/11/24 @ 10:35am

Provisional Diagnosis: Calcific CAD & RCA disease

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):

PTCA FIVUS

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: 15000/- approved

Instructions to Nurse (if any):

→ to do Hb, RBS, S. creatinine
& ECG - billing done in OPD.

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

Dr. G. Gnanaavelu

Dr. Gnanaavelu

39469

10/11/24

10:35am

For admission desk staff only:

Room Category: ☐ General Ward

☒ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others _____

Admission Intimation Receipt Details

Date

Time

10/11/24

10:34am

Admission Time in HIS

Date

Time

10/11/24

10:40

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

Prithi KP

Prathiba

0192

10/11/24

10:40



ADMISSION FORM

Marital Status M	Full Address No 56/93 Dr Radhakrishnan Nagar Thiruvottriyur Chennai - 15		Telephone Number 9840572276
Occupation III			
Referred from Dr. C. G	Date of Time of Admission 10/1/24 10:40	Date & Time of Discharge 12/1/24 at 8:30	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 - SIGNIFICANT CALCIFIC LAD & RCA	I25.1
DURABLE (26.12.23) BIFASCULAR BLOCK.	
NORMAL LV FUNCTIONAL TYPE II DIABETES	I50.1
MELLITUS HYPOTHYROIDISM,	E11.9
DYSLIPIDEMIA	E03.9
	E78.5

DATE	OPERATION / PROCEDURES	ICPM Code
10/1/24	SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD USING RESOLUTE ORLYX 2.75X26MM & PTCA + STENT TO RCA USING SYNERGY 2.75X16MM DONE ON 10.1.24	00.66
DATE	TYPE OF ANESTHESIA	
10/1/24	<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. 34409 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 மதிப்பிடக்கூடி 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.

செனிலியர் கையொப்பம்

தேதி

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of Admitting Nurse

Date

Signature of the Patient / Relative / Gurdian

10/1/24

Alone

உறவுமுறை Husband

Nature of Relationship



GENERAL CONSENT FOR ADMISSION



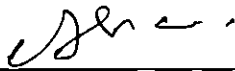
I, uma. P the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient		P. Uma	10.1.24	10:45
Surrogate/Guardian (if applicable #)		P. ARUNACHALAM (Write name and relationship with patient)	10/1/25	10:48
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		P. ARUNACHALAM	10/1/23	10:40
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.	IPH2024000083	D.O.A	: 10/01/2024
UHID	MHI202381495	D.O.P	: 10/01/2024
Name	Mrs. UMA. P	Room No.	: 112
Age / Gender	56Years / FEMALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 12/01/2024

DIAGNOSIS:

CAD – SIGNIFICANT CALCIFIC LAD & RCA DISEASE (26.12.2023)

BIFASCICULAR BLOCK

NORMAL LV FUNCTION

TYPE II DIABETES MELLITUS

HYPOTHYROIDISM

DYSLIPIDEMIA

PROCEDURE:

SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD USING RESOLUTE ONYX 2.75 X 26 MM & PTCA + STENT TO RCA USING SYNERGY 2.50 X 16 MM DONE ON 10.01.2024.

BRIEF HISTORY:

Mrs. Uma. P, 56 years old Female, Presented with complaints of chest pain & shortness of breath (NYHA class-II) .She underwent Coronary angiogram on 26.12.2024 which revealed CAD – **SIGNIFICANT CALCIFIC LAD & RCA DISEASE**. Hence she was advised for **IVUS GUIDED PCI to LAD & RCA** for which she has been admitted.

No H/O fever, cough, pedal edema, vomiting, diarrhea.

Known case of Type II diabetes mellitus, hypothyroidism and dyslipidemia.

N/K/C/O systemic hypertension , CVA.

ALLERGY: SULPHA

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

P I C C L E - NIL

HR - 92bpm

BP - 130/90mmHg

SPO₂ - 99% in room air

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1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118



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UHID: MHI202381495

IP.NO: IPIH2024000083



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

INVESTIGATIONS:

BLOOD(10.12.23): Hb- 12.0gm/dl, Creatinine – 0.47mg/dl, Na+- 138mmol/l, K+- 3.51mmol/l,

ECG: Sinus rhythm, HR – 78 bpm, PVC(+)

ECHO: Normal valves & chambers. No wall motion abnormality. Normal LV function. EF – 75%. Normal pulmonary artery pressures. Occasional ventricular ectopic.

POST PROCEDURE INVESTIGATIONS:

BLOOD(11.12.23): Urea – 13 mg/dl, Creatinine – 0.51mg/dl.

ECG: : Sinus rhythm, HR – 82 bpm, PVC(+)

ECHO: S/P PTCA. Chambers normal sized. No RWMA. Normal LV systolic function. EF – 62%. Grade I diastolic function. Normal RV systolic function. All valves are normal. IAS /IVS intact. Trivial MR. Trivial TR. No PAH. No pericardial / pleural effusion. No clot / vegetation.

COURSE IN THE HOSPITAL:

Mrs. Uma. P, 56 years old Female, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, She underwent **SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD USING RESOLUTE ONYX 2.75 X 26 MM & PTCA + STENT TO RCA USING SYNERGY 2.50 X 16 MM DONE ON 10.01.2024** by Right femoral approach. Post procedure period was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. She was treated with DAPT, statin and other supportive measures. Her general condition improved & Right femoral site normal, no hematoma/ bleeding. She got shifted to ward, RFT within normal limits, maintained adequate fluid balance. Her medications are optimized and she 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

PR - 80/min

BP - 130/70mmHg

SPO2 - 97% in room air

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IP.NO: IPH2024000083



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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	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. AX CER	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. CREVAST	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. CORDARONE	200 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. CALBRIT	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. EVION LC	1 TAB	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. FOURTS B	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. THYROX	75 MCG	1	0	0	ORAL	EMPTY STOMACH	TO CONTINUE
9.	TAB. REMMAG	400 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. PANTOCID	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
11	SYP. CREMAFFIN	15 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

+ DIABETES MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. TRIVOLIB	1 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. STALIX	50 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE

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NAME: MRS. U.A. P
JCI ACCREDITED NABH ACCREDITED

UHID: MHI202381495

IP.NO: IPH2024000083



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DISCHARGE ADVICE	
DIET	LOW FAT & DIABETIC DIET.
PHYSICAL ACTIVITY	AS TOLERATED.
REVIEW	REVIEW WITH DR.GNANA VELU AFTER 1WEEK 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.

CONSULTANT SIGNATURE

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

Typed by: Ezhilarasi.

"I understood the Content of the
discharge summary."

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

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INPATIENT INITIAL ASSESSMENT

Date:

10/1/24

Time of arrival in ward: 12.00

Allergies (if Yes, specify details):

Drugs

☒ Yes ☐ No

Sulfa Allergy

Blood Transfusion

☐ Yes ☒ No

Food

☐ Yes ☒ No

Others

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 92 (beats/min) | BP: 180/90 (mmHg)

Respiration: 22 (breaths/min) | SpO₂: 99 (%) | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 25.6 kg/m²

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

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

Duration:

Location:

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

56 yrs old female k/c/o T2DM came with
Complaints of Shortness of Breath less on (NYHA - class II)
& 3 days:

- no H/o Palpitation

- no H/o fever, vomiting, loose stools

- no H/o urine output.

Patient came for PTCA & LAD & RCA

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☒ Yes ☐ No. If Yes, duration: 16 yrs Hypertension: ☐ Yes ☒ No. If Yes, duration:

Others:

N/A / Bronchial Asthma / COPD / Pulmonary TB / CKD / epilepsy

Past Surgical History:

N/A

Present Medication (for Medication Reconciliation):

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	T. Trivolib	1mg	Pb	1-0-1	9/1/24 9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2.	T. Founts B	1tab	Pb	1-0-0	9/1/24 9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.	T. Statix	5mg	Pb	1-0-1	9/1/24 9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4.	T. Calbrit.	1tab	Pb	1-0-0	9/1/24 9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5.	T. Thyrox	75mcg	Pb	1-0-0	9/1/24 9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6.	T. Ranzex	50mg	Pb	1-0-0	9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7.	T. Evion LC	1tab	Pb	0-0-1	9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8.	T. Pantocid	40mg	Pb	1-0-1	9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9.	T. Ecosprin	75mg	Pb	0-1-0	9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10.	T. Axxen	90mg	Pb	1-0-1	9/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Family History:

11. T. Cerebral
Nil

4mg Pb 0-0-1 9/1/24

Yes / No

Personal / Social History (Tick whichever is applicable)

Lifestyle: ☐ Sedentary ☒ Active Occupation: _____

Smoking: ☐ Yes ☒ No

Alcohol: ☐ Yes ☒ No

Recreational Drug Use: ☐ Yes ☒ No

Others: _____

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

obstetric code: P2 A0.

Patient attained menopause 10yrs before.

General Physical Examination:

Pallor: ☐ Yes ☒ No

Icterus: ☐ Yes ☒ No

Clubbing: ☐ Yes ☒ No

Edema: ☐ Yes ☒ No

Lymphadenopathy: ☐ Yes ☒ No

SYSTEMIC EXAMINATION

CVS:

S1 S2 ⊕, no murmurs

Respiratory System:

BAE ⊕, no added sounds

Gastrointestinal System:

Soft, NT, no organomegaly

Central Nervous System:

No focal neurological deficit

Urinary / Reproductive / Locomotor System:

(N)

Skin / Ophthalmic / ENT

(N)

Suspected of contagious disease: ☐ Yes ☒ No

Immuno compromised status: ☐ Yes ☒ No

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

Psychological Evaluation:

☒ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

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

Weight loss within the last 3 months? ☐ Yes ☒ No

Is the patient severely ill? (e.g. in Intensive Therapy) ☐ Yes ☒ No

Reduced dietary intake in the last week? ☐ Yes ☒ No

Is the BMI < 20.5? ☐ Yes ☒ No

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

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

Provisional Diagnosis: T2DM | Calcific LAD & RCA disease | Dyslipidemia / Hypothyroidism

Plan of Care:

- Plan: PICA + IVUS. (Today.) LAD & RCA.
- NPO from 10³⁰ AM.
- Monitor vitals
- No follow day chart
- Consent.

Investigations Advised:

To do Hb, RBS,

Sr. Creatinine

Diet Advice:


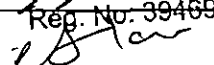
- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: low salt, low fat

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 checked="" type="checkbox"/> No	If Yes, specific education given

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. Mohamedhy dross	165302	10/11/24	12.00
Consultant	Dr. G. GRANAVALU Reg. No. 39469	Dr. Ananavelu	29469	11/11/24	00.00
Patient Attendant		Relationship <u>husband</u>	<u>←</u>	10/11/24	11.20

CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mrs. Uma 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 tests 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): _____

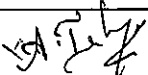
Possible alternatives:

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.

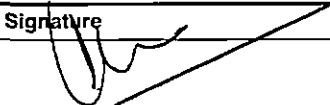
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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 #)		A. ISHWARYA (Daughter) <small>(Write name and relationship with patient)</small>	10-1-24	9:10
Reason for surrogate consent	Patient is unable to give consent because:			
Witness				
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. Ashish	91810	10/1/24	14:00

உயிரகாப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

_____ என்ற பெயர் கொண்ட டி நோயாளியான அல்லது டி நோயாளியின் பிரதிநிதியான _____ நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உள்ளவற்றில் சரியான விருப்பத்தோடுவை தயவுசெய்து டிக் செய்யுங்கள்)

□ 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 தமீழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சுவாச வழிமுறை, மத்திய சிரை அணுகுவசதி இதய தமனி தமனிக்குழல்கள் உட்பட மூச்சுப் பெருங்குழல்களுக்குள் குழாய் செருகதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செயல்படவும் 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. ஆண்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு ஆபத்தான நிலையிலுள்ள நோயாளிகளுக்கு ஒன்றுக்கு மேற்பட்ட பல மருந்து உட்செலுத்தல்களை வழங்குவதற்கு.
- ஒரு பெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனையகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிக்குத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வகை செய்கிறது.
- வாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- புறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாலிசிஸ் 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 நின்றனவாகும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதிட்டர்), சருமத்திலிருந்து பாக்கிரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதிட்டர் பொருத்தப்படும் இடத்தை தாய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉறைவு
- ஒழுங்கற்ற இடப்படுத்துப்பு
- 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 நிகழுமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காரற்ற அகற்றுவதற்கு விளக்கங்களுக்கு 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 வாசோபிரெசர்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தஓட்டத்தை.

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: 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 முச்சத்தினால் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவு, உங்களது / உங்களது நோயாளியின் முச்சக்குழலுக்கு ஒரு நெகிழ்வுத்திறன் 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 சற்றுக்கீழே 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 இணைப்புத்திசு ஆகியவற்றால் உருவானது. இதன் அகலுறை மிகுதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது முச்சக்குழாய் சற்றே நளமானதாக 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 அடைப்பிற்றி 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
- உறுஞ்சி வெளியிழுத்தல் (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 உறுதிப்படுத்திக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழுகின்ற நேரில், சில நேரங்களில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறைபோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன். இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

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

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

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

மீதே, 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 அவர், இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

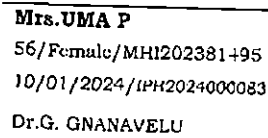
	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					



DOCTOR'S PROGRESS NOTES

DATE	NOTES
10/1/24 14:30	<p><u>Revascularization</u></p> <ul style="list-style-type: none"> - App - (R) Femoral artery - GK sheath. - Give Depoarin 900 R & Give Nicardipine 2mg IV + Give Fentanyl 2mg
<u>LAD</u>	<p>- Give nitro GK Bx 2.0 given; Subcutaneous, Left coronary</p> <p>- Semi closed with BMR guidewire, predilatation with 2x10 Apollo MC 2x10 at 18 atm 1.5</p> <p>2.5 x 2.0 Acrom 10P at 24 atm 1.5 → wire back cutting balloon 2x10 at 9 atm 1.5</p> <p>Stented with Resolute only 2.25 x 26mm at 12 atm 2.0, 14 atm 1.5. Postdilatation with Pot 3x8mm at 24 atm 1.5.</p>
<u>DRD</u>	<p>pre - MSA - 2.25mm²</p> <p>360° Calcification (circumferential)</p> <p>plaque burden 77%</p> <p>DRD - 2.25mm</p> <p>post MSA - 6.12mm²</p> <p>No edge dissection, Thrombus</p> <p>Stent well apposed, no Malapposition</p>

DATE	NOTES
10/11/24 10:30	
Ref -	By mini GP IR 3.0 guiding catheter Ref engaged Lumen crowd with Dura Tip guidewire. Predilation with Apollo MC 2x10cm at 12atm 10s. Lumen stented with Synergy 2.5 x 16mm at 14atm 15s. Post dilation with Acros 18P 2.5 x 16mm at 18atm 10s.
	Check cath Residual no flap, dilation, thrombus
	<div> Resolute Onyx™ RX DES 2.75 mm x 26 mm REF RONYX27526X LOT 0011681828 2026-03-12 Medtronic </div> <div> Boston Scientific SYNERGY™ 2.50mm x 16mm GTIN 08714729841050 REF H7493926216250 LOT 31936669 </div>
	R Drugs as per chart Five 30cc/hr R 10:40
10/11/24 5:30 PM	C/O B: Dr. H. A. A. A. A. Came Discharge from Cath lab - of PCT 15 LAD & RCA done today HR = 92/min BP = 140/80 SpO2 = 98% LRA RR = 18/min of Cur: 3.32 ⊕ Rs: 2000 ⊕ P70 = 88% Cns: neuro- has 20/20



MHI/IP/2022/041



Every heart beat counts

DATE	NOTES
10/1/24 5:13 PM	<p>h:</p> <ul style="list-style-type: none">- Days on per chart- # of chart.- High Morning.- (e) removed sheath in after → removed tonight- w/f bleeding / Haemorrhage.- to do S. Glycerolys now to GCG.- to do GCG / B. wear / S. create famous Morning. <p><u>9:10</u></p>



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



Mrs.UMA P
56/Female/MHI202381495
10/01/2024/IPH2024000083
Dr.G. GNANAVELU



MHI/ICU/2022/040



Every heart beat counts

Date: 10/1/24

Time: 20.00

Doctor's Name: DR. VELMURUGIAN

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 1
Background

90 CAD

Issues last 24 hours

PCU to LTH

Central nervous system

Conscious / oriented / sedated with
Sedation score

GCS - E V M
Pain score

Pupils - 2 mm
Drains

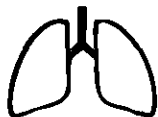
Cardiovascular system

HR - 78/min Rhythm - NSL Cardiac Output -

BP - 140/70 mmHg
CVP -
Cardiac Medications

Respiratory system

Oxygen supplementation - 10L
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. 2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

Labs

Hb / 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

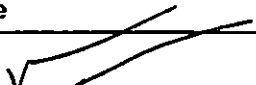
Alpha bed Y / N

Plan for the day

• I/o charity

• Urce/went/ at 5m
/ 60g

• 2g/m 10g

Doctor	Signature	Name	Reg. No.	Date	Time
	✓ 	Dr-vcl	95465	10/1/24	10m

[illegible]

Medway
Heart
Institute

Every heart beat counts

NOTES

Sb Dr 6th & 7th

25/11/24

CLAM

No chest pain.

to handle &

of course

$\rho = 837 \text{ mm}$

Br 157/83 m169

0.07

$\frac{1300}{9} = 144$
 (144)

for the first

Signature
P. (2)

Feb

Rafaela Bloch

✓✓✓✓

12/10/2011

702

collect when S. over
reports

- word with

Caring Behav

Cor/cr-13/0.51

(024V)

Add Cordone 200 1-0-

Shin Renorep

3946 a



Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs.UMA P

56/Female/MHI202381495

10/01/2024/IPH2024000083

Dr.G. GNANAVELU



MHI/ICU/2022/040



Every heart beat counts

Date : 11/1/2024

Time : 9 AM

Doctor's Name : DR ANISHA

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 2
Background

CAO
OM / OLP / Hypertension / Diabetes

Issues last 24 hours

PCI TO CAO & RCA

Central nervous system

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

Cardiovascular system

HR - 70 Rhythm - Cardiac Output -
BP - 110/70 CVP -
Cardiac Medications:

Respiratory system

Oxygen supplementation - 98%
Saturation / PaO2-
Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

GIT

P/A 6/6
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. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1.
2.
3.

Labs

Hb 12 TC Platelets
Urea 68 Creatinine 0.47 → 0.15
Na 138 K 3.5
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

- ~~7th~~ mobilize
- start to wound post rounds
- ? ~~start~~ ~~surround~~ ~~equip~~ — ✓

Doctor	Signature	Name	Reg. No.	Date	Time
	<i>Amulya</i>	Dumir 18th	88123	11/1/2024	9m

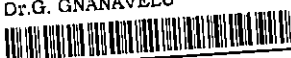


Medway
Heart
Institute
beat counts

DATE	NOTES
11/1/24	S/B. Dr. Singh. B. (Dmo)
1300	pt. received toward.
	PTCA to LAD & RCA
BP-180/70mm HR-84 bpm SpO2-98.1. InRA	pt. reviewed - no complaints - pt. feels better S/E - pt. conscious, oriented, Alert
Inlet 1320 Outlet 1900ml	S/E - cos to S (+) Re - BA (+) Adv - stable vitals - follow by chut - all discontinue - 2 for 501 - Flu + urea, creat.
	183543



56/Female/MH1202381+95
10/01/2024/IPH2024000083
Dr. G. GNANAVELU



MHI/IP/2022/041



Every heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/1/24, 9:00	<p>s/o: Dr. Brannanville + team.</p> <p>No Clut pan.</p> <p>No SWS</p> <p>No pa / fully over. (R) leg</p> <p>O/B: Cover</p> <p>Ans: Sg @</p> <p>Brp: 130 / 80 n 6 / 1A</p> <p>PR 80 / m</p> <p>Rg</p> <p>Plan change. Add</p> <p>Rpt Ren.</p> <p>8</p> <p>438000</p>

PRE/POST OPERATIVE ECHO

Mrs. UMA P

56/Female/MHI202381495

10/01/2024/UPH2024000083

Dr.G. GNANAVELU



Screening Echo

Date & Time	S/P PTCA
11.01.2024	
8:20am	<ul style="list-style-type: none"> - NO pericardial / pleural effusion - Chambers normal sized - NO RUMA - Normal LV systolic function - Grade I diastolic function - Normal RV systolic function - All valves are normal - IAS / IVS intact - Trivial MR - Trivial TR. NO PAH - NO clot / vegetation - Ectopics during study, HR: 77 bpm
	<div> <div> LVIDD: 43 mm LVIDS: 28 mm EF: 62% Simpson's EF </div> <div> EMA: 0.88 Med E/E': 9.91 Lat E/E': 6.0 TRPG: 15 mmHg RVSP: 25 mmHg </div> </div>
	<div> EDV: 61 ml ESV: 27 ml EF: 55% </div> <div> RV TDI: 12 cm/s TAPSE: 16 mm </div>
	Done by: Zibiah (PA, RCS) MHI/DOSS/AD.

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

Mrs.UMA P
56/Female/MHI202381495
10/01/2024/IPH2024000083

Dr.G. GNANAVELU



DIABETIC CHART

ACTUAL WEIGHT 70 kg HbA_{1c}
PREVIOUS DIABETIC MEDICATIONS T. Trivolib 1mg to 1. (A4)
T. Stalix 5mg to 1 (A4)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
10/1/24	11:30	265 mg/dl	-	Redha	Dr. AKILAN
11/24	17:30	132 mg/dl	-	Redha	Dr. AKILAN
11/1/24	6:45	196 mg/dl	T. Trivolib 1mg T. Stalix 5mg	Redha	Dr. Veludugan
	12:00	233 mg/dl	4 units Actrapid	Redha	Dr. Salvi
	12:30	157 mg/dl	T. Trivolib 1mg T. Stalix 5mg	Redha	Dr. Salvi
12/1/24	6:30	181 mg/dl	T. Trivolib 1mg T. Stalix 5mg	Redha	Dr. Salvi
	12:30	234 mg/dl	Insulin - 12U	Redha	Dr. Salvi

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
<ul style="list-style-type: none"> * Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.) * Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.). * Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm. * Target Blood Sugar 150-200 mgs. * To monitor K⁺ separately. 	150-200	Adjust Infusion rate to 2u / hr.
	201-250	Adjust Infusion rate to 4u / hr.
	251-300	Adjust Infusion rate to 6u / hr.
	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
Urine Acetone	>400	Adjust Infusion rate to 20u / hr.

BLOOD GROUP

B positive

INVESTIGATION SHEET

Mrs.UMA P

56/Female/MHI202381495

10/01/2024 /IPH2024000083

Dr.G. GNANAVELU



Date	23/12/23	10/1/24	11/1/24			
HAEMATOLOGY						
Hb		12.0				
P.C.V						
Platelets						
TLC						
Polymorphs						
Lymphocytes						
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY	23/12/23					
Urea			13.			
Creatinine	0.56	0.47	0.51			
Sodium		138				
Potassium		3.51				
Bicarbonate		18				
Chloride		103.1				
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						

RBS

249

[illegible]



ALLERGY
Script c

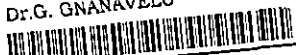


Mrs. UMA P

Mrs. UELIA F
56/Female/MH1202381+95

10/01/2024/IPH2024000083

Dr.G. GNANAVELU



VITAL INFORMATION SHEET

BLOOD GROUP	
-------------	--

ON ADMISSION

Height in CM

Weight in Kg.

166

7.

Diagnosis: CAO-DVD, DYSLIPIDEMIA

Procedure : PTCA + RCA + LAD + IVUS

[illegible]



Mrs.UMA P
56/Female/MH1202381+95
10/01/2024/IPH2024000083
Dr. G. GNANAVELU

Dr.G. GNANAVELU

EARLY WARNING

DRING 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 % or in hypercapnic respiratory failure only use scale 2 under the direction of qualified clinician					
Air or Oxygen ?					
C Blood Pressure					
D Consciousness Score for New onset of confusion (no score if chronic)					
E 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 393 (100) when they get score of 3 in any single parameter or aggregate score of > 5

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



Every heart beat counts

[illegible]

Date	From: 11/1/24	To: 12/1/24	Bed No:	INTAKE & OUTPUT CHART													
24 Hrs : Started Time : 7:00			Ended Time : 7:00														
NPO Started at :			NPO Over at :														
SHIFT	Morning		Afternoon													Night	Restricted Fluid (RF)
INTAKE	580ml		1050ml		2625ml												
OUTPUT	280		1400ml		2320ml												
Total Intake:			Total Output:			Difference:											
INTAKE (ml)							OUTPUT (ml)										
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by		
			Type of Fluid	Additions	Amount												
			Total Intake		= 2025 ml												
			Total Output		= 2320 ml												
11:30	180				380	250						290					
12:00	200				580	12pm 500						870ml					
14:00	150				700	14:00 250						1070					
14:30	150				850	16:00 400						1570					
15:20	150				1000	18:00 200						1770					
16:00	150				1150	20:00 200						2020					
17:00	150				1300	5:30 200						2320					
18:00	200				1500												
19:00	100				1600												
20:00	125				1725												
5:20	300				2025												
							TOTAL		INTAKE -		2025 ml						
									OUTPUT -		2320 ML						
							Balance				290ml		N [Signature]				

[illegible]

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Mrs. UMA P

56/Female/MHI202381+95

10/01/2024/IPH2024000083

Dr.G. GNANAVELU




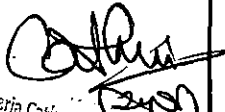

Diagnosis: <u>PTCA / DM / Dyslipidemia / Hypothyroidism / HT-75%.</u>				
Height: <u>155</u> cms	Weight: <u>57</u> Kgs	Food allergies: Yes/ No/ yes, specify.....		
Religious Beliefs:	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Non Vegetarian	<input checked="" type="checkbox"/> Eggetarian	<input type="checkbox"/> Jain
Diet Prescription: <u>1000 calories, low fat, low salt, diabetic diet.</u>				

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 type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" 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				
Well Nourished		<input checked="" type="checkbox"/> (7 to 14)		
Moderately Malnourished		<input type="checkbox"/> (15 to 18)		
Severely Malnourished		<input type="checkbox"/> (19 to 25)		
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
Enteral / Parenteral		<input type="checkbox"/> Daily		Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Dietitian Signature / Name / Date / Time:

Maria Catherine J. 10/1/24, 12:40
Senior Dietitian (2401)

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
10/1/24, 15:00	<p>A 56 year old female came to do chest pain was assessed to be well nourished as evident by SGA.</p> <p>Kills - DM / Dyslipidemia / Hypertension.</p> <p>Patient shifted to Cathlab for procedure (pex) and kept on HSM. Patient <u>united</u> to Cev. HSM over. Patient presented diabetes; lipid diet. Can initiate on diabetes; soft solid diet.</p>	 Maria Catherine John Senior Dietitian
18/1/24, 14:00	<p>Patient <u>united</u> Broad. Reemphasized on free diet restriction. Motivated to eat well.</p>	 Maria Catherine John Senior Dietitian
12/1/24, 10:00	<p>Diet intake is good. Educated the patient and family on 1600 calories, low fat, low salt, diabetes diet on discharge.</p> <p>Emphasized on more fruit meals. Low glucose control. Diet modification and education done. Diet chart given on discharge.</p>	 Maria Catherine John Senior Dietitian

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD - DUE Allergies if any: Eng - Subherlungs

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
1 st Floor.	Cath lab	10/1/24	14:50	PTCA

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

ASSESSMENT OF PATIENT:

General condition of Patient: ☒ Conscious ☐ Semi-conscious ☐ Un-conscious

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

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

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

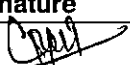

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
97.1	24	92	99	180/100	—

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

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
		R. Sushma.	0201	10/1/24	14:50
Handed over to	Signature	Name	Emp. No.	Date	Time
		Dr. Sushma	0176	10/1/24	14:50


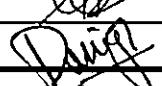
After Procedure:

Procedure completed: ☒ Yes ☐ No | Any critical information: Ni

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
97.5	22 breath/min	84 bt/min	100%	150/73 mmHg	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)

Handover by	Signature	Name	Emp. No.	Date	Time
		Dr. Sushma	0176	10/1/24	17:00
Handed over to	Signature	Name	Emp. No.	Date	Time
		Dr. Sushma	0181	10/1/24	17:00

Patient Name	Mrs. UMA P 56/Female/MHI202381-95 10/01/2024/IPH2024000083	Sex: M/F
Consultant:	Dr.G. GNANAVELU	UHID

IOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

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. 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		P. Uma	10/1/24	11-20
witness		P. Arunachalam	10/1/24	11-20
Doctor		Dr. G. Gnanavelu	10/1/24	11-20
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 இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாறாடப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீடிக் (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 கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே 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 அடையு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டிக் (புலான் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

சிகிச்சையின்முறையிலுள்ள 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 கீவைகள் 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) மாறாடப்பு (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 அளவினை சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவினை 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 கொண்டேன். 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 கிரத்தமேற்றாதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். சிகிச்சையின்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எந்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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



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TRANSFEMORAL PERCUTANEOUS CORONARY INTERVENTION + IVUS STUDY REPORT

Patient name MRS. UMA.P	ID: MHI202381495
Age/Gender 56 F	IPH: IPH202400083
Cath No. 3584/3585	D.O.P. 10.01.2024

Done by DR. GNANAVELU

Technician : Mr. Ram

Scrub nurse : Ms. Sathya

DIAGNOSIS: CAD, BIFASCICULAR BLOCK, NORMAL LV FUNCTION,
TYPE II DM, HYPOTHYROIDISM, DYSLIPIDEMIA.

CAG: SIGNIFICANT CALCIFIC LAD & RCA DISEASE

PLAN : IVUS GUIDED PTCA X LAD & RCA

APPROACH : Right femoral artery

Total exposure time: 3133"

HARDWARE : 6F sheath, 6F EBU 3.0 / 6F JR 3.5 guide catheter

Total RAK: 467.10 mGy

CONTRAST : CONTRAPAQUE 200 ml

Total DAP: 229.33 Gy.cm2

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 7500 IU;

HEMODYNAMIC DATA: ABP 153/71 (105); HR 90 bpm; SPO2 99%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
LAD	70-80% TUBULAR STENOSIS	BMW J	2.0 X 10mm Apollo NC & 2.5 X 20mm Across HP 18 atms	2.75 X 26 RESOLUTE ONYX 12 atms 20 s	3 X 8mm POT 14 atms	TIMI III FLOW
RCA	70% TUBULAR STENOSIS	BMW J Tip	2.0 X 10mm Apollo NC 12 atms	2.5 X 16 SYNERGY 11 atms 15 s	2.5 X 10mm Across HP 18 atms	TIMI III FLOW

REMARKS: IVUS study with Opticross 60MHZ catheter was used to optimize and assess stent deployment pre & post dilatation. LAD - Pre MLA – 2.2 mm² with 77% plaque burden(Calcific). IVUS parameters of LAD stent were satisfactory. MSA of LAD stent was 6.17 mm². ACT at the end of the procedure was 275 sec.

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

Dr. G. GNANAVELU, MD, DM

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

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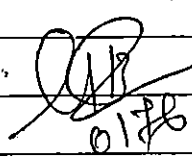
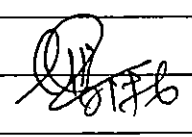

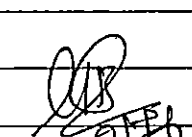
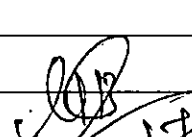
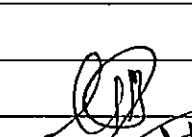
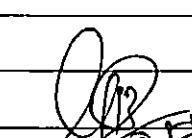
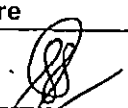
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Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
10/1/24	Cath Lab:				
14.10	⇒ Pt received from 1st floor to Cath Lab. conscious and oriented. ⇒ vitals stable. IV line Rt and left side Patent. VPD Score 0/5	 0176			
14.30	⇒ IVF: NS 30ml/hr IV started. sterile drapping done. PTCA + IVUS Cath Procedure started.	 0176			
14.40	⇒ Rt femoral arterial approach under local anaesthesia.				
14.40	⇒ IN: Heparin 5000 ^{IU} IA given O/R Dr. GGC (Sr)	 0176			
14.40	⇒ IN: Fentanyl 25 mcg + IN: Emeract 4mg IV given O/R Dr. GGC (Sr)				
14.45	⇒ BP: 140/80 (100) mmHg, HR: 88 b/min SpO2: 99%. vitals stable.	 0176			
14.50	⇒ IN: Heparin 2500 ^{IU} IV given O/R Dr. GGC (Sr)				
15.30	⇒ BP: 146/74 (95) mmHg, HR: 80 b/min SpO2: 99%. vitals stable.	 0176			
15.50	⇒ ACT - 294 sec checked O/R Dr. GGC (Sr)				
16.00	⇒ IN: Heparin 1500 ^{IU} IV given O/R Dr. GGC (Sr)	 0176			
16.20	⇒ BP: 150/73 (100) mmHg, HR: 80 b/min SpO2: 100%. vitals stable.				
16.30	⇒ ACT - 275 sec checked.				
16.35	⇒ Procedure IVUS + PTCA + LAD and RCA done. Rt femoral arterial sheath removed kept in	 0176			
Document endorsed by	Signature 	Name Sathya	Emp. No. 0016	Date 10/1/24	Time 16:35

NURSES PROGRESS NOTES

[illegible]



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MHI/CATH/2022/085



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Procedure Monitoring Sheet (Cath Lab)

Patient Name : Mrs.UMA P
56/Female/MHI202381+95
10/01/2024/IPH2024000083
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:130/90 Temp:37.1 Pulse:92 RR:24 SPO2:99%	✓		
Urine voided	✓		
Bowel preparation	✓		
Pre-procedure medication administered		✓	
Procedure site marked		✓	
Skin preparation done	✓		
NPO 10.30 AM			
Loose Tooth removed		✓	
Contact lenses / Eye glasses removed		✓	
Prosthesis present		✓	
Jewellery/Nail polish removed		✓	
Checked for Allergies (Drug / food) Sulpha Allergy / SGP: Aspirin	✓		
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse : [Signature]	Date & Time : 10/1/24 at 11:00.		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
10/1/24 14.30	86 bt/min	22 br/min	162/96(114)	99%	-	[Signature]
14.45	88 bt/min	22 br/min	140/80(100)	99%	-	[Signature]
15.15	80 bt/min	22 br/min	146/74(95)	99%	-	[Signature]
15.45	88 bt/min	22 br/min	135/82(100)	99%	-	[Signature]
16.15	76 bt/min	22 br/min	132/83(103)	100%	-	[Signature]
16.30	80 bt/min	22 br/min	180/73(100)	100%	-	[Signature]
			Procedure got over			

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

Time : 16.45 Route : Rt femoral arterial

Complication : Nil approach

BP : 150/73 (100) mmHg, HR : 80 b+1mt, RR : 22 br/mt, SpO2 : 99-1

Distal Pulse: felt, Puncture Site: no oozing & hemo to me

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 8 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt femoral artery.
- ◆ Diet Dm diet.
- ◆ Inform Duty Medical Officer SOS
 - a) If patient complains of any Discomfort
 - b) If dressing is Loose or Socked with Blood
 - c) If limbs are Cold / Absent Pulse.
- ◆ Remove Rt femoral arterial dressing on 11/1/24 at 16.00 AM / PM after informing to the consultant.
- ◆ Special instruction if any: Nil

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
<u>16.45</u>	<u>150/80</u>	<u>72</u>	<u>20</u>	<u>100%</u>	<u>no oozing & hematoma</u>	<u>Good</u>	<u>-</u>	<u>[Signature]</u>
<u>17.00</u>	<u>148/74</u>	<u>70</u>	<u>22</u>	<u>100%</u>	<u>no oozing & hematoma</u>	<u>Good</u>	<u>-</u>	<u>[Signature]</u>

Nurses Notes : ±VVS+

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

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time : 10/1/24 @ 17.00

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086



Every heart beat counts

Mrs. UMA P

56/Female/MHI202381495

10/01/2024/IPH2024000083

Dr. G. GNANAVELU



Name of the Procedure : PTCA + TIVUS Location : Cath Lab Date & Time : 10/1/24

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
Identify by two identifiers <input checked="" type="checkbox"/> Yes	Identify 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 <u>PTCA + TIVUS</u> <input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations confirms labeling and sent to lab <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA
Side <input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt femoral arterial</u> <input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	
	Expected Blood loss <u>NA</u>	
Consent <input checked="" type="checkbox"/> Yes	Position <u>Supine</u> <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 <u>Am. Sulpha</u>	Consent <input checked="" type="checkbox"/> Yes	If Yes, Pls. specify :
	Required equipment and implants available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
Difficult airway / aspiration risk / dentures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
	Antibiotic prophylaxis within last 60 minutes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
Possibility of hypothermia <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Name of the Antibiotic given	Any Equipment / Instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None
	Venous Thromboembolism Prophylaxis Provided <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :
All concerned anesthesia equipment and medication check complete	Anticipated duration briefed <input checked="" type="checkbox"/> Yes	
<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify <u>ECG</u>	Anticipated blood loss briefed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
Pre OP medication taken <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	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	Corrective action :
Required equipment for procedure available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	For procedural sedation cases	
	Any patient specific concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
	Intra procedure glyceric 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	Doctor performing the Procedure :	Nurse : <u>RIN. Sathiyag</u>	Technician : <u>Mr. Tami</u>	Others Please Specify :
Date : <u>10/1/24</u>	Date : <u>10/1/24</u>	Date : <u>10/1/24</u>	Date : <u>10/1/24</u>	Date :
Time : <u>16-45</u>	Time : <u>16-45</u>	Time : <u>16-45</u>	Time : <u>16-45</u>	Time :

Mei
n
(AL)

ALLERGY

7- Sulpha
meds Asthma

Patient Details (Affix Label)

Mrs. UMA P

56/Female/MHI202381495

10/01/2024/IPH2024000083

Dr. G. GNANAVELU



MHI/NUR/2022/053



Every heart beat counts

ADMISSION ASSESSMENT (ADULT)

Date of Admission: 10/1/24 Time of Arrival: 12:00 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: _____

Relationship with Patient: _____

Contact Person's Name: MR. Anurag Khanna

Relationship: Husband

Contact No.: 9840542846

Primary language spoken: ☒ Tamil ☐ English ☒ Indian ☐ International

Interpreter needed: ☒ Yes ☐ No Patient status: ☒ Conscious ☐ Unconscious ☐ Disoriented

Menstrual History: LMP: _____

Menopause: 10 yrs

Patient Vulnerable: ☐ Yes ☒ No

Medical History: DM / HTN / Co - Morbidity: 16 yrs If Yes, specify _____

Drugs History: Antiplatelet (Specify) _____

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

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than one half of the days	Nearly every day	Total
1. Little Interest or pleasure in doing things	0	1	2	3	0
2. Feeling down, depressed, or hopeless	0	1	2	3	0

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: 97.4 (°F) | Pulse / HR: 92 (beats/min) | BP: 150/80 (mmHg)

Respiration: 24 (breaths/min) | SpO₂: 99% (%) | CBG: 265 (mg/dl) | Height: 166 (cms) | Weight: 71 (kgs)

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

If Yes, specify: Drug: Subcutaneous syp: Asthalin.

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

Duration: _____ Location: _____

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

Nutritional Screening:

Last 3 months Appetite: ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight: ☐ Increased ☐ Decreased ☒ No Change

Type of Patient: ☒ Diabetic ☐ Non Diabetic Type of Diet: Normal diet

Dietician Informed: ☐ Yes ☐ No. If Yes, mention the Name: _____ Time: _____

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 checked="" 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: 30 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 Yes	0 25
Secondary diagnosis (≥ 2 medical diagnosis)	No Yes	0 15
Ambulatory Aid		
None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No Yes	0 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 Yes	0 15
Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk		Total Score
		<u>30</u>

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		<input checked="" type="checkbox"/>	

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

1 to 2

10/1/24 11-20

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
		P. Narasimham	Relationship	10/1/24	11-20
Nurse		R. Sushma	0201	10/1/24	12-20
Unit In-Charge		S. Neel PNP	0024	10/1/24	16-20

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

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

GCS: 15/15
POD: _____
Central line days: _____

VIP Score: 0/5

B

BACKGROUND

Type of surgery: _____ Date of surgery: _____
Allergies if any: NKDA
On room air / oxygen: PO
Complaints / New Symptoms in last shift: _____
IV fluids on flow: _____

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 24 (breaths/min)
BP: 130/90 (mmHg) | SpO₂: 99 (%) | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 22.6 kg/m²
Others: _____
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High
Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA Wound Dressing done: ☐ Yes ☒ No ☐ NA
Current diet: DM 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		R. Sushma	0001	10/1/24	12:00
Handover taken by		P. Paratharaj	0176	10/1/24	12:10
Document endorsed		S. Nalini	0024	10/1/24	16:00

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: T2 DM1 dyslipidemia
NEWS / PEWS Score:
Ventilator day:
Peripheral line day: Right: Brachial Left: Brachial
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 TOLAD + REA + TRUS
Allergies if any: Salbutamol, 3yr, asthma
On room air / oxygen: RA
Complaints / New Symptoms in last shift:

Date of surgery: 10/1/24
IV fluids on flow: D5W NS - 30ml/hr

A

ASSESSMENT

Vital Signs: Temp: 98.2°F | Pulse / HR: 78 (beats/min) | Respiration: 25 (breaths/min)
BP: 141/78 (mmHg) | SpO₂: 98% | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 25.6 kg/m²
Others:
Pain Score: 0/10 Pain Scale used: PIRPS / GRIES / 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: DM diet Drains:

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Rathanapouraj	0187	10/1/24	19:30
Handover taken by		Jeyaraj	0244	10/1/24	19:45
Document endorsed		Jeyaraj	002	10/1/24	19:45

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: T2DM / DLP / Hypothyroidism
NEWS / PEWS Score: -
Ventilator day: -
Peripheral line day: Right: brachial Left: brachial
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 + LAP + RCA
Allergies if any: Syp. ASHALLI
On room air / oxygen: R.A - 99%
Complaints / New Symptoms in last shift: -
Date of surgery: 10/1/24
IV fluids on flow: WF NS 30ml/hr
onflow

A

ASSESSMENT

Vital Signs: Temp: 97.8°F | Pulse / HR: 77 (beats/min) | Respiration: 24 (breaths/min)
BP: 130/79 (mmHg) | SpO₂: 99 (%) | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 25.6 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 Wound Dressing done: ☐ Yes ☒ No
Current diet: - Drains: -
SND 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: To do dressing echo. Plan for wound shift

	Signature	Name	Emp. No.	Date	Time
Handover given by		Maathumitha	02AH	11/1/24	4:30
Handover taken by		S. Jeyamalatha	021	11/1/24	7:30
Document endorsed		J. Jeyaraj	002	11/1/24	7:30

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: T2DM / DLP / Hypertension

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: Buochial left: Buochial

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: PTCA TO LAD + RCA

Allergies if any: SYN. ASTHMA

On room air / oxygen: ROOM AIR - 99%

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)

BP: 146/82 (mmHg) | SpO₂: 99 (%) | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 22.6 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: DM diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -




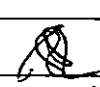

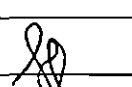
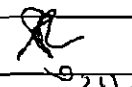



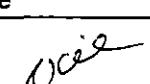
Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: -

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>S. P. Datta</u>	<u>S. P. Datta</u>	<u>0211</u>	<u>11/1/24</u>	<u>10:30</u>
Handover taken by	<u>Hann</u>	<u>Hannah Gase</u>	<u>0105</u>	<u>11/1/24</u>	<u>12:30</u>
Document endorsed	<u>nee</u>	<u>S. P. Datta</u>	<u>0024</u>	<u>11/1/24</u>	<u>16:30</u>

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
21/1/24	<u>Morning Duty Notes</u>				
7:20	⇒ Pt taken over from night duty staff. Pt is conscious & oriented. Pt haemodynamically stable & afebrile.	 024			
7:40	⇒ T-98°F, P-87b/min, R-20b/min, BP-147/83 (103) mmHg, SpO2-98%.	 024			
7:50	⇒ Pt R & Lt Buccal line Present & Patent	 024			
8:30	⇒ Pt had diet. Medication given as per drug chart.				
9:00	⇒ Pt hourly I/O chart maintained & recorded. Screening echo done. ⇒ Dr. Granavolu SA seen the Pt. Shifted to ward. T. Cardemone Add. & Granaffin Ad. Eranoxer stopped.	 024  024			
10:00	⇒ Pt Pressure bandage removed. No oozing & hematoma as order by Dr. Anish SA.	 024			
10:30	⇒ Pt shifted to ward. Pt file reports hand over to 1st class staff.	 024			
	<u>Received Notes</u>				
10:50	-> patient is shift received by from S nd floor -> patient IV line ② & Pt personal bandage apparatus done.				
	-> patient ② vital signs chart re				
11:50	-> patient to chart record.				
12:30	-> patient hand over given per evening duty staff.				
Document endorsed by	Signature 	Name S. Nalini P	Emp. No. 0024	Date 21/1/24	Time 16:22

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: 0

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 → LAD & RCA

Allergies if any: NKA

On room air / oxygen: on room air

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.8°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 98 (%) | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 22.6 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: DM 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: plan dls tomorrow

	Signature	Name	Emp. No.	Date	Time
Handover given by	Hay	Hannah Grace	8105	11/1/24	19:30
Handover taken by	WJ	D. Monahan	2161	11/1/24	06:30
Document endorsed	WJ	S. Vail PNP	0024	11/1/24	06:30

NURSES PROGRESS NOTES					
Date & Time	Observations / Action			Signature with Emp. No.	
11/1/24	<u>Evening duty notes</u>				
12:30	patient handing over taken from Morning duty Staff in a hemodynamically stable condition			Hay osr	
13:00	Vital signs checked & Recorded			Hay osr	
14:00	Due drugs are given as per drug chart			Hay osr	
15:00	=> patient was stable & NO complaints				
16:00	-> vital signs checked & record => Tomorrow plan discharge.			MD OSR	
18:30	=> vital signs Checked & recording -> I/O chart monitored-				
19:30	=> Patient handover given to the night duty staff			MD OSR	
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Neez	S. Nalpan	0024	11/1/24	16:50

Time

1650



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - DVP

NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: D2

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 - CAD & RCA

Date of surgery: 10/1/24

Allergies if any: NKA

On room air / oxygen: on room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp 97.8 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 98 (%) | Height: 166 (cms) | Weight: 71 (kgs) | BMI: 25.6 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: DM 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: plan dls tomorrow.

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>Jeni</u>	<u>Jeni Priya</u>	<u>0284</u>	<u>10-1-24</u>	<u>19:30</u>
Handover taken by	<u>[Signature]</u>	<u>Parameeswari</u>	<u>2733</u>	<u>12/1/24</u>	<u>19:20</u>
Document endorsed	<u>[Signature]</u>	<u>S. Nalini</u>	<u>0024</u>	<u>12/1/24</u>	<u>10:50</u>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

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

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

B

BACKGROUND

Type of surgery: NKDA
Allergies if any: —
On room air / oxygen: RA
Complaints / New Symptoms in last shift: —
Date of surgery: —
IV fluids on flow: —

A

ASSESSMENT

Vital Signs: Temp: 98°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 100/60 (mmHg) | SpO₂: 96% | Height: 160cms | Weight: 71 (kgs) | BMI: 22.6 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: 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		paramur	2333	12/1/24	12:30
Handover taken by		discharged			
Document endorsed		S. Vaidya	0024	12/1/24	16:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12/1/24	<u>Morning Duty Reports</u>	
7:30	=> patient taken over from night. Duty S/N	P 2373
	=> patient as checked & received.	
10:30	=> patient had a diet	P 2373
10:45	=> patient Drugs are given	P 2373
11:30	=> S/O monitor.	
12:30	=> Pt Today D/S Plan	
	<u>Discharge notes</u>	
13:00	=> Patient stable & Conscious => Patient Vital Signs all Stable => IV line Removed => Discharge Summary explained => ID band Removed => patient got discharged @ 16:30	Hay 6105 Hay 6105
Document endorsed by	Signature weel	Name S. weel PNP
	Emp. No. 0024	Date 12/1/24
	Time 16:00	

ADULT NURSING CARE PLAN

Patient Details
Mrs. UMA P
56/Female/MHI202381495
10/01/2024/IPH2024000083
Dr. G. GNANAVELU

Initial Date: 10/1/24 Time:		Modified Date: Time:		
Reason for Modification:		Diagnosis: T2DM / dyslipidemia		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input 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	
			E pt on dm diet	Pavan
			N pt had dm diet	02/11/24
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 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 pt on RA SPO ₂ - 94%	Pavan
			N pt on room air	02/11/24
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 pt on IUF NS 30ml hrs	Pavan

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 E pt on Immobilizing N pt on bed rest	
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 incontinence 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 / consistency / volume / Hematemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M E pt @ elimination pattern N pt @ elimination pattern	
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 @ skin integrity N pt on @ skin integrity	

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 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	
			E	PT clean & well groomed
			N	PT on clean & well groomed
SAFETY <input 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 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	PT ID Band & Dr line checked
			N	PT on ID band
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	PT comfortable position
			N	PT on comfortable sleep
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 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	PT hourly VLS & vital signs
			N	PT on VLS 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	
			E	PT (N) Psychological support given
			N	PT on Psychological support given

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 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 E pt on verbal communication N pt on good communication	 [Signature] 02/11/24
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 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 pt administer medication as / chart N pt on medication given as per doctor's chart	 [Signature] 02/11/24
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	J. (P. J. S. M.)	0002	11/1/24	9.45

ADULT NURSING CARE PLAN

Mrs.UMA P
56/Female/MHI202381+95
10/01/2024/IPH2024000083
Dr.G. GNANAVELU



MHI/NUR/2022/044



Every heart beat counts

Initial Date: <u>11/1/24</u> Time: <u>8.00</u>		Modified Date: _____ Time: _____		
Reason for Modification: _____		Diagnosis: <u>T2DM / CALCIFIC LAD / PEA DISEASE / @ LV FUNCTION</u>		
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 had regular diet E Pt had DM diet N Pt had DM diet	[Signature] Hay 01/01/24
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 checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input checked="" 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 SpO ₂ - 98% E Pt was stable on room air N Pt was stable on room air	[Signature] Hay 01/01/24
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 checked="" 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 Pt intake well E I/O chart Maintained N I/O chart Monitored	[Signature] Hay 01/01/24

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-Embollic 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 mobilized	Jan 24
			E Pt mobilized well	Hay 26
			N Pt mobilized well	Jan 27
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 incontinence 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 / consistent / volume / Hematemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Pt @ elimination pattern	Jan 24
			E Pt had normal elimination pattern	Hay 26
			N Pt had normal elimination pattern	Jan 27
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 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 Pt maintain normal skin integrity	Jan 24
			E Pt had normal skin integrity	Hay 26
			N Pt had normal skin integrity.	Jan 27



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 clean & well groomed E Pt groomed well N Pt groomed well	[Signature] Hay Jan
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 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 ID band present E ID band present N ID band present	[Signature] Hay Jan
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 Pt provide comfortable position E — N —	[Signature] Hay Jan
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 Pt V/S checked & recorded E Patient vital signs all stable N Pt vital signs are stable	[Signature] Hay Jan
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 Pt provide psychological support E — N —	[Signature] Hay Jan

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 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 Pt Communicated well N	[Signature] Hay
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 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 drug chart E Due drugs are given N Due drugs are given.	[Signature] Hay
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	S. W/PNP	0024	11/1/24	8:00



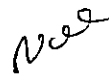
ADULT NURSING CARE PLAN

JMA P
56/Female/MH1202381495
10/01/2024/IPH2024000083
Dr.G. GNANA VELU

Initial Date: 12.1.2024		Time: 8:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD - DLD			
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 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 had diet E Pt had @ diet N	(Signature) 27/1			
OXYGENATION <input checked="" 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 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 Pt on Room air N	(Signature) 27/1			
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 checked="" 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 5l0 monitor E 2l0 monitor N	(Signature) 27/1			

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-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 walk c Assist E N	
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 / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Elimination pattern E N	
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 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 groomed well E N	(P 233)
SAFETY <input checked="" 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 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 ID band E N	(P 255)
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 vs if stable E N	(P 233)
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	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 Good communication E N	
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 Medication was given E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		S. Nelpap	0024	12/1/24	16:20

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				
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				
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				
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				
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				
FRICION & 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					
					TOTAL SCORE	23	16	15
					Initial & Emp. No. of Staff Nurse:	06	001	001
					Initial & Emp. No. of Sr. Staff Nurse:	001	001	001

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	3	3	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	3	2	
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	4	4	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or 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	
FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3	
					TOTAL SCORE	17	20	20
					Initial & Emp. No. of Staff Nurse:	8/11/24	11/1/24	11/1/24
					Initial & Emp. No. of Sr. Staff Nurse:	11/1/24	11/1/24	11/1/24

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 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	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	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	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	4	
FRICITION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
					TOTAL SCORE	23	
					Initial & Emp. No. of Staff Nurse:	2333	
					Initial & Emp. No. of Sr. Staff Nurse:	2333	

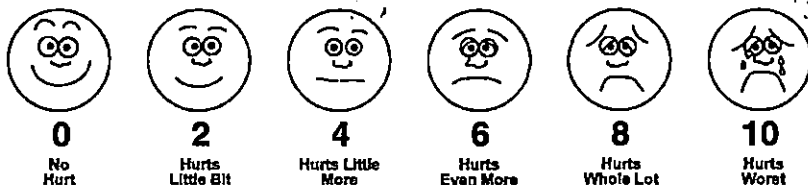
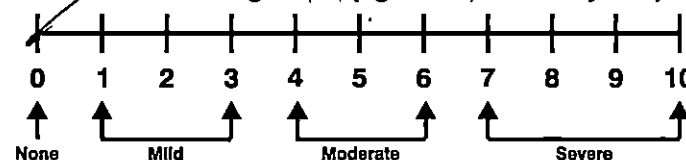
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

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.
10/1/24 11:20	0/10	No pain	-	-	-	Dr. Jay	Dr. Jay
10/1/24 17:00	0/10	No pain	Nil	Nil	Nil	Dr. Jay	Dr. Jay
18:00	0/10	No pain	Nil	Nil	Nil	Dr. Jay	Dr. Jay
19:00	0/10	No pain	Nil	Nil	Nil	Dr. Jay	Dr. Jay
20:00	0/10	No pain	-	-	-	Dr. Jay	Dr. Jay
21:00	0/10	No pain	-	-	-	Dr. Jay	Dr. Jay
22:00	0/10	No pain	-	-	-	Dr. Jay	Dr. Jay
23:00	0/10	No pain	-	-	-	Dr. Jay	Dr. Jay

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
11/12/21 00:00	0/w	no pain	-	-	-	D 0244	Jay 1000
1:00	0/w	no pain	-	-	-	D 0244	Jay 1000
2:00	0/w	no pain	-	-	-	D 0244	Jay 1000
3:00	0/w	no pain	-	-	-	D 0244	Jay 1000

PAIN SCALES

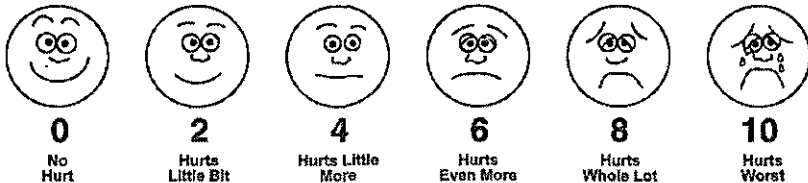
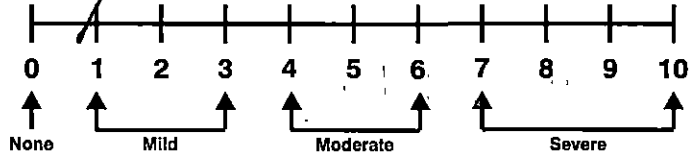
PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention	
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. 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)	 <p>0 No Hurt</p> <p>2 Hurts Little Bit</p> <p>4 Hurts Little More</p> <p>6 Hurts Even More</p> <p>8 Hurts Whole Lot</p> <p>10 Hurts Worst</p>	Numerical Rating Scale (age more than 12 years)  <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>None Mild Moderate Severe</p>
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/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.
11/12/24 4:00	0/10	NO Pain	-	-	-	D 0244	Jay 0000
5:00	0/10	NO Pain	-	-	-	D 0244	Jay 0000
6:00	0/10	NO Pain	-	-	-	D 0244	Jay 0000
7:00	0/10	NO Pain	-	-	-	D 0244	Jay 0000
8:00	0/10	No Pain	-	-	-	D 0244	Jay 0000
9:00	0/10	No Pain	-	-	-	D 0244	Jay 0000
10:00	0/10	No Pain	-	-	-	D 0244	Jay 0000
11:00	0/10	No pain	-	-	-	Hay 0000	Jay 0000
12:00	0/10	No pain	-	-	-	Hay 0000	Jay 0000

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.
22.00	0/10	No Pain	—	—	—	Jan 22	Neil 24
12/1/24 23.00	0/10	No Pain	—	—	—	Jan 22	Neil 24
10.00	0/10	No Pain	—	—	—	Jan 22	Neil 24







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)		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	10/1/24	11/1/24	12/1/24				
		Time	11:20	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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	10/1	10/10/24	10/11/24	11/1/24	11/11/24	11/16/24	12/1/24		
	Time	11:20	17:30	21:00	8:00	14:00	20:00	8:00		
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	50	50	50	50	50	50		
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

[illegible]



CONSULTANT:



Medway
Heart
Institute

Every heart beat counts

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 <u>10/1/24</u> Time <u>11:20</u>		Nurse Signature : <u>[Signature]</u>

Learning Record

[illegible]

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			P	RD			P	RD			P	RD	Maria Catherine [Signature]
<input checked="" type="checkbox"/> Diet advice for home			P	RD			P	RD			P	RD	Nurse [Signature]
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)

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			<input checked="" type="checkbox"/>	CT Scan Film			<input checked="" type="checkbox"/>
X-Ray Report			<input checked="" type="checkbox"/>	ECHO Report			<input checked="" type="checkbox"/>
X-Ray Film	<input checked="" type="checkbox"/>			Ultrasound Report			
Compact Disk				Any Other Report			

Name of Attendant / Patient : Mrs P. Uma Signature : P. Uma

Name of Discharge Nurse : Stal monisha Signature : [Signature]



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

Mrs.UMA P

56/Female/MHI202381495

10/01/2024/IPH2024000083

Dr.G. GNANAVELU



MHI/ICU/2022/056



Every heart beat counts

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 10/1/24

Time: 11:20

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. Anusoyan	134559	10/1/24	12:20
Nursing Staff		R. Sushma	0201	10/1/24	12:20
Dietician		Maria Catherine John Senior Dietician	2021	10/1/24	12:20
Physiotherapist					
Patient Care Service Staff					



IN-HOUSE TRANSFER FORM

Part A (to be filled by Nurses)

Date of Transfer: 11/1/24 Time: 10:30 Transferred from: CICU To: 1st Floor R-NO(111)

Diagnosis: CAO / DM / HUN / INSOMNIA / DLP / GP PCI TO CMO TRCA

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | BP: 116/69 (mmHg) | Respiration: 20 (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 checked="" 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 checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No
CNS	<input checked="" type="checkbox"/> Conscious <input type="checkbox"/> Oriented GCS Score: _____	<input checked="" 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 checked="" 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	W. LORAZEPAM	2mg	P.O.	1-0-1	11/1/24 @ 9:50	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	CDP. CLOMIPRAMINE	15ml	P.O.	0-0-1		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	T. REMEMAZ	400mg	P.O.	1-0-1	11/1/24 @ 8:30	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	T. FOLINAT - B		P.O.	1-0-1	11/1/24 @ 8:30	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	T. CREVAST	40mg	P.O.	0-0-1	10/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	T. ACUPR	90mg	P.O.	1-0-1	11/1/24 @ 8:30	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	T. ECOSPRIN	75mg	P.O.	0-1-0	11/1/24 @ 14:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	T. PANTOUCO	40mg	P.O.	1-0-1	11/1/24 @ 8:30	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	T. CLOMIPRAMINE		P.O.	0-0-1	10/1/24 @ 21:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	T. PANTOUCO	75mg	P.O.	1-0-0	11/1/24 @ 8:30	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11	T. CLOMIPRAMINE	1mg	P.O.	1-0-0	11/1/24 @ 8:30	<input checked="" 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	<i>[Signature]</i>	Dr. Anusya	88434	11/1/24	10:30
Receiving Doctor	<i>[Signature]</i>	Dr. Anusya	134559	11/1/24	10:30

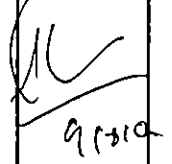
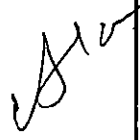
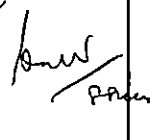
Part C (to be filled by Nurses)

Check for	Transferring Nurse	Receiving Nurse
Drains	<input type="checkbox"/> Chest <input type="checkbox"/> Abdominal <input type="checkbox"/> Others: <u>Nil</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	Air Way Type: <input type="checkbox"/> Patent <input type="checkbox"/> Tracheostomy <input checked="" 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 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 type="checkbox"/> Yes <input type="checkbox"/> No
Score	Fall Risk: <u>SD</u> WELLS: _____ NEWS / PEWS: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Belongings	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input 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	<i>[Signature]</i>	S. Puemalatha	0211	11/1/24	10:30
Receiving Nurse	<i>[Signature]</i>	B. Vanish	0190	11/1/24	10:30

FAMILY COUNSELLING FORM

CONSULTANT- DR. GNANAVELU			DIAGNOSIS- T2DM / DYSLIPIDEMIA / ADLDP			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
10/1/24	Doctors		Pt. Condition updated to family	-	A. J. J.	 9/1/24
11/1/24	Doctor		Pt. condition explained to parents	-		 9/1/24



19/01/2024

REQUISITION

Mrs. UMA P
56/Female/MHI202381495
10/01/2024/IPH2024000083
Dr. G. GNANA VELU

IP No. :
DOA :
UHID No. :
Room No. : CCU

S.No.	Date	Medicine Name	Qty.
1	10/01/24	Coloace	18 Dose
2	"	Moval Code	5
3	"	CCU 100	1
4	"	CCU 100	1
5	"	Red blood	1
6	"	Indinavir 10mg	1
7	"	T. Cefixime 1 tab	5
8	"	T. Hygro 10mg	1
9	"	T. Paracetamol 500mg	5
10	"	T. Evion 10 tabs	5
11	"	T. Eubiotic 7mg	5
12	"	T. Axicon 10mg	5
13	"	T. Cefixime 10mg	5
14	"	T. Paracetamol 1 tab	5
15	"	T. Paracetamol 10mg	5

Nurse Name

Pharm Bill & Name

Pharm Bill & Name



DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
10/1/24	11:30	Rt Brachial Lt Brachial	0/5	patent	flushed	-	Patterson
	17:30	Lt Brachial	0/5	patent	flushed	Followed	Patterson
	2:00	Rt Brachial	0/5	patent	flushed	Followed	Patterson
11/1/24	8:00	Rt Brachial	0/5	Patent	flushed	Followed	Patterson
		Rt Brachial		line removed			
12/1/24	17:30	Rt Brachial	0/5	Patent	flushed	Followed	Patterson
	2:00	Rt Brachial	0/5	patent	flushed	Followed	Patterson
1/1/24	8:00	Rt Brachial	0/5	Patent	flushed	Followed	Patterson
	14:00	Rt Brachial	0/5	Patent	flushed	-	Hayes
	20:00	Rt Brachial	0/5	Patent	flushed	-	Hayes
				2nd line removed			

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

T. Calbrit

Dose

1 tab

Route

p/b

Frequency

100.

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24

Stop Date & Time

Additional Info:

DRUG NAME

T. Thyrox

Dose

75mcg

Route

p/b

Frequency

100.

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24

Stop Date & Time

Additional Info:

DRUG NAME

T. Ranoxex

Dose

50mg

Route

p/b

Frequency

101

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24

Stop Date & Time

11/02 @ 9:30.

Additional Info:

DRUG NAME

T. Evion LC

Dose

1 tab

Route

p/b

Frequency

0-01

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24.

Stop Date & Time

Additional Info:

DRUG NAME

T. Pantacid

Dose

6mg

Route

p/b

Frequency

101

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

Clinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given				
			Time ↓	10/1/24	11/1/24	12/1/24		
DRUG NAME T. Ecospirin								
Dose 75mg	Route p/o	Frequency o-t-o	14:00	13:40	14:00			
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 10/1/24						
		Stop Date & Time						
Additional Info:								
DRUG NAME T. AxCen			8:00	8:30	8:40			
Dose 90mg	Route p/o	Frequency t-o-t						
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 10/1/24	20:00	20:30	20:00			
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Crestavast								
Dose 40mg	Route p/o	Frequency o-o-t						
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 10/1/24	20:00	20:30	20:30			
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Fournis - B.			8:00	8:30	8:40			
Dose 1tab	Route p/o	Frequency t-o-t						
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 10/1/24						
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Reminax (Mag Chelate)			8:00	8:30	8:40			
Dose 200mg	Route p/o	Frequency t-o-t						
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 10/1/24 @ 15:45	20:00	20:30	20:30			
		Stop Date & Time						
Additional Info:								
Area In-charge Nurse Signature:				[Signature]	[Signature]	[Signature]		

REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given					
			Time ↓						
DRUG NAME T. COPIRACIN			8.00	11/1/24	12/1/24				
Dose 200mg	Route P.O.	Frequency 1-0-1		9.50	8.45				
Dr. Sign & Reg. No. / Seal <i>[Signature]</i>		Start Date & Time 11/1/24 @ 9.30							
		Stop Date & Time							
Additional Info:			21.00	21.00					
DRUG NAME 828. CEFTRIAXONE									
Dose 15ml	Route P.O.	Frequency 0-0-1							
Dr. Sign & Reg. No. / Seal <i>[Signature]</i>		Start Date & Time 11/1/24 @ 9.30							
		Stop Date & Time							
Additional Info:			24.00	24.00					
DRUG NAME									
Dose	Route	Frequency							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
		Stop Date & Time							
Additional Info:									
DRUG NAME									
Dose	Route	Frequency							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
		Stop Date & Time							
Additional Info:									
DRUG NAME									
Dose	Route	Frequency							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
		Stop Date & Time							
Additional Info:									
Area In-charge Nurse Signature:									

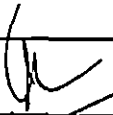


AS REQUIRED PRESCRIPTIONS			Date →	To be filled by Nursing Staff only. Sign and time given								
			Time ↓									
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
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			</							

[illegible]

A 111.

[illegible][illegible]

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
10/1/24	17:30	Om diet		91210					
11/1/24	8:00	Om Diet		88439					
12/1/24	9:00	Diabetic diet		13455					

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			
10/1/24	Evening	Rathina Priya	0187	RS		Evening			
10/1/24	Night	Mathuritha	0244	K.		Night			
11/1/24	Morning	S. Premalatha	0211	PS		Morning			
11/1/24	Evening	M. Ravalhi	0225	MD		Evening			
11/1/24	Night	Genipya	0284	GS		Night			
12/1/24	Morning	P. M. S. S. S. S.	2373	H.		Morning			
02/1/24	Evening	Hannah E. S. S.				Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

ASIS:- 72DM) CALCIFIC LAD & REA DISEASE / (N) JF FUNCTION /



Mrs.UMA P
56/Female/MH1202381495
10/01/2024/IPH2024000083
Dr.G. GNANAVELU

MHI/ICU/2022/064



every heart beat counts

INTERMEDIATE CARE FLOWCHART

A

NAME : Mrs. UMa

UHID NO : 202381495 AGE : 56y SEX : f

SURGICAL PROCEDURE : PTCB TO LAD + REA + Trus

POSTOP DAY : D₁

FLUID REQUIREMENT :

10/1/24 → 11

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS			ORAL/ R.T.			TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T. (Cath)		AIR LEAK	H.T.	G.T.		NS			H.T.	H.T.	G.T. (Cath)		
17:00		300					300	30			30		550	580	+280ml
18:00		300					300	30			30	120	670	700	+400ml
19:00	900	1200					1200	30			30	20	690	750	+450ml
20:00		1200					1200	30			30	50	740	830	+370
21:00		1200					1200	30			30	150	890	1010	+790
22:00		1200					1200	30			30	50	940	1090	+110
23:00	400	1600					1600	30			30	50	990	1140	+430
00:00		1600					1600	DL					990	1140	+430
1:00		1600					1600					50	1040	1220	+380
2:00		1600					1600						1040	1220	+380
3:00		1600					1600						1040	1220	+380
4:00	300	1900					1900					50	1090	1240	+630
5:00		1900					1900						1090	1240	+630
6:00		1900					1900						1090	1240	+630
7:00		1900					1900					50	1140	1320	+580

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS

R.NO : 111



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Medway
Heart
Institute
heart beat counts

B

SEX : F

B.S.A: 1.28 M²

[illegible]

DYSIDEMIA / HYPOTHYROIDISM



Mrs.UMA P
56/Female/MHI202381495
10/01/2024/IPH2024000083
Dr.G. GNANAVELU

MHI/ICU/2022/064
Medway Heart Institute
Every heart beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : Mrs. UMA

UHID NO : 202381495

AGE : 56y

BLOOD GROUP :

HEIGHT : 166 cm

WEIGHT : 71 kg

B.S.A : 1.28 m².

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
17:00	73	sinus	98%	124/75	91	warm	++	13	B/c	99%	ON RA
18:00	71	sinus	98%	141/78	99	warm	++	20	B/c	98%	"
19:00	73	sinus	98%	130/83	99	warm	++	18	B/c	99%	"
20:00	89	sinus	97%	153/80	104	warm	++	15	B/c	98%	"
21:00	85	sinus	97%	132/71	91	warm	++	16	B/c	98%	"
22:00	80	sinus	97%	136/64	90	warm	++	21	B/c	97%	"
23:00	78	sinus	97%	122/64	83	warm	++	20	B/c	98%	"
00:00	92	sinus	97%	138/70	93	warm	++	23	B/c	97%	"
01:00	93	sinus	97%	114/66	83	warm	++	20	B/c	98%	"
02:00	78	sinus	97%	120/70	84	warm	++	18	B/c	97%	"
03:00	68	sinus	97%	112/81	104	warm	++	23	B/c	98%	"
04:00	60	sinus	97%	129/76	33	warm	++	22	B/c	97%	"
05:00	80	sinus	97%	142/81	104	warm	++	24	B/c	98%	"
06:00	60	sinus	97%	129/76	33	warm	++	25	B/c	97%	"
07:00	88	sinus	97%	146/79	101	warm	++	18	B/c	99%	"
PREVIOUS DAY - HOURS											
DRAINAGE						TOTAL INTAKE					
URINE						TOTAL OUTPUT					
						BALANCE					

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



Medway Hospitals

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

Mrs.UMA P

56/Female/MHI202381495

26/12/2023/IPH2023002598

Dr.G. GNANAVELU



Consultant:

(Affix Label here)

UMA

Sex:

Dr. JS

MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Gnanavelu

Speciality: Cardiologist

Advised Date & Time: 26/12/23

10:43 AM

Provisional Diagnosis:

DM
DLP

Reason for Admission:

☐ Medical Management

☐ Surgical Management

☐ Others (please specify details)

CAG

Admission Type:

☒ Day Care

☐ ER

☐ Ward

☐ ICU

(Specify details)

Surgery / Procedure Name (if planned):

CAG

Blood Product Requirement: ☒ No

☐ Yes (Kindly specify details of components required in space below)

Expected Duration of Stay:

Day Care

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

Payer: ☒ Self ☐ Insurance ☐ Others:

Instructions to Nurse (if any):

Admit in ERL

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

[Signature]

Dr. Gnanavelu

39469

26/12/23

10:43

For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☒ Others PL

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

26/12/23

11:05 AM

26/12/23

11:05 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

[Signature]

Jenab/cy

MH/273

26/12/23

11:05 AM

ADMISSION FORM

Marital Status M	Full Address No. 56/99 Dr. Radhakrishna nag Thiruvananthapuram Co. 19		Telephone Number 9176284850
Occupation R	Referred from Dr. Anand K. V.		Date of Time of Admission 26/12/2023 11.05
Date & Time of Discharge 26/12/23 at 18.00		Total No. of Days 7hr	
UNIT RL	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
BIFASCICULAR BLOCK			T45.2
NORMAL RL FUNCTION			I50.2
TYPE II DIABETES MELLITUS			E11.9
HYPOTHYROIDISM			E03.9
DYSLIPIDEMIA			E78.5
SINUS RHYTHM			I49.8
DATE	OPERATION / PROCEDURES		ICPM Code
26/12/23	CORONARY ANGIOGRAM		88-50
DATE	TYPE OF ANESTHESIA		
26/12/23	<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			
Signature of the Consultant (Signature)		Signature of Medical Records Officer (Signature)	

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 the 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

26/12/2022

தேதி

Date

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

உறவுமுறை

Nature of Relationship


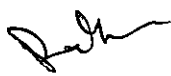

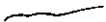

GENERAL CONSENT FOR ADMISSION

I, Uma 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		Uma	26/12/23	11:05 am
Surrogate/Guardian (if applicable #)		Rathna (Write name and relationship with patient)	26/12/23	11:05 am
Reason for surrogate consent	Patient is unable to give consent because:			
Witness				
Interpreter (if applicable)				

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



JCI ACCREDITED



NABH ACCREDITED



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

DAY CARE DISCHARGE SUMMARY

IP No.	IPH2023002598	D.O.A	: 26/12/2023
UHID	MHI202381495	D.O.P	: 26/12/2023
Name	Mrs. UMA. P	Room No.	: RL
Age / Gender	56 Years / FEMALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 26/12/2023

DIAGNOSIS:

BIFASCICULAR BLOCK

NORMAL LV FUNCTION

TYPE II DIABETES MELLITUS

HYPOTHYROIDISM

DYSLIPIDEMIA

SINUS RHYTHM

PROCEDURE: CORONARY ANGIOGRAM DONE ON 26.12.2023 – SIGNIFICANT CALCIFIC LAD & RCA DISEASE.

BRIEF HISTORY:

Mrs. Uma. P, 56 years old Female, Presented with complaints of chest pain. She was advised Coronary angiogram and referred to Medway Heart Institute on 26.12.2023 for which she has been admitted.

EXAMINATION:

HR: 84bpm ; BP: 150/90mmHg ; SPO₂ : 99% in room air
CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD(14.11.2023): Hb- 13.0gm/dl.

EKG: sinus rhythm, HR – 80bpm, complete RBBB, VPD

ECHO: Normal valves & chambers. No wall motion abnormality. Normal LV function. EF – 75%. Normal pulmonary artery pressures. Occasional ventricular ectopics.

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

f @MedwayHospitals @medwayhospitals in @medway-hospitals @medwayhospitals



94457 94457
1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

MHI/HOSP/2022/118

CORONARY ANGIOGRAM FINDINGS:

Right-dominant system; **SIGNIFICANT CALCIFIC LAD & RCA DISEASE** .(reports enclosed)

ADVICE : IVUS GUIDED PCI to LAD / RCA

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. ECOSPRIN	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. AX CER	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ROZAVEL	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. THYROX	75 MCG	1	0	0	ORAL	EMPTY STOMACH	TO CONTINUE
5	TAB. RANOZEX	500 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	TAB. CALBRIT	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
7	TAB. EVION LC	1 TAB	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
8	TAB. PANTOCID	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
9	TAB. TRIVOLIB	1 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. STALIX	50 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11	TAB. FOURTS B	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE

DIET	LOW FAT & DIABETIC DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH DR. G. GNANAVELU FOR PCI.

To report: If temp > 101 °F / Difficulty in breathing / chest pain / Giddiness/ palpitations.

In case of emergency Contact: Medway Hospitals @ 4310 8959.

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

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

"I understood the Content of this discharge summary."

Typed by: Ezhilarasi.

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

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PATIENT HELPLINE 94457 94457 1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959

Institute of Pulmonology 044-2473 4454



DAY CARE INITIAL ASSESSMENT FORM

Date: 26/12/23 Time of arrival: 11.30

Part A (to be filled by Nurses)

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 84 (beats/min) | BP: 150/90 (mmHg)
Respiration: 20 (breaths/min) | SpO₂: 99 (%) | Height: 158 (cms) | Weight: 72.1 (kgs) | BMI: 28.9 kg/m²

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

Allergies ☒ Yes ☐ No If Yes, specify: SULPHA DRUG

Psychosocial Assessment:

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

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

If Yes, specify details: _____

Pain Screening

Pain: ☐ Yes ☒ No. If Yes, Score: _____

Pain Scale used: ☐ PIPPS (28 weeks to < 38 weeks) ☐ CRIES (38 weeks - 2 months)

☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)

☒ Numerical Rating Scale (Age more than 12 years)

Duration: _____ Location: _____

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

Nutritional Screening:

Last 3 months Appetite ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight ☐ Increased ☐ Decreased ☒ No Change

Fall Risk Screening for adults:

☒ No Risk

☐ Age more than 65 years ☐ History of fall in last 3 months

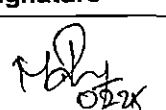
☐ Walks with assistance ☐ Any neurological problem

In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

Fall Risk Screening (for pediatrics).

☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ☒ No Risk

In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

	Signature	Name	Emp. No.	Date	Time
Nurse		M. Revathy	0225	26/12/23	11.30

Part B (to be filled by Physicians)

Chief Complaints

cto of chest pain

Past Medical History

Personal History

Significant Family History

Current Medication

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	TAB. ECOSPRIN	75mg	PO	0-1-0	25/12/23 at 2pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. AXCEL	90mg	PO	1-0-1	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. ROZAVEL	40mg	PO	0-0-1	25/12/23 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. THYROX	75mcg	PO	1-0-0	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. RAPDOZEX	500mg	PO	1-0-1	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. CALBATT	1TAB	PO	1-0-0	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. EVION LC	1TAB	PO	0-0-1	25/12/23 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. PANTOZIP	40mg	PO	1-0-1	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. TRIVOLIB	1mg	PO	1-0-1	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	TAB. STALIX	50mg	PO	1-0-1	26/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

TAB. FOLVITEB 1TPB PO Now 26/12/23 at 8am

Clinical Examination / Investigation

oriented & conscious.
CNS - S. N. ③
Abdomen soft.

Hb = 13.0 gm/dl.
EF = 75%.

Provisional Diagnosis

BRIBASCULAR BLOCK
NORMAL LV FUNCTION
TYPE II DIABETES MELLITUS
HYPOTHYROIDISM
DYSLIPIDEMIA
SINUS RHYTHM

Plan of Care (including Investigations Ordered)

CAG

Doctor's Signature

Name

Dr. Koushik

Reg. No.

85851

Date

26/12/25

Time

11.40



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



Mrs.UMA P

56/Female/MH1202381+95

26/12/2023/IPH2023002598

Dr.G. GNANAVELU



MHI/IP/2022/041



heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
	<u>CAR Notes</u>
26 Nov 23 13:30	App - (C) Radial artery A-DVD plan - PCC to start / for (DWS guided)
	R 102766
14:30	pt received. Stable No ooze. GAG - DVD Plan :- PTCA to LAD & RCA.
16:00	plan discharge today.
	K 8588

Department of Dietetics

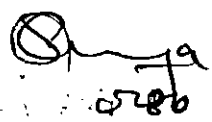
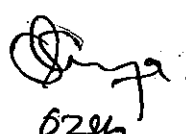
NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Affix Label here)
Name: Mrs. Uma
UHID: MHI 202381495
DOB: 56Y Sex: F
DOA: 26/12/23
Consultant: Dr. Gnanakumar

Diagnosis: CAG / ACS / T2DM / SIP PC / (2023) / EF - 82%
Height: 158 cms Weight: 72.1 Kgs Food allergies: Yes/No, if yes, specify:
Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain
Diet Prescription: 1600 calories, Low Fat, low salt, Diabetic diet

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<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 (7 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Frequency of re-assessment: <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Fort-night <input type="checkbox"/> Monthly				
Enteral / Parenteral <input type="checkbox"/> Daily <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes				

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>26/12/22 10:00</p>	<p>75 years old female came c/c chest pain was assessed to be well-nourished as evident by SGA. K/clo- T2DM/HTN. patient shifted to cath lab for procedure (CABG). kept NBM. patient received to radial lounge. Educated the patient & family on 1600 calories, low fat, low salt, diabetic diet on discharge. Emphasized on small frequent meals & low glycaemic control. Diet modifications & classifications done. Diet chart given on discharge.</p>	<p> 02/12/22</p>
<p>26/12/23 10:00</p>		<p> 02/12/23</p>



PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: BIFASCICULAR Block
Normal ECG function
7.20 PM

Allergies if any: UNKNOWN

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
R2	cath lab	26/12/23	13.00	CAG

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

ASSESSMENT OF PATIENT:

General condition of Patient: ☒ Conscious ☐ Semi-conscious ☐ Un-conscious

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

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.6	20 bpm	80 bpm	100%	120/84	0/10

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

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
		A. Sankar	0202	26/12/23	13.00
Handed over to		V. Shrinaya	0202	26/12/23	13.00

After Procedure:

Procedure completed: ☐ Yes ☒ No Any critical information: Ni/

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 bpm/min	82 bt/min	100%	128/86(92)	4/10

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)

Handover by	Signature	Name	Emp. No.	Date	Time
		V. Shrinaya	0202	26/12/23	13.45
Handed over to		A. Sankar	0202	26/12/23	13.45

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

Mrs.UMA P	
Patient Name	56/Female/MHI202381495
	26/12/2023/IPH2023002598
Consultant:	Dr.G. GNANAVELU
	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		UMA	26/12/23	13.06
witness		ARUNA CHALAM	26/12/23	13.06
Doctor		Dr. GNANAVELU	26/12/23	13.00
Interpreter				

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஹெசுஈடி (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 லோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவடை/கையினுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டிருள்ள காண்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே 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 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 (புனான் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள 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 இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (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) அவசரமாக 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 கவாடை 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 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 முன்மொழியப்பட்டு செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத்தேர்வுகள், 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 கிரத்தமேற்றாதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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

TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mrs. UMA.P	ID:	MHI202381495
Age/Gender :	56 F	IPH:	IPH2023002598
Cath No. :	3469	DOP:	26.12.2023
Done by	Assisted by	Technician	Physician assistant
Dr.Gnanavelu	Ms. Panchavarnam	Mr. Pandiyan	Ms. Shalini

DIAGNOSIS: T2DM; DYSLIPIDEMIA; HYPOTHYROID; BIFASCICULAR BLOCK; NORMAL LV FUNCTION

Access: Right radial artery

Total exposure time: 205.8"

Hardware used: 5F sheath, 5F TIG

Total DAP: 18.35 Gy.cm²

Contrast used: CONTRAPAQUE 50 ml

Total RAK: 89.53 mGy

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

Hemodynamic data: Aortic pressure: 126/75(93) mmHg; HR 82 bpm; SpO2 99%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx. Calcified coronaries.
LAD	Type 3 vessel. Proximal LAD has luminal irregularities. Mid LAD has 70-80% tubular stenosis with calcification. Distal LAD has 50-60% tubular stenosis. Gives 3 diagonals which are thin vessels with luminal irregularities.
LCx	Nondominant. Proximal LCX after OM1 shows 30% discrete stenosis. Distal LCX is a thin vessel with luminal irregularities. Gives 4 OMs. OM1 and OM2 are major vessels which have luminal irregularities.
RCA	Dominant. Proximal RCA is normal. Mid RCA has 70% tubular stenosis. Distal RCA has 30% discrete stenosis. PDA and PLV are normal.
IMA	LIMA & RIMA are normal.


FINDINGS: RIGHT DOMINANT SYSTEM; SIGNIFICANT CALCIFIC LAD & RCA DISEASE

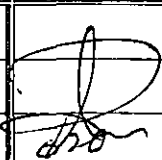
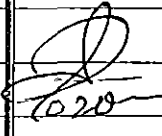
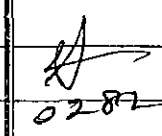
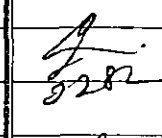
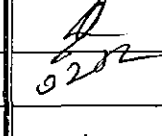
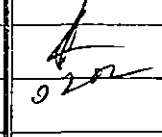
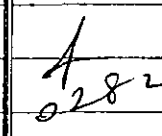

ADVICE: IVUS GUIDED PTCA TO LAD & RCA


Dr. G. GNANAVELU, MD, DM

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



DATE & TIME	Observation / Action	Signature with Emp.No
26/12/23	Admission Note.	
at 11.50	⇒ Patient got admitted for RI	MD 0358
	⇒ Patient hemodynamically stable.	
	⇒ conscious & oriented.	
	⇒ vitals checked & recorded.	
	⇒ Today's plan NPO from	MD 0358
	⇒ Patient shifted to Cath lab	
	⇒ Patient hand over given to the Cath lab staff.	
26/12/23	CATH LAB	
12.10	⇒ pt arrived RI to Cath lab	MD 0358
	pt conscious & oriented pt vital stable	
	pt RV line patient	
13.15	⇒ CAB procedure started. pt Radial artery approach.	MD 0358
13.15	⇒ ENJ: NTG 300 mcg + ENJ: Heparin 5000 IU given (o/b DR.G.V. (SR))	MD 0358
13.15	⇒ HR: 82 bpm Bp: 125/78 (83) mm Hg SpO2: 100% vital stable.	MD 0358
13.30	⇒ CAB procedure done.	MD 0358
Document endorsed by	Signature	Name
		Dr. G. Gnanavelu
	Emp. No.	Date
	00/6	26/12/23
		Time
		13.30

DATE & TIME	Observation / Action	Signature with Emp.No			
26/12/22 13:40	⇒ Rt Radial artery sheath removed tight pressure bandage applied no oozing no haematom	 0282			
13:45	⇒ pt shifted Cath lab to Re	 0282			
13:45	Received pt from Cath lab, pt is haemodynamically stable with out support. No oozing & no haematuria. While receiving HR: 80bpm, NIRS = 148/44 mmHg, SpO2 = 99%, RR = 20bpm.	 0282			
14:00	pt tolerated oral feeds.	 0282			
14:30	Urine out put adequate.	 0282			
16:00	pt is haemodynamically stable. plan for discharge today.	 0282			
18:00	pt get discharged with all old report, discharge summary, Angio report, & Angio image. while discharge pt is stable	 0282			
Document endorsed by	Signature 	Name JAYAKRISHNAN	Emp. No. 0282	Date 26/12/22	Time 18:30

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086



Mrs.UMA P

56/Female/MHI202381495

26/12/2023/1PH2023002598

Dr.G. GNANAVELU



Name of the Procedure : CAG Location : Cath lab Date & Time : 26/12/23

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>13:10</u> Before Induction of Procedural Sedation		TIME OUT <u>13:15</u> After procedural Sedation and before procedure		SIGN OUT <u>13:30</u> 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 <u>CAG</u> <input checked="" type="checkbox"/> Yes	
Procedure	<input type="checkbox"/> Yes	Procedures <u>CAG</u>	<input type="checkbox"/> Yes	Name and site of all specimens / investigations confirms labeling and sent to lab <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>RT Radical artery approach</u>	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		
		Expected Blood loss <u>NA</u>			
Consent	<input checked="" type="checkbox"/> Yes	Position <u>supine</u>	<input 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>	
		Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Difficult airway / aspiration risk / dentures	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Possibility of hypothermia	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
		Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify : <u>2</u>	
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	<input type="checkbox"/> Yes		
<input checked="" type="checkbox"/> Spo2 <input type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify <u>ECG</u>		Anticipated blood loss briefed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Adequate fluids and blood available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input type="checkbox"/> Yes	Corrective action : <u>2</u>	
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	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	Doctor performing the Procedure : <u>Dr. G. Gnanavelu</u>	Nurse <u>SN Panchavaram 0020</u>	Technician : <u>Prathap 018</u>	Others Please Specify :
Date : <u>26/12/23</u> Time : <u>13:45</u>	Date : <u>26/12/23</u> Time : <u>13:45</u>	Date : <u>26/12/23</u> Time : <u>13:45</u>	Date : <u>26/12/23</u> Time : <u>13:45</u>	Date : <u>26/12/23</u> Time : <u>13:45</u>

Procedure Monitoring Sheet (Cath Lab)

Patient Name : Mrs.UMA P
56/Female/MH1202381495
UHID / IP : 26/12/2023/IPH2023002598
Consultant : Dr.G. GNANAVELU

Age / Sex : 56y / Female
Ward Unit : RL
Diagnosis :

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

PARAMETERS	YES	NO	NA
Vital signs : BP:..... Temp:..... Pulse:..... RR:..... SPO2:			
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered		✓	
Procedure site marked	✓		
Skin preparation done	✓		
NPO <u>11.00</u>	✓ <u>11.00</u>		
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 : <u>MD [Signature]</u>	Date & Time : <u>26/12/23 at</u>		

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

Time	HR / min	RR / min	BP mmHg	SpO ₂ %	Medication / Remarks	Sign. of Nurse
<u>13.20</u>	<u>82b/min</u>	<u>22b/min</u>	<u>125/78(83)</u>	<u>100%</u>	<u>—</u>	<u>[Signature]</u>
<u>13.30</u>	<u>82b/min</u>	<u>22b/min</u>	<u>124/78(84)</u>	<u>100%</u>	<u>—</u>	<u>[Signature]</u>
			<u>procedure got over</u>		<u>—</u>	

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

Time : 13.30 Route : RT Radial artery approach
 Complication : Nil

BP : 123/86 (78) mmHg, HR : 82 b/min, RR : 22 b/min SpO2 : 100%

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

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 arterial dressing on 27/12/23 at 13.15 AM / PM after informing to the consultant.

- ◆ Special instruction if any:

Nil

homb

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
26/12/23 13.40	123/86	82	22	100%	no oozing no hematoma	Good	-	Dora

Nurses Notes :

CABG procedure done RT Radial artery
 sheath removed tight pressure bandage applied
 no oozing no hematoma

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time :

[Signature]

26/12/23 13.40



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		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	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	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	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	3		
					TOTAL SCORE	23	23	
					Initial & Emp. No. of Staff Nurse:	[Signature]		
					Initial & Emp. No. of Sr. Staff Nurse:	[Signature]		

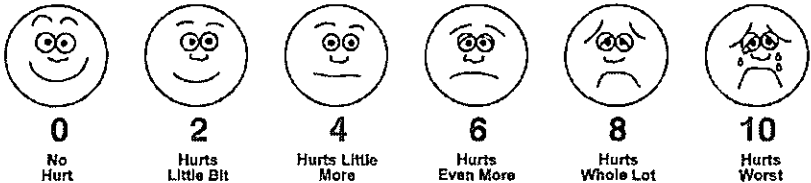
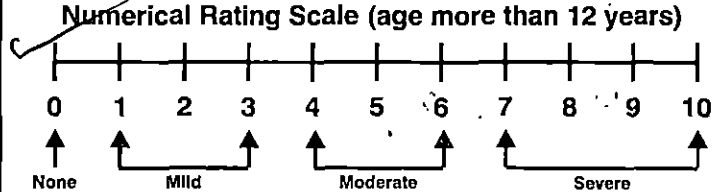
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

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.
26/12/23 12.00	0/10	NO pain	-	-	-	MD 0202	Jaf 0001
		pt shifted to cath lab at 13.00 pt received from cath lab at 13.45					
14.00	0/10	No pain	-	-	-	MD 0202	Jaf 0001
15.00	0/10	No pain	-	-	-	MD 0202	Jaf 0001
16.00	0/10	No pain	-	-	-	MD 0202	Jaf 0001
17.00	0/10	No pain	-	-	-	MD 0202	Jaf 0001
18.00	0/10	No pain	-	-	-	MD 0202	Jaf 0001
			P/C				

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


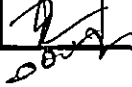
PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - 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)	 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst					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							

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		26/12/23						
Time		12-00						
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0						
5	Entire leg swollen (Assess for both legs)	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0						
9	Previously documented DVT (Assess for both legs)	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0						
FINAL SCORE		0						
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		Low						
DVT prophylaxis started		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								

MODIFIED MORSE FALL RISK ASSESSMENT CHART

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

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

[illegible]

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

, 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, India


044-2473 4455


care@medwayhospitals.com

Registration No	: MHI202381495	Patient Name	: UMA P
Age	: 56	Gender	: Female
IP Number	: MMH/HM/IPH2023002598	Discharge Date	: 26/12/2023 7:32:00PM
Bill No	: MMH/HM/IPH00612	Bill Date	: 26/12/2023 7:30:41PM
Ward Name	: RADIAL LOUNGE	Bed Name	: V_RL-6

NO DUE


Prepared By


Approved By


Checked By