

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



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Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Anbarasu Mohanraj Speciality: Cardiology

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

Provisional Diagnosis:

CAD - TVD / ACS - Evolved ANMI /
mod. LV systolic function
EF - 41% / T2DM

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):

CABG

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

Expected Duration of Stay: 5 days

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

Payer: ☒ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Follow drugs as per chart

Any other Instructions (if any):

Doctor's Signature

Dr. Anbarasu Mohanraj

Name

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

Reg. No.

55476

Date

10/01/24

Time

10:10

For admission desk staff only:

Room Category:

☒ General Ward

☐ Single Room

☒ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others 104

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

10-1-24

10:06

10-1-24

10:06

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

Prithika

Prathiba.K.P

0192

10-1-24

7A44
255

ADMISSION FORM

Marital Status M	Full Address 12/62 Old Street, Karukudi, Arakkudi - 53.	Telephone Number 9176672726 9500142206.	
Occupation LOA			
Referred from Dr. A.M	Date of Time of Admission 10-1-24 10:06	Date & Time of Discharge 17/1/24@16:00	Total No. of Days 18 days
UNIT Cardiothoracic	MLC ☐ Yes ☒ No If Yes AR No. :		

FINAL DIAGNOSIS	ICD Code
Triple vessel coronary artery disease ACS - Evolved	I25.1
Anterior wall myocardial infarction class II - III Angina	I24.9
Acute LV Failure - accompanied moderate LV systolic	I50.9
Dysfunction - EF - 40% Type II Diabetes mellitus	T50.1
Systemic Hypertension	E11.9
	I10

DATE	OPERATION / PROCEDURES	ICPM Code
11/1/24	off pump coronary artery Bypass grafting surgery (OPCAB) x 3 grafts LIMA TO LAD, SVG TO OM and SVG to PDA done on 11.01.24	36.13 99.00
DATE	TYPE OF ANESTHESIA	
11/1/24	☒ GENERAL ☐ SPINAL ☐ LOCAL ☐ REGIONAL ☐ EPIDURAL	

DISCHARGE STATUS		
☐ Cured	☐ Discharge at Request	☐ Expired < 48 hours
☒ Improved	☐ Against Medical Advice	☐ Expired > 48 hours
☐ Unchanged	☐ Absconded	☐ Post-Operative Death
Dr. Anbarasu Mohanraj Reg No: 55476 Signature of the Consultant		
Signature of Medical Records Officer		

100

Father

...
worthy

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

ਸਿੰਧੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸ਼ਬਦ "ਮਾਧਵ" ਦਾ ਅਰਥ ਹੈ "ਸ਼ਾਕਤੀਸ਼ਾਲੀ"।

மாநத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையாப்பமிட்டேன்.

May 0105

தேதி

V. T. Galtsoff

Date _____

Signature of the Patient / Relative / Gurdian

10-1-24

son

உறவுமுறை

Nature of Relationship

GENERAL CONSENT FOR ADMISSION

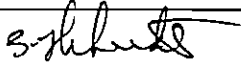
I, Thandava Moorthy S the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ 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		S. THANDAVA MOORTHY	10-1-24	10:06
Surrogate/Guardian (if applicable #)		T. SATHISH (Write name and relationship with patient)	10-1-24	10:06
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		T. Chandan	10-1-24	10:06
Interpreter (if applicable)				

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



ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE	
1	Hemodynamic instability defined as		
	Pulse less than 40 or more than 150 beats/minute		
	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure		
	Mean arterial pressure less than 60 mm Hg		
	Diastolic arterial pressure more than 120 mm Hg		
	Respiratory rate more than 35 breaths/minute		
2	Cardio-vascular System		
	Acute myocardial infarction		
	Cardiogenic shock		
	Complex arrhythmias requiring close monitoring and intervention		
	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support		
	Hypertensive emergencies		
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain		
	Post cardiac arrest		
	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms		
	Complete heart block		
3	Miscellaneous Conditions		
	Septic shock with hemodynamic instability		
	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
4	Post procedure elective admission		
	Post Coronary Angioplasty		
	Post Cardio-vascular Surgery	✓	
5	Following angiographic procedure		
	Complication resulting from the angiographic procedure including any significant change in pulse in the affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-procedure		
	Significant findings on diagnostic angiography warranting further therapy that would necessitate inpatient admission is also a reasonable indication for admission		
	Admission at the time of the study is encouraged if problems are suspected or arise		
6	Pulmonary System		
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		
	Pulmonary emboli with hemodynamic instability		
	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory deterioration		
	Need for nursing / respiratory care not available in such intermediate care units		
	Massive hemoptysis		
	Respiratory failure needing imminent intubation		
7	Renal failure		
	Oliguria or anuria for more than 12 hours		
	Metabolic acidosis (pH <7.1)		
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
8	Endocrine System and Metabolism related	
	Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis	
	Thyroid storm or myxedema coma with hemodynamic instability	
	Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl	
	Other endocrine problems such as adrenal crises with hemodynamic instability	
	Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring	
	Hypo or hyponatremia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered mental status	
	Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias	
	Hypo or hyperkalemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or muscular weakness	
	Hypophosphatemia with muscular weakness	

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Pavan	112236	11/1/24	12

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

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

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Pavan	112236	13/1/24	10.45



DISCHARGE SUMMARY

IP No.	: IPH2024000081	D.O.A	: 10/01/2024
UHID	: MHI202381312	D.O.D	: 17/01/2024
Name	: Mr. THANDAVA MOORTHY.S	Room No.	: 104
Age / Gender	: 57Years / MALE		
Consultant	: Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead – Cardio Vascular and Thoracic Surgery		

D.O.S: 11.01.2024

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE
ACS – EVOLVED ANTERIOR WALL MYOCARDIAL INFARCTION
CLASS II – III ANGINA
ACUTE LV FAILURE – RECOVERED
MODERATE LV SYSTOLIC DYSFUNCTION – EF: 40%
TYPE II DIABETES MELLITUS
SYSTEMIC HYPERTENSION

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS:
LIMA TO LAD, SVG TO OM AND SVG TO PDA DONE ON 11.01.2024

BRIEF HISTORY:

Mr. Thandava Moorthy.S, 57 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, ACS – Evolved anterior wall myocardial infarction, Acute LV failure – recovered, CAG – Triple vessel disease, Moderate LV systolic dysfunction, has come for CABG. Patient was apparently normal till 26.11.2023 when he developed chest pain – retrosternal, radiating to jaw and both shoulders associated with palpitation and sweating. H/o breathlessness on exertion. Initially, he was taken to Chennai Health Foundation where he was diagnosed as ACS – Evolved anterior wall myocardial infarction. He was managed conservatively and was referred to Madras Medical Mission for further management. He was treated with IV diuretics, LMWH, antiplatelets, statin, antihypertensives and other supportive medications. After medical stabilization, he underwent Coronary Angiogram on 28.11.2023 which showed Triple vessel disease. He then came to Medway Heart Institute on 15.12.2023 and was advised early CABG. Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, he is getting admitted for the same. No H/O Syncope or Swelling of Legs. No H/O CVA, CKD, BA or Hypothyroidism.



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NAME : Mr. THANDAVA MOORTHY.S UHID : MHI202381312

IPNO: IPH2024000081

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP - 98° F
HR - 86bpm
BP - 130/70mmHg
SPO₂ - 96% in room air
CVS - S1S2 (+)
RS - BAE (+)
Abdomen - Soft, BS (+)
CNS - NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	17.1	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	50.6	39-52	%
TWBC	7960	4000 - 10000	Cells/Cumm
NEUTROPHILS	59.8	40-70	%
LYMPHOCYTES	31.0	20 - 40	%
EOSINOPHILS	3.9	0 - 6	%
MONOCYTES	4.7	0 - 6	%
BASOPHILS	0.6	0 - 2	%
PLATELET	170000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Cells/Cumm
Urea	35	14 - 40	mgs/dl
Creatinine	0.86	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na ⁺)	138	135 - 145	mmol/l
Potassium (K ⁺)	4.29	3.4 - 5.5	mmol/l
T. Bilirubin	0.55	0.2-1.0	mg/dl
D. Bilirubin	0.23	0.00 - 0.4	mg/dl
I. Bilirubin	0.32	0.4-0.6	mg/dl
S.G.O.T	30	<38	U/L
S.G.P.T	44	<41	U/L
ALP	118	Adult: 42 - 141	U/L
GGT	25	Male : 10 - 45 Female : 5 - 32	U/L
Total Protein	8.0	6.0 - 8.0	gm/dl
S. Albumin	5.2	3.5 - 5.0	gm/dl

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Heart Institute | Institute of Pulmonology
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NAME : Mr. THANDAVA MOORTHY.S UHID : MHI202381312 IPNO: IPH2024000081

PROTHROMBIN TIME	11.6	Normal : 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction : 2.0 - 3.0 Deep Vein Thrombosis : 2.0 - 3.0 Pulmonary Embolism : 2.0 - 3.0 Artificial Cardiac Value : 3.0 -4.5 Recur.Systmic Embolism: 3.0 - 4.5 INR	
INR	0.9		
HBA1C	7.7	Normal: Below 6.0 Good control: 6.1-7.0 Fair Control : 7.1-8.0 Unsatisfactory: 8.1-10.0 Above 10 : poor control (GHB is an index of your blood Sugar control for the past (3 months)	%
T.S.H	1.43	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	uIU/ml
T3	5.02	"Adult : 60 - 152 New born - 4 days : 96 - 730 1 - 11 Months : 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	20.1	"Adult : 4.6 - 9.3 New born - 4 days : 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs : 6.3 - 13.16	ug/dl

ECG: HR – 90bpm, sinus rhythm, A WMI (+)

ECHO: EF CALCULATED BY SIMPSON'S METHOD: LV EDV : 128ML, ESV: 83ML, EF: 40 %, AORTIC GRADIENT – MAX GRADIENT – 5 MM HG, MEAN GRADIENT – 3 MM HG, E/A RATIO : 0.56, MEDIAL E/E: 6.62, LATERAL E/E : 6.03, TR GRADIENT – 31MM HG, RVSP: 41 MM HG, ALL CHAMBERS NORMAL SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT – SEPTUM, MID AND APICAL ANTERIOR, APICAL INFERIOR HYPOKINETIC. APEX THINNED. MODERATE LV SYSTOLIC DYSFUNCTION – EF : 40 %, GRADE I DIASTOLIC DYSFUNCTION, NORMAL RV SYSTOLIC FUNCTION, IAS / IVS INTACT, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, MILD PAH, IVC NORMAL IN SIZE AND COLLAPSING, NO CLOT / VEGETATION / EFFUSION.

CXR: PA film, lung fields clear.

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NAME : Mr. THANDAVA MOORTHY.S UHID : MHI202381312 IPNO: IPH2024000081

COURSE IN THE HOSPITAL:

Mr. Thandava Moorthy.S, 57 years old male, was admitted with above mentioned complaints. He underwent **OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS: LIMA TO LAD, SVG TO OM AND SVG TO PDA DONE ON 11.01.2024.** He was shifted to SICU with stable hemodynamics and Inj. Nor adrenaline 0.05µg/kg/min, Inj. Adrenaline 0.03µg/kg/min supports. He was extubated on the same day (11/01/2024) at 14.50 pm. Drains were removed on POD1 (12/01/2024). He was shifted to ward on POD 2 (13/01/2024). Suture removal was done on POD5 (16/01/2024). Patient course in the hospital was uneventful. His medications are optimized and he is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR - 78/min BP - 110/70mmHg
SPO2 - 96% in room air

POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	8.4	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	25.1	39-52	%
TWBC	6700	4000 - 10000	Cells/Cumm
NEUTROPHILS	66.8	40-70	%
LYMPHOCYTES	25.0	20 - 40	%
EOSINOPHILS	3.3	0 - 6	%
MONOCYTES	4.7	0 - 6	%
BASOPHILS	0.2	0 - 2	%
PLATELET	197000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Lakhs/cumm
Urea	25	14 - 40	mgs/dl
Creatinine	0.74	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na ⁺)	134	135 - 145	mmol/l
Potassium (K ⁺)	4.26	3.4 - 5.5	mmol/l

ECG: HR: 72bpm, sinus rhythm, A WMI, no fresh ST – T changes.

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NAME : Mr. THANDAVA MOORTHY.S UHID : MHI202381312 IPNO: IPH2024000081

ECHO : S/P CABG, ALL CHAMBERS NORMAL IN SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT – SEPTUM, MID AND APICAL ANTERIOR HYPOKINETIC. APEX THINNED. MODERATE LV SYSTOLIC DYSFUNCTION – EF : 40 %, NORMAL RV SYSTOLIC FUNCTION, RV TDI : 9 CM/S, TAPSE: 16MM, AORTIC VALVE SCLEROSIS, OTHER VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 6 MM HG, MEAN GRADIENT – 4 MM HG, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, MILD PAH, IVC NORMAL IN SIZE AND COLLAPSING, MIDL LEFT, MINIMAL RIGHT PLEURAL EFFUSION, NO CLOT / VEGETATION / PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, lung fields clear, no effusion.

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NAME : Mr. THANDAVA MOORTHY.S UHID : MHI202381312

IPNO: IPH2024000081

ADVICE MEDICATIONS:

Sl. NO.	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB.FORTIUS (ROSUVASTATIN)	1 TABLET	20MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	12.5MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. IVABRAD (IVABRADINE)	1 TABLET	5MG	1	0	1	ORAL	AFTER FOOD	X 1 WEEK
5	TAB. DYTOR PLUS LS (TORSEMIDE + SPIRONOLACTONE)	1 TABLET	10 / 25MG	1	0	0	ORAL	AFTER FOOD	X 6 WEEKS
6	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
7	TAB. LIVOGEN (FOLIC ACID + FERROUS FUMARATE)	1 TABLET	1500MCG + 152MG	1	0	0	ORAL	AFTER FOOD	X 30 DAYS
8	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATION)
9	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	1 MONTH
10	SYP. MUCOLYTE (AMBROXOL)	5ML		1	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
11	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED



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

NAME : Mr. THANDAVA MOORTHY.S UHID : MHI202381312 IPNO: IPH2024000081

DIABETIC MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. GLYCOMET GP3 (GLIMEPIRIDE + METFORMIN)	1 TABLET	3MG/ 500MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE
2	TAB. GLYCOMET GP2 (GLIMEPIRIDE + METFORMIN)	1 TABLET	2MG / 500MG	0	0	1	ORAL	BEFORE FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	HIGH PROTEIN, LOW SALT LOW FAT AND DIABETIC DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	1800ML / DAY
REVIEW	REVIEW WITH DR. ANBARASUMOHANRAJ AFTER 24/01/2024 WITH FBS, PPBS, HB, UREA, CREATININE, SODIUM, POTASSIUM, CHEST X RAY

To report: If fever > 101 °F / Difficulty in breathing / Headache / Giddiness / chest pain / Groin swelling / bleeding / discharge at operated site / Any other significant symptoms.

In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai

CONSULTANT SIGNATURE

Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)
Director and Clinical lead – Cardio Vascular and Thoracic Surgery

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

"I understood the Content of the discharge summary."

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1800 572 3003

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MHI/HOSP/2022/118

INPATIENT INITIAL ASSESSMENT

Date: 10/1/24

Time of arrival in ward: 10am

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98 (°F) | Pulse / HR: 87 (beats/min) | BP: 130/80 (mmHg)

Respiration: 18 (breaths/min) | SpO₂: 97 (%) | Height: 162 (cms) | Weight: 59.3 (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

57 yrs old male k/c/o T2DM / ACS-evolved AWM / Acute Heart failure - recovered / CAG-TVD. Patient was apparently (N) 1 month ago. When he developed Chest pain - retrosternal, radiating to jaw & both shoulders associated with Palpitation / Sweating - 4% Shortness of Breaths on exertion of 4-5 days.

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☒ Yes ☐ No. If Yes, duration: 15 yrs Hypertension: ☐ Yes ☒ No. If Yes, duration:

Others:

Not a k/c/o Bronchial Asthma / COPD / PTB / CKD / CVA.

Past Surgical History:

Not significant in Surgical history.
- No H/o fever, vomiting, loose stools.
- No H/o ↓ urine output, constipation, Obstruction.

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. Rosuva Gold	20/75mg	P/b	o-o-1	6/1/24.	☐ Yes ☒ No
2.	T. Con Con	1-25mg	P/b	h-o-o.	9/1/24	☒ Yes ☐ No
3.	T. Coversyl	2mg	P/b	o-o-1	6/1/24.	☐ Yes ☒ No
4.	T. Tide Plus	20/50mg	P/b	h-o-o.	9/1/24	☒ Yes ☐ No
5.	T. Metformin +	500mg	P/b	h-o-1	9/1/24.	☒ Yes ☐ No
	T. Glimipide	1mg				☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

Nil

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):

General Physical Examination:

Pallor: ☐ Yes ☒ No Icterus: ☐ Yes ☒ No Clubbing: ☐ Yes ☒ No
 Edema: ☐ Yes ☒ No Lymphadenopathy: ☐ Yes ☒ No

SYSTEMIC EXAMINATION

CVS:

S1 S2 ⊕, no murmur.

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 | ACS - evolved AAMI / acute LV failure
CAD - TUD / Moderate LV. / E_t - 41%
recovered.

Plan of Care:

- Plan: CABG Tomorrow (↓ GHA)
- Monitor vitals
- To follow drug chart
- Consent
- Parts & Preparation

- To get Anaesthetic fitness

Investigations Advised:

Reports enclosed

Diet Advice:

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

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

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor	Dr. Anuragu Mohan	Dr. Mohamed Lythoon	165308	10/1/24	11:00
Consultant	Reg No: 55476	DR. Anandeshu	55476	10/01/24	12:30
Patient Attendant	T. Nagesh	Relationship Son		10/1/24	11:00



Mr. THANDAVA MOORTHY S

57/Malc/MHI202381312

10/01/2024/1PH2024000081

Dr. ANBARASU MOHANRAJ



DOCTOR'S PROGRESS NOTES

DATE	NOTES
10/1/24 3:35 PM	Dr. Dr. Sujith. B. (DMO.)
	Case of CAD-TUD / mod. LV dysfunction. / DM
	Rf - 40%.
	Plan - CABG. tomorrow
Vitals Stable	pt. reviewed - no complaint
	of 12 fol. cardiac oriented Alert no ball
	SR - CS - S. S. (P) Re - BAR (P)
	Adm - vitals monitoring - followed by diet. - NPO from 12 AM - T. Alprax 0.5mg + T. Pantocid 404 12 AM - 2 Morphine 10mg + 2 Phenylen 12.5g In. (1hr before thru to OT.)
	Pls 183577 - 2 for 107



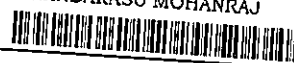
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Mr. THANDAVA MOORTHY S

57/Male/MH1202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



DATE	NOTES
11/01/2024 @ 12-10	Mr. Thandava moorthy 57y/male underwent OPCAB x3 grafts:
	He was shifted to SICU following hemodynamics
	HR - 82Bpm
	BP - 120/50 mmHg
	CVP - 7 mmHg
	SPO ₂ - 100% on ventilator
	Ventilator:
	Mode: Vc Rti: 0.6 PEEP: 5 mmHg
	Supports: inj. noradrenaline 0.05 µg/kg/min
	inj. Adrenaline 0.03 µg/kg/min
	Plan:
	Wean & extubate when fully awake.
	For SL ~~112256~~ Dr. Anbarasu PA. Karthika

DATE	NOTES
12/01/2024 @ 8.15	S/B: Dr. Anbarasu / Dr. Rajesh / Dr. Praveen
	s/p: OPCAB x 3 grafts.
PDDH1	. patient comfortable.
Hb - 7.5	O/E: conscious, oriented, Afebrile
U - 23	. BP - 110/54 mmHg
Cr - 0.75	. HR - 104 Bpm
Na - 135	. SpO ₂ - 96% on room air
K - 3.98	. I/O - 2931ml / 2816ml ; Bal +/- 15ml
	. on weath
RBS - 190 mg/dl	. Adequate urine output
	. tolerating feeds
ABC	. peripheries warm (+)
pH - 7.520	supports: inf. noradrenaline 0.07mg/kg/min
pO ₂ - 33.7	total drain: 720ml <u>plan</u>
pCO ₂ - 82.6	. RF - 1.8 litres/day
HCO ₃ - 26.9	. Good chest physio
BE - 4.1	. Remove drains by 11am
	. Mobilize
	. nebulization & spirometry
	. Tapin dt Nural
	. Restart OHA.
	. T.M.E.P.A.O.L.S.T 12.5mg 1-0-1
	Sperveen 11/2/24

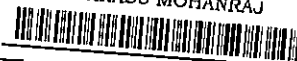


Mr. THANDAVA MOORTHY S

57/Male/MH1202381312

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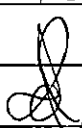
Dr. ANBARASU MOHANRAJ



DOCTOR'S PROGRESS NOTES

DATE	NOTES
13.01.2024 @ 8:00 am	SfB Dr. Anbarasu / Dr. Rajesh / Dr. Praveen
RBS:	SfB OPCAB x 3 grafts. DOD-2
CB2ny/dl	 Pt. conscious, oriented, afebrile
@ 6:00 am	o/e: ~~Para~~ BP: 101/64 mmHg
	HR: 100 bpm
Hb, 10.0	 SpO2: 97% on room air
U. 21	I/O: 2350 / 3180 ml → -ve 830 ml
Cr. 0.62	→ Adequate urine output.
Nat. 134	→ Tolerating oral feeds.
Kt. 4.17	→ Peripheries felt warm
	Supports: Nil
	Plan:
	• PE: 1.8 litres / day
	• Good chest physio.
	• Remove neck line
	• ↑ Spirometry
	• Nebulization & Mobilize to chair
	• Shift to ward once voided.
	• T. IVABESTIN 5mg 1-0-1
	For:
	Dr. Anbarasu / Dr. Rajesh
	RA Manoj (MH20217)

Specimen
112236.

DATE	NOTES
13/01/2023	S/B Dr. G. Lakshmi deega.
11:51	Pt received.
	received from SICU.
	POD-2. Asls- CAD- TRO / moderate LV - EF-40%.
	S/P- OPLAB x 3 grafts. 20-DM.
	[Off pump coronary artery bypass surgery]
	clo mild breathlessness associated
	with minimal chest pain
	pain score 2/10.
	O/E- Conscious
	oriented
	afebrile
Self wound -	BP vitals stable.
last wound	PA
↓ wound.	T-
	SpO ₂ -
	S/E. Ws-SiS ₂ +
	RS-BAE+
	PA- soft.
	CNS- NEND.
	<u>Adv</u>
	L/E- Dressing intact Fluid restriction 1.8 L/day
	No soaking. Chest physio
	Incentive spirometry
	Nebulizations.
	Follow drug chart.
	Monitor vitals OAP
	Inform sos.
	Follow drug chart.
	
	12/01/2023



2024000081

DOCTOR'S PROGRESS NOTES

DATE	NOTES
13/1/25	<u>Dr. M. Singh. B. (Dmo).</u>
2:05 PM	Sp - OPCS 394
	POD.2
BP - 110/60 mm	ft. normal.
HR - 100 bpm	- no complaints
SpO ₂ - 95% on RA	Sp. ft. conscious
	oriented,
	Afebrile
2350 ml	
3180 ml	
	SpE - CUS - S.S. (P)
	Re - RDE (P)
	<u>Adh</u>
	- vitals normal
	- follow up chart
	- PE $< 18^{\circ}C/dy$
	- chest physio
	- Spicately
	- rehydration
	- Inferior son
	<u>Rh</u>
	183573.

DATE	NOTES
13/1/24 10Pm	5/B Dr. Mohamed Hydar
	Post OP Care of OPCAB X 3grafts POD-2
	Patient Conscious oriented Afebrile
	Vitals PR-96/min RR-18/min BP-130/80mmHg SpO2-97% C/S → S, S2 ⊕ M → BAE ⊕ P/A → S/E, NY
	Adv - Monitor vitals - To follow daily chart - F.R < 1.8 litre/day - Chest Physio/ Spirometry - nebulisation ~~1632~~ 1630h

DOCTOR'S PROGRESS NOTES

DATE	NOTES
14-01-24	S/B Dr. Anbarasu
11:00 POD-2 F-R-1.8/litres	reviewed c/o generalised freeness
	Advice - mobilise the patient - continue the drugs as per chart w/f fever spikes / desaturation
14-01-24	S/B Dr. Anbarasu
11:00 POD-2 F-R-1.8/litres	Pt reviewed c/o generalised freeness
day	Vitals stable H/B Dressing intact no scaling
	Advice - mobilise the patient - continue the drugs as
per chart	plan. SR tomorrow

DATE

NOTES

14/1/24

10pm

S/B Dr. Mohamed HyderosPost OP case of OPCAB x Bgrafts.
POD-3.Patient conscious
oriented
OfebrileVitalsPR-84/min
RA-18/min
BP 100/70 mmHg
SpO₂ 97%.CNS → S₁S₂ ⊕R₂ → BAE ⊕

P/A → Sft, NT

Plan

- Monitor vitals

- No follow drug
chart

- Mobilise the Patient

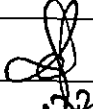
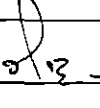
- Spirometry / Rehab



(last)

DOCTOR'S PROGRESS NOTES

DATE	NOTES
14/1/24	c/B Dr - G. Lakshmi
9:30 AM	PT - received.
	c/o cough unable to expectorate
	No fever spikes
	O/E Conscious oriented afebrile
	vitals stable
	S/E. WS - S ₁ S ₂ +
	Rs - BAE+
	PA - soft -
	CNS - NFD.
	Adv
	• Monitor vitals Q4H.
	• N/E fever spikes.
	• Inform sos.
	• Incentive spirometry
	• PR 1-5L/day as advised.
	 122068-

DATE	NOTES
15/1/24 12pm.	Strict ASP drain sutures removed. - wound healthy  122068
15/1/24 3:00pm	 B. Dr. Sujith. B. (Dmo)
3:00pm (POB 4)	- DPCAB X3 graft Reviewed.
BP-110/70 mm HR-86 bpm SpO2-94% RA	- no complaint  ft conscious, alert
1300h 2550h	SR - cut 4.5% RA RATE 4% Ade
	- vitals monitoring - Follow up chest - RR < 1.5 L/day - w/fe lower, discharge - Inform soc  183577



Mr. THANDAVA MOORTHY S
57/Male/MH1202381312
10/01/2024/1PH2024000081
Dr. ANBARASU MOHANRAJ

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DATE _____

NOTES

15/1/24

10/1/11

S/B Dr. Mohamed Hydoo

Post op care of OPCABx3 graft
POD-4.

Robert Cousins

Overleaf

Hesula

vitals

Stable

WS 2024

107 BAE (7)

1/2 → soft, red

Alu

~~-Votes mon...~~

Wals

- No following charts

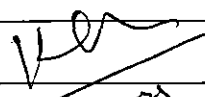
- FR < 1.5 litre/day

- w/f fever

Exposition

- Spirometry/nethers

[Signature]

DATE	NOTES
16/1/24 2:40pm	S/B. Dr. Sijth. B. (Ono)
POD-5-	S/B - OPCA 3 graft pt. reviewed - No complaint
Citalis Plus	S/B pt. common overed, Afelwa
	S/B - CS - L.S. (X) AS - R.A.P. (X) <u>Ad</u> - citalis mostly - follow up chx - w/Edenbura - FR C.I.S.I. by - Spironety / mobilisation - T. Jansen
	 18/3/23



MR. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr.ANBARASU MOHANRAJ



022/041

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titute

At counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
16/1/24	Sto Dr. Mohamed Hyder
10PM	Post op care of OPAB x3 graft POD-5 Patient conscious oriented Afebrile CVS → S1 S2 ⊕ ND → BAE ⊕ P/A → Soft, NT ADJ - Monitor vitals - To follow in chest - Plan! Pleura tapping tomorrow - (Spontaneous) hemothorax Worm

DATE	NOTES
17.01.24	S/B Dr. Anusuya
9.00	S/p OP chbx 2 grafts patient reviewed.
POD-6	CO: mild pain in the surgical site. O/E: Patient conscious, oriented S/E: CNS - G1 G2 (+) RS - BAF (+) CNS - WFPD
TO do	L/E: Dressing intact / suture removed no leakage. Wound healthy & healing.
screening Echo today	Vitals: HR - 82 b/m BP - 110/80 mmHg RR - 18/min SpO2 - 98% RA.
F.R - 1-8 litres/day	Advice - monitor vitals - continue the drugs as per chart
CBG - 83 mg/dl	- Recheck CBG after breakfast - mobilise the patient - continue the chest physio & spirometry
Rxn (134759)	



MHI/IP/2022/041

Mr.THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr.ANBARASU MOHANRAJ

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
17-01-24	S/B Dr. Ambabasu
9:30	Patient reviewed
	Advice
	- Continue the drugs as
TO do	perchart
	- mobilise the patient
screening	- plan. D/s today
Echo	
K ⁿ In	
134559	



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Mr. THANDAVA MOORTHY S

57 / Male / MH1202381312

10/01/2024 / IPH2024000081

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RE-OPERATIVE CHECKLIST

Name	Dr. ANBARASU MOHANRAJ	Age :	Gender :	UHID No. :
Ward :	I st floor	IP No. :	Bed No. :	B.S.
			101-A	A.S.
Clinical Diagnosis :				
CAD - TLD				
Proposed Procedure :				
CABG				
CHECKLIST				
1.	Identification Band on Hand Checked ?	Yes	✓	✓
2.	Surgical consent Signed? a. Special Consent signed if required.		✓	✓
3.	Anesthetist Consultation (If required?)		✓	✓
4.	History AND Physical Onchart? a. Height..... 167 cm. b. Weight..... 59.3 kg		✓	✓
5.	Allergic to drugs ?	not known.	✓	✓
6.	Surgical Preparation done ?	Yes.	✓	✓
7.	Nill by Mouth From	12.00		✓
8.	Blood Grouping & Rh Typing	B+ positive	✓	✓
9.	Investigation ☒ X-Ray ☒ ECG ☒ LAB		✓	✓
10.	Blood Sugar..... 209 mg/dl Time..... 6:30		✓	✓
11.	TPR Chart Pulse..... 80 Temp..... 96.1°F BP 110/50 RR..... 22		✓	✓
12.	Time Voided a. Retention ☐ Yes ☒ No		✓	✓
13.	Enema ☐ Yes ☒ No		✓	✓

MMC - POC - 2102

14.	a. Prosthesis Removed ☐ Yes ☐ No / ☒ Not Applicable b. Plates present Removed ☐ Yes ☐ No / ☒ Not Applicable c. Contact Lenses Removed ☐ Yes ☐ No / ☒ Not Applicable d. Dentures Removed ☐ Yes ☐ No / ☒ Not Applicable	✓	✓
15.	Valuables and Jewellery Removed ☒ Yes ☐ No Secured ☒ Yes ☐ No	✓	✓
16.	Pre-Operative Medication Administered <u>Dr. MORFINE</u> <u>Dr. PHEN</u> a. Time <u>7:50</u> b. Nurse <u>Seni</u>	✓	✓
17.	Blood Transfusion requisition Onchart	✓	✓
18.	X-Ray <u>1</u> No	✓	✓
	ECG / ECHO <u>2</u> <u>CAC - 1</u>	✓	✓
	Ultra Sound	—	
	C.T. Scan	—	✓
	MRI Scan	—	
	TMT	—	
	Medication	—	
	<u>10/10/20</u> <u>1. PAAAL 10mg</u>		
	<u>21/12/20</u> <u>1. ALPRAX 0.5mg</u>		
	Others <u>Dr. MORFINE</u>		
	<u>Dr. PHENERGAN</u> given	✓	✓


Nurse Signature

B+ve

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Mr. Thandara Moorthy. Age 57M UHID MHI202381212

Diagnosis ACS - evolved AMI / Plan CABG
acute co-failure - recovered / TVD / Mod. LV

Serology Negative

EURO Score / STS Score 1.22%

Diabetes Mellitus (Hb1AC) 7.7%

Carotid Doppler 40 within (N) study.

Sr. Creatinine 0.86

INR 0.9

Allen's Test

7. Dapatum
7. Rosuvastatin & 7. Clopidogrel
PRE OP DRUGS (ACE/ARB/ANTIPLATELETS): stopped
on 6/1/24

Associated Illness 2DM / HTN

Thyroid Enzymes FT3 : 5.02 TSH : 1.42
FT4 : 20.1

Any other illness of concern

Myocardial viability if needed

Varicose Veins

Pulmonologist Clearance -

Nephro Clearance: -

Neurology Clearance : -

Dental Clearance: -

Mitral Regurgitation Assessment Trivial MR / mild PM

Nursing:

Billing Clearance:

Physiotherapy

Spirometry taught

Concerns from Surgical Team :

SIGNATURE :

Pa. Rang. (MHI0217)

Mr. Thandava Moorthy 57/M a K/C/O T2DM, SHTN, ACS - evolved AMI, Acute Heart failure - recovered, CAG - Triple vessel disease, Moderate LVH come for CABG. Pt. was apparently (N) till 1 month ago when he developed chest pain - retrosternal, radiating to jaw and both shoulders associated with palpitation & sweating. H/o breathlessness on exertion on 5 of 6. Initially, he was taken to Chennai Health foundation where he was diagnosed as ACS - evolved AMI. He was managed conservatively and was referred to RHH for further management. [He was treated with IV diuretics, LMWH antiplatelets, statins, antihypertensives and other supportive medication.] After medical stabilization, he underwent CAG on 08/11/2022 which showed TAD. He then came to RHH and was advised early CABG.

ECG: 90bpm, Sinus rhythm, AMI (+).

CXR: PA film, lung fields clear.

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



CONSENT FOR SURGERY

Mr./Ms./Mrs. Thandava moorthy ☒ the Patient or ☒ Representative of patient have (Please tick correct option and below):

☒ Read

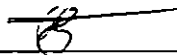
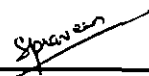
☒ I/We have been explained the current clinical condition of me/my patient

☒ Been explained this consent form in English, which I fully understand and understood the information provided about the disease CAD, T.V.P., Acute cardiac failure, STT, med lv, EF-40% and about the procedure Coronary Artery Bypass Grafting (full name of operation / procedure given below in this consent form)

- I am now aware of the intended benefits, possible risks and complications and available alternatives to the said operation / procedure. I am also aware that results of any operation / procedure can vary from patient to patient and I declare that no guarantees have been made to me regarding success of this operation / procedure. I am aware that while majority of patients have an uneventful operation and recovery few cases may be associated with complications. I am aware of the common risks and complications associated with this operation / procedures and understand that it is not possible to list all possible risks and complications of any operation / procedure.
- I have been told about additional procedure that may be come necessary during the surgery which includes Re-implantation
- I also understand that sometimes a planned operation / procedure may need to be postponed or cancelled if patient's clinical condition worsens or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequence by submitting the withdrawal in writing.
- I am aware that I may require administration of blood and / or blood products during or after the operation / procedure as found necessary by the doctor (for which a separate consent shall be obtained).
- I am now also aware that during the course of this operation / procedure the doctor will be assisted by medical and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the need arises.
- I am also aware of the expected course after the operation / procedure and the care to be provided and understand that sometimes admission to an Intensive Care Unit and or extension of duration of hospitalization may be required and or there may be requirement of extra medicines or treatments thereby leading to increase in the treatment expenses depending upon the body's response to the treatment / procedure.

- Possible risks & complications ①. Bleeding ②. Infection
③. arrhythmias ④. Stroke ⑤. prolonged Pcr stay /
ventilator ⑥. risk to life
- Benefits Relief symptoms
- Alternatives medical management
- The likelihood of success of the surgery (Percentage / Other commands) 95%.
- Possible results of non-treatment ①. cardiac failure
②. myocardial Infarction
- I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery 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 sign this form.

Euroscore II 1.22%

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	S-THANDAVAMOO (TH)	T. Chandan
Relationship	Self.	Wife
Signature		T. Chandan
Date & Time	10/11/24 @ 19:00	10/11/24 @ 19:00
Name & Signature of Doctor with Registration No.:  Dr. PRAVEEN JEYAKUMAR 112236		

Dr. Anbarasu Mohanraj
Reg No: 55476

Doctor Seal

நோயாளி விவரங்கள்: (Affix Label here)

வயது :

UHID :

பிறந்த தேதி :

பாலினம் :

அறுவை சிகிச்சை ஒப்புதல் படிவம்

1. நான் நோயாளி அல்லது நோயாளியின் பிரதிநிதி தயவுசெய்து மேலேயும் கீழேயும் பொருத்தமானதை

தேர்வு செய்யவும்

☐ படியுங்கள்

☐ எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.

இந்த ஒப்புதல் படிவம் ஆங்கிலத்தில் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகிச்சையின் செயல்பாட்டின் முழுப்பெயர் செயல்முறை பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.

- நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கிடைக்கச் செய்கிறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும் நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கிறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும் மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் தொடர்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கிறேன்.

நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில நேரங்களில் திட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்

- மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நிர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் (ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).
- இந்த அறுவை சிகிச்சை / நடைமுறையின் போது மருத்துவர் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவார் என்பதையும், தேவை ஏற்பட்டால் தொடர்புடைய நிபுணர்களிடமிருந்து மருத்துவர் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது அறிவேன்.

• சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் _____

• நன்மைகள் _____

• மாற்று வழிகள் _____

• அறுவை சிகிச்சையின் வெற்றி வாய்ப்பு (சதவீதம் / பிற கட்டளைகள்) _____

• சிகிச்சையின்றி சாத்தியமான முடிவுகள் _____

• செயல்பாடு / நடைமுறை மற்றும் வழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்பார்க்கப்படும் போக்கையும் நான் அறிவேன். சில நேரங்களில் தீவிரமான பராமரிப்பு அல்லது மருத்துவமனையில் அனுமதிக்கப்படும் கால அளவு தேவைப்படலாம் மற்றும் / அல்லது கூடுதல் மருந்துகள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம். இதன் மூலம் உடல் சிகிச்சையில் அதிகரிக்கும்.

• இந்த செயல்பாடு / நடைமுறையை நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய எந்தவொரு தீசு அல்லது உடல் பகுதியை அகற்ற மருத்துவமனையை நான் அங்கீகரிக்கிறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட தகவல்களை நான் பெற்றேன் மற்றும் முழுமையாகப் புரிந்து கொண்டேன் என்று அறிவிக்கிறேன். எனது வியாதி, செயல்பாடு / நடைமுறை தொடர்பான கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அதன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும் நோக்கம் கொண்ட நன்மைகள் மற்றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும் பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நான் கையெழுத்திடுகிறேன் நேரத்தில் என் முன்னிலையில் செருகல் மற்றும் நிறைவு செய்ய வேண்டிய அனைத்து துறைகளும் (இந்த வடிவத்தில்) நிரப்பப்பட்டன என்று நான் மேலும் அறிவிக்கிறேன்.

விபரங்கள்	நோயாளி / உறவினர்	சாட்சியம்
பெயர்		
உறவுமுறை		
கையொப்பம்		
நாள் & நேரம்		
மருத்துவரின் பெயர் மற்றும் பதிவு எண், கையொப்பம்:		

CONSENT FOR ANAESTHESIA SERVICES

I, THANDAVA MOORTHY S ☒ the patient or ☒ the representative of patient have,
(please tick the correct option above and below)
☒ Read
☒ We have been explained the current clinical condition of me / my patient
☒ I have been explained this consent form in English, which I fully understand and understood the information provided about
Operation / Procedure CABG -

(full name of operation / procedure given below in this consent form)

- My surgeon has explained the risks of the procedure and has advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anaesthesia services are needed for this operation, so that my doctor can perform the operation or procedure.
- It has been explained to me that all forms of anaesthesia involve some risks. Although rare, unexpected severe complications with anaesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.
- I understand that these risks apply to all forms of anaesthesia and that additional or specific risks have been identified below, as they may apply to a specific type of anaesthesia. I understand that the type(s) of anaesthesia service checked below will be used for my procedure and that the anaesthetic technique to be used is determined by many factors including my / my relative's physical condition, the type of procedure, my doctor's preferences, as well as my own desire.
- It has been explained to me that sometimes an anaesthetic technique which involves the use of local anaesthesia, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anaesthesia.

It has been explained to me that the following may be needed as part of anaesthesia during or after surgery

- ☒ Central Venous catheter ☒ Arterial Line ☐ Lumbar Puncture ☒ Tracheostomy
☒ Transesophageal ☒ Blood & Blood product Transfusion ☒ ICU Admission / Recovery ☒ Others

☒ General Anaesthesia	Expected Results	Total unconscious state that may involve placement of a tube into the windpipe to maintain airway
Alternatives	Technique	Drug injected into the blood stream, breathed into the lungs, or given by other routes
☐ Spinal	Risks	Sore throat, injury to vocal cords, teeth, lips, eyes; awareness during the procedure, memory dysfunction / memory loss, aspiration pneumonia, permanent organ damage, brain damage
☐ Epidural	Benefits	- Early Recovery - Relief of Anxiety
☐ Others	Expected Results	Temporary decreased or loss of feeling and / or movement in the lower half of the body
☐ Spinal or Epidural Analgesia / Anaesthesia	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal
☐ With Sedation / GA ☐ Without Sedation	Risks	Nerve damage, persistent back pain, headache, infection, convulsions, bleeding / hematoma, toxicity due to local anaesthetic, chronic pain, medical necessity to convert to general anaesthesia, brain damage
Alternatives	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions
☐ GA	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area
☐ Others	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
☐ Major / Minor Nerve Block	Risks	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to local anaesthetic, medical necessity to convert to general anaesthesia, brain damage
☐ With Sedation / GA ☐ Without Sedation	Benefits	- Pain Free - Safer under certain conditions
Alternatives		
☐ GA		
☐ IV Regional Anaesthesia ☐ Spinal/Epidural Anaesthesia		
☐ Others		

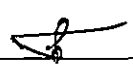
☐ Intravenous Regional Anaesthesia ☐ With Sedation / GA ☐ Without Sedation Alternatives ☐ Major/Minor Nerve Block ☐ GA ☐ Others	Expected Results	Temporary loss of feeling and / or movement of a limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risks	Infection, convulsions, persistent numbness residual pain, injury to blood vessels
	Benefits	- Pain Free - Safer under certain conditions
☐ Monitored Anaesthesia care (with sedation) Alternatives ☐ General anaesthesia ☐ Spinal / Epidural ☐ Others	Expected Results	Decreased anxiety and light sedation similar to normal sleep
	Technique	Drug injected into vein of arm
	Risks	Prolonged sedation, need for airway control
	Benefits	Anxiety free; Early discharge
☐ Monitored Anaesthesia Care (without sedation) Alternatives ☐ General anaesthesia ☐ Mild Sedation ☐ Others	Expected Results	No changes in the system
	Technique	None
	Risks	Patient may have pain and anxiety
	Benefits	Early discharge

PRENATAL / EARLY CHILDHOOD ANAESTHESIA

- Potential long term negative effects on memory, behaviour and learning with prolonged or repeated exposure to general anaesthesia / moderate sedation / deep sedation during pregnancy and in early childhood
- 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

For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said operation / 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 about 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		S. THANDAVAMOORTHY	10/1/24	14:30
Surrogate/Guardian (if applicable #)		T. Chandana (Wife) (Write name and relationship with patient)	10/1/24	14:30
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		R. N. Bhavathi	10/1/24	14:30
Interpreter (if applicable)				

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

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned operation / 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
Consent obtained by		Dr. A. S. S. WESTIN	43570	10/1/24	14:30

மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1. ☐ நோயாளி அல்லது ☐ நோயாளியின் பிரதிநிதி,

மேலேயும் கீழேயும் சரியான விருப்பத்தைத் தேர்ந்தெடுங்கள்) படித்தல்

என்னை / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்ட தகவல்களை நான் முழுமையாக புரிந்துகொண்டேன்.

செயல்பாடு / செயல்முறை _____

இந்த ஒப்புதல் படிவத்தின் கீழே கொடுக்கப்பட்ட செயல்பாட்டு நடைமுறையின் முழு பெயர்)

- * எனது அறுவை சிகிச்சை நிபுணர் நடைமுறையின் அபாயங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி என்னிடம் கூறினார். எனது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து சேவைகள் தேவை என்பதையும் நான் புரிந்து கொள்கிறேன். இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.
- * அனைத்து வகையான மயக்க மருந்துகளும் சில அபாயங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத கடுமையான சிக்கல்கள் ஏற்படலாம். தொற்று நோய், இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு செயல்பாடு, பக்கவாதம், மூளை பாதிப்பு அல்லது மரணம் போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.
- * இந்த அபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை நான் புரிந்து கொள்கிறேன்.
- * சில நேரங்களில் உள்ளூர் மயக்க மருந்துகளைப் பயன்படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் முழுமையாகப் பெறாமல், மற்றொரு நுட்பத்தை மயக்க மருந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.

☐ பொது மயக்க மருந்து மாற்று மருந்து ☐ முதுகெலும்பு ☐ இவ்விடைவெளி ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாறையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை
	நுட்பம்	இரத்த ஓட்டத்தில் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகின்றன
	அபாயங்கள்	தொண்டைப்புண், குரல் வயிர்கள், பற்கள், உதடுகள், கண்கள், செயல்முறை, நினைவக செயலிழப்பு, நினைவக இழப்பு, அபிலாஷைகள், நிரந்தர உறுப்பு சேதம், மூளை சேதம் ஆகியவற்றின் போது விழிப்புணர்வு
	நன்மைகள்	- ஆரம்ப மீட்பு - பதட்டத்தின் நிவாரணம்
☐ முதுகெலும்பு அல்லது இவ்விடைவெளி / மயக்க மருந்து ☐ மயக்க மருந்து / பொது மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல் மாற்று மருந்து ☐ பொது மயக்க மருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	உடலின் கீழ்பாதியில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு
	நுட்பம்	உணசி / வடிகுழாய் வழியாக செலுத்தப்படும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாய்க்கு வெளியே வைக்கப்படுகிறது.
	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தப்போதல், ஹெமோமே, உள்ளூர் மயக்க மருந்து, நாள்பட்ட வலி, மயக்க மருந்து, மூளை சேதத்திற்கு மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை
	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிப்யூவில் பாதுகாப்பாக விடக்கூடிய எபிடரி வடிகுழாய்களுடன் செயல்பட்டு வலி நிவாரணம்
பெரிய / சிறிய நரம்புத் தொகுதி ☐ மயக்க மருந்துடன் / பொது மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல் மாற்று மருந்து ☐ பொது மயக்க மருந்து ☐ IV பிராந்திய மயக்கமருந்து ☐ முதுகெலும்பு / இவ்விடைவெளி மயக்கமருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு அல்லது பகுதியின் தற்காலிக இழப்பு
	நுட்பம்	செயல்பாட்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகில் மருந்து செலுத்தப்படுகிறது
	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெமோமே, உள்ளூர் மயக்க மருந்து, மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூளை சேதத்திற்கு மாறுதல்
	நன்மைகள்	- வலி இலவசம் - சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை

☐ நரம்பு மண்டலம் மயக்க மருந்து ☐ மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல் மாற்றுகள் ☐ பெரிய / சிறிய நரம்பு தொகுதி ☐ பொதுவான மயக்க மருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு இயக்கத்தின் தற்காலிக இழப்பு
	நுட்பம்	ஒரு றீனிக்கேயைப் பயன்படுத்தும் போது கை அல்லது கை நரம்புகளில் செலுத்தப்படுகிறது
	அபாயங்கள்	தொற்று, வலிப்பு, தொடர்ச்சியான உணர்வின்மை, மீதமுள்ள வலி, இரத்த காயங்களுக்கு காயம்
	நன்மைகள்	- வலி இலவசம் - சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை
☐ கண்காணித்த மயக்க மருந்து கவனிப்பு (மயக்கத்துடன்) மாற்றுகள் ☐ பொதுவான மயக்க மருந்து ☐ முதலெலும்பு / இவ்விடைவெளி மயக்க மருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	சாதாரண தூக்கத்தைப்போன்ற கவலையும் ஒளியும் குறைந்து வருகிறது
	நுட்பம்	கையின் நரம்பில் மருந்து செலுத்தப்படுகிறது
	அபாயங்கள்	நீண்ட கால மயக்கம், காற்றுப்பாறை கட்டுப்பாடு தேவை
	நன்மைகள்	கவலை இலவசம், ஆரம்ப கால வெளியேற்றம்
☐ கண்காணித்த மயக்க மருந்து கவனிப்பு (மயக்கம் இல்லாமல்) மாற்றுகள் ☐ பொதுவான மயக்க மருந்து ☐ இலேசான மயக்கம் ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	கணினியில் மாற்றங்கள் இல்லை
	நுட்பம்	இல்லை
	அபாயங்கள்	நோயாளிக்கு வலி மற்றும் கவலை இருக்கலாம்
	நன்மைகள்	ஆரம்ப வெளியேற்றம்

பிறப்புக்கு முந்தைய / ஆரம்பகால குழந்தை பருவ மயக்க மருந்து

★ நினைவாற்றல், நடத்தை மற்றும் கற்றலில் நீண்டகால எதிர்மறை விளைவுகள் பொது மயக்க மருந்து / மிதமான மயக்கம் / கர்ப்ப காலத்தில் மற்றும் ஆரம்ப பருவத்தில் ஆழமான மயக்கத்துடன் நீண்ட அல்லது மீண்டும் மீண்டும் மீண்டும் வெளிப்படுதல்

★ நான் / மேற்கூறிய நோயாளி / பெயரிடப்பட்ட நோயாளியின் பிரதிநிதி, இந்த வடிவத்தில் கையொழுத்திடப்பட்ட தேதி, மன ரீதியாக ஒலி மற்றும் எந்தவொரு பயமும் இல்லாமல் ஒப்புதல் அளிக்கிறேன் என்று நான் 18 வயதுக்கு மேற்பட்டவன் என்று இதன்மூலம் அறிவிக்கிறேன்.

மேற்கூறிய செயல்பாட்டிற்கு (எஸ்) / நடைமுறை (எஸ்) எனக்கு தெரிந்துவிட்டது. நான் தானாக முன்வந்து எனது ஒப்புதலை வழங்குகிறேன்

டாக்டர் (டாக்டர்) டி. அல்லது டி-யில் கூறப்பட்ட செயல்பாடு / நடைமுறையை செய்வதற்கு அறுவை சிகிச்சை செயல்முறையைச் செய்வதற்கான டாக்டர் பெயர், நோயாளியிடம் முழுமையாக அறிந்திருக்கிறார். சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் மற்றும் சாத்தியமான மாற்றுகள்

நான் / மேற்கூறிய நோயாளி / பெயரிடப்பட்ட நோயாளியின் பிரதிநிதி, இந்த வடிவத்தில் கையொழுத்திடப்பட்ட தேதி, மன ரீதியாக 18 ஆண்டுகள் நிரம்பிய நான் எந்தவொரு பயமும், அச்சுறுத்தல் அல்லது தவறான அனுமதியின்றி ஒப்புதல் அளிக்கிறேன் என்று மேலும் இதன்மூலம் அறிவிக்கிறேன்.

	கையொப்பம் / கட்டை விரல் புதிவு *	பெயர்	தேதி	நேரம்
நோயாளி				
நோயாளிகளின் பிரதிநிதி / பாதுகாவலர் (பொருந்தும் என்றால்)		(நோயாளியுடன் பெயர் மற்றும் உறவை எழுதவும்)		
நோயாளிகளின் பிரதிநிதி சம்மதத்திற்கான காரணம்	நோயாளி ஒப்புதல் அளிக்க முடியவில்லை ஏனெனில்			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருந்தினால்)				

* நோயாளி ஒரு சிறியவராக இருந்தால் அல்லது சம்மதத்தை வழங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான வலது கை மற்றும் பெண்களுக்கான இடது கை

நான் நியமிக்கப்பட்ட மருத்துவர், இயல்பு, சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட நன்மைகள், எதிர்பார்க்கப்பட்ட பின் நடைமுறைக்கு வரும் நடைமுறைகள் மற்றும் தீயபரிசுபட்ட செயல்பாடு / நடைமுறைக்கு சாத்தியமான மாற்றுகள், நோயாளி / நோயாளி பிரதிநிதிக்கு விளக்கியுள்ளார். இந்த ஆவணத்தில் விவரிக்கப்பட்டுள்ள தகவல்களை அவர் / அவள் முழுமையாகப் புரிந்து கொண்டார் என்று நான் நம்புகிறேன்.

	கையொப்பம்	பெயர்	புதிவு எண்	தேதி	நேரம்
பெறப்பட்ட ஒப்புதல்					

ANAESTHESIA RECORDP: **Mr. THANDAVA MOORTHY S**

N: 57/Male/MHI202381312

U: 10/01/2024/IPH2024000081

D: Dr. ANBARASU MOHANRAJ

C: Type of Surgery : ☐ Day Care ☒ Elective ☐ EmergencyBlood Group: B+ve Height: 154 cms Weight: 59.3 Kgs

Pre-Operative Diagnosis:

CAD, T2D, Mod LV dysfunction EF 41%, DM

Proposed Surgery:

Anaesthetic Plan

ASA Grade: ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ E**History of Present Illness:**

- ☒ ANGINA Acc. Evolved AMI
☒ DYSPNOEA Acute cardiac failure.
☐ SYNCOPE Pain/dizziness, sweating
☐ MI
☐ CCF
☐ OTHERS

Previous Surgery :**COMORBIDITY**

- ☐ HT ☐ SMOKING
☒ DM ☐ ALCOHOL
☐ ASTHMA / COPD ☐ GERD
☐ HYPO THYROID ☐ CKD / NEPHROPATHY
☐ STROKE / TIA ☐ DRUG ALLERGY
☐ EPILEPSY ☐

Present Medication :

Robaxa Gold
cardias/coversyl
Dapaamn.
Canasor.
Anti Platelet Stopped on :

5/1/24**Physical Examination :**

- ☐ JAUNDICE ☐ PEDEL OEDEMA
☐ CYANOSIS ☐ CAROTID BRUIT
☐ CLUBBING

SYSTEMIC EXAMINATIONCVS: S/SCNS: WNLRS: WNLOthers: WNLHR: 90/min NIBP: 130/80 mmHg SPO2: 97% TEMP: 98°F**INVESTIGATION**

HB: 17.1 T.BILIRUBIN: 1.51 T3: 5.02 SEROLOGY: Normoactive
 PLAT: 1,70,000 I.D.: 0.32 T4: 20.1 Urine:
 TC: 2,950 D.: 0.23 TSH: 1.43 Others:
 UREA: 35 T-PROTEINS: 8.0 HBA1C: 7.7
 CREAT: 0.82 S.ALBUMIN: 5.20 RBS:
 Na+: 138 PTT/INR: 11.6/12.1 0.9
 K+: 4.29 APTT: 25.8

ANGIO LAD, total occlusion -
LES 50-60%, RCA 90%ECG NSR. AMICXR within normal limits.

ECHO EF 41%
TAPSE: 21mm
RWMA +
Ante valve sclerosis
Tand. MR/TR

AIRWAY

Teeth Normal
 Mallampatti class II
 Mouth Opening Adequate
 Neck Movement WNL
 TM Distance WNL

CAROTID DOPPLER**Other Opinions:****Pre OP Instruction :**NPO From: 12 mid night**Pre Medication :**Night Before Surgery: Key Tab. Atropine 0.5mg + Tab. Pantocid 40mg.Day of Surgery: Key, Morphine 5mg + Key, Phenygram 12.5mg
5m - 1 hr before sending to O.T.**Special Instruction :****Blood Reservation**PCV: one Platelet:FFP: CRYO:

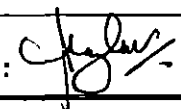
Whole Blood:

Remarks:

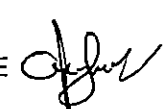
Dr. A. SAMUEL SYLVESTER

Reg. No: 43570

Anaesthetist Name with Reg.No. :

Signature: 

Date: 11/12/24		Anaesthetist: DR. SYLVESTER		Surgeon: DR. ANBARASU		Anaesthesia Technique: ☒ GA ☐ Regional ☐ Others					
PRE INDUCTION ANAESTHESIA RECORD				MONITORS AND EQUIPMENTS				GENERAL ANAESTHESIA			
Pulse: 78 BP: 138/70 RR: 16 to 20/min Sensorium: WNL Sign-in Completed: ☒ Yes ☐ No Equipment Checked: ☒ Yes ☐ No Sight: <u>DR. A. SAMUEL SYLVESTER</u> Name: <u>DR. A. S. Sylvest</u> Time: <u>8.30</u> No: 43570				☐ NIBP ☐ Left ☐ Right ☒ ECG ☐ Pulse Oximeter ☒ End Tidal CO ₂ ☐ Gas Analyzer ☐ Oxygen Sensor ☐ Disconnect ☐ Temperature Probe ☒ Foley Catheter ☐ Nerve Stimulator ☐ TEE ☐ Others: ☐ CVC Type: <u>8.5 FR 4 Lumbr</u> Site: <u>LA IN</u> ☒ Standard Asepsis ☐ USG Guidance ☐ Complications: ☐ Yes ☒ No If Yes, details: ☒ Arterial Line - Type: <u>204 Insyte</u> Site: <u>Lt Radial</u> ☒ PVC Type: <u>16 Fr Insyte</u> Site: <u>Rt Groin</u> ☐ PVC Type: Site: ☐ Others:				INDUCTION: ☒ Pre O ₂ ☐ Rapid Sequence ☒ IV ☐ Inhalation - Agent used: <u>Propofol</u> Mode of Ventilation: ☐ Spontaneous ☒ Controlled AIRWAY MANAGEMENT: Intubation: Oral / Nasal ETT Size: <u>8.5</u> Type: <u>Cuffed</u> CL Grade: I / II / III / IV Secured at: <u>22</u> cm Any difficulties and accessories: Throat Pack: ☐ Yes ☒ No ☐ Removed NeTOG Tube: ☒ Yes ☐ No OTHER AIRWAY DEVICES: ☐ LMA Type & Size: ☐ Via Tracheostomy ☐ Face Mask ☐ Nasal Prongs ☐ Others: Antibiotic / Dose / Time <u>Trj: Cefuroxime 1.5gm @ 9.00 am</u> Reversal of Anaesthesia			
PATIENT SAFETY											
Position on Table: <u>Supine</u> Pressure points checked & Padded: ☐ Yes ☒ No Eye Care: ☒ Yes ☐ No Safety Belt: ☐ Yes ☒ No Warming Blanket: ☒ Yes ☐ No Fluid Warmer: ☐ Yes ☒ No TED Stockings: ☐ Yes ☒ No Sequential Compression / Decompression: ☐ Yes ☒ No											
DRUGS											
PROPOFOL				3				30			
MIDAZOLAM				125				125			
FENTANYL				6				2			
MORPHINE				2				2			
VECURONIUM				1				2			
ETOMIDATE											
KETAMINE											
SUXA/ROCURONIUM											
CISATRACURIUM/ATRACURIUM											
SEVO/SOFLURANE											
AIR/O											
Time				8.30				9.30			
200								10.30			
Systolic V								11.30			
180								12.30			
Diastolic A											
160											
Pulse											
140											
120											
Resp. *											
100											
Operation											
80											
60											
40											
Temp X											
20											
0											
MONITOR											
SP02				100%				100%			
CVP				7				10			
PAP				30				28			
ETCO ₂				30				26			
Urine Output								25			
								25			
								800ml			
ABG											
PH				7.476				7.424			
PCO ₂				48.6				32.1			
PO ₂				99.4				96.0			
Na ⁺				138				138			
K ⁺				3.7				3.6			
HCT				44				39			
RBS				160				209mg/dl			
LAC											
BE				-4.2				-2.6			
HCO ₃				27.9				20.8			

		START	STOP	FLUID TRANFUSED		BLOOD PRODUCTS	
ANAESTHESIA		8.40	11.55	CRYSTALLOID	COLLOID	nil	
PROCEDURE		9.35	11.49	KAB 147E 500	nil		
CPB				KAB 147E 500			
AXC							
CUF:		MUF:					
HEPARIN				PRESSURE MONITOR			
DOSE	TIME	ACT		PRE OP			
125	10.18	1117		PA	RV	PCWP	
				ABP			
PROTAMINE				POST OP			
DOSE	TIME	ACT		PA	RV	PCWP	
100mg	11.25	112					
INOTROPES & INFUSIONS				ABP			
DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME	DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
NORADRENALINE 4mg/50cc	0.05mg/kg/min	9.45	ICU	HUMAN ALBUMIN 40unit/40cc	4unit/kg/h	10.15	ICU
ADRENALINE 6mg/50cc	0.04mg/kg/min	10.30	ICU				
NIPT 25mg/25cc	0.5mg/kg/h	11.00	11.40				
REGIONAL ANAESTHESIA (YES) NO DETAILS: ESPB B/L 20ml + 30ml Inj: Ropivacaine 0.25% Ins: Dexmedetomidine 50mg (1F) FNB Inj: Bupivacaine 0.125%				IABP: NO ECMO: NO TEE: NO			
REMARKS / CRITICAL EVENTS							
Dr. A. SAMUEL SYLVESTER Reg. No: 43570				SIGNATURE 			
ANAESTHESIOLOGIST NAME : REG.NO.							

POST OPERATIVE PLAN

Transfer to: ☒ SICU ☐ Others, specify: _____

Arrival in Recovery / ICU Time: 12:10

SpO₂: 100 % HR: 93 beats/min Rhythm: Regular RR: 14 breaths/min

ABP: 112/47 mmHg CVP: 5 mmHg PAP: _____ mmHg C.O.: _____ L/min

Conscious state: _____ Pain score: _____

VENTILATOR SETTINGS: Volume control;
RR 14/min; TV 500 ml; FIO₂ 0.6
PEEP 5 mmHg;

IONOTROPES:

Dig. Morphine 105 µg/min
Dig. Adrenaline 0.3 µg/min

POST OP ORDERS:

- 1) DO A&S / charting / Act
- 2) Mean f continue when fully awake

MODIFIED ALDRETE'S SCORE (Score against each criteria)

CRITERIA	PARAMETER	Scale
Activity, able to move, voluntarily or on command	4 extremities	2
	2 extremities	1
	No	0
Breathing	Able to breath deeply and cough freely	2
	Dyspnea, shallow or limited breathing	1
	Apnea	0
Consciousness	Fully awake	2
	Arousable on calling	1
	unresponsive	0
Circulation (Blood Pressure)	+20% of pre-anaesthesia level	2
	+20% to 49% of pre-anaesthesia level	1
	+50% of pre-anaesthesia level	0
SPO ₂	Maintains SPO ₂ >92% in ambient air	2
	Maintains SPO ₂ > 90P% with O ₂	1
	Maintains SPO ₂ <90% with O ₂	0

Total Score: 10

Patient fit for discharge:

☒ YES ☐ NO

Dr. A. SAMUEL SYLVESTER

Reg. No: 43570

Anaesthetist Name & Reg.No. :

Signature

OPERATION NOTES

Pre-Operative Diagnosis : CAD-TVD, Mod JV, EF-40%.

Post-Operative Diagnosis : -do-

Operation Procedure OPCAB x 3 grafts
LIMA → LAD SVG → PDA
SVG → OM

D.O. Operation

1	1	0	1	2	0	2	4
---	---	---	---	---	---	---	---

Please tick the type of procedure :

Closed ☒ Open ☐

Operation Commenced :	9.45	Operation Completed :	11.50	Nature of Anaesthetic :	LCA
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Surgeons Dr. Anbarasu (PA. Sai / Kartika) / Divya Perfusionist
Anaesthetist Dr. Sylvester Nurse Ms. Radhika

Incision Midline Sternotomy

annulation Arterial Venous
Oxygenator Median sternotomy, pericardiectomy.

LIMA & SVG harvested. systemic heparinization.
Heart stabilized & myocardial stabilizer (guidant).
distal anastomosis done & T-to prolene.

Findings and Relevant Details :

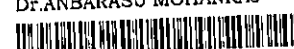
Good myocardial contraction LIMA → LAD, SVG → OM, SVG → PDA
LIMA - 1.75mm, good flow, good quality
SVG - 4mm, from left leg, thick wall good quality,
LAD - 2.0mm, healthy target
OM - 2.05mm, healthy target
PDA - 1.75mm, healthy target
aorta occluded partially. two 4mm holes were made on the aorta. proximal anastomosis done & 6-0 prolene sutures. protaminized. Hemostasis secured. pericardium reapproximated partially.
Routine chest closure done & two drain tubes insitu.

Mr. THANDAVA MOORTHY S

57 / Male / MH/202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



POST-BY PASS HAEMODYNAMICS

RA

LA

Cardiac Output

RV

LA

CI

SVS

SYS

PA

MEAN

BP

MEAN

DIAS

DIAS

PACW

Support:

Isoprin

Adrenaline

Dopamine

I A B P

Dobutrex

Others

POST-OPERATIVE INSTRUCTIONS :

Watch for bleeding, Hypotension

Blood loss : 300ml

Blood transfusion : NIL

Drains: Chest (dt) — 1
Mediastinal — 1
Pericardial — 2
Others —

Sponge Count : correct

Dr. Anbarasu Mohan

Reg No: 55476

Surgeon : Dr. ANBARASU MOHAN RAJ Date : 11/01/2022



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

OPERATION NOTES

NAME: Mr. THANDAVA MOORTHY.S	AGE/GENDER: 57Years / MALE
UHID NO: MHI202381312	IP NO: IPH2024000081
DOA: 10/01/2024	DOS: 11/01/2024
SURGEON: DR. ANBARASU MOHANRAJ	ANESTHETIST: DR. SAMUEL SYLVESTER
ASSISTED BY: MS. SAIKUMARI	PHYSICIAN ASSOCIATE: MS. KARTHIKA
SCRUB NURSE: MS. RADHIKA	

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

MODERATE LEFT VENTRICULAR DYSFUNCTION (EF – 40%)

TYPE II DIABETES MELLITUS

CLASS II – III ANGINA

SURGERY DONE:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3

LIMA TO LAD

SVG TO OM

SVG TO PDA

FINDINGS:

Fair myocardial contractions

Mild scarring of apical region

LIMA – 1.75mm, Good quality, good flow

SVG – 4mm, from left leg, Good quality

LAD – 1.8mm, Healthy target

OM – 2.0mm, Healthy target

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

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Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED



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

PDA – 1.6mm, Healthy target

Good distal run off in all the grafts

PROCEDURE:

Median sternotomy. Pericardiotomy. LIMA and SVG harvested. Systemic heparinisation.

Heart positioned and stabilized with myocardial stabilizer for OM grafting. Arteriotomy was made and 2.0mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the OM artery with 7-0 prolene suture. (SVG TO OM)

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD)

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the PDA artery with 7-0 prolene suture. (SVG TO PDA)

Aorta occluded partially. Two 4mm holes were made on the aorta with aortic punch. Proximal anastomosis of vein grafts done onto aorta with 6-0 prolene suture. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural tubes insitu

SUPPORTS:

He was shifted to ICU with inj. Nor Adrenaline 0.05µg/kg/min, inj. Adrenaline 0.03µg/kg/min supports.

CONSULTANT SIGNATURE

Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)
Director and Clinical lead – Cardio Vascular and Thoracic Surgery

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

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

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Kodambakkam 044-2473 4455	Mogappair 044-26530011	Chengalpattu 044-27426829	Villupuram 04146-242000	Kumbakonam 044-2473 4455	Kakinada 0884-2333367
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

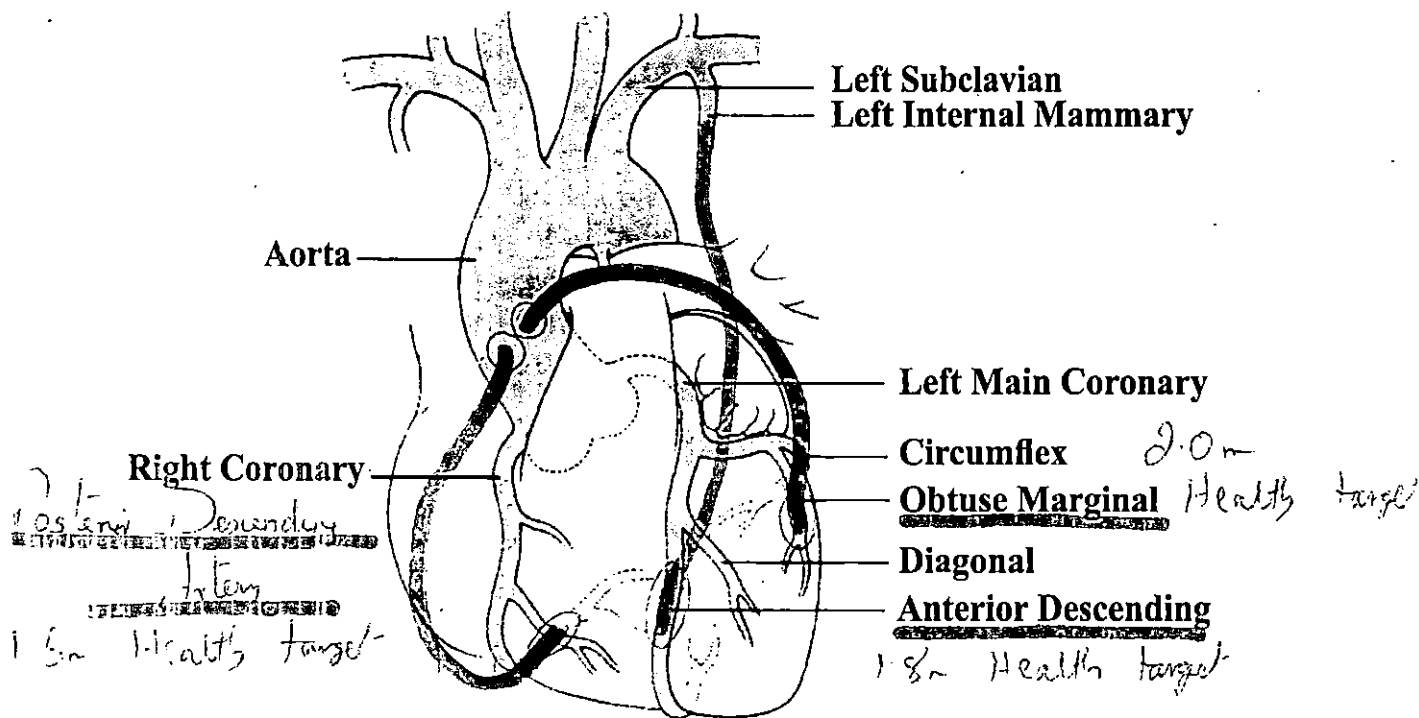
Medway Centre of Excellence (Chennai)

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

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

- Triple Vessel Coronary Artery Disease
- Medians to Dysfunction
- Diabetes Mellitus
- Class II-III Angina



- For myocardial contraction.
- Mild scarring of apical region.

Left Internal Mammary Artery (LIMA) } Healthy
Saphenous Vein Graft (SVG) } conduit

Name Mr. THANDAN MOORTHY 57/14 Date of Surgery 11/01/2024 UHID. No. NHS 20238131

Operation Performed OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCABG)

3 LIMA TO LAD; SVG TO OM, SVG TO PDA

Dr. Anand Kumar

11/01/2024

SAFETY FIRST

MHI/ICU/2022/092



Every heart beat counts

Medway Hospitals

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



PATIENT'S INFORMATION SHEET

	AGE / SEX	UHID NO
CONSULTANT	SURGEON	ANAESTHETIST
DR. ANBARASU.	DR. ANBARASU	DR. SYLVESTER
DIAGNOSIS (In Capital Letters)	1. CAD - TUD	
	2. RULMA (+)	
	3. MODERATE LV SYSTOLIC DYSFUNCTION	
	4. GRADE I DIASTOLIC DYSFUNCTION	
	5. EF - 41%	
	6. T2DM	
	7.	
	8.	
PRESENT PROCEDURE/ SURGERY	OPCAB x 3 GRAFTS LIMA → LAD SUA → OM SUA → PDA	
PREVIOUS PROCEDURE/ SURGERY	-	
CONTACT NO. & RELATIONSHIP	1. MR. SATHISH (SON) 9176672726 2. MR. SATHISH (SON) 9500142206	

N/Alo : 16/16

(Ve)

CAT : SELF PAY

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	10/01/2024	T. CONLOR	1.25mg	plw	1-0-0 ?	
2	10/01/2024	T. TIDE PLUS	20/500mg	plw	1-0-0 } continue	
3						
4						
5						
6						
7						
8						
9						
10						

ANTI-PLATELET Stopped ON 07/01/2024

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	11/1/24	SYP. SUCRALFATE	10ml	Plo	1-1-1 ?	
2	11/1/24	NEB. IENOLIN	0.13mg	INH	1-1-1	
3	12/1/24	TAB. FRUSEMIDE	40mg	Plo	1-1-0	
4	12/1/24	TAB. SPIRONOLACTONE	25mg	Plo	1-1-0	
5	12/1/24	TAB. BEPILEX FORTIC	1TAB	Plo	1-0-0	
6	12/1/24	TAB. CLOPIDOGREL + ASPIRIN	75/75mg	Plo	0-1-0	continue
7	12/1/24	TAB. ATORVASTATIN	20mg	Plo	0-0-1	
8	12/1/24	TAB. PARACETAMOL	650mg	Plo	1-1-1	
9	12/1/24	SYP. CRETAFENIN R	15ml	Plo	0-0-1	
10	12/1/24	TAB. TIETAPRAV	12.5mg	Plo	1-0-1	

ANY RELEVANT INFORMATION:

Admission / OT Receival Date and Time : 11/01/24 @ 12.10 From : OT To : SW	Condition of the Patient : 1. ~~Stable~~ / Unstable 2. ^{on venti} Oriented / Disoriented 3. ^{on venti} Conscious / Semiconscious / Unconscious 4. Febrile / ~~A febrile~~ 5. ~~Intubated~~ / Extubated		
Transfer Out Date and Time : 13/01/24 @ 10.45 From : SW To : 4 floor	Condition of the Patient : 1. ~~Stable~~ / Unstable 2. ~~Oriented~~ / Disoriented 3. ~~Conscious~~ / Semiconscious / Unconscious 4. Febrile / ~~A febrile~~ 5. Intubated / ~~Extubated~~		
Transfer In Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD	Year	Months	Days
	15 YEARS		
	—		
	—		
4) Known Case Of Others	—		
Denture	☐ Yes ☒ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	☐ Yes ☒ No If you means mention about Drug / Food Name :		
Pressure Ulcer Present	☐ Yes ☒ No If you means mention about Grade : 1 / 2 / 3 / 4 & Site:		

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site: RT CUBITAL	1. Inserted Date and Time 11/01/24 @ 8.40	1. Removed on :	
	2. Site:	2. Inserted Date and Time	2. Removed on :	
	3. Site:	3. Inserted Date and Time	3. Removed on :	
Neck Line : IJL / EJL	Site: LT JYU	Inserted Date and Time 11/01/24 @ 9.00	Removed on 13/01/24 @ 10.00	V. K. 10/01
Arterial Line : Right/Left	Site: LT RADIAL	Inserted Date and Time 11/01/24 @ 8.50	Removed on 12/1/24 at 11.30	h.
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on	
Pressure Bandage	Site: RT RADIAL	Inserted Date and Time 12/1/24 at 11.40	Removed on 13/01/24 @ 6.00	Donner
Drain Site	1. Mediastinal : Inserted Date and Time + 2. Pleural Right / Left : Inserted Date and Time 11/01/24 @ 11.30		Removed on Removed on 12/1/24 at 12.25	h.
Urinary Catheterization	Inserted Date and Time 11/01/24 @ 9.10	Removed on 13/1/24 AT 4.30	Donner 01/1	
Nasal / Oral Gastric Tube	Inserted Date and Time 11/01/24 @ 9.15	Removed on 12/01/24 @ 14.45	V. K. 10/01	
Intubation Date and Time 11/01/2024 @ 12.10	Extubation Date And Time (2 HRS 40 mins) 11/01/24 @ 14.50	Reintubation Date And Time		
Other Information	patient c/o retrosternal chest pain radiating to jaw & both shoulder associated with palpitation S. ECHO DONE ON 02/01/2024 CABG DONE ON 28/11/2023 (MMM HOSPITAL) ECG DONE ON 27/11/2023 (HR-99 bpm)			Nag 02/1



Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

IT'S INFORMATION SHEET

NAME	Dr. ANBARASU MOHANRAJ	AGE / SEX	UHID NO
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CONSULTANT	SURGEON	ANAESTHETIST
DR. ANBARASU	DR. ANBARASU	Dr. sylvestan

DIAGNOSIS (In Capital Letters)	1. CAD - TVD ACS - EVOLVED ANMI
	2. MODERATE LV SYSTOLIC FUNCTION EF - 41%
	3. RWMA ⊕ / TRIVIAL MR / TR / AR MILD PAH
	4. AORTIC VALVE SCLEROSIS
	5. T2DM
	6. —
	7. —
	8. —
PRESENT PROCEDURE/ SURGERY	CABG
PREVIOUS PROCEDURE/ SURGERY	H/D CABG done on 28.11.28 showed TVD
CONTACT NO. & RELATIONSHIP	1. 9126672726 mr. navesh (son)
	2.

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	28-11-23	T. ROSUVASTATIN	20/15mg	P/O	0-0-1	6/1/24
2	"	T. COVER84L	2MG	P/O	0-0-1	06/1/24
3	"	T. CONCOR	1-25MG	P/O	1-0-0	} continue
4	"	T. TIDEPILUS	20/500mg	P/O	1-0-0	
5	"	T. METFORMIN	500mg	P/O	1-0-0	
6	"	T. OMEPRIDE T. DAPTUM				
7						
8						
9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	10-1-24	T. CONCOR	1-25mg	P/O	1-0-0	} continue
2	"	T. TIDEPILUS	20/500mg	P/O	1-0-0	
3						
4						
5						
6						
7						
8						
9						
10						

ANY RELEVANT INFORMATION:

Admission / OT Reveal Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer Out Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer In Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD	Year	Months	Days
	17yrs		
	-		
	-		
4) Known Case Of Others			
Denture	☐ Yes ☒ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	☐ Yes ☒ No If you means mention about Drug / Food Name : 		
Pressure Ulcer Present	☐ Yes ☒ No If you means mention about Grade : 1 / 2 / 3 / 4 & Site: 		

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site:	1. Inserted Date and Time	1. Removed on :	
	2. Site:	2. Inserted Date and Time	2. Removed on :	
	3. Site:	3. Inserted Date and Time	3. Removed on :	
Neck Line : IJL / EIJL	Site:	Inserted Date and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on	
Pressure Bandage	Site:	Inserted Date and Time	Removed on	
Drain Site	1. Mediastinal : Inserted Date and Time		Removed on	
	2. Pleural Right / Left : Inserted Date and Time		Removed on	
Urinary Catheterization	Inserted Date and Time		Removed on	
Nasal / Oral Gastric Tube	Inserted Date and Time		Removed on	
Intubation Date and Time	Extubation Date And Time		Reintubation Date And Time	
Other Information	10 pcu respiration done confirmed c blood in la stuff [Signature]			

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



Name of the Procedure : open aortic heart

Location : CT-01 T

Date & Time : 11/1/24 @ 12:00

Does the Procedure involve Procedural Sedation : ☒ Yes ☐ No

SIGN IN : <u>8:30</u> Before Induction of Procedural Sedation		TIME OUT : <u>9:35</u> After procedural Sedation and before procedure		SIGN OUT : <u>12:00</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	☒ Yes	Identity by two identifiers	☒ Yes	Name of the Procedure done written down ☒ Yes	
Procedure	☒ Yes	Procedures	☒ Yes	Name and site of all specimens / investigations ☐ Yes ☒ NA	
Side	☐ Rt ☒ Lt ☐ NA <u>Chest Leg</u>	Side	☐ Rt ☒ Lt ☐ NA <u>Chest, Leg</u>	confirms labeling and sent to lab	
Consent	☒ Yes	Position	☒ Yes ☐ NA <u>Supine</u>	Any recovery concerns : ☐ Yes ☒ None	
Known Allergy	☐ Yes ☒ Not known If yes, please specify	Consent	☒ Yes	If Yes, Pls. specify :	
		Required equipment and implants available	☒ Yes ☐ NA		
Difficult airway / aspiration risk / dentures	☒ No ☐ Yes, equipment and assistance available	Essential Imaging displayed	☒ Yes ☐ NA ☒ X-ray		
Possibility of hypothermia	☐ No ☒ Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes	☒ Yes ☐ NA		
		Name of the Antibiotic given	<u>Inj-Cefuroxime 1.5g @ 9:00</u>	Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☒ None	
		Venous Thromboembolism Prophylaxis Provided	☒ Yes ☐ NA	If Yes, Pls. specify :	
All concerned anesthesia equipment and medication check complete	☒ SpO2 ☒ NIBP ☐ Others pls. specify	Anticipated duration briefed	☒ Yes	<u>Instruments, sponges, Count, Drains</u>	
Pre OP medication taken	☒ Yes ☐ No	Anticipated blood loss briefed	☒ Yes ☐ NA	<u>Counts or correct</u>	
Required equipment for procedure available	☒ Yes ☐ NA	Adequate fluids and blood available	☒ Yes ☐ NA	Corrective action :	
		Team briefed on any critical or unexpected steps	☒ Yes		
		For procedural sedation cases			
		Any patient specific concerns :	☐ Yes ☒ None		
		Intra procedure glyceric control	☐ Yes ☒ NA		
		Any concerns about sterility	☐ Yes ☒ None		

Anaesthetist / Doctor giving Procedural Sedation : Dr. A. SAMUEL SYLVESTER

Date : 11/1/24
Time : @ 12:00

Doctor performing the Procedure : Dr. ANBARASU

Date : 11/1/24
Time : @ 12:00

Nurse :

AIN ABITHA

Date : 11/1/24
Time : @ 12:00

Technician :

Dr. SATIYA

Date : 11/1/24
Time : @ 12:00

Others Please Specify :

Dr. INC. CHRISTINA

Date : 11/1/24
Time : @ 12:00

CONSENT FOR BLOOD / BLOOD COMPONENTS

A Blood transfusion is life saving medical procedure, prescribed by a physician. Blood can be given 'whole' but more often a component or combination of component is transfused. Among the most common components are:

- Red Cells for bleeding or low hemoglobin
- Platelets for bleeding or low counts
- Plasma for restoring blood volume or providing clotting factors
- Cryoprecipitate for special clotting factors

The Doctor has explained the benefirs that are expected from my/the patients being transfused as well as the risk are:

1. I have been informed the transfusion option available, which may include banked blood (allogenic) provided by voluntary donors or self-donation (autologous). If an emergency condition exists, banked blood will be invariably be used. Self-donation is possible if time permits.
2. I have been informed that despite careful screening in accordance with national regulations, there are rare instances of life threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risks. I also understand that unpredictable reactions may occur which include but are not limited to, fever, rash, and shortness of breath, shock and in rare occasions, death.
3. Expected benefits of the transfusion may include minimizing shock, brain and other organ damage, hastening recovery and limiting blood loss, however, I understand that there are no guarantees offered as to the expected benefits.
4. I have had the opportunity to ask questions about transfusions, alternate forms of treatment, risks of non-treatment, the procedures to be used, and the relative risks and hazards involved and I believe that I have sufficient knowledge to make an informed decision.
5. I agree/Not agree the administration of blood and/or components in the interest of proper medical care, with my signature I give consent to administering blood products for myself or for the patients. I agree this informed consent may serve for consent to give additional necessary blood products for a time certain to end with this hospitalization or for the complete course of this illness. If I have been advised that the future need for transfusion blood products is quiet likely and possibly on a recurrent basis but still related to the same illness.

Witness P. N. Bhavatharan
Doctor [Signature] 43570
Time 14.30
Date 10/1/24

Patients name S. THANDAVA MOORTHY
Patient signature [Signature]
or Guardians name T. Chandra
Guardians signature T. Chandra
Relationship to patient wife

Informed consent not obtained because of a life threatening/emergency medical condition. I have provided the patient information sufficient to be considered informed consent and I have proceeded with ordering blood products to be administered in sufficient quantity to alter, improved or reverse a life-threatening/emergent medical condition.

Time: 19.00 Date: 10/1/24

Doctors Signature:

ஒப்புதல் : இரத்தம் / இரத்தத்தின் பாகங்களை செலுத்துதல்

இரத்தம் செலுத்துதல் என்பது, மருத்துவரால் பரிந்துரைக்கப்படுகின்ற ஓர் உயிர் காக்கும் மருத்துவ செயல்முறையாகும். முழுமையான இரத்தம் அளிக்கப்படலாம் என்றாலும், பெரும்பாலும் ஒரு பாகம் அல்லது பாகங்களின் கலவை செலுத்தப்படுகிறது. மிகப் பொதுவான பாகங்களில் கீழ்க்கண்டவை அடங்கும்.

சிலப்பு அணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு
தட்டணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு
குருதிநீர்	இரத்த கன அளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு
கிரையோபிரைஸிபிடேட்	சிறப்பு உறைவு அம்சங்களுக்காக

எனக்கு / நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்

1. இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானமளிப்பவர்கள் வழங்கியுள்ள வாங்கியிலுள்ள இரத்தம் (அலோஜெனிக்) அல்லது சுயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வாங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானமளிப்பதற்கு வாய்ப்புள்ளது.
2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்பட்டுள்ளதாலும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்ட்ஸ் - ஹெபடைடஸ் மற்றும் இதர வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களை நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம். இவை காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொண்டேன்.
3. இரத்தம் செலுத்துவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலை துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம் என்றாலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
4. இரத்தம் செலுத்துதல், மாற்று சிகிச்சை முறைகள், சிகிச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள், மற்றும் இதுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய விவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.
5. முறையான மருத்துவ பராமரிப்பின் பொருட்டு, இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முழுமையான காலகட்டத்திற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்பு கொள்கிறேன்.

நோயாளியின் பெயர்.....

சாட்சி நோயாளியின் கையொப்பம்

மருத்துவர் அல்லது பாதுகாவலரின் கையொப்பம்

நேரம் பாதுகாவலரின் கையொப்பம்

தேதி நோயாளியுடனான உறவு

உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நிலை காரணமாகத் தகவலறிந்த ஒப்புதல் பெறப்படவில்லை. தகவலறிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அளவிற்கு நான் போதிய அளவு தகவலை நோயாளிக்கு வழங்கிவிட்டேன். மேலும் ஓர் உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நிலையை மாற்றுவதற்கு, மேம்படுத்துவதற்கு, நேர்மாறாக ஆக்குவதற்கான போதிய அளவில் இரத்தப் பொருட்களை வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான் மேற்கொண்டுள்ளேன்.

நேரம் :

நோயாளியின் பெயர் :

மருத்துவரின் கையொப்பம்.....

தேதி :

CONSENT FORM - PHYSIOTHERAPY

I, Mr. Thandava Moorthy the ☐ Patient or ☒ representative of patient have (please tick the correct option above and below):

☒ Read

☒ I/We have been explained the current clinical condition of me / my patient

☒ Been explained this consent form in Tamil (Name of language) which I fully understand and understood the information provided about Operation / procedure

Post operative Cardiac Pulmonary Rehabilitation
(full name of operation / procedure given below in this consent form)

Brief description of the Operation / Procedure: DBP, Spirometry ex, Chest Percussion to
the Chest wall, Arm to Bk U/L & R Mobilization

I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are:

To Improve Joint Rom, To Improve Lung Capacity & function,
To improve breathing, To clear lung secretion

I understand that all procedures carry certain risks. The potential risks and complications from this procedure:

Pain

I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:

Nil

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 ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery, 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.

Signature of Patient / Patient's Relative (only if Patient is unable to sign): * T-Santhosh

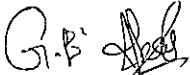
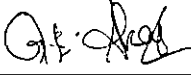
For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to Dr. AKASH-G.E (name of doctor performing the operation / procedure) for carrying out the said operation / procedure on ☒ myself or ☐ my above named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives

* T-Santhosh
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 #)	* T-Santhosh	T. Santhosh (Write name and relationship with patient)	11/1/24	14:30
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		D. PAVEENA	11/1/24	14:30
Interpreter (if applicable)				

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

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned operation / 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
Consent obtained by		AKASH-G.E	0256	11/1/24	14:30
Procedure performed by		AKASH-G.E	0256	11/1/24	14:30

Name: **Mr. THANDAVA MOORTHY S**
UHID: 57/Male/MHI202381312
DOB: 10/01/2024/IPH2024000081
DDA: Dr. ANBARASU MOHANRAJ
Consultant: 

IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints:

PT c/o chest pain (retrosternal) radiating to Jaw
Both shoulders - x (month ago)
Associated with palpitation / sweating.
c/o SOB - on exertion (3 days)

Occupation: ☐ Heavy Activity ☐ Moderate Activity ☐ Light Activity

Past Medical / Surgical History:

K/c/o T2DM x 15 yrs.
K/c/o ACS - evolved AWM I
K/c/o Acute heart failure - resolved
- CAG - TND.

On Observation:

Built: ☐ Thin ☐ Fair ☒ Well Built ☐ Obese | Postural Deviation: ☐ Yes ☒ No | Muscles Wasting: ☐ Yes ☒ No
Deformity: ☐ Yes ☒ No | Swelling: ☐ Yes ☒ No | Gait Deviation: ☐ Yes ☒ No | External Appliances: ☐ Yes ☒ No

On Palpation:

Tenderness: ☐ Yes ☒ No | Warmth: ☐ Yes ☒ No | Muscle spasm: ☐ Yes ☒ No
Oedema: ☐ Yes ☒ No | Crepitus: ☐ Yes ☒ No | Tone: ☐ Normal ☒ Abnormal ☐ INSIGNIFICANT

FALL RISK SCREENING NA

Fall Risk Screening for Adults: ☐ 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 is met, initiate detailed fall assessment and fall prevention protocol.

Fall Risk Screening for Pediatrics: NA

☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged mobility

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

Respiratory Status:

☒ Room Air ☐ O₂ Support ☐ Ventilatory Support ☐ BIPAP

☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask

Intubated: ☐ Yes ☒ No

Tracheostomy: ☐ Yes ☒ No

Brain Injury (if applicable): NA

☐ Traumatic ☐ Non Traumatic

☐ Mild ☐ Moderate ☐ Severe

☐ Conscious ☐ Unconscious

GCS: E +V +M = | RLA: levels

Spine Injury: ☐ Present ☒ Absent

AIS:ISNCSCI SCALE: *NIL*

☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx

Associated Injuries: Speech impaired: ☐ Yes ☒ No

Voluntary Movements: ☐ Present ☒ Absent | Tone Modified: ☐ Hypotonic ☒ Normal ☐ Hypertonic

ASHWORTH SCALE: *NIL*

☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit

Balance: ☐ Good ☐ Fair ☐ Poor | Co-ordination: ☒ Good ☐ Fair ☐ Poor

Functional Activities

Self Care: ☒ Independent ☐ Dependent | Bed Mobility: ☒ Independent ☐ Dependent

Transfers: ☐ Independent ☐ Dependent | Ambulation: ☒ Independent ☐ Dependent

FIM Score:

Breathlessness (If applicable):

Dyspnoea Grading Scale: *Grade II*

Abnormal Breathing Sounds: ☐ Wheezing ☐ Stridor ☐ Crackles ☐ Pleural Rub ☐ Pneumothorax Click ☐ Stertor

Abnormal Breathing Pattern: *Abdominal breathing.*

Pain Assessment: Pain: ☒ Yes ☐ No

Pain Score: *6/10*

Tick whichever is applied: ☒ Numerical Rating Pain Scale ☐ Visual Analog Scale ☐ Wong-Baker Faces

☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC

Location: *Chest, R/C Shoulder* Duration: *1 month* Frequency: *—* Character: *—*

☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness

☐ Sharp ☐ Cramping ☒ Stabbing ☐ Crushing

Aggravating Factors:

Relieving Factors:

Examination (Please tick and mention abnormal findings only):

☐ Range of Motion:

Normal

☐ Muscle Strength:

Normal

☐ Reflexes:

Normal

Plantar Response: ☒ Diminished ☐ Brisk ☐ Clonus

Biceps: ☒ Diminished ☐ Brisk ☐ Clonus

Triceps: ☒ Diminished ☐ Brisk ☐ Clonus

Supinators: ☒ Diminished ☐ Brisk ☐ Clonus

Knee: ☒ Diminished ☐ Brisk ☐ Clonus

Ankle: ☒ Diminished ☐ Brisk ☐ Clonus

Sensation: Good.

Investigation & Findings:

T2DM / ACS - Arched AVM / Acute LV failure
CAD - TND / moderate LV / EF - 41% ↓ recovered

Physiotherapy Management Plan:

- Ili
- Spinal surgery
- Chest percussion
- Mobilization
- To Improve Joint ROM

	Signature	Name	Emp. No.	Date	Time
Physiotherapist	G. F. Alag	AKASH G. E	0256	11/1/24	15:00

RE-ASSESSMENT FORM

Date &
Time

13/1/24

&

11:00

Fall Risk Score: -

Pain Score: 3/10

Surgical Site pain

- Been encouraged

- Spirometry as encouraged

In: 6000 Exp: 6000

- Chest percussion to BL chest wall

- Aron to BL cuff

- Mobilization

- To Improve Joint ROM

- To Improve Lung capacity & function

- To improve breathing

- To clear out lung secretion

Post Intervention Pain Score: 5/10

Treatment Care & Plan:

Post operative Cardiac Pulmonary Rehabilitation

Signature

Name

Emp. No.

Physiotherapist

G.B. Akal

ARASH GB

0256



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Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
11/1/24	13:40	S/B AKASH - Oral suctioning done yielded blood stain	G.P. Akash MH10256
11/1/24	14:50	S/B ABASH - BT Oral / Nasal suctioning done yielded thick blood secretion - PT extubated - PT voice clear & audible - PT Nebulized - PT connected to Nasal pronges (4 litres) - spirometry air encouraged Ins: 600cc Exp: 600cc	G.P. Akash MH10256
11/1/24	22:00	S/B Ramanathan P - DBE's encouraged - Chest percussion to B/L Chest wall - ABOM A's to B/L UL & RU - spirometry A's encouraged Ins: 600cc Exp: 600cc	Dr. P MH10256



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Mr. THANDAVA MOORTHY S

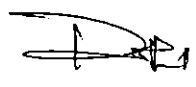
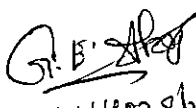
57/Male/MH1202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
12/1/24	8:00	S/B <u>Ramanathan</u> DBE's encouraged - Chest percussion to BL chest wall - Arcom G's to BL Chest Spirometry G's encouraged Insp: 600cc Exp: 600cc - H Chin mobilized	 MH10260
12/1/24	9:00	S/B <u>AKASH</u> - DBE's encouraged - Spirometry as encouraged Insp: 600cc Exp: 600cc - Chest percussion to BL chest wall - Arcom to BL wall	 MH10256
12/1/24	16:00	S/B <u>AKASH</u> - DBE's encouraged - Spirometry as encouraged Insp: 600cc Exp: 600cc - Chest percussion to BL chest wall - Arcom to BL wall	 MH10256



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10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
12/1/24	22:00	S/B Ramanathan J - DBE's encouraged - Spirometry & encouraged Ins: 600cc Exp: 600cc - Chest percussion to B/L Chest wall - AROM & to B/L UL & LL	Dth MH10260
13/1/24	6:00	S/B Ramanathan J - DBE's encouraged - Chest percussion to B/L Chest wall - AROM & to B/L UL & LL - Spirometry & encouraged Ins: 600cc Exp: 600cc - PT Chain mobilised.	Dth MH10260
13/1/24	9:00	S/B ARASU - DBE's encouraged - Spirometry & encouraged Ins: 600cc Exp: 600cc - Chest percussion to B/L Chest wall - AROM to B/L UL & LL	R.B. Arasu MH10256



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Mr. THANDAVA MOORTHY S

57/ Male/ MH1202381312

10/01/2024/ IPH2024000081

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
13/1/24	16:00	S/P <u>AKASH</u> - Drex encouraged - Sprometry & encouraged - Ins: booe Exp: booe - Chest percussion to Blc - Chest wall - ARom to Blc velle - PT Mobil. Zed	G. E. MH10256
14/1/24	10:00	S/P <u>AKASH</u> - Drex encouraged - Sprometry & encouraged - Ins: booe Exp: booe - Chest percussion to Blc - Chest wall - ARom to Blc velle - PT Stand amb encouraged	G. E. MH10256
15/1/24	10:00	S/P <u>AKASH</u> - Drex encouraged - Sprometry & encouraged - Ins: booe Exp: booe - Chest percussion to Blc - Chest wall - ARom to Blc velle - PT Stand amb encouraged	G. E. MH10256



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Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
16/1/24	10:00	S/O AKASH - Encouraged - Spraying to Encouraged - Ins: Boce Rpt Boce - Chest percussion to BL - Chest wall - Arm to BL side - PT Mobilised	G.E. MHI256

Mr. THANDAVA MOORTHY S
57/Male/MH12023810

57/Male/MHI202381312
10/01/2024/IPH2024000081

DR. ANBARASU MOHANRAJ



MICROBIOLOGY SHEET

DATE	2/1/20		
COLOUR	PALE YELLOW		
REACTION	6.0		
SPECIFIC GRAVITY	1.010		
APPEARANCE	CLEAR		
ALBUMIN			
SUGAR	+++		
ACETONE			
BILE SALT	Negative		
BILE PIGMENT	Normal		
UROBILINOGEN	Normal		
PUS CELLS	3-5		
EPITHELIAL CELLS	2-4		
RBC	N.I.		
CASTS	N.I.		
CRYSTALS	N.I.		
OTHERS	-		

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

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.

Adjust Infusion rate to 2u / hr.

Adjust Infusion rate to 4u / hr.

Adjust Infusion rate to 6u / hr.

Adjust Infusion rate to 8u / hr.

Adjust Infusion rate to 10u / hr.

Adjust Infusion rate to 20u / hr.

Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ

**DIABETIC CHART**

T. GLIMEPRIDE 2mg + T. METFORMIN 500mg 1-0-0 (BF)

ACTUAL WEIGHT 57.3 kg HbA_{1c} 7.7 %

PREVIOUS DIABETIC MEDICATIONS T. METFORMIN 500mg + GLIMEPRIDE 1mg 0-0-1 (BF)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
11/01/2024	12.15	185 mg/dl	Ins. Human Actrapid 4 u / hr on flow	DR. SYLVESTER	DR. SYLVESTER
	14.20	179 mg/dl	Ins. Human Actrapid 4 u / hr	DR. SYLVESTER	DR. SYLVESTER
	16.40	184 mg/dl	Ins. Human Actrapid 4 u / hr	DR. SYLVESTER	DR. SYLVESTER
	20.00	180 mg/dl	Ins. HUMAN ACTRAPID 4 u / hr	DR. PRANEEN	DR. PRANEEN
	22.00	200 mg/dl	Ins. HUMAN ACTRAPID 4 u / hr	DR. PRANEEN	DR. PRANEEN
12/1/24	24.00	160 mg/dl	Ins. HUMAN ACTRAPID 4 u / hr	DR. PRANEEN	DR. PRANEEN
	6.30	208 mg/dl	Ins. H. ACTRAPID 4 u / hr	DR. PRANEEN	DR. PRANEEN
	6.30	190 mg/dl	T.GP2 p/b GIVEN at 8.20	DR. PRANEEN	DR. PRANEEN
	11.00	239 mg/dl	INT. ACTRAPID 4 u / hr ON INFUSION	DR. PRANEEN	DR. PRANEEN
	13.00	210 mg/dl	INT. ACTRAPID 2 u / hr ON INFUSION	DR. PRANEEN	DR. PRANEEN
	17.00	171 mg/dl	INT. ACTRAPID 1 u / hr ON INFUSION	DR. PRANEEN	DR. PRANEEN
	20.00	194 mg/dl	INT. H. ACTRAPID 2 u / hr on Infusion	DR. PRANEEN	DR. PRANEEN

INSTRUCTIONS FOR INSULIN INFUSIONS

T. GLIMEPRIDE 2mg + T. METFORMIN 500mg

	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.
* Mix 40u short acting Insulin in 40 ml. of normal Saline (I/J - 1 ml.)	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.
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	>400	Adjust Infusion rate to 20u / hr.
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.		
* Target Blood Sugar 150-200 mgs.		
* To monitor K ⁺ separately.		
Urine Acetone		

Every heart beat counts
Mr. THANDAVA MOORTHY S

Patient ID: 57/Male/MHI202381312
Name: 10/01/2024/IPH2024000081
UHID: Dr. ANBARASU MOHANRAJ
DOB: 

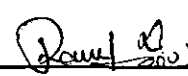
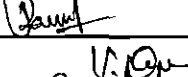
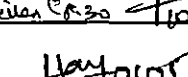
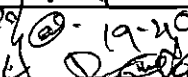
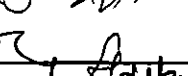
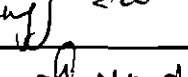
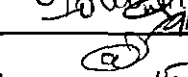
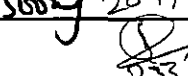
DIABETIC CHART

T. GLYCOMET GP₃/250 1-0-0 (BF)

T. GLYCOMET GP₂/500 0-0-1 (AF).

ACTUAL WEIGHT 57.3 kg HbA_{1c} 7.7%

PREVIOUS DIABETIC MEDICATIONS Insulin (Humalog) 200 units (100 units)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
12/1/24	24:00	182 mg/dl	Insulin H. ACTRAPID 2 IU/hr		DR. PRANEESH
12/1/24	4:00	194 mg/dl	Insulin H. ACTRAPID 2 IU/hr Insulin		DR. PRANEESH
13/1/24	6:00	162 mg/dl	Insulin stopped at 6:00		DR. PRANEESH
			T. METFORMIN 500mg + T. GLIMEPIRIDE 2mg given @ 3:30		
13/1/24	12:30	212 mg/dl			K.M. (34077)
	18:30	269 mg/dl	T. GP2 1 (BF) + Insulin H. Actrapid 8 units		DR. PRANEESH
14/1/24	6:30	195 mg/dl	T. MF 500mg + T. Glimepiride 2mg		DR. PRANEESH
	12:30	265 mg/dl	HA - 12U		K.M. (34077)
	6:30	155 mg/dl	T. Glycomet GP ₂ /500		DR. PRANEESH
					

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
* Mix 40u short acting Insulin in 40 ml. of normal Saline (I/U - 1 ml.)		
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.	150-200	Adjust Infusion rate to 2u / hr.
	201-250	Adjust Infusion rate to 4u / hr.
	251-300	Adjust Infusion rate to 6u / hr.
* Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
* To monitor K ⁺ separately.	>400	Adjust Infusion rate to 20u / hr.
Urine Acetone		



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MHI/IP/2022/065



Every heart beat counts

Mr. THANDAVA MOORTHY S

Pati: 57/Male/MHI202381312

Narr: 10/01/2024/IPH2024000081

UHI: Dr. ANBARASU MOHANRAJ



DIABETIC CHART

ACTUAL WEIGHT 57.3 kg HbA_{1c} 7.7 % 850 mg.

PREVIOUS DIABETIC MEDICATIONS T. GLYCOMET GP₂ 850 1-0-0 (B/F) T. GLYCOMET GP₂/500 0-0-1 (A/F)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
15/1/24	6.30	180 mg/dL	T. Glycomet GP 850mg	7.30	16.5m
	12.30	256 mg/dL	H. Mirtad 10mg	@ 14.30	for Dr. Anbarasu
	18.30	209 mg/dL	T. Glycomet GP ₂ 500	@ 19.30	Dr. Anbarasu
			T. Glycomet GP ₂ 500	@ 20.10	Dr. Anbarasu
16/1/24	6.30	107 mg/dL	T. Glycomet GP 850mg		16.5m
	12.30	168 mg/dL			K. 16.5m
	18.30	227 mg/dL	T. Glycomet GP ₂ 500		Dr. Anbarasu
17/1/24	6.30	82 mg/dL	After Recheck		16.5m
	12.30	151 mg/dL			16.5m

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
* Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)		
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.	150-200	Adjust Infusion rate to 2u / hr.
* Target Blood Sugar 150-200 mgs.	201-250	Adjust Infusion rate to 4u / hr.
* To monitor K ⁺ separately.	251-300	Adjust Infusion rate to 6u / hr.
Urine Acetone	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
	>400	Adjust Infusion rate to 20u / hr.

BLOOD GROUP

B +ve

INVESTIGATION SHEET

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/1PH2024000081

Dr. ANBARASU MOHANRAJ

P
N
U
D

Date	02/01/2024	11/01/2024	12/1/24	13/01/24	15/01/24	
HAEMATOLOGY						
Hb	17.1	12.5	11.5	10.0	8.4	
P.C.V	50.6	36.4	33.9		25.1	
Platelets	170000	169000	204000		194000	
TLC	7960		12550		6700	
Polymorphs	59.8		79.3			
Lymphocytes	31.0		15.4		25.0	
Eosinophils	3.9		0.1		3.3	
Mono / Basophils	4.7/0.6		5.1/0.1		4.7/0.2	
E.S.R						
BIO-CHEMISTRY						
Urea	35		23	124	25	
Creatinine	0.86		0.75	0.62	0.74	
Sodium	138			134	134	
Potassium	4.29			4.17	4.26	
Bicarbonate						
Chloride						
Magnesium		2.5	2.0			
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.55		0.60			
D.Bilirubin	0.23					
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protein						
S.Albumin	5.2		3.5			
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK			292			
CK - M.B. MASS			16.1			
LDH						
Ntpro bnp						

[illegible]

Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



BLOOD GROUP

"B" positive

INVESTIGATION SHEET

Date	2/1/24					
HAEMATOLOGY						
Hb	17.1					
P.C.V	50.6					
Platelets	170000					
TLC	7960					
Polymorphs	59.8					
Lymphocytes	31.0					
Eosinophils	3.9					
Mono / Basophils	4.7 / 0.6					
E.S.R						
BIO-CHEMISTRY						
Urea	35					
Creatinine	0.86					
Sodium	138					
Potassium	4.29					
Bicarbonate	23					
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.55					
D.Bilirubin	0.23					
I.Bilirubin	0.32					
S.G.O.T	30					
S.G.P.T	44					
ALP	118					
GGT	25					
Total Protien	8.0					
S.Albumin	5.2					
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]



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MR. THANDAVA MOORTHY S

p: 57/Malc/MHI202381312

N: 10/01/2024/IPH2024000081

III Dr.ANBARASU MOHANRAJ

Di 

MHI/IP/2022/074



Every heart beat counts

VITAL INFORMATION SHEET

BLOOD GROUP

ON ADMISSION

Height in CM

Weight in Kg.

167 cm

59.3k

Diagnosis: CAP-TRD

Procedure :

NO. OF DAYS																																																												
DATE																																																												
HOUR																																																												
40.5°																																																												
40°																																																												
39.5°																																																												
39°																																																												
38.5°																																																												
38°																																																												
37.5°																																																												
37°																																																												
36.5°																																																												
36°																																																												
PULSE																																																												
RESP																																																												
B.P.																																																												
SPO2																																																												
DAILY WEIGHT																																																												
24 HRS INTAKE																																																												
24HRS OUTPUT																																																												
BALANCE																																																												
MOTION																																																												

ANTI PLATELET ~~AP~~ STOPPED on 7/1/24



DO



Medway
Heart
Institute

Every heart beat counts

BSA - 1.56 m^2 BLOOD GROUP B +ve

ON ADMISSION

Weight in Kg.

5.7. 2r2

Procedure: OPLATB x 3 GRAFIS

Lima $\rightarrow$ CAD
Sulu $\rightarrow$ BM
Sulu $\rightarrow$ PDA

[illegible]



EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex:

Patient Id No:

[illegible]

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

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



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

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



EARLY WARNING SCORE MONITORING CHART

Name: _____

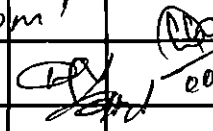
Age/Sex: _____

Patient Id No: _____

NEWS key	DATE	TIME	DATE	TIME
0	15/1/2024	15:00	15/1/2024	15:00
1	15/1/2024	19:00	15/1/2024	23:00
2	16/1/2024	00:00	16/1/2024	10:00
3	16/1/2024	18:00	16/1/2024	22:00
	17/1/2024	06:00	17/1/2024	10:00
	17/1/2024	14:20		
A+B Respirations Breath/ min	>25	3	>25	
	21-24	2	21-24	
	18-20		18-20	
	15-17		15-17	
	12-14		12-14	
	9-11	1	9-11	
	<8	3	<8	
A+B SpO2 Scale 1 Oxygen Saturation (%)	>96		>96	
	94-95	1	94-95	
	92-93	2	92-93	
	<91	3	<91	
SpO2 scale 2 oxygen saturation (%) use scale 2 target range is 88-92 % in hypercapnic respiratory failure only scale 2 under the direction of qualified person	>96 on oxygen	3	>96 on oxygen	
	95-96 on O2	2	95-96 on O2	
	93-94 on O2	1	93-94 on O2	
	>93 on air		>93 on air	
	88-92		88-92	
	86-87	1	86-87	
	84-85	2	84-85	
	<83%	3	<83%	
Air or Oxygen ?	A= Air		A= Air	
	O2litre/ min	2	O2litre/ min	
	Device		Device	
C Blood Pressure	>220	3	>220	
	201-219		201-219	
	181-200	2	181-200	
	161-180		161-180	
	141-160		141-160	
	121-140		121-140	
	111-120		111-120	
	91-100	1	91-100	
	81-90	2	81-90	
	71-80	3	71-80	
	61-70	3	61-70	
	51-60	3	51-60	
	<50	3	<50	
Diastolic BP	mmHg		mmHg	
	>131	3	>131	
	121-130	2	121-130	
	111-120	2	111-120	
	101-110	1	101-110	
	91-100	1	91-100	
	81-90		81-90	
	71-80		71-80	
	61-70		61-70	
	51-60		51-60	
	41-50	1	41-50	
	31-40	3	31-40	
	<30	3	<30	
D Consciousness Score for New onset of confusion (no score if chronic)	Alert		Alert	
	Confusion	3	Confusion	
	V	3	V	
	P	3	P	
	U	1	U	
E Temperature Degree Celsius	>39.1 degree Celsius	2	>39.1 degree Celsius	
	38.1-39.0	1	38.1-39.0	
	37.1-38.0		37.1-38.0	
	36.1-37.0		36.1-37.0	
	35.1-36.0	1	35.1-36.0	
	< 35.0	3	< 35.0	
NEWS Total				
Monitoring Frequency				
Escalation of Care Y/N				
Initials by RN				
Initials by Sr. RN				

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

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

Date	From: 10/1/24	To: 11/1/24	Bed No: 104-A	INTAKE & OUTPUT CHART											
24 Hrs : Started Time :	9:11.30	Ended Time :	7:20												
NPO Started at :		NPO Over at :													
SHIFT	Morning	Afternoon	Night												
INTAKE	—	450 ml	550 ml	Restricted Fluid (RF)											
OUTPUT	—	400 ml	800 ml												
Total Intake:		Total Output:		Difference:											
INTAKE (ml)				OUTPUT (ml)											
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
Patient admission 10:30pm															
10:00	200				200	14:00	200						200		
14:00	100				300	18:00	200						400		
18:00	50				350	21:00	200						600		
16:00	100				450	21:00	300						900		
20:00	200				650	6:00	800 ml						1200 ml		
21:00	100				750										
22:00	100				850										
10:00	180 ml				1000										
Total Intake - 1000 ml															
Total output - 1200 ml															
Balance - 200 ml															
 10/1/2024															



Date	From: 13/01/2024	To: 14/01/2024	Bed No: 104-A	INTAKE & OUTPUT CHART											
24 Hrs : Started Time : 8.00		Ended Time : 07.00													
NPO Started at :		NPO Over at :													
SHIFT	Morning	Afternoon	Night											Restricted Fluid (RF)	
INTAKE	320ml	305ml	350ml	RF-1.8lit/day											
OUTPUT	70ml	950ml													
Total Intake: 975ml		Total Output: 2650ml		Difference: -1675ml											
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
10.45	300ml					300ml	10.45	300ml					300ml	10.45	
12.00	20ml					320	12.00	400					700ml		
13.00	150					470	16.15	550					1250		
17.10	80					550	18.00	400					1650		
18.30	75					625	22.00	400					2050		
19.00	50					675	4.30	500					2550		
21.35	100					775	6.30	200					2650		
4.45	100					875									
6.00	100					975									
							TOTAL INTAKE : 975ml								
							TOTAL OUTPUT : 2650ml								
							BALANCE : -1675ml							SDS	



Date	From: 14/1/24	To: 15/1/24	Bed No: 104-A	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	850 ml		400 ml		550		1.8 lts / day								
OUTPUT	400 ml		1100 ml		600										
Total Intake: 1300			Total Output: 2550			Difference: (-) 1250 ml									
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
7am	100					100	7am	400					400 ml		
9:30	125					225	12:00	450 ml					850 ml		
10:30	50					275	15:00	600					1450		
11:40	75					350	17:30	500					1950		
13:20	100					450	21:30	100					2050		
14:30	100					550	22:00	100					2150		
15:30	100					650	6:00	400					2550		
17:20	100					750									
18:45	100					850									
21:20	200					1050									
21:45	50					1100									
1:45	100					1200									
6-30	100					1300									
							TOTAL INTAKE: 1300								
							TOTAL OUTPUT: 2550							N 24	
							BALANCE: 1250							5.00	



Date	From: 15/1/24	To: 16/1/24	Bed No: 104-A	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	650 ml		175		350 ml		1.8 lts / day								
OUTPUT	1020 ml		720		840 ml										
Total Intake:	1525 ml		Total Output:		1600 ml		Difference: - 75 ml								
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										
6.15	200					200	6.10	320					320		
7.20	125					325	9.45	300					620		
9.50	100					425	11.00	200					820		
10.30	100					525	11.40	200					1020		
11.35	125					650	12.50	300					1320		
12.30	100					750	15.30	300					1620		
13.30	125					875	17.10	120					1740		
17.15	250					1125	19.30	140					1880		
20.15	100					1225	19.55	100					1980		
22.00	50					1325	3.25	420					1400		
3.30	50					1375	6.30	200					1600		
6.30	150					1525									
							TOTAL INTAKE : 1525 ml								
							TOTAL OUTPUT : 1600 ml							Nil	
							BALANCE : - 75 ml							SDS SIL	

Date	From: 16/1/24	To: 17/1/24	Bed No: 104-A	INTAKE & OUTPUT CHART											
24 Hrs : Started Time : 7.00			Ended Time : 9.00												
NPO Started at :			NPO Over at :												
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)								
INTAKE	550ml		400ml		600ml		1.8 ltr/day								
OUTPUT	570ml		760ml												
Total Intake: 1550 ml			Total Output: 1410 ml			Difference: +140 ml									
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
7.00	125				125	7.00	420						420		
9.00	200				325	9.30	150						570	MR	
10.30	125				450	12.45	300						870		
14.30	100				550	14.30	120						990		
17.30	200				750	17.25	340						1330		
17.00	100				850	19.30	280						1610		
18.50	100				950	21.45	300						1910		
21.40	200				1150	1.00	300						1210		
23.00	200				1350	6.30	200						1410		
6.30	200				1550										
												</			



Date		From: 17/1/24		To: 18/1/24		Bed No: 104-A		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	400ml									1.8 lts / day					
OUTPUT	450ml														
Total Intake:				Total Output:				Difference:							
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
8.30	150ml					150ml	9.45	200ml					200ml		
10.30	150ml					300ml	11.30	250ml					450ml		
11.30	100ml					400ml									
discharged															

Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: DM - Insulin AWM / CAD - T2D / DM / HEN / CAD / SP - 41r/.

Height: 167 cms Weight: 69.3 Kgs Food allergies: Yes/No, if yes, specify: No

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

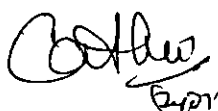
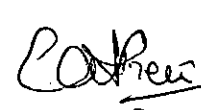
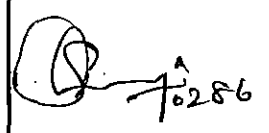
Diet Prescription: 1000 calories low fat, low salt, 2000 ml fluid restricted, high protein, diabetic diet.

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time:

Maria Catherine John 10/1/24, 14:40
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
10/1/24, 04:40	A 57 year old gentleman came to do chest pain was assessed to be well nourished as evident by SGA. Kills- 10/1/24/2024. Educated the patient and family on 1600 calories, low fat, low salt, high protein, diabetic diet (FR - 2000 kcal/day). Empfied on small fruit meals & low glucose control.	 Maria Catherine John Senior Dietitian
11/1/24, 14:00	Patient <u>shifted</u> to OT for surgery (CAD) and kept on MDH. Patient <u>needed</u> to start with initiate on diabetic, lipid diet as per doctor's advice.	 Maria Catherine John Senior Dietitian
12/1/24. 10:00AM	NBM over. Patient tolerated diabetic liquid diet. can initiate on diabetic soft solid, ~~diabetic~~ high protein diet	 70286
13/1/24, 12:00	Patient <u>needed</u> to ward. Reempfied on the diet restriction. Motivated to eat well.	 Maria Catherine John Senior Dietitian



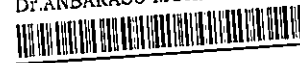
Medway Hospitals
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



MHI/DIET/2022/148



Every heart beat counts

Department of Dietetics

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
14/1/24, 10:00	Diet intake is good. Resumed after diet restriction. Motivated to eat well.	 Maria Catherine John Senior Dietitian
17/1/24, 10:00	Diet intake is good. Educated for patient and family a low calorie, low fat, low salt, low fluid diet, high protein, diabetic diet on discharge. Supplied a small diet menu to go for control. Diet modification and clarification done. Diet chart given on discharge.	 Maria Catherine John Senior Dietitian

INTRAOPERATIVE NURSING RECORD

Patient Details (Affix)	Mr. THANDAVA MOORTHY S
Name:	57 / Male / MHI202381312
UHID:	10/01/2024 / IPH2024000081
DOB:	Dr. ANBARASU MOHANRAJ

it :

Name of Surgery OP CAB (CLOSED HEART)Date of Surgery : 11/01/24Mode of Transfer to OR ☒ Bed ☐ Stretcher ☐ Other ☐Anaesthesia Type : ☐ Epidural ☐ Spiral ☐ LOC ☐ MAC
☒ GEN ☐ Regional _____Position : ☐ Lithotomy ☐ Prone ☒ Supine ☐ Right Down ☐ Left down
☐ Lateral ☐ Other ☐Pressure Protection Pad : ☒ Headrest ☐ Sand Bag ☒ Pillow ☐ Axillary roll
☒ Shoulder roll ☒ Eye protection ☐ Chest roll ☐ Cysto/Gyn
☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
☐ L arm rest padded / Secured ☒ Arms tucked / padded
☐ Nil ☐ R ☐ L ☐ Other (Specify) _____Skin preparation in OT ☒ Chlorhexidine Prep ☒ Providone Iodine ☐ Iodophor scrub
☐ Alcohol Prep ☐ Others (specify) _____Electrocautery : ☒ Monopolar ☒ Pad Location Right upper arm ☐ BipolarTourniquet : ☐ Location _____
☐ Applied Time _____ ☐ Released Time _____
☐ Applied Time _____ ☐ Released Time _____
☐ Applied Time _____ ☐ Released Time _____

Other equipment used : _____

Personal : ☒ Surgeon Dr. Anbarasu ☐ Asst. _____
☒ Anaesthetist Dr. Sylvester ☐ Asst. _____

Type of Specimen :

Lab :

☐ Pathology ☐ Permanent ☐ Frozen ☐ Time sent _____
☐ Cytology ☐ Time of report _____
☐ Microbiology ☐ Time sent _____
☐ Biochemistry

Packing / Drains / Catheters

Type	Size	Site	Type	Size	Amount	Sign
Robinsons	2.5	1st Flange	—	—	—	
"	"	Midline	—	—	—	

Urinary Catheterization done by AT. Balakrishnan using 16Fr Foley's catheter
Sponge Count Record

Count	Raytex Sponges	Gauze Lined	Gauze Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	Needle	Circ. Nurse sign	Scrub Nurse Sign
Pre-op	Correct	Correct				Correct	Correct	Correct	NO 0104	Rf 0238
Change over count	Correct	Correct				Correct	Correct	Correct	NO 0104	Rf 0238
First closure count	Correct	Correct				Correct	Correct	Correct	NO 0104	Rf 0238
Final closure count	Correct	Correct				Correct	Correct	Correct	NO 0104	Rf 0238

☒ Count Correct

Corrective action taken

Surgeon informed

Dressing / Cast Immobilizer Chest Dressing Done with Primafone & leg Dressing Done with the G-Preel

Condition of patient at end of surgery : ☒ Stable ☐ Fair ☐ Critical

Transferred to : SICU ☐ Patient Room ☐ CCU ☐ Recovery Room

Scrub Nurse Signature Rf

Name : RIN Radhika 0238

Date & Time : 11/1/24 @ 12:00

Circulating Nurse Signature

Name : RIN Charuty/Abhishek 0104

Date & Time : 11/1/24 @ 12:00



Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



re)

PSYCHOLOGICAL WELLBEING REPORT

Date: 13.1.24

Time: 11.38 am

Unit: 104A

Clinical diagnosis: OPCA 3 x 3 grafts - Podi

Surgery/ Procedure:

Impression: functioning well

- calm affect, oriented, responsive
- sleep & appetite (N)
- no psychological distress reported.

Employee ID: MHI0215854

Signature of the Psychologist:

L. K. K.

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 10/1/24 Time of Arrival: 11-0 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher
Accompanied by Relative: ☐ Yes ☐ No If Yes, Name of the Relative: MR NARESH
Relationship with Patient: SON Contact Person's Name: _____ Relationship: _____
Contact No.: 9176672726 Primary language spoken: ☒ Tamil ☐ English ☐ Indian ☐ International
Interpreter needed: ☐ Yes ☒ No
Patient status: ☒ Conscious ☐ Unconscious ☐ Disoriented | Patient Vulnerable: ☐ Yes ☒ No
Menstrual History: LMP: _____ Menopause: _____
Medical History: DM / HTN / Co - Morbidity: 15 years Yes If yes specify
Drugs History: Antiplatelet stopped on 6/1 (Specify)

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

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

If Yes, specify details: _____

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

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 76 (beats/min) | BP: 110/84 (mmHg)
Respiration: 20 (breaths/min) | SpO₂: 97 (%) | CBG: 295 (mg/dl) | Height: 167 (cms) | Weight: 59.3 (kgs)

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

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10 Pain Scale Used: ☐ Wong-Baker FACES Pain Rating Scale (7-12 years)
☒ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: _____ Location: _____

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

Nutritional Screening:

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

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

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

Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: Dr. C. S. Srinivas Time: 14:00

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

Functional Assessment:

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

Daily Activity Of Living:			
Activity	Independent	Assisted	Dependent
Bathing	☒	☐	☐
Dressing	☒	☐	☐
Eating	☒	☐	☐
Walking	☒	☐	☐
Toilet Use	☒	☐	☐

Pressure Injury Risk Assessment: Braden Scale

Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	<u>4</u>	Rarely Moist	<u>4</u>	Walks Frequently	<u>4</u>
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	<u>4</u>	Excellent	<u>4</u>	No apparent problem	<u>3</u>
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: 22 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	<u>0</u>
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	<u>15</u>
Ambulatory Aid		
None / Bed Rest / Nurse Assist		<u>0</u>
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	<u>0</u>
	Yes	20
Gait		
Normal / Bed Rest / Wheel Chair		<u>0</u>
Weak		10
Impaired		20
Mental Status		
Oriented to own stability		<u>0</u>
Overestimated or forgets limitations		15
Medications		
Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppressant and psychotropics	No	0
	Yes	<u>15</u>
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
- ☒ Advise the patient to use grab bars near the toilet, bathtub, and shower
- ☒ Make sure the family and other visitors understand the restrictions mentioned above

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT):

Final Score

Tick the score obtained (✓)

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

Personal Belongings / Valuables:

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

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
	<i>T. Nareesh</i>	T. NAREESH	Relationship Son	10/1/24	11.00
Nurse	<i>Pk</i>	Pavithra	0072	10/1/24	11.00
Unit In-Charge	<i>(Signature)</i>	Sharanmani	0005	10/01/24	14.00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S	SITUATION Diagnosis: CABG + JUS NEWS / PEWS Score: — Ventilator day: — Peripheral line day: Right: — Left: — Ryle's Tube: ☐ Yes ☒ No Day: — Urinary Catheter: ☐ Yes ☒ No Day: — Barrier nursing: ☐ Yes ☒ No MDR: ☐ Yes ☒ No. If Yes, specify organism: — GCS: 6/15 POD: — Central line days: — VIP Score: 0.5
B	BACKGROUND Type of surgery: — Date of surgery: — Allergies if any: — On room air / oxygen: O2 room air Complaints / New Symptoms in last shift: Nil IV fluids on flow: —
A	ASSESSMENT Vital Signs: Temp: 98.6°F Pulse / HR: 76 bpm (beats/min) Respiration: 20 (breaths/min) BP: 110/80 (mmHg) SpO ₂ : 94 (%) Height: 167 (cms) Weight: 59.5 (kgs) BMI: 20.4 kg/m ² Others: — Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☐ High Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA Current diet: Normal diet Drains: —
R	RECOMMENDATION Referral doctors: — Pending medications: — Pending medication indent: — Pending lab reports / Investigations: — Critical value alert and its corrections: — Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: — Pending follow-up orders: — Special instructions if any: 11m plan CABG

	Signature	Name	Emp. No.	Date	Time
Handover given by		H. Desai	002	10/1/24	12:00
Handover taken by		RIN Bhawathi	0071	10/1/24	12:30
Document endorsed		Dr. Anbarasu Mohanraj	005	10/1/24	14:00

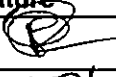
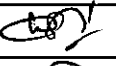
NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S	SITUATION Diagnosis: CAD - TVD 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: - On room air / oxygen: On Room air IV fluids on flow: - Complaints / New Symptoms in last shift: NIL
A	ASSESSMENT Vital Signs: Temp: 97.2 (°F) Pulse / HR: 84 (beats/min) Respiration: 22 (breaths/min) BP: 120/80 (mmHg) SpO ₂ : 98% Height: 167 (cms) Weight: 89.3 (kgs) BMI: 29.4 kg/m ² Others: - Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☐ High Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA Current diet: Normal diet Drains: -
R	RECOMMENDATION Referral doctors: - Pending medications: - Pending medication indent: - Pending lab reports / Investigations: - Critical value alert and its corrections: - Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: - Pending follow-up orders: - Special instructions if any: Tim Plan CABG

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. N. Ranga	0271	10/1/24	19:30
Handover taken by		A. Manjha	0161	10/1/24	19:30
Document endorsed		Dhanaraj	005	11/01/24	08:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: CAD - cu

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

POD: -

Central line days: -

VIP Score: 0

B

BACKGROUND

Type of surgery: ST

Date of surgery: -

Allergies if any: not known

On room air / oxygen: on room w

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/70 (mmHg) | SpO₂: 98 (%) | Height: 167 (cms) | Weight: 67.3 (kgs) | BMI: 24.4 / m²

Others: -

Pain Score: 2/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

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

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: normal diet

Drains: nil

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A-R Jones	01/21	10/1/24	7:22
Handover taken by		Shifted to OT			
Document endorsed		Dr. Anbarasu	005	10/1/24	08:00

NURSES PROGRESS NOTES

[illegible]

Mr. THANDAVA MOORTHY S

57/Male/MH1202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



MH1/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp No.			
	CTOT RECEIVAL REPORT				
11/1/24	Patient Received From 1 st floor To CTOT With Blue Op File And Case Sheet				
@	ECG: 01 <i>Screening</i> ECHO: 01 X-RAY: 01 ANGIO CD: NIL				
8:30	CT FILE: -NIL				
	Patient Posted For Procedure:	<i>dhp</i>			
	Under Anesthesia: OPCAB <i>↓ LCA</i>	0104			
	Allergy Status: Not : Known				
	Known Case Of: DM x 15 yrs				
	Past Surgical History: -				
	VITAL SIGN: TEMP: 37°C HR: 80/min SPO2: 97% BP: 110/70 mmHg				
	CTOT SHIFTING REPORT				
11/1/24	Patient Shifted From CT - 01 To 8110 With Blue Op File And Case Sheet Along With				
@	*Surgery Safety Check List 01				
12:00	*Intra Operative Record 01				
	*Nurses' Record 01				
	* <i>Screening</i> ECG: 01 ECHO: 01 X-RAY: 01 ANGIO CD: NIL				
	CT FILE: NIL				
	Patient Posted And Underwent For Procedure: OPCAB				
	Under Anesthesia: <i>↓ LCA</i>				
	Procedure: OPCAB (CLOSED HEART)				
	Drain tube size and placement: 28 <i>→ L-Pharynx</i> <i>→ Mid-larynx</i>	<i>dhp</i>			
	Pacing wire placement: Present/Absent <i>GRAFT</i> Site: -	<i>ewg</i>			
	Implants: - LINA-LAB SV4 - PDA SV4 - DM				
	Cautery burn/skin peeling/towel clip mark: Present/Absent				
	Site: -				
	VITAL SIGN: TEMP: 37°C HR: 100/min SPO2: 100% BP: 130/90				
	Notes: *Anti plt stopped on 11/1/24				
Document endorsed by:	Signature <i>dhp</i> <i>ewg</i>	Name <i>dhp</i> <i>ewg</i>	Emp. No. 0104	Date 11/1/24	Time 2:00

SAFETY FIRST



Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/048



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/01/2024

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - T10, EF - 41%.

NEWS / PEWS Score: -

Ventilator day: 01

Peripheral line day: Right: 01 Left: 01

Ryle's Tube: ☒ Yes ☐ No

Urinary Catheter: ☒ Yes ☐ No

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

GCS: 3E11S

POD: 002

Central line days: 01

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPAS X 3URAFS

Allergies if any: NKDA

On room air / oxygen: on venti

Complaints / New Symptoms in last shift: -

Date of surgery: 11/01/2024

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: (°F) | Pulse / HR: 79 (beats/min) | Respiration: 16 breaths/min

BP: 116/43 (63) (mmHg) | SpO₂: 100% (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 kg/m²

Others: BSA - 1.56m²

Pain Score: 0/8 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 80 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

Current diet: Npo

Wound Dressing done: ☒ Yes ☐ No ☐ NA in 07

Drains: Mediastinal + Lt pleural

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		V. Deepa Lakshmi	0101	11/01/24	19.30
Handover taken by		D. Dhanisha	0111	11/01/24	19.30
Document endorsed		Jona Florance S	0074	12/1/24	9.00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TND

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: CUBSA Left: D₁

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☒ Yes ☐ No Day: D₁

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

GCS: 15/15

POD: D₀S

Central line days: D₁

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPUB x 3 GRAFTS

Date of surgery: 11/1/24

Allergies if any: NKDA

On room air / oxygen: ON Nasal prongs 2L/min

IV fluids on flow: KABWTE

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 97.7 (°F) | Pulse / HR: 102/min (beats/min) | Respiration: 18/min (breaths/min)

BP: 105/52/71 (mmHg) | SpO₂: 100 (%) | Height: 154 (cms) | Weight: 53.3 (kgs) | BMI: 22.1 kg/m²

Others: CNP - 7mmHg, BSA - 1.56m²

Pain Score: 2/10 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: LIQUID DIET

Drains: MEDIASTINAL

R

RECOMMENDATION

Referral doctors: } NIL

Pending medications: }

Pending medication indent: }

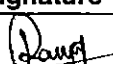
Pending lab reports / Investigations: }

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: } NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		D. RAVEENA	0171	12/1/24	7:30
Handover taken by		Sathya Varma	0265	12/1/24	7:30
Document endorsed		ANA FLORANCE S	0074	12/1/24	9:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TMD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right ~~20/1/24~~ Left: D2

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: D2

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

GCS: 15/15

POD: I

Central line days: D2

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCABX 3 GRAFTS

Allergies if any: NKDA

On room air / oxygen: ON Room air

Complaints / New Symptoms in last shift: -

Date of surgery: 11/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 106 (beats/min) | Respiration: 22 (breaths/min)

BP: 101/52/66 (mmHg) | SpO₂: 96 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 kg/m²

Others: BSA 1.5 m²

Pain Score: 2/10 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: Liquid diet

Drains: Mediastinal

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:

NIC

NIC

	Signature	Name	Emp. No.	Date	Time
Handover given by		Sathya Vani R.	0265	12/1/24	12:30
Handover taken by		S/A BRAVANI. R.	0287	12/1/24	12:30
Document endorsed		Dr. ANBARASU MOHANRAJ	0084	12/1/24	12:00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: CUBITAL DAY -2 Left:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☒ Yes ☐ No

Barrier nursing: ☒ Yes ☐ No

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

GCS: 15/15

POD: I

Central line days: D2

VIP Score:

B

BACKGROUND

Type of surgery: OPCAB X 3 GRAFTS

Allergies if any: NKDA

On room air / oxygen: ON ROOM AIR

Complaints / New Symptoms in last shift: -

Date of surgery: 11/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.5 (°F) | Pulse / HR: 94 b/m (beats/min) | Respiration: 24 b/m (breaths/min)

BP: 104/71 (mmHg) | SpO₂: 100% | Height: 154 cms | Weight: 54.3 (kgs) | BMI: 24.1 kg/m²

Others: BGA 1.5 m²

Pain Score: 2/10 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: LIQUID DIET

Drains: Removed @ 12:25

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:

NIL

NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		S/N BHAVANI R.	0287	12/1/24	19:30
Handover taken by		D. RAMEEN	0171	12/1/24	19:30
Document endorsed		GONDA FERNANDO	0034	13/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	<u>EVENING DUTY NOTES</u>	
12:30.	patient taken over from Morning duty staff nurse. While receiving patient was hemodynamically stable. Temp = 97.2°F, RR = 28b/m, NIBP = 104/71 (82), PR = 10.5b/m. patient is on Room air with SpO ₂ = 99%. patient having (LE) IJV line. line was patent, peripheral line present in (RE) cubital line. flushed and checked. Line was patent. Inf. H.A. 4ml/hour is on flow. IVF. KABILYTE. 100ml/hour is on-flow. Abdomen was soft. Skin was intact. peripheries are warm. peripheral pulses are felt.	R 0227
@ 13:30.	Due drugs given as per drug chart order	R 0237
@ 14:00	patient had lunch.	R 0237
@ 15:00	vital signs are checked and recorded.	R 0237
@ 16:00	Tab. Furosemide withheld due to polyuria. order given by Dr. praveen Jayakumar	R 0237
@ 17:00	Neb. Levolin was not given. Due drugs are given as per drug chart. order. CBG was checked. Dr. advised to given Inf. H.A. 1ml/hour	R 0237
@ 18:00	Bedside x-ray taken. Report was collected and film seen by Dr. praveen Jayakumar. patient mobilized to chair. patient felt comfortable. no more difficulties found.	R 0237
@ 19:00	patient attendant came and seen the patient.	R 0237
@ 19:30	Handing over given to night duty staff nurse.	R 0237
Document endorsed by	Signature	Name
		SANTA FLORANCE S
		Emp. No.
		0024
		Date
		13/1/24
		Time
		8:00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TVD, EF-H/L

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: LUB, Left: D2

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☒ Yes ☐ No Day: D2

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

GCS: 15/15

POD: D1

Central line days: D2

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPABX 361RFTS

Allergies if any: NKDA

On room air / oxygen: ON Room air

Complaints / New Symptoms in last shift: -

Date of surgery: 11/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 98/min (beats/min) | Respiration: 12/min (breaths/min)

BP: 101/31/24 (mmHg) | SpO₂: 98 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 kg/m²

Others: BSA - 1.56m²

Pain Score: 2/10 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: SOFT DIET

Drains: -

R

RECOMMENDATION

Referral doctors: } NIK

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: } NIK

	Signature	Name	Emp. No.	Date	Time
Handover given by		D. RANEEA	0151	13/1/24	7:30
Handover taken by		AGARWAL	006	13/1/24	7:50
Document endorsed		ANNA FLORENCE	0024	13/1/24	9:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/01/2024

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TUD, EF 41%

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: CUBA left: - D3

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: 11/01/2024

Central line days: D3

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPEN x 3 GRAFTS

Date of surgery: 11/01/2024

Allergies if any: NKDA

On room air / oxygen: ON Room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: Nil

A

ASSESSMENT

Vital Signs: Temp: 36.5 (°F) | Pulse / HR: 104 (beats/min) | Respiration: 20 (breaths/min)

BP: 101/64 (mmHg) | SpO₂: 96 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 kg/m²

Others: BSA - 1.56 m²

Pain Score: 2/10 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 in DT

Current diet: Soft solid diet.

Drains: Nil

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		C. Deepalakshmi	101	13/01/24	10:30
Handover taken by		Agasthya	006	13/01/24	12:21
Document endorsed		ANITA FLORENCE S	0094	13/01/24	9:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
12/01/2021	Morning Duty Report on 12/01/2021				
07:30-12:30	Took over the patient in hemodynamically stable & will support on continuous monitoring patient is conscious & oriented GCS-15/15, pain score-2/10.	V. D. Jones			
07:40	ex-ray taken, film to be.				
8:30.	patient had soft solid diet, tolerating well. One medication given as per chart. Dr. praveen jayaraman came and seen the patient, added 4. Warfarin 5mg PO.	V. D. Jones			
9:30	Nebulization & spirometry provided				
10:00	patient voided urine. I/O removed as per order.	V. D. Jones			
10:45	patient shifted to I floor 104-A at 10:45. while shifting patient is conscious & oriented vitals are stable. Case sheet, one medication and patient things handed over to ward duty staff. Skin intact.	V. D. Jones			
Receiving notes 11:00 ⇒ Patient Received from SICU to room no: 104A in a hemodynamically stable condition ⇒ Vital Signs checked & Recorded ⇒ Skin Intact, no issues. ⇒ Patient mobilized well. Has no other complaints.					
pt handed over to Evening duty staff					
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[Signature]	FLORANCE S	1004	13/1/21	9:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

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

B

BACKGROUND

Type of surgery: OPUB 3 grafts Date of surgery: 11/1/24
Allergies if any: WADA
On room air / oxygen: on room air IV fluids on flow:
Complaints / New Symptoms in last shift:

A

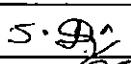
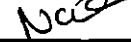
ASSESSMENT

Vital Signs: Temp: 98.6 (F) | Pulse / HR: 97 (beats/min) | Respiration: 20 (breaths/min)
BP: 101/70 (mmHg) | SpO₂: 96% | Height: 154 (cms) | Weight: 59.5 (kgs) | BMI: 24.1 kg/m²
Others:
Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 5 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: Normal diet Drains: nil

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Agustina	DUB	13/1/24	19:00
Handover taken by	S. D. 	S. Dhandhachini	0212	13/1/24	19:30
Document endorsed	NAB 	S. Nalini	0024	13/1/24	20:00

NURSES PROGRESS NOTES					
Date & Time		Observations / Action		Signature with Emp. No.	
		Evening duty roster			
13/1/24 12-24 04:00		Pt taking over from the morning duty staff Pt conscious & oriented Pt had on normal diet hydration administration as per doctor's chart Pt had no complaints.		Sub	
15:00		hydration given. Spironol given			
16:00		vital signs stable. monitor vital checked & recorded.		Sub	
17:00		=> monitor Intake & Output chart.			
19:00		=> Pt had no complaints. vital signs stable. Pt handing over to the Night duty staff		Sub	
Document endorsed by		Signature		Name	
		Nae		S. Nalini	
		Emp. No.		Date	
		0024		13/1/24 2020	

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: **13/1/24**

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: **CAD-TVD**

NEWS / PEWS Score: **-**

Ventilator day: **-**

Peripheral line day: Right: **D2** Left: **-**

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: **-**

Day: **-**

Day: **-**

MDR: ☐ Yes ☒ No: If Yes, specify organism: **-**

GCS: **15/15**

POD: **11**

Central line days: **-**

VIP Score: **0/5**

B

BACKGROUND

Type of surgery: **OPCABX 3 GRAFTS**

Date of surgery: **-**

Allergies if any: **NKDA**

On room air / oxygen: **RA**

IV fluids on flow: **-**

Complaints / New Symptoms in last shift: **-**

A

ASSESSMENT

Vital Signs: Temp: **97** (°F) | Pulse / HR: **94** (beats/min) | Respiration: **20** (breaths/min)

BP: **110/70** (mmHg) | SpO₂: **97** (%) | Height: **154** (cms) | Weight: **57.3** (kgs) | BMI: **24.1** kg/m²

Others: **-**

Pain Score: **1/10** 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	<i>S. D.</i>	<i>S. Dhandharashini</i>	<i>0211</i>	<i>14/1/24</i>	<i>7:00</i>
Handover taken by	<i>Cherry</i>	<i>R. Sushma</i>	<i>0201</i>	<i>14/1/24</i>	<i>7:00</i>
Document endorsed	<i>Nice</i>	<i>S. Velpu</i>	<i>0022</i>	<i>14/1/24</i>	<i>6:00</i>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: CAD - TAD

NEWS / PEWS Score: _____

Ventilator day: _____

Peripheral line day: Right: _____ Left: _____

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: _____

Day: _____

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

GCS: 15/15

POD: 1

Central line days: _____

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB X SURG

Date of surgery: _____

Allergies if any: NKA

On room air / oxygen: _____

IV fluids on flow: _____

Complaints / New Symptoms in last shift: _____

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 48 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/80 (mmHg) | SpO₂: 99% (%) | Height: 154 (cms) | Weight: 57.2 (kgs) | BMI: 24.1 Kg/m²

Others: _____

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / OPOT

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: _____

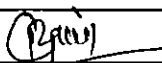
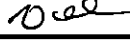
Pending lab reports / Investigations: _____

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		R. Sushma	0001	13/1/24	12.00
Handover taken by		A. Monisha	0121	14/1/24	12.34
Document endorsed		S. Nalini	0022	14/1/24	16.25

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: CAD - MI

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: 021 Left: -

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: -

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

GCS: OTS

POD: 1

Central line days: -

VIP Score: 015

B

BACKGROUND

Type of surgery: open heart surgery

Date of surgery: 11/1/24

Allergies if any: no known

On room air / oxygen: on room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp 98.6°F | Pulse / HR: 85 (beats/min) | Respiration: 22 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 98 (%) | Height: 155 (cms) | Weight: 67.2 (kgs) | BMI: 27.1 kg/m²

Others: -

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

Fall Risk Score: 5 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: normal diet

Drains: nil

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Monisha	0111	12/1/24	09:30
Handover taken by		S. D. Sathya	0211	12/1/24	10:30
Document endorsed		S. Nalini	0021	12/1/24	10:30

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - TUD

NEWS / PEWS Score: 2

Ventilator day: —

Peripheral line day: Right: D4 Left: —

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: —

Day: —

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

GCS: 15/15

POD: —

Central line days: —

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCABX 3 GRAFTS

Date of surgery: 11/1/24

Allergies if any: NKDA

On room air / oxygen: RA

IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 97 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 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: T/M 5/R plan.

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>S. Di</u>	<u>S. Dewachashini</u>	<u>0212</u>	<u>15/1/24</u>	<u>7:00</u>
Handover taken by	<u>F. Cok</u>	<u>F. Cathrine</u>	<u>0207</u>	<u>15/01/24</u>	<u>7:30</u>
Document endorsed	<u>Ude</u>	<u>S. Na PNP</u>	<u>0024</u>	<u>15/1/24</u>	<u>16:20</u>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/01/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TVD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: D5 Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

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

GCS: 15/15

POD: IV

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCABX 3 grafts

Allergies if any: NKDA

On room air / oxygen: -

Complaints / New Symptoms in last shift: -

Date of surgery: 11/01/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 84 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/80 (mmHg) | SpO₂: 97 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 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: diabetic 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>E. Cathrine</u>	<u>E. Cathrine</u>	<u>0207</u>	<u>15/01/24</u>	<u>12.20</u>
Handover taken by	<u>AS</u>	<u>A. monisha</u>	<u>0141</u>	<u>16/1/24</u>	<u>12.23</u>
Document endorsed	<u>AS</u>	<u>S. NaipNP</u>	<u>0024</u>	<u>16/1/24</u>	<u>16.20</u>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S	SITUATION Diagnosis: CAD - T2DM NEWS / PEWS Score: - Ventilator day: - Peripheral line day: Right: 25 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: 4 Central line days: - VIP Score: 2/5
B	BACKGROUND Type of surgery: OPCAB X 3 grafts Allergies if any: not known On room air / oxygen: on room air Complaints / New Symptoms in last shift: - Date of surgery: 11/1/24 IV fluids on flow: -
A	ASSESSMENT Vital Signs: Temp: 98.6 (°F) Pulse / HR: 86 (beats/min) Respiration: 20 (breaths/min) BP: 120/80 (mmHg) SpO2: 96 (%) Height: 154 (cms) Weight: 57.3 (kgs) BMI: 24.1 kg/m² Others: - Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 0 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA Wound Dressing done: ☐ Yes ☒ No ☐ NA Current diet: normal diet Drains: nil
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: _____ Pending follow-up orders: Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. monisha.	0161	16/1/24	19:23
Handover taken by		Parameswari	2333	15/1/24	19:45
Document endorsed		S. Nalini	0004	16/1/24	16:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S	SITUATION Diagnosis: <u>CAD-TVD</u> NEWS / PEWS Score: <u>—</u> Ventilator day: <u>—</u> Peripheral line day: Right: <u>—</u> Left: <u>—</u> Ryle's Tube: ☐ Yes ☒ No Day: <u>—</u> Urinary Catheter: ☐ Yes ☒ No Day: <u>—</u> Barrier nursing: ☐ Yes ☒ No MDR: ☐ Yes ☒ No. If Yes, specify organism: <u>—</u> GCS: <u>15/15</u> POD: <u>15</u> Central line days: <u>—</u> VIP Score: <u>—</u>
	BACKGROUND Type of surgery: <u>OP CABG 3 grafts</u> Allergies if any: <u>NKA</u> On room air / oxygen: <u>RA</u> Complaints / New Symptoms in last shift: <u>—</u> Date of surgery: <u>11/1/24</u> IV fluids on flow: <u>—</u>
A	ASSESSMENT Vital Signs: Temp: <u>97</u> (°F) Pulse / HR: <u>78</u> (beats/min) Respiration: <u>20</u> (breaths/min) BP: <u>110/70</u> (mmHg) SpO ₂ : <u>99</u> (%) Height: <u>154</u> (cms) Weight: <u>57.3</u> (kgs) BMI: <u>24.1</u> kg/m ² Others: <u>—</u> Pain Score: <u>0/10</u> Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: <u>30</u> 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: <u>② diet</u> Drains: <u>—</u>
	RECOMMENDATION Referral doctors: <u>—</u> Pending medications: <u>—</u> Pending medication indent: <u>—</u> Pending lab reports / Investigations: <u>—</u> Critical value alert and its corrections: <u>—</u> Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: <u>—</u> Pending follow-up orders: <u>—</u> Special instructions if any: <u>Dls on wednesday day</u>

	Signature	Name	Emp. No.	Date	Time
Handover given by		<u>Panayiotis</u>	<u>2333</u>	<u>16/1/24</u>	<u>7:30</u>
Handover taken by		<u>A. ALBINUS</u>	<u>0088</u>	<u>16/1/24</u>	<u>7:30</u>
Document endorsed		<u>S. Nalini</u>	<u>0082</u>	<u>16/1/24</u>	<u>16:00</u>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-TUD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: D5 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: 1

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB x 3 GRAFTS

Date of surgery: 11/1/24

Allergies if any: NRDA

On room air / oxygen: ON Room AIR

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

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

BP: 130/70 (mmHg) | SpO₂: 97 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.2 kg/m²

Others: Nil

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

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: NORMAL diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

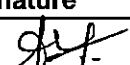
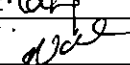
Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0088	16/1/24	12:00
Handover taken by	E. Cathrine	E. Cathrine	0207	16/01/24	12:30
Document endorsed		S. VajPNP	0024	16/1/24	16:20

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 16/01/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TND

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: 25 Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

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

GCS: 15/15

POD: 1

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB 3 grafts

Allergies if any: NKDA

On room air / oxygen: -

Complaints / New Symptoms in last shift: -

Date of surgery: 11/01/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/70 (mmHg) | SpO₂: 97 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.2 kg/m²

Others: NIL

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: Diabetic 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: Tomorrow to do FETO

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>E. Catherine</u>	<u>E. Catherine</u>	<u>0207</u>	<u>16/01/24</u>	<u>19.30</u>
Handover taken by	<u>P. Anand</u>	<u>P. Anand</u>	<u>2333</u>	<u>16/01/24</u>	<u>19.40</u>
Document endorsed	<u>Ure</u>	<u>S. N. N. N. P.</u>	<u>0024</u>	<u>16/01/24</u>	<u>16/01/24</u>

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 16/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score: —

Ventilator day: —

Peripheral line day: Right: — Left: —

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: —

Day: —

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

GCS: 15/15

POD: 0

Central line days: —

VIP Score: —

B

BACKGROUND

Type of surgery: open x 3 grafts

Allergies if any: NKA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: —

Date of surgery: 11/1/24

IV fluids on flow: —

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 94 (%) | Height: 157 (cms) | Weight: 57.3 (kgs) | BMI: 24.1 (kg/m²)

Others: —

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

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

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: 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: The Ds plan.

	Signature	Name	Emp. No.	Date	Time
Handover given by		Parameswari	2333	17/1/24	7.00
Handover taken by		A. Albinus	0088	17/1/24	7.00
Document endorsed		S. Nalini	0000	17/1/24	16.20

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 17/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TUD

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: 5

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB x 3 GRAFTS

Allergies if any: NKDA

On room air / oxygen: ON ROOM AIR

Complaints / New Symptoms in last shift: -

Date of surgery: 11/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/70 (mmHg) | SpO₂: 97 (%) | Height: 154 (cms) | Weight: 57.3 (kgs) | BMI: 24.3 Kg/m²

Others: NIL

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

Fall Risk Score: 25 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: NORMAL Diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

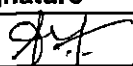
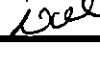
Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: TMRW DISCHARGE PLAN

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0088	17/1/24	7:00
Handover taken by		A. MONY	0121	17/1/24	2:30
Document endorsed		S. NALINI	0024	17/1/24	1:20

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 17/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD + T2DM

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: -

B

BACKGROUND

Type of surgery: SPINAL 3 vertebrae

Allergies if any: not known

On room air / oxygen: on Room air

Complaints / New Symptoms in last shift: -

Date of surgery: 11/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp 98.5 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/60 (mmHg) | SpO₂: 96 (%) | Height: 5'4 (cms) | Weight: 73 (kgs) | BMI: 24.3 (kg/m²)

Others: -

Pain Score: 2/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 5 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: normal diet

Drains: nil

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. monisha.	0141	17/1/24	12:00
Handover taken by		discharged			
Document endorsed		S. Volpna	0024	17/1/24	16:00

NURSES PROGRESS NOTES

[illegible]

ADULT NURSING CARE PLAN

Mr. THANDAVA MOORTHY S

57 / Male / MHI202381312

10/01/2024 / IPH2024000081

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 10/1/24 Time: 12 PM

Modified Date: Time:

Reason for Modification:

Diagnosis:

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

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☒ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt well communication E Pt well communication N Pt communicate well	[Signature] [Signature] [Signature]
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☒ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Pt medication given. E Pt med's contraindicated given as p. N med's for use given	[Signature] [Signature] [Signature]
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	Dhanu...	0005	11/01/24	08:00



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 11/01/2024		Time: 18:05		Modified Date: —		Time: —	
Reason for Modification: —				Diagnosis: CAD-TUD, EF-41%.			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
PAIN ☒ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	☒ Patient will have less pain	☒ Evaluate location, character, quality and severity of pain ☐ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M Patient had tolerable pain after intervention	V. Anbarasu 10/1			
OXYGENATION ☐ Room Air ☐ Oxygen Hood ☒ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☒ Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☒ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☒ Administer oxygen and nebulizer therapy if needed ☒ Encourage spirometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M Patient is on O2 mask E Neb & spiro provided	V. Anbarasu 10/1			
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M E NA	Patient is on Nasal prongs SpO2 - 96% V. Anbarasu 10/1			
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Emboic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E Patient is on bed rest	Patient is on Bed rest V. Anbarasu 10/1			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☒ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☒ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M	
			E	patient is on IV fluids on Kabiety to be monitored
			N	No chart maintained
RISK OF INFECTION ☐ Prevent Infection ☐ Others:	☒ The patient will be discharged with no hospital acquired infection	☐ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☒ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☒ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to be changed by surgeons	M	
			E	Aseptic precautions followed in all aspects of patient care
			N	Antibiotic precautions are followed
RISK OF FALL ☐ Giddiness ☐ Independent State ☒ Dependent State	☐ The patient will have safe, free from fall hospitalization	☐ Keep bed on low position ☒ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	M	
			E	Safety precautions followed
			N	Fall side Safety precautions are followed
SKIN & WOUND CARE ☒ Observe REEDA ☐ Oozing ☐ Foul Smell	☒ The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M	
			E	Surgical site intact no oozing
			N	Skin - Intact
DIET & NUTRITION ☐ NPO ☐ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☐ Patient will have adequate nutrition with no nausea and vomiting	☐ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parenteral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M	
			E	patient is on NPO, liquid diet to be start
			N	patient is on 11:45 dis.

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		☒ Patient will have patent, properly maintained catheters, drains etc	☐ Check the catheters, drains etc frequently ☒ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☒ Maintain adequate cleaning and dressing	M E Maintained adequate cleaning & dressing N on CBD, I/O chart maintain	11.12.24 161 Paul
DISTURBED BODY IMAGE		☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M E N NA	Paul
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:		☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	M / E patient is hemodynamically stable N Vital Signs are hemodynamic stable	11.12.24 161 Paul
HEALTH EDUCATION ☐ Patient ☐ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:		☐ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ Provide proper education regarding follow-up diet ☐ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☐ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M E Educated patient & attenders regarding treatment process & followup N Patient gained knowledge regarding Personal Exams	11.12.24 161 Paul
ANY OTHER NEEDS				M E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>[Signature]</i>	JOHN FLORENCE	0054	12/1/24 @ 9:00	



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 12/1/24 Time: 8:00		Modified Date: — Time: —		
Reason for Modification: —		Diagnosis: CAD - TUD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☒ Comfortable Position ☒ Pain Scale ☐ Pain Score ☐ Others:	☒ Patient will have less pain	☒ Evaluate location, character, quality and severity of pain ☐ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☒ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M Provided comfortable position for patient. E Evaluated location, character, quality & severity of pain. N Patient had decreased level of pain - 1/10	
OXYGENATION ☒ Room Air ☐ Oxygen Hood ☐ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☒ Patient will have no shortness or difficulty of breathing	☒ Provide well ventilated environment ☒ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☒ Encourage spirometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M Patient maintains oxygen level on room air. E Checked saturation level of the patient SpO ₂ = 98% N Patient is on Room air - SpO ₂ = 98%	
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M N/A E N/A N N/A	
MOBILITY ☒ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☒ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Provided safe environment. E provided safe environment. N Patient had mobilized	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☒ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☒ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Monitored I/O every hour.	<i>J. 0265</i>
			E Checked IV sites and assessed if there is any complication.	<i>Post</i>
			N I/O chart maintained	<i>Paul 017</i>
RISK OF INFECTION ☒ Prevent Infection ☐ Others:	☒ The patient will be discharged with no hospital acquired infection	☒ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☒ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to be changed by surgeons	M Followed sick fail aseptic techniques.	<i>J. 0265</i>
			E Followed meticulous hand washing before and after patient's care	<i>Post</i>
			N Aseptic precautions are followed	<i>Paul 017</i>
RISK OF FALL ☐ Giddiness ☐ Independent State ☒ Dependent State	☒ The patient will have safe, free from fall hospitalization	☒ Keep bed on low position ☐ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	M Followed sick fail prevention.	<i>J. 0265</i>
			E Kept bed on low position to prevent from fall	<i>Post</i>
			N Fall rule safely prevented one fall	<i>Paul 017</i>
SKIN & WOUND CARE ☐ Observe REEDA ☒ Oozing ☐ Foul Smell	☒ The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M Skin is intact	<i>J. 0265</i>
			E Skin is intact	<i>Post</i>
			N Skin - Intact	<i>Paul 017</i>
DIET & NUTRITION ☐ NPO ☒ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☒ Patient will have adequate nutrition with no nausea and vomiting	☒ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☒ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parenteral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M Encouraged the patient to adequate nutrition.	<i>J. 0265</i>
			E provided high calories, high protein diet as prescribed.	<i>Post</i>
			N Patient is on liquid diet	<i>Paul 017</i>

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		☒ Patient will have patent, properly maintained catheters, drains etc	☒ Check the catheters, drains etc frequently ☒ Observe I/O Chart ☒ Watch for any symptoms related to kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M Urine output is adequate on CSD E Checked the catheters, drains etc frequently N I/O Chart maintained	J. 0225 P. 0224 P. 0224
DISTURBED BODY IMAGE		☒ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M NA E NA N NA	J. 0225 P. 0224 P. 0224
OBSERVATION ☒ Vital Signs ☐ GCS ☒ Blood Sugar ☐ Others:		☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☒ Monitor GCS of patient	M Monitored vitals & assessed for GCS. E Monitored vital signs & assessed the GCS of patient N Vital signs are hemodynamically stable	J. 0225 P. 0224 P. 0224
HEALTH EDUCATION ☒ Patient ☐ Family / Guardian ☒ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:		☒ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☒ Provide proper education regarding follow-up diet ☒ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☐ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M Provided education regarding diet E Insisted on importance of hand hygiene N Patient gained knowledge regarding Rom Exams	J. 0225 P. 0224 P. 0224
ANY OTHER NEEDS				M E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		GLORIA FLORANCE	0024	13/1/24	8:00



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 12/01/2024 Time: 8:00		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - TUD.		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☐ Comfortable Position ☐ Pain Scale ☒ Pain Score ☐ Others:	☒ Patient will have less pain	☒ Evaluate location, character, quality and severity of pain ☒ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☒ Assess incision area for redness, heat, induration, swelling, separation and drainage ☒ Non-Pharmacological therapy	M Patient had decreased level of pain E Pt. used on comfortable position N Pt. provide comfortable position	S. D. 10/1 S. D. 10/1 S. D. 10/1
OXYGENATION ☐ Room Air ☐ Oxygen Hood ☐ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☐ Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☒ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☒ Monitor rate, depth of respiration ☒ Administer oxygen and nebulizer therapy if needed ☐ Encourage spirometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M Patient is comfortable on room air. Neb & spiro provided E Pt on room air N Pt on room air	S. D. 10/1 S. D. 10/1 S. D. 10/1
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M NA E N NP	
MOBILITY ☒ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☒ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☒ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Embotic stocking / SCD ☐ Evaluate the need for assistive devices ☒ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Patient is mobilized to chair & walk with assistance E Pt. walk independently N Pt. mobilized well	S. D. 10/1 S. D. 10/1 S. D. 10/1

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☒ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☒ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Patient is on adequate oral fluids, I/O monitored E Monitored I/O well N Pt I/O chart monitored	10 Apr 10 Sub S.D. 02/10
RISK OF INFECTION ☐ Prevent Infection ☐ Others:	☒ The patient will be discharged with no hospital acquired infection	☒ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☒ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☒ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to be changed by surgeons	M Aseptic precaution followed in all aspects of patient care E Aseptic technique followed N —	10 Apr 10 Sub —
RISK OF FALL ☐ Giddiness ☐ Independent State ☒ Dependent State	☒ The patient will have safe, free from fall hospitalization	☐ Keep bed on low position ☒ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	M Safety precaution followed E Safety precaution followed N —	10 Apr 10 Sub —
SKIN & WOUND CARE ☒ Observe REEDA ☐ Oozing ☐ Foul Smell	☒ The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☒ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M Surgical site intact No oozing E Surgical site No oozing N Pt skin is intact	10 Apr 10 Sub S.D. 02/10
DIET & NUTRITION ☐ NPO ☒ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☒ Patient will have adequate nutrition with no nausea and vomiting	☒ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☒ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parenteral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M Patient tolerating soft solid diet E Pt had on normal diet N Pt had N Diet	10 Apr 10 Sub S.D. 02/10

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		☒ Patient will have patent, properly maintained catheters, drains etc	☐ Check the catheters, drains etc frequently ☒ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☒ Maintain adequate cleaning and dressing	M Maintained adequate cleaning & dressing E maintained proper normal holding of N PT Self Voided	T. Dye 101 S. Dye 5/11
DISTURBED BODY IMAGE		☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M NA E N NA	
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:		☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☒ Assess physically for any abnormality ☒ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	M Patient is hemodynamically stable E no vital signs N	V. Dye 101 S. Dye
HEALTH EDUCATION ☒ Patient ☐ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:		☒ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☒ Provide proper education regarding follow-up diet ☐ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☒ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☒ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M Explained to patient regarding treatment process & follow up care E explain about diet N	V. Dye 101 S. Dye
ANY OTHER NEEDS				M E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		GLORIA FLORANCE	0034	13/1/24	9:00

ADULT NURSING CARE PLAN

Patient: **Mr. THANDAVA MOORTHY S**
Name: 57/Male/MHI202381312
UHID: 10/01/2024/IPH2024000081
DOB: Dr. ANBARASU MOHANRAJ
DOA:
Cons:

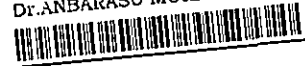
Initial Date: 14/1/24 Time: 8.00		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - TUD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☒ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☒ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had DM diet E pt had diet N pt had diet	P P P
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O ₂ ☒ Mask ☐ BIPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt SpO ₂ 99% E SpO ₂ 98% N Pt on Room air	P P P
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☒ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt I/O chart maintained E I/O chart was monitored N I/O Monitor	P P P

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☒ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☒ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M pt well groomed E pt groomed well N groomed well	Jg Pam P 2533
SAFETY ☐ Check ID Band ☒ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☒ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M pt ID band checked E ID band checked N ID band checked	P P P 2533
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M E N Pt Sleep well	 P 2533
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M pt v/s checked E v/s checked N v/s stable	P P P 2533
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M E N	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M pt well communication E pt communicate well N Good communication	P 07/01 AN P 2333
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M pt due drugs are given E medication over given N Medication was given	P 07/01 AN P 2333
Endorsed by	Signature	Name	Emp. ID	Date	Time
		S. Nalpan	0024	11/1/24	1600

ADULT NURSING CARE PLAN

Fr: **MR. THANDAVA MOORTHY S**
Ni: 57 / Male / MH1202381312
Uf: 10/01/2024 / IPH2024000081
DO: Dr. ANBARASU MOHANRAJ
DO: 
Cor: 

Initial Date: <u>15/1/24</u> Time: <u>8.00</u>		Modified Date: _____ Time: _____		
Reason for Modification: _____		Diagnosis: <u>CAD - TUD</u>		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☒ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☒ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had Om diet E pt had Diet N pt had (P) Diet	P.C 0807 08/12/24 5/12/24
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☒ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☒ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt is on room air E SpO ₂ - 96% N Pt on Room air	FZC 0207 08/12/24 5/12/24
FLUID & ELECTROLYTES ☒ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☒ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt I/O chart maintained E I/O chart very monitored N Pt I/O chart monitored	P.C 0807 08/12/24 5/12/24

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☒ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embotic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt well mobilized E pt mobilized well N pt mobilized well	P.C 0807 P.K. S.D. 0811
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☒ Urination ☐ Others:	☒ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	☒ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenc / volume / Hemetemeses as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M pt normal elimination pattern E elimination pattern N pt self voided	P.C 0807 P.K. S.D. 0811
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M — E — N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☒ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☒ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M pt well groomed E — N pt good hygiene maintained	RL 0207 SD 0212
SAFETY ☒ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☒ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M P+ ID Band ⊕ E ID Band ⊕ N P+ ID Band checked	RL 0207 WY 01/4 SD 0212
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E — N —	
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M P+ V/S checked & recorded E vital signs stable N P+ V/S checked & recorded	RL 0207 JAW SD 0212
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E — N —	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M patient well communicated E pt communicate well N Good communication	D.C. 12/07 [Signature] [Signature]
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M patient due drugs are given E medication given N medication given	D.C. 02/09 [Signature] [Signature]
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	S. Nalpan	0024	12/1/24	11:50

ADULT NURSING CARE PLAN

Pt. THANDAVA MOORTHY S
57/Male/MHI202381312
10/01/2024/IPH2024000081
Dr. ANBARASU MOHANRAJ

Initial Date: 16/1/24 Time:		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - TUD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☒ Keep NPO ☐ Regular Diet ☐ Others:	☒ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt is on normal diet E Pt is on normal diet. N Pt had diet	Jy 0085 Jan on. D 333
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M SpO ₂ - 95% E Pt on Room air. N Pt on Room air	Jy 0085 Jan on. D 2333
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt is on oral fluids E Pt is D/O chart monitored. N D/O monitored	Jy 0085 Jan on. D 333

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☒ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☒ Apply Anti-Embotic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M PT Mobilized well	dy 0080
			E PT Mobilized well.	Joni on.
			N Mobilized freely	P 2531
ELIMINATION ☒ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenc / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Elimination Pattern Good	dy 0080
			E Normal Elimination pattern	Joni on
			N Elimination pattern	P 2531
SKIN INTEGRITY ☒ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☒ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Skin is intact	dy 0080
			E Normal skin integrity.	Joni on.
			N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☒ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☒ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M PT is on self hygiene E PT is on self hygiene N Groomed well	dy 0088 Jan 0537
SAFETY ☒ Check ID Band ☐ IV care ☐ EJV ☐ CENTRAL LINE ☐ Side rails ☐ Others:	☒ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M ID Band @ E ID band present N ID band @	dy 0088 Jan 0537
COMFORT AND SLEEP ☒ Pain Control ☐ Sleep Patterns ☐ Others:	☒ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☒ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M PT sleep pattern good E PT sleep pattern good N	dy 0088 Jan 0537
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M vital signs is checked E v/s checked. N v/s is stable	dy 0088 Jan 0537
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☒ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M Psychological support given E psychological support given. N	dy 0088 Jan 0537

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☒ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M pt communication good E pt communication good N Good communication	Jy Jy Jy
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☒ Double check for high alert medication ☒ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Medications are given E Medication given as per drug chart. N Medication given	Jy Jy Jy
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Jy	S. Jy PNP	0024	16/1/24	16:00

ADULT NURSING CARE PLAN

Patient: **Mr. THANDAVA MOORTHY S**
Name: 57 / Male / MHI202381312
UHID: 10/01/2024/1PH2024000081
DOB: Dr. ANBARASU MOHANRAJ
DOA:
Consul:

MHI/NUR/2022/044



Every heart beat counts

Initial Date: 17/1/24		Time: 8:20		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD - TVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION ☒ Keep NPO ☐ Regular Diet ☐ Others:	☒ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☒ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M PT is on NORMAL Diet E PT had diet N	M Edst E AN N			
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M SPO ₂ - 95% E SPO ₂ - 98% N	M Edst E AN N			
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M PT ON ORAL Fluids E E10 chest monitored N	M Edst E AN N			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☒ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☒ Encourage regular ambulation ROM exercise ☐ Apply Anti-Emboic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M PT Mobilized well	Hy 0088
			E pt mobilized well	WJ 0088
			N	
ELIMINATION ☒ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☒ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☒ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenc / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M elimination Pattern good	Hy 0088
			E @ elimination pattern @	WJ 0088
			N	
SKIN-INTEGRITY ☒ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☒ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Skin is intact	Hy 0088
			E	
			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☒ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M PT is on Self hygiene E N	Jy 00/88
SAFETY ☐ Check ID Band ☐ IV care ☐ EJV ☐ CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M ID Band E ID Band N	Jy 00/88 Jy 00/11/
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M PT Sleep Pattern good E N	Jy 00/88
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Vital signs is Stable E Vitals are stable N	Jy 00/88 Jy 00/11/
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☒ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M Psychological support given E N	Jy 00/88

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M COMMUNICATION is good E pt communicate well N	Jy 0088 Jy 0101
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Medications are given E medication given N	Jy 0088 Jy 0101
Endorsed by	Signature	Name	Emp. ID	Date	Time
	we	S. ValPNP	0024	07/1/24	1100

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	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	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		03	03	3
					TOTAL SCORE	23	23
					Initial & Emp. No. of Staff Nurse:	08	08
					Initial & Emp. No. of Sr. Staff Nurse:	08	08

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	1	1	2
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	1	1	2
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	1
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	1	1	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	1	1	2
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		1	1	2
TOTAL SCORE					6	6	11
Initial & Emp. No. of Staff Nurse:					11/01/2024	10/1	2165
Initial & Emp. No. of Sr. Staff Nurse:					11/01/2024	10/1	2165

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	2	2	3	
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	2	2	2	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	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	2	2	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	2	2	2	
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		2	2	2	
					TOTAL SCORE	11	11	13
					Initial & Emp. No. of Staff Nurse:	12/1/24	12/1/24	12/1/24
					Initial & Emp. No. of Sr. Staff Nurse:	12/1/24	12/1/24	12/1/24

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



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond 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	2	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	3	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	3	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 IVs for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	3	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		
					19	23	
					Initial & Emp. No. of Staff Nurse:		
					24	58	62
					Initial & Emp. No. of Sr. Staff Nurse:		
					24	24	

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	9	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	9	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	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	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	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	3
TOTAL SCORE					23	23	23
Initial & Emp. No. of Staff Nurse:					601/2/277		
Initial & Emp. No. of Sr. Staff Nurse:					N/A		

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	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	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	4	
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	23	23	27
					Initial & Emp. No. of Staff Nurse:	PC 0007	PC 0007	PC 0007
					Initial & Emp. No. of Sr. Staff Nurse:	PC 0007	PC 0007	PC 0007

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	2	4	5	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	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	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	4	
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	23	23	23
					Initial & Emp. No. of Staff Nurse:	8008	5008	5008
					Initial & Emp. No. of Sr. Staff Nurse:	1008	1008	1008

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	
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:		
					4	1008	
					Initial & Emp. No. of Sr. Staff Nurse:		
					1008	1008	

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

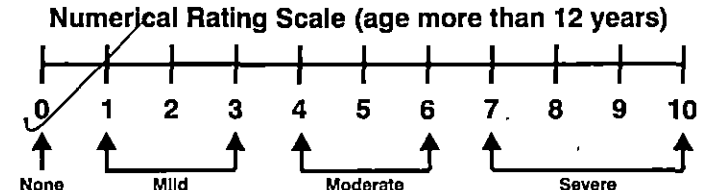
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10/1/24 11:00	0/10	No pain	—	—	—	Dr. S. Anbarasu	Dr. P. S. Sankar
15:00 4	0/10	No pain	—	—	—	Dr. S. Anbarasu	Dr. P. S. Sankar
19:00 0/10	0/10	No pain	—	—	—	Dr. S. Anbarasu	Dr. P. S. Sankar
21:00 0/10	0/10	No pain	—	—	—	Dr. S. Anbarasu	Dr. P. S. Sankar
23:00 0/10	0/10	No pain	—	—	—	Dr. S. Anbarasu	Dr. P. S. Sankar
5:00 0/10	0/10	No pain	—	—	—	Dr. S. Anbarasu	Dr. P. S. Sankar

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.
11/01 2024 12:30	0/8	By cport	-	-	on Ventilator support	V. Sre 101	[Signature]
14:30	0/8	By cport	-	-	on Ventilator support	V. Sre 101	[Signature]
16:30	2/10	Achy pain	10sec	Sternum	pharmacological intervention provided	V. Sre 101	[Signature]
18:30	2/10	Achy pain	10sec	Sternum	Non-pharmacological intervention provided	V. Sre 101	[Signature]
20:30	1/10	Achy PAIN.	10-15 SEC	SURVIVAL SITE	Pharmacological Intervention are provided	[Signature] a.t.	[Signature]
22:30	1/10	DULL PAIN	210 SEC	STERNUM	Non-Pharmacological Intervention are provided	[Signature] a.t.	[Signature]
12/1/24 AT 24:30	-	-	-	-	Patient was Sleeping comfortably	[Signature] a.t.	[Signature]
2:30	-	-	-	-	Patient was Sleeping comfortably	[Signature] a.t.	[Signature]
4:30	-	-	-	-	Patient was Sleeping comfortably	[Signature] a.t.	[Signature]

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
6:30	1/10	ACHY PAIN	10-15 Sec.	SURGICAL SITE	Non-Pharmacological Interventions are provided	[Signature] 0265	[Signature] 0265
8:40	2/10	Dull ache	20 Sec.	Surgical site	Non-pharmacological intervention done.	[Signature] 0265	[Signature] 0265
10:40	1/10	Dull ache	15 Sec.	Surgical site.	Followed non-pharmacological intervention done.	[Signature] 0265	[Signature] 0265
12:40	2/10	DULL ACHE.	15 Sec	BACK	Followed Non-pharmacological intervention done.	[Signature] 0289	[Signature] 0265

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)  0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain	
Non-pharmacological Interventions	Distraction: A - Relaxation-conductive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counseling: K - Individual Counseling; L - Family counseling	
Pharmacological Interventions as per doctor's prescription		

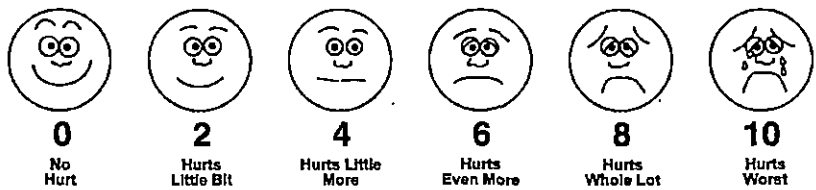
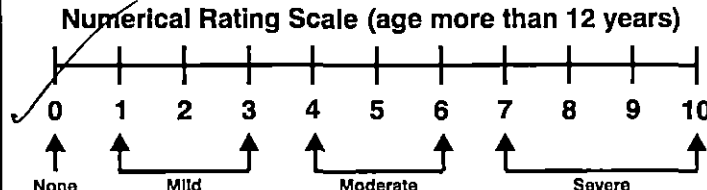


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
12/1/24 @ 17:40	1/10	Dull ache	10 sec	Back pain	Followed pharmacological interventions	P. 0287	[Signature]
12/1/24 @ 16:40	1/10	Dull ache	10 sec	Back pain	Followed non-pharmacological Interventions	P. 0287	[Signature]
12/1/24 @ 18:40	1/10	Dull ache	5 sec	sternum	Followed non-pharmacological Interventions	P. 0287	[Signature]
20:00	2/10	DULL PAIN	210-15 SEC	SUBCLAVICULAR SITE	Pharmacological Interventions are followed	P. 0171	[Signature]
22:00	1/10	ACHY PAIN	210 SEC	STERNUM	Non-Pharmacological Interventions are followed	P. 0171	[Signature]
13/1/24 @ 24:00	2/10	-	-	-	Patient was Sleeping comfortably	P. 0171	[Signature]
2:00	-	-	-	-	Patient was Sleeping comfortably	P. 0171	[Signature]
4:00	-	-	-	-	Patient was Sleeping comfortably	P. 0171	[Signature]
6:00	1/10	ACHY PAIN	210 SEC	SUBCLAVICULAR SITE	Non-Pharmacological Interventions are followed	P. 0171	[Signature]

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
13.01.24 @ 8.00	2/10	Achy pain	10 sec	Sternum	Pharmacological intervention provided	V. Dyer 101	[Signature]
10.00	1/10	Dull pain	5 sec	Base	provided comfortable position	V. Dyer 101	[Signature]
14.00	1/10	dull pain	on & off	Abdomen	Pharmacological Intervention given	Sub	Naz 024
12.00	1/10	dull pain	on & off	Sternum	non-pharmacological intervention given.	Sub	Naz 024

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)  0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain	
Non-pharmacological Interventions	Distraction: A - Relaxation-conductive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling	
Pharmacological Interventions as per doctor's prescription		

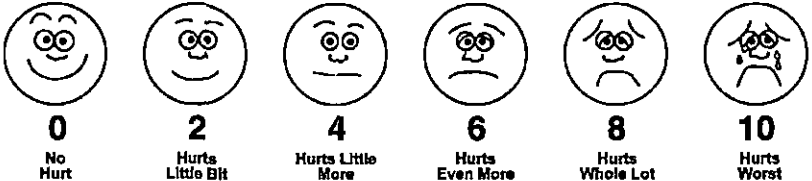
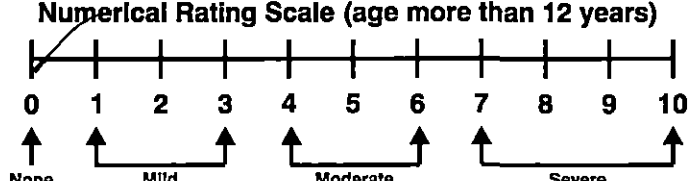


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
22.00	1/10	dull pain	-	-	-	S.D. 01/24	Nee 24
2.00	6/10	PT	sleep well	-	-	-	Nee 24
6.00	0/10	NO PAIN	-	-	-	S.D. 01/24	Nee 24
10.00	0/10	No pain	-	-	-	Dr. 01/24	Nee 24
12.00	0/10	no pain	-	-	-	Dr. 01/24	Nee 24
4.30	0/10	no pain	-	-	-	Dr. 01/24	Nee 24
22.00	0/10	no pain	-	-	-	Dr. 23/24	Nee 24
15/1/24	0/10	no pain	-	-	-	Dr. 23/24	Nee 24
2.00	0/10	no pain	-	-	-	Dr. 23/24	Nee 24
6.00	0/10	no pain	-	-	-	Dr. 23/24	Nee 24

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.
15/01/18 10:00	0/10	NO Pain	—	—	—	DC 0909	Neil 09
14:00	0/10	NO pain	—	—	—	0141	Neil 09
18:00	0/10	NO pain	—	—	—	0141	Neil 09
22:00	0/10	NO pain	—	—	—	2337	Neil 09

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)  0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe
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 counselling

Pharmacological Interventions as per doctor's prescription

Patient **Mr. THANDAVA MOORTHY S**
Name **S7 / Male / MHI202381312**
UHID **10/01/2024 / IPH2024000081**
DOB: **Dr. ANBARASU MOHANRAJ**
DOA:
Cons:



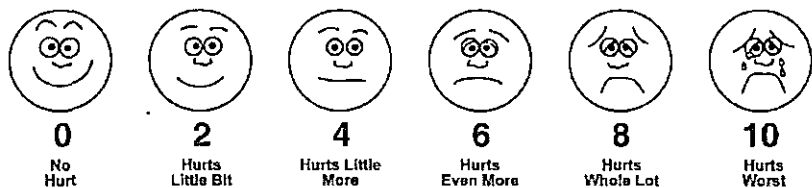
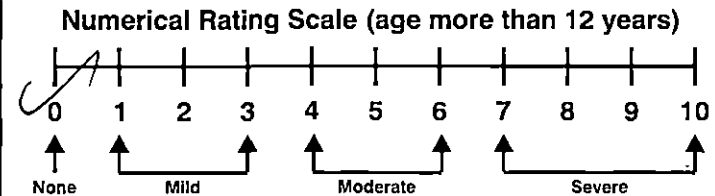
very heart beat counts

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.
16/1/24 2:00	0/10	No pain	-	-	-	P 2332	Nee 24
6:00	0/10	No pain	-	-	-	P 2333	Nee 24
10:00	0/10	No Pain	-	-	-	Jef 0085	Nee 24
14:00	0/10	No pain	-	-	-	Jani om.	Nee 24
18:00	0/10	No pain	-	-	-	Jani om.	Nee 24
22:00	0/10	No pain	-	-	-	P 233	Nee 24
17/1/24 2:00	0/10	No pain	-	-	-	P 237	Nee 24
6:00	0/10	No pain	-	-	-	P 233	Nee 24
10:00	0/10	No Pain	-	-	-	Jef 0085	Nee 24

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.
14.00	0/10	No pain	-	-	-	Jen on	Neil Nrl
14.00	0/10	No pain	-	-	-	Jen on	Neil Nrl

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	
CRIS (38 weeks - 2 months)	The CRIS scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIS 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/counseling: K - Individual Counseling; L - Family counseling	
Pharmacological Interventions as per doctor's prescription		

DVT RISK ASSESSMENT

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

		Date	Time						
		10/11/24	11:00						
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0						
2	Bedridden recently >3 days or major surgery within four weeks	0	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0						
5	Entire leg swollen (Assess for both legs)	0	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0						
9	Previously documented DVT (Assess for both legs)	0	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0						
FINAL SCORE		0	0						
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		Low	Low						
DVT prophylaxis started		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Signature & Emp. No. of RN		[Signature] 05/01/24							
Signature & Emp. No. of Sr. RN		[Signature] 05/01/24							

		Date	11/01/24	12/1/24	13/1/24	14/1/24	15/1/24	16/1/24	17/1/24
		Time	12:30	6:00	6:00	6:00	6:00	6:00	6:00
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)		0	0	0	0	0	0	0
2	Bedridden recently >3 days or major surgery within four weeks		+1	+1	+1	+1	+1	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	0	0	0	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)		0	0	0	0	0	0	0
5	Entire leg swollen (Assess for both legs)		0	0	0	0	0	0	0
6	Localized tenderness along the deep venous system (Assess for both legs)		0	0	0	0	0	0	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)		0	0	0	0	0	0	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)		0	0	0	0	0	0	0
9	Previously documented DVT (Assess for both legs)		0	0	0	0	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	0	0	0	0
FINAL SCORE			+1	+1	+1	+1	+1	0	0
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8			Mod	MOD	MOD	MOD	MOD	LOW	LOW
DVT prophylaxis started			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No
Signature & Emp. No. of RN			[Signature] 101	[Signature] an	[Signature] an	[Signature] 021	[Signature] 021	[Signature] 021	[Signature] 27
Signature & Emp. No. of Sr. RN			[Signature] 2A	[Signature] 2A	[Signature] 2A	[Signature] Nee 2-0	[Signature] Nee 021	[Signature] Nee 021	[Signature] Nee 2-0



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	10/1/24	10/1/23	10/1/24						
	Time	11:00	11:00	20:20						
History of falling (immediate or within 6 months)	No	0	10	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	30	26						
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

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

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	11/01/2024	11/1/24	12/1/24	12/1/24	12/1/24	13/01/24	13/1/24	13/1/24	14/1/24
	Time	12:30	20:00	8:00	12:30	20:00	12:30	14:30	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	45	15	45	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	45	15	45	15	15	15	15	15	15	15
Total Score		80	50	50	50	50	50	50	50	50
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN		K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101
Signature & Emp. No. of Sr. RN		K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101	K. M. S. 101

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

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	01/1/24	12/1/24	15/01/24	16/1/24	15/1/24	16/1/24	16/1/24	16/1/24	17/1/24
	Time	12:00	20:00	8:00	12:00	20:00	8:00	14:00	20:00	8:00
History of falling (immediate or within 6 months)	No	☒	☒	☒	☒	☒	☒	☒	☒	☒
	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		☒	☒	☒	☒	☒	☒	☒	☒	☒
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		☒	☒	☒	☒	☒	☒	☒	☒	☒
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		☒	☒	☒	☒	☒	☒	☒	☒	☒
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		40	50	50	60	50	50	50	30	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]



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

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/046



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
AMBULATORY AID None / Bed Rest / Nurse Assist Crutches / Cane / Walker Furniture		0	0	0	0	0	0	0	0	0
		15	15	15	15	15	15	15	15	15
		30	30	30	30	30	30	30	30	30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
GAIT Normal / Bed Rest / Wheel Chair Weak Impaired		0	0	0	0	0	0	0	0	0
		10	10	10	10	10	10	10	10	10
		20	20	20	20	20	20	20	20	20
MENTAL STATUS Oriented to own stability Overestimated or forgets limitations		0	0	0	0	0	0	0	0	0
		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		50								
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (above 45)		✓								
Signature & Emp. No. of RN		Jany 09/01/24								
Signature & Emp. No. of Sr. RN		Neel 09/01/24								

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

[illegible]

[illegible]

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☒ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>11/01/24</u> Time <u>18.00</u>		Nurse Signature : <u>Rat V. Deepalashmi</u>

Learning Record

Need	Date <u>11/1/24</u>	Visit 1			Date <u>12/1/24</u>	Visit 2			Date <u>12/1</u>	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Disease													Doctor
☒ Information on Disease / Diagnostics		-	-	-		S	OD	V		P	OD	V	<u>1.80</u> <u>134555</u>
☒ Treatment Medications		-	-	-		S	OD	V					Doctor / Nurse
☒ Information on Safe and Effective use of medicines		-	-	-		S	OD	V		P	OD	V	<u>1.80</u>
☐ Information on drug / drug and drug / food interactions		-	-	-		-	-	-					
☐ Discharge Medications		-	-	-		-	-	-					
Surgical Instructions		-	-	-		-	-	-					Nurse
☐ Pre - Operative Instructions		-	-	-		-	-	-					<u>Sub</u>
☐ Post - Operative Instructions (Wound / Dressing Care)		S	OD	U		S	OD	V		P	OD	V	
Pain Management		S	OD	U		S	OD	V					Nurse
☐ Reporting of pain						-	-	-		P	OD	V	
☒ Pain Management		S	OD	U		S	OD	V					
Safe and effective use of medical Equipment (if required)		S	OD	U		S	OD	V		P	OD	U	Doctor / Nurse <u>Sub</u>
Name of Equipment													
Rehabilitation Techniques		S	OD	U		S	OD	V					

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance	10/1				11/1								Dietician
☒ Diet Instruction for patients at Nutritional risk			P	OPV			S	OPV			S	OPV	Senior Dietitian
☐ Diet advice for home													Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)

nil

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____

PATIENT AND FAMILY EDUCATION RECORD

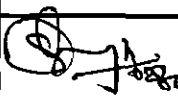
Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☒ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>14/1/24</u> Time <u>9:00</u>		Nurse Signature : <u>[Signature]</u>

Learning Record

Need	Date <u>14/1/24</u> Visit 1				Date <u>15/01/24</u> Visit 2				Date <u>16/1/24</u> Visit 3				Signature
	L	P	O		L	P	O		L	P	O		
Disease													Doctor
☐ Information on Disease / Diagnostics													<u>[Signature]</u>
☐ Treatment Medications													<u>[Signature]</u>
☐ Information on Safe and Effective use of medicines													Doctor / Nurse
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													<u>[Signature]</u>
Surgical Instructions													Nurse <u>[Signature]</u>
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)													<u>[Signature]</u>
Pain Management													Nurse <u>[Signature]</u>
☐ Reporting of pain													<u>[Signature]</u>
☐ Pain Management													
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment													
Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____



Pz	Mr. THANDAVA MOORTHY S
Ni	57/Male/MH1202381312
UI	10/01/2024/1PH2024000081
DI	Dr. ANBARASU MOHANRAJ
DI	
Ca	

MHI/IP/2022/055



Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☐ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>17/1/24</u> Time <u>8:00</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
☐ Diet Instruction for patients at Nutritional risk													
☐ Diet advice for home													Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : T. Chandra Signature : T. Chandra

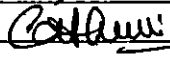
Name of Discharge Nurse Sal Njonghe Signature : Sal Njonghe

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 10/01/24 Time: 16:10

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

Doctor	Signature	Name	Reg. / Emp. No.	Date	Time
		DR. Thandava Moorthy S	162265	10/01/24	16:10
Nursing Staff		M. Dairiba	018	10/01/24	16:10
Dietician		Maria Catherine John Senior Dietitian	2401	10/01/24	16:10
Physiotherapist					
Patient Care Service Staff					

FAMILY COUNSELLING FORM

CONSULTANT- DR. ANBARASU			DIAGNOSIS- CAD-TVD, EF -41%.			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
11/01/2024	R/N. A. Deepa Laxmi	NARESH (SON)	Explained Regarding hemodynamic stability, isotropic supports, Drain, the stay and visiting hours.	-	T. Mohanraj	8/11/24
12/01/2024	S/N. R. Bhavani	NARESH (SON)	Explained Regarding Conditions of the patient. Explained about the ICU stay and Hemodynamic status of the patient.	-	T. Mohanraj	8/12/24

IN-HOUSE TRANSFER FORM

Part A (to be filled by Nurses)

Date of Transfer: 13/01/24 Time: 1045 Transferred from: Su To: 1 floor 104-A

Diagnosis:

CAD - TND

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 93 (beats/min) | BP: 108/69 (mmHg) | Respiration: 14 (breaths/min)

Part B (to be filled by Physicians)

Any Critical Investigations: _____

Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	☒ Clear ☐ Crepitation ☐ Rhonchi ☐ Others: _____	☒ Yes ☐ No
Abdomen	☒ Soft ☐ Tender ☐ Distended ☐ Others: _____	☒ Yes ☐ No
Heart Sound	☒ Normal ☐ Feeble ☐ Loud ☐ Others: _____	☒ Yes ☐ No
CNS	☒ Conscious ☒ Oriented GCS Score: <u>15/15</u>	☒ Yes ☐ No
For Surgical Patients (if applicable)	Surgical Site: ☒ Healthy ☐ Soakage ☐ Others: _____	☒ Yes ☐ No

Present Medication (for Medication Reconciliation)

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	SYP. SULFATE	10ml	P/O	1-1-1	13/1/24 AT 7:30	☒ Yes ☐ No
2.	NEB. IENOLIN	0.63mg	INH	1-1-1	13/1/24 AT 10:00	☒ Yes ☐ No
3.	TAB. FRUSEMIDE	40mg	P/O	1-1-0	13/1/24 @ 8:00	☐ Yes ☐ No
1.	TAB. SPIRANOLACTONE	25mg	P/O	1-1-0	13/1/24 AT 10:00	☐ Yes ☐ No
1.	TAB. BEPILEX FORTE	1TAB	P/O	1-0-0	13/1/24 AT 8:00	☐ Yes ☐ No
6.	TAB. Clopidogrel ^{ASPIM}	75mg	P/O	0-1-0	13/1/24 AT 14:00	☒ Yes ☐ No
7.	TAB. ATORVASTATIN	20mg	P/O	0-0-1	13/1/24 AT 21:00	☐ Yes ☐ No
8.	TAB. PARALLETAMOL	650mg	P/O	1-1-1	13/1/24 AT 8:00	☒ Yes ☐ No
9.	SYP. CRETAFFIN PWS	15ml	P/O	0-0-1	12/1/24 AT 21:00	☒ Yes ☐ No
10.	TAB. METAPROLOL	12.5mg	P/O	1-0-1	13/1/24 AT 8:00	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details (if any):

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

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	✓	Dr. Pawan Jagtapkar	112236	13/1/24	10.45
Receiving Doctor	Wb	K. Anbum	134556	13/1/24	11.00

Part C (to be filled by Nurses)

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

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	U. R.	C. Deepalacchini	0101	13/01/24	10.45
Receiving Nurse	Hay	Hannah Bruce	0105	13/1/24	11.00

WOUND ASSESSMENT CHART

EXUDATE AMOUNT								
none	☒	☒	☒	☐	☐	☐	☐	☐
evidence of some moisture	☐	☐	☐	☐	☐	☐	☐	☐
evidence of significant flow	☐	☐	☐	☐	☐	☐	☐	☐
EXUDATE								
serous	☐	☐	☐	☐	☐	☐	☐	☐
sero - sanguinous	☐	☐	☐	☐	☐	☐	☐	☐
Purulent	☒	☒	☒	☐	☐	☐	☐	☐
ODOUR								
none	☒	☒	☒	☐	☐	☐	☐	☐
some evidence of odour	☐	☐	☐	☐	☐	☐	☐	☐
significantly malodorous	☐	☐	☐	☐	☐	☐	☐	☐
PAIN AT WOUND SITE (nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)								
	5	5						
INFECTION SUSPECTED*	☐	☐	☐	☐	☐	☐	☐	☐
SWAB SENT	☐	☐	☐	☐	☐	☐	☐	☐
ANTIBIOTIC THERAPY	☐	☐	☐	☐	☐	☐	☐	☐
BLOOD GLUCOSE / URINE ANALYSIS	☐	☐	☐	☐	☐	☐	☐	☐
PATIENT / CARER TO DO DRESSING	☒	☒	☒	☐	☐	☐	☐	☐
SIGNATURE	<i>AL</i> 0087	<i>P.C</i> 0207	<i>P.C</i> 0207					

***SIGNS & SYMPTOMS OF WOUND INFECTION :**

- Pyrexia
- localised pain
- erythema
- local oedema
- excess exudate
- pus
- offensive odour

***SUSPECT WOUND INFECTION IF :**

- granulation tissue bleeds easily
- fragile bridge of epithelium occurs
- odour increases
- healing is slower than anticipated
- wound breakdown

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : **Mr. THANDAVA MOORTHY S**
57 / Male / MHI202381312
10/01/2024 / IPH2024000081
AGE / SEX : **Dr. ANBARASU MOHANRAJ**

IP No. / UHID No

Ward / Bed No. Sec/1

ANY SCORE > 0 SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
11/01 2024	12-30	RIGHT CUBITAL	0/5	IV line patent	flushed & NS	Observation	V. Ign 101
	20:00	RIGHT CUBITAL	0/5	IV LINE PATIENT	FLUSHED	NO SIGNS OF PHLEBITIS	Dr. Ign 101
12/1/24	8:00	② CUBITAL	0/5	PATIENT & HEALTHY	FLUSHED & NS	ON OBSERVATION	Dr. Ign 101
	12:30	② CUBITAL	0/5	PATIENT & HEALTHY	FLUSHED & NS	ON OBSERVATION	Dr. Ign 101
	20:00	RIGHT CUBITAL	0/5	IV LINE PATIENT	FLUSHED	NO SIGNS OF PHLEBITIS	Dr. Ign 101
13/01/24	09:20	Rt cubital	0/5	iv line patent	flushed	No sign of phlebitis	V. Ign 101
	14:00	Rt cubital	0/5	patent	flushed	no sign of phlebitis	Dr. Ign 101
	20:00	Rt cubital	0/5	patent	flushed	observation	S. Dr. Ign 101
14/1/24	8:00	Rt cubital	0/5	patent	flushed	followed	Dr. Ign 101
	16:50	Rt cubital	0/5	patent	flushed	-	Dr. Ign 101
	20:00	Rt cubital	0/5	patent	flushed	-	Dr. Ign 101
15/01/24	8:00	Rt cubital	0/5	patent	flushed	-	Dr. Ign 101
	14:00	Rt cubital	0/5	patent	flushed	-	Dr. Ign 101
	20:00	Rt cubital	0/5	patent	flushed	-	Dr. Ign 101
16/1/24	8:00	Rt cubital	0/5	Patent	flushed	-	Dr. Ign 101
	14:00	Rt cubital	0/5	patent	flushed	-	Dr. Ign 101
				IV line removed		② 16:00	

[illegible]

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 11:25

DRUG NAME

7. CONCOR

8.00

Dose

1.25mg

Route

p/b

Frequency

100

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24 @ 11.00

Stop Date & Time

Additional Info:

DRUG NAME

7. TIDE PLUS

8.00

Dose

20/somy

Route

p/b

Frequency

100

Dr. Sign & Reg. No. / Seal

16522

Start Date & Time

10/1/24 @ 11.00

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

10/1/24 11:25

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
10/1/24	11 AM	Diabetic Diet	<i>[Signature]</i>	165802					
11/1/24	8 AM	NPO	<i>[Signature]</i>	1341559					

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	Evening	PIN Bharti Gupta	0271	E.		Evening			
10/1	Night	A. N. Jones	0161	A.		Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			



Dr.ANBARASU MOHANRAJ



Medway
Heart
Institute

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

11/01/2024 12/01/2024 13/01/24 14/01/24 15/01/24 16/01/24 17/01/24

DRUG NAME

TAB. PARACETAMOL

Dose

1gm

Route

2x

Frequency

Q 8th hourly

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No:112236

Start Date & Time

11/01/24 15.00

Stop Date & Time

12/01/24 at 10.00

Additional Info:

DRUG NAME

SYP. SUCRALFATE SUSPENSION

Dose

10ml

Route

p.o

Frequency

1-1-1

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No:112236

Start Date & Time

11/01/24 19.30

Stop Date & Time

Additional Info:

DRUG NAME

TAB. LEVOSALBUTAMOL

Dose

0.63mg

Route

2xH

Frequency

Q 6th hourly

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No:112236

Start Date & Time

11/01/24 15.00

Stop Date & Time

Additional Info:

DRUG NAME

TAB. PRUDEXIDE

Dose

40mg

Route

p.o

Frequency

1-1-0

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No:112236

Start Date & Time

12/01/24 8.00

Stop Date & Time

14/01/24 at 10.00

Additional Info:

DRUG NAME

TAB. SPIRANOLACTONE

Dose

25mg

Route

p.o

Frequency

1-1-0

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No:112236

Start Date & Time

12/01/24 10.00

Stop Date & Time

14/01/24 at 10.00

Additional Info:

Area In-charge

Nurse Signature:

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.00

16.00

10.00

17.00

10.00

7.00

15.00

23.00

07.30

13.15

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

7.00

15.00

23.00

07.30

13.30

19.30

04.00

10.00

16.00

22.00

8.30

16.00

10.00

17.00

10.00

10.00

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. METOPROLOL (BETALOC)

Dose

12.5 mg

Route

PO

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

8
112236

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

12/1/24 20.00

Stop Date & Time

8.00

12/1/24 8.30
13/1/24 9.10
14/1/24 9.10
15/1/24 9.10
16/1/24 8.30
17/1/24 8.30

Additional Info:

DRUG NAME

T. IVABRADINE

Dose

5mg

Route

PO

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

8
112236

Start Date & Time

13/1/24 9.00

Stop Date & Time

9.00

20/00
20/30
20/15
20/10
20/10
20/10

Additional Info:

DRUG NAME

T. FRUSEMIDE

Dose

40mg

Route

PO

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

8
112236

Start Date & Time

14/1/24 10.00

Stop Date & Time

15/01/24 @ 11.00

21.00

9.00
9.15
9.00
9.00
9.00

Additional Info:

DRUG NAME

T. SPIRONOLACTONE

Dose

25mg

Route

PO

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

8
112236

Start Date & Time

14/1/24 10.00

Stop Date & Time

15/01/24 @ 11.00

10.00

21.00
21.00
21.00
21.00
21.00

Additional Info:

DRUG NAME

SYP. MUCOLYTE

Dose

5ml

Route

PO

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

8
112236

Start Date & Time

15/1/24 10.00

Stop Date & Time

8.00

14.00
14.00
14.00
14.00
14.00

Additional Info:

Area In-charge

Nurse Signature:

20.00

20.00
20.00
20.00
20.00
20.00

20.00
20.00
20.00
20.00
20.00

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

15/01 16/01 17/01

DRUG NAME

T. ANANT

Dose

0.25mg

Route

PO

Frequency

0-6-1

Dr. Sign & Reg. No. / Seal

Start Date & Time

15/1/24 10-00

Stop Date & Time

Additional Info:

DRUG NAME

T. LINGEN

Dose

12b

Route

PO

Frequency

0-1-0

Dr. Sign & Reg. No. / Seal

Start Date & Time

15/1/24 10-00

Stop Date & Time

Additional Info:

DRUG NAME

T. LAKS LAKTONE

Dose

20/50

Route

PO

Frequency

1/2-0-0

Dr. Sign & Reg. No. / Seal

Start Date & Time

15/1/24 10-00

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:

Nurse
15/01/24
16/01/24
17/01/24

ANTIMICROBIALS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given									
			Time ↓	11/01/2024	12/01/2024								
DRUG NAME PNJ · CEFUROXIME SODIUM			5.00	→	5.00								
Dose 1.5gm	Route PN	Frequency Q 12th hourly			D1	D2							
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No: 112236		Start Date & Time 11/01/24 @ 9.00	17.00		17.00	17.00							
		Stop Date & Time 12/1/24 at 17.00											
Additional Info:													
DRUG NAME													
Dose	Route	Frequency											
Dr. Sign & Reg. No. / Seal		Start Date & Time											
		Stop Date & Time											
Additional Info:													
DRUG NAME													
Dose	Route	Frequency											
Dr. Sign & Reg. No. / Seal		Start Date & Time											
		Stop Date & Time											
Additional Info:													
DRUG NAME													
Dose	Route	Frequency											
Dr. Sign & Reg. No. / Seal		Start Date & Time											
		Stop Date & Time											
Additional Info:													
DRUG NAME													
Dose	Route	Frequency											
Dr. Sign & Reg. No. / Seal		Start Date & Time											
		Stop Date & Time											
Additional Info:													
Area in-charge Nurse Signature:													

200/200

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

[illegible]

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

[illegible]

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
11/01/24	12.10	Npo	P	112236	16/1	8:00	Soft diet	P	183573
11/1/24	20.00	LIQUID DIET	P	112236	17/1/24	8:00	Normal diet	12/12	134559
12/1/24	9.00	liquid diet	S	112236					
13/1/24	8:00	SOFT SOLID LIQUID DIET	V	112236					
14/1	8:00	Soft diet	P	183573					
15/1	8:00	Soft diet	P	183573					

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				15/01/24	Morning	E. Cathrine	0207	E.C
11/01/24	Evening	V. Deepalaxmi	0001	V.D	15/1/24	Evening	Hannah Grace	0105	H.G
11/1/24	Night	D. RAVEENA	0171	D.R	15/1/24	Night	panameguri	2333	N.
12/1/24	Morning	Sathya Vani-M	0265	S.V	16/1/24	Morning	A. ALBINUS	0088	A
12/1/24	Evening	R. BHAVANI	0287	R.B	16/1/24	Evening	Jenipriya	0284	J.
12/1/24	Night	D. RAVEENA	0171	D.R	16/1/24	Night	panameguri	2333	N.
13/01/24	Morning	V. Deepalaxmi	0001	V.D	17/01/24	Morning	E. Cathrine	0207	E.C
13/01/24	Evening	Agastya	0006	A	17/1/24	Evening	Jenipriya	0284	J.
13/1/24	Night	Dowadharshini	0212	D		Night			
14/1/24	Morning	Agastya	0006	A		Morning			
14/1/24	Evening	A. monisha	0141	A		Evening			
14/1/24	Night	panameguri	2333	N.		Night			

OPCARB x 3 GRAFIC

LIMA → LAD

SICA → OM

SICA → PDA



Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Name

Dr. ANBARASU MOHANRAJ

UHID No



Blood Group -

B +ve

Height

154cm

Weight

57.3

BSA

1.56m²

MHI/ICU/2022/076

Sheet No.

①

A

SURGICAL PROCEDURE:

DATE OF SURGERY:

11/1/24

POST-OP DAY:

DD S

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO ₂		pH	PCO ₂	PO ₂	HCO ₂	SAT%	BE
11/1/24	12:10	VCV	14.0	1	19.0	5.0	9.0	6.9	500	497	60%							
	12:15	Simv	12.0	20.0	26.0	5.0	8.0	8.5	500	499	60%	12.15	7.373	37.5	146.4	21.3	99.2	-3.9
	12:45	Simv	10.0	16.0		5.0			500		60%							
	13:15	Simv	8.0	12.0		5.0			500		50%							
	13:45	PS cpap		10.0		5.0					50%	14.20	7.358	36.0	119.2	20.3	98.2	-5.7
	14:50	EXTUBATED									6lit	16.40	7.432	36.6	164.5	23.9	99.2	-0.4

CRITICAL CARE FLOWCHART

Received the patient from OT at 12:10
OT urine : 700ml

NEURO

EYES

Spon-4
Opens to speech-3
Opens to pain-2
Remains closed-1

VERBAL

Oriented-5
Confused/Disoriented-4
Inappropriate words-3
Sounds-2
No response-1

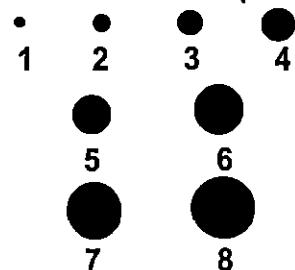
MOTOR

Obeys commands-6
Localise pain-5
Non-localising-4
Abn. Flexion-3
Abn. Extension-2
No response/flacid-1

MOTOR ARMS/LEGS

S-Strong
Wk-Weak
O-Absent
A-Anaesthesia
CP-Chemical paralysis

PUPILS SCALE (mm)



PUPILS REACTION

Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL

Br-Brisk
Sl-Sluggish
O-Absent

EDEMA

D-Dependent
G-Generalised
O-Absent

HEART SOUNDS

S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS

JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced /
Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING

Ab-Abdominal
TA-Thoraco-abdominal
L-Laboured

SUCTION

ET-Endotracheal
N-Nasal
Or-Oral

BREATH SOUNDS

CL-Clear
Ro-Ronchi
Wh-Wheezes
CR-Crackles
BECL-Bilat
equal & clear

SECRETIONS

COLOUR
CL-Clear
Y-Yellow
W-White
Pk-Pink

CHARACTER

M-Moderate
Sc-Scanty
Th-Thin
Tk-Thick
Cs-Copious
R-Red

GASTROINTESTINAL

BOWEL SOUNDS

+Present
O-Absent

NGT POSITION

Air injected
+Heard in Abd
O-Absent
GA-Gastric contents aspirated
Dr-Dependent Drainage

ABDOMINAL TONE

So-Soft
F-Firm
Tn-Tender
Ob-Obese
D-Distended

GASTRIC RESIDUAL

G-Green B-Bleeding
Y-Yellow C-Coffee ground

LIVERSIZE

N-Normal
E-Enlarged

CRITICAL CARE FLOWCHART

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Opens to pain-2
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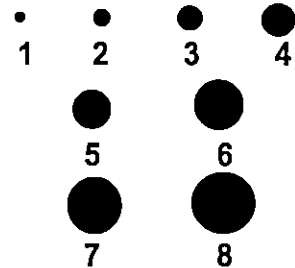
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OPRAB X 3 GRAFTS
 LIMA → LAD
 Ruy → OM
 Ruy → PDA



Mr. THANDAVA MOORTHY S 57/Male/MHI202381312		MHI/ICU/2022/076	
Name	10/01/2024/IPH2024000081	Sheet No.	
UHD No.	Dr. ANBARASU MOHANRAJ	Age	Sex
Blood Group	B +ve	Height	Weight
	154cm	57.3kg	BSA
		1.56m ²	A

SURGICAL PROCEDURE:

DATE OF SURGERY:

11/01/2024

POST-OP DAY:

3rd po0.

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FI _O ₂		pH	PCO ₂	PO ₂	HCO ₂	SAT%	BE
12/1/24	8:00	Clear	Room		Dir													

CRITICAL CARE FLOWCHART

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EYES

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Opens to pain-2
Remains closed-1

VERBAL

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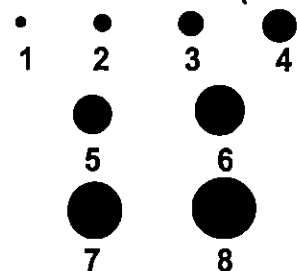
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PULMONARY

WORK OF BREATHING

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L-Laboured

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Mr. THANDAVA MOORTHY S
57/Male/MHI202381312
10/01/2024/IPH2024000081
Dr. ANBARASU MOHANRAJ

Sheet No. ①

Name

UHID No.

Blood Group B +ve

Age 154cm

Sex 57.3kg

BSA 1.56m²



MHI/ICU/2022/076



DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd™G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
11/24							12:10		cl	100%	VCV14		93°F						
	12:15	12.4	142	2.98	~~1.08~~ 185		13:00		cl	100%	Scm 10								
							14:00		cl	100%	24/mt								
							15:00		cl	100%	12/mt								
	14:20	11.6	140	2.89	~~0.97~~ 179		16:00		cl	100%	20/mt		95°F						
	16:40	12.1	140	3.53	~~0.93~~ 184		17:00		cl	100%	12/mt								
							18:00		cl	100%	12/mt								
							19:00		cl	100%	13/mt		96°F						
					180		20:00		cl	100%	24/mt								

CRITICAL CARE FLOWCHART

Patient got awake & moved all the limbs at 12:15

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME			12:00	20:00		
	EYES			CP	4		
	VERBAL			ET	5		
	MOTOR			CP	6		
	ARMS R/L			CP	ST		
	LEGS R/L			CP	ST		
PUPILS	R.SIZE/REACTION			3/BR	3/BR		
	L.SIZE/REACTION			3/BR	3/BR		
CARDIO-VASCULAR	HEART SOUNDS			S/S	S/S		
	VALVE CLICK				-		
	CAPILLARY REFILL			B ₂	BR		
	EDEMA			0	0		
	NECK VEINS			N	N		
PULMONARY	WORK OF BREATHING			TA	TA		
	SUCTION			ET/OLN	-		
	SECREATIONS			mid	-		
GASTRO INTESTINAL	BOWEL SOUNDS			+	+		
	ABDOMINAL TONE			Left	Soft		
	N/G POSITION			In situ	-		
	GASTRIC RESIDUAL			C	-		
	LIVER			N	N		

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE			C	CL		
	PD - FUNCTION				-		
	DRAINAGE				-		
	PD - SITE				-		
	COLOUR				-		
SKN	Sx WOUND-CHEST			C	CL		
	LEG			C	CL		
	DRESSING			OT	OT		
	PRESSURE SORE-SITE				NIL		
	AREA				-		
	DRESSING CONDITION				CL		
MISCELL	POSITION CHANGE				Q2H		
	CHEST-PHYSIO				NEB SHH		
	ACTIVITY			CP	PE		
				ABP	ABP		
				AP	WP		
	S/N NAME			Estay	Dani		
	TIME			12:00	20:00		
	SIGNATURE				Dani		

Sheet No. (2)	Name	Mr. THANDAVA MOORTHY S 57/Male/MHI202381312 10/01/2024/IPH2024000081 Dr. ANBARASU MOHANRAJ 	Age	Sex
	UHID No.			
B	Blood Group	B+ve	Weight	BSA
		154cm	57.3kg	1.56m



MHI/ICU/2022/076



DATE	TIME	BIOCHEMISTRY						VITAL PARAMETERS							CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N, BP	TEMP°F	Abd™G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
10/1/24					200		22.00		CL	100%	23/mt		97°F						
							23.00		CL	100%	26/mt								
					160		24.00		CL	100%	26/mt								
							1.00		CL	100%	24/mt		97°F						
							2.00		CL	100%	26/mt								
							3.00		CL	100%	26/mt								
					208		4.00		CL	100%	26/mt		97°F						
							5.00		CL	100%	18/mt								
	6.30	10.4	135	3.98	1.01 190		6.00		CL	100%	32/mt								
							7.00		CL	94%	34/mt								

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME					2400	1100
	EYES					4	4
	VERBAL					5	5
	MOTOR					6	6
	ARMS R/L					ST	ST
	LEGS R/L					ST	ST
PUPILS	R.SIZE/REACTION					3/BR	3/BR
	L.SIZE/REACTION					3/BR	3/BR
CARDIO-VASCULAR	HEART SOUNDS					S1S2	S1S2
	VALVE CLICK					—	—
	CAPILLARY REFILL					BR	BR
	EDEMA					0	0
	NECK VEINS					N	N
PULMONARY	WORK OF BREATHING					TA	TA
	SUCTION					—	—
	SECREATIONS					—	—
GASTRO INTESTINAL	BOWEL SOUNDS					+	+
	ABDOMINAL TONE					Sgt	Sgt
	N/G POSITION					—	—
	GASTRIC RESIDUAL					—	—
	LIVER					N	N

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE					CL	CL
	PD - FUNCTION					—	—
	DRAINAGE					—	—
	PD - SITE					—	—
	COLOUR					—	—
SKN	Sx WOUND-CHEST					CL	CL
	LEG					CL	CL
	DRESSING					OT	OT
	PRESSURE SORE-SITE					NIL	NIL
	AREA					—	—
	DRESSING CONDITION					—	—
	POSITION CHANGE					Q2H	Q2H
MISCELL	CHEST-PHYSIO					NEB SPIR.	NEB SPR
	ACTIVITY					PE	PE
						ABP CNP	ABP CNP
	S/N NAME					Danny	Danny
	TIME					2400	1100
	SIGNATURE					Danny	DT

Sheet No. 3	Name	Mr. THANDAVA MOORTHY S 57/Malc/MHI202381312 10/01/2024/IPH2024000081 Dr. ANBARASU MOHANRAJ 		
	UHID No.		Age	Sex
B	Blood Group	B+ve 154cm 57.3kg 1.56m		



MHI/ICU/2022/076



DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N, BP	TEMP°F	Abd ^{cm} G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
12/11/24							8:00		cl	95%	32/m		98.6°F						
							9:00		cl	97%	34/m								
							10:00		cl	98%	12/m								
	11:00				239		11:00		cl	97%	32/m								
							12:00		cl	97%	26/m	104/71 TK 22	97.2°F						
							13:00		clear	99%	28/m	104/71 (82)							
							14:00		clear	98%	30/m	114/72 (82)							
							15:00		clear	99%	32/m	106/70 (80)	97.2°F						
							16:00		clear	98%	24/m	103/71 (82)							
							17:00		clear	98%	30/m	104/71 (82)							
							18:												

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	8:00	12:00	16:00			
	EYES	4	4				
	VERBAL	5	5				
	MOTOR	6	6				
	ARMS R/L	4+	4+				
	LEGS R/L	4+	4+				
PUPILS	R.SIZE/REACTION	2/B _r	2/B _r				
	L.SIZE/REACTION	3/B _r	2/B _r				
CARDIO-VASCULAR	HEART SOUNDS	S ₁ S ₂	S ₁ S ₂				
	VALVE CLICK	-	-				
	CAPILLARY REFILL	B _r	B _r				
	EDEMA	0	0				
	NECK VEINS	4	4				
PULMONARY	WORK OF BREATHING	7A	7A				
	SUCTION	-	-				
	SECREATIONS	-	-				
GASTRO INTESTINAL	BOWEL SOUNDS	+	+				
	ABDOMINAL TONE	Soft	Soft				
	N/G POSITION	-	-				
	GASTRIC RESIDUAL	-	-				
	LIVER	N	N				

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE	cl	cl				
	PD - FUNCTION	-	-				
	DRAINAGE	-	-				
	PD - SITE	-	-				
SKN	COLOUR	-	-				
	Sx WOUND-CHEST	cl	cl				
	LEG	cl	cl				
	DRESSING	OT	OT				
	PRESSURE SORE-SITE	NIL	NIL				
	AREA	-	-				
	DRESSING CONDITION	-	-				
MISCELL	POSITION CHANGE	Q2H	Q2H				
	CHEST-PHYSIO	Neb sp100	Neb sp100				
	ACTIVITY	PE	PE				
		ASP cup	ASP sp100				
	S/N NAME	Sathya	Sathya				
	TIME	8:00	12:00	16:00			
	SIGNATURE						

Mr. THANDAVA MOORTHY S		MHI/ICU/2022/076	
57/Male/MHI202381312		Sheet No. ①	
Name	10/01/2024/1PH2024000081	Age	Sex
UHID No.	Dr. ANBARASU MOHANRAJ	Weight	BSA
Blood Group	B +ve	154cm	57.3kg
		1.56m ²	C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOTAL	ADRE 6/50	NODAD 4/50	ADRA 4/10	KLL 20/50
11/12/24	12.10														KARBYTE	1.0	3.0	4.0	50.0	
	13.00	150	150			100		100	100			7.0	7.0	257	300	300	1.0	3.0	4.0	
	14.00	80	230			60		60	160			7.0	7.0	397	200	500	1.0	3.0	4.0	
	15.00	150	380			140		140	300			1.0	8.0	680	200	700	1.0	3.0	4.0	25.0
	16.00	250	630			70		70	370				8.0	1008	200	900	1.0	3.0	4.0	25.0
	17.00	100	730			20		20	390			1.0	9.0	1128	100 + 100	1100	1.0	3.0	4.0	
	18.00	75	805			20		20	410				9.0	1224	100	1200	1.0	3.0	4.0	
	19.00	60	865			20		20	430				9.0	1304	100	1300	1.0	3.0	4.0	
	20.00	75	940			20		20	450				9.0	1397	100	1400	1.0	3.0	4.0	
	21.00	100	1040			20		20	470				9.0	1519	100	1500	1.0	3.0	4.0	

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

Act @ 108 Sec @ 12.15

DATE	TIME

GENITOURINARY (GU)**PD****URINE**

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

C-Clean
R-Redness
BD-Block discoloration

DRAINAGE

CL-Clear
BS-Blood

MISCELLANEOUS**POSITION CHANGE**

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

V-Vibrator
CP-Chest percussion
DC-Deep breath & cough
N-Nebulizer

TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

SKIN**COLOUR**

Pk-Pink
F-Flushed
P-Pale
Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

DRESSING

B-Betadine
AI-Antibiotic
Irrigation

PRESSURE SORE**SITE**

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

R-Redness
BD-Black discoloration
BL-Blister
SP-Skin Peeling
D-Deep

DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air
R-Redness at site
Sw-Swelling at site
Dr-Draining
D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

Mr. THANDAVA MOORTHY S
57/Male/MHI202381312

MHI/ICU/2022/076

Name

10/01/2024/IPH2024000081

UHID No.

Dr. ANBARASU MOHANRAJ

Age

Sex

Sheet No.

Blood Group

Height

Weight

BSA

C

B +ve

154cm

57 kg

1.56m²

0.01ml/hr 0.01ml/hr 4 IU 25ml/hr

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOTAL	APPE	NORAD	ACTRA	FENTAN
12/1/24	22:00	150	1190			30		30	500				9.0	1699	100	1600	1.0	3.0	4.0	1.0
	23:00	100	1290			10		10	510				9.0	1809	100	1700	1.0	3.0	4.0	1.0
12/1/24	24:00	80	1370			20		20	530				9.0	1909	100	1800	1.0	3.0	4.0	1.0
	1:00	150	1520			40		40	570				9.0	2099	100	1900	1.0	3.0	4.0	1.0
	2:00	100	1620			30		30	600				9.0	2229	100	2000	1.0	3.0	2.0	1.0
	03:00	100	1720			20		20	620				9.0	2349	100	2100	1.0	3.0	2.0	1.0
	4:00	100	1820			20		20	640				9.0	2469	100	2200	1.0	3.0	2.0	1.0
	5:00	100	1920			20		20	660			6.0	15.0	2595	100	2300	1.0	2.0	4.0	1.0
	6:00	80	2000			50		50	710				15.0	2725	100	2400	-	3.0	4.0	-
	7:00	80	2080			10		10	720			1.0	16.0	2816	-	2400		3.0	-	

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)**PD****URINE**

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BS-Blood

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Am-Ambulated

CHEST PHYSIO

V-Vibrator
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N-Nebulizer

TRANSDUCER ZERO

PARAMETER
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SKIN**COLOUR**

Pk-Pink
F-Flushed
P-Pale
Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air
R-Redness at site
Sw-Swelling at site
Dr-Draining
D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

PRESSURE SORE**AREA**

R-Redness
BD-Black discoloration
BL-Blister
SP-Skin Peeling
D-Deep

DRESSING

B-Betadine
AI-Antibiotic
Irrigation

DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

Mr. T. DAVA MORTHY S
57/Male/MHI202381312
10/01/2024/IPH2024000081

MHI/ICU/2022/076

Name	Dr. ANBARASU MOHANRAJ			Age	Sex	Sheet No. 3		
UHID No.								
Blood Group	B+ve	Height	154cm	Weight	59.3kg	BSA	1.56m ²	C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS				
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOTAL	NEEDLE		
12/1/24	8:00	80	80			20		20	20					100			3.0		
	9:00	100	180			10		10	30					210			2.0 ⁺		
	10:00	250	430			30		30	60					490			1.0		
	11:00	500	930						60					990	KABIANTE 250	250	-	KCL 250	
	12:00	500	1430						60					1520	250	500		25.0	ACTRA 10/100
	13:00	200	1630			CHEST DRAIN REMOVED @ 12:25			60					1720	100	600		25.0	4.0
	14:00	150	1780						60					1870	100	700			2.0
	15:00	150	1930						60					2020	100	800			2.0
	16:00	150	2080						60					2170	100	900			2.0
	17:00	150	2230						60					2320	100	1000			2.0

SPECIFIC OBSERVATIONS/PROBLEMS 11:30 REMOVED (L) RADIAL ARTERIAL LINE (R) DR. PRAVEEN.
12:25 REMOVED MEDIASTINAL DRAIN + PLEURAL

CRITICAL CARE FLOWCHART

GENITOURINARY (GU)

PD

URINE

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HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

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BS-Blood

MISCELLANEOUS

POSITION CHANGE

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SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

DRESSING

B-Betadine
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Irrigation

PRESSURE SORE

SITE

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Sc-Scapular
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AREA

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Dr-Draining
D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

Mr. THANDAVA MOORTHY S
 57/Male/MHI202381312
 10/01/2024/IPH2024000081
 Dr. ANBARASU MOHANRAJ

Name: _____ Sheet No.: _____
 Age: _____ Sex: _____
 UHID No.: _____
 Blood Group: **B+ve** Height: **154cm** Weight: **57.3kg** BSA: **1.56m²** **D**



MHI/ICU/2022/076



FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: **B+ve**

DATE	TIME	INFUSIONS (contd.)					N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						ml/cc	AMT.	TOTAL														
11/6/24	12:10										87	Sinus	0.03	116/43	63	6		cool	++			
	13:00					2.0		10.0	310.0	+53	82	Sinus	0.02	112/53	72	5		cool	++			
	14:00					2.0		10.0	520	+123	78	Sinus	0.01	96/49	67	8		cool	++			
	15:00					2.0		35.0	755	+75	94	Sinus	0.03	135/68	90	8		Warm	+			
	16:00	1.0				2.0		35.0	990	-78	85	Sinus	0.05	105/51	69	4		Warm	++			
	17:00	1.0				2.0	11.0	Slip	1201	+73	97	Sinus	0.06	127/61	84	8		Warm	++			
	18:00	1.0				2.0	11.0	100	1412	+188	100	Sinus	0.05	108/56	74	4		Warm	++			
	19:00	1.0				2.0	11.0	100	1523	+219	104	Sinus	0.06	105/52	70	4		Warm	++			
	20:00	1.0				2.0	11.0	100	1634	+235	106	Sinus	0.09	113/52	70	4		Warm	++			
	21:00	1.0				2.0	11.0	50	1795	+276	110	Sinus	0.09	111/52	72	6		Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

- @ 14:30 INJ. MYOPHYROLATE 5ml w stat given
- @ 14:30 INJ. SODIUM BICARBONATE 50ml w stat given
- @ 14:40 INJ. CASIX 10mg w stat given
- @ 15:10 INJ. PROPRANOLOL 2mg w stat given

PREVIOUS DAY HRS

DRAINAGE: Dr. Sylvester

URINE: (Dr. Sylvester)

TOTAL INTAKE:

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

Name 10/01/2024/IPH2024000081

UHID No. Dr. ANBARASU MOHANRAJ

Blood Group B+ve

154cm

Weight 57.3kg

BSA 1.56m²

D

Sheet No.

Age

Sex

21



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



MHI/ICU/2022/076

Medway Heart Institute

Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: B+ve

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						Misc		AMT.	TOTAL														
12/1/24	22:00					2.0	11.0		150	1906	+207	108	Sinus Tachy	001	113/56	76	6		Warm	++			
	23:00					2.0	11.0		150	2017	+208	106	Sinus	004	117/51	77	7		Warm	++			
	24:00					2.0	11.0		150	2128	+219	103	Sinus	002	113/51	76	6		Warm	++			
	1:00					2.0	8.0		150	2236	+137	98	Sinus	0.01	109/50	72	3		Warm	++			
	02:00					2.0	8.0		150	2344	+115	100	Sinus	0.02	112/53	74	4		Warm	++			
	03:00					2.0	8.0		150	2452	+103	99	Sinus	0.03	122/52	76	4		Warm	++			
	4:00					2.0	8.0	50	200	2610	+141	103	Sinus	0.01	117/59	67	6		Warm	++			
	5:00					2.0	11.00		200	2721	+226	102	Sinus	0.02	116/63	70	6		Warm	++			
	6:00					2.0	5.0	50	250	2876	+151	104	Sinus	0.04	106/54	72	8		Warm	++			
	7:00					2.0	5.0	50	300	2931	+115	110	Sinus Tachy	0.04	100/53	70	8		Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME

PREVIOUS DAY HRS

DRAINAGE:

TOTAL INTAKE:

URINE :

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

Name

10/01/2024/IPH2024000081

Sheet No.

UHID No.

Dr. ANBARASU MOHANRAJ

Age

Sex

3

Blood Group

B+ve

Height

154cm

Weight

57.3kg

BSA

1.56m²

D



Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



JCI ACCREDITED



NABH ACCREDITED

MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group:

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
						ml/hr		AMT.	TOTAL														
21/1/24	8:00					20	5.0	100	100	105	+5	104	Sinus	0.02	92/50	65	4		Warm	++			
	9:00					2.0	4.0	150	250	259	+49	106	Sinus	0.02	99/55	69	5		Warm	++			
	10:00					20	3.0	100	350	363	-128	112	Sinus	0.01	108/56	72	8		Warm	++			
	11:00					2.0	2.0	100	450	665	-325	105	Sinus	0.02	118/58	79	7		Warm	++			
	12:00					2 -	25.0	130	580	1070	-450	108	Sinus	0.01	-	-			Warm	++			
	13:00					-	29.0	25	605	1224	-496	105	Sinus	0.01	-	-			Warm	++			
	14:00					-	2.0	50	655	1376	-494	109	Sinus	0.01	-	-			Warm	++			
	15:00					-	2.0	25	680	1503	-517	99	Sinus	0.00	-	-			Warm	++			
	16:00					-	2.0	100	780	1705	-465	103	Sinus	0.01	-	-			Warm	++			
	17:00					-	2.0	50	830	1857	-463	108	Sinus	0.00	-	-			Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME

PREVIOUS DAY 18 HRS. 50 ml HRS

DRAINAGE: 720 ml TOTAL INTAKE: 2931 ml

URINE: 2080 ml TOTAL OUTPUT: 2816 ml

TOTAL BALANCE: +115 ml

P.T.O.

SVQ $\rightarrow$ PDA

MEDICATION / DRUGS

SVGL $\rightarrow$ PDA



Every heart beat counts

A

[illegible]

FLUID REQUIREMENT : 1-8 litres / day

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL / R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.		H.Aux			H.T.	H.T.	G.T.		
12/1/24 @ 18:00	75	2305				60	2395	1.0			-		830	1857	520
12/1/24 @ 19:00	75	2380				60	2470	1.0			-	25	855	1882	588
20:00	100	2480				60	2570	1.0					855	1882	688
21:00	75	2555				60	2645	2.0				50	905	1934	711
22:00	75	2630				60	2720	2.0					905	1936	781
23:00	75	2715				60	2795	2.0				800	1105	2138	657
12/1/24 @ 24:00	75	2780				60	2870	2.0				100	1205	2240	630
1:00	80	2860				60	2950	2.0					1205	2242	708
2:00	75	2935				60	3025	2.0					1205	2244	781
3:00	75	3010				60	3100	2.0					1205	2246	854
4:00	80	3090				60	3180	2.0					1205	2248	932
5:00	R	3090				60	3180	2.0					1205	2250	930
6:00		3090				60	3180	2.0				100	1305	2350	830
7:00		3090				60	3180	-					1305	2350	830

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS

Mr. THANDAVA MOORTHY S

57/Male/MHI202381312

10/01/2024/IPH2024000081

Dr. ANBARASU MOHANRAJ

NA

INTERMEDIATE CARE FLOWCHART

B

UHID NO :

AGE : 57 yrs SEX : MALE

BLOOD GROUP : B+ve

HEIGHT : 154 Cm

WEIGHT : 57.3 Kg

B.S.A : 1.56m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
97.0 F	114	SINUS TACHY	0.01	104/71 (82)	-	Warm	++	32	clear	100%	
	111	SINUS	0.02	104/71 (82)		Warm	++	24	clear	100%	on Room air & SPO2 100%
	110	SINUS Tachy	0.01	104/70	82	Warm	++	20	cl	98%	
97.0 F	110	SINUS Tachy	0.02	110/62	80	Warm	++	20	cl	98%	
	98	SINUS	0.01	106/62	68	Warm	++	18	cl	96%	
	96	SINUS	0.01	102/59	70	Warm	++	18	cl	96%	
	88	SINUS	0.01	104/72	80	Warm	++	20	cl	94%	
97.0 F	86	SINUS	0.02	110/69	76	Warm	++	28	cl	94%	
	84	SINUS	0.03					24	cl	96%	
	92	SINUS	0.02	90/54	68	Warm	++	20	cl	94%	
	96	SINUS	0.03			Warm	++	20	cl	96%	
97.0 F	104	SINUS	0.03	100/54	64	Warm	++	26	cl	94%	
	106	SINUS	0.04	101/64	70	Warm	++	14	cl	96%	CBG - 162 mg/dl.
	108	SINUS	0.03	102/64	78	Warm	++	18		96%	

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE