

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



Medway Hospitals

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



Mr. KALIDASS R

56/Male/MHI202371159

27/12/2023/PH2023002612

Dr. ANBARASU MOHANRAJ



MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor:

Dr. Anbarasu

Speciality:

Cardiothoracic

Advised Date & Time:

27/12/23 @ 10:44am 11.21 AM

Provisional Diagnosis:

→ Acute chest pain
→ S/P

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):

Medical management

Blood Product Requirement:

☒ No

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

Expected Duration of Stay:

2-3 days

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

Not indicated

Payer:

☐ Self

☒ Insurance

☐ Others:

INSURANCE

Instructions to Nurse (if any):

ward.
→ Admit to semi-private ward.
→ do blood investigations.
purchased by Dr. Anbarasu.

Any other Instructions (if any):

→ to collect Rs. 5000/-

Doctor's Signature

Dr. Anbarasu

Name

Dr. Anbarasu

Reg. No.

Date

27/12/23

Time

10:44am

For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☒ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others 202

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

27/12/23

11:29 AM

27/12/23

11:21 AM

Source: ☒ OPD

☐ ER

☐ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time

[Signature]

Leesett K

MT/0273

27/12/23

11:21 AM



ADMISSION FORM

Marital Status Married	Full Address No 26 / 19 Damayanthi A Apartment Puzhal murugesan street Perambur CH II	Telephone Number 9941398950
Occupation		
Referred from DR Vijaya Kumar Anbarasu mmm	Date of Time of Admission 27/12/23 11:30 AM	Date & Time of Discharge 29/12/23 @ 17:00
Total No. of Days 3 DAYS		
UNIT 1ST FLOOR	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes AR No. :
FINAL DIAGNOSIS		ICD Code
UNSTABLE ANGINA		I20.0
S/P OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS LIMA TO LAD, SVG TO G, & RAMUS INTERMEDIUS (SEQUENTIAL) AND SVG TO PDA DONE ON 25/01/2022. TRIPLE VESSEL DISEASE ACS - IPWMI - THROMBOLYSED WITH INT-TENECTAPLASE (05/01/22). CAD - OLD ACWMI - DIAGONAL DISEASE - ON MEDICAL MANAGEMENT (21/06/23) MILD LV SYSTOLIC DYSFUNCTION EF - 42%		I25.1 / I25.9
TYPE II DIABETES, MELLITUS, HYPERTENSION		I25.2
		I50.1
		E11.9
		I10
DATE	OPERATION / PROCEDURES	ICPM Code
DATE	TYPE OF ANESTHESIA	
	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL	
DISCHARGE STATUS		
<input checked="" type="checkbox"/> Cured	<input type="checkbox"/> Discharge at Request	<input type="checkbox"/> Expired < 48 hours
<input type="checkbox"/> Improved	<input type="checkbox"/> Against Medical Advice	<input type="checkbox"/> Expired > 48 hours
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Absconded	<input type="checkbox"/> Post-Operative Death
<input type="checkbox"/> For	<input type="checkbox"/> Transferred to	
Signature of the Consultant Dr. P. Jayanthi		Signature of Medical Records Officer Dr. P. Jayanthi

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

12/10/23
செவிலியர் கையொப்பம்

Signature of Admitting Nurse

தேதி 27/12/23

Date

K. Lidassir
எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

Daughter

உறவுமுறை

Nature of Relationship



GENERAL CONSENT FOR ADMISSION

I, Kalidass R 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.

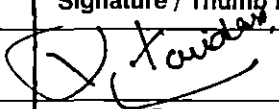
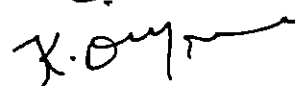
I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.

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.

Handwritten signature/initials

	Signature / Thumb Impression*	Name	Date	Time
Patient		Kalidas t	27/12/23	11:21 AM
Surrogate/Guardian (if applicable #)		Diyyani (Write name and relationship with patient)	27/12/23	11:21 AM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	Devaki	Devaki. K	27/12/23	11:21 AM
Interpreter (if applicable)				

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



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



DISCHARGE SUMMARY

IP No.	: IPH2023002612	D.O.A	: 27/12/2023
UHID	: MHI202371159	D.O.D	: 29/12/2023
Name	: Mr. KALIDASS R	Room No.	: 202
Age / Gender	: 56Years / MALE		
Consultant	: Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead – Cardio Vascular and Thoracic Surgery		

DIAGNOSIS:

UNSTABLE ANGINA

S/P OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD, SVG TO D1 & RAMUS INTERMEDIUS (SEQUENTIAL), AND SVG TO PDA DONE ON 25.01.2022.

TRIPLE VESSEL DISEASE

ACS – IPWMI -THROMBOLYSED WITH INJ. TENECTEPLASE (05/01/2022)

CAD – OLD AWMi – DIAGONAL DISEASE – ON MEDICAL MANAGEMENT (21/06/2021)

MILD LV SYSTOLIC DYSFUNCTION- EF:42%

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

BRIEF HISTORY:

Mr. Kalidass R, 56 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, CAD – Old AWMi - diagonal disease – on medical management – 21.06.2021, ACS – IPWMI – Thrombolysed with Inj. Tenecteplase (05/01/2022), CAG- Triple Vessel disease, S/P Off Pump Coronary Artery Bypass Grafting Surgery (OPCAB) X 4 Grafts: LIMA to LAD, SVG to D1 & RAMUS INTERMEDIUS (sequential), and SVG to PDA on 25.01.2022, Mild LV systolic dysfunction, presented to our hospital with complaints of chest pain, radiating to left shoulder. H/o Burning micturition for past 2 days. He was advised admission for further management. No H/O Breathlessness, Palpitations, Syncope or Swelling of Legs. No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism.

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

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



94457 94457
1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

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

MHI/HOSP/2022/118



Every heart beat counts

NAME : Mr. KALIDASS R UHID : MHI202371159 IPNO : IPN2023602642 (Alliance Healthcare Pvt Ltd)

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP - 98° F
HR - 74bpm
BP - 90/60mmHg
SPO₂ - 98% in room air
CVS - S1S2 (+)
RS - BAE (+)
Abdomen - Soft, BS (+)
CNS - NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	11.9	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
Urea	26	14 - 40	mgs/dl
Creatinine	0.93	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na ⁺)	139	135 - 145	mmol/l
Potassium (K ⁺)	4.30	3.4 - 5.5	mmol/l
HBA1C	7.6	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)	%

ECG: HR – 82bpm, sinus rhythm, ST T changes in inferolateral leads.

ECHO: S/P CABG, EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 148ML, ESV:83ML, EF: 43%, MILDLY DILATED LV, OTHER CHAMBERS NORMAL SIZED, DILATED CORONARY SINUS, REGIONAL WALL MOTION ABNORMALITY PRESENT – SEPTUM, APEX, MID AND APICAL ANTERIOR, BASAL INFERIOR HYPOKINETIC, MILD LV SYSTOLIC DYSFUNCTION, EF: 42%, NORMAL RV SYSTOLIC FUNCTION. RV TDI: 10CM/S, TAPSE: 18MM, SCLEROSSED AORTIC VALVE, OTHER VALVES ARE STRUCTURALLY NORMAL, IAS/IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 14MMHG, MEAN GRADIENT – 7MMHG, TRIVIAL MR, TRIVIAL AR, NO AS, TRIVIAL TR, NO PAH, NO CLOT/ VEGETATION/ EFFUSION. ECTOPICS NOTED DURING STUDY, HR – 66BPM.

TMT: Negative for inducible ischemia.

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

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

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

PATIENT
HELPLINE
94457 94457
1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

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

MHI/HOSP/2022/118



JCI ACCREDITED, NABH ACCREDITED

UHID : MHI202371159

IPNO : IPH2023002612

**Every heart beat counts**

(A Unit of United Alliance Healthcare Pvt Ltd)

COURSE IN THE HOSPITAL:

Mr. Kalidass R, 56 years old male, was admitted with above mentioned complaints. Baseline investigations were done. He was treated with antiplatelets, IV heparin, statin, ARNI, anti hypertensives and other supportive medications. 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 - 68/min BP - 100/70mmHg
SPO2 - 99% in room air

ADVICE MEDICATIONS:

SL. NO.	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. NOVASTAT GOLD (ASPIRIN + ROSUVASTATIN + CLOPIDOGREL)	1 TABLET	75MG/10MG/75MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. MET XL (METOPROLOL SUCCINATE)	1 TABLET	25MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ARNIPIN (SACUBITRIL + VALSARTAN)	1 TABLET	50MG	½	0	½	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. DYTOR PLUS LS (TORSEMIDE + SPIRONOLACTONE)	1 TABLET	10 / 25MG	½	0	0	ORAL	AFTER FOOD	X 6 WEEKS
5	TAB. VERTIN (BETAHISTINE)	1 TABLET	8 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
6	SYP. DUPHALAC (LACTULOSE)		3.335MG / 5ML	0	0	10 ML	ORAL	AFTER FOOD	X 1 WEEK
7	TAB. LEVOCET (LEVOCETIRIZINE)	1 TABLET	5 MG	0	0	1	ORAL	AFTER FOOD	X 3 DAYS
8	TAB. TRIKA (ALPRAZOLAM)	1 TABLET	0.5 MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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

[f @MedwayHospitals](#)
[@medwayhospitals](#)
[in @medway-hospitals](#)
[@medwayhospitals](#)

94457 94457
1800 572 3003
Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)
Heart Institute
 044 - 4310 8959

Institute of Pulmonology
 044-2473 4454

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

MHI/HOSP/2022/118



JCI ACCREDITED NABH ACCREDITED



Every heart beat counts

NAME : Mr. KALIDASS R

UHID : MHI202371159

IPNO : IPH2023002642 (Alliance Healthcare Pvt Ltd)

DIABETIC MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. UDAPA M (DAPAGLIFLOZIN + METFORMIN)	1 TABLET	5MG/ 500MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	HIGH PROTEIN, LOW SALT LOW FAT AND DIABETIC DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	NIL
REVIEW	REVIEW WITH DR. ANBARASUMOHANRAJ AFTER 05/01/2024 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: S.Hari

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

K. Ding
29/12/2023
I have read the Content of the discharge summary

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

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



94457 94457
1800 572 3003

Medway Group of Hospitals

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

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

MHI/HOSP/2022/118



INPATIENT INITIAL ASSESSMENT

Date: 27/12/23

Time of arrival in ward: 11:50 Am

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98 (°F) | Pulse / HR: 74 (beats/min) | BP: 90/60 (mmHg)

Respiration: 20 (breaths/min) | SpO₂: 98 (%) | Height: 171 (cms) | Weight: 80.2 (kgs) | BMI: 27.4 kg/m²

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

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

Duration: _____ Location: Sternum / **(RT) Shoulder**

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

Patient was admitted with Complaints of chest pain for past 3 days & Radiating to **(RT) shoulder**.

No Burning / Irritation for past 2 days.

No H/o Palpitation / chest discomfort / Hematuria

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☒ Yes ☐ No. If Yes, duration: 10 yrs Hypertension: ☒ Yes ☐ No. If Yes, duration: 10 yrs

Others:

CAD - s/p (CABG)

Past Surgical History:

- H/o CABG (OPCAB) x 4 graft (25/1/22)
- H/o **(LT)** side of Neck - Biopsy Done on 2011
- H/o **(RT)** eye Cataract Lx done on 2019.

Present Medication (for Medication Reconciliation):

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	TAB. UDAPA	5/500	p/o	1-0-0	27/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2.	TAB. NOVOSTAR GOLD	20/500	p/o	0-0-1	26/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3.	TAB. MET XL	2mg	p/o	1-0-0	27/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.	TAB. ARNIPIN	50mg	p/o	1/2-0-1/2	27/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5.	TAB. DYTOR PLUS	10/20mg	p/o	1/2-0-0	27/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6.	TAB. VERTIN	8mg	p/o	1-0-0	27/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.	TAB. MPH	750/1mg	1cap	1-0-0	27/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8.	TAB. TRIKA	0.5mg	1tab	0-0-1	26/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.	SYP. DOPHALAX	10ml	p/o	0-0-1	26/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.	TAB. ULTRACET	1tab	p/o	SOS		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Family History:

NO Significant

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:

S₂ (+)

Respiratory System:

BAE (+)

Gastrointestinal System:

Soft, BS (+)

Central Nervous System:

CN FND

Urinary / Reproductive / Locomotor System:

(N)

Skin / Ophthalmic / ENT

(L) eye Cataract (+)

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:

Atypical chest pain / \uparrow dm / SHIN / CAD (S/P-CABG)
/ UT /

Plan of Care:

- Monitor vitals
- Follow drug chart

Investigations Advised:

Urine R/t

Urine C&S

Diet Advice:

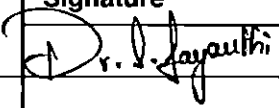
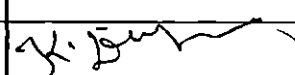
- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☒ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: _____

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

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		DR. R. JAYANTHI	170318	29/12/23	12:05 PM
Consultant					
Patient Attendant		Relationship wife		29/12/23	12:05 PM

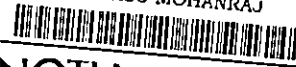


Mr. KALIDASS R

56/Male/MHI202371159


27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ



DOCTOR'S PROGRESS NOTES

DATE	NOTES
27/12/23	CL/B - Dr. Santlargo (DMO)
4:00pm	
	A: CAD / T2DM / HTN /
	S/P - CABG
	Presented. 90 - chest pain, non-radiating
	atypical.
	O/E: conscious, oriented, afebrile.
	S/E:
	U/L: L/S2 ⊕
	I/L: BAEC ⊕
	P/A: soft.
	<u>Advice:</u>
	- Vitals monitoring.
	- Follow up daily
	chest.
	- To do: ECG, ECHO
	LFT
	Eh
	Tracy

DATE	NOTES
27/12/23	S/B Dr. Mohamed Hyder
10pm	Δ: Atypical chest Pain / T2DM / HTN / CAD (s/p CABG) / UTI (2022)
	Patient comfortable
	conscious
	oriented
	afebrile
Vital Stable	CUS → S, R ⊕ N → B ⊕ P/A → S, NT
	ADW
	- Monitor vitals
	- Do follow up chart
	- To do ECG, Tm ECG, LFT
	 (1650)

DOCTOR'S PROGRESS NOTES

DATE	NOTES
28/12/23	orders by Dr. Anbarasu (cardio)
10:00 AM	cto rashes over the face in night - Calamine lotion
	- T. Leucocet 0-0-1
28/12/23	
9:30 PM	SIB - Dr. S. Elango (Dmo)
	A: Atypical chest pain T2DM HTN CAD (S/P CABG) UTI
PR-72/min	O/E: Conscious, oriented, afebrile.
BP-110/70 mmHg	P/E: C/O: S1S2 ⊕ P2: RAET ⊕ P/A: soft.
	Advice: - monitor vitals - Follow up day chart. - Inform SAs

Elango
Internist.

Mr. KALIDASS R

56/Male/MHI202371159

27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM



Diagnosis: CAD / T2DM / SATN / S/P CABG (2022) / TUD / EF-42%

Height: 170cm cms Weight: 80.2 Kgs Food allergies: Yes/No; If yes, specify: None

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


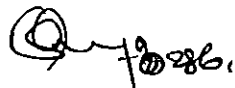
Diet Prescription: 1600 Calorie, low fat, low salt, 2000ml fluid restricted, Diabetic diet

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(A) Patient's related Medical History				
1) Weight Change (overall) change in past 6 months				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/gain	<5%	5-10%	10-15%	>15%
2) Dietary Intake				
Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Oral	No change	Sub-optimal solid diet	Full liquid diet/moderate overall decrease	Hypo-caloric liquid diet
Enteral/Parenteral Nutrition	Adequate/Excessive	Sub-optimal	Inadequate	Starvation
3) Gastrointestinal Symptoms Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No symptoms	Nausea	Vomiting/moderate GI symptoms	Diarrhoea	severe anorexia
4) Functional Capacity (Nutrition related functional impairment) Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
None/Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed/chair-ridden with no or little activity
5) Co-morbidity (Disease and its relationship to nutrition requirements)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Healthy	Mild co-morbidity	Moderate co-morbidity/age >75 years	severe co-morbidity	Very severe multiple co-morbidity
B) Physical examination				
1) Decreased fat stores or loss of subcutaneous fat				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate	Severe	
2) Sign of muscle wasting				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate	Severe	
Total Score = Sum of above 7 components				
Nutritional Status : Based on this patient is				
Well Nourished		<input checked="" type="checkbox"/> (17 to 14)		
Moderately Malnourished		<input type="checkbox"/> (15 to 18)		
Severely Malnourished		<input type="checkbox"/> (19 to 35)		
Nutrition Intervention:				
<input checked="" type="checkbox"/> Oral		<input type="checkbox"/> Enteral <input type="checkbox"/> Parenteral		
Diet counselling provided:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Frequency of re-assessment:		<input type="checkbox"/> Fort-night <input type="checkbox"/> Monthly		
Enteral / Parenteral		Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Dietitian Signature / Name / Date / Time:

0286 27/12/23 / 18:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>27/12/23 18:00</p>	<p>A 56 years old gentleman came T C/O chest pain was assessed to be well-nourished as evident by SGA.</p> <p>IC/C/O - CAD/T2DM/HTN.</p> <p>Educated the patient & family on 1600 calories, low fat, low salt, Diabetic, 2000 ml fluid restricted diet.</p> <p>Emphasized on small frequent meals & low glycaemic control.</p>	<p> 0286</p>
<p>29/12/23 12:00</p>	<p>goal intakes is good.</p> <p>Educated The patient & family on 1600 calories, low fat, low salt, 2000ml fluid restrict, Iron rich, Diabetic diet on <u>discharge</u>.</p> <p>Diet modifications & Clarifications done.</p> <p><u>Diet chart</u> given on <u>discharge</u></p>	<p> 0286</p>



DATE	2-5-12/23		
COLOUR	Pale yellow		
REACTION			
SPECIFIC GRAVITY			
APPEARANCE	clear		
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	2-4		
EPITHELIAL CELLS	1-2		
RBC	Nil		
CASTS	Nil		
CRYSTALS	Nil		
OTHERS	Nil		

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

DIABETIC CHART

Mr. KALIDASS R

56/Male/MHI202371159

27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ



ACTUAL WEIGHT 80.2 kg HbA_{1c} 9.4% (7/3/23)

PREVIOUS DIABETIC MEDICATIONS TAB. UDAPA 5/500mg 1-0-0 (B/F)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
27/12	12:30pm	105 mg/dL	-	ffayorios	Dr. praveen
	7:00pm	149 mg/dL	-	Abus	Dr. Praveen
28/12/23	6:30	106 mg/dL	T. Udapa 5/500mg	M.D.	165mm
	12:30	106 mg/dL	-	M.D.	K.M. (134579)
	18:30	106 mg/dL	-	M.D.	165mm
29/12/23	6:30	108 mg/dL	T. Udapa 5/500mg	glucose 9.5	Dr. Praveen
	12:30	124 mg/dL	-	Refn	Dr. Praveen

INSTRUCTIONS FOR INSULIN INFUSIONS

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

BLOOD GROUP

INVESTIGATION SHEET

Mr.KALIDASS R

56/Male/MHI202371159

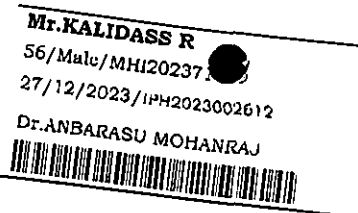
27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ



Date	7/3/23	27/12/23	28/12/23			
HAEMATOLOGY						
Hb	11.9	11.9				
P.C.V						
Platelets						
TLC						
Polymorphs						
Lymphocytes						
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY						
Urea	32	24				
Creatinine	0.82	0.93				
Sodium	139	139				
Potassium	4.32	4.30				
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin			0.45			
D.Bilirubin			0.16			
I.Bilirubin			0.29			
S.G.O.T			16			
S.G.P.T			15			
ALP						
GGT			18			
Total Protien			10.1			
S.Albumin			4.1			
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]



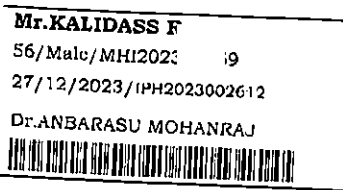
Medway
Heart
Institute

Every heart beat counts

[illegible]



Date	From: 22/12/23	To: 29/12/23	Bed No: 202.	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	250														
OUTPUT	0.00														
Total Intake: 1000ml.		Total Output: 1350ml		Difference: 350ml											
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										
7:00	100					100	6:30	100					100		
9:00	50					150	8:50	100					100		
10:30	100					250	10:30	200					400		
11:15	100					350	12:45	150					500		
12:35	100					450	14:00	300					650		
14:10	100					550	12:10	200					1150		
12:10	100					650	22:00	50					1200		
14:25	150					800	6:35	150					1350		
21:50	100					900									
6:30	100					1000									
							Total Intake : 1000ml								
							Total Output : 1350ml								
							Difference : 350ml								



Medway
Heart
Institute

Every heart beat counts

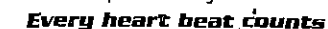
[illegible]



Dr.ANBARASU MOHANRAJ



MHI/IP/2022/074



ON ADMISSION

Weight in Kg.

80.2kgs

Procedure :

[illegible]



EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex: _____

Patient Id No: _____

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



NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 24/12/23 Time of Arrival: 11:50 Mode of Admission: ☒ Walking ☒ Wheelchair ☐ Stretcher

Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: MRS. Delivani

Relationship with Patient: Daughter Contact Person's Name: 9941398950 Relationship: _____

Contact No.: _____ 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 : 4 years Yes If yes specify HTN 1 year 8 / PCABG 1/22

Drugs History : Antiplatelet _____ (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: 74 (beats/min) | BP: 90/60 (mmHg)

Respiration: 20 (breaths/min) | SpO₂: 95 (%) | CBG: 105 (mg/dl) | Height: 171 (cms) | Weight: 80.2 (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: DM diet

Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: MRS. Catherine Time: 12:00

Orient Patient if: ☒ Conscious

Orient Patient Attendant if: ☐ Unconscious ☐ Disoriented

☒ Room ☒ Side Rails ☒ Toilet Bell ☒ Patient Information Board ☐ Bathroom ☐ Bed Controls

☒ Use of Footstool ☒ Grab Bars ☒ Nurses Call Bell ☐ Television ☐ Light Controls ☐ Telephone

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<u>Rt cataract 2019</u>	
Hearing Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Chewing Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Walking Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

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

Pressure Injury Risk Assessment: Braden Scale					
Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	4	Rarely Moist	4	Walks Frequently	4
Slightly Limited	3	Occasionally Moist	3	Walks Occasionally	3
Very Limited	2	Very Moist	2	Chair Fast	2
Completely Limited	1	Constantly Moist	1	Bed Fast	1

Mobility	Score	Nutrition	Score	Friction & Shear	Score
No Limitation	4	Excellent	4	No apparent problem	3
Slightly Limited	3	Adequate	3	Potential Problem	2
Very Limited	2	Probably In-Adequate	2	Problem Present	1
Completely immobile	1	Very Poor	1		

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

Total Score: 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	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
Ambulatory Aid		
None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait		
Normal / Bed Rest / Wheel Chair		0
Weak		10
Impaired		20
Mental Status		
Oriented to own stability		0
Overestimated or forgets limitations		15
Medications		
Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppressant and psychotropics		0
	Yes	15
Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk	Total Score	<u>30</u> <u>Medium</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		<input checked="" type="checkbox"/>	
Patients with intense chronic pain		<input checked="" type="checkbox"/>	
Woman in labour or experiencing termination of pregnancy		<input checked="" type="checkbox"/>	
Patients with emotional or psychological distress		<input checked="" type="checkbox"/>	
Patient suspected of drug or alcohol dependency		<input checked="" type="checkbox"/>	
Victims of abuse and neglect		<input checked="" type="checkbox"/>	
Patients whose immune system is compromised		<input checked="" type="checkbox"/>	
Patient with infections and communicable diseases		<input checked="" type="checkbox"/>	
Does the patient have implants		<input checked="" type="checkbox"/>	
Has tracheotomy been done		<input checked="" type="checkbox"/>	
Has colostomy been done		<input checked="" type="checkbox"/>	
Any other potential needs of the patient		<input checked="" type="checkbox"/>	

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT):

Tick the score obtained (✓)

Final Score

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

Personal Belongings / Valuables:

Valuables	Description	With Patient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant	Remarks
Dentures	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both <input checked="" type="checkbox"/> Nil				
Hearing Aid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Nil				
Eye glasses / Contact lens	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	✓		<i>[Signature]</i>	
Jewellery	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Other valuables (specify)					

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
	<i>[Signature]</i>	Mr. Kalios	SELF	27/12/23	12:00
Nurse	<i>[Signature]</i>	Hannah Grace	0108	27/12/23	12:00
Unit In-Charge	<i>[Signature]</i>	A. ACBIRUS	0088	27/12/23	12:00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 27/12/23

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: ATYPICAL CHEST PAIN

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: -

Day: -

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: -

B

BACKGROUND

Type of surgery: -

Allergies if any: NIK DA

On room air / oxygen: -

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/80 (mmHg) | SpO₂: 98 (%) | Height: 171 (cms) | Weight: 80.2 (kgs) | BMI: 27.4 kg/m²

Others: -

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

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

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: 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	E. Cathrine	E. Cathrine	0207	27/12/23	19:30
Handover taken by	Agastya	Agastya	046	27/12/23	19:30
Document endorsed	Agastya	A. ALBINUS	0088	27/12/23	19:30

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28/12/23

Shifts ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: ATYPICAL CHEST PAIN

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: -

Left: D1

Ryle's Tube: ☐ Yes ☒ No

Day: -

Urinary Catheter: ☐ Yes ☒ No

Day: -

Barrier nursing: ☐ Yes ☒ No

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: -

B

BACKGROUND

Type of surgery: -

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: 97.6 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/70 (mmHg) | SpO₂: 97 (%) | Height: 171 (cms) | Weight: 80.2 (kgs) | BMI: 27.2 kg/m²

Others: -

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

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

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains: -

Diabetic diet

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders: -

Special instructions if any: LFT report due.

	Signature	Name	Emp. No.	Date	Time
Handover given by	M. Ravathi	M. Ravathi	0225	28/12/23	2:36
Handover taken by	F. Cathrine	F. Cathrine	0207	28/12/23	12:30
Document endorsed	A. A. B. N. U. S.	A. A. B. N. U. S.	2085	28/12/23	12:38

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28/12/23

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: ATYPICAL CHEST PAIN

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: - Left: D1

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: -

Date of surgery: -

Allergies if any: NK PA

On room air / oxygen: -

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

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

BP: 110/80 (mmHg) | SpO₂: 98 (%) | Height: 171 (cms) | Weight: 80.8 (kgs) | BMI: 27.2 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>28/12/23</u>	<u>17.30</u>
Handover taken by	<u>R. Sushma</u>	<u>R. Sushma</u>	<u>0201</u>	<u>28/12/23</u>	<u>19.30</u>
Document endorsed	<u>A. ACBINUS</u>	<u>A. ACBINUS</u>	<u>0086</u>	<u>28/12/23</u>	<u>13.30</u>

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:

28/12/23

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: *Atypical chest pain*

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

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

GCS: *15/15*

POD:

Central line days:

VIP Score: *015*

B

BACKGROUND

Type of surgery:

Allergies if any: *NKA*

On room air / oxygen: *RA*

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: *97.4* (F) | Pulse / HR: *82* (beats/min) | Respiration: *18* (breaths/min)

BP: *130/80* (mmHg) | SpO₂: *98%* (%) | Height: *171* (cms) | Weight: *80.2* (kgs) | BMI: *27.2* 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	<i>[Signature]</i>	<i>R. Sushma</i>	<i>0001</i>	<i>28/12/23</i>	<i>7:00</i>
Handover taken by	<i>[Signature]</i>	<i>Janipya</i>	<i>0084</i>	<i>29/12/23</i>	<i>8:00</i>
Document endorsed	<i>[Signature]</i>	<i>A. ALBINUS</i>	<i>0088</i>	<i>29/12/23</i>	<i>10:00</i>

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29/12/23

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: Atypical chest pain

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: NKDD

On room air / oxygen: Room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 98 (%) | Height: 171 (cms) | Weight: 80.1 (kgs) | BMI: 27.2 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>Jeevi</u>	<u>Jeevi Priya</u>	<u>0284</u>	<u>29/12/23</u>	<u>12.00</u>
Handover taken by	<u>M. Revathi</u>	<u>M. Revathi</u>	<u>0225</u>	<u>29/12/23</u>	<u>12.30</u>
Document endorsed	<u>A. ALBINUS</u>	<u>A. ALBINUS</u>	<u>0088</u>	<u>29/12/23</u>	<u>12.45</u>

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29/12/23

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: ATYPICAL CHEST PAIN

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: -

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: -

Date of surgery: -

Allergies if any: NKDA

On room air / oxygen: RA

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 97 (%) | Height: 171 (cms) | Weight: 80.2 (kgs) | BMI: 27.2 kg/m²

Others: -

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

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

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains: -

Diabetic diet

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: Today plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>M.R.</u>	<u>M. Ravathi</u>	<u>0225</u>	<u>29/12/23</u>	<u>14:00</u>
Handover taken by	<u>[Signature]</u>	<u>DISCHARGED</u>	<u>-</u>	<u>-</u>	<u>-</u>
Document endorsed	<u>[Signature]</u>	<u>A. ALBINUS</u>	<u>0088</u>	<u>29/12/23</u>	<u>20:00</u>

NURSES PROGRESS NOTES

[illegible]

ADULT NURSING CARE PLAN

Mr. KALIDASS R
56/Male/MHI202371159
27/12/2023/IPH2023002612
Dr. ANBARASU MOHANRAJ

Initial Date: 27/12/23		Time:		Modified Date:		Time:	
Reason for Modification:				Diagnosis:			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	F pt had normal diet E N pt had on normal diet	L S Sub			
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	F pt on Room air E N pt on room air	Jan Sub			
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	F pt D/O Chart monitored E N monitored 20 Chart	L Sub			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	<p><i>M^E pt mobilized well</i></p> <p>E</p> <p>N <i>H well mobilized</i></p>	<p><i>See 0201.</i></p> <p></p> <p><i>Bus</i></p>
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemeses as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	<p><i>M^E pt Elimination @ Pattern</i></p> <p>E</p> <p>N <i>Pt self voiding</i></p>	<p><i>See 0214.</i></p> <p></p> <p><i>Bus</i></p>
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	<p><i>M^E pt maintain Normal skin integrity.</i></p> <p>E</p> <p>N <i>maintained normal skin</i></p>	<p><i>See 0214.</i></p> <p></p> <p><i>Bus</i></p>

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M pt communication well E N pt good communication	Jan on. Love
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M pt due drugs are given as per chart E N due drug given	Jan on. Love
Endorsed by	Signature	Name	Emp. ID	Date	Time
	dy	A. ALBINOZ	0088	27/12/23	19.45

ADULT NURSING CARE PLAN

Mr. KALIDASS R

56/Male/MHI202371159

27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 28/12/23 Time: 8:00		Modified Date: Time:	
Reason for Modification:		Diagnosis: Atypical Chest Pain	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M DE had DM diet E PT had diet N PT had diet
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M DE is on room air E SpO ₂ - 98% N SpO ₂ 99%
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M I/O chart monitored. E S/O chest assessment maintained N S/O chest maintained

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input checked="" type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M DE good Hys mobilizing	MD
			E Pt mobilized well	MD
			N Pt mobilized well	MD
ELIMINATION <input checked="" type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenc / volume / Hemetemesi as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Normal Elimination Pattern	MD
			E @ 10 min after pattern	MD
			N Elimination Pattern Normal	MD
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Maintain normal skin intact	MD
			E	
			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input checked="" type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M pt good hygiene E pt groomed well N pt groomed well	M.D. 03/28 J. 01/14 J.
SAFETY <input type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV <input type="checkbox"/> CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M ID Band present E ID band (+) N	M.D. 03/28 J. 01/14 J.
COMFORT AND SLEEP <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M E N	
OBSERVATION <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M vitals checked & recorded E vital signs stable N v/s checked	M.D. 03/28 J. 01/14 J. 03/21
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M E N	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M DE good communication E PT communicate well N PT communication well	M. [Signature] [Signature]
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Medication given as per as doctor E N the drugs are given	[Signature] [Signature] [Signature]
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	A. ALBINUS	0088	29/12/23	12-00

ADULT NURSING CARE PLAN

Mr. KALIDASS R

56/Male/MHI202371159

27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 29/12/23 Time:		Modified Date: Time:		
Reason for Modification:		Diagnosis: ATYPICAL CHEST PAIN		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt had DM Diet. E Pt had DM diet N	Seen on. MD 27/23
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on room air. E Pt is on room air N	Seen on. MD 27/23
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Pt I/O chart monitored. E I/O chart monitored N	Seen on. MD 27/23

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt communication well E PE used communication N	Jen on Mdy 05/2
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M pt due drugs are given E - N	Jen on
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Jy.	A. A. BINUS	0088	29/12/23	12-30



MR.KALIDASS R

56/Male/MHI202371159

27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ



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
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions
Completed By : Date <u>27/12/23</u> Time <u>12-30</u>		Nurse Signature : <u>E. Caffo 0207</u>

Learning Record

[illegible]

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

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

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

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

Written Material given and explained (if any)

--

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 : Dilgrani . K Signature : [Signature]

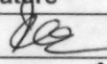
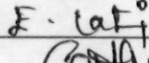
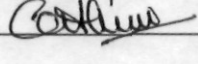
Name of Discharge Nurse Signature :

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 27/12/23 Time: 12.30

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

Inter Disciplinary Team Members

Doctor	Signature	Name	Reg. / Emp. No.	Date	Time
		Dr. Mohamed hydhar	16527	27/12	15.00
Nursing Staff		F. latif		27/12	14.30
Dietician		Maria Catherine John Senior Dietitian	2401	27/12	15.00
Physiotherapist					
Patient Care Service Staff					



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	3	3	3	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	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	22	22	22
					Initial & Emp. No. of Staff Nurse:	[Signatures]		
					Initial & Emp. No. of Sr. Staff Nurse:	0088	008	006

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	9	
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	3	3	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	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	
					Initial & Emp. No. of Staff Nurse:		
					Initial & Emp. No. of Sr. Staff Nurse:		

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



Mr. KALIDASS R
56/Male/MHI202371159
27/12/2023/IPH2023002612
Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/05



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.
25/12/23 12:30	0/10	No pain	-	-	-	Jen on.	Jy 0088
14:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
16:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
18:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
20:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
22:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
24:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
06:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
08:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
10:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
12:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
14:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088
16:00	0/10	NO pain	-	-	-	Jen on.	Jy 0088

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

PAIN SCALES

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



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	A	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	A	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	A	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	A	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	A	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:	AC	2	
					Initial & Emp. No. of Sr. Staff Nurse:	A	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


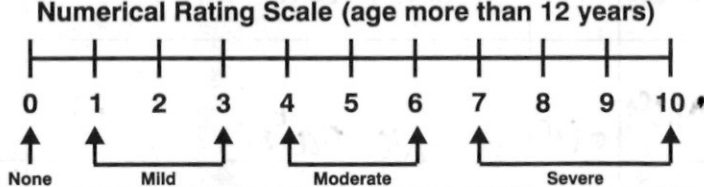


PAIN RE-ASSESSMENT & MONITORING CHART

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	0/10	No pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085
23/12 2.00	0/10	No pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085
6.00	0/10	No pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085
8.00	0/10	No Pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085
10.00	0/10	No Pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085
14.00	0/10	No pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085
18.00	0/10	No pain	—	—	—	Dr. Jey 0261	Dr. Jey 0085

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

PAIN SCALES


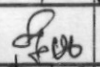




PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention					
CRIS (38 weeks - 2 months)	The CRIS scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. 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/counselling: K - Individual Counseling; L - Family counseling					

Pharmacological Interventions as per doctor's prescription



DVT RISK ASSESSMENT

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

		Date	27/12/23 12:30		28/12/23 7:00		28/12/23 7:00	
		Time	12:30		7:00		7:00	
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0				
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0				
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0				
5	Entire leg swollen (Assess for both legs)	0	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0				
9	Previously documented DVT (Assess for both legs)	0	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESKD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0				
FINAL SCORE		0	0	0				
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		Low	Low	Low				
DVT prophylaxis started		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	27/12	27/12	27/12	28/12	28/12	28/12	29/12	29/12	
		Time	12.30	14.00	20.00	8.00	14.00	20.00	8.00	14.00
History of falling (immediate or within 6 months)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	30	30	50	50	50	50	50	
Low Risk (0 - 24)										
Medium Risk (25 - 44)		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>							
High Risk (45 or above)				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Signature & Emp. No. of RN		Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	
Signature & Emp. No. of Sr. RN		Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	Dr. K. Kalidass R	

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

INTERVENTIONS		Date	27/12	27/12	28/12	28/12	28/12	29/12	29/12		
Tick as per the Risk Score		Time	12.30	2.00	8.00	12.00	2.00	8.00	14.00		
Low Risk Interventions (0 - 24)											
Familiarize the patient with the immediate surroundings			✓	✓	✓	✓	✓	✓	✓		
Remind the patient to use call bell before getting out of bed			✓	✓	✓	✓	✓	✓	✓		
Keep the two side rails in the raised position at all times for all patients regardless of age			✓	✓	✓	✓	✓	✓	✓		
Keep the call bell, bedside table, water, glasses within the patient's easy reach			✓	✓	✓	✓	✓	✓	✓		
Remove excess equipment or furniture to make a clear path			✓	✓	✓	✓	✓	✓	✓		
Keep the patient's bed in the low position at all times except during procedure			✓	✓	✓	✓	✓	✓	✓		
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed			✓	✓	✓	✓	✓	✓	✓		
Bed wheels should be locked			✓	✓	✓	✓	✓	✓	✓		
Encourage family participation in the patient's care			✓	✓	✓	✓	✓	✓	✓		
Ensure that floor of the bathroom is dry and not slippery			✓	✓	✓	✓	✓	✓	✓		
Review medications for potential side effects that can promote falls			✓	✓	✓	✓	✓	✓	✓		
Use safety belts during movement in wheelchair			✓	✓	✓	✓	✓	✓	✓		
The patients are not ambulated by themselves. They are to be ambulated only with assistance			✓	✓	✓	✓	✓	✓	✓		
Medium risk interventions (25 - 44)											
Apply all the low risk interventions			✓	✓	✓	✓	✓	✓	✓		
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher			✓	✓	✓	✓	✓	✓	✓		
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat			✓	✓	✓	✓	✓	✓	✓		
Use restraints and bed monitors as ordered by the doctor			✓	✓	✓	✓	✓	✓	✓		
Allow the patient to ambulate only with assistance			✓	✓	✓	✓	✓	✓	✓		
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care			✓	✓	✓	✓	✓	✓	✓		
Do not leave patients unattended in diagnostic or treatment areas			✓	✓	✓	✓	✓	✓	✓		
Accompany the patient while going to bathroom			✓	✓	✓	✓	✓	✓	✓		
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 (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											



Medway
Heart
Institute

Every heart beat counts

PATIENT NAME : Mr. Kalidoss

IP No. / UHID No

AGE / SEX :

Ward / Bed No. 202

[illegible]



Mr. KALIDASS R

56/Male/MHI202371159

re)

27/12/2023/IPH2023002612

Dr. ANBARASU MOHANRAJ



PSYCHOLOGICAL WELLBEING REPORT

Date: 28/12/23

Time: 11.30 am

Unit: 202B


Clinical diagnosis: Atypical chest pain

Surgery/ Procedure:

Impression: Functioning well

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

Employee ID: MH10278PSY


Signature of the Psychologist:

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

TAB. NOVOSTAT GOLD

Dose

20/75mg

Route

p/o

Frequency

0-0-1

Dr. Sign & Reg. No. / Seal

Dr. L. Jayanthi
170318

Start Date & Time

27/12/23 at 12.00

Stop Date & Time

8:00 pm
21/12/23 at 11:00

Additional Info:

DRUG NAME

TAB. MET XL

Dose

25mg

Route

p/o

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

Dr. L. Jayanthi
170318

Start Date & Time

27/12/23 at 12.50

Stop Date & Time

8:00 am

8:56 9:30
10:00 10:00

Additional Info:

DRUG NAME

TAB. ARNIP IN

Dose

50mg

Route

p/o

Frequency

1/2 0-1/2

Dr. Sign & Reg. No. / Seal

Dr. L. Jayanthi
170318

Start Date & Time

27/12/23 at 12.50

Stop Date & Time

8:00 am

8:58 9:31
9:00 9:00

Additional Info:

DRUG NAME

TAB. DYTOR PLUS

Dose

10/2mg

Route

p/o

Frequency

1/2 0-0

Dr. Sign & Reg. No. / Seal

Dr. L. Jayanthi
170318

Start Date & Time

27/12/23 at 12.00

Stop Date & Time

8:00 am

9:00 9:32
9:00 9:00

Additional Info:

DRUG NAME

TAB. VERTIN

Dose

8mg

Route

p/o

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

Dr. L. Jayanthi
170318

Start Date & Time

27/12/23 at 12.00

Stop Date & Time

8:00 am

9:02
9:00 9:00

Additional Info:

Area In-charge

Nurse Signature:

del
008 008 008Clinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart InstituteClinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

27/12/23

29/11

DRUG NAME

CAP. MPD

Dose

100/15

Route

P/O

Frequency

1-0-0

8 am

3 NA NA

Dr. Sign & Reg. No. / Seal

Dr. Jayanthi 170320

Start Date & Time

27/12/23 at 12:00

Stop Date & Time

Additional Info:

DRUG NAME

TAB. TRIKA

Dose

0.5mg

Route

P/O

Frequency

0-0-1

Dr. Sign & Reg. No. / Seal

Dr. Jayanthi 170320

Start Date & Time

27/12/23 at 12:00

Stop Date & Time

Additional Info:

DRUG NAME

SYP. DUPHALAC

Dose

10ml

Route

P/O

Frequency

0-0-10ml

Dr. Sign & Reg. No. / Seal

Dr. Jayanthi 170320

Start Date & Time

27/12/23 at 12:00

Stop Date & Time

Additional Info:

DRUG NAME

TAB. ULTRACET

Dose

1Tab

Route

P/O

Frequency

(SOS)

Dr. Sign & Reg. No. / Seal

Dr. Jayanthi 170320

Start Date & Time

27/12/23 at 12:00

Stop Date & Time

Additional Info:

DRUG NAME

INT. HEPARIN

Dose

5000 U

Route

I/V

Frequency

1-1-1

6:00 pm

18:15

Dr. Sign & Reg. No. / Seal

Dr. Jayanthi 170320

Start Date & Time

27/12/23 at 12:00

Stop Date & Time

2:00 am

10:00

Additional Info:

Area In-charge

Nurse Signature:

Dr. Jayanthi 170320

Dr. Jayanthi 170320

Dr. Jayanthi 170320

Dr. Jayanthi 170320

Dr. Jayanthi 170320

Dr. Jayanthi 170320

Dr. Jayanthi 170320

Dr. Jayanthi 170320

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
25/12/23	Night	Agastaya	014	J		Night			
28/12/23	Morning	M. Porathy	0225	MP		Morning			
28/12/23	Evening	A. Mond...	0141	A		Evening			
29/12/23	Night	Agastaya	014	J		Night			
29/12/23	Morning	Pavithra	0072	PK		Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			