

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient		
- Name, Age & Sex of Patient		
- General Admission Consent		
- Initial Assessment of Patient / Diagnosis	~	
- Nutritional Assessment by Consultant		
- Plan of care counter signed by the Consultant	5	
- Treatment Orders - Date, Time, Name & Sign.	~	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	~	
- Vital Signs Chart (TPR Chart)	~	
- Intake Output Chart	5	
- 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	7	_



Mr.KALIDASS R

56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd) ADMISSION SLIP
Admitting Doctor: Anthralv Speciality: Coudo thorai C-
Advised Date & Time: 27 12 23 @ 10.44cm 11. 21 m
Provisional Diagnosis:
flymal Clar pair
-> 8 P.
Reason for Admission: Medical Management Surgical Management
Others (please specify details)
Admission Type: Day Care ER Ward
CU (Specify details)
Surgery / Procedure Name (if planned):
forten. C meny court
Blood Product Requirement: 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): Warindiv All Work
Payer: Self Insurance Others:
Instructions to Nurse (if any): Admit i compu'vale
word.
Durebord by De Anderson
Any other Instructions (if any):
-> 10 w/(let \$18. 5000/-
, '
Doctor Signature Name Name Peg No Date 12 Time 1
Doctores Signature Name Reg. No. Date Time 1
2 l. Layouthold

For admission desk staff of	only:		y]
	General Ward		_	
	Single Room			1
	Twin Sharing			ł
	Deluxe Room		, <u>(</u>	
	Suite Room		· •	l
	Others 202			
Admission intimation	Receipt Details	Admission Ti	me in HIS	
Date	Time	Date	Time	
21/12/23	11.29	27/12/23	11'.21 12	j.
	OPD ER Direct			
	requirement specified by the		☐ No	
Front office Staff Signature	Name Land	Emp. No. 1773	Date Time 27/12/m 11'2111	,
				·
-				
	· · · · · · · · · · · · · · · · · · ·		. , .	

Medway Hospitals The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



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

MHI/HOSP/2022/129



ADMISSION FORM

Marital Statu	s Full Address	Telephone Number							
Occupation	No 26 (19 Damayanthi A Part ment 994/398950 Puzhal murugesan street Parambur CH 11								
Referred fro	m Date of Time of Admission Date & Time of Discharge To	tal No. of Days							
r Anbay	Referred from Date of Time of Admission Date & Time of Discharge Total No. of Days Anbarasan mmn 27/12 13 11:3/12 29/12/23@1700 3DAYS								
UNIT 187 FL	MLC Yes To If Yes AR No.:								
	FINAL DIAGNOSIS	ICD Code							
MASTA	ABLE ANGIND	Teo.0							
SIP OFF	PUMP CORDINARY ARTERY BYPASS GRAFTING 16RY (OPCAB) X AGRAFTS, LIMA TO LAD, SUGTOG	(D)							
& RAMU	1 PATERMERIUS (SEQUENTIAL) AND SUB TO PDA	Tos. 1 Pos.9							
ACS IP	ON 25-101/2022 TRIPLE VESSEL DISCHES WITH INT-TENECTAPLASE 22) CAD - OLD AWMT - DIAGNOL DISCHES - ON	Tos. 2							
DYSFU	MANAGENERIT (21/06/23) MILD LY SYSTOUR	750.)							
•	I DIABETES, MELLITUS, HYPERTENASION	E11.9							
		Tio							
DATE	OPERATION / PROCEDURES	ICPM Code							
DATE	TYPE OF ANESTHESIA								
	☐ GENERAL ☐ SPINAL ☐ LOCAL ☐ REGIONAL	☐ EPIDURAL							
	DISCHARGE STATUS	-							
Cured	☐ Discharge at Request☐ ☐ Against Medical Advice☐	Expired < 48 hours							
☐ Improve	Expired > 48 hours								
☐ Unchan	☐ Unchanged ☐ Transferred to ☐ Post-Operative Death								
Signature	of the Consultant Signature of Med	dical Records Officer							

AUTHORISATION FOR TREATMENT I PAYMENT

, (011101)		A HOLEN TO A HOLEN	
I hereby authorise the Administration, Madminister such drugs as may be necessed deemed necessary and / or advisable in who is my (F	sary and to perform such the diagnosis and treatm	operation under anaesthesia or othe	er wise as may be
I hereby under take to settle all the bills basis. In any case, I shall pay all the due	es before getting discharg	·	•
However, in case I fail to pay the charge me/the patient to any other hospital/inst	es due to the hospital as a	greed above, I hereby authorise the t as deemed fit and proper by the he	hospital to transfer
I also acknowledge having been informed and valuables belonging to the patient of next of kin and I absolve the hospital of	or theis attendants have be	d Regulations of the Hospital and the een removed to a place of safety / ha	at all cash, jewellery
l have read out and explained the conte சிகீச்சை, பணம் செலுத்துதல் முதலியவை (_	•	
இதன் மூலமாக நான் நிர்வாகம், மருத்துவம்			
மருந்துகள் கொடுத்து செய்முறைகள்/அறுச செலவுக்கன தொகை முழுவதும் செலுத்த இ	றவ சிகீச்சை செய்யவும் அ <u>த</u> ி	காரம் வழங்குகிறேன். நான் / இதில் குற	
மேல் கூறியது போல் வேளை நான் தங்கம மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை அளிக்கிறேன்.	_, _ , , , , ,	• • • • • • • • • • • • • • • • • • • •	
் மருத்துவமனையின் பொது சட்ட தீட்டங்கள்	பற்றி தெரிவிக்கிப்பட்டிருக்கி	றேன்.	
நோயானிக்கு உரிமையான எல்லா பணம், ந நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள் என உறுதி செய்கிறேன்.			
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரி	க்கப்பட்ட பிறகுதான் கையெ	ாப்பமிட்டேன். -	
ടെങ്ങിலിயர் തகயொ: பம்	ess 27/12/2	த ஆ. இரி 7 எனது/உறவினர்/காப்பாளர்	கையொப்பம்
Signature of Admitting Nurse	Date	Signature of the Patient /	√ 1

உறவுமுறை

Nature of Relationship



discharge.





Patient Netails (Affix Lahol horo)

Mr.KALIDASS R

56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





GENERAL CONSENT FOR ADMISSION

I,
(please tick the correct option above and below)
☐ Read
Been explained this consent form in English, which I fully understand.
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.
is local to define and to define an additional floodboary by the floating account team.
Jalso consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor/ team.
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 !
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

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

	Signature / Thumb Impression*	Name	Date	Time	
Patient	Nous and Impression	Kalidasst	27/12/23	11:2)1	
Surrogate/Guardian (if applicable #)	x.oup	Dilyvan; (Write name and relationship with patient)	27/11/29	11.24	
Reason for surrogate consent	Patient is unable to give consent t	because:	•		
Witness	Devaki	Deraki. K	27/12/23	11:21	
Interpreter (if applicable)				i i	

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









Everu 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

🕇 @MedwayHospitals

(C) @medwayhospitals

medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam 044-2473 4455

Mogappair 044-26530011

Kumbakonam 044-2473 4455

Chengalpattu 044-27426829

Villupuram 04146-242000

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

IPNO: IRAIQ02900264中Alliance Healthcare Pvt Ltd)

NAME: Mr. KALIDASS R

UHID: MHI202371159

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	gms%		
		Female: 11.2 - 15.7			
Urea	26	14 - 40	mgs/dl		
Creatinine	0.93	Male: 0.7 - 1.2	mgs/dl		
		Female: 0.5 - 1.0			
		Child: 0.2 - 0.8			
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			
l	<u></u>	Sugar control for the past (3 month	ns)		

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, SCLEROSED 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, Un	94457 94457			
f @MedwayHospitals	(i) @medwayhospitals	in @medway-hospitals	@medwayhospitals	94457 94457 1800 572 3003
Medway Group of Hospitals			Medway Centre of E	xcellence (Chennai)

nnai)

Kodambakkam Kumhakonam Chengalpattu Villupuram Mogappair Heart Institute Institute of Pulmonology 044-2473 4455 044-26530011 044-2473 4455 044-27426829 04146-242000 044 - 4310 8959 044-2473 4454

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



UHID: MHI202371159



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	NAME OF THE DRUGS	CERENCEL	DOSA GE	FRE	QUEN	CY	ROUT	RELATIONSHI	DUDATION
NO.	WITH GENERIC NAME	STRENGTH	DOSAGE	М	A	N	E	P WITH MEAL	DURATION
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	I	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ARNIPIN (SACUBITRIL + VALSARTAN)	1 TABLET	50MG	1/2	0	1/2	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. DYTOR PLUS LS (TORSEMIDE + SPIRONOLACTONE)	I TABLET,	10 · /25MG	1/2	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 I 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

★ @MedwayHospitals

(O) @medwayhospitals

@medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam Mogappair 044-2473 4455 044-26530011

Kumbakonam

Chengalpattu 044-2473 4455 | 044-27426829 |

Villupuram 04146-242000

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454

MHI/HOSP/2022/118

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





Every heart beat counts IPNO: IRA 2002 3600 6402 Alliance Healthcare Pvt Ltd)

' NAME : Mr. KALIDASS R

UHID: MHI202371159

DIABETIC MEDICATIONS:

S1.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FRE	FREQUENCY		ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME			M	A	N		WITH MEAL	
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 WITH				
REVIEW	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

កន្លែងនៅក្នុង និមាយប្រហ

Dr. ANBARASU MOHANRAJ Reg. No: 55476

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

₱ @MedwayHospitals

Kodambakkam

044-2473 4455

@medwayhospitals

medway-hospitals

medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Kumbakonam

Medway Centre of Excellence (Chennai) **Heart Institute**

Institute of Pulmonology

Mogappair

044-26530011

044-2473 4455 044-27426829

Villupuram 04146-242000

044 - 4310 8959 044-2473 4454

Chengalpattu





Mr.KALIDASS R

56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.Anbarasu mohanraj



Every heart beat counts

INPATIENT INITIAL ASSESSMENT

INPAILENT INITIAL ASSESSIVIENT
Date: at la 25 Time of arrival in ward: 11:50 Am
Allergies (if Yes, specify details):
Drugs ☐ Yes ☐ Mb
Blood Transfusion
Food Yes No
Others
Vital Signs: Temp: 98 (°F) Pulse / HR: 中 (beats/min) BP: 9060 (mmHg) Respiration: 如 (breaths/min) SpO ₂ : 98 (%) Height: 社 (cms) Weight: 图 2(kgs) BMI: 2千4 以
Pain: Yes No. If Yes, Score: Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location: Standard Referred / Radiant Pain 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 Pat 3 days & Jadialing to Rt shoulder. Pat Burning Hickorition for past & days. No Ho Palpitation that discomfort Herralium PAST MEDICAL HISTORY (with duration of illness): Diabetes Mellitus: Pres No. If Yes, duration: 1785 Hypertension: Pres No. If Yes, duration: 1785
Others: CAD — 2/p (CAB6)
Past Surgical History: Ho CABG (OPCAB) X 4 graffs (25/1/22) Ho CABG (OPCAB) X 4 graffs (25/1/22)

Dro	sent Medication (for Medication R	econoilia	etion):		<u>. </u>	
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1,	TAB. UDAPA	5/500	ρlo	1-00	27/12/23	☐ Yes ☐ No
ર	Tab. Novastat Gold	,	y Plo	400	26/12/23	Yes □ No
3.	TAB. HETXL	amu	plo	100	27/12/23	Yes □ No
ųζ	TAB. ARNIPIN	50ma	Plo	1/2-0-1/2	27/12/23	√⊒Yes □ No
5	TAB. DYTOR PLUS	10/25	plo	1/2-00	27/12/23	4⊒Yes □ No
6.	TAB. VERTIN	8mg	Plo	100	27/12/23	Yes □ No
٧,	CAP. HPH	-150/1m	lcap	100	21/12/23	∟⊒Yes □ No
8.	TAB. TRIKA	0.2018	Itab	00 f	26/12/23	└
9,	Syp. Duphala	1011	plo	0-0-7	26/12/23	¹⊟ Yes □ No
מי	TAB . ULTRACET	1703	plo	202	, - 	☐ Yes ☐ No
Personal / Social History (Tick whichever is applicable) Lifestyle: Sedentary Cocupation:						
	oking: ☐ Yes ြ\No Alcohol: ers:	: ∐ Yes Ľ	 ⊼\u0		ll Drug Use: ☐ Yes ☐	NO .
Menstrual and Obstetric History (to be filled up for female patients):						
	neral Physical Examination or: ☐ Yes ☐ No lcte		es □.No	÷	Clubbing: ☐ Yes	
	,			Yes □ No		_
	-			•		

SYSTEMIC EXAMINATION
·cvs: '
S, S, (4)
Respiratory System:
BAE G)
Gastrointestinal System:
loft, Bs (7)
Central Nervous System:
en fn D
Urinary / Reproductive / Locomotor System:
Skin / Opthalmic / ENT Eye Calaual (2)
Suspected of contagious disease: Yes No Immuno compromised status: Yes No Isolation required: Yes No, if yes, Contact Airborne Droplet
Psychological Evaluation: 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 fdm / SHTM CAN (S/p-CABE
Plan of Care: Henifor vitaly
- Follow drug chart

Investigations Advised:			~		
Unine CES					
- Unine CES					i
		·			
Diet Advice:					j
☐ Nil per Oral ☐ Clear liquid diet │	■ Normal liquid	l diet	□ Diabetic	liquid diet	
☐ Semisolid diet ☐ Soft solid diet ☐	South Indian	normal diet	☐ North Inc	dian normal d	diet
☐ Neutropenic liquid diet ☐ Others:					- 1
Early Discharge Planning (fill in those which are a	appropriate at this	stage):	PFE: Pe	atient Family	Education
Special support needed at home	☐ Yes ☐ Nø	If Yes, PF	E done		
Home equipment anticipated	☐ Yes ☐ Nø	If Yes, PFE done and equipment advised			sed
Physiotherapy at home anticipated	☐ Yes ☐ No	If Yes, edu	ucated on phys	ical limitation	ns, if any
Wound care needs anticipated at home	□ Yes ☑ No	If Yes, edu	ucated on signs	on infection	
Pain Management	□Yes□No	If Yes, PFE done and medication advised			sed
Special Dietary needs	☐ Yes ☐ No		ucated on dieta actions and alle		s, food
Continuous / ongoing care anticipated	□ Yes □ No	If Yes, edu	ucated on vario	us aspects o	fongoing
Other special education need, i.e.:	☐ Yes ☐ No	If Yes, PFI	∃ done		
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed	□Yes□N6	If Yes, spe	ecific education	given	
Others:		•	·		
	•				
					İ
Signature	Name		Reg. No.	Date	Time
Resident Doctor	DR. Q. JAY	HTMA	1-10318	24/223	12:05 Pm
Consultant				17	
Patient Attendant	Relationship	· 		25/2/20	10-07







MHI/IP/2022/041

Medway

Yeart

nstitute

t beat counts

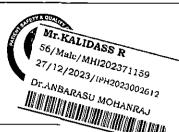
Dr.Anbarasu mohanraj

<u> </u>	
	DOCTOR'S PROGRESS NOTES
DATE	NOTES
Q7/12/23	cli/B-12r.sistlango (Dno)
4:00pm	
, ,	A: CAD SZDM [SHTN].
	S/P- CABG
_	
	1st reviewed. 40- thest pain, man-molauti;
	provinced. 90- chast pain, non-rudiulij argpiral Et.
	P/E: conciou, oriental, apporte.
	€/e;
	CAI: CIS2 (F)
	MI: CILLA
	P/a: soft.
· 	, · · · · · · · · · · · · · · · · · · ·
	Adyne 1
	- Vitals movietoring.
	- Follow up duy chart. - To do: Ecq, ECHO
•	charsts.
	- To do: ECG, ECHO
	LFT .
	Eh ?
	<u> </u>

DATE	NOTES
	C)2 D 00 9 11.1
27/12/23	5)& Dr. Mhaned Hydros
10pm	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	(Atypical wheat Pain) T2Dm 1 HTN) CAD (S/P CABA) 1 UTT
	(2022)
	Patient Combordable
	Patient Comfortable Connin awanted Hebrile
	amented
	Han Hebule
	CUS-> Si SiD
	CUS-SISTED P/A-> Soft, NT
	P/A>Syt, NT
	8 du
	- Momber Waly
,	- Momber Waly - No-fellen ang Chard - To do Soss, Tm7 8000000000000000000000000000000000000
	- To do 600, Tm7
	gozano, LFJ
	Oder
	(LASTO)







MHI/IP/2022/041

Medway
Heart
Institute

(A Unit of United Alliance Healthcare Pvt Ltd)	CTOR'S PROGRESS NOTES	eart beat counts
DO	CTOR'S PROGRESS NOTES	
DATE *	NOTES	
08/12/23	orders by Dr. Anbarasu	(cardio)
10.00 Pm CO	odshes own the faces	2 1 - 1 - 2
in nie	- Culanti,	ve hotion
	T. Lewocot	0-0-1
7/81 1		
Killing		
1340		
20 120108		
28 12 2	1/13 - Dr. Snº Elango DM	0)
q:30pm		
Δ:	Alypsial chee's point (T2D)	
2) 1000	CAP (SIP CARG)	UTI
2 mi		1
12 - 1/0 / m th = 0/E;	concurry prentil, afebri	le.
S/E.	COS: C162 (2)	
	PI, RAED	
	Plancoch	Adora.
		
		wo down should
	- Inton	up day have.

Elizary.





Department of Dietetics



Every heart beat counts

Mr.KALIDASS R

56/Male/MH1202371159

27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ

NUTRITION ASSESSMENT AND CARE PLAN FORM Diagnosis: Weight: 80.2 Height:....cmsKgs Food allergies: Yes/ No; if Yes, specify...... tom Religious Beliefs: 🔲 Vegetarian Non Vegetarian Eggetarian. ☐ Jain Diet Prescription: 1600 Calorer es, Lous Fat Low N NOUTH SUBJECTIVE GLOBAL ASSESSMENT (ADULTS) biobetic wet Patient's related Medical History 1) Weight Change (overall change in past 6 months) 网 Пз 1 1 2 □4 TT 5 >15% No weight change/ 5, 10% ومناومة أجراز galn' 2) Dietary Intake Durations □ ₂, □ 3 Full liquid diet/ Hypo - caloric liquid diet Starvatio Oral No change Sub - cottmal moderate solid diet overall decrease Enteral / Adequate / Sub - optimal Inadequate Typo - caloric feeds Starvation Parentera Excessive Nutrition Gastrointestinal Symptoms Duration: 3) 石, □ 2 ď No symptoms Naires Vomiting/ Diarrhoga Karoné ateval moderate GI Functional Capacity (Nutrition related functional impairment) Duration: . 11 Ø 1 **4** □ 3 □ シ ՝ Light activ Bed / chair -_rambulation ,] ridden with no. or little activity Co - morbidity (Disease and its relationship to nutrition requirements) r □ 5 704 П 2 Healthy Moderate co -Mild co severe co-Very severe morbidity morbidity/age multiple co -morbidity >75 years Decreased fat stores on loss of subcutaneous fat 1) 12 1 □ 2 □ 3 **4** □ 5 Modérate . Normal Mild Severe 2] Sign of muscle wasting ø. □ 3 **□**4 **5** Mild Moderate Normal Severe Total Score = Sum f above 7 components Nutritional Status: Based on this patient is (17 to 14) Moderately Mainourished ☐ (15 to 18) Severely Malnourished (19 to 35)

Dietitian Signature / Name / Date / Time: 27/12/23/18:00

🗖 Fort - night

Parenteral

I□ Yes

☐ Monthly

216

☐ Enteral

□ No

c oni

Dyes.

⊘πeekly

☐ Dally

Diet counselling provided:

Enteral / Parenteral

Frequency of re-assessment:

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
27/12/23	N 56 years old gentlemen came T Clo chest pain was assessed to be well-nourished as evident by SQA.	
	Educated the patient & familyon 1600 calories, Low Fat, Low salt, Diabetic, of 2000 me fluid restriction diet. Emphasized on Small prequent meals & Low glycenic control.	eu -
29/12/23	Educated The patient of parnily on 1600 calorsies, Low Fact, Low Salt, 2000ml pluid 9000 From sich, Diabatic diet on dis Diet modifications of Charlications done. Diet canant given on discharge	Dasa 2
<u>-</u>		

Ź





Mr.KALIDASS R

56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.Anbarasu mohanraj

URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

DATE	3 = 12/23	
COLOUR	Pale yellow	
REACTION		
SPECIFIC GRAVITY		
APPEARANCE	Cleur	
ALBUMIN		
SUGAR		
ACETONE		
BILE SALT		
BILE PIGMENT		
UROBILINOGEN		
PUS CELLS	2-4	
EPITHELIAL CELLS	1-2	
RBC	Wil	-
CASTS	Hil	
CRYSTALS	Lil.	
OTHERS	110	
		_

MICROBIOLOGY-CULTURE REPORTS

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







Every heart beat counts

Mr.KALIDASS R

56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.Anbarasu mohanraj

MINIMARASU MOHANRAJ

DIABETIC CHART

ACTUAL WE	EIGHT	80.2 kg HbA,c	7.41/. (7/3	23)	TO KRIPT BELLEVILLE KOLET ERIN SET
PREVIOUS	DIABETIC N	MEDICATIONS TAB. L	DAPA 5/500Mg !	-0-0 (B/F)	······
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
27/12	12:30pm	105 mg/dL	-	How 10105	Dr. praveeur
1	7 opp	ug moldl	*	Au	Dr. Prayeon.
28/12/23	6, 30	10 6 mg/d	T. Udapa 5/50	en Holy	100 165m
	12-30	iobmaldl.		My	K. 124509
	18.30	106 mg/d1		Solh	Daniera
29/12/23	g.30	103 mgldl	T- udapa 5/500	given of 7's	Dr. Pravo
	12.30	124 mg/dl	1(Alln	DR-Peacon
	-	~~ <i>y</i> :			
					
		4			

INSTRUCTIONS FOR INSULIN INFUSIONS

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



BLOOD GROUP

CK - M.B. MASS

LDH Ntpro bnp





Every heart beat counts

Mr.KALIDASS R

56/Male/MHI202371159 27/12/2023/IPH2023002612

	INVE	ESTIGATION SHEET		·	Dr.ANBARASU MOHAI	
Date	7/3/23	22/10/23	28/12/23			
HAEMATOLOGY						
Hb	11.9	11.9				
P.C.V				<u> </u>	_	
Platelets						
TLC						
Polymorphs						
Lymphocytes						
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY)			
Urea	<u> 3</u> 2	24				
Creatinine	0.82	0-93				
Sodium	139	139				
Potassium	4.32	4.30				
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT			_			
T.Bilirubin	@		20.0			
D.Bilirubin			0.16			
I.Bilirubin			0.29			
S.G.O.T			16			
S.G.P.T			. 15			
ALP			•			
GGT			8			
Total Protien			(육 년 .)			
S.Albumin			41			
CARDIAC ENZYMES						
Troponin I						
CKNAC " CBK						

	- A	1		<u> </u>		4 1,
Date	7/3/23					L
COAGULATION						
PT / INR				_		
Fibrinogen						
D Dimer	-					
LIPID PROFILE						
Total Cholesterol	89					
Triglyceride	60					-
H.D.L	\ \frac{1}{2} \cdots					-
L.D.L	28 49 12					-
VLDV	12					
THYROID FUNCTION	ια			_		<u> </u>
T.S.H						
		-				
T.3		-		<u> </u>		<u> </u>
T.4						
SEROLORY			<u> </u>			
HIV						<u> </u>
HBsAg		ļ	<u> </u>			
V.D.R.L						
COVID 19			<u>_</u>			
RT- PCR						
lgM	-					
lg						
HBA1C	74	7776				
FBS/PPBS				-		
RBS		<u> </u>		-		
S.AMYLASE						
S.LIPASE					-	,
C.R.P			_			
PROCALCITONIN						
DDIMER						
S.Osmolality		-				
URINE						
Osmolality					<u> </u>	-
Spot - Na				-		
		<u> </u>			<u> </u>	
		-				-
						<u> </u>
		 			 -	
		1	<u>-</u>			
		ļ				
		<u> </u>				
		ļ				
	·	<u> </u>				
		L				
		<u> </u>				
						<u> </u>









Date	Fre	om: 25ff1	elas To	0:28/12/	es Be	ed No: გე	⊳ २						VE 0	OUT	DIIT
24 Hı	's : S	tarted Tim	e: 2,'00		Ended T	ime : ⊯	_G@ <u>/</u> _					INTA			PUI
NPO	Start	ed at :			NF	O Over	at :					_	CHA	KI	
SHIF	_		Morning		After	noon			Nigh	t		Rest	ricted F	luid (R	.F)
INTA	KE				For m				<u> </u>	<u> 18100</u>					
OUT	<u> 20T </u>		_		con m				کے	pomi.					
Total	Intake	: 1200			Total Outpo	ut: 01	ואטכ			Differen		<u>ooml _</u>			
			INTAKE							ַסט	PUT	<u>(mi)</u> _			-
Time	Oral	Tube		nous Infus		1662	Tìme	Urine	Vomitus	N/G	Drain	Others	Total	R/N Sign	Endorsed
		Feeding	Type of Fluid	Addition	s Amount	L	Tune	Offic	Voinitus	Aspirate	Tube	Others	UCAED ,	. Gir O.gir	by
850	200	n		<u> </u>	_	200	18.45	300					200		
_	200		<u></u>	<u> </u>		Bo	l6-egn	2000					<u> </u>		
•	a ನಿರಾ					Fro	22.30	उ०६					\$00		
مور. م	150					350	a, to	900					1000		_
1.35	ರೊಂ					0000									\ \ \
4,10	50					100			fota	1 Inte	lbs	- (%	o my		bob
30						1200				ના ગ	HOU	nb	oml		
_		1		 			<u> </u>			Balar	,	200			
		•												of the	
				1											
			<u> </u>	<u> </u>									P.4		
			 	 											
			†	 								 			
			 	 	 				<u> </u>			 			



C1 00

OUTPUT

Mr.KALIDASL ... 56/Malc/MH1202371159 27/12/2023/IPH2023002612 Dr.anbarasu mohanraj







Date From: 22/12/23 To	29/12/28 Bed No: 10d.	INTAKE & OUTDUT
24 Hrs : Started Time : ರ ೧೮೦	Ended Time: 4.00	INTAKE & OUTPUT
NDO Started at :	NIDO Over et :	CHART

NPO Started at : NPO Over at: SHIFT Morning Night Restricted Fluid (RF) Afternoon INTAKE

Total	Intake:		loooml.	т [Total Outpเ	it: 1350	เมไ			Differen	ce: <u>3</u>	somy		_	
		_	INTAKE	(ml)						OU	[PUT	(ml)			
Time	Oral	Tube Feeding	Intraver Type of Fluid	ous Infusions		िंखी	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fidia	Additions	Amount					Aspirate	Tube		*		
100	100					100	6.30	LOO					100	_	
9.00	50	ı				RTO	8.50	100					106		
1030	100					250	10-30	200					400	_	
11, 12	100					350	12,45	120					512	•	4
12.35	Oat					450	U,VD	30°					25		9) 10081
10,40	(DD)					550	12110	वेठ० व					1150		
15.10	100					4 10	22-00	Ŋ					1200	-	
lal. 372	17,00					700	6 35	110) <u>5</u> 20		
21.30	.lo0	•				900									
B . 30	် <u>လ</u>					[000]			to 1	el A	1 talle	, ,	00010		
									fot		mand_		10.00		
									B	scrienza			-	Z BUB	
									Ì						
				<u> </u>											



Mr.KALIDASS F 56/Malc/MHi2023 9

27/12/2023/IPH2023002612









Date	Fro	om: <i>₫</i> @	112/29 To	عادا العدد:	مِ Be	ed No: હ્ર	b		•			INITA	VE 0	OUT	DUT
24 Hr	's : S	tarted Time			Ended T							INIA	KE &		PUI
NPO	Start	ed at:	_		NP	O Over a	at:						CHA	IKI	
SHIF	T	<u> </u>	Morning		Aftern	noon			Nigh	t		Rest	ricted F	luid (R	F)
INTA	KE		530				-		-						_
OUT	?UT		700												
Total	Intake	<u>:</u>		7	Total Outpu	ıt:				Differen	ce:				
			INTAKE	<u> </u>						OUT	PUT		,		
Time	Oral	Tube Feeding	Intraver Type of Fluid	Additions		්ල්ක් ,	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	िश्ची	R/N Sign	Endorsed by
I.45-	150)				150	8,20	300					3500		
833	50		<u> </u>			کسی	11-20	400		<u> </u>		ļ	700		
9-30 ·	ಲಲ					400									
-20	l.					صاک								X-	
11-45	ľ					550								00%	
															Non
		<u></u>		<u> </u>						_					
									_						



(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.KALIDASS R

56/Male/MHI202371159

27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ



VITAL INFORMATION SHEET

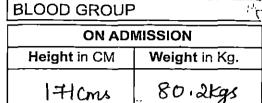
MHI/IP/2022/074

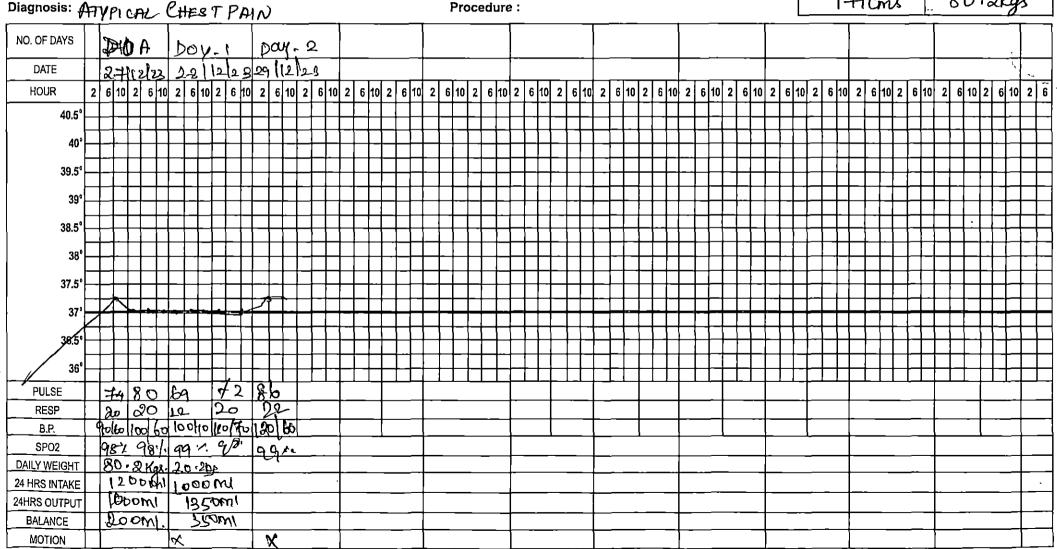
Medway

Heart

Institute

Every heart beat counts







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

Mr.KALIDASS R

56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name:	DATE	2 Hed	2/10	10	1100	2 /19	/Sex:_	_	_	- 1.	110	Id No:		
1 2 3		1182	2210	231 11	12	2581	non	98112	28/12	28/12	291	50/15		DATE
	TIME	12:0	16.00	20:00	240	4.00	10.00	14.00	28/12	22.00	200	6.00		TIME
‡B	>25							3						>25
spirations	21-24							2						21-24
eath/ min	18-20													18-20
	15-17	-0-	-	-	-		0	-		,	-	_		15-17
	12-14													12-14
1 1900000000000000000000000000000000000	9-11							1						9-11
	<8					2-5-10-1		3				THE REAL PROPERTY.		<8
В	>96	- 0	-	,	-		-	-	-		-			>96
o2 Scale 1	94-95							1						94-95
ygen Saturation (%)	92-93							2						92-93
2 1 2	<91													<91
o2 scale 2 oxygen turation (%) use scale 2 larget range is 88-92 % tin hypercapnic spiratory failure only	>96 on oxygen							,						>96 on oxygen
scale 2 under the	95-96 on o2							2						95-96 on o2
ection of qualified	93-94 on O2							1		THE REAL PROPERTY.			TARGE BY	93-94 on O2
nician	>93 on air													>93 on air
	88-92													88-92
	86-87							1						86-87
	84-85							2						84-85
	<83%	A 23/25						3						<83%
r or Oxygen ?	A= Air	-		,		_	-	-	-		*			A= Air
The Contract of	O2litre/ min							2					The same of the same of	O2litre/ min
	Device													Device
ood Pressure	>220							1						>220
	201-219													201-219
	181-200							2						181-200
	161-180													161-180
	141-160													141-160
	121-140													121-140
	111-120							1	7		- 0			111-120
	91-100	-	-	,	-	-3	-6	1						91-100
	81-90							2						81-90
	71-80							3						71-80
	61-70							3						61-70
	51-60							3						51-60
	<50							3						<50
stolic BP	mmHg	60	NO!	20	90	70	78	78	82	71	29	28		mmHg
	>131							3						>131
se	121-130				10.686			2						121-130
its / min	111-120							2						111-120
	101-110							1						101-110
	91-100							1						91-100
	81-90													81-90
	71-80	-	*	,	6	-	*	*		1	- 2			71-80
	61-70													61-70
	51-60													51-60
	41-50							1						41-50
	31-40							3						31-40
	<30			1000		10000		3	500 A		42 15 32	1-1-20		<30
	Alert	-0		-	4	-	0	-	-	-	•	-		Alert
sciousness	Confusion							3					2000	Confusion
re for New onset of	V							3						V
fusion	Р	1000						3						P
score if chronic)	U	2000	145.23	29.8	100	25 75	10000	3	2 2 40			Mary Mary		U
	>39.1 degree Celsius							2						>39.1 degree Celsius
mperature	38.1-39.0							1						38.1-39.0
gree Celsius	37.1-38.0													37.1-38.0
	36.1-37.0	-0	,			-	6	_	-	1	-	ý		36.1-37.0
	35.1-36.0							1						35.1-36.0
	< 35.0		STEEL ST	No. of	THE REAL PROPERTY.	NO SERVICE		3	E39639		1000	THE REAL PROPERTY.	THE RESERVE	< 35.0
WS Total		0	do	0	0	10	1	•	1	0	0	0		
CONTRACTOR OF THE PARTY OF THE		AH	Athi	8h	4th	410	41	Ath	ATA	100	HA	No		
nitoring Frequency				44		-		771	1111	100		100		-
nitoring Frequency alation of Care Y/N		NO	100	MOD	ND	MON	00 1	NO	NO	MODE	MADO	NOTO		
		NO	NO.	1900	NO	ror	40	5.6	500	MOD	M00	1200		

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





Mr.KALIDASS R

56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





NURSING ADMISSION ASSESSMENT (ADULT)

Daily Activity Of Li	ving:	et en					i.	
Activity	Independe	ent	As	ssisted		Dep	endent	2
Bathing			PRIVATE NAMED IN		alliana de la casa			
Dressing			April 19 (19)					
Eating				n			П	
Walking				H			$\overline{\Box}$	-
Toilet Use			<u> </u>	H				
	als Assessments Bross	les Ceele	A 1000 A			Lie S		
	sk Assessment: Brad			-	D	A - 4114		0
Sensory Percept	ion Score	Moisture		Score	Degree of		-	Score
No Impairment	4	Rarely Moist	Maiet	4	Walks Fred Walks Occ		1	- 4
Slightly Limited	3	Occasionally Very Moist	MOIST	3 2	Chair Fast		-	2
Very Limited	2	Constantly M	oiet	1	Bed Fast		-	1
Completely Limite		-	Oist				-	
Mobility	Score	Nutrition		Score	Friction &			Score
No Limitation	A	Excellent		A	No appare		em	3
Slightly Limited	3	Adequate		3	Potential P		-	2
Very Limited	2	Probably In-A	Adequate	2	Problem P	resent		1
Completely immo	bile 1	Very Poor		1	San San San San	<u> Santana a de la como /u>		
If yes, Location: Witnessed by:								
	MODIFIED MORS	E FALL ASSES	SMENT SCA	ALE (Age a	bove 16 year	rs)		
Fall Risk Assess	ment (Modified Mors	se Scale):		3.1	-		·	
Variables				N		. 1	Nume	ric Value
Liston, of folling /	immediate or within 6	months)			~	No		0
nistory of failing (immediate or within 6	months)				Yes		25
Socondany diagno	osis (≥ 2 medical diag	anocie)				No		0
Secondary diagno	osis (2 2 medicai dia(griosis)			1	Yes	1 40	15
Ambulatory Aid					V	_		
None / Bed Rest /					~			0
Crutches / Cane /	Walker							15
Furniture								30
Intravenous Thera	apy / Heparin Lock / T	ubes Insitu				No		0
		-				Yes		20
Gait	. / \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
Normal / Bed Res Weak	st / Wheel Chair			N HORE IN	V			10
Impaired				-1.		\vdash		20
						\vdash		
Mental Status Oriented to own s	tability							
	forgets limitations							0 15
	goto iiriitationo			+			21	10
Medications Includes PCA / or	piates, anticonvulsants	anti-hypertens	ives diuretic	s hypnotic	es.	No		0
	cemics, sedatives, im				,	Yes	}	15
	: 0-24: Low-risk; 25-44: I				Total Score			
Score interpretation:	0-24. LOW-118K, 25-44. 1	Mediuiii Hisk, ADO	ve 45. nigri Ri	SA.	iotal Score	30	Modi	UIT

As per the score, tick the following appropriate	boxes:		ng a rigiga/A
Low Risk Interventions (0 - 24)			- 671.2kg
Eamiliarize the patient with the immediate surrounding	S		The second of the second
Remind the patient to use call bell before getting out of			
Reep the two side rails in the raised position at all times	for all patients	regardless of age	The section of the se
Keep the call bell, bedside table, water, glasses within t			
Remove excess equipment or furniture to make a clear			Sales Maria
Keep the patient's bed in the low position at all times ex	cept during pr	ocedure	
Teach fall-prevention techniques, such as sitting up for	a moment bef	fore rising from the bed	Dona distribute por la constitución
☐ Bed wheels should be locked			
Encourage family participation in the patient's care			allowed the same later is
Ensure that floor of the bathroom is dry and not slipper	у		
Review medications for potential side effects that can p			er hottestilkood at te
 Use safety belts during movement in wheelchair 			and the second second
The patients are not ambulated by themselves. They a	re to be ambula	ated only with assistan	ce
Medium risk interventions (25 - 44)			which appropriate the
Apply all the low risk interventions			
Tie yellow fall risk tag in the bed and Wheel chair / Stret		the second metal	med where the - Strain
Make sure that proper transfer precautions are institu	uted for heavy	or debilitated patients	in a
bed or wheel chair or on a toilet seat	20 100 E		the state of the state of the state of
Use restraints and bed monitors as ordered by the doc	ctor		
Allow the patient to ambulate only with assistance	to at a larged of	The second second second	storovell
Consider peak effects of the medications that eff	fects level of	consciousness, gair	and
elimination when planning patient's care	mont grose		
Do not leave patients unattended in diagnostic or treat	menialeas		(a)
 Accompany the patient while going to bathroom Advice the patient to use grab bars near the toilet, bath 	tub and show	Or.	and the second second second second
Make sure the family and other visitors understand the			语图操 wes
High-risk interventions (above 45)	Testrictions in	entioned above	1.0
Apply all the low and medium risk interventions			Jaszi Mariera
☐ Tie red fall risk tag in the bed, wheel chair and stretcher	,		to the Material William
Locate the high-risk patients in a room close to the nurs			
Answer these patients call bells as quickly as possible	oco ottation.		Inspired turnered
Provide a commode at bedside (if appropriate)			and the second s
☐ Urinal / bedpan should be within easy reach (if appropri	riate)		V.
☐ Encourage family members or other visitors to stay with			r =
☐ If appropriate, consider using protection devices: safe			2 -
	.,		
Initial Assessment to Special Needs and Vulnera	shility of Da	tiont:	
initial Assessment to opecial Needs and Valler	Yes No	Remarks (plea	se specify)
Terminally ill patients	Yes No	nemarks (prea	se specify)
Patients with intense chronic pain			2 3
Woman in lab or or experiencing termination of pregnancy	H		29 27 4 4 5
Patients with emotional or psychological distress	$+r_{\perp}$		
Patient suspected of drug or alcohol dependency			
Victims of abuse and neglect			
Patients whose immune system is compromised			
Patient with infections and communicable diseases			
Does the patient have implants			
Has tracheotomy been done			
		37.6	Patrigue
Has colostomy been done		95,27	Patrick Committee

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 Active cancer (on-going treatment or diagnosed within 6 months or palliative care) 1 No 2 No Bedridden recently > 3 days or major surgery within four weeks Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle 3 Yes (Assess for both legs) 4 Collateral (nonvaricose) superficial veins present (Assess for both legs) Entire leg swollen (Assess for both legs) 5 Yes No 6 Localized tenderness along the deep venous system (Assess for both legs) Yes No Pitting edema, greater in the symptomatic leg (Assess for both legs) No 7 Yes 8 Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs) Yes No 9 Previously documented DVT (Assess for both legs) Yes No 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) 10 Yes No 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. Risk Score Interpretation (Probability of DVT): **Final Score** Tick the score obtained (✓) **Action Taken** Date Time Low Risk -2 to 0 **Moderate Risk** 1 to 2 **High Risk** 3 to 8 Personal Belongings / Valuables: Name & Signature of the With With Patient's Description Remarks Valuables Patient / Patient's Attendant Patient Attendant □Upper □ Lower **Dentures** Both Wil □Right □ Left **Hearing Aid ☑**Nil Yours Eye glasses / □Yes □No Contact lens UNO ☐ Yes Jewellery Other valuables (specify) Report (List of X-ray, ECG, lab reports retained with the nurse): Emp. No. Date Time Name Patient / Relationship Patient's Attendant 000 00:00 Nurse 0008 **Unit In-Charge** A CBINUS





Mr.KALIDASS R

56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





Every heart beat counts

PATIENT CLINICA	HANDOVER	RECORD	FOR NURSES
-----------------	----------	---------------	-------------------

		THE SELECTION E	ANDOVERT	LOUIL		OLO	
Date: 8=	f 12 2	Shift: Morn	ing	Night	/1 A	2 11	
S	Ventilator Periphera Ryle's Tul Urinary C	S: ATVPICAL CHE PEWS Score: O day: — Il line day: Right: — Left be:	1	GCS: 15 15 POD: Central line da VIP Score:	ays:		2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -
В	Allergies i	urgery: — if any: NA DA air / oxygen: its / New Symptoms in last sl	nift:	Date of surge	7.3	1	11
Α	Others: Pain Sco Fall Risk Braden S Pressure	ms: Temp: 98 & (°F) Pulse Ro (mmHg) SpO ₂ : 9; re: 10 Pain Scale used Score: 10 Fall Risk Pro Score: 10 Hinimal Risk: 23-19 Ulcer Scale for Healing (PUS)	(%) Height: F (c	cms) Weight: C / Wong-Bake um	er FACES Pain Rating k: 14-13 High Risk:	g Scale / NA	S/CPOT
R	Pending Pending Pending Critical va Changes Pending	imendation doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:		care plan date:			
		Signature	Name		Emp. No.	Date	Time
Handover g	jiven by	E. lati	f. cathriene	2	0207	27/12/20	19:30
Handover taken by		G	Lacethya		DUG	29/12/25	19.39
Document endorsed		97-	AL ALBIN	008	0088	27/12/23	19-30

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
	Nigut duty nookes	
Atriba	Dr factory over som the	(° -1)
日.50	pt consions 2 oriented	Dub
	medication administration	
21,00	as por charge chart por complaints.	
	trainer to do LA	
u' oo	Collect Glood famous	Louis
<u>u'</u>	yeter figus clied &	uib
6-20	monitored Thoursones	
4.00	Andring duty Auf	EW
	0	
	\$ - C	
Document	Signature Name Emp.	1122
endorsed by	A. ALBINES DO	88 27/12/20 19/00



Document endorsed





Mr.KALIDASS R Pati 56/Malc/MHI202371159 Nan 27/12/2023/IPH2023002612 UHI DOI DOI DOI Consultant:



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

	28/12/23 Shifts	The same		31. 14.0		
	Diagnosis: DTVDICD) C	HECT PAIN	GCS:15/15			
0	Diagnosis: ATYPICAL C NEWS / PEWS Score: _	10-31	POD:			
S	Ventilator day: — Peripheral line day: Right:	Left: D1	Central line day	'S: -		
0	Ryle's Tube: Yes No	Day:	VIP Score: ¬			
	Urinary Catheter: ☐ Yes ☐ No Barrier nursing: ☐ Yes ☐ No		es, specify organism:	wil		
	BACKGROUND				-	
	Type of surgery: -		Date of surgery	: _		
B	Allergies if any: UKDA		,			
	On room air / oxygen: RA		IV fluids on flow			
	Complaints / New Symptoms in	n last shift: -				
	ASSESSMENT		44. 6-		5) 8	
	Vital Signs: Temp: 97.6 (°F)	Pulse / HR: 16 (b	eats/min) Respiratio	n: 20 (breath	ns/min)	
	BP: 100/70 (mmHg) Sp	A CONTRACTOR OF THE PARTY OF TH				2
	Others:	2 1 1 1 1 1 1 1			11-19/1	0)
	Pain Score: ©/10 Pain Scale	a ward: DIDDS / CDIES /	LACC / Wong Boker	EACES Boin Botin	a Caala / ND4	(CPOT
	Fall Risk Score: 50 Fall R			FACES Fairi Halini	g Scale / NA	3/0001
	Braden Score: Minimal Risk:			14 10 High Bioks	10 10 Covers	Dick: 0.6
	Pressure Ulcer Scale for Healin			ssing done: Yes		HISK. 5-0
	Current diet:	ig (FOSFI). [_] res[_Z140 [_	Drains:	_		
	Diabotic die	Lt.				
	RECOMMENDATION	\sim				
1	Referral doctors:)				
	Pending medications:	/				
	Pending medication indent:	0				
l		ations: 7 Mil				
_		itions:				
R	Pending lab reports / Investiga	/				
R	Pending lab reports / Investiga	ections:	fied care plan date:			
R	Pending lab reports / Investiga Critical value alert and its corre Changes in nursing care plan:	ections:	fied care plan date: _	-		
R	Pending lab reports / Investiga Critical value alert and its corre Changes in nursing care plan: Pending follow-up orders:	ections: Yes Mo. If Yes, mod				
R	Pending lab reports / Investiga Critical value alert and its corre Changes in nursing care plan: Pending follow-up orders:	ections:				
R	Pending lab reports / Investiga Critical value alert and its corre Changes in nursing care plan: Pending follow-up orders:	ections: Yes Mo. If Yes, mod	due.	Emp. No.	Date	Time
R	Pending lab reports / Investigation Critical value alert and its correct Changes in nursing care plan: Pending follow-up orders: Special instructions if any:	ections: Yes No. If Yes, mod FT YOPOSE (due.		Date >≈ 10 23	15-16-16-16-16-16-16-16-16-16-16-16-16-16-

		NURSES PROGRESS NOT	ES	
Date & Time		Observations / Action	Signa	ture with Emp. No
28/12/23	MON	ing duty Note.	for so fages	
at -				region (A)
7.30	= pationt	hand over taken) to	AT AT I
	the night o			2
		Pus & oriented	O)	125
		signs chockeds	2000 day	
		homodynamicall		
8.00	=> Patien	had a Diabo	tic diet	
		tion given as Po) L
	doing cha		02	bs
9.00		, Plan JUT	- 10 de 20	
10.00	/ 0>	CHOCKOOLE SOO	ordod.	
	·	report Olio.		
	=> TMT			22
11.30	> vital	signs chocked & ?	provided Mil	<u> </u>
		sharet montored.	X	2
12.30	sh PE	rand outry gill	non to	<u> </u>
	the evening	g deety staff.	great to the last of the last	
	(to the second second	
			32.11 8 192.30	
		/		
			in the second	n <u>y</u> 1
			30100 800	<u> </u>
	4	A Comment	2 (1.78)	
- Total	Signature	Name	Emp. No.	Date Time
Document	Orginataro	Tunio	Emp. No.	Date Time







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



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28	12/23	Shift:	Morning Evening	Night	FOR NO	INGES	
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul	ON S: ATY PICAL (DEWS Score: D day: Il line day: Right: De: Yes No atheter: Yes No		GCS: 15/15 POD: Central line da VIP Score:	ys: —	27	
B	Type of si Allergies On room	urgery: if any: NK PF air / oxygen: its / New Symptoms in	last shift:	Date of surger	1 2 1		
A	Others: Pain Sco Fall Risk Braden S	ns: Temp: 98-2 (°F) 80 (mmHg) Spore: O Pain Scale Score: 50 Fall Ri Score: Minimal Risk: 2	Pulse / HR: 80 (to pulse / HR: 80 (to pulse) Height: 1 Height: 1 Pulse Height: 1 Pulse Height: 1 Hei	FLACC / Wong-Baker Medium High 18-15 Moderate Risk:	Kgs) BMI	ating Scale / NRS	
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigat	ctions: — Yes Mo. If Yes, mod	lified care plan date:			
		Signature	Name		Emp. No.	Date	Time
Handover giv	100	E. Cati	F. cath	vire	0207	28/12/03	19.30
Handover tak Document en	1 5-9-12	Croy	1	uffrier 1	080	28/12/23	12.30

Date & Time	7.469	Observations / Action	Sign	nature with Emp. No
-1-1		0 1 4		nature with Emp. 14
28 12 23	<i></i>	vening duly NO	tes	
Van Van		0 7 0	\	No. of the second
	pat herro	1 over faken	MOVING EM	31744
いかか	from ou	on morning dut	1	20-
	Streft	J		7
	01 40	Stuple & conso	2011	701h
	of feel ar	1) 1)	· Lister
		is choelded &		
907 10	Recoved			
(fr. 130	P+	heed good		
	MOOPCE	affor was y	von	· ·
	Ed nor d	Leste /		Soph!
	et	make Wood		
	well'			
(B) 30	Dr. P	aresh sty ust	fool	daacen j
C	aD .	ajesh sing bisi	50	+1
- FN 7	The pt			oph
	01 1		1 6	
18200		us chacked	9	ACCEPTED TO THE PERSON OF THE
100	Recogned	1		70 M
	DA 6	and over to		
19100	right d	lung Staff	Disdoit To	Yosh
	l			And the American Phys. The Control of the Control o
		241	4 20 11 20 41 20 41	
			10.00	
			e se de la especial de la companie d	Fage Su. 15
			a grand out of the billion	
	-	-		
			and the second s	
190	State From L	A CONTRACTOR OF THE CONTRACTOR		a and another
Document	Signature	Name	Emp. No.	Date Time







56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:	28/12/	Shift: ☐ Morr	ning Evening Night	N. Addin	.020	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	c: A function Colores day: day: Right: Lef be: Yes No Day atheter: Yes No Day	POD: Central line	days:	G+	19.
В	Allergies i	round urgery: if any: A air / oxygen: A ats / New Symptoms in last s	Date of surg		3.5	1 Page 1
A	Others: Pain Sco Fall Risk Braden S	re: Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PU		ker FACES Pain Ratir isk: 14-13 High Risk: Dressing done: Yes	ng Scale (NB)	e Risk: 9-6
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care plan date	e:		
		Signature	Name	Emp. No.	Date	Time
Handover g		(qui)	K. Sushna	020/	9/12/20	200
Handover to	10211	dif	Demprya.	0284	29/12/23	8.00

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
28/12/28	Night duty Notes	formality .
(@)		And Date Agent Agent
12.00	I perficult handison only taken from	
<i></i>	Vight duty Staff	2
	King was county disass	BW!
1900	of patient Consions & Orienter	A .
	The Country of Carry	20 Table 1
20.00	3pt dies drigs alse gives.	2
20-30	Spt hard a diet	6W).
81.00	Det Well Mobilities.	30 A P
25.30	Soft Well sleeping.	in the control of the
	Opt well sleeping.	R
3.40	The west says.	600
6,00	3pt vs cheered & Rorded.	
630	2/2/2/	minor.
700	2) pt popone mediculion is given.	Ø
4.00	of thousanding over given by	621.
	Homing sluff Haff.	nutralisation BT
	The foreign street	P
	100 01100	sol,
		1
	11/1	teur gav i
14.7.4		- · ·
1 . 1		234.2
1 1/2	Signature Name Emp. No.	Date Time
Document endorsed by	A. ALBINUS 608	\$ 30/12/72-13-00
endorsed by	M. MINDLINUS GOOD	











Date: 3	,		HANDOVER F	ight	JRSES
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	PEWS Score: day: - al line day: Right: Le tether: Yes No Da tetheter: Yes No Da		GCS: US US POD: — Central line days: — VIP Score: O(S	
В	On room			Date of surgery:	
A	Others: Pain Sco Fall Risk Braden S Pressure	re: OD Pain Scale use Score: Minimal Risk: 23-19	d: PIPPS / CRIES / FLAC rotocol: Low Mediu At Risk-Mild Risk: 18-15 JSH): Yes No	nin) Respiration:(boxed) Meight: _& (kgs) BMC / Wong-Baker FACES Pain Form High R Moderate Risk: 14-13 High R Wound Dressing done: Drains:	Ali: 12-10 Severe Risk: 9-6
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its correction in nursing care plan: Yes follow-up orders:	s:J	are plan date:	
		Signature	Name	Emp. No.	Date Time
Handover g	iven by	Tone	Lani Briya	0284	Do. \$180/00
Handover ta	aken by	MDI	M. Downt	1' 0225	29/12/28/17/20
Document e	endorsed	A.T.	A. ALBINU	1	29/12/23 12-46

		NURSES PROGRESS N	OTES	The same of the
Date & Time		Observations / Action		Signature with Emp. No
29/12/23	MORN	INUT DUTY NOTES	Alt	Benk year
0	-			
7·30	=> P4 J	handing over	balo m	Sen Jone.
		Lit deep staff.		Jone.
8.00		consionses and		SECULO, 183 Aug
	prientatio			A A SAMPA
		had DM diet.		Jan
8.30		tals checked as	nd	200
	recorded		TWO STATES	oniano rameti Altri
		lue drings are	givon	uosokofa 📑 🚐
	as lei	dug chart	The state of the s	Court from the second s
9.30		nobilized well.		
()		itals checked		
		cheeked and	ρ	Maskash
A .	Pecarde 1			
10.60		had DM		See
	Diet.	5. Teps. 1001 170 3946	nes en Pase de	Tom
	, , ,	Mobilized well		
11.30		Ilo chart M		Ser
	and feed		ch shirt	1020
12.00	55 P+	handing over	100	
	night de			COLUMN TOTAL
		9	1 100	get up jakon 9. I-
			Macro Conje	per la
	-		anders to the second	
			Dille	
			กาลด์ ดูร	180 (180)
	77-			
	Signature	Name	Emp. No	. Date Time
Document endorsed by	Ay	ALBINUS	008	9-15 F-15







Patient Details (Affix Label here)
Name: プリル・ドカレック 433
UHID: かはになる3年により
DOB: Sex: カレップ

DOA: 27/12/23

Consultant: DR- PINBARASO



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29	112123	Shift:	Morning Evening	Night			
S	Ventilator Periphera Ryle's Tul Urinary C	DTYPICAL CHES DEWS Score: day: day: Right:	Left: Day: Day: MDR: Yes No. If Yes	GCS: /5//5 POD: Central line of VIP Score: 6	days:		21
В	On room		ast shift: —	Date of surge			
A	BP: 11 CO Others: Pain Sco Fall Risk Braden S Pressure Current of RECOM Referral of Pending Pending Pending Critical vo Changes Pending	ins: Temp: The sport of the second of the se	ns: No. If Yes, modified day Plan O	cms) Weight: ACC / Wong-Bake dium	er FACES Pain Ratinsk: 14-13 High Risk: pressing done: Yes	ng Scale / NR 12-10 Sever	S / CPOT e Risk: 9-6
		Signature	Name		Emp. No.	Date	Time
Handover g	SICIL T	Moly	M.Royalti	<i>l</i> '	0225	29/12/23	1690
Handover t		\$		ARMED		inam	noti
Document	endorsed	A4-	A- ABIN	108	0088	29/12/2	20-60

	14/3 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /	NURSES PROGRESS NOTI	ES		
Date & Time		Observations / Action		Signature with Emp	p. No
09/12/23	FV	oning duty Mole.	32 114	tiqeati un as	, A
at			40	Section 14	
12.30	= Pation	t hard over tak	son to	. 87	
		ing duty staff.	/C1 m/s .	Dey.	
		scious corientanta	J-	02.65	
		13 Checked From	Additional to the control of	TO CONTRACT	
13.30	=& Dat	ignt rad a Dias	otic dios		
	= MOa	lication given as	POY	-	Pa-
	as down	a chasit.			
15.00	- TO8	lay Plan discha	1990.	100	
16.00	-s vital	signs Chockods	YO COHOO	Toly	**************************************
	Q	ischarge state.		CASS	44
18.00	DISCHARGE				
	-L- Ration b	duchasego cumo	nou	Marin Sacra	
	explain to	attendoy.		NO	
2.6	~ TD !	20 md romovod 9:	TV	dy	
	line som	oved.	1845	0325	
	(5)	signs chocked	e i ka sije i i i i		A P
		tions homodynan	nically		
	stable				
	- 00	scharge Modiration	bn	20	
	explain	to patient and	attemby	dy	
	DAG	report given.	to	Uq2-	
	altendo	1.	2.0		
		11/4	11.00		
				3	Ŕ
			30000	4 1 1 1 1	
					-
-		1		1 7 20 7	Unt
Document	Signature	Name	Emp. No.		Time
endorsed by	47.	A. ALBIMUS	008	8 27/12/23	12/2





ADULT NURSING CARE PLAN





Initial Date: >\$\frac{1}{2}\big(2)	3 Time:	Modified Date: Time:		
Reason for Modification:	harm H	Diagnosis:		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	Pt had nomal	Ly COX,
			N Pt Cred On dough	Loub
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP	Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O ₂ saturation and pulse rate	pt on from	Ser
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	 If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis 	E	
i Au I a		Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N D+ On room	Bu
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output	F pt 210 Chart	Len
☐ Parenteral Nutrition ☐ Others:	50 p	Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss	E	38.5
	3 2 12 JAN 19 1	Monitor BP for orthostatic changes	N Mo witared	Lous

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance	mt pt mobilized well	Ser 5000.
_ outside	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E contract and a contract and a	
ensell enseller enseller			N H wen	Sub
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's /	ME pt Elimination @ Pattern	Jan 5234.
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E	
. J.:	FI W.	□ Check for malena / constipation / urinary retention	N Dt rothing	Eug
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain	M pt Maintain Normal Son Integrity.	Sin
GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4	00 14		Normal Spin snilgury.	
☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased		Monitor the healing status Educate patient and family members about further skin care	E	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	e e e e e e e e e e e e e e e e e e e		N abornel Stin	Bu
	1 × 1 × 1			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices	ME groomed well	Jen ;
(if present)	Patient will recognize individual weakness or needs	☐ Apply moisturizing solution	E P± cool	250r
SAFETY Check ID Hand	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the nation	F Pt DD band	Jen -
☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	1- W) (g	interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient	E Chooked	-63-61.
	75	☐ Follow restrain policy (if needed)	N	
COMFORT AND SLEEP Pain Control	Patient will verbalize / or through Provide privacy at all time	М —		
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	 ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy 	None provided postic	n Bus
OBSERVATION Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality	M	
Others:		☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	E pt vitals checked	Jen oon.
			N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	м	
Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	Patient will maintain normal psychological pattern	 ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance 	E	
- 1010.			N phylological Supp	es Lou

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation	Evaluation			
COMMUNICAT Verbal Non-verbal	TON	Patient will communic with positive feedbac		Introduce the care giver Encourage the use of call to Obtain interpreter if needed	d	M pt con	Jonn .			
Sigh language Others:				No negative speaking about or prognosis in the patient!		E		tac n		
die	The horast		×	3		m nuetron	Lou			
SPECIAL INTE Medication Wound care Isolation	Nound care			Double check for high alert Observe and report any me Provide proper measures of Follow hospital polices and	edication reaction of wound care	M pt du are gi	re drugs	Jem		
Ostomy Care Blood / Blood p transfusion Fluid tapping	Ostomy Care Blood / Blood products transfusion Fluid tapping			and explain to the patient / Check for cross matching a compatibility Practice strict asepsis while	family and typing, to ensure	E				
DVT Manageme Others:	ent	h		blood products and fluids Monitor DVT score and cor as per doctors order	ntinue treatment	N due	given	Row		
	Signature	14	Name	7 37 3 1 1 1 2	Emp. ID	F 13 W	Date	Time		
Endorsed by	dry A	7	A.	ALBINUS	00) Le	27/R/23	19-46		
		h			Caracana A	(e) a. Mak				
		MIN +3								
	2071									





ADULT NURSING CARE PLAN

Mr.KALIDASS R 56/Malc/MHI202371159 27/12/2023/IPH2023002612





Initial Date:	12/2 Time: 8:00	Modified Date: Time:		
Reason for Modification:	114.	Diagnosis: Atypical Cliest	Pain	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	MPE had DY diet EPT had Bet NPT had Siet	Con Cont
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O2 saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O₂ saturation and pulse rate If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	M DE 25 ON 800M aig E Sport 984 N 8 POX 994.	Sol Sol
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	MIlo chaodo monitorod. E so chist nes mens posso Noto chist Monitored	Who has a second

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease P-tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M PE 40000 Aygrobilized E Pt mobilized Well MODIFIED All San!	
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Check for malena / constipation / urinary retention	M Normal Etimination Pattorn E Primin from puffen D N Elimination N Dattern Normal	Stor Star
SKÍN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	M skin intact E	1984 0325

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	MPt 4000 hygiege EPT groomed NPT groomed Well	Polhi
SAFETY Check ID Hand V care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	MID Band prosont E SD band D N	H.Dy
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	M	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M Vitals Chocked & se coordoof E wife! stute N V/S cheeked	HO AND SOL
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	 □ Pray or encourage the patient to pray □ Use inspirational words □ Respond to spiritual needs as they arise □ Evaluate spiritual needs □ Encourage verbalization of feelings / therapeutic touch □ Provide empathy and reassurance 	M E	

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation	15 m	Sign & Initials		
COMMUNICATE Verbal Non-verbal	TION	Patient will communic with positive feedbac		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		MPE YOUR	Communication			
Sigh language Others:		- Say ha		No negative speaking about the or prognosis in the patient's pre		E PA com	e m			
1	113	11 300		3		121	insperte , see , s	F291		
SPECIAL INTE Medication Wound care Isolation Ostomy Care	ERVENTIONS \	To manage on time		Double check for high alert med Observe and report any medication Provide proper measures of wood Follow hospital polices and produced and explain to the patient / fam.	ation reaction bund care tocols of isolation	M M edica	ation given as dougchou	Mag		
☐ Blood / Blood p transfusion ☐ Fluid tapping	Blood products on oping			 ☐ Check for cross matching and to compatibility ☐ Practice strict asepsis while training and the companion of the c	yping, to ensure	E) (1/3) (1/5)		
DVT Managem Others:	ent			blood products and fluids Monitor DVT score and continual as per doctors order	e treatment	n dere d	ngs auce	Qui del		
	Signature		Name	su strugger (g) ou or nee	Emp. ID		Date	Time		
Endorsed by	\$	4	P)·	ALBINUS	008	8	29/12/23	12-00		
Sign		and the state of the		A TUBERT FROM PLANTS OF THE STATE OF THE STA	**************************************	Communicación de la rec Participación	м ио:	TAVE di		
130	1/4	1. Min.								
(Sold	74.	ujo ofin								





ADULT NURSING CARE PLAN

Mr. KALIDASS R

56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





Initial Date: 29 12 8	C Time:	Modified Date: Time:		
Reason for Modification:		Diagnosis: ATYPICAL CHES	PAIN	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	MPf had DM Diet. EPt had DM diet N	Jew.
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O₂ saturation and pulse rate If any O₂ abnormalities detected inform immediately to	MPt on ilsom	Jen
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness	e Pt is on room	4) var
- ji	1 0 7 1	Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N	-
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output	M Pt Ilo chaut Monifered.	Jam
Parenteral Nutrition Others:		Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	E Ilo Chasit of monitoria	MD
			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease P-tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt Mobilized E Pt 4000 M obilized N	Jone .
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Check for malena / constipation / urinary retention	M ft Normal elimination pattern E Normal Elimination Protogen	Son.
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	M Pt Maintain normal skin Integrity. Maintain normap E Skin intact	Jen.

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	1
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	m pt groomed well. E Pt 4000 hygiene	July 1
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	Mpt ID band present. E &D Band Procont	\$ 1
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	 □ Provide clean calm and restful environment □ Provide privacy at all time □ Monitor pain scale / sleep pattern □ Provide pharmacological and non-pharmacological therapy 	MEN	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M Pt . Vitals Monitered. E Vital Chockeds, recorded	1
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal psychological pattern	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	M	

Patient Specif Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICA Verbal Non-verbal Sigh language Others:	lon-verbal igh language			Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patie or prognosis in the patient's presence	M Pt con E PE UCI N	Jon Moly		
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood / transfusion Fluid tapping DVT Managem Others:	products	To manage on time		Double check for high alert medication of Observe and report any medication of Provide proper measures of wound of Follow hospital polices and protocols and explain to the patient / family Check for cross matching and typing compatibility Practice strict asepsis while transfusing blood products and fluids Monitor DVT score and continue treat as per doctors order	eaction are of isolation to ensure ng blood or	E	due drugs given	Jen
		À	None	do por dostoro order	/ Form ID	N	Date	Time
Endorsed by	Signature	y.	Name	A CBIMUS	Emp. ID	B\$	29/12/23	12-30
					7 Mg	ngiaj iloz	arg	, 1 - 120 1 - 120 1 - 121 1 - 121







56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f	illed by co													
Barriers to	Learnin	g							Plan t	o A	ddr	es	s Factors	
None	☐ Visio	on / H	earin	g lin	nitations	5			Use	of l	nterp	rete	er	
Limited Reading Abilities	Physical barriers] Edu	cate	fam	ily		
Religious / Cultural Factors	Lang	guage	barr	iers				Simple Language						
Congnitive Limitations - unable to	Low	motiv	vation	ı / d	esire to	lear	1		Writ	ten	Instu	ctio	ons	
understand and follow directions														
Completed By : Date 27 12 23 Tim	ne_ [2 -	3 o	1	lurs	se Signa	ture	:	£.	Cati	02	οŦ			
Learning Record														
Need	Dat	е	Visit	1	Date	\	/isit	2	Date	,	Visit	3	Signature	
	27/12	A L	Р	0	20/12	L	Р	0	20/1º	7	Р	0		
Disease		+	\top	Г				П	C (I		Т		Doctor	
☐ Infermation on		\top	\top	Г				П						
Disease / Diagnostics		0	OD	1		P	OD	V		P	OD	V		
Treatment		1	\top	Г				1						
Medications		10	0,9	\checkmark		P	9	(/		P	00	V	Doctor / Nurse	
☐ Information on Safe and		7				Г		,						
Effective use of medicines		0	OD	V		P	OP	6		P	00	Y		
Information on drug / drug and		77		Г										
drug / food interactions						P	OD	4		P	00	Ϋ́		
☐ Discharge Medications		Т	Т											
Surgical Instructions													Nurse	
Pre - Operative Instructions													\$200 T	
Post - Operative Instructions		T	Г										Car	
(Wound / Dressing Care)														
Pain Management									2				Nurse	
Reporting of pain		I				P	OP	Ø		P	ton	U	DC +	
Pain Management		T				P	OD	0		P	PD	Γ	0801	
Safe and effective use of medica		T	Г										Doctor / Nurse	
Equipment (if required)														
Name of Equipment														
Rehabilitation Techniques	- 1			1							1	1 1		

		- 1	Date	1	Visit	1	Date	1	/isit	2	Date	١ ١	/isit	3	Signatur
		- 1		L	Р	0		L	P	0		L	Р	0	
Nutritional Guidance					11913							19			Dietician
Diet Instruction for Nutritional risk	patients a	1		0	an	5		0	en	2		n	م	5	Maria Cone Johne Johnson
☐ Diet advice for hom	е	4	321	-		Ħ	NA 2	-			a mir	-	-		Nurse
Discharge Planning			10.2				3000					1			
Self care			No services				- Det								1300 - 1 - 1 B B B
Follow up															
Reporting Concerns Immunizations	3			istr	(B)	n.g	kali i rucii Di becarea	IV.		1		int le	14.		a i malana
Parenting education	Nova ?				-		rijakiy0				2.0	36/5	les to		Pandole i
Others	8.1 12	-	9 9	No.			લાંદાલ હૈ			.01	eld Julia	our	1		and mac.
Risk Factor Reduction						П	- 40				ecilibur	1	los.		atmentab.tv
☐ Smoking Cessation	en He	1 1		8			- 30	23	78		00/6	116			Doctor
☐ Weight Control											-				91.7 - 310
Exercise							1					3.23		-	1
		1 40													Per come
Hypertension					_	-					2.5		17		inced?
Hypertension Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD - Written Material give	Oral Disc	cussion, D Demonstr	- Dem ation,	ons	trati	on,	W- Wr	itter					(;	Stat	e Relations
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD Written Material give	Oral Disc	cussion, D Demonstr oplained (i	- Dem ation, f any)	ons	trati	on,	W- Wr	itter					(:	Stat	e Relations
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD Written Material give	Oral Disc - Return en and ex	cussion, D Demonstr oplained (i	- Dem ation, f any)	ons	trati	on,	W- Wr	itter					(;	Stat	e Relations
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD Written Material give	Oral Disc - Return en and ex	cussion, D Demonstr oplained (i	- Dem ation, f any)	ons	trati	on,	W- Wr	itter				1		Stat	
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD Written Material give	Oral Disc	cussion, D Demonstr xplained (i	- Dem ation, f any)	ons	Verb	on,	W- Wr	ders				1			
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD - Written Material give	Oral Disc	cussion, D Demonstr xplained (i	- Dem ation, f any)	ons	verb	on, paliz	W- Wr	ders	tand			1			
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD Written Material give Reports Given :	Oral Disc	cussion, D Demonstr xplained (i	- Dem ation, f any)	ons	Verb	on, paliz	W- Wr	epor	tand			1			
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD Written Material give Reports Given : Discharge Summary ECG Report	Oral Disc	cussion, D Demonstr xplained (i	- Dem ation, f any)	ons	Verb	Diet CT S	W- Wried Und	eport	tand						
Other Risks LEARNER (L) - P-Par PROCESS (P)- OD - OUTCOME (O) - RD - Written Material give Reports Given : Discharge Summary ECG Report Doppler Report	Oral Disc	cussion, D Demonstr xplained (i	- Dem ation, f any)	ons	Verb	Oiet CT S	Advice	eport	tand			1			







Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 27 12 23	Time: \	2.3	0				
Checklist	Yes	No	NA	Ac	ction / Remarks		
MEDICAL							
Daily Consultant Visit	6						
Plan of care discussed	/	/					
Discharge Planning	1						
Others if any							
NURSING							
Safety Precautions Ensured	1						
Care of Lines and Tubes							
Infection Control Measures	1						
Skin Care	-						
Response to assistance	1						
Others if any							
DIETICIAN							
Diet Adequate	/	/					
Special Request	1						
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living							
Others if any							
PATIENT CARE SERVICES							
Room Cleaning satisfactory							
Room Amenities Adequate							
Billing Update available							
Non-Availability of any service							
Spiritual Needs (if yes specify)							
Others if any							
		In	ter Dis	sciplinary Team Members			
	Signatur	е		Name 0 0	Reg. / Emp. No.	Date	Time
Doctor	20	2		Dr. Whamed hydr	m 165807	27/19	15.00
Nursing Staff	F.1	ati		F-calhrune		2718	14.30
Dietician	Co	May	M	Maria Catherine John Senior Dietitian	2401	27 luh	1500
Physiotherapist							
Patient Care Service Staff					PARTY CONTRACTOR		





56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ



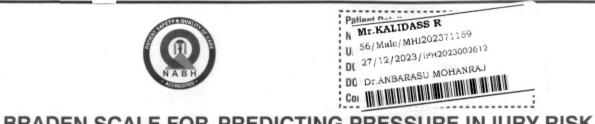


Date: 2 10

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	18	5	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	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 Responds to verbal commands, but Responds to verbal commands. Has no sensory impairment which limits ability to feel pain or discomfort over 1/2 of body		Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or	4	H	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	8 T	eq
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	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. Stight 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 diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs 4. Excellent . Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation			4	4
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	Moves in bed and in chair independent strength to lift up completely during move. It or chair		3	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair	of ordain	TOTAL SCORE		22	28
as	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	MX	No.	N CO
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; h	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	008	E CON	000







MHI/NUR/2022/045

Every heart beat counts Date:

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	m	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	9	925
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	ARarely 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	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	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	Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	37	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 diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	A Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	4	
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. Nor chair		3	3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair	2	TOTAL SCORE	Fur	.23	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down	4.	Initial & Emp. No. of Staff Nurse:	000 80	W.	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	8008	the sole	







56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/05



counts

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.
1230	olio	Nopain	-	_	_	Jon:	Ley ods
1400	olio	No Pain	-	-	_	Jen 624.	Ay
18.00	olio	No pain				Jony.	CODS
19.00	0/60	No pain	_	_		Lus	Ay ods
200	0/10	No poig	_			Sus	dy
8,00	0/00	Ho Pain		_		Lub	Ly
1000	olio	No pain	1	-		42	Loss
1h120	do	NO pwn	_	(OS oihl	0088
)	ofo	no pir	-	-	10.000	and he	det so

ate &	Pain Score		Pain Character y, sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	T	Interventions		Staff Initial & Emp. No.	Senior Staf Initial & Emp. No.
1								20.	e hyen if	00
	1				ing,	Ma bello i	+	-144	124-31	
-38						sid anthro			7 1	
		-24-07						A OD	711	idal)
1		- (4-25 3	M 0	100
	1	2.			PA	IN SCALES				1 4
28 week	PIPPS s to < 38	B weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		n		7 63 9) (3	
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score esic administration is indicate			4 2	1/6
	ACC Sca nths - 7 y		0: Relaxed & comfortable	le, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe	discomfort / pain / both			
Pain	-Baker F Rating S ars - 12 y	cale	0 2 No Hurts Hurt Little Bit	4 Hurts Little	6 Hurts	8 10	Numerical Rati	ng Scale (age mo	7 8	years) 9 10
Observa	cal care l ition Tool itor / com	(CPOT)	FACIAL EXPRESSION: 0 BODY MOVEMENTS: 0 - COMPLIANCE WITH VE	Absence of manual Absence of manual Absence of the Manual Absence of the Absence	eutral, 1 - Tense, 2 - G novements or normal ntubated patients): 0 nts): 0 - Talking on no ense, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restle - Tolerating Ventilator or Moven rmal tone or no sound, 1 - Sighi nse, Rigid	nent, 1 - Coughing but to		yentilator (or)	ere
	harmacol	ogical	Distraction: A - Relaxatio	n-conducive e	environment; B - TV; C E - Positioning; F - R	- Music; D - Physical and menta	•)	





56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





Every heart beat counts

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK	Date:	27	12	23
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	Responds to ve commands. Has no se deficit which would ability to feel or voice produced to the common of the comm	erbal ensory	٨	Cq.	
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	K. Rarely Moist Skin is usually dry, line requires changing at 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	Walks Frequently Walks outside room a twice a day and inside at least once every two during waking hours	e room	4	4	
MOBILITY ability to change and control body position	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	A No Limitation Makes major and from the changes in position to 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 diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Eats most of every Never refuses a Usually eats a total of more servings of mediary products. Occase eats between meals not require supplement	meal. of 4 or eat and sionally . Does	A	4	
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	y and has sufficient n Maintains good position	nuscle in bed	3	3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL S	CORE	23	23	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down	1	Initial & Em of Staff N	p. No. lurse:	500	SUB SUB	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Em of Sr. Staff N		As	A	







56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052



Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staf Initial & Emp. No.
22-00	9/10	No pain				Shuij	Light
2.00	%0	No poin	_			Paul	Ay good
6.00	0/10	No pain	_			Pul	Af
8.00	olio	No Pain	_			Jam Ozer	Ac 388
10.00	plio	No Pain	-	_		Jan osa,	Ay 608
M.00	0(10	No Pain	1			D	Ay
18.00	olvo	No pain				MA	Aug 6
				100		TRASE .	
				6 ° sa noren 1	to seem to describe the seem of	h, 21	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -

Date &	Pain Score	(dull, achy	Pain Character y, sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7 1	e se e e	1		34,41		- N	diezeli (Medwa
2:				71		HOUSE HALL TO THE SEES	84 BB	MAG
400, 00, 2 00 0		1 (10 mm) 10 4 8	. 5	7 . V. V.	2 co	ain Character see canage and treating to the Silvertee and	ni Vios ison esc Significant	Date & Pa Time Scr
7		ust.				2000	10/10	3 03 B
	1165	9		X 1		- 200g ola	, oi	0 1 1/1/30
Th		(u.ia)			PA	IN SCALES	0/	· 10.1
(28 week	PIPPS cs to ≤ 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on .		
(38 we	CRIES eks - 2 m	onths)	The CRIES scale is used further pain assessment	for infants >	than or = 38 weeks	of gestation. A maximal score of 10 is possible. If the CRIES score is > 4 esic administration is indicated for a score of 6 or higher.	, t/ p\	13. 13
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		
Pain	-Baker F/ Rating S ars - 12 ye	cale	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age m 7 8	years) 9 10 *	
Observa	cal care F ition Tool itor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (in ubated patien delaxed, 1 - Te	novements or normal p ntubated patients): 0 nts): 0 - Talking on no ense, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting rmal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	ventilator (or)	14 25 1
	harmacol		Cutaneous Stimulation a Thermal Therapies (no lo	nd massage: onger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counselling: K - Individual Counse	seling; L - Family	y counseling
Int	tervention	ıs	Cutaneous Stimulation a Thermal Therapies (no lo	nd massage: onger than 15 al nerve stim	E - Positioning; F - R to 20 minutes): G - Co	ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy	seling; L - Famil	/ (





56/Male/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ





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	2न एक	23/12/24	2012				
	Time	12:30	700	100				
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	N	D				
2	Bedridden recently >3 days or major surgery within four weeks	0	D	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 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.	D	0	0				
	FINAL SCORE	0	0	0				
Low R	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	Low	con	Low	1			
	DVT prophylaxis started	□ Yes	☐ Yes ☐ No	□Yes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	影台干	800	Cypro				
	Signature & Emp. No. of Sr. RN	900	2008	ded,				



Medway Hospitals

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



Mr.KALIDASS R

56/Malc/MHI202371159 27/12/2023/IPH2023002612

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/046



Where heart beat never stops.

MODIFIED MORSE FALL RISK ASSESSMENT CHART

W. Jakka	Date	27/12	24/10/22	271/2	28/2	8/12/	28/12	29/12/29	29/10/3	
Variables	Time	12.30	14.00	20,00	8.00	14/20	20,00	8.00	8	
History of falling	No	0	0	9	6	8	.0	0	ver	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	-15	15	15	15	18	15	18	15
Intravenous Therapy /	No	0	0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	_20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		.0	0	0	9	0	.0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	. 15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	10	0	10	0/	0	20	10	0
Weak		10	10	10 /	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	,_0	9	0	8	0 -	70	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	-15
MEDICATIONS Includes PCA / opiates, diuretics,										
laxatives, hypnotics, sedatives,	No	0	0	0	0	0	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	30	50	50	0	50	50	50	
Low Risk (0 - 24)	-	7				/				
Medium Risk (25 - 44)	-						/	2		
High Risk (45 or above)			1	V	~	/	1	1		
Signature & Emp. No. of RN		P.C.	Postso	Solt	Month	and	Open Co	Jon	100	
				1	-	21 8 9	1 2 2 8	1 0	-11/0/1	

INTERVENTIONS	Date	27/12	24/12	28/12/23	2012	38/12	20/12/23	29/12	3	
Tick as per the Risk Score	Time	12.30	De. 20	800	1820	0,00	8.00	14.00		•
Low Risk Interventions (0 - 24) Familiarize the patient with the immediate surroun		1	2		~		1	2		
Remind the patient to use call bell before getting o		-			1	1	/		_	
Keep the two side rails in the raised position at all			()			/			\rightarrow	
all patients regardless of age	111100101	1	7	V	/	1	-	1 - 1		
Keep the call bell, bedside table, water, glasses v	within the			111111		/			-	
patient's easy reach	With III to 10	~	7	V	/	/	/			
Remove excess equipment or furniture to make	e a clear		9						_	
path	o a oldar	-	0	~	(~		
Keep the patient's bed in the low position at all time	es except		/			0				
during procedure		-	0	1	/	/		-	-	
Teach fall-prevention techniques, such as sitting	up for a		/		-					
moment before rising from the bed		-	5		-		/			
Bed wheels should be locked			-		/	1		1/		
Encourage family participation in the patient's care	е	0		1	/	/		1		
Ensure that floor of the bathroom is dry and not slip		1	-	1	1		-	1		
Review medications for potential side effects					11	/			_	
promote falls		/	-		-					
Use safety belts during movement in wheelchair	- 43	~			/	1	/	-		
The patients are not ambulated by themselves. The	nev are to		1		/		/	75 VA 95 4		
be ambulated only with assistance		1		/		/				
Medium risk interventions (25 - 44)			7	_		/		1		
Apply all the low risk interventions		1	0	V	-	//	-	-		
Tie yellow fall risk tag in the bed and Wheel chair / S	Stretcher	0			/	/				_
Make sure that proper transfer precautions are		1			,	/	1	-/	-	_
for heavy or debilitated patients in a bed or whee		~			/	1				
on a toilet seat	orian or		1	-		/				
Use restraints and bed monitors as ordered by the	doctor	1			1	1	/			
Allow the patient to ambulate only with assistance			1		/	1	/			
Consider peak effects of the medications that effe						1		-		
of consciousness, gait and elimination when		-	5	~	/	1				
patient's care	planning	-			-	/		-)		
Do not leave patients unattended in diagn	nostic or			,						_
treatment areas	100110 01	1	1		-	/	/		-	
Accompany the patient while going to bathroom		0	1		-	-			7,577	
Advice the patient to use grab bars near the toilet,	hathtub		1			/	-			
and shower	, butilities,	~			-		1			
Make sure the family and other visitors unders	stand the		1			1	7.			
restrictions mentioned above	staria trio	/		1	/	/	/	-		
High-risk interventions (45 or abovc)	100000000000000000000000000000000000000		5							
Apply all the low and medium risk interventions			1	-	/	1		-		
Tie red fall risk tag in the bed, wheel chair and stret	cher		1	1	/	/				_
Locate the high-risk patients in a room close to th			//			/		1	_	
station	Onarooo		1		V	1/	1	-		
Answer these patients call bells as quickly as poss	sible		1	1/	1	1				
Provide a commode at bedside (if appropriate)	100		1		/	1				
Urinal/bedpan should be within easy reach (if app	ropriate)		1		/	/	1			
Encourage family members or other visitors to			1	-		1				
them		V	//	1	1	/		-		
If appropriate, consider using protection device	es: safety		1	1	1	1/	1			
belts	Janoty	1778	1	1	1	V	1			
Signature & Emp. No	of PN	Qc.	had	WILL	A.I	RID	184.	MO		
		1301	Tu	1000	No fe		and the	got!		
Signature & Emp. No. of	Sr. RN	7000	NO BY	1220	Ando	70	7688	999		







VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME: Mr. Kalidoss

IP No. / UHID No

AGE / SEX :

Ward / Bed No. 902

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
97/12/23	17.30	neta carpal	0 5	patent	flushed	followed	DC 5007
9711260	80.00	metacagnol	012-	Datent	Juco!	followal	%
28/12/23		Hotangal	012	Patent	beeshood	followood	Moles
	- FLYD	metacen	85	puterl	the deel	-	Mall
	12691151151151	Moccorpal	0/5	partent	Hushid		Del
09/12/23	8.00	Mocarpal LT Welocoppo	210	Patent	flushed	_	Nem NID
29/12/2	14.00	welgraspo	015	patent	blushof	-	1 Cops



56/Malc/MHI202371159 27/12/2023/IPH2023002612 ere)

Dr.ANBARASU MOHANRAJ



PSYCHOLOGICAL WELLBEING REPORT

Date: 28/12/23

Time: 11.30 am

Unit: 2023

Clinical diagnosis: Atypical chest pain

Surgery/ Procedure:

Impression: Functioning well

- calm affect, oviented, responsive

- sleep & appetite (1)

- no jongelvosogical shumes reported.

Employee ID: HH10 278 PSY

Signature of the Psychologist:

It. Q.le.





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

MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

		KNOWN MEDICINE AL						_		
Drug D	etails		Descriptio	on of A	Allergy			Docto	or's Sign:	> -
								Name	: D. m	Para
									Hyl	s s
								Reg.	No.	535
[осто	RINSTRUCTIONS					TAFF INSTRU	CTIONS	3 - 1	
. Write . Sign a . No pre	in BLOCK and enter I escription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	3. For new p follow star 4. Standard Q8hrly: 06: 11:00hrs, 1	charge rescrip ndard Timing :00hrs, 17:00hr	should ver otion, follow timings gs: Q24hrly: 14:00hrs, 2 rs, 23:00hrs	rify drug ch v the timing 10:00hrs, 0 2:00hrs or 0 , Q4hrly: 02:	art on daily basis as of doctor's preso 212hrly: 10:00hrs, 22 19:00hrs, 14:00hrs, 10: 00hrs, 06:00hrs, 10:	2:00hrs or 0	6:00hrs, 18:00h Shrly: 05:00hrs,	rs,
		Stat / C	Once Only	y / P	remed		Drugs Doctor	,	Administered	4
Date	Time	Drug	D	ose	Route	Sign.	Reg. No.	Sign.	Emp. No.	Time
		Şto 2						7		
							2.119	OLOVIA.		
		400								
37		74						41		31
								ist o	f .	,
- 1										i i
									1	
26-4							YT	DATA		
<u> </u>								-		
				-	25.5					
							170	lan y	-//-	-
								- 3		
			7 + -							

Date -> To be filled by Nursing Staff only. Sign and time given REGULAR PRESCRIPTIONS To be filled in by Doctors only Time 4 **DRUG NAME** Clinical Pharmacist Medway Heart Institute G040 MOVOSTAT TAB. Dose Route Frequency 20/7m plo 001 Dr. Sign & Reg. No. / Seal Start Date & Time 12038 Stop Date & Time 8 8,000 81.0 21:35 Additional Info: DRUG NAME MET XU TAB. 8-567.30 Clinical Pharmacist Medway Heart Institute Route Dose Frequency 8:00m 100 100 amy Start Date & Time Dr. Sign & Reg. No. / Seal 120348 Stop Date & Time 40 Additional Info: DRUG NAME ARNIP IN TAB-Clinical Pharmacist Medway Heart Institute 8.8 9.31 Route Frequency Dose 000 8 plo 50mg Dr. Sign & Reg. No. / Seal Start Date & Time 190318 Stop Date & Time 8:00 21.35 1.0 Additional Info: **DRUG NAME** PLUS DYTOR TAB. 1909.32 100 poss Frequency Route Clinical Pharmacist Medyay Heart Institute Dose 8:00 plo 1/2-00 10/2my Start Date & Time 1200 Dr. Sign & Reg. No. / Seal aulti Stop Date & Time 170318 Additional Info: **DRUG NAME** VERTIN TAB. 9.02 Route Frequency Dose £ 100 Clinical Pharmacist Plo Sme 100 Start Date & Time Dr. Sign & Reg, No. / Seal Stop Date & Time 1703V Additional Info: Area In-charge 00 Nurse Signature:

Clinical Pharmacist Medway Heart Institute

REC	GULAR PRESCR	RIPTIONS I	Date -		filled b	y Nurs	ing Sta	iff only.	Sign a	nd time	e give
	be filled in by Doo		Time ↓	28/12	100			30.0	3		
DRUG NAME	T. LEYOC	eT.									
	1.00 40 0				1-4	10-1		-,			
Dose	Route	Frequency				l		l	L		
	Po	0-0-1 (204	Congra	6-1			9		= 101	P-1	
Dr. Sign & Re		Start Date & Time	100 as	2133		,					
E	1 don't	Stop Date & Time		81/3		1.00		· . / .		- ;	\vdash
Additional Inf	fo:										
DRUG NAME											
_		1	1		1	ST	-	. 2	7		
Dose	Route	Frequency					ato				
Dr. Sign & Re	na No / Soal	Start Date & Time	-			- 6-5		-		-	\vdash
DI. SIGIT & NE	eg. No. / Seal	Clart Bato a Time	elegi To								·
		Stop Date & Time		2 2		100	98.1	-0	-		\vdash
Additional Inf	fo:		-								
		T. 16-11	3 2000	-				-		-	-
DRUG NAME	=										
	T	1-	-	<u> </u>		300			.01		
Dose	Route	Frequency	Tree sta								
Dr. Sign & Re	eg. No. / Seal	Start Date & Time									ļ
		Stop Date & Time		7 11	स	No.	us.	1	12-1	-	-
Additional Inf	fo:	The state of the s	1					¥			ļ
DRUG NAME	6-14-2		-		2						
						7 7 4	ġ.	1			
Dose	Route	Frequency	1 2 2								
			1				3.3			5-1	
Dr. Sign & Re	eg. No. / Seal	Start Date & Time									\vdash
		0. 0.07	-			·	54				·
		Stop Date & Time			~		-		100	·	
Additional Inf	fo:	1									
DRUG NAME						5					
D	Route	Fraguenay	+	-		74 1		-		-	\vdash
Dose	Houle	Frequency									
Dr. Sign & Re	eg. No. / Seal	Start Date & Time									ļ
		Stop Date & Time	_	0.3	Total Control		-				-
Additional Info:											
Area In-char	ae		Andrew tanks of the	Bux							
Nurse Signa				66861							

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No
	1 100					-			
		,		-					į
							4 +		
A								2	
		48	1 1 2 2	3			T. A. S.		1-
								**	
							ications prescribed in the char		1
Date	Shift	(to be entered by all the	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
Date	Morning					Shift Morning	Name of Nurse		Initials
	Morning Evening		Emp. No.			Shift	Name of Nurse		Initials
	Morning Evening					Shift Morning	Name of Nurse		Initials
2412	Morning Evening Night	Name of Nurse	Emp. No.			Shift Morning Evening	Name of Nurse		Initials
24/12	Morning Evening Night Morning	Name of Nurse	bith	Initials		Shift Morning Evening Night	Name of Nurse		Initials
2月12	Morning Evening Night Morning Evening	Agastaya M. Rovathy	Emp. No.	Initials		Shift Morning Evening Night Morning	Name of Nurse		Initials
3/0/02	Morning Evening Night Morning Evening	Agastaya M. Rovathy A. Mongh. Agastaya	614 0225 0141	Initials S		Shift Morning Evening Night Morning Evening	Name of Nurse		Initials
3/0/2	Morning Evening Night Morning Evening Night	Name of Nurse Agastayo M. Rovathy A. Mongh.	bith DDX old i	Initials		Shift Morning Evening Night Morning Evening Night	Name of Nurse		Initials
3/062	Morning Evening Night Morning Evening Night Morning	Agastaya M. Rovathy A. Mongh. Agastaya	614 0225 0141	Initials S		Shift Morning Evening Night Morning Evening Night Morning	Name of Nurse		Initials
3/062	Morning Evening Night Morning Evening Night Morning Evening	Agastaya M. Rovathy A. Mongh. Agastaya	614 0225 0141	Initials S		Shift Morning Evening Night Morning Evening Night Morning	Name of Nurse		Initials
3/062	Morning Evening Night Morning Evening Night Morning Evening Night Morning	Agastaya M. Rovathy A. Mongh. Agastaya	614 0225 0141	Initials S		Shift Morning Evening Night Morning Evening Night Morning Evening Night	Name of Nurse		