

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

INSURANCE

Mrs. MARY PREMA SHARMILA /

53 / Female / MHI202381551

28/12/2023 / IPH2023002627

Dr. G. GNANAVELU



MHI/IPD/2022/002

Medway Hospitals®

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



ADMISSION SLIP

Admitting Doctor: Dr. G. G.

Speciality: Cardio

Advised Date & Time: 28/12/23 11:00 PM

Provisional Diagnosis:

NSTEMI

Reason for Admission: ☒ Medical Management ☐ Surgical Management
☐ Others (please specify details) _____

Admission Type: ☐ Day Care ☐ ER ☐ Ward
☒ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):

- CABG ± PUA

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

Expected Duration of Stay:

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

Payer: ☒ Self ☐ Insurance ☐ Others: _____

INSURANCE

Instructions to Nurse (if any):

- Send cath pack - 1

Any other Instructions (if any):

Doctor's Signature

[Signature]

Name

Dr. vel

Reg. No.

95468

Date

28/12/23

Time

11 PM

For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☒ Others CCU

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

28/12/2023

10.59

28/12/2023

10.59

Source:

☐ OPD

☐ ER

☒ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time



Alone

169

28/12/23

10.59



ADMISSION FORM

Marital Status <i>M</i>	Full Address <i>No: 30/2, Venkateshwar st, Boyspuram Ch:13</i>		Telephone Number <i>99626 84179 88383981301</i>
Occupation <i>ccc</i>			
Referred from <i>Dr. ucy</i>	Date of Time of Admission <i>28/12/23 - 10.59</i>	Date & Time of Discharge <i>29/12/23 at 2.00</i>	Total No. of Days <i>1 Day.</i>
UNIT <i>ccc</i>	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
<i>CAP - XISTEM</i>			<i>P24.1</i>
<i>MILD LV DYSFUNCTION</i>			<i>P50.1</i>
<i>SYSTEMIC HYPERTENSION</i>			<i>P10</i>
<i>TYPE II DIABETES MELLITUS</i>			<i>E11.9</i>
DATE	OPERATION / PROCEDURES		ICPM Code
<i>29/12/23</i>	<i>CORONARY ANGIOGRAM</i>		<i>88.50</i>
DATE	TYPE OF ANESTHESIA		
<i>28/12/23</i>	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL		
DISCHARGE STATUS			
<input type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input checked="" type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Signature of the Consultant <i>[Signature]</i>		Signature of Medical Records Officer <i>[Signature]</i>	

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.



செவிலியர் கையொப்பம்

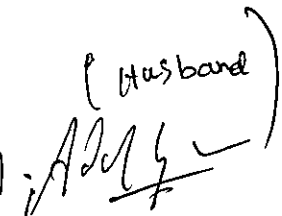
Signature of Admitting Nurse

தேதி 28/12/2023

Date 10.59

எனது உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

(husband)

உறவுமுறை
Nature of Relationship

GENERAL CONSENT FOR ADMISSION

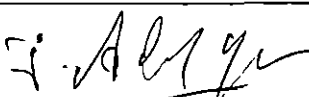
I, Mrs. Mary Prema the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

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

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

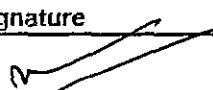
	Signature / Thumb Impression*	Name	Date	Time
Patient			28/12/23	10.59
Surrogate/Guardian (if applicable #)		J. ADALAZHALI (Write name and relationship with patient)	28/12/23	10.59
Reason for surrogate consent	Patient is unable to give consent because:			
Witness				
Interpreter (if applicable)				

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

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

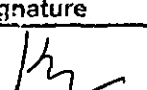
S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
1	Hemodynamic instability defined as	
	Pulse less than 40 or more than 150 beats/minute	
	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure	
	Mean arterial pressure less than 60 mm Hg	
	Diastolic arterial pressure more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

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
8	Endocrine System and Metabolism related	
	Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis	
	Thyroid storm or myxedema coma with hemodynamic instability	
	Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl	
	Other endocrine problems such as adrenal crises with hemodynamic instability	
	Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring	
	Hypo or hypernatremia (Serum Sodium less than 10 mEq/L or more than 155 mEq/L) with seizures, altered mental status	
	Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias	
	Hypo or hyperkalemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or muscular weakness	
	Hypophosphatemia with muscular weakness	

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Velamuri P.	95458	28/12/24	11PM

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

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

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Karthi	85851	29/12/23	



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DISCHARGE AGAINST MEDICAL ADVICE

IP No.	IPH2023002627	D.O.A	: 28/12/2023
UHID	MHI202381551	D.O.P	: 29/12/2023
Name	Mrs. MARY PREMA SHARMILA	Room No.	: CCU
Age / Gender	53 Years / FEMALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 29/12/2023

DIAGNOSIS:

CAD- NSTEMI

MILD LV DYSFUNCTION

SYSTEMIC HYPERTENSION

TYPE II DIABETES MELLITUS

PROCEDURE:

CORONARY ANGIOGRAM DONE ON 29.12.2023 – TRIPLE VESSEL DISEASE.

BRIEF HISTORY:

Mrs. Mary Prema Sharmila, 53 years / Female, presented with the complaints of chest pain since morning. History of shortness of breath. She came to Medway heart institute on 28.12.2023 for further evaluation and management.

No H/O cough, vomiting, diarrhea.

Known case of systemic hypertension, type II diabetes mellitus on medication.

N/K/C/O bronchial asthma, dyslipidemia and Seizure disorder

ON EXAMINATION:

Patient Conscious, Oriented, Febrile

HR	-	118bpm
BP	-	136/100 mmHg
SPO ₂	-	99%
CVS	-	S1S2 (+)
RS	-	BAE (+), Mild crepts
Abdomen	-	Soft
CNS	-	NFND

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

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94457 94457
1800 572 3003

Medway Group of Hospitals

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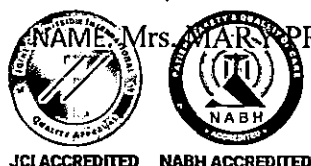
E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

MHI/HOSP/2022/118



NAME: Mrs. MARY PREMA SHARMILA

UHID: MHI202381551



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INVESTIGATIONS: Reports Enclosed

POST INVESTIGATIONS:

ECHO(29.12.2023) : Concentric LVH. RWMA (+) all apical segments, apex, mid septum, mid anterior hypokinetic. Mild LV systolic dysfunction. EF – 43%. Grade I diastolic dysfunction. Normal RV systolic function. Aortic valve sclerosis. No AR / AS. Mitral annular calcium present. Trivial MR. Trivial TR. No PAH. No clot / vegetation / effusion.

COURSE IN THE HOSPITAL:

Mrs. Mary Prema Sharmila, 53 years / Female, admitted with above mentioned complaints. Basic investigation were done. underwent Coronary Angiogram by right radial access on 29.12.2023 which revealed **TRIPLE VESSEL DISEASE**. She is advised for **CABG & CTVS** opinion was obtained and orders followed. Her medications are optimized and she is being discharged against medical advice.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS - 15/15

Temp - 98.6°F

PR - 71/min

BP - 117/70mmHg

SPO2 - 99% in room air

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. ECOSPRIN	75 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. AZTOR	80 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. AX CER	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. IVABRAD	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. ALPRAX	0.5 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. FLAVEDON MR	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	SYP. CREMAFFIN	20 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. PAN	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
9.	TAB. EZEDOC	10 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
10.	TAB. VALENTAS	50 MG	½	0	½	ORAL	AFTER FOOD	TO CONTINUE

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED

NAME: Mrs. JAR PREMA SHARMILA

UHID: MHI202381551



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11.	TAB. ALDACTONE	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
12.	TAB. LASIX	40 MG	½	0	½	ORAL	AFTER FOOD	TO CONTINUE
13.	TAB. ANGISPAN TR	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
14.	INJ. HUMAN MIXTARD		20 U	0	10 U	S/C	AFTER FOOD	TO CONTINUE
15.	INJ. FONDARED	2.5 MG	1	0	0	S/C	AFTER FOOD	X 2 DAYS

DISCHARGE ADVICE	
DIET	LOW FAT, SALT & DIABETIC DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES
REVIEW	REVIEW WITH DR. GNANA VELU.G AFTER 1 WEEK.

To report: If temp > 101 °F / Difficulty in breathing / chest pain / Giddiness/ palpitations.
Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 4310 8959.

Typed by: Ezhilarasi.

"I understood the Content of the discharge summary."

CONSULTANT SIGNATURE

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

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

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

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1800 572 3003

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044-2473 4454

MHI/HOSP/2022/118

INFORMED CONSENT FOR LEAVING / DISCHARGE AGAINST MEDICAL ADVICE

At request

I/We the attendants of patient Mr./Mrs./Ms./Master MARY PREMA SHARMILA
S/O WIDOW SATHEER have been explained about the medical
condition of self/our patient in the language which I / we Understand by
Dr. Karthik as mentioned below.
a. Clinical Diagnosis : CAD - NSTEMI / mild LV dysfunction
b. Present Condition : CAD - NSTEMI
c. Treatment planned / required : CAD
d. Possible outcomes of continuing the treatment : CAD - Triple vessel disease
e. Complications of not continuing the treatment : -

- I/We would request the concerned health professional to discharge me/our patient immediately by discontinuing the medical management / procedure.
- I/we in my/our full senses, without any correction and unreservedly and solemnly hereby declare that I/We am/are entirely responsible for any consequences that may arise due to such a discharge against medical advice. At any point of time, now or in the future, I/we will not hold the concerned health professionals and staff of Medway Heart Institute responsible / liable for any consequences that may arise due to such a discharge against medical advice.
- I/we also undertake the responsibility of paying all the amounts that are payable to Medway Heart Institute before leaving the hospital Premises.
- If the patient is unable to sign, then mention the reason :

	NAME	SIGN	DATE	TIME
Patient / Representative with Relationship	<u>J. ASHLEY</u>	<u>[Signature]</u>	<u>29/12/23</u>	<u>20:20 PM</u>
Witness	<u>Jay</u>	<u>JAYARAJ</u>	<u>29/12/23</u>	<u>20:30</u>
Doctor	<u>Dr. Karthik</u>	<u>[Signature]</u>	<u>29/12/23</u>	<u>20:20 PM</u>

INPATIENT INITIAL ASSESSMENT

Date: 28/12/2023

Time of arrival in ward: 11 PM

Allergies (if Yes, specify details):

Drugs

☐ Yes ☒ No

Blood Transfusion

☐ Yes ☒ No

Food

☐ Yes ☒ No

Others

Vital Signs: Temp: 98.6°F | Pulse / HR: 118 (beats/min) | BP: 136/100 (mmHg)

Respiration: 15 (breaths/min) | SpO₂: 96% | Height: 153 (cms) | Weight: 60 (kgs) | BMI: 24.9 kg/m²

Pain: ☒ Yes ☐ No. If Yes, Score: 2/10

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

Duration: 1 hour morning Location:

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

40 chest pain x since morning
no dyspnoea / palpitation / chest syncope / dizziness
fever / weakness of arms

PAST MEDICAL HISTORY (with duration of illness):

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

Others:

- K/CPO CAD - 2010 - Last MI -

- Advised CABG, pt refused surgery / managed medically

Past Surgical History:

- no surgery

Present Medication (for Medication Reconciliation):

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	Tab - Enalapril	5mg	P/O	1-2		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Mt. Coarct	2-3mg	P/O	1-2	Friday	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Dr - Clozapine	75mg	P/O	1-2	Y	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Dr - Rosuvastatin B	40/180	P/O	5-7		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Dr - Edox	15mg	P/O	5-7		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Dr - Statin - M	10mg	P/O	5-7		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History:

- NI

Personal / Social History (Tick whichever is applicable)

Lifestyle: ☐ Sedentary ☒ Active Occupation: _____
 Smoking: ☐ Yes ☒ No Alcohol: ☐ Yes ☒ No Recreational Drug Use: ☐ Yes ☒ No
 Others: _____

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

not post menopausal state

General Physical Examination:

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

SYSTEMIC EXAMINATION

CVS:

S1 S2 ⊕

Respiratory System:

B/L equal HE / mild crackles

Gastrointestinal System:

Soft

Central Nervous System:

NFND

Urinary / Reproductive / Locomotor System:

NFND

Skin / Ophthalmic / ENT

NFND

Suspected of contagious disease: ☐ Yes ☐ No

Immuno compromised status: ☐ Yes ☐ No

Isolation required:

☐ Yes ☐ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☐ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

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

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

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

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

Is the BMI < 20.5? ☐ Yes ☐ No

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

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

Provisional Diagnosis:

NFND / Uncontrolled DM / ANV

Plan of Care:

CAC team

Investigations Advised:

Carbap - 1 / HbA1c

Diet Advice:

Diabetic diet

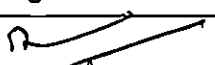
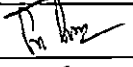

- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: _____

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

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. Ravi	92468	28/12/21	11 PM
Consultant		Dr. Gnanavelu	39469	28/12/23	11 PM
Patient Attendant		Relationship A-Esther (SISTER)	SISTER	28/12/23	8:00 PM



CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mrs. MARY PREMA SHARMILA the ☐ Patient or ☒ Representative of patient have (please tick the correct option above and below):

- ☒ Read
- ☐ I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my patient's illness and I am aware of the all the possible outcomes.
- ☒ I have been explained this consent form in English / Tamil, which I fully understand and understood the information provided about ICU Treatment

I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

A Central venous catheter or central line is a long, soft, thin, hollow tube placed into a large vein (blood vessel). Compared to a peripheral line, central line is larger, longer and is placed into a large vein in the neck, upper chest or groin.

Intended benefits:

Common reasons for having a central line include:

- To give IV medications over a long period of time because a large vein can tolerate an IV catheter for a longer time than a small vein. Examples of such medications are antibiotics and chemotherapy.
- To rapidly deliver large amounts of fluid or blood, for example when a person is in shock.
- To give multiple drug infusions in critically ill patients
- To directly measure blood pressure in a large or central vein. This can help determine how much fluid a person needs.
- For patients who require frequent blood draws to be sent to the laboratory, the central line allows for blood to be drawn without repeatedly pricking the patient.
- To deliver nutrition directly into the blood when food or liquids cannot be given through the mouth, stomach, or intestine.
- To give vasopressors (Blood pressure increasing drugs) for a patient in shock, as giving vasopressors through peripheral line can cause injury to the small blood vessels.
- In some cases, two of the lumens on the central line can be used to perform dialysis, with one lumen used to take blood out of the vascular system and another lumen used to return the dialyzed blood to the body.

Possible risks and complications:

- Discomfort during placement: Discomfort can result from the needle stick and placement of the catheter at the time it is inserted.
- Bleeding: Bleeding can occur at the time the catheter is inserted. The bleeding is usually mild and stops by itself
- Infection: Any tube (catheter) entering the body can make it easier for bacteria from the skin to get into the bloodstream. Special care in cleaning and bandaging the skin at the catheter site can decrease the risk of infection.
- Thrombosis
- Arrhythmia
- Pneumothorax (Collapsed lung): When a central venous catheter is placed in the chest area, if the needle passes through or misses the vein, the needle could pierce the lung causing the lung to collapse. If this happens, lung will be re inflated by placing a tube between the ribs to remove the air that has leaked from the lung.

I have been explained the implications of not undergoing this procedure like:

- Worsening of clinical condition of the patient.
- Repeated pricking for blood samples.
- Difficulty in getting peripheral venous access.
- When high dose vasopressors are needed, ischemia to the distal part of the limb.

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:

Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.

The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:

The procedure might be needed for you / your patient for any of the following reasons:

- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
- when patient needs help to breathe
- when patient has a head injury and cannot breathe on his / her own
- when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:

- Injury to teeth or dental work
- Injury to the throat or trachea
- Bleeding
- Lung complications or injury
- Aspiration (stomach contents and acids that end up in the lungs)
- Other Risks (if any): _____


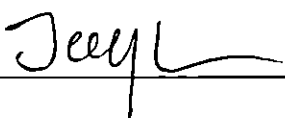
Possible alternatives:

Non invasive ventilation can be helpful in a few situations. But when Endotracheal Intubation is required, there can be no alternative treatment offered.

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful procedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.

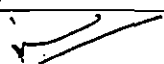
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		A. ESTHER (SISTER) <small>(Write name and relationship with patient)</small>	28/12/23	11 PM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		JAYADEVI	28/12/23	11 PM
Interpreter (if applicable)				

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

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned procedure, to the patient / patient representative. I am confident that he / she has understood the information fully as described in this document.

	Signature	Name	Reg. No.	Date	Time
Doctor		Dr. Velumy P.	95402	28/12/23	11 PM

உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

என்ற பெயர் கொண்ட டோயாளியான அல்லது டோயாளியின் பிரதிநிதியான நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உள்ளவற்றில் சரியான விருப்பத்தேர்வை தயவுசெய்து டிக் செய்யுங்கள்)

- ☐ வாசித்திருக்கிறேன்
☐ சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.
☐ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சவாச வழிமுறை, மத்திய சிறை அணுகுவசதி இதுவரை தமனி தமனிக்குழல்கள் உட்பட முச்சுப் பெருங்குழலுக்குள் குழாய் செருகுதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பீடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:

மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

- ஒரு சிறிய நாளத்தைவிட, ஒரு பெரிய நாளமானது நீண்ட காலஅளவிற்கு ஒரு IV கதீட்டரை தாங்கும் என்பதால், நீண்ட காலஅளவிற்கு IV மருந்துகளை வழங்குவதற்காக. ஆக்டிவியாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு ஆபத்தான நிலையிலுள்ள நோயாளிகளுக்கு ஒன்றுக்கு மேற்பட்ட பல மருந்து உட்செலுத்தல்களை வழங்குவதற்கு.
- ஒரு பெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனையகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிக்குத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வகை செய்கிறது.
- வாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- புறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேரங்களில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாலிசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பொருத்தப்படும்போது அசௌகரியம்: ஊசியால் குத்தும்போது மற்றும் கதீட்டரைப் பொருத்தும் நேரத்தில் அதனை உட்செலுத்துகின்ற நேரத்தில் அசௌகரியம் ஏற்படக்கூடும்.
- இரத்தக்கசிவு: கதீட்டர் உட்செலுத்தப்படும் நேரத்தில் இரத்தக்கசிவு நிகழக்கூடும். இந்த இரத்தக்கசிவு வழக்கமாக மிகச்சிறிய அளவில் லேசாக இருக்கும் மற்றும் அது தானாகவே நின்றுவிடும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதீட்டர்), சருமத்திலிருந்து பாக்கிரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதீட்டர் பொருத்தப்படும் இடத்தை தாய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉறைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுரையரில் உறைக்காற்று நோய் (நுரையரில் துவண்டு மடிதல்): மார்பு பகுதியில் ஒரு மைய சிரைகதீட்டர் பொருத்தப்படும்போது ஊசி சிரை / நாளத்தின் வழியாக கடந்து செல்லுமானால் அல்லது அதை தவறவிடுமானால் அந்த ஊசி நுரையரிலுக்குள் ஊடுருவி, நுரையரில் துவண்டு மடிவதை விளைவிக்கும். இது நிகழமானால், நுரையரிலிருந்து வெளியே கசிந்திருக்கின்ற காற்றை அகற்றுவதற்கு விலக்கங்களுக்கு இடையே ஒரு குழாயை வைப்பதன் மூலம் நுரையரில் மீண்டும் மீட்பு வீக்கம் பெறுமாறு செய்யப்படும்.

இந்த மருத்துவ செயல்முறையை மேற்கொள்ளவில்லை எனில், கீழ்க்கண்டவை போன்ற விளைவுகள் நிகழலாம் என்று எனக்கு விளக்கிக் கூறப்பட்டிருக்கின்றன:

- நோயாளியின் மருத்துவ / உடல்நிலை மோசமடைதல்.
- இரத்த மாதிரிகளுக்காக திரும்பத்திரும்ப ஊசி குத்துவது.
- புறவெளி இரத்தநாள அணுகுவசதியை பெறுவதில் சிரமம்.
- அதிக அளவிலான வாசோபிரெசர்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தஓட்டத்தை

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

முச்சப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

முச்சப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை முச்சப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் முச்சத்தினால் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவு, உங்களது / உங்களது நோயாளியின் முச்சக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. முச்சக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த முச்சக்குழல், ஆக்சிஜனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும். சுவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். முச்சக்குழாய், குரல்வகைக்கு சற்றுக்கீழே தொடங்குகிறது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு முச்சக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான முச்ச சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த முச்ச சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. முச்சக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திசு ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது முச்சக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. முச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. முச்சப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் முச்சப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது முச்ச / காற்றுப்பாதையை அடைப்பின்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிஜன் தடையின்றி, தராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கூடும்:

- உணர்விறப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக முச்சப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது / உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது
- சுவாசிக்க உதவு:
- சுவாசிப்பதை நோயாளி நிறுத்திவிடப்போது அல்லது சுவாசிப்பதில் சிரமம் இருக்கும்போது
- சுவாசிப்பதற்கு நோயாளிக்கு உதவி தேவைப்படும்போது
- நோயாளிக்கு தலைக்காயம் ஏற்பட்டிருக்கும்போது மற்றும் தானாகவே அவரால் சுவாசிக்க இயலாதபோது
- ஒரு கடுமையான காயம் அல்லது நோயிலிருந்து மீண்டு வருவதற்காக நடை காலஅளவிற்கு ஒரு நோயாளி உணர்விறப்பு மருந்தின் கீழ் அல்லது மயக்க நிலையின் கீழ் வைக்கப்படுவது அவசியமாக இருக்கும்போது.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது முச்சக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியீடுதல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

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

மேற்கூறப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடையத் திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிப்படுத்திக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேரவில், சில நேரங்களில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன். இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள என்ன நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

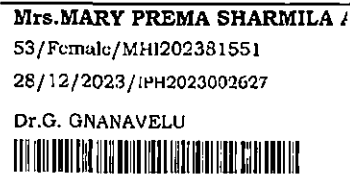
மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு ஒப்புதல் அளிக்கிறேன் என்று இதன்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

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

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

கீழே, கையொப்பமிட்டுள்ள மருத்துவராகிய நான், திட்டமிடப்பட்ட ஆபரேஷன் / நடைமுறை குறித்த தன்மை, ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள், கிடைக்கும் என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பின் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அவர், இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

மருத்துவர்	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்



Medway
Heart
Institute

Every heart beat counts

Dr. Pondered 20y dec 1-20

7388



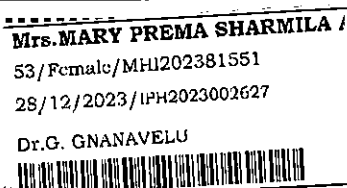
DOCTOR'S PROGRESS NOTES

DATE	NOTES
29/12/23	Sp. Dr. Gnanavelu et al.
7.50 AM	No claps No sup No flt signs
Dr. T. Palanisubramanian MD, DNB (Internal Medicine) Intensivist	WS - 88 @ HR: 126/50 PR: 80/1
g hrs I 400 O 800	Plan echo today NPO after Breakfast (8am)
	TC - 10530 Hb - 14.3 Plt - 2.28 lakh Wt/ht - 25/0.59 NA/E - 134/4.42
	93705
	88 3848
29/12/23	Can Motu
13.00	App (P) Rr A 5V Plan - echo
	PO de
	Screening Echo
	1024

DATE	NOTES
24/12/23	
7:45 pm	<p>pb attending wants to discharge the patient hence disagreed against medical advice</p>

[Signature]
55530

Dr. T. Palaniappan
MD., DNB., MNAMS., MRCP(UK)
Intensivist
Reg. No: 55530




Medway
Heart
Institute

Every heart beat counts

Doctor's Name : Dr. Kenthale

ICU PROGRESS NOTES

ICU SCORES (as Appropriate)	CLIF ACLF / AD score:	MELD score:	AARC score:
	SOFA score:	SAPS II score:	APACHE II score:
ICU Day Background	CAD / TVD NSTEMI PACED. ELVD. T2DM.	Issues last 24 hours	
Central nervous system Conscious / oriented / sedated with Sedation score GCS - E V M 15/15 Pupils Pain score Drains		Cardiovascular system HR - 79 Rhythm - Sinus Cardiac Output - BP - 130/80 CVP - Cardiac Medications:	
Respiratory system Oxygen supplementation - BAP @ Saturation / PaO2- SpO2 = 99. Ventilator : Spontaneous / Controlled  Last C x R - Drains -		GIT Soft. P/A Bowels - Y / N Loose stools / Melena Drains NG tube : Y / N Day NGA- USG CT	
Nutrition & Fluids Oral feeds / NG feeds Oral feeds. TPN - formula used Npo. now. Supplements Calories / Proteins achieved : IV fluids - 24 hour Urine output Fluid balance Creatinine clearance Acidosis Lactate DR. T. J. ... RRT - SLED / CRRT MD.. DNB ..		Microbiology peripheral lines Invasive lines 1. 2. Foley's Yes / No ET Tube / Tracheostomy tube - Y / N Day Culture reports Antimicrobials with days 1. 2. 3.	
Labs Hb TC Platelets Urea Creatinine 0.59 Na K 4.49 Bilirubin AST ALT INR Others		DVT prophylaxis - Y/N Fondered. Drugs : Mechanical - TEDS / SCD Stress Ulcer Prophylaxis - Y/N Drugs Pressure sore Y (N) Alpha bed Y (N) -	

Plan for the day

Adm ✓

Drgs as charted

fls chrt.

monitor vitals.

CRA body

Npo from 8am

Shift to Cath lab on call

1/2

85851

4PM

pt reviewed

reviewed from cath lab.

Vitals stable

Observation

Oral feeds.

Drgs as charted

1/2 85851

5pm

Shift toward

1/2 85851

Dr. T. Palaniappan
MD., DNB., MNAMS., MRCP(UK)
Intensivist
Reg. No: 55530

Doctor	Signature	Name	Reg. No.	Date	Time
	<u>1/2</u>	Dr. Harthik	85851	29/12/23	9.00

PRE/POST OPERATIVE ECHO

Mrs. MARY PREMA SHARMILA /

53/Female/MHI202381551

28/12/2023/IPH2023002627

Dr. G. GNANAVELU



Date & Time	
29/12/23 3.30pm	<u>Swearing Echo Report</u>
	<ul style="list-style-type: none"> - Concentric LVH - RWMA ⊕ all apical segments, Apex, mid septum, mid anterior hypokinetic - mild LV systolic dysfunction - Grade I Diastolic dysfunction - Normal RV systolic function - Aortic Valve Sclerosis - NO AR/AS. - Mitral annular calcium present - Trivial MR. - Trivial TR. No PAM - No clot / vegetation / effusion.
	HR: 86 bpm
	LV1Dd: 46 mm EDV: 89 ml LV1Dd: 36 mm ESV: 48 ml EF: 43% EF: 44%
	TR gdt: 29 mmHg RVTOI: 10 cm/s RVCP: 39 mmHg Tapsc: 1 T mm
	E/A: 0.74 mE/E: 12.49
	- Done by: Ms. Ravathy Cardiac Tech
	MHI/DO 98/UNED10.

Mrs. MARY PREMA SHARMILA

53/Female/MHI202381551

28/12/2023/IPH2023002627

Dr.G. GNANAVELU



MICROBIOLOGY SHEET

DATE	28/12/23		
COLOUR	PALE YELLOW		
REACTION			
SPECIFIC GRAVITY	1.015		
APPEARANCE	SLIGHTLY TURBID		
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT	N		
UROBILINOGEN	NORMAL		
PUS CELLS	NEGATIVE 9-3		
EPITHELIAL CELLS	2-4		
RBC	NIL		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL.		

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

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

BLOOD GROUP

O+ve

INVESTIGATION SHEET

Mrs. MARY PREMA SHARMILA /

53 / Female / MHI202381551

28 / 12 / 2023 / IPH2023002627

Dr. G. GNANAVELU



Date	28 / 12 / 23					
HAEMATOLOGY						
Hb	14.3					
P.C.V	42.2					
Platelets	288					
TLC	10530					
Polymorphs						
Lymphocytes	29.8					
Eosinophils	1.0					
Mono / Basophils	3.3 10.2					
E.S.R						
BIO-CHEMISTRY						
Urea	25					
Creatinine	0.59					
Sodium	134					
Potassium	4.42					
Bicarbonate	21					
Chloride	96.4					
Magnesium						
Calcium						
Phosphorus						
LFT						
T. Bilirubin						
D. Bilirubin						
I. Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protein						
S. Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]

Mrs. MARY PREMA SHARMILA /

53/Female/MH1202381551

28/12/2023/IPH2023002627

Dr.G. GNANAVELU



T2 DM1 / SHTN. EF-401.

VITAL INFORMATION SHEET

BLOOD GROUP

ON ADMISSION

Height in CM

Weight in Kg.

$\pm 155 \text{ km}$

$\pm 60 \text{ kg}$

Diagnosis: NSTEMI / UNCONTROLLED DM

Procedure : CAGFEVDJ

[illegible]



41/IP/2022/066



Every heart beat counts

[illegible]

CONSENT FOR HIV TESTING


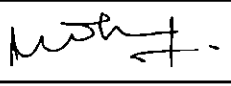
Patient Name : Mrs. Mary Prema . Age : 53 / F Sex : M / F
Consultant : Dr. Gnanavelu . UHID :

- I _____ have been given verbal and written educational information for HIV antibody testing.
- I have been informed that a sample of my blood will be drawn and tested and tested to detect HIV antibodies I have been informed of the purpose, potential uses of the test and the consequences of not having the test done.
- I hereby acknowledge that I have read or have had read to me this information regarding HIV antibody testing.
- I have been given the opportunity to ask questions and all the questions have been answered to my satisfaction.
- I acknowledge that I have given consent for performance of this blood test to detect HIV antibodies. This has been explained to me in _____ language, which I can understand.

	Signature	Name	Date	Time
Patient				
Doctor / Nurse / Counsellor				
Interpreter				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because _____
and I, _____ (name / relationship to the patient), therefore,
consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated
above, with the doctor or doctor's designee, and hereby consent to this procedure.

	Signature	Name	Date	Time
Patient Representative with relationship		A. E. R. S.	28.12.23	22.30
Doctor / Nurse / Counsellor		Dr. Mohanraj	28.12.23	22.30
Interpreter				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because _____

and I, _____ (name / relationship to the patient), therefore, consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and hereby consent to this procedure.

	Signature	Name	Date	Time
Patient Representative				
Witness				
Doctor				
Interpreter				

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 28/12/23 Time of Arrival: 22.59 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: Mrs. Esther.

Relationship with Patient: Sister. Contact Person's Name: Mrs. Esther. Relationship: Sister.

Contact No.: 9962684179 Primary language spoken: ☒ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☐ Yes ☒ No

Patient status: ☒ Conscious ☐ Unconscious ☐ Disoriented | Patient Vulnerable: ☐ Yes ☒ No

Menstrual History : LMP : _____ Menopause: _____

Medical History : DM / HTN / Co - Morbidity : _____ Yes If yes specify

Drugs History : Antiplatelet _____ (Specify)

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

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

If Yes, specify details: _____

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

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 118 (beats/min) | BP: 130/80 (mmHg)

Respiration: 20 (breaths/min) | SpO₂: 98 (%) | CBG: 379 (mg/dl) | Height: 155 (cms) | Weight: 60 (kgs)

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

If Yes, specify: _____

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

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

Duration: _____ Location: _____

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

Nutritional Screening:

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

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

Type of Patient: ☐ Diabetic ☐ Non Diabetic Type of Diet: DM diet

Dietician Informed: ☐ Yes ☐ No. If Yes, mention the Name: Mrs. Catherine. Time: 23.14

Orient Patient if: ☐ Conscious

Orient Patient Attendant if: ☐ Unconscious ☐ Disoriented

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

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

Functional Assessment:

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

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

Pressure Injury Risk Assessment: Braden Scale					
Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	4	Rarely Moist	4	Walks Frequently	4
Slightly Limited	3	Occasionally Moist	3	Walks Occasionally	3
Very Limited	2	Very Moist	2	Chair Fast	2
Completely Limited	1	Constantly Moist	1	Bed Fast	1
Mobility	Score	Nutrition	Score	Friction & Shear	Score
No Limitation	4	Excellent	4	No apparent problem	3
Slightly Limited	3	Adequate	3	Potential Problem	2
Very Limited	2	Probably In-Adequate	2	Problem Present	1
Completely immobile	1	Very Poor	1		

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

Total Score: 20 Action needed: ☐ Yes ☒ No Pressure injury present at the time of admission: ☐ Yes ☒ No

If yes, Location: _____ Grade: _____ Size: _____

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)		
Fall Risk Assessment (Modified Morse Scale):		
Variables		Numeric Value
History of falling (immediate or within 6 months)	No	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
Ambulatory Aid None / Bed Rest / Nurse Assist Crutches / Cane / Walker Furniture	0	0
		15
		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait Normal / Bed Rest / Wheel Chair	0	0
		10
Weak Impaired		20
Mental Status Oriented to own stability Overestimated or forgets limitations	0	0
		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppressant and psychotropics	15	0
		15
Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk		Total Score <u>20</u>

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

- ☒ Familiarize the patient with the immediate surroundings
- ☒ Remind the patient to use call bell before getting out of bed
- ☐ Keep the two side rails in the raised position at all times for all patients regardless of age
- ☐ Keep the call bell, bedside table, water, glasses within the patient's easy reach
- ☒ Remove excess equipment or furniture to make a clear path
- ☒ Keep the patient's bed in the low position at all times except during procedure
- ☒ Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed
- ☒ Bed wheels should be locked
- ☒ Encourage family participation in the patient's care
- ☒ Ensure that floor of the bathroom is dry and not slippery
- ☒ Review medications for potential side effects that can promote falls
- ☒ Use safety belts during movement in wheelchair
- ☒ The patients are not ambulated by themselves. They are to be ambulated only with assistance

Medium risk interventions (25 - 44)

- ☐ Apply all the low risk interventions
- ☒ Tie yellow fall risk tag in the bed and Wheel chair / Stretcher
- ☒ Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat
- ☒ Use restraints and bed monitors as ordered by the doctor
- ☒ Allow the patient to ambulate only with assistance
- ☒ Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care
- ☒ Do not leave patients unattended in diagnostic or treatment areas
- ☒ Accompany the patient while going to bathroom
- ☒ Advise the patient to use grab bars near the toilet, bathtub, and shower
- ☒ Make sure the family and other visitors understand the restrictions mentioned above

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

S. No.	Parameters	Yes / No	Score
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
2	Bedridden recently >3 days or major surgery within four weeks	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
5	Entire leg swollen (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
6	Localized tenderness along the deep venous system (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
9	Previously documented DVT (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	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.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

Risk Score Interpretation (Probability of DVT):

Tick the score obtained (✓)

Final Score

0

		✓	Action Taken	Date	Time
Low Risk	-2 to 0	✓		28/12/23	23.14
Moderate Risk	1 to 2				
High Risk	3 to 8				

Personal Belongings / Valuables:

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

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
	<i>[Signature]</i>	A. ENTU	Relationship Sister.	28/12/23	23.14
Nurse	<i>[Signature]</i>	R. Mohanraj	2352	28/12/23	23.14
Unit In-Charge	<i>[Signature]</i>	JAYADEVI	0002	28/12/23	23.14

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28/12/23

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

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

B

BACKGROUND

Type of surgery: - Date of surgery: -
Allergies if any: unknown
On room air / oxygen: Room air
IV fluids on flow: -
Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 118 (beats/min) | Respiration: 20 (breaths/min)
BP: 130/80 (mmHg) | SpO₂: 98 (%) | Height: 155 (cms) | Weight: 60 (kgs) | BMI: 24.2 kg/m²
Others: -
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High
Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: DM diet Drains: -

R

RECOMMENDATION

Referral doctors: -
Pending medications: -
Pending medication indent: -
Pending lab reports / Investigations: Serology, ABG, @ due
Critical value alert and its corrections: -
Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: -
Pending follow-up orders: Echo
Special instructions if any: PD do Cx, Sr. Echo

	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>[Signature]</i>	D. Mohanraj	2352	29/12/23	7-30
Handover taken by	<i>[Signature]</i>	Pamela D	0159	29/12/23	7-30
Document endorsed	<i>[Signature]</i>	JAYASIN	0002	29/12/23	7-30

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29/12/23

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: ACS - NSTEMI, UNCONTROLLED DM, HTN

NEWS / PEWS Score: -

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: cephalic

Day:

Day:

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: -

Date of surgery: -

Allergies if any: UNKNOWN

On room air / oxygen: R.A - 99%.

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 71 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/50 (mmHg) | SpO₂: 99 (%) | Height: 155 (cms) | Weight: 60 (kgs) | BMI: 24.2 kg/m²

Others: -

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

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

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

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

Current diet:

Drains: -

⇒ DND DIET

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

Sr. Echo to old

	Signature	Name	Emp. No.	Date	Time
Handover given by		Ranjan R	0107	29/12/23	14:00
Handover taken by		Ranjan R	0107	29/12/23	14:30
Document endorsed		JAYARAJ	0002	29/12/23	14:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
29/12/23	MORNING DUTY NOTES				
@ 7.30					
	→ pt taken over from night duty staff, pt on conscious & oriented, v/s checked & recorded				
	W. line patient, pt on no complaints				
8.30	→ pt had breakfast done, Medication given as per drug chart	Don			
	→ pt on self reading	Don			
	→ DR. KARHICK sip order to Sy. Fortat 2.5mg pt given				
9.40	→ DR. GINANIVELU sip order to continue same drug chart, today CAG plan				
13.00	→ pt on shifted to cath-lab	Don			
13.45	→ pt on received from Cath lab pt on conscious & oriented v/s checked & recorded, in line patient CAG + TVD @ radial approach pressure bandage @ no oozing & hematoma, no complaints				
14.00	→ pt on give intake given CBG checked				
	→ pt on self reading no complaints				
14.30	→ pt on handing over to evening duty staff	Don			
Document endorsed by.	Signature	Name	Emp. No.	Date	Time
	Jayl	JAYAPRANSU	002	29/12/23	19.00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29/12/23

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: UNCONTROLLED DM / BMTN

NEWS / PEWS Score: 7

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: CEPHALIC

Day: -

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: EACRTVD

Allergies if any: NKDA

On room air / oxygen: ON ROOM AIR - 9

Complaints / New Symptoms in last shift: -

Date of surgery: 29/12/23

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 101.4 (°F) | Pulse / HR: 68 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/82 (mmHg) | SpO₂: 99 (%) | Height: 55 (cms) | Weight: 69 (kgs) | BMI: 24.2 kg/m²

Others: -

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

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

Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-16 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6

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

Current diet: ON diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

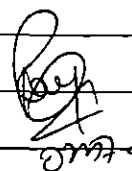

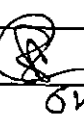
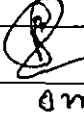
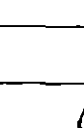

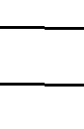
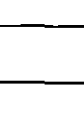
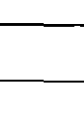
Changes in nursing care plan: ☐ Yes ☐ No. If Yes, modified care plan date: -


Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>[Signature]</u>	<u>Kamya S</u>	<u>0257</u>	<u>29/12/23</u>	<u>2030</u>
Handover taken by	<u>[Signature]</u>	<u>P/K</u>	<u>-</u>	<u>-</u>	<u>-</u>
Document endorsed	<u>[Signature]</u>	<u>JANABEN</u>	<u>002</u>	<u>29/12/23</u>	<u>2040</u>

NURSES PROGRESS NOTES


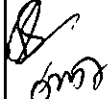




Date & Time	Observations / Action	Signature with Emp. No.
29/12/23 14:30	EVENING DUTY NOTES	
	→ Pt took over from morning duty staff, Pt on conscious & oriented v/s checked & reassured. In line patient	 0251
14:40	Pt had lunch.	 0251
15:30	Discharge alone no special intervention.	 0251
16:00	T. 6112222222 given	 0251
16:30	S/B DR. Gnanaseelan advised to plan for ward shift.	 0251
17:00	S/B DR. Anandaraman advised to continue the same & plan for ex.	 0251
19:00	Wily v/s checked & reassured.	 0251
20:00	→ Pt had diet no other complaints → Pt not night medication given as per drug chart.	 0251
20:30	⇒ Pt Got IAMA at request so Pt Discharged Pt reports hand over to Pt attendant & Pt Discharge Summary due.	 0251

Document endorsed by.	Signature	Name	Emp. No.	Date	Time
		JAYASHREE	002	29/12/23	20:20






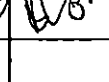
ADULT NURSING CARE PLAN

Patient Details (AM...)
Mrs. MARY PREMA SHARMILA /
53 / Female / MHI202381551
28/12/2023 / IPH2023002627
Dr. G. GNANAVELU

Initial Date: 29/12/23 Time: 8:00.		Modified Date: Time:		
Reason for Modification:		Diagnosis: ACS - NSTEMI / UNCONTROLLED DM / BHTN.		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt had DM diet given E not on DM diet N	[Signature] [Signature]
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Patient on Room AIR SpO ₂ - 99% E not on on room air N	[Signature] [Signature]
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Patient not Chart maintained E not on fluid maintained N	[Signature] [Signature]


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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Self introduction E upon blood test communication N	  
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Patient medicine given as per chart E Medication given as per chart N	  
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Jay	JAYADEN	000	29/12/23	21:00

ADULT NURSING CARE PLAN

Mrs. MARY PREMA SHARMILA /
53 / Female / MHI202381551
28/12/2023 / IPH2023002627
Dr. G. GNANAVELU



Initial Date: 28/12/23		Time: 23.00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: AC - NSTEMI, uncontrolled DM, HPT.			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M				
			E				
			N	pt Had a DM diet			
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M				
			E				
			N	pt on Room air			
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M				
			E				
			N	pt take a oral fluids.			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E N pt Bed mobilization	 non 2200
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input checked="" type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistent / volume / Hematemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M E N pt (N) elimination pattern	 non 2200
SKIN INTEGRITY <input type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M E N pt maintain (N) skin Integrity.	 non 2200

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M E N pt Clean & Hygiene	 <i>not 230.</i>
SAFETY <input checked="" type="checkbox"/> Check ID Hand <input type="checkbox"/> IV care <input type="checkbox"/> EJV CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M E N pt ID Band present	 <i>not 230.</i>
COMFORT AND SLEEP <input checked="" type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input checked="" type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M E N pt comfort position	 <i>not 230.</i>
OBSERVATION <input type="checkbox"/> Vital Signs <input checked="" type="checkbox"/> GCS <input checked="" type="checkbox"/> Blood Sugar <input checked="" type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M E N pt Hemodynamically stable.	 <i>not 230.</i>
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input checked="" type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input checked="" type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M E N pt Good Psychological support	 <i>not 230.</i>

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M E N pt good verbal communication	
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M E N administered the medication as per drug chart	
Endorsed by	Signature	Name	Emp. ID	Date	Time
	JayL	JAYADH, J	0002	29/12/23	29/12/23

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION 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 discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body discomfort	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	1	2	3	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	1	2	3	4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	2	3	4
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	1	2	3	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	1	2	3	4
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		1	2	3	4
TOTAL SCORE					1	2	3	20
Initial & Emp. No. of Staff Nurse:					1	2	3	20
Initial & Emp. No. of Sr. Staff Nurse:					1	2	3	20

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

Date: 29/12/23
Time: M E N

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	7
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	3	7
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	2	7
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	3	7
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	3	7
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	7
TOTAL SCORE					2	19	7
Initial & Emp. No. of Staff Nurse:					17	010	7
Initial & Emp. No. of Sr. Staff Nurse:					17	002	7

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

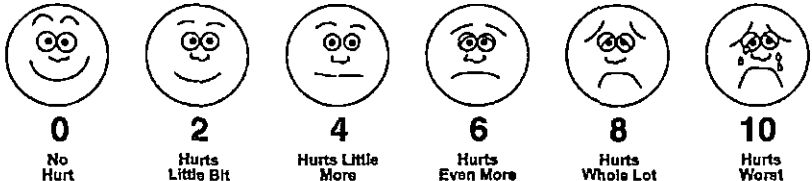
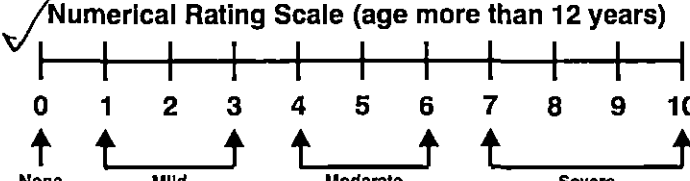


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
28/12/23 23.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
24.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
28/12/23 1.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
2.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
3.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
4.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
5.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
6.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000
7.00	0/10	No pain	-	-	-	Nur 2300	Jay 0000

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
8:00	0	no pain	—	—	—	Don	Jay 1000
9:00	0	no pain	—	—	—	Don	Jay 1000
11:00		PT received from both lab @ 13:45					
13:45	0	no pain	—	—	—	Don	Jay 1000

PAIN SCALES

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

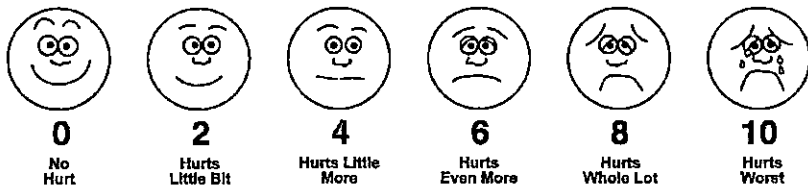
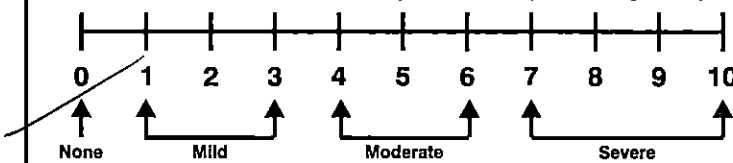


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
28/12/23 14:45	0/10	No pain	—	—	—	Dr. Jay	Jay 005
15:45	0/10	No pain	—	—	—	Dr. Jay	Jay 005
16:45	0/10	No pain	—	—	—	Dr. Jay	Jay 005
17:45	0/10	No pain	—	—	—	Dr. Jay	Jay 005
18:45	0/10	No pain	—	—	—	Dr. Jay	Jay 005
19:45	0/10	No pain	—	—	—	Dr. Jay	Jay 005
20:00	0/10	No pain	—	—	—	Dr. Jay	Jay 005
Pt GOT LAMA ON 29/12/23 @ 20:00.							

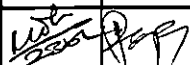

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures > 12 = Moderate to severe pain - Pharmacological intervention
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 <p>0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst</p> <p>Numerical Rating Scale (age more than 12 years)</p>  <p>0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe</p>
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

DVT RISK ASSESSMENT

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

		Date	Time					
		31/12/23	29/12/23					
		23.00	8.00					
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0					
2	Bedridden recently >3 days or major surgery within four weeks	0	0					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0					
5	Entire leg swollen (Assess for both legs)	0	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	plc				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0					
9	Previously documented DVT (Assess for both legs)	0	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESKD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction, Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0					
FINAL SCORE		0	0					
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		low	low					
DVT prophylaxis started		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	28/12/23	29/12/23	30/12/23						
	Time	23:00	8:00	11:00						
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	30	30						
Low Risk (0 - 24)										
Medium Risk (25 - 44)		✓								
High Risk (45 or above)										
Signature & Emp. No. of RN		<i>[Signature]</i> 3300	<i>[Signature]</i> 3300	<i>[Signature]</i> 3300						
Signature & Emp. No. of Sr. RN		<i>[Signature]</i> 0000	<i>[Signature]</i> 0000	<i>[Signature]</i> 0000						

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

INTERVENTIONS <i>Tick as per the Risk Score</i>	Date	Time								
	28/12/22	29/12/22	29/12/22							
	08:00	8:00	11:00							
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings	✓	✓	✓							
Remind the patient to use call bell before getting out of bed	✓	✓	✓							
Keep the two side rails in the raised position at all times for all patients regardless of age	✓	✓	✓							
Keep the call bell, bedside table, water, glasses within the patient's easy reach	✓	✓	✓							
Remove excess equipment or furniture to make a clear path	✓	✓	✓							
Keep the patient's bed in the low position at all times except during procedure	✓	✓	✓							
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed	✓	✓	✓							
Bed wheels should be locked	✓	✓	✓							
Encourage family participation in the patient's care	✓	✓	✓							
Ensure that floor of the bathroom is dry and not slippery	✓	✓	✓							
Review medications for potential side effects that can promote falls	✓	✓	✓							
Use safety belts during movement in wheelchair	✓	✓	✓							
The patients are not ambulated by themselves. They are to be ambulated only with assistance	✓	✓	✓							
Medium risk interventions (25 - 44)										
Apply all the low risk interventions	✓	✓	✓							
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher	✓	✓	✓							
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat	✓	✓	✓							
Use restraints and bed monitors as ordered by the doctor	✓	✓	✓							
Allow the patient to ambulate only with assistance	✓	✓	✓							
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care	✓	✓	✓							
Do not leave patients unattended in diagnostic or treatment areas	✓	✓	✓							
Accompany the patient while going to bathroom	✓	✓	✓							
Advise the patient to use grab bars near the toilet, bathtub, and shower	NA	✓	✓							
Make sure the family and other visitors understand the restrictions mentioned above	✓	✓	✓							
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓							
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓							
Locate the high-risk patients in a room close to the nurses' station		✓	✓							
Answer these patients call bells as quickly as possible		✓	✓							
Provide a commode at bedside (if appropriate)		✓	✓							
Urinal/bedpan should be within easy reach (if appropriate)		✓	✓							
Encourage family members or other visitors to stay with them		NA	✓							
If appropriate, consider using protection devices: safety belts		✓	✓							
Signature & Emp. No. of RN	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>							
Signature & Emp. No. of Sr. RN	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>							

FAMILY COUNSELLING FORM

CONSULTANT- Dr. Gnanavelu. G.			DIAGNOSIS- Aes - NSTEMI, Uncontrolled DM, HTN.			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
28/12/23	DOCTOR	SISTER.	Condition explained		the	the
29/12/23	DOCTOR	HUSBAND	clinical condition updated to family members.		the	the
			L/C			

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

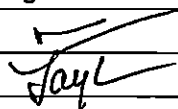
Name of Discharge Nurse _____ Signature : _____

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 28/12/23 Time: 23.00

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		Dr. V. S. Jayaram	9565	28/12/23	10.45
Nursing Staff		JAYARAM	0002	28/12/23	10.45
Dietician					
Physiotherapist					
Patient Care Service Staff					

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mrs. MARY PREMA SHARMILA

PATIENT NAME : 53/Female/MHI202381551
28/12/2023/IPH2023002627

IP No. / UHID No 20238/551.

AGE / SEX : Dr.G. GNANAVELU

Ward / Bed No. 003.



ANY SCORE>0 SHOULD BE MONITORED IN EVERY SHIFT

[illegible]

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

Tlb- ECOSPILLAI

Dose

7mg

Route

P/O

Frequency

1 - 0 - 0

8:00

Dr. Sign & Reg. No. / Seal

✓ 95468

Start Date & Time

28/12/23 @ 08:00

Stop Date & Time

Additional Info:

DRUG NAME

Tlb- ALDOL

Dose

20mg

Route

P/O

Frequency

0 - 0 - 1

20:00

Dr. Sign & Reg. No. / Seal

✓ 95468

Start Date & Time

28/12/23 @ 22:00

Stop Date & Time

Additional Info:

DRUG NAME

Tlb- AXCEL

Dose

90mg

Route

P/O

Frequency

1 - 0 - 1

8:00

Dr. Sign & Reg. No. / Seal

✓ 95468

Start Date & Time

28/12/23 @ 22:00

Stop Date & Time

Additional Info:

DRUG NAME

Tlb- IVABRAD

Dose

5mg

Route

P/O

Frequency

1 - 0 - 1

8:00

Dr. Sign & Reg. No. / Seal

✓ 95468

Start Date & Time

28/12/23 @ 22:00

Stop Date & Time

Additional Info:

DRUG NAME

Tlb- CEFIXIME

Dose

0.6ml

Route

S-C

Frequency

1 - 0 - 1

8:00

Dr. Sign & Reg. No. / Seal

✓ 95468

Start Date & Time

28/12/23 @ 22:00

Stop Date & Time

29/12/23 @ 8:00

Additional Info:

Area In-charge

Nurse Signature:

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

Tab. ALPRAX

Dose

0.5mg

Route

P/O

Frequency

HS

Dr. Sign & Reg. No. / Seal

[Signature]
95468

Start Date & Time

28/10/23 @ 22:00

Stop Date & Time

Additional Info:

DRUG NAME

Syp. Cefamandol PLUS

Dose

20ml

Route

P/O

Frequency

HS

Dr. Sign & Reg. No. / Seal

[Signature]
95468

Start Date & Time

28/10/23 @ 23:00

Stop Date & Time

Additional Info:

DRUG NAME

Tab. FLAVEDON - MR

Dose

35mg

Route

P/O

Frequency

12

Dr. Sign & Reg. No. / Seal

[Signature]
95468

Start Date & Time

28/10/23 @ 23:00

Stop Date & Time

Additional Info:

DRUG NAME

20- PAM

Dose

40mg

Route

N

Frequency

120

Dr. Sign & Reg. No. / Seal

[Signature]
95468

Start Date & Time

28/10/23 @ 23:00

Stop Date & Time

Additional Info:

DRUG NAME

Tab. ELODOC (ELETIMIBE)

Dose

10mg

Route

P/O

Frequency

HS

Dr. Sign & Reg. No. / Seal

[Signature]
95468

Start Date & Time

28/10/23 @ 23:00

Stop Date & Time

Additional Info:

Area In-charge
Nurse Signature:

[Signature]
000

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

PRAL VALANTHIS

Dose

100mg

Route

P/O

Frequency

1/2 - 1/2

Dr. Sign & Reg. No. / Seal

95408

Start Date & Time

28/12/23 @ 22:00

Stop Date & Time

8:00

Additional Info:

DRUG NAME

DR. ADALTONIS

Dose

2mg

Route

P/O

Frequency

1 - 0

Dr. Sign & Reg. No. / Seal

95408

Start Date & Time

28/12/23 @ 22:00

Stop Date & Time

8:00

Additional Info:

DRUG NAME

TRU-LASIX

Dose

40mg

Route

P/O

Frequency

1/2 - 1/2

Dr. Sign & Reg. No. / Seal

95408

Start Date & Time

28/12/23 @ 23:00

Stop Date & Time

8:00

16:00

Additional Info:

DRUG NAME

Py-Bonded

Dose

20mg

Route

SC

Frequency

1 - 0

Dr. Sign & Reg. No. / Seal

25851

Start Date & Time

29/12/23 @ 8:10

Stop Date & Time

8:00

Additional Info:

DRUG NAME

G. ANGLIS PAN-OR

Dose

2.5mg

Route

PO

Frequency

1 - 1

Dr. Sign & Reg. No. / Seal

62461

Start Date & Time

29/12/23 @ 12:40

Stop Date & Time

8:00

26:00


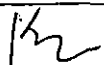
Additional Info:

Area In-charge

Nurse Signature:




200

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
28/12/23	23:00	DM Diet		92468					
09/12/23	8:00	DM Diet		85851					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
28/12/23	Night	MOHANPAT.	2350			Night			
09/12/23	Morning	Ramya	0159			Morning			
29/12/23	Evening	Ramya J	0257			Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: NGRNI / UNCONTROLLED DM / HTN Allergies if any: NADA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
CCU	CATH LAB	28/12/23	12:50 ^P	CAG

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

ASSESSMENT OF PATIENT:

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

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

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

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


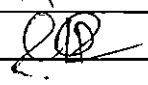
Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.3	10	86	99	110/63	0/10

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

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
		Dr. Mary - P	0159	29/12/23	13:00
Handed over to		Dr. Gnanavelu	0176	29/12/23	13:00

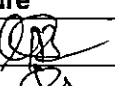
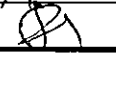
After Procedure:

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.4	22	58/min	98.1	136/74	0/10

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

Handover by	Signature	Name	Emp. No.	Date	Time
		Dr. Gnanavelu	0176	29/12/23	13:45
Handed over to		Dr. Mary - P	0159	29/12/23	13:45

Mrs. MARY PREMA SHARMILA /

53/Female/MHI202381551

28/12/2023/1PH2023002627

Dr. G. GNANAVELU



CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr. GNANAVELU has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with blood. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

- (i) The nature of coronary artery disease (ii) The pumping status of the heart (iii) Your age and general health

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

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	(i) the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I, MARY PREMA SHARMILA, acknowledge that Dr. GNANAVELU has explained my medical condition and the proposed procedure. I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment. He has explained my prognosis and the risks of not having the procedure. I have been explained that some reprocessed items might be used once its sterility and integrity is confirmed. I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	<u>MARY PREMA SHARMILA</u>	<u>MARY PREMA SHARMILA</u>	<u>29/12/23</u>	<u>12.30</u>
witness	<u>[Signature]</u>	<u>ADALAL HAGAN</u>	<u>29/12/23</u>	<u>12.30</u>
Doctor	<u>[Signature]</u>	<u>Dr. G. GNANAVELU</u>	<u>29/12/23</u>	<u>12.30</u>
Interpreter				

Patient Details (Affix Label here)

Name:

UHID:

DOB:

Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

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

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

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

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாறடையு (d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரமாக இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(i) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவினை சிராய்ப்பு அல்லது வீக்கம்
வரும்பாலான மக்களுக்கு	(n) சிறிய அளவினை சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு கிரத்தமேற்றாதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்வதற்கு

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

SES PROGRESS NOTES

Date & Time

Observations / Action

Signature with Emp. No.

29/12/23

Cath can

13-00

⇒ Pt Received from CCU to
Cath can. Conscious and oriented
Vitals stable.

13-10

⇒ Sterile Drapping done.
CAG Procedure started.

13-20

⇒ Rt Radial arterial approach
under local anaesthesia.

13-20

⇒ Giv: 1500 20mg + Giv: Heparin 2000
FA given o/B Dr. G.G. (Sir)

13-20

⇒ BP: 112/80 (90) mmHg, HR: 90 b/min
SpO2: 98% Vitals stable.

13-30

⇒ Procedure CAG done. Rt
Radial Arterial sheath removed.
Tight plaster bandage applied
no oozing & hematoma.

13-45

⇒ Pt shifted to CCU all
reports hand over to Plt Ramya


Signature

Name

Emp. No.

Date

Time

Document
endorsed by


Jsthige

0016

29/12/23 13.45



JCI ACCREDITED



NABH ACCREDITED



Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mrs. MARY PREMA SHARMILA	ID:	MHI202381551
Age/Gender :	53 F	IPH:	IPH2023002627
Cath No. :	3502	DOP:	29.12.2023
Done by	Assisted by	Technician	Physician assistant
Dr.Gnanavelu	Ms. Sandhiya	Mr. Prathap	Ms. Shalini

DIAGNOSIS: CAD-NSTEMI; CAG: DIFFUSE TVD (2013); VPCs; T2DM; HBP; MODERATE LV DYSFUNCTION

Access: Right radial artery

Total exposure time: 238.9"

Hardware used: 5F sheath, 5F TIG

DAP : 17.84 Gy.cm²

Contrast used: CONTRAPAQUE 50ML

Total RAK: 72.65 mGy

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

Hemodynamic data: Aortic pressure 112/80(90) mmHg; HR 94 bpm; SpO2 99%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCX.
LAD	Type 3 vessel. LAD has diffuse adventitial calcification. Proximal LAD has luminal irregularities. Mid LAD has 80% discrete stenosis. Distal LAD has significant diffuse disease followed by total occlusion. Gives 3 diagonals which are diffusely diseased.
LCx	Nondominant. LCX after major OM is a thin vessel with significant diffuse disease. OM1 is an early and major vessel, has non flow limiting disease.
RCA	Dominant. Proximal RCA has 70% tubular stenosis. Mid RCA has non flow limiting disease. Distal RCA has significant diffuse disease followed by total occlusion. PDA and PLV are visualized by Grade II heterocollaterals.
IMA	LIMA & RIMA are normal. Left vertebral artery ostium has 50% discrete stenosis.

FINDINGS: RIGHT DOMINANT; DIFFUSE DISTAL TRIPLE VESSEL DISEASE**ADVICE: OPTIMAL MEDICAL MANAGEMENT****DR. G. GNANAVELU, MD, DM**

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

Advisor & Mentor

Chief Cardiologist

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

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

Medway Centre of Excellence (Chennai)

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

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist


Mrs. MARY PREMA SHARMILA /
53/Female/MHI202381551
28/12/2023/IPH2023002627
Dr. G. GNANAVELU

Name of the Procedure : CAG Location : Cath Lab Date & Time : 29/12/23

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>13.10</u> Before Induction of Procedural Sedation		TIME OUT <u>13.20</u> After procedural Sedation and before procedure		SIGN OUT <u>13.30</u> When Doctor indicates that the Procedure is complete	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done <u>CAG</u>	<input checked="" type="checkbox"/> Yes
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>CAG</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt Radial Arterial approach</u>	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input checked="" type="checkbox"/> Yes	Position <u>supine</u>	<input checked="" type="checkbox"/> Yes	Any recovery concerns : If Yes, Pls. specify :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes		
		Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : If Yes, Pls. specify :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None
Pre OP medication taken	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Required equipment for procedure available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes	Corrective action :	
		For procedural sedation cases	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Intra procedure glycaemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure : <u>Dr. G. GNANAVELU</u>	Nurse : <u>P.N. Panchavaram</u>	Technician : <u>Mr. Pandiyan</u>	Others (Please Specify :	
Date : <u>29/12/23</u>	Date : <u>29/12/23</u>	Date : <u>29/12/23</u>	Date : <u>29/12/23</u>	Date :	
Time : <u>13.40</u>	Time : <u>13.40</u>	Time : <u>13.40</u>	Time : <u>13.40</u>	Time :	

Procedure Monitoring Sheet (Cath Lab)

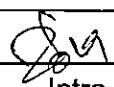
Patient Name : **Mrs. MARY PREMA SHARMILA /**
53 / Female / MHI202381551
28 / 12 / 2023 / IPH2023002627
UHID / IP : **Dr. G. GNANAVELU**
Consultant : 

Age / Sex :

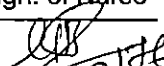


Ward Unit :

Diagnosis :

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 114/65 Temp: 98.5 Pulse: 88 RR: 19 SPO2: 99	<input checked="" type="checkbox"/>		
Urine voided	<input checked="" type="checkbox"/>		
Bowel preparation	<input checked="" type="checkbox"/>		
Pre-procedure medication administered	<input checked="" type="checkbox"/>		
Procedure site marked	<input checked="" type="checkbox"/>		
Skin preparation done	<input checked="" type="checkbox"/>		
NPO - 8.30	<input checked="" type="checkbox"/>		
Loose Tooth removed			
Contact lenses / Eye glasses removed			<input checked="" type="checkbox"/>
Prosthesis present			<input checked="" type="checkbox"/>
Jewellery/Nail polish removed			<input checked="" type="checkbox"/>
Checked for Allergies (Drug / food)			
IV line/In-situ	<input checked="" type="checkbox"/>		
Consent taken	<input checked="" type="checkbox"/>		
Investigation reports / Documents received	<input checked="" type="checkbox"/>		
Signature of Nurse : 	Date & Time : 29/12/23 @ 9.40		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
29/12/23 12.10	94 bt/min	22 bt/min	112/80 (90)	98.1	-	
12.20	90 bt/min	22 bt/min	116/78 (90)	98.1	-	
12.30	90 bt/min	22 bt/min	136/74 (94)	98.1	-	
			Procedure	got over		

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

Time : 12.45 Route : Rt Radial arterial
 Complication : Nil approval

BP : 136/74 (90) mmHg, HR : 90 b/min, RR : 20 br/min, SpO2 : 98%

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

Advise:

- ◆ Shift To: Ward / ICU ☒
- ◆ Bed rest up to 6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt Radial artery.
- ◆ Diet Dm diet
- ◆ Inform Duty Medical Officer SOS
 - a) If patient complains of any Discomfort
 - b) If dressing is Loose or Socked with Blood
 - c) If limbs are Cold / Absent Pulse
- ◆ Remove Rt Radial arterial dressing on 30/12/23 at 13.00 AM /PM after informing to the consultant.
- ◆ Special instruction if any:

h. amb
 Name & Signature of Consultant

POST PROCEDURE OBSERVATION

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

Nurses Notes :

procedure etc done. Rt Radial arterial
sheath removed. Tight Plaster bandage
applied. no oozing & hematoma

Condition at the end of procedure : ☒ Stable ☐ Critical
 Patient shift to : ☐ Recovery Room ☐ Patient Room ☒ CCU ☐ Other _____

Name & Signature of the Nurse :

Date & Time : 29/12/23
@ 13.45

QIP 0176

**ACQUISITION FOR MEDICINE**

IP No. :
Name of Patient : DOA :
Age / Sex : UHID No. :
Consultant Name : Room No. : C10

S.No.	Date	Medicine Name	Qty.
16	28/12/23	7 - AZTOR 80mg	(10)
17	"	7 - AZOR 90mg	(10)
18	"	5 - VALER 5mg	(10)
19	"	9 - CLEXANE 0.6ml	(2) (1)
20	"	7 - ALPRAX 0.5mg	(3)
21	"	7 - CREMAFIN	(7)
22	"	9 - FIVLDM MR 35mg	(10)
23	"	3 - FAN 10mg	(2)
24	"	7 - ELLDOC (10mg)	(10)
25	"	7 - VALENITAS 10mg	(6)
26	"	7 - ADDACTON 25mg	(10)
27	"	7 - LASIX 10mg	(10)
28	"		

Nurse Name

Pharm Bill & Name

**REQUISITION FOR MEDICINE**

Name of Patient : *Mary PRema* IP No. :
Age / Sex : *Sharmila* DOA :
Consultant Name : UHID No. :
Room No. : *CCU*

S.No.	Date	Medicine Name	Qty.
1.	23/12/22	Humon misted	— (1)
2.	"	Insulin Syringe	— (1) (2)
3.	"	ECG leads	— (15)
4.	"	Dose flush	— (1)
5.	"	10000 antibiotics	— (1)
6.	"	Vanflex 200	— (1)
7.	"	Easy Fin	— (1)
8.	"	Urdia 500	— (1)
9.	"	Calmarin 1000	— (1)
10.	"	Easy Bath	— (1)
11.	"	HP-Lasix 100mg	— (2)
12.	"	Glebel 1000	— (5)
13.	"	500ml D/I	— (2)
14.	"	8ml D/I	— (2)
15.	"	1 - JCO3 p.m.h 75mg	— (10)

Nurse Name

Pharm Bill & Name



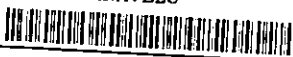
JCI ACCREDITED NABH ACCREDITED

Mrs. MARY PREMA SHARMILA /

53/Female/MHI202381551

28/12/2023/1PH2023002627

Dr. G. GNANAVELU



(A Unit of United Alliance Healthcare Pvt)

Mrs. Mary Prema Sharmila

29/12/23

NSSTEMI / CAD-TVD / uncontrolled T2DM / moderate

Re

T. ASCOPRIN	75g	Plo	1-0-0
T. AZOR	80g	Plo	0-0-1
T. ANGER	90g	Plo	1-0-1
T. IVABRAD	5g	Plo	1-0-1
T. ALPRAP	0.5g	Plo	0-0-1
Syp. CEFEMAFIN PLUS	20ml	Pu	0-0-1
T. FLAVIZONE-MR	35g	Plo	1-0-1
T. PAN	40g	Plo	1-0-1
T. ELEPOL	10g	Plo	0-0-1
T. VALENTAS	50g	plo	1-0-1/2
T. ALDACTON	25g	Plo	1-0-0
T. LASIX	40g	Plo	1/2-0-1/2-0
T. ANGLISPANTR	2.5g	Plo	1-0-1
Sy HUMAN MIXTARD 50		SL	20-0-10
Sy FONDARID	2.5g	SL	1-0-0 x 2 days

Consider...

11, PHS Main Road, United India Colony, Kodambakkam, Chennai - 600024, Tel: 044-26100233

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MHI/ICU/2022/064



THE UNIVERSITY OF CHICAGO



A

FLUID REQUIREMENT :

29/12/23 → ②

[illegible]

BALANCE 7400M1

MHI/ICU/2022/064



**Medway
Heart
Institute**
heart beat counts

A

FLUID REQUIREMENT :

28/12/23 \rightarrow ①.

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.			TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.			
08:00.	-	-					-					200	200	200	+ 200	
09:00.	-	-					-					100	300	200	+ 300.	
10:00	-	-					-					-	300	300	+ 300	
12:00	800	800					800					-	300	300	- 500	
03:00	-	800					800					-	300	200	- 500	
04:00	-	800					800.					100	400	400	- 400	
05:00	-	800					800					-	400	400	- 400	
06:00	-	800					800					-	400	400	- 400	
07:00	-	800					800					-	400	400	- 400	
SPECIFIC OBSERVATIONS/REMARKS								MEDICATION / DRUGS								

[illegible]

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

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

044-2473 4455

care@medwayhospitals.com

Registration No	: MHI202381551	Patient Name	: MARY PREMA SHARMIL
Age	: 53	Gender	: Female
IP Number	: MMH/HM/IPH2023002627	Discharge Date	: 30/12/2023 11:32:00AM
Bill No	: MMH/HM/IPH00652	Bill Date	: 30/12/2023 11:30:32AM
Ward Name	: CCU	Bed Name	: CCU-5

NO DUE

