

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175915

Admit Date : 03-Jul-2026

Admit Time : 11:18 AM UHID : BAH-00660566

Patient Details :

Patient Name : Baby Of Y. SREE RAMYA

Age : 0 D

Guardian : Mr Y .KRISHNA CHAITANYA

DOB : 03-07-2026 09:47 AM

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO-401 BLOCK -3 MY HOME AVTHER
Manikonda Hyderabad Telangana INDIA
500089

Phone No : 8977665959/ 9885452340

E-mail : na123@rainbowhospitals.in

Admission Details :

Bed Type : BASINET

Bed No : CRDL-SW-418-1

Ward Name : 4F-BIRTHING CENTRE

Room No : CRDL-SW-418-1

Admission Type : First Visit

Contact Details :

Name : Mr Y .KRISHNA CHAITANYA

Relationship : Father

Contact Address : FLAT NO-401 BLOCK -3 MY HOME AVTHER
Manikonda Hyderabad Telangana INDIA 500089

Phone No : 9885452340 / 8977665959


Signature

Doctor Details :

Doctor Name : Dr. VENKATA LAKSHMI A

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELF PAY

willing

New Born Screening	: Y. Sreedamya
TFT	:
OAE	:
Mother's Blood Group	: O+ve
Baby's Blood Group	:
Anomaly Scan	:
Vaccination	: OPV, DPT, Hep-B given 3/12/20 Nanchy

(P.T.O)

[illegible]



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Y. Sree Ramya Age : 34 Father's Name : Age :
Date of Birth : Date of Admission : UHID No :
NICU Consultant : Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : Y. Sree Ramya Mother's Blood Group : OPPOSITIVE
Gender : ☒ M ☐ F Blood Group : O+ Birth Weight (gms) : 2809 Length (cms) : 48
Date of Birth : 2/7/26 Time of Birth : 9:45 AM OFC (cms) : 35
Place of Birth : CHP: BH Estimated Gesth Age : 38+5

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 34 Ht : Wt : BMI : Married Life : LMP : 14/9/25 EDD : 12/7/26

Conception : Spontaneous or with Rx :

Booked at what GA : 9 wks AN Steroids Drugs / Doses :

Last Scans Details : 2/6/26 235+1 AFI: 11.7 cms AC: 76 EFW: 2678

(N) Doppler TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

H/o value of recent BP recording, proteinuria, edema,
oliguria, any investigations (LFT, platelet count) :

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

H/o GDM/ pre GDM/ on diet or insulin

Controlled or not, recent values, HbA1 values :

GDM on Insulin

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Gestational hypothyroidism

Any other Chronic Medical Problems, when detected Thyroid

drugs ? Fibroid complicating pregnancy

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : Any culture :

PPROM: Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 2 P: 1 A: L1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1-	2024	1555	3-22 kg	ASH	male	

PERINATAL HISTORY

Treating Obstetrician : Dr. Sankala Kola Hospital : KCH, BH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : Bow - LSCS -

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITATION DETAILS

APGAR SCORE

Gestational Age : Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
1	1	
8	8	

TOTAL

Snapee II Score

Score

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Mean BP (mmHg)	> 30 (0)	20-29 (9)	< 20 (19)		
Lowest Temp (oF)	> 96 (0)	96-95 (8)	< 95 (15)		
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)	
Lowest Serum PH	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)		
Multiple Seizures	No (0)	Yes (19)			
U. Output (ml / kg / hr)	> = 1 (0)	0.1-0.9 (5)	< 0.1 (18)		
Apgar Score	> = 7 (0)	< 7 (18)			
Birth Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		
SGA	> 3rd percentile (0)	< 3rd (12)			
Total					

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Equipment check done



Baby received in a prewarmed linen



Dried / Stimulated / warmed.



Saturations were not time appropriate

← Supplemental O₂ given
for 5 minutes



Cord cleaned / clamped / cut



cyt. vitamin K given 0.5ml 1.m



Vitals checked



Shifted to mother's side

Investigation details in previous Hospital :

Feeding History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic pink
d/t As good
hemodynamics are stable

VITALS : Temperature : Euthermic HR : 121/min RR : 49/min NIBP : CFT : 13

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 97%

ANTHROPOMETRY: Birth Weight : 2809 Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

AF open

Shape / Moulding :

Edema / Bruising :

No caput

Size - (H.C.) :

FACIES :

(Any Facial
Dysmorphism)

— N —

NECK and CLAVICLES :

Range of Motion :

Asymmetry :

— N —

Masses :

EYES :

Symmetry :

Red Reflex : to be checked

Discharge :

EARS, NOSE MOUTH and THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

No cleft lip/palate

THORAX and BREASTS :

Shape of Thorax :

Position of Nipples and Number :

— N —

ABDOMEN and UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump : 2A FW

Discharge :

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

(N)

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

N

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

(N)



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 99/min SCR / ICR / See - Saw breathing :

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings :

SpO₂ : 95.1 Auscultation: BAE (+) Breath Sounds: NVBS (+) Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 121/min BP :

Femoral Pulses : all well felt

Other Peripheral Pulses :

Precordial Activity :

Murmurs :

Signs of Cardiac Failure :

ABDOMEN:

Shape :

Palpation :

Palpable masses :

Abdominal girth :

Hernia orifice :

Anal Patency : looks patent

Umbilical Cord : 2A + W

First urine passed : ✓

Meconium passed : ✓

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtl Score :

Nerves : all

MOTOR SYSTEM:

Passive Tone :

Active Tone : all are good

Neonatal Reflexes :

Grasp : ☒ Palmar ☒ Plantar ☒ Sucking ☒ Rooting ☐ Crossed adductor :

Moro's : all symmetrical DTR :

ATNR :

Skull and Spine :

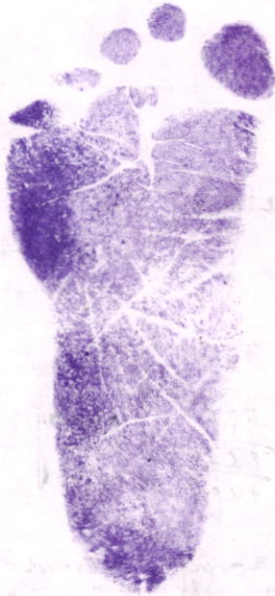


Diagnosis :

G2P1U | 38+5 | GDM on insulin | Gest Hypothyroid | Fibroids /
CIAB | 2809.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Consultant :

Signature :

Name :

Date & Time :

DR. VENKATA LAKSHMI A
Registration No: 50115

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :
..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

Vital : HR : RR : BP : SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

1- Cord blood for
Blood grouping

2- Vaccines OPV today
BCG
Hep B

Plan during ward follow up :

3- OBS monitoring 30 min after
Post feed
3, 6, 12, 18, 24, 36, 48 Hrs -
Post feed
inform if < 45 mg/dl

Feeding Plan at the time of shifting :

10:20 AM to 10:30 AM

4- SBR/NBS/OAE @ 48 Hrs.

5- W/F RD / Feed intolerance

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Doctor Signature (Handover Given): Doctor Signature (Handover Taken):

Doctor Name: Doctor Name:

Date & Time: Date & Time:

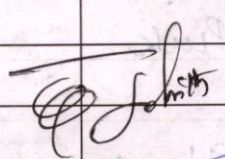
BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 0 D 3 H (M)
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 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

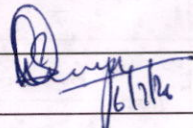
Date & Time	Progress Notes	Doctor's Order
2/7	clerk <u>RESIDENT.</u>	
4 PM	G2P14 38+5 GDM on insulin Gest Hypothyroid Fibroids 2809.	
		<u>Plan</u>
n m m	OT	1- Vaccines - OPV/BCG/Hep-B today
	clerk: good	2- SRE/NBS/OAE - @ HCTOT
	Eutermic baby.	3- ct RBS monitoring as advised.
	Euglycemic so far.	4- BBF 2nd hourly
		
		notes by Sr Kanth (01/08/21)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:45	<u>lactation care plan:</u> - well formed breast and nipples - colostrum seen - suck good.	
	<u>dehmi</u> - Direct breast feeding - dem for deep latch as demonstrated in cross cradle or cradle hold. - make baby suck for 15-20 min on each side. - Demand feeding not exceeding 2-2 1/2 hrs	
		<i>[Signature]</i> Deepa
4/1/26 3:20pm	<u>AS/B Resident</u>	
	2940L / 38+5 / 6Dm on insulin / Gest Hypo / 2809 / LSCS	
	Baby on room air sleeping well	<u>Plan</u>
U / ✓	Euthermic - Pink	① DBF @ 2 hrs
m / ✓	Euglycemic	② monitor GRBS @ 36 HOL 11 P.m
	Wt → 2.63kg	③ warm care
	Feeding well	④ OAE
	Eng	NBS
	Tone	SBR
	activity } good	T/m 10 am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 8:00am	S/B Resident	
	GAHOL 38+5 GDM Gest LSCS 2809g hypothyroidism Plan SBR - 12.7	
	M 0+ B 0+	① DBP 2nd hily measured feedP
	U ✓ m ✓	FF 20-23 ml 2nd hily
	Twet → 2.552 Kg. 9% ↓	
	Baby on room air	
	zuglycemic - GRBI 82mg/dl. ② OAE - Today	
	Cry } Tone } good activity }	③ warm care ④ watch for Urine output
	discharge	Sohels
	PLV wednesday	
		6/7/26 OAE - New born hearing screening Bilateral responses are present. Bilateral Pass
		



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660566 IP5-00175915
Baby Of Y. SREE RAMYA
03-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. VENKATA LAKSHMI A



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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

(Select and 'tick mark' [✓] the boxes as applicable)

Baby's Name: Mother's Name:
Date of Birth: 31/12/26 Time of Birth: 9:47 am Gender: ☒ Male ☐ Female
Birth Weight: 2.809 kg Kgs HC: 35 cm Length: 48 cm
Meconium in Liquor: ☐ Yes ☐ No Cried at Birth: ☐ Yes ☐ No
Term / Pre-term / Post-term: Term
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: Baby:
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time:

AFFIX MOTHER'S
IDENTIFICATION LABEL

Mode of Delivery: ☐ Normal ☒ LSCS - Emergency/ Elective ☐ Instrumental ☐ AVD
Indication:

Physical Assessment of New Born:

Temp: 98.5 °C HR: 142 /Min RR: 39 /Min BP: SpO₂: 100 %
Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☒ Yes ☐ No Score: 16 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: ☒ Yes ☐ No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: ☐ Sleeping ☒ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

Skin: ☒ Pink ☐ Meconium Stain ☐ Others, Specify:

Nursing Management: (Please strike through If not applicable e.g. Yes / No)

Vitamin K 1 mg I.M Administered: ☒ Yes / ☐ No

Routine Care Provided: ☒ Yes / ☐ No

Capillary Blood Glucose Monitoring Done: ☒ Yes / ☐ No

Neonatal Screening Done: ☒ Yes / ☐ No

1. Nutritional Screening: Feeding Problem ☒ Yes / ☐ No

2. Functional Screening: Musculoskeletal Congenital Abnormality ☒ Yes / ☐ No

3. Socio History: Siblings ☒ Yes / ☐ No

All information obtained from ☒ Mother ☒ Father ☐ Other Family Member

Newborn Screening Discussed: ☒ Yes / ☐ No

Nurse Name: Raj

Signature: Raj

Date & Time:

Docu. No. : RCHBH / FRM / CLINICAL / 144

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MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis:

new born Baby

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
<i>8/10/26</i>	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>DBF needed</i>	<i>DBF needed</i>	<i>warm care provided</i>	<i>[Signature]</i>	☐ Medical ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/8/24	12pm	2	Infection Control	pt	1	0	1	1	-	[Signature]

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									

CONSENT FOR FORMULA FEEDS

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03-07-2026 0 Y 0 M 2 D (M)
Dr. VENKATA LAKSHMI A

Patient Name : Age : Gender : ☐ Male ☐ Female
UHID No : Department : Date :

I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature :
Name :
Relationship with Patient :
Date & Time :

Witness :

Signature :
Name :
Date & Time :

Doctor (who is taking the consent) :

Signature :
Name :
Date & Time :

Doc. No : RCH / FRM / CLINICAL / 124

Pratiksha TM
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Date: 2/10/20 Time: 4PM 2PM 6PM 12PM 6AM

Doctor/Nurse/Family Concern?

Temperature
(°F)Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score in early warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
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23	95.0
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35	95.0
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37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
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81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

Conscious Level	Normal Altered
-----------------	-------------------

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00660566 IP5-00175915
Baby Of Y. SREE RAMYA
03-07-2026 0 Y 0 M 0 D 7 H (M)
Dr. VENKATA LAKSHMI A



RCH / FRM / CLINICAL / 124

INFANT (< 1 year) Children's Observation & Early Warning Scoring Chart

Children's
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 12:00

Doctor/Nurse/Family Concern?

Temperature
(F)

4/7/26

104
103
102
101
100
99
98
97
96
95
94

98.8°F 98.7°F 98.5°F 98.1°F

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

122 140 122bpm 140bpm 120bpm

Heart Rate (Number)

Resp. Rate (bpm)
(over 1 Minute) *

70
60
50
40
30
20
10

39bpm 40bpm 40bpm 40bpm

Resp Rate (Number)

Resp Distress
Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level
Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge and PICU /NICU fellow or PICU/NICU consultant to be informed

ACTIONS

NB: Scores 3 should be
recorded overleaf

Note: If GCS is below 12 or the Oxygen requirement is > 3 L/min, then irrespective of rest of the score, the Nurse MUST inform the PICU team.

ACTIONS

NB: Scores 3
recorded over

3: If GCS is below

CHILDREN’S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child’s routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
 - Following a Early Warning Score assessment, senior help may be required
- The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child’s clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don’t know what’s wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00660566 IP5-00175915

Baby Of Y. SREE RAMYA

03-07-2026 0 Y 0 M 2 D (M)

Dr. VENKATA LAKSHMI A

: RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation &
Early Warning Scoring ChartPratiksha
Rainbow
Children's
Hospital
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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(°F)
104
103
102
101
100
99
98
97
96
95
94Heart Rate
(bpm)
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
and
Blood Pressure
(mmHg) *
Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
or 1 Minute) *
70
60
50
40
30
20
10

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild
Receiving O₂ (l/min)
O₂ Saturations (%)Conscious Normal
Level Altered
GCS *TOTAL SCORE
Number of shaded boxes
Pain Score
Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. : 21

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
3/7/26	08:00 am										1	
	09:00 am										1	
	10:00 am	DBF									no	
	11:00 am										1	
	12:00 pm										1	
	01:00 pm											
Total Intake :						Total Output : U - M -						
3/7/26	02:00 pm	DBF									1	
	03:00 pm						✓			✓	1	
	04:00 pm										no	
	05:00 pm	DBF									1	
	06:00 pm										1	
	07:00 pm											
Total Intake :						Total Output : M - U -						
3/7/26	08:00 pm										1	
	09:00 pm	DBF					✓				1	
	10:00 pm										1	
	11:00 pm									✓	1	
	12:00 am	DBF									1	
	01:00 am											
Total Intake :						Total Output : M - U -						
3/7/26	02:00 am										1	
	03:00 am										1	
	04:00 am	DBF					✓			✓	1	
	05:00 am										1	
	06:00 am	DBF									1	
	07:00 am											
Total Intake :						Total Output : M - U -						
Total 24 hrs. Intake		Total 24 hrs. Output										

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. VENKATA LAKSHMI A

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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
9/7/26			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am	DBF											
	11:00 am												
	12:00 pm												
	01:00 pm	DBF											
Total Intake :						Total Output : m-2 u-10							
	02:00 pm												
	03:00 pm	DBF											
	04:00 pm												
	05:00 pm	DBF											
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output : m-01 u-0							
	08:00 pm												
	09:00 pm	DBF											
	10:00 pm												
	11:00 pm												
	12:00 am	DBF											
	01:00 am												
Total Intake :						Total Output : m-1 u-1							
	02:00 am												
	03:00 am	DBF											
	04:00 am												
	05:00 am												
	06:00 am	DBF											
	07:00 am												
Total Intake :						Total Output : m-2 u-1							
Total 24 hrs. Intake													
Total 24 hrs. Output		m-6 u-3											

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FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

Patient Sticker

FLUID CHART

Rainbow Children's Hospital
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BirthRight
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Your Right to a Safe Delivery

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. VENKATA LAKSHMI A

NURSING CARE RECORD

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BirthRight
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Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/8/26

Assessment: New Born Baby

Goals

- ☒ Maintain Airway and Oxygenation ☒ Relieve Pain & Discomfort ☒ Maintain Fluid Balance ☒ Improve Activity Tolerance ☒ Maintain Good Nutritional Status ☒ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☒ Meet Elimination Needs ☒ Ensure Safety ☒ Early Ambulation Reduce Anxiety ☒ Patient & Family Education
☐ Identify Potential Complications ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
9AM	→ monitor vitals	9AM	→ vitals checked and recorded	Baby is stable
10AM	→ R/o chest		→ R/o chest maintained	
	→ warm care	11AM	→ warm care provided	
	→ crib care		→ crib care provided	
12M	→ DBT feeding	12M	→ DBT feeding given	
1PM	→ Burping	2PM	→ Burping done	

Re-Assessment: Vitals checked and recorded.

Special Notes:

Nurse Signature: Sweeper Nurse Name: Sweeper Date & Time: 3/8/26 @ 2PM

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: New Born Baby

Goals

- | | | | | | |
|---|---|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the general condition of the Baby	2:05pm	* Assessed the general condition of the Baby	* Baby is stable
3pm	* monitor vitals	3:05pm	* monitored vitals.	
4pm	* DBF & Burping	4:05pm	* DBF & Burping done 2nd handly	
5pm	* Ilo chart	5:05pm	* monitored Ilo chart	
6pm	* was Vaccination	6:05pm	* Vaccination done	
7pm	* Safety	7:05pm	* Ensure safety provided	

Re-Assessment:

Special Notes: GRBS monitoring

Nurse Signature:

Nurse Name: Saruna

Date & Time: 3/7/26 @ 2pm

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. VENKATA LAKSHMI A

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/24

Assessment: New born Baby care

Goals

- ☐ Maintain Airway and Oxygenation ☐ Relieve Pain & Discomfort ☐ Maintain Fluid Balance ☐ Improve Activity Tolerance ☐ Maintain Good Nutritional Status ☒ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☐ Meet Elimination Needs ☒ Ensure Safety ☐ Early Ambulation Reduce Anxiety ☐ Patient & Family Education
☐ Identify Potential Complications ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the Baby General condition	8:10 pm	⇒ Assessed the Baby General condition	Baby is stable
10pm	⇒ Assess the Baby vitals signs	10:15 pm	⇒ Assessed the Baby vitals signs	
12Am	⇒ To maintain ILO chart	12:10 Am	⇒ maintained ILO chart	
2Am	⇒ To provide warmth care	2:15 Am	⇒ provided warmth care	
4Am	⇒ To establish the feeds	4:20 Am	⇒ established for feeds	
6Am	⇒ Ensure safety	6:20Am	⇒ Ensure safety	

Re-Assessment: Baby is active

Special Notes: GRBS monitoring

Nurse Signature: [Signature] Nurse Name: [Signature]

Date & Time: 4/7/24 @ 8Am

BAH-00660566
Baby Of Y. SREE RAMYA
03-07-2026 0 Y 0 M 0 D 7 H (M)
Dr. VENKATA LAKSHMI A

NURSING CARE RECORD

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BY RAINBOW HOSPITALS
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Newborn baby for neonatal care

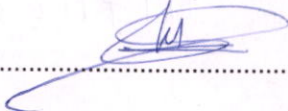
Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☒ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☒ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess to the baby condition	8.10 am	Assessed to the baby on sleep	Baby well
10am	To maintain y/o chart.	11am	Maintained y/o chart.	
12pm	To monitor vitals		Monitored vitals.	
2pm	plan to keep baby warm	12.30 pm	provided warm care by	
4pm	plan to give feed every 2to3rd hly.	3pm	covering with cloth	
6pm	NRBS monitoring	5pm	provided feeding every 2to3rd hly.	
		6.30pm	NRBS to be done at night	

Re-Assessment:

Special Notes: Reassessment after 2 hrs baby well
SBR, NBS, ONE 48HRS.

Nurse Signature: 

Nurse Name: Loubhasini

Date & Time: 4/7/26 @ 8pm

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: newborn baby monitoring jaundice assessment

Goals

- | | | | | | |
|---|---|---|---|---|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the Baby general condition	8:30 pm	→ Assessed the Baby general condition under the crib	→ Baby was taking feed well & slept under the crib
10pm	→ To monitor vitals	10:30 pm	→ monitored vitals	
12am	→ To maintain ILO chart	12:30 am	→ maintained ILO chart	
4am	→ To monitor CRBS	4:30 am	→ monitored CRBS	
7am	→ To provide crib care	7:30 am	→ provided crib care to the Baby	

Re-Assessment:

Re-assessment has done after 1 hour Baby was sucking well

Special Notes:

CRBS monitoring as per advise
 SBR, WBS, ILO @ 10 am

Nurse Signature: [Signature]

Nurse Name: Peralvi

Date & Time: 3/7/26 @ 8am

BAH-00660566 IP5-00175915
Baby Of Y. SREE RAMYA
03-07-2026 0 Y 0 M 2 D (M)
Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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Hospital
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BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: new born Baby care

Goals

- | | | | | | |
|---|---|---|---|---|--|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Baby General condition	8:30 am	Assessed the Baby General condition on cradle	Baby well
9am	To monitor vitals	9:30 am	monitored Baby vitals	
10am	To monitor I/O chart	10:15 am	monitored Baby I/O	
11am	To plan BBF feeding	11:15 am	every 2nd Chart feeding & burping	
12pm	To plan ensure safety	12:30 pm	given Baby ensure safety	

Re-Assessment:

Reassessment after 2 hr baby well

Special Notes:

SPR, NIBI, ORE 4pm 5am

Nurse Signature:

Nurse Name:

Soubhasini

Date & Time:

5/7/26 @ 2pm

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA (M)
 03-07-2026 0 Y 0 M 2 D
 Dr. VENKATA LAKSHMI

NURSING CARE RECORD

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Shift: ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Newborn baby.

Goals

- | | | | | | |
|---|---|---|---|---|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the baby condition	2:30 pm	* Assessed the baby condition	* Baby is stable.
3pm	* plan to monitor vitals			
4pm	* plan to maintain I/O Chart.	3:20 pm	* monitor vitals stable.	
5pm	* plan to recheck wt	4:20 pm	* maintain I/O Chart	
7pm	* plan to warm care	5:5 pm	* I checked wt wt at 4pm.	
8pm	* plan to feeding 2-3ml hourly.	7:30 pm	* provide warm care for baby.	
		8pm	* Given feeding support 2-3ml hourly.	

Re-Assessment:

provide warm care for baby.

Special Notes:

SBR, NBS 7/10 AM

Nurse Signature: 

Nurse Name: Leema

Date & Time: 5/7/26 @ 8 AM

BAH-00660566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMIA



NURSING CARE RECORD

Rainbow
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BirthRight™
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/21/26

Assessment: New born Baby Care

Goals

- | | | | | | |
|---|---|---|---|---|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the Baby General condition	8:10 pm	⇒ Assessed the Baby General condition	Baby is stable
10pm	⇒ Assess the Baby vitals signs	10:15 pm	⇒ Assessed the Baby vitals signs	
12am	⇒ To maintain I/O Chart	12:10 am	⇒ Maintain I/O Chart	
2am	⇒ To establish the feeds	2:10 am	⇒ Establish the feeds	
4am	⇒ To Encourage Breast Saffy	6:10 am	⇒ Encourage saffy	

Re-Assessment: Baby is stable

Special Notes: NRS, SBR, Done OAE TLM

Nurse Signature: [Signature] Nurse Name: [Signature]

Date & Time: 06/5/26 @ 8AM

BAH-00660566 IP5-00175915
Baby Of Y. SREE RAMYA
03-07-2026 0 Y 0 M 2 D (M)
Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

Patient Sticker

NURSING CARE RECORD


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BirthRight™
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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: OBS Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>New Born Baby</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
	Area		Shift Time				
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NB</u>	<u>NB</u>
			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NB</u>	<u>NB</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.5°F</u>	Temp: <u>98.1°F</u>	Temp: <u>98.2°F</u>	Temp: <u>98.7°F</u>	Temp: <u>98.0°F</u>
			Res: <u>42b/m</u>	Res: <u>46b/m</u>	Res: <u>40b/m</u>	Res: <u>40</u>	Res: <u>40b/m</u>
			SpO ₂ : <u>100%</u>	SpO ₂ : <u>100%</u>	SpO ₂ : <u>99%</u>	SpO ₂ : <u>99</u>	SpO ₂ : <u>100%</u>
			Pulse: <u>142b/m</u>	Pulse: <u>144b/m</u>	Pulse: <u>130b/m</u>	Pulse: <u>140</u>	Pulse: <u>130b/m</u>
			BP: <u>—</u>	BP: <u>—</u>	BP: <u>—</u>	BP: <u>—</u>	BP: <u>—</u>
			Fall Risk Score: <u>16</u>	Fall Risk Score: <u>16</u>	Fall Risk Score: <u>16</u>	Fall Risk Score: <u>16</u>	Fall Risk Score: <u>16</u>
Recommendations	Safety Needs:		<u>crib</u>	<u>crib</u>	<u>yes</u>	<u>yes</u>	<u>crib</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>CRBS monitoring</u>	<u>CRBS monitoring</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Kruthi</u>	<u>Aruna</u>	<u>Deepa</u>	<u>Soukhami</u>	<u>Riya</u>	<u>Soukhami</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>
Time:		<u>2PM</u>	<u>3PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>
Taken Over By Name :		<u>Aruna</u>	<u>Deepa</u>	<u>Soukhami</u>	<u>Riya</u>	<u>Soukhami</u>	<u>Soukhami</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>
Time:		<u>2PM</u>	<u>3PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. VIL Department: 3rd Floor Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>Newborn baby</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	<u>3rd Floor</u>	<u>3rd Floor</u>			
	Shift Time	<u>8pm</u>	<u>8AM</u>			
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NB</u>	<u>NB</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.2°F</u>	Temp: <u>98.0°F</u>			
	Res:	<u>30b/m</u>	<u>40b/m</u>			
	SpO ₂ :	<u>98%</u>	<u>99%</u>			
	Pulse:	<u>132b/m</u>	<u>120b/m</u>			
	BP:	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>16</u>	<u>16</u>			
	Pain Score:	<u>0/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>ABR/NB</u> <u>TLM</u> <u>8AM</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>SRM9</u>	<u>Wing</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>5/7/26</u>	<u>5/7/26</u>			
Time:		<u>@ 8pm</u>	<u>@ 8AM</u>			
Taken Over By Name :		<u>Wing</u>	<u>Rachana</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>5/7/26</u>	<u>5/7/26</u>			
Time:		<u>@ 8pm</u>	<u>@ 8AM</u>			

BAH-00660566

IP5-00175915

Baby Of Y. SREE RAMYA

03-07-2026

0 Y 0 M 0 D 3 H (M)

Dr. VENKATA LAKSHMI A



BRADEN 'Q' SCALE

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					Date : 3/26/26	Time : 8:17 AM	3/26/26	3/27/26
Mobility	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 completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2	2
"Activity The 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. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1
Sensory Perception	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 the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, 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 every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	2	2
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. 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 repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half 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: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	19	19	19
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. Venkata Lakshmi A	Dr. Venkata Lakshmi A	Dr. Venkata Lakshmi A

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00860566 IP5-00175915
 Baby Of Y. SREE RAMYA
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMI A



BRADEN 'Q' SCALE

					Date :			
					Time :			
Mobility	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 completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	6:17 8AM 9			
"Activity The 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. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	9			
Sensory Perception	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 the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	8			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, 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 every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2			
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. 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 repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half 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: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, 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			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
					TOTAL SCORE	19		
					Evaluator's Name	Devi		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23*

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						3:00 PM	3:00 PM	3:00 PM	3:00 PM				
						2:00 PM	2:00 PM	2:00 PM	2:00 PM				
						1:00 PM	1:00 PM	1:00 PM	1:00 PM				
						12:00 PM	12:00 PM	12:00 PM	12:00 PM				
						11:00 AM	11:00 AM	11:00 AM	11:00 AM				
						10:00 AM	10:00 AM	10:00 AM	10:00 AM				
						9:00 AM	9:00 AM	9:00 AM	9:00 AM				
						8:00 AM	8:00 AM	8:00 AM	8:00 AM				
						7:00 AM	7:00 AM	7:00 AM	7:00 AM				
						6:00 AM	6:00 AM	6:00 AM	6:00 AM				
						5:00 AM	5:00 AM	5:00 AM	5:00 AM				
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NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3				
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			16	16	16	16	16

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		X	X	X	X	X
Call device within reach		✓	X	X	X	X
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	X	X	X	X
Nurse's Name :		Raj	Kanna	Ar	Prin	Prin
Signature :		Raj	Prin	Ar	Prin	Prin
Date :		2/7	3/7	4/7	5/7	6/7
Time :		10pm	3pm	8am	6am	8am

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
BAH-00660566 IP5-00175915 Baby Of Y. SREE RAMYA 03-07-2026 0 Y 0 M 0 D 7 H (M) Dr. VENKATA LAKSHMI A 		3/7/26 11:45	3/7/26 5:30
		Transfer Ordered by	Reason for Transfer
		Dr. Lakshmi	New born baby
From Unit	To Unit	Information to Attendant	
OBs	Room (3A)	☒ Yes ☐ No	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant	
25	—	☐ Yes ☒ No If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : ☐ Yes ☐ No			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
Sr. Kanungo		Dr. Lakshmi	
Patient & Clinical Records Received by : Shinshu			
Date & Time of Patient Received : 3/7/26 6:30 pm			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready