



Sheet No: 10 **REGULAR PRESCRIPTIONS** Weight 10.9 Ward PFLV

DRUG : <u>IND PANTOPRAZOLE</u>				Date/Time <u>28/5</u>	<u>29/5</u>				
Dose <u>10mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Dt. <u>28/5</u>	<u>8 PM</u>	<u>6 AM</u>				
Name & Signature of the Doctor Starting the Drugs: <u>A Madhu 111790</u>				<u>stop</u> <u>Ch</u> <u>147159</u>					
Additional Instructions:				<u>29/5/21</u>					
Daily Doctor's Endorsement by a Sign									
DRUG : <u>SIP CLOBIAM</u>				Date/Time <u>28/5</u>	<u>29/5</u>	<u>30/5</u>			
Dose <u>2.5ml</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>28/5</u>	<u>7 PM</u>	<u>7 AM</u>	<u>7 AM</u>	<u>7 AM</u>	<u>7 AM</u>	
Name & Signature of the Doctor Starting the Drugs: <u>A Madhu 111790</u>				<u>7 PM</u> <u>7 AM</u>					
Additional Instructions: <u>5ml/5mg</u>									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>Saline nasal drops</u>				Date/Time <u>29/5</u>	<u>30/5</u>				
Dose <u>2</u>	Route <u>PN</u>	Frequency <u>Q 6H</u>	Start Dt. <u>29/5/21</u>	<u>10 AM</u>	<u>10 AM</u>	<u>10 AM</u>	<u>10 AM</u>	<u>10 AM</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Ch 147159</u>				<u>10 AM</u> <u>10 PM</u>					
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : <u>SIP P250</u>				Date/Time <u>29/5</u>					
Dose <u>3ml</u>	Route <u>PO</u>	Frequency <u>Q 6H</u>	Start Dt. <u>29/5/21</u>	<u>6 PM</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Ch 147159</u>									
Additional Instructions: <u>(5ml 250mg)</u>									
Daily Doctor's Endorsement by a Sign									

Signature
VERIFIED BY: Name


GUC-00070789 IP28-00004481
 Baby NILA V
 10-09-2024 1 Y 8 M 19 D (F)
 Dr. KRITHIKA P



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : 54P. IBUGESIC				Date Time																	
Dose	Route	Frequency	Start Dt.																		
4.5ml	PO																				
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:				(5ml / 100mg)																	
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

VERIFIED BY : Name Signature



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 28/5/22

Source of Admission: OPD Ward Other: Home

Reason for Admission: abandoned Admitted by Family

Admission Diagnosis: febrile illness

Accompanied By: Parent Guardian Other Name: _____

Primary Language: Telugu English Hindi Other Specify Tamil

Do you require an interpreter? Yes No

Allergies: Yes No Medications Blood Transfusion Food Other: _____

If yes, identify _____

Source of Information: <input type="checkbox"/> Family <input type="checkbox"/> Patient <input type="checkbox"/> Others, Specify _____			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	-	-	-
	Family History: <u>no significant history</u>		
	Has the child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes please list, _____ Was the child's birth normal? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, please describe problems: _____ Are the child's immunization up to date? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
CURRENT MEDICATIONS	Taking Medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Fill the reconciliation form Medicine brought to the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Observations: Weight: <u>10.4 kg</u> Length: <u>74 cm</u> Head Circumference (< 2 years): <u>48 cm</u> Temp.: <u>101.4 F</u> HR: <u>162 bpm</u> RR: <u>32 bpm</u> BP: <u>98/59</u>			
Pain Score: <u>0</u> Specify Site: _____ (Follow Pain Assessment Sheet & Document)			
Fall Risk Assessment: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Score: <u>15</u> (Document in the Humpty Dumpty Sheet)			
Risk of Pressure Sore (Braden Q Score <u>21</u>) (Document in the Braden Q Assessment Sheet)			



FUNCTIONAL STATUS ON ADMISSION:

- Sleeping Crying Calm Distressed/Console Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

- Mobility problem Walking Problem No Abnormality Detected
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Underweight Overweight Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Parents

Siblings in household Yes No (if yes How Many?)

Orientation has been given regarding the following aspects:

- ID Band in situ
 Bedside safety explained
 PICU Routine: Doctor's rounds/Medication time
 Visiting policy explained

Orientation given to: Family Others specify

Name of Person Orientation was given to: Father

Orientation not given Reason:

Nurse Name: Prachi

Nurse Signature: Prachi

Date & Time: 28/09/2024 6:00 PM

DISCHARGE PLAN

Source of Information: Family Friend

Will patient require transportation arrangements to go home: Yes No

Will Physiotherapy require at home: Yes No

Is home medical equipment anticipated: Yes No

Is home oxygen therapy anticipated: Yes No

Are dressing needs at home anticipated: Yes No

Any other needs anticipated: Yes No If Yes Specify

Discharge Medications: Yes No

Details:

Final Diagnosis:

Nurse Name:

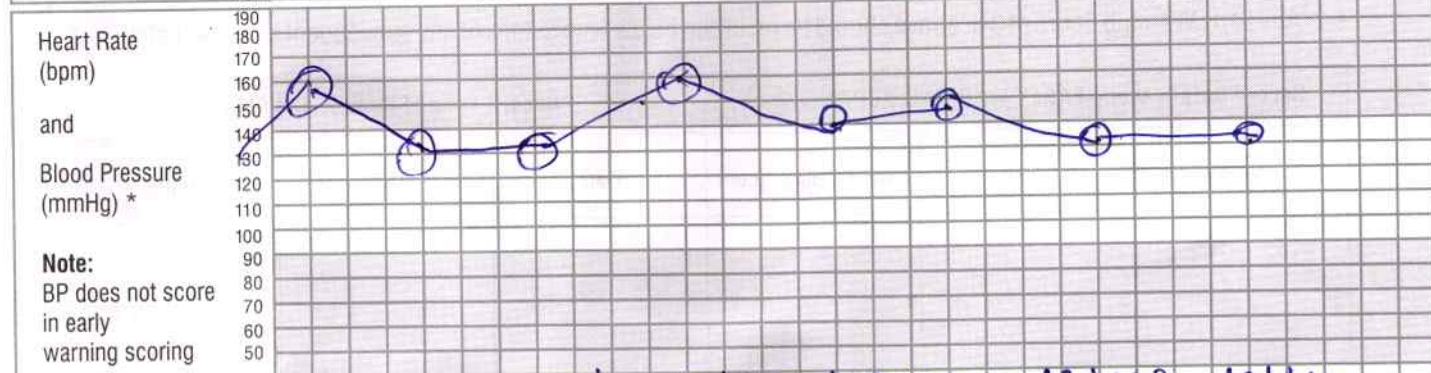
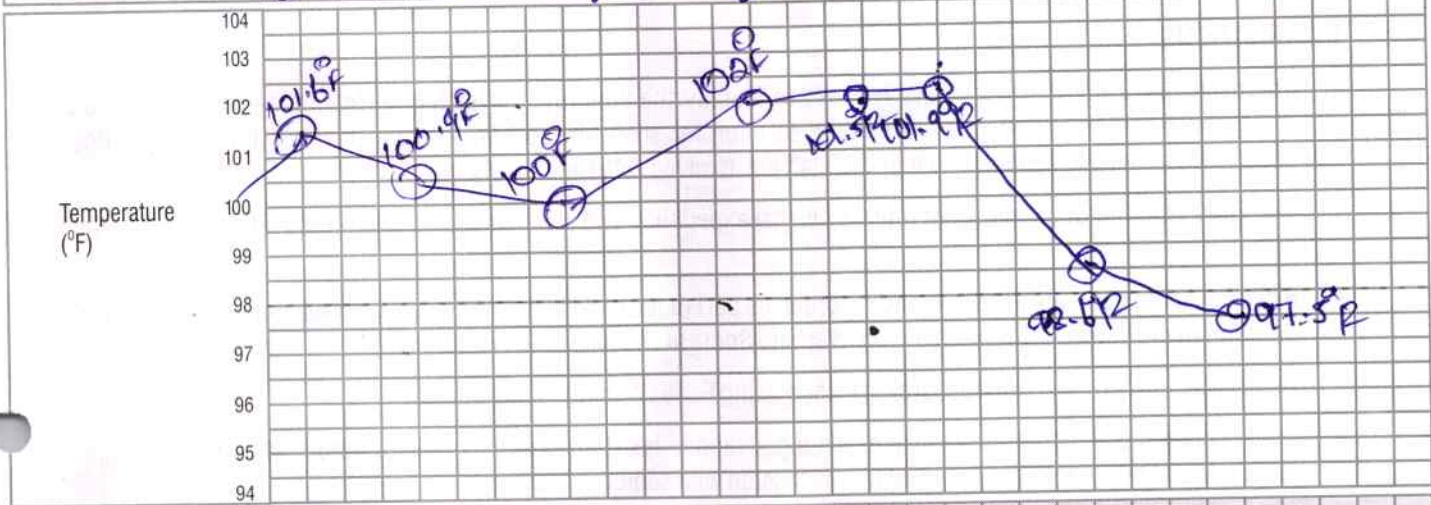
Nurse Signature:

Date & Time:

child shifted to ward.

EARLY WARNING SCORE: CHILDREN'S UNIT

Date	09/11/26	Time	12:30 PM	1:00 PM	4:30 PM	6 PM	8 PM	10 PM	12 AM	1 AM
Doctor / Nurse / Family Concern?										



Heart Rate (Number)	160bpm	140bpm	140bpm	160bpm	150bpm	140bpm	140bpm
---------------------	--------	--------	--------	--------	--------	--------	--------



Resp Rate (Number)	22bpm	22bpm	22bpm	22bpm	22bpm	22bpm	22bpm
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Resp Distress	Mod/ Severe	None / Mild	✓	✓	✓	✓	✓	✓
---------------	-------------	-------------	---	---	---	---	---	---

Receiving O ₂ (l/min)	0.2l	0.2l	0.2l	0.2l	0.2l	0.2l	0.2l
O ₂ Saturations (%)	98.1	98.1	98.1	98.1	98.1	98.1	98.1

Conscious Level	Normal	Altered	✓	✓	✓	✓	✓	✓
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GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
-------	-------	-------	-------	-------	-------	-------	-------

TOTAL SCORE	02	01	01	02	01	02	01	01
Number of shaded boxes	02	01	01	02	01	02	01	01
Pain Score	0/10	0/10	0/10	0/10	0/10	0/10	0/10	0/10
Observer's Initials	K	A	V	B	S	S	S	S

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 in charge AND PICU fellow or PICU 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)

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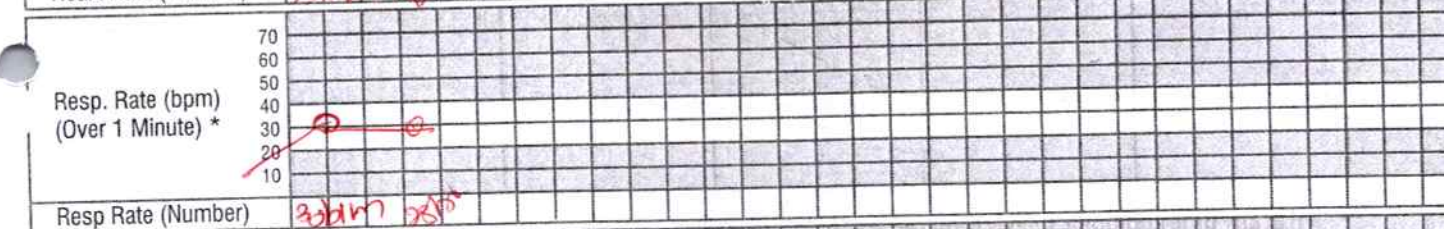
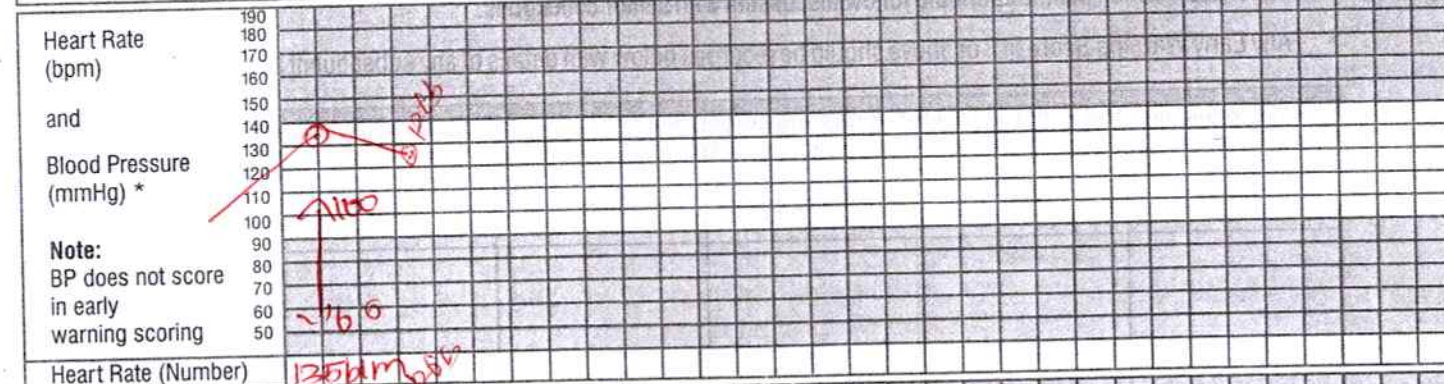
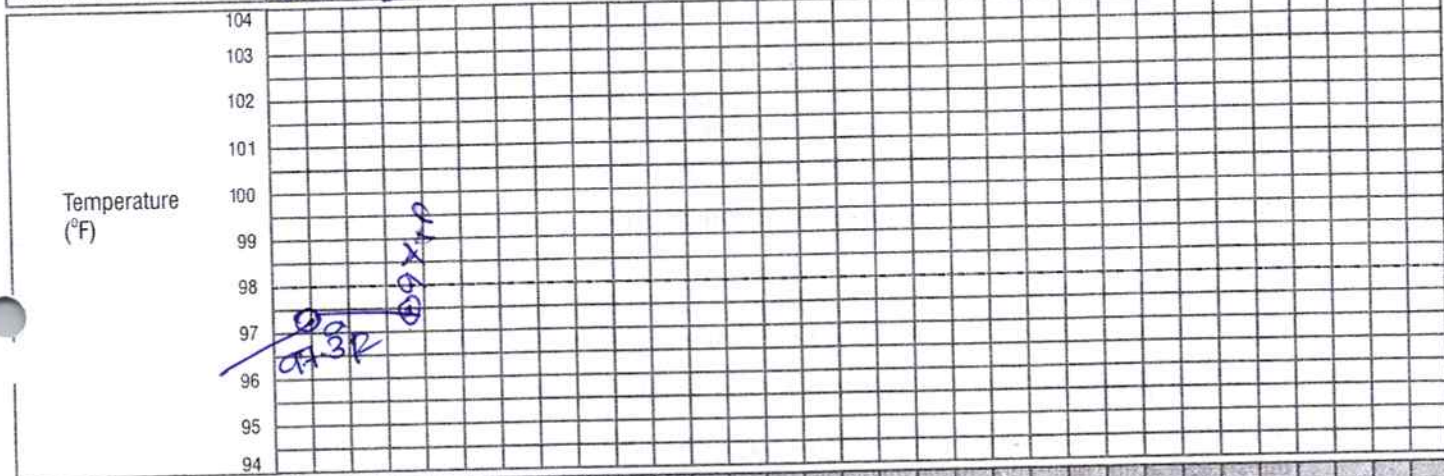
Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 30/5/26 Time: 8:00 AM
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe None / Mild	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Receiving O ₂ (l/min)	O ₂ Saturations (%)	0.5	98
Conscious Level	Normal / Altered	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
GCS *		15/15	15/16
TOTAL SCORE		0/1	0/1
Number of shaded boxes		0/0	0/0
Pain Score		0/0	0/0
Observer's Initials		RE	W

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 in charge AND PICU fellow or PICU 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.

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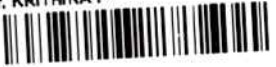

FLUID CHART

Sheet No. : 01

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

Date		Time		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
				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		H ₂ O	20ml							0	}	
		03:00 pm									0			
		04:00 pm		H ₂ O	20ml						0			
		05:00 pm									0			
		06:00 pm		H ₂ O	50ml						0			
		07:00 pm									0			
Total Intake : 20ml				Total Output : 0										
		08:00 pm										0	}	
		09:00 pm		H ₂ O	10ml						0			
		10:00 pm									0			
		11:00 pm		H ₂ O	10ml						0			
		12:00 am									0			
		01:00 am									0			
Total Intake : 20ml				Total Output : 0										
		02:00 am										0	}	
		03:00 am		H ₂ O	10ml						0			
		04:00 am									0			
		05:00 am		H ₂ O	10ml						0			
		06:00 am									0			
		07:00 am		H ₂ O	10ml						0			
Total Intake : 30ml				Total Output : 0										
		02:00 pm										0	}	
		03:00 pm		H ₂ O	10ml						0			
		04:00 pm									0			
		05:00 pm		H ₂ O	10ml						0			
		06:00 pm									0			
		07:00 pm		H ₂ O	10ml						0			
Total Intake : 30ml				Total Output : 0										
Total 24 hrs. Intake		590ml												
Total 24 hrs. Output		U - 3 times M - 0												

GUC-00070789 IP28-00004481
 Baby NILA V
 10-09-2024 1 Y 8 M 18 D (F)
 Dr. KRITHIKA P



FLUID CHART

Sheet No. : 02

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.

Date		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
				Mouth	I.V	N.G							
<u>20/5/20</u>		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.

Date	Time	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		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							



①



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Simple Fibroadenoma</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:
	Surgery / Procedure:	
BACKGROUND	Date	Shift
	Medical Condition (Any special condition to be noted):	
ASSESSMENT	Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp: <u>98.2</u> <u>98.2</u> <u>98.4</u> <u>98.6</u> <u>98.5</u>
	Res:	<u>20</u> <u>20</u> <u>20</u> <u>20</u> <u>20</u>
	SpO ₂ :	<u>95</u> <u>95</u> <u>95</u> <u>95</u> <u>95</u>
	Pulse:	<u>120</u> <u>120</u> <u>120</u> <u>120</u> <u>120</u>
	BP:	<u>100/60</u> <u>100/60</u> <u>100/60</u> <u>100/60</u> <u>100/60</u>
	LOC:	<u>Alert</u> <u>Alert</u> <u>Alert</u> <u>Alert</u> <u>Alert</u>
Recommendations	Fall Risk Score:	<u>12</u> <u>13</u> <u>13</u> <u>13</u> <u>13</u>
	Pain Score:	<u>0/10</u> <u>0/10</u> <u>0/10</u> <u>0/10</u> <u>0/10</u>
	Skin Integrity:	<u>Intact</u> <u>Intact</u> <u>Intact</u> <u>Intact</u> <u>Intact</u>
	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Critical Lab Test / Values:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):	<u>Dependent</u> <u>Dependent</u> <u>Dependent</u> <u>Dependent</u> <u>Dependent</u>	
Post Operative Procedure Special Orders:		
Handed Over By Name :		
Signature / ID :		
Date:		
Time:		
Taken Over By Name :		
Signature / ID :		
Date:		
Time:		

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:						
	Temp:						
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	LOC:						
Fall Risk Score:							
Pain Score:							
Skin Integrity:							
Recommendations	Safety Needs:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
PU Prophylaxis:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

GUC-00070789 IP28-00004481
 Baby NILA V 1 Y 9 M 18 D (F)
 10-09-2024
 Dr. KRITHIKA P



NURSING CARE RECORD



Date: 28.05.20

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

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning						
Afternoon						
Night	<ul style="list-style-type: none"> * Assess general condition * maintain hygiene * Personal hygiene 		<ul style="list-style-type: none"> * General condition * assessed * personal hygiene maintained 	<ul style="list-style-type: none"> vitals stable 	<ul style="list-style-type: none"> assessed re assessed 	<i>[Signature]</i>



NURSING CARE RECORD

- 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

Date: 22/11/24

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8:00am	Assessed the general condition hygiene	9:30am	Assessed for general condition hygiene	verbally are stable	Re-Assessment done	Prerna
Afternoon	3:00pm	Assessed the baby general condition hygiene	3:30pm	Assessed the baby general condition hygiene	verbally are stable	Re-Assessment done	Prerna
Night	8:00pm	Assessed the baby general condition hygiene	9:00pm	Assessed the baby general condition hygiene	verbally are stable	being when monitor Temp 101°F	Prerna

NURSING CARE RECORD

IP28-00004481

GUC-00070789

Baby NILA V

10-09-2024

1 Y 8 M 18 D (F)

Dr. KRITHIKA P



Date: 30/5/26

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications

- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify.....

- Improve Activity Tolerance
- Ensure Safety

- Maintain Fluid Balance
- Meet Elimination Needs

- Maintain Good Nutritional Status
- Early Ambulation Reduce Anxiety
- Maintain Skin Integrity
- Patient & Family Education

Goals

Goals	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Goals

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

Date:

	Morning	Afternoon	Night
Time			
Plan of Care			
Time			
Implementation			
Evaluation			
Re-Assessment			
Nurse Name & Signature			

①



NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies ... *nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<i>receiving note on - 28/5/24</i>
<i>28/5</i>	<i>6:30pm</i>	<i>Child received by via transport from home with (no fever) & 1 episode of seizure. After coming to PICU child is stable. Fever still present. 101.4 F. Not by full - 15/15, PRN. New line inserted by H/L works in R/L metacarpal vein etc. sendd the out blood sample. <i>28/5/24</i></i>
	<i>7pm</i>	<i>PRN DORS 40 mg/ml started. Empiric 160 mg given on PICU drug chart order. 5yr. Cloxacillin 2.5 mg given on PICU drug chart, order that had issue. Prmed the issue. <i>28/5/24</i></i>
	<i>2pm</i>	<i>5yr. 10 mg given on PICU drug chart order. Fever reduced child is by 101.4 F. line also present & band over arm to right of vein. <i>28/5/24</i></i>
		<i>Night duty on 28/5/24</i>
<i>28/5</i>	<i>8pm</i>	<i>Demolva received from evening duty. stable vitals stable and monitored. PR line in pt. Metacarpal 22S patent. PR DORS 40mg/ml on flow. POWIF lines (aseptic) <i>28/5/24</i></i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES
 (USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies milk

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
28/09	10pm	Vitals stable. T. 98.9F Baby had milk, passed curd stool. Input orally not taking well. Little fluids by taking
29/09	12.30pm	Temp 101.5F. Vitals stable. Tsp. para given as ordered in day chart
	2pm	T. 101.5F. Sparging given warm water. Tachycardia present
	4pm	T. 100.9F. If fever continues can give Tsp. para every 4 hours advised by Dr. Mahesh
	5pm	Tsp. para given as ordered in day chart vitals stable
	6pm	Routine morning care given and. The medication given as ordered in day chart
	7pm	Referral to Dr. Bhatnagar regarding fever spikes can advised to give ibuprofen for next spike
	8pm	Handover given to the morning duty staff vitals

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



2



NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		morning duty on 28/5/24
		child hand over taken from night duty staff when child on medication from the ward. continue fever present. Axilla present on rt metacarpal joint and line over pcp. child on @ chest.
		child temp. 103°K so 54P. Ebu Profun 4.5ml given in PR stat when temp 103°K
		child joints are swollen from cold reduced & shifted to ward (311) & hand was given to ward staff. 7/18/24
	11:30am	<u>child receiving from PICU</u>
		child details handing over taken from PICU staff
		child is stable. No other complaints
	12pm	vitals checked and recorded. child's mother says that child has shivering. Inform doctor Divya mam she said check temp 101.6. Give IV para 160mg.
	1pm	child vomiting 1 episode. Inform doctor Divya mam. she advised. next episode inform
	2pm	child details handing over from to evening duty staff

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00070789

IP28-00004481

Baby NILA V

10-09-2024

1 Y 8 M 18 D

(F)

Dr. KRITHIKA P



NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<i>Night duty notes</i>
29/5/26	8:30pm	child handover taken from evening duty staff Kayal -> child is active and alert -> child on line present and pattern -> jps / bsw
	10pm	Administer nasal bear drops as per drug chart -> child vitals checked and recorded Temp 101.9° F sup. Ibuprofen given as per drug chart -> jps / bsw
30/5/26	2am	baby vitals checked and recorded Vitals stable -> jps / bsw
	6am	baby sleep well no other complaints. -> jps / bsw
	7am	baby vitals checked and recorded Vitals stable. -> jps / bsw
	8am	baby stable no other complaints. -> jps / bsw
	7am	medication given as per drug chart -> baby vitals checked and recorded Vitals stable -> jps / bsw
	8am	baby handover given to morning duty staff -> jps / bsw

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

