

ANC-00015788 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2026 0 Y 0 M 4 D (M)
 Dr. THINESH KUMAR J




DISCHARGE TRACKING SHEET

UHID : FLOOR: CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing		28/5/26 at 12 Pm	Parab 018905	
Activity Sheet updated by Pharmacy	7:01	7:02	Jai	

ACTIVITY RECORD FOR BILLING

Name: ANC-00015788 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2028 0 Y 0 M 0 D 10 H 1M
 Dr. THENESH KUMAR J

UHID No:  Consultant: Dept: NICU

Date of Admission: Time: Date of Discharge: Time:

Room / Bed No: Ward: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/5/28	8am	OT [RCH]	NICU	<u>ABB</u>
23/5/28	4pm	NICU	1st floor	<u>[Signature]</u>

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
24/5/26	Infusion Pump	24/5/26 12:30am	25/5/26 @ 8:00am	146489	J [Signature]
24/5/26	Syringe Pump	1am	25/5/26 @ 8:11am		
/					
Radiology					
26/5/26	2 DEcho (3966)	PD 23/6/26			
26/5/26	NSG (3974)	E			
/					

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
26/5/26	IV placement	1	146447	<i>[Signature]</i>

ANY OTHER INFORMATION:

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Date: 26/5/26 Time: 3:30pm Prepared By: R. Rogers

Staff Nurse <i>[Signature]</i>	Shift / Ward	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/2026 12 AM	C/S/B Dr. Thinesh Kumar / to delivery	
	<u>Adv</u> - To do CBC, Calcium, blood U	
	- To start IV Piptaz	
	- 10/1-D + 4 Calcium	
	180 CC	
	- 2ml O2u feeds	
	- w/t distens., plan CRP 80 S	
	<u>Adv</u>	
	1530	



2



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/2026	C/S/B Dr Shokane	
	CVS - continue 4-5mg.	
	PIA - 2ml @ 8u	
	Sepris:	
24/5/2026 9 AM	C/S/B Dr Dislwaney	
	Δ - Modulate proteins / AcA / male / pcn / @	
	RS - Baby in room in	
	maintaining saturation	
	WOR - (w)	
	not on caffeine.	
	BAB @ NO added sounds.	
	CVS: pink, peripheries norm	
	pulse well felt	
	S ₂ @ NO murmur	
	on 4mg / w / mi dobutamine	
	PIA - soft BS @	
	on 2ml @ 2u of feeds.	
	bowel not opened.	
	CNS: AF @ lens	
	very, norm @	


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	NOT ON A/D	
	P/O - V/O - 1.4 ml/mlk. ON 80CC WF + 4 Cal.	
	Hb - 18.4.	
	Sepsis: NOT @ ON dry prptag	
	<i>[Signature]</i> 25/5/26	
24/5/26 6:30pm	s/o. Dr. Lomanya	
	Moderate PT 32 ⁺³ / AGA / DCDA-② Boy 1.720kg for preterm care feed establishment	
	DOL ~ 19hrs 32 ⁺³ .	
	on 04 feeds; dobutamine	
	RS: off oxygen maintaining SpO ₂ in RA, RR - 44/m BLAE ⊕ SpO ₂ 98%	



J

PROGRESS NOTES AND DOCTOR'S ORDER

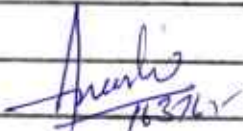
Date & Time	Progress Notes	Doctor's Order
	CVS: HR - 150/m +++/++	
	BP - 50/34	
	U/O ✓	
	CNS: AFO T/P @	
	active cry - good	
	P/A: soft not passed	6ml Q2h feed
	meconium	to ↑ 2ml Q8h
	fluids - ↓ 60cc ivf	
	RP2/CRP/TFT at 48hrs.	
	sepsis: Peripheral line @	
	on inj pipyaz	
	Plac: feed established	 126940
	as planned	
	↓ ivf	
	w/ meconium passage.	

ANC-00015786
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 23-05-2028 0 Y 0 M 2 D (M)
 Dr. THINESH KUMAR J

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 9:15AM	S/B Dr. Aneesh	
	MOD. PRETERM (32+2). ~32 hrs of life. CGA - 32+4.	AGA DCDA (2) BOY 1.720Kg FEED ESTABLISHMENT.
	RS- B/LAE (+) RE- S6/m No added sounds. Not on oxygen support. Baby pink - Grashes (+)	SpO ₂ = 95% in RA
	CVS - HR - 142/m SS ₂ (+) CRT < 3sec. BP - 61/9mm Hg On dobutamine 2mg/kg/min	no murmurs +/+/+
	CNS - AF @ level. Tone activity G ₄ - (N)	
	P/A - Soft meconium passed. No distension On 10ml feeds	to ↑ 2ml Q8H → Q6H
	Fluids - 60ml/kg/day - RP ₂ CRP TKT	4ca U _o - 3.5ml/kg/h at 4hrs.
	Sepsis - Duj. Piptaz	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26	S/B Dr. Shobana mam. feeds upto 25ml IV Fluids → 40ml/kg/day No new IV line. Paladai feeds. To do RP ₂ CRP TFT - tom. morning USG Cranium Echo tom. Kid rich Calcimax. Day after tom. Discharge. continue Dobutamine.	Anesh 113765
26/5/2026 9:50 AM	C/S/B Dr. Shobana P/A - upto 25ml train PF. kmc every shift out if feeds well. ROP KENT @ Mon Kidn Calcimax r. Tom after 2 weeks	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/2028 10:20 AM	C/S/B/D/Discharge	
	A - Moderate prematurity. HUA / DCPA - 2 / Boy / food establishment	
	HDL - 3.	
	RS - Baby VKA SpO ₂ - 96% WOB (w) BAP (w) NO added sounds RR - 50/min.	
	CVC: pink, warm, pulses well felt. S ₁ S ₂ (w) NO murmur Hb - 163/uL RR - 5 - 50 th centile. Plan - Echo today.	
	CNS: AF at level very good tone no jells / seizure NOT ON A/D	
	PLA: soft RJA (w) on PF 16ml meconium passed	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	P/B - U/P - 28ml/ly/day not on WR	
	Sepms: not not on tra NOD	
	<u>C/S/B DR. Hamea VC</u>	
26/5/26 9:30pm	Moderate PT / AYA / DCA-2 / Boy / Fed Baby sucking & feeding well passing urine & stool normally o/e cng w/low activity s/e cn R1 cn P/A	establishment. vitals stable Advice:- • WARM TH • PF 22ml @ 2Hly till 1Am ↓ PF 25ml @ 2Hly
	✓-Sill (Dr Hamea VC) 96066	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	SIB Dr. Kuthuna	
9 AM	A: Moderate PI / PCH / DCDA-2 / Boy / Feed Establishment	
	DOL-4	
	Baby Fuel NO review.	B-wt: 1.720 kg T-wt: 1.680 kg (3y. loss)
	On FF - 25ml - 2nd try ERM → Paladar fuel	M / Otu B / Btu.
	U/o: One zinc mouth Munium: One zinc mouth	26/5 CRP, L S not on antibiotic
	O/e: Gyt + Activity (⊕) Normothin PRUF CRT check.	
	S/e: CVC: 2IC (⊕) RS: B/LAS (⊕) P/A: 80 ft.	
	Plan: The fuel 25 ml - FF/ERM - 2nd try Paladar	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26		
27/5/26	SIB Dr. Milhana	
3:20 PM	Baby Feed	
	On FF + EBM - 25 ml - paladai fully.	
	U/S: Adequate (twice 20 min)	
	Mammogram: Adequate.	
	D/S: Cyst + Activity (u)	
	NORMOTIC	
	PPWF	
	S/S: NAD	
	SIB Dr. Milhana	
	Baby Feed.	
	No new issues	
	U/S: Adequate (3-4 times)	
	Mammogram: Adequate (3 times)	
	D/S: Cyst + Activity (u)	
	PPWF	
	S/S: NAD	
	Plan: If feeds 25ml - EBM/FF by paladai	

U9947



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 10:30 AM	S/B Dr. Aneeshw / Dr. Shobana	
MOD. PT Days of life	AGA DCDA -2 BOY	FEED ESTABLISHMENT
	Baby feeding upto 20-22ml. passing urine & stools	
	Cry } Tone } (N) Activity } pulses well felt CRT < 3sec	MBG - 0 trv. BBG - B trv. Bwt - 1.720kg Y.wt - 1.680kg I.wt - 1.680kg
	S/E US - GS (+) PS - B/LAE (+) Cals - AF @ level P/A - soft	
28/5/26 11:30 AM	S/B Dr. Shobana D/C	Aneeshw 165765
	Review monday @ Dr. Thinesh RPP @ 1 month BERA @ 1 month Vaccination to be done. DBF + 25-30ml / paladar	
	S/Shobana	



DRUG CHART

Date of Admission: 24/5/26 Drug Allergies: Nil Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospital's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight: 1.7 Kg Ward: MICU

DRUG : INJ PIPZAZ				Date/Time: 25/5/28
Dose: 100mg	Route: IV	Frequency: Q12H	Start Date: 25/5	
Name & Signature of the Doctor Starting the Drugs: [Signature]				100mg IV Q12H
Additional Instructions: 100mg/12hr				changed to oral
Daily Doctor's Endorsement by a Sign				[Signature]

DRUG : TAXIMO DROPS				Date/Time: 25/5/28
Dose: 0.3ml	Route: PO	Frequency: BD	Start Date: 25/5	
Name & Signature of the Doctor Starting the Drugs: [Signature]				stop
Additional Instructions: 1ml/20mg				[Signature]
Daily Doctor's Endorsement by a Sign				[Signature]

DRUG :				Date/Time:
Dose:	Route:	Frequency:	Start Date:	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time:
Dose:	Route:	Frequency:	Start Date:	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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 23-05-2026 0Y0M0D3H (M
 Dr. THINESH KUMAR J

I.V. FLUID CHART

DATE	TIME	Composition of I.V. FLUID (If infusion, mention ml/hr = Mcg/kg/min. etc.)	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
25/5/20		wt - 1.720 kg 80cc/kg/day = 137.6 ml/day							
		4 Cal = 6.8 ml 10% D = 130 ml } @ 5.7 ml/hr							
		10% D				10/5/20			

FACILITY REPORT

Sl. No.	Name of the Facility	Type of Facility	Status	Remarks	Date
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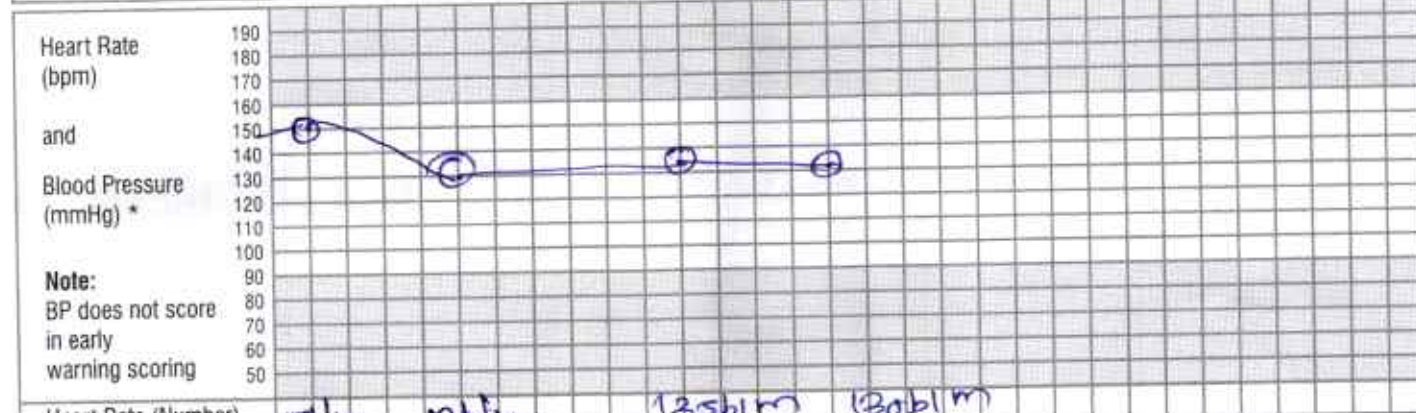
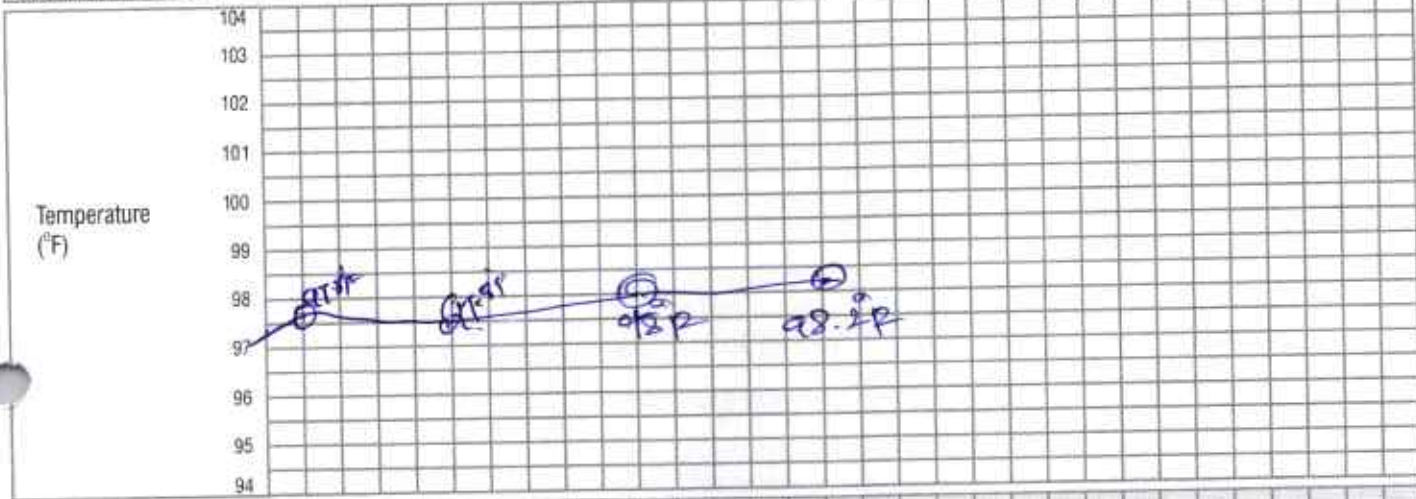


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

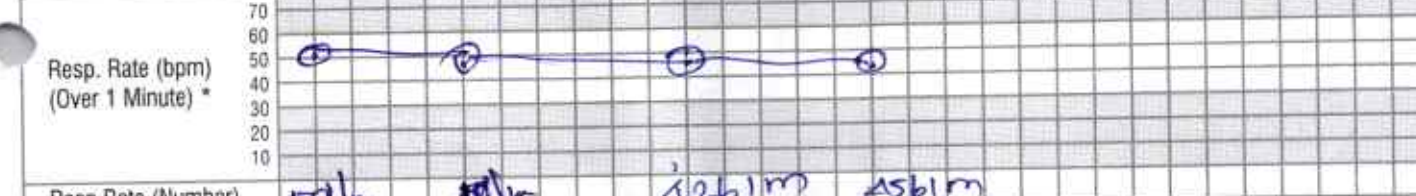


EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/5/26 Time: 4pm 7pm 12am 4am
 Doctor/Nurse/Family Concern?



Heart Rate (Number) 148bpm 135bpm 135bpm 130bpm



Resp Rate (Number) 50bpm 48bpm 42bpm 45bpm

Resp Mod/ Severe Distress	None / Mild	-	-	✓	✓
Receiving O ₂ (l/min)	O ₂ Saturations (%)	<u>100%</u>	<u>99%</u>	<u>92%</u>	<u>100%</u>
Conscious Level	Normal / Altered	✓	✓	✓	✓
GCS *		<u>15/15</u>	<u>15/15</u>	<u>15/15</u>	<u>15/15</u>

TOTAL SCORE	
Number of shaded boxes	<u>0/0</u> <u>0/0</u> <u>0/0</u> <u>0/0</u>
Pain Score	<u>0/0</u> <u>0/0</u> <u>0/0</u> <u>0/0</u>
Observer's Initials	<u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u>

ACTIONS	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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

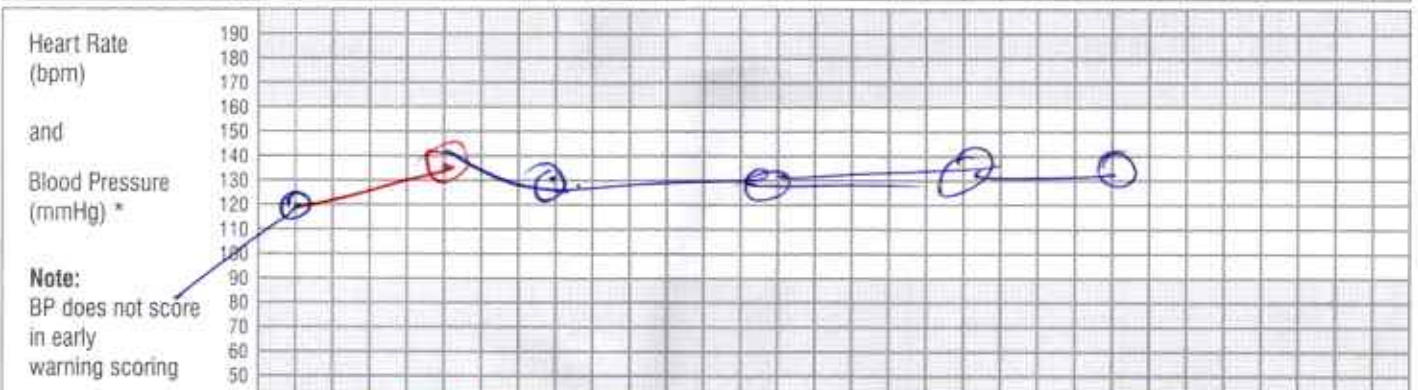
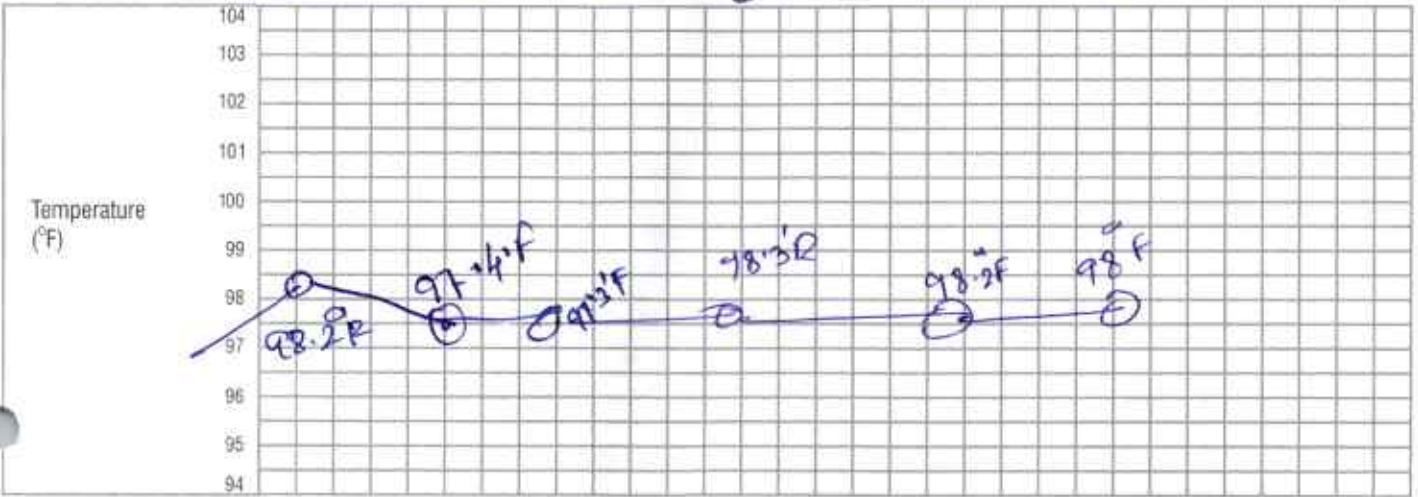


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/5/25 Time: 2am 12pm 4pm 8pm 12am 4am
 Doctor/Nurse/Family Concern?



Note:
 BP does not score
 in early
 warning scoring

Heart Rate (Number) 126 bpm 136 bpm 130 bpm 130 bpm 136 bpm 138 bpm



Resp Rate (Number) 45 bpm 42 bpm 44 bpm 42 bpm 44 bpm 44 bpm

Resp Distress	Mod/ Severe None / Mild	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	Normal / Altered	GCS *	TOTAL SCORE
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%	<input checked="" type="checkbox"/>	Normal	15/15	01
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	99%	<input checked="" type="checkbox"/>	Normal	15/15	01
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%	<input checked="" type="checkbox"/>	Normal	15/15	01
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%	<input checked="" type="checkbox"/>	Normal	15/15	01
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	99%	<input checked="" type="checkbox"/>	Normal	15/15	01
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	98%	<input checked="" type="checkbox"/>	Normal	15/15	01

Number of shaded boxes	Pain Score	Observer's Initials
01	0/10	[Signature]
01	0/10	[Signature]
01	0/10	[Signature]
01	0/10	[Signature]
01	0/10	[Signature]
01	0/10	[Signature]

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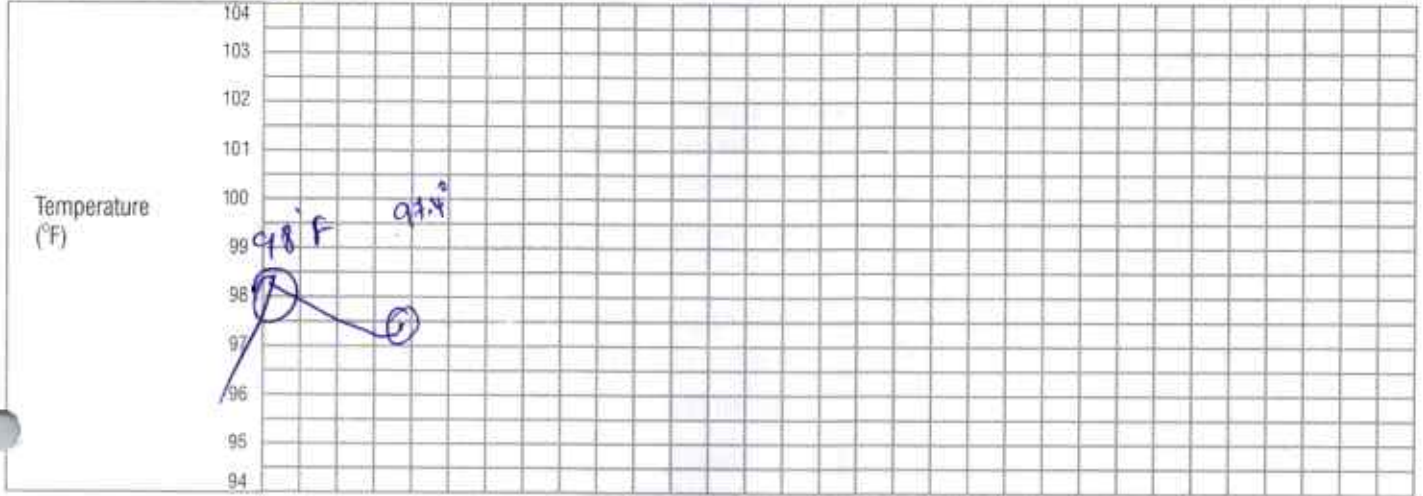
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/5/24 Time: 7 AM 5:30 AM

Doctor/Nurse/Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *
 Note: BP does not score in early warning scoring

Heart Rate (Number) 142b/m 150b/m

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

Resp Rate (Number) 44b/m 38b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 97%

Conscious Level Normal Altered

GCS * 15/15 15/15

TOTAL SCORE Number of shaded boxes 0 0

Pain Score 0/10 0/10

Observer's Initials SS SS

ACTIONS

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- 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)



FLUID CHART

Sheet No. : 1

- 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 Thrombopnebitis 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	FF 20ml								✓		
	06:00 pm											
	07:00 pm	FF 22ml					✓			✓		
Total Intake : 42ml					Total Output : 0 - 2 times							
	08:00 pm											
	09:00 pm	FF 22ml								✓		
	10:00 pm						✓					
	11:00 pm	FF 22ml								✓		
	12:00 am											
	01:00 am	FF 23ml					✓			✓		
Total Intake : 67ml					Total Output : 0 - 2 times							
	02:00 am											
	03:00 am	FF 25ml										
	04:00 am											
	05:00 am	FF 25ml										
	06:00 am						✓					
	07:00 am	FF 25ml								✓		
Total Intake : 75ml					Total Output : 0 - 2 times							
Total 24 hrs. Intake		186ml			Total 24 hrs. Output		0 - 5 times 1 - 5 times.					



FLUID CHART

Sheet No. : 2

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

23/5/26		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G									
	08:00 am										} PP 08:00	} PP 08:00		
	09:00 am	FF 25ml					✓			✓				
	10:00 am													
	11:00 am													
	12:00 pm	FF 25ml					✓			✓				
	01:00 pm													
Total Intake :		50 ml.				M-2		Total Output : U-2						
	02:00 pm	FF 25ml									} PP 08:00	} PP 08:00		
	03:00 pm						✓			✓				
	04:00 pm	FF 25ml												
	05:00 pm													
	06:00 pm	FF 25ml					✓			✓				
	07:00 pm													
Total Intake :		FF - 75ml				M-2		Total Output : U-3						
	08:00 pm										} SS 08:00	} SS 08:00		
	09:00 pm													
	10:00 pm	FF 25ml					✓			✓				
	11:00 pm													
	12:00 am	FF 25ml								✓				
	01:00 am													
Total Intake :		FF - 50ml				M-1		Total Output : U-2 times						
	02:00 am										} SS 08:00	} SS 08:00		
	03:00 am	FF 20ml								✓				
	04:00 am													
	05:00 am	FF 20ml								✓				
	06:00 am													
	07:00 am													
Total Intake :		FF - 40ml				M-0		Total Output : U-2 times						
Total 24 hrs. Intake		FF + EBM -> 215ml						Total 24 hrs. Output					U-9 times	

ANC-00015788 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2028 0 Y 0 M 4 D (M)
 Dr. THINESH KUMAR J



FLUID CHART

Sheet No. : 3

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am											<div style="font-size: 2em; font-weight: bold;">I</div>	
	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							

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Observe the infant for a minute before selecting a score for each behavior. Select only one numeric value per behavior.
Scoring/ Documentation	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Desired levels of sedation vary according to the situation. Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> The premature infant's response to prolonged or persistent pain/stress Neurologic depression, sepsis, or other pathology 	<ul style="list-style-type: none"> 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

23/5 24/5 24/5 24/5 25/5

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			N	M	E	N	M
Age	Less than 3 years old	4	0	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	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	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				
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3		1	1	1	1
	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			15	15	15	15	18

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		X	F	F	X	F
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		X	F	F	X	F
Other Intervention(s) Specify		X	F	F	X	F
Nurse's Name:		Samir	Hem	Pooja	Pooja	Hem
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		23/5	24/5	24/6	24/5	25/5
Time:		Am	pm	8pm	8pm	pm



2



THE HUMPTY DUMPTY SCALE

25/5 26/5 26/5 27/5/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			N	M	E	N	M
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	3	3	3		
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1				1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3				3	3
	Patient Placed in Bed	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			15	15	15	14	14

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		x	x	x	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		x	x	x	✓	✓
Other intervention(s) Specify		x	x	x	✓	✓
Nurse's Name:		Sanyu	Quin	De	Srinai	Pam
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		25/5	26/5	26/5	26/5	27/5/26
Time:		8pm	2pm	8pm	11pm	9Am



THE HUMPTY DUMPTY SCALE

2-15-2026 P 10:08 E/W

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			E	N	M		
Age	Less than 3 years old	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		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3		
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2		
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	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		
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		
Total			15	15	15		

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓		
Call device within reach		x	✓	✓		
Wheels Locked		✓	✓	✓		
Room free of clutter		✓	✓	✓		
Adequate lighting		✓	✓	✓		
Wheel chair support		x	✓	✓		
Other intervention(s) Specify		x	✓	✓		
Nurse's Name:		Danya Singh Lamb				
Signature:		[Signature]				
Date:		20/5/2026				
Time:		9 PM				

Patient Sticker



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
	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					
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					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
Total							

Intervention: -Fall Risk Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position							
Call device within reach							
Wheels Locked							
Room free of clutter							
Adequate lighting							
Wheel chair support							
Other intervention(s) Specify							
Nurse's Name:							
Signature:							
Date:							
Time:							

ANC-00015788

Baby Of C S K SUPRIYA VINESH
23-05-2026 0 Y 0 M 0 D 2 H (M)

Dr. THINESH KUMAR J



IP28-00004442

BRADEN 'Q' SCALE



Date: 23/5/2026		Time: N M		24/5	N		
Mobility	<p>1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.</p> <p>1. Bedfast: Confined to bed</p> <p>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.</p>	<p>2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.</p> <p>2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*</p> <p>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.</p> <p>2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.</p> <p>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.</p> <p>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. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p>	<p>3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.</p> <p>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.</p> <p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is normal.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	2	2	2
Activity The degree of physical activity	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasmodic, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	1	1	1	
Sensory Perception	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasmodic, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	2	2	2	
Moisture Degree to which skin is exposed to moisture	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasmodic, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	4	4	4	
Friction-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surfaces slide across one another	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasmodic, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	3	3	3	
Nutritional Usual food intake pattern	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasmodic, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	3	3	3	
Tissue Perfusion & Oxygenation	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasmodic, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>1. Very Poor: NPO/or maintained on clear liquids, or IV's 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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.</p> <p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lift up completely during move. Maintains good position in bed or chair at all times.*</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal high; capillary refill < 2 seconds.</p>	3	3	3	
TOTAL SCORE				18	18	18	
Evaluator's Name				AS	AS	AS	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23
 Docu. No. : RCH/FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces <small>(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)</small>
15-18	At Risk	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

ANC-00015748 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2 (M)
 23-06-2028 0 Y O M 2 D
 Dr. THINESH KUMAR J

BRADEN 'Q' SCALE



<p>1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.</p> <p>1. Bedfast: Confined to bed</p> <p>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.</p> <p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p> <p>1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.</p> <p>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.</p>	<p>2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.</p> <p>2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</p> <p>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.</p> <p>2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.</p> <p>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.</p> <p>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.</p> <p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p> <p>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.</p> <p>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.</p> <p>3. Adequate: Normotensive oxygen saturation may be < 95%, hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is normal.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p> <p>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.</p> <p>4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.</p> <p>4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p> <p>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 lie up completely during move. Maintains good position in bed or chair at all times.</p> <p>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.</p> <p>4. Excellent: Normotensive, oxygen saturation > 95%; normal hb; capillary refill < 2 seconds.</p>	<p>Date: 23/06/28 Time: 11:15 AM</p>	<p>26652815 M N E</p>
<p>Mobility</p>	<p>2</p>	<p>2</p>	<p>2</p>	<p>2</p>	<p>2</p>
<p>"Activity The degree of physical activity"</p>	<p>1</p>	<p>1</p>	<p>1</p>	<p>1</p>	<p>1</p>
<p>Sensory Perception</p>	<p>2</p>	<p>2</p>	<p>2</p>	<p>2</p>	<p>2</p>
<p>Moisture Degree to which skin is exposed to moisture</p>	<p>4</p>	<p>4</p>	<p>4</p>	<p>4</p>	<p>4</p>
<p>FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>3</p>
<p>Nutritional Usual food intake pattern</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>3</p>
<p>Tissue Perfusion & Oxygenation</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>3</p>
<p>TOTAL SCORE</p>	<p>19</p>	<p>18</p>	<p>18</p>	<p>18</p>	<p>18</p>
<p>Evaluator's Name</p>	<p>SKS</p>	<p>SKS</p>	<p>SKS</p>	<p>SKS</p>	<p>SKS</p>

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk : 19-23
 Docu. No. : RCH/FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces <small>(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)</small>
15-18	At Risk	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

ANC-00015786

IP28-00064447

Baby Of C S K SUPRIYA VINESH T-2

23-05-2026 0 Y 0 M 3 D (M)

Dr. THINESH KUMAR J



BRADEN 'Q' SCALE



	Date: <u>15/02/2026</u> Time: <u>11:30</u>						
Mobility	<p>1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.</p> <p>1. Bedfast: Confined to bed</p>	<p>2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.</p> <p>2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</p>	<p>3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.</p> <p>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.</p>	<p>4. No limitations: Makes major and frequent changes in position without assistance.</p>			
Activity The degree of physical activity	<p>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.</p>	<p>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.</p>	<p>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.</p>	<p>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.</p>			
Sensory Perception	<p>1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.</p>	<p>2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.</p>	<p>3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.</p>	<p>4. Barely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.</p>			
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<p>1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.</p>	<p>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.</p>	<p>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.</p>	<p>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 lie up completely during move. Maintains good position in bed or chair at all times.</p>			
Nutritional Usual food intake pattern	<p>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.</p>	<p>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.</p>	<p>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.</p>	<p>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.</p>			
Tissue Perfusion & Oxygenation	<p>1. Extremely compromised: Hypotensive (MAP < 50 mm Hg, < 40 in a newborn) or the patient does not physiologically tolerate position changes.</p>	<p>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.</p>	<p>3. Adequate: Normotensive oxygen saturation may be < 95%, hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.</p>	<p>4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.</p>			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk : 19-23							
Docu. No. : RCH /FRM / CLINICAL / 119							
TOTAL SCORE							
Evaluator's Name							

Risk Score	Category	Action	Support Surfaces
15-18	At Risk	<ul style="list-style-type: none"> 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 	<p>Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)</p> <ul style="list-style-type: none"> High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> Use the Same Protocol as for "At Risk" Patients Position patient at 30 degree lateral incline using foam wedges 	<ul style="list-style-type: none"> High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> Follow the same protocol as for "Moderate Risk" Patients In addition to regular turning schedule Make small shifts in their position frequently 	<ul style="list-style-type: none"> High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> Use same protocol as for "High Risk" Patients Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	<ul style="list-style-type: none"> High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

ANC-0015786 IP28-00004447
 Baby Of C S K SUPRIYA VINESH
 23-05-2026 0 Y 0 M 0 D 2 H (M
 Dr. THINESH KUMAR J



CHECKLIST FOR THROMBOPHLEBITIS

08/5/2026

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
		Signature of the Nurse											

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : *[Signature]* Name : A.S. Sangeetha

Signature of Ward In Charge :

Signature : *[Signature]* Name : M. Rajani



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>VP-TLUBO/RDS</u>						Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:							
	Surgery / Procedure: _____						Post OP Day: _____							
BACKGROUND	Date	03/5 N		24/5 ML		24/5 E		24/5 N		24/5A MHE		25/5 N		
	Shift													
ASSESSMENT	Medical Condition (Any special condition to be noted):	VPT LBW		VPT LBW		VPT LBW		VPT LBW		VPT LBW		PT LBW		
	Diet:	PreNan		PreNan		PreNan		PreNan		PreNan		PreNan		
RECOMMENDATIONS	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Ventilation (RA, NP, NIV, VENTI):	RA		RA		RA		RA		RA		RA		
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	Vital Signs:	Temp:	36.4		36.5		36.5		36.5°C		36.5°C		36.5°C	
		Res:	40b/min		48b/min		51b/min		54b/min		52b/min		48	
		SpO ₂ :	99%		98%		98%		98%		97b/min		98%	
		Pulse:	140b/min		142		151		150b/min		140b/min		150/min	
		BP:	56/39(45)		49/29		51/33						60/42(43)	
	LOC:	Active		Active		Active		Active		Active		Active		
	Fall Risk Score:	15		15		15		15		15		15		
Pain Score:	0/10		0/10		0/10		0/10		0/10		0/10			
Skin Integrity	Intact		Intact		Intact		Intact		Intact		Intact			
Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Physiotherapy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Special Diet:	PreNan		PreNan		PreNan		PreNan		PreNan		PreNan			
Critical Lab Test / Values:														
Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
ADL (Dependent / Non Dependent):	dependent		dependent		dependent		dependent		dependent		dependent			
Post Operative Procedure Special Orders:														
Handed Over By Name:	Sasani		Sasani		Sasani		Sasani		Sasani		Sasani			
Signature / ID:	[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			
Date:	24/5		24/5		24/5		25/05/26		25/05/26		25/5/26			
Time:	8pm		8pm		8pm		8:00AM		8pm		8pm			
Taken Over By Name:	Sasani		Sasani		Sasani		Sasani		Sasani		Sasani			
Signature / ID:	[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			
Date:	24/5		24/5		24/5/26		24/5		25/5/26		25/5/26			
Time:	8pm		8pm		8pm		8pm		8pm		8pm			



NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: VPT / LBW / RDS					Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND		Surgery / Procedure:					Post OP Day:					
BACKGROUND	Date	26/5/26	26/5	26/5	27/5/26	27/5/26						
	Shift	M	E	N	M	E						
ASSESSMENT	Medical Condition (Any special condition to be noted):	VPT	VPT/RDS	-	VPT/RDS	VPT/RDS						
	Diet:	Pre-nan	Pre-nan	Pre-nan	Pre-nan	Pre-nan						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	36.6	36.0	36.0	37.4	38.3					
		Res:	54b/m	55b/m	42b/m	42b/m	46b/m					
		SpO ₂ :	100%	100%	98%	98%	98%					
		Pulse:	139b/m	140b/m	142b/m	136b/m	134b/m					
		BP:	59/39	53/32(A)	-	-	-					
		LOC:	active	active	Alert	Alert	Alert					
	Fall Risk Score:	16	16	14	14	19						
Pain Score:	0/10	0/10	0/10	0/10	0/10							
Skin Integrity	Intact	Intact	Intact	Intact	Intact							
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Physiotherapy:	-	-	-	-	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Special Diet:	Intact	-	-	Pre-nan	Pre-nan						
Critical Lab Test / Values:												
Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):		Depend	Dependent	Dependent	Depend	Dependent						
Post Operative Procedure Special Orders:												
Handed Over By Name :		Lakshmi	P. Deepika	Srinethi	Pammi	Pammi						
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]						
Date:		26/5/26	26/5/26	26/5/26	27/5/26	27/5/26						
Time:		8:30pm	8:30pm	8:30pm	2pm	8:30pm						
Taken Over By Name :		P. Deepika	Srinethi	Pammi	Pammi	Sugra						
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]						
Date:		26/5/26	26/5/26	27/5/26	27/5/26	27/5/26						
Time:		2pm	8:30pm	8:15pm	2pm	8:30pm						

ANC-00015788
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2026 0 Y 0 M 3 D (M)
 Dr. THINESH KUMAR J



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: YPT / LBW / RDS	Any Infection: <input type="checkbox"/> Yes <input checked="" 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):	YPT/RDS					
ASSESSMENT	Diet:	EBN+FF					
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA					
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.8				
		Res:	44b/m				
		SpO ₂ :	99%				
		Pulse:	126b/m				
		BP:	-				
		LOC:	Alert				
	Fall Risk Score:	18					
	Pain Score:	0/10					
	Skin Integrity:	Intact					
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-					
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	Special Diet:	YPT+RDS					
	Critical Lab Test / Values:	-					
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	Dependent						
Post Operative Procedure Special Orders: -							
Handed Over By Name: Surya							
Signature / ID: [Signature]							
Date: 28/5/26							
Time: 8 AM							
Taken Over By Name: [Signature]							
Signature / ID: [Signature]							
Date: 28/5/26							
Time: 8:30 AM							

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	
	ADL (Dependent / Non Dependent):							
	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	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							

ANC-00015788 IP28-00004447
 Baby OYCSK SUPRIYA VINESH T-2
 23-05-2026 0Y0M0D3H (M)
 Dr. THINESH KUMAR J



NURSING CARE RECORD

Date: 23/5/26

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

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning						
Afternoon						
Night	<p>→ maintain fluid balance</p> <p>→ maintain nutritional status</p>		<p>→ 80ml/kg/day C</p> <p>→ Urea/Dro is on flow</p> <p>→ Pronon OG/IF 2ml given for</p>	<p>Baby noddynes vomiting & aspiration</p>	<p>re-assessment was done</p>	

ANC-00015728
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2028 0 Y 0 M 0 D 3 H 1 M
 D. VINESH KUMAR J



2

NURSING CARE RECORD

Rainbow Children's Hospital
 A MARK IN THE WAY TO BETTER CARE

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

- 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: 21/5/26

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 8 am	Assess the general condition Baby is on room air	10 am	Provided the comfortable position Provided the feed and give	no vomit no aspiration no desaturation	Re-assessment done done	R. Han Durai
Afternoon 3 pm	Assess the general condition Baby is on room air		Assessed the general condition of the baby. Administered IV fluids provided feed and	no vomit no aspiration no desaturation	Re-assessment done	R. Han Durai
Night 8 pm	Assess the general condition of the baby. Administer IV fluids and abx, stoprops provide feed and	11 pm	Administered IV fluids provided feed and	Baby's vitals are stable,	Re-assessment done	R. Han Durai

ANC-00015786 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2
 23-06-2026 0 Y 0 M 2 D (M
 Dr. THINESH KUMAR J



NURSING CARE RECORD



Date: 25/5/2026

- Goals**
- Maintain Airway and Oxygenation
 - Maintain Fluid Balance
 - Improve Activity Tolerance
 - Maintain Good Nutritional Status
 - Relieve Pain & Discomfort
 - Maintain Personal Hygiene
 - 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	Nurse Name & Signature
Morning	Assess the general condition proceeded the Comfortable position		Assess the general condition proceeded the Comfortable position	No vomit no aspiration no desaturation	Re-assessed baby None	[Signature]
Afternoon	Assess the general condition proceeded the Comfortable position		Assess the general condition proceeded the Comfortable position	No vomit no aspiration No desaturation	checked sugars checked and found	[Signature] 02/14/20
Night	Assess the general condition of the baby maintain personal hygiene	upon	Assess the general condition of the baby. maintained personal hygiene	Baby vitals are stable	Re-assessment was done	[Signature]

NURSING CARE RECORD



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

- Relieve Pain & Discomfort
- Prevent Infection
- Advise Others: Speechy

- 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: 23/5/28

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 8 am	Baby given the Paladim - feed only	10 AM	Baby vitals stable Calm after feed.	Baby vitals are stable	Re-assessment done	Dr. Calbb
Afternoon 2 pm	→ TO provided feed → TO provided comfortable position		→ TO provided feed as per previous → TO provided P/F → TO provided comfortable position	→ During feed No vomiting Not distressed	→ Baby is vital signs stable	Dr. GORISSA
Night 8 pm	- Assess baby's position - 2 hourly PP given to baby	9 pm	- Assessed baby's position - 2 hourly PP given to the baby	Baby is stable	Baby is active	Dr. GORISSA

NURSING CARE RECORD

ANC-0015788 IP28-00064447
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2028 0 Y 0 M 3 D (M)
 Dr. THINESH KUMAR J



Date: 27/5/26

- 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
 - Early Ambulation
 - Reduce Anxiety
 - Patient & Family Education
 - Identify Potential Complications
 - Any Others. Specify.....
 - Ensure Safety

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 8 AM	→ To assess the feeding and KPPP Bngg warm.		→ Assessed the feeding and wrapped baby properly.	Baby is stable and Active.	Baby is stable in room.	[Signature]
Afternoon 2 PM	→ To assess the feeding → baby cyclic vitals	9 AM	→ Assess the baby condition. - lack vitals	Baby is stable	Re-assessment was done.	[Signature]
Night 8:30 PM	→ To assess the feeding → Baby vitals have to be checked	9:30 PM	→ Feeding was averted. → Baby vitals are checked & documented	Baby is stable and active	Re-assessment was done	[Signature]

ANC-00015786 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2028 0 Y 0 M 4 D (M)
 Dr. THINESH KUMAR J



NURSING CARE RECORD

Rainbow Children's Hospital
 It takes a lot to have the best.

BirthRight
 DR RAINBOW HOSPITALS
 Your Right to a Safe Delivery

- 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: 28/5/26

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM	→ Assess for the feed.	10 AM	→ Assessed the baby for the feed.	Baby is stable and Active.	Baby Spss in Mouth.	for feeds.
Afternoon							
Night							



]

NURSES NOTES



No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>Receiving Notes</u>	
<u>24/5/24</u>			
	12am	Baby received from OT and checked weight 1.7 kg and shifted to radiant warmer and Dr. Thinesh came advised to put IV line and send CBC, ion cal, Blood clt and start 80mls/day fluid to oral and watch for retraction & grunting if any worsen take gas b x-ray and start wml feed	(Ass)
	12:30am	IV line placed and samples send to lab and	
	1am	IV fluid 80mls/day to oral D10 and inj. Piptas 170mg given via peripheral line as per drug chart	(Ass)
		→ OGIF 2ml prenan given no vomiting & aspiration	(Ass)
	3am	→ OGIF 2ml prenan given no vomiting & aspiration	
	5am	→ OGIF Baby care done and checked weight	(Ass)
		→ OGIF 2ml prenan given	
	7am	→ OGIF 2ml prenan given no vomiting & aspiration and Dr. Aiswarya came assessed & advised to start Dobutamin	(Ass)

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



- No Known Drug Allergies
- Drug Allergies *nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	8am	→ baby details hand over given to the next duty staff	<i>[Signature]</i>
		<i>Morning duty notes :-</i>	
	8am	baby hand over taken. night duty staff baby is on Room air support	
	9am	Diaper changed urine passed. Feed 8AM abradly given no vomit no aspiration no desaturation	<i>[Signature]</i> 02/11/20
		Baby vital signs checked and recorded	
	11am	Baby Diaper changed urine passed. Feed 1ml show gun no vomit no aspiration no desaturation	<i>[Signature]</i> 02/11/20
	1pm	Diaper changed urine passed. Feed 1ml abradly given no vomit no aspiration no desaturation	<i>[Signature]</i> 02/11/20
	2pm	Baby hand over taken given by evening duty staff	<i>[Signature]</i> 02/11/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

No Known Drug Allergies

Drug Allergies m/j

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Evening Duty on-24/5/26	
	2:30 PM	Relief hand over during from morning duty staff. When child on mt & mentions the r/dts. to have breast & doing care per mt. Evk 5:1 pm/mt on (low) for. Dobermann's p. 4.5 pm/mt on for. Child on mt feed. Wmt/and baby.	P.M. 10/2/20
	3 PM	Child is passed the urine. Wt feed and given on per order & baby is tolerating well no vomit.	P.M. 10/2/20
	5 PM	Monitored the r/dts & relieved & r/dts are stable. Wt feed 6 pm increased on per order & baby is tolerating well. no (to vomit) or distress.	P.M. 10/2/20
	7 PM	Wt feed 6 pm given on per order & baby is tolerating well changed. the drs per & baby is passed the urine	P.M. 10/2/20
	8 PM	r/dts are stable & babies also passed & hand over. Given to night duty staff.	P.M. 10/2/20

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<i>Night duty notes</i>	
<i>24/5/26</i>	<i>8.00pm</i>	Baby's details handed over taken from evening duty staff. baby on under radiant warmer temp 36.5°C and is on room air, vitals are monitored and recorded. vitals are stable, Iv fluid is ongoing 4ml/hr, Inj. Dobutamine 0.4ml/hr.	<i>Devi</i> <i>02/06/24</i>
	<i>9.00pm</i>	Baby on room air, vitals are stable, Iv fluid is ongoing 4ml/hr, Inj. Dobutamine 0.4ml/hr, feed 6ml Prenan formula given through or tube, abdomen soft.	<i>Devi</i> <i>02/06/24</i>
	<i>11.00pm</i>	Baby on room air, tone and activity is good. vitals are monitored and recorded. vitals are stable, Iv fluid is ongoing Inj. Dobutamine 0.4ml/hr, feed 6ml Prenan formula given or.	<i>Devi</i> <i>02/06/24</i>
	<i>1.00pm</i>	Baby on room air, tone and activity is good. vitals are monitored and recorded. diaper changed urine passed. Inj. Pipraz 170mg Iv given, feed 8ml prenan formula given.	
	<i>3.00am</i>	Baby on room air and is on prone position, vitals are monitored recorded. feed 8ml prenan	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ANC-00015766
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2026
 Dr. THINESH KUMAR J
 IP28-00004447
 0 Y 0 M 0 D 23 H 1M

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NURSES NOTES



- No Known Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	5:00AM	Baby on room air, tone and activity is good. vitals are monitored and recorded. vitals are stable, iv fluid is ongoing 4ml/hr, Inj. Dobutamine 0.4ml/hr. Feed 8ml prenan formula given through or tube.	<i>[Signature]</i> 5/25/26
	7:00AM	Baby on room air, vitals are monitored and recorded. Vitals are stable, Iv fluid is ongoing Inj Dobutamine 0.4ml/hr, diaper changed urine passed. sponge bath given. Feed 8ml prenan formula given through or	<i>[Signature]</i> 5/25/26
	8:00AM	Baby on room air, Iv fluid is ongoing, Inj. Dobutamine on flow baby's details handed over given to morning duty staff	<i>[Signature]</i> 5/25/26
25/5/26		Morning duty notes	
	9 AM	See baby hand over taken night duty staff baby is on room air Support Diaper Changed urine passed and stool passed.	<i>[Signature]</i> 5/25/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

- NO KNOWN DRUG
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/5/20	9am	Feed 10ml & hourly given in Pre-nan no vomit no observation no aspiration	RJ 02140
	11am	Feed 10ml feed per nan Given through NIF No desaturation, no vomiting	- RJ
	1pm	Baby fed 10ml per nan Given through NIF No desaturation, no vomiting	- RJ
	3pm	baby's vital signs checked and recorded Feed 12ml & hourly given no vomit no aspiration no desaturation	RJ 02140
	5pm	Diaper changed urine Pressure Feed 12ml & hourly given no vomit no aspiration no desaturation	
	7pm	Baby vital signs checked and recorded Feed 12ml & hourly given no aspiration no desaturation	RJ 02140

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES

- No Known Drug Allergies
 Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	8pm	baby hand over given by night duty staff	<i>[Signature]</i> oliver
25/5/28		Night duty Notes:-	
	8pm	Baby hand over received from evening duty staff Baby is in under the radiant warmer.	Ass.
	9pm	Baby is alert, cry tone and skin colour is normal. Baby is on room air Baby vitals are monitoring and recording Temp- 36.6°C RR-48 HR-156 SpO2 - 97% Feed 4ml @ 2nd hourly per plan Palisadei feed given as per doctor advise.	Ass.
	12am	@ 6th hourly. 2nd assessment as per during doctor advise Baby passed urine and motion.	Ass.
	2am	Monitoring intake and Output chart	Ass.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



No Known Drug Allergies

Drug Allergies *None*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Feed time increased at 3am	
	4am	Baby tolerating feeds. No any issues	AS
		Tomorrow plan to do Echo, NSU, RP2, TFT CRP.	
		morning routine care given	
	6am	Go the baby.	
		Today weight 1.660kg.	AS
		CRP - 25mg/dl B P - 56 (33 (42)	
		Baby in stable.	
		Tolerating feeds, samples are sented Report done	
	8am	Baby hand over given to new-duty staff	AS
		Morning Duty Notes 26/5/26	
	8am	Baby Details had over taken from the night duty staff	
		Baby is on Room air only	
		Continue paleidhi feed in BTh. Only 2ml & plan. No any antibiotic	
	9am	16 ml of paleid in given to Baby during no vomiting no stool change.	
	10am	Baby diaper changed found in urine	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ANC-00015788 IP28-00004447
 Baby Of C S K SUPRIYA VINESH T-2
 23-05-2026 0 Y 0 M 3 D (M)
 Dr. THINESH KUMAR J

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NURSES NOTES



Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	11 am	Baby feed 10ml of gum to palcedi during no desert no Brady.	
		Dr. Shobana mam sends Cene advised in trained in Mother to give palcedi evening room side shift plan.	PP 02/10/26
	12 pm	Dr. Thinesh Cene advised in one feed gives 10ml after you gives 20ml	PP 02/10/26
	1 pm	Baby feed 20ml of gum to palcedi during no desert no Brady.	PP 02/10/26
	2 pm	Baby details hand over gum to next duty staff. <u>Evening duty Notes</u>	
	2 pm	-> Baby details handover taken from morning duty staff -> Baby is on room air & under waeman -> Baby is +one Normal & skin pink colour & vital sign Temp - 36.0°C / RR - 55 / Pulse - 143 SpO2 - 100 / BP - 58/32 (40) acantane &	PP 02/10/26
	3 pm	-> Baby urine + stool passed Change diaper	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

No Known Drug Allergies @
 Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Feed given some prenan sake through PLF	<i>[Signature]</i>
		→ During feed No vomit Not desaturation & vital Sign stable.	<i>[Signature]</i>
	4pm	→ Baby shifted to M ofloor	<i>[Signature]</i>
		Receiving Notes	
	4pm	Baby received in mfloor handover over taken from NICO staff Baby is active, Baby tone normal & stump pink colour. Present.	
	4pm	Baby in room air Baby feed given 20ml. FF. No consulting.	
	4pm	Formula feed given. Intake and output monitoring.	
	8pm	Handing over given to night duty	
		Night duty notes:	
	8:30pm	Baby handover taken from evening duty staff.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

Nin.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>Morning Duty (27/5/26)</u>	
27/5/26	8 Am	Patient Hand over taken from Night. Duty Staff, Baby is stable and A&P, →	PP 01905
27/5/26	10 Am	Baby is stable and Active pink in colour and warm →	PP
27/5/26	12 Pm	Repeating PRM Now 23 ml milk to Baby and vital signs checked and documented in file →	PP 01905
27/5/26	1 Pm	Baby I to coughed and documented in file →	PP
27/5/26	2 Pm	Patient Hand over with to Evening Duty Staff →	PP
		<u>Evening duty notes</u>	
27/5/26	2 Pm	Baby detail Landaces taken from morning duty staff.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Baby is stable and active, Baby is pink in colour and well.	
	5pm	Baby given feed EBM + FF 25ml.	
	4pm	Baby checked vitals, vitals is recorded	
	6pm	child was sleeping pink and warm the no other complain.	
	7pm	R/O discharged and documented child fed well no complain of vomiting, baby pink and alert	
	8pm	vitals checked and documented vitals stable.	
	8:30 pm	Handing over given to the next duty staff 8pm - 8supriya. <u>Evening duty</u>	<u>LS</u>
27/5/24	8:30pm	Baby hand over taken from evening duty staff Baby active alert awake baby stable baby on room air Baby pink and warm EBM + FF - 20-25ml paladei feed only	<u>over</u>
	10pm	FF - 25ml given no vomiting	<u>LS</u> 01/06

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



No Known Drug Allergies
 Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
27/5/26	10pm	Baby passed urine and motion	SS SN
		Baby is slept	
28/5/26	12AM	vitals stable room air saturation maintain FF -> 25ml given no vomiting Baby passed urine Baby is slept	
	4AM	vitals checked and recorded	
	5:30AM	FF -> 20 ml given no vomiting Baby is slept	
	8AM	Baby vitals checked and recorded Baby hand over to next duty staff	
<u>Morning Shift (28/5/26)</u>			SS SN
28/5/26	8AM.	Patient hand over taken from Night duty staff Baby is stable and well oriented fluid No IV line present	
28/5/26	10AM	Baby is pink in colour, No other complaints present	
28/5/26	12PM	Patient is stable DR. Shobana Maam came and saw the child she	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

