

ANC-00015862 IP28-00004472  
Baby AARADHANA  
09-05-2022 4 Y 0 M 18 D (F)  
Dr. KRITHIKA P



### DISCHARGE TRACKING SHEET

UHID : 15862 FLOOR: PICU CONSULTANT NAME: DR. KRITHIKA P.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing	26/5 11:57 PM	28/5 8 AM		
Activity Sheet updated by Pharmacy	8:5 AM	8:16 AM	Jain	




# ACTIVITY RECORD FOR BILLING



Name: ANC-00015862 IP28-00004472  
 Baby AARADHANA  
 09-05-2022 4 Y 0 M 18 D (F)  
 UHID N Dr. KRITHIKA P Consultant: Dept:  
 Date of Time: Date of Discharge: Time:  
 Room / Bed No: Ward: Suggested Billable bed type:



## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/5/26	12-10 Am	BR	PICU	 020901

## CROSS CONSULTATION VISIT

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









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## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/2026	<p>CL/B DR. HANSA VS</p>	
1:30 PM	<p>PARACETAMOL poisoning                  FEVER ↓ EVALUATION.</p>	
	<p>NO fresh complaints                  no do vomiting / abdominal pain                  no do cough / cold                  do fever - 101° 8 → at 1 AM                  last paracetamol 8 PM</p>	
	<p>O/E Alert, febrile                  Hydration - Good                  +++/++                  CRT &lt; 3 sec</p>	<p>vitals                  HR - 142/min                  RR - 30/min                  T - 101° 8 F</p>
	<p>S/E                  P/A - soft, non-tender                  no organomegaly                  Cn - S1S2 (+) no murmur                  Rr - B/C AE (+) no added sound                  Cm - AFFND</p>	<p>SpO2 - 98% @ RA                  Bp - 100/69 (78)</p>
		<p><u>ADVICE</u> wt 12 kg.</p>
		<p>Syrup PARA 2.5 ml p/o</p>
		<p>(5ml/250mg) <u>805</u></p>
		<p>10ml/kg/dose</p>



ANC-00015862 IP28-00004472

Baby AARADHANA  
09-05-2022 4 Y 0 M 17 D (F)

Dr. KRITHIKA P



# PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	cls/B Dr Suenera	
<del>27/5 Mon 7:30 AM</del>	Case of Acute Febrile illness paracetamol poisoning	
	paracetamol poisoning (25mg/kg) - cumulative dose - over 1 day	
	F - oral feeds +	
	I - NAC Tylenol	
	R - B/L AEC <sup>+</sup> , chest clear RR - 28/min, SpO <sub>2</sub> - 96% LNA on room air	
	I - Not on Antibiotics TLC - 7280, Wb - 10.8, pIT - 2.3 PL, CAP 25	
	R - RR - 120/min, BT - 99/07 mmHg CRT 1sec, +++/++ S <sub>1</sub> S <sub>2</sub> ⊕, no murmurs Not on motry	



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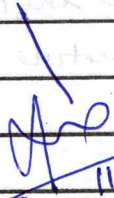
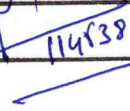
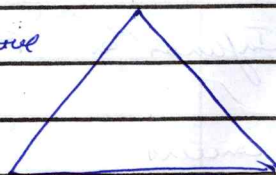
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2#15/06	S/B Mr. Divya Reddy	Dr. Sameer
9am		
	Case of Paracetamol poisoning	
	Intake of Paracetamol	125mg/kg - cumulative dose
	(5m) 250mg	→ 1500mg/day
		↓
		125mg/kg
	F - on oral feeds.	
	+ NAC - 100mg/kg over 16 hours infusion @ 15.6ml/hr	
	(A. 30 am)	
	(S. Paracetamol level - 14 Ng/ml)	
	0.0 - 2.3 ml/kg/hr	
	R - RA	
	RR - 35/min	(Temp - 100.8F)
	B/LAE @	clear
	SpO <sub>2</sub> - 97%	RA.
	I - CRP - 25	WBC - 7.28
	plt - 2.38	
	Not on Antibiotics.	
	Temp - 101.8	→ 100.8F





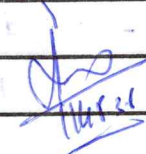
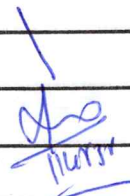
## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	Plan - to continue NAC infusion	S/O T / S/C P / TT, TTT, SDR
	to repeat S. Paracetamol after completion of NAC	
	Nil Paracetamol toxicity signs	
	To plan sleeping to ward late in the evening	
	after NAC infusion is over.	
	Parents counselled.	
		 114159.
		 114138.
27/5/26	S/B Dr. Binaya Sahu	
2.45 pm		
	Alerts Active	HR - 125/min
	Debride	CRT - 2 sec, CP/PP +/+/+
		S1S2 @, No murmurs
	RR - 21/min	
	B/L AE @, clear	
	SpO2 - 100% RA	
	Continue oral feeds.	





**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<del>2/15/20</del>	<u>S/O Dr. Sarma</u>	
	Child examined	
	No fever spikes after afternoon	
	and intake - better	
	To do Sr. Pan level, SPT/SAPT, PT/APTT BCR	
	once NAC is over.	
		
<del>2/15/20</del>	<u>S/O Dr. Sarma</u>	
6 AM	Child exam	
	No specific complaints	
	Pan CLO	HR 69/min
	PT - 18.7	RR 20/min
	APTT - 22.1	Plac soft
	Jvitamin two doses given.	
		



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/21	S/B Dr. Divya Sree	
8:25 am		
	Case of Paracetamol poisoning.	
	F - on oral feeds, off IVP	
	U.O - 2.9 ml/kg/hr	
	R - Fr RA.	
	RR - 23/min	
	B/L of $\Phi$ , clear	SpO <sub>2</sub> - 100%
	I - CRP - < 5, WBC - 7.28, Pct - 2.38	
	Not on Antibiotics	
	Afebrile since 18 hours.	
	E - CRP - < 3.0, CP/PP - +/+	
	HR - 109/min	
	S/S <sub>2</sub> $\Phi$ , Normoxia	
	H - Ab - 10.8	
	Repeat PT - 18.9, INR - 1.36	
	APTT - 32.1	
	Totally 2 dose of IMV-VIT K 5mg given	
	since admission	





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 Baby AARADHANA 4 Y 0 M 18 D (F)  
 09-05-2022  
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### RESULT SHEET

Date	26/05	27/5			
Time	11pm	11pm			
Hb	10.8				
PCV	31				
RBC	4.12				
WBC	7.28				
N/L	58/32				
Platelets	238				
CRP	5				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT	26	27			
SGOT	36	32			
T.Bill/Conj	0.3/0.0				
T.Protein	6.6				
S.Albumin	4.0				
S.Globulin	2.6				
A/G Ratio	1.5				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	11.2/1.23	18.9/1.36			
APTT	36.8	32.1			
CSF Protein / Sugar					
Cells					
N/L					

Date	27-5	27-05				
Time	12AM	11PM				
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
gr.						
paracetamol level	14	<10				

Culture and Sensitivities : .....

.....  
 .....  
 .....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI : .....

Others (ECG, Contrast Studies etc.) : .....



## MEDICATION RECONCILIATION FORM

Drug Allergies: Nil  Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: PIW

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

**MEDICATION HISTORY RECORDED / VERIFIED BY**

Doctor Name & Signature : U.S.K. (Dr. Harman) 96066

Date & Time : 27/5/26 @ 12AM

Nurse Name & Signature: Baldhi 020901

Date & Time : 27/5/26 @ 12AM

## MEDICATION RECONCILIATION FORM

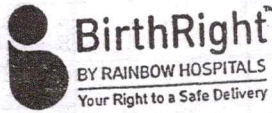
Medication Reconciliation will be done at the time of admission and at a subsequent time if change in the treating team or shifting from one unit to another unit. (Example: at the time of admission shifting from ICU to Ward or Vice Versa)

Shifted to: ICU From: ICU

OR ADMISSION STARTING	DATE	TIME	LOCATION	PHYSICIAN	PHYSICIAN (GENERIC NAME CAPITAL LETTERS)
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

MEDICATION HISTORY RECORDED & VERIFIED BY: [Signature]  
 Doctor Name & Signature: [Signature]  
 Date & Time: 10/10/00  
 Nurse Name & Signature: [Signature]  
 Date & Time: 10/10/00

Ref. No. : F / HW / DC / INPR / 05



Patient Name : ANC-00015862 IP28-00004472 Age : .....  
 Baby AARADHANA  
 09-05-2022 4 Y 0 M 18 D (F)  
 Gender  M Dr. KRITHIKA P  
 Consultant : .....



Date of Admission : .....

DRUG ALLERGIES : Nil

**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 Hospitals's Verbal Order Policy.

**SOS / PRN (As Required Medication)**

(5ml)  
 250mg  
 10mg/5ml dose

DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
120mg (2.5ml)	P/O	SOS	26/5/26	12:15
Doctor's Signature		Valid Period	Pharm.	
		28/5/26		
Additional Instructions				
DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions				
DRUG :				Date
Dose	Route	Frequency	Start Dt.	Time
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions				









## NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 27/5/22  
 Source of Admission:  OPD  Ward  Other: ER  
 Reason for Admission: Accidental ingestion of Paracetamol  
 Admission Diagnosis: Paracetamol Poisoning  
 Accompanied By:  Parent  Guardian  Other Name: \_\_\_\_\_  
 Primary Language:  Telugu  English  Hindi  Other Specify: TAMIL  
 Do you require an interpreter?  Yes  No  
 Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other: \_\_\_\_\_  
 If yes, identify \_\_\_\_\_

Source of Information: <input checked="" type="checkbox"/> Family <input type="checkbox"/> Patient <input type="checkbox"/> Others, Specify _____			
<b>SIGNIFICANT HISTORY</b>	Past Medical History	Past Surgical History	Last Hospital Admission
	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	Family History: _____ <u>Nil</u>		
	Has the child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes please list, _____ Was the child's birth normal? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, please describe problems: _____ Are the child's immunization up to date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<b>CURRENT MEDICATIONS</b>	Taking Medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Fill the reconciliation form Medicine brought to the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Observations: Weight: <u>21.10kg</u> Length: _____ Head Circumference (< 2 years): _____ Temp.: <u>101.8 F</u> HR: <u>158b/m</u> RR: <u>29b/m</u> BP: <u>100/60</u> Pain Score: <u>2/10</u> Specify Site: _____ (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Score: <u>11</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>25</u> ) (Document in the Braden Q Assessment Sheet)			



- Sleeping  Crying  Calm  Distressed/Console  Drowsy

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**

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

Inform consultant for positive criteria

**Psychological Screening:**  No Significant Findings

Unusual concerns about patient's Psychological Status:  Yes  No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With Parents

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

Orientation has been given regarding the following aspects:

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

Orientation given to:  Family  Others specify .....

Name of Person Orientation was given to: Father

Orientation not given Reason: .....

Nurse Name: Asejany Nurse Signature: Asej

Date & Time: 27/05/20 @ 12:25 AM

**DISCHARGE PLAN**

Source of Information:  Family  Friend

Will patient require transportation arrangements to go home:  Yes  No

Will Physiotherapy require at home:  Yes  No

Is home medical equipment anticipated:  Yes  No

Is home oxygen therapy anticipated:  Yes  No

Are dressing needs at home anticipated:  Yes  No

Any other needs anticipated:  Yes  No If Yes Specify .....

Discharge Medications:  Yes  No

Details: .....

Final Diagnosis: Paracetamol poisoning

Nurse Name: J. GIRIJA Nurse Signature: J. Girij

Date & Time: 28/5/20 @ 9 AM



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## NURSING SHIFT HAND OVER FORM

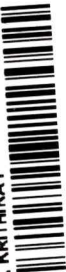
<b>SITUATION</b>	Diagnosis: <u>Paracetamol Poisoning</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known				
	Surgery / Procedure:	If Yes Specify: ..... Post OP Day: <u>-</u>				
<b>BACKGROUND</b>	Date	<u>27/05</u>	<u>27/05</u>	<u>27/05</u>	<u>27/05</u>	
	Shift	<u>N</u>	<u>M</u>	<u>E</u>	<u>N</u>	
	Medical Condition (Any special condition to be noted):	<u>Paracetamol Poisoning</u>	<u>Paracetamol Poisoning</u>	<u>Poisoning</u>	<u>Paracetamol Poisoning</u>	
	Diet:	<u>(N)</u>	<u>(N)</u>	<u>(N)</u>	<u>(N)</u>	
<b>ASSESSMENT</b>	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	
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	
	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	
	Vital Signs:	Temp:	<u>100.3 F</u>	<u>101.3 F</u>	<u>99.4 F</u>	<u>99.8 F</u>
		Res:	<u>24/m</u>	<u>25/m</u>	<u>21/m</u>	<u>21</u>
		SpO <sub>2</sub> :	<u>96%</u>	<u>99%</u>	<u>98%</u>	<u>98%</u>
		Pulse:	<u>119/m</u>	<u>115/m</u>	<u>86/m</u>	<u>90</u>
		BP:	<u>93/54/66</u>	<u>95/55/65</u>	<u>109/68</u>	<u>-</u>
		LOC:	<u>Alert</u>	<u>Alert</u>	<u>Alert</u>	<u>Alert</u>
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Skin Integrity:	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>		
<b>Recommendations</b>	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	
	Physiotherapy:	<u>-</u>	<u>-</u>	<u>-</u>	<u>X</u>	
	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	
	Special Diet:	<u>-</u>	<u>-</u>	<u>-</u>	<u>X</u>	
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>	<u>X</u>	
	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	
	ADL (Dependent / Non Dependent):	<u>Dependent</u>	<u>Dependent</u>	<u>-</u>	<u>-</u>	
Post Operative Procedure Special Orders:						
Handed Over By Name :						
Signature / ID :						
Date:						
Time:						
Taken Over By Name :						
Signature / ID :						
Date:						
Time:						

Patient Sticker



## NURSING SHIFT HAND OVER FORM

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



**NURSING CARE RECORD**

Date: 27/5/26

- Goals**
- Maintain Airway and Oxygenation
  - Maintain Fluid Balance
  - Improve Activity Tolerance
  - Maintain Good Nutritional Status
  - Re-Assessment
  - Nurse Name & Signature
  - Relieve Pain & Discomfort
  - Meet Elimination Needs
  - Ensure Safety
  - Early Ambulation
  - Patient & Family Education
  - Prevent Infection
  - Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	<p>Assess the child general condition.</p> <p>Maintain Fluid Balance.</p>	am 9-30	<p>Assessed the child general condition.</p> <p>maintained fluid balance.</p>	<p>child had Temp. 100.8°F</p> <p>⇒ child on oral diet</p>	<p>done.</p>	<p>Anshika          021623</p>
Afternoon	<p>Assess the general condition.</p> <p>Maintain the personal hygiene.</p>	3pm	<p>Assessed the general condition.</p> <p>Maintained personal hygiene.</p>	<p>child vitals are stable</p>	<p>done.</p>	<p>Pooja          01920</p>
Night	<p>Assess the general condition.</p> <p>Maintain personal hygiene.</p>	9pm	<p>General condition assessed.</p> <p>Personal hygiene maintained.</p>	<p>vitals were stable</p>	<p>re-assessment done</p>	<p>[Signature]</p>

Patient Sticker

# NURSING CARE RECORD



Date: .....

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

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	Hand hygiene Administer meds	8:00 AM	Hand hygiene Administer meds	Hand hygiene Administer meds	Hand hygiene Administer meds	[Signature]
Afternoon	Hand hygiene Administer meds	2:00 PM	Hand hygiene Administer meds	Hand hygiene Administer meds	Hand hygiene Administer meds	[Signature]
Night	Hand hygiene Administer meds	8:00 PM	Hand hygiene Administer meds	Hand hygiene Administer meds	Hand hygiene Administer meds	[Signature]



# NURSES NOTES

(USE BALL POINT PEN ONLY)



No Known Drug Allergies

Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Receiving notes on 27/05/22.
27/05	12:10AM	Child details taken handing over from ER. Child received from ER child had clo. Accidental ingestion of Paracetamol about 30ml in Bco. today. While receiving child is on EA. Vitals checked and recorded. IV was good. Gcs was 15/15. Plan for Nac infusion.
27/05	1AM	Sy. Nac infusion started running in 20ml/hr over 4hr. Child has fever 101.8°F. SYP. Bco = 2.5ml given on Pa order. Child slept well.
27/05	4:30AM	Sy. Nac infusion changed, being infused over 16hr. Child fever spike decreased. Pump urine wet.
27/05	6AM	Morning care given. IV line drawing done. Gcs was 15/15. Take orally wat. Child has
27/05	7AM	Continuous hypothermia Dr. Smitha advised to give Sy. Para, being IV given as Pa order. Take water wet.
27/05	8AM	Child details given handing over to morning due to Smitha

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

**NURSES NOTES**  
 (USE BALL POINT PEN ONLY)

NO KNOWN Drug Allergies

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
27/5	9am	child report taken from night duty staff. child general condition was good, vitals are temp. 100.8° F HR. 132/min, RR 20/min, Blood pressure 103/70 mmHg. child on oral diet, 22 cc nonflow present in the right hand cephalic site, injection VAC infusion 15-6ml/hr onflow.
	11am	Dr. krithika mam come and seened the child she advised continuous vac infusion and take oral diet
	2pm	child had fever spike Temp. 100.8° F informed dr. sameera mam she advised give syp. Ibuprofen 6ml.
	2-15pm	Syp. Ibuprofen 6ml given per oral
	2-30pm	child general condition good, vitals stable, child taken orally, syp. vac infusion 15-6ml onflow. child report hand over to evening staff s/n pradeep.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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# NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies ..... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<b>Breeding Duty on 22/5/22</b>
	2:30pm	BCVT hand over taken from morning duty staff while child on pt & maintain the vitals. tv line present in Rt Cephalic vein rate & maintain the vitals. Fri. was Enters on 15.6ml/hr on flow. child on @ Diet. P 22/5/22
	4pm	monitored the vitals & recorded & vitals are stable. child is present the room. P 22/5/22
	6pm	child is taken some new Kanti & H2O & chuparti. Do some more incision ordered to do blood test after some intake run over & plan to shift ward by night. P 22/5/22
	8pm	monitored the vitals & recorded & vitals are stable. cant run intubation on going hand over given to night duty staff. P 22/5/22
		<b>Ⓢ Night duty on 22.05.22</b>
22/5	8p	Handover received from evening duty staff. vitals stable. plan to send diet, apt, paracetamol and pt. DR. P 22/5/22

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies ..... none

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
27-05	9am	Baby taken dinner plan to cut same and to send samples and to follow up. <i>[Signature]</i>
	11pm	Nb infusion completed all samples asked by Dr. Kritika
28-05	2am	vitals stable no fever. Sample values D/W Dr. Kritika plan discharge morning. <i>[Signature]</i>
	6a	Routine morning care given vitals stable and monitored. <i>[Signature]</i>
	7am	SIR Dr. Sameera advised to plan discharge and given one deep vitals in the morning due to PT/PR elevated after d/w Dr. Kritika to plan discharge and to follow up PT/PR after ads. <i>[Signature]</i>
	8a	Handover given to the morning duty staff vitals stable.
	8:10am	SIR Dr. Sameera advised to start the discharge process. <i>[Signature]</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS