

**Rainbow Childrens Hospital-Himayatnagar**

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.  
TEL NO :040-48873000  
WEB : <https://rainbowhospitals.in>

**ADMISSION SHEET****Registration Details :**

Admission No : IP26-00006612      Admit Date : 19-Jun-2026      Admit Time : 06:11 PM      UHID : HNH-00007207

**Patient Details :**

Patient Name : Baby AROOSH OMER      Age : 8 Y 1 M 15 D  
Guardian : Mr OMER FAROOQ      DOB : 04-05-2018  
Gender : Female      Religion :  
Occupation :      Martial Status :  
Address (H) : 16-2-867/A/20 Saidabad Hyderabad      Phone No : 9100333155/ 8297196741  
Telangana INDIA 500059      E-mail : omerfarooqai6424@gmail.com

**Admission Details :**

Bed Type : DAY CARE      Bed No : ER02      Ward Name : GF -EMERGENCY  
Room No : ER02      Admission Type : First Visit

**Contact Details :**

Name : Mr OMER FAROOQ      Relationship : Father  
Contact Address : 16-2-867/A/20 Saidabad Hyderabad Telangana INDIA 500059      Phone No : 9100333155

  
Signature

**Doctor Details :**

Doctor Name : Dr. ANIKET ANIL PARASHAR      Specialisation : GENERAL PEDIATRICS  
Referral Doctor : Self.      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : DC/CC Card      Deposit Amount : 5000.00  
Payor Name : GO DIGIT GENERAL INSURANCE LIMITED

Q

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**ACTIVITY**

HNH-00007207 IP26-00006612  
Baby AROOSH OMER  
04-05-2018 8 Y 1 M 15 D (F)  
Dr. ANIKET ANIL PARASHAR

Name: -----

UHID No: --- 

----- Consultant : ----- Dept : *pediatric*

Date of Admission : *19/6/26* Time : ----- Date of Discharge : ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<i>19/6/26</i>	<i>7pm</i>	<i>ER</i>	<i>ward</i>	<i>Bhargava</i>

**Cross Consultation Visit**

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








Ref.No. F/IN/PR/10



**Rainbow<sup>®</sup>  
Children's  
Hospital**

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

Patient Name : \_\_\_\_\_  
HNH-00007207 IP26-00006612  
Baby AROOSH OMER  
04-05-2018 8 Y 1 M 16 D (F)  
Dr. ANIKET ANIL PARASHAR

Patient ID# : \_\_\_\_\_  


Consultant : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

HNH-00007207 IP26-00006612  
Baby AROOSH OMER  
04-05-2018 8 Y 1 M 15 D (F)  
Dr. ANIKET ANIL PARASHAR



Name : \_\_\_\_\_ Age, \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

c/o vomiting since 2 days.  
c/o. loose stools. since 2 days  
c/o fever since 2 days  
c/o decreased activity & decreased appetite of  
food.

History of present illness :

Child presented to ER with c/o vomiting  
multiple episodes since 2 days after taking food  
non projectile / non bilious.

c/o loose stools since 2 days watery in consistency  
not blood stained. multiple episodes.

c/o fever since 2 days, high grade, Intermittent.  
not accompanied with rigors & chills.

c/o decreased activity & decreased appetite of food.

c/o decreased urine output.



Pediatric Multiorgan History & Physical Examination

HNH-00007207 IP26-00006612  
Baby AROOSH OMER  
04-05-2018 8 Y 1 M 15 D (F)  
Dr. ANIKET ANIL PARASHAR



Anthropometry

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) \_\_\_\_\_ (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 99.3°F Pulse Rate: 134/min Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 98% at \_\_\_\_\_

Resp. rate and type of breathing : ~~16~~ (n)

*sign of dehydration (+)*

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

*dry lips, oral mucosa,*

Oedema : \_\_\_\_\_

*sunken eyes, decreased urine output  
dull look*

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : 0/c AC (+)

Any added sounds : RVBS (+)

Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

**Cardiovascular System :**

Inspection of precordium : \_\_\_\_\_

Heart Sounds : S1, S2 (+)

Any murmur : no murmur.

Relevant data from outside (Chest X-Ray, ECG, ECHO, Etc.,) \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : Soft, not distended.

Auscultation : no organomegaly.

Spine: \_\_\_\_\_ External Genitalia: \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

HNH-00007207 IP26-00006612  
Baby AROOSH OMER  
04-05-2018 8 Y 1 M 15 D (F)  
Dr. ANIKET ANIL PARASHAR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : 15/15

Cranial Nerves : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Motor System :

Nutrition : \_\_\_\_\_

Tone : (N) Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

Reflexes :

DTR

Superficials :

Plantars (N) \_\_\_\_\_

Sensory System :

\_\_\_\_\_  
(N)  
\_\_\_\_\_  
\_\_\_\_\_

Bladder / Bowel : \_\_\_\_\_

Clinical Summary & Diagnostic :

Age i dehydration  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

HNH-00007207 IP26-00006612  
Baby AROOSH OMER  
04-05-2018 8 Y 1 M 15 D (F)  
Dr. ANIKET ANIL PARASHAR



Preventive aspects of the treatment :

Prevent hypovolemic shock.

Desired goals of the treatment :

**Planned Labs :**

CBP,  
CRP,  
CUE,  
VBG,  
B/ds (2 samples)

Extra plain sample  
Noted by vijaya

**Planned Management :**

~~IV fluids DNB @ 60ml/h  
(full maintenance)~~  
- ORS sachets.  
- PROG-9 sachet.  
- 1g ONDAM.  
- 1mg (SOS).  
- 1g ESMOPRAZOLE 20mg.  
- 1g CEFTRIAXONE.  
- IV fluid plasmolyte @ 40ml/h  
+ 25% D  
100ml  
Noted by vijaya

**Please fill up the following details**

- Name of the Referring Doctor : \_\_\_\_\_
- Name of the Referring Hospital : \_\_\_\_\_  
(Including the name of City)
- Contact number of the Referring Doctor : \_\_\_\_\_  
(Preferring Mobile #)
- Name of the doctor in Rainbow Team Dr. Aniket P on  
whose name the patient is being referred

Doctor's Signature Name

*[Signature]*

Date

19/6/26

Time



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
20/06/26 8AM	<p><u>C/O/B. Dr. Sandhya / Dr. Ananya</u></p> <p>AGE 8 Dehydration.</p> <p>Swat @</p> <p>Vomiting - non vomiting</p> <p>Looritoolk - reduced.</p> <p>O/C: Ac-fair</p> <p>Vitals: Stable</p> <p>Hydration - good</p>	
S/O: MAD		
		<p><u>Also</u></p> <ul style="list-style-type: none"> <li>✓ IV fluids</li> <li>✓ Taj Ceftiozone</li> <li>✓ Supportive care</li> <li>✓ Monitor vitals and</li> </ul> <p>Tajfam 500</p> <p>Sandhya</p>
		<p>noted by sr. Sandhya.</p> <p>20/6/26</p> <p>@ 8:am</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26 11:30AM	c/o/b Dr. Aniket Sir <u>AGE C DEHYDRATION</u>	
	- fever spikes (+)	
	- Nausea (+)	
	- NO vomiting / loose stools.	
	- Took <u>Idi</u>	
	PE - vitals stable.	
	PE - <u>WNL</u> .	<div style="border: 1px solid black; padding: 2px; display: inline-block;">Plan</div>
		- Send <u>SRS panel</u> .
		- ct. IVF 1/2 M.
		- Trace blood c/s.
	Signs of dehydration (+).	- ct. Ceftriaxone.
		- Rest continue as per Rx chart.
		<p style="text-align: right;">Aniket Parashar</p>
		<p style="text-align: right;">noted by Sr Sandhya 20/6/26 @ 11:30</p>





















HNH-00007207 IP26-00006612

Baby AROOSH OMER  
04-05-2018 8 Y 1 M 15 D (F)  
Dr. ANIKET ANIL PARASHAR



### MEDICATION RECONCILIATION FORM

Drug Allergies: N/A  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: ward

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 : Dr. Anushka

Date & Time : 19/6/26 @ 5:10pm

Nurse Name & Signature: Bhargava

Date & Time : 19/6/26 @ 5:15pm

Docu. No. : RCH / FRM / GENERAL / 090



## DRUG CHART

Date of Admission: 19/6/26 Drug Allergies: N/A  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 Hospitals's Verbal Order Policy.

### SOS / PRN (As Required Medication)

<b>DRUG :</b> ORS - Wtlo				Date/Time	19/6/26															
Dose	Route	Frequency	Start Date		11pm															
200 ml	oral	as req.	19/6/26																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:		4.4g sachets in 200ml water																		

<b>DRUG :</b> SYR. CROCIN DS				Date/Time																
Dose	Route	Frequency	Start Date																	
6.5ml	PO	Sus/6H	19/06																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

<b>DRUG :</b> SYR. IBUGESIC				Date/Time	19/6/2026															
Dose	Route	Frequency	Start Date		12:20 pm															
6.5ml	PO	Sus/8H	19/06																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:		(5ml/100mg)																		

HNM-0007207 IP26-0006612  
 Baby AROOSH OMER (F)  
 04-05-2018 8 Y 1 M 15 D  
 Dr. ANIKET ANIL PARASHAR



Sheet No. .... **REGULAR PRESCRIPTIONS** Weight ..... Ward .....


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

SIGNATURE .....  
 VERIFIED BY Name





# PATIENT TRANSFER FORM

Patient Name & UHID No.  HNH-00007207      IP26-00006612 Baby AROOSH OMER 04-05-2018      8 Y 1 M 15 D      (F) Dr. ANIKET ANIL PARASHAR 		Date & Time of Admission 19/6/26 @ 6:11pm	Date & Time of Transfer Order 19/6/26 @ 7pm
		Transfer Ordered by Dr. Anusha	Reason for Transfer Admission
From Unit ER	To Unit ward		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 25/-	Number of Imaging Films		Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name		Quantity
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor :      Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Bhargava		Name of Person Ordered Transfer Dr. Anusha	
Patient & Clinical Records Received by : Suranda			
Date & Time of Patient Received : 19/6/26 @ 7:20pm.			

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

- Unavailable Bed     
  Nurse not Available     
  Available Bed not ready

11M

209

# NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 19/6/26 Time: 6:40pm

Weight: 20.93kg Centile: 10<sup>th</sup>

Height: Centile: -

Inference: underweight child

RDA: Calories: 1550 kcal/d Protein: 27gms/d

Diet Recommendations: Gastro Diet: can have - ORS (WHO), Coconut water, soy water + rice based food

Re-Assessment: Avoid - milk, oats, Ragi, sugar, citrus, wheat & egg.

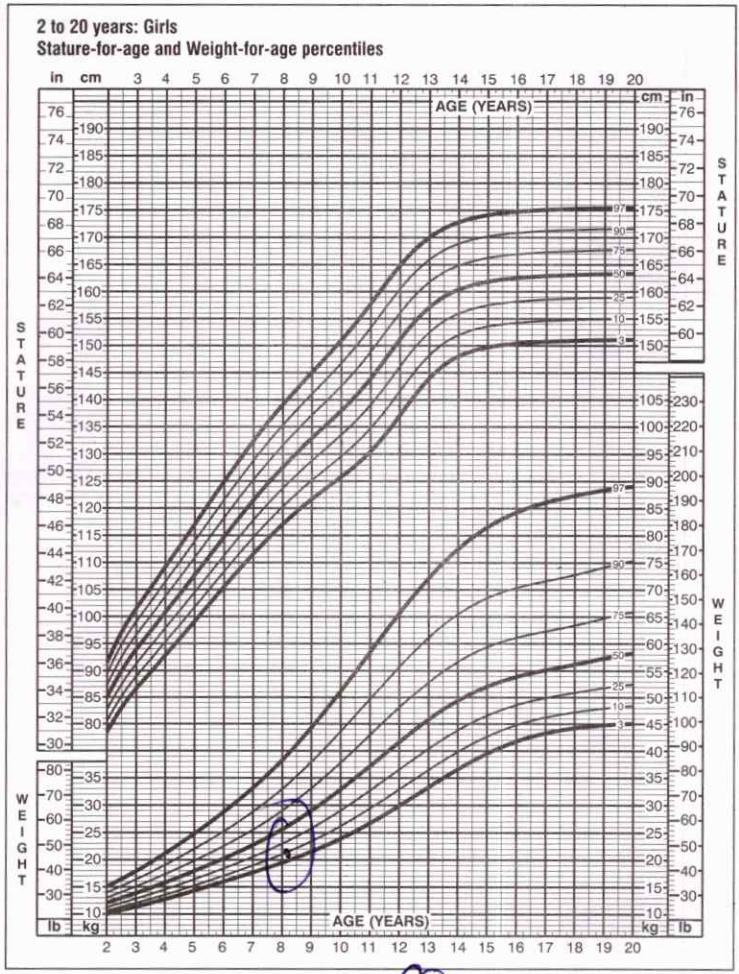
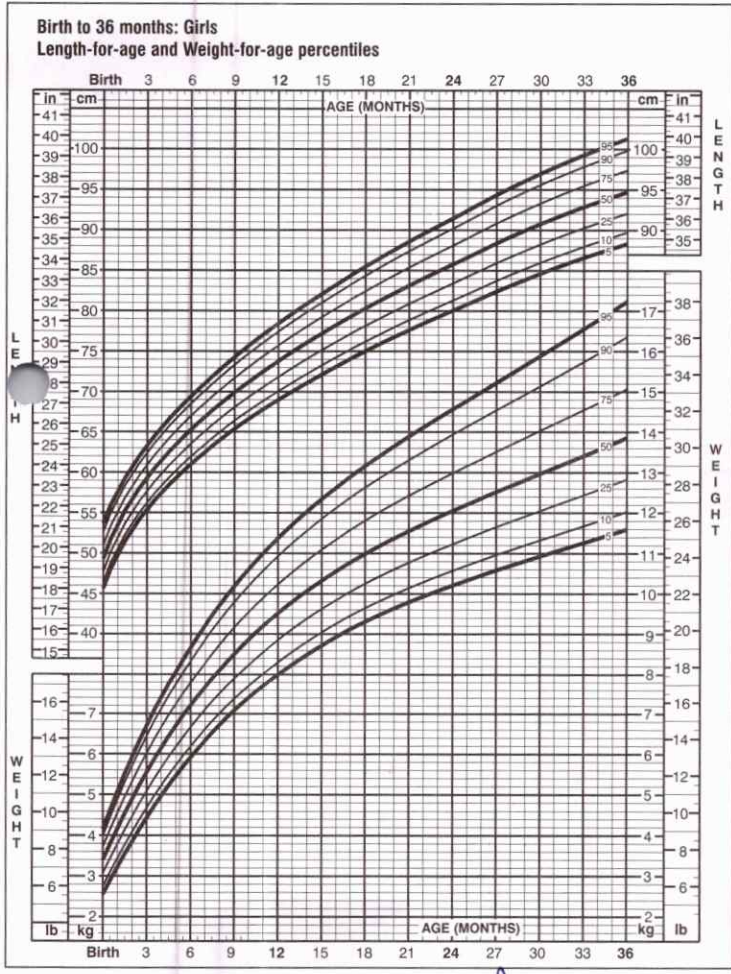
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: AGE with dehydration

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: [Signature]

## GROWTH CHART (GIRLS)



Dietician's Name: Sathwika G.

Dietician's Signature: [Signature]



wt - 20.93 kg



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Aroosh omer Age : 8 yr Gender:  Male  Female

Date : 19/6/26 Time of Arrival : 4:50pm

Allergies:  No  Yes  Food  Medications  Blood Transfusion  Other (Specify): .....  Not known

Source of Information :  Parents  Others (Specify) .....

Mode of Arrival :  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 99.3°F PR: 100b/m BP: ..... RR: ..... SpO<sub>2</sub>: 97%

Chief Complaints: low stomach pain, sore 3 days fever since 2 days loose stools 5 times

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking	Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening
Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

**NOTE :** All immunocompromised children and preterm babies to be considered Level 2.  
 All Children less than 2 years age with high fever to be considered Level 3.

Signature of Parent / Guardian

Triage Completion Time : .....

\* CTAS - Canadian Triage and Acuity Scale

## Communicable Disease Triage Screening

**PART A. The following questions should be asked to all patients at the initial screening:**

- Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
- Have you had cough or a rash in the past 2 weeks  Yes  No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks  Yes  No

**PART B. For patients reporting fever and respiratory/rash symptoms:**  Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks?  Yes  No  
 If yes, State Location: .....
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease?  Yes  No

**PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:**

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

**PART D. ACTION / INTERVENTION:** (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Bhargava

Signature of Triage Nurse : (B)

Date & Time : 19/6/26 @ 4:52pm



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 19/6/26 Time of arrival : 11:50pm  
 Chief Complaints : clo. fever, stomach pain, loose stools since 2 days RBS: .....

Height : ..... Weight 20.93kg BMI : ..... Head Circumference (<2 years) .....

**Allergies:**  Yes  No  Medications  Blood Transfusion  Food  Other: .....

If yes, identify .....

**Pain Screening:**  Yes  No If Yes, Pain Score: ..... Pain Tool Used:  N Pass  FLACC  Wong Baker

Character .....  Location .....  Frequency .....  Duration .....

**RISK FOR FALL:**

- If patient is < 6 years  
tick below fall risk intervention directly
- If Patient is > 6 years  
Assess the below parameters

History of Falling: within past 3 months  Yes  No

**Ambulatory Aids:**

- Wheelchair  Yes  No
- Uses furniture for support  Yes  No

**Gait/Transferring:**

- Bedrest / immobile  Yes  No
- Weak  Yes  No
- Impaired  Yes  No

**Mental Status:** Forgets limitations  Yes  No

**IF YES FOR ANY CATEGORY = RISK FOR FALLING**

**Fall Risk Intervention:**

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

**Functional Screening:**  No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

**Inform consultant for positive criteria**

.....

.....

**Nutritional Screening:**  No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

**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 family .....

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

Time of Initial assessment completed by ER Nurse : @@ 11:55pm

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
4:56pm	Assess the pt condition monitor the vitals

Samples collected by: *VPJ*  
 Samples sent by: *VPJ*

Time: *6:30pm*

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
4:52pm 19/6/26	Cocorin syp	oral	6ml	Dr. Aniket	

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>140b/m</i> BP: ..... CFT: ..... RR: <i>36b/m</i> SPO <sub>2</sub> : <i>97%</i> GCS: ..... Temperature: <i>99.3°F</i> Pain Score: ..... Repeat RBS (if applicable): .....	Shift - out from ER to: <i>ward</i> Time of Shift - out: <i>7pm</i> Handover given to: <i>Sunanda</i> (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): *IV placement done*

Name of the Nurse: *Bhargava* Signature of the Nurse: *(B)*  
 Date & Time: *19/6/26 @ 4:58pm*

IH-00007207 IP26-00006612

by AROOSH OMER

-05-2018 8 Y 1 M 15 D (F)

ANIKET ANIL PARASHAR



209 210

Rainbow<sup>®</sup>  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight<sup>™</sup>  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## RESULT SHEET

Date	19/6/26				
Time					
Hb	12.0				
PCV	34.1				
RBC	4.65				
WBC	7.28				
N/L	11.4/19.5				
Platelets	226				
CRP	22				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	19/6/26				
Time					
CUE - Alb					
CUE - Sugar	Nil				
CUE - Ketones	Negative				
CUE - PUS Cells	2-3				
CUE - RBC Cells	Nil				
CUE					
Stool Pus Cell					
OVA / Cyst					
Occult Blood					

Culture and Sensitivities : 19/6/26 Blood c/s - )

.....

.....

.....

Radiology :      USG : .....

                         X-Ray : .....

                         ECHO : .....

                         CT : .....

                         MRI : .....

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

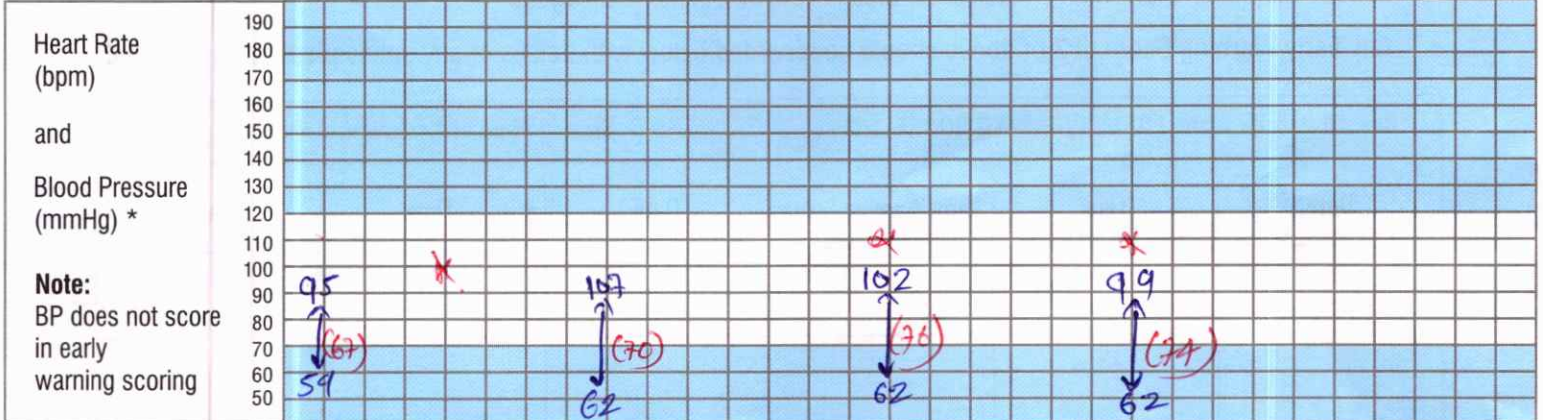
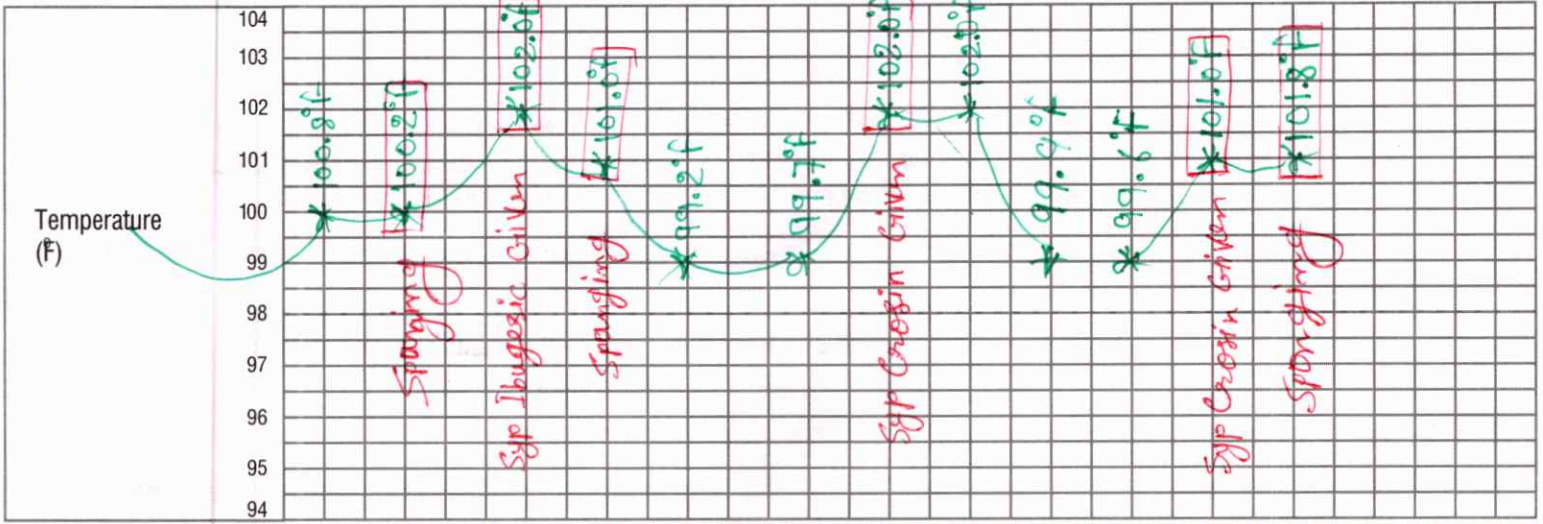
Patient



CLINICAL / 126

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : ... <u>29/6</u> ... Time: <u>7:11</u>	<u>8</u>	<u>8:20</u>	<u>10</u>	<u>11</u>	<u>12:40</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>6</u>	<u>7</u>	<u>8:20</u>
Doctor / Nurse / Family Concern?	<u>pro</u>	<u>pro</u>	<u>pro</u>	<u>pro</u>	<u>Am</u>	<u>Am</u>	<u>Am</u>	<u>Am</u>	<u>Am</u>	<u>Am</u>	<u>Am</u>



Heart Rate (Number)	<u>119b/min</u>	<u>105b/min</u>	<u>110b/min</u>	<u>120b/min</u>	<u>106b/min</u>
Resp Rate (bpm) (Over 1 Minute) *	<u>28</u>	<u>28</u>	<u>29</u>	<u>30</u>	<u>28</u>
Resp Rate (Number)	<u>28b/min</u>	<u>28b/min</u>	<u>29b/min</u>	<u>30b/min</u>	<u>28b/min</u>

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

<b>TOTAL SCORE</b>										
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>	<u>AS</u>

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

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 20/6/26 Time: 9:00 am 10:00 am 12:30 pm

Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
<b>Note:</b> BP does not score in early warning scoring	90 60
Heart Rate (Number)	105 bpm

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

Resp Distress: Mod/ Severe / None / Mild

Receiving O<sub>2</sub> (l/min) / O<sub>2</sub> Saturations (%)

Conscious Level: Normal / Altered

GCS \*

<b>TOTAL SCORE</b>	
Number of shaded boxes	
Pain Score	0
Observer's Initials	AS

<b>ACTIONS</b> NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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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 $\geq$ 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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IH-00007207 IP26-00006612

by AROOSH OMER  
-05-2018 8 Y 1 M 16 D (F)  
ANIKET ANIL PARASHAR



# FLUID CHART

Sheet No. : .....

- 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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm	<i>Pluchko</i>											
	06:00 pm	<i>multivitamin</i>											
	07:00 pm		<i>45ml</i>	<i>45ml</i>									
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm	<i>Plasma</i>		<i>45ml</i>									
	09:00 pm	<i>Plasma</i>		<i>45ml</i>									
	10:00 pm	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
	11:00 pm	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
	12:00 am	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
	01:00 am	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am	<i>Plasma</i>		<i>45ml</i>									
	03:00 am	<i>Plasma</i>		<i>45ml</i>									
	04:00 am	<i>Plasma</i>		<i>45ml</i>									
	05:00 am	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
	06:00 am	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
	07:00 am	<i>Plasma</i>		<i>45ml</i>		<i>NA</i>		<i>NA</i>					
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							

# FLUID CHART

Sheet No. : .....

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		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
20/6	08:00 am	plasma		45ml		N/A			/		3	MS
	09:00 am	lyte (iso)		45ml								
	10:00 am	ml-test		45ml								
	11:00 am			45ml								
	12:00 pm	D(100ml)		45ml								
	01:00 pm			45ml								
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



# FLUID CHART

Sheet No. : .....

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

		Intake				Output							
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G								
	08:00 am												
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	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
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<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
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<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



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Sheet No. : .....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
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<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
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<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# NURSING CARE RECORD

Date: 19/6/26

**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
- 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							
Afternoon	2pm	<ul style="list-style-type: none"> <li>→ Assess the pt condition.</li> <li>→ Monitor the vitals.</li> <li>→ maintain I/O chart.</li> <li>→ plan IVF full maintenance.</li> <li>→ drugs give as per drug chart.</li> </ul>	2pm	<ul style="list-style-type: none"> <li>→ Assessed the pt condition.</li> <li>→ monitored the vitals.</li> <li>→ maintained I/O chart.</li> <li>→ planned IVF full maintenance.</li> <li>→ drugs given as per drug chart.</li> </ul>	→ pt is stable now.	→ Reassessed the vitals	
Night	8pm	<ul style="list-style-type: none"> <li>Assess the pt condition.</li> <li>Monitor vitals &amp; record.</li> <li>Maintain I/O chart.</li> <li>Provide the comfortable position.</li> <li>Medication given as per as doctor order.</li> </ul>	8pm	<ul style="list-style-type: none"> <li>Assessed the pt condition.</li> <li>monitored vitals &amp; record.</li> <li>Maintained I/O chart.</li> <li>provided the comfortable position.</li> <li>medication given as per as doctor order.</li> </ul>	→ pt is stable.	<ul style="list-style-type: none"> <li>→ monitor vitals.</li> <li>→ maintain I/O chart.</li> </ul>	<p>Srda</p>

HNH-00007207 IP26-00006612  
 Baby AROOSH OMER  
 04-05-2018 8 Y 1 M 15 D (F)  
 Dr. ANIKET ANIL PARASHAR



# NURSING CARE RECORD

Date: 20/6/26

**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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am ↓ 2pm	<ul style="list-style-type: none"> <li>→ Assess the patient general condition</li> <li>→ monitor vitals</li> <li>→ iv fluids plasmalyte 15ml/hr</li> <li>→ Administered medications as per orders.</li> </ul>	8am ↓ 2pm	<ul style="list-style-type: none"> <li>→ Assessed the patient general condition</li> <li>→ monitored vitals</li> <li>→ Administered medications as per doctor's orders</li> </ul>	Patient is stable.	Rechecked vitals.	
Afternoon							
Night							

# NURSING-CARE-RECORD



Date: .....

**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

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

Patient Sticker

# NURSING CARE RECORD



Date: .....

**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
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- Patient & Family Education

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

J0007207 IP26-00006612  
 by AROOSH OMER  
 05-2018 8 Y 1 M 15 D (F)  
 ANIKET ANIL PARASHAR



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis: <span style="font-size: 1.5em; color: blue;">AGE</span>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date	19/6/26 E	19/6/26 N1	20/6/26 Ming			
	Shift						
	Medical Condition (Any special condition to be noted):	—	—	—			
	Diet:	—	—	—			
<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	—	—	—			
	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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	99.1 F	98.29	98.3 F		
		Res:	28b/m	28b/m	20b/m		
		SpO <sub>2</sub> :	100%	99%	99%		
		Pulse:	129	130b/m	140b/m		
		BP:	—	—	—		
		LOC:	—	—	—		
		Fall Risk Score:	—	—	—		
Pain Score:	0	0	0				
Skin Integrity	Good	Good	Good				
<b>Recommendations</b>	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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input 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 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 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):	—	—	—				
Post Operative Procedure Special Orders:		—	—	—			
Handed Over By Name :		Sunanda	Sneha	Sandhya			
Signature / ID :		(S): 40603	40603	40603			
Date:		19/6/26	20/6				
Time:		8pm	8am				
Taken Over By Name :		Sneha	Sandhya				
Signature / ID :		40603	40603				
Date:		19/6	20/6/26				
Time:		8pm	8am				

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:								

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:								

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:								

M-00007207 IP26-00006612  
 by AROOSH OMER 8 Y 1 M 15 D (F)  
 05-2018 ANIKET ANIL PARASHAR



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	19/6 DAY-1			20/6 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		0	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		-	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	NA							
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		-	NA							
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		-	NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	NA							
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature :  Name : 

Signature of Ward In Charge :

Signature :  Name : 

## CHECKLIST FOR THROMBOPHLEBITIS

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 cord pyrexia	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 of Ward In Charge :

Signature : ..... Name : .....

Signature : ..... Name : .....

Patient Sticker



## CHECKLIST FOR THROMBOPHLEBITIS

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 cord pyrexia	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 personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : ..... Name : .....

Signature : ..... Name : .....

H-00007207 IP26-00006612  
 by AROOSH OMER  
 05-2018 8 Y 1 M 15 D (F)  
 ANIKET ANIL PARASHAR

# BRADEN 'Q' SCALE



				Date :	14/10/20	19/5/20	20/6/26
				Time :	6	11	11:30
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	3
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	4	4
<b>FRICITION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	4	4
				<b>TOTAL SCORE</b>	25	27	27
				<b>Evaluator's Name</b>	[Signature]	[Signature]	[Signature]

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

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

# BRADEN 'Q' SCALE

Patient ID

					Date :				
					Time :				
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.					
*Activity The degree of physical activity*	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.					
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.					
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.*					
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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.					
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.					
					<b>TOTAL SCORE</b>				
					<b>Evaluator's Name</b>				

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

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for <b>"At Risk"</b> Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for <b>"Moderate Risk"</b> Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for <b>"High Risk"</b> Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

# BRADEN 'Q' SCALE



Patient ID

Date :  
Time :

Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.
*Activity The degree of physical activity*	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.*
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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.
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.

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

**TOTAL SCORE**

Evaluator's Name

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>
At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

# BRADEN 'Q' SCALE

Patient ID

					Date :
					Time :
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient in position change, moves chair independently and has muscle strength to move in bed or chair.	
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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 offered.	<b>4. Excellent:</b> Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement offered.	
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.		

*Less than 9*

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



# PAIN ASSESSMENT FORM

Date	Time	Pain score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/6/20	8pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
19/6	10pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
20/6	2am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
20/6	8am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
20/6/20	10 am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

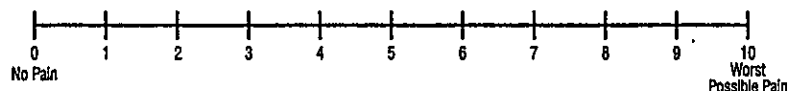
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

## Numerical Pain Scale (Obstetric and Gynecology)



## Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
<b>Behavior State</b>	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years



## PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character		Modifying Factors	Patient-/ Family Educated	Intervention	Sign
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Aching	<input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

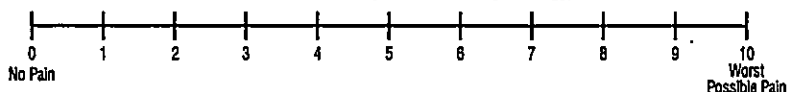
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs' brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



## Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
<b>Behavior State</b>	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO <sub>2</sub> , 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> , less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



# BRADEN 'Q' SCALE

Patient ID \_\_\_\_\_

					Date :				
					Time :				
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.					
'Activity The degree of physical activity'	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.					
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.					
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."					
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.					
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.					
					<b>TOTAL SCORE</b>				
					<b>Evaluator's Name</b>				

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

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

Patient ID \_\_\_\_\_

# BRADEN 'Q' SCALE



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Docu. No. : RCH /FRM / CLINICAL / 119

<b>TOTAL SCORE</b>				
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