

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174898

Admit Date : 08-Jun-2026

Admit Time : 08:02 PM UHID : BAH-00658355

Patient Details :

Patient Name : Master MOHAMMED ZAYNUDDIN AHMED

Age : 1 Y 3 M 1 D

Guardian : Mr MOHAMMED IKRAMUDDIN AHMED

DOB : 07-03-2025 01:00 AM

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO 5-6-179, CHAR KHANDIL Agapura
Hyderabad Telangana INDIA 500001

Phone No : 9000219706/ 8143327003

E-mail : IKRAMUDDIN05@GMAIL.COM

Admission Details :

Bed Type : DELUXE ROOM

Bed No : DLX 310

Ward Name : 3F-ZONE A

Room No : DLX 310

Admission Type : First Visit

Contact Details :

Name : Mr MOHAMMED IKRAMUDDIN AHMED

Relationship : Father

Contact Address : H NO 5-6-179, CHAR KHANDIL Agapura
Hyderabad Telangana INDIA 500001

Phone No : 9000219706


Signature

Doctor Details :

Doctor Name : Dr. FAISAL B NAHDI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant : Dr. GYANESHWAR

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING


Name : _____

UHID No. : _____

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

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

BAH-00658355 IP5-00174898
Master MOHAMMED ZAYNUDDIN
07-03-2026 1 Y 3 M 1 D (M)
Dr. FAISAL B NAHDI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	9:00pm	ER	310	<i>[Signature]</i>
09/6/26	10:20pm	300	317	Sneha

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Gnaneshwar	9/6/26	9605316	Sangeetha
2				
3	Dr. G.S. Gnaneshwar	10/6/26		Dr. Sangeetha
4				Rs 5000/-
5				
6				
7				
8				
9				
10				



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00858355
Master MOHAMMED ZAYNUDDIN
07-03-2025
Dr. FAISAL B NAHDI
1 Y 3 M 1 D
IPS-00174898
(M)

Patient Name:

Zaynuddin Ahmed

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Go Burns x 3 days ago
Fever x 1 day
Loose Motion x 1 day

History of present illness :

Pt. was apparently alright 3 days ago

to start with she had burn x 3 days ago

- Extending from neck till mid abdomen
↳ Superficial burn ~~area~~ in chest
↳ Deep burn around neck.

% of BSA involved - ~ 18%

Fever since 1 day

→ Intermittent in nature

→ Med. to high grade in nature

→ Responding to Antipyretics

→ Not a/w myalgia, rigors, chills, rigors

Not a/w dysentery

Loose motion x 1 day

→ 5-6 e/o w/d

Not a/w blood in stool, pain during defecation

Received Cyp Amoxiclav BD x 3 day
from Krishna hospital for burn



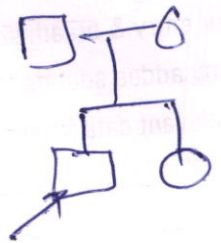
Pediatric Multiorgan History & Physical Examination

Past History : (Including details of any previous investigation or treatment)

~~Admitted~~ went to Krishna hospital on
Thursday
where they gave Augmentin
& Moxifloxacin

Birth & Neonatal History:

Full term | 3.6kg | NVD | CIAB | 1 day
NICU stay
↳ for phototherapy



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : Not significant

Developmental History :

Advanced as per age

Immunization History :

Received all vaccines as per age as per NIS

& neck, involving upper & mid chest



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head C:



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Lepra, dehydratⁿ

Desired goals of the treatment : Resolutⁿ

Planned Labs:

- CBP
- CRP
- RP-2
- Blood C/S
- LFT
- ~~N/B~~
- ~~Abhishta~~

Planned Management

- IV fluids DORS
- Inj. Ceftriaxone
- Inj. clindamycin
- Inj. Esomeprazole
- Econorm
- Zinnonia
- Paracetamol
- Ondem

~~N/B~~
~~Abhishta~~

Signature of the Doctor: Neelika

Name of the Doctor: Dr. Nanda

Date & Time: 08/06/2026, 8 PM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. FAISAL B NAHDI

Date & Time: 08/06/2026

Reg. No: 06028

(8400)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26	C/L/S (D)	
8:10 AM	Dx: Severe Sepsis	
	Fever: 1 day	
	Vomiting: 1 day	Plan
	Loose stool: 1 day	- ct w fluid
	Last temp - 99.5°F (7 AM)	- 2x Ceftriaxone (D1)
	2 episodes loose stool	- 1x Clindamycin (D1)
	1 episode vomiting	- monitor vitals
	O/E	- w/ loose stool, fever resolved
	- sleeping comfortably	
	- w/ H&T	Pey
	R1 TAGE H	
	C/L/S 20 FN 80	
	Dx: Severe Sepsis	
	Fever, vomiting,	Plan
Dad	Loose stool,	- Add Enteroceomins
9/6		- ct antibiotics
8:45 AM		- Discharge to Dr. Ganeshaiah Ar
	Dr. FAISAL B NAHDI Reg. No: 66228	Pey
		Noted by Sangeetha @ 601728

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5/26 3:30pm	<u>CS/B Resident</u>	
	D. scald burn	<u>Plan</u>
	C/O ↓ Fever (AFI) +	
	Acute gastroenteritis	① IVF DNS ↓ to
	with dehydration	(1/2 MF) 2/3 MF (75%)
		② 30ml/hr
	child is having	② Rest to continue
	Periorbital swelling	
		③ strict I/O chart
	oral intake - poor	
	Fever spike - 11am	④ RIV Dr. Gyaneshwar
	ongoing loose stools	sir.
	<u>OIE</u>	⑤ Monitor temp
	child is dull, aslepy	Litholy
	RS - chest clear	
	RR - 39 bpm	<u>Sohel</u>
	vitals stable	
		9/6/26 ease d/w Dr. Gyaneshwar
		4:00pm sir
		① syp Atarax 3ml BD
		② rest changing of
		burns dressing
		7/1m by S. nurse.
		③ rest to continue

Sohel
 noted by



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 4:00pm	SB.	
10/06/26 8:00am	e/s/B Resident Plan. Δ: Scald burn 40 - AFI + Acute gastro enteritis + dehydration	<ol style="list-style-type: none"> ① IVF 1/2 MF @ 20ml/hr ② INJ CEFTRIAXONE ③ INJ CLINDAMYCIN ④ INJ ESMOPRAZOLE ⑤ ECONORM SACHET ⑥ ZINCONIA SYP
	child is presently afebrile ongoing fever spikes - 100F @ 3am	<ol style="list-style-type: none"> ⑦ PARACETAMOL SYP (500) ⑧ INJ ONDENSETRON ⑨ SYP ATARAX
	loose stools - better - consistency changed - 7cp/7 yesterday	<ol style="list-style-type: none"> ⑩ Strict I/O chart ⑪ RIV Dr. Gyneshwar sir for burn dressing today.
	oral intake - poor nausea - (+) Rash - better	Free Bld c/s
	OH! child is asleep.	Soheli (Dr. Soheli)
	WS - S ₁ S ₂ (+)	
	RS - BAET, chest clear	
	PIA - -	Plan
	Dressing - Dry, not soaked ENT - clear.	emp / CRP / S. Cult.

Child (8:30am)
10/06/26

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 2 D (M)
 Dr. FAISAL B NAHDI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6 11:40 am	<p>Pus culture done at Star Hospital.</p> <p>S/O MSSA</p> <p>Pseudomonas growth</p> <p>Upgrade antibiotics to Magnex (Cefperazone + Sulbactam) & Linzolid</p>	
12 Noon		
10/6/26 4:20 PM	<p>Seen by Resident</p> <p>Scald burns & AFI + acute gastroenteritis & dehydration</p> <p>fever - last no fever since morning last spike 3 AM 102.6°F.</p> <p>oral intake poor.</p> <p>loose stools - better.</p> <p>hemodynamically stable</p> <p>dressing - minimal soaks.</p> <p>abdomen soft, non tender</p>	<p>Plan</p> <ol style="list-style-type: none"> 1. continue LINZOLID MAGNEX 2. Plan burn dressing today. 3. monitor vitals & w/f fever spikes

[Signature]
Santini

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/06 8:00am	CS/B Resident	
	<p>Δ: Scald burn MRA (+) Acute gastroenteritis</p>	<p>① Continue I.V fluids I.V antibiotics</p>
	<p>child is afebrile 1 spi low gradient over 7pm 10/06.</p>	<p>② Rest medication as charted</p>
	<p>Loose stools - better 2 spi yesterday semisolid</p>	<p>③ monitor vitals <u>Solids</u></p>
	<p>no vomiting hemodynamically stable</p>	
	<p>O/E: child alert, active CVS - S.S. (+) CR - clear, BAE (+) A/A - soft ENT - clear</p>	<p>Plan: DIC today</p>
		<p>① 2ij Magnex BD.</p>
		<p>② Syf Linezolid TID.</p>
		<p>③ Keep dressing dry</p>
		<p>F/U Dr. Ganeswar on Monday.</p>
		<p>N. B. Anna m. A. 906583 2/24</p>

Dr. FAISAL B NAHDI
 Reg. No.: 66228

Child
 11/06
 CS-406

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN (M)
 07-03-2026 1 Y 3 M 1 D
 Dr. FAISAL B NAHDI

RESULT SHEET

Date	8/6/26	10/6/25			
Time		9:15am			
Hb	10.4	7.8			
PCV	32.4				
RBC	4.53	3.48			
WBC	14.40	8.60			
N/L	83.4/5.6	54/38			
Platelets	336	148			
CRP	195.	60.0			
ESR					
PCT					
RBS					
Na	128				
K	4.1				
Cl	102				
Ca/Mg					
Phosphate					
Urea	47				
Creatinine	0.7	0.5			
ALP	165				
SGPT	34				
SGOT	54				
T.Bill/Conj	2.3 < 1.8	0.5			
T.Protein	4.7				
S.Albumin	2.7				
S.Globulin	2				
A/G Ratio	1.3				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L Bicarbonate	12				

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
 Dr. FAISAL B NAHDI

Patient



MEDICATION RECONCILIATION FORM

Drug Allergies: 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	Syp Moxikind cr	3ml	P/O	BD	8/6/26 10a	<input type="checkbox"/> C <input checked="" 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

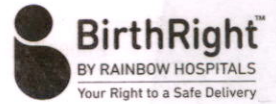
Doctor Name & Signature: Naresh Dr. Nanda

Date & Time: 08/06/2026, 8 PM

Nurse Name & Signature: Abhishek

Date & Time: 8/6/26 @ 8pm

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
 Dr. FAISAL B NAHDI



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : ECODORM SACHET				Date	8/6	9/6	10/6	11/6										
Dose	Route	Frequency	Start Dt.	Time														
1 Sachet	PO	q 12hrly	08/06	10am	X	10am	10am											
Name & Signature of the Doctor Starting the Drugs:				<p>Dr. Nandan</p> <p>Additional Instructions: 10pm 100mg Ataxol 100mg Ataxol 100mg Ataxol 100mg Ataxol</p>														
Daily Doctor's Endorsement by a Sign				<p>Sm 8 9</p>														
DRUG : DROZ 3&D				Date	8/6	9/6	10/6											
Dose	Route	Frequency	Start Dt.	Time														
1 ml	PO	q 24hrly	08/06															
Name & Signature of the Doctor Starting the Drugs:				<p>Dr. Nandan 11pm</p> <p>Additional Instructions: 1 ml = 20mg</p>														
Daily Doctor's Endorsement by a Sign				<p>Sm 8 9</p>														
DRUG : INS. ONDANSETRON				Date	8/6	9/6	10/6	11/6										
Dose	Route	Frequency	Start Dt.	Time														
1.5mg	IV	q 8hrly	08/06	6am	X	6am	6am	6am										
Name & Signature of the Doctor Starting the Drugs:				<p>Dr. Nandan 2pm</p> <p>Additional Instructions: 10pm 100mg Ataxol 100mg Ataxol 100mg Ataxol</p>														
Daily Doctor's Endorsement by a Sign				<p>Sm 8m 9</p>														
DRUG : 5YP ATARAX				Date	9/6	10/6	11/6											
Dose	Route	Frequency	Start Dt.	Time														
3ml	ORAL	night	09/06	10am	X	10am	10am											
Name & Signature of the Doctor Starting the Drugs:				<p>sohik</p> <p>Additional Instructions: twice daily</p>														
Daily Doctor's Endorsement by a Sign				<p>8 9</p>														

Signature

VERIFIED BY: N

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN (M)
 07-03-2025 1 Y 3 M 1 D
 Dr. FAISAL B NAHDI



Sheet No:

REGULAR PRESCRIPTIONS

Weight 10kg Ward

DRUG : INJ LINEZOLID				Date Time	10/6	11/6															
Dose	Route	Frequency	Start Dt.																		
100mg	I.V	TID	10/06	6am																	
Name & Signature of the Doctor Starting the Drugs:																					
<u>Sohih</u>																					
Additional Instructions:																					
<u>10mg/kg/dose</u>																					
Daily Doctor's Endorsement by a Sign																					
DRUG : INS MAGNEX				Date Time	10/6	11/6															
Dose	Route	Frequency	Start Dt.																		
200mg	I.V	BID	10/06	6am																	
Name & Signature of the Doctor Starting the Drugs:																					
<u>Sohih</u>																					
Additional Instructions:																					
<u>20mg/kg/dose</u>																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

VERIFIED BY : Name Signature

DRUG CHART

Date of Admission: 08/06/2025 Drug Allergies: 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)

DRUG : SYP. CROCI-N-DS				Date Time	08/06															
Dose	Route	Frequency	Start Date																	
3ml	PO	SOS	08/06																	
Doctor's Signature		Valid Period	Pharm.																	
Dr. Nanda																				
Additional Instructions: 240mg/5ml																				
if temp > 100°f, minimum 6 hrs gap between 2 doses																				
DRUG : SYP. IBU4ESIC				Date Time	08/06															
Dose	Route	Frequency	Start Date																	
4ml	PO	SOS	08/06																	
Doctor's Signature		Valid Period	Pharm.																	
Dr. Nanda																				
Additional Instructions: if temp > 102°f																				
minimum 8hrs gap between 2 doses.																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

VERIFIED BY : Name _____ Signature _____

BAH-00658355 IP5-00174898
Master MOHAMMED ZAYNUDDIN
07-03-2025 1 Y 3 M 2 D (M)
Dr. FAISAL B NAHDI



TATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

Emergency

Urgent

Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

S/O Dr. hshamane waw

C/S - psudomonas
MRSA

→ Soak of dressing.

→ dressing done

- Mixed to deep burn involving.

neck / submandibular area &
upper chest

ARW
CST

- Rew (SR),

Consultant :

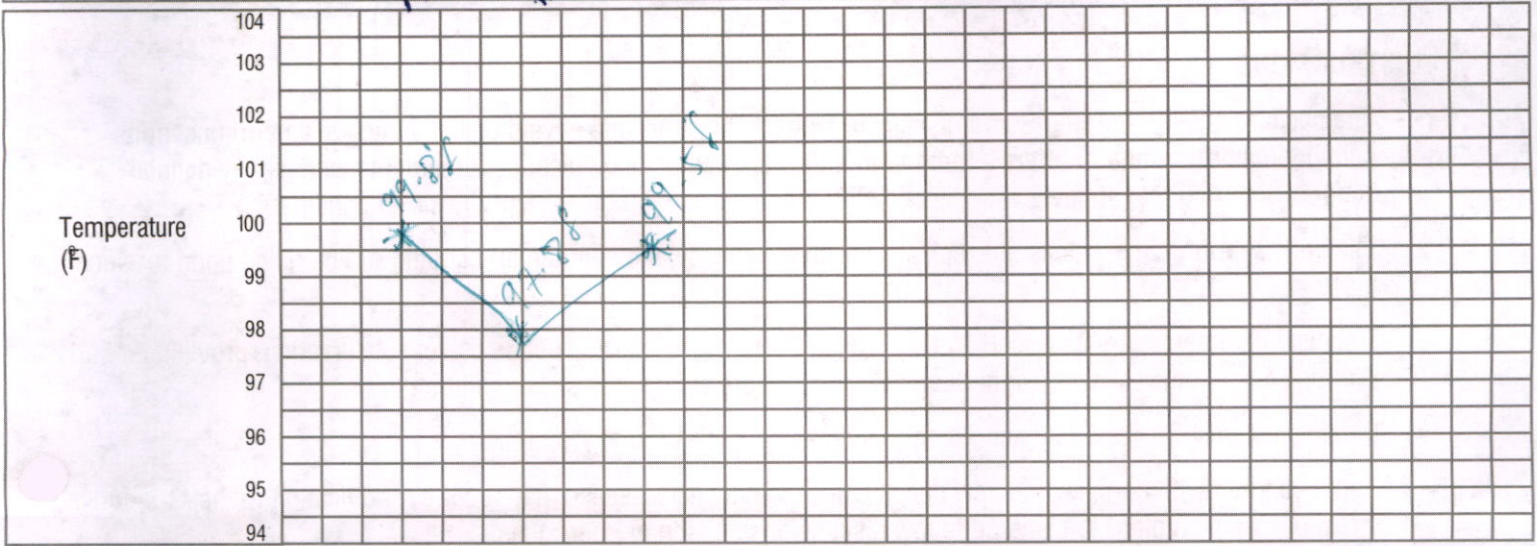
Name : GS hshamane waw Signature : hbw Date & Time : 10/6/2025

8/6/26

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10 PM, 12 AM, 7 AM

Doctor / Nurse / Family Concern?



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

Heart Rate (Number) 134b/m, 134b/m

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	26b/m, 26b/m

Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	98%, 98%

Conscious Level	Normal / Altered
GCS *	11, 11

TOTAL SCORE	
Number of shaded boxes	0, 0
Pain Score	0, 0
Observer's Initials	[Signatures]

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

9/6/2026

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	8 AM	11 AM	11:30 AM	3 PM	6 PM	8:30 PM	11 PM	3:30 AM	6 AM
Doctor / Nurse / Family Concern?										
Temperature (F)	104									
	103									
	102									
	101									
	100									
	99									
	98									
	97									
	96									
	95									
94										
Heart Rate (bpm)	190									
and	180									
Blood Pressure (mmHg) *	170									
	160									
	150									
	140									
	130									
	120									
	110									
	100									
	90									
	80									
	70									
	60									
	50									
Heart Rate (Number)		130bpm	130bpm	122bpm	120bpm	123bpm	123bpm	120bpm	120bpm	
Sp. Rate (bpm) (Over 1 Minute) *	70									
	60									
	50									
	40									
	30									
	20									
	10									
Resp Rate (Number)		20bpm	21bpm	29bpm	28bpm	29bpm	29bpm	28bpm	29bpm	
Resp Distress	Mod/ Severe									
	None / Mild									
Receiving O ₂ (l/min)										
O ₂ Saturations (%)		99%	99%	99%	99%	99%	99%	99%	100%	
Conscious Level	Normal									
	Altered									
GCS *		(15/15)	(15/15)	(15/15)	(15/15)	(15/15)	(15/15)	15/15	15/15	
TOTAL SCORE										
Number of shaded boxes		0	0	0	0	0	0	0	0	
Pain Score		0	0	0	0	0	0	0	0	
Observer's Initials		By	By	By	By	By	By	By	By	

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 2 D (M)
 Dr. FAISAL B NAHDI

RCHBH / FRM / CLINICAL / 125

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	11am	6pm	7pm	10pm	9AM	6AM
Doctor / Nurse / Family Concern?							
6/6/26 Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98	98.9F	99.6F	100.0F			97.9F
	97						
	96						
	94						
Heart Rate (bpm) and Blood Pressure (mmHg) *							
Note: BP does not score in early warning scoring							
Heart Rate (Number)	154bpm	122bpm				126bpm	
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	41bpm	32bpm				30bpm	
Resp Distress	Mod/ Severe	None / Mild					
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	100%				100%	
Conscious Level	Normal	Altered					
GCS *	15/14	15/15				16/15	
TOTAL SCORE							
Number of shaded boxes	0	0				0	
Pain Score							
Observer's Initials							

ACTIONS

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

NB: Scores 3 should be recorded overleaf

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

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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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

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 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
 Dr. FAISAL B NAHDI



FLUID CHART



8/8/26

Sheet No. :

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

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												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm			30ml			✓			✓	0	Aleehya	
	10:00 pm	ORS	top	30ml						✓	0	Aleehya	
	11:00 pm			30ml			✓			✓	0	Aleehya	
	12:00 am		milk	30ml			✓			✓	0	Aleehya	
	01:00 am			30ml			✓				0	Aleehya	
Total Intake :						Total Output : 0-2 m-3							
	02:00 am			30ml							0	Aleehya	
	03:00 am			30ml							0	Aleehya	
	04:00 am	ORS	milk	30ml			✓			✓	0	Aleehya	
	05:00 am			30ml							0	Aleehya	
	06:00 am		milk	30ml			✓			✓	0	Aleehya	
	07:00 am			30ml			✓			✓	0	Aleehya	
Total Intake :						Total Output : 0-2 m-2							

Total 24 hrs. Intake Total-111 ml

Total 24 hrs. Output 0-5 m-4



9/6/25 Dyspnea weight 31

FLUID CHART

Sheet No. : *2*

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
<i>9/6</i>											0	<i>Sangee</i>	
	08:00 am										0	<i>Sangee</i>	
	09:00 am	<i>DNS</i>		<i>38ml</i>			<input checked="" type="checkbox"/>				0	<i>Sangee</i>	
	10:00 am		<i>milk</i>								0	<i>Sangee</i>	
	11:00 am	<i>DNS</i>		<i>28ml</i>			<input checked="" type="checkbox"/>				0	<i>Sangee</i>	
	12:00 pm		<i>milk</i>				<input checked="" type="checkbox"/>				0	<i>Sangee</i>	
	01:00 pm	<i>DNS</i>		<i>38ml</i>							0	<i>Sangee</i>	
Total Intake :						Total Output : <i>U-2 m-3</i>							
<i>9/6</i>	02:00 pm										0	<i>Sangee</i>	
	03:00 pm	<i>DNS</i>	<i>milk</i>	<i>38ml</i>							0	<i>Sangee</i>	
	04:00 pm						<input checked="" type="checkbox"/>				0	<i>Sangee</i>	
	05:00 pm	<i>DNS</i>	<i>milk</i>	<i>38ml</i>			<input checked="" type="checkbox"/>				0	<i>Sangee</i>	
	06:00 pm						<input checked="" type="checkbox"/>			<i>131ml</i>	0	<i>Sangee</i>	
	07:00 pm	<i>DNS</i>	<i>milk</i>	<i>38ml</i>							0	<i>Sangee</i>	
	Total Intake :						Total Output : <i>U-131ml m-3</i>						
<i>9/6</i>	08:00 pm										0	<i>Sangee</i>	
	09:00 pm	<i>DNS</i>	<i>milk</i>	<i>20ml</i>							0	<i>Sangee</i>	
	10:00 pm						<input checked="" type="checkbox"/>			<i>490ml</i>	0	<i>Sangee</i>	
	11:00 pm	<i>DNS</i>	<i>milk</i>	<i>20ml</i>							0	<i>Sangee</i>	
	12:00 am	<i>DNS</i>		<i>20ml</i>							0	<i>Sangee</i>	
	01:00 am	<i>DNS</i>	<i>milk</i>	<i>20ml</i>							0	<i>Sangee</i>	
Total Intake :						Total Output : <i>M-1 U-1</i>							
	02:00 am		<i>milk</i>								0		
	03:00 am	<i>DNS</i>		<i>20ml</i>							0		
	04:00 am	<i>DNS</i>	<i>milk</i>	<i>20ml</i>			<input checked="" type="checkbox"/>				0		
	05:00 am	<i>DNS</i>		<i>20ml</i>							0		
	06:00 am	<i>DNS</i>	<i>milk</i>	<i>20ml</i>							0		
	07:00 am										0		
Total Intake :						Total Output : <i>M-1 U-1</i>							

Total 24 hrs. Intake *DNS 400ml*

Total 24 hrs. Output *M-3 U-5*



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.
- 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/6/20	08:00 am	Milk	Milk	20ml							0	Anwar
	09:00 am	Milk									0	
	10:00 am	Milk	Milk	20ml							0	
	11:00 am	Milk									0	
	12:00 pm	Milk	Milk	20ml							0	
	01:00 pm										0	
Total Intake :						M-1					Total Output : 0-2	
10/6	02:00 pm										0	Kalyani
	03:00 pm		Milk								0	
	04:00 pm										0	
	05:00 pm	Milk	Milk								0	
	06:00 pm			20ml							0	
	07:00 pm		Milk	20ml							0	
Total Intake :						M-1					Total Output : 0-2	
	08:00 pm		Milk	20ml							0	Srinish
	09:00 pm			20ml							0	
	10:00 pm	Milk	Milk	20ml							0	
	11:00 pm			20ml							0	
	12:00 am		Milk	20ml							0	
	01:00 am			20ml							0	
Total Intake :						M-1					Total Output : 0-2	
	02:00 am		Milk	20ml							0	Srinish
	03:00 am			20ml							0	
	04:00 am	Milk	Milk	20ml							0	
	05:00 am										0	
	06:00 am		Milk								0	
	07:00 am										0	
Total Intake :						M-0					Total Output : 0-2	

Total 24 hrs. Intake **220**

Total 24 hrs. Output **M-0**

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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			
											0	} Amman	
	08:00 am	milk	20ml							✓	0		
	09:00 am		20ml								0		
	10:00 am	milk	20ml								0		
	11:00 am		—								0		
	12:00 pm	milk	—							191 ml	0		
	01:00 pm		—								0		
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



310 → 317

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 9/6/26 Time: 9 am

Weight: 9.3 kg Centile: <5th

Height: 55 cm Centile: <5th

Inference: underweight child

RDA: Calories: 1200 kcal/d Protein: 20 gm/d

Diet Recommendations: soft high protein diet

Re-Assesment: Avoid Spicy, chilled & outside foods

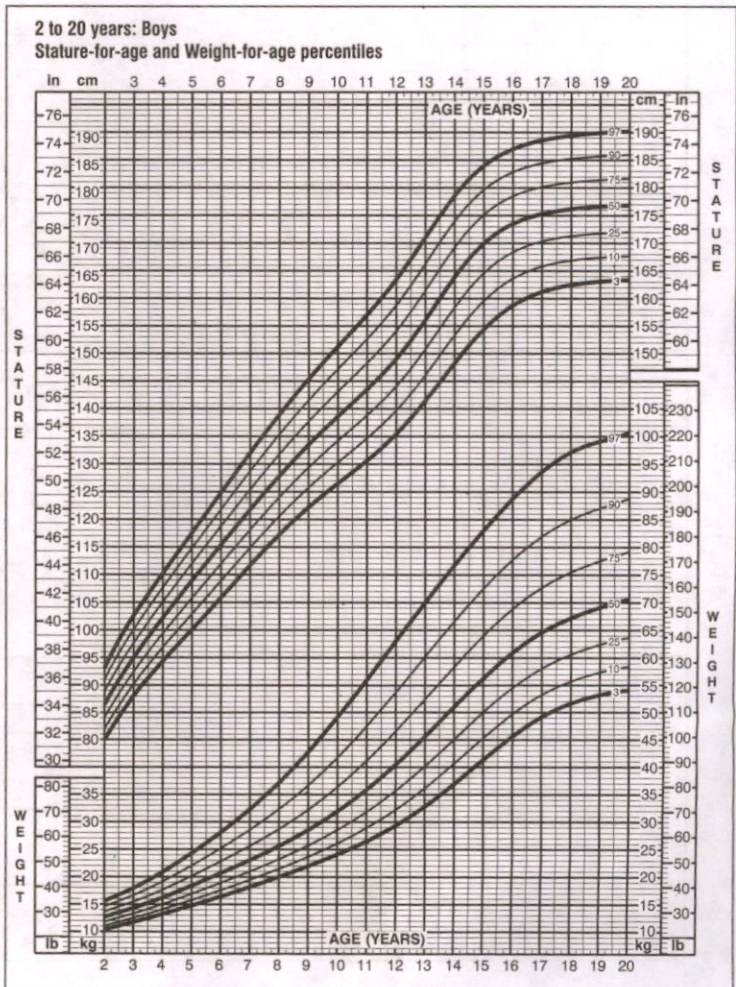
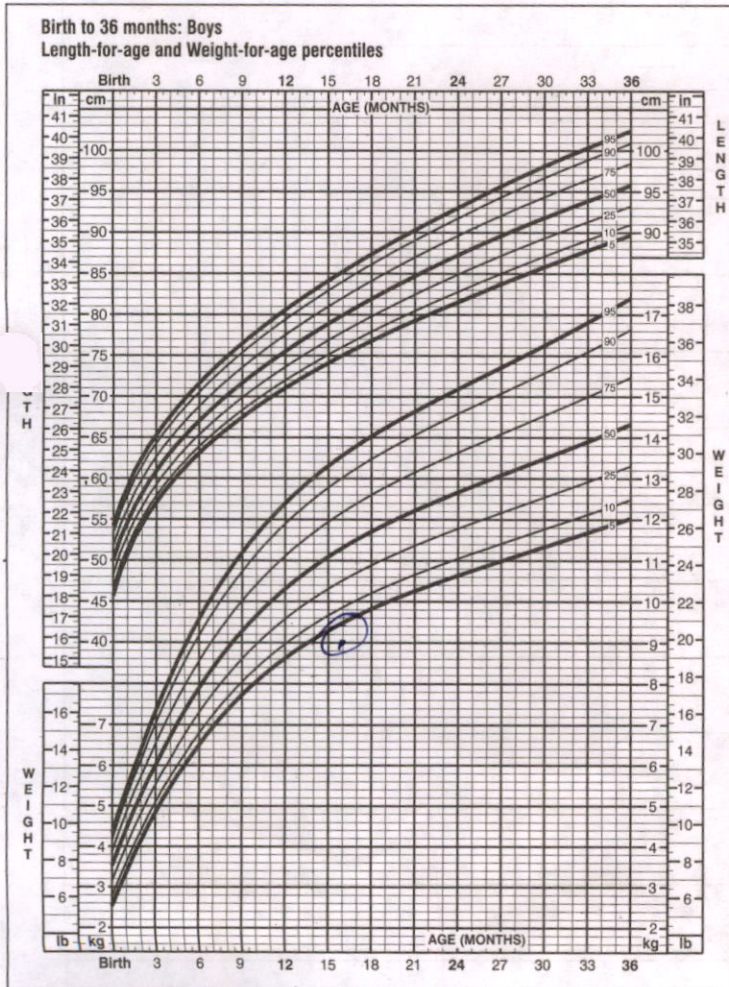
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: scald burns

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Amira

GROWTH CHART (BOYS)



Name: Amira

Dietician's Signature: Amira

Daily Notes:

10/6/26

child is stable, Intake is suboptimal

skin

condle soft high protein diet large

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
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NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: Morning Afternoon Night

Date: 8/6/28

Assessment: Baby is crying.

- 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
8pm	Assess the pt condition	8:10pm	Assessed the pt condition	
11pm	plan for monitor vitals	11:30pm	monitored vitals	no fever
1AM	plan for maintain Ilo chart	1:30am	maintained Ilo chart & recorded	pt is
3am	plan for Administer medication as per drug chart	3:30am	Administered medications as per drug chart	stable
5am	plan for continue IV fluids	5:30am	Continuing IV fluids	
8am	plan for ensure safety	7:30am	Ensured safety	

Re-Assessment: Re-assessment done Baby is sleeping.

Special Notes: Continue IV fluids

Nurse Signature: Alexhya

Nurse Name: Jovani/Alexhya

Date & Time: 9/6/28 @ 8am

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 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
 Dr. FAISAL B NAHDI

NURSING CARE RECORD



Shift: Morning Afternoon Night

Date: 9/6/26

Assessment: Baby is Having fever

- 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
8 AM	→ Assess the patient general condition.	8:20 AM	→ Assessed the patient general condition.	patient is stable now fever is reduced
10 AM	→ monitor vitals and record	10:20 AM	→ monitored vitals & recorded	
12 PM	→ maintain Ilo clut	12:20 PM	→ maintained Ilo clut	
3 PM	→ continue IV fluids	3:20 PM	→ continued IV fluids	
7 PM	→ Ensure Safety	7:20 PM	→ Ensured safety	

Re-Assessment: patient is stable

Special Notes: Ntl continue IV fluids ntl hourly fever checking.

Nurse Signature:

Nurse Name: Sangeetha @ 607728

Date & Time: 9/6/26 @ 8 PM



NURSING CARE RECORD

Shift: Morning Afternoon Night

Date: 10/06/26

Assessment: Baby is having Fever

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby condition and vitals check	8:30 pm	* Assessed the baby condition and vitals checked	* now baby condition is stable
9pm	* monitor the I/O chart	9:30 pm	* monitored the I/O chart	
10pm	* Continue IV fluids	10:30 pm	* Continued w fluids	
12am	* plan for dressing tomorrow	12:30 am	* planned for dressing tomorrow	
6am	* Administer medicine as per chart	6:30 am	* Administered medicine as per chart	
7am	* ensure safety	7:30 am	* ensured safety	

Re-Assessment: Assess the baby condition, now baby condition is stable

Special Notes: changing of burn dressing to nurse by 8x nurse

Nurse Signature: Sueha Nurse Name: Sueha - 607638 Date & Time: 10/06/26 @ 8pm

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 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 2 D (M)
 Dr. FAISAL B NAHDI

NURSING CARE RECORD



Shift: Morning Noon Night

Date: 10/16/26

Assessment: Baby having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	=> Assess the Baby General condition	8:10 Am	=> Assessed the Baby General condition	Baby is stable
10 Am	=> Assess the Baby vitals signs	10:15 Am	=> Assessed the Baby vitals signs	
11 Am	=> To maintaine ILO chart	11:20 Am	=> maintaine ILO chart	
12pm	=> To provide comfortable position	12:15 pm	=> provided comfortable position	
2pm	=> To encourage orals liquids	2:10pm	=> Encourage orals liquids -> provided ensure safety	

Re-Assessment: Baby is stable & activity well

Special Notes: Dressing Today

Nurse Signature: *[Signature]*

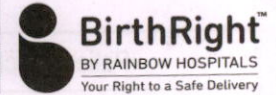
Nurse Name: Anaman

Date & Time: 10/16/26 @ 2pm

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 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 2 D (M)
 Dr. FAISAL B NAHDI



NURSING CARE RECORD



Shift: Morning Afternoon Night

Date: 10/6/26

Assessment: Fever, Poor Oral Intake, Burns (discomfort)

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ To assess the general condition of the patient	2pm	→ Assessed the general condition of the patient	Baby feels stable Has fever 100.0°C → feels comfort
3pm	→ To monitor vital signs	3:30pm	→ Monitored vitals and documented.	
4pm	→ To maintain personal hygiene	4pm	→ Dressing done	
5pm	→ To provide comfortable position	5pm	→ Provided comfortable position	
7pm	→ To administer medicines	7:10pm	→ Administered medicines	

Re-Assessment: After dressing feels comfort

Special Notes:

Nurse Signature:

Nurse Name: zalyani

Date & Time: 10/6 at 8pm



NURSING CARE RECORD

Shift: Morning Afternoon Night

Date: 10/6/26

Assessment: Baby having fever.

- 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
8pm	ASSESS the Baby General condition	8:05pm	Assessed the Baby General condition.	Baby was stable.
9pm	monitor the vitals.	9:05pm	monitored the vitals.	
10pm	maintain Ilo chart.	10:05pm	maintained Ilo chart.	
12AM	provide comfortable position to Baby.	12:05AM	provided comfortable position to Baby.	
2AM	To encourage orally intake.	2:05AM	encouraged orally.	
4AM	maintain fluids Balance.	4:05AM	maintained fluids Balance.	
6AM	ensure safety.	6:05AM	Ensured safety.	
7AM	TO Administer medications.	7:05AM	Administer medications.	

Re-Assessment: ok. providing comfortable position Baby was feeling better.

Special Notes: NA. continue. IV fluid.

Nurse Signature: shish

Nurse Name: shish

Date & Time: 11/6/26

H-00658355 IP5-00174898
 Patient MOHAMMED ZAYNUDDIN
 03-2025 1 Y 3 M 4 D (M)
 FAISAL B NAHDI



NURSING CARE RECORD



Shift: Morning Afternoon Night

Date: 12/6/26

Assessment: Baby having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Baby General Condition	8:30 am	assessed the Baby general condition	=> patient is stable
9am	TO monitor vitals	9:30 am	monitored patient vitals	
10am	TO monitor ILO chart	10:15 am	monitor ILO chart	
11am	TO provide comfortable position	11:15 am	provided patient comfortable position	
12pm	TO prevent infection	12:15 pm	prevent patient infection	

Re-Assessment: provided comfortable position Baby was sleeping

Special Notes: NA

Nurse Signature: *Ammara*

Nurse Name: *Ammara*

Date & Time: 12/6/26 2pm

H-00658355 IP5-00174898
 Patient MOHAMMED ZAYNUDDIN
 03-2025 1 Y 3 M 4 D (M)
 FAISAL B NAHDI

NURSING CARE RECORD



Shift: Morning Afternoon Night

Date:

Assessment:

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:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: CR Date of Admission: 8/6/26

SITUATION	Diagnosis: <u>Scald burns involving upper & mid chest & neck</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area	<u>CR</u>	<u>8:30pm-2nd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	
	Shift Time	<u>8:30pm-2nd floor</u>	<u>9am-2A</u>	<u>3rd floor</u>	<u>8pm-8am</u>	<u>2nd floor</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.2°f</u>	<u>99.8°f</u>	<u>99.8°f</u>	<u>97.6°f</u>	<u>98.9°f</u>
		Res:	<u>29 blm</u>	<u>25 blm</u>	<u>25 blm</u>	<u>28 blm</u>	<u>28 blm</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>97%</u>	<u>100%</u>
		Pulse:	<u>132 blm</u>	<u>126 blm</u>	<u>126 blm</u>	<u>144 blm</u>	<u>145 blm</u>
		BP:	<u>98/69</u>	<u>96/68</u>	<u>96/69</u>	<u>95/65</u>	<u>90/76</u>
	Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Other Special Orders / Medications:	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>side rails</u>	
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	<u>yes</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :	<u>Shawin</u>	<u>Alexis</u>	<u>Sangeetha</u>	<u>Sudha</u>	<u>Ananya</u>		
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>8/6/26</u>	<u>8/6/26</u>	<u>9/6/26</u>	<u>9/6/26</u>	<u>10/6</u>		
Time:	<u>8:30pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>		
Taken Over By Name :	<u>Alexis</u>	<u>Sangeetha</u>	<u>Sudha</u>	<u>Ananya</u>	<u>Kalyani</u>		
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>8/6/26</u>	<u>9/6</u>	<u>9/6/26</u>	<u>10/6</u>	<u>10/6</u>		
Time:	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Faisal B. NAHDI Department: 3rd floor Date of Admission: 8/6/26

SITUATION	Diagnosis: <u>Scalid burn</u>	Any infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area	<u>3rd floor</u>	<u>3rd floor</u>					
	Shift Time	<u>8AM</u>	<u>2PM</u>					
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input 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	
	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 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:	<u>99.1F</u>	<u>98.6</u>				
		Res:	<u>35b/m</u>	<u>35b/m</u>				
		SpO ₂ :	<u>100%</u>	<u>100%</u>				
		Pulse:	<u>122b/m</u>	<u>135b/m</u>				
		BP:	<u>100/70</u>	<u>85/72</u>				
		Fall Risk Score:	<u>13</u>	<u>13</u>				
Pain Score:	<u>0</u>	<u>0</u>						
Recommendations	Safety Needs:	<u>side rails</u>	<u>side rails</u>					
	Physiotherapy	<input type="checkbox"/> Yes <input 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	<u>NA</u>	<u>NA</u>					
	Special Diet:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Shwink</u>	<u>Armani</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>8/6/26</u>	<u>8/6/26</u>					
Time:		<u>8AM</u>	<u>2PM</u>					
Taken Over By Name :		<u>Armani</u>	<u>Kalyani</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>8/6/26</u>	<u>8/6/26</u>					
Time:		<u>8am</u>	<u>2pm</u>					

Pati



THE HUMPTY DUMPTY SCALE

8/6 9/6 10/6 11/6

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	✓
Call device within reach	yes	yes	yes	✓
Wheels Locked	yes	yes	yes	✓
Room free of clutter	yes	yes	yes	✓
Adequate Lighting	yes	yes	yes	✓
Wheel Chair Support	no	no	NA	NA
Other Intervention(s) Specify	no	no	NA	NA
Nurse's Name :	Shawain	Aleky	Rush	Sluis
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	8/6	9/6	10/6	11/6
Time :	11:44pm	5am	8am	8AM

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
 Dr. FAISAL B NAHDI



BRADEN 'Q' SCALE



					Date :	8/6	9/5	20/6	1/6
					Time :	7:49a	6m	8:07	3:4n
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and insic'e room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					28	29	28	28	
Evaluator's Name					Bhavav	Alexan	Sueh	Skinst	

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00658355 IP5-00174898
 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 1 D (M)
 Dr. FAISAL B NAHDI

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6/26	2:45pm	0/10	—	<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Bhavani
9/6/26	2pm	0/10	—	<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	Aleesha
9/6/26	6AM	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	Sangeetha
9/6/26	12pm	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	Sangeetha
9/6/26	6pm	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	Sangeetha
9/6/26	9pm	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	Such
9/6/26	6AM	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	under observation	Shirish
10/6/26	1pm	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	under observation	Annamma
10/6	6pm	2/10	Burn site	<input checked="" type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input checked="" type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Dressing done	Kalyani
10/6	7pm	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	Under observation	Kalyani

Re-assessment Frequency:

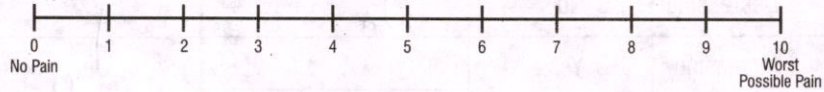
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief interve

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, right, 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

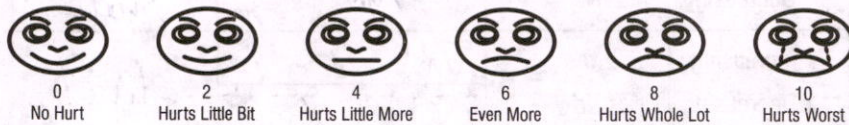
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	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
Behavior State	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)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	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
Vital Signs HR RR, BP, SaO₂	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 ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



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 Master MOHAMMED ZAYNUDDIN
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 Dr. FAISAL B NAHDI



PAIN ASSESSMENT FORM

Time	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/6	OPW	0/10	<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	under observation skinsh
11/6	6AM	0/10	<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	under observation skinsh
11/6	11AM	0/10	<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	under observation Annames
11/6	12PM	0/10	<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	under observation Annames
			<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:

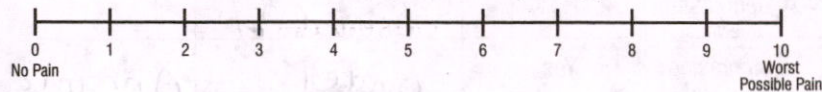
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

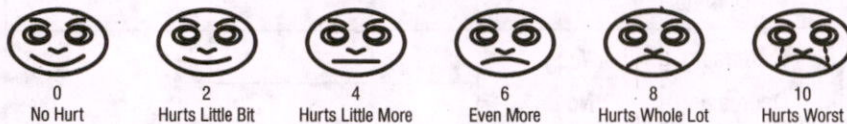
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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, right, 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)



Wong - Baker (Pediatrics) Above 7 Years



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	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
Behavior State	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)
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Vital Signs HR, RR, BP, SaO₂	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 ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

CHECKLIST FOR THROMBOPHLEBITIS

8/6/26 9/6/26 10/6/26

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			0	0	0	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			-	-	-	-	-	-		
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						Alexia	Sangee	Sangee	Subhasree	Kalyan	Slonish		

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 : Javeed Name : Javeed

Signature of Ward In Charge :

Signature : Anisha Name : Anisha

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 Master MOHAMMED ZAYNUDDIN
 07-03-2025 1 Y 3 M 2 D (M)
 Dr. FAISAL B NAHDI



CHECKLIST FOR THROMBOPHLEBITIS

n/6/26

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	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	—									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	—									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	—									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—									
Signature of the Nurse				<i>Ana</i>									

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 :

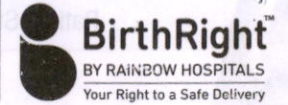
Signature : Name :

Signature : Name :

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 star MOHAMMED ZAYNUDDIN
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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/6	7:45pm	7	Infection control measures	M	1	0	1	1	-	Obhavi
9/6/26	9am	9	Soft high protein diet	M/L	1	0	1	1	-	Saim

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/6/26 8/8/2024	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Scald burn	Improve Phy heal Prevent Antibiotic	IV fluid Wound care	[Signature]	<input type="checkbox"/> Nursing <input type="checkbox"/> Others:
8/6/26 7:44 PM	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Scald burn	Hemodynamic stability	IV fluids Antibiotics	[Signature]	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Others:
9/6/26 9 AM	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input checked="" type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Scald burns	Soft high protein diet	RDA E-1200 kcal/d P- 20g/d	[Signature]	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input checked="" type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:

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 Dr. FAISAL B NAHDI



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9pm Mode of Arrival: By Walk Admitting From: ER OPD Direct

Allergy / Adverse Reaction Body Weight: 9.3 kg Kg

..... NA Height: cm

Past Medical History: Obtained From Patient Family Member Medical Record Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: DTO

Has the child or close family member had recent contact with a communicable disease? Yes No

..... s please list,

Was the child's birth normal? Yes No If No, please describe problems:

Are the child's immunization up to date? Yes No

Current Medication: None Yes, If Yes, fill reconciliation form

Observations: Weight: 9.3 kg Length: Head Circumference (< 2 years):

Temp.: 99.8 F HR: 134 bpm RR: 26 bpm BP: -

Pain Score: 0/10 Specify Site: NA (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: Yes No Score: 13 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No If Yes, Pain Score: 0/10 Pain Tool Used: N Pass FLACC Wong Baker

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

Psychological Screening:

No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: Yes (Date/Time): 9/6 at 8:45am

Cultural & Spiritual Needs: Yes No if Yes specify Inform consultant for positive criteria.

Social History: Lives With family

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

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

- Call Bell in Reach : Yes No
- Waste Disposal Explained: Yes No
- Infusion Pump : Yes No
- Hand hygiene Explained: Yes No Others
- Patient Rights & Responsibilities: Yes No

Information given to Mother

Nurse Signature: Aleclya

Nurse Name: Aleclya

Date: 8/6/20

Time: 9pm

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Waster MOHAMMED ZAYNUDDIN
07-03-2025 1 Y 3 M 2 D (M)
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DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: As doctor advice

2. Destination Post Discharge: Home
Family Members Notified (Person Contacted)
 Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status: Self Care Family Home Care Home Professional Assistance

<input type="checkbox"/> Needs Assistance In:			Remarks
<input type="checkbox"/> Medication	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	} no need Assistance
<input type="checkbox"/> Bathing	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
<input type="checkbox"/> Eating	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
<input type="checkbox"/> Walking	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
<input type="checkbox"/> Dressing	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
<input type="checkbox"/> Toileting	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	

4. Nutritional Plan:
 Dietary Instruction Discussed with the:
 Patient Family Member Others:

5. Discharge Planning Discussed with the:
 Patient Family Member Others:

6. Patient/Family Educational Plan:
 Educational Topic/s: About patient condition
 Patient's Educational Topic/s discussed with the:
 Patient Family Member Others:

Nurse Signature: Alexya

Nurse Name: Alexya

Date and Time: 8/6/26 @ 9:30pm