

DISCHARGE SUMMARY

Name	Baby NAGULAPALLY SKANDA VEDHYASRI	UHID	HNH-00003298
Father/Guardian	Mr MR.VENKAT RAMANA N	Age/Gender	1 Y 10 M 9 D/ Female
Address	H NO. 1-9-537,, Adikmet, Hyderabad, Telangana, INDIA		
IP No	IP26-00006611	Admission Date	19-06-2026
Ref Doctor	self		
Discharge Date	21.06.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
ACUTE FEBRILE ILLNESS WITH DEHYDRATION	
SARS-COV2 -POSITIVE	
URINARY TRACT INFECTION- CYSTITIS	

History: Baby NAGULAPALLY SKANDA VEDHYASRI , 1 Y 10 M 9 D , old girl presented with the history of fever since 3 days, vomitings, decreased oral intake since 2 days prior to admission. For the above complaints she was

Name	Baby NAGULAPALLY SKANDA VEDHYASRI	UHID	HNH-00003298
IP No	IP26-00006611	Admission Date	19-06-2026

admitted at Rainbow Children's Hospital - for further management.

Examination: She was afebrile, maintaining saturations at room air and was hemodynamically stable. Her heart rate was 106/min and Respiratory Rate - 36/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, dry oral mucosa, decreased skin turgor, were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 8.6 kilo grams.

Investigations: Enclosed reports

VBG showed pH of 7.34, pCO₂ of 39.6 mmHg, pO₂ of 53 mmHg, HCO₃ of 21.3 mmol/L and BE of -4.4 mmol/L.

Adenovirus PCR test was sent, which was negative.
Blood culture shows: No growth after 24 hrs of incubation

GENEXPERT SARS-CoV-2, FLU A, FLU B AND RSV

SARS-CoV-2	POSITIVE
Influenza A	NEGATIVE
Influenza B	NEGATIVE
Respiratory Syncytial Virus (RSV)	NEGATIVE

Name	Baby NAGULAPALLY SKANDA VEDHYASRI	UHID	HNH-00003298
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Initial hemogram showed Hemoglobin of 11.3 gm%, White Blood Cell count of 5460 cells/cumm, platelet count of 2.75 lakhs/cumm and C-Reactive Protein of 5 mg/l.

Ultrasound abdomen showed

* Few fine internal echoes in urinary bladder. Minimal free fluid in the peritoneal cavity. Few non specific lower mesentery nodes.

Management: She was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. She was treated symptomatically with antipyretics.

In view SARS-COV positive, child was kept in isolation room.

In view of abdominal pain, USG abdomen was done which showed few fine internal echoes in urinary bladder, hence urine culture was sent and antibiotics were given.

She was regularly monitored for fever spikes, hemodynamic status. Her fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

She remained hemodynamically stable during the hospital stay. She improved with the above line of management and is being discharged with the following advice.

At the time of discharge : She is active, afebrile and hemodynamically stable.

Medication during hospital stay:

Name	Baby NAGULAPALLY SKANDA VEDHYASRI	UHID	HNH-00003298
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Syrup. Crocin DS
Injection. Ceftriaxone

Advice:

* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. ZIPRAX (Cefixime - 5ml/100mg)	2.5 ml	8am - 8pm (after food)	For 5 days.
2	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Plan: To collect blood and urine culture report on followup.

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).

* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on (24.06.2026) Wednesday at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Food instructions while taking medications:

* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

Name	Baby NAGULAPALLY SKANDA VEDHYASRI	UHID	HNH-00003298
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Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.
To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

P. Prasad
Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006611 **Admit Date :** 19-Jun-2026 **Admit Time :** 05:35 PM **UHID :** HNH-00003298

Patient Details :

Patient Name :	Baby NAGULAPALLY SKANDA VEDHYASRI	Age :	1 Y 10 M 8 D
Guardian :	Mr MR.VENKAT RAMANA N	DOB :	11-08-2024 09:25 AM
Gender :	Female	Religion :	
Occupation :		Martial Status :	
Address (H) :	H NO. 1-9-537, Adikmet Hyderabad Telangana INDIA	Phone No :	9885441368/ 9949648474
		E-mail :	seema.nagulapally@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY
Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr MR.VENKAT RAMANA N **Relationship** : Father
Contact Address : H NO. 1-9-537, Adikmet Hyderabad Telangana INDIA **Phone No** : 9885441368


Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : self **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00
Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD

Laboratory Report

Baby NAGULAPALLY SKANDA VEDHYASRI

9885441368

1 Y 10 M 9 D

HN26010030

Female

19-06-2026 05:47 PM

IP26-00006611

19-06-2026 07:05 PM

HNH-00003298

20-06-2026 09:41 AM

Dr. SINDHURA MUNUKUNTLA

GF -EMERGENCY / ER01

RESPIRATORY PANEL (5 VIRUSES) (Specimen :THROAT SWAB)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

GENEXPERT SARS-CoV-2, FLU A, FLU B AND RSV.

Specimen Type	Nasopharyngeal swab
SARS-CoV-2	POSITIVE
Influenza A	NEGATIVE
Influenza B	NEGATIVE
Respiratory Syncytial Virus (RSV)	NEGATIVE

Comments:

The Genexpert findings in a 1 year old child with fever is suggestive of a SARS-CoV-2 infection. Kindly await Adenovirus RT PCR report.

Principle:

Multiplex Real-Time PCR assay for qualitative detection of SARS-CoV-2, Influenza A, Influenza B, and Respiratory Syncytial Virus (RSV) viral RNA by amplifying and detecting unique sequences in the genes that encode the proteins: SARS-CoV-2 Nucleocapsid (N2) and Envelope protein (E), influenza A matrix (M), influenza A basic polymerase (PB2), Influenza A acidic protein (PA), influenza B matrix (M), influenza B non-structural protein (NS), and the RSV A and RSV B nucleocapsid.

Note:

1. Test done using Xpert® Xpress CoV-2/Flu/RSV plus cartridge on Cepheid® GeneXpert System
2. Specimen processed at Molecular Genetics Laboratory, Rainbow Children's Medicare Limited, Road No.2, Banjara Hills, Hyderabad.

Dr. VIJENDRA KAWLE MD DNB
(CONSULTANT MICROBIOLOGIST)

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

..... End of the Report

ACTIVE HNH-00003298 IP26-00006611
Baby NAGULAPALLY SKANDA (F) **VG**
11-08-2024 1 Y 10 M 8 D
Dr. SINDHURA MUNUKUNTLA

Name:  -----

UHID No : ----- IP 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>6:17pm</i>	<i>ER</i>	<i>ward</i>	<i>[Signature]</i>

Cross Consultation Visit

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



INVESTIGATIONS

Date	Investigations	Order No.	Sign
17/6/26	CRP		
	CRP	10030	
	Blood clt		
	Respon panel	10029	Sachin
	WBG	10023	
	Urine clt		
20/6/26	USG Abdomen	7377	done by Sachin

cross

Checked


done by Sachin



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00003298 IP26-00006611
: Baby NAGULAPALLY SKANDA
: 11-08-2024 1 Y 10 M 8 D (F)
: Dr. SINDHURA MUNUKUNTLA

Patient ID# : 

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

HNH-00003298 IP26-00006611
Baby NAGULAPALLY SKANDA
11-08-2024 1 Y 10 M 8 D (F)
Dr. SINDHURA MUNUKUNTLA



Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- 1/ Fever since 3 days
- 2/ Vomiting since 2 days
- 3/ Decreased oral intake since 1 day.

History of present illness:

Child was apparently asymptomatic 3 days back after which she had fever which is high grade, intermittent responding to oral paracetamol.

Vomiting started 2 days back non-bilious, non-projectile, multiple episodes per day.

Child has decreased oral intake since 1 day.

Pediatric Multiorgan History & Physical Examination

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11-08-2024 1Y 10 M 8 D (F)
Dr. SINDHURA MUNUKUNTLA

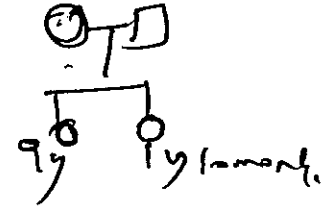


Past History : (Including details of any previous investigation or treatment)

Blank lined area for Past History.

Birth & Neonatal History :

Term / 3.160 / DIS / CSAB



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal.

Immunization History :

Up-to-date - IAP Schedule

Pediatric Multiorgan History & Physical Examination

HNH-00003298 IP26-00006611
Baby NAGULAPALLY SKANDA
11-08-2024 1 Y 10 M 8 D (F)
Dr. SINDHURA MUNUKUNTLA



Anthropometry

Head Circum (cms) _____ (Centile _____) Height (cm) : _____ (Centile _____)

Weight (kgs) 8.6 kg (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 96% at RA

Resp. rate and type of breathing : _____

Rash _____ dry lips ⊕

Lymphadenopathy _____ dry nose 1 mucous ⊕

Oedema : _____ ↓ skin turgor

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ BLL - AFE ⊕

Any addles sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____ S1 S2 ⊕

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____

Palpation : _____ PIA to U

Ausculation : _____

Spine: _____ External Genitalia: _____

Relevant data from outside (CT, USG etc.,) _____

Pediatric Multiorgan History & Physical Examination

HNH-00003298 IP26-00006611
Baby NAGULAPALLY SKANDA
11-08-2024 1 Y 10 M 8 D (F)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

→ 1 S/Ly

Cranial Nerves : _____ (M)

Motor System :

Nutrition : _____ (M)

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____ (M)

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Δ AFI Echydration

Pediatric Multiorgan History & Physical Examination

HNH-00003298 IP26-00006611
Baby NAGULAPALLY SKANDA
11-08-2024 1 Y 10 M 8 D (F)
Dr. SINDHURA MUNUKUNTLA



Preventive aspects of the treatment :

IV fluids

IV Antibiotics

Desired goals of the treatment :

Fever subsidence

Planned Labs :

VBG

CBP

CRP

CVE - done

Urine C^{c}

Blood C^{c}

Resp. panel (S virus)

Extra plain - 1

USG Abdomen

↳ Tamara reu

noted by upjaya

Planned Management :

- Syp. CROCIN - DS (Sw/24h)

2.5ml B^{c}

- Syp. IBULERIC

2.5ml S^{c} / B^{c}

- Inj. CEFTIAZONE

850mg IV OD

- IVF DNS @ 30ml

noted by upjaya

Please fill up the following details

1. Name of the Referring Doctor : _____

2. Name of the Referring Hospital : _____
(Including the name of City)

3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)

4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Dr. Sindhura - M

Doctor's Signature Name

[Handwritten Signature]

Date

11/6/24

Time

6 pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/06/26 6 PM	S/D Dr. Sindhura Δ AFI & dehydration ? UTI	
	CNS - S ₁ S ₂ ⊕ M - BL - AFB ⊕	<input checked="" type="checkbox"/> Inj. CEFTRIAXONE 850mg IV OD
	PLA JOL Conscious	<input checked="" type="checkbox"/> Send VBG ECG Urine S ^c Blood S ^c
	Signs of dehydration ⊕	<input checked="" type="checkbox"/> Urinary and renal <input checked="" type="checkbox"/> Start IV fluids 2/1/1.
		<input checked="" type="checkbox"/> Trace reports. - protein <input checked="" type="checkbox"/> (Upr @ 11).
		P of immature ANTIBIOTIC - M NB Sunda

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No. 5697D



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26	s/b Dr Sindhura	
10Am	<p>△ AFI = Dehydration (UTI) (COVID +ve) Last fever 100.7°F 12:40 AM Oral intake - better passed urine.</p>	<p>Stand 7/4/2024</p>
	Cold (+)	1) CT. IV fluids ↓ <i>↓ 10ml</i>
	O/E GC fair.	2) CT. by Ceftriaxone
	Vitals stable	3) Supportive care
	Hydration - fair.	4) infom sos
	P/s: BAE +	5) USG. abdomen now.
	No added sounds	6) Trace urine c/s
		7) If further high grade spikes - To in bedpt further / unusual symptoms
		8) If stable T/M Plan discharge
		9) ↓ W.P 15 ml/kg
		10) Trace adenovirus

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No: 66970

[Signature]
 ANMUNA-M



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26	C/S/B - Dr. Prashanti / Dr. Pranav	
2:20 PM	<p>A - <u>AFI - Dehydration</u> <u>[UTI / SARS COV 2 +]</u></p> <p>- No further fever spikes.</p> <p>- taking orally better</p> <p>urine ✓ stool - last past yesterday</p> <p>O/E G/C by dehydration fair vitals stable</p> <p>S/E RS - clear P/A - soft</p>	<p>plan</p> <p>1) stop IV fluids</p> <p>2) USG abdomen done - abdominal chest</p> <p>3) ceftriaxone - D2</p> <p>4) Trac ucs</p> <p>5) if further fever to consider investigations</p> <p>6) if stable +/m consider d/s</p>
		<p><i>Prashanti</i> MB Srinanda</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26 6:40 PM	S/B Dr. Sindhura	Plan
	<p>△ AFIE dehydration ? UTI SANCOLZ</p>	<p>✓ IF LEFTRIAXONE</p>
	<p>CUT - S, D, B</p>	<p>✓ Trace Urine ♂</p>
	<p>R - BK - AFIE</p>	<p>✓ Encourage orally</p>
	<p>PIA - SOB coughing</p>	<p>✓ Plan discharge if no fever spikes till PIA</p>
		<p>M. Sindhura SINDHURA M.</p>
		<p>NB Sunanda</p>

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No. 66970



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/26	c/s/hy. <u>Dr Anusha / Dr Srighan.</u>	
7:35 AM	? UTI (cystitis)	
	SARCOV 2 + VR.	
	fewer - No fever spikes @	
	Intake. better.	
	<u>vital</u> stable.	
		<u>Plan</u>
	<u>S/E</u>	→ Enter orally.
	<u>RB</u> B/LAE (+)	
	N/VBS (+)	→ (+) u/c/s.
	<u>CES</u> side	+ ct rent Managmt.
	No mucus.	
		Monitor vitals.
		- <u>CROCIN Sy. 505</u>
	A/	
		N.B. Manisha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/08/2024 11 am	S/B Dr. Sindhura SARS-cov-2 <u>Cystitis</u>	
	no fever spikes oral intake better chest - P/A soft.	Plan ① o/c today ② Encourage orally ③ sup. cefixime ④ RIV on Tuesday E urine cfs & blood cfs reports.
		⑤ urine w/ ceftriaxone done today before discharge
		<p style="text-align: center;">Dr. Sindhura Dr. Sindhura M.</p>
		N.B. maheshwari
		<p style="text-align: right; color: purple;">Dr. Sindhura Munkuntla Consultant, Pediatrics Reg. No. 152074</p>

MNH-00003298 IP26-00006611
 Baby NAGULAPALLY SKANDA
 11-08-2024 1 Y 10 M 9 D (F)
 Dr. SINDHURA MUNUKUNTLA



212



RESULT SHEET

Date	19/6/26				
Time					
Hb	11.3				
PCV	32.1				
RBC	4.12				
WBC	5.46				
N/L	45.0/469				
Platelets	275				
CRP	5				
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	op basic	19/8/26					
Time							
CUE - Alb							
CUE - Sugar		NIL					
CUE - Ketones		Negative					
CUE - PUS Cells		8-10					
CUE - RBC Cells		NIL					
CUE - Epithelial		4-6					
Stool Pus Cell							
OVA / Cyst							
Occult Blood							
Flu - Covid		+ve					
Adenovirus :-							
Flu -		⊖ve					

Culture and Sensitivities : Blood c/s

Urine c/s :-

.....

.....

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Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.,) :

H-00003298 IP26-00006611
 by NAQULAPALLY SKANDA
 08-2024 1 Y 10 M 8 D (F)
 SINDHURA MUNUKUNTLA

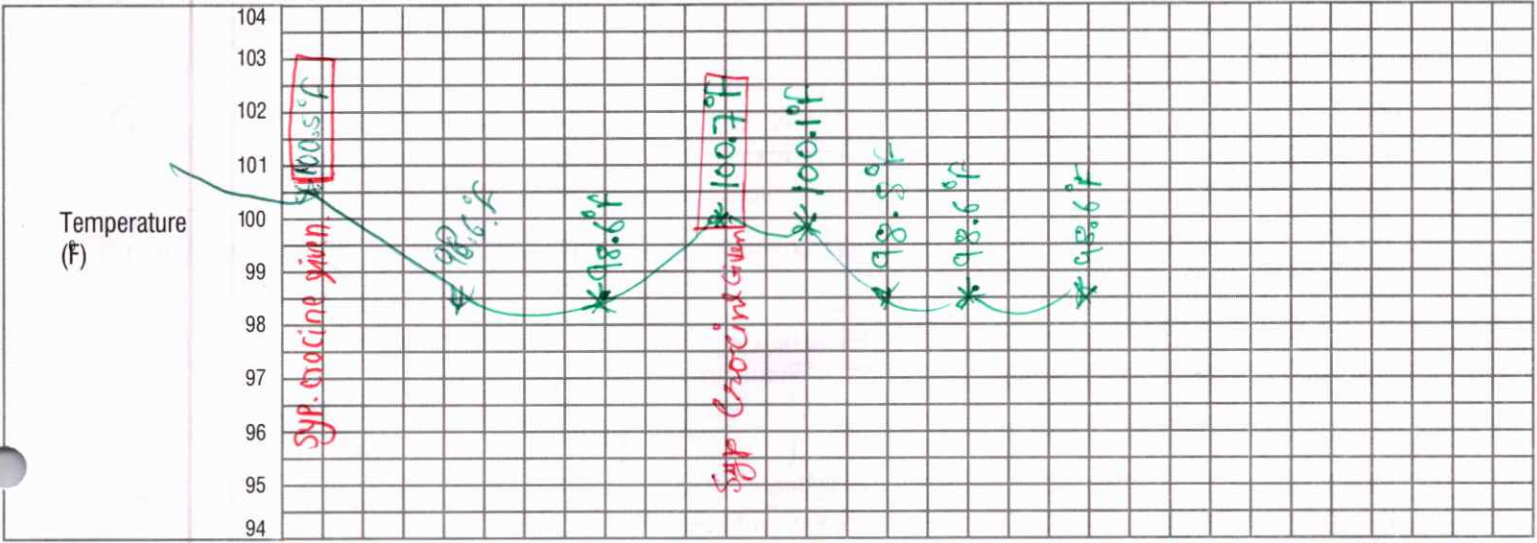
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PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



.Y WARNING SCORE: CHILDREN'S UNIT

Date : 19/07/26	Time: 6:40pm	6:50pm	10	12:40	2	3	4	6
Doctor / Nurse / Family Concern?			pro	pro	Amo	Amo	Amo	Amo



Heart Rate (bpm) and Blood Pressure (mmHg) *								
Note: BP does not score in early warning scoring								
Heart Rate (Number)	138b/m	135b/m	128b/m	130b/m				120b/m
Blood Pressure (mmHg)	98/65	110/58	110/53	120/60				130/56

Resp. Rate (bpm) (Over 1 Minute) *								
Resp Rate (Number)	33b/m	31b/m	32b/m	30b/m				28b/m

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

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

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

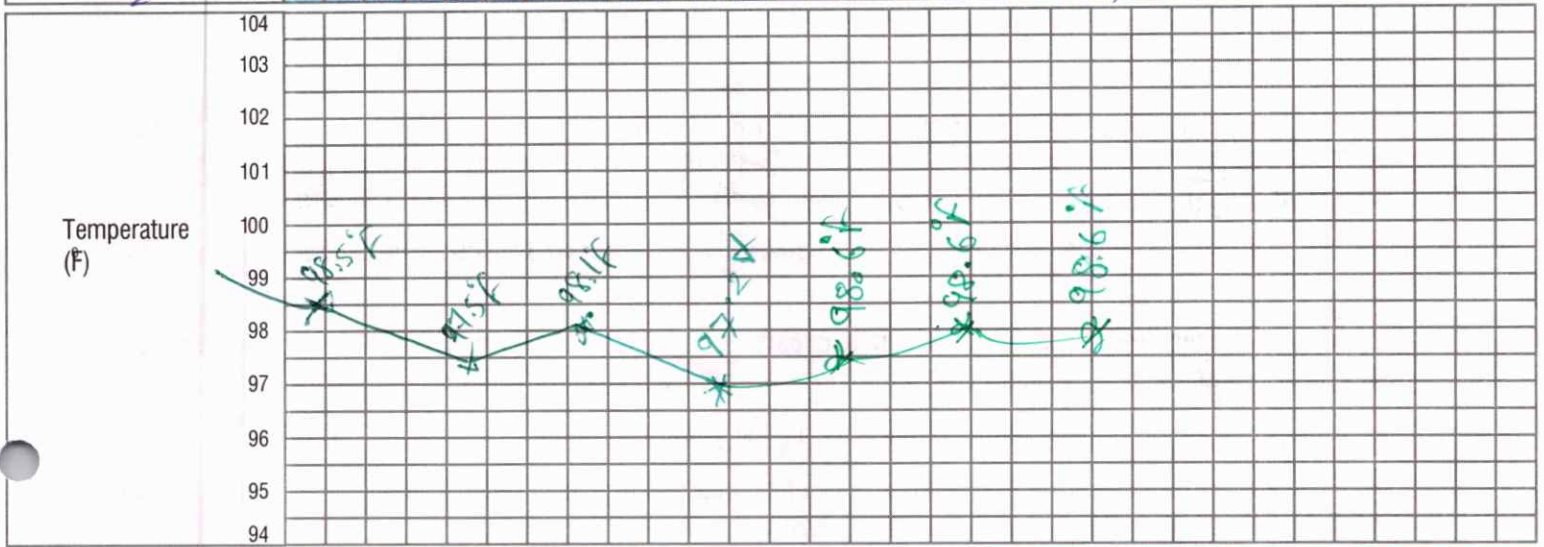
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/6/24	Time: 10Am	12pm	2pm	6pm	10	2:30	6
Doctor / Nurse / Family Concern?					pro	no	no



Heart Rate (bpm)							
Blood Pressure (mmHg) *	96/65	99/70	100/66	98/57	87/62	89/61	100/64
Note: BP does not score in early warning scoring							

Heart Rate (Number)	128b/m	128b/m	120b/m	127b/m	120b/m	124b/m	128b/m
Resp. Rate (bpm) (Over 1 Minute) *	30	32	30	31	32	30	28
Resp Rate (Number)	30b/m	32b/m	30b/m	31b/m	32b/m	30b/m	28b/m

Resp Distress	Mod/ Severe	None / Mild					
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	99%	98%	98%	99%	99%	99%
Conscious Level	Normal	Altered					
GCS *							

TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	M	M	M	A	A	M	B

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

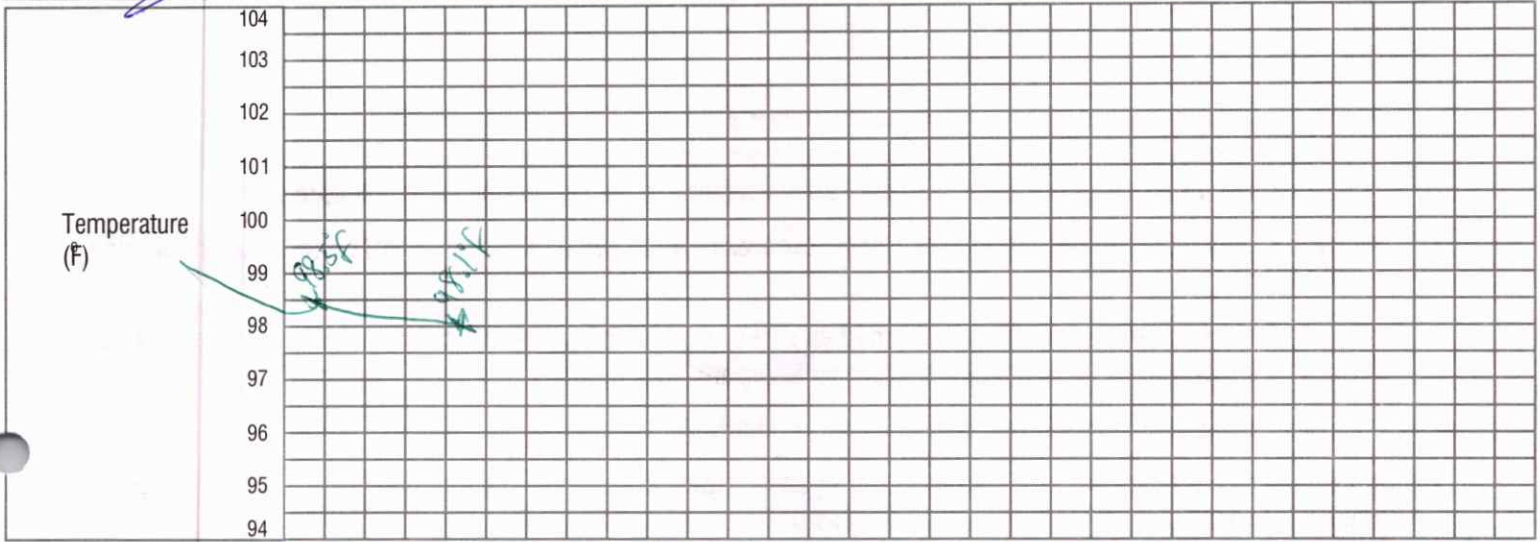
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/1/6 Time: 8 AM 10 AM

Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190	
	180	
	170	
	160	
	150	
	140	
and	130	
Blood Pressure (mmHg) *	120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	

Note:
BP does not score in early warning scoring

Heart Rate (Number) 128 bpm 125 bpm

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

Resp Rate (Number) 36 bpm 36 bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 98% 99%

Conscious Level Normal / Altered

GCS *

TOTAL SCORE Number of shaded boxes 0 0

Pain Score 0 0

Observer's Initials MB MB

- 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:

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

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- Following a Early Warning Score assessment, senior help may be required

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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)

NH-00003298 IP26-00006611
 rby NAGULAPALLY SKANDA
 1-08-2024 1 Y 10 M 8 D (F)
 r. SINDHURA MUNUKUNTLA



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											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:30 pm	DNS Milk	80ml									
	07:00 pm	DNS	30ml									
Total Intake :						Total Output :						
	08:00 pm	DNS	30ml									
	09:00 pm	DNS	30ml									
	10:00 pm	DNS	30ml									
	11:00 pm	DNS	30ml									
	12:00 am	DNS	30ml									
	01:00 am	DNS	30ml									
Total Intake :						Total Output :						
	02:00 am	DNS	30ml									
	03:00 am	DNS	30ml									
	04:00 am	DNS	30ml									
	05:00 am	DNS	30ml									
	06:00 am	DNS	30ml									
	07:00 am	DNS	30ml									
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/6	08:00 am			30ml									
	09:00 am	milk		30ml									
	10:00 am			30ml									
	11:00 am	DNS		15ml									
	12:00 pm			15ml									
	01:00 pm			15ml									
Total Intake :						Total Output :							
20/6	02:00 pm												
	03:00 pm												
	04:00 pm	IRF stop	milk										
	05:00 pm		+ idly										
	06:00 pm												
	07:00 pm												
Total Intake : Taken						Total Output : m-0 0-1							
20/6	08:00 pm												
	09:00 pm												
	10:00 pm		Khichdi										
	11:00 pm		milk										
	12:00 am												
	01:00 am												
Total Intake : Taken						Total Output : U-2 M-0							
21/6	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake : Taken						Total Output : U-2 M-0							
Total 24 hrs. Intake						Total 24 hrs. Output							
						U-7 M-0							

NH-00003298 IP26-00006611

Baby NAGULAPALLY SKANDA

11-08-2024 1 Y 10 M 8 D (F)

Pa. Dr. SINDHURA MUNUKUNTLA



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	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
2/6	08:00 am											
	09:00 am		Idly									
	10:00 am	0	Milk							0		
	11:00 am				NA							
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker



FLUID CHART

Sheet No. :

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

		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												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--



NURSING CARE RECORD



Date: 19/6/26

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							
Afternoon	2pm	→ Assess the baby condition. → monitor the vitals. → continue IV fluids & medications. → plan to trace reports.	2pm	→ Assessed the baby condition. → monitored the vitals. → continued IV fluids & medications. → planned to trace reports.	→ Baby is stable NOW	→ Re-assessed the vitals	<i>[Signature]</i>
Night	8pm	Assess the Pt condition. Monitor vitals & record. Maintain I/O charts. Provide the comfortable position.	8pm	Assessed the Pt condition. Monitored vitals & record. Maintained I/O charts. Provided the comfortable position.	Pt is stable.	Monitor vitals.	<i>[Signature]</i>
	8am	Medication given as per as doctor order.	8am	Medication given as per as doctor order.	Vitals normal.	Maintain I/O charts	

17-00003298 IP26-00006611
 by NAGULAPALLY SKANDA
 08-2024 1 Y 10 M 8 D (F)
 SINDHURA MUNUKUNTLA



NURSING CARE RECORD



Date: 20/6/26

- 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	8Am	<ul style="list-style-type: none"> → Assess the pt condition. → monitor the vitals. → maintain I/O chart. → drugs give as per drug chart. 	8Am	<ul style="list-style-type: none"> → Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → drugs given as per drug chart. 	→ pt is stable now	→ Re assessed the vitals	
Afternoon	2pm to 8pm	<ul style="list-style-type: none"> - Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart 	2pm to 8pm	<ul style="list-style-type: none"> - Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart 	→ Now baby is stable	→ Rechecked the v/s	
Night	8pm to 8Am	<ul style="list-style-type: none"> Assess the pt condition monitor vitals & record maintain I/O chart provide the comfortable position medication given as per order 	8pm to 8Am	<ul style="list-style-type: none"> Assessed the pt condition monitored vitals & record maintained I/O chart provided the comfortable position medication given as per order 	→ pt is stable	<ul style="list-style-type: none"> → monitor vitals → maintain I/O chart 	

HNM-00003298 IP26-00006611
 Baby NAGULAPALLY SKANDA
 11-08-2024 1 Y 10 M 9 D (F)
 Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD



Date: 21/6/26

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	8Am	→ Assess the pt condition. → monitor the vitals. → plan to fluid stop. → maintain I/o chart. → plan to discharge today.	8Am	→ Assessed the pt condition. → monitored the vitals. → planned to fluids stop. → maintained I/o chart. → planned to discharge today.	→ pt is stable now	→ reassessed the vitals.	
Afternoon	8pm		8pm				
Day							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

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

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

NH-00003298 IP26-00006611
 aby NAGULAPALLY SKANDA
 I-09-2024 1 Y 10 M 8 D (F)
 r. SINDHURA MUNUKUNTLA



BRADEN 'Q' SCALE



					Date :	19/6/2016	20/6/2016	20/6/2016	20/6/2016
					Time :	11:30	11:30	11:30	11:30
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		3	3	3	3
"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 inside room at least once every 2 hours during walking hours.		3	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.		3	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.		3	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."		3	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 meat 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.		3	4	5	4
TOTAL SCORE						25	27	27	27
Evaluator's Name						AB	amy	AB	AB

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

NH-00003298 IP26-00006611
 by NAGULAPALLY SKANDA
 -08-2024 1 Y 10 M 8 D (F)
 r. SINDHURA MUNUKUNTLA

BRADEN 'Q' SCALE



					Date :	20/6	21/6/24		
					Time :	NI	M		
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	3		
"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 inside room at least once every 2 hours during walking hours.		3	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		
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		
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		
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		
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	3		
					TOTAL SCORE	24	26		
					Evaluator's Name	BR	BR		

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

BRADEN 'Q' SCALE

Patient ID _____

					Date :				
					Time :				
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
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 inside room at least once every 2 hours during walking hours.					
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.					
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.					
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.*					
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.					
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Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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

TOTAL SCORE

Evaluator's Name

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	19/6 DAY-1			20/6 DAY-2			21/6 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		0	NA	NA	NA	NA	NA			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		0	NA	NA	NA	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		0	NA	NA	NA	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		0	NA	NA	NA	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		0	NA	NA	NA	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 : *Sneha*
 Signature : Name : *Sneha*

Signature of Ward In Charge :
 Signature : *Balarani* Name : *Balarani*

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 :



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/6/24	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	PS
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	SA
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	SA
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	SA
20/6	2pm	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	PS
20/6	6pm	1/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	PS
20/6	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	SA
21/6	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	SA
21/6	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	SA
21/6	8pm	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	PS

Re-assessment Frequency:

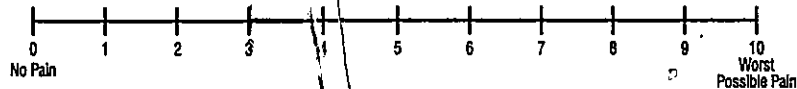
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn 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
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



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst

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"/> 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		
				<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:

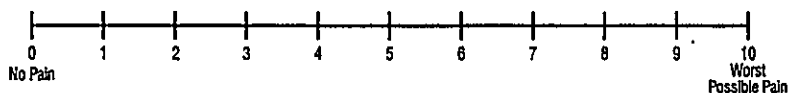
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
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PAIN ASSESSMENT TOOLS

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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

Wong - Baker (Pediatrics) Above 7 Years





NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>AFI + dehydration</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known						
	Surgery / Procedure:	If Yes Specify:						
BACKGROUND	Date	19/6/24 G	19/6/24 NI	20/6/24 Mc	20/6/24 E2	20/6/24 NI	21/6/24 Ms	
	Shift							
	Medical Condition (Any special condition to be noted):	—	—	—	—	—	—	
	Diet:	—	—	—	—	—	—	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.1°F	98.2°F	98.1°F	98.3°F	98.3°F	98.1°F
		Res:	33blm	32blm	33blm	32blm	32blm	33blm
		SpO ₂ :	100%	99%	99%	99%	99%	99%
		Pulse:	133blm	135blm	133blm	132blm	133blm	133blm
		BP:	—	—	—	—	—	—
		LOC:	—	—	—	—	—	—
		Fall Risk Score:	—	—	—	—	—	—
Pain Score:	0	0	0	0	0	0		
Skin Integrity	Good	Good	Good	Good	Good	Good		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	—	—	—	—	—	—		
Post Operative Procedure Special Orders:								
Handed Over By Name :		Sandhya	Sneha	Sandhya	Annasha	Sneha	Mahi	
Signature / ID :								
Date:		19/6/24	20/6	20/6/24	20/6/24	21/6	21/6/24	
Time:		8pm	8AM	2pm	8pm	8PM	8pm	
Taken Over By Name :		Sneha	Sandhya	Annasha	Sneha	Mahi		
Signature / ID :								
Date:		19/6	20/6/24	20/6/24	20/6	21/6/24		
Time:		8pm	8AM	2pm	8pm	8AM		

Patient Sticker

NURSING SHIFT HAND OVER FORM

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

Patient Sticker



NURSING SHIFT HAND OVER FORM

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

Patient Sticker



NURSING SHIFT HAND OVER FORM

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

DRUG CHART

Date of Admission: 19/6/26 Drug Allergies: all 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: <u>Syp. CROCI PRN</u>				Date Time															
Dose <u>2.5ml</u>	Route <u>oral</u>	Frequency <u>50/6hr</u>	Start Date <u>19/6</u>																
Doctor's Signature <u>Dr</u>		Valid Period	Pharm.																
Additional Instructions: <u>Paracetamol (5-1240g)</u>																			

DRUG: <u>Syp. IBUPROFEN</u>				Date Time															
Dose <u>2.5ml</u>	Route <u>oral</u>	Frequency <u>50/6hr</u>	Start Date <u>19/6</u>																
Doctor's Signature <u>Dr</u>		Valid Period	Pharm.																
Additional Instructions: <u>IBUPROFEN (5-1100g)</u>																			

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



REGULAR PRESCRIPTIONS

Weight. 8.6 kg Ward.

DRUG : 90% CEFTRIAXONE				Date Time
Dose	Route	Frequency	Start Date	
850mg	IV	OD	19/6	19/6 20/6
Name & Signature of the Doctor Starting the Drugs: B. Sreelakshmi				
Additional Instructions: dilute in 20ml NS and give over 2 hrs				
Daily Doctor's Endorsement by a Sign				

DRUG : Symp. CROCIAM DS				Date Time
Dose	Route	Frequency	Start Date	
2.5ml	oral	6HLY	19/6	19/6 20/6 21/6 12am X 12:40 PM 6am X 6:30 PM 6pm X 6:30 PM
Name & Signature of the Doctor Starting the Drugs: B. Sreelakshmi				
Additional Instructions: Paracetamol (5ml/240mg)				
Daily Doctor's Endorsement by a Sign				

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

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



Weight. Ward.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature
VERIFIED BY.

HNH-00003298 IP26-00006611
 Baby NAGULAPALLY SKANDA
 11-08-2024 1 Y 10 M 8 D (F)
 Dr. SINDHURA MUNUKUNTLA



MEDICATION RECONCILIATION FORM

Drug Allergies: all 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: ICU 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. Sreegham

Date & Time: 19/6/26 @ 5:30 PM

Nurse Name & Signature: Shreejaya

Date & Time: 19/6/26 @ 5:30 PM

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

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 19/6/26 Time: 6:30 PM

Weight: 8.6 kg Centile: 25th

Height: Centile:

Inference: underweight child

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

Diet Recommendations: soft diet with more liquids

Re-Assesment: Avoid spicy, chilled & outside foods

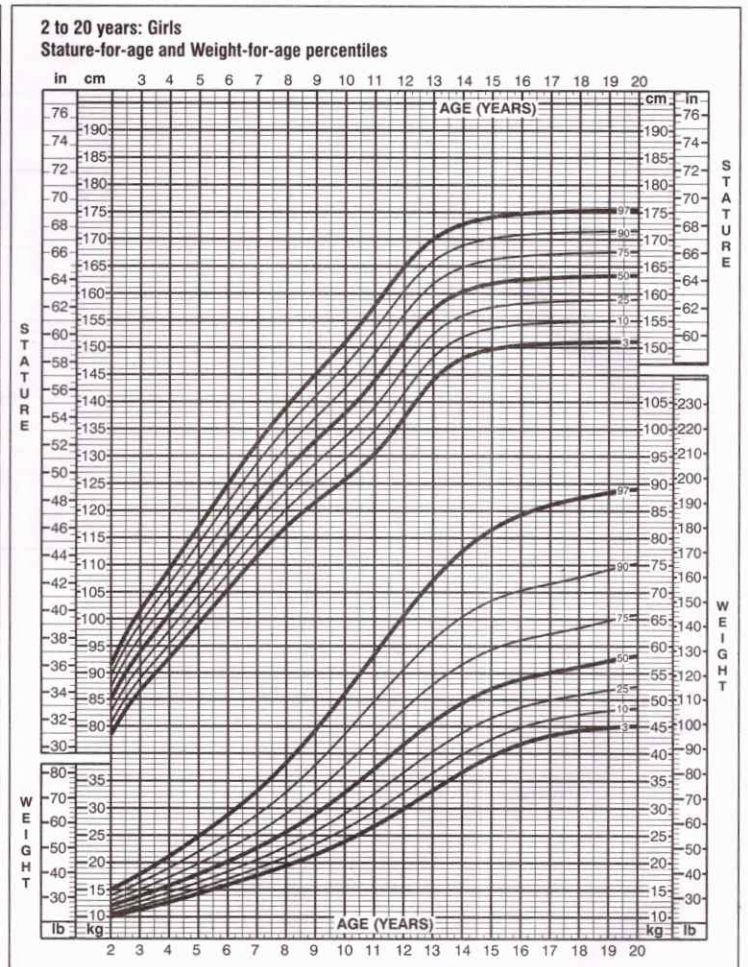
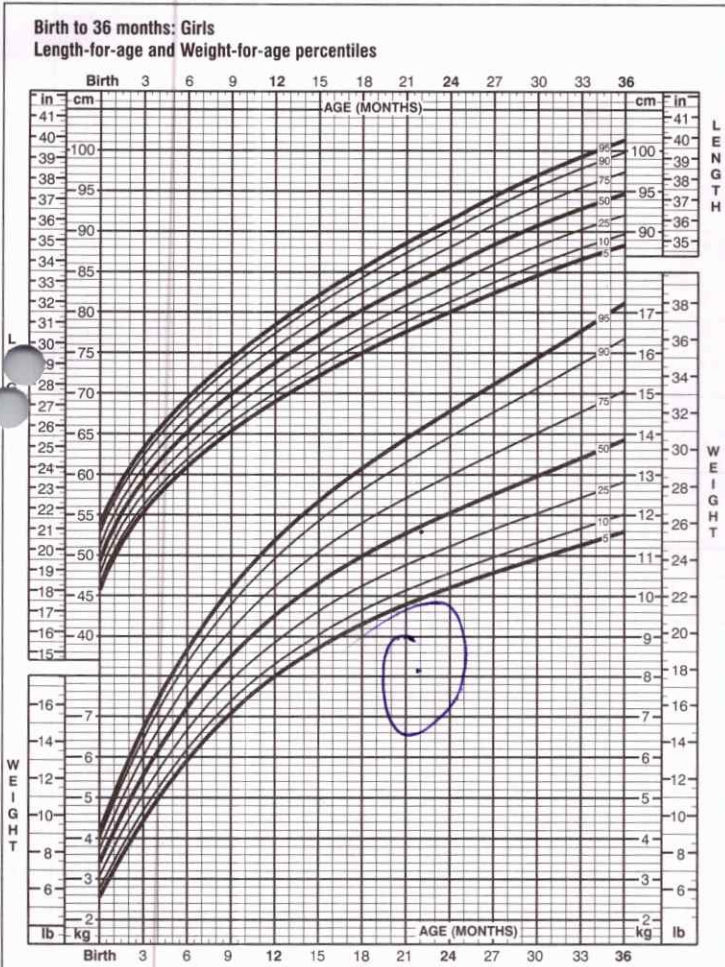
Food Allergies: NO Veg/Non-veg: NON-Veg

Diagnosis: AFI & dehydration & ?UTI

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Dobleek

GROWTH CHART (GIRLS)



Dietician's Name: Sathwika-G

Dietician's Signature: [Signature]

PATIENT TRANSFER FORM

HNH-00003298 IP26-00006611

Baby NAGULAPALLY SKANDA
11-08-2024 1 Y 10 M 8 D (F)
Dr. SINDHURA MUNUKUNTLA



Date & Time of Admission <i>19/6/26 @ 5:35pm</i>	Date & Time of Transfer Order <i>19/6/26 @ 6:17pm</i>	
Treating Consultant Name	Transfer Ordered by <i>Dr. Sreegham .</i>	Reason for Transfer <i>Admission .</i>
From Unit <i>ER</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>14</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" 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 No

Name & Signature of Person who is Transferring <i>Sindhura Munukuntla</i>	Name of Person Ordered Transfer <i>Dr. Sreegham .</i>
--	--

Patient & Clinical Records Received by :

Snanda @ 6.17 pm

Date & Time of Patient Received :

19/6/26

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

wt - 8.60kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby. Nagulapally. Skanda Age: 1y Gender: Male Female

Date: 19/6/26 Time of Arrival: 5:20pm

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: 98.3°F PR: 106b BP: RR: 26b SpO₂: 97%

Chief Complaints: cb. high grade fever since 2 days

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
 Triage Completion Time : 5:30 PM

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: [Signature]

Signature of Triage Nurse: [Signature]

Date & Time: 19/6/26 @ 5:30pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 17/16/26 Time of arrival : 5:20 PM

Chief Complaints: do fever since 2 days RBS:

Height : Weight : 8.60 kg BMI: Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

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

Character: n/a Location: n/a Frequency: n/a Duration: n/a

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: n/a (Date/Time): n/a

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse: n/a @ 5:30 PM

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

Time	Nursing Notes
5:20pm	Assessed The general condition ⇒ vitals checked and recorded.

Samples collected by: *[Signature]*
 Samples sent by: *[Signature]*

Time: *[Blank]*
 Time: 5:30 pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 106b/m BP: CFT: RR: 36b/m SPO ₂ : 97% GCS: Temperature: 98.3°F Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: ward Time of Shift - out: 6:17pm Handover given to: Sunanda (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

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

Name of the Nurse: *[Signature]* Signature of the Nurse: *[Signature]*

Date & Time: 12/6/26 @ 5:40pm