Govt. of NCT of Delhi

CHACHA NEHRU BAL CHIKITSALAYA

(An Autonomous Institute under Govt. of NCT of Delhi)

Geeta Colony, Delhi-110031

NURSING CARE PLAN (1)

Name :- Ricorika   Age/Sex 1.5y/F   CR no. 3985   Unit   Date - 28/3/22

Diagnosis :-

NURSING Diagnosis	GOAL	IMPLEMENTATION	Morning Done	Morning Evaluation	Evening Done	Evening Evaluation	Night Done	Night Evaluation
1. Ineffective airway clearance related to aspiration.	To maintain patent airway	1. Observe for change in color of skin, mucous membrane. Nail beds	✓	MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Monitor and record vital signs.	✓		✓			
		3. Provide comfortable position.	✓					
		4. Clear airway with frequent suctioning.						
		5. Provide supplemental oxygen as ordered.			✓			
2 Ineffective thermoregulation related to immaturity. (Hyperthermia/ Hyperpyrexia)	To maintain normal body temperature	1. Monitor neonate's condition, to determine the need for intervention and the effectiveness of therapy.		MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Monitor vital signs to have a baseline data	✓		✓			
		3. Give Tepid sponge						
		4. Administer antipyretics as prescribed.						
3 Fluid-volume imbalance and imbalance nutrition less then body requirement.	To maintain the normal nutritional status and prevent from malnutrition	1. Assess the nutritional status, Wt., length		MET OR UNMET	✓	MET OR UNMET		MET OR UNMET
		2. Assess hydration level.						
		3 Maintain the intake-output chart.			✓			
		4. Administer IV fluid to the child as advised.	✓					
4. Altered in comfort, pain r/t the disease condition	to provide the comfort and alleviate the pain	1. Pain scoring done.		MET OR UNMET	✓	MET OR UNMET		MET OR UNMET
		2. Provide comfortable position.	✓		✓			
		3 Provide diversion activities such as play, music etc.			—			
		4. Administer the analgesics as prescribed.						
5. Impaired personal hygiene	to maintain personal hygiene	1. Provide / assist the parents to give sponge bath to the child.	✓	MET OR UNMET	✓	MET OR UNMET		MET OR UNMET
		2. Encourage to change the clothes daily.	✓		✓			
		3. Give back cares 2hrly			✓			

HANDING AND TAKING OVER

Nurse's notes-		Time	Hand over given by (name & signature)
Morning (8am-2pm)	Vital sign checked & recorded. I/O chart maintained. All due medication given. No feed given. All NG care given	2pm	[illegible]
Evening(2pm-8pm)	~~Patient received from previous duty staff.~~ ~~Gen al stable.~~ NG feed well accepted. ~~Vital checked and recorded.~~ All due medicine as given. No Hazard	8pm	[illegible]
Night (8pm-8pm)			

CNBC-183

Name of patient: Khushi
Age: 15yr Sex: Female
CR.No.: 2856
Diagnosis: Meningitis

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An Associate Hospital of Maulana ...
Geeta Colony : Delhi ...

29/03/2022

PICU FLOW CHA...

TREATMENT CHART

ANTIBIOTICS & INJECTION

	10	12	2	4	6	8
① INJ MEROPENAM 300MG IV × 8HOURLY						
② INJ ACYCLOVIR 150MG IV × 8HOURLY			[signature]			
③ INJ PHENYTOIN 30MG IV × BD 10am — 10pm			[signature]			
④ INJ Na+ VALPORATE 150MG IV × BD 2pm — 2am	[signature]					
⑤ INJ LAVERA 80MG IV × BD 6pm — 6am			[signature]			
				[signature]		

ORAL & OTHER MEDICATION

...od Transfusion Notes

Time	Product	Bag no.	Blood group	D.O.C.	D.O.E.	Volume

INTAKE	Amount	OUTPUT
IVF		RTA
INFUSION		URINE
REPLACEMENT		STOOL
BLOOD		DRAIN
OTHER/FEED		OTHER
TOTAL		TOTAL

Ruhanika

28/03/2022

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
	PT Re-ove 4th Lead at 10:10pm on 28/3/22		10Am 75ml 1Pm 75ml 4pm NIL 75ml 7pm NIL 75ml 10pm nil 75ml ~~1Am~~ ~~4Am~~ ~~7Am~~		8Am — 2pm 60ml + 7ml 2pm — 8pm 146ml Count Stool 8pm — 8Am 116ml	nil	Feed — NG feed 75ml x 3hrly	
Total								@ 34/min

- Maintain TNE
- Ilocharting
- HEE at 30°
- O2 by ~~HFNP~~ nasal

Amount

nil
312ml
3 time

Ruanika 25/03/22

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
25/03/2022 8am 2pm. 8pm ↓ 8am.	[100+20] [100+20] 100 @10ml/h.	3% nacl @ 3.5ml/hr	8Am – 2Pm Nil. 2Pm – 8Pm 10pm Nil 30ml. 1am Nil – 30ml 4am Nil – 30ml 7am nil 30ml	NPO NPO	8Am – 2Pm 76ml. 2Pm – 8Pm 56ml + 46ml c stool 8 – 8 50ml c stool. + 44ml c stool T = 272ml. 40 312ml.		IVF:- Line II – Feed:- L.P done at 2Pm by Dr Anshul Others:-	DNS c KCl @ 20ml/hr or 60ml Inj. 6hrly Inj. 3% nacl @ 3.5ml/hr OG – 30ml x 3hrly. – Maintain TNE – vitals monitoring – I/O charting
			12am					HOB at 30° NPO

Name of patient: Kunika
Age: 1.5yr Sex: F
CR No.: 2985
Diagnosis:
27/03

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An Associate Hospital of Maulana Az...
Geeta Colony : Delhi - 1...

PICU FLOW CHA

ANTIBIOTICS & INJECTION

TREATMENT CHART

	10	12	2	4	6	8
Inj. Monocef 370mg x BD 10—10	omitted					
Inj. Eptoin 30mg x BD 10—10						
Inj. Na Valporate 150mg x BD 2—2						
Inj. Lavera 80mg x BD 6—6						
Inj. Pcm 75mg x SOS						
Inj. Midazolam 0.8mg x SOS omitted						
Inj. Acyclovir ~~40mg~~ 150mg x 8 Hrly						
Inj. Meropenem 300mg						

ORAL & OTHER MEDICATION

Blood Transfusion Notes

	Time	Product	Bag no.	Blood group	D.O.C.	D.O.E.	Volume

INTAKE
IVF
INFUSION
REPLACEME
BLOOD
OTHER/FEE
TOTAL

Ruanika 27/03/22

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
	IVF:- N/2 in 5% dextrose Kcl (1:100) @ 10ml/hr		8am ——— 2pm		8am ——— 2pm			N/2 + 5% D ...
			10Am		52ml (1st Stool)			IVF:- Kcl (1:100) @ 5ml/hr
	IVF @ 5ml/hr at 10Am		N/2	60ml				
	omitted - 1Pm IVF		1Pm		2 ——— 8			Line - Sol NaCl 3% @ 3.5ml/hr
			N/2	75ml	78ml + 56ml			
			4Pm					
			Nil	75ml				feed:- OGF 3hrly 75ml
			7Pm Nil	→ 75ml	8 ——— 8			
			10Pm Nil	75ml	42ml NB.			
			1Am Nil	75ml.				
			4Am Nil	75ml				other Maintain TNE t/o chasing
			7Am Nil	75ml				O2 by prongs HFC @ 300

Amount

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
05/3/22	2am (100 + 20) 8am		12:50am – 8am	NPO	12:50am – 8am 66 ml			NPO Head end elevation (30°) IVF:- DNS c KCl (1:100) @ 90ml/hr Inj. 3% NaCl @ 3.5ml/hr Others: maintain TNB vital monitoring I/O charting
Total								

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CHACHA NEHRU BAL CHIKITSALAYA

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Geeta Colony, Delhi-110031

NURSING CARE PLAN (1)

Patient name: Ruanika Age/Sex: 1.54/F CR no: 2985 Unit Date: 26/03/22

D.A: Diagnosis:

Nursing Diagnosis	Goal	Implementation	Morning Done	Morning Evaluation	Evening Done	Evening Evaluation	Night Done	Night Evaluation
1. Ineffective airway clearance related to aspiration	To maintain patent airway	1. Observe for change in color of skin, mucous membrane, Nail beds	✓		✓		✓	
		2. Monitor and record vital signs	✓	MET OR UNMET	✓	MET OR UNMET	✓	MET OR UNMET
		3. Provide comfortable position	✓		✓		✓	
		4. Clear airway with frequent suctioning	✓		✓			
		5. Provide supplemental oxygen as ordered	✓		✓			
2. Ineffective thermoregulation related to immaturity (Hyperthermia/ Hyperpyrexia)	To maintain normal body temperature	1. Monitor neonate's condition, to determine the need for intervention and the effectiveness of therapy	✓	MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Monitor vital signs to have a baseline data	✓		✓		✓	
		3. Give Tepid sponge					✓	
		4. Administer antipyretics as prescribed						
3. Fluid-volume imbalance and imbalance nutrition less than body requirement	To maintain the normal nutritional status and prevent from malnutrition	1. Assess the nutritional status, Wt., length		MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Assess hydration level						
		3. Maintain the intake-output chart	✓		✓		✓	
		4. Administer IV fluid to the child as advised	✓		✓			
4. Altered in comfort, pain r/t the disease condition	to provide the comfort and alleviate the pain	1. Pain scoring done		MET OR UNMET		MET OR UNMET	✓	MET OR UNMET
		2. Provide comfortable position	✓		✓			
		3. Provide diversion activities such as play, music etc						
		4. Administer the analgesics as prescribed						
5. Impaired personal hygiene	to maintain personal hygiene	1. Provide / assist the parents to give sponge bath to the child	✓	MET OR UNMET	✓	MET OR UNMET		MET OR UNMET
		2. Encourage to change the clothes daily						
		3. Give back cares 2hrly	✓		✓			

HANDING AND TAKING OVER

Nurse's notes-		Time	Hand over given by (name & signature)	Hand over taken by (name & signature)
Morning (8am-2pm)	Pt received from Ⓝ staff, pt's vital sign checked & recorded. due Rx given on time.	2pm	[signature]	[signature]
Evening (2pm-8pm)	[illegible] vitals are checked & recorded. all care [illegible]	8pm	[signature]	[signature]
Night (8pm-8am)	Pt is on W.C PAP. vitals checked and recorded x 2 hourly. I/O [illegible]		[signature]	[signature]

CNBC-183

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CHACHA NEHRU BAL CHIKITSALAYA

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Geeta Colony, Delhi-110031

NURSING CARE PLAN (1)

Patient name :- Baby Rounika Age/Sex 1.5yr/F CR no. 2985 Unit II Date - 25-03-22

DOA - 22-03-22 Diagnosis - Meningitis

NURSING Diagnosis	GOAL	IMPLEMENTATION	Morning Done	Morning Evaluation	Evening Done	Evening Evaluation	Night Done	Night Evaluation
1. Ineffective airway clearance related to aspiration.	To maintain patent airway	1. Observe for change in color of skin, mucous membrane. Nail beds.	✓	MET OR UNMET		MET OR UNMET	✓	MET OR UNMET
		2. Monitor and record vital signs.	✓					
		3. Provide comfortable position.	✓					
		4. Clear airway with frequent suctioning.	✓					
		5. Provide supplemental oxygen as ordered.						
2. Ineffective thermoregulation related to immaturity. (Hyperthermia/ Hyperpyrexia)	To maintain normal body temperature.	1. Monitor neonate's condition, to determine the need for intervention and the effectiveness of therapy.	✓	MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Monitor vital signs to have a baseline data	✓					
		3. Give Tepid sponge	✓					
		4. Administer antipyretics as prescribed					✓	
3 Fluid-volume imbalance and imbalance nutrition less then body requirement.	To maintain the normal nutritional status and prevent from malnutrition	1. Assess the nutritional status, Wt., length		MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Assess hydration level.						
		3.Maintain the intake-output chart						
		4. Administer IV fluid to the child as advised.						
4. Altered in comfort, pain r/t the disease condition	to provide the comfort and alleviate the pain.	1. Pain scoring done.		MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Provide comfortable position.						
		3.Provide diversion activities such as play, music etc.						
		4. Administer the analgesics as prescribed						
5.Impaired personal hygiene	to maintain personal hygiene	1. Provide / assist the parents to give sponge bath to the child.	✓	MET OR UNMET		MET OR UNMET		MET OR UNMET
		2. Encourage to change the clothes daily.	✓					
		3. Give back cares 2hrly	✓					

HANDING AND TAKING OVER

		Time	Hand over given by (name & signature	Hand over taken by (name & signature
Nurse's notes-	* pt is on ventilator support - NCPAP mode. vitals are checked & recorded. All nursing care are given. All due medications given. Maintain I/O chart maintained			
Morning (8am-2pm)	from morning baby patient received [illegible] vent CPAP vitals [illegible]	10am	[illegible]	[illegible]
Evening(2pm-8pm)	All nsg care done All due medication given	2pm	[illegible]	
Night (8pm-8pm)	8pm 4. c/c poor. on ventilator - cpap. [illegible]. All due medicine given. 8am no [illegible]	8pm	[illegible]	

DAILY ASSESSMENT CHART

	Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula inserted	Cannula Removed	Remarks	Sign
	Nil	changed	given	changed	—	—	given	—	left foot	—	[signature]
	"	"	"	"	—	—	"	—	—	—	[signature]
	Nil	changed	given	changed	—	—	given	—	—	—	[signature]
	"	"	"	"	"	—	"	—	—	—	[signature]
	"	"	"	"	"	—	—	—	—	—	[signature]
		✓	✓	✓	—	—	✓	✓	—	—	[signature]
	"	✓	✓	✓	—	—	✓	—	—	—	[signature]
	"	✓	✓	✓	—	—	✓	—	—	—	[signature]
	"	✓	✓	✓	—	—	✓	—	—	—	[signature]
	"	✓	✓	✓	—	—	✓	—	—	—	[signature]
	"	✓	✓	✓	—	—	✓	—	—	—	[signature]
	"	✓	✓	✓	—	—	✓	—	—	—	[signature]

	Patient Condition	Peripheries	Any Bed Sore	Any Injury Mark	Any ADR	Any Blood Reaction (BTR)	Special Note
Mo[illegible]	Stable/ Unstable ✓	Cold/ Warm ✓			Yes / No	Yes / No	
[illegible]	Stable/ Unstable ✓	Cold/ Warm ✓	—	—	Yes / No ✓	Yes / No ✓	[illegible]
[illegible]	Stable/ Unstable ✓	Cold/ Warm ✓	—	—	Yes / No —	Yes / No —	— [illegible]

RESTRAINT MONITORING CHART

	1. Roll Belt ✓	2. Mittien	3. 1 or 2 Point	4. 4 Point

...oring: 2nd hurly excessive movement presented.

	10	12	2	4	6	8	10	12	2	4	6
[illegible]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	—
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
...of Limb	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
...art	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
...24Hour	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	
	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	

E. [signature]   N. [signature]

PAIN ASSESSMENT SCALE

erbal Analogue Scale

0 1 2 3 4 5 6 7 8 9 10

No pain | Mild pain | Moderate pain | Moderate pain | severe pain | Worst pain

Wong-Baker Facial Grimace Scale

(No pain)(Mild pain)(Moderate pain) (Severe pain) (Worst pain)

Signature of Nursing Officer

DAILY ASSESSMENT CHART

...ess site	Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula inserted	Cannula Removed	Remarks
	NO	Changed	given	Changed			given	Lt Hand	R Hand	
		Changed	given	Changed			given			

Patient ...ndition	Peripheries	Any Bed Sore	Any Injury Mark	Any ADR	Any Blood Reaction (BTR)	Special Note
Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	
Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	
Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	

RESTRAINT MONITORING CHART

	1. Roll Belt	2. Mittien	3. 1 or 2 Point	4. 4 Point

...ring :

...nitoring :

10	12	2	4	6	8	10	12	2	4	6
NO	NO	NO								
NO	NO	NO								
YES	YES	YES								

...uf Units

...ent

...ther

E..... N.....

VENTILATOR MONITORING CHART

Mode of Ventilation	Size of Tube	Position of ET	Day of Ventilation	Cuffed (C)/Uncuffed (UC)	Remarks

Vital Monitoring					Ventilator Parameters					ABG				
Time	Temp	Pulse/ HR	RR	BP	SAT RR	PEEP (mm)	TV / MV	FiO_2%	MAC/RON	PH	CO_2	PO_2	HCO_3	BE
10:00 AM														
12:00 Noon														
02:00 PM														
04:00 PM														
06:00 PM														
08:00 PM														
10:00 PM														
12:00 AM														
02:00 AM														
04:00 AM														
06:00 AM														

PAIN ASSESSMENT SCALE

Verbal Analogue Scale

0 No pain | 1 | 2 Mild pain | 3 | 4 Moderate pain | 5 | 6 Moderate pain | 7 | 8 severe pain | 9 | 10 Worst pain

Wong-Baker Facial Grimace Scale

(No pain)(Mild pain)(Moderate pain) (Severe pain) (Worst pain)

Signature of Nursing Officer

Govt. of NCT of Delhi

CHACHA NEHRU BAL CHIKITSALAYA

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Geeta Colony, Delhi-110031

NURSING CARE PLAN (1)

Patient name: Reenika Age/Sex: 1.5 yr/F Unit Date: 27/03/2022

D.O.A. Diagnosis:

NURSING Diagnosis	GOAL	IMPLEMENTATION	Morning Done	Morning Evaluation	Evening Done	Evening Evaluation	Night Done	Night Evaluation
1. Ineffective airway clearance related to aspiration	To maintain patent airway	1. Observe for change in color of skin, mucous membrane, Nail beds.		MET OR UNMET		MET OR UNMET	✓	MET OR UNMET
		2. Monitor and record vital signs	✓		✓		✓	
		3. Provide comfortable position	✓		✓		✓	
		4. Clear airway with frequent suctioning	✓		✓			
		5. Provide supplemental oxygen as ordered						
2. Ineffective thermoregulation related to immaturity (Hyperthermia/ Hypothermia)	To maintain normal body temperature	1. Monitor neonate's condition, to determine the need for intervention and the effectiveness of therapy	✓	MET OR UNMET	✓	MET OR UNMET	✓	MET OR UNMET
		2. Monitor vital signs to have a baseline data	✓		✓		✓	
		3. Give Tepid sponge	✓					
		4. Administer antipyretics as prescribed			✓			
3. Fluid-volume imbalance and imbalance nutrition less then body requirement	To maintain the normal nutritional status and prevent from malnutrition	1. Assess the nutritional status. Wt. length	✓	MET OR UNMET	✓	MET OR UNMET	✓	MET OR UNMET
		2. Assess hydration level	✓		✓			
		3. Maintain the intake-output chart	✓					
		4. Administer IV fluid to the child as advised			✓		✓	
4. Altered in comfort, pain r/t the disease condition	to provide the comfort and alleviate the pain	1. Pain scoring done	✓	MET OR UNMET	✓	MET OR UNMET		MET OR UNMET
		2. Provide comfortable position	✓				✓	
		3. Provide diversion activities such as play, music etc	✓		✓			
		4. Administer the analgesics as prescribed						
5. Impaired personal hygiene	to maintain personal hygiene	1. Provide / assist the parents to give sponge bath to the child.	✓	MET OR UNMET	✓	MET OR UNMET	✓	MET OR UNMET
		2. Encourage to change the clothes daily	✓				✓	
		3. Give back cares 2hrly	✓					

HANDING AND TAKING OVER

	Nurse's notes	Time	Hand over given by (name & signature)	Hand over taken by (name & signature)
Morning (8am-2pm)	Patient received from previous duty staff. Vitals checked and recorded. All due medicine are given. No [illegible] baby nursing care given.	11Am	[signature]	[signature]
Evening (2pm-8pm)	[illegible] vital signs checked. Vital signs [illegible] and recorded.	5pm	[signature]	[signature]
Night (8pm-8pm)	Pt is on [illegible] feed by o/g, vitals checked and neuro [illegible]		[signature]	

CNBC-183

Ruanika 26/03/22

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
	8am — @ 10ml/hr at 10pm @ 20ml/hr 2pm ... @ 10ml/hr	pt sent for MRI at 10.10am.	8am — 8pm 10am — NPO 2pm — 8pm 4pm NJ 40ml 7pm NJ 40ml 10pm NJ 40ml 1am NJ 40ml. 4am NJ 40ml. 7am		8am — 8pm 172ml + 2pm — 8pm 242ml + 82ml ē stool 8 — 8 56 + 60 ml ...		IVF: Line — Feed:	M... DNS ... (1:100) ml/hr or ~~...~~ ... NaCl 3% @ 3.5ml/hr ... feed. 40ml × 3hrly. other ... I/O charting HOB @ 30°

70
80

AYA

DAILY ASSESSMENT CHART

ness site	Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula inserted	Cannula Removed	Remarks
NAD	NAD	changed	given	changed	—	—	given	—	—	—
NAD	NAD	"	—	"	—	—	—	—	2	—
NAD	NAD	"	—	"	—	—	—	—	—	—
NAD	NAD	changed	given	changed	—	—	given	—	—	—
"	"	"	—	"	—	—	—	—	—	—
"	"	"	—	"	—	—	—	—	—	—

Patient condition	Peripheries	Any Bed Sore	Any Injury Mark	Any ADR	Any Blood Reaction (BTR)	Special Note
Stable/ Unstable	Cold/ Warm	—	—	Yes / No	Yes / No	—
Stable/ Unstable	Cold/ Warm	—	—	Yes / No	Yes / No	
Stable/ Unstable	Cold/ Warm	—	—	Yes / No	Yes / No	

RESTRAINT MONITORING CHART

1. Roll Belt | 2. Mittien | 3. 1 or 2 Point | 4. 4 Point

ring :

nitoring :

10	12	2	4	6	8	10	12	2	4

imb

E..... N.....

DAILY ASSESSMENT CHART

Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula inserted	Cannula Removed	Remarks	Sign

Patient Condition	Peripheries	Any Bed Sore	Any Injury Mark	Any ADR	Any Blood Reaction (BTR)	Special Note
Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	
Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	
Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	

RESTRAINT MONITORING CHART

	1. Roll Belt	2. Mitten	3. 1 or 2 Point	4. 4 Point

	10	12	2	4	6	8	10	12	2	4	6	8

VENTILATOR MONITORING CHART

Mode of Ventilation		Size of tube		Position of ET		Day of Ventilation		Cuffed (C)/Uncuffed(UC)		Remarks

VITAL Monitoring								VENTILATOR PARAMETERS							ABG					Remarks
Time	Temp	Pulse	HR	RR	SpO_2	RBS	BP	SAT.RR	PEEP	PIP	TV	MV	FiO_2%	SUCTION	PH	CO_2	PO_2	HCO_3	BE	
10:00 AM	[illegible]		[illegible]		[illegible]															
12:00 Noon	[illegible]		72/16		98%															
02:00 PM	96°		90/16		98%															
04:00 PM	97.6°F		88/22		96%															
06:00 PM	98.4°F		86/20		98%															
08:00 PM	98.6°F		84/20		96%															
10:00 PM	98.4°F		108		98%															
12:00 AM																				
02:00 AM																				
04:00 AM																				
06:00 AM																				
08:00 AM																				

PAIN ASSESSMENT SCALE

Verbal Analogue Scale

0 1 No pain — 2 3 Mild pain — 4 5 Moderate pain — 6 7 Moderate pain — 8 9 severe pain — 10 Worst pain

Wong-Baker Facial Grimace Scale

(No pain)(Mild pain)(Moderate pain) (Severe pain) (Worst pain)

Signature of Nursing Officer

Name

Name of patient: RUANIKA

Age: 1·5 Y Sex: F

CR.No.: 2985 25/3/22

Diagnosis:

CHACHA NEHRU BAL CH

(An Autonomous Institute under Govt. of

Affiliated to Delhi University

An Associate Hospital of Maulana Azad M

Geeta Colony : Delhi - 1100

PICU FLOW CHAR

TREATMENT CHART

ANTIBIOTICS & INJECTION	10	12	2	4	6	8
INJ CEFTRIAXONE 370MG IVxBD	Tf					
INJ PHENYTOIN 30MG IVxBD 10Am–10Pm	Tf					
INJ VALPORATE 150MG IVxBD 2Am–2Pm			Tf			
INJ LEVERA 80MG IV xBD 6Am–6Pm						
Inj Midazolam 0.8mg IV SOS						
Inj. PCM 75mg IV SOS			Tf			
IM - Acyclovir 110 mg 1/0 TDS						
ORAL & OTHER MEDICATION						

Blood Transfusion Notes

No.	Time	Product	Bag no.	Blood group	D.O.C.	D.O.E.	Volume

INTAKE	
IVF	
INFUSION	
REPLACEMENT	
BLOOD	
OTHER/FEED	
TOTAL	

T = 0

Mob. : 9821253869

JEEVAN CARE FOUNDATION

Address:- 697, Village Madanpur Khadar, New Delhi 110076
Mail- Jeevancarefoundation@gmail.com

Reg No. 92

Ref. No. .....

Date 31-03-22

सेवा में,

श्रीमान संस्थापक महोदय
जीवन केयर फाउंडेशन
मदनपुर खादर नई-दिल्ली

महोदय,

मैं स्वाधिका की माँ अनीता गोरखा आप से निवेदन करती हूँ कि मेरी बच्ची जैन ह्यूमर नामक गंभीर बीमारी से पीड़ित है जिसका कुल ईलाज का खर्च (२.४०) दो लाख अस्सी हजार है जिसमें हमारा परिवार इलाज करवाने में असमर्थ है मेरी बच्ची चाचा नेहरू बाल चिकित्सालय में भर्ती है।

मैं आपसे और आपके अनुदान-कर्ता से निवेदन करती हूँ हमारी बच्ची के इलाज में हमारी सहायता करें। हम आप सभी का जीवन-भर आभारी रहेंगी।

प्रार्थी
अनीता

JEEVAN CARE FOUNDATION
Reg. No.
DELHI