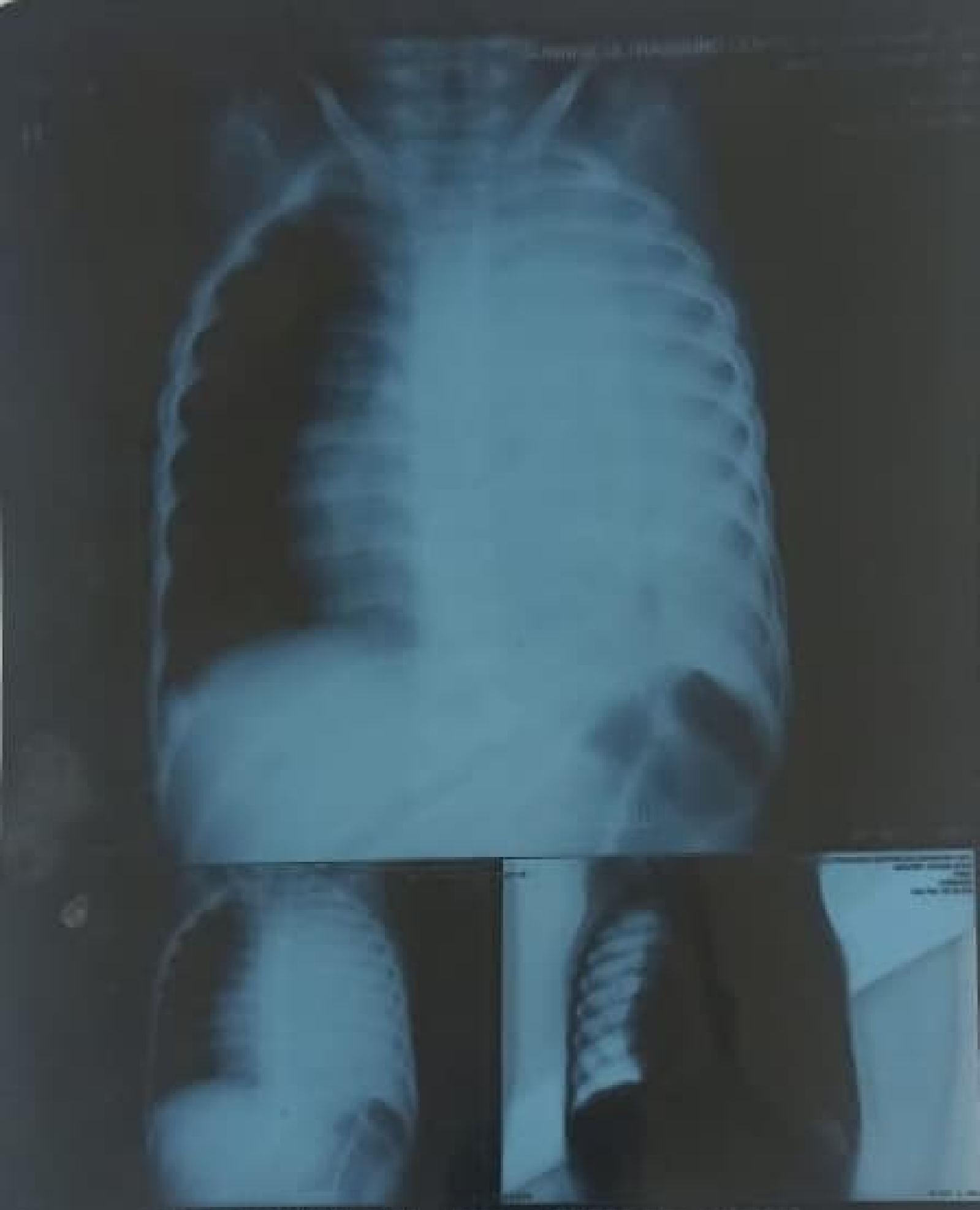
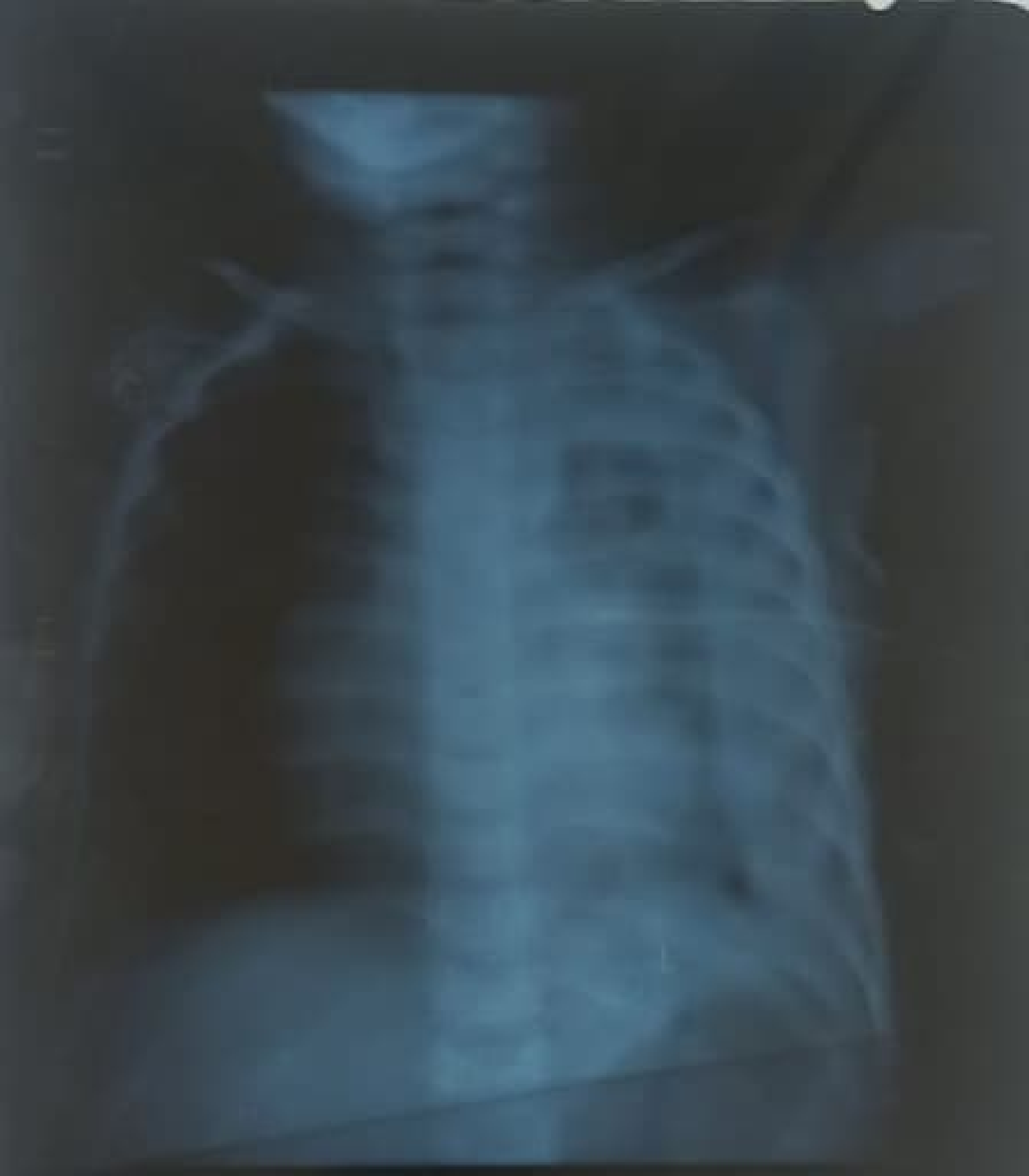

MASTER SHADIK 2Y/M F200 CHEST AP
(U)RISE ULTRASOUND CENTRE BULANDSHAHR (UP)



INTAKE/OUTPUT CHART

Sadiq 21/02/22

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
8am	@ 7ml/hr 2pm @ 2.5ml/hr Stop IVF @10pm	ICD Replacement: 8a.m–2pm: Nil 2pm–8pm Nil 8–2 NIL 2–8 NIL	8am——10pm 5ml (Remnant) 1pm Nil 4pm Nil 7pm Nil 10pm NIL 1Am NIL 4Am NIL 7Am NIL	– 40ml – 40ml 50ml 50ml 60ml 60ml 60ml 60	8am——8pm 85ml 2pm–8pm 54ml + 130ml 8——8 70ml	N.P. Ø stool		IVF- DNS c̄ KCl [1:100] @ 2.5ml/hr ICD Replacement- Inj. 1/3 ST OEX 1/4 1/2 6thly Feed- OG feed 8ml/3hrly 2 feed ↓ 60ml & Ⓑ Others- - Maintain TNE / Ilactation - knee chest position

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
		8am-2pm	8Am—2pm		8am—2pm			→ OCF 60ml (B) 2hly
		ICD-NIL	10Am / NIL	60ml	124ml + 60ml	1 time stool / stool		ICD Rep [illegible]
		2pm-8pm / nil	1pm / NIL	60ml				[illegible]
		8-2 / Nil	4pm / [illegible]	60ml	2pm—8pm / 80ml c stool			
		2-8 / 100ml	7pm / [illegible]	60ml	8—8 / 144ml Not [illegible]			
			10pm / Nil	60ml				
			1am / Nil	60ml.				→ maintain I/O
			4am / Nil	60ml.				→ keep chest PT position
			7am / Nil	60ml.				
Total								

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Geeta Colony, Delhi-110031

NURSING CARE PLAN (1)

Patient name :- SADIA   Age/Sex 2-11 M   CR no. 1487   Unit   Date -

DOA 14/2/22   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

		Time	Hand over given by (name & signature)	Hand over taken by (name & signature)
Nurse's notes-				
Morning (8am-2pm)				
Evening(2pm-8pm)	~~Pt Taken from from 4th floor ward at 12:50 AM~~	8PM	[signature]	
Night (8pm-8pm)	Pt G.C is [illegible] vitals are charted 2 hrly. All the medication given as per Dr. order			

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NURSING CARE PLAN (1)

Patient name :- Sadiq Age/Sex 2y/m CR no. 1487 Unit Date:- 23/12/22

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/ 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 in 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)	[illegible] received, vitals checked & recorded. NO fresh [illegible] Due medicine given. All NS/care [illegible]	10[illegible]	[illegible]	[illegible]
Evening(2pm-8pm)	Vital signs [illegible] checked and recorded. All due medicines given [illegible]	8[illegible]	[illegible]	
Night (8pm-8pm)	vitals checked & recorded. Due medicine given. NO APR noted.	8am	[illegible]	

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NURSING CARE PLAN (1)

Patient name :- SADIQ Age/Sex 2½m/M. CR no. 1487. Unit II Date:- 21-02-22

D.O.A:- 16-02-22 Diagnosis:- Cyanotic heart disease ĒD̄L c effusion

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 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.	K					
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)
Nurse's notes- / Morning (8am-2pm)	* pt is on O₂ by nasal bubble cpap. vitals are checked & recorded. All nursing care & due medications are given. [illegible] of right dorsal [illegible] changed. Maintain I/O. I/O chart maintained	10am	[signature]	[signature]
Evening(2pm-8pm)	Pt on flow [illegible] vitals are checked & recorded. Care given	8pm	[signature]	
Night (8pm-8pm)	Pt. received from night staff. Vitals checked & recorded. Due medicine given.	8am	[signature]	

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INTAKE OUTPUT CHART

Name:- Sadiq Age/Sex:- 7 y/m C.R.No.:- 1487 Diagnosis:- left sided pleural effusion Ward/Unit:- (I) Date of Admission: 16/2/22

Date / Time	Intake: I/V Fluid	Amount	Oral/NGT	Amount	Output: Time	Urine	Aspiration /Drainage	Vomitus	Stool	Orders/BT Notes
1-8 to 4 am	DNS (lovl/hr)				8P – 8A	✓				- Orally allowed. NPO. O2 by prongs @ 2 lit/min. Chest physiotherapy as advised. - keep propped up. [signature] 22/2/22
Total I/V/Oral/NGT Intake										
Blood/Blood Components										
Whole blood/Packed Cells/FFP			Amount							
									16/2 1-8	5r NS 20ml @ Bolus. DNS c KCl (1:10) @ 16ml/hr
Grand Total Intake					Total Output					

Signature of Staff Nurses

Signature of Doctor

C-28 Version-3

INTAKE/OUTPUT CHART

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
12/2/[illegible] 8pm	[illegible] 44 8pm [illegible] + 02 8pm 17ml/hr feed 10ml 13ml/hr feed 20ml ↓ 10ml/hr feed 30ml ↓ [illegible] at 2am	ICD Replacement 8 — 2 Nil (initial [illegible]) 2 — 8 10ml 8pm — 2Am Nil 2Am — 8Am 10ml	10Am 1PM nil 4pm Nil 7pm Nil 10Pm Nil 2Am Nil 4Am Nil 2Am Nil	 10ml 10ml 20ml 20ml 30ml 30ml 20ml	8 — 2 78ml 2 — 8 100ml 8Pm — 8Am 68ml [illegible] + 65ml	not [illegible] NP [illegible]	IVF	DNS c KCL (1/100) @ ~~15 [illegible]~~ 24 ml/hr (~~[illegible]~~) [illegible] ICD Replacement V/U c 6mg [illegible] [illegible] Feed 0/4 feed 10ml x 3 feed ↓ 20ml x 3 feed ↓ 30ml x 3 feed OTHER → Maintain TPC → I/O Chart [illegible] → Vitals monitoring → [illegible] position → O_2 [illegible]
Total								

DAILY ASSESSMENT CHART

Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula Inserted	Cannula Removed	Remarks	Si
NO	Wnl	WNL	Wnl			WNL	-	-	-	
"	"	"	"	-		"	-	-	-	
"	"	"	"	-		"	-	-	-	
"	"	"	"	-	-	"	4pm	4pm	-	
"	"	"	"	-	-	"	"	"	-	
"	"	"	"	-	-	"	"	"	-	
"	"	"	"	-	-	"	"	"	-	
"	"	"	"	-	-	"	"	"	-	
"	"	"	"	-	-	"	"	"	-	
"	"	"	"	-	-	"	"	"	-	
"	"	"	"	-	-	"	"	"	-	

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

RESTRAINT MONITORING CHART

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

Freezing :

Reas

Dri

Pos nitoring :

	10	12	2	4	6	8	10	12	2	4	6
Le											
Ri											
Le											
Ri											
Limb											
Di											
Bo											
Hour											
Bo											
Sk											
B											
T											
W											

WNL

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NURSING CARE PLAN (1)

Patient name - Sadiq   Age/Sex 24/M   CR no. 1487   Unit   Date 18/1/22

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/ 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)	Hand over taken by (name & signature)
Morning (8am-2pm)	Pt is NPO. ICD drain replacement done. No ADR seen. TNC done		[signature]	[signature]
Evening (2pm-8pm)	IVF is flow. Vitals signs checked and recorded. All nursing care given	8pm	[signature]	[signature]
Night (8pm-8am)	Patient receive from previous duty staff. Given all [illegible]. Vitals checked and taken [illegible]. All due medicine are given. No ADR note. Nursing care given	8am	[signature]	[signature]

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DAILY ASSESSMENT CHART

...ss ...ite	Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula inserted	Cannula Removed	Remarks	Si...
	Nil	changed	given	changed	—	—	given	Rt hand	Rt hand	—	
	Nil	changed	given	changed	—	—	given	—	—	—	
	Nil	changed	given	changed	—	—	given	—	—	—	
	nil	nil	dry	qn	—	—	qn	—	—	—	
					—	—		—	—		
					—	—		—	—		
					—	—		—	—		
					—	—		—	—		
					—	—		—	—		
					—	—		—	—		
					—	—		—	—		

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

RESTRAINT MONITORING CHART

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

Frequency of Monitoring:

Reason:

Drug:

Purpose:

Monitoring :	10	12	2	4	6	8	10	12	2	4
L Arm										
R Arm										
L Ll										
R Ll										
Chang...r of Limb										
Release ...part										
Restrai... ...Hour										
Signature ...N										

Pain ...											
Time											
Pain Sco...											

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

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NURSING CARE PLAN (1)

Patient name : SA019   Age/Sex 2y/m   CR no. 1489   Unit   Date:- 20/7/22

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/ 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					1✓	
		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)	Pt on nasal prong [illegible] [illegible] [illegible] [illegible] [illegible]. Medication given as [illegible] [illegible] [illegible] no [illegible] [illegible]	2pm	B	M[illegible]
Evening(2pm-8pm)	pt on O2 by nasal prongs. vitals checked & recorded. All due medication given as per doctor's order. [illegible]	4pm	M[illegible]	[illegible]
Night (8pm-8am)	Pt received from (E) staff. His vital sign checked & recorded, due [illegible] given [illegible]	8pm	[illegible]	[illegible]

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DAILY ASSESSMENT CHART

...te	Swelling	Probe change	Oral and Back Care	Position Changing	CVP Line Care	Catheter Care	Cannula care	Cannula inserted	Cannula Removed	Remarks
D	NO	Change	Given	Change	–	–	Given	–	–	–
	〃	〃	〃	〃	–	–	〃	–	–	–
	〃	〃	〃	〃	–	–	〃	–	–	–
	Nil	–	–	–	–	–	–	–	–	
	Nil	–	–	–	–	–	–	–	–	
	Nil	–	–	–	–	–	–			

	Patient Condition	Peripheries	Any Bed Sore	Any Injury Mark	Any ADR	Any Blood Reaction (BTR)	Special Not...
MOR...	Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	–
EVEN...	Stable/ Unstable	Cold/ Warm	–	–	Yes / No	Yes / No	
NIGH...	Stable/ Unstable	Cold/ Warm			Yes / No	Yes / No	

RESTRAINT MONITORING CHART

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

Freq...ring :

Reas...

Dr's...

Para Monitoring :	10	12	2	4	6	8	10	12	2	4
L Ar...										
R Ar...										
L Le...										
R Le...										
Co... of Limb										
Ro... part										
Re... *24Hour										
Sp... N										

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

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NURSING CLINICAL ASSESSMENT NOTES

Name Sadiq

Age/sex 2y/m

CR No. 1487

Date of admission

Diagnosis:-

Date																													
Hospitalization Day																													
Post operative day																													
Spo2%	BP-mm of Hg	Temp.(°F)	Pulse/ Min	Resp/M in.	AM		PM		AM		PM		AM		PM		AM		PM		AM		PM		AM		PM		
●	∧	O	□	X	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10
	Systolic																																							
100	150	105	150	100																																				
98	140	104	140	90																																				
96	130	103	130	80																																				
94	120	102	120	70																																				
92	110	101	110	60																																				
90	100	100	100	50																																				
88	90	99 / 98.6	90	40																																				
86	80	98	80	30																																				
84	70	97	70	20																																				
82	60 Diastolic	96	60	10																																				
	V																																							
Date and time of cannula insertion																																							
Peripheries-Warm/Cold																																							
Patient Stable Y/N																																							
Risk of fall (Y/N)																																							
Restraint Assessed Y/N																																							
IV Cannula (patent & no swelling) Y/N																																							
Bed Sore (skin intact)Y/N																																							
Pain scoring (0,1,2,3,4,5)																																							
Staff Nurse's Signature																																							

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)

Patient name: Sadiq Age/Sex: 24/m CR no. 1487 Unit Date: 22/2/22

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 patient 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	Hand over taken by (name & signature
Morning (8am-2pm)	patient taking OG feed. Vitals checked & recorded. Due Medicine given. All Nsg care provided.	10am	[signature]	[signature]
Evening(2pm-8pm)	[illegible] shift. Vitals are checked & [illegible] All due medication given as per Dr order	8PM	[signature]	
Night (8pm-8am)	[illegible] at 9:10 [illegible]	9:10	[signature]	

CNBC-183

SADIA (11) 18/12/22 **INTAKE/OUTPUT CHART** [illegible] 12:50AM

Date &Time	IV Line -I	IV Line -II	RTA	RTF	URINE	STOOL	DRAIN	TREATMENT
12:30AM ↓ 2-AM 1 8AM	N.S [70] · [9c]	IC [illegible] Replace 12AM - 8AM (water load) Inj. Soda bicarb [illegible] 5d [illegible] over 20 min given at 5:30 am Inj. metoprolol 0.7 over 5 min	12:50AM - 8AM	NPO	1 time diapper Changed	0 time pass	Nil	DNS c KCl (70) [illegible] (glucose [illegible]) [illegible] IC [illegible] Replaced VI/UR 6 [illegible] c N/2 [illegible] OTHER → Maintain TPR → [illegible] → Knee [illegible] position → [illegible] monitor → O_2 [illegible]
Total								

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415

INTAKE OUTPUT CHART

17/2

Name:- Sadiq Age/Sex:- 2 h C.R.No.:- 1467 Diagnosis:- Left sided pleur... Ward/Unit:- Date of Admission:

Date | Intake | Output

Time | I/V Fluid | Amount | Oral/NGT | Amount | Time | Urine | Aspiration /Drainage | Vomitus | Stool | Orders/BT Notes

4am ↓ 10am: DNS (100 + 80)

10am | 4pm: (DNS 100 + 80)

Total I/V/Oral/NGT Intake

4pm ↓ 10pm: DNS (100 + 80)

Blood/Blood Components

Whole blood/Packed Cells/FFP | Amount

10pm to 4am: DNS (100 + 80)

4am to 10am: Grand Total Intake (100 + 80)

Output: 8am | 2pm to 8pm to 8am

Total Output

Orders/BT Notes:

* NPO / O2 by CPAP
* Chest physio, positioning exercise, Mother
* DNS with KCl (100) @ 18 ml x 6 hrly

T = 900

Signature of Doctor

Signature of Staff Nurses

J8 Version-3

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Affiliated to Delhi University
An Associates Hospital of Maulana Azad Medical College
Geeta Colony, Delhi-110031

SADIQ. NIC

DRUG / MEDICATION ADMINISTRATION SHEET

Patient Name - Sadiq   Age / Sex - 2y/M   Ward -   CR. No. - 1487   Medical Diagnosis-

Date & Time (Starting)	Drug Particulars (Name, Dose, Route, Frequency)	Date & Time (Stopping)	Date- [illegible] 12-6 AM	6-12 AM	12-6 PM	6-12 PM	Date- 12/12 12-6 AM	6-12 AM	12-6 PM	6-12 PM	Date- 12-6 AM	6-12 AM	12-6 PM	6-12 PM	Date- 12-6 AM	6-12 AM	12-6 PM	6-12 PM	Date- 12-6 AM	6-12 AM	12-6 PM	6-12 PM	Date- 12-6 AM	6-12 AM	12-6 PM	6-12 PM	Date- 12-6 AM	6-12 AM	12-6 PM	6-12 PM
Inj	Ceftriaxone (1000mg IV BD)		[illegible]			[illegible]		[illegible]		[illegible]																				
Inj	PCM 180mg SOS																													
Inj	Ketamin [illegible] stat					[illegible]																								
Inj	PCM [illegible]																													
Inj	Propofol [illegible] in [illegible] over 1 min. not available						[illegible]																							
Inj	NaCl [illegible] over 2 min																													

Mob. : 9821233869

JEEVAN CARE FOUNDATION

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

Reg No. 92

Ref. No. .....

Date 24-02-22

सेवा में,
श्री मान संस्थापक महोदय,
जीवन केयर फॉउन्डेशन,
मदनपुर खादर,

सर,
मेरा बच्चा साहिल जो की 2 साल का है मेरे बच्चे का ICD लगाया जाएगा पर्ची की बहुत मँहगा है। और हम इलाज करवाने में असमर्थ हैं।

कृप्या करके हमारे बच्चे के इलाज मे सहायता प्रदान करें।

आपका आभारी
ताहीर

JEEVAN CARE FOUNDATION
DELHI