

<b>Hospital Number</b>	202507070007	<b>IP Number</b>	11663
<b>Patient Name</b>	CHANDRIKASRI	<b>Age</b>	23
<b>Doctor</b>	DR.BHASKARAN	<b>Deperament (Unit)</b>	GENERAL SURGERY (1)
<b>Ward</b>	ICU	<b>Room</b>	ICU
<b>Assessment Date</b>	09-07-2025 03:32	<b>Assessment done by</b>	SUDARSHAN

## Nursing Assessment

Mode of Arrival

Wheel Chair

Transported With

Oxygen

Language

MARATHI

Next of Kin

Relation	Name	Mobile Number	Email
BROTHER	SAI	9878987898	sai@dalvkot.com

Vulnerability Details

**Vulnerability Type:** Physically Challenged

**Reason:** dwefrg

Reason for Hospitalization

fd

Past Medical History

cdsfg

History of allergies

xcvd

Pregnancy

fdsg

VITAL SIGNS

BP :	6 mmHg
Height :	6 Cm

Height :	0.2 F
Weight :	6.00 Kg
TempF :	43 F
TempC :	6 C
Pulse :	6 per min
BMI :	1614.59 Kg/m <sup>2</sup>
GRBS :	6 mg/dL
RR :	6 per min
SPO <sub>2</sub> :	6 %
	OTHERS: FSCS: hgfd

### ROS

#### REVIEW OF SYSTEMS: dsfgh

**General:** No weight change, generally healthy, no change in strength or exercise tolerance.

**Head:** No headaches, no vertigo, no injury.

**Eyes:** Normal vision, no diplopia, no tearing, no scotomata, no pain.

**Ears:** No change in hearing, no tinnitus, no bleeding, no vertigo.

**Nose:** No epistaxis, no coryza, no obstruction, no discharge.

**Mouth:** No dental difficulties, no gingival bleeding, no use of dentures.

**Neck:** No stiffness, no pain, no tenderness, no noted masses.

**Breast:** No noted lumps, no tenderness, no swelling, no nipple discharge.

**Chest:** No dyspnea, no wheezing, no hemoptysis, no cough.

**Heart:** No chest pains, no palpitations, no syncope, no orthopnea.

**Abdomen:** No change in appetite, no dysphagia, no abdominal pains, no bowel habit changes, no emesis, no melena.

**GU:** No urinary urgency, no dysuria, no change in nature of urine.

**Musculoskeletal:** No pain in muscles or joints, no limitation of range of motion, no paresthesias or numbness.

**Neurologic:** No weakness, no tremor, no seizures, no changes in mentation, no ataxia.

**Psychiatric:** No depressive symptoms, no changes in sleep habits, no changes in thought content.

**Ext:** no pain, no swelling, no pain.

### Glasgow Coma Scale

Eye Opening	Score	Motor Response	Score	Verbal Response	Score
<b>Spontaneously</b> ✓	4.00	Obeys Commands	6.00	Oriented and Converses	5.00
To Verbal Stimuli	3.00	Localizes Pain	5.00	Confused	4.00
To Pain	2.00	<b>Flexion Withdrawal</b> ✓	4.00	Inappropriate Words	3.00
No Response	1.00	Abnormal Flexion	3.00	<b>Incomprehensible Sound</b> ✓	2.00
Eyes Closed	0.00	Abnormal Extension	2.00	No response to pain	1.00
-	-	No Response	1.00	ET Tube/Tracheostomy	0.00
<b>Patient Score :</b>					<b>10</b>

### Pain Assessment

Surgery Details

-

Date-Time

2025-07-09  
15:29:00

Site Of

Pain  
kjhg

Intervention

kjhgf

Pain Scale

No Pain



### Skin Assessment

Bedsore present on admission

No

Mobility

Mobile

Bed Sore Present

Yes

S.No	Scores	4	3	2	1	Score
1	SENSORY PERCEPTION	✓ NO IMPAIRMENT				4
2	MOISTURE		✓ OCCASIONALLY MOIST			3
3	FRICTION & SHEAR		✓ NO APPARENT PROBLEM			3
4	ACTIVITY		✓ WALKS OCCASIONALLY			3
5	NUTRITION		✓ ADEQUATE			3
6	MOBILITY			✓ VERY LIMITED		2
<b>Total Score :</b>						<b>36</b>

### Plan Of Care

- Special Mattress - Alpha / Alpha Excell
- Reposition

- Skin inspection
- Promote Activity
- Educate patient and family
- Evaluate on change of condition
- Special Mattress - Alpha Excell / Nimbus
- Position change
- Manage individual Risk Factors

#### Corrective and Preventive Action (CAPA)

zDZfgfhg

#### Fall Risk Assessment

UR Number

876

SURNAME

kjhg

GIVEN NAMES

jh

DATE OF BIRTH

2025-07-09

### FALL RISK STATUS

S.No	RISK FACTOR	LEVEL	RISK SCORE
1	MEDICATIONS	✓ TAKING TWO	3
2	COGNITIVE STATUS	✓ AMTS 7-8	2
3	PSYCHOLOGICAL	✓ DOES NOT APPEAR TO HAVE ANY OF THESE	1
4	RECENT FALLS	✓ NONE IN LAST 12 MONTHS	2
<b>Low Risk</b>			<b>Total Score : 8</b>

#### RISK FACTOR CHECKLIST

Vision

Difficulty seeing objects

Mobility

Mobility status unknown

Transfers

Transfer status unknown

Behaviours

Observed or reported agitation

ADL's

Observed risk-taking behaviour

Environment

Difficulties with orientation to environment

Nutrition

Underweight

Contenance

Reported or known urgency

Other

kjhgfx

#### Nursing Care Plan

Sl No	Nursing Diagnosis	Plan of Care and Intervention	Evaluation
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l	lkjhv	ijhikjhb	
kjnb	kj	kj	kjn
kjn	kj	j	kjb