



1. Purpose

This Procedure is performed as a means of ensuring that a clinical record will be maintained to provide accurate, concise and up to date information reflecting the complete picture of all West Coast District Health Board (WCDHB) patients health status, treatment and progress from admission to discharge (whether as an inpatient or an outpatient).

2. Application/Responsibilities

This Procedure is to be followed by all WCDHB clinical staff members.

3. Definitions

For the purposes of this Procedure:

Clinical Documentation is taken to mean a process of recording and communicating a written rationale of intervention, and as such becomes an integral part of the patient medical record. It should include: comprehensive assessment, identified problems, expected outcomes, the plan of care and care delivered (or not delivered); advice sought in decision-making, and the patient's response to treatment, discharge and plans for ongoing care.

Clinical record is taken to mean a record reflecting the complete picture of the patients health status, treatment and progress from admission to discharge from which other health professionals can take over responsibility for the patient concerned and for the retrieval of data for research and management.

4. Responsibilities

For the purposes of this Procedure:

All Clinical Staff Members are responsible for

- documentation of clinical care given and ensuring that the standard of that documentation meets all legal, professional and WCDHB Policy and Procedure requirements;
- the timely completion of their documentation;
- contact their direct line manager. if they have concerns or problems/issues are encountered as to the standard of clinical documentation within a patient's clinical record.

5. Resources Required

This Procedure requires:

- i) clinical record

6. Process

1.00 Entries In The Clinical Record

1.01 An integrated clinical record is to be maintained for every patient. The clinical record is to be a multi-disciplinary document.

1.02 The person designated to coordinate the patient's care is to be identified.



- 1.03 The clinical record is to relate to the patient and is to be a continuous record of each problem for that episode of care.
- 1.04 The clinical record is to adhere to the requirements of the Code of Health and Disability Services Consumer Rights and the Health Information Privacy Code.
- 1.05 Each entry in the clinical record must clearly identify: date and time the entry is recorded, and time of event, printed name, signature and designation of the person making the entry. However, exceptions to this can occur but only in the following circumstances:
 - i) where only one health care professional is making entries into the record it is acceptable for that health care professional to print and sign their name and add designation once per page. All other entries on that page may be initialled.
 - ii) where Clinical Pathways are used health care professionals are to ensure names, designations and signatures are in the Signature Key on each page where an entry is made.
- 1.06 All entries into the clinical record must be made in permanent ink using a firm pressure and be legible.
- 1.07 The supervising registered nurse is to countersign entries in the clinical record made by an enrolled nurse/health service assistant entry.
- 1.08 Health service assistants can only make entries into clinical records following:
 - i) successful demonstration of competency in clinical documentation;
 - ii) detailed discussion with the supervising staff member on the shift.
- 1.09 Only approved abbreviations to be used by staff members when they are making entries into the clinical record. All health care professionals are not to use abbreviations that have not been approved or are in any way misleading or potentially misleading.
- 1.10 Illustrations for clinical purposes are acceptable and can be add to the clinical record.
- 1.11 Errors to the record should be indicated by clearly ruling a single line through the area and signing the section. If any entry is to be crossed out on behalf of the writer then the person crossing out the entry is to sign and then it is to be countersigned by the writer as soon as practicable.
- 1.12 Once an entry is made in the clinical record it must not be obliterated in any way. The use of an erasing agent (eg. Twink, liquid paper, special erasers) is prohibited.
- 1.13 Additions and or late entries to the clinical record should be written as a separate entry. They are not be squeezed in between entries.
- 1.14 Originals (where possible) of all reports are to be filed in the clinical record.
- 1.15 Each patient's clinical records is to be complete. This is to includes telephone conversations directly impacting on client/patient care. Where notes are held elsewhere this must be clearly identified in the front of the clinical record.



2.00 Documenting Consent

- 2.01 In most circumstances it is satisfactory for a written description in the individual's clinical record to include:
- i) that a discussion regarding the proposed service took place; and
 - ii) the information that was provided; and
 - iii) the decision of the individual, or of their representative (to consent or not consent).
- 2.02 Formal written and signed consent is only required by law in the following circumstances:
- i) Mental Health (Compulsory Assessment and Treatment) Act (1992) and Amendments
 - after first month of compulsory treatment; and
 - for electro-convulsive treatment (ECT); and
 - for brain surgery
 - ii) if the individual is to participate in research; and/or
 - iii) the procedure to be performed is experimental; and/or
 - iv) the individual will be under a general anaesthetic; and/or
 - v) where there is a significant risk of adverse effects to the individual. (see Part 10 – Guidelines).

3.00 Content Of The Clinical Record

- 3.01 Each clinical record is to contain a unique clinical record number or client/patient identifier, name in full, address, date of birth, sex, and person to contact in an emergency (in some circumstances this may not be necessary eg. in an outpatient record). The clients/patients name and the clinical record or reference number are included on each page of the record.
- 3.02 Each admission form is to signed and the clinical record is to contain the time, date and mode of admission, whether next of kin have been notified/are to be notified and a statement about the patients general condition.
- 3.03 An "alert" notation for conditions such as allergic responses, adverse drug reactions, and infection risks is to be prominently displayed in the record. (See Guidelines at the end of this document for further information)
- 3.04 A risk assessment is to be completed on all Mental Health Service (MHS) patients on entry to the MHS and as necessary. These are to be placed in the front of the clinical record. (see *WCDHB MHS Risk Assessment Procedure*)
- 3.05 For each entry of a patient into A WCDHB Service, there is to be a documented diagnosis made by a health professional. In the case of an in-patient admission, this diagnosis is to be made by a medical practitioner.
- 3.06 The clinical record is to contain a patient history pertinent to the condition being treated, including relevant details of present and past medical history, family history, and social considerations, documented using the WCDHB General Nursing History/Assessment Form.
- 3.07 A copy of the referral is to be maintained in the record. Acceptance or declination of the referral and re-referral to a more appropriate service is to be documented on the original referral in the record.



- 3.08 A copy of all referrals are to be maintained in the clinical record. Acceptance or declination of the referral and re-referral to a more appropriate service is to be documented on the original referral in the record by the health professional concerned.
- 3.09 For each admission or entry to the service there is to be a record of a current and pertinent clinical examination/assessment performed by a health professional in sufficient detail to permit continuing patient care to be provided in the absence of that health professional. (When a history and examination/assessment have been carried out and recorded prior to admission, these reports can be used in the clinical record by the health professional, provided that such reports are current and pertinent to that admission).
- 3.10 There is to be documented evidence that the patient or designated representative has either given consent or declined treatment, or that consent has not been obtained (*as per the requirements of the WCDHB Consent Procedure*).
- 3.11 Medication orders are to be entered on to the WCDHB Medication Chart (*as per the requirements of the WCDHB Medication Policy and Procedures*). Staff are to sign the sample signatures section in the front of the medication charts and also to add their practicing certificate number NOTE: WCDHB has two types of Medication Charts; one for short term admissions and one for long stay patients.
- 3.12 Blood transfusions are to be recorded using the WCDHB Blood Transfusion Record.
- 3.13 IV Fluids are to be prescribed, and details of IV Fluid administration are to be recorded using the WCDHB IV Fluid Prescription Chart.
- 3.14 Therapeutic orders and the ordering of special diagnostic tests are to be entered into the clinical record. Every diagnostic test result is to display the name of the staff member responsible for the request and all recipients of the report
- 3.15 All diagnostic test results are to be recorded in the clinical record. Every diagnostic test result is to be signed and dated by the patient's responsible clinician or delegate, prior to filing into the clinical record. Any abnormalities and actions taken to address these are to be recorded into the clinical record.
- 3.16 Invasive devices are to be noted when in place. (NOTE: Administration of IV Fluids requires double signing by two nurses)
- 3.17 The clinical record is to contain specific information relating to anaesthesia and peri-operative events, where the patient undergoes these.
- 3.18 Medical practitioners are to record the pre-operative diagnosis of a patient prior to surgery and to ensure that the operative report is written immediately after surgery. This report is to be adequate for clinical, medico-legal and evaluation purposes and should include:
- Time of return from theatre
 - Procedure performed
 - Type of anaesthetic
 - General statement of condition on return to the ward including;
 - conscious state, responsiveness



- blood pressure, pulse and temperature,
- respirations and oxygenation
- blood loss
- urine output
- pain status and analgesic modalities
- wound status
- therapies.

- 3.19 General Patient observations (where taken) such as temperature, pulse, respiration, O₂ sats, Pain Score, IV site check, heart rhythm, bowel motions, weight, BSL and urinalysis, are to be recorded on the WCDHB Patient Observation Chart along with the date and time that the observations are taken.
- 3.20 Health professionals are to record (in the patient's clinical record) all significant events/contacts, such as alteration in the client/patient's condition and responses to treatment and care and incorporate patient/family/whanau input document progress notes, observations, supporting documentation and consultation reports.
- 3.21 Nursing staff are to document patient care using WCDHB Clinical Pathways. WCDHB Clinical Pathways are available for a range of specific medical and surgical conditions. Where a specific Clinical Pathway is not available for the patient's condition, staff are to use the blank Clinical Pathway and customise for the patient's specific need.
- 3.22 Clinical Pathways are to be updated every shift (AM, PM and Night). In a "long stay" setting entries are required as conditions change or at least once every month.
- 3.23 Each WCDHB Clinical Pathway Form covers one 24-hour period of care. At the completion of each 24-hour period, a new WCDHB Clinical Pathway is to be started. Each completed WCDHB Clinical Pathway Form is to be file consecutively within the patient's clinical record.
- 3.24 WCDHB Clinical Pathways Forms cover most cares and treatments likely to be given to a patient. However where a specific care/treatment is given that requires a more detailed and specific plan, then this is to be documented on the relevant WCDHB Form e.g. wound treatments. An entry is to be made on the WCDHB Clinical Pathway Form indicating that this care/treatment is detailed on another WCDHB Form.
- 3.25 A summary for each admission is to be completed (by the relevant medical practitioner) at the time of discharge or death or as soon as the relevant information is available. It includes all relevant diagnoses and procedures to enable a classification to be assigned using a current revision of the International Classification of Diseases or another nationally recognises classification system.
- 3.26 A discharge summary (which may be an interim summary) or letter must accompany the patient returning to the care of the health professional or agency assuming responsibility for the care. A discharge letter is to be sent to the health professional or agency within 14 days of discharge. A legible copy is to remain in the patient's clinical record.



- 3.27 A transfer summary must accompany the patient if they are being transferred to another health or disability service agency/organisation. The transfer summary is to include the same information that would be contained in a discharge letter. A legible copy is to remain in the clinical record.
- 3.28 If the patient is being transferred between a WCDHB facility, a summary report is to be also completed at the time of transfer and include the intended ward/unit for transfer and if the relevant patient representative/next of kin have been informed. The summary should also include:
- State the relevant feelings/symptoms as expressed by the patient and their representative/next of kin;
 - Include when the patient was admitted - what has been done in the interim. Describe the patient's present physical and emotional condition. Mention any loss of function, disabilities or prosthesis and relevant observations;
 - Describe the patient's/family's understanding of the diagnosis and the reason for treatment/length of stay in the hospital;
 - A photocopy of the patient's medication chart.
- 3.29 A record of events, time of death and when the deceased was seen and certified by the responsible medical practitioner is to be made in the clinical record. Where a post-mortem is performed, the autopsy report is filed in the clinical record.
- 3.30 Regular audits will be undertaken of WCDHB Clinical Documentation to ensure that the requirements of this Procedure are being met. Where deficiencies are identified, the relevant Unit/Service/Ward Manager is responsible for ensuring that the deficiencies are rectified.

7. Precautions And Considerations

- ➔ An integrated clinical record is to be maintained for every patient. The clinical record is to be a multi-disciplinary
- ➔ The clinical record is to relate to the patient and is to be a continuous record of each problem for the episode of care
- ➔ All entries into the clinical record must be made in permanent ink using firm pressure and be legible

8. References

- MK Shaughnessy, CN Burnett, *Implementation of the Problem-Orientated Progress Note in the Skilled Nursing Facility*; Physical Therapy Volume 59/Number 2, February 1979, pages 161-167.
- G Peterson, *SOAP Revolution*; The Journal of PRACTICAL NURSING, September 1977, pages 32-35.
- The Royal Melbourne Hospital Documentation Policy 1997
- Hospital Regulations 1993
- Medicine Regulations 1984
- Hospital Act 1957



- Health and Disability Sector Standards (NZS 8134:2000)
- National Mental Health Standards (NZS8143:2001)
- Health Records Standard (NZS8153:2002)

9. Related Documents

WCDHB Collation Of Personal Health Information Procedure
WCDHB Medications Policy and Procedures
WCDHB MHS Management Of Mental Health One Clinical File Procedure
WCDHB Storage Of Personal Health Information Procedure

10. Guidelines

SOAPIE FORMAT

The SOAPIE format provides a way of recording information in a way that includes evidence or validation of our statements/assessments and is applied when writing progress. The format is as follows:

Problem number is indicated

Problem #

- S** = **Subjective Data**
Consists of verbal information from client/patient and significant others
- O** = **Objective Data**
Consists of information obtained about the client/patient through observation.
Includes non-verbal behaviour, laboratory data and physical signs.
- A** = **Assessment**
Is an analysis of the subject and objective data and includes:
1. Rationale for problems
 2. The effect of medication and interventions
 3. Progress in specific problems
 4. Prognosis/conclusion
- Px** = **Plan**
Within the framework laid down by the overall plan for this problem and including specific plans for collecting further information, treatment approaches, client/family education and referrals.
- I** = **Interventions**
Of the health worker, what was done for the client/patient.
- E** = **Evaluation**
Of all of the above information. Was it accurate? Did the plan and interventions have the desired effect?

(A narrative note can be used where information needs to be recorded but is not directly related to a current problem.)

The SOAPIE format complies with good record keeping principles as it:

- Demonstrates continuity of care
- Shows that care is evaluated
- Includes subjective and objective data
- Shows how the care was delivered
- Shows how the client/patient responded to that care
- Gives reasons for progress/lack of progress

**APPROVED ABBREVIATIONS AND DEFINITIONS**

#	Fracture
♀	Female
- ve	Negative
%	Percentage
↓	Decrease or down
↑	Increase, up, elevated
♂	Male
Chol	High Cholesterol
JACCOL	No jaundice, anaemia, clubbing, cyanosis, oedema, lymphadenopathy
/c	With
/c out	Without
?	Query
@	At
+ + +	plus, plus, plus
+ ve	Positive
0.9S	Normal Saline
°LKKS	No abnormality felt in liver, kidneys, kidney or spleen
1/12	One Month
1/14	Two weekly
1/52	One Week
1/7	One day
1:1	One to One
A, Ax, Assmt	Assessment
A&D Act	Alcohol and Drug Act 1966
A&E	Accident and Emergency
A/N	Ante Natal
AAA	Abdominal Aortic Aneurysm
AB, ABs, ABx	Antibiotics
Abdo	Abdominal
Abdo Pain	Abdominal pain
ABG	Arterial Blood Gas
ABI	Acquired Brain Injury
ac	Before Food
ACBT	Active Cycle Breathing Technique
ACC	Accident Compensation Commission
ACL	Anterior Cruciate Ligament
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
Adj	Adjustable
ADL	Activities of Daily Living
AF	Artificial Feeding
AFib	Atrial Fibrillation
AIDS	Acquired Immune Deficiency Syndrome
AKA	Above Knee Amputation
alt	Alternative
alt die	Alternate days
am	Morning



AMI	Acute Myocardial Infarction
AMPS	Assessment of Motor and Process Skills
APH	Anti Partum Haemorrhage
approx	Approximately
Appt	Appointment
AROM	Artificial Rupture of Membranes
Art	Arterial
asap	As soon as possible
asp	Aspiration
AT&R	Assessment, Treatment and Rehabilitation
AWOL	Absent without Leave
AXr	Abdominal xray
B/Bd	Bathboard
BF	Breakfast
B/F	Breast Feeding
Ba Enema	Barium Enema
Ba Swallow	Barium Swallow
BBA	Born Before Arrival
BCC	Basal Cell Carcinoma
bd, bid, bds	Twice daily
Bilat	Bilateral
BKA	Below Knee Amputation
Bkwd	Backward
BLS	Basic life support
BM	Bowel Motion
BNO	Bowels not open
BO	Bowels open
BOTMP	Bruininks-Oseretsky Test of Motor Proficiency
BP, B/P	Blood Pressure
Brady	Bradycardia
BS	Breath sounds
BS	Bowel sounds
BSL	Blood Sugar Level
BSU	Bag Specimen Urine
BW	Birth Weight
BWO	Bladder washout
Bx	Biopsy
C Xr	Chest Xray
c/-, c/o,	Complaining of
C/S	Caesarean Section
Ca	Cancer
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CAMHS	Child and Adolescent Mental Health Service Team
CAPE	Clifton Assessment Procedure for the Elderly
CASEIIR	Cognitive Assessment Scale for Elderly - revised version
CBC	Complete Blood Count
CCS	(formerly the Crippled Children Society)
CCT	Controlled Cord Traction
CCTO	Compulsory Community Treatment Order



CCU/ICU	Coronary/Intensive Care Unit
CE	Cardiac Enzymes
CF	Cystic Fibrosis
CHC	Coast Health Care
CHCH	Christchurch
CHE	Crown Health Enterprise
Chemo	Chemotherapy
CHF	Congestive Heart Failure
CIN	Carcinoma Insitu
CITO	Compulsory Inpatient Treatment Order
CM	Case Manager
CMH	Community Mental Health
CMHN	Community Mental Health Nurse
CNL	Care Needs Level Score
CNS	Central Nervous System
CNSp	Clinical Nurse Specialist
CO ₂	Carbon Dioxide
COC	Continuity of Care
Cont	Continuous
COPD	Chronic obstructive pulmonary disease
CORD/COAD	Chronic obstruction respiratory/airways disease
CP	Cerebral palsy
CPAP	Continuous Positive Airway Pressure
CPR	Cardio-Pulmonary Resuscitation
cr	Cream
CR	Controlled release
CSF	Cerebro-Spinal Fluid
CSSD	Central Sterilising And Supply Department
CSU	Catheter Specimen of urine
CT Scan	Computerised Tomography Scan
CTG	Cardiotocograph
CTO	Community Treatment Order
CVA	Cerebral Vascular Accident
CVC	Central Venous Catheter
CVL	Central venous line
CVP	Central Venous Pressure
CWMS	Colour, warmth, movement, sensation
CX	Cervix
CYPS/CYPFA	Children, Young Persons Service/ Children, Young Persons and Family Agency
D&C	Dilatation and Curettage
D&V	Diarrhoea and Vomiting
D/D	Dry Dressing
D+F	Diet and fluids
D4S	Dextrose 4% in Saline 0.18% (ie Barts)
D5W	Dexrose 5% in Water
DAO	Duly Authorised Officer
Dept	Department
Dev	Development
DHS	Dynamic Hip Screw



DIC	Disseminated Intravascular Coagulation
DIC	Drunk In Charge
DIL	Daughter in Law
DM	District Manager
DN	District Nurse
DNA	Did not Attend
DNC	Duty Nurse Coordinator
DOA	Dead on Arrival
DOB	Date of Birth
Dr	Doctor
Dtr	Daughter
DVT	Deep Vein Thrombosis
DW	Discussed with
E	Evaluation
ECG	Electrocardiograph
ECT	Electro-convulsive Therapy
ECV	External Cephalic Version
ED	Emergency Department
EDD	Estimated Date of Delivery
EDM	Early Diastolic Murmur
educ	Education
EEG	Electroencephalogram
EMS	Equipment Management Services
EMU	Early Morning Urine
EN	Enrolled Nurse
ENT	Ear, Nose, Throat
EP	Epilepsy
EPS	Extrapyramidal symptoms
Equip	Equipment
ER	Extended release
ERCP	Endoscopic Retrograde Cholangio-pancreagram
ESM	Ejection Systolic Murmur
ETA	Estimated Time of Arrival
EUA	Examination Under Anaesthetic
Exs	Exercises
Extn	Extension
FBC	Fluid Balance Chart
FET	Forced Expiration Techniques
FEV ₁	Forced expiratory volume in 1 second
FFD	Fixed Flexion Deformity
FFP	Fresh Frozen Plasma
FHH	Foetal Heart Heard
FHx	Family history
Fib	Fibula
FiO ₂	Fractional Index of Oxygen
FOB	Faecal occult blood
FOOSH	Falls over on outstretched hand
Freq	Frequency
Fri	Friday
Frwd	Forward



FTF	Fixed Toilet Frame
FU	Follow up
FVC	Forced vital capacity
FWB	Full Weight Bearing
g	Gram
GA	General Anaesthetic
GB	Guillian Barre
GBH	Grievous Bodily Harm
GCS	Glasgow Coma Scale
GI	Gastrointestinal
GIT	Gastro-intestinal Tract
GP	General Practitioner
GSR	Global Shoulder Replacement
GTN	Glyceryl Trinitrate
GTT	Glucose Tolerance Test
GUT	Genito-urinary Tract
gutt	Eyedrop
H	Husband
H/H	Home Help
H/Hd	Helping Hand
H ₂ O	Water
HAV	Hepatitis A Virus
Hb	Haemoglobin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HFA	Health Funding Authority
HHS	Health and Hospital Services
HI	Head Injury
HIV	Human Immunodeficiency Virus
HNPF	Has not passed flatus
HNPU	Has not passed urine
HOP	Hypertension of Pregnancy
Hosp	Hospital
HPC	History of presenting complaint
HPF	Has passed flatus
HPU	Has passed urine
HR	Heart rate
HS	Heart Sounds
ht	Height
Ht	Hypertension
HV	Home Visit
HVS	High Vaginal Swab
Hx	History
I	Intervention
I/MW	Independent Midwife
ICN	Infection Control Nurse
ICP	Intra-cranial Pressure
Id	Identity
ID	Intellectual Disability
IDC	Indwelling Catheter



IDDM	Insulin Dependent Diabetes Mellitus
Ig	Immunoglobulin
IHC	Services for people with intellectual disabilities
IHD	Ischaemic Heart Disease
Im or im	Intramuscular
IMI or imi	Intramuscular injection
Imp	Impression
In Situ	In place
Indep	Independent
Inf	Informal (Patient)
inf	Inferior
inf	Infusion
info	Information
inh	Inhaler
inj	Injection
Int	Intermittent
IOL	Induction of Labour
IP	Intra Partum
IPP	Individual Programme Plan
IRQ	Inner range quads
Iso	Isolation
ISQ	In status quo
IUD	Intra Uterine Device
IUD	Intra Uterine Death
IUGR	Intra Uterine Growth Retardation
IV	Intravenous
IVI	Intravenous Infusion
IVU	Intravenous Urogram
Ix	Investigations
Jt	Joint
JVP	Jugular Venous Pressure
L	Litre
L),Lt, L	Left
L/T	Long Term
LA	Local Anaesthetic
Lab	Laboratory
Lat	Lateral
LAVH	Laparoscopically assisted vaginal hysterectomy
LCL	Lateral Collateral Ligament
LD	Learning Disability
LFT	Liver function tests
lg	large
LIF	Left iliac fossa
LL	Lower Limb
LL	Lower lobe
LLETZ	Large Loop Excision Transverse Zone
LM	Laryngeal Mask
LMC	Lead Maternity Care Giver
LMP	Last Menstrual Period
LOA	Left Occipito Anterior



LOC	Level of consciousness
LOP	Left Occipito Posterior
LOS	Length of Stay
LOT	Left Occipito Transverse
LP	Lumber Puncture
LRTI	Lower Respiratory Tract Infection
Lt. IH	Left Inguinal Hernia
LUSCS	Lower Uterine Segment Caesarean Section
LVF	Left Ventricular Failure
MABC	Movement Assessment Battery for Children
Mane	Morning, 0800 hours
MBA	Motor Bike Accident
mcg	microgram
MCL	Medial Collateral Ligament
MCL	Mid Clavicular Line
MD	Muscular Dystrophy
MDM	Mid Diastolic Murmur
MDT	Multidisciplinary Team
Mec Liq	Meconious Liquor
meds	medication
Met Ca	Metastatic Cancer
mg	Milligram
MH(CAT) Act	Mental Health (Compuls. Assessment & Treatment) Act 1992
MHS	Malignant Hyperthermia Syndrome
MigoGAS	Nitrous Oxide
mixt	Mixture
ml	Millilitre/s
MM	Malignant Melanoma
mmHg	Millilitres of mercury
MMHW	Maori Mental Health Worker
MND	Motor Neurone Disease
MO	Medical Officer
Mod	Moderate
Mon	Monday
MOW	Meals on Wheels
MPSO	Medical Practitioner Supply Order
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphlococcus Aureus
MS	Multiple Sclerosis
MSQ	Mental Score Quotient
MSU	Mid-stream Urine
MVA	Motor Vehicle Accident
n&m	At night and in the morning
n/a, na	Not Applicable
NAD	No Abnormality detected
NAI	Non-accidental Injury
NB	Nota Bene
NB	New Born
NBM	Nil by Mouth
ND	Normal Delivery



neb	nebuliser
NFO	No Further Orders
NFR	Not for Resuscitation
NG	Naso-gastric
NGT	Naso-gastric Tube
NIDDM	Non-insulin Dependent Diabetes Mellitus
NKDA	No known drug allergies
NNU	Neo-Natal Unit
Nocte	Through the night, at night
NOF	Neck of Femur
NOH	Neck of Humerus
NOK	Next of Kin
NPO	Nil Per Os
NPU	Not Passed urine
NWB	Non-weight Bearing
NZDRC	New Zealand Disabilities Resource Centre
NZISS	New Zealand Income Support Service
O	absent
O	Objective
O/A	On Arrival
O/L	On Leave
o/n/l	over night leave
O ₂	Oxygen
OA	Osteo Arthritis
Obs	Observations
oc	Eye ointment
OD	Overdose
od	Once daily
OE	On Examination
Op	Operation
OPD	Outpatients Department
OR	Operating Room
ORIF	Open Reduction Internal Fixation
OSH	Occupational Safety and Health
°SOB	No shortness of breath
OT	Occupational Therapy/Therapist
OTA	Occupational Therapy Assistant
P	Pulse
PAC	Pressure Area Care
PACU	Post Anaesthetic Care Unit
PAst.	Psychiatric Assistant
Path	Pathology
PAX	Per Axilla
pc	After Food
PC	Present Condition/Complaint
PCA	Patient Controlled Anaesthesia
PCL	Posterior Cruciate Ligament
PCV	Packed Cell Volume
PD	Provisional Diagnosis
PE	Pulmonary Embolus



PEARL	Pupils equal and reacting to light
PEEP	Positive End Expiratory Pressure
PEFR	Peak expiratory flow rate
PES	Psychiatric Emergency Services
pess	Pessary
PHN	Public Health Nurse
PID	Pelvic Inflammatory Disease
PKU	Phenylketonuria
PL	Peripheral line
plat	Platelets
pm	Afternoon
PMHx	Past medical history
PN	Practice Nurse
Pn	Percussion
po	Per Oral
POP	Plaster of Paris
POP	Persistent Occipito Posterior
Post	Posterior
Post op	Post operative/ly
PP	Post Partum
PPH	Post Partum Haemorrhage
pr	Per Rectum
PR	Pulse Rate
Pre Op	Pre operatively
Prem	Premature
Premed	Premedication
PRN, prn	When required
PROM	Premature Rupture Of Membranes
Prox	Proximal
PSC	Patient Services Coordinator
PSM	Pan Systolic Murmur
PT	Physiotherapist
Pt	Patient
PTA	Physiotherapist Assistant
PU	Passed Urine
PUD	Peptic ulcer disease
PUO	Pyrexia of Unknown Origin
PV	Per Vagina
PVD	Peripheral Vascular Disease
PWB	Partial Weight Bearing
Px	Plan
Q6H	6 hourly
Q8H	8 hourly
qid	4x daily
qqh or q4h	Every 4 hours
R	Respirations
R), Rt, R	Right
RA	Rheumatoid Arthritis
RBC	Red Blood Count
ref	Referral



Rehab	Rehabilitation
Resps	Respirations
Rh	Rhesus Factor
RhF	Rheumatic Fever
RICP	Raised Intra-cranial Pressure
RIF	Right iliac fossa
RM	Registered Midwife
RMO	Resident Medical Officer
RN	Registered Nurse
RNS	Rural Nurse Specialist
ROA	Right Occipito Anterior
roc	Removal of clips
ROM	Range of Movements
RON	Registered Obstetric Nurse
ROP	Removal of Plaster
ROP	Right Occipito Posterior
ROS	Removal of Sutures
ROS	Review of Surgery
ROT	Right Occipito Transverse
RPN	Registered Psychiatric Nurse
RPOC	Retained Products of Conception
rpt	Repeat
RR	Respiratory Rate
RS	Respiratory System
Rt IH	Right Inguinal Hernia
RTA	Road Traffic Accident
RTS	Raised Toilet Seat
RTW	Return to ward
S	Subjective
S<	Speech and Language Therapist
S/B	Seen by
S/T	Short Term
S1+S2+o	Dual Heart Sounds
SABO	Sub-acute bowel obstruction
SAD	Sub-acromial Decompression
SAH	Subarachnoid Haemorrhage
SaO ₂	Oxygen Saturation of Arterial Blood
Sat	Saturday
SBO	Small bowel obstruction
SCC	Squamous Cell Carcinoma
SCO	Subcapsular Orchidectomy
SES	Special Education Services
ShS	Shower stool
SHx	Social History
SIDS	Sudden Infant Death Syndrome
SIL	Son in Law
SIMV	Synchronised Intermittent Mandatory Ventilation
SIP	Special Interest Person
sl	Sublingual
SLR	Straight leg raise



sm	small
SN	Staff Nurse
SNAF	Support Needs Assessment Form
SOB	Short of Breath
SOBAR	Shortness of Breath at Rest
SOBOE	Shortness of Breath on Exertion
SOL	Space occupying lesion
SOS	If necessary
SPC	Supra-pubic Catheter
SPE	Serum Protein Electrophoresis
Spec	Specimen
SpO ₂	Pulse Oxygen Saturation
SQ	Static Quads
SR	Sinus Rhythm
SR	Systems Review
SR	Slow or sustained release
SROM	Spontaneous Rupture of Membranes
SSG	Split Skin Graft
SSS	Sick Sinus Syndrome
stat	Immediately
STD	Sexually Transmitted Disease
sub cut	Subcutaneous
Sun	Sunday
Sup	Superior
supp	Suppository
susp	Suspension
SVD	Spontaneous Vaginal Delivery
SVT	Supra-ventricular Tachycardia
SW	Social Worker
SWO	Stomach Washout
syr	Syrup
T&P	Temperature and Pulse
T.P.P.	Time, Person, Place
TPR	Temperature, Pulse, Respirations
TAH	Total Abdominal Hysterectomy
TB	Tuberculosis
TCA	To come again
TCB	To come back
TCI	To come in
td, tid, tds,	Three times daily
TED	Thrombo-embolitic Deterrent (anti-emboli stocking)
temp	Temperature
THR/THJR	Total Hip Replacement/ Total Hip Joint Replacement
Thurs	Thursday
TIA	Transient Ischaemic Attack
Tib	Tibia
TKR/TKJR	Total Knee Replacement/ Total Knee Joint Replacement
TKVO	To keep vein open
TL	Team Leader
TOP	Termination of Pregnancy



top	Topical
TPN	Total Parental Nutrition
TPR	Temperature, Pulse, Respirations
TSR	Total Shoulder replacement
Tues	Tuesday
TURP	Trans Urethral Resection Prostate
TVPS	Test of visual & perceptual Skills
TWB	Touch Weight Bearing
TWOC	Trial without catheter
Tx	Treatment
U&E	Urea and Electrolytes
U/S	Ultra Sound
UL	Upper Limb
UM	Unit Manager
Ung	Ointment
UNM	Unit Nurse Manager
URTI	Upper Respiratory Tract Infection
UTI	Urinary Tract Infection
UWSD	Under Water Seal Drain
vag	Vaginal
VF	Ventricular Fibrillation
VMI	Developmental test for Visual-Motor Integration
Vol. Cont	Volume Control
VSD	Ventricular Septal Defect
VT	Ventricular Tachycardia
VV's	Varicose Veins
W	Wife
w/c	wheelchair
w/e	Weekend
WBC	White Blood Count
WCC	White cell count
WCDHB	West Coast District Health Board
WDFE	Womens Division of Federated Farmers
Wed	Wednesday
WINZ	Work and Income, New Zealand
WNL	Within normal limits
Wt	Weight
XM	Cross match



MEDICAL ALERTS / ALLERGIES

On many patient registration forms patients note alerts or allergies to various items. These might range from specific names of drugs to medical conditions. There is the ability to put warnings into the national database which is accessed by all New Zealand health care facilities and it is important that we try and ensure that information that is put into that database is verified as correct.

We would therefore request that you review with each patient the true nature of the “allergy” and establish:

- Is it a true allergy.
- Is it a drug intolerance.
- Is it a drug side effect.

It is very important to establish the difference between these things.

Allergy:

An acquired potential for developing an adverse reaction that is immunologically mediated. Allergy and hypersensitivity are often used interchangeably.

*This is a **true hypersensitivity response** - an enhanced immunologic reaction with potentially life-threatening implications.*

True allergy to drugs accounts for 6-10% of all adverse drug effects. There are a number of specific characteristics that are generally helpful in distinguishing drug allergy from other adverse drug reactions, such as:

- Previous treatment without adverse event
- Occurs in only a small fraction of patients
- Symptoms can be reproduced by a very small dose of drugs
- Onset is usually after several days but within several months of initial administration of the drug
- Subsides within several days to weeks following discontinuation of the drug.
- Differs from any known pharmacologic manifestation
- Can mimic other known allergic reaction including anaphylaxis and serum sickness
- Definitively established only by special skin testing units such as in Christchurch Hospital

**Pseudoallergic Reactions**

Allergic-like side effects can be produced directly by certain drugs in the absence of any evidence of hypersensitivity. In contrast to true allergic reactions, these occur promptly the first time the drug is taken, if the dose is sufficiently high, appear only when the dose is increased. There are drugs that directly release histamine from mast cells. These histamine releasers produce reactions that are similar to anaphylaxis. Since they are not immunologically mediated they are referred to as anaphylactoid reactions.

Examples of histamine releasing drugs:

- Opiates
- Vancomycin
- Polymyxins
- Radiograph contrast Media

Intolerance:

The condition in which a drug produces its expected toxic side effects at an unusually low dose. About 90% of adverse reactions to drugs fall into the intolerance group.

The incidence is actually quite small. Antibiotics are the most commonly implicated, along with latex and opioids. A drug intolerance is an adverse effect from a drug, such as stomach irritation caused by taking aspirin. Common drug intolerances include drowsiness and stomach upset. If the patient has a drug intolerance, the drug may be able to be continued by taking the dose with food or at bedtime, or by lowering the dose. Sometimes drug intolerances simply disappear as drug therapy continues.

Side Effect:

An often undesirable effect that occurs in association with the use of a particular medication.

Examples of common drug side effects include: nausea, vomiting, sedation, dizziness, headache and weakness. Drug side effects that occur in 1% or more, of patients taking a particular medication are considered to be causally related to the use of that medication.

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