Audit Ref: 124/97-8 (Int)

AUDIT OF PATIENT RECORDS

Authors:

Lesley Humphrey — Quality Manager
Portsmouth HealthCare Trust
St James' Hospital
Locksway Road
Portsmouth
Hants PO4 8LD

Jocelyn Franey — Clinical Auditor
Clinical Audit Department
Portsmouth HealthCare Trust

December 1997 - July 1998

CONTENTS

SUMMARY

Patient record keeping is an essential part of clinical care. The standards for the audit were drawn from the requirement of the Clinical Negligence Scheme for Trusts (CNST) and the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC). Data were collected from three different patient specialties, 10 patients from each, discharged during September 1997.

The results confirmed anecdotal suggestions that action was needed to address some key problems:

- Filing and storage of records.
- Identification of author, date, time etc.
- Making changes to records made.
- Use of abbreviations.

Two existing projects will influence achievement against the action plan; the introduction of new record folders and development of a trust wide policy on record keeping. The Risk Management Group and the Medical Records Review Group will take the lead on the action plan, charging individual professions and departments with responsibility for ensuring change.

INTRODUCTION

Information about patients and their care is recorded in patient records or 'casenotes' and therefore making and maintaining accurate records constitutes a fundamental part of quality patient care within the health service. Such records should provide accurate, current, comprehensive information concerning the condition of the patient, together with evidence of any care or interventions given by professional practitioners (UKCC 1993). The resulting records are complex documents containing many separate pieces of information (Audit Commission 1995).

To ensure that patient care is effectively chronicled, entries in patient records should be legible, clear and unambiguous and the author identifiable (UKCC 1993, Audit Commission 1995). Records should be stored to minimise loss, with a clear order of organisation within each set of records (Audit Commission 1995).

The consequences of poor record keeping can be far-reaching and include possible compromise to patient care, inadequate protection against negligence claims and poor statistical information with ramifications for planning, management, funding and research (Audit Commission 1995).

Many authorities, such as the Audit Commission, the General Medical Council (GMC), UKCC and the CNST have issued guidance towards the optimum maintenance of patient records. The UKCC updated their guidelines at the end of 1998. This audit and the action plan remain congruent with the most recent guidelines.

METHODOLOGY

Standards

Standards were derived from guidance issued by the CNST (1995), UKCC (1993) and local guidelines for medical staff, in collaboration with the Medical Records Manager and the management of the specialities to be audited.

Sample

The sample was drawn from patients discharged during September 1997 from wards of three specialities - Adult Mental Health (AMH), Elderly Mental Health (EMH) and Medicine for Elderly People (EM).

The sampling strategy used involved tracing the notes of patients discharged in chronological order through September until the notes of 10 patients in each speciality had been located. It is acknowledged that this method of sampling was not random and had ramifications for the results of standard 1. However, following the pilot study (see below), it became apparent that this method should be employed to ensure a minimum of 10 patient records in each speciality were analysed. Thus the sample comprised 30 patient records, containing 1971 entries by nursing and medical staff.

It is not possible within this audit to comment on the variations of ease of locating casenotes because of the great differences in records' management between each speciality.

Data Collection

Data were collected by detailed analysis of the patient casenotes using the audit tool (appendix 1) and data collection form as shown in appendix 2. Some methods of analysis, such as determining the identification of authors, legibility of entries in patient records, and the use of ambiguous statements for example, were therefore subjective. However, all data were collected by the same clinical auditor who was aware of this problem and attempted to adopt an objective stance throughout. When examining the notes, the term 'readily' was defined as 'on first reading' (see standards 4 and 5).

Apart from standard 1, which was applied to the entire casenotes, data were collected from the last in-patient episode.

Data for standard 1a were collected by removing the casenotes from the outer folder and noting which documents, if any, became detached from the records when inverted.

Data for standards 6 - 10 were collected from the last in-patient episode. If this episode lasted one month or less, all entries were analysed. If the last in-patient lasted over one month, then all entries for the last calendar month of the episode were included in the audit.

Pilot study

A pilot study was performed on the casenotes of 10 patients, of which only 6 sets of records could be found. This resulted in the modification of sampling strategy to ensure a minimum number of records were examined. Other modifications of data collection following the pilot study included the collection of more detailed data, for example whether entries were fully or partially dated.

Acknowledgement

The authors would like to thank all medical records staff, especially those at Central Team, Adult Mental Health Services, for their help.

RESULTS

Standard 1: *a)* *Records are bound and stored so that loss of documents is minimised*

b) *All documents/papers are filed in appropriate sections of the folder.*

Expected Standard: 100%

Exceptions: nil

Results: a) **50%** (15/30)
b) **57%** (17/30)

Discussion

Data were collected as described on page 4. Data for this standard were derived from the entire patient records, rather than the last in-patient episode.

The results were distributed as follows;

Speciality	Records bound/stored to minimise loss	All documents/papers filed in appropriate sections
AMH	7	8
EMH	5	5
EM	3	4
Total	**15**	**17**

Loose paper items are fully detailed in appendix 3, and included nursing notes, prescription and observation sheets. The majority of documents incorrectly filed were the loose papers as detailed above.

Action Plan

The new record folders currently being developed/introduced in all areas will help future achievement against this standard. The new folders are being generated for all new patients and for existing patients with new episodes, it will however take years before the new system is in place for all records.

- Standards for approved system of filing and filing responsibilities will be developed by the Medical Users' Group and incorporated into the Trust-wide generic policy on Record Keeping. (See results synopsis for further detail).

Standard 2: *Investigations and machine-produced recordings are ;*
a) securely stored and
b) securely mounted.

Expected Standard: 100%

Exceptions: nil

Results: Investigations securely stored = **84%** (21/25)
Investigations securely mounted = **64%** (16/25)

Machine-produced recordings securely stored = **92%** (12/13)
Machine-produced recordings securely mounted = **85%** (11/13)

Discussion

25 sets of casenotes contained investigation results, whilst 13 sets contained machine-produced recordings for the salient in-patient episode.

The results were as follows:

Speciality	Investigations securely stored	Investigations securely mounted	Machine recordings securely stored	Machine recordings securely mounted
AMH	5/6	0/6	n/a	n/a
EMH	7/9	7/9	2/3	1/3
EM	9/10	9/10	10/10	10/10
Totals	**21/25**	**16/25**	**12/13**	**11/13**

Some investigation results were securely stored within the casenotes without being mounted on the appropriate page. Methods of doing this included threading results onto the treasury tags running through the records and stapling results to pages within the casenotes.

Additional Information
The Department of Medicine for Elderly People requested information on the inclusion within patient records of X-Ray reports. These results are given in appendix 4.

Action Plan

As for Standard 1.

Standard 3: *Nursing, medical and other records are filed together when patients are discharged.*

Expected Standard: 100%

Exceptions: nil

Results: **100%**

Discussion

All records included medical and nursing notes and care plans together with other documentation from professionals such as Occupational Therapists, within the same folder. However, it is acknowledged that the format of this audit would not have highlighted any omissions should other notes have been generated and then lost from the casenotes.

Action Plan

Although audited performance was 100%, there is no guarantee that all appropriate records were filed together.

- The Trust-wide policy on Record Keeping to include the requirement that all records (nursing/medical/therapy etc.) to be appropriately filed in the case notes folder on patient's discharge, before the notes leave the ward. (See results synopsis for further detail.)

Standard 4: *Patient's diagnosis is readily available in the medical records.*

Expected Standard: 100%

Exceptions: nil

Result: **100%**

Discussion

In all records examined, the patient's diagnosis regarding the salient in-patient episode was identified on first reading of the casenotes.

Action Plan

- The following revision of this standard to be incorporated into Trust-wide policy on Record Keeping, "Patient's current medical/psychiatric etc. diagnosis is readily available in medical records". (See results synopsis for further detail.)

Standard 5: *Any operation and/or key procedures are readily identifiable in the medical records.*

Expected Standard: 100%

Exceptions: nil

Results: Operation notes readily identifiable = **67%** (2/3)
Key procedures readily identifiable = **58%** (7/12)

Discussion

The remaining 6 notes regarding operation or key procedure were identified with difficulty, that is the auditor had to read through the notes for the in-patient episode more than once to identify them.

A list of key procedures identified as identified by the clinical auditor is given in appendix 5.

The results were distributed as follows;

	AMH	EMH	EM
Op notes readily identified	-	1	1
Op notes identified with difficulty	-	-	1
Op notes not applicable	10	9	8
Total	**10**	**10**	**10**
Key procedure notes readily identified	2	2	3*
Key procedure notes identified with difficulty	-	-	5*
Key procedure notes not applicable	8	8	5*
Total	**10**	**10**	**13** *(8 procedures in 5 patients)

Action Plan

Very few operation notes are within our control, most operations and invasive procedures are performed by PHT staff.

- Lesley Humphrey will initiate discussions with PHT to ascertain whether their Record Keeping policy contains reference to identification of key procedures in patient records.

- Trust policy on Record Keeping to specify that key procedures carried out by PHCT staff are to be clearly stated; examples will be given following consultation with individual services. (See results synopsis for further detail).

Standard 6: *Each entry in patient records is:*
a) dated
b) timed
c) signed.

Expected standard: 100%

Exceptions: nil

Results:
a) dated = **70%** (1378/1971)
b) timed = **15%** (287/1971)
c) signed = **98%** (1922/1971)

Discussion

The full date was given in 66% of entries in the notes, with 4% of entries giving some of the date (usually day and month, with year omitted).

Although the majority of entries were not timed, many of those written by nursing staff were preceded by terms such as 'am' or 'nocte'.

Authors' signatures or initials were given as follows:

	No. of entries (n=1971)
Full signature given	89% (1757)
Initials of author - no explanation of identity	8% (161)
Initials of author - with some explanation of identity (e.g. 'SHO')	0.5% (4)
No initials or signature given	2.5% (49)

A full illustration of results, which demonstrates both medical and nursing staff entries is given in appendix 6.

Action Plan

- Trust-wide policy on Record Keeping to specify requirements for recording date (dd/mm/yy), time (24 hour clock), and full signature (with initials and surname printed underneath). (See results synopsis for further detail.)

Standard 7: *Authors of entries in patient records are:*

a) clearly & easily identifiable
b) appear on the register for the speciality.

Expected standard: 100%

Exceptions: nil

Results: a) **38%** (728/1922)
b) **51%** (805/1568)

Discussion

The results were calculated using the 1922 entries which gave some indication of identification of the author, i.e. a signature or initials.

A register of signatures was not available for one area of one speciality, therefore the sample for standard 7b was 1568.

The identification of author was difficult and subjective as some signatures which the auditor perceived as legible, may in fact have been incorrectly read. Other difficulties included signatures in the speciality register differing from those used in the notes. For example, one specimen signature in a register gave full first and surnames, whilst in the notes initials only and surname were given, resulting in quite a different signature.

The results were distributed as follows;

	Number of entries signed/initialled	Author identifiable*	Author in speciality register*
AMH: Nursing Staff	393	256 (65%)	266 (68%)
Medical Staff	74	8 (11%)	13 (18%)
EMH: Nursing Staff	683	261 (38%)	229 (34%)
Medical Staff	84	19 (23%)	0 (0%)
EM: Nursing Staff	543	167 (31%)	297 (55%)
Medical Staff	145	17 (12%)	0 (0%)
Totals	**1922**	**728**	**805**

* These data should be regarded as individual entities and cannot be compared. This is because some authors made several entries in the casenotes.

Several authors gave bleep numbers as identification, however the switchboard operators do not keep retrospective records of bleep holders. Additionally some authors printed their names after their signatures, however not all of these were legible.

Action Plan

The aim is for easy and clear identification of author and the current system is clearly failing

- Trust-wide policy on Record Keeping to specify requirement for surname to be printed under each signature. (See results synopsis for further detail.)

- A universal signature identification sheet, to be attached to each set of records, to be designed by Mandy Leaman and Lesley Humphrey. Each member of staff will be required to enter their details on this sheet, the first time they write in the notes. The departmental signature books will be withdrawn once this new system is fully operational. (See results synopsis for further detail).

Standard 8: *All entries in patient records are clearly written in black ink.*

Expected standard: 100%

Exceptions: nil

Result: **88%** (1742/1921)

Discussion

Mediums other than black ink which were used included blue and green inks and carbon copy.

The results were distributed as follows;

	No. of entries	No. written in black ink
AMH: Nursing	397	364 (92%)
Medical	77	62 (81%)
EMH: Nursing	698	591 (85%)
Medical	92	78 (85%
EM: Nursing	552	547 (99%)
Medical	155	100 (65%)
Totals	**1971**	**1742**

Action Plan

- Trust-wide policy on Record Keeping will include this standard. (See results synopsis for further detail.)

Standard 9: *Alterations in patient records are made by scoring out with a single line and are:*

a) initialled
b) dated
c) timed.

Expected standard: 100%

Exceptions: nil

Results: Scored out with a single line = **33%**
a) initialled/signed = **15%**
b) dated = **0%**
c) timed = **0%**

Discussion

The results were distributed as follows;

	Alterations	Scored with single line	Initialled/ signed	Dated	Timed
AMH: Nursing	6	2	1	0	0
Medical	2	0	0	0	0
EMH: Nursing	10	3	2	0	0
Medical	2	1	1	0	0
EM: Nursing	12	6	1	0	0
Medical	8	1	1	0	0
Totals	40	13 (33%)	6 (15%)	0 (0%)	0 (0%)

Although several alterations occurred in the middle of an entry in the casenotes and therefore were presumably done by the author of the entry, other alterations included the date being changed, which may not have been done by the author.

Some alterations remained legible despite being scribbled through by more than one line.

Action Plan

- Trust-wide policy on Record Keeping will include this standard. (See results synopsis for further detail.)

Standard 10: *Entries in patient records do not contain:*

a) ambiguous abbreviations
b) meaningless phrases or
c) offensive or subjective statements.

Expected standard: 100%

Exceptions: nil

Results: a) not audited - see discussion below
b}
c} see discussion

Discussion

Lists of acceptable abbreviations for use were requested from each speciality but were unavailable at the time of writing. A list of all abbreviations found in the audit is given in appendix 7.

The use of meaningless phrases and offensive or subjective phrases was investigated, but it became apparent that analysis was not possible due to subjectivity. Some phrases which might be considered to be meaningless or subjective are given in appendices 8 and 9 respectively. No offensive statements were found in the audit.

Action Plan

- Trust-wide policy on Record Keeping will advise staff to keep to the facts, avoiding meaningless phrases and offensive or subjective statements.
- The policy will also contain a new standard on the use of abbreviations:
  "The use of abbreviations should be kept to a minimum and refer only to clinical diagnostic issues, as generally recognised within the specialty".

(See results synopsis for further detail.)

CONCLUSION

Record keeping may well be the most important clinical governance issue, outside of hands-on clinical care. The audit shows a clear need for action in many areas, especially in changing the habits of individual practitioners. The new record folders currently being developed/introduced in all areas will meet the requirements for document storage, but only if there is compliance with the associated standards. It will take years for the new system to be in place for all records, so the new standards for filing of records must be incorporated into our existing systems.

The Medical Records User Group is already developing standards for filing of records. Mandy Leaman is facilitating the work of a small group who are currently developing a generic Trust wide policy on Record Keeping. These two groups, linking together, will be driving much of the action plan.

Policy alone will not change practice. The two working groups will advise the Medical Records Review Group and the Risk Management Group on how the policy should be implemented. Clinical staff must embrace their responsibilities with regard to the written content of patient records, whilst records and administrative staff must ensure that all material is appropriately filed. Individual professional groups will ultimately be charged with ensuring that change happens.

Success of the project depends on more than achievement against the individual standards. The results synopsis reflects the need for broader action.

Audit Title: Audit of Patient Records

Audit Ref: 124/97-8

PORTSMOUTH HealthCare NHS TRUST

Audit Leader:

Contract Lead Group: Management/Quality

RESULTS SYNOPSIS

No	STANDARD	Target	Result	ACTIONS	Responsibility	Completion Date	Risk
1	a) Records are bound and stored so that loss of documents is minimised b) All documents/papers are filed in appropriate sections of the folder	100% 100%	50% 57%	1. Medical User's Group will develop standards for approved system of filing and filing responsibilities 2. Filing standards incorporated into Trust-wide policy on Record Keeping.	Barbara Hall Mandy Leaman/Barbara Hall	End Oct '98 End Dec '98	
2	Investigations (I) and machine-produced recordings (II) are: a) securely stored and b) securely mounted	100% 100%	I a) 84% b) 64% II a) 92% b) 85%	3. Trust-wide Policy on Record Keeping to include the following standards/requirements: • All records(nursing/medical/therapy etc.) to be appropriately filed in the case notes folder on discharge before the notes leave the ward • Patient's current medical/psychiatric etc. diagnosis is readily available in medical records. • Key procedures carried out are to be clearly stated (following further discussion between individual services and PHT). • Practitioners writing in a patient's records for the first time should complete the signature identification sheet. • Details to be recorded in the casenotes as specified - date (dd/mm/yy), time (24 hour clock) and a full signature (with surname printed underneath). • Initials and surname to be printed under each signature • All entries to be written in black ink • Alterations in patient's records are made by scoring out with a single line and are: initialled, dated, timed.	Mandy Leaman	End Dec '98	
3	Nursing, medical and other records are filed together when patients are discharged.	100%	100%				
4	Patient's diagnosis is readily available in the medical records.	100%	100%				
5	Any operation and/or key procedures are readily identifiable in the medical records.	100%	Operation 67% Key 58%				

6	Each entry in patient records is: a) dated b) timed c) signed	 100% 100% 100%	 70% 15% 98%	• Keep to the facts, avoid meaningless phrases and offensive or subjective statements. • The use of abbreviations should be kept to a minimum and refer only to clinical diagnostic issues, as generally recognised within the specialty.			
7	Authors of entries in patient records are: a) clearly & easily identifiable b) appear on the register for the speciality	 100% 100%	 38% 51%	4. The guide to medical records, for medical staff, will be updated in line with the new policy. Consideration will be given to using this leaflet, or developing a similar one, for agency staff. 5. An implementation plan will be developed by the policy review group and the Medical Records User Group to ensure the new policy on Record Keeping is adopted and adhered to across the Trust. This plan will include details of reaudit. The P.R. Group will arrange a Trust wide launch of the new policy and associated training events.	Barbara Hall/Lesley Humphrey Mandy Leaman/ Barbara Hall	Jan '99 Jan '99	
8	All entries in patient records are clearly written in black ink.	100%	88%				
9	Alterations in patient records are made by scoring out with a single line and are: a) initialled b) dated c) timed	100% 100% 100% 100%	33% 15% 0% 0%				
10	Entries in patient records do not contain: a) ambiguous abbreviations b) meaningless phrases or c) offensive or subjective statements	 100% 100% 100%	 Not audited/ not analysed				

REFERENCES

Audit Commission 1995 **'Setting the Records Straight'** HMSO, London

Clinical Negligence Scheme for Trusts 1995 **'Risk Management Standards and Procedures - Manual of Guidance'** CNST, Howard House, Queens Avenue, Bristol

United Kingdom Central Council for Nurses, Midwives & Health Visitors 1993 **'Standards for Records & Record Keeping'** UKCC, London

APPENDICES

Appendix 1 - Audit Tool

PORTSMOUTH HealthCare NHS TRUST

Topic: PATIENT RECORDS

Area: Elderly Medicine, Elderly Mental Health, Adult Mental Health

Sample: 30 records from each area, from patients having an In Patient episode ending in September, 1997

Audit Reference: 124/97-8

Aspect	Expected Standard	Exceptions	Definitions / Instructions
1a) Records are bound and stored so that loss of documents and traces are minimised. 1b) All documents/papers are filed in appropriate section of the folder	100%		Examine patient records
2. Investigations and machine-produced recordings are securely stored and mounted	100%		Examine patient records
3. Nursing, medical and other records (e.g. care plans) are filed together when patients are discharged	100%		Examine patient records
4. Patient's diagnosis is readily identifiable in the medical records	100%		Examine medical records
5. Any operation notes and/or other key procedures are readily identifiable in the medical records	100%	Patients not undergoing any such procedure	Examine medical records
6. Each entry in patient records is dated, timed and signed	100%		Examine a selection of entries in patient records
7. Authors of entries in patient records are a) clearly and easily identifiable b) appear on the register of signatures for the speciality	100%		Examine a selection of entries in patient records
8. All entries in patient records are clearly written in black ink	100%		Examine a selection of entries in patient records
9. Alterations in patient records are made by scoring out with a single line and a) initialled, b) dated and c) timed	100%	Records containing no alterations	Examine a selection of entries in patient records
10. Entries in patient records do not contain a) ambiguous abbreviations b) meaningless phrases or c) offensive or subjective statements	100%		Examine a selection of entries in patient records ? identify accepted abbreviations for each specialty

Appendix 2 - Data Collection Sheet

PORTSMOUTH HealthCare NHS TRUST

PATIENT RECORDS AUDIT REF: 124/97-8

Pt ID Location

1. Records located in expected place yes ☐ no ☐
comment:

1a. Records bound/stored to minimise loss yes ☐ no ☐
comment:

1b. All documents filed in appropriate places yes ☐ no ☐
comment:

---

2. Notes contain:

nursing	yes ☐ no ☐	see below ☐
medical	yes ☐ no ☐	see below ☐
care plans	yes ☐ no ☐	see below ☐
other records	yes ☐ no ☐	see below ☐

comment:

3a. All Investigations are securely mounted yes ☐ no ☐ securely stored yes ☐ no ☐
b. All machine-produced recordings are securely mounted yes ☐ no ☐ securely stored yes ☐ no ☐
comment:

4. Patient's diagnosis is identifiable in the medical records (readily = on first reading of notes)
readily ☐
yes, with some difficulty ☐
no ☐
comment:

5. Operation notes are identifiable in the medical notes
readily ☐
yes, with some difficulty ☐
no ☐
not applicable ☐
comment:

Any other key procedure notes are identifiable in the medical notes

readily ☐

yes, with some difficulty ☐

no ☐

not applicable ☐

comment:

---

6. Number of entries in notes for last episode:

Number dated:
Number timed:
Number signed:
Number initialled with explanation:
Number initialled, **NO** explanation:

7. Number where author identifiable:
Number where author **NOT** identifiable:

Number where author appears on specialty register:
Number where author does **NOT** appear on register:

8. Number written in black ink
Number **NOT** written in black ink

Comment:

---

9. Number of alterations to records in last episode:

Number scored out with single line:
No. **NOT** scored out with single line:

No. initialled:
No. dated:
No. timed:
Comment:

10. **LIST** abbreviations:

Accepted list available: Y/N No. appearing on list: No. NOT on list:

LIST meaningless phrases:

LIST offensive/subjective statements:

Appendix 3 - Loose papers found in patient records

	AMH	EMH	EM
Nursing Notes	2	3*	3
Prescription Sheets	-	2	3
Consent Form	-	1	-
Procedure Notes	1	1	1
Correspondence	1	-	1
Investigation report	-	-	1
Observation Sheet	-	-	2
Fluid Balance Sheet	-	-	1

* One set of casenotes also appeared to have one week's nursing notes missing according to the dates of the remaining notes.

Totals are not given as some casenotes had more than one loose paper.

Appendix 4 - Incidence of x-ray reports in patient records

	AMH	EMH	EM
X-rays definitely taken	-	4	4
? x-rays taken*	-	-	3
x-ray reports found in notes	-	4	0

- The auditor was unable to ascertain from the patients' records whether the x-rays requested (according to entries made by medical staff) had been performed.

Appendix 5 - 'Key Procedures' identified

AMH	EMH	EM
ECT Sutures	ECT OGD + stent EEG	Doppler U/S CT scan Rigid sigmoidoscopy Flexi sigmoidoscopy

Appendix 6 - Compilation of results for standard 6

	AMH		EMH		EM	
	Nursing	Medical	Nursing	Medical	Nursing	Medical
Number of entries	397	77	698	92	552	155
Fully dated	234	77	540	83	237	129
Some of date	23	0	8	7	22	18
Timed	26	5	104	10	134	8
Full signature	388	35	644	58	497	135
Initials + explanation	4	4	0	0	0	0
Initials no explanation	5	35	39	26	46	10
No sig. or initials	4	3	15	8	9	10

Appendix 7

List of abbreviations used in Adult Mental Health, Elderly Mental Health and Elderly Medicine patient records

Adult Mental Health

/c
15'
2/52
A+B
Abdo
AC
App
asap
AU
BD
bd
BP
c/o (? Company off)
CNS
Cog
CPA
CPZ
CVS
D/W
DH
DSH
ECT
FH
g
HPC
HS
Ht
Hx
ICU
IMI
Imp
M (as in M health)
mane
med
mg
MHA
MSE
N
NAD
O
O/E
obs
OCP
OD
OK
onl
OPA
P
PΨH
P/C (? Phone call)
PC
Pe3H
PH
Pl
PMF
PMH
prn
Pt
Px
Reg
rm
RS
RS
Rx
S
S17
S3
satis
SB
Sec
SH
STM
tds
TTOs
U/E
V Bl
W
W/R
WE
WR

Elderly Mental Health

†
#
↓
↑
↓
+
++
+++
+HR
/c
0/E
2°
4/7
Ab
Ab's
AF
alb
ATSP
AXR
BM
BO
BP
bpm
c/o
Ca
CPHx1
CPN
CPR
CVA
CVS
CXR
D/C
d/w
D/W
DH
DHH
DM
DVT
E/A
ECG
EEG
EMI
EMI
EMURH
Ep
F/U
F/U
FH
GP
HPCF
HS
Ht
Hx
IM
Imp
IV
JVP
JVP
KOB
L
LOC
mg
MI
ml
mls
MSE
MSSU
MSU
MTS
NA
nd
nocte
OA
Ohx
OK
P
Palp
PC
PE
PMH
Psych
PU
qds
QDS
R/V
reg
rel
RH
RR
RS
Rx
S/B
SH
SIADH
SOA
SOB
SOBOE
tds
TIA
TLC
Tx
UTI
VRCT
WR
yrs

Elderly Medicine

Abdo	ETOH	RS	U/S
AB	Exp	Rx	UTI
ABG	FBC	S/C	Wgt
AB's	FHx	SE	Wt
ADL	GI	SHx	yrs
AE	GP	SIADH	↑
Afib	GU	Siggy	→
App	HD	Sl	↓
Apy	HE	SNT	2^0
Ax	HH	SOA	3/52
AXR	h'oids	SOB	4/7
BC's	HPC	SOBOE	c
bd	HS	SR	+++
Bilat	HV	S/S	L
BO	Imp	PHx	N
BOR	Inh	PMHx	P
BP	irreg	PN	R
BS	IV	PN res	V
BSV	Ix	PNR	N = V
BUA	JALCOL	PPP	R=L
C/P	JVP	PR	-ve
CBD	LL	PRHO	O
CIBH	LOC	PSM	6^0x2
CN	LRTI	Pt.	+/_
CNII	Micro	PV	#
CNS	Mg	qds	
COAD	Mg OH	RA	
COPD	MI	Ref	
Co Prox	min	Reg	
CPN	MMSE	Resp	
CRD	MSU	RHD	
Creps	MTS	Rpt	
CVA	NAD	STM	
CVS	NKA	SVE's	
CXR	NSAID	SW	
DHx	OA	tachy	
DM	Occ	tds	
DU	od	TB	
D & V	O/E	Temp	
DVT	OHx	THR	
D/W	OK	THJR	
E/A	OP	TIA	
ECG	OT	Trach	
Ep	P	Tx	
ERCP	PC	u	
ESM	PE	US	

Appendix 8 - possibly meaningless/subjective phrases used:-

Nil of note
Self Caring morning/afternoon
Off legs
Pleasant lady
Wait CSR ABG + bloods
Bottom half washed
To be written up for canestan cream
Pt offered a bowl and given minimal assistance
Independent afternoon
Legs creamed
Weighed and recorded
Independently washed by bedside
Please push mobility
Able to walk with wheeled zimmer and 1
Had a small diet
Pleasant on approach
Has taken 500mls this lunchtime
Reluctant to food or fluids
Weetabix and yoghurt excepted
Remained calm & appropriate
Keeping it together
Seems quite low
Happy and appropriate
Not set fire
Appropriate and settled
Became very verbal with staff
Appropriate and warm
Noisy, silly afternoon
Moping around