وزارة الصحة
Ministry Of Health
المديرية العامة للمؤسسات الصحية الخاصة
Directorate General of Private Health Establishments

Medical Record Documentation Guideline

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Ministry of Health

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Acronyms

- **MoH:** Ministry of Health
- **PHEs:** Private Health Establishments
- **DGPHE:** Directorate General of Private Health Establishments

Definitions

- **Patient:** A patient is any individual treated or admitted in any private health establishment.

- **Patient Record:** is a documentation of medical service rendered to a patient that is performed at the direction of a physician or other licensed healthcare professionals such as dentists, nurses or other allied healthcare professionals. Patient's records include diagnostic documentations such as x-rays, ECG, lab investigations, etc.

- **Attending Healthcare Professional:** is the healthcare provider or most recently responsible for coordinating the patient care in a facility or in the case of outpatient services, is the custodian of the record of the outpatient service. If the attending healthcare professional is deceased or unavailable, the current custodian of the record shall designate a substitute attending healthcare professional, for purposes of compliance with these guidelines.

- **Designated Representative (Legal Guardian)** is a person authorized in writing or by court order to act on behalf of the patient or in front of attending healthcare professional. In the case of a deceased patient, the personal representative or, if none has been appointed, heirs shall be deemed to be designated representatives of the patient.

- **Custodian of medical record:** is that person/department who has "care, custody and control of medical records, for such persons or institutions" that prepare medical records. Persons who could be the custodian of medical records include "a chiropractor, physician, registered physical therapist or licensed nurse," as well as employee or agent of the same. The definition also includes facilities for convalescent care, medical laboratories and hospitals.

- **Competent person:** Refers to a person legally capable of consenting a medical procedure. Every adult person is 18 years old and above is assumed to be competent to consent for

medical procedure (He/she should be fully conscious and aware about his/her condition, able to receive and understand information relevant to their medical care, possible alternatives and consequences, capable to make decisions.

- **Next of Kin:** The person who is authorized to make decision on behalf of the patient (In case of the patient is unconscious, minor or mentally ill), Next of Kin may include: Father, Mother, Adult sons – daughters or brothers / Husband or wife / Legal guardian or the sponsor (if next of kin as per the above mentioned level is not available, then relatives available from the same origin of the spouse's side will be considered as a next of kin.

- **Minor:** any person from the birth to the age of 18 years

- **Health Information:** Patient medical records, reports, registers, identified information.

- **Registers:** Paper-based log book or electronic database

- **Indefinite Period of Retention:** Storage of records/information in their original form continuously without interruption; when indicated as indefinite, the original information will never be destroyed even if electronic/scanned versions are made available.

- **Scanning:** Process of converting paper documents into electronic formats through document imaging process.

- **Allied Health Professional:** are healthcare practitioners with formal education and clinical training who are credential through certification, registration and licensure. They collaborate with physicians and other members of the health care team to deliver high quality patient care services for the identification, prevention and treatment of diseases, disabilities and disorder

Chapter 1

Introduction

Accurate medical record documentation is a fundamental aspect of healthcare delivery in private health facilities. It plays a vital role in ensuring continuity of care, legal compliance, and supporting quality improvement initiatives. Proper documentation is essential to maintaining the accuracy, confidentiality, and accessibility of patient health information in all private healthcare establishments licensed by the Ministry of Health in the Sultanate of Oman.

All private health establishments should adhere strictly to the National Policy for Health Information Governance and Management (issued on May 2024). This national policy is considered the core legislation of Health Information Management in Sultanate of Oman. This guideline shall be read in conjunction with the National Policy.

However, failure to adhere to that national policy and this guideline by any private health establishment will be subjected to legal penalties according to The Law Regulating the Practice of Medicine and Allied Health Professions and its Executive Regulations.

Furthermore, over the last few years, the dramatic rise by almost all violation committees have highlighted the need for improved clinical record keeping. While it is critical that there is accountability within the health system when errors do occur, in many cases the health care provider or establishment is unable to defend the care given due to the poor quality of the clinical records. The generally accepted rule is that "If it isn't recorded-it wasn't done".

Purpose

This document provides guidelines for the management, retention, and disposal of medical records and health information.

It aims to ensure that medical records and health information are readily accessible, properly maintained for patient care, and meet the legal requirements. Additionally, it seeks to uphold privacy, optimize storage space, minimize retention costs, and facilitate the timely disposal of records in accordance with the established policy guidelines.

Scope

This policy applies to all Private Healthcare Providers (Establishments and Professionals) licensed by MOH.

Chapter 2

Structure

1. Policy Statement

It is the policy of all private health establishments that the medical record shall contain sufficient information to identify the patient, support the diagnosis, to justify the treatment, document the results accurately and facilitate continuity of care.

2. Procedures

2.1 General Requirements:

2.1.1. Each healthcare facility must maintain records and reports in a manner to ensure accuracy and easy retrieval.

2.1.2. All private health establishments should have a legible, complete, comprehensive, and accurate patient record which must be maintained for each patient.

2.1.3. All information relevant to a patient should be readily available for auditing by authorized officers from MoH.

2.1.4. Patient information should be treated as confidential and protected from loss, alteration, destruction, and unauthorized or inadvertent disclosure.

2.1.5. Records should be organized in a consistent manner that facilitates continuity of care.

2.1.6. Discussions with patients concerning the necessity, appropriateness and risks of procedures, as well as discussion of treatment alternatives, should be incorporated into a patient's patient record as well as documentation of informed consent

2.1.7. Each healthcare facility shall provide Patient records room or other suitable patient record area with adequate supplies and equipments. Patient records should be stored safely to provide protection from loss, damage, and unauthorized access and use..

2.1.8. Patient records shall be maintained in the custody of health facility by a qualified medical record officer/technician in the case specialized clinics/center, polyclinic and hospital; and shall be available to a patient or his/her designated representative through the attending healthcare professional or his/her designated representative at reasonable times and upon reasonable notice.

2.1.9. Patient Records must be maintained for every patient, including newborn infants, admitted for care in the hospital or treated in the emergency or outpatient service. Patient records maybe created and maintained in written or electronic format, or a combination of both, and must contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately and facilitate continuity of care.

2.1.10. All PHEs should maintain various indices like Master Patient Index, Diagnostic Index, Operation Index, etc, to retrieve information whenever required either in manual or electronic formats.

2.1.11. All PHEs should maintain Patient Register, Operation Register, Birth & Death Register, etc, either in manual or electronic format.

2.1.12. Patient records must contain entries which are dated, legible and indelibly verified. The author of each entry must be identified by the name and designation and authenticated. Authentication must include official stamp, signature, written initials, or computer entries that can be validated

2.1.13. Telephone or verbal orders of authorized individuals are accepted and transcribed by a qualified professional. Telephone or verbal orders must be documented immediately by the professional who receives the order and should be authenticated within 24 hours by the professional who is responsible for ordering, providing or evaluating the service furnished.

2.1.14. If any changes, corrections, or other modifications are made to any portion of a patient record, the person must note in the record the date, time, nature, reason, correction, or other modification, his/her name and the name of a witness, to the change, correction, or other modification. Electronic form of patient record should have that ability to trace any change, or other modifications in the record with identification of the persons responsible for the change and the time and/or change took place.

2.2 Medical Records Completion & Review:

2.2.1. Medical records are reviewed, during the abstracting and coding functions, for timeliness and completeness. This process is called the Discharge Analysis. For example, the record is checked to ensure that if the patient has had an operation, an operation report is in the record. In addition, the reviewer needs to check that all progress notes, investigation reports including pathology in case of operated patients, nursing notes etc., are available. There should also be a final discharge note made by the attending doctor indicating to where the patient has been discharged and arrangements to follow-up.

2.2.2. Sort the forms into the correct order as per the prescribed order. If the patient has been in hospital before, the older records are retrieved and the latest admission forms are added by placing them behind the appropriate admission divider.

2.2.3. Check if the doctor has completed the diagnosis column in the front sheet. That is the main condition has been recorded along with any other condition treated while in the hospital.

2.2.4. Check that if an operation or other surgical procedures were performed that they are recorded and the doctor has signed the front sheet. The signature of the doctor is important as it shows that the doctor has completed the medical record and takes the responsibility of the content.

2.2.5. With the completion of the discharge analysis, two important procedures need to be undertaken. They are clinical coding and the collection of health care statistics.

2.2.6. Medical Records are to be coded by the qualified coders to enable the retrieval of information on diseases and injuries, as per the latest revision of International Classification of Diseases (ICD), World Health Organization.

2.2.7. Coded data are used to compile institutional morbidity and mortality statistics, for planning health care facilities at the respective healthcare facility and furnishing information to the MoH.

2.2.8. A closed medical record review is done monthly on a representative sample of all practitioners by representatives of the medical staff.

2.2.9. Aggregated reports of findings from the Medical Records staff and medical record reviews are forwarded to the Performance Management Committee (only for hospitals) on a quarterly basis.

2.3 Collection of Health Care Statistics

2.3.1. Each facility obliged to furnish the monthly/annual Statistical Report as per the booklet supplied by the MoH.

2.3.2. All supporting registers and diagnostic indexes as per ICD-10 are to be maintained to support furnished statistics.

2.4 Protection & Availability of Medical Records

2.4.1. Records shall be kept on all patients admitted or accepted for treatment.

2.4.2. The medical record is the property of the facility and is maintained for the benefit of the patients, the medical staff and the facility.

2.4.3. All required records, either as originals or accurate reproductions of the

contents of such originals, shall be maintained in such form as to be legible and readily available upon request by:

A. The attending physician
B. The facility or its medical staff or any authorized officer, agent or employee or either:
C. Authorized representatives of the DGPHE
D. Any person authorized by law to make such a request

2.4.4. Access to medical records is restricted to authorized personnel and medical staff.

2.4.5. The facility shall safeguard the information in the medical record against loss, defacement, tampering or use by unauthorized persons.

2.4.6. Controlled, locked access to the inactive medical record storage files is maintained.

2.4.7. The Medical Records Department shall remain locked at all times when Medical Records personnel are not present. During such times, the Nursing Supervisor shall control access.

2.4.8. The facility shall provide adequate measures and the maintenance of means to physically safeguard the medical record from loss by fire, water and foreseeable sources of potential damage.

2.4.9. Medical Records shall be filed in an easily accessible manner in the facility or in an approved medical record storage facility off the facility premises.

2.4.10. Records will be removed from the facility premises only by legal orders.

2.4.11. Written consent by the patient or his/her legally qualified representative is required for release of information from the medical record.

2.4.12. Records shall be signed out when removed from the Medical Records Department.

2.4.13. Records needed for reasons other than patient care, (i.e., case studies, committee review) must be returned to the Medical Records Department before it closes. Records signed out for readmissions must be returned to Medical Records within 24 hours after patient's discharge.

2.4.14. Records shall be readily accessible at all times in the Medical Records Department or on the nursing unit while patient is in the facility. (Exception: Designated legal cases will be maintained in locked file cabinet.)

2.4.15. When certain portions of the medical records are so confidential that extraordinary means are considered necessary to preserve their privacy (such as the treatment of some psychiatric disorders), those portions may be stored separately, provided the complete record is readily available when required for current medical care or follow- up, for review functions or for use in quality assessment activities. The medical record shall indicate that a portion has been filed elsewhere, in order to alert authorized reviewing personnel of its existence.

2.5 Legibility of Medical Records Documentations

It is the policy of DGPH to set legibility standards for medical record documentation and to monitor compliance with these standards as part of the performance improvement and medical error reduction activities. And this policy is applicable to all documentations within the medical records.

2.5.1. Whenever possible, all consultations, histories and physicals, interpretations of diagnostic testing, and post-operative/procedure results shall be dictated/recorded.

2.5.2. Only approved abbreviations will be allowed to be used in medical records documentation. Abbreviations should not be used while writing diagnostic statements. They could be used only in clinical notes.

Note: Refer to the Annex 3.1 : Approved list of abbreviations and Annex 3.2 : **Unaccepted use of abbreviations.**

- **Medication Orders:**

1. Should include a brief notation of purpose.
2. All prescription orders are to be written in the metric system.
3. “Units” should be spelt out.
4. The order must include drug name, exact metric weight or concentration and dosage form.
5. A leading zero must precede a decimal expression of less than one.
6. A terminal zero is not to be used after a decimal.
7. Prescribers are to avoid the use of abbreviations for drug names and Latin directions for use.

8. The age and weight of the patient (especially geriatric and pediatric patients) should be included where appropriate.

- If a healthcare professional writes an order that is not legible, the order must be clarified with the healthcare professional prior to implementation.
- Clarification of orders will be documented on the order sheet as a "clarification", timed and dated and signed by the healthcare professional receiving the clarification.
- Failure to clarify an illegible order will result in employee counseling.
- Legibility will be monitored via concurrent and retrospective medical record review:
- Unresolved legibility issues with physicians and allied healthcare professionals will be forwarded to the Information Management and/or Credentialing Committee.
- Unresolved legibility issues with other healthcare professionals will be forwarded to their respective department managers and will be included as part of the annual review process.

2.6 Verbal and Written Orders (General)

2.6.1. Orders for patient treatment and medications, including the administration of medications, to be carried out only when given by a qualified physician, surgeon, dentist, podiatrist or other person duly licensed or authorized to prescribe by MoH and who has been approved as a member of the medical staff of that PHE. All orders of medication and treatment shall be written into the medical record of the patient or, if appropriate, on a prescription form if taken by a Pharmacist.

2.6.2. All orders for medications shall include the date and time of the order, the name of the drug, the dosage, the route, frequency of administration, age and weight of the patient, known allergies, the reason the medication is ordered for the patient and the name of the prescriber.

2.6.3. All orders for treatment shall include the type of treatment, specific requirements of the treatment (such as wet or dry dressings, etc.) and the frequency of treatment.

- **Written Orders:**
    - These shall be filled when written as stated above and signed by the practitioner.

- **Verbal/Telephone Orders:**

    - Only verbal/telephone orders from an approved licensed physician will be taken.

    - Verbal/telephone orders of medication shall be received and recorded by the Pharmacist or licensed nurse. This does not preclude the taking of a verbal/telephone order by a specialty technician within the scope of their specialty allowed by law, which includes the Respiratory Technician, Physical Therapist, Imaging/Radiology Technician and Nuclear Medicine Technician.

    - The order will be written on the physician order sheet by the person receiving the order and noting the date and time received, the name of the Physician issuing the order and the receiver's name and title.

    - Record the verbal/telephone order immediately in the patient's medical record or, for pharmacists, on a prescription form as appropriate.

    - A "read back" process will be conducted by the individual receiving the order, whereby the individual will read back, to the physician, the frequency and/or all instructions for use in the non-abbreviated format. Example: If an order is received for BID frequency, the receiver will read back the order to the prescriber as "to be administered or performed twice daily, or two (2) times per day". The physician shall verbally confirm that the order is correct.

    - Indicate either telephone or verbal order in the written record.

    - Sign the written record and indicate level of licensure.
    - The prescribing practitioner, or another practitioner responsible for the patient's care, must date, time and authenticate the verbal/telephone order within 48 hours of giving the order (or in a time frame that complies with state regulation).

    - The healthcare professional implementing the verbal or telephone order will document that the order was implemented in the appropriate portion of the medical record.

- **Pre-printed Order:**

    - Pre-printed orders will be accepted if they have been approved by the Pharmacy and Therapeutics Committee of PHE.

    - The Pharmacy and Therapeutics Committee will review and update pre-printed order sheets as needed. This review will ensure pre-printed orders are clear, accurate and safe.

- **New Orders:**

- New orders must be written for the patient upon transfer into and out of the ICU/CCU, postoperatively and at each facility admission, regardless of frequency of admission.

- **Blanket Orders Prohibited:**

  - The use of blanket orders is prohibited. Blanket orders that are prohibited include, but are not limited to:

    - Continue previous medications
    - Resume preoperative orders
    - Resume orders from floor
    - Discharge on current medications

  - All orders that are a resumption or continuation of previous orders must be rewritten in their entirety by the prescribing physician.

  - All orders for treatment or medications for discharge must be rewritten in their entirety by the prescribing physician.

2.7 Documentation of Operative and Other High Risk Procedures

2.7.1. Reports of operative and other high-risk procedures will be dictated for inclusion in, or written in, the medical record immediately after the operative or other high-risk procedure.

2.7.2. The comprehensive operative report must contain:

- Preoperative diagnosis
- Procedure(s) performed
- Description of the procedure(s)
- Clinical findings
- Any specimens removed
- Disposition of each specimen
- Estimated blood loss
- Postoperative diagnosis
- Postoperative plan
- Discharge details
- Name of the primary surgeon, assistants and the anesthetist, if anesthesia was provided

2.7.3. In the event the operative report is not available immediately following surgery, an

operative progress note shall be entered into the patient's medical record containing pertinent information that may be required for anyone to care for the patient.

2.7.4. An operative report that has been dictated and transcribed must be authenticated by the surgeon and placed in the medical record within 24 Hours of the procedure.

2.7.5. In the event the operative/procedure report is not available immediately following the operative or high-risk procedure, an operative/procedure progress note shall be entered into the patient's medical record containing pertinent information that may be required for anyone to care for the patient. This progress note may be a more condensed, less detailed version of the comprehensive operative/procedure report; however, it should contain comparable information to the full report.

2.7.6. At a minimum the operative /procedure progress note must contain:

- Procedure(s) performed
- Findings
- Technical procedures used
- Specimens removed
- Disposition of each specimen
- Estimated blood loss
- Postoperative diagnosis
- Name of primary surgeon and any assistants

2.7.7. Operative and other high-risk procedure reports and/or progress notes will be dictated and/or written and authenticated by the individual performing the procedure.

2.8. Post-Operative Documentation

2.8.1. Following surgery, the patient is monitored by qualified registered nurses for an appropriate period of time, prior to discharge. Documentation of this recovery period includes:

- Patient's vital signs and level of consciousness
- Medications and IV fluids

- Any blood or blood products administered
- Any unusual events or complications and management of those events

2.8.2. A physician qualified in resuscitative techniques is immediately available until all patients have been discharged.

2.8.3. Patients are either discharged by the responsible licensed practitioner or by criteria approved by the medical staff of PHE.

2.9. Tracking and Locating of Medical Records

2.9.1. The Medical Records Department is responsible for tracking the location of each medical record.

2.9.2. Records must be signed out of the department and an "outguide" is filed in its place. The outguide should include the following information:

- **Patient name**
- **Medical record number**
- **Date requested**
- **Name of person requesting the medical record**
- **Where the record was sent**

2.9.3. Medical records are to be returned to the department within 24 hours.

2.9.4. A list of medical record requests and locations is kept and updated daily

3. Component of Patient Records

3.1 Registration record content:

The registration section/department is responsible for collecting sufficient information to identify the patient. The information is documented on the face sheet, which is a permanent part of the patient's record. Sufficient information includes, but may not be limited to:

- Patient's file number
- Patient's full name
- Gender
- Patient's full Address

- Date of birth / Age
- Contact details
- Allergies

3.2 Outpatients' visit's record content:

An individual clinical record is established for each person receiving care and will follow an established format as per this medical records documentation guideline.

3.2.1. Date of visit
3.2.2. Complete medical history including: chief complaint, known medical conditions, past surgeries, drugs allergies and known adverse drugs reactions.
3.2.3. Clinical findings
3.2.4. Diagnosis or impression
3.2.5. Investigations ordered
3.2.6. Plan of management including: therapies administered, prescriptions, referrals, admissions, etc.
3.2.7. All reports of diagnostic and therapeutic procedures, tests and their results are documented and authenticated in the medical record.
3.2.8. Documentation of missed/canceled appointments and follow-up
3.2.9. All medications ordered.

3.3 Medications Record

Medication administration is documented in the patient's medication record which includes:

- Strength
- Dose, rate of administration
- Route
- Administration devices used
- Practitioner name and title

Note: Documentation of all care and treatment, medical and surgical, signed and stamped by attending physician.

3.4 Prescription sheet content:

- Name of clinic
- Address of clinic
- No. of clinic license
- Name of doctor, No. of doctor license and specialization
- Treatment.
- Name of the drug and form
- Strength
- Dosage

- Route of administration
- Duration of treatment

3.5 Patients' Sick Leave Certificates

- Name of Health care Facility
- Full name of the patient
- Nationality
- Place of work
- Medical record number
- Date of visit
- Date of Inpatient and Discharge
- Diagnosis including reason for granting the sick leave
- Date of start of sick leave and end
- Name of doctor, designation, license number and signature
- Stamp of facility

3.6 Patients' Referral Files (Forms)

- Clinic name, license number and contact address
- Name of Doctor, license's number and specialization
- Patient's full name *I* tribe *I* family, age and sex
- Date of examination
- Laboratory and radiography tests
- Diagnosis
- Treatment
- Referred to
- Type of referral (routine, urgent, emergency)
- Person coordinated referral within the receiving institution
- In case patient refuse referral and/or use of ambulance such refusal is documented
- Doctor's signature and clinic stamp

3.7.In-Patients Medical Record:

3.7.1. General Requirements:

A. Clinical observations are made daily in the progress notes by the physician. Other persons making observations shall report on designated forms. These progress notes give a pertinent chronological report of the patient's course in the facility and reflect any change in condition, the results of treatment and plan of care revisions when indicated.

B. Consultation reports contain a written or dictated opinion by the consultant that reflect an actual examination of the patient, when applicable, and the patient's

medical record.

C. Nurses' notes and entries by non-physicians contain pertinent and meaningful information and observations. This information is documented on the respective forms as approved by the Hospital Medical Records Committee.

D. Opinions requiring medical judgment are written and authenticated only by the medical staff members in the progress notes or on consultation reports.

E. All reports of diagnostic and therapeutic procedures, tests and their results are documented and authenticated in the medical record.

F. There is evidence of informed consent in the patient's medical record

G. Imaging/Radiology, Anesthesia and any other diagnostic or therapeutic procedure are filed in the medical record within 24 hours of completion.

H. All medications ordered are documented in the medical record.

I. Medication administration is documented in the patient's medication record to include:

- Strength
- Dose, rate of administration
- Route
- Administration devices used

3.7.2. Inpatients medical records contents:

A. Date and time of admission
B. Complete and accurate identification data which include: patient' medical record number, full name of patient, age (date of birth), sex, nationality, marital status, occupation, address and telephone number and next of kin's name and address.
C. A through medical history completed within 24 hours of admission
D. A physician assessment
E. Admission diagnosis
F. Final diagnosis, secondary diagnosis, complications
G. Plan of care.
H. Reports of consultation by consulting physicians, when applicable.
I. Evidence of appropriate informed consent
J. Reports of all diagnostic and therapeutic procedures
K. Reports of pathology, radiology and laboratory examinations
L. Operative reports and anesthesia reports
M. Discharge summary.
N. Any documentation signed by the patient relating to the treatment e.g. Consent for a procedure /operation
O. Signature and official stamp of attending physician.

3.7.3. Progress notes record:

A. The progress notes are written as frequently as may be required or as indicated by the condition of the patient.
B. Should provide a summary of the condition of the patient on admission
C. The writing should be definite and accurate statement.
D. It should include a summary of the patient's general condition.

3.7.4. Discharge summary record content:

Discharge report: must be given to the patient on discharge without charge, the discharge card should contain the following (where applicable and as per case type):

- Patient demographic information
- Date of admission and discharge
- Diagnosis and allergies
- Any operation or procedure
- Discharge medication and plan
- Name and signature of attending physician with facility name
- Autopsy findings; and death certificate
- Advanced Directives, if available.
- Patient education
- Social and psychological review.
- Vaccination records
- Future treatment plan and follow up requirements
- Police care clearance
- Incident summary report of patient leaving against medical advice (LAMA) Signature and official stamp of attending physician.

3.7.5. Nursing Records

- Basic Nursing Forms (mandatory):
    - Initial Nursing Assessment Form
    - Nursing Care Plan
    - Nurses Notes Form (progress notes)
    - Temperature, Pulse, Respiration and blood pressure chart
    - Paediatric Observation Chart
    - 42Hour Nursing Report
    - Medication chart
    - Pain documentation
    - Patient/family Education
    - Any special dietary requirements

- Special Nursing forms (when applicable)
    - Special observation chart

- Pre operative checklist
- Labour record (patogram chart)
- Weight Chart
- Fluid Balance Chart
- Diabetic Chart
- Newborn identification form
- Nursing assessment of the newborn in SCBU(special care baby unit)
- ICU (intensive care unit) Chart
- Infection chart
- MICU(medical ICU) / PICU(paediatric ICU) flow chart
- NICU(neonatal ICU) chart
- Neonatal intensive care unit / IV fluid intake / output chart
- Feeding chart
- NICU/SBCU for high frequency
- Investigation flow sheet
- Partial exchange transfusion chart
- Paediatric peritoneal dialysis
- Anticoagulant drug chart
- Conscious sedation
- Haemodialysis profile
- Manual peritoneal dialysis chart
- Diabetic ketoacidosis chart
- Out and pass forms
- Transfer slip

3.7.6. Obstetric Content

- Records of all obstetric patients shall include, in addition to the requirements for patient records, the following:
- Record of previous obstetric history and pre-natal care including blood serology, and RH factor determination.
- Admission obstetrical examination report describing condition of mother and foetus.
- Complete description of progress of labour and delivery, including reasons for induction and operative procedures. (patogram chart)
- Records of ansesthesia, analgesia, and medications given in the course of labour and delivery
- Records of fetal heart rate and vital signs
- Signed reports of consultants when such services have been obtained
- Progress notes including description of involution of uterus, type of lochia, condition of breast and nipples, and report of condition of infant following delivery
- Names of assistants/midwives present during delivery

3.7.7. Newborn Records Content

Records of newborn infant shall be maintained as separate records and shall contain the following:

- Date and time of birth, birth weight and length, period of gestation, sex .
- Mode of birth or mode of delivery
- Parents' names and addresses.
- Type of identification placed on the infant in the delivery room.
- Description of complications of pregnancy or delivery includes premature rupture of membranes; condition at birth including colour, quality of cry, method and duration of resuscitation.
- Record of prophylactic instillation into each eye at delivery.
- Results of Phenyl Keto Urea (PKU) tests.
- Report of initial physical examination, including any abnormalities, signed by the attending physician.
- Progress notes including temperature, weight, and feeding charts; number, consistency, and colour of stools; condition of eyes and umbilical cord; condition and colour of skin; and motor behavior.

3.7.8. Operation / Surgical Procedures Record Content:

Records of all patient undergoing surgery shall include, in addition to the requirement for patient record, the following:

- Consent to operation/procedure
- preoperative diagnosis
- name of operation
- full description of findings
- both normal and abnormal of all organs explored
- procedures, ligatures and sutures used
- the technique used
- the tissue removed or altered
- post-operative diagnosis
- the patient condition at the conclusion of the procedure
- the details of tissue removed and sent for histopathological examination
- The pathologist's report on all tissues removed at the operation
- names of all surgeons, anaesthetists and nurses who are involved
- the operation report should be written immediately after the operation and signed by the surgeon and his or her assistants.

3.8. Anaesthesia record:

- preoperative medication given: name, type, dose, date and time
- Techniques used
- Fluid balance and supplementary drugs given
- Vital signs record
- Any complications occurring during surgery.

4. Medical Records Retention and Disposal

This section provides direction on medical records / health information retention and disposal

(regardless of the media – paper, electronics, films) and to ensure that medical records/health information are readily accessible, properly maintained as required for patient care purposes and also to meet legal standards, ensure privacy, optimize the use of space, minimize the cost of record retention and to destroy the medical record/ information according to decided schedule for disposal as per policy.

4.1 POLICY STATEMENT

- A medical record shall be retained on all patients admitted or accepted for treatment to private health establishment.
- The medical record is the property of the facility and is maintained for the benefit of the patient, the professional staff and the facility.

4.2 Responsibilities:

All Private health establishments (PHE) are required to maintain medical records/health information for specified period of time. While minimum retention requirements are absolute, there is nothing to prevent a facility from retaining records of periods well beyond the specified minimum. This may be considered appropriate at a local level for ongoing access or future research.

4.3 Procedures

4.3.1. Scanning / other reproduction methods and offsite storage systems can be adopted as retention options.

4.3.2. The offsite storage system should ensure the same level of access, safety and security of the records/information.

4.3.3. Destruction of records/information should be practiced in accordance with the disposal schedule.

4.3.4. The inspection will be conducted by DGPHE inspectors to ensure that the private health establishment's management has applied this policy for retention and disposal of medical record and if non-compliance is identified then disciplinary action will be taken against that facility.

4.3.5. Access on behalf of a patient or deceased includes any use of the record concerning the patient or deceased, or access to the record for any purpose such as in the provision of a report to another health care worker or agency or inspection by the patient or deceased's next of kin. Access in response to release of information, requests for research or for the education of health professionals would not be counted as "access on behalf of the patient".

4.3.6. There must be bi-annual meetings between the management of PHE and outsourced companies (if applicable to the facility) to discuss the ways of destruction of medical record/health information and also ensure improvement in the process.

4.3.7. The Medical Records/Health Information Management Department is responsible for establishing appropriate record retention and disposal management practices as per the following:

- Implement record retention and disposal practices
- Ensure that record management, retention and disposal procedures are consistent with the policy.
- Educate staff within the department as well as other concerned department staff in understanding sound record retention and disposal practices.
- Ensure the confidentiality of records/information during the process weeding /transferring to the offsite location.
- Ensure that storage systems (offsite & onsite) are equipped with environmental control, applicable safety & security measures. If commercial storage system is opted, regular site visits to such companies should be arranged to confirm safety & confidentiality aspects.

4.4.Disposal and destruction of records

4.4.1. The systematic permanent disposal of medical records that have been maintained for the prescribed retention period is the overall responsibility of concern health care facility. The purpose of disposal or destruction is to permanently remove records from active use, with no possibility of reconstructing the information.

4.4.2. The following steps are must be adopted by the management of health care facilities before the destruction of medical records:

4.4.3. Medical record that is scheduled for destruction must be placed in a secure location to guard against unauthorized or inappropriate access until the destruction takes place.

4.4.4. Create a record destruction log, individually listing all medical records (i-e individual patient care records) to be destroyed. That log book should include following information:

1. Patient name and medical record number

2. Dates of service included
3. Date of destruction
4. The name of the company performing the destruction
5. Signature(s) of individuals witnessing destruction
6. Method of destruction

4.4.5. Record destruction logs must be maintained/retained and secured permanently for tracking purposes.

4.4.6 There must be planned site visit by health care facility management in coordination with the disposal company to ensure the confidentiality of medical record and to witness that the record has completely destroyed.

4.4.7 The methods of destroy such as burning and burial are not reliable. Therefore MoH is not recommending these methods. It is critical that the method of destruction does not compromise the confidentiality and integrity of patient information, either in the short or long term.

4.4.8. It is recommended that records which are approved for destruction after completing the retention period be destroyed by methods of shredding, trammeling or pulping.

5 Compliance and Enforcement with this guideline

5.1. All private health facilities licensed by MoH shall submit to DGPHE a copy of their policy and procedure to comply with this guideline and all forms used to implement it, and shall promptly submit to DGPHE any future amendments to such policies and procedures.

5.2. To ensure compliance of these policies, periodic visits will be done by DGPHE audit team.

5.3. DGPHE has full authority to request the original medical records if needed with promising to return it to the facility with its original arrangement.

5.4. Non compliance with these standards and after investigation and verification that the violation of rules and regulations is true, one of the following penalties will apply based on the seriousness' of violation:

5.4.1. Warning letter
5.4.2. Financial penalties
5.4.3. Suspension of duty of physician for no more than 1 (one) year
5.4.4. Closing the facility for a period of no more than 60(sixty) days
5.4.5. Cancellation of the person’s license

Chapter 3 :

Responsibilities:

- DGPHE shall:
    - Monitor the compliance of this policy by random audits of all types of medical records.
- Administration/ management of all private health care establishments shall:
    - Ensure the implementation of this policy through setting up and maintaining the required medical records system and functions.
- The Medical Records/Health Information Management of PHE shall:
    - Establish appropriate record management practices under supervision of a qualified medical record offices/ technician as per the following:
        1. Implement medical record practices.
        2. Ensure that record management, retention and disposal procedures are consistent with the policy.
        3. Educate staff within the department as well as other concerned department's staff in understanding record retention, maintenance and disposal practices.
        4. Ensure the confidentiality of records/information during the process weeding/transferring to the offsite location.
        5. Ensure that storage systems (offsite & onsite) are equipped with environmental control, applicable safety & security measures. If commercial storage system is opted for, regular site visits to such companies should be arranged to confirm safety & confidentiality aspects.

Chapter 4 :

Document history and version control table

Version	Description	Author	Review date
1	**Initial Release, 1st edition** **Policy code: P003-2012**	**Dr. Hamad Al-Adawi**	**2012**
2	**2nd edition**	**Dr. Hamad Al-Adawi**	**2025**
3			

References

1. Ministry of Health, National Policy for Health Information Governance and Management (issued on May 2024).
2. Ministry of Health, DGPHE, Medical Record Policy, Policy Code: P003-2012
3. Ministry of Health, Medical Records Policies & Procedures Manual, 1998
4. Dubai Health Authority, Patients Records Guidelines, Draft version.
5. Health Authority- Abu Dhabi: Medical Record/Health Information Retention & Disposal Policy, version 1, last revision May 2009.
6. World Health Organization, Medical Records Manual: A Guide for Developing Countries, Revised and updated 2006.

Annexes

3.1. Approved list of abbreviations and Annex II: Unaccepted use of abbreviations.

A	
A&O	alert and oriented
A&P	auscultation and percussion
AB	Abortion
ABG	arterial blood gases
ABX	Antibiotics
Abd	Abdomen
ADA	American Diabetic Association
ADC	average daily census
ADH	antidiuretic hormone
ADL	activities of daily living
AF	atrial fibrillation
AFB	acid fast bacilli
AGA	appropriate for gestational age
AgNO	silver nitrate
AIDS	Acquired Immune Deficiency Syndrome
AK	above knee
AKA	above knee amputation
AM	Morning
AMA	against medical advice
AMI	acute myocardial infarction
AODM	adult onset diabetes mellitus
AP	Anteroposterior
Ap	Apical pulse
ARF	acute renal failure
AROM	Active Range of Motion
AS	Arteriosclerosis
ASA	aspirin (acetylsalicylic acid)
ASAP	as soon as possible
ASCVD	arteriosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASVD	arteriosclerotic vascular disease
AV	Arterioventricular
Ax	Axillary
A/G	albumin-globulin ratio
Aa	Each
Abn	Abnormal
Ac	before meals
ad lib	at pleasure; as desired
Adm	admission
Alb	albumin
Amb	ambulatory
Anes	anesthesia
angio	angiogram
Appt	appointment
Appy	appendectomy
as tol	as tolerated

B	
B ~	black female
B |	black male
BBB	bundle branch block
BE	barium enema
BF	breast feeding
B/G; BG	Blood Glucose
BIB	brought in by
BILI	bilirubin
BK	below the knee

BKA	below the knee amputation
BM	bowel movement
BMR	basal metabolic rate
BOOP	bilateral organizing obstructive pneumonia
BOW	bag of waters
BP	blood pressure
BPH	benign prostatic hypertrophy
BRP	bathroom privileges
Bs	blood sugar
BS	breath sounds
BSO	bilateral salpingo-oophorectomy
BST	breast stimulation test
BSW	Bachelor of Social Work
BUN	blood urea nitrogen
BUR	back up rate
baso	Basophil
bid	twice a day
bil	Bilateral
bilat	Bilateral
bs	bowel sounds
bx	Biopsy

C

C/O	complaints of
C/S	cesarean section
C&S	culture and sensitivity
C	Centigrade
C.spine	cervical spine
CA	Carcinoma
CABG	coronary artery bypass graft
CAD	coronary artery disease
Ca	Calcium
Cal	Calorie
Cap	Capsule
Cat	Cataract
CBC	complete blood count
CBS	chronic brain syndrome
CC	chief complaint
CCU	Coronary Care Unit
CEA	carcinoembryonic antigen
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHD	congestive heart disease
CHF	congestive heart failure
Cl	Chloride
Clliq	clear liquid
CMV	Cytomegalovirus
CAN	Certified Nurse Assistant
CNS	central nervous system
CO_2	carbon dioxide
COO	Chief Operating Officer
COPD	chronic obstructive pulmonary
COS	Chief of Staff
CPD	cephalopelvic disproportion
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CRF	chronic renal failure
CRNA	Certified Registered Nurse Anesthetist
Cr nn 2-12	cranial nerves two through 12
CSF	cerebrospinal fluid
CST	contraction stress test
CT	crutch training
CTS	Carpal Tunnel Syndrome
CT Scan	computerized axial tomography (CAT) scan
CVA	cerebrovascular accident
CVD	cerebrovascular disease
CVP	central venous pressure
CXR	chest x-ray
Cath	catheter

Cauc	Caucasian
Chol	cholesterol
Cm	centimeter
Cont	continued
Ctx	contraction
Cx	cervix

D

D&I	dry and intact
D_5W	IV Dextrose, 5% in water
DDS	dentist
DIP	distal interphalangeal
Diff	differential count
DJD	degenerative joint disease
DM	diabetes mellitus
DOA	dead on arrival
DOB	date of birth
DON	Director of Nursing
DNR	do not resuscitate
DPT	diptheria, pertussis, tetanus vaccine
DTR	deep tendon reflexes
DTs	delirium tremens
Dx	diagnosis
D&C	dilation and curettage
dist	distilled
disch	Discharge
dr	Dram
dsg	Dressing

E

EBL	estimated blood loss
EBV	Epstein-Barr Virus
ECG	Electrocardiogram
ED	Emergency Department
EDC	estimated date of confinement
EDD	estimated date of delivery
EEG	Electroencephalogram
EENT	eyes, ears, nose and throat
EFM	external fetal monitor
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ELF	elective low forceps
EMG	Electromyogram
ENG	Electroneptagmogram
ENT	ears, nose and throat
EOM	extraocular muscles
Eos	eosinophil count
EPC	electronic pain control
ER	emergency room
ERCP	Endoscopic retrograde cholangiopancreatography
ES	electrical stimulation
ESR	erythrocyte sedimentation rate
ETIOL	Etiology
ETOH	ethyl alcohol
EVAL	Evaluation
EX	Exercise
EXTR	Extraction
Elix	Elixir
Exam	Examination
Ext	External

F

F	Fundus
F/U	follow up
FB	foreign body
FBS	fasting blood sugar
FEV_t	timed forced expiratory volume
Fe	iron
FFP	fresh frozen plasma

FH	family history
FHM	fetal heart monitor
FHR	fetal heart rate
FHT	fetal heart tones
FIL	fetal intolerance to labor
$FI0_2$	fractional inspired oxygen
FLM	fetal lung maturity
FOB	foot of bed
FROM	full range of motion
FS	frozen section
FUO	fever of undetermined origin
FVC	forced vital capacity
FWB	full weight bearing
FWW	front wheel walker
Flliq	full liquid
Fx	fracture
Fib	fibrillation
Ft	foot

G

G	gravid
GA	gestational age
GB	gallbladder
GBS	Guillain-Barré Syndrome
GC	gonorrhea
GI	gastrointestinal
Gm	gram
GSW	gunshot wound
GT	gait training
GTT	glucose tolerance test
GU	genitourinary
GYN	gynecology
gr	grain
gtt	Drops

H

H/H	hemoglobin/hematocrit
H&H	hemoglobin and hematocrit
H&P	history and physical
HA	Headache
HB	heart block
HBP	high blood pressure
HCO_3	Bicarbonate
HCVD	hypertensive cardiovascular disease
Hct	Hematocrit
HEENT	head, eyes, ears, nose and throat
Hgb (Hg)	Hemoglobin
HIV	human immunodeficiency virus
HL	Heparin Lock
HLP	Hyperlipoproteinemia
HNP	herniated nucleus pulposus
HOB	head of bed
HP	hot packs
HPF	high power field (microscopic field)
HPPE	hyperpermeability pulmonary edema
HR	heart rate
HTL VIII	lab test for AIDS virus
HTN	Hypertension
HVD	hypertensive vascular disease
Ht	Height
Hx	History
H_2O	Water
H_2O_2	hydrogen peroxide
Hgm	Hemogram
Hr	Hour

I

I&D	incision and drainage
I&O	intake and output
ICU	Intensive Care Unit

IM	Intramuscular
IMI	brand name abbreviation for a radiant
IOL	intraocular lens
IP	interphalangeal
IPPB	intermittent positive pressure breathing
ISE	internal scalp electrode
IUD	intrauterine device
IUP	intra uterine pregnancy
IV	Intravenous
IVAB	intravenous antibiotics
IV push	intravenous push
IVC	inspiratory vital capacity
IVF	IV fluids
IVP	intravenous pyelogram
IVPB	intravenous piggyback
in	Inch
inf mono	infectious mononucleosis
int	Internal

J

Jt	Joint
JVD	jugular venous distention
JVP	jugular venous pressure or pulse

K

K	potassium
KCl	potassium chloride
KUB	kidney, ureter, bladder
kg	kilogram

L

L	left
LAO	left anterior oblique
Lab	laboratory
Lap	Laparotomy
LBBB	left bundle branch block
LCSW	Licensed Clinical Social Worker
LDH	lactic acid dehydrogenase
LE	lower extremity
LFT	lower function test
LGA	large for gestational age
LLE	left lower extremity
LLH	left lateral heelstick
LLL	left lower lobe (of lung)
LLQ	left lower quadrant
LMH	left medial heelstick
LMP	last menstrual period
LOA	left occipitoanterior position
LOC	loss of consciousness
LOS	length of stay
LOT	left occiput transverse position
LP	lumbar puncture
LR	lactated ringers
LS	Lumbosacral
LSD	lysergic acid diethylamide
LTV	long term variability
LUE	left upper extremity
LUL	left upper lobe (of lung)
LUQ	left upper quadrant
LVF	left ventricular function
LVN	Licensed Vocational Nurse
LWBS	left without being seen
Lymphs	Lymphocytes
L&W	living and well
lytes	Electrolytes
lat	Lateral
lb	Pound

M

M.A.E.	moves all extremities

MAC	monitored anesthesia care
MAT	multifocal atrial tachycardia
MCH	mean corpuscular hemoglobin
MCL	mid clavicular line
MD	medical doctor
MED/ SURG	medical/surgical unit
MEF	maximal expiratory flow
Meds	Medicines
MG	Magnesium
MI	myocardial infarction
ML	mediolateral
MMT	manual muscle test
MN	midnight
MOM	milk of magnesia
MR x 1	may repeat times one
MRI	magnetic resonance imaging
MRSA	methicillin resistant staphylococcus aureus
MS	Morphine Sulfate
MSG	massage
MSW	Medical Social Worker
MT	multiple trauma
M+T	myringotomy and tubes
MVA	motor vehicle accident
MVP	mitral valve prolapse
m	minimum
mcg	microgram
mec	meconium
mg	milligram
mid	midline
min	minute
mL	milliliter
mm	millimeter
mono	monocytes

N

N/A	not applicable
N&T	nose and throat
N&V	nausea and vomiting
NA	Nursing Assistant
NAD	no acute distress
Na	Sodium
NaCL	sodium chloride
$NaHCO_3$	sodium bicarb
NB	newborn
NBN	newborn nursery
NG	nasogastric
NH_3	ammonia
NKA	no known allergies
NKDA	no known drug allergies
NN	Nerves
NP	non-productive
NPO	nothing by mouth
NS	normal saline
NSAID	nonsteroidal anti-inflammatory drugs
NSR	normal sinus rhythm
NST	non-stress test
NSY	Nursery
NT	non-tender
NTG	Nitroglycerin
N/V/D	nausea, vomiting, diarrhea
NWB	no weight bearing
neg	Negative
neuro	Neurological
nl	Normal

O

O_2	Oxygen
OA	occiput anterior
OB	Obstetrics

OBS	organic brain syndrome
OCT	oxytocin challenge test
OK	Okay
OM	otitis media
OOB	out of bed
OP	Outpatient
OPS	outpatient surgery
OR	operating room
ORIF	open reduction, internal fixation
occ	Occasional
ophth	Ophthalmology
ortho	Orthopedic
oz	Ounce

P

P&A	percussion and auscultation
P&PD	percussion and postural drainage
PA&L	posterior, anterior and lateral chest x-ray
PA	Physician Assistant
PAC	premature atrial contraction
PACU	Post Anesthesia Care Unit
PAR	post anesthesia room
PAT	paroxysmal atrial tachycardia
Pap	Papanicolaou, smear test
Para	parity
PBI	protein bound iodine
PCA	patient controlled analgesia
PCN	penicillin
PCO_2	carbon dioxide pressure
PDR	Physician's Desk Reference
PE	physical examination
PE tubes	pressure equalizer tubes
PEEP	positive end-expiratory pressure
PERRLA	pupils equal, round, reactive to light and accommodation
Ped	pediatric
PEG	percutaneous endoscopic gastrostomy
PF	peak flow
PFT	pulmonary function tests
PI	present illness
PID	pelvic inflammatory disease
PIP	proximal interphalangeal (joint)
PIT	pitocin
PKU	phenylketonuria
PM	afternoon, evening
PMD	private medical doctor
PMH	past medical history
PMI	point of maximum impulse
PMR	polymyalgia rheumatura
PMS	premenstrual syndrome
PND	paroxysmal nocturnal dyspnea
PO_2	oxygen partial pressure
PO_4	phosphate
POD	postoperative day
POS	positive
PP	post partum
PPD	purified protein derivative
PRBC	packed red blood cells
PRBOW	prolonged ruptured bag of waters
PROM	premature rupture of membranes
iPROM	prolonged rupture of membranes
PT	prothrombin time
PTA	prior to admission
PTC	prior to consult
PTT	partial thromboplastin time
PUD	peptic ulcer disease
PUW	pick-up walker
PVC	premature ventricular contraction
PWB	partial weight bearing
path	pathology, pathologist

pc	after meals
peri	Perineal
pH	Hydrogen Iron concentration
pneumo	pneumoencephalogram
po	by mouth (per os)
post	Posterior
postop	Postoperative
pre	Before
preop	Preoperative
prep	Preparation
prn	whenever necessary
pt	Patient

Q

QNS	quantity not sufficient
QS	quantity sufficient
QUAD	Quadrant
q2h	every two hours
qam	every morning
qh	every hour (quaque hora)

R

R/O	rule out
(R)	rectal temperature
R	Right
RA	rheumatoid arthritis
RBBB	right bundle branch block
RBC	red blood cells
RBOW	ruptured bag of waters
RBS	random blood sugar
RCNA	Restorative Certified Nursing Assistant
RHD	rheumatic heart disease
Rh	Rhesus blood factor
RL	ringers lactate
RLE	right lower extremity
RLH	right lateral heel
RLL	right lower lobe (of lung)
RLQ	right lower quadrant
RMH	right medial heel
RN	Registered Nurse
RO	routine orders
ROA	right occiput anterior
ROM	Range of Motion
ROP	right occiput posterior
ROS	review of systems
ROT	right occiput transverse
RR	respiratory rate
R/T	related to
RUE	right upper extremity
RUL	right upper lobe (of lung)
RUQ	right upper quadrant
RV	right ventricle
Rx	prescription
reg	regular
rehab	rehabilitation

S

SBO	small bowel obstruction
SCH	Supra Condylar Humerus
Schiz	Schizophrenia
SFP	superficial femoral artery
SGA	small for gestational age
SGOT	serum enzymes (serum glutamic-oxaloacetic transaminase)
SGPT	serum glutamic pyruvic transaminase
SH	social history
SIADH	Syndrome of Inappropriate Antidiuretic Hormone Secretion
SL	Sublingual
SLR	straight leg raising
SNF	Skilled Nursing Facility

SOAP	subjective, objective, assessment, plan
SOB	shortness of breath
S/P	status post
SPgr	specific gravity
SR	sinus rhythm
SS#	social security number
SSE	soapsuds enema
S/S	signs and symptoms
STAT	at once (statim)
STV	short term variability
SVT	supraventricular tachycardia
St WP	sterile whirlpool
Staph	staphylococcus (bacteria)
Strep	streptococcus (bacteria)
Subling (SL)	sublingually; under the tongue
Surg	surgery or surgical
Sx	Symptoms
S/P	status post
sat	Saturate
sed rate	erythrocyte sedimentation rate
sol	Solution
spec	Specimen

T

T	Thermoscan (thermometer)
T&A	tonsillectomy and adenoidectomy
T&C	type and crossmatch
T spine	thoracic spine
T.C.	traffic collision
T.U.R.	transurethral resection
TAB	therapeutic abortion
TAH	total abdominal hysterectomy
TB	tuberculosis
TBA	to be admitted
TEA	thromboendarterectomy
TENS	Transcutaneous Electrical Nerve Stimulator
TIA	transient ischemic attack
TIC	Transitional Inpatient Care
TKO	to keep open
TLC	total lung capacity
TMJ	temporomandibular joint
TMs	tympanic membranes
TO	telephone order
TOLAC	trial of labor after cesarean
TORCH	toxoplasmosis, syphilis, rubella, cytomegalovirus, herpes
TPN	total parenteral nutrition
TPR	temperature, pulse and respiration
TR	transfer
TURBT	transurethral resection of bladder tumor
TURP	transurethral resection of the prostate
TVH	total vaginal hysterectomy
Tx	treatment
tab	tablet
tbsp	tablespoon
tid	three times a day (ter in die)
tsp	teaspoon

U

U/C, UC	uterine contraction
UA	urinalysis
UE	upper extremity
UGI	upper gastrointestinal
UKE	unknown etiology
UO	undetermined origin
URI	upper respiratory
US	ultrasound
UTI	urinary tract infection

V	
VA	visual acuity
VBAC	vaginal birth after cesarean
VC	vital capacity
VD	venereal disease
VDRL	venereal disease lab test (for syphilis)
VE	vaginal exam
Vent	mechanical ventilator
VO	verbal order, voice order
VPB	ventricular premature beat
Vre	Vancomycin Resistant Enterococci
VS	vital signs
v.f.	ventricular fibrillation
v, vs	Versus
via	By
vol	Volume

W	
WBAT	weight bearing as tolerated
WBC	white blood cells
WDWN	well developed, well nourished
W ~	white female
W |	white male
WNL	within normal limits
WP	Whirlpool
W/U	work up
w/a	while awake
w/c	Wheelchair
w/o	Without
wk	Week
wt	Weight

Y	
Y/O	year old
yr	Year

Symbols	
p,‾	After
≈	Approximate
@	at
a,‾	before
↓	decreased
°	degree
≠	does not equal
=	equal
q,‾	every (quaque)
~	female
′	foot
″	inch
↑	increased
|	male
-	minus/negative
0	none
1x	once
$\frac{1}{u}$	position of fundus (i.e., 1 finger above umbilicus)
+	plus/positive
#	pound
?	questionable
2°	secondary
2x; x2	twice
c,‾	with
s,‾	without (sine)

3.2. Unacceptable abbreviation and symbol list

Do Not Use Any of the Following When Ordering, Prescribing or in Documentation:

* The Joint Commission's "do not use" list of abbreviations. (BOLDED)

** Institute of Safe Medication Practices (ISMP) list of dangerous abbreviations relating to medication use. The ISMP recommends these abbreviations should be explicitly prohibited.

Unacceptable Abbreviation/Symbol	Code	Why this is not to be used	What is acceptable practice
Decimal point preceding dose without preceding zero Example: .5 mg	*/**	Can be mistakenly read as multitudes of the intended amount without notice of the decimal	Include the preceding zero (0) before a decimal point when the dose is less than a whole unit Example: 0.5 mg
Trailing or terminal zero after decimal point - prohibited for all medication orders and other medication-related documentation Example: 3.0 mg	*/**	Can be mistakenly read as multitudes of the intended amount without notice of the decimal point	Do not use trailing or terminal zeros. Write doses as whole numbers Example: 3 mg *Acceptable practice does include reporting laboratory values and in certain other numeric notations, i.e., equipment size where the precision of the numeric value is indicated by the digits after the decimal point*
IU	*/**	Can be mistaken for intravenous or 10 (ten)	Write out the words "international units"
$MgSO_4$	*/**	Can be mistaken for morphine sulfate	Write out the complete name of drug
MS, MSO_4	*/**	Can be mistaken for magnesium sulfate	Write out the complete name of drug
q.d., qd, Q.D. or QD (every day)	*/**	Can be mistaken for q.i.d., four times daily	Write out the word "daily" or "every day"

Unacceptable Abbreviation/Symbol	Code	Why this is not to be used	What is acceptable practice
q.o.d., qod, Q.O.D. or QOD (every other day)	*/**	Can be mistaken for daily or four times daily	Write out the phrase "every other day"
U or u	*/**	Frequently mistaken for the number zero or the number four	Write out the word "unit"
A.D., A.S., A.U.	**	Can be mistaken for each other or for O.D., O.S., O.U.	Write out the term "left ear", "right ear" or "both ears"
Apothecary symbol for the word dram	**	Can be mistaken for the number three (3)	Use the metric system instead of this apothecary symbol
Apothecary symbols for the word minim	**	Can be mistaken for the abbreviation mL	Use the metric system instead of this apothecary symbol
BT	**	Can be mistaken for BID (twice daily)	Write out the phrase "at bedtime"
Cc	**	Can be mistaken for units (with the cc looking like a "u")	Use the term mL or write out the term "cubic centimeters"
D/C	**	Can be interchanged to mean discontinue or discharge	Write out your intent, either "discontinue" and the name of the drug or "discharge the patient"
HS, qhs	**	Can be mistaken for every hour or half-strength	Write out the word "nightly" or the phrase "nightly at bedtime"; write out "half-strength"
IJ (injection)	**	Can be mistaken for IV, intravenous or intrajugular	Write out the word "injection"
IN (intranasal)	**	Can be mistaken for IM or IV	Write out the word "intranasal"
OD or o.d. (once daily)	**	Can be mistaken for "right eye"	Write out "daily" or "once a day"
O.D., O.S., O.U.	**	Can be mistaken for each other or for A.D., A.S., A.U.	Write out the term "left eye", "right eye" or "both eyes"
OJ (orange juice)	**	Can be mistaken for OD or OS (right or left eye)	Write out the words "orange juice"

Unacceptable Abbreviation/Symbol	Code	Why this is not to be used	What is acceptable practice
per os	**	The abbreviation "os" can be mistaken for left eye	Write out the term "per mouth", or the word "orally" or use the abbreviation "PO"
Qn	**	Can be mistaken for every hour	Write out the word "nightly"
q1d (daily)	**	Can be mistaken for q.i.d, four times daily	Write out the word "daily"
q6PM, etc.	**	Can be mistaken for every six (6) hours	Write out "6PM nightly" or "6PM daily"
ss (sliding scale or 1/2 apothecary)	**	Can be mistaken for the number 55	Write out the phrase "sliding scale" or write out "one half" or "1/2"
SSRI (sliding scale regular insulin)	**	Can be mistaken for selective-serotonin reuptake inhibitor	Write out "sliding scale insulin"
SSI (sliding scale insulin)	**	Can be mistaken for Strong Solution of Iodine (Lugol's Solution)	
Sub q	**	The "q" can be mistaken for the term "every"	Write out the word "subcutaneous" or the abbreviation "subcut"
SC	**	SC can be mistaken for sublingual	
SQ	**	Can be mistaken for "5 every"	
TIW or tiw	**	Can be mistaken for three times per day	Write out "three times per week"
> and <	**	Can be misinterpreted to mean the opposite of what is intended	Write out the terms "greater than" or "less than"
1/2	**	Can be mistaken for 55	Write out the phrase "one-half" or use quotes around the numbers "1/2"
Use of the slash mark (/)	**	Can be mistaken for the number 1	Do not use a slash mark to separate doses, write out the word "per"

Unacceptable Abbreviation/Symbol	Code	Why this is not to be used	What is acceptable practice
µg (for microgram)	**	Can be mistaken for mg (milligram), which can result in a ten-fold dosing overdose	Use the abbreviation "mcg" or write out the word "microgram"
x3d	**	Can be mistaken for three doses	Write out the phrase "for three days"
@	**	Can be mistaken for the number 2	Write out the word "at"
&	**	Can be mistaken for the number 2	Write out the word "and"
+	**	Can be mistaken for the number 4	Write out the word "and"
Symbol of hour (°)	**	Can be mistaken for zero (0)	Write out "hour" or "h" or "hr"

Unacceptable Abbreviation/Symbol	Code	Why this is not to be used	What is acceptable practice
The following Drug Abbreviations are not to be used because they can be mistaken for other drugs:			Write out the complete name of the drug
ARA-A - Vidarabine	**		
AZT- Zidovudine (Retrovir)	**		
CPZ - Prochlorperazine (Compazine)	**		
DPT - Abbreviation for Demerol-Phenergan-Thorazine	**		
HCl - Hydrochloric Acid	**		
HCT - Hydrocortisone	**		
HCTZ- Hydrochlorothiazide	**		
MTX - Methotrexate	**		
PCA - Procainamide	**		
PTU - Propylthiouracil	**		
T3 - Tylenol with Codeine No. 3	**		
TAC - Triamcinolone	**		
TNK - TNKase	**		
ZnSO4 - Zinc sulfate	**		

Unacceptable	Why this is not to be used	What is acceptable practice
Do not Shorten Names of Drugs Example: "Nitro drip"	Can be mistaken for other drug names, such as in the example - "Nitro" drip can mean nitroglycerin or sodium nitroprusside	Write out the complete name of drug
The name of the drug and dose run together Example: Inderal40 mg	Inderal 40 mg is mistaken for Inderal 140 mg	Ensure adequate space between the name of the drug, the dose and the unit of measure
The dose of the drug runs together with the unit of measure Example: 10mg	The "m" is mistaken for another zero	Place a space between the dosage and the unit of measure Example: 10 mg
A period is placed after an abbreviation Example: mg. or mL.	If poorly written, the period could look like the number 1	Do not place a period after abbreviations, such as: Example: mg, mL

Unacceptable	Why this is not to be used	What is acceptable practice
Commas not placed when large doses are written Example: 10000 units of heparin	Orders are not clear without the commas; wrong dosages are given	Remember to place commas appropriately at or above 1,000 units, or to write out the complete dosage Example: 10,000 units of heparin