Ombudsmen Access in Nursing Homes and Assisted Living Facilities

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June 2008
500 ACCESS

PURPOSE: This section provides guidance for Certified Ombudsmen to access residents, facilities, information, and records. This section also provides guidance to Ombudsman Interns to access residents and facilities.

REVISION HISTORY
1-1-2009

POLICY: Access by the LTCOP accomplishes three vital functions: (1) investigate and resolve complaints, (2) represent the interests of a resident, and (3) ensure the protection of resident rights in LTC facilities. Federal law authorizes the Texas LTCOP to gain access to facilities, residents, confidential information, certain facility records, and resident records.

Subsection 101.058 of the Texas Human Resource Code applies to the LTCOP’s access. The statute currently states volunteer ombudsmen do not have access to resident records or information. Subsection 712 (b) of the Older Americans Act (OAA) directs a “representative” of the LTCOP access to residents and their records; therefore, subsection 101.058 of the state ombudsman statute is obsolete. In Texas, certified ombudsmen, both staff and volunteers, have such access.

PROCEDURE:

501 FACILITIES

501.1 BUILDING

Notification and check-in
A CO or Ombudsman Intern makes unannounced visits to nursing homes and assisted living facilities. Regular visitation may be varied to include visits on evenings and weekends, as well as different weekdays and times of day. Exceptions to unannounced visits include meeting with management, care plan meetings, and attendance at a family or resident council meetings.

Facilities often have a sign-in procedure for visitors and professionals. This procedure may be tied to security and monitoring practices necessary to protect resident health and safety. If a facility policy requires all visitors to sign-in, a CO may sign-in as a courtesy. Sign-in is not expected of the CO if the facility policy does not apply to all visitors in the building.

A CO respects other check-in procedures that do not impede ombudsman access. Such procedures may include notifying the front desk or administrator of the CO’s presence in the building and attempting to exit with the administrator at the end of the CO’s visit. However, the CO’s time is valuable and facility policies that are used to control ombudsman access or to limit the CO’s time in the facility will not be tolerated. If the CO suspects facility requests are intended to restrict the CO’s access, report to the local LTCOP for resolution. The Office is also available for assistance.

Visitation times
Facilities may develop policies to set visitation times. These policies should not violate resident rights. A CO typically visits during hours when residents are awake; however, a specific complaint may necessitate other visitation times. If a complaint is of a particularly unusual time or nature, the CO should consult with local LTCOP staff before investigating.

Restricted areas
A CO may access areas where residents live and receive services. In general, areas restricted to residents are also restricted to a CO. These areas may include kitchens, medicine storage closets, electrical, and utility rooms. However, depending upon a specific complaint, inquiry, or if invited to view a restricted space under facility staff supervision, limited access to a usually-restricted area is appropriate.
501.2 RESIDENT & FAMILY GROUPS

A representative attends a resident or family council meeting by invitation only. “Standing” invitations are permissible; however, if a CO attended every council meeting, the council might not act independently. As a matter of protocol during the DADS Regulatory Services’ resident group interview, Regulatory Services staff asks residents if they approve of the CO’s presence. This policy reinforces respect for resident rights and resident councils.

502 FACILITY INFORMATION

Facilities develop policies and forms such as admission agreements, facility policies, and staffing records. Formats vary by facility but are available to the public and thus available to a CO.

Admission agreement (resident agreement)

When first assigned to a facility, and annually, request an admission packet given to newly admitted residents. Review the contents and be familiar with the language in the agreement. Consider any requirements that appear to violate resident rights and bring to the attention of facility staff and the local LTCOP. Admission agreements are especially important in licensed-only nursing homes and assisted living facilities; they serve as contracts and describe conditions for a resident’s stay, reasons for discharge, costs, refund and services information, and other contractual requirements.

Facility policies and staffing records

State and federal laws require long-term care facilities to have policies and procedures, which outline general and emergency facility operations. Nursing homes are required to conspicuously and prominently post daily for each shift, the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. Monitoring this record on a routine basis can help a CO identify staffing trends and determine if staffing patterns are adequate to meet the needs of residents in the building.

Records available from other sources

DADS Licensing (new applications and change of ownership applications), DADS Regulatory Services, DADS Provider Services (trust fund information), Medicaid (cost reports), and certain court records can be accessed by request of the Office or by a Public Information Act request.

Health and Human Services websites are resources for reports and statistics:

- Regulatory Services
  - Reports and Statistics [www.dads.state.tx.us/providers/reports/index.html](http://www.dads.state.tx.us/providers/reports/index.html)
  - Closures [www.dads.state.tx.us/providers/closures/index.html](http://www.dads.state.tx.us/providers/closures/index.html)
  - Licensing [www.dads.state.tx.us/providers/NF/howto.html#nlicense](http://www.dads.state.tx.us/providers/NF/howto.html#nlicense)
  - Nurse Aide Registry [www.dads.state.tx.us/providers/NF/credentialing/nar/index.html](http://www.dads.state.tx.us/providers/NF/credentialing/nar/index.html)

- Health and Human Services Commission Medicaid cost reports [http://www.hhsc.state.tx.us/default.htm](http://www.hhsc.state.tx.us/default.htm)

- DADS court-appointed trustee program [www.dads.state.tx.us/providers/trustee/index.html](http://www.dads.state.tx.us/providers/trustee/index.html)

503 RESIDENTS

Residents are the LTCOP’s primary clients. An effective advocate builds trusting relationships with residents and balances working relationships among residents, family members, visitors, facility staff, and other professionals affiliated with residents, e.g., therapists.
Private communication
Always knock before entering a resident’s room; this action models respect of privacy to residents and facility staff. Residents determine the location to visit with a CO. If a CO believes more privacy is needed, suggest meeting in a room with the door closed.

A representative’s access to a resident should not interfere with therapies, wound care, bathing, incontinent care, or other services. If visiting with a resident and care is offered by facility staff, excuse yourself and offer to come back at a later time.

Legally authorized representatives (LAR)
LARs may include the guardian of an adult, a parent or a managing conservator of a minor, or an agent authorized to consent to the disclosure of a resident’s record under a medical POA or durable POA. An LAR must have current documentation that complies with state law. If a person states he is an LAR, a CO must verify the statement by reviewing the documentation establishing the person’s authority, including letters of guardianship or the POA. As part of the review, the CO must determine the scope of the LAR’s authority. A resident, regardless of the resident’s capacity, may revoke a POA at any time, ending the agent’s authority.

The term “responsible party” is commonly used in nursing homes and assisted living facilities. However, this term has no legal authority associated with it. The responsible party is usually a family member or relative but may be guardian of the person or POA. Notation of the responsible party may be in writing or given orally; exercise caution when a facility extends decision-making power to the responsible party. If the resident can speak for himself, seek the resident’s input.

Contact isolation and other health issues
When a resident’s condition limits accessibility, contact isolation should be clearly marked on a resident’s door. A CO may consult with facility staff regarding safeguards and precautions, when necessary, to facilitate communication with an isolated resident. Wash hands regularly and use antibacterial lotions to protect the spread of infectious disease and to protect your own health. When a CO is ill, he or she should not visit the facility. If a CO receives a complaint when ill, ask another CO to respond.

Some residents have difficulty communicating orally. Try different techniques for communication based on the disabling condition. Investigate assistive communication devices to facilitate communication opportunities for the resident.

Related Resources: Certification Training Manual, Modules 1, 2, 3, 6

504 RESIDENT RECORDS

In some circumstances, a record review may be the most appropriate action. Local LTCOPs must not develop local procedures that violate the OAA, restrict resident rights, or deny a CO access to records. Local LTCOP structure establishes a chain of command for communication, consultation, and guidance to a CO.

Before reviewing a record, a CO takes the following steps in the inquiry or intake phase:
1. Visit the resident to gather information regarding a complaint or inquiry
2. Determine if the concern is a regulatory issue
3. If the resident was not the original complainant, inform the resident of the concern
4. Ask the resident if he or she wants you to investigate (obtain consent)
5. Determine courses of action necessary to proceed

The review of clinical records may be used by a CO to: 1.) investigate a complaint or 2.) represent or respond to a resident’s expressed interests. A CO often can get quality information by consultation with professionals, rather than review of a record. Resident care records are confidential; therefore, a CO
must obtain resident consent before review, unless the resident is unable to consent. In such a case, refer to Section 402.3 Consent to Access Confidential Information.

Under no circumstances may a CO randomly review resident records.

Ombudsman interns do not have access to a resident's record or its contents.

Related Resource: Certification Training Manual, Module 1

504.1 ASSESS NECESSITY OF A RECORD REVIEW

Resident or guardian requested
A CO may help a resident access his own records and support this resident right. If facility staff resists this endeavor, the CO informs the facility staff of resident rights and may seek guidance from the local LTCOP. When assisting a resident with access to his own record, a CO takes the following steps:

1. Document the request and resident consent to act
2. Encourage resident participation
3. Ensure privacy
4. Report to local LTCOP on monthly report as “request for assistance”

Family or POA requested
If a family member or POA requests assistance in accessing a resident’s record, a CO seeks resident consent before proceeding. Instances in which the resident is unable to or refuses consent are addressed in Section 402.3 Consent to Access Confidential Information.

CO requested
When a CO believes a record review may be appropriate, consider the questions in Figure 5.1 in preparation for local LTCOP consultation:

Figure 5.1
1. What is the issue or concern?
2. What actions has the resident or CO already taken to resolve the situation?
3. What factors exist making review of a record necessary?
4. What specifically are you looking for, e.g. a pattern, omission, or verification of fact?
5. Has the resident been informed of the right to review his own records?
6. Does the resident understand the request for records will identify him?
7. Does the resident have an LAR?
8. Does distrust of facility staff seem to be the primary reason for the request?
9. What alternative sources could provide the same information?
10. Will record review cause any possible negative outcomes?

Office requested
The Office may request a record review related to a government or consumer inquiry. The request will be made in writing and consultation between the acting CO and the Office is required.

504.2 CONSULT WITH LOCAL LTCOP STAFF & STATE OFFICE

When a CO initiates the request and believes responses to questions in Figure 5.1 confirm that a record review is necessary, the CO follows the local LTCOP chain of command to consult (via telephone or in person) with local LTCOP staff for agreement that a record review is an appropriate action. If the CO cannot reach local LTCOP staff, the CO may seek alternative sources for information until local LTCOP consultation can be provided. If the situation is an emergency, the CO consults with the Office.
When a resident is unable to consent

- If the Certified Volunteer Ombudsman is the requestor, he or she consults with his or her program supervisor (MLO or Certified Staff Ombudsman). Then, the Certified Staff Ombudsman or MLO consults with the Office.
- If the MLO or Certified Staff Ombudsman is the requestor, he or she consults with the Office before accessing a record.

After local LTCOP consultation, the CO documents the discussion. If the local LTCOP staff person does not agree that a record review is necessary, the pursuit of record review must conclude.

Direct any grievances regarding this process to the local LTCOP supervisor, then to the SLTCO for a final decision. See Ombudsman Volunteer Support Manual [to be developed] for guidance regarding volunteer grievances.

504.3 Obtain Consent

Obtain consent before accessing a confidential record.

- If the complainant is not the resident, if possible, seek resident consent before proceeding.
- If the resident is unable to consent, a CO must follow the consultative chain of command before taking further action.
- If the resident has an LAR, that person may have authority to consent.

In all cases, documentation of consent is required. See Section 402, Consent for additional detail on issues of consent.

504.4 Request, Review, and Use of a Record

Request

Request a record from the nurse’s station or administrative office. Present documentation of written consent to appropriate facility staff, if requested. If the resident provided oral consent, advise the facility staff who may confirm the request with the resident.

Types of resident records include but are not limited to:

- care notes
- care plans
- physician orders
- incident reports
- grievance reports
- bathing schedules
- medication administration records
- trust fund (financial) records

Facility staff may provide the entire clinical record, and the CO may accept it. A CO is expected to limit a review to necessary information specific to the complaint or inquiry. Some resident records are kept separately. If the CO needs additional information, ask the nurse or administrative office for assistance.

Restricted records include:

- personnel
- facility budget, accounting
- quality assurance committee documentation

Review

When viewing a resident’s record, start by finding a private location. Review only the records pertinent to the concern or inquiry. If possible, involve the resident in the review.

During the record review, take notes as needed. These notes are the property of the local LTCOP (See Section 800, Records of the Local LTCOP).

A CO may consult with other professionals about record content but does not make medical assumptions, interpretations, or provide medical advice.
Use
Proceed with local LTCOP investigation or activity. Determine if a copy of a portion of the record is needed.

Inform the resident or LAR, if appropriate, of findings on an ongoing basis. Present information to facility staff per resident wishes.

504.5 DOCUMENTATION AND PHOTOCOPYING

Documenting Consent
Document consent (Section 402 Consent) as either:

- WRITTEN: Use DADS “Consent to Disclose Records to the Certified Ombudsman” – [Form currently under development]. Complete all sections with appropriate signatures and dates.
- ORAL: Document consent on DADS "Consent to Release Records" - Form 8624 or in representative’s case notes and note the consent on the LTCOP monthly report form.

Provide proof of consent upon request to facility staff.

Photocopying Documents
Photocopying may be necessary on occasion to use in formal hearings or care plan meetings and to collect information that may contradict or confirm oral statements made by professional staff, LARs, or others regarding a resident’s care.

A facility may charge for photocopies at a cost not to exceed the community standard. Center for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP, provides additional information for determining a “community standard.”

Submitting Documentation
At the time a case is closed, submit all documentation to the local LTCOP with the corresponding monthly report.

Once the CO submits documentation, the local LTCOP maintains it according to retention procedures.

504.6 EMERGENCY RECORD REVIEW

In situations when a facility is immediately closing or in response to a disaster, a CO may access resident records to assist in closure support activities or disaster response in coordination with facility staff, corporate staff, and other professionals. Immediately notify the local LTCOP and the Office in these cases. The Office may approve other emergency instances as needed.
# Policies and Procedures Manual

## ACRONYMNS

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AAA</td>
<td>Area Agency on Aging</td>
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<tr>
<td>APS</td>
<td>Adult Protective Services (a division of DFPS)</td>
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<tr>
<td>CO</td>
<td>Certified Ombudsman, both certified volunteer and/or certified staff</td>
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<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<tr>
<td>DFPS</td>
<td>Department of Family and Protective Services</td>
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<tr>
<td>LAR</td>
<td>Legally Authorized Representative, such as a guardian, a parent, managing conservator of a minor, or an agent authorized under a POA</td>
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<td>LTC</td>
<td>Long-Term Care</td>
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<tr>
<td>LTCOP</td>
<td>Long-Term Care Ombudsman Program, e.g., the local office of the 28 ombudsman programs</td>
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<tr>
<td>MLO</td>
<td>Managing Local Ombudsman, also a Certified Ombudsman</td>
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<td>OAA</td>
<td>Older Americans Act</td>
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<td>POA</td>
<td>Power of Attorney</td>
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<td>MPOA</td>
<td>Medical Power of Attorney</td>
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<tr>
<td>DPOA</td>
<td>Durable Power of Attorney</td>
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<td>RS</td>
<td>Regulatory Services</td>
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<td>SLTCO</td>
<td>State Long-Term Care Ombudsman</td>
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<tr>
<td>TAC</td>
<td>Texas Administrative Code</td>
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<tr>
<td>TOPPS</td>
<td>Texas Ombudsman Program Performance System, i.e., the Internet-based system</td>
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6/24/2008
Hello Texas Ombudsmen. My name is Patty Ducayet, and I am your State Long-Term Care Ombudsman.

Thank you for your advocacy efforts in nursing homes and assisted livings. Your tenacity to uphold Resident Rights and to protect the health and safety of residents is absolutely critical to giving individuals the care and quality of life they deserve. Your presence in their lives, and in long-term care facilities, means so much.

As a certified ombudsman, you know that the Older Americans Act authorizes the ombudsman program, and requires each State to ensure an ombudsman has access to residents and facilities. In Texas, we accomplish this access by laws and rules that require facilities to allow our entry and private visitation with residents. Not only do we need access to residents, we also need to access information about them. This information, whether shared orally by a caregiver, the resident, or physician, or documented in the resident's clinical record, is all confidential. Remember, an Ombudsman is required by law to protect a resident’s confidentiality. Never share information about a resident without the resident’s consent.

We are lucky enough to have Dr. Schindeler-Trachta to give us an overview of the basic contents of a medical record. Although you won't likely need to review a medical record in its entirety, Dr. S-T will give you a sense of what you can expect to find in a record from front to back. You should have a couple of handouts to follow along with the presentation. One is a set of PowerPoint slides; the other is a list of common medical abbreviations.

This training can’t make you an instant expert on clinical records, nor is that your role. The record or its contents is one source for information as you investigate a complaint or respond to an inquiry. You can usually get good information by consulting with a professional, rather than reviewing a record. As ombudsmen, we must not make medical assumptions, interpretations, or provide medical advice. Our advocacy efforts will center around asking good questions and staying grounded in resident rights.

In every case that a record needs to be accessed, follow our ombudsman procedures. When the resident requests you to look at his record, you may assist immediately and involve the resident in the request to facility staff. If you are the requestor, consult with the Staff Ombudsman before proceeding. Always document that consent was given by the resident or her representative and provide that documentation to your ombudsman office. For more information on our procedures for access, contact your Managing Local Ombudsman.

I want to thank you again for all that you do on behalf of residents in long-term care. Keep up the great work, stay in close contact with your ombudsman program staff, and continue to be the voice of common sense and resident rights.

Thank you.
Organization of a Medical Chart

Dr. Rita Schindeler-Trachta, FAAFP
Department of State Health Services
Medical Clinic
Professional Medical Services Manager
Purpose

Facilitates communication among all members of the health care team involved in a person’s care
Organization of a Medical Chart

- **Location**
  - Medical Office
  - Hospital
  - Care Facility

- **Type**
  - Paper
  - Electronic
  - Combination
Privacy Laws

- **State Law**: Health and Safety Code Chapter 181 Medical Records Privacy

- **Federal Law**: Public Law 104-191 Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Sections

- Administration
- History and Physical
- Vital Signs
- Progress Notes
- Physician Orders
- Nurses Notes
- Labs
- Imaging
- Therapy
- Case Management
Administration

- Patient demographics
  - Name, Date of birth
  - Family Contacts
  - Primary Physician
Administration

- Advance Directive Information
  - Out-of-Hospital Do not Resuscitate
  - Durable Medical Power of Attorney
  - Directive to Physician
History and Physical (H&P)

- Latest comprehensive medical history and physical exam done by the Physician
- Sometimes includes a discharge summary from a recent hospitalization
- Good medical overview of the patient
Mr. Jones

- 88-year-old widow with no children
- **Past medical history**
  - **Diabetes**: Complications included surgical removal of gangrenous toes
  - Hypertension
  - **Coronary artery disease**: Coronary stent placed after his heart attack last year
  - **Prostate cancer**: Treatment for prostate cancer included a seeding procedure
- **Found in squalid conditions in his home prior to placement in this facility**
Vital Signs

- Temperature
- Blood Pressure
- Heart Rate
- Respiratory Rate
- Pain Assessment
- Other Measurements
  - I/Os (input and outputs), e.g., bowel movement log
Physician Progress Notes

Dated “SOAP” Notes

S = Subjective

O = Objective

A = Assessment

P = Plan
Physician Progress Notes

Subjective: What the patient states or is reported

- Pt. reports pain in side; states vomited 3x overnight and unable to tolerate solids; + nausea. No F/C/dysuria.
- Nursing reports patient agitated overnight.
Objective: What the Physician can measure or evaluate by a physical exam

- **Gen:** A&O x3, NAD or Sleeping in bed
- **VS:** T=99.5; HR=95; RR=18; BP=166/95
- **Cardio:** RRR w/o murmur
- **Lungs:** CTAB
- **Abdomen:** Slightly tender to LLQ
- **Lab:** UA: wnl
- **BM log:** last stool 3 d ago
Assessment: Summary of the current situation and working diagnoses

- 87 yo C Male w/ CRI, dementia and hypothyroidism
- Abdominal Pain: DDX: Obstipation vs. Diverticulitis vs. Chronic constipation
Physician Progress Notes

Plan: What the Physician plans to do next

- CT Scan w/ and w/o contrast
- NPO except clears
- Will f/u in AM

Physician must sign the Notes.
Physician Orders

All instructions to any support personnel for any service to be done for patient

- Medication
- Lab test or X-ray
- Therapy: Speech, Physical, Occupational
- Activity level
Physician Orders

- **CT scan abdomen and pelvis w/ w/o IV contrast**
- **Diet: NPO except meds and clears**
- **Nursing: Turn q 2 hours**
- **Strict I/Os**
- **Guiac all stools**
Patient seen @ beginning of shift, resting w/o complaints

1225: Pt. vomitus, green w/ chunks

1310: Pt c/o LLQ pain

1425: Pt c/o 4/10 LLQ pain

1430: Tylenol given

1600: Pt. vomiting clears

1620: Dr. paged
Labs

Reports of laboratory results

- Blood chemistry
- Urine cultures
- Sputum cultures
- Feces test
- Other

- stool guiac + X 3
Imaging

Reports of any imaging study

- X-rays
- CT scans
- MRIs
- Others

- CT scan abd/pelvis: Dilated loops of bowel to sigmoid colon; inflammation noted throughout bowel, several diverticulosis noted. No free air.
Therapy

Physical Therapy (PT)

Occupational Therapy (OT)

Speech Therapy (ST)
PT:

Pt. unable to transfer from bed to wheelchair 2nd to pain. PT not performed today.
Therapy

- **PT:** OOB x 3 w/ hallway walking.
- **OT:** Able to accomplish ADLs w/ min. assist.
- **ST:** Pt. aphasia improving with tongue exercises.
Case Management

- **Transfer or discharge plan**
  - Which location
  - When

- **Social service notes**
Information Not in the Medical Chart

- **Medication Administration Record (MAR)**
  - Lists all medication given
  - Usually found in or near the “Med Room”

- **BM Log**
  - In the chart or in a BM Log in a hallway or assigned to a particular RN, LVN, or CNA

- **Social Services & Activity Director Notes**
  - Individual charts
  - Separate folder
FINAL THOUGHTS

- If you can’t find it, ask the “charge nurse.”

- Every facility may have a somewhat different chart organization.

- Find out if the medical charts are electronic, paper, or a combination.

If you need more help ~~~

Call your local ombudsman program

We are all here to help!
Common Medical Chart Abbreviations

AB — Antibody
ABD, ABDOM — Abdomen
ABN — Abnormal
ADENOCA — Adenocarcinoma
ADM — Admission
ADR — Adverse drug reaction
AK(A) — Above knee (amputation)
AKA — Also known as
BCC — Basal cell carcinoma
BE — Barium enema
B/F — Black female
BIL — Bilateral
BK(A) — Below knee (amputation)
BM — Bone marrow
BM — Bowel movement
B/M — Black male
BP — Blood pressure
BX — Biopsy
Ca — Ca-Journal of the American Cancer Society
CC — Chief complaint
CHF — Congestive heart failure
CIS — Carcinoma-in situ
CRF — Chronic renal failure
CT SC — Computerized (axial) tomography scan
CVA — Cerebrovascular accident
CVA — Costovertebral angle
CXR — Chest x-ray
DC — Discharge
DC — Discontinued
DNR — Do not resuscitate
DO — Doctor of Osteopathic Medicine
DTR — Deep tendon reflex
DX — Diagnosis
ECF — Extended care facility
ECG, EKG — Electrocardiogram
EEG — Electroencephalogram
EENT — Eyes, ears, nose, & throat
EGD — Esophagogastroduodenoscopy
EMG — Electromyogram
ENL — Enlarged
ENT — Ear, nose & throat
FBS — Fasting blood sugar
FU — Follow up
FUO — Fever unknown origin
FX — Fracture
GB — Gallbladder
GI — Gastrointestinal
HB — Hemoglobin
HEENT — Head, eyes, ears, nose & throat
HGB — Hemoglobin
H&P — History and physical
IM — Intramuscular
IV — Intravenous
K — Potassium
L1-L5 — Lumbar vertebrae
LE — Lower extremity; Lupus erythematosus
LFT — Liver function test
LLE — Left lower extremity
LLL — Left lower lobe (lung)
LLQ — Left lower quadrant (abdomen)
L-SPINE — Lumbar spine
LUE — Left upper extremity
LUL — Left upper lobe (lung)
LUQ — Left upper quadrant (abdomen)
MD — Doctor of Allopathic Medicine
MI — Myocardial infarction
MRI — Magnetic resonance imaging
NEURO — Neurology
N&V — Nausea and vomiting
OP — Operation
OP — Outpatient
OPHTH — Ophthalmology
OR — Operating room
OSTEO — Osteomyelitis
OT — Occupational therapy
OV — Office visit
PA — Posteroanterior
PA — Pulmonary artery
PA — Physician assistant
PALP — Palpable, palpated, palpation
PATH — Pathology
PDR — Physician’s Desk Reference
PE — Physical examination
PEG — Percutaneous gastrostomy tube
PMD — Personal (primary) medical doctor
PMH — Past medical history
PND — Postnasal drip
POD — Postoperative day
PT — Patient
PT — Physiotherapy
Q — Quadrant
q — every
QID — Four times a day
qd — Every day
RLE — Right lower extremity
RLL — Right lower lobe (lung)
RLQ — Right lower quadrant
RML — Right middle lobe (lung)
RO, R/O — Rule out
ROM — Range of motions
RT — Right
RUE — Right upper extremity
RUL — Right upper lobe
RUQ — Right upper quadrant
**DIFFERENTIAL DIAGNOSIS**

The process of weighing the probability of one disease versus that of other diseases possibly accounting for a patient's illness. For example, the differential diagnosis of rhinitis (a runny nose) includes allergic rhinitis (hayfever), the abuse of nasal decongestants, and of course the common cold.