RCN eHealth programme

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eHealth and nursing practice:

Abbreviations and other short forms in patient / client records

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Introduction

To support safe, effective care and communication, patient records must be up to date, factual, accurate, and be written so that the meaning is clear to all those who use the record (Nursing and Midwifery Council (NMC) 2007). The NMC advises that the record should not include abbreviations; these and other short forms such as acronyms and initialisations can be misinterpreted with significant risks to quality of care and patient safety (NMC 2007, NHS Information Standards Board for Health and Social Care 2008). Some abbreviations are known to lead to increase errors (Dimond 2005, Institute for Safe Medication Practices 2006).

Despite these concerns, use of abbreviations in patient records is common practice and guidance is often conflicting. For example, the benchmarks for record keeping state that agreed abbreviations may be used (NHS Modernisation Agency 2003).

This policy paper reflects the RCN position on the use of abbreviations and other short forms in patient / client records, including specific guidance on electronic records.

Short forms in patient / client records

1. The RCN's chosen definition of 'short forms' is as follows: abbreviations, acronyms, initialisations and any other form of text reduction (NHS (England) Information Standards Board for Health and Social Care 2008)

2. The record is a tool for communication; content of the record needs to be understood by all those using the record, including patients and clients.

3. The RCN endorses best practice benchmarks in the Essence of Care benchmark for record keeping (NHS Modernisation Agency 2003), specifically, that records:
    - are kept jargon free, abbreviation free and unambiguous;
    - are user friendly and any special needs are met so that patients can be supported to understand the content.

4. However, some abbreviations are so pervasive in society that using the full term of phrase would be a barrier to understanding. For example: am, pm, NHS, HIV. A standard list should be agreed at the national level by the appropriate organisations, including professional bodies and patient groups.

5. Some units of measure and related terms may also be acceptable in shortened form. However, there are specific safety issues related to the use of short forms for units. Until national / UK standards are agreed, short forms for units and those used in relation to medicines management must conform to the guidance issued in the British National Formulary (recommendation from the NHS (England) Information Standards Board for Health and Social Care).

Short forms in electronic records

Good system design can solve some of the challenges of efficient record keeping whilst ensuring good quality content and communication. For example, a nurse can enter information quickly into the electronic record using abbreviations or truncated words but the computer is then able to display the words in their full form, preventing mistakes or subsequent misinterpretation.

However, electronic patient / client records introduce new risks to patient safety and to the quality of care and communications. For example, computers cannot interpret meaning so humans designing and using electronic record systems must use defined, unambiguous terminology. Abbreviations that are well understood in a local setting can be misinterpreted when records are made available between agencies or through national systems.

Design constraints can mean

8. Although it is important that information about patient/client needs and nursing care is structured using standardised terminology, this requirement does not outweigh the need for the information to be understood. Free text should be used in preference to short forms that could be misinterpreted.

9. There is a practical limitation to the number of characters that can be included in an entry, display or message field. For example, 35 characters is the maximum length allowed for a person's family name in a number of standards in the NHS in England. In such cases, consistent truncation is a safety requirement so that, for example, names match when the nurse is tracing a patient record.

10. The nurse is accountable for the accuracy and completeness of his or her record of patient care. Risks related to restricted field lengths, truncation or concatenation must be identified during system design and safety testing; any risk that is deemed unacceptable by the nurses who will be using the system must be fully mitigated.

Find out more

The Royal College of Nursing supports the overall direction of travel of the eHealth programmes in each of the four UK countries including the introduction of electronic patient records. However, the single most important factor in realising the potential of IT in health care is the people who use it. Resources still need to be allocated to ensure that nurses understand eHealth and can use information and technology effectively in their practice.

For more information about eHealth and how you can get involved, visit the RCN's eHealth web pages: www.rcn.org.uk/development/practice/e-health

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