Medical Terminology 2

Self-study course

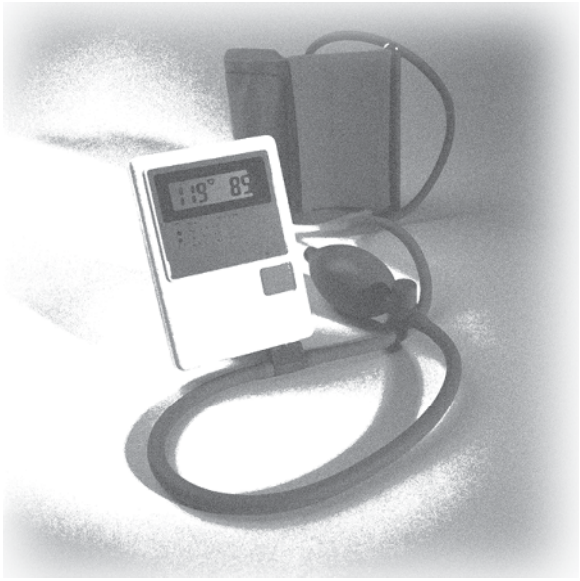
Course objectives:

At the end of this course you will be able to:

1) Identify three benefits of knowing medical terminology;
2) Identify 10 medical words, terms or phrases used in documentation;
3) Define the medical terms of DNR , PRN, OTC medications, and POLST.

Medical terminology — Part 2

During the course of your day to day work, you will come across many words, symbols, terms and phrases of medical terminology. As a member of the care team it is important that you know what these words, symbols, terms and phrases mean. You will see them written in diagnoses, doctor's orders, registered nurse's instructions, and will use them as part of your every day documentation.



This study guide is part two of *Medical Terminology*. It is intended to help you understand some common medical terms used by health care professionals.

The benefits of learning medical terminology

The benefits of learning medical terminology include:

1) Being able to communicate better with other health care team members;
2) Being able to carry out orders and instructions correctly; and
3) Improving the quality of your documentation.

Medical acronyms

Some medical terms are an abbreviated or shortened form of the original word(s). This avoids having to write out the entire word — some of which can be quite long. An acronym is an abbreviation formed from the first letter of each word in a title. For example, COPD is the acronym formed from the words Chronic Obstructive Pulmonary Disease. As you can see, it is easier to say the resident has COPD then to say the resident has Chronic Obstructive Pulmonary Disease.

The following is a list of medical acronyms. This is not an all inclusive list, just a listing of the more common medical acronyms for your reference. If you have questions about an acronym with which you are not familiar, there are many resources available to you. Most drug handbooks and medical dictionaries have an appendix with a list of medical acronyms. You can also contact a physician, pharmacist or registered nurse for assistance. Because there are acronyms that have more than one meaning, always check with a resource if you have any questions.

A

a: arterial

A/O: Alert and Oriented

AAOx3: Awake, Alert, Oriented x 3 [person/place/time]

abn: abnormal

ABNL: Abnormal

ac: before meal

ACLS: Advanced Cardiac Life Support

AF: Atrial Fibrillation

AHA: American Heart Association

AIDS: Acquired Immune Deficiency Syndrome

ALS: Amyotrophic Lateral Sclerosis

AMA: American Medical Association

AMA: Against Medical Advice

ASA: Acetylsalicylic acid (aspirin)

ASHD: Arteriosclerotic (or atherosclerotic) Heart Disease

B

BBP: Blood-Borne Pathogen

BHT: Blunt head trauma

BID: Twice daily

BLS: Basic Life Support (a level of certification)

BM: Bowel movement (stool)

BP: Blood pressure

C

c: with

C/O: Complaints of

CA: Cancer

CABG: Coronary Arterial Bypass Graft

CAD: Coronary Artery Disease

CBC: Complete blood count

CC: Chief complaint

CHF: Congestive heart failure

CHI: Closed head injury

CNS: Central nervous system

COPD: Chronic Obstructive Pulmonary Disease

CP: Cerebral Palsy

CP: Chest pain

CPR: Cardiopulmonary resuscitation

CT: CAT scan (computed axial tomography or computer assisted tomography)

CVA: Cerebrovascular accident

CVP: Central venous pressure

CXR: Chest x-ray

D

D/C: Discharge

D/C: Discontinue

DM: Diabetes mellitus

DNR: Do Not Resuscitate

DOB: Date of birth

Dr.: Doctor

E

ECG: Electrocardiogram

ED: Emergency department

EEG: Electroencephalogram

EENT: Ears, Eyes, Nose, Throat

EKG: Electrocardiogram

EMD: Emergency medical doctor

EMT: Emergency medical technician

EP: Emergency physician

ER: Emergency room

ETOH: Ethyl Alcohol (ethanol)

F

F/U: Follow-up

FOS: Full of stool (constipated)

FU: Follow-up

Fx: Fracture

G

GI: Gastrointestinal

H

H & P: History and physical

HIV: Human immunodeficiency virus

HMO: Health Maintenance Organization

HTN: Hypertension

Hx: History

I

ICU: Intensive care unit

IDDM: Insulin Dependent Diabetes Mellitus

IM: Intramuscular

IV: Intravenous, or intravenous line

L

LE: Lower extremities

LOC: Laxative of choice

LOC: Loss of consciousness

LPM: Liters per minute

LTC: Long-term care

M

MD: Medical doctor

ME: Medical examiner

MgS04: Magnesium sulfate

MI: Mental illness

MI: Myocardial infarction

MR: Mental retardation

MS: Morphine sulfate

N

N/V: Nausea/vomiting

NAD: No acute distress

NAD: No apparent distress

NC: Nasal cannula

NG: Nasogastric tube

NH: Nursing home

NKDA: No known drug allergies

NL: Normal

NPO: Nothing by mouth

NS: Normal saline (e.g. 0.9% NaCl)

NSAID: Non-Steroidal Anti-Inflammatory Drug

O

O2: Oxygen

OBS: Organic Brain Syndrome

OD: Overdose

OR: Operating room

OT: Occupational therapy

P

PCN: Penicillin

PCP: Pneumocystis carinii pneumonia

PCP: Primary care physician

PDR: Physician's Desk Reference (book of medication information)

PE: Physical examination

PE: Pulmonary edema

PEG: Percutaneous endoscopic gastrostomy (G-tube)

PMH: Past medical history

PO: By mouth

POLST: Physician's Orders for Life Sustaining Treatment

PRN: As needed

PT: Patient

PT: Physical therapy

Q

QD: Each day

QID: 4 X daily

QR: Quick release

R

RBC: Red blood cells

RMA: Refuse(s) medical assistance

RRR: Regular rate and rhythm

Rx: Prescription

S

s: Without

SBP: Systolic blood pressure

SOB: Shortness of breath (Dyspnea)

STD: Sexually transmitted disease

STD: Standard

SX: Symptoms

T

TB: Tuberculosis

TBI: Traumatic brain injury

TIA: Transient ischemic attack

TID: Three times per day

TKO: To keep open

TPR: Temperature, pulse, respiration

TX: Treatment

U

U: Unit

U/A: Urine analysis

URI: Upper respiratory infection

US: Ultrasound

UTI: Urinary tract infection

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V

V: Volume

VD: Venereal disease

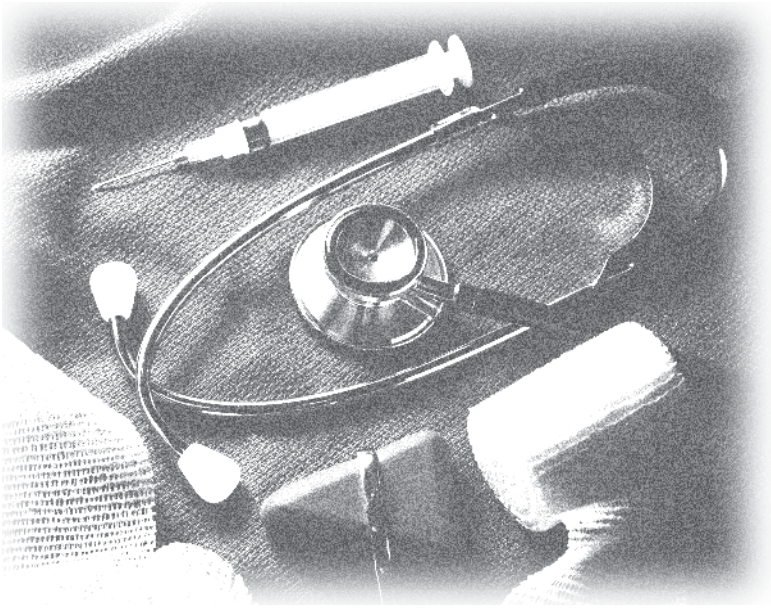
VS: Vital sign

W

WBC: White blood cells

WNL: Within normal limits

Most commonly used acronyms



Following are some of the most commonly used medical acronyms and terms. As a care provider you need to know what they stand for in order to carry out orders or instructions correctly.

DNR — Do Not Resuscitate

A *do not resuscitate* order:

- Can only be requested by the resident to whom the order applies unless that resident has a court appointed guardian;

- Cannot be legally requested for a resident by a family member unless they can provide information to support a belief that DNR was the residents wish; and

- Cannot be legally ordered by a physician unless she or he has consent of the resident or the resident had documented the request in a POLST or in *advance directives*.

***Resuscitate* — To revive somebody or be revived from apparent death.**

Resuscitation:

- If there is no physician's order, *POLST or advance directive* to the contrary, resuscitation must be initiated.

- A resident who lacks capacity to make a decision about their advanced care directives must be resuscitated.

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- It is important to remember that the information in the *POLST*, *advance directives* or an order for *DNR* is directed to physicians and other licensed health care professionals. **An adult foster home provider or caregiver is not qualified to determine that emergency medical treatment should not be initiated.**

- The caregiver must react to an emergency by calling 911. An order for *DNR* does not mean do not respond. The resident may be experiencing a stroke, heart attack, pneumonia, urinary tract infection, adverse reaction to medication or any number of health issues which are treatable.

It is **not** necessary for the provider or caregiver to call 911 if:

- The resident is receiving hospice services and it has been determined that death is imminent;

- The resident's condition is in decline and a physician or home health nurse has determined the resident is in the dying process;

- The provider or caregiver discovers that the resident has died and there is no sign of life.

P.R.N. — As needed **means those medications and treatments that have been ordered by a qualified practitioner and are to be administered as needed.**

When giving a PRN medication, you must document:
- the time
- the dose
- the reason the medication was given, and
- whether or not it worked.

Written parameters (for PRN medications) You must have clear written instructions for administering the P.R.N. medications. If the medication label and/or the order do not give instructions on what the medication is for, when, how much and how often the medication is administered, you must obtain this information through specific written directions

from the physician, nurse practitioner, RN or pharmacist. These written directions are called written parameters. These written parameters must be recorded on the medication administration record. The written parameters then supplement the original order by giving you guidelines to follow when giving PRN medications.

OTC medications — Over-the-counter **medications are medications that can be purchased by anyone without a prescription.**

OTC medications:
- Do not require an order from a physician or nurse practitioner, but must be reviewed by a physician, nurse practitioner or pharmacist before they can be administered. This is to be sure the OTC medications will not have a negative interaction with the resident's other medications. For example — Antacids interfere with the effectiveness of some anibiotics.

- Must be left in the original container. The label on the container will give you the information required including what the medication is for and when, how much and how often it can be given. Although labels don't always tell side effects, some labels will advise you of what side effects may occur and when to call the resident's physician or nurse practitioner. The medication's specific dosage and the time administered should be documented on the medication administration record (MAR).

Residents' medications (both prescribed and OTC medications) must be locked in a central location separate from other household members' medications, such as the provider or provider's family.

Advance directive — Advance directive means the legal document signed by the resident giving instructions for health care should she/he no longer be able to give directions regarding her/his wishes. The directive gives the resident the means to continue to control her/his own health care in any circumstance.

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POLST — Physician Orders for Life-Sustaining Treatment

Care providers are frequently challenged by urgent medical circumstances in which the resident's preference for treatment with life-sustaining procedures is not known. The Physician Orders for Life-Sustaining Treatment (POLST), a one-page physician order form, is designed to help care providers honor the treatment desires of their residents. The POLST form is not intended to replace **advance directive** documents. The POLST translates the person's *advance directives* into physician orders. The voluntary use of the POLST form by the provider is intended to enhance the quality of resident care and is expected to complement *advance directives* if they have been completed.

In an adult foster home setting, the POLST, a bright pink-colored form (8.5 inches x 11 inches), should be kept on the refrigerator door inside a large envelope (to protect residents' privacy). Emergency medical services personnel are all trained to locate these forms in the same place (the refrigerator door), in all homes.

A wallet card (2 inches by 4 inches) of the POLST is also available to summarize physician orders for residents. This card is not a substitute for a completed POLST document. The physician must sign both the POLST document and the wallet card to make the document valid.

The POLST form should accompany the resident while transferring from one setting to another. A copy of the original is legal.

How do I obtain a POLST document?

Information and forms for the POLST program is available online at *www.polst.org* or contact the Center for Ethics in Health Care, Oregon Health & Science University, 3181 Sam Jackson Park Road, UHN-86, Portland, OR 97239-3098; or by phone: 503-494-3965.

Appendix

Note: These rules are found in the Administrative Rules for Adult Foster Homes and do not necessarily apply to other care settings.

411-050-0447 Standards and Practices for Care and Services

(2) Admission

(c) At the time of admission, the provider must ask for copies of the following documents, if the resident has them: Advance Directive, Physicians Order for Life Sustaining Treatment (POLST), letters of guardianship, or letters of conservatorship. The copies must be placed in a prominent place in the resident record and sent with the resident when transferred for medical care; and

(4) Standards for Medications, Treatments and Therapies

(b)The provider must obtain and place a written signed order in the resident's record for any medications, dietary supplements, treatments, and/or therapies which have been prescribed by the physician/nurse practitioner. Orders must be carried out as prescribed unless the resident or the resident's legal representative refuses to consent. Changes may not be made without a physician/nurse practitioner's order and the physician/nurse practitioner must be notified if a resident refuses to consent to an order. Order changes obtained by telephone must be followed-up with written signed orders. Changes in the dosage or frequency of an existing medication require a new pharmacy label. If a new pharmacy label cannot be obtained, the change must be written on the existing pharmacy label and match the new medication order. Attempts to obtain the written changes must be documented in the resident's record. Over-the-counter medications or home remedies requested by the resident must be reviewed by the resident's physician/nurse practitioner or pharmacist as part of developing the initial care plan and at time of care plan review;

(d)Prescription medications ordered to be given "as needed" or "pr.n." must have additional directions which show what the medication is for and specifically when, how much and how often it may be administered. These written directions may be given by a physician, nurse practitioner, registered nurse or pharmacist. P.R.N. medications with specific parameters must be

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recorded on the medication administration record. Any additional instructions must be available for the caregiver to review before the medication is administered to the resident.

(6) Resident Care

(d) In the event of a serious medical emergency, the provider/staff must call 911 or the appropriate emergency number for their community. The physician/nurse practitioner, family or resident representative and the case manager (when applicable) must also be called. The provider must have copies of Advance Directives, Do Not Resuscitate (DNR) orders and/or pertinent medical information available when emergency personnel arrive;

(7) Resident Records

(a) An individual resident record must be developed, kept current, and available on the premises for each person admitted to the adult foster home. The record must contain the following information:

(D) Medical information, including:

(iv) Letters of Guardianship and/or Conservatorship, Advance Directive and Physicians Order for Life Sustaining Treatment (POLST), if applicable.

This brochure is available in
alternate formats.
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