ADMINISTRATION

UND CFM Bismarck Welcome

UND Program Goals/Mission Statement

UND CFM Staff

Clinic and University Websites

Resident Recruitment Criteria

Clinic Responsibilities

Clinic Chief Resident Responsibilities

AMTS Intern Responsibilities

AMTS Senior Resident Responsibilities

Conference Attendance Policy

Goals and Objectives Policy

Criteria for Advancement to Senior Resident Level

Well Baby Clinic

Weekly Time Records for Residents

Resident Procedure/Experience Database Instructions

Miscellaneous Hospital Policies

Hospital Admission Responsibilities

Protocols for Care for Complex Patients

Admission Order Signature Policy

Clinic Patient Scheduling

Rural Rotations

Inpatient Pediatrics

Medical Coverage for Sporting Events

Moonlighting

Vacation

Medical Record Documentation

Dictation Time Limits

Diagnostic Reports/ Notification

Consent for Treatment

Patient Education

Patient History

Geriatric Protocol

Attending Physician's CFM Clinic Responsibilities

Graduation Requirements

Concern Cards

Complaint Management

Patient Satisfaction

Electronic Communication
(Smartphones, tablets ,etc)

ABBREVIATIONS AND SYMBOLS; "COMMON USE" AND "DO NOT USE"

The University of North Dakota Center for Family Medicine, Bismarck, is a fully accredited residency training facility that has graduated over 150 physicians. The Center is administered by the University of North Dakota School of Medicine and Health Sciences. We are a three-year program and accept five first year residents annually through the match system.

Our program is well accepted and respected by both hospitals in the community —Sanford and St. Alexius Medical Center — and enjoys the tremendous support of the local teaching faculty. More than 100 specialists participate in our program.

Bismarck-Mandan combines true progressive technology of a large city with the sincere friendliness of a small town. The basic elements for a happy life, clean living, true friendships, a community of families, fresh air environment-are still found around here.

FACULTY:

DIRECTOR: JEFF HOSTETTER, M.D.

ASSOCIATE DIRECTOR: JACKIE QUISNO, M.D.

ASSISTANT PROGRAM DIRECTORS: GARY BETTING, M.D.
GUY TANGEDAHL,MD
KARIN WILLIS, M.D.
JOSEPH LUGER, MD (Dermatology)
Brynn Luger, MA, LPCC, NCC (Clinical Counselor)

COMMUNITY PART-TIME FACULTY

Peter Woodrow, M.D. (OB/GYN)
George Johnson, M.D. (Pediatrics/Diabetes)

Thomas Jacobsen, M.D. — West River Health Clinic
Joan Connell, M.D. — Center for Family Medicine-UND
Kristin Melby, FNP — Center for Family Medicine-UND

Home

Overall Program Goals/Mission Statement

1) To provide well-trained family medicine physicians to meet the needs of the people of North Dakota.

2) To provide continuing, comprehensive quality healthcare in family medicine.

3) To provide an integrated and progressive educational program for resident physicians.

4) To provide the opportunity for each resident physician to develop and maintain a continuing physician-patient relationship.

Home

Paramedical/Ancillary Staff

The Center for Family Medicine is fortunate to have a dedicated and enthusiastic ancillary staff. The following is an abbreviated description of the duties for each classification of positions. The staff performs many other duties other than those described below; however, this information is to provide you with the basic function of each job classification.

Business Manager
The Business Manager is responsible for the overall supervision of the ancillary staff and insures the efficient function of most aspects of the clinic. She/he is involved with the budget process (clinic operations and financial management), risk management, personnel administration/human resources (staff procurement), marketing and public relations, and ensures compliance with regulatory agencies. In addition to this, this person is in charge of coordinating the Practice Management/Management of Health Systems module rotation and training for the Residency Program and is involved in the Residency Recruitment process. The Business Managers at the UND-CFMs now have a direct reporting relationship on our Organizational Chart the Associate Dean of Administration & Finance at UND's School of Medicine & Health Sciences. The Business Manager is also a member of the UND-CFM's Oversight Committee.

Administrative Assistant/Residency Coordinator
The Admin Assistant is responsible for the overall scheduling of the Residents. He/ She coordinates Resident schedules with Community Preceptors, Director's schedules, and clinic Preceptor schedules. He/ She is responsible for the monthly calendars (call schedules and rotation schedules) as well as preparing evaluations for dissemination for all of the required residency rotations. The Admin Assistant also is responsible for maintaining Accreditation documents for the Residency Program, and completes the Residency Billings that are invoiced to our sponsoring hospitals for GME reimbursement/reconciliation. This person is responsible for tracking the Resident's clinical and hospital encounters, rural rotations, and elective experiences.

Nursing Staff – Team
This department consists of clinic nursing staff (RNs & LPNs). In addition to this we have a Geriatric Nurse Coordinator and Diabetic Nurse Coordinator. Our nursing staff is efficient and knowledgeable. You will find that you can depend on them to serve you and your patients effectively. They prepare patients to be seen by the physicians, maintain the exam rooms for procedures, schedule appointments for your patients with other physicians and services based on your orders, keep the team pod stocked with supplies and medications, and prioritize patient messages.

Medical Records
Medical Records staff manage all patient charts prior to their visit, file test results, etc. in the patient charts and re-file the charts after the preceptor process is completed. This department is also in charge of HIPAA compliance as well as Release of Information. Presently, our Medical Transcription is outsourced, so the Medical Records Staff are responsible for obtaining signatures and filing of transcription as well.

Front Desk Receptionist/Schedulers
The receptionists are responsible for answering telephone calls that come into the clinic and maintain the core switchboard, routing calls as appropriate. They are responsible for setting up physician schedules and scheduling all patient appointments for physicians, nurses and ancillary support services. The receptionists are also responsible for collecting co-pays and writing receipts for the patients. The receptionists validate patient demographics and insurance information upon the patient's entry to the clinic system. In addition, they follow-up on no-show appointments with a letter to the patient. This department is also in charge of sorting the daily mail and payments. The payments are written on the daily payment log.

Radiology
The department is staffed with a radiologic technologist and a certified Diagnostic Operator. Service is provided during regular clinic hours. Our department performs general diagnostic x-rays and is equipped with a computerized radiology system. Images are read by Sanford's radiologists by means of a PACS system. Radiology is cross-trained to do electrocardiograms, holter monitors, event monitors, pulmonary function tests and hearing screenings.

Laboratory
This department consists of laboratory scientists. Our in- house testing is broad and includes urinalysis, chemistry, hematology, microbiology, serology, and coagulation. What we are unable to do on-site is sent to our reference laboratory, Northern Plains Laboratory. Turn around time for most reference lab results is 12-24 hours. The lab is cross-trained to assist radiology staff with several ancillary testing procedures. The Laboratory Director/Supervisor acts as a lead team member on the UND-CFM's Risk Management Committee and is responsible for tracking/trending of our Incident Reports.

Patient Accounts & Billing (Business Office)
This department consists of certified Professional Coders. The department is in charge of the clinic and hospital billing. They are responsible for maintaining proper billing procedures along with coding the charges with the correct ICD9 diagnosis and CPT Procedures. They make sure all insurance is filed and updated on any major insurance changes. They manage the accounts receivable for charges and collections and reconcile the daily deposit.

Pharmacy
This department consists of a PharmD and a Pharmacy Tech. The department is in charge of assisting the residents/faculty with any medication/prescriptions needs. CFM Pharmacy is open Monday-Friday from 8am-5pm. The pharmacy offers a variety of over-the-counter medications, supplies, and prescriptions to our staff, residents, and patient populations. All pharmaceutical representatives report to the pharmacy for scheduling, displays, and drug samples where the samples are stored, inventoried, and dispensed to the patient (with a valid order from MD's).

Home

Clinic and University Websites:

Policy and Procedures will be emailed to residents and all clinic departments. A hardcopy of the manual can be found in lab, medical records, nursing and administration.

The URL for the **UND Center for Family Medicine-Bismarck** is as follows:

http://www.cfmbismarck.und.edu

Direct patients and prospective residents to the site as necessary. Biographical sketches/photos are included on the site for all Faculty and Residents.

The **University of North Dakota's School of Medicine & Health Sciences** Home Page is as follows:

http://www.med.und.edu/

You can link back to UND Center for Family Medicine - Bismarck by locating the Departments Academic tab.

The University of North Dakota's School of Medicine & Health Sciences **GME Residency Training Program** Home Page is located at

http://www.med.und.edu/residency

All UND Researches are required to complete the **UND Institutional Review Board's (IRB) Human Subjects Training Modules**: www.citiprogram.org

Home

Resident Recruitment Criteria

Purpose: To provide the UND Center for Family Medicine Bismarck with qualified candidates for residency selection.

Policy: The UND Center for Family Medicine Bismarck will use the following guidelines for resident selection:

1. All applicants must hold a doctor of medicine or doctor of osteopathic degree from a medical school approved by the North Dakota Board of Medical Examiners with the date of graduation to be five years or less from start of residency.
2. All applicants must have completed USMLE Step I and Step II, preferably with a score of 80 or above.
3. All applicants must meet the requirements set forth by the North Dakota Board of Medical Examiners to be licensed in the state of North Dakota. In specific, applicants are permitted a maximum of three attempts to pass each step of the licensing examination. The examination requirements must be successfully completed within a seven (7) year period.
4. All applicants must submit two letters of recommendation from a US clinic/hospital or US practicing physician.
5. If an applicant does not meet the above criteria, they can be considered only if they successfully complete an observership at the UND Center for Family Medicine Bismarck.

Home

CFM Clinic Responsibilities

1. Clinic has priority over rotational responsibilities.

2. Notify the receptionist and/or your nurse at the earliest possible time if you will be late/absent from clinic.

3. Morning clinic schedules ***begin promptly at 9:00 a.m.*** Please call your team nurse directly if you anticipate running late.

4. Afternoon clinic schedules Tuesday through Friday begin promptly at 1:00 p.m.

5. Monday afternoon schedules begin after the residents business meeting (1:30 p.m.)

6. A maximum number of six physicians are scheduled per one-half day. No more than four residents per half day, unless a second preceptor is available.

7. Effective May 1st of each year, third year residents drop to two half days per week until graduation. (During the last five clinic days in June, third year residents are scheduled to work ½ day). This is contingent upon having adequate clinic numbers. Residents are required to see 1650 total patients for the three years.

8. All PGY-1 clinic patient encounters need to be precepted by a CFM faculty member **BEFORE** the patient leaves the clinic.

9. For PGY-2 and PGY-3 residents, a minimum of every third clinic patient encounters needs to be precepted by a CFM faculty member.

10. All Medicare patient encounters need to be precepted by a CFM faculty member. A faculty member must see and examine Medicare patients that are scheduled in clinic for PGY-1 residents during the first 6 months of the PGY-1 training. All Medicare patients provided Level IV or V care must be seen and examined by a precepting faculty. Also a faculty member must be physically present and actively participate for all procedures on Medicare patients. The precepting faculty must write a brief note in the patient chart for all Medicare visits.

11. Resident clinic notes will be audited/reviewed by CFM faculty preceptors.

12. It is mandatory for all OB visits seen by a Resident to be precepted with the Attending Physician **BEFORE** the patient leaves the clinic.

Home

Clinic Chief Resident Responsibilities

1. Meetings and Conferences:
   A. Chair the resident weekly business meeting or arrange for the Clinic Chief Resident to do so.

      1. Coordinate questions or problems that need to be discussed at the business meeting.
      2. Inform residents of policies and/or policy changes.
      3. Take and dictate minutes of the meeting.
      4. Place weekend call schedule on board in large conference room.

   B. Represent Center for Family Medicine at meetings as assigned or required.

   C. Follow guidelines of Conference Attendance Policy-please see policy for details.

3. Clinical:
   A. Act as back-up physician in clinic for: medical students, interns, physicians on extended vacations/leave and walk-in patients.

   B. Arrange medical student orientation and work/call schedule as well as be involved in overseeing their clinical education.

   C. Act as liaison between the residents and the CFM Clinical Staff.

   D. Screen telephone calls requested by receptionists and other staff.

   E. Attend all Center for Family Medicine deliveries as able.

   F. From 8:00 a.m. to 5:00 p.m., assist in taking telephone questions from Nursing Homes regarding UND's Nursing Home patients when the primary care physician cannot be reached. The Geriatric Nurse, Chris, can be very helpful when these situations arise.

4. Other duties as required or assigned:
   A. Promote educational activities.

   B. Receive and handle items referred by the program coordinator, nursing staff, and/or other clinical staff.

   C. Act as back-up to interns for the AMTS.

   D. Coordinate orientation of new interns to various departments.

   E. Escort prospective residents on date of interview.

I acknowledge that I have read and understand the above responsibilities.

________________________________ ____________________________

Name Date

Home

AMTS Intern Responsibilities

1. Interns are expected to, under the direction of the Senior resident, utilize every opportunity to gain experience in the Emergency Room or the Inpatient ward.

2. As directed by the Senior resident, Interns will be responsible for admitting patients to the Adult Medicine Teaching Service (AMTS), performing daily rounds on AMTS patients, and finding patient information among other duties as necessary for patient care.

3. The Senior resident is expected to give the Intern requested guidance and teaching regarding patient care, so ask for help.

4. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

________________________________ ______________________________
Name Date

Home

AMTS Senior Resident Responsibilities

1. Senior residents are responsible for admitting all UND Center for Family Medicine (CFM) faculty patients, patients transferred from outlying communities and facilities as well as all "unassigned" patients that are admitted to the Adult Medicine Teaching Service (AMTS) through the hospital Emergency Rooms at either hospital (Sanford and St. Alexius).

   A. If the Senior resident admits a CFM patient that has been previously admitted and cared for by another CFM resident or another CFM resident is that patient's primary care physician, the care is transferred to the other resident the following working day at 8:00 a.m. This is contingent upon the patient's request (priority #1) and mutual understanding between the physicians involved

   B. All patients on the AMTS must have an Information Sheet (BOHICA Sheet) in order to facilitate communication at sign-out to the other residents. It is the responsibility of the admitting resident to complete the Information Sheet initially. It should be filled out at the time of admission and must be updated before each sign-out.

2. The attending physician must be notified of all acute status changes (i.e. ICU admissions, emergent surgeries, marked clinical deterioration, etc.) on patients on the AMTS.

3. Emergency Room Responsibilities.

   The Senior resident may be called for all CFM patients seen at both Emergency Rooms. The Emergency Room physician may call the CFM resident (s) on call at his/her discretion for the care of CFM patients and assistance with the Emergency Room workload. No patient may be discharge from the Emergency Room with out being seen and the chart signed by a licensed physician.

4. The Senior resident is responsible for responding to CFM patient telephone calls after regular clinic hours.

5. Senior residents are responsible for supervising and teaching PGY-1 residents assigned to the AMTS. Specifically,

   A. The Senior resident is responsible for promptly reviewing (in person) all admissions done by the PGY-1 resident to the AMTS. The Senior resident is required to promptly review (in person) all CFM patients cared for by PGY-1 residents in the Emergency Room.

   B. The Senior resident is responsible to give the PGY-1 resident requested guidance regarding patient care.

6. Senior residents should confirm conference speakers and conference dates at rounds daily.

7. Senior residents should assign case topics to residents and medical students based on interesting cases from clinic or inpatient experience or as needed.

8. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

___________________________________ ____________________________

Name Date

Home

Conference Attendance Policy

1. Residents are required to attend 70% of all required conferences.

   Expectations:
   A. Attendance not required if you are on vacation, CME, personal days, or sick leave.
   B. Residents on rotations other than adult medicine are encouraged to attend morning rounds (when able) but will not be required to do so. They will, however, be required to attend 70% of the other mandatory events.

2. Mandatory Conferences/Events will be marked on the monthly E*Value calendar put out by Pat.

3. Attendance reports will be distributed quarterly.

4. Deficient residents must make up their deficiency in the next quarter.

5. Consequences for deficient attendance:

   A. Residents may not use ANY of their vacation time if they are below the 70% attendance mark. This includes time for family events and elective doctor's appointments. Pat keeps track of this on a daily basis.

   B. If you are out of vacation time, you will be assigned to produce one presentation of 30 minutes in length for each five conferences you are behind in attendance. The topic for each presentation will be chosen by the faculty.

6. Two deficient quarters in a row will result in extension of the resident's training time.

Goals and Objectives Policy

1. Residents are required to review the Goals and Objectives for each rotation with their preceptor no later than the end of the first week of the rotation.

2. Residents are required to have the preceptor sign the Goals and Objectives, and then turn them into the Program Coordinator by the Monday after the end of the first week of the rotation.

3. If the resident fails to turn in the signed Goals and Objectives form, the resident can be placed on vacation until the form is turned in. They can also be taken out of their continuity clinic until the form is turned in.

4. Goals and Objectives are provided to each resident at a minimum of one week prior to any rotation. Goals and Objectives can also be downloaded from the residency website by following the link below.

   http://www.cfmbismarck.und.edu/?id=54

Home

Criteria for Advancement to Senior Resident Level

Purpose:
To ensure that a senior resident is qualified to supervise first year residents.

Policy:
The following criteria must be met in order for a resident to assume Second Call duties:

1. The USMLE Step 3 must be taken by June 30th of the calendar year; i.e. by the end of the PGY-1 year.
2. Faculty must confirm that the resident is qualified to provide PGY-1 supervision in a manner that is safe for patients.
3. If the USMLE Step 3 is failed, whether the resident may continue on Second Call will be determined on an individual basis. Criteria considered by faculty in this situation will include, but not be limited to:
    A. In-Service Training Exam scores
    B. Academic standing documented on evaluations
    C. Number of rotations passed during the PGY-1 year

Well Baby Clinic

This scheduled clinic (first Friday of each calendar month) is the responsibility of the PGY-1 residents on a rotating basis. Similar to PGY-1 call, this scheduled responsibility may be traded between PGY-1 residents.

Home

Weekly Time Records for Residents

Purpose:
To insure compliance with all duty hour time regulations stipulated by the ACGME.

Policy:
1. All residents will daily log their duty hours using the E*Value website.
2. If the duty hours are not submitted by the end of the third day of the week, the resident will be contacted by the Program Coordinator; then, the Program Director will recall the resident from their assigned duties and place them on vacation time until they submit their duty hours. This will likely have a negative impact on the evaluation for their current rotation.

Home

Resident Procedure/Experience Data Base Instructions

All residents are required to turn in a listing of their procedures during their time spent at the UND Center for Family Medicine. These records will be used to obtain hospital privileges at the hospital when you have completed residency. You may use one of the following three options to record your procedures:

1. Experience Cards (Yellow Cards) Please fill in as much information as you have on the patient, the diagnoses, and procedures performed. (You may use a hospital sticker for the patient information section, but please be sure to list your preceptor).

2. Procedure Notebook. You may start your own notebook with patient information. Please be sure to include patient's name, age/DOB, site of visit, preceptor, diagnoses, and procedures performed.

3. PDA. Please enter the information you have on your PDA in a database.

4. This information can be turned into the Program Coordinator at any point in time. You **must** have something turned in **before** you leave the program. It is to your advantage as the hospitals do call to validate this information.

Home

Miscellaneous Hospital Policies

The following is a general overview of Hospital Issues. Please refer to the Medical Staff Policy Manuals for both Sanford Health Systems and St. Alexius Medical Center for details.

1. All Admissions, Discharge Summaries, and Procedures need to be done under the name of an attending physician. It is important to write the name of the attending physician on **all** orders and to specifically mention the name of the attending physician on **all** dictations.

2. Family Medicine Residents are not responsible for coverage of any area of either hospital except at outlined in the section titled Residents and as assigned by rotational preceptors. This means that residents are NOT solely responsible for running CODES or coverage of the ER; however, it is expected that residents will participate in these activities.

3. It is expected that ALL documentation will be timely, written or dictated clearly, concisely and with completeness. Use **only** well recognized and approved abbreviations.

4. Services available to residents at either hospital at no charge include: Lab coats, Meals at St. Alexius, Library services, and Parking.

5. Although there is no specific dress code at the CFM or at either hospital, it is required that physicians dress in a professional and responsible manner. Scrubs are discouraged, and are not allowed to be worn when residents are seeing their clinic patients unless the resident is on an Obstetrics rotation.

6. Family Medicine residents do not have Active Staff clinical privileges at either hospital. Clinical privileges for residents are determined by the clinical privileges of their attending physicians. The level of supervision of residents is determined by level of training of the resident and level of comfort of the attending physician.

Home

Protocol for Care for Complex Patients

Protocols defining common circumstances requiring faculty involvement: care of complex patients, ICU transfer, DNR decisions, etc.

1) Inpatient AMTS service
When issues arise where there is need for 1) increased supervision of care, 2) expert consultation on the complex patient, 3) overwhelming volume of patient care, or 4) any other situation where the resident does not feel comfortable making decisions, the following protocol should be followed:

a. Contact the attending physician – explain situation and ask for guidance.
*The attending physician is responsible for determining the course of action.

b. If unable to contact the attending, contact the Program Director.

Related policies/protocols:

A. If resident on the AMTS is ill, they should contact the attending physician who will adjust staffing and patient load as they deem necessary to ensure balance between service and educational obligations.

B. The AMTS has a hard cap of 20 patients.

2) Outpatient continuity clinic
When issues arise where there is need for acute patient care outside the scope of the clinic setting, the following protocol should be followed:

a. Contact the precepting physician – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

3) Nursing home or other long-term care facility:
When issues arise where there is need for higher level of care or any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

b. During the night, contact the AMTS attending physician – explain situation and ask for guidance.
*The AMTS attending physician is responsible for determining the course of action.

c. If unable to contact the precepting or attending physicians, contact the Program Director.

4) Patient phone calls
When issues arise where there is any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

b. During the night, contact the AMTS attending physician – explain situation and ask for guidance.
*The AMTS attending physician is responsible for determining the course of action.

c. If unable to contact the precepting or attending physicians, contact the Program Director.
Home

Hospital Admission Responsibilities

1. Weekdays (7:00 a.m. – 7:00 p.m.)

    A. All patients are to be admitted by AMTS residents.
    B. When a clinic patient is admitted to the hospital by other than the primary care resident, the patient is transferred to the primary care resident or AMTS resident as soon as possible. The admitting resident is responsible for the orders and the history and physical.
    C. Unassigned patients admitted through the ER are admitted by the AMTS residents.

2. Weekday Nights (7:00 p.m. – 7:00 a.m.)

    A. All patients to be admitted and cared for by the AMTS residents.

Admission Order Signature Policy

Purpose:

1. To ensure admission orders are accurate and that patient safety is maximized.
2. To maximize the amount of learning experienced for PGY-1 residents on the UND AMTS from each hospital admission.

Policy:

1. All admission orders are to be reviewed and co-signed by a PGY-2 or PGY-3 resident BEFORE they are given to the unit secretary to be implemented.

2. This only applies to the initial set of admission orders, not to orders for ongoing care.

3. If a PGY-2 or PGY-3 is the admitting resident, the orders do not need to be co-signed.

Home

Patient Scheduling

1. First year residents are scheduled 3-6 patients per afternoon; half an hour per patient. Please contact the front desk if more time per patient is needed or if more patients can be scheduled.

2. Schedules can be checked by going to Medicat.

3. Except in emergencies or special arrangements, patients are seen by appointment; however, walk-ins are welcome.

4. If a physician asks an unscheduled patient to come to the clinic, the physician needs to notify the front desk so the patient's chart can be pulled before the patient is seen. If a patient comes in for an exam and is to return for lab work the nurse must be notified.

5. Residents that have morning clinic are expected to arrive at 9:00A.M. Those with afternoon clinic hours are expected to arrive at 1:00 P.M. and remain in the clinic until 5:00 P.M. to cover walk-ins and/or late scheduled patients.

6. If a physician is delayed for a scheduled appointment at the clinic, always notify the appointment desk personnel.

OB Scheduling

1. OB patients will be scheduled with a specific resident if they request so.

2. If the patient does not have a preference or does not request a physician, the patient is scheduled with a resident on a rotating basis.

3. If a resident notifies the receptionist not to schedule any more OB patients, the request is taken into consideration.

4. If a resident notifies the receptionist to schedule more OB patients, the request is taken into consideration.

5. If a patient requests a pregnancy test but does not have a physician, the test is ordered through Chief/Dr. Hostetter. If the test is positive the nurse will instruct the patient to see a physician as soon as possible. If the patient wishes to continue with the Family Practice Center and asks whom they should see, the patient is told to check with the receptionist to see which physicians are available. A patient will occasionally ask the nurse who the physicians are that she works with and will make a choice from the group of physicians

Home

Rural Rotations

1. Rural rotations will be conducted in a community office outside of the Center for Family Medicine, for a period of not less than two weeks and a maximum of eight weeks, within the second and third years of residency.

2. The Program Director or designee will coordinate, negotiate, and approve all rural rotations.

3. Rural rotations during the last two weeks of June and the first two weeks of July will not be granted.

Inpatient Pediatrics

Purpose:
Provide adequate funding for the required inpatient pediatrics rotation.

Policy:
1. All residents will be required to do a one month rotation with the University of Colorado Pediatrics Department.
2. In addition to the regular monthly salary that the resident will continue to receive while in Denver, the UND Center for Family Medicine will refund the resident mileage to and from Denver at the current state rate.

Medical Coverage for Sporting Events

Purpose:
To delineate the procedures for insuring adequate medical coverage when residents and faculty are providing medical coverage for sporting events.

Policy:
1. Either a faculty member or a PGY-2 or PGY-3 resident will be allowed to provide medical coverage at sporting events in the community.

2. If a resident is providing coverage, a faculty member must be either concurrently present at the event or be available by phone to provide immediate consultation. The resident is responsible for establishing the consulting coverage arrangements BEFORE the start of the sporting event.

3. Medical care will be provided by either the faculty or resident physician based on the policies, procedures and medical releases/permissions of the team.

Moonlighting

1. Moonlighting activities will not interfere with the resident’s clinic, hospital, or rotational responsibilities.

2. Moonlighting will **NOT** take priority over the resident’s clinic schedule. Clinic or rotation responsibilities will not be shortened for moonlighting purposes.

3. Residents must keep track of moonlighting in their log book.

4. Residents may not moonlight when scheduled on second call or as chief.

5. Residents must log their time spent moonlighting as duty hours in E*Value

Home

Vacation

1. Vacation time with pay is earned by residents for the purpose of freeing the resident from his/her regular duties to spend time in rest and recreation. Vacation time **cannot** be carried forward from year to year, or accumulated at the end of the residency. **Use it or lose it.**

2. Vacation requests should be presented as far in advance as possible and must be approved by the Vacation Committee. The Vacation Committee is made up of the Program Director, Associate Program Director, and the scheduling faculty member. It will meet every two weeks to review leave requests.

   The committee will use the following guidelines for approving leave:
   a) First come, first served.
   b) No leave allowed if resident is on **NICU**, **Inpatient Peds**, or **AMTS** rotations.
   c) No leave allowed the last week of June and first week of July.
   d) For a two week rotation, only is two days of leave allowed. For a month rotation, only is five days of leave allowed.
   *e) For situations involving emergency, health, family problems, or other special circumstances, please attach a written explanation requesting variance from the above policies to the Leave Slip.

3. Procedure residents are to follow in requesting leave:
   a) Arrange call coverage for the days off requested.
   b) Submit request at least two weeks in advance by completing a Leave Slip and placing it in the black box on the Program Coordinator's desk.
   c) Leave slip will be returned to you in your mailbox with either approval or denial written on it. If denied, the reason for denial will be written as well. Special circumstances will be considered, but are not a guarantee that approval will be granted.
   d) Have front desk supervisor sign off that clinic is covered.
   e) Return slip to Program Coordinator.
   ***f) Leave not officially approved until you get front desk approval and return the slip!**

4. Vacation requests, during the last two weeks of June and the first two weeks of July may be granted with prior approval.

5. A maximum of one week is granted during any single rotation.

6. If more than two residents from a given year of training (PGYI, PGY II, PGY III) requests vacation for the same period, approval shall be subject to the Program Director's discretion.

7. Annual leave with pay is earned on the following basis:
   First Year Resident – 15 working days plus 5 CME days
   Second Year Residents – 15 working days plus 5 CME days
   Third Year Residents – 15 working days plus 5 CME days
   * Total leave time for conferences **includes** travel time.

8. Personal leave may be granted for illness, maternity, paternity, funerals, interviews, or family emergencies.

9. If personal leave days, plus vacation days total more than twenty working days in a calendar year (July - June), those days shall be made up, without pay at the completion of the residency.

Home

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about the individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is important element contributing to high quality care.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient should include:

   - Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;

   - Assessment, clinical impression or diagnosis;

   - Plan for care;

   - Date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-9CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

Home

Dictation Time Limits

Purpose:
To keep our clinic chart dictations as up to date as possible to ensure the best possible patient care and safety.

Procedure:
1. All faculty and staff providers will have 7 days after the date of visit to have a note for the visit dictated.

2. All dictation must be verified and signed by the Provider within ten days of the clinic visit.

3. If dictation is delinquent, the medical records staff will inform the Program Director.

4. The intervention for being delinquent will be to not allow any patient visits to be scheduled beyond what is already on the Provider's schedule.

   a. Patient's visits will not be cancelled, but no visits will be added until the Provider has completed all delinquent visits and all current visits.

5. Although Providers are strongly encouraged to complete and sign all dictation before going on vacation, the above time limits can be interrupted by vacation time without penalty. For example, if a provider goes on vacation after five days of seeing a patient. They will have an additional two days to complete their dictation upon returning to work.

Notification of Diagnostic Report Results

Notification of diagnostic results to patients is to be monitored to insure that physicians are reviewing patient results and patients are receiving their diagnostic test results in a timely manner.

a. Routine reports will be communicated with the patient within 2 weeks of receiving the report.
b. Critical reports will be communicated ASAP from when the report was received.

Internal tracking of diagnostic tests will be done periodically by risk management (lab, xray, EKG, Audiograms, Pap, biopsy). Providers will be reminded monthly if outstanding reports are present in their Medicat tasks.

Notification and reading of results can be documented in Medicat in the Order/Results tab. Mark the read box to document the physician reviewing the result and that the patient has been notified of the result. Fill in the comment field how the patient was notified, by PHONE, VISIT, LETTER or OTHER.

Home

Notification of Results

Physicians, lab, x-ray and nurses can **explain** to the patients when a referral or diagnostic test is ordered to contact the clinic if results have not been communicated to them. This information (business card) will be given to the patient along with referral appointment, take home instructions and when lab tests are ordered.

> You are having a diagnostic test today or in the near future. If you do not receive your results from your physician within one week of your test, please contact the Center for Family Medicine at 701 751-9500 for your results. If you reschedule this diagnostic test, please notify your physician's nurse. Thank you for choosing UND Center for Family Medicine for your family's healthcare needs.

Home

Consent for Treatment

Informed Consent

I. Purpose:

A. The informed consent process is viewed as being integral to the physician/patient relationship and to the practice of medicine. Informed consent is not simply a signature on a preprinted form; instead, it is a process of information exchange and an opportunity to educate the patient about recommended treatment. Anytime a "material risk" is associated with a procedure, informed consent should be obtained. The attending physician is responsible for obtaining the informed consent from the patient or legal guardian of a minor.

B. Basic consent entails letting the patient know what you would like to do and asking if it is alright to proceed. Basic consent is important and valid in regard to noninvasive and routine procedures such as x-rays and venipunctures.

C. The physician, may exercise "therapeutic privilege" and not inform a patient of a particular risk if the physician can document that explanation of such risk would affect the patient's ability to make a rational decision or cause harm that would exceed the risk itself.

D. The patient's consent should only be "presumed" rather than obtained, in emergency life threatening situations, when the patient is unconscious, or incompetent and no surrogate decision maker is available.

1. Procedure:

A. The informed consent process should be obtained for the following:
1. Minor surgery which involves entry into the body
2. Non-surgical procedures involving more than a slight risk or harm to the patient, or involving a risk of change in the patient's body structure.
3. Experimental procedures
4. Patient photographs (involving medical care)
5. Procedures in which the medical staff determines that a specific explanation to the patient is required.

B. The consent for diagnostic and/or surgical procedure form should be obtained for the following:
1. Any minor surgical procedure
2. Colposcopy
3. Colonoscopy
4. Laryngoscopy
5. Endometrial biopsy
6. HIV testing
7. Implanon Insertion

C. The physician will explain and discuss the proposed procedure with the patient and/or legal guardian.

D. The diagnostic and/or surgical procedure consent form will be executed, and the physician will obtain informed consent to include the following:
1. A description of the procedure to be performed in terms understandable to the patient.
2. A statement of the possible risks, complications and the alternative methods of treatment.
3. The identity of the physician who will perform or order the procedure.
4. A statement that indicates that the patient has read and understands the consent form.

5. A statement that indicates that the patient has had an opportunity to ask questions and has had those questions answered in terms understandable to the patient.
6. The patient or legal guardian's signature, the date and time the consent was signed.
7. The signature of a witness, (may be a physician), and the date signed.

E. Special consent forms should be obtained for the following:
   1. Against medical advice
   2. Sterilization – Tubal ligation and Vasectomy
   3. Stress test
   4. Influenza vaccines
   5. Immunizations
   6. Pulse Light Therapy
   7. HIV Testing
   8. Colonoscopy

F. For Medicaid (female) sterilization procedures:

   1. The attending physician is responsible for obtaining the informed consent from the patient, but the physician or the nurse may need to read the contents of the consent form to the patient before instructing the patient to read and sign it.
   2. Thirty days must elapse after the date of the patient's signature on the consent form, before the sterilization procedure may be performed.
   3. One week in advance of the procedure, the nurse will send the completed form to the physician performing the sterilization procedure, one copy to the hospital, and one copy is retained in the patient's medical record.
   4. The physician's statement on the consent form is to be signed by the physician at the time of the hospital admission or shortly before the sterilization procedure.
   5. Refer to the Department of Health Information for Women packet.

2. Documentation

In all cases the physician is responsible to document in the progress note or procedure note that the essential elements of informed consent were discussed. At a minimum this should include:
1. Treatment options
2. The risks and complications of the procedure
3. The opportunity for the patient to ask questions

3. Incapacitated persons

Informed consent for health care for a minor patient or a patient who is determined by a physician to be an incapacitated person and unable to consent may be obtained from a person authorized to consent on behalf of the patient. The following is in order of priority that may provide consent to health care on behalf of the patient.
1. The individual to whom the patient has given a durable power of attorney that gives them the authority to make health care decisions for that patient.
2. The appointed guardian of custodian of the patient.
3. The patient's spouse who has maintained significant contacts with the incapacitated person.
4. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person.
5. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person.
6. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person.

7. Grandparents of the patient who have maintained significant contacts with the incapacitated person.
8. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person or
9. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Informed consent for health care for a minor patient or a patient who is an incapacitated person must make reasonable efforts to locate and obtain authorization for the health care from a competent person.

Before any person authorized to provide informed consent, the person must first determine in good faith that the patient, if not incapacitated, would consent to the health care.

No person authorized to provide informed consent pursuant to this section may provide consent for sterilization, abortion, or psychosurgery or for admission to a state mental health facility for a period of more than forty-five days without a mental health evaluation or other court order.

4. Minors

A general rule, a minor cannot consent to their own treatment and the consent of a parent or legal guardian is required to treat the minor for non-urgent matters.

Written consent, **Consent for Minors Medical Care and Information**, is required when someone other than parent/guardian will accompany the minor patient to the appointment if anticipated that the parent/guardian will not be present for the appointment.

Parents/guardian can sign the **Authorization of Release of Information form** for information to go to another person approved by the parent/guardian.

A provider seeking consent for a minor patient must make reasonable efforts to locate and receive authorization for the health care from a parent/guardian.

If written consent cannot be obtained from the parent/guardian, attempt to contact the parent/guardian to discuss the office visit findings and treatment plan, unless the minor patient is permitted by law to obtain treatment without parental consent. State of ND explains a minor to be ≥ 14 years of age for the following exceptions that can be treated without parental consent.

1. Treatment of Minor for sexually transmitted disease
2. Emergency Care
3. Blood donations
4. Prenatal Care and other pregnancy care services

A minor who has been deemed emancipated by a court of law may also consent for their own treatment.

The HIPAA rules provide an exception to protecting a minor patient's PHI when that minor patient seeks treatment without parental consent. If the Provider's professional judgment deems it in the best interest of the minor patient to inform the parent/guardian of the minor patient's visit, the provider may do so. Document the reason for disclosing information in order to support the disclosure was in the minor patient's best interest.

To prevent the unwanted release of information, to include billing charges, to a parent/guardian when a minor seeks treatment the dictation note and that date of service billing charges will need to be flagged to alert all staff to this RESTRICTED note and charges. Follow the **RESTRICTED MINOR VISIT checklist.**

5. Refusal to be Informed

An exception to the informed consent process occurs when a patient refuses to be informed about a treatment or procedure. There could be many reasons for this and it is the responsibility of the physician to attempt to find out why the patient is refusing to be informed before a treatment or procedure is done. Another option is to see if the patient will allow the physician to provide this information to a relative or friend.

Documentation necessary in the event of Refusal to be Informed:

1. Information that was given to the patient before they refused further information, and that the patient refused to be informed.
2. Plan of care.

6. Refusal of Treatment

A mentally competent patient may refuse any medical treatment. In order to satisfy the requirements of the informed consent process, it is important that patients are provided with the risks associated with not undergoing a treatment.

When informing a patient who is refusing a treatment do and document the following:

1. Evaluate the patient's capacity to make decisions.
2. Assess the patient's overall understanding of the information provided.
   Re-educate the patient when necessary.
3. Document
   a) diagnosis and recommended treatment,
   b) risks and benefits of the recommended treatment,
   c) alternative treatments if available
   d) risks and consequences of not having the recommended treatment, and reasons for refusal.

Home

Patient Education

Patient education is given to a patient to provide help in solving his/her health problem. It should be incorporated in to routine office visits for all patients. Effective patient education ensures that patients have a sufficient level of knowledge and understanding, which allows them to make informed decisions regarding their care.
Patient education is selected to recognize the education level, literacy and language needs of patients. Select education materials that are written at a 5th to 8th grade level. Education materials need to support education provided and not take place of provider education.

Approved Websites to provide patient handouts for education are listed below. Multiple copies of handouts that cover common health problems in the community can be printed. Periodically check website for revisions and update handouts. If education materials are not on this list or part of current handouts the information needs to be approved by a faculty member.

Family Medicine:	http://familydoctor.org/online/famdocen/home.html
Sports Medicine:	http://www.summitmedicalgroup.com/library/sports_health/
Pediatric Medicine:	www.cpnonline.org
Dermatology:	www.aad.org
Diabetes:	http://www.diabetes.org www.internationaldiabetescenter.com
Health Maintenance:	http://epss.ahrq.gov/ePSS/GetResults.do?method=search&new=true
American Academy of Pediatrics:	http://brightfutures.aap.org/tool_and_resource_kit.html

Approved Patient Handouts to provide education to patients are listed below. If new education handouts are to be implemented they need to be approved by a faculty member.

OB: First OB packets
Diabetic Patients

Interpreters:

Pacific Interpreters Service-Nursing will be trained in how to access these services when needed.
Microsoft Office Word Document Language Translation

Documentation Guidelines:

1. Medicat; Choose the correct transaction in the EDUCATION field to find the education handout. It is possible to search by diagnosis also. A Treatment Set can be found in PLAN section of a SOAP note also.
2. Evaluation of the patient's ability to comprehend the information provided.
3. The content name and source of patient education materials that were provided to the patient. Remember to include all education used-verbal, audio, written. There is NO need to include a copy of the handout in the medical record.
4. Evaluation of the patient's understanding of the information provided. (e.g., teach back, repeat back)
5. Interpreters-Document use of and service (ex. telephone). Document name of the interpreter services, name of the interpreter, and description of the information provided, patient's stated level of understanding of the information, signature of nurse of medical provider making the entry.
6. Nursing must have approval of the provider for all education given. List source and handout given per physician. **Home**

Patient Summary (Medicat)

Patient's medical history is summarized in the patient's electronic record on the Patient Summary page. The patient's medical history needs to be reviewed routinely.

MEDICATIONS: Reconciled by nursing for each clinic visit in the Patient Summary. If dosage changes have occurred, nursing will review changes with the physician. Physicians will review and make appropriate changes in Rcopia.

HISTORY: Medical, Family, Surgical and Social history needs to be reviewed and updated by the physician for all established patients on an annual basis. New patients will need to be entered during their initial exam.

For health maintenance and annual medication recheck physicals, all categories in the Patient History Summary need to be reviewed.

For problem focused visits, only the Patient History Summary categories related to chief complaint visit need to be reviewed.

ALLERGIES: Reconciled by nursing every visit in the Patient Summary.

EXCEPTIONS:

OB: Refer to ACOG

PEDS: Forms approved by the American Academy of Pediatrics Bright Futures will be used.

The Child Health Questionnaire needs to be completed on both sides and filed on the left side of the chart. Forms will be scanned and attached to the visit. The clinic Residents using the Pediatric forms are still subject to preceptor review.

Well Child forms are designed for different age brackets. We will as a clinic use these forms for patients up to the age of fourteen. After the age of fourteen the Patient Summary will applicable. An exception would be for patients with disabilities, we can then use the form marked Teen/14-21 years.

The form labeled Ped's Problem List is an optional form that can be used.

Home

Geriatric Protocol

Nursing Home Rounds

1. Objectives

a) Identify aspects of the aging process.

b) Gain an awareness and sensitivity to the medical, emotional, social, economic and physical needs of the elderly.

c) Enhance perceptions and attitudes toward the elderly.

d) Develop an insight into the continuity of care of the elderly in a long-term health care center.

e) Gain knowledge regarding the role of the physician caring for the elderly patient in a long-term health care center.

2. **Protocol**

a) There will be an assigned "nursing home week," where each physician will see their nursing home patient. To meet the Medicare guidelines, this visit will be at least every 30 days on a new admission to the nursing home facility for the first 90 days and at least every 60 days thereafter.

b) Nursing home teaching rounds will be held one time per month, after the above completed nursing home week. A schedule will be made up for a 1-month rotation.

c) At the nursing home teaching rounds, all residents will meet during a noon luncheon, along with the geriatric nurse and a preceptor.

d) One assigned resident will present a short lecture on an assigned geriatric topic.

e) Each resident physician will present his or her patient to the group. This will give the resident an opportunity to discuss their patient's care with a preceptor and other residents.

f) One or two residents will be assigned to go on walking rounds with the preceptor and the geriatric nurse. This is where we will see each patient and sign the appropriate forms.

g) Resident physicians are required to attend a minimum of one nursing home care conference per year, preferably when the patient's family members are present, if applicable.

h) The schedule of the above mentioned care conference dates will be given at the beginning of each month. A reminder of a memo or call will be done closer to the date.

In Summary:

1) Residents will become primary care physicians for their nursing home patients by making visits every 60 days and therefore providing continuity of care.

Home

2) Residents will become more family oriented by attending care conferences on their patients. This gives the resident the opportunity to meet the family and to better understand the care that each department of the nursing home provides for their patients.

3) Residents will share their geriatric experiences by attending group rounds every month.

Geriatric Home Visits

1. Objectives

a) Demonstrate the informational value of a home visit.

b) Develop and maintain observational skills.

c) Learn about cultural, social and environmental habits of the patient.

d) Increase understanding of family dynamics.

e) Aid the resident in developing a more holistic approach to geriatric care, utilizing the information obtained on the home visit.

2. Protocol

a) The resident is responsible for selecting an appropriate patient for a home visit. The geriatric nurse or preceptor may also suggest patients. When possible the selection of the patient will take place at least 1 week prior to the home visit date.

b) Geriatric team members that will attend the home visit will include the preceptor, resident physician, geriatric nurse and social worker when possible.

c) Each resident will participate in a minimum of one geriatric team home visit per year.

d) The geriatric nurse will schedule home visits. The visits will occur during the day from 0930 to 1200, and from 1330 to 1630, with the approval of the patient and family and in accordance with the other team members' schedules.

e) The geriatric team visit will be brief (30-60 minutes), and by appointment. The geriatric nurse will have the billing sheet, the patient data base, and chart when available. The nurse will also obtain the patient's vital signs, when appropriate. The geriatric nurse is available to perform venous blood draws, if needed, but this needs to be discussed in advance.

f) Following the home visit, the resident physician will dictate findings and follow-up plans of treatment.

In Summary:

1) The resident will be asked to select a patient for home visit, and make a minimum of one home visit per

year.

Home

2) The resident will be asked to share his or her initial impressions and expectations prior to the visit. This impression will be based on previous contact with the patient either in the office or from the chart.

3) The resident will compare the actual findings to the original expectations. This will assist the resident in understanding how stereotypes and preconceived attitudes often affect objectivity about patients.

4) The resident physician will observe the following data during the home visit:
   a) Medication management -including OTC and prescription, as well medication storage.

   b) Nutritional data - including diet, appetite and weight change.

   c) Folstein mini-mental status.

   d) Functional activities of daily living.

   e) Family issues- including social, financial and emotional.

   f) Environmental observations - including external and internal.

   g) Support services - including those utilized or referral if needed.

   h) A family history and physical exam.

Geriatric Nurse Availability Communication

1) The geriatric nurse schedule will be given to the front desk. Because I only work 24 hours/week, I am available for urgent calls at home. Please check with front desk for the number.

2) If the issue is not urgent, a note on my desk will be sufficient, and I will get back to you the next time that I am in clinic.

3) The calls from the nursing home will come to the geriatric nurse (when available). The question will then be followed up to a physician.

4) Please take note to watch for any nursing home orders for you to sign. I will put them on your desk, and after they are signed, they can go into the resident's outgoing mail bin.

5) The geriatric nurse is available for questions or concerns.

6) Together we need to communicate patient information, to provide continuity of care.

Resident Physician Responsibilities

1) See nursing home patients during the assigned time, and in a timely manner to meet Medicare regulations.

2) Attend nursing home teaching rounds during the scheduled noon luncheon.

Home

3) Present a brief lecture on an assigned topic at the designated time. The resident physician is expected to provide a supplement source of information on the assigned topic, other than that of the article supplied by the geriatric nurse.

4) Attend the walking nursing home rounds when assigned.

5) Select a patient for a home visit and attend a minimum of one per year.

6) Attend a minimum of one nursing home care conference per year, preferably with the family member's present, if applicable.

7) Communicate to the geriatric nurse any potential or new nursing home patients.

8) Observe for any telephone orders that need to be signed. Then place them into the resident's out going mail bin in a timely manner.

9) Communicate to the geriatric nurse when you are not able to attend any of the above-mentioned assignments.

Home

Graduation Requirements

TO RECEIVE A CERTIFICATE OF COMPLETION YOU MUST:

- **Successfully complete all required rotations including Practice Management and Research.**
- **Make sure all completed rotations have a filled out evaluation form from the preceptor.**
- **Turn in all experience cards and/or documentation.**
  Must have 30 vaginal deliveries (plus 10 continuity deliveries)
  ICU patients (must have 15 patients)
  AGB Form-10 documented and card signed
  Foley Cath Form-10 documented and card signed
  Pap Smear Form-10 documented + 5 Wet Mounts and card signed
  - **Have adequate clinic numbers (1,650 patients) as well as all clinic dictation completed. Need to have 150 patient encounters at the end of the first year.**
    - **Documentation of patient numbers from any rural rotation.**
- **Updated Procedure Log**
- **Resident Dues Paid in Full each year**
- **Duty Hours Up to Date**
- **Complete GME-TODAY Series**
- **Complete QA audit**
- **Complete Residency to Reality Series**
- **Help Desk Answer Published (FPIN)**

TO BE TURNED IN ON LAST WORKING DAY OF WORK: Book Club Book#:
Key to clinic key
Parking Card (or $10 if you lost the card)
St. Alexius Access Card
St. Alexius Meal Card
UND Passport Card
Beeper (please let me know of any problems)
Moonlighting Log
Sanford One Access Card
Practice and Home Address

REMINDER:

Apply for your own Medicaid ID#

Home

Attending Physician's CFM Clinic Responsibilities

1. Attending Physician's need to be available at the clinic during the hours that they are assigned as Preceptor.
2. It is mandatory for all OB visits seen by a Resident be precepted with the Attending Physician.
3. It is mandatory that the precepting Attending observe a significant portion of one patient visit for each Resident during the clinic session. This will apply to all levels of residents.

Home

Confidentiality and Disclosure of Concern Cards

Purpose: To delineate the procedures for insuring confidentiality of Concern Cards submitted to Program Director (PD).

Policy:
I. Concern Cards submitted to the PD via e*Value or written suggestion will be kept strictly confidential by the PD and the Program Coordinator.

II. If the PD deems that patient safety is in jeopardy from the information on the Concern Card, the PD may choose to intervene immediately in such a way that anonymity of the content of the Concern Card cannot be maintained. However, the actual Concern Card itself will not be shared with the person who is the subject of the report.

III. The PD may use general information from Concern Cards to shape resident or faculty feedback. However, every attempt to maintain the anonymity of the author of the Concern Card will be made.

IV. The Program Coordinator will keep all Concern Cards about a resident in a separate section of their personnel file. These will be not be able to be viewed by anyone other than the PD and Program Coordinator. They will be removed from the personnel file and destroyed when the resident graduates from the program.

Home

Complaint Management

The Risk Management Team will effectively manage the risk associated with minor and noncritical events. Complaints will be received and responded to within 30 calendar days for both oral and written complaints. All complaints should be resolved at the level the issue occurred.

Complaints will be processed, reviewed and the Risk Management Team & Program Director will be provided with a biannual report.

Purpose:
Complaints or concerns received by clinic staff reflect patient perceptions and expectations. Feedback, solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service.

Procedure:

All clinic and administrative staff will be responsible for receiving complaints. Complaints related to a specific department will be forwarded to the department supervisor. Complaints related to physicians will be forwarded either to the Business Manager or the Program Director.

1. The patient complaint is received either verbally or in writing by any staff person.
2. The complaint form (Patient Relations Communication form or State of ND Incident Report) will be initiated by the person receiving the complaint.
3. If the complaint can be resolved at this level, staff member receiving the complaint will:
    - Resolve complaint
    - Complete complaint form including signature and date
    - Completed form will be forwarded onto the Business Manager to be reviewed and original to be filed with the assigned CFM Risk Management Representative & copy to the Risk Management Division of the State of N.D. if warranted.
4. If the complaint cannot be immediately resolved, the complaint form will be forwarded to the Business Manager, Nursing Supervisor, or Provider/Preceptor. An investigation will be initiated and a timely quality review of the event or complaint will be done. Documentation will be made on the complaint form.
5. Changes will be made in policy/process in a timely manner and communicated to all staff as appropriate.
6. The complaint will be filed and tracked for trends during a quarterly review. Any trends found will be reported and discussed with the Program Director. Improvements will be made as needed.

Patient Complaint Records

Improvement activities and training will be identified and monitored by the Risk Management Committee.

Home

Patient Satisfaction Survey

Policy:
Currently, the UND Center for Family Medicine – Bismarck has two different surveys to measure patient satisfaction.

Purpose:
Patient Satisfaction Surveys reflect patient perceptions and expectations. Feedback, either solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service.

Mission:
In making UND Center for Family Medicine the healthcare facility of choice, we are committed to recapture the trust our customers have in UND and our Residency Program, and to insure we exceed our customers' expectations in the event dissatisfaction with service occurs. The patient satisfaction surveys will help us to create individual relationships with our customers and build a service recovery culture within our organization.

Procedure:

Patients are "handed/mailed" the "Physician/Resident" surveys by Nursing Staff at the completion of their clinic visit. This process will occur biannually for Faculty/Resident Evaluations with a random sampling of 5surveys per Faculty/Resident(Upper level) and 5 per first year Resident. Results of this particular survey will be shared with Residents during their respective evaluation(s). Qualtrics Survey Software is used to record results and view reports per the University of North Dakota policy.

Patient Satisfaction Surveys
General statistical information is gleaned from quarterly reports. Patient Satisfaction Surveys will be reported biannually, or more frequently as determined by Administration, to the Business Manager, Risk Management Committee, Program Directors, Residents, and Ancillary Staff.
Improvement activities will be identified and monitored by the Risk Management Committee.
At a minimum, an annual report will be presented to the Medical Practice Providers including improvement made as a result of patient complaint/concerns. Results of "Patient Satisfaction Surveys" are routinely reviewed and evaluated by the governing board, the medical staff and administration. Complaints identified through patient satisfaction surveys are forwarded to the Risk Management Committee. Risk Management shall collaborate with appropriate staff to investigate and provide follow-up to the patient and/or family.

Home

Electronic Communications

Purpose

To assure the appropriate use of electronic communication within the UND Center for Family Medicine in addition to the general UND Computing and Network Usage Policy.

Procedure

Password Protection:

All assigned to or created passwords by an employee are private and should not be shared with others. All electronic devices and applications shall be password protected. Passwords need to be changed frequently using a unique password.
Workstation screensavers shall be password protected to prevent a possible breach of PHI.
Only use a program under your personal login information. Do not use a program accessed by another employee. Log employee out and then log in with your information.

E-mail:

When using the University of North Dakota's e-mail system, the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect against a HIPAA breach.

E-mail is used within the clinic appropriately by staff using the University assigned email address for an employee. By State of North Dakota law, university email content is considered public record, and thus is open and accessible for inspection.

E-mail communication with patients shall be done with a secure system. Encryption is the only approved mechanism to electronically transmit PHI. The use of the Medicat EMR patient portal will provide a secure means to communicate with patients.

Mobile Applications:

Google Drive is accessed on mobile devices to be used by Providers for patient care. It is administered by a designated UND Center for Family Medicine Faculty member. Each member (Provider's Only) is added by the Administrator to the application. A password is needed to access the application. Information on is updated by Providers and provides a means of communication for each patient.

Personal Device:

All personal devices are not required by staff to fulfill an employee's job requirements. By State of North Dakota law, all electronic communication records are public records, and thus are open and accessible for inspection. The use of personal devices opens the employee to personal liability for discoverable electronic communication.

Texting:

Intelliweb is available on all computers in the clinic to text providers. Follow this link:
http://206.208.80.22/amcom/amcomweb/

When using texting the individual user must understand that it is an secure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect confidential information.
Texting should not replace a phone conversation in order to avoid miscommunication between you and the patient or employee. Texting should be avoided during patient care to prevent errors.

Texting is not to be used for communication with patients.

Social Media:

Social media is a means of communication using web-based and mobile technologies for the exchange of information. Social Media is not to be used for communication with patients or for work-related communication between employees. No health or medical related information that relates to official activities may be posted on social media.

Lost or Stolen Device:

All lost or stolen devices need to be reported to the department supervisor as soon as possible. The mobile provider will need to be called to deactivate the phone. If a PHI breach is a concern the HIPAA officer will need to notified of the breach.

Applications are available for devices that can locate the lost device and the phone can be remotely locked or the information can be deleted from the phone. i.e. Find My iPhone. It is recommended that electronic mobile devices have this or a similar application.

Termination or Resignation of Employment:

All employee access to current software applications and devices will be deactivated. This includes but is not limited to Medicat, Orchard Harvest, Round's List, e-mail, e-prescribe etc.

For complete UND policy see the office of Human resources and Payroll Services Annual Notification of Policies.

Home

ABBREVIATIONS AND SYMBOLS; "COMMON USE" AND "DO NOT USE"

Purpose:
Establish a comprehensive list of abbreviations and symbols to use for notes and charting in a patient's medical record.

Procedure:
Use the following list of abbreviations and symbols when charting in a patients chart. Use this list as a reference to notes made by nurses or doctors.

A Home

A_1C--glycosolated hemoglobin
A.A---Alcoholics Anonymous
AAA---Abdominal Aortic Aneurysm
AAROM-------------------------------------active assistive range of motion
AB--abortion
abd.---abdomen
ABG--arterial blood gases
Abx---Antibiotics
AC--acromioclavicular, assist control
ac---before meals
accel--acceleration
ACHES--------------------------------------Abdominal pain, chest pain, headaches, eye problems, severe leg cramps
ACL--anterior cruciate ligament
ACTH---------------------------------------adrenocorticotropic hormone
ad lib.--as desired
ADD--attention deficit disorder
add---adduction
ADH--antidiuretic hormone
ADHD-- attention deficit hyperactive disorder
ADL's-- activities of daily living
adm. -- admission
AE--- above elbow, adaptive equipment
AFB--- acid fast bacillus
AFI--- amniotic fluid index
AFIB-- auricular fibrillation
AFO--- ankle/foot orthosis
A/G-- albumin globulin ration
AI--- aortic insufficiency
AIDS-- acquired immunity deficiency syndrome
AK--- above knee
AKA -- above knee amputation
alb. -- albumin
ALG--- antilymphocyte globulin
Alk. Phos. ------------------------------------ alkaline phosphatase
ALS--- ametropic lateral sclerosis

ALT--- alanine aminotransferase
A.M. --- morning
AMA-- against medical advice
AMI--- acute myocardial infarction
AML-- acute myelogenous leukemia
amp. --- ampule
amt --- amount
ANA-- antinuclear antibody
ant -- anterior
AP--- anterior/posterior or anteroposterior
A&P Repair---------------------------------- Anterior & posterior colporrhapy
approx. -------------------------------------- approximately
appt -- appointment
ARC--- AIDS related complex
ARDS--- adult respiratory distress syndrome
AROM-- active range of motion
AROM-- artificial rupture of membranes
ASA-- aspirin
ASAP-- as soon as possible
ASCUS-------------------------------------- atypical Squamous cells of undetermined significance
ASCVD-------------------------------------- arteriosclerotic cardiovascular disease
ASD-- atrioseptol defect, atrial septal defect
ASHD-- arteriosclerotic heart disease
ASIS--- anterior superior iliac spine
ASO-- antistreptolysin-o
AST-- aspartate aminotransferase
ATN-- acute tubular necrosis
ATNR-- asymmetrical tonic neck reflex
ATR-- Achilles tendon reflex
A_2-- aortic second sound
AV-- arteriovenous
AV block------------------------------------ atrioventricular block
AVR-- aortic valve replacement
AVF, AVL, AVR--------------------------- EKG leads – augmented right arm, left arm, left leg
A/V/H-- auditory/visual/hallucinations

B [Home]

Ba--- barium
baso -- basophils
BBB--- bundle branch block
BCM-- birth control method
BCP--- birth control pills
b.e. --- base excess
BE--- barium enema
BF--- boyfriend
BG--- blood glucose
bid -- twice daily
bilat .--- bilateral
bili. -- bilirubin
BK--- below knee
BKA--- below knee amputation
BLE--- both lower extremities

BM-- bowel movement
BMAT--- bilateral myringotomy and tube insertion
BMI--- Body Mass Index
BOS--- base of support
BOT--- base of tongue
B.O.W. --------------------------------------- bag of waters
BP--- blood pressure
BPH--- benign prostatic hypertrophy
BPP--- biophysical profile
BR--- bathroom
BRP--- bathroom privileges
b.s. -- breath sounds
BS -- bowel sounds
BSE--- Breast self exam
BSO -- bilateral salpingo-oophorectomy
BTB--- Breakthrough bleeding
BTL--- bilateral tubal ligation
BUE--- both upper extremities
BUN--- blood urea nitrogen
BV--- bacterial vaginosis
Bx, BX--- biopsy

C Home

c--- with
C--- Centigrade
C1-C7-- cervical vertebrae 1-7
Ca--- calcium
CA -- carcinoma
CABG--- coronary artery bypass graft
CAD--- coronary artery disease
cap. -- capsule
CAPD--- continuous ambulatory peritoneal dialysis
CARF--- Commission of Accreditation of Rehabilitation Facilities
cath. --- catheter
CBC--- complete blood count
CBE--- Clinical breast exam
CBG--- capillary blood gas
CBI-- continuous bladder irrigation
CC--- chief complaint
CCU--- coronary care unit
CEA--- carcino-embryonic atigen
CGA--- contact guard assist
CHF--- congestive heart failure
CHO--- carbohydrate
Chol--- cholesterol
C.I. --- Cardiac Index
CIN-- cervical intraepithelial neoplasia
circ -- circumcision
CIS--- carcinoma in situ
Cl--- chloride

CLL-- chronic lymphatic leukemia

cm. --- centimeter (2.54cm = 1 in.)
CM--- case manager/management
CML--- chronic myelogenous leukemia
CMSS--- color, motion, sensation, swelling
CMT--- Cervical mothion tenderness
CMV--- cytomegalovirus
CNA-- Certified Nurse Assistant
CNS-- central nervous system
Coag-- coagulation
C.O. -- Cardiac Output
Colpo--- Colposcopy
c/o--- complains of
CO -- carbon monoxide
cont --- continue
COPD-- chronic obstructive pulmonary disease
CORF--- Comprehension Outpatient Rehabilitation Facility
CO_2 --- carbon dioxide
COTA--- Certified Occupational Therapy Assistant
CPAP--- continuous positive airway pressure
CPD--- cephalopelvic disproportion
CPK--- creatinine phosphokinase
CPM--- continuous passive motion
CPR--- cardiopulmonary resuscitation
CPT--- chest physiotherapy
crani. --- craniotomy
creat -- creatinine
CRP--- C-reactive protein
CRTT--- Certified Respiratory Therapy Technician
Cryo-- cryoprecipitate
C-Section, C-sect---------------------------- cesarean section
C&S, C/S------------------------------------ culture and sensitivity
CSF--- cerebrospinal fluid
CST--- contraction stress test
CT--- computerized tomography
CTRS--- Certified Therapeutic Recreational Specialist
ctx -- contractions
cult --- culture
cu. mm.-------------------------------------- cubic millimeter
CV-- cardiovascular
CVA -- cerebrovascular accident
CVP-- central venous pressure
CXR-- chest x-ray
cysto .--- cystoscope/cystoscopy

D Home

DAT-- diet as tolerated
DAU-- daughter
D&C-- dilation and curettage
decel -- deceleration
dept --- department
D/I--- dry and intact
disch. -- discharge
DIC--- disseminated intravascular coagulopathy

DID--- dissociative identity disorder
DIP--- distal interphalangeal
DJD--- degenerative joint disease
DM--- diabetes mellitus
DME--- durable medical equipment
DO --- Doctor of Osteopathy
DOA--- dead on arrival
DOB --- date of birth
DP--- dorsalis pedis
DPT--- diptherial toxoid, Pertussis, tetanus toxoid
Dr. --- doctor
drng --- drainage
drsg --- dressing
DSM(edition) -------------------------------- Diagnostic&Statistical Manual of Mental Disorder(edition)
DT's --- delirium tremens
DTR--- deep tendon reflex
DUB--- dysfunctional uterine bleeding
DUI--- driving under the influence
DVT--- deep vein thrombophlebitis
D/W--- dextrose and water
Dx--- diagnosis

E [Home]

EAB--- Elective abortion
EBL--- estimated blood loss
ECG or EKG---------------------------------- electrocardiogram
echo. --- echocardiogram
E.coli--- Escherichia coli
ECP--- Emergency Contraceptive Pill
ECT--- electoconvulsive therapy
ED--- Emergency Department
EDC--- estimated date of confinement
ed--- Education
EEG--- electroencephalogram
enc--- Encourage
EENT--- eyes, ears, nose and throat
e.g. --- for example
EGD--- esophagastroduodenoscopy
EIA--- exercise induced asthma
ELOS--- estimated length of stay
EMG--- electomyogram
ENT--- ears, nose and throat
EOA--- esophageal obturator airway
EOB--- edge of bed
EOM--- extraocular movements
EOR--- end of range
eos. --- eosinophils
ER--- Emergency Room
ESI--- epidural steroid injection
ESR--- erythrocyte sedimentation rate
ESRD--- end stage renal disease
et --- and

ET-- endotracheal
etc. -- and so forth
ETD-- Eustachian Tube Dysfunction
ETOH-- ethyl alcohol
ETT-- endotracheal tube
eval-- evaluate, evaluation
expir -- expiration
ext --- extension
ext.rot. -- external rotation

F Home

F. -- Fahrenheit
FANA-- fluorescent antinuclear antibody
FCA-- functional capacity assessment
FB--- foreign body
FBS-- fasting blood sugar
Fe-- Iron
FECG-- fetal electrocardiogram

Fetal Position and Presentation:
Vertex Presentations:
LOA-------------------------left occiput anterior
LOP------------------------left occiput posterior
LOT------------------------left occiput transverse
ROA------------------------right occiput anterior
ROP------------------------right occiput posterior
ROT------------------------right occiput transverse

Face Presentations:
LMA-------------------------left mentum anterior
LMP------------------------left mentum posterior
LMT------------------------left mentum transverse
RMA------------------------right mentum anterior
RMP------------------------right mentum anterior
RMT------------------------right mentum transverse

Breech Presentations:
LSA------------------------left sacrum anterior
LSP------------------------left sacrum posterior
LST------------------------left sacrum transverse
RSA------------------------right sacrum anterior
RSP------------------------right sacrum posterior
RST------------------------right sacrum transverse
FFP-----------------------fresh frozen plasma
FH------------------------family history
FHR-----------------------fetal heart rate
FHT-----------------------fetal heart tones
FiO_2--- fractional inspiratory oxygen
fl -- fluid
FM -- fetal monitor
FNP-- Family Nurse Practitioner
FOB-- Father of Baby
Fr -- French catheter size

freq. --	frequent
FSH---	follicle stimulating hormone
FTA---	fluorescent treponema antibody
FTA-ABS test --------------------------------	fluorescent treponemal antibody absorbed test
FTI ---	free thyroxin index
F/U---	follow up
FUO --	fever of unknown origin
FWB--	full weight bearing
FWW--	front wheel walker
fx ---	fracture

G [Home]

GAF---	global assessment of functioning
GB---	gallbladder
GC---	gonococcus
GCS---	Glasgow coma scale
GERD---	Gastro Esophageal Reflux Disease
Gest---	gestational
GI--	gastrointestinal
gm --	gram
G --	gravida
G6PD---	glucose-6-phosphodehydrogenase
gtt ---	drops
GTT ---	glucose tolerance test
GU---	genitourinary
GVHD---	graft-versus-host disease
Gyn. --	gynecology
GXT ---	graded exercise test

H [Home]

HA---	headache
HCL---	hydrochloric acid
HCO_3 --	bicarbonate
Hct. ---	hematocrit
HDL---	high density lipo-protein
HEENT---------------------------------------	head, eyes, ears, nose & throat
HEP---	home exercise program
Hg. --	mercury
Hgb---	hemoglobin
HGSIL--	high grade Squamous cell intraepithelial lesion
H/H--	hemoglobin & hematocrit
HHN--	hand held nebulizer
HIAA---	hydroxylindol acetic acid
HLA---	Human Leukocyte Antigen
HOB---	head of bed
Hosp. ---	hospital
H&P---	history & physical
/hpf--	per high power field
HPI--	history of present illness
HOH--	hard of hearing
HR---	heart rate

hr. -- hour
HS-- at bedtime
HSV-- Herpes simplex virus
ht. --- height
HTN-- hypertension
H_20-- water
hx -- history
Hz-- hertz

I Home

IAB-- Incomplete abortion
IBC-- iron binding capacity
ICC-- Intensive Care Center
ICP-- intracranial pressure
ICU-- Intensive Care Unit
I&D-- incision and drainage
IDDM-- insulin dependent diabetes mellitus
i.e. --- that is
IGG-- immune gamma globulin
IM-- intramuscular
IMV-- intermittent mandatory ventilation
incl -- including
indep -- independent
INF-- Infection
INH-- trademark for preparations of isoniazid
inj-- Injection
INR-- International Ratio
insp -- inspiration
Int. Rot. -------------------------------------- internal rotation
I&O-- intake and output
IOL-- Intraocular lens
I-131-- radioactive iodine
IPPB--- intermittent positive pressure breathing
IQ-- intelligent quotient
IS-- Insentive Spirometry
ITTP--- idiopathic thrombotic thrombocytopenic purpura
IUD-- intrauterine device
IUPC-- Intrauterine Pressure Catheter
IV-- intravenous
IVP-- intravenous pyelogram

J Home

JP-- Jackson-Pratt
JVD-- jugular venous distention
JVP-- jugular venous pressure or pulsation

K Home

K--- potassium

KAFO--- knee ankle foot orthosis
KS--- Kaposi's Sarcoma
K cal. --- kilocalorie
KCl-- potassium chloride
K.pad --- aquamatic pad
kg. -- kilogram
KUB-- kidney, ureter, bladder

L Home

l --- liter
L1-L5-- lumbar vertebrae 1-5
L--- left
lab. -- laboratory
lac --- laceration
LAD-- left axis deviation, left anterior descending
LAH-- left anterior hemiblock
Lami--- laminectomy
Lap-- +name of procedure would indicate laparoscopic, i.e.Lap Chole, Lap Nissen Fundiplication, etc.
lap --- laparotomy
lat .-- lateral
lb. --- pound
LBQC-- large based quad cane
LD--- learning disorder
LDH--- lactic dehydrogenase
LE--- lupus erythematosus, lower extremity
LEEP-- Loop Electrocautery Excision Procedure
LFT-- liver function test
lg. --- large
LGA--- large for gestational age
LGSIL--- low grade Squamous cell intraepithelial lesion
liq. -- liquid
LLB--- long leg brace
LLE--- left lower extremity
LLL--- left lower lobe
LLQ--- left lower quadrant
LMA --- left mentum anterior
LML-- left mediolateral (episiotomy)
LMP-- last menstrual period, left mentum posterior
LMT-- left mentum transverse
LNMP-- last normal menstrual period
LOA --- left occipitoanterior, leave of absence (pass)
LOB-- loss of balance
LOC-- level of consciousness
LOP-- left occipitoposterior
LOS-- length of stay
LOT --- left occipitotransverse
LP-- lumbar puncture
LPH-- left posterior hemiblock
lpm -- liters per minute
LPN-- Licensed Practical Nurse
LR-- lactated ringers
LS-- lumbosacral

LSA-- left sacrum anterior
LSC-- last sexual contact
LSD-- lysergic acid diethylamide
LSO-- left salpingo-oophorectomy
LSP-- left sacrum posterior
LST-- left sacrum transverse
LTC-- long term care
LTG-- long term goals
LUE-- left upper extremity
LUL-- left upper lobe
LUOB--- left upper outer buttock
LUQ-- left upper quadrant
LVH-- left ventricular hypertrophy
lymphs -- lymphocytes
lytes -- electrolytes

M Home

M2-- meters squared
MAC -- monitored anesthesia care
MAE--- moves all extremities
MAESEW------------------------------------- moves all extremities spontaneously equally and well
Mammo-- Mammogram
MAP--- mean arterial pressure
MAST-- Medical Anti-Shock Trousers
mat--- Maternal(mother)
max --- maximum
max A -- maximum assist
MBC--- minimum bactericidal concentration
MCA--- middle cerebral artery
mc --- millicurie
mcg. -- microgram
MCH--- mean corpuscular hemoglobin
MCHC--- mean corpuscular hemoglobin concentration
MCL--- mid-clavicular line
MCP--- metacarpalphalangeal joint
MCV--- -mean corpuscular volume
MD -- doctor of medicine
MDD-- Major Depressive Disorder
MDI-- metered dose inhaler
MDS--- Minimum Data Set (logging of activities for reimbursement in long-term care)
med-- medicine
mEq. or meq.---------------------------------- milliequivalents
Mg. --- magnesium
mg. -- milligram
MGF--- maternal grandfather
MGGM-- maternal great grandmother
mg.% --- milligrams per 100 milliletes
MGUS--- Monoclonal Gammopathy of Undetermined Significance
MH-- medical history
MI -- myocardial infarction
M.I.C. -- minimum inhibitory concentration
min -- minimal, minute(s)

min A --- minimal assist
misc. --- miscellaneous
ml. --- milliliter
mm. -- millimeter
MMPI--- Minnesota Multiphasic Personality Inventory
MMT -- manual muscle test
mo. --- month
mod. --- moderate
mod A-- moderate assist
MOM--- milk of magnesia
mono -- monocyte
MPC--- mucopurulent cervicitis
MPGN--- membranoproliferative glomerulonephritis
MR--- mental retardation
MRI-- magnetic resonance imaging
MS--- multiple sclerosis
MSW-- Masters Social Worker
MTP--- metatarsophalangeal joint
MV-- minute volume
MVA-- motor vehicle accident
MVC-- motor vehicle crash/collision
MVP-- mitral valve prolapse
MVR-- mitral valve replacement

N Home

N/A-- not applicable
Na --- sodium
NaCl--- sodium choloride
NaHCO3------------------------------------- sodium bicarbonate
NB -- newborn
NC -- nasal cannula
neg. --- negative
Neuro. -------------------------------------- neurological
NFP--- natural family planning
ng. -- nanogram
NG -- nasogastric tube
NGU-- nongonococcal urethritis
NICU--------------------------------------- Nursery Intensive Care Unit
NIDDM------------------------------------ non-insulin dependent diabetes mellitus
NIF--- negative inspiratory force
NKA-- no known allergies
NKDA------------------------------------- no known drug allergies
noct. or noc------------------------------ nocturnal - at night
NL-- normal
NOS-- not otherwise specified
NPO--------------------------------------- nothing per os (by mouth)
N/S, NS --------------------------------- normal saline
NSAID----------------------------------- nonsteroidal anti-inflammatory drug
N.S.R. ---------------------------------- nasoseptal reconstruction
NSR------------------------------------- normal sinus rhythm
NST------------------------------------- non-stress test
NSU------------------------------------ nonspecific urethritis
NSVD---------------------------------- normal spontaneous vaginal delivery

NT --- nasotracheal, not tested
NTG--- nitroglycerine
N&V, N/V--- nausea & vomiting
NWB--- non-weight bearing
NWBCW--- non-weight bearing crutch walking

O Home

OB --- obstetrics
OBS --- organic brain syndrome, observation
obst. --- obstruction
occ. --- occasionally
OCD --- obsessive compulsive disorder
OCP--- oral contraceptive pill
OD--- right eye, overdose
ODD --- oppositional defiant disorder
OET --- oral endotrachel tube
OG --- orogastic
OOB --- out of bed
oint. --- ointment
OM --- oral motor
OP --- outpatient
Ophth. --- Ophthalmology, ophthalmic
OR --- Operating Room
ORIF --- open reduction internal fixation
Ortho--- orthopedics
OS --- left eye
OSA --- Obstructive Sleep Apnea
O.T. --- occupational therapy
OTC --- over the counter
OTR/L --- occupational therapist registered/licensed
O2--- oxygen
OU--- both eyes
ox --- oximeter
oz. --- ounce

P Home

p--- post, after
P--- pulse, para
P&A--- percussion and auscultation (also A & P)
PA --- Physician Assistant
PAC--- premature atrial contractions
PA-C--- Physician Assistant Certified
PACU--- Post Anesthesia Care Unit
$PaCO_2$ --- arterial carbon dioxide tension
PaO_2 --- arterial oxygen tension
Pap--- Papanicolaou smear
PAP--- pulmonary artery pressure
PAS--- periodic acid Schiff
PAT--- paroxysmal arterial tachycardia
path --- pathology
PAWP--- pulmonary artery wedge pressure

pc -- after meals
PCA--- patient controlled analgesia
PCO_2--- carbon dioxide partial pressure
PCP--- Primary Care Physician
PCWP--- pulmonary capillary wedge pressure
PDA--- patent ductus arteriosus
PDD--- Pervasive Development Disorder
PDR--- Physician's Desk Reference
PE -- physical examination, pulmonary embolus
PEA--- pulseless electrical activity
peds -- pediatrics
PEEP-- positive and expiratory pressure
Peri-Op-- Peri-operative
PERL-- pupils equal, reactive to light
PERLA --- pupils equal, reactive to light and accommodation
PERRLA--------------------------------------- pupils equal, round, react to light and accommodation
PF--- peak flow
pg -- pictogram
PGF--- paternal grandfather
PGGF--- paternal great grandfather
PGGM-- paternal great grandmother
PGM-- paternal grandmother
Preg -- pregnant
PH -- past history
pH -- hydrogen ion concentration
PICU --- Pediatric Intensive Care Unit
PID--- pelvic inflammatory disease
PIN--- prostate intraepithelial neoplasia
PIP-- proximal interphalangeal joint, positive inspiratory pressure
PKD--- Polycystic Kidney Disease
PKU--- phenylketonuria
plt -- platelet
P.M. --- afternoon or evening
PMD--- primary medical doctor
PMH-- past medical history
PMI -- point of maximum impulse
PMN--- polymorphonuclear
PMP-- previous menstrual period
PMS-- premenstrual syndrome
PN-- progress notes
PNC-- Prenatal (care)
PND-- paroxysmal nocturnal dyspnea
PNV-- prenatal vitamins
po -- by mouth
POA --- power of attorney
POC-- Plan of Care
POD-- post-operative day
pos. -- positive
post -- posterior
post-op -- postoperative
PO_2--- oxygen partial pressure
PP-- postpartum
PPD-- purified protein derivative
PPROM-- pre-term premature rupture of membranes

PPS	Prospective Payment System
PPTL	post-partum tubal ligation
PRBC	packed red blood cells
PRE	progressive resistive exercises
pre-op	preoperative
prep	preparation
prev	previous
PROM	passive range of motion, premature rupture of membranes
PRN	whenever necessary
PT	prothrombin time, physical therapy
prox	proximal
PSV	pressure support ventilation
psych	psychiatry
pt.	patient
PTB	patellar tendon bearing
PTCA	percutaneous transluminal coronary angioplasty
PTL	pre-term labor
PTSD	post traumatic stress disorder
PTT	partial thromboplastin time
P_2	pulmonary second heart sound
PVC	premature ventricular contractions
PVCU	post voiding cystourethrogram
P wave	deflection in electrocardiographic tracing
PWB	partial weight bearing
PWP	pulmonary wedge pressure

Q Home

q	every
Q&R	Quain&Ramstad
qid	four times a day
QNS	quantity not sufficient
QRS complex	electrocardiographic tracing
QT interval	electrocardiographic tracing
Q wave	deflection in electrocardiographic tracing

R Home

R	right
RA	room air, rheumatoid arthritis
RAD	right axis deviation
RBC	red blood cells
RCA	right coronary artery
RCM	right costal margin
RDS	respiratory distress syndrome
reg.	regular
rehab.	rehabilitation
rep	repeat
resp.	respiration, respiratory
retic.	reticulocyte
retro.	retrograde
Rh	Rhesus blood factor
RLE	right lower extremity

RLL-- right lower lobe
RLQ-- right lower quadrant
RMA--- right mentum anterior
RML--- right mediolateral (episiotomy)
RMP--- right mentum posterior
RMT--- right mentum transverse
RN--- Registered Nurse
R/O-- rule out
ROA --- right occiput transverse
ROI-- release of information
ROM--- range of motion, rupture of membranes
ROP-- right occiput posterior
ROS-- review of systems
ROT-- right occiput transverse
RPR-- rapid plasma reagin
RPT-- registered physical therapist
RR--- respiratory rate
RRT-- Registered Radiology Technician
RSA-- right sacrum anteior
RSD-- Reflex Sympathetic Dystrophy
RSO-- right salpingo-oophorectomy
RSP-- right sacrum posterior
RST-- right sacrum transverse
RTS-- raised toilet seat
r/t-- related to
RT--- respiratory therapist, recreational therapist
RTC-- return to clinic
RUE-- right upper extremity
RUL-- right upper lobe
RUQ-- right upper quadrant
RVH-- right ventricular hypertrophy
Rx. --- prescription

S Home

s or (sine)------------------------------------- without
S--- subjective
S_1-- first heart sound
S_2-- second heart sound
S_3-- third heart sound
S_4-- fourth heart sound
SA--- sinoatrial
SAB-- spontaneous abortion
SACH-- solid ankle cushioned level
SaO_2-- percent arterial saturation
sat-- saturation
SB-- stillbirth, stillborn
SBA-- stand-by assistance
SBE-- self breast exam
SBQC-- small based quad cane
sched-- scheduled
SED-- seriously emotionally disturbed
sed --- sedimentation
SGA-- small for gestational age

SGOT--- serum glutamic oxaloacetic transaminase (now AST-aspartate aminotransferase)
SGPT--- serum glutamic pyruvic transaminase (now ALT-alanine aminotransferase)
S/H/I--- Suicidal Homicidal Ideation
SI-- sexual intercourse
SIADH-- syndrome of inappropriate antidiuretic hormone
SIDS-- sudden infant death syndrome
sig. -- let it be labeled
SIMV--- synchronized intermittent mandatory ventilation
SL-- sublingual
SLB-- short leg brace
SLC-- short leg cast
SLE-- systemic lupus erythematosus
SLR-- straight leg raising
SLWC-- short leg walking cast
sm. -- small
SMO's --- supramalleolar orthotics
SN-- student nurse
SNF-- skilled nursing facility
SO-- significant other
SOB-- shortness of breath
sol. -- solution
S/P--- status post
sp.gr. -- specific gravity
spec. --- specimen
spont --- spontaneous
SpO_2--- percent peripheral pulse saturation
SR-- sinus rhythm
SROM-- spontaneous rupture of membranes
SS-- Social Services
SSE-- soap suds enema
staph -- Staphylococcus
stat -- at once
STD-- sexually transmitted diseases
STG-- short term goal
STI--- sexually transmitted infection
STNR-- symmetrical tonic neck reflex
strep -- streptococcus
SQ--- subcutaneous
suppos. -- suppository
surg. -- surgery
SVD-- spontaneous vaginal delivery
SVE-- sterile vaginal exam
SVN-- small volume nebulizer
SVO_2--- saturation of venous oxygen
SVR-- Systematic Vascular Resistance
SVT-- supraventricular tachycardia
SW--- Social Worker
Sx. -- symptoms
Sz-- seizure

T Home

Abbreviation	Meaning
T1-T12	Thoracic vertebrae 1-12
T&A	tonsillectomy and adenoidectomy
T. or temp.	temperature
T-3	triiodothyronine
T wave	deflection in electrocardiogram
T-4	thyroxine
tab	therapeutic abortion
tach	tachycardia
TAH	total abdominal hysterectomy
tbsp.	tablespoon
TB	Tuberculosis
TC,T/C	Telephone call
T&C	type & cross match
TEDS	Thromboembolous Deterrent Stocking
T.E.	tracheoesophageal
TENS	transcutaneous electrical nerve stimulation
THR	total hip relacement
TIA	transient ischemic attack
tid	three times a day
tinct.	tincture
TKO	to keep open
TKR	total knee replacement
TL	tubal ligation
TLC	tender loving care
TM	tympanic membrane
TMJ	temporomandibular joint
TO	telephone order
TOC	test of cure
TOD	thoughts of death
tol.	tolerated
TOLAC	trial of labor after Cesarean
TP	thought process
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TR	Therapeutic Recreation
TRACH	tracheostomy
Trich	Trichomonas (vaginalis)
T&S	type and screen
TSH	thyroid stimulating hormone
tsp.	teaspoon
TSS	Toxic Shock Syndrome
TTP	thrombotic thrombocytopenic purpura
TUR	transurethral resection
TURP	transurethral resection of the prostate
TV	tidal volume
TVH	total vaginal hysterectomy
Tx	treatment
TYM	trichomonas, yeast, or monilia

U Home

Abbreviation	Meaning
UA	urinalysis
UE	upper extremity
UGI	upper gastrointestinal

umb --- umbilius
UPJ --- ureteropelvic junction
URI --- upper respiratory infection
urol. -- urology
US -- ultrasound
U.S.P. -- United States Pharmacopoeia
UTI --- urinary tract infection
U.V. junction, U.V.J. ---------------------- ureterovesical junction
U wave --------------------------------------- deflection in electrocardiographic tracing

V Home

Vag-- vagina, vaginal
VAIN--- vaginal intraepithelial lesion
VBAC--- vaginal birth after c-section
V leads--------------------------------------- unipolar chest leads
VC-- vital capacity, verbal cues
VD-- venereal disease
Vent --- ventilator
V-Fib--- ventricular fibrillation
VH-- vaginal hysterectomy
VIN--- vulvar intraepithelial lesion
Vit-- vitamin
VMA-- vanillylmandelic acid
VO-- verbal order
VP-shunt------------------------------------ ventriculoperitoneal shunt
vs. -- versus
VS-- vital signs
VSD--- ventricular septal defect
VT-- ventricular tachycardia, tidal volume gas

W Home

WAIS--- Wechsler Adult Intelligence Scale
WAIS-R -------------------------------------- Wechsler Adult Intelligence Scale-Revised
WB-- weight bearing
WBAT--- weight bearing as tolerated
WBC-- white blood count
WBQC-- wide based quad cane
w/c-- wheelchair
w/d-- well developed
WDL-- within defined limits
WFL-- within functional limits
WPW--- Wolf-Parkinson-White
wt. -- weight

XYZ Home

x--- times
-x-- except
y/o -- year old

OTHER SYMBOLS: Home

+-- plus
♂-- male
♀-- female
>-- greater than
<-- less than
1^0 -- primary
2^0-- secondary
↑-- increased
↓-- decreased
▲ -- change
Ø--- no/none, negative
#-- number, pound
'--- feet
"-- inches

Home

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary Symbols	dram minim	Misunderstood or misread(symbol for dram misread for 3" and minim misread as "ml").	Use the metric system.
AU	aurio uterque(each ear)	Mistaken for OU (oculo uterque-each eye).	Don't use this abbreviation.
D/C	discharge discontinue	Premature discontinuation of medications when D/C (intended to mean discharge)has been misinterpreted as "discontinued" when followed by a list of drugs.	Use "discharge" and "discontinue"
µg	microgram	Mistaken for "mg"when hand written.	Use "mcg".
o.d. or OD	once daily	Misinterpreted as "right eye"(OD-oculus dexter)and administration of oral medications in the eye.	Use "daily".
TIW or tiw	three times a week	Mistaken as "three times a day".	Don't use this abbreviation.
q.o.d. or QOD	every other day	Misinterpreted as "q.d."(daily) or "q.i.d."(four times daily) if the "o" is poorly written.	Use "every other day".
U or u	unit	Read as a zero (0) or a four (4) causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as "44").	"Unit" has no acceptable abbreviation. Use "unit".
X3d	for three days	Mistaken for "three doses."	Use "for three days."

SS or ss	sliding scale (insulin) or ½ apothecary	Mistaken for 55.	Spell out “sliding scale”. Use “one-half” or use “1/2”.
Zero after decimal point (1.0)	1mg	Misread as 10mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers.
No zero before decimal dose (.5mg)	0.5mg	Misread as 5 mg.	Always use zero before a decimal when the dose is less than a whole unit.
q.d.or QD	every day	Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “i” .	Use “daily” or “every day”.
qhs	nightly at bedtime	Misread as every hour.	Use HS (capital letters)
Sub q	subcutaneous	The “q” has been mistaken for “every” (e.g., one heparin dose ordered “sub q 2 hours before surgery” misunderstood as every 2 hours before surgery).	Use SQ or write “subcutaneous”.
SC	subcutaneous	Mistaken for SL (sublingual).	Use SQ or write “subcutaneous:.
@	at	Mistaken for “2”.	Spell out “at”.
MS	morphine sulfate	Can mean morphine sulfate or magnesium sulfate	Write Morphine Sulfate
MgSo4 and MSO4	magnesium sulfate	Confused for one another	Write Magnesium Sulfate
Cc	cubic centimeter	Mistaken for u (units) when poorly written	Write “ml” or milliliters

Home