WHAT YOU OBSERVE & ASSESS

Assessment Language

Subjective	What the patient TELLS you — their words & feelings. E.g. "Pain 7/10"
Objective	What you SEE, MEASURE, or TEST — reproducible by another clinician
Assessment	Your clinical INTERPRETATION. E.g. "Patient in moderate respiratory distress"
Plan / Intervention	What you DID or will DO in response to your assessment
Baseline	The patient's NORMAL or pre-existing state. E.g. "O2 sat baseline 96%"
Acute vs. Chronic	Acute = new/sudden onset · Chronic = long-standing, ongoing
A&O x4	Alert & oriented to: person, place, time, and situation
LOC	Level of Consciousness — from alert to unresponsive
De-sat	Desaturation — O2 sat drops below acceptable level
Tachy- / Brady-	Fast (tachycardia / tachypnea) · Slow (bradycardia / bradypnea)

HOW YOU DOCUMENT

Written Documentation Formats

SOAP	Subjective · Objective · Assessment · Plan — written clinical notes
DAR	Data · Action · Response — focus charting, common in LTC & community
Narrative Note	Free-form documentation structured by time and clinical events
Late Entry	Must be labelled: "Late Entry — care at [time], documented at [time]"
Incident Report	Separate formal document for unexpected events — NEVER referenced in the chart
Co-sign	CNO (2025): nurses do NOT co-sign entries they cannot independently verify
Rounding	Nurse's scheduled patient check-ins (hourly/as needed) — documented as routine
Team Rounds	Interdisciplinary meeting to review patient status. Nurse reports via SBAR

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HOW YOU COMMUNICATE

Verbal Communication & Escalation

SBAR	Situation · Background · Assessment · Recommendation · VERBAL reporting & escalation ONLY — not a written format
Escalation of Care	Communicating a change in patient condition to a higher level of care
Handover / Shift Report	Transfer of care between nurses — requires structured verbal communication
Critical Value	Lab or vital sign so abnormal it requires IMMEDIATE physician notification
Rapid Response	Team called when patient is deteriorating but has not yet arrested
Call a Code	Activates emergency response for cardiac or respiratory arrest
MRP	Most Responsible Physician — primarily responsible for the patient's care
Attending vs On-call MD	Attending = patient's own MD · On-call = covering after hours

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DOCUMENTATION TOOLS

Chart Tools & Systems

MAR	Medication Administration Record — every med given, time, dose, signature
TAR	Treatment Administration Record — non-medication treatments
Kardex / Care Plan	Summary of patient care needs, goals, and ongoing interventions
EMR / EHR	Electronic Medical Record / Electronic Health Record — the digital chart
PCC	PointClickCare — EHR used widely in LTC & community settings in Ontario
VSS	Vital Signs Stable — no acute change in VS findings
DNR	Do Not Resuscitate — MUST be a documented physician order
DNI	Do Not Intubate — MUST be a documented physician order
I&O	Intake and Output — fluid balance monitoring

CLINICAL SHORTHAND — PART 1

Abbreviations A – M

ABx	Antibiotics
ALC	Alternate Level of Care — no longer needs acute care, awaiting placement
c̄ (c with line)	With
c/o	Complains of — introduces subjective data
CBGM / BS	Capillary Blood Glucose Monitoring / Blood Sugar
CNO	College of Nurses of Ontario — regulatory body for nurses in Ontario
D/C	Discharge OR Discontinue — context-dependent, always clarify
Dx / Rx / Tx / Sx / Ax	Diagnosis / Prescription / Treatment / Symptoms / Assessment
Hx / PMHx	History / Past Medical History
hs	Hour of sleep — medication given at bedtime
ISO	Isolation — patient requires infection control precautions

CLINICAL SHORTHAND — PART 2

Abbreviations N – Z & Med Timing

NKA / NKDA	No Known Allergies / No Known Drug Allergies
NPO	Nothing by mouth — patient must not eat or drink
PRN	As needed — given when required, not on a fixed schedule
PSW / HCA	Personal Support Worker / Health Care Aide
s̄ (s with line)	Without
SC / SQ / Sub-Q	Subcutaneous — injection given under the skin
SL	Sublingual — medication placed under the tongue
SOB / DOE	Shortness of Breath / Dyspnea on Exertion
UA	Urinalysis
"Culture"	Culture & Sensitivity — identifies bacteria and effective antibiotics
OD* / BID / TID / QID	Daily* / Twice / Three / Four times daily (*avoid OD, use 'daily')
q2h / q4h / q8h	Every 2 hrs / every 4 hrs / every 8 hrs

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WHO'S WHO ON THE TEAM

Healthcare Roles & Designations

RN	Registered Nurse
RPN	Registered Practical Nurse
NP	Nurse Practitioner
MD	Medical Doctor
MRP	Most Responsible Physician
PT	Physiotherapist
OT	Occupational Therapist
RT	Respiratory Therapist
RD	Registered Dietitian
SW	Social Worker
RPh	Registered Pharmacist
PSW	Personal Support Worker
SLP	Speech Language Pathologist

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REPLACE THESE — EVERY TIME

Words to Avoid in Documentation

"Seemed" / "appeared"	Vague — replace with specific objective observation
"Good" / "fine" / "normal"	Not measurable — use specific values or findings
"Patient was uncooperative"	Judgmental — describe the specific behaviour observed
"I think" / "I believe"	Undermines clinical authority — state observations factually
"Patient denies having concerns."	Better: "Patient states no chest pain"
"Tolerated well"	What was tolerated? state VS, pain level, O2 sat, patient response
"Non-compliant"	Identify the reason and document your education/response
Documenting BEFORE care	Never document care before it is provided — CNO 2025

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