

A DOCUMENTATION GUIDE FOR NURSES

# Charting with Clarity

Australian edition

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Preface by Jean-Pierre Ménard, Ad.E.



## PREFACE

I had the pleasure of reading Ms. Mireille Guillemette's work on documentation in medical records. This guide explores the evolution of record-keeping practices from the adoption of the Act Respecting Health Services and Social Services to the present day.

The healthcare sector is evolving at an astonishing pace, whether in terms of population, scientific advances or legal responsibilities, significantly increasing the accountability of all professionals involved.

In fact, the pace of work in healthcare today is much different than in previous decades.

This makes it all the more important to emphasize the importance of all actions taken by healthcare professionals and the urgency of finding ways to ensure that patients' records thoroughly and accurately reflect the care provided.

This guide provides essential support for the healthcare professionals who are required to write concise, high-quality, and unambiguous notes. It provides a framework for writing notes to meet the growing demands of all of those directly or indirectly involved in healthcare. It is both a contribution to nursing education and a valuable reference for all professionals.

*Me Jean-Pierre Ménard LL.B, LL.M, Ad.E.*

## FOREWORD

Working in the healthcare sector is under constant pressure. The nursing profession, already burdened by the complexity of care, comorbidities, and an aging population, has undergone numerous transformations in recent years. Recruitment challenges have added to the workload. There are more patients, shorter hospital stays, and consequently, more notes to write—notes that must be thoroughly documented and often written more quickly to keep up with demands. In addition to these new realities, there have been significant changes in the roles and scope of practice of healthcare professionals. Recent legislation on the administrative reorganisation of care and the advent of new technologies have had a major impact on many tasks, including the writing of clinical notes. Over time, through meetings and visits to healthcare settings in Canada, Switzerland, and Australia, and research, I quickly realised that the need for a documentation guide was shared by nurses everywhere. We all face similar challenges. The laws and regulations are broadly similar.

**This edition is tailored to nurses registered under the Nursing and Midwifery Board of Australia (NMBA)** but could also be adapted for international use.

The quality of the daily work of health professionals is not always reflected in the reading of progress notes. Sometimes, there is a significant difference between the care provided to patients and families and the notes recorded in their health records.

This guide is a practical tool that addresses the many challenges we face in healthcare and helps us respond to its new realities. It is intended for use by university or vocational students, as well as professionals in all care settings, in both the private and public sectors.

Mireille Guillemette, *Bachelor of Nursing, Author*

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**RECORDING OF CLINICAL DATA:  
AN OBLIGATION**

The care plan is an integral part of the nurse's clinical monitoring activities. It includes the results of the nurse's assessment of the patient, the decisions made, and guidelines for care and monitoring. It follows the same rules and instructions as a progress note.

## 1.1 LEGAL AND REGULATIONS FRAMEWORK

The healthcare sector in Australia, and more specifically medical record-keeping and clinical documentation, is strictly governed by a combination of federal laws, state and territory legislation, and professional standards. These instruments ensure patient safety, protection of patient rights, and compliance with clinical practice requirements. [1]

### Key legislative and normative instruments

Clinical practice and record-keeping must comply with the following legal and professional instruments:

- **National and federal legislation:**

- National legislation governing the registration and practice of health professionals. [1]
- Federal legislation governing confidentiality and the protection of personal health information. [2]
- Federal legislation governing the national electronic health record system. [3]

- **State and territory legislation:**

- Specific laws governing the management, confidentiality and archiving of health records. [4]
- Child protection and youth justice legislation. [5]
- State laws governing the management of therapeutic substances and poisons. [6]

### **Mandatory elements to record**

It is required to document systematically and in a structured manner:

- objective and subjective assessment findings, as well as physical and mental monitoring; [11]
- development and adjustment of the care plan; [11]
- interventions performed and therapeutic education provided to optimise patient autonomy; [11]
- interprofessional collaboration and the partnership developed with the person through shared decision-making. [12]

## **1.5 CONFIDENTIALITY, PROFESSIONAL SECRECY AND ACCESS TO RECORDS**

The protection of privacy and the confidentiality of health information are fundamental rights guaranteed by federal law and specific state legislation. [2]

**It is imperative that** all information contained in the record be handled with the greatest rigour in order to prevent any unauthorised disclosure. A clinician must access only the information strictly necessary for the current episode of care. [12] Although the organisation owns the medium containing the record, the clinical information belongs to the patient, who has a legal right of access. [4]

### **The principle of professional confidentiality and its exceptions**

The nursing code of conduct states that confidentiality is absolute, which requires strict compliance with non-disclosure obligations within healthcare organisations. [12] However, professional confidentiality may be overridden by law in specific circumstances:

## Consent by minors and substitute decision-makers

Australian law assesses a minor's capacity to consent according to the principle of **Gillick competence**. If the clinician determines that the adolescent has sufficient maturity to understand the implications of the treatment, the adolescent is legally capable of consenting to or refusing it. This autonomy must be formally documented in the progress notes. [22]

For an adult patient who has been determined to lack capacity, the care team must verify whether an advance care directive exists or identify a substitute decision-maker in accordance with the legal hierarchy applicable in the relevant state, for example, an enduring guardian, a de facto partner or a close relative. [8]



### Examples:

- Implied consent, e.g., before venepuncture or wound care;
- Consent to the question "do you consent?" before an assessment;
- Signed consent before surgery;
- Shared decision making for a young person over the age of 14 in a major situation such as chemotherapy, bone marrow transplant, or surgery.

## 1.7 INCIDENT AND ADVERSE EVENT

Reporting a clinical incident is one of the most critical medico-legal obligations within healthcare organisations. Formal reporting of these events makes it possible to quantify risk and maintain a strong safety culture at the national level. [13]

# 2

**WHAT MUST BE RECORDED  
AND REPORTED**

## 2. WHAT MUST BE RECORDED

**“What is written shall be deemed to have been done, and what is not written shall be deemed not to have been done.”**

This statement is often found in the jurisprudence of courts and ethics committees that have had to judge professional acts. It's a reminder that the note is essential to attest to the credibility and quality of a service. A rigorous, clear note that respects the treatment plan serves everyone, including the judiciary. Quality clinical content lends credibility both professionally and judicially. This should not obscure the fact that **we write only what is relevant**. Evidence is easier to establish when the record is rigorously documented. However, proof that an act has been carried out can also be confirmed in other ways, for example by interviewing the nursing staff.

In Australia, clinical documentation standards emphasise accurate, timely and relevant recording. When notes contain excessive or routine detail, the essential clinical information may be harder to identify.



Be careful: when too much data is entered, the essential information can be lost.

There's no need to note, for example, that a site was disinfected before an injection, a detail that is part of the care protocol. The injection, and its effect on the patient's health, is the care. Therefore, what is documented and signed is the injection.

Continuity of care must be provided at all times. This means that the information needed for safe patient follow-up is communicated to the right person at the right time. This ensures that the care provided is safe and tailored to the patient's needs. All of this information is contained in the chart notes.

Sending an end-of shift report is part of the routine of care and therefore does not need to be recorded. What is communicated in the report should already be documented in the patient's file. It is important to distinguish between sending an end-of-shift report and ensuring continuity of care.

### Unnecessary words to avoid / Suggestions for essential information

X	✓
1. End-of-shift report given	Dr Smith advised of shortness of breath and weakness.
2. Report given	Nurse advised of 1st dose of opioid administered at 15:40 and monitoring scheduled for 16:10.
3. First round	08:10 Awake, alert.
4. Last round	15:40 No new symptoms.

A user's record contains all kinds of documents. All these documents relate to the different steps of clinical monitoring. They include assessment reports, intervention plans, progress notes, photographs, monitoring documents, results of paraclinical examinations, observation and parameter grids, the therapeutic nursing plan, and medicine administration records. It is a set of data relevant to clinical follow-up. The information contained in these documents should not be repeated in the medical record.

The progress note should provide an overview of all documents. The following are some of the elements that should be monitored and prioritised in the progress note:



## Example of a brief ISBAR handover when a nurse leaves for a break

The nurse leaving for a break	
<b>I</b>	<b>Identification</b> I'm handing over Mrs Leah Murray, DOB 20/02/1945, aged 80.
<b>S</b>	<b>Situation</b> She needs close monitoring because she is at high risk of delirium and respiratory depression. She was given subcutaneous morphine at 09:40, and the peak effect is expected at 10:25.
<b>B</b>	<b>Background</b> Mrs Murray was admitted three days ago with a fractured hip. Her history includes a stroke in 2020, mild cognitive impairment, and deafness.
<b>A</b>	<b>Assessment</b> She is at increased risk of respiratory depression around the peak effect of the morphine, and she remains at high risk of delirium.
<b>R</b>	<b>Recommendation</b> Please assess her at 10:25 using the sedation scale and R.A.D.A.R., and continue close monitoring for any signs of respiratory depression or increasing confusion while I'm on break.
The nurse who received the report summarizes its essence	
	Mrs Leah Murray, 80 years old, admitted three days ago with a fractured hip, had SC morphine at 09:40. She is at high risk of respiratory depression and delirium, and I need to assess her at 10:25 using the sedation scale and R.A.D.A.R.

If the handover is very brief and focused, some practice settings will not explicitly refer to it as "ISBAR" when speaking, even though the structure is similar. In practice, the exchange may sound quite natural, for example:

**"I'm going on break. Can you keep an eye on Mrs Murray? She had subcut morphine at 09:40, peak effect is due at 10:25, and she's at high risk of respiratory depression and delirium. She'll need a sedation score and R.A.D.A.R. at 10:25."**

This is still an ISBAR-type clinical handover, even if nobody says, "I'm going to give you an ISBAR."

Eats well.	Give details about autonomy, tastes, amounts, etc.
Large amount of greenish secretions.	Productive cough. Greenish sputum.
Restless.	Specify whether restlessness is verbal or physical, describe behaviour.
No voiced complaints.	Pain well controlled with current interventions <b>OR</b> No new symptoms.
Catheter drains well.	Urinary catheter drains 500 ml of dark yellow urine with whitish deposits.
Cooperates well.	06:45 I talk to her about cars. IV right forearm. Calm for duration of treatment x 10 minutes (for a patient who often refuses treatment).

### ✗ Example of a note that is imprecise and open to interpretation

#### EXAMPLE OF PROGRESS NOTES

2026-11-25 | Respiration 24/min. **Significant** rales. **Bed rest in the morning.**

### ✓ Example of precise information

#### EXAMPLE OF PROGRESS NOTES

2026-11-25 | 09:40 Abdominal respiration 24/min, deep, regular amplitude.

Rales 3/3 Victoria scale. Calm, no indrawing. \_\_\_\_\_

This note will also include any education or non-pharmacological interventions, outcome and signature.



**Confused** is the vaguest of terms. It is often used to describe a mental state. It should be **banned**. It is one of those catch-all words with as many definitions and explanations as there are people who use it.

The note should be clear and specify the **mental state, behaviour, autonomy or signs and symptoms of delirium**. **Forget** the term "**confused**". **Mental state** assessment, with all its components, is described in **Chapter 5**.



Another commonly used term to avoid is "**seems**". There are no circumstances that justify its use. Comments such as "seems", "appears to be", "looks like" are far too imprecise to be useful. In fact, they can cause serious confusion. This is the case when a person appears to be asleep. To avoid confusion with a person **who is dying but appears to be asleep, we will instead enter observed data such as respiratory rate**.

The case has happened before and was the subject of a coroner's inquest.

In July 2018, Mr. René, who had been admitted with a urinary tract infection, died in the hospital a few hours after being admitted. Coroner Yvon Garneau investigated this sad death. He said he found a major flaw in "communication between the different professionals, as well as ambiguity about the roles and responsibilities of each." "It is a whole series of gestures, words and **notes that are not in the file, or are in the file, but in a confused way**," adds Yvon Garneau. At 1 a.m., the nurse's note says: "right lateral decubitus, eyes closed, seems to be sleeping." At 1:50 a.m., the staff noticed that he was no longer breathing. The patient had unsuccessfully requested his BiPAP machine several times during the evening to control his sleep apnea.

### Example 1

Summary of variable measurements entered on observation chart.

#### EXEMPLE OF PROGRESS NOTES

2026-11-25	08:00 to 15:30 Pulse fluctuates between 54 and 66 BPM. Irregular. Asymptomatic. <b>M. E. Voltier, RN.</b>
------------	---

Monitoring frequency and instructions are included in the medical notes / health record.

### Example 2

Summary of measurements recorded on the observation chart because blood pressure is abnormal.

#### EXEMPLE OF PROGRESS NOTES

2026-01-05	VS assessment q 30 minutes between 10:00 and 15:30.
------------	---

	Alert and attentive. Sluggish, but symmetrical pupil reaction. Normal motor function.
--	---

	BP varies from 205/100 to 190/95, asymptomatic. _____
--	---

	<b>P. Garneau, RN</b>
--	-----------------------

This note gives an overview of this shift.

	Swallow test started: clears his throat, wet voice after 1st swallow, test stopped.
	Post-test AUSCULTATION: Normal BS to all lobes on the anterior and posterior surfaces.
	09:00 Dr Frigon informed of my clinical impression of dysphagia. <b>M. Pierre, RN</b>
N.B. Interventions, monitoring and assessment elements will be added to this note or to the care plan.	

### Example of a note about new clinical signs

#### EXEMPLE OF PROGRESS NOTES

2026-11-25 | 13:30 Presents with RUQ abdominal pain. Chills and nausea.

Clinical examination performed. Murphy's sign positive. \_\_\_\_\_

N.B. This note must also include the interventions, references, results and signature.

\*\*\* The results of the clinical examination, including the PQRSTU, do not appear in this note as a special form is used.

### Never forget that what is not written in the note may be considered never to have been done.

This is a statement that can be found everywhere in case law, as here in 2003, in the Quebec Court of Appeal, in a judgment concerning the death of a teenager who had undergone breast reduction surgery. The judge pointed out that there was no record of the pulse and blood pressure, although a nurse had testified under oath that she had taken them when taking the temperature, without recording them. The judge did not believe her, and rather chose to rely on the notes in the file.

## Example of a note for a new symptom

### EXAMPLE OF PROGRESS NOTES

2026-11-25	08:45 Reports mouth pain and metallic taste.
	<u>Physical Examination</u>
	Dry mucosa, cracked tongue, pink gums. No lesions.
	Care plan adjusted. <b>M. Thibault, RN</b>

## 5.1 ASSESSMENT OF THE PHYSICAL CONDITION OF A SYMPTOMATIC PERSON

An assessment is necessary whenever a new symptom suggests a deterioration in health. The clinical examination must include an **history** using the PQRSTU and a **physical examination** (inspection, palpation, percussion, auscultation).

To ensure that the note can be read **easily and quickly** by the care team, it is advisable to:

- Highlight sections by using capital letters or underlining them;
- Do not draw a line at the end of a line to make the content easier to read.

Voyer, P., Willcocks, K., L'examen clinique de l'aîné, 3rd edition ERPI, 2024.

### Example of a note

#### EXAMPLE OF PROGRESS NOTES

2026-11-04 | Bilious vomiting 4 times between 08:00 and 12:00. \_\_\_\_\_

This note is to be followed by interventions, results, and signature.

### Example of a note

#### EXAMPLE OF PROGRESS NOTES

2026-11-04 | 11:45 Vomits 250 ml of food. 13:00 takes broth and dry biscuits. 14:30 Food tolerated.

No nausea. \_\_\_\_\_

This note should also include a follow-up and signature.

In situations of **dehydration**, priority must be given to preventing the condition and monitoring the most fragile and vulnerable clientele. Young children, older people and people who are losing their autonomy and are unable to clearly express their physiological needs are among those at high risk of suffering significant consequences. Signs and symptoms of dehydration must be recorded in the patient's chart.

In the case of an **infant**, the appearance of the **fontanelle** is an important element in assessing dehydration.

- Normal = soft and full
- Hollow = dehydration
- Bulging = risk of Intracranial Hypertension (ICH)

## 8. SPECIFIC STEPS OF THE CARE EPISODE

When a patient is admitted to hospital, the following basic information is included in the health record:

- Time of arrival;
- Accompanying person;
- Mode of transport, use of mobility aids;
- Known allergies;
- Person's reactions, expectations and goals;
- Clinical assessment data on admission;
- Admission procedures (specimen collection, etc.).

When admitted to a residential aged care facility, the record should include:

- Biographical history;
- Degree of independence;
- Preferences and lifestyle habits;
- The person's adaptation to the new living environment (close monitoring for signs of delirium related to the change in living environment).

A clinical examination on admission must complete the observations to assess potential risks (falls, pressure sores, dysphagia, etc.) and to personalize interventions.



CLINICAL EXAMINATION GERIATRIC ADMISSION			
Medical record no.:	Date: ___/___/___	<input type="checkbox"/> Admission	Surname: _____
Time: ___:___	<input type="checkbox"/> Reassessment	Given name: _____	
DX: _____			
<b>VITAL SIGNS</b>			
Temperature: _____ °C <input type="checkbox"/> Rectal <input type="checkbox"/> Oral (fever if T >= 37.8 °C or increase of 1.1 °C from usual baseline)			
Respiration: _____ /min Rhythm: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Depth: <input type="checkbox"/> Normal <input type="checkbox"/> Deep <input type="checkbox"/> Shallow			
Saturation: _____ % Room air and/or with O2 at _____ L/min Intermittent O2: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Pulse: _____ /min <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Side: <input type="checkbox"/> Right <input type="checkbox"/> Left Amplitude: Normal / Abnormal			
Blood pressure: Lying _____ / _____ Sitting _____ / _____ Standing _____ / _____ <input type="checkbox"/> Right arm <input type="checkbox"/> Left arm Diff: _____			
Weight: _____ kg	Height: _____ cm	BMI: _____	
Time: _____	Initials: _____		
<b>MENTAL STATE EXAMINATION</b>			
History: _____			
Glasgow Coma Scale: _____ /15 PERRLA (pupils): <input type="checkbox"/> Yes <input type="checkbox"/> No Eye: Right _____ Left _____			
Attention span: <input type="checkbox"/> Attentive <input type="checkbox"/> Inattentive If abnormal, specify (e.g. catactacts): _____			
Level of consciousness: <input type="checkbox"/> Hyperalert <input type="checkbox"/> Alert <input type="checkbox"/> Lethargic (verbal) <input type="checkbox"/> Stuporous (physical) <input type="checkbox"/> Comatose			
Hearing normal: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____			
Language normal: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____			
4AT: <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____			
MMSE: _____ /30			
Time: _____	Initials: _____		
<b>CARDIAC EXAMINATION</b>			
History: _____			
1 Aortic area <input type="checkbox"/> S1 and S2 normal <input type="checkbox"/> Murmur			
2 Pulmonary area <input type="checkbox"/> S1 and S2 normal <input type="checkbox"/> Murmur			
3 Tricuspid area <input type="checkbox"/> S1 and S2 normal <input type="checkbox"/> Murmur			
4 Mitral area <input type="checkbox"/> S1 and S2 normal <input type="checkbox"/> Murmur <input type="checkbox"/> Gallop sounds <input type="checkbox"/> S3 <input type="checkbox"/> S4			
Chest pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Pain score: _____ /10 > 20 min <input type="checkbox"/> Yes <input type="checkbox"/> No			
Relieved by aim: <input type="checkbox"/> Yes <input type="checkbox"/> No Puff: _____			
Lower limb oedema: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lower limb diameter (cm): Right calf _____ Left calf _____ Right ankle _____ Left ankle _____			
Refill / resorption time: _____ seconds Depth on pressure: _____			
Time: _____	Initials: _____		
1/3			
<b>GERIATRIC ADMISSION CLINICAL EXAMINATION (continued)</b>			
<b>RESPIRATORY EXAMINATION</b>			
History: _____			

## Paediatrics

"Global developmental delay (GDD) and intellectual disability (ID) affect up to 3% of the paediatric population. The diagnosis of GDD is reserved for children under five years of age who often meet the diagnostic criteria for ID, suggesting that they may represent the same population. Since the etiological diagnoses of GDD and ID overlap, the investigations required for a definitive diagnosis are similar. Early detection is crucial to initiating rehabilitation services and treatment as quickly as possible. In a recent analysis, clinicians made etiological diagnoses based on history and physical examinations in 12.5% to 38.6% of cases, confirming the critical importance of these elements in diagnosis."

S.Belanger et al., Evaluation of the Child with Global Development Delay and Intellectual Disability Canadian Paediatric Society, Aug.16, 2018

Normal follow-up results are documented in the child's health record or local service form. Abnormal results are documented in detail so that the child can be referred to specialist services quickly.

### Example of a note for a four-year-old child seen at an immunization clinic

#### EXAMPLE OF PROGRESS NOTES

2026-04-03	14:30 DTPa-IPV and hepatitis A clinic.
	Father is concerned about development.
	No change in condition in the last month.
	No other symptoms.
	Appointment scheduled in 4 days with NP. Electronically signed: <b>Ann Field, RN</b>

The assessment was not completed immediately because the vaccination context and situation were not considered an emergency.

## Violence-related terminology

Blackmail, threats	Traumatic alopecia	Perforation
Control, material deprivation	Injury with a sharp object	Abrasion by friction
Denigration	Scarring	Laceration, skin tear
Humiliation, rejection	Cutting	Neglect
Insult	Ecchymosis, contusion	Hematoma
Isolation, emotional deprivation	Self harm	Offensive statements

## Example of a note detailing the signs of abuse and neglect toward an incapacitated person living at home

### EXAMPLE OF PROGRESS NOTES

2026-11-20 | 10:00 Presents bruises on arms and thighs. Poor hygiene.

Dressed too lightly for the temperature.

Shows signs of distrust, inattentiveness, shifty gaze and hyperalertness. \_\_\_\_\_

This note will be completed with interventions, references, reporting and signature.

## APPENDIX 1

### DANGEROUS ABBREVIATIONS

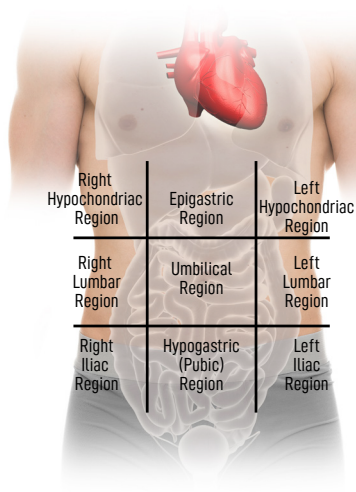
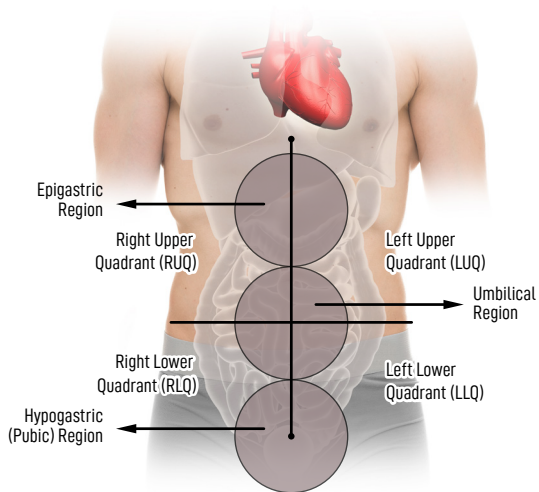
**Never use** these abbreviations, symbols or dose expressions **in handwriting, electronically or verbally**. They are listed as error-prone by the ACSQHC because they are readily misread and have caused serious medication errors. Write the intended word or unit in full.

#### Error-prone abbreviations

Do not use	Intended meaning	Use instead / reason
AS, AD, AU	left ear, right ear, both ears	Write 'left ear', 'right ear', 'both ears'. Can be mistaken for the eye abbreviations or for one another.
cc	cubic centimetre	Write 'mL'. 'cc' is poorly understood and risks inconsistency; can be read as '00' or 'u'.
D, d	day / dose / daily	Write 'day(s)', 'dose(s)' or 'daily' as intended. Can be mistaken for one another or for the number '0'.
D/C	discharge / discontinue	Write the intended word in full. Ambiguous, risks premature cessation of medicines when discharge is meant.
gtt, gtte	drop(s)	Write 'drop(s)'. Latin term not universally understood.
ID	intra-dermal	Write 'intra-dermal' in full to avoid confusion with other routes.
HS, hs	half-strength / bedtime	Write 'bedtime' or 'half-strength' as intended. Ambiguous Latin term.

## APPENDIX 4

### Anatomical Landmarks: Abdomen



## APPENDIX 8

### Australian High-Risk Medicine

A high-risk medicine is a medicine with a heightened potential to cause significant harm if it is prescribed, dispensed or administered incorrectly.

In Australian health services, the APINCHS classification is widely used to help clinicians recognise medicines that require increased vigilance and stronger safety controls.

This framework supports health services to develop organisation-specific high-risk medicines lists and to implement targeted risk-reduction strategies.

**It is recommended to use the APINCHS** framework alongside local policies, standardised protocols and current medicines safety guidance. Note that the purpose of the APINCHS list is

- to identify high-risk medicines
- to support safer prescribing
- dispensing
- administration and monitoring across the continuum of care.

<https://www.safetyandquality.gov.au/clinical-topics/medicines-safety-and-quality/high-risk-medicines-and-systems#about-high-risk-medicines>

Government of Western Australia  
Department of Health

**STOP**

**High risk  
medications  
'APINCHS'**

**A pinch in time, saves lives**

Take the time to ensure safe prescribing, administration and dispensing of these high risk medications!  
Refer to available information and guidelines.

**A** Antimicrobials, Antiarrhythmics  
**P** Potassium and other electrolytes; Psychotropic medications  
**I** Insulin  
**N** Narcotics/opioids and other sedatives  
**C** Chemotherapeutic agents  
**H** Heparin, other anticoagulants and thrombolytics  
**S** Systems (e.g. safe administration of liquid medications)

Remember that **all** medications carry risk of adverse events if prescribed, administered or dispensed inappropriately.

Acknowledgment to Royal Perth Hospital Medication Safety Committee © Department of Health Western Australia 2015