EEPD Key Words & Concepts

“R.I.O.s” (Realistic Input-Output Opportunities)

Times when it is realistic for busy front-line acute medicine health care workers (doctors, nurses, midwives, ward clerks etc.) - especially those who do not work at a single desk or in a single department and who cannot therefore spend all day logged on to their own computer - but instead have to find a place to sit down (?), log on, find the right place on a different computer to enter data and then make use of a terminal or hand-held device to interact with each EPR. Each RIO generally consists of A) Display on Screen of Basic Demographic Data and Important Information with relevant Risks especially highlighted ; B) Appropriate Flow-Patterned Data Entry; C) Offer to display or print any relevant Guidelines; D) Suggestions for Tests and for Prescriptions; E) Offer to print appropriate communication items e.g. Letters, Memos etc (including Action Suggestions, and Letter or Summary for Patient - encouraging patient to check for accuracy of data); F) Offer to print any relevant Patient Information Leaflets; G) Suggestion regarding currently relevant Clinical Trials. See EEPD Volume VI. R.I.O.s

“S.IN.B.A.D.”

(Standard INter-program Bundles of Associated Data)

Nationally defined data sets either a) to allow data to pass from one computer system to another or for adding to or downloading from an EHR (Electronic Health Record) e.g. Standardised NHS Patient Demographic Dataset [Surname, Preferred First Name, Initials, Date of Birth, etc.]. or Haemoglobin Result [Patient’s Identification Data, Date of Test, Nature of Test e.g.Hb, Result e.g. 12.5 G/L] etc or b) to suggest which data items in a future all singing and dancing system, out of an incomprehensible mass of comprehensive data, will be required in a particular context e.g. maternity care. In 2008 the buzz word is now INTEROPERABILITY which is impossible without a) standardisation of primary data and b) universally agreed S.IN.B.A.D.s.

“Maternent”

It is now difficult to find a universally acceptable collective term for those who are in receipt of maternity care. “Patient” has been used in the past but there are now many who strongly object to the use for a woman with a normal and healthy pregnancy. “Client”, although widely advocated, has connotations of social work which are unacceptable to the majority of doctors and midwives. The term “Expectant mother” can be used antenatally but is inappropriate in a post-natal context. No suitable foreign word has so far been suggested, and, with no alternative so far suggested, it will surely not be long before government agencies start to use the abbreviation “MCR” (Maternity Care Recipient).

For these reasons, the new word “maternent” has been proposed. This can be used to encompass all those (pre and post delivery, male or female, healthily pregnant or with obstetric or other medical problems) for whom maternity care of any kind is provided. It is short, easily understood, and in practice has proved to be unambiguous. Since being introduced it has proved to be invaluable, and is now commended to others.

“Birth Event”

On paper it does not matter if a birth data item refers to information which, in a multiple birth, is the SAME FOR EACH BABY (e.g. “Was there a labour?”, “Were the Membranes and Placenta Apparently Complete?” etc); and data which DIFFERS FOR EACH BABY (e.g. “Time of Birth?”, “Appearance of Placenta?” etc) To avoid duplication of data entry an electronic record dataset must distinguish clearly between these two types of data.

In order to avoid confusion in matters related to the birthing process, and because of opposition to the use of the old fashioned word “Confinement” I started to use the term “Birth Event” data for all data items which are the same regardless as to how many babies are born, with “Birth” being exclusively used with regard to each different baby. I did this first in the Protos system and subsequently throughout the EEPD (especially in Volume IV. The Resource Document and Volume V. The Logical Prioritisation Dataset) This concept has now been taken up by many others and is increasingly widely used.

“Route of Birth”

Data entry into an electronic record frequently involves picking one item from a list of exclusive alternatives, but such pick lists are inefficient and unreliable if too long a list of options is offered in answer to a single question. For this reason I made use of the term “Route of Birth” with the options a) Vaginal, b) Caesarean and c) Other (e.g. Abdominal) and the question “Lie just before birth” before offering a manageable shorter list of the options relevant to each route and lie. In this way the 20 different “Methods of Birth” can much more efficiently be entered (For the full details of the 20 “Methods of Birth” see the EEPD Volumes IV and V

“Gestation by Final (or Agreed or Working) Due Date”

Now that early scans are so often done, and now that they have, despite my initial scepticism, been shown to general agreement to be more reliable than any calculation based on the Last Menstrual Period, it is to me unbelievable that, by government decree, so much midwifery time is still being wasted entering the date of the LMP onto the national Baby Number computer system. Those responsible should be shot!

When an early scan has not been done, an attempt always needs to be made to work out some sort of “Due Date” even if this is only an estimate. Late pregnancy care these days depends on the obstetrician or midwife’s estimate of the probable gestation. Even when the LMP and the Menstrual Pattern has been recorded on the paper medical record and then used as the best basis for a calculation of the Final Due Date and the current Gestation at each consultation, entering the actual date of the LMP onto a computer is totally unnecessary.

Cut off at 20 weeks Gestation

While it is accepted that “viability” is now usually based on 24 weeks Gestation and on the Birth Weight, a maternity computer system is much easier to design if the pattern of questions and answer options can different before and after 20 weeks gestation, with a much simpler dataset being used for all pregnancies which end before 20 weeks. For example one does not need to ask for the “Length of the First” and “Second Stages”, or to request data on who “did” the delivery etc. for a “Labour” before 20 weeks. But such question still need to be asked regarding all pregnancies beyond 20 weeks gestation. After 20 weeks the “Outcome” answer options can at that stage then be used to clarify the viability of the fetus and whether it was a Spontaneous Birth or a Termination.

Early and Late Post Partum Haemorrhage

Traditionally the cut-off between these two entities used to be 2 hours. However trying to fit this in with the fact that data is not entered onto computer systems exactly 2 hours after the birth would have led to a whole series of extra questions which in any case were unlikely to be answered accurately in the transition from the labour ward to the post natal ward. In view of the very small number of borderline cases it seems best to propose that in future we use the term “Early PPH” for serious bleeding while still in the labour ward, and “LatePPH” for bleeding after the mother has arrived in the post natal ward.

Plain English - not Medical Jargon

Who, in normal life goes on an “Elective” holiday. So why not simply “**Planned Caesarean**” never “**Elective Caesarean**”?

When working in a London Teaching Hospital, it was only when I commiserated with a patient that we were still using her **as a pin cushion** only to find that the massively overstretched nurses had forgotten to give Heparin to my high risk patient on the third day after her burst abdomen!

“**Troubled by**” or “**Presenting Problems**” NEVER “**Complaints**” or “**This Patient is complaining of”!!!**; Why be so patronising.

“**2X/day**” or “**3X/day**” or “**4X/day**” or “**Nightly**” or “**When Needed**” are simple plain English so why not use them. NEVER use the medical jargon phrases “**b.d**.” or “**t.d.s**.”, or “**q.d.s**.” or “**q.i.d**” or ”**nocte**” or “**p.r.n**.” Why keep the patient in ignorance that a mistake has happened when, as sometimes happens in a busy ward, the nursing staff have forgotten to give some vital medication?

“**Seeds of Cancer**” (which might, or might not, eventually come to life and grow into Cancer) NEVER the medical jargon words “**Carcinoma in site**”, “**Pre-Invasive Carcinoma**” which no ordinary lay person understands and probably things it is a cancer which will kill her.

“**Grade Three”** or **“Grade Four Perineal Tears**”. Why frighten people with “**Third Degree**” (Sounds far too much like frightening “**Third Degree Burns”** or **“The Third Degree (Torture**)”

Otherwise we re-inforce the sad observation by G B Shaw that

“All professions are a conspiracy against the public”

“Presentem Groups”

Classification by Presenting Problem or Need, Not Diagnosis. The essential basis for all Integrated Care Pathways, for rational Clinical Audit and for Purchaser/Provider relationships.
EEPDPCFILES/00_ESSAYS/G_CODING/G05_Presentm.pdf

Mnemonic for Vaginal Examination

D.I.S.C.O. (Items in Bishop's Assessment)

D = **D**ilatation (cm), **I** = **I**nternal Length of Cervix (cm), **S** = **S**tation, **C** = **C**onsistency, **O** = p**O**sition of Cervix.
Created by R Fawdry in 1976 while a Registrar at the Western General Hospital, Edinburgh.

For A4 Version for Lamination see www.fawdry.info/EEPDPCFILES/21_TRAINING/LAMINATES/A1_Disco.pdf

Mnemonic for Eclamptic Fits

HELP, F.O.A.M. B.B.B.B.B.A.D.

HELP = Send for Help, **F** = Manage the **FIT, O** = **OXYGEN, A** = **AIRWAY**, (**B** = Breathing, **C** = Circulation), **M** = **MAGNESIUM SULPHATE**, **B.B.B.B.B.** = **B.P**. CONTROL, **BLADDER CATHETER**, **BLOOD TESTS**, **BALANCE OF FLUIDS**. **BABY DOCTOR** informed, **A** = **A**VOID POLYPHARMACY, **D** = Decide on the Mode of **DELIVERY.** *Created by R Fawdry in 2000 Based on the A.L.S.O. course manual.*

For A4 Version for laminating see www.fawdry.info/EEPDPCFILES/21_LEARNING/LAMINATES/B1_Foam.pdf

For Filofax Version www.fawdry.info/EEPDPCFILES/19_HANDBOOKS/ONEPAGERS/Mnemonics.doc

“Di-Di-Daaa” = “You are Running into Danger!”

When regional anaesthesia is used for major surgery (especially for a Caesarean with the husband present) a dangerous situation can arise when the surgeon becomes aware of potentially serious difficulties but cannot attract the attention of the anaesthetist without causing excessive anxiety to the patient and her partner. Rather than the traditional curse, which is likely to terrify the mother and her husband, it is suggested that some standard coded means of communication is required.

The ‘U’ flag is the traditional naval signal for “You are running into danger”. We would therefore commend to all our colleagues the tuneful but loud repetition of the morse ‘U’ equivalent (“DEE-DEE-DAAAA”) as an excellent and potentially unambiguous means of vital communication. It has already proved it’s worth on several occasions, allowing a final check of the intra-venous lines and the cross-match situation before the incision into an unexpectedly vascular lower segment.

From the June 1999 letter to Hospital Doctor from Michael Wee, Consultant Anaesthetist, Poole and Rupert Fawdry, at that time Consultant Obstetrician in Milton Keynes

Rupert Fawdry. (Updated 5.11.08)