### Challenges to Reducing Abbreviation Use and Possible Strategies

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<td><strong>Limited reporting of abbreviation-related errors</strong></td>
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| Organizations rely on reports of errors or close calls to identify hazards in the system that need to be addressed. | - Assess the culture of safety and address concerns.  
- Provide patient safety training to leaders and staff.  
- Encourage reporting of abbreviation-related close calls and adverse events.  
- Address gaps and share the learning to prevent similar errors.  
- Make error reporting less labour intensive. |
| Staff may not recognize when new technology contributes to an error.                    | **Individuals**                                                                     |
|                                                                                       | - Actively participate in safety initiatives.  
- Accept that errors will occur and be vigilant to the possibility of error when abbreviations are used.  
- Report close calls and errors involving abbreviations.  
- Consider how technology can contribute to errors. |
| **Today’s culture reinforces use of abbreviations and other communication short-cuts** | **Organizations/facilities**                                                        |
| Abbreviations, acronyms, and other short forms of communication are increasingly used outside the workplace. | - Monitor the use of abbreviations in documentation and provide feedback to individuals who regularly use nonstandard or error-prone abbreviations.  
- Design pre-printed forms that minimize handwriting. |
| Due to time constraints, staff may be under pressure to take shortcuts.                | **Technology**                                                                       |
| Professional journals, pharmaceutical industry communications, and educational materials contain error-prone abbreviations. | - Look for technology solutions to streamline processes.  
- Place alerts in the electronic medical record to warn when error-prone abbreviations are used.  
- Use autocorrect features to prevent abbreviation use.  
- Assess whether there is a potential for an abbreviation to be interpreted incorrectly by the software. |
|                                                                                       | **Industry**                                                                         |
|                                                                                       | - Revise publishing guidelines to prohibit use of error-prone abbreviations.  
- Remove error-prone abbreviations from pharmaceutical labelling, packaging, and advertising. |
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| **Today's culture reinforces use of abbreviations and other communication short-cuts** | **Individuals**  
- Take time to write out medication orders completely.  
- Avoid use of error-prone abbreviations and other shortcuts when documenting or transcribing orders.  
- Examine your personal habits to identify and change ‘at risk’ behaviour.\(^{51}\)  
- Encourage others to write out rather than abbreviate.  

**Colleges and universities**  
- Eliminate the use of error-prone abbreviations from teaching materials.  
- Establish expectations for student performance that discourages the use of error-prone abbreviations in presentations and reports.  

| **Limited knowledge of patient safety concerns related to abbreviations** | **Organizations/Facilities**  
- Include expectations for abbreviation use in medication ordering and other documentation in orientation of new staff and students.  
- Develop an e-learning module with a self-assessment and post-test for self-directed education.  
- Develop a dangerous abbreviation policy.  
- Provide frequent reminders for all staff using posters, chart stickers, or reminders in the electronic medical record.  

**Professional Organizations**  
- Develop continuing education programs to address this safety concern.  
- Update practice standards to discourage the use of abbreviations.  

**Individuals**  
- Know the abbreviations that cause errors and eliminate them from your practice.  

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Healthcare workers are unaware of the safety concerns with using certain abbreviations, symbols, dose designations, and shortened medication names. This includes individuals involved in prescribing, dispensing, and administering medications as well as those that document in the medical record:  
- physicians  
- nurses  
- pharmacists and pharmacy technicians  
- other healthcare professionals (e.g., dentists, physiotherapists, respiratory therapists)  
- health care aides/attendants  
- medical records technicians  

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| **Limited knowledge of patient safety concerns related to abbreviations** | Colleges and universities  
- Include information about safety concerns with abbreviations in the curriculum.  
- Stop using abbreviations in teaching and discourage the use of abbreviations by students.  
- Remove abbreviations from manuals and teaching material.  
- Ensure that clinical practice sites and preceptors are aware of the safety concern and have resources to discourage the use of abbreviations. |
| **Variable prescribing practices** | Organizations and facilities  
- Establish standards and guidelines for medication order writing.  
- Redesign order forms to provide guidance or reminders about expected standards for order writing.  
- Develop pre-printed protocols for high alert medications.  
- Train new prescribers in safe prescribing practices.  
- Encourage staff to contact prescribers when prescriptions are unclear and contain an error-prone abbreviation.  
- Provide a variety of reminders about expected standards for order writing.  
- Monitor prescriptions for unapproved abbreviations and provide targeted feedback to prescribers. |
| There is a lack of guidelines and training on safe prescribing practices and medication order writing standards. | Technology  
- Implement electronic prescribing, either stand alone or integrated, within the electronic health record.  
- Provide adequate training to prescribers about electronic prescribing. |
<p>| Prescribers are not informed when their orders do not meet expected order writing standards. | |
| Some prescribers are not concerned about the quality or completeness of their prescriptions and expect the system to catch any errors. | |
| Poor handwriting contributes to the misinterpretation of medication orders. Illegible orders often contain abbreviations. | |</p>
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| **Variable prescribing practices**                          | **Prescribers**<sup>54</sup>  
- Use a standardized prescription format (e.g., the five ‘Rs’ – right patient, medication, dose, route, and frequency) when writing medication orders.  
- Print if handwriting is illegible and include name and contact number.  
**Colleges and universities**  
- Incorporate education on safe prescribing practices into programs.  |
| **Variable documentation and transcription skills**         | **Organizations and facilities**  
- Develop a documentation and transcription policy.  
- Discourage verbal orders.  
- Create a list of approved abbreviations and their intended meaning.  
- Adopt ISMP Canada’s ‘Do Not Use’ list and add additional abbreviations, as appropriate to the site.  
- Monitor orders and health records for unapproved abbreviations and provide feedback to individuals on their use of abbreviations.  
**Technology**  
- Ensure error-prone abbreviations are not used or allowed by the system.  
- Include alerts that warn when an unapproved abbreviation is used or use an autocorrect feature.  
- Provide a definition when the user hovers over an abbreviation.  
- Implement a computerized prescriber order entry system (CPOE).  
- Integrate the CPOE system with a pharmacy information system to reduce transcription errors.  
- Use an electronic medication administration record (e-MAR) to decrease transcription. |

Abbreviations are often introduced during transcription or documentation. For example:  
- updating medication records  
- transcribing verbal orders  
- completing medication reconciliation forms  

Poor practices may be introduced during practical training and reinforced on the job.  

Electronic medical records do not eliminate the use of abbreviations in clinical notes or other free-text entry fields.  

Poor handwriting compounds the problem of abbreviation use in transcription and documentation.
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| | • Avoid the use of prohibited abbreviations when transcribing orders or documenting care.  
  • Print out orders if you have poor handwriting and include your name and contact number.  
  • Use an electronic method or dictation to transcribe or document.  
  • Do not use abbreviations or communication shortcuts during free-text entry or dictation. |
| **Poorly designed technology** | **Organizations/Facilities** |
| | • Review computer programs for the use of abbreviations and confusing screen displays.\(^{44}\)  
  • Provide adequate technology training for employees, prescribers, and contracted service providers (e.g., outside pharmacists who provide medications to a continuing care facility).  
  • Pharmacy providers remove abbreviations from computer generated reports and labels.\(^{55}\)  
  • Ensure a prescriber’s ‘favourite’ prescriptions or protocols are free of abbreviations. Write out in full the name of each medication in a protocol rather than using an acronym to designate the protocol.  
  • Place alerts on the electronic medical record to warn when abbreviations are used.  
 | | **Individuals** |
| | • Avoid the use of abbreviations in free-text fields.  
  • Avoid workarounds (e.g., turning off alert features) or reverting to a paper system to avoid safety features of the technology. |
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**References**

Note: Take from the reference list for the Abbreviations Toolkit.


