



## **Patient Safety is in YOUR Hand!**

### **Collaborative Abbreviation Project**

#### **EVALUATION TIPS**

- It may be useful to consider a baseline survey of health professionals prior to initiation of education and implementation of the “Do Not Use” abbreviations list. A follow-up survey may then be useful in capturing any shift in the safety culture with health professionals as your program of change unfolds.
- A baseline review of existing occurrence reporting may be helpful. This baseline data may capture the number of current occurrences that are related to abbreviations on the “Do Not Use” list. It may also capture local examples of abbreviations related occurrences that may add credibility to your implementation/education. Follow-up tracking of abbreviation related occurrence can be used as a quality indicator. Caution should be taken in interpretation of the results as an increase of abbreviation-related occurrences may occur due to the increased focus on this activity.
- The most direct measure of “Do Not Use” abbreviations can be obtained by baseline and periodic audit of medication orders in your facility/region. Given the documented association of these abbreviations and errors, the rate of use of “Do Not Use” abbreviations can act as a surrogate for safety.
- How an audit is conducted in a given region or facility will be highly dependent on its size and the resources available to conduct the audit. Pragmatic visible measures to avoid bias and ensure appropriate sampling of medication orders will add to the credibility of any audit.
- In large facilities, where several hundred orders are written every day, reviewing every order sent to pharmacy over a specific period of time such as 2-4 weeks is likely to generate a substantial data set. It is important not to have too short a sampling interval to insure that the writing patterns of one or two prescribers don’t skew the results. Another option is to target a specific number of prescriptions, but be sure that they are sampled from various areas of the hospital (different units or wards). In an audit of written prescriptions conducted by the WRHA, they targeted to review 1000 prescriptions, from various units, from each regional facility.



- In small or medium sized facilities, where the number orders are limited, trying to sample 1000 orders is likely to be impractical. Another strategy is to select a random sample of charts from recently discharged patients. Data can be collected on all the orders for a given patient along with all the medication administration records recorded in the chart. The sample of charts should be large enough that it captures orders and administration records written by a wide range of physicians, nurses, pharmacists and support staff.
- Any audit of medication orders should be conducted in a reasonable period of time (3-6 months) after the education has been conducted. This will insure that there has been both enough time for the information to be disseminated throughout the system, but not so early as to catch the immediate, non-sustained improvement that may come after an educational intervention.
- Remember that the purpose of the audit is not to identify “good” or “bad” order writers, but to get either a baseline idea how often inappropriate abbreviations or symbols are being used, or, in subsequent audits, assess how much your education programs or interventions are improving order writing.
- An annual survey of all order forms, computer software, protocols, guidelines, policies and clinical pathways with a view to identifying any documents that contain any “Do Not Use” abbreviations may be a helpful evaluation tool. The percentage of surveyed documents that contain “Do Not Use” abbreviations may be an important indicator of the success of your program. Over time 100% compliance is an achievable and important quality indicator benchmark.