MANITOBA INSTITUTE FOR PATIENT SAFETY
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Patient Safety is in YOUR Hand!
Collaborative Abbreviation Project
Implementation Strategies

General Implementation Strategies

- In advance of introducing any initiative to improve medication order writing, collect examples of where the use of inappropriate order writing or transcription may have lead to a medication error or near miss.
- Make use of existing occurrence reporting mechanisms to flag a local history of problems with the use of "Do Not Use" abbreviations.
- Prominent posting of the "Do Not Use" card and posters in locations where orders are written, transcribed, taken over the phone, or faxed.
- Ensuring high visibility of the poster of the "Do Not Use" list of dangerous abbreviations, symbols, and dose designations will make it easier for staff to remember to avoid error prone abbreviations. Go to http://mbips.ca/wp/initiatives/patient-safety-is-in-your-hand#POSTER
- Append the "Do Not Use" card on commonly used prescribing aids and reference texts such as the Pediatric Dosing Handbook or the CPS.
- Introduce the "Do Not Use" card in a multi-disciplinary program that includes physicians, nurses, pharmacists, other healthcare professionals and support staff. It is important to recognize that all staff involved at any point of the order writing, transcription and interpretation process should be cognizant of the strategy and the "Do Not Use" list.
- Expect resistance from some individuals within your organization to any attempt to change order writing patterns. Start by partnering with groups in your organization that are positive to the concept and will embrace practice change.
- Don't expect changes to occur "overnight", it will take time to change the culture of medication order writing. But, in the end, time and effort to reduce the use of error-prone abbreviations will improve patient safety within your healthcare facility.

For Pharmacy Department

- Eliminate the use of error prone abbreviations in health care software applications like dispensing systems and computerized physician order entry systems. This may require working with your computer software vendor for changes in programming.
- Ensure all medication labels and forms do not contain any abbreviations (especially those from the "Do Not Use" list).
- Insure all pre-printed orders and clinical pathways that are currently in use do not contain any of the "Do Not Use" abbreviations.
- Remove any "Do Not Use" abbreviations from labeling in drug storage areas.
- Pharmacists should be encouraged to set the stage for other healthcare professional by ensuring all recorded verbal orders and other chart documentation is free of "Do Not Use" abbreviations.

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For Nursing Staff

- Ensure all nursing related protocols, policies, guidelines and clinical pathways are free of “Do Not Use” abbreviations
- Engage the nursing culture to encourage fellow nurses to maintain a high standard in order writing, transcription and charting that avoids the use of “Do Not Use” abbreviations.
- Use “learn at lunch”, self study, computer based and pre-recorded videos to help ensure all front line nursing staff are aware of the order writing standards and related “Do Not Use” abbreviations.
- Nurses should be encouraged to set the stage for other healthcare professional by ensuring all recorded verbal orders and other chart documentation is free of “Do Not Use” abbreviations

For Physician Staff

- As the key prescribers in any organization, it will be important to work collaboratively with physicians at every stage of the implementation of a “Do Not Use” list.
- Allow some contemplation time in your process. Change is a staged project and physicians (as well as other professionals) may need a little time to consider the change and reflect on the pros of such actions before moving ahead.
- Look for an opinion leader / physician champion for your “Do Not Use” list implementation. A respected physician spokesperson can be the most effective person to bring this message of change to other physicians.
- High visibility of the “Do Not Use” list will make it easier for physicians to remember to avoid error prone abbreviations.

For All Healthcare Professionals and Support Staff (Transcriptionists, Ward Clerks)

- Acquire a copy of the “Do Not Use” Abbreviations List and have it available when writing or transcribing medication orders.
- Be on the lookout for the use of error-prone abbreviations by colleagues, co-workers or students. Discuss the patient safety implications of the use of these abbreviations and the importance of avoiding them.

For Regional Administration

- Consider adopting Medication Order Writing Standards in your region that reference the abbreviations on the “Do Not Use” list. For examples, http://mbips.ca/wp/initiatives/patient-safety-is-in-your-hand#medication_order
- Ensure that the “Do Not Use” abbreviations list becomes part of the orientation of any new staff that will be involved with medication order writing, transcribing or interpretation.

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