



Patient Safety is in YOUR Hand! Collaborative Abbreviation Project

Reference List: Abbreviation and Safe Medication Use

- **Abushaiqa, M.E., Zaran, F.K., Bach, D.S., Smolarek, R.T., Farber, M.S. 2007. Educational interventions to reduce use of unsafe abbreviations. *American Journal of Health-System Pharmacy*. 64(11):1170-1173.**
Educational interventions were found to reduce the use of unsafe abbreviations in medication orders, including inservice education programs for the medical, pharmacy, and nursing staffs; laminated pocket cards; patient chart dividers; stickers; and interventions by pharmacists and nurses during medication prescribing.
- **Brunetti, L., Santell, J.P., Hicks R.W. 2007. The impact of abbreviations on patient safety. *Joint Commission Journal on Quality and Patient Safety*. 33(9):576-83.**
http://www.wapatientssafety.org/downloads/Brunetti_JCJQPS_2007.pdf
This study shows that nearly 5% of 643,151 reported adverse events were attributable to abbreviation use and that many of the 'problem' abbreviations were on The Joint Commission's 'do not use' list. Recommendations are provided on how to improve the reporting of adverse medication events and additional abbreviations to be added to the "do no use" list are provided.
- **Benjamin, D.M. 2003. Reducing medication errors and increasing patient safety: Case studies in clinical pharmacology. *Journal of Clinical Pharmacology*. 43:768-783.**
This article summarizes what is currently known about adverse medication events and translates the information into case studies illustrating common scenarios that lead to adverse medication events. Each case is analyzed to provide insight into how the medication error could have been prevented.
- **Joint Commission. 2008. *Facts about the Official "Do Not Use" List*.**
http://www.jointcommission.org/AboutUs/Fact_Sheets/facts_dnu.htm
The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States. In May 2005, The Joint Commission affirmed its "Do Not Use" list of abbreviations: http://www.jointcommission.org/NR/rdonlyres/2329F8F5-6EC5-4E21-B932-54B2B7D53F00/0/dnu_list.pdf
-  **Koczmara, C., Jelincic, V., Dueck C. 2005. Dangerous abbreviations: "U" can make a difference! *Dynamics*. 16(3):11-5. <http://www.ismp-canada.org/download/CACCN-Fall05.pdf>**
This article highlights several adverse medication events that are caused by using dangerous abbreviations. It provides examples of dangerous abbreviations and strategies to eliminate their use.



- **Kuhn, I.F. 2007. Abbreviations and acronyms in healthcare: when shorter isn't sweeter. *Pediatric Nursing*. 33(5):392-8.**

<http://www.pediatricnursing.net/ce/2009/article33392398.pdf>

Abbreviations are a barrier to clear communication. No one strategy aimed at eliminating dangerous abbreviations appears to ensure a better patient safety outcome. This article argues that the Joint Commission's "do not use" list is an excellent beginning, but is only focused on adverse medication events. The author therefore recommends that all healthcare education programs must eliminating the use of *all* abbreviations from their curricula.

-  **Poloway, L., Greenall, J. 2006. Medication safety alerts. *CJHP*. 59(4):206-209.**
<http://www.ismp-canada.org/download/cjhp0609.pdf>

Eliminating prohibited error-prone abbreviations, acronyms, symbols, and dose designations is an example of a medication safety initiative that can help organizations develop a culture of safety. This article describes how the David Thompson Health Region, in Alberta, undertook a region-wide multidisciplinary project to eliminate the use of error-prone abbreviations, acronyms, dose designations, symbols, and truncated drug names from all clinical documentation project. ISMP Canada's recently proposed list of dangerous abbreviations, symbols and dose designations is reproduced in Appendix 1.