Patient Safety Tip of the Week

August 14, 2018

ISMP Canada's Updated "Do Not Use" Abbreviation List

ISMP Canada recently updated its "Do Not Use" abbreviation list after doing an analysis of use of abbreviations in healthcare settings (ISMP Canada 2018). We like the basic tenet they use about abbreviations: "…abbreviations, as well as symbols and dose designations, are only helpful when their intended meaning is fully understood by all persons who will be deciphering the information and when there is no potential for misinterpretation." ISMP Canada also stresses that inappropriate use of abbreviations can be particularly hazardous at transitions of care (ISMP Canada 2017).

The report particularly highlights problematic use of route designations such as SL, SQ, and SC, and use of the abbreviation "d" to represent days or doses, and use of the ampersand symbol (&) to denote the word "and".

SL (intended to mean sublingual), SQ (intended to mean subcutaneous), and SC (also intended to mean subcutaneous) can easily be confused with each other. In addition, "SQ" is sometimes misinterpreted as a "5 every".

The abbreviation "d" can be interpreted as either days or doses. An example given was the order "Lactulose 15 mL po bid x 2d". That order was intended to mean "for a duration of 2 doses" but was mistaken as "for a duration of 2 days".

They also note some abbreviations that we, quite frankly, have not seen used. These include use of fractions meant to convey information about duration or frequency. Examples given are #/24, #/7, #/52 (denoting numbers per 24 hours, 7 days, and 52 weeks, respectively). Another example was a direction for tapering a corticosteroid written as "2/7" and then "1/7". The intended meaning was that the prescribed dose be given "for2 days" and then "for 1 day", but the instructions were interpreted to mean treatment "for 2 weeks" and then "for 1 week", resulting in the patient receiving a longer duration of therapy than was intended and experienced adverse effects for which admission to hospital was required.

There is some good news, however, about fewer dangerous abbreviations with the electronic medical record. The current ISMP Canada bulletin notes that a recent Canadian hospital audit found the rates of dangerous abbreviation use on electronic medication orders was significantly less than on paper orders (0.4% vs. 24.1%, respectively). That is

reassuring because during one quality improvement implementation we found numerous dangerous abbreviations in order entry screens and standardized order sets and some third party vendor modules in an EHR (see our July 14, 2009 Patient Safety Tip of the Week "Is Your "Do Not Use" Abbreviations List Adequate?"). Dangerous abbreviations also have a nasty habit of showing up in texted information and are one of our many arguments that orders should never be texted.

The ISMP Canada list (ISMP Canada 2018b) and the even more comprehensive ISMP (US) list (ISMP 2017) are considerably longer than Joint Commission's list of dangerous abbreviations. In that July 14, 2009 Patient Safety Tip of the Week "Is Your "Do Not Use" Abbreviations List Adequate?") we discussed that many hospitals only adhere to the shorter Joint Commission "Do Not Use" abbreviation list. In reviewing a hospital's "Do Not Use" abbreviation list for potential expansion, we found about 4% of total orders had an abbreviation that appears on the ISMP list. However, about one in every seven verbal or telephone orders contained such an abbreviation.

We take heart that the detrimental effect of dangerous abbreviations has likely been mitigated somewhat as we've transitioned from handwritten orders to electronically formatted orders. In fact, some of the old ISMP samples of dangerous handwritten abbreviations seem anachronistic when we show them in presentations. But they've been replaced by the new kid on the block: texting. In our several columns (listed below) about the dangers of texting orders, we cited use of dangerous abbreviations as one example. In our January 30, 2018 Patient Safety Tip of the Week "Texting Errors Revealed" we noted common texting **abbreviations** are a threat. We've spoken before about the example of a texted "2day" (meaning "today") getting misinterpreted as "two daily" (ISMP 2009). ISMP provided some other examples of errors related to texted abbreviations last summer (ISMP 2017b) and the latest ISMP survey (ISMP 2017a) uncovered a new one: the text abbreviation "BTW" (meaning "by the way") was misinterpreted as meaning "twice daily". And, while we were happy The Joint Commission saw the light and did not reverse its ban on texting orders, the above mentioned ISMP survey notes that the practice probably continues to exist to some degree despite hospital policies banning it.

We recommend healthcare organizations use the ISMP (US) list and perform due diligence in purging such abbreviations that might be buried in their EHR's in order sets (particularly old ones or "personalized" ones if you allow them) or in third party vendor software modules. Every organization also needs to periodically audit records to see how often dangerous abbreviations continue to be used. You may be surprised at what you find. We also suggest you look at the recommendations in our December 22, 2015 Patient Safety Tip of the Week "The Alberta Abbreviation Safety Toolkit".

Some of our previous columns on the impact of abbreviations in healthcare**:**

March 12, 2007 "10x Overdoses"
June 12, 2007 "Medication-Related Issues in Ambulatory Surgery"

September 2007 "The Impact of Abbreviations on Patient Safety"
July 14, 2009 "Is Your "Do Not Use" Abbreviations List Adequate?"
April 2015 "Pediatric Dosing Unit Recommendations"
December 22, 2015 "The Alberta Abbreviation Safety Toolkit"

See our other Patient Safety Tip of the Week columns dealing with texting:

- February 9, 2016 "It was just a matter of time…"
- May 24, 2016 "Texting Orders – Is It Really Safe?"
- January 2017 "Joint Commission Thinks Twice About Texting Orders"
- June 27, 2017 "Texting – We Told You So!"
- January 30, 2018 "Texting Errors Revealed"

References:

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ISMP Canada's "Do Not Use Dangerous Abbreviations, Symbols and Dose Designations" list. Original 2006, reaffirmed 2018. https://www.ismp-canada.org/download/ISMPC_List_of_Dangerous_Abbreviations.pdf

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