# Abbreviations Bookmarks

HQCA Health Quality Council of Alberta

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**Available Now!**

The Health Quality Council of Alberta (HQCA) has identified five high-risk medication ordering and communication shortcuts that should be curtailed by ALL health care providers. To ensure patient safety, communications about medications must be clear and free from ambiguity, which means minimizing the use of dangerous abbreviations. The HQCA bookmarks are a colourful, graphic reminder of key shortcuts to avoid when ordering or communicating about medications.

Abbreviations are commonly used in communications about medication orders by all health care providers. Audits in a variety of settings have shown more than 20% of medication orders contain dangerous abbreviations, symbols and dose designations. Risk of errors from these ordering practices is a particular problem in written communication where the chance of misinterpretation is increased by poor handwriting. These medication communication shortcuts are a common source of preventable medication errors.

The HQCA is asking all health care providers to look at the way they use shortcuts to communicate about medication orders, and make changes in their practice to eliminate hazardous abbreviations and dose designations that put patients at risk of medication errors. Even if you are not currently prescribing medications, we ask that you also consider how the use of these hazardous abbreviations is perpetuated in other areas of your practice, including:

- Preprinted order sets and standing orders
- Clinical pathways and protocols
- Notes in patient records
- Electronic medical records/clinical information systems
- Publications that you author
- Teaching messages and materials used with students and colleagues, including teaching in undergraduate and continuing education programs

Improving patient safety by eliminating these high-risk abbreviations and dose designations from everyday communication about medications will take the combined efforts of all health care providers and organizations.

If you would like to order bookmarks to remind your staff or colleagues of dangerous shortcuts to avoid when communicating about medications, please contact the HQCA. Bookmarks will be provided free of charge although we request that ordering organizations pay for shipping and handling of large orders.

**shortcuts! to patient safety**

| DO NOT USE | WHY? | GO |
|---|---|---|
| U,u,IU | Misread as IV (intravenous), 0 (zero) or 4 | Write *unit* |
| qd, od, QD, OD for *daily* | Misread as q.i.d. or right eye | Write *daily* or *every day* |
| x.0 mg | Misread as 10x dose | No trailing 0 for whole number doses (e.g. 1 mg) |
| .x mg | Misread as x mg (whole number) dose | Use leading 0 for doses less than one (e.g. 0.1 mg) |
| Abbreviated drug names | Misread as an incorrect drug | Write generic drug names in full |

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