Designations and abbreviations essay

The use of confusing dose designations and abbreviations is one of the leading causes of errors in medications in many healthcare institutions. Studies show that the continued use of such abbreviations and dose designations account for 10% of all medical errors. The use of ambiguous medical notations is one of the most common causes of medication errors. These misinterpretations can lead to mistakes which can in turn result in patient harm or delay the start of a therapy and also waste a lot of time clarifying the terms (Senholzi, 2003).

Reduction of errors by eliminating abbreviation.

The use of abbreviations of drug names increases the chances of confusion between those drugs that look alike or even sound alike. For example, the wide spread use of the word “ morph’ to mean morphine has been found to be among the contributing factors that bring about fatal incidences whereby patients are given hydromorphine instead of morphine. This also calls for the need for the medical practitioners to write legibly. The use of letters such as “ u” to represent the word units has also been, on many occasions, misinterpreted by patients as a “ 0’, leading to a ten times dose error. For instance the intended dose of “ 6u” was misinterpreted as “ 60” where the patient went ahead to have 60 units of the dose. A third example in which misinterpretations has occurred is whereby an administration of an octreotide infusion was done at 25 mL/h instead of at 5mL/h as it was intended. Misinterpretation of abbreviations whether computer generated or handwritten occur more often in healthcare institutions. Elimination of such abbreviations will ensure that patients and medical practitioners follow the right dose designations for the wellbeing of the patient (Novis, 2008).

It is totally true that it is high time for written policies to be developed to guide the use of abbreviations. The improvement of communication through the reduction and standardization of abbreviations, symbols and acronyms is a very important step towards the reduction of the occurrence of errors that are related to the inability of one to read and interpret accurately medical orders that are written or transcribed verbally. This guidance statement aims at increasing the awareness of preoperative registered nurses on the dangers that are accompanied with the use of abbreviations, with a sole aim of eliminating them from the healthcare practice. The issue of error prone abbreviations should be addresed by all preoperative settings. These settings include operating rooms in hospitals, centers for ambulatory surgery, care units of preanesthesia and post anesthesia, departments of cardiac catheterization, suites for endoscopy, departments for radiology and any other area where operative and invasive procedure can be carried out (Chard, 2008).

The safety of the patient can be greatly improved in the preoperative setting by improving the communication among caregivers by creating a standardized list of do-not-use abbreviations, symbols and acronyms. A list of dangerous abbreviations, symbols and acronyms, was developed by the Joint Commission on Accreditation of Healthcare Organizations. These are not to be used by any accredited medical facility. This is aimed at assisting organizations with the expansion of error-prevention programs in their facilities to improve the safety of patients. JCAHO recommended that healthcare organizations should limit their use of abbreviations by first eliminating the main error-prone abbreviations from the health care

documentation. Other errors will be reviewed on an annual basis to determine whether they can be included on the official do-not-use list (John, 2007).

Abbreviations are acceptable when a facility puts in place a policy that lists specifically the ones that are acceptable for its employees to use during documentation. These lists can be long or short, sometimes including those abbreviations unique to their facility alone in that they can not be found in any other facility in the world. All healthcare facilities should have a minimum required list of do-not-use abbreviations and also should educate their nurses in regard to the removal of those abbreviations from all healthcare documentation, and compliance to the same should be closely monitored. A process should be put in place to ensure that the provider initiating the medical order and the care giver transcribing the verbal order use legible signatures. They should use block-print and sign with their names to all orders whether written or verbal. This enables the caregiver to contact the provider on an issue, question or even when a concern arises. Another important source that helps reduce errors made by using abbreviations is the handbook for preoperative nursing which has drug information. It contains descriptions of not less than 700 commonly used medications. It helps the perioperative nurses confidently administer medications to their patients (Osborne, 2008).

I do not think that enough is being done to reduce errors caused by abbreviationss. One of the biggest problems in medical facilities, is that there are many often interruptions to those who work with and dispense medication to patients in those facilities. Systems should be put in place

which will ensure that hospitals and areas of medication preparation are made quieter and more ergonomic for the staff carrying out medication. Places where checking and transcribing of chart orders is done should be away from open areas where family members and visitors come to discuss or ask questions about the patient. This is aimed and reducing interruptions in the medical practitioner's train of thought. There have been strategies put in place to help practitioners in the process of transition in reducing or doing away with do-not-use abbreviation, symbols and acronyms. These include: providing pharmacy, nursing and medical students together with nursing staff members with in-service education programs with periodic updates, providing visual reminders which will display those abbreviations and other information regarded unsafe, pharmacy personnel should be told to always notify physicians and any other prescriber on orders containing unsafe abbreviation, standardized order sheets for high-alert medication should be developed and implemented and many others. But despite all these, there has not been concrete evidence to guide practice. Controlled trails have not been done to ascertain the use of medication abbreviation, and as such, errors keep occurring in institutions of healthcare on a daily basis. It is the cases in published reports and in headlines on medication errors from the media houses that are driving the few changes that are seen in practice. It is time that those charged with safe guarding the well being of people realized that they should carry out proactive and not reactive measures. Practice should be changed now, not just when and adverse event happens. This way many complications will be avoided and also many lives will be saved (Clifton-Koeppel, 2008; Gebhart, 2005).

Conclusion

Misinterpreting or confusing abbreviations put many people not just caregivers at a risk of making errors. The only difference is that for caregivers, an error made may just mean a life lost or put in danger. Therefore efforts must be put in place to reduce these unintentional but dangerous errors. That is why the Joint Commission on Accreditation of Health Organization came up with a list of dangerous abbreviation, symbols and acronyms that should not be used by any accredited medical facility. This, if followed will help improve the safety of patients.