On the Line

Save to myBoK

by Beth Hjort, RHIA, CHP

Q: Please explain the new Joint Commission requirement for "do not use" abbreviations, acronyms, and symbols. Does this mean that the abbreviation list requirement is being reinstated?

A: Standards have not required an approved list since 1991. IM.3 does require standardization of abbreviations, acronyms, and symbols (hereafter referred to simply as "abbreviations") when used. According to a FAQ posted on its Web site, through the National Patient Safety Goals (NPSG), the Joint Commission on Accreditation of Healthcare Organizations is focusing on behavioral change to alleviate the effects of miscommunication caused by the use of abbreviations. A comprehensive list may not be supportive of that intent.

Client organizations using approved abbreviation lists—and those with no list—must modify their processes to comply with NPSG no. 2b. The relationship between abbreviation miscommunication and misinterpretation and the incidence of national medical errors is so strong that Joint Commission has outlawed certain abbreviations as dangerous.

In 2004 the Joint Commission requires at a minimum a do-not-use list incorporating its do-not-use list and at least three organization-selected items. Some organizations may be compliant with custom-picked items already in use, but this is not about numbers—it is about patient safety. The Joint Commission recognizes it will take time to reach the long-term objective of 100 percent compliance in all forms of clinical documentation. Through 2004 the survey approach will target only handwritten abbreviations for survey and scoring, but it is up to healthcare organizations to optimize opportunities to improve patient safety without delay.

The minimum do-not-use list is maintained on the Joint Commission Web site, along with a second list. While it is not required, the second set of problem-prone abbreviations must be considered when organization-selected items are chosen.

The Joint Commission is not the only source for do-not-use lists. The Institute for Safe Medication Practices and the National Coordinating Council for Medication Error Reporting and Prevention also recommend a prohibition list related to medication use.

Whether or not your organization maintains an approved list along with the do-not-use list, it is critical to establish a process that is dependable and supportive of patient safety concerns. HIM professionals are talking about this issue in AHIMA's online Communities of Practice forums. Tapping into this professional exchange can bring insight into their challenges and approaches, such as the following:

How can HIM influence change?

- Elimination of abbreviations on preprinted forms or computer-generated formats can have a significant effect.
- Health system or community standardization efforts reduce confusion for caregivers who practice in a variety of settings.
- Minimal use of abbreviations in transcribed reports has been a common transcription practice for decades.

Are current processes effective?

- How do you ensure an updated, approved list that is used by all medical record documenters?
- How are staff educated and updated on changes in a timely manner?
- Do monitoring practices accurately measure compliance?
- When third-party publications are used as the abbreviation list, does the process ensure a consistent single definition for one abbreviation?

Is it time for a paradigm shift?

- "Use of abbreviations is discouraged" is an emerging policy for some organizations recognizing risk and logistical difficulties.
- With prepublished lists, some place responsibility on the documenter to ensure understanding. With two or more meanings, context must be considered and the abbreviations written out as appropriate.

Is monitoring adequate and effective?

- Does monitoring catch errors before damage is done? For example, concurrent monitoring can be done by the pharmacy for medication orders and by the nurse transcribing verbal orders or "taking orders off."
- Are policies addressed in medical staff bylaws and employee policies?
- What steps are taken when unapproved or forbidden abbreviations are used? Is this process consistent?
- Is an educational tone more effective than a punitive one to encourage safe reporting?
- Is behavioral change encouraged by routing monitor findings to employee files and physician profiles?

Visit the CoP and post your policies, procedures, and abbreviation lists. Best practices will emerge from our shared knowledge. ❖

References

Discussion threads in the following Communities of Practice were used in the preparation of this article: JCAHO Accreditation Standards, Documentation Improvement, IDS HIM Directors, Acute Care, Behavioral Health, Rehab Facilities, Transcription. For more information, go to www.ahima.org.

Hjort, Beth. "On the Line." Journal of AHIMA 73, no. 5 (2002): 52–53.

Institute for Safe Medication Practices. "Frequently Asked Questions." Available online at www.ismp.org/Pages/ismp_faq.html#Question%202.

Joint Commission on Accreditation of Healthcare Organizations. "2004 National Patient Safety Goals—FAQs." Available online at www.jcaho.org/accredited+organizations/patient+safety/ 04+npsg/04_faqs.htm.

National Coordinating Council for Medication Error Reporting and Prevention. "Recommendations to Correct Error-Prone Aspects of Prescription Writing." Available online at www.nccmerp.org/ council/council1996-09-04.html.

Beth Hjort *(beth.hjort@ahima.org) is a professional practice manager at AHIMA.*

Article citation:
Hjort, Beth. "On the Line." *Journal of AHIMA* 75, no.4 (April 2004): 51,53.