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Accreditation Canada Survey will take place September 19-23, 2016

In this issue, we focus on 1 of the 6 Required Organizational Practices (ROPs) related to Medication Management Standards

Medication Management Standards Newsletter

- The VCH Accreditation Medication Management Standards Advisory Group is working on Accreditation Canada's Medication Management Standards to address improvement opportunities identified from the self assessments surveys conducted during the previous year.
- These standards focus on the safe and effective management of medications; and address all aspects of the medication use process from selection to patient administration.

Required Organization Practice:
List of Do Not Use Dangerous Abbreviations, Symbols and Dose Designations

- VCH has adopted Institute for Safe Medications (Canada) "Do Not Use-Dangerous Abbreviations, Symbols and Dose Designations" list (see page 2).
- This list specifies abbreviations which are **frequently misinterpreted** and involved in harmful medication errors.
- These abbreviations should **never** be used.
- Medication orders must be written clearly and completely to convey the intentions of the prescriber.
- Quarterly AUDITS of written prescribers orders are being conducted and those who do not comply are notified.
- This DO NOT USE list can be accessed in the VA Formulary, is available as a pocket card, and is found on nursing units as a poster and as a chart insert. Additional copies can be ordered from Printing (poster-form RGNL 0018, Prescriber card-form VCH.0076, Nursing card-form VCH.RD.RH.0186.

Did you read it correctly?

- Many medication names within the same therapeutic group look and sound the same. This poses a significant risk when reading medication labels and interpreting written orders. **TALLman lettering** has been implemented in health care settings to **reduce the risk.**
- In TALLman lettering, upper case letters are used to highlight the main dissimilarities in look-alike drug names to make them visually different.
- VCH will incorporate TALLman lettering on the following:
  - -Medication Administration Records
  - -Unit-dose packaged medications
  - -Wardstock medication shelf labels on the units
  - -Medication shelf labels in pharmacy
  - -Pre-Printed Orders
  - -Omnicell machines
  - -Newsletters
- Examples of TALLman lettering (from ISMP):

azaCITIDine	azaTHIOprine
carBAMazepine	OXcarbazepine
CARBOplatin	CISplatin
ceFAZolin	cefTRIAXone
dimenhyDRINATE	diphenhydrAMINE

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Accreditation Canada Survey will take place September 19-22, 2016

Medication Management Standards Newsletter

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Do Not Use

Providence HEALTH CARE
How you want to be treated.

Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

Abbreviation	Intended Meaning	Problem	Use Instead
U	Unit	Mistaken for "0" (zero), "4" (four), or cc.	unit
IU	International unit	Mistaken for "IV" (intravenous) or "10" (ten).	unit
Abbreviations for drug names		Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO_4 (morphine sulphate), $MgSO_4$ (magnesium sulphate) may be confused for one another.	full drug names
QD QOD	Every day Every other day	QD and QOD have been mistaken for each other, or as 'QID'. The Q has also been misinterpreted as "2" (two).	daily every other day
OD	Every Day	Mistaken for "right eye" (OD = oculus dexter).	daily
OS, OD, OU	Left eye, right eye, both eyes	May be confused with one another.	left eye, right eye both eyes
D/C	Discharge	Interpreted as "discontinue whatever medications follow" (typically discharge medications).	discharge.
cc	cubic centimetre	Mistaken for "u" (units).	mL
µg	microgram	Mistaken for "mg" (milligram) resulting in one thousand-fold overdose.	mcg
Symbol	**Intended Meaning**	**Potential Problem**	**Use Instead**
@	at	Mistaken for "2" (two) or "5" (five).	at
> <	Greater than Less than	Mistaken for "7"(seven) or the letter "L" . Confused with each other.	greater than/above less than/below
Dose Designation	**Intended Meaning**	**Potential Problem**	**Use Instead**
Trailing zero	X.0 mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point: X mg
Lack of leading zero	.X mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point: 0. X mg

Adapted from ISMP Canada's "Do Not Use" List (2006) at: http://www.ismp-canada.org/dangerousabbreviations.htm

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