

Abbreviation Use in Patient Notes: Is Electronic Documentation the Way Forward?

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INTRODUCTION

Protocols for documentation have been said to improve communication between healthcare professionals, and therefore patient outcomes. However, inconsistencies in reporting by use of abbreviations have been shown to impact both interpersonal communication, and patient outcomes (1, 2). This study evaluates the use of abbreviations taking into account those that adhere to the HSE guidelines.

OBJECTIVES

The main objective of this study is to evaluate compliance of abbreviation use, against those outlined by HSE guidelines. A secondary objective is to highlight abbreviation error rates, in order to potentially improve interpersonal communication between staff. In addition this audit aims to emphasize the importance of introducing electronic documentation.

METHODS:

A prospective chart review was conducted in Temple Street Children's University Hospital from 10/7/17-25/7/17. In this single blinded audit, 28 charts were selected from each hospital ward at random. They were then assessed based on the patient's most recent hospital admission. Each chart was anonymised and assessed for four abbreviation errors. These abbreviations included; left or right, up or down, < or > and + or -. We examined the appropriateness of the abbreviations in addition to the frequency of use. Appropriate abbreviation use was defined using the HSE guidelines (3).

RESULTS

Review of 28 charts in the Temple Street Children's Hospital showed that all charts contained abbreviations (Fig. 1), of which only 7% were used appropriately (Fig. 2) according to the HSE guidelines on abbreviation use (3). This 7% was confined to the use of '+' or '-' which related only to biochemical results of urine and blood analyses. All others were inappropriate.

Figure 1: Bar chart depicting percentage of patients notes containing abbreviations.

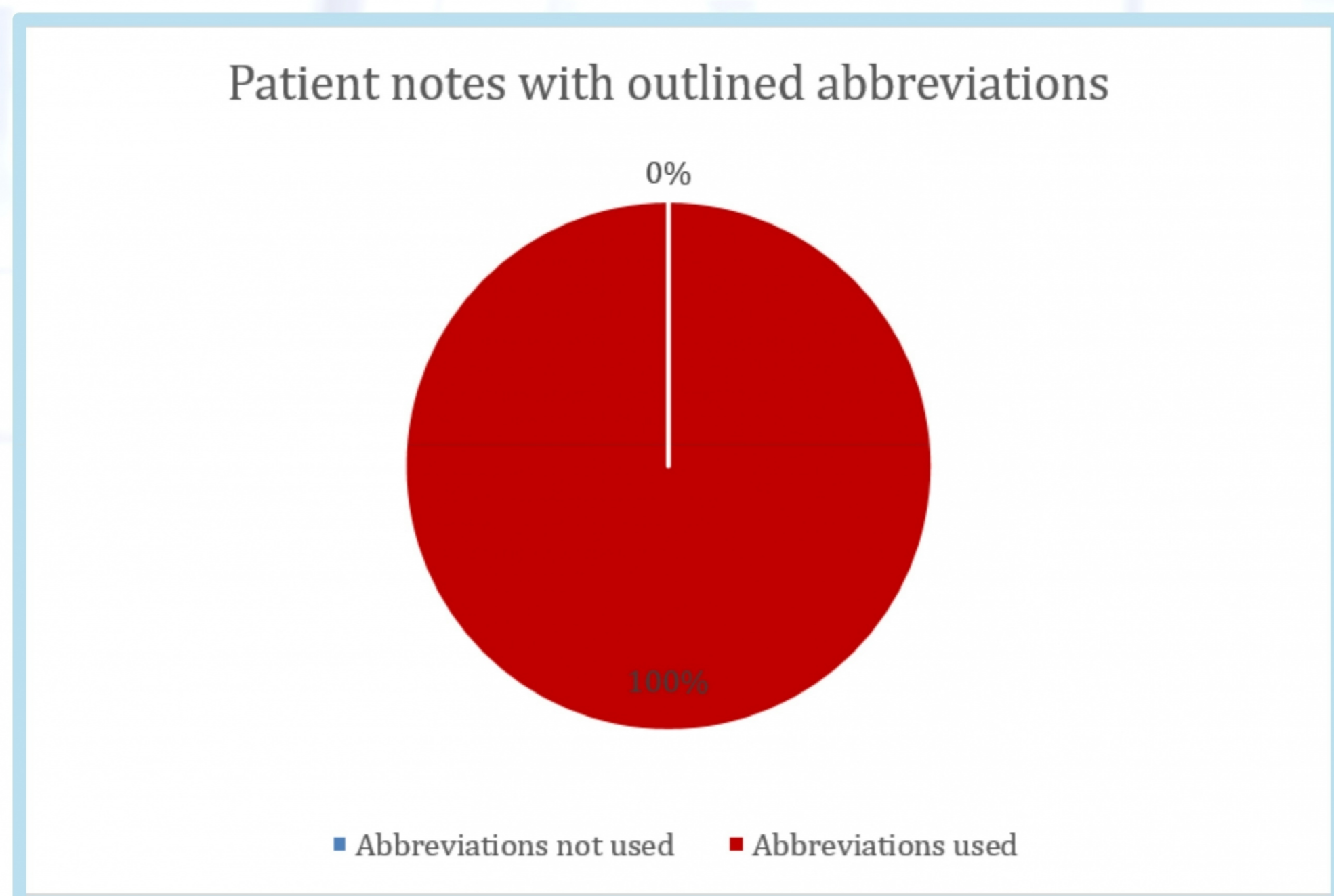
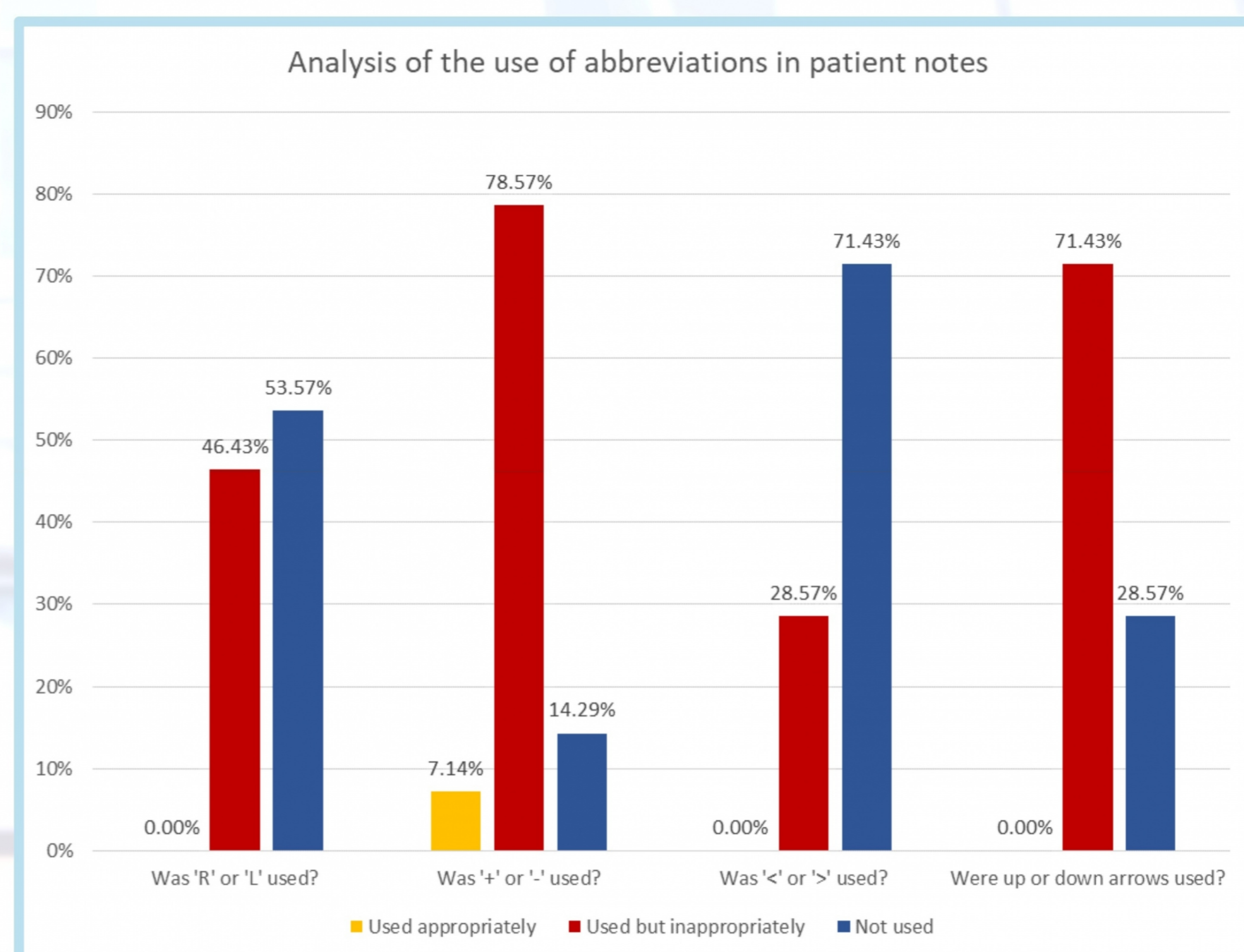


Figure 2: Bar chart depicting breakdown of abbreviation use in patients notes.



CONCLUSION

Abbreviation use was evident in patient documents. These abbreviations were deemed ambiguous, and electronic pediatric medical records are recommended.

REFERENCES

1. Capraro A, Stack A, Harper M, Kimia A. Detecting Unapproved Abbreviations in the Electronic Medical Record. The Joint Commission Journal on Quality and Patient Safety. 2012; 38(4):178-AP2.
2. Sheppard J, Weidner L, Zakai S, Fountain-Polley S, Williams J. Ambiguous abbreviations: an audit of abbreviations in paediatric note keeping. Archives of Disease in Childhood. 2008; 93(3):204-206.
3. Murphy G. Health Service Executive Code of Practice for Healthcare Records Management - Abbreviations [Internet]. 2nd ed. Health Service Executive; 2010 [cited 7 August 2017]. Available from: http://hse.ie/eng/about/Who/QID/Quality_and_Patient_Safety_Documents/abbreviations.pdf

