Open Book
Learning from close calls and adverse events

Delay due to the use of an unfamiliar acronym

This report alerts providers to the potential danger of using unfamiliar acronyms in communications between services.

In this case, the use of an unfamiliar acronym resulted in a delay for a patient receiving an urgent diagnostic test to inform treatment decisions. It highlights the risk of using service-specific language in communications between different services involved in a patient's care.

This report is relevant to:

- quality and patient safety staff in hospitals and primary care
- managers responsible for booking services
- all clinicians sending and receiving referrals between different services.

Incident

A patient's MRI scan was delayed because of the use of an unrecognised acronym.

Chronology

- The acronym 'HSCAN' ('high suspicion of cancer') was introduced in 2012 for use by GPs when referring cases requiring urgent triage priority to cancer specialists. It is a well-known acronym within this specialty group, but not intended for use elsewhere.
- Following an ultrasound scan, patient A was referred by his GP for an orthopaedic opinion. The GP used the acronym 'HSCAN' on the referral to signify the urgency.
- The orthopaedic consultant who reviewed the referral immediately completed a referral for an MRI scan, using 'HSCAN' as the level of priority.
- The referral was triaged in the radiology department and an MRI was subsequently performed as a priority 2 case (priority 2: to be performed within 1–3 months of receipt of referral).

Review findings

- The orthopaedic consultant assumed the acronym 'HSCAN' was widely understood, and therefore did not write 'Urgent' on the referral, or anything else to indicate there was a high level of urgency.
- The acronym 'HSCAN' was not officially used in the hospital's radiology triage or referral process.
- The MRI provider who received the referral was unfamiliar with the acronym 'HSCAN' as meaning the need for an immediate response.

Actions subsequently taken

- A structured internal referral process is to be developed and implemented. This will encourage use of consistent terminology and adequacy of clinical information.
- A project team was established to review the referral process.

Cont. over

Health Quality & Safety Commission comment

- Allocating patients a priority level (for receiving health care) is always a critical step. For the process to be reliable, staff must adhere to precise business rules designed to minimise system failure due to human factors.
- All information necessary to inform the triage process must be included on referrals.
- Be aware acronyms are not always understood across different specialties involved in a patient's journey through the health care system.
- Providers are advised to review their guidance on use of terminology and accepted acronyms.
- Close the communication loop when a referral is received. Advise the referrer that the referral has been received and the anticipated timeframe for the procedure. This provides a back-up system for referrers, and helps them identify any issues relating to triage decisions.