Do Not Use Abbreviations

Do Not Use Abbreviations

1. Introduction
2. Purpose/Overall Goal
3. Course Objectives
4. Abbreviations Overview
5. Official “Do Not Use” List
6. Additional Abbreviations, Acronyms, and Symbols
7. Conclusion

NA: 1
NA: 1
NA: 1
NA: 2
NA: 3
NA: 4
NA: 5
INTRODUCTION

Using abbreviations can lead to misunderstandings and miscommunications between prescribers and other members of the healthcare team, including pharmacists and nurses. It may result in incorrect medications being given to patients.

To help reduce the numbers of medical errors related to incorrect use of terminology, The Joint Commission (TJC) has issued a list of abbreviations, acronyms, and symbols that should no longer be used in the healthcare setting.

TJC wants to ensure that any terms on the list of dangerous abbreviations are not found in handwritten clinical documentation.

PURPOSE/OVERALL GOAL

This module provides the Official “Do Not Use” list, along with additional abbreviations, acronyms and symbols that could be misinterpreted.

The goal of this module is to ensure that you as a healthcare provider are aware of the abbreviations that should not be used, the reasons why they should be avoided, and what should be used in their place.

COURSE OBJECTIVES

After completing this module, the learner should be able to:

1. Explain why certain abbreviations should not be used
2. Describe The Joint Commission’s Official “Do Not Use” List of abbreviations
3. Describe additional abbreviations, acronyms, and symbols that are identified as problematic
ABBREVIATIONS OVERVIEW

Most errors are caused by relatively few abbreviations, including:
- QD (once daily)
- U (units)
- cc (milliliter)
- MSO4 or MS (morphine sulfate)
- HS (at bedtime)

In addition, decimal errors (for example, no leading zero or a trailing zero) are also troublesome.

A “minimum list” of dangerous abbreviations, acronyms and symbols has been approved by The Joint Commission (TJC). Medication orders are subject to the initiative – but so is all clinical documentation including:
- Orders
- Progress notes
- Consultation reports
- Operative reports
- Educational materials
- Protocols/pathways

The Joint Commission’s “Do Not Use” List is part of the Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future.

Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols, and dose designations from the software.
**OFFICIAL “DO NOT USE” LIST**

Below is The Joint Commission’s Official “Do Not Use” List of abbreviations. This list applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

<table>
<thead>
<tr>
<th>DO NOT USE</th>
<th>POTENTIAL PROBLEM</th>
<th>USE INSTEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number “10” (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod (every other day)</td>
<td>Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate Confused for one another</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO4 and MgSO4</td>
<td></td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may NOT be used in medication orders or other medication-related documentation.
## ADDITIONAL ABBREVIATIONS, ACRONYMS, AND SYMBOLS

Below are additional abbreviations, acronyms, and symbols that The Joint Commission has identified as problematic. These are being considered for possible future inclusion in the Official “Do Not Use” List.

<table>
<thead>
<tr>
<th>DO NOT USE</th>
<th>POTENTIAL PROBLEM</th>
<th>USE INSTEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; (greater than)</td>
<td>Misinterpreted as the number “7” (seven) or the letter “L”</td>
<td>Write “greater than”</td>
</tr>
<tr>
<td>&lt; (less than)</td>
<td>Confused for one another</td>
<td>Write “less than”</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td>Misinterpreted due to similar abbreviations for multiple drugs</td>
<td>Write drug names in full</td>
</tr>
<tr>
<td>Apothecary units</td>
<td>Unfamiliar to many practitioners</td>
<td>Use metric units</td>
</tr>
<tr>
<td>@</td>
<td>Mistaken for the number “2” (two)</td>
<td>Write “at”</td>
</tr>
<tr>
<td>cc</td>
<td>Mistaken for U (units) when poorly written</td>
<td>Write “ml” or “milliliters”</td>
</tr>
<tr>
<td>qg</td>
<td>Mistaken for mg (milligrams) resulting in one-thousand-fold overdose</td>
<td>Write “mcg” or “micrograms”</td>
</tr>
</tbody>
</table>
CONCLUSION

The magnitude of harm due to abbreviations and other shorthand notations such as acronyms and symbols is not entirely clear – but these types of errors are known to happen.

By following The Joint Commission guidelines, and by being aware of abbreviations that can be misinterpreted, you can help ensure safety of the patients in your care.

REFERENCES: