**Dangerous Abbreviations**

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In 2002, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) approved their first National Patient Safety Goals. A portion of these safety goals includes recommendations to improve communication among caregivers with a focus on eliminating the use of dangerous abbreviations, acronyms, and symbols. Facilities seeking accreditation have been asked to develop a list of prohibited abbreviations ("Do not use" list). Beginning January 1, 2004, these healthcare facilities must include in their "Do not use" list specific abbreviations prohibited by JCAHO. Additional abbreviations (three or more), chosen by the institution, should be used to expand the list. The following chart contains examples of abbreviations that can cause errors and compromise patient safety, including JCAHO's "Do not use" list. The Joint Commission's complete 2004 safety goals are available at www.jcaho.org.

| Abbreviation | Intended Meaning | Potential Error | Recommendation |
|---|---|---|---|
| **Abbreviations to avoid (JCAHO-mandatory)[1]** | | | |
| U | Unit | Misread as "0", "4", or "cc" | Write "unit" |
| IU | International unit | Misread as IV (intravenous) or "10" | Write "international unit" |
| q.d., Q.D. | Every day | Misread as four times daily (qid) | Write "daily" |
| q.o.d., Q.O.D. | Every other day | Misread as daily (q.d.) or four times daily (qid) | Write "every other day" |
| X.0 mg | X mg | Decimal point is missed | Never write a "0" by itself after a decimal point |
| .X mg | 0.X mg | Decimal point is missed | Write "0" before a decimal point |
| MS | Morphine sulfate | Confused for magnesium sulfate | Write "morphine sulfate" |
| $MSO_4$ | Morphine sulfate | Confused for magnesium sulfate | Write "morphine sulfate" |
| $MgSO_4$ | Magnesium sulfate | Confused for morphine sulfate | Write "magnesium sulfate" |
| **Suggested abbreviations to avoid (JCAHO-optional)[1]** | | | |
| µg | Microgram | Misread as milligram (mg) | Write "mcg" |
| H.S. | Half-strength or at bedtime | Misread as the opposite intended; if written "qH.S." misread as every hour | Write out "half-strength" or "at bedtime" |
| T.I.W. | Three times a week | Misread as three times a day or twice weekly | Write "three times weekly" |
| S.C. or S.Q. | Subcutaneous | Misread as "SL" for sublingual, or "5 every" | Write "Sub-Q", "subQ", or "subcutaneously" |

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|---|---|---|---|
| D/C | Discharge | Misread as "discontinue" whatever meds follow (i.e., discharge meds are discontinued) | Write "discharge" |
| c.c. | Cubic centimeter | Misread as "U" (units) | Write "mL" for milliliters |
| A.S., A.D., A.U. | Left, right, or both ears | Misread as OS, OD, OU (left, right, or both eyes) | Write "left ear," "right ear," or "both ears" |
| O.S., O.D., O.U. | Left, right, or both eyes | Misread as AS, AD, AU (left, right, or both ears) | Write "left eye," "right eye," or "both eyes" |
| **Examples of other abbreviations to avoid**[2,3,4] | | | |
| / | Separate doses or "per" | Misread as the numeral "1" | Write "per" |
| + | "Plus" or "and" | Misread as the numeral "4" | Write "and" |
| q 6PM, etc. | Nightly at 6 PM | Misread as every 6 hours | Write "nightly at 6 PM" |
| x3d | For three days | Misread as for three doses | Write "for three days" |
| >,< | Greater or less than | Misread as the opposite | Write "greater than" or "less than" |
| ss | One-half or sliding scale (insulin) | Misread as "55" | Write "1/2" or "one-half;" write "sliding-scale" |
| AZT | Zidovudine (*Retrovir*) | Mistaken as azathioprine | Write full drug name |
| CPZ | *Compazine* (prochlorperazine) | Mistaken as chlorpromazine | Write full drug name |
| MTX | Methotrexate | Mistaken as mitoxantrone | Write full drug name |
| TAC | Triamcinolone | Mistaken as tetracaine, *Adrenalin*, cocaine | Write full drug name |
| qn | Nightly or at bedtime | Misread as "qh" (every hour) | Write "nightly" |
| IN | Intranasal | Misread as "IV" (intravenous) or "IM" (intramuscular) | Write "intranasal" |

***References***


1. Joint Commission on Accreditation of Healthcare Organizations. 2004 National Patient Safety Goals-FAQs (Updated November 3, 2003). http://www.jcaho.org/accredited+organizations/patient+safety/04+npsg/04_faqs.htm. (Accessed November 6, 2003).

2. Anon. Special issue-do not use these dangerous abbreviations or dose designations. Institute for Safe Medication Practices. http://www.ismp.org/msaarticles/specialissuetablePrint.htm. (Accessed November 14, 2003).
3. Burson SC. Medication errors in pharmacy: an update. Ohio Pharmacists Association. http://www.ohiopharmacists.org/opaeducation.html.
4. Cohen MR. ISMP medication error report analysis: hazardous abbreviation for "intranasal." *Hospital Pharmacy* 2003;38:1004-5.

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