

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"

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 (<i>Retrovir</i>)	Mistaken as azathioprine	Write full drug name
CPZ	<i>Compazine</i> (prochlorperazine)	Mistaken as chlorpromazine	Write full drug name
MTX	Methotrexate	Mistaken as mitoxantrone	Write full drug name
TAC	Triamcinolone	Mistaken as tetracaine, <i>Adrenalin</i> , 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).

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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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