MCMC MID-COLUMBIA MEDICAL CENTER	**Mid-Columbia Medical Center** 1700 East 19th Street The Dalles, OR 97058	*Department:* Health Information Management *Source:* Medical Consultants

Title:

MEDICAL ABBREVIATIONS POLICY

Approved by:	*Origination Date:*	*Reviewed:*	*Revised:*
	11/76	3/83, 9/84, 11/85, 4/86, 6/87, 4/89, 01/07, 01/09, 7/15	7/83, 6/85, 01/88, 5/91, 12/97, 10/00, 6/03, 11/03, 4/04, 3/16, 5/16

Abbreviations save time and effort and are commonly used as a convenience in medical documentation. But abbreviations are often misread or misinterpreted, which can result in patient harm.

In the interest of patient safety, Mid-Columbia Medical Center (MCMC) has adopted an abbreviation policy that includes a list of unapproved abbreviations and symbols to guide documentation and the interpretation of handwritten notes. This list of dangerous abbreviations and symbols should not be used, as they have been found to create confusion and could compromise patient safety.

Abbreviation Policy:

1. Abbreviations, symbols and/or initials are not allowed in recording the final diagnosis.
2. A list of commonly used abbreviations can be found in Neil Davis' book *Medical Abbreviations: 32,000 Conveniences at the Expense of Communication and Safety*, www.medabbrev.com. Also acceptable are abbreviations found in *The Charles Press Handbook of Current Medical Abbreviations.*
3. Abbreviations on the dangerous abbreviations list should not be used. Written reminders will be sent to staff and practitioners who continue to use abbreviations that can potentially lead to medication errors.
4. Staff will call and verify any orders that cannot be clearly interpreted or have the possibility of having two different meanings.
5. Printed forms: as a guide any abbreviations must be spelled out the first time used, or must be listed in a key on the form. Dangerous abbreviations are prohibited on printed forms.
6. Abbreviations cannot be used on Informed Consent forms.
7. Apothecary symbols should not be used; instead, use the metric system.
8. Abbreviations may have multiple meanings. If there is potential for confusion, spell out the word.

Dangerous Abbreviations and Why They Should be avoided:

Medication management is a complex process, involving multiple caregivers and multiple steps across four principal stages – ordering, preparation, administration and monitoring - each susceptible to error. Studies have shown that 49% of medication errors originate in the ordering phase and that many are due to orders that are illegible, incomplete or unclear.

Physician orders are the basic written communication tool for patient care. What an order says, or is interpreted to say, directly impacts the care of the patient. In carrying out an order, there are many "handoffs" by physicians, nurses, pharmacists and other health care professionals. If it is not written clearly, each individual who acts on the order may interpret it a different way. Most importantly, errors can occur when orders are misinterpreted.

To reduce the chance for error, prescribers must not use dangerous abbreviations and must include the required elements in all medication orders.

OFFICIAL DO NOT USE LIST

Applies to all orders and all medication related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

Dangerous Abbreviation/Symbol	Why this is dangerous to use	What is recommended practice
U (for unit)	Mistaken as "0"(zero), the number "4" (four) or c.c.	Write "unit".
IU (International Unit)	Mistaken for IV (Intravenous) or the number 10 (ten)	Write "International Unit"
Trailing zero (X.0 mg)*	Decimal point is missed	Never write a zero by itself after a decimal point (X mg)
Lack of leading zero (.X mg)	Decimal point is missed	Always use a zero before a decimal point (0.X mg)
Q.D. QD q.d. qd (daily)	Can be mistaken for Q.O.D. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for an "I".	Write out word "daily"
Q.O.D. QOD q.o.d. qod (every other day)	Can be mistaken for Q.D.	Write "every other day"
MS	Confused with "$MgSO_4$"	Write "morphine sulfate"
MSO_4	Confused with "$MgSO_4$"	Write "morphine sulfate"
$MgSO_4$	Confused with "MS" or "MSO_4"	Write "magnesium sulfate"

* Exception: A "trailing zero" may be used only when 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

Practice Standards for Physician Orders:

1. **BE CAREFUL WITH DECIMALS -** Ten-fold errors in drug strength and dosage have occurred with decimals due to the use of a trailing zero (1.0 mg) or the absence of a leading zero (.5 mg). A terminal or trailing zero should NEVER be used after a decimal and a leading zero should always precede a decimal expression of less than one.
2. **VERBAL ORDERS** - Communicate verbal orders clearly and succinctly. Have the person on the receiving end REPEAT back the order to you to ensure that the order is taken correctly.
3. **CHANGE AN ORDER** - Correcting erroneous orders the right way is important. Cross out the entire order and REWRITE IT. Initial beside the erroneous order along with the word "error" and date. In the electronic health record, use the amendment process.
4. **ADD AN ORDER** - If you need to ADD an additional order AFTER you have written orders and completed that section of the order sheet, BEGIN A NEW ORDER SECTION.
5. **DISCONTINUE AN ORDER** - Every action on a patient's medication profile requires an order, so BE EXPLICIT in your order writing. If an action such as discontinuation is required, write it out. DO NOT ASSUME an action will be taken if it is not ordered.