Subject:	Section:	Policy Number:	Page:
PROHIBITED ABBREVIATIONS, ACRONYMS, AND SYMBOLS	Quality Management	QM 100	1 of 4
	Application: System Wide		Date of Issue: August 2022
	Contact Person: Director, Accreditation Compliance		Supersedes: August 2020
Recommended: Signature Pending Joann M. Sanders, M.D. Chief Quality Officer	Approved: Signature Pending Rick W. Merrill President and Chief Executive Officer		
Source of Policy: Accreditation: The Joint Commission (TJC)	Review: Initial/Date		

PURPOSE

To specify the list of prohibited abbreviations, acronyms, and symbols for all handwritten/ electronic entry / dictated, typed and preprinted patient-specific communications and stipulate the additional following requirement.

Recommended abbreviations are referenced in Neil Davis medical abbreviations. The link is located on the Library Online Resources page:
Davis, Neil M. *MedAbbrev.com* https://www.medabbrev.com/

Cook Children's Health Care System (CCHCS) maintains a list of abbreviations not approved for all handwritten, electronic entry, dictated, typed, and preprinted patient-specific communications (progress notes, nursing notes, operative / anesthesia notes, orders, prescriptions pre-printed forms, etc.) because of the potential for misinterpretation:

A. All handwritten patient-specific communications must be legible.

B. All handwritten / typed patient-specific communications must be written using the metric system except therapies that use standard units such as insulin and vitamins.

C. A leading zero must always precede a decimal expression of less than one. A terminal or trailing zero should never be used after a decimal.

D. Prescriptions in the outpatient practice setting will be written in accordance with the CCHCS approved abbreviations.

POLICY

The following abbreviations **may not** be used on handwritten / electronic entry / dictated, typed, and preprinted patient-specific communications because of the potential for misinterpretation.

The following have great potential for miscommunication and are not approved:

Abbreviations not approved for all handwritten/ electronic entry / dictated, typed, and preprinted, patient-specific communications (progress notes, nursing notes, operative / anesthesia notes, orders, pre-printed forms, etc.) because of the potential for misinterpretation are:

ABBREVIATION	POTENTIAL PROBLEM	PREFERRED TERM
U, u (for unit)	Mistaken as zero, four or cc	Write “unit”
IU, iu (for international unit)	Mistaken as IV (intravenous) or 10 (ten)	Write “International Unit”
Q.D., QD, q.d., qd (for every day)	Mistaken for each other. The period after the Q can be mistaken for an “I”	Write “daily”
Q.O.D., QOD, q.o.d, qod (for every other day)	Mistaken for each other. The period after the Q can be mistaken for an “I” and the “o” can be mistaken for “I”	Writer “Every Other Day”
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 (.Xmg)	Decimal point is missed	Always use a zero before a decimal point (0.X mg)
MS, ms	Confused for another. Can mean morphine sulfate or magnesium sulfate	Write “Morphine Sulfate”
MSO4, mso4	Confused for another. Can mean morphine sulfate or magnesium sulfate	Write “Morphine Sulfate”
MGSO4, mgso4	Confused for another. Can mean morphine sulfate or magnesium sulfate	Write “Magnesium Sulfate”

The following have great potential for miscommunication and **are strongly discouraged due to potential for harm:**

ABBREVIATION	POTENTIAL PROBLEM	PREFERRED TERM
ug (for microgram)	Mistaken for mg (milligrams) resulting in ten-fold dosing overdose	Write “mcg”
H.S. (for half-strength or Latin abbreviation for bedtime)	Mistaken for either half-strength or hour of sleep. (at bedtime). q.H.S. mistaken for every hour. All can result in dosing error	Write out “half-strength” or at bedtime
T.I.W (for three times a week)	Mistaken for three times a day or twice weekly resulting in an overdose	Write “3 times weekly” or “three times weekly”

ABBREVIATION	POTENTIAL PROBLEM	PREFERRED TERM
S.C or S.Q (for subcutaneous)	Mistaken as SL for sublingual, or "5 every"	Write "Sub-Q", "sub-Q", or "subcutaneously"
c.c. (for cubic centimeter)	Mistaken for U (units) when poorly written	Write "ml" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears) O.S., O.D, O.U. (Latin abbreviation for left, right, or both eyes)	Mistaken for each other (e.g. AS for OS, AD for OD, AU, for OU, etc.)	Write: "left ear", "right ear", or both ears; "left eye", "right eye". or "both eyes"

The safest practice is to not use abbreviations for drug names.

The following have great potential for miscommunication and **are strongly discouraged due to potential for harm:**

Abbreviation	Medication
Barb	Phenobarbital
DHP	Dilantin
CTC	Curare
GG	Gamma Globin
Hep	Heparin
HL	Hickman Line
I2	Iodine
INH	Isoniazid
Lido	Lidocaine
Na Pent	Sodium Pentothal
PU	Iv push
PZI	Protamine Zinc Insulin
Succ	Anectine
Sux	Anectine
OB	Phenobarbital
CMZ	Tegretol
ESM	Zarontin
FBM	Felbatol
Klon	Klonopin
Meb	Mebaral
Mys	Mysoline
Obarp	Phenobarbital
PB	Phenobarbital
Prim	Primidone
VPA	Depakote

References:

Davis< Neil M. Medicalabbrev.com

The Joint Commission (TJC) July 1, 2022 IM.02.02.01 EP 2 & 3

End of Policy