COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Unacceptable Abbreviations		**DRM-047**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	Institute for Safe Medication Practices	

SCOPE

It is the policy of Mangum Regional Medical Center to follow the "Do Not Use" list of abbreviations recommended by the ISMP (Institute for Safe Medication Practices) and The Joint Commission to improve patient safety and outcomes.

PURPOSE

To define abbreviations that have been proven to be a safety risk when used and to avoid the use of "dangerous" abbreviations, acronyms and symbols in clinical documentation (including order forms, progress notes, and consultation reports).

POLICY

To improve the effectiveness of communication among caregivers, the following list of unacceptable abbreviations will be maintained and followed. These unacceptable abbreviations should **NEVER** be used when communicating medical information including but not limited to: internal communications, telephone/verbal orders, computer-generated labels for drug storage bins, medication administration records, preprinted forms, medication-related documentation and transcribed reports, either hand-written or within the electronic medical record system.

PROCEDURE

A. The use of abbreviations is discouraged at MANGUM REGIONAL MEDICAL CENTER. The abbreviations listed in attachment A are **not** to be used.
B. It is the responsibility of the Medical Staff Committee to approve the "Do Not Use" abbreviation list for use at MANGUM REGIONAL MEDICAL CENTER.
C. Unacceptable abbreviations cannot be used in any of its form, that is, upper or lower case; with or without periods.
D. If a prescribing physician or mid-level provider utilizes an unacceptable abbreviation, the physician or mid-level provider must be contacted by the licensed care provider and the

treatment order clarified before it is acted on. If the Pharmacy receives the order before it is clarified, the Pharmacist will contact the prescribing physician or mid-level provider to have it clarified.

E. In the event an unacceptable abbreviation IS used and in the judgement of the licensed care provider, the delay in clarifying the order with the prescribing physician or mid-level provider would put the patient at greater risk, the order should be carried out and the clarification obtained as soon as possible thereafter.

F. A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as 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.

G. Abbreviations should not be used on consents. Appropriate medical terminology should be used to describe the procedure to which the patient is consenting. Abbreviations **WILL NOT** be used on any consent form to distinguish laterality.

H. The use of other abbreviations ("approved abbreviations") for the purpose of standardizing terminology, definitions, vocabulary, and nomenclature is allowed if the use of the abbreviation(s) is considered customary in the scope of the service and/or discipline and the abbreviation(s) does not pose the potential for miscommunication or compromising patient safety. An "approved abbreviations" list **MAY** be created/maintained by a department/discipline if deemed necessary/beneficial. When writing an abbreviation, evaluate the context in which it is used.

I. Additional guidelines/recommendations:

1. The use of symbols is discouraged.
2. Do **not** abbreviate drug names, especially when communicating medical information (i.e. APAP, HCI, HCTZ, TNK, Vanc or tPA, etc.).
3. It is preferred that the Metric system be used for writing dosages.
4. Always use a space between drug name, dose, and unit of measure.
5. "Left" and "Right" are to be spelled out on all consent forms, and procedural records.

PROHIBITED ABBREVIATIONS	INTENDED MEANING	MISINTRPRETATION	CORRECT USE
IU	International unit	Misread as IV (intravenous) Or the number "10" (ten)	Write **"international unit"**
ug	Microgram	Mistaken for "mg" when handwritten	Use **"mcg"**
Q.D., QD, q.d., qd	Every Day Daily	Mistaken for each other. Misread as "q.i.d." especially if the period after the "q" or tail of the "q" is misread as an "i"	Write **"daily"**
Q.O.D., QOD, q.o.d., qod	Every other day	The "O" can be mistaken for "i"	Write **"every other day"**
U or u	Unit	Misread for "0" (zero), The number "4" (four) or "cc".	Write **"unit"**
Apothecary symbols	Dram Minim	Misunderstood or misread (symbol for dram misread for "3" and minim misread as "mL")	Use the metric system
Trailing zero	X.0 mg	Decimal point is missed or not visible, leading to an inaccurate dose.	Do not use **terminal zeros** for doses expressed in whole numbers
Lack **of leading zero**	.X mg	Decimal point is missed or not visible, leading to an inaccurate dose.	Always use **zero** before a decimal point when the dose is less than a whole unit
MS MSO4 MgSO4	Morphine Or Magnesium Sulfate	Confused for one another.	Write **"Morphine sulfate"** OR **"Magnesium sulfate"**
SC, SQ, sub q	Subcutaneous	Mistaken as SL (sublingual). Mistaken as "5 every" the "q" in "sub q" has been mistaken as "every".	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or ½ (apothecary)	Mistaken for "55"	Spell out "sliding scale" Use "one-half" or "1/2"
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken for Strong Solution of Iodine (Lugol's)	Spell out "sliding scale (insulin)"

RESPONSIBILITIES

A. It is the responsibility of the Medical Record Department to coordinate the review of the list of abbreviations by the Hospital and Medical Staff.
B. All Mangum Regional Medical Center personnel responsible for documenting in the patient medical record will abide by the list of unacceptable abbreviations.

REFERENCES

The Joint Commission (2019). Official "Do Not Use" List Fact Sheet. [Electronic Version] Retrieved on 07/15/19 from www.jointcommission.org/facts_about_do_not_use_list/

Institute for Safe Medication Practices (2015). ISMP's List of Error-Prone Abbreviations, Symbols and Dose Designations. [Electronic Version] Retrieved on 07/15/19 from www.ismp.org

REVISIONS/UPDATES

Date	Brief Description of Revision/Change