

OPERATING POLICY & PROCEDURE

TITLE: Prohibited Abbreviations

NUMBER: 01-02-45

POLICY:

The National Coordinating Council for Medication Error Reporting and Prevention emphasizes that illegibility of prescriptions and medication orders has resulted in injuries to, or deaths of patients. The following abbreviations and practices are prohibited from use in patients' medical records to help minimize errors.

PROCEDURE:

1. The following list of abbreviations is prohibited at \_\_\_\_\_. Please utilize the correct terminology as indicated below.

PROHIBITED ABBREVIATION LIST

Abbreviation: "U"  
Intended Meaning: Units  
Common Errors: Mistaken as a zero (0), four (4) or cc  
Utilize: Write "unit"

Abbreviation: "IU"  
Intended Meaning: International unit  
Common Errors: Mistaken as IV (intravenous) or ten (10)  
Preferred Term: Write "International unit"

Abbreviation: Q.D. or Q.O.D.  
Intended Meaning: Once daily and every other day  
Common Errors: Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I"  
Preferred Term: Write "daily" and "every other day"

Abbreviation: Trailing zero (X.0 mg), Lack of leading zero (.X mg)  
Common Errors: Decimal point is missed.  
Preferred Term: Never write a zero by itself after a decimal point (X mg) and always use a zero before a decimal point (0.X mg)

Abbreviation: MS MS04 MgSO4  
Intended Meaning: Morphine Sulfate and Magnesium Sulfate  
Common Errors: Confused for one another.  
Preferred Term: Write "morphine sulfate" or "magnesium sulfate"

Abbreviation: T.I.W.  
Intended Meaning: Three (3) times a week  
Common Errors: Mistaken for three times a day or twice weekly resulting in an overdose.  
Preferred Term: Write "3 times weekly" or "three times weekly"

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EFFECTIVE DATE: NEXT REVIEW DATE: 02/06; Ey 2 yrs  
AUTHORIZED BY: REVIEWED BY:  
SOURCE:  
DATE(S) REVIEWED:  
NO. AND DATE REVISED:

Abbreviation: S.C. or S.Q.  
Intended Meaning: Subcutaneous  
Common Errors: Mistaken as SL for sublingual or "5 every"  
Preferred Term: Write "Sub-Q", "subQ", or "subcutaneously"

Abbreviation: c.c.  
Intended Meaning: Cubic centimeter  
Common Errors: Mistaken for U (units) when poorly written  
Preferred Term: Write "ml" for milliliters

2. To be compliant with not using the prohibited abbreviations, these must ultimately not be written in any portion/section of the chart. However, if these abbreviations are accidentally used, HOSPITAL Pharmacy and Nursing has developed a procedure to handle these orders:

- Orders containing these abbreviations are not considered valid and prior to medication dispensing MUST be clarified with the physician and a clarification order written in the patient's chart.

- Telephone physician orders are an acceptable means of clarification but the physician MUST be contacted.

- Medications may be dispensed without a clarification ONLY if the pharmacist and nurse both agree that the order is clear/accurate and that delay of the medication would cause patient harm.

- \* This is accomplished via verbal communication between the nurse and pharmacist, which must be documented by the nurse in the patient's chart (include pharmacist name and that said order is clear and urgent/emergent) and by the pharmacist in the patient's medication profile (include nurse name and that said order is clear and urgent/emergent).

- \* After a medication is dispensed urgently/emergently, a clarification order must still be obtained within a clinically reasonable timeframe.

- The key is to prevent the abbreviations from being written and to catch physicians before they depart from the patient care area. Nurses and Unit Secretaries will have the best opportunity in this area. Unit Secretaries should be advised to review orders for these abbreviations PRIOR to faxing to pharmacy.

The procedure for clarifying these orders containing prohibited abbreviations is as follows:

I. The pharmacist will call the nurse on all orders that contain a prohibited abbreviation.

II. The nurse will contact the physician and obtain a clarification order (which may be written as verbal or telephone order and titled "Clarification Order for") within a clinically appropriate time frame. This should be done prior to dispensing medications unless the delay of medication administration by obtaining the clarification would cause patient harm.

III. If the nurse and the pharmacist collaboratively determine that the patient would be compromised by delay of the medication, the medication may be dispensed immediately (first dose antibiotics, stat magnesium or morphine, etc.) provided:

- a. The pharmacist and nurse both verbally agree the order is clear.
- b. The pharmacist documents the conversation in the patient's medication profile (including nurse name and that said order is clear and urgent/emergent) and then dispenses the medication.
- c. The nurse documents the conversation in the patient's chart (including pharmacist name and that said order is clear and urgent/emergent) and then administers the medication.
- d. The nurse then contacts the physician and obtains a clarification order (which may be written as verbal or telephone order and titled "Clarification Order for") within an appropriate time frame.

IV. The pharmacist will maintain copies of the orders that have not been clarified. Problem orders will be highlighted and urgent medication dispensing will be documented on the copy. The pharmacist will contact the nurse on any orders that have been not been clarified in a clinically appropriate time frame.

EXAMPLE:

Order written for "Pepcid 20 mg po qd"

- \* Nursing will call the prescribing physician to clarify the above order
- \* Order will be clarified and re-written as follows: Clarification of above Pepcid order. Order should be:  
"Pepcid 20 mg po once daily", T.O. from Dr.\_\_\_\_\_/nurse signature.
- \* The order can be sent/faxed to pharmacy
- \* Pharmacy will fill the order

3. The Pharmacy Department, along with the P&T Committee, will identify medications with the potential for look-alike and sound-alike medication errors. Warnings will be tagged to those medications in the Meditech pharmacy dictionary. If necessary, visual warnings (e.g. stickers or special packaging) will be applied to products on the shelves.

REFERENCES:

1. National Coordinating Council for Medication Error Reporting and Prevention. Web site. Dangerous Abbreviations. Available at <http://www.nccmerp.org>.