Abbreviations Policy
Org Wide Chapters – Information Management and Record of Care
University of Utah Hospitals and Clinics Standard

PURPOSE:

A. To provide/improve accurate communication among health care providers at University Health Care by providing a standard abbreviation process and defining a list of “Do Not Use” abbreviations.

SCOPE:

A. University of Utah Hospitals & Clinics, Orthopaedic Hospital, Huntsman Cancer Hospital, Moran Eye Center, University Neuropsychiatric Institute, Community Clinics.

POLICY:

A. The reference source for approved abbreviations at the University of Utah Hospitals & Clinics will be an on-line published abbreviations list, available on the UUHC intranet web site. http://www.medabbrev.com/
B. An abbreviation not found in this reference may be used in the body of a document if it is defined when it is first used in that document.
C. To provide Exceptional Patient Care we encourage avoidance of abbreviations in discharge summaries, final discharge orders and reports of operation.
D. Abbreviations may not be used on consent forms. Spell out each word of the operation or procedure in its entirety.
E. To provide Exceptional Patient Care and avoid the potential for confusion we encourage the process of always spelling out drug names completely.
F. Abbreviations on the “Do Not Use” list cannot be used.

Official "Do Not Use" List 1

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod</td>
<td>Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>(every other day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium</td>
<td>Write &quot;morphine sulfate&quot;</td>
</tr>
</tbody>
</table>
MSO4 and MgSO4

Write "magnesium sulfate"

Confused for one another

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

*Exception: A "trailing zero" may be used only where 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.

**IMPLEMENTATION:**

A. Medical orders that contain any abbreviation on the "Do Not Use" list will be verified for accuracy with the ordering provider prior to implementing the order.

B. Verification includes provider notification and a new order by the provider. Cross through original part of the order containing the abbreviation write "error abbreviation" and rewrite the order for LIP signature if verified over the phone.

**REFERENCES:**

1. Hospital Accreditation Standards
2. Joint Commission NPSG.02.02.01 Do Not Use-Abbreviation List
3. Institute for safe medication practices, ISMP list of error-prone abbreviations, symbols, and dose designations.

**HISTORICAL INFORMATION -**

**ORIGIN DATE:**


**OWNER:** Health Information Management; Quality and Patient Safety

**APPROVAL BODY:** Medical Board; AUTHOR: Medical Record Committee; APPROVER: CMO, CNO