Dangerous Abbreviations

The Joint Commission has focused on communication among healthcare professionals for a number of years. One aspect, which has been incorporated into their standards, is to eliminate the use of dangerous abbreviations, acronyms, and symbols.[1] Organizations seeking accreditation must develop and adhere to a list of abbreviations not to be used within the organization. These abbreviations can't be used on handwritten or computer free-text orders or medication-related documentation, or on pre-printed orders. The list MUST include the abbreviations on Joint Commission's "Do Not Use" list.[1] These abbreviations are provided in the chart below. The chart also includes abbreviations listed by the Institute for Safe Medication Practices (ISMP). Their full and most current list can be found at www.ismp.org/recommendations/error-prone-abbreviations-list. **ISMP recommends against abbreviating drug names in general**.[2]

Abbreviation	Intended Meaning	Potential Error	Recommendation
Joint Commission's "Do Not Use" List[1]			
U or u	Unit	Misread as "0," "4," or "cc"	Write "unit"
IU	International unit	Misread as IV (intravenous) or "10"	Write "international unit"
q.d., Q.D., qd, QD	Every day	Misread as four times daily (qid)	Write "daily"
q.o.d., Q.O.D., QOD	Every other day	Misread as daily (q.d.) or four times daily (qid)	Write "every other day"
X.0 mg	X mg	Decimal point is missed	Never write a "0" by itself after a decimal point
.X mg	0.X mg	Decimal point is missed	Write "0" before a decimal point
MS	Morphine sulfate or magnesium sulfate	Confused for the opposite intended	Write "morphine sulfate"
MSO_4	Morphine sulfate	Confused for magnesium sulfate	Write "morphine sulfate"
$MgSO_4$	Magnesium sulfate	Confused for morphine sulfate	Write "magnesium sulfate"

Abbreviation	Intended Meaning	Potential Error	Recommendation
Examples of other error-prone abbreviations[2-5]			
µg	Microgram	Misread as milligram (mg)	Write "mcg" or "micrograms"
>	Greater than	Misread as "7" or "less than"	Write "greater than"
<	Less than	Misread as "L" or "greater than"	Write "less than"
Drug abbreviations (e.g., TAC)	Varies	Misread as drug with similar name or abbreviation	Write entire drug name
@	At	Misread as "2"	Write "at"
c.c.	Cubic centimeter	Misread as "U" (units)	Write "mL" or "milliliters"
Apothecary units (e.g., minims, grains)	Varies	Confused with metric units; unfamiliar to some healthcare professionals	Use metric system
APAP	Acetaminophen	Not recognized as meaning acetaminophen	Write full drug name
AZT	Zidovudine (*Retrovir*)	Mistaken as azathioprine, aztreonam	Write full drug name
CPZ	*Compazine* (prochlorperazine)	Mistaken as chlorpromazine	Write full drug name
HCT	Hydrocortisone	Mistaken as hydrochlorothiazide	Write full drug name
HCTZ	Hydrochlorothiazide	Mistaken as hydrocortisone	Write full drug name
MTX	Methotrexate	Mistaken as mitoxantrone	Write full drug name
Nitro	Nitroglycerin	Nitroprusside	Write full drug name
PTU	Propylthiouracil	Mistaken as mercaptopurine	Write full drug name
IV vanc	Intravenous vancomycin	Mistaken as *Invanz*	Write full drug name

Abbreviation	Intended Meaning	Potential Error	Recommendation
Examples of other error-prone abbreviations[2-5] *continued*			
SSRI	Sliding scale regular insulin	Mistaken as selective-serotonin reuptake inhibitor	Spell out "sliding scale (insulin)"
T3	Tylenol with codeine No. 3	Mistaken as liothyronine	Write full drug name
TAC	Triamcinolone	Mistaken as "tetracaine, *Adrenalin*, cocaine"	Write full drug name
TKA	Tenecteplase (*TNKase*)	Mistaken as alteplase (*Activase*)	Write full drug name
TPA or tPA	Alteplase (*Activase*)	Mistaken as tenecteplase (*TNKase*)	Write full drug name
TXA	Tranexamic acid	Mistaken as alteplase	Write full drug name
/	Separate doses or "per"	Misread as the numeral "1"	Write "per"
H.S.	Half-strength or at bedtime	Misread as the opposite intended. If written "qH.S." misread as every hour.	Write "half-strength" or "at bedtime"
T.I.W.	Three times a week	Misread as three times a day or twice weekly	Write "three times weekly"
S.C., S.Q., sub q	Subcutaneous	Misread as sublingual (SL), "5 every," or the "q" as "every"	Write "subcut" or "subcutaneously"
D/C	Discharge	Misread as "discontinue" whatever follows (e.g., discharge meds are discontinued)	Write "discharge"
A.S., A.D., A.U.	Left, right, both ears	Misread as OS, OD, OU (left, right, both eyes)	Write "left ear," "right ear," "both ears"
O.S., O.D., O.U.	Left, right, both eyes	Misread as AS, AD, AU (left, right, both ears)	Write "left eye," "right eye," "both eyes"
UD	Use as directed	Misread as unit dose	Write "as directed"
+	"Plus" or "and"	Misread as the numeral "4"	Write "and"
q 6PM, etc.	Nightly at 6 PM	Misread as every 6 hours	Write "nightly at 6 PM"

Abbreviation	Intended Meaning	Potential Error	Recommendation
Examples of other error-prone abbreviations[2-5] *continued*			
x3d	For three days	Misread as for three doses	Write "for three days"
ss	One-half or sliding scale (insulin)	Misread as "55"	Write "1/2" or "one-half"; write "sliding-scale"
qn	Nightly or at bedtime	Misread as "qh" (every hour)	Write "nightly"
IN	Intranasal	Misread as "IV" (intravenous) or "IM" (intramuscular)	Write "intranasal"
IT	Intrathecal	Mistaken for other routes of administration (e.g., intratracheal)	Write "intrathecal"
QM, QW, etc	Every month, every week, etc	Mistaken for other dosing intervals such as every day	Write out intended dosing interval
B-L-D	With breakfast, lunch, and dinner	May be misread as "BID" (twice daily)	Write out intended dosing interval
BT	Bedtime	Mistaken for "BID" (twice daily)	Write out intended dosing interval
IJ	Injection	Mistaken for "IV" (intravenous) or "IJ" (intrajugular)	Write "injection"
l	Liter	Mistaken for number "1"	Write "L"
ml	Milliliter	Lowercase "l" could be mistaken for number "1"	Write "mL"
K or M	Thousand	Mistaken to mean million	Write "thousand"
M or MM	Million	Mistaken to mean thousand	Write "million"
Ng or ng	Nanogram	Mistaken for "mg" (milligram) or to mean nasogastric route of administration	Write "nanogram" or "nanog"

In the U.S., report adverse drug events, product quality problems, or product use errors to the FDA MedWatch program. FDA MedWatch can be contacted at 800-FDA-1088. The MedWatch reporting form is available at https://www.accessdata.fda.gov/scripts/medwatch/index.cfm. Medication errors, preventable adverse drug reactions, close calls, and hazardous conditions may be reported to ISMP's National Medication Errors Reporting Program (ISMP MERP). The reporting form for ISMP MERP can be accessed at www.ismp.org/orderforms/reporterrortoismp.asp.

In Canada, report adverse events to Canada Vigilance at 866-234-2345 or online at www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/ar-ei_form-eng.php. Medication incidents and near misses can be reported to ISMP Canada at www.ismp-canada.org/err_ipr.htm.

Users of this resource are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.

References

1. The Joint Commission. Official "Do Not Use" list. The Joint Commission fact sheet. June 2019. https://www.jointcommission.org/standards/national-patient-safety-goals/-/media/5d62fa0f81e8459e9e156378d992b7c6.ashx. (Accessed March 15, 2021).
2. Institute for Safe Medication Practices. List of error-prone abbreviations, symbols, and dose designations. February 5, 2021. www.ismp.org/Tools/errorproneabbreviations.pdf. (Accessed March 15, 2021).
3. Anon. "IT" abbreviation misunderstood. *ISMP Medication Safety Alert!* March 7, 2013. www.ismp.org. (Accessed March 15, 2021).
4. Anon. Ambiguous abbreviation B-L-D. *ISMP Nurse AdviseERR.* April 2016. www.ismp.org. (Accessed March 15, 2021).
5. ConsumerMedSafety.org. Unsafe Medical Abbreviations. 2021. consumermedsafety.org/tools-and-resources/medication-safety-tools-and-resources/know-your-medicine/unsafe-medical-abbreviations. (Accessed March 15, 2021).

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