

# Medical terminology project



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The Medical Abbreviation Controversy The (ISMP) Institute for Safe Medication Practices and the (FDA) U. S. Food and Drug Administration have introduced a national education campaign. This campaign is an attempt to remove one of the most common but preventable sources of medication errors—the use of misinterpreted medical abbreviations.

Some symbols, abbreviations, and dosage calculations are all too often misunderstood and lead to mistakes that harm or fatally kill patients. The ISMP-FDA campaign aims to advocate safe practices in medication orders. This campaign concentrates on removing the use of error-prone abbreviations by healthcare professionals and students. ISMP and the FDA plan to accomplish this through educational materials, in professional journals, and lectures at seminars.

It is recommended by ISMP and FDA that ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations be referenced whenever medical information is being shared. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, and pharmacy and prescriber computer order entry screens, as well as product labeling, industry promotional materials, and medical publications.

Some of the abbreviations on ISMP's list are included in the current Joint Commission on Accreditation of Healthcare Organizations (JC) National Patient Safety Goal 2B, a “do not use” list of error-prone abbreviations, but ISMP's full listing includes additional medical notations that have been associated with medication errors reported to the ISMP Medication Errors Reporting Program.

The Medical Abbreviation Controversy

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Eliminating medical abbreviations would reduce errors because many abbreviations are very similar and therefore people get confused between them, however, if abbreviations were eliminated it would make it very difficult on medical professionals who would have to write out very lengthy medical terms. That's why many organizations are developing written policies stating which abbreviations should not be used and medical professionals are trained to write legible when using other abbreviations. Simple electronic prescription program can eliminate errors caused by handwriting and transcription errors, assist with dosing, and provided quick access to drug information.

Medical professionals should use abbreviations and acronyms only when you really need them. You should introduce an abbreviation or acronym by putting it in parentheses immediately after the words it stands for and you should always confirm that others correctly understand your abbreviation or acronym.

Abbreviations are acceptable in nurse's notes, progress notes and therapy notes.

Abbreviations should not be used for a doctor's order. Licensed and credentialed personnel who are trained in

abbreviations may use the acceptable abbreviations to shorten lengthy notes. The " do not use abbreviation " policy is not enough to prevent medication errors. Along with the use of the policy, proper information dissemination and adequate education of the health care members should be enhanced. All abbreviations should be standard to avoid confusion and policies should include all abbreviations that are used and add new ones promptly. A list should also be provided and should be given to all staff members that write in the medical records.

Policies should also contain how to report improper usage.

Facts about the Official “ Do Not Use” List of Abbreviations, June 6, 2011  
June 6, 2011

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its “ do not use” list of abbreviations (see next page) as part of the requirements for meeting that goal. In 2010, NPSG. 02. 02. 01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM. 02. 02. 0

Institute for Safe Medication Practices

ISMP’s List of Error-Prone Abbreviations, Symbols, and Dose Designations  
Abbreviations Intended Meaning Misinterpretation Correction

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µg Microgram Mistaken as “ mg” Use “ mcg”

AD, AS, AU Right ear, left ear, each ear Mistaken as OD, OS, OU (right eye, left eye, each eye) Use “ right ear,” “ left ear,” or “ each ear”

OD, OS, OU Right eye, left eye, each eye Mistaken as AD, AS, AU (right ear, left ear, each ear) Use “ right eye,” “ left eye,” or “ each eye”

BT Bedtime Mistaken as “ BID” (twice daily) Use “ bedtime”

cc Cubic centimeters Mistaken as “ u” (units) Use “ mL”

D/C Discharge or discontinue Premature discontinuation of medications if D/C (intended to mean “ discharge”) has been misinterpreted as “ discontinued” when followed by a list of discharge medications Use “ discharge” and “ discontinue”

IJ Injection Mistaken as “ IV” or “ intrajugular” Use “ injection”

IN Intranasal Mistaken as “ IM” or “ IV” Use “ intranasal” or “ NAS”

HS

hs

Half-strength

At bedtime, hours of sleep

Mistaken as bedtime

Mistaken as half-strength

Use “ half-strength” or “ bedtime”

IU\*\* International unit Mistaken as IV (intravenous) or 10 (ten) Use “ units”

o. d. or OD Once daily Mistaken as “ right eye” (OD-oculus dexter), leading to oral liquid

medications administered in the eye

Use “ daily”

OJ Orange juice Mistaken as OD or OS (right or left eye); drugs meant to be

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diluted in

orange juice may be given in the eye Use "orange juice"

Per os By mouth, orally The "os" can be mistaken as "left eye" (OS-oculus

sinister) Use "PO," "by mouth," or "orally" q. d. or QD\*\* Every day

Mistaken as q. i. d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i"

Use "daily"

qhs Nightly at bedtime Mistaken as "qhr" or every hour Use "nightly"

qn Nightly or at bedtime Mistaken as "qh" (every hour) Use "nightly" or "at bedtime"

q. o. d. or QOD\*\* Every other day Mistaken as "q. d." (daily) or "q. i. d. (four times daily) if the "o" is

poorly written

Use "every other day"

q1d Daily Mistaken as q. i. d. (four times daily) Use "daily"

q6PM, etc. Every evening at 6 PM Mistaken as every 6 hours Use "daily at 6 PM" or "6 PM daily"

SC, SQ, sub q Subcutaneous SC mistaken as SL (sublingual); SQ mistaken as "5 every;" the "q" in

"sub q" has been mistaken as "every" (e. g., a heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)

Use "subcut" or "subcutaneously"

ss Sliding scale (insulin) or  $\frac{1}{2}$

(apothecary)

Mistaken as "55" Spell out "sliding scale;" use "one-half" or " $\frac{1}{2}$ "

SSRI

SSI

Sliding scale regular insulin

Sliding scale insulin

Mistaken as selective-serotonin reuptake inhibitor

Mistaken as Strong Solution of Iodine (Lugols)

Spell out “ sliding scale (insulin)”

i/d One daily Mistaken as “ tid” Use “ 1 daily”

TIW or tiw

(also BIW or biw)

TIW: 3 times a week

BIW: 2 times a week

TIW mistaken as “ 3 times a day” or “ twice in a week”

BIW mistaken as “ 2 times a day”

Use “ 3 times weekly”

Use “ 2 times weekly”

U or u\*\* Unit Mistaken as the number 0 or 4, causing a 10-fold overdose or greater

(e. g., 4U seen as “ 40” or 4u seen as “ 44”); mistaken as “ cc” so dose given in volume instead of units (e. g., 4u seen as 4cc)

Use “ unit”

UD As directed (“ ut dictum”) Mistaken as unit dose (e. g., diltiazem 125 mg

IV infusion “ UD” misinterpreted

as meaning to give the entire infusion as a unit [bolus] dose)

Use “ as directed” tended Meaning Misinterpretation Correction

Trailing zero after

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decimal point

(e. g., 1. 0 mg)\*\*

1 mg Mistaken as 10 mg if the decimal point is not seen Do not use trailing

zeros for doses

expressed in whole numbers

No leading zero before

a decimal point

(e. g., . 5 mg)\*\*

0. 5 mg Mistaken as 5 mg if the decimal point is not seen Use zero before a

decimal point when the

dose is less than a whole unit the abbreviations, symbols, and dose

designations found in this table

have been reported to ISMP through the ISMP Medication Error Reporting Program (MERP) as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

The Joint Commission has established a National Patient Safety Goal that specifies that certain abbreviations must appear on an accredited organizations “ do-not-use” list; we have highlighted these items with a double asterisk (\*\*). However, we hope that you will consider others beyond the minimum Joint Commission requirements. By using and promoting safe practices and by educating one another about hazards, we can better protect our patients.

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## Summary

" A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use."

The Council urges medication errors researchers, software developers, and institutions to use this standard definition to identify errors.

## References

Institute for Safe Medication Practices (ISMP) from the World Wide Web:

<http://www.ismp.org>

Underwood, k. (2010, 12 August). Medical Errors From Abbreviations.

Jacksonville, FL Medical

Terminology.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

<http://www.jcaho.org>

Institute for Safe Medication Practices. The World Wide Web: [www.ismp.org](http://www.ismp.org)

National Coordinating Council for Medication Error Reporting and Prevention.

(1998-2011) From the World Wide Web: <http://www.nccmerp.org/aboutMedErrors.html>

Drug Safety and Availability Medication Errors from the World Wide Web:

[Http://](http://)

[www.fda.gov](http://www.fda.gov)

MediLexicon International Ltd Medical Abbreviations Dictionary

<https://assignbuster.com/medical-terminology-project/>

From the World Wide Web: [www. medilexicon. com/medicalabbreviations. php](http://www.medilexicon.com/medicalabbreviations.php)