GREATER WESTERN AREA HEALTH SERVICE

AREA STANDARD OF PRACTICE **DANGEROUS ABBREVIATIONS**			
Manual:	Area Clinical Operations and Service Development Standard of Practice Manual	**Date Devised:**	June 2006
Section:	Clinical Governance	**Date/s Revised:**	
SOP Number:	1.6.4	**Date to be Reviewed:**	June 2008
Supersedes:		**Endorsed by:**	Chief Executive
		Endorsed by Signature:	
Contact:	Clinical Governance Unit	**Date Endorsed:**	03 / 07/ 2006

POLICY STATEMENT:

There are a number of risks associated with the use of abbreviations in patient records and medication charts. Some abbreviations have double meanings and can often be misinterpreted. To reduce the risk of error, a list of abbreviations considered dangerous has been developed.

It is the policy of Greater Western Area Health Service that this list is adhered to by all staff responsible for documenting in the patient records or medication charts. The abbreviations listed are deemed dangerous and are **NOT** be used.

OUTCOME/S:

- Standardisation and consistent documentation in patient records and medication charts.
- Reduction in adverse events due to misinterpretation of abbreviations used.

PROCEDURE:

When documenting in patient records or medication charts, the following abbreviations are considered dangerous and are **NOT** to be used:

Abbreviations NOT to be used in Patient Record or Medication Chart	Intended Meaning	Why?	What should I use?
1/7	for one day	Mistaken for one week	Write ‘for one day’
x3d	for 3 days	Mistaken as three doses	Write ‘for three days’
6/24	every six hours	Mistaken as six times a day	Write ‘6 hourly’
OD o.d. d	once daily	OD can be mistaken as twice a day, d can be easily missed	Write ‘once daily’ and specify the time of the day
q.d. QD	every day	Mistaken as Q.I.D or four times a day	Write ‘daily’ and specify the time of the day
TIW	three times a week	Mistaken as three times a day	Write ‘three times a week’ and specify which days

Abbreviations NOT to be used in Patient Record or Medication Chart	Intended Meaning	Why?	What should I use?
U or U/s	unit or units	Mistaken for 0	Write 'unit'
IU, eg 3 IU	international unit	Mistaken as IV (intravenous) or misread as 31 U (ie 31 units)	Write 'international unit'
cc	cubic centimetres	Misread as u when handwritten	Write 'mL' for millilitres
mcg µg	microgram	Mistaken as milligram when handwritten	Write 'microgram'
> or <	greater than or less than	Mistaken for opposite of what is intended	Write 'greater than' or 'less than'
Zero after a decimal point, eg 5.0 mg	5 mg	Misread as 50 mg if decimal point not seen	Do not write decimal points after whole numbers
No decimal point before fractional dose, eg .5 mg	0.5mg	Misread as 5 mg	Always use a zero before a decimal when dose is less than one
Chemical symbols, eg MgSO4	magnesium sulfate	May not be understood or may be misunderstood eg morphine sulfate	Write 'magnesium sulfate'
Drug names, eg epo (NB This is just one example, there are several more)	Erythropoietin Epoetin alpha	Mistaken as evening primrose oil	Write all drug names out in full – generic name for single active ingredient, and trade name for combination drugs
E	ear or eye	Misinterpreted as the other organ	Write 'ear' or 'eye'
SC	subcutaneous	Mistaken for sublingual	Write 'subcutaneous'
S/L	for sublingual	Mistaken for S/C - subcutaneous	Write 'sublingual' or 'under tongue'
D/C	discharge or discontinue	Misinterpreted as the other intention	Write 'discharge' or 'discontinue'
R or ®	right	Prohibited in NSW Health PD 2005_380	Write 'right'
L	left	Prohibited in NSW Health PD 2005_380	Write 'left'

REFERENCE/S:

NSW Department of Health. Patient Identification - Correct Patient, Correct Procedure and Correct Site Model Policy (PD 2005_380) 2005, p. 3

Australian Council for Safety & Quality in Health Care. National In-patient Medication Chart 2006, p. 15

SEARCH ENGINE WORDS: **DANGEROUS ABBREVIATIONS**

APPENDICE/S: Nil