DANGEROUS ABBREVIATIONS POLICY
(“Do NOT Use” Abbreviations)

Policy:
It is the policy of Windsor Regional Hospital that there is a standard list of abbreviations, acronyms, and symbols that are NOT to be used during throughout the organization.¹ This list shall be updated based on recommendations from ISMP Canada to reflect evidence-based patient safety (see Appendix A).

Dangerous abbreviations, acronyms, and symbols on the list:
- will NOT be used for clinical documentation,
- will NOT be used in prescribing medications, and
- will NOT be present in software applications where the application permits an appropriate alternative

Purpose:
The purpose of this policy is to eliminate the use of dangerous abbreviations in clinical documentation and prescribing of medications as part of the Windsor Regional Hospital commitment to providing a standard of excellent patient-centered care by ensuring the safety of all patients through safe medication practice.

“The use of some abbreviations, symbols, and dose designations has been identified as an underlying cause of serious, even fatal medication errors.”²

Scope:
This policy applies to all Windsor Regional Hospital health care providers or persons who provide health care on behalf of Windsor Regional Hospital who order medications or provide clinical documentation while caring for and treating patients.

Definitions:
Allied Health Practitioner: Health care providers who are not physicians, but by virtue of their special training, are able to provide services to the hospital or its Medical Staff, as defined by medical staff bylaws. These would include, but are not limited to, physicians assistants, registered nurse extended class (RNEC), midwives, pharmacists, dietitians, and respiratory therapists.

Medication: Any prescription medication; sample medication; herbal remedy; vitamin; neutraceutical; over-the-counter drug; vaccine; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal condition; radioactive medication; respiratory therapy treatment; parenteral nutrition; blood derivative; intravenous solution (plain, with electrolytes and/or drugs) and any product designated by the Health Canada as a drug. This definition of medication does not include enteral nutrition solutions (which are considered food products); oxygen and other medical gases
Define key terms contained in the policy for clarity

Prescriber: Can include a physician or allied health practitioner (under delegated authority) who has been granted prescribing privileges according to medical staff bylaws and hospital policy.

Process:
1. Windsor Regional Hospital preprinted forms, related to medication use, will not contain any of the dangerous abbreviations, acronyms, or symbols identified on the policy list. Preprinted forms will be reviewed for removal and clarification of any dangerous abbreviations by the appropriate approval committee (e.g. Forms Documentation Committee, Pharmacy & Therapeutics Order Set Subcommittee).
2. Wherever possible, Windsor Regional Hospital pharmacy-system generated labels and forms will not contain any of the dangerous abbreviations, acronyms, or symbols identified on the policy list.
3. Order writing
   If a dangerous abbreviation, acronym, or symbol is used by a prescriber, the order will not be processed unless the abbreviation, acronym, or symbol is clarified with the prescriber or their designee. Clarification of the order by
the prescriber or designee must take place prior to documenting, dispensing, administering, or carrying out the order. Whenever possible the prescriber will rewrite the order clarification. In situations where the prescriber is not physically present to rewrite the order, the clarification may be taken as a telephone order and documented as such.

For orders received during pharmacy hours – the pharmacy staff will contact the nursing unit to determine if a clarification has already been completed. If not, the pharmacy staff will contact the prescriber for clarification and a clarification order will be written for placement in the chart.

For order identified after pharmacy hours – the nurse will contact the prescriber for clarification and a clarification order will be written in the patient chart and faxed to pharmacy.

i. If a **physician** writes an order using a dangerous abbreviation:
   In the event that the call/page is not returned; the Department Chief will be contacted for clarification.

ii. If a **resident/CTU clerk** writes an order using a dangerous abbreviation;
   In the event the call/page is not returned; the senior resident/assigned physician will be contacted for clarification.

iii. If a **nurse** writes a telephone/verbal order using a dangerous abbreviation;
   In the event the nurse is not available, the Clinical Practice Manager/Coordinator or Nursing Unit Manager will be contacted for clarification. The Clinical Practice Manager/Coordinator or Nursing Unit Manager will be responsible for delegating the clarification of the order and educating the nurse.

iv. If an **allied health care provider** writes an order using a dangerous abbreviation;
   In the event the call/page is not returned; the most responsible physician will be contacted for clarification.

4. Blank physician order forms will identify the dangerous abbreviations and their corrections for quick reference by the prescriber.

5. **Monitoring**

Windsor Regional Hospital will randomly audit patient charts to determine compliance with this policy.

At any time, orders found to be non-compliant with the policy may be reported into the Windsor Regional Hospital electronic incident reporting system.

Appendix B outlines the February 2015 Medical Advisory Committee approved process for incident reports that identify unclear/illegible orders and those orders containing dangerous abbreviations.

**References:**

1. Accreditation Canada: Medication Management Standards, August 13, 2014
3. Internal Memorandum: Dr. Gary Ing, Chief of Staff, February 18, 2015
## APPENDIX A

### Do NOT Use

Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should **NEVER** be used when communicating medication information.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Intended Meaning</th>
<th>Problem</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Unit</td>
<td>Mistaken for “0” (zero), “4” (four)</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU</td>
<td>International unit</td>
<td>Mistaken for “IV” (intravenous) or “10” (ten)</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td></td>
<td>Misinterpreted because of similar abbreviations for multiple drugs; e.g. MS, MSO₄ (morphine) and MgSO₄ (magnesium) confused for one another</td>
<td>Do NOT abbreviate any drug names</td>
</tr>
<tr>
<td>QD, OD</td>
<td>Every day</td>
<td>Mistaken as QID or every other day</td>
<td>Write “daily” or “once daily”</td>
</tr>
<tr>
<td>QOD</td>
<td>Every other day</td>
<td>Mistaken as QID or every day</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>OS, OD, OU</td>
<td>Left eye, right eye, both eyes</td>
<td>Confused with one another</td>
<td>Write “left eye”, “right eye”, or “both eyes”</td>
</tr>
<tr>
<td>D/C</td>
<td>Discharge</td>
<td>When medications followed discharge orders, the medications were unintentionally “discontinued”</td>
<td>Write “discharge”, “discontinue” or “stop”</td>
</tr>
<tr>
<td>cc</td>
<td>Cubic centimeter</td>
<td>Mistaken for “0” (zero)</td>
<td>Use “mL”</td>
</tr>
<tr>
<td>ug</td>
<td>Microgram</td>
<td>Mistaken for “mg” (milligram) resulting in a one thousand-fold overdose</td>
<td>Use “mcg”</td>
</tr>
<tr>
<td>Symbol</td>
<td>Intended Meaning</td>
<td>Potential Problem</td>
<td>Correction</td>
</tr>
<tr>
<td>@</td>
<td>at</td>
<td>Mistaken for “2” (two) or “5” (five)</td>
<td>Write “at”</td>
</tr>
<tr>
<td>&gt;</td>
<td>Greater than</td>
<td>Mistaken for “7” (seven) or the letter “L” Confused with each other</td>
<td>Write “greater than” or “more than” Write “less than” or “lower than”</td>
</tr>
<tr>
<td>&lt;</td>
<td>Less than</td>
<td>Confused with each other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dose Designation</th>
<th>Intended Meaning</th>
<th>Potential Problem</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trailing zero</td>
<td>x.0mg</td>
<td>Decimal point is overlooked resulting in a 10-fold dose error</td>
<td>Never use a zero by itself after a decimal point. Write “x mg”</td>
</tr>
<tr>
<td>Lack of leading zero</td>
<td>.x mg</td>
<td>Decimal point is overlooked resulting in a 10-fold dose error</td>
<td>For doses less than 1mg, always use a zero before the decimal point. Write “0.x mg”</td>
</tr>
</tbody>
</table>

5. Adapted from ISMP’s List of Error-Prone Abbreviations, Symbols, and Dose Designations 2006. ISMP Canada July 2006
APPENDIX B

DATE: February 18, 2015
TO: All Professional Staff
CC: MAC; Dr. R. Smith, C. Donaldson, G. Bulcke, J. Bennett, M. Staley
FROM: Dr. Gary Ing, Chief of Staff
RE: A Plan to Address UNCLEAR ORDERS/NPO – NEXT STEPS

Importance: HIGH

The enhanced plan, which is effective immediately, will be as follows:
1. All unclear orders shall NOT be accepted by nursing or pharmacy.
2. All prescribers shall NOT use blank physician orders without patient demographic information.
3. Individual prescribers will be contacted for clarification whenever unclear orders are received. This will also serve as notice to the prescriber of an “Occurrence of an Unclear Order”.
4. First Occurrence of an Unclear Order: Nursing or pharmacy will write a clarification order and enter the First Occurrence into RL6 to track the occurrence.
5. Second Occurrence of an Unclear Order: Nursing or pharmacy will write a clarification order and enter the Second Occurrence into RL6 to track the occurrence.
6. Third Occurrence of an Unclear Order: Nursing or pharmacy will write a clarification order and enter the Third Occurrence into RL6 to track the occurrence. The Department Chief and the Chief of Staff will be notified of the Third Occurrence. The Department Chief shall meet with the prescriber to discuss the Occurrences to date and, with input from the prescriber, outline an action plan for remediation, including a date for completion of the action plan. The action plan shall be in writing and shall be forwarded to the Chief of Staff. The action plan shall, at a minimum, include a requirement that an online handwriting course approved by the Department Chief be completed by the prescriber, and a date by which the action plan shall be completed. The prescriber shall provide written confirmation to the Department Chief and the Chief of Staff when the action plan has been completed. Failure to complete the action plan by the date specified shall require follow-up by the Department Chief.
7. Fourth Occurrence of Unclear Order (New Occurrence Following the Date After Which the Action Plan is to be Completed): Nursing or pharmacy will write a clarification order and enter the Fourth Occurrence into RL6 to track the occurrence. The MQA and the Credentials Committee shall be notified of the Fourth Occurrence. The Credentials Committee shall meet with the prescriber to review the Occurrences to date, including considering incidents that occurred between August 6, 2014 – February 18, 2015. The Credentials Committee may recommend further action as it deems appropriate, including recommending initiation of action pursuant to the By-Law.
8. Fifth and Subsequent Occurrence(s) of Unclear Order(s): Nursing or pharmacy will write a clarification order and enter the Occurrence into RL6 to track the occurrence. The MQA and the Credentials Committee shall be notified of the Occurrence. The Credentials Committee shall meet with the prescriber to review the Occurrences to date, including considering incidents that occurred between August 6, 2014 – February 18, 2015. The Credentials Committee shall recommend further action, including, if appropriate, recommending initiation of action pursuant to the By-Law.