

Medication Alert

Abbreviations when Prescribing Medicines !

ALERT 4 April 2007

- For the attention of :** DHB CEOs, PHO CEOs, DHB Chief Medical Officers, DHB Directors of Nursing, DHB Quality Managers
- For action by :** Medicines Advisory Committees, Pharmacy and Therapeutic Committees, Clinical Boards, PHO Clinical Leaders
- For information to :** Schools of Medicine, Midwifery, Nursing and Pharmacy, Medical Colleges, Pharmacy Council, Pharmacy Facilitators

Purpose of this alert

To highlight the safety issues surrounding the use of abbreviations when prescribing medicines.

Background to this Safe Use of Medicines alert

It is expected that all hospitals would have standard operating procedures or guidelines about the use of abbreviations when prescribing medicines within their organisations. This alert is to highlight the need for such guidelines and identify some abbreviations, acronyms and symbols that can be dangerous and when used can lead to serious adverse incidents¹. There is also the risk that health professionals who have worked in other parts of the world might use or interpret abbreviations in a different way to their host nation.⁵ These abbreviations should be included in a “do not use” list.

Recommended action

Secondary Care

- All hospitals should review the guidelines/standard operating procedures within their organisation regarding the use of abbreviations when prescribing medicines
- Abbreviations included in the “do not use” list should not be allowed
- Include education for prescribers on the use of abbreviations in induction training and RMO handbooks

Primary Care

- Primary care practitioners should review their prescribing practice and not use the abbreviations included in the “do not use list”

References

1. Cohen, Michael R. Medication Errors, American Pharmaceutical Association 1999, sections 5.9, 8.4
2. Institute for Safe Medication Practices – Preventing Medication Errors available from URL: <http://www.ismp.org/msarticles/specialissuetable.html>
3. Joint Commission on Accreditation of Healthcare Organisations (JACHO) – 2004 National Patient Safety Goals “Do not use” list. available from URL: <http://www.jointcommission.org/PatientSafety/DoNotUseList/>
4. Health and Disability Commissioner from URL: <http://www.hdc.org.nz/complaints/opinions?98HDC14229>
5. Adcock, Harriet, Learning from Medication Errors The Pharmaceutical Journal: 267, 1; Sept 2001, 287 - 289

“Do Not Use” Abbreviations and Symbols

“Do not use” Abbreviation / Symbol	Intended Meaning	Potential Problem	Preferred Term
Do not abbreviate the name of any medicine ¹		May be incorrectly mistaken for something else e.g. MTX has been used for both methotrexate and mitozantrone e.g. HCT has been used for both hydrocortisone and hydrochlorothiazide e.g. HCT has been used for both hydrocortisone and hydrochlorothiazide e.g. ISMN has been used for isosorbide mononitrate and may be confused with ISMO®	Always write names of medicines in full.
Do not abbreviate the names of any chemical ^{2,3} e.g. MgSO ₄ HCl KCl	Magnesium sulphate, Hydrochloric acid, Potassium Chloride	May be incorrectly mistaken for something else. MgSO ₄ has been mistaken for morphine sulphate HCl has been mistaken for potassium chloride	Always write chemical formulas in full e.g. magnesium sulphate hydrogen chloride potassium chloride
U ^{1,2,3} or IU ^{1,2,3}	Unit International Unit	Mistaken as zero, four or cc Mistaken as IV(intravenous) or as 10 (ten): or as a trailing 1 (one)	Write unit or international unit
OD, od or O.D. ^{1,4}	Once daily	Mistaken as QID or BD	Write daily
Q.D. or q.d. ^{1,2,3}	Every day	Mistaken as QID	Write daily
SC ²	Subcutaneous	Mistaken for SL (sublingual)	Write subcutaneous or subcut
SL	Sublingual	Mistaken for SC (subcutaneous)	Write sublingual or subling
Trailing zero ^{2,3} Incorrect use: 1.0mg	1 mg	Decimal point is missed leading to a tenfold error –read as ten mg rather than one mg	Never write a zero by itself after a decimal point Correct use: 1 mg
Lack of a leading zero ³ Incorrect use: .5mg	0.5 mg	i.e Decimal point missed leading to a tenfold error - read as five mg rather than half a milligram	Always use a zero before a decimal point Correct use: 0.5 mg
µg ³	microgram	Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose	Write microgram or mcg
ng	nanogram	Mistaken for mg	Write nanogram
mEq or milliequivalent		Confusion between milliequivalent and millimole. Only SI units should be used.	Always use millimole or mmol

If you require any further information or wish to provide feedback on this alert, please go to www.safeuseofmedicines.co.nz