



Provincial Health Services Authority

## DO NOT USE ABBREVIATIONS POLICY

### Summary of Changes

	NEW	Previous
BC Cancer	16-MAR-2023 New Headings to organize policy statements	Created: April 21, 2009 Revised: February 18, 2013

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# DO NOT USE ABBREVIATIONS POLICY

## 1. Introduction

### 1.1. Purpose

The purpose of the policy is to identify and eliminate the use of dangerous abbreviations, symbols and dose designations particularly associated with potential errors. Medication errors may occur as a result of misinterpretation of written orders utilizing ambiguous abbreviations. These abbreviations must be eliminated from use by health care providers, to decrease the risk of medication errors which can cause patient harm.

### 1.2. Scope

This policy is intended to apply to all BC Cancer employees, managers, physicians, other healthcare professionals, researchers, contractors (i.e. security, housekeeping, food services (*contract companies will be expected to have their own policies in place as per legislation*), students, and volunteers.

## 2. Policy

### 2.1. Identifying Error Prone Abbreviations

A list of error prone abbreviations, symbols and dose designations that are NOT to be used within the organization for clinical documentation will be identified. These abbreviations are prohibited; they will NOT be used in any medication-related documentation, whether hand written or entered as a free text into a computer. The prohibited abbreviations will NOT be used in any medication-related pre-printed forms or pharmacy-generated labels or forms.

### 2.2. The Institute for Safe Medication Practices Canada (ISMP Canada) "Do Not Use Dangerous Abbreviations, Symbols and Dose Designations" List

The Institute for Safe Medication Practices Canada (ISMP Canada) "Do Not Use Dangerous Abbreviations, Symbols and Dose Designations" List will be used to identify abbreviations, symbols and dose designations that are NOT to be used for clinical documentation. This List will be published in the appropriate organizational forums to ensure staff awareness.

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## 3. Responsibilities and Compliance

### 3.1. Responsibilities

All staff will be educated about this Directive, at departmental orientation and whenever changes are made to the List. This education should include examples of errors that have resulted from the use of dangerous abbreviations, symbols and dose designations, such as those included in the ISMP Canada Safety Bulletin referenced below.

The List will be reviewed and updated annually by the Provincial Pharmacy Professional Practice Council or when a revised ISMP Canada List is released.

### 3.2. Compliance

Periodic audits will be conducted by the appropriate Provincial Leaders to ensure compliance with this Directive. Results will be reported to the BC Cancer Executive and shared with practitioners to maintain focus on this safety strategy. Process changes will be implemented based on identified issues.

## 4. References

ISMP Canada Safety Bulletin, July 16, 2006: [www.ismp-canada.org](http://www.ismp-canada.org)

<https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf>

## 5. Appendices

[Appendix 1: The Institute for Safe Medication Practices Canada “Do Not Use Dangerous Abbreviations, Symbols and Dose Designations” List](#)

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## Appendix 1: The Institute for Safe Medication Practices Canada "Do Not Use Dangerous Abbreviations, Symbols and Dose Designations" List

### 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.

Abbreviation	Intended Meaning	Problem	Correction
<b>U</b>	unit	Mistaken for "0" (zero), "4" (four), or cc.	Use "unit".
<b>IU</b>	international unit	Mistaken for "IV" (intravenous) or "10" (ten).	Use "unit".
<b>Abbreviations for drug names</b>		Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO <sub>4</sub> (morphine sulphate), MgSO <sub>4</sub> (magnesium sulphate) may be confused for one another.	Do not abbreviate drug names.
<b>QD QOD</b>	Every day Every other day	QD and QOD have been mistaken for each other, or as 'qid'. The Q has also been misinterpreted as "2" (two).	Use "daily" and "every other day".
<b>OD</b>	Every day	Mistaken for "right eye" (OD = oculus dexter).	Use "daily".
<b>OS, OD, OU</b>	Left eye, right eye, both eyes	May be confused with one another.	Use "left eye", "right eye" or "both eyes".
<b>D/C</b>	Discharge	Interpreted as "discontinue whatever medications follow" (typically discharge medications).	Use "discharge".
<b>cc</b>	cubic centimetre	Mistaken for "u" (units).	Use "mL" or "millilitre".
<b>µg</b>	microgram	Mistaken for "mg" (milligram) resulting in one thousand-fold overdose.	Use "mcg".
Symbol	Intended Meaning	Potential Problem	Correction
<b>@</b>	at	Mistaken for "2" (two) or "5" (five).	Use "at".
<b>&gt; &lt;</b>	Greater than Less than	Mistaken for "7" (seven) or the letter "L". Confused with each other.	Use "greater than"/"more than" or "less than"/"lower than".
Dose Designation	Intended Meaning	Potential Problem	Correction
<b>Trailing zero</b>	1.0 mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point. Use "1 mg".
<b>Lack of leading zero</b>	. 1 mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point. Use "0.1 mg".

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Adapted from ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations 2006

Report actual and potential medication errors to ISMP Canada at  
[https://www.ismp-canada.org/err\\_report.htm](https://www.ismp-canada.org/err_report.htm) or by calling 1-866-54-ISMP.



Institute for Safe Medication  
Practices Canada  
Institut pour la sécurité des médicaments  
aux patients du Canada

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<b>Final Sign Off:</b>	<b>Name</b>	<b>Title</b>	<b>Date Signed</b>
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