Medical Abbreviations to Avoid

Health care professionals should be aware of abbreviations to avoid when communicating verbally or in writing. There are specific lists from the Joint Commission (see below) that include abbreviations to refrain from using. Organizations can also expand upon this list for their specific needs. The Institute for Safe Medication Practices (ISMP) also has an accessible list of abbreviations to avoid using, which is derived from reported medication errors that have led to unintended consequences. While abbreviations are meant to save time, they can often lead to misinterpretation and errors, which can have drastic results, especially regarding medication errors. It is important to avoid these abbreviations in any form of communication, including written and verbal.

Joint Commission List

The Joint Commission requires every health care facility to develop a list of approved abbreviations for staff use. Certain abbreviations should be avoided because they are easily misunderstood, especially when handwritten. The Joint Commission has identified a minimum list of dangerous abbreviations, acronyms, and symbols. This do-not-use list includes the following items.

Official "Do Not Use" List[1]		
Do not use	**Potential problem**	**Best Practice**
U, u (unit)	Mistaken for "0" (zero), the number "4" (four), or "cc"	Write "unit"
IU (International Unit)	Mistaken for "IV" (intravenous) or the number "10" (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) **Q.O.D., QOD, q.o.d, qod (every other day)**	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write "X mg" Write "0.X mg"
MS **MSO4 and MgSO4**	Can mean morphine sulfate or magnesium Sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

1 Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube size. It may not be used in medication orders or other medication-related documentation.

ISMP

The ISMP notes that the do-not-use abbreviations must be avoided in all communications, including in labeling of medication storage bins and medication dispensing systems, written and electronic records, prescriptions, smart infusion pumps, pharmacy and prescriber order entry systems, and verbal communications. The following table outlines additional common abbreviations to avoid.

Additional Common Abbreviations to Avoid		
Avoid	**Potential problem**	**Best Practice**
cc (cubic centimeters)	Mistaken as u (units)	Use "mL"
ug (microgram)	Mistaken as mg	Use "mcg"
AD, AS, AU (right ear, left ear, each ear) **OD, OS, OU (right eye, left eye, each eye)**	Mistaken as OD, OD, OU Mistaken as AD, AS, AU	Write out right, ear, left ear, each ear Write out right eye, left eye, each eye
IN (intranasal)	Mistaken as IM or IV	Use intranasal
IT (intrathecal)	Mistaken as intratracheal, intratumor, intratympanic, or inhalation therapy	Use intrathecal
Per os (by mouth, orally)	Mistaken as left eye (OS)	Use PO, by mouth, or orally
SC, SQ, sq, or sub q (subcutaneously)	SC and sc mistaken as SL or sl (sublingual) SQ mistaken as "5 every" The "q" in sub q has been mistaken as every	Use SUBQ (all uppercase letters, without spaces or periods between letters) OR write out subcutaneously
< And > (less than and more than)	Mistaken as opposite of intended, or used as incorrect symbol, or mistaken for number 4	Write out "more than" or "less than"
↑ and ↓ (increase and decrease)	Mistaken as opposite of intended, or used as incorrect symbol, or mistaken for letter T	Use increase and decrease

The full ISMP list is more exhaustive and includes symbols, medication name abbreviations, and coined names of medications to avoid using. See the complete list on the ISMP website.

Remember

It is essential that the healthcare provider be familiar with the approved abbreviation list for their organization and use only those acceptable abbreviations. Each approved abbreviation should only have one accepted meaning. The Joint Commission recommends against using abbreviations in patient communication material, such as discharge instructions, to help avoid any confusion. If a nurse encounters an abbreviation in a medication order, they should request clarification and a rewrite of the order.

Through the avoidance of the abbreviations on the Joint Commission and ISMP lists, the goal is to reduce miscommunication and thereby reduce the risk of errors and improve patient safety. The individual health care provider, along with all health care workers and the organization within which they work, all play a role in promoting safe communication.

References

Institute for Safe Medication Practices (ISMP). (2024, April 28). List of Error-Prone Abbreviations. ISMP Website. https://home.ecri.org/blogs/ismp-resources/list-of-error-prone-abbreviations

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