

# Official “Do Not Use” List

- This list is part of the Information Management standards
- Does not apply to preprogrammed health information technology systems (i.e. electronic medical records or CPOE systems), but remains under consideration for the future

Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

## Official “Do Not Use” List<sup>1</sup>

| Do Not Use  | Potential Problem  | Use Instead   |
|---|--|---|
| 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)                              | Mistaken for each other  | Write "daily"   |
| Q.O.D., QOD, q.o.d, qod (every other day)               | Period after the Q mistaken for "I" and the "O" mistaken for "I" | Write "every other day"                               |
| Trailing zero (X.0 mg)*<br>Lack of leading zero (.X mg) | Decimal point is missed  | Write X mg<br>Write 0.X mg                            |
| MS  | Can mean morphine sulfate or magnesium sulfate                   | Write "morphine sulfate"<br>Write "magnesium sulfate" |
| MSO <sub>4</sub> and MgSO <sub>4</sub>                  | Confused for one another   |   |

<sup>1</sup>Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

**\*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 sizes. It may not be used in medication orders or other medication-related documentation.

## Development of the “Do Not Use” List

In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its “Do Not Use” List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

8/20

The Joint Commission

# FACT SHEET

### For more information

- Complete the [Standards Online Question Submission Form](#).
- Contact the Standards Interpretation Group at 630-792-5900.