

Attachment #3 Policy #2047 Medication Verification, Reconciliation and Management

**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.

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

<b>Do Not Use</b>	<b>Potential Problem</b>	<b>Use Instead</b>
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)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" 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.