

LOS ANGELES GENERAL MEDICAL CENTER POLICY

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Subject: HEALTH/MEDICAL RECORDS: USE OF ABBREVIATIONS, ACRONYMS, AND SYMBOLS		Original Issue Date: 4/19/05 Supersedes: 1/10/17	Policy # 412 Effective Date: 4/25/23
Policy Owner(s): Director, Health Information Management Executive Sponsor(s): Chief Operations Officer			
Departments Consulted: Health Information Management Diagnostic Services Patient Safety Committee Nursing Services Health Records Committee	Reviewed & approved by: Attending Staff Association Executive Committee Senior Executive Officer	Approved by: (Signatures on File) Chief Operations Officer (Signatures on File) Chief Executive Officer	

PURPOSE

To increase safe patient care delivery and reduce potential miscommunication, the purpose of this policy is to establish Los Angeles County + University of Southern California (Los Angeles General) Medical Center standards on the use of abbreviations, acronyms, and symbols for documentation in the health/medical record (handwritten or electronic).

POLICY

Abbreviations, symbols, and acronyms may be used for health/medical record documentation when found in either a published professional dictionary such as Dorland's or Stedman's Medical Dictionary or by a professional association or approved by clinical departments **and** are not on the Los Angeles General Medical Center's prohibited abbreviation list. The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic. Prohibited abbreviations that are hard-coded into electronic health records by the software vendor in a manner that prevents editing, will be permissible. Any user-defined or customizable fields/forms created by the medical center will not include prohibited abbreviations and acronyms. Medication labels that contain prohibited abbreviations from the manufacturer are acceptable. Any electronic health record (EHR) system optimizations should strive to eliminate prohibited abbreviations as well as acronyms, symbols and dose designations that may create risk.

Computer generated laboratory reports are exempt from this policy.

PROCEDURES

- An abbreviation may be used for health/medical record documentation if it is not included on the Medical Center's prohibited/unapproved abbreviation list **and** it is found in either a published professional dictionary such as Dorland's or Stedman's Medical Dictionary or by a professional association or approved by clinical departments.
- For non-prohibited abbreviations that are not found in either a published professional dictionary such as Dorland's or Stedman's Medical Dictionary or by a professional association or approved by clinical departments, the following documentation method must be used:

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HEALTH/MEDICAL RECORDS: USE OF ABBREVIATIONS, ACRONYMS, AND SYMBOLS

Chief Executive Officer's Initials:

(Initials on File)

- ◆ The abbreviation's meaning must be spelled out the first time it is used in the documentation of an episode of care for inpatient admissions or ambulatory visits.
- The list of abbreviations, acronyms, and symbols are "prohibited" and shall not be used for documentation in the health/medical record.

PROHIBITED & UNSAFE 	SAFE AND ACCEPTABLE DO USE	RATIONALE
Drug Name Abbreviations MgSO4 MSO4 MS	Use the complete spelling for drug names Magnesium Sulfate Morphine Sulfate Morphine Sulfate	Helps reduce misinterpretation Clarifies which medication is being ordered.
Q.D.	Write: daily	Clarifies frequency of dose
Q.O.D.	Write: every other day	Clarifies frequency of dose
U or u	Write: unit	The abbreviation can look like an "0" and result in dosage errors.
IU	Write: international units	The abbreviation can look like a "10" and result in dosage errors.
Do not use apothecary symbols for dram and minim	Write out the metric system equivalent	Reduces the chances of order/directions being misread.
qn (nightly)	Write: bedtime	Clarifies time that medication is to be taken.
BT	Write: bedtime	Clarifies time that medication is to be taken.
<i>Prohibited only for medication related notations</i> Do not use trailing zeros (example: 5.0 mg)	Write: 5 mg	Unnecessary 0's after the decimal point can be misread and result in dosage errors.
Do not omit preceding zeros when writing decimals that are less than a whole number (example: .2mg)	Write: 0.2 mg	Always put a ZERO before a decimal point to avoid the dosage being misread as a whole number.

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RESPONSIBILITY

Administration	Allied Health Professionals
Attending Staff	Nursing Staff
Residents	Health Information Management

PROCEDURE DOCUMENTATION

Attending Staff Manual

REFERENCES

Joint Commission National Patient Safety Goals
 Joint Commission Standards (Management of Information; Ethics, Rights, and Responsibilities)

REVISION DATES

October 03, 2008; March 8, 2011, November 12, 2013; January 10, 2017; April 25, 2023