Guidelines for use of the Paediatric Inpatient (Short-Stay) Medication Chart in WA hospitals

Safer prescribing, dispensing and administration of medicines to minimise patient harm

August 2012
Acknowledgements

The Office of Safety and Quality in Health Care adapted these guidelines from material provided by the Australian Commission on Safety and Quality in Health Care and the Commission’s National Inpatient Medication Chart Oversight Committee.

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GUIDELINES FOR USE OF THE WA PAEDIATRIC INPATIENT MEDICATION CHART

Target Audience: All nursing, medical pharmacy, administrative and allied health staff that are authorised to access and use medication charts.

Exceptions: The WA Paediatric Inpatient Medication Chart is to be used as a record of orders and administration of general medicines. Where they exist for more specialised purposes, (such as intravenous fluids, anticoagulants, management of Diabetes, Palliative Care and Acute Pain) separate, specific charts should be used.

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* Pages are referred to in the following manner:

The *front page* is the first page seen if reading the folded chart like a book (i.e. turning pages right to left). ‘As Required “PRN” Medicines’ is written at the top.

The *middle pages* (fold-out) contain boxes for ‘Regular Medications’.

The *back page* has the top part cut-away revealing the top of the left middle page. ‘Paediatric Short-Stay Medicine Chart’ is written at the top.
1. Introduction

The National Inpatient Medication Chart (NIMC) is an initiative of the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The ACSQHC’s National Inpatient Medication Chart Oversight Committee (NIMCO) developed the Paediatric Inpatient Medication Chart and Paediatric Long-Stay Medication Chart based on work undertaken by Children’s Hospitals Australasia.

The National Paediatric Inpatient Medication Chart and the National Paediatric Long-Stay Chart were developed after extensive stakeholder consultation.

In December 2008, Australian Health Ministers endorsed the implementation of the National Paediatric Inpatient Medication Chart and the National Paediatric Long Stay Medication Chart for use in public general hospitals in Australia whenever paediatric patients are treated.

The Office of Safety and Quality in Healthcare (OSQH) and Princess Margaret Hospital established a working group to review the National Paediatric Inpatient Medication Chart. The working group identified a number of changes that are required to make it suitable for use in WA hospitals.

The WA Paediatric Inpatient Medication Chart is the final product of consultations that have taken place across WA Health and represents the consensus opinion of WA clinicians.

The WA Paediatric Inpatient Chart is intended to reflect best practice and assist clinicians in improving all steps of the medication management cycle for safer prescribing, dispensing and administration of medicines in order to reduce the potential for medication error.
### 2. General Instructions

The following are general requirements regarding use of the Paediatric Inpatient Medication Chart:

- The Australian Standard for Paper-based health care records AS2828-1999 specifies that the colour of paper should be White or Pastel. Pale yellow has been selected for use in WA to identify the Paediatric Inpatient Medication Chart.

- All medical officers must order medicines for inpatients in accordance with the WA Poisons Regulations 1965.

- A Paediatric Inpatient Medication Chart is to be completed for all admitted paediatric patients and placed at the foot of the bed unless ward/unit procedures state otherwise.

- All medications should be reviewed regularly to identify potential drug interactions and to discontinue medicines that are no longer required.

- Specific ordering charts are required for specialised medication orders such as insulin, intravenous fluids, anticoagulants, parenteral cytotoxic and immnosuppressive agents, epidural and regional infusion and patient controlled analgesia.

- A separate order is required for each medicine. A medication order is valid only if the medical officer enters all the required items (refer Section 4.1).

- No matter how accurate or complete an order is, it may be misinterpreted if it cannot be read. All orders are to be written legibly in ink.
  - Water-soluble ink (e.g. fountain pen) should not be used.
  - No erasers or whiteout can be used.

- All information, including drug names, should be PRINTED.

- Only accepted abbreviations outlined in the WA Health’s Acceptable Prescribing Terms and Abbreviations may be used (see Operational Directive OD 0184/09 Standardisation of terminology, abbreviations and symbols in the prescribing and administration of medicines). These accepted abbreviations are available from the WAMSG website at: http://www.watag.org.au/wamsg/publications.cfm

- The medical officer or pharmacist must calculate the dose rate for every medication order in accordance with Hospital policy (e.g. dose per mg/kg, mg/m², mg/kg per day). Staff must not use the dose calculation box unless the correct units of measurement are used.

- Hospitals/Health Services should enforce a zero tolerance policy whereby medication orders are not administered until any incorrectly written prescriptions have been corrected.
3. Front Page of Paediatric Inpatient Medication Chart

3.1 Patient Location

Ward/Unit: ___________________

The patient’s current location should be clearly marked on the medication chart.

3.2 Identification of the Patient

Every medication chart must have:
- EITHER the current patient identification label
- OR, as a minimum, the patient name, UR number, date of birth and gender written in legible print
- AND the first prescriber must print the patient’s name and check that the identification label is correct

Medication Orders cannot be administered if the prescriber does not document the patient identification.

Rationale
Patient identification guidelines and the printing of patient name will reduce the risk of wrong identification label being placed on the chart and the wrong patient receiving medication.

3.3 As required ("PRN") Medicines

<table>
<thead>
<tr>
<th>Date</th>
<th>Medicine (Print Generic Name)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route</td>
<td>DOSE</td>
<td>Hourly Frequency</td>
</tr>
<tr>
<td>Pharmacy/Additional Information</td>
<td>DOSE</td>
<td></td>
</tr>
<tr>
<td>Indication</td>
<td>Calculation of Dose as required</td>
<td></td>
</tr>
<tr>
<td>Prescriber Signature</td>
<td>Print Name</td>
<td></td>
</tr>
</tbody>
</table>

Superseded by: MP 0078/18 31 March 2018
Prescribing:
A ‘PRN’ medication order is valid only if the prescribing medical officer enters all listed items:

- **Date** that the medication order was started
- **Generic Drug Name**
- **Dose and hourly frequency**. “PRN” (pre-printed) alone is not sufficient
- **Indication and maximum daily dose** (e.g. maximum dose in 24 hours) *eg Paracetamol 4g/24 hrs*
- **Route** - only approved *Commonly Used and Understood Abbreviations* are to be used to indicate the route of administration. These accepted abbreviations are available from the OSQH website at: http://www.safetyandquality.health.wa.gov.au/medication/index.cfm
- **Pharmacy** - This section is for use by the ward/clinical pharmacist. Annotations include:
  - **I** for medicines available on imprest
  - **S** for non-imprest items that will be supplied and labelled for individual use from the pharmacy
  - **Pts own** for medicines checked by the pharmacist and confirmed to be acceptable for use during the patient’s admission
  - **CD** to indicate a Schedule 8 medicine (stored in CD cupboard)
  - **Fridge** to indicate a medicine that is stored in the fridge
- **Doctor Signature and Print Name** - The signature of the medical officer must be written to complete each medication order. Each medication order must also have the printed name of the medical officer.
- **Pager/Contact** - The medical officer must provide their contact number or pager number with every medication order.
- **Dose Calculation** - The medical officer or pharmacist must calculate the dose rate in accordance with Hospital policy (e.g. dose per mg/kg, mg/m², mg/kg per day). Staff must not use the dose calculation box unless the correct units of measurement are used.

**Rationale**
PRN Medications are separate from Regular Medicines section to reduce risk of giving regularly. This section also includes additional information (maximum dose in 24 period) to prevent overdose.
3.4 ‘PRN’ Administration Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Person Administering</th>
<th>Dose</th>
<th>Route</th>
<th>Comments</th>
</tr>
</thead>
</table>

Administration:
- The date and time must be entered whenever a dose of a PRN medication is administered.
- The actual dose and route given must be recorded.
- The person administering each dose is responsible for checking that the maximum daily dosage will not be exceeded.
- Two nurses must sign to verify administration.
- The medication administration record provides space to record up to ten doses of therapy. At the end of ten doses, the medication should be re-written if therapy is the continue.
- The shading of the dosage row is intended to reduce the risk of administering a drug incorrectly.

3.5 Discharge Supply

For each drug prescribed for an inpatient, the following information must be documented in the discharge supply section:
- Continue on discharge yes/no
- Dispense yes/no
- Duration / Quantity

For each page the following information is only required to be documented once:
- Prescriber’s signature
- Prescriber to print name
- Prescriber’s contact number
- Date discharge ordered
- Dispensing pharmacist’s signature
- Date discharge medication dispensed

For schedule 8 medications:
- Hospitals may have their own procedures in place for prescribing discharge supplies of schedule 8 medications which must be followed.

Note:
A drug prescribed for discharge where the dosage is changed should be written up by the prescriber as a new prescription, ceased in the administration columns (refer to Section 4.3) but indicated as being a required medication for discharge.

Rationale:
The discharge supply section is designed to facilitate the dispensing of discharge medication directly from the chart as a mechanism to avoid transcription errors.
4. Middle Pages of the Paediatric Inpatient Medication Chart

4.1 Regular Medications

A medication order is valid only if the prescribing medical officer enters all listed items:

(a) **Date** - the date that the medication order was started during this hospital admission should be entered. It is not the date that the chart was written or rewritten.

(b) **Generic Drug Name** - because there may be several brands of one agent available, the generic name should be used if possible unless combination preparations are being ordered (eg Timentin, Panadeine etc). Generally the pharmacy department will stock and supply only one brand of each generic drug.

(c) The red **Tick if Slow Release** box is included as a prompt to prescribers to consider whether or not the standard release form of the drug is required. This box must be ticked to indicate a sustained or modified release form of an oral drug (eg Verapamil SR, Diltiazem CD). If not ticked, then it is assumed that the standard release form is to be administered. Further explanation is in the margin of the medication chart.

(d) **Route** - only accepted abbreviations outlined in the WA Health’s *Acceptable Prescribing Terms and Abbreviations* may be used (see Operational Directive OD 0184/09 Standardisation of terminology, abbreviations and symbols in the prescribing and administration of medicines). These accepted abbreviations are available from the WAMSG website at: http://www.watag.org.au/wamsg/publications.cfm

### ACCEPTABLE PRESCRIBING TERMS AND ABBREVIATIONS

<table>
<thead>
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<th>Abbreviation</th>
<th>Meaning</th>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Ointment</td>
<td>Eye Ointment</td>
<td>PO</td>
<td>per oral / by mouth</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular injection</td>
<td>PEG</td>
<td>Percutaneous enteral gastronomy</td>
</tr>
<tr>
<td>intrathecal</td>
<td>intrathecal</td>
<td>PR</td>
<td>per rectum</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous injection</td>
<td>PV</td>
<td>per vagina</td>
</tr>
<tr>
<td>intranasal</td>
<td>Intranasal</td>
<td>subcut</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>intraarticular</td>
<td>Intraarticular</td>
<td>subling</td>
<td>sublingual</td>
</tr>
<tr>
<td>MA</td>
<td>metered aerosol</td>
<td>topical</td>
<td>Topical</td>
</tr>
<tr>
<td>MDI</td>
<td>metered dose inhaler</td>
<td>inhale / inhalation</td>
<td>Inhalation</td>
</tr>
<tr>
<td>neb</td>
<td>nebulised / nebuliser</td>
<td>epidural</td>
<td>Epidural</td>
</tr>
<tr>
<td>NG</td>
<td>nasogastric</td>
<td>Irrigation</td>
<td>Irrigation</td>
</tr>
</tbody>
</table>
In the case of liquid medicines, the strength and the dose in milligrams or micrograms (not millilitres) must always be specified e.g. morphine mixture (10mg/mL) Give 10mg every 8 hours.

The ward/clinical pharmacist will clarify when the strength supplied is different from that ordered e.g. for 10mg, the pharmacist may write 2 x 5mg tablets or for 25mg, the pharmacist may write ½ x 50mg.

e) **Dose** - doses must be written using metric and Arabic (1,2,3...) systems. Never use Roman numerals (i, ii, iii, iv,...). Acceptable abbreviations are listed below.

Always use zero (0.) before a decimal point (eg 0.5g) otherwise the decimal point may be missed. However if possible it is preferable to state the dose in whole numbers, not decimals (eg write 500mg instead of 0.5g or write 125mcg instead of 0.125mg).

Never use a terminal zero (.0) as it may be misread if the decimal point is missed (eg 1.0 misread as 10).

Do not use U or IU for Units because it may be misread as zero. Always write units in full.

### ACCEPTABLE TERMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>mL</td>
<td>Millilitre</td>
</tr>
<tr>
<td>L</td>
<td>Litre</td>
</tr>
<tr>
<td>g</td>
<td>Gram</td>
</tr>
<tr>
<td>mg</td>
<td>Milligram</td>
</tr>
<tr>
<td>microg</td>
<td>Microgram</td>
</tr>
<tr>
<td>mmol</td>
<td>Millimol</td>
</tr>
<tr>
<td>m</td>
<td>Milli</td>
</tr>
<tr>
<td>unit(s)</td>
<td>Unit(s)</td>
</tr>
<tr>
<td>international unit(s)</td>
<td>International Unit(s)</td>
</tr>
</tbody>
</table>
DANGEROUS ABBREVIATIONS
NOT TO BE USED

<table>
<thead>
<tr>
<th>Abbreviation to Avoid</th>
<th>Intended Meaning</th>
<th>Reason for Avoiding</th>
<th>Acceptable Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>ug, mcg or μg</td>
<td>microgram</td>
<td>mistaken for milligram when handwritten</td>
<td>write mcg clearly or write microgram</td>
</tr>
<tr>
<td>U or U/s</td>
<td>Unit or units</td>
<td>mistaken for 0</td>
<td>write unit(s)</td>
</tr>
<tr>
<td>IU or iu (eg 3 IU)</td>
<td>international unit</td>
<td>mistaken as iv (intravenous) or as 31u (thirty-one units)</td>
<td>write international unit(s)</td>
</tr>
<tr>
<td>No zero before decimal point (eg .5mg)</td>
<td>0.5mg</td>
<td>Misread as 5mg</td>
<td>Write 0.5mg or write 500microgram</td>
</tr>
<tr>
<td>Zero after decimal point (eg 5.0mg)</td>
<td>5mg</td>
<td>Misread as 50mg</td>
<td>Do not use decimal points after whole numbers</td>
</tr>
</tbody>
</table>

f) **Frequency and Administration Times** - The medical officer writing the order must enter the frequency and administration time(s) when writing the medication order. If these details are not entered, the dose may not be administered by nursing staff.

Acceptable frequency abbreviations are are available from the WAMSG website at: http://www.watag.org.au/wamsg/publications.cfm

Administration times should be entered using the 24-clock (this nomenclature is the global standard), according to the **Recommended Administration Times**:

Note

Medical officers should enter administration times using the Recommended Administration Times that are listed in the margins of the Chart. Nursing staff are authorised to change the times to meet local ward policies BUT, out of courtesy, should inform the prescribing medical officer of this action. A nurse, changing the administration time, is not considered to be attempting to interpret the frequency in the prescription and therefore not encountering the risk of transcriptional error.

ACCEPtable TERMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>bd</td>
<td>Twice daily</td>
</tr>
<tr>
<td>mane</td>
<td>Morning</td>
</tr>
<tr>
<td>nocte</td>
<td>Night</td>
</tr>
<tr>
<td>qid</td>
<td>Four times a day</td>
</tr>
<tr>
<td>tds</td>
<td>Three times a day</td>
</tr>
<tr>
<td>prn</td>
<td>As required</td>
</tr>
<tr>
<td>stat</td>
<td>Immediately</td>
</tr>
</tbody>
</table>
### DANGEROUS ABBREVIATIONS NOT TO BE USED

<table>
<thead>
<tr>
<th>Abbreviation to Avoid</th>
<th>Intended Meaning</th>
<th>Reason for Avoiding</th>
<th>Acceptable Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD, od or d</td>
<td>Once a day</td>
<td>Mistaken for twice a day</td>
<td>write ‘daily’ and specific time of day</td>
</tr>
<tr>
<td>QD or qd</td>
<td>Every day</td>
<td>Mistaken as qid (four times a day)</td>
<td>Write ‘daily’ and specific time of day</td>
</tr>
<tr>
<td>m</td>
<td>Morning</td>
<td>Mistaken for m (night)</td>
<td>Write ‘mane’</td>
</tr>
<tr>
<td>n</td>
<td>Nocte</td>
<td>Mistaken for m (morning)</td>
<td>Write ‘nocte’</td>
</tr>
<tr>
<td>6/24</td>
<td>Every six hours</td>
<td>Mistaken for six times a day</td>
<td>Write ‘q6h’ or ‘6 hourly’</td>
</tr>
<tr>
<td>1/7</td>
<td>For one day</td>
<td>Mistaken for one week</td>
<td>Write ‘for one day’ in full</td>
</tr>
<tr>
<td>X 3d</td>
<td>For 3 days</td>
<td>Mistaken as for three doses</td>
<td>Write ‘for 3 days’ in full</td>
</tr>
<tr>
<td>qod or QOD</td>
<td>Every other day</td>
<td>Mistaken as qd (daily) or qid (four times daily)</td>
<td>Write ‘every second day’ or ‘on alternate days’</td>
</tr>
<tr>
<td>½</td>
<td>Half</td>
<td>Mistaken as ‘one of two’</td>
<td>Write ‘half’</td>
</tr>
<tr>
<td>TID</td>
<td>Three times a day</td>
<td>Mistaken as ‘bd’</td>
<td>Write ‘tds’</td>
</tr>
<tr>
<td>TIW</td>
<td>Three times a week</td>
<td>Mistaken as ‘three times daily’</td>
<td>Write ‘three times a week’ and specify exact days in full</td>
</tr>
<tr>
<td>i/D</td>
<td>Once daily</td>
<td>Mistaken as ‘id’</td>
<td>write ‘daily’ and specific time of day</td>
</tr>
<tr>
<td>Qh</td>
<td>Every hour</td>
<td>Not universally understood</td>
<td>Write ‘hourly’ or ‘every hour’</td>
</tr>
<tr>
<td>Qhs</td>
<td>Nightly at bedtime</td>
<td>Mistaken as ‘qhs’ or every hour</td>
<td>Write ‘night’ or ‘daily at bedtime’</td>
</tr>
<tr>
<td>OW</td>
<td>Once a week</td>
<td>Not universally understood</td>
<td>Write ‘once a week’</td>
</tr>
<tr>
<td>p/f</td>
<td>Per fortnight</td>
<td>Not universally understood</td>
<td>Write ‘every two weeks’ or ‘per fortnight’</td>
</tr>
<tr>
<td>q6pm etc</td>
<td>Every evening at 6pm</td>
<td>Mistaken as every six hours</td>
<td>Write ‘6pm daily’, ‘every night at 6pm’ or ‘every day at 6pm’</td>
</tr>
</tbody>
</table>

---

g) Pharmacy - This section is for use by the ward/clinical pharmacist. Annotations include:
- I for medicines available on imprest
- S for non-impress items that will be supplied and labelled for individual use from the pharmacy
- Pts own for medicines checked by the pharmacist and confirmed to be acceptable for use during the patient’s admission
- CD to indicate a Schedule 8 medicine (stored in CD cupboard)
- Fridge to indicate a medicine that is stored in the fridge

h) Indication - This section is for the medical officer to document the indication for use or pharmacist to add or clarify any specific details (eg may be used to specify administration methods or rates etc).

i) Doctor Signature and Print Name - The signature of the medical officer must be written to complete each medication order. Each medication order must also have the printed name of the medical officer.

j) Pager/Contact - The medical officer must provide their contact number or pager number with every medication order.

k) Dose Calculation - The medical officer or pharmacist must calculate the dose rate in accordance with Hospital policy (e.g. dose per mg/kg, mg/m², mg/kg per day). Staff must not use the dose calculation box unless the correct units of measurement are used.
4.2 Limited Duration Medicines

When a medicine is ordered for a **limited duration**, or only on certain **days**, this must be clearly indicated using crosses (X) to **block out day/times** when the drug is **NOT** to be given.

4.3 Ceased Medicines

When **stopping** a medicine, the original order must **not** be obliterated. The medical officer must draw a clear line through the order in both the prescription and the administration record sections, taking care that the line does not impinge on other orders.

The medical officer must write the reason for changing the order (eg cease, written in error, increased dose etc) at an appropriate place in the administration record section.

When a medication order needs to be changed, the medical officer **must not** over write the order. The original order must be **ceased** and a new order written.

**Note**

The acronym “D/C” should not be used for ceased orders since this can be confused with “DISCHARGE”. Always use “CEASED”.
4.4 Administration Record

- The first person administering medication on any day must write the date in the box at the top of the column, this column is then for medications administered on this date only.

The medication administration record provides space to record up to seven days of therapy. At the end of seven days, a new chart should be written.

The last column (which is partially blocked out) is present only as a safety net if the order has not been rewritten. If the medication chart is full, then the medication orders written in it should not be considered valid/current prescriptions.

The shading of alternate columns is intended to reduce the risk of administering a drug on the wrong day.

4.5 Reasons for Not Administering

When it is not possible to administer the prescribed medicine, the reason for not administering must be recorded by entering the appropriate code (refer below) and circling. By circling the code it will not accidentally be misread as someone’s initials.

If a patient refuses medicine(s), then the medical officer must be notified.

If medicine(s) are withheld, the reason must be documented in the patient’s medical notes.

If the medicine is not available on the ward, it is the nurse’s responsibility to notify the pharmacy and/or obtain supply or to contact the medical officer to advise that the medicine ordered is not available.

(Refer to Appendix B - Guidelines for Withholding Medicines)

4.6 Clinical Pharmacist Review

The clinical pharmacist will sign this section as a record that they have reviewed the medication chart on that day.

If the chart is reviewed by an appropriately credentialed professional, they should sign immediately under the ‘Clinical Pharmacist Review’ signoff box.

Rationale

Review by a clinical pharmacist will ensure that all orders are clear, safe and appropriate for that individual patient, therefore the risk of an adverse drug event is minimised.
4.7 Discharge Supply

For each drug prescribed for an inpatient, the following information must be documented in the discharge supply section:

- Continue on discharge yes/no
- Dispense medication yes/no
- Duration / Quantity

For each page, the following information is only required to be documented once:

- Prescriber's signature
- Prescriber to print name
- Prescriber's contact number
- Date discharge ordered
- Dispensing Pharmacist's signature
- Date discharge medication dispensed

For schedule 8 medications:

- Hospitals may have their own procedures in place for prescribing discharge supplies of schedule 8 medications which must be followed

Note

A drug prescribed for discharge where the dosage is changed should be written up by the prescriber as a new prescription, ceased in the administration columns (refer to Section 4.3) but indicated as being a required medication for discharge.

Rationale

The discharge supply section is designed to facilitate the dispensing of discharge medication directly from the chart as a mechanism to avoid transcription errors.
5. Back Page of Medication Chart (including top section of left middle page)

5.1 Patient Location

Facility/Service: ________________

Ward/Unit: ________________________________

The patient’s current location should be clearly marked on the medication chart.

5.2 Identification of the Patient

Every medication chart must have:
- EITHER the current patient identification label
- OR, as a minimum, the patient name, UR number, date of birth and gender written in legible print
- AND the first prescriber must print the patient’s name and check that the identification label is correct

Medication Orders cannot be administered if the prescriber does not document the patient identification.

Rationale

Patient identification guidelines and the printing of patient name will reduce the risk of wrong identification label being placed on the chart and the wrong patient receiving medication.

5.3 Patient Age, BSA Index, Weight and Height

- Pages 1 and 2 - staff are to record the patient’s weight in the space provided. The date that the patient’s weight was taken should also be recorded.
- Page 2 - staff are required to record the patient’s age, BSA index, height and weight in the space provided. The date that the patient’s height, weight and BSA index was taken should also be recorded.

Rationale

Many high risk and paediatric medication doses are calculated using the patient’s body weight.
5.4 Numbering of the Medication Chart

If more than one paediatric medication chart is in use, then this must be indicated by filling in the appropriate numbers using the spaces provided. E.g. Paediatric Medication Chart 1 of 2.

If additional charts are written, this information will need to be updated.

5.5 Additional (specialised) Charts

When additional (specialised) charts are written, this should be indicated by placing a tick or cross in the space provided on each chart in use.

5.6 Adverse Drug Reaction Alerts

If the patient and/or his/her carer is not aware of any previous Adverse Drug Reaction (ADR), then the Nil known box should be ticked and the person documenting the information must sign, print their name and date the entry.

If a previous ADR exists, then the following steps must be completed:

a) Document the following information in the space provided on the medication chart and in the patient’s medical notes:
   - Name of drug/substance (include allergies to drugs, food, lotions, plaster, latex etc)
   - Reaction details (e.g. rash)
   - Date that reaction occurred (or approximate timeframe e.g. “20 years ago”)
   - Initials of person completing information

   This is the minimum information that should be documented. It is preferable to also document how the reaction was managed (e.g. ‘withdraw & avoid offending agent’) and the source of the information (e.g. patient self report, previous documentation in medical notes etc).

b) Affix ADR alert sticker to the front and back page of the paediatric medication chart in space provided.

c) Complete any hospital ADR and alert requirements as per hospital policy.
d) **Affix large, red ADR alert sticker** to the front of the patient’s medical record and complete the relevant information.

If any information is added to this section after the initial interview the person adding the information must document their initials in the designated area.

e) Replace the patient’s white patient identification bracelet with a **red alert bracelet**. The red patient identification bracelet should be annotated with the patient name, UR number and date of birth in legible print. Refer to the Hospital policy, WA Health policy or National Patient Identification Band Standards for further information.

Details of the ADR should **not** be written on the bracelet. The bracelet is only to be used as an alert. For details about the allergy refer to the patient’s medication chart.

**Note**

Medical officers, nurses and pharmacists are obliged to complete ‘Allergies and Adverse Drug Reactions (ADR)’ details for all patients. (*Patients may be more familiar with the term allergy, than ADR, so this may be a better prompt*). Once the information has been documented, the person documenting the information must sign, print their name and date the entry.

For further information, refer to the WA Medication Safety Group Adverse Drug Reaction (ADR) Alert (2009) and Department of Health Operational Circular OP 2079/06 *Red Alert Bracelet for Patients with a Known Allergy* (2006).

**Rationale**

- Information about a previous ADRs or allergies can assist staff in making decisions about medication therapy and avoid re-prescribing, dispensing and administering a medication involved in a previous ADR.
- Signing of ADR histories by the clinician helps to assign accountability for the information obtained.
- Alerts provide a physical reminder to help prevent ADRs.
5.7 Once Only Medications

Once only medication orders:

The following must be documented for once only medication orders:

- Date prescribed
- Generic name of medicine
- Route of administration (accepted abbreviations may be used, refer to Section 4.1)
- Dose to be administered
- Date and time medicine is to be administered
- Prescriber’s signature and printed name
- Initials of person that administers the medicine
- Date and Time medicine administered
- Pharmacy information including if medicine requires supply (S) or is on imprest (I)

5.8 Telephone Orders

The following must be documented for telephone orders:

- Date prescribed
- Generic name of medicine
- Route of administration (accepted abbreviations may be used, refer to Section 4.1)
- Dose to be administered
- Date and time medicine is to be administered
- Name of doctor giving verbal order
- Initials of two nursing officers to confirm that verbal order heard and checked (see example below)
- Time of administration
- Initials of person that administers the medicine

The telephone order MUST be signed and dated, or otherwise confirmed in writing, within 24 hours.

For example

Rationale

Telephone orders are discouraged, as they are a high error prone activity. To reduce the potential for error, telephone orders are to be countersigned by two nurses who have both independently received and read back the order to the prescribing physician.
## 5.9 Register of Initials

<table>
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<tr>
<th>Initials</th>
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<th>Print name and designation</th>
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</table>

Each Paediatric Inpatient Medication Chart must document the names, initials and designation of each of the medical officer, nurses and pharmacists who are involved in the prescribing, dispensing and administration of medications to each patient.

**Rationale**

In order to prevent incorrect prescribing, dispensing and administration of medications, this section is designed to facilitate the easy identification of doctors, nurses and pharmacists who are involved in the prescribing, dispensing and administration of medications to each patient.
5.10 Drugs Taken Prior to Admission

Medication reconciliation, including an accurate medication history, is to be conducted for all inpatients by an appropriately credentialed professional, ideally within 24 hours of admission for high-risk patients.

A history of the medicines taken prior to presentation to Hospital (including over the counter and complimentary medicines) should be recorded either on the Paediatric Inpatient Medication Chart or on a standalone Medication History Form. As part of the clinical handover process, medicines prescribed/administered by Emergency Department staff, St John Ambulance staff, Royal Flying Doctor Service staff, NETS (Newborn Emergency Transport Services) should be checked and transcribed onto the appropriate Paediatric Inpatient Medication Chart or Medication History Form.

The admitting medical officer, a pharmacist or other credentialed clinician trained in medication history documentation may complete this section. The following must be documented:

- A complete list of all medicines taken normally at home (prescription and non-prescription) including drug identification details (generic name, strength and form), dose and frequency, and duration of therapy/when therapy started
- Whether the patient has their own medicines with them
- Contact details for patient’s community health providers (GP and Community Pharmacist)
- Details of who usually administers the medicines to the patient

Any discrepancies noted by the person documenting the medication history must be brought to the attention of the attending medical officer.

When a subsequent Paediatric Inpatient Medication Chart is required, the prescribing officer is to write “refer to original Paediatric Medication Chart for this admission” in the drugs taken prior to admission section.

Note

The medication chart provides space for the minimum information that should be documented. It is helpful to also document the indication for use and to use a checklist as a prompt to ensure a comprehensive history is obtained. For more information about medication history documentation refer to relevant WA Health Policies or local health service policy.

This section is included in the medication chart to facilitate quick and effective documentation of, and access to, medication history information. At local levels, facilities may choose to implement a more comprehensive approach to documentation.

Rationale

Medication history provides an essential source of information for staff when making decisions about appropriate medication therapy. As part of the clinical handover process, medicines prescribed/administered by Emergency Department staff, St John Ambulance staff, Royal Flying Doctor Service staff, NETS (Newborn Emergency Transport Services) should also be documented on the Paediatric Inpatient Medication Chart or Medication History Form. Having this information on the chart also facilitates communication back to the GP of changes made to a patient’s medications during admission.
APPENDIX A - GUIDELINES FOR WITHHOLDING MEDICINES

The medication chart is a legal document and therefore must be written in a clear, legible and unambiguous form.

Every nurse has a responsibility to ensure they can clearly read and understand the order before administering any medicines. For all incomplete or unclear orders, the medical officer should be contacted to clarify.

Never make any assumptions about the prescriber’s intent.

Every medication chart must have the patient’s identification details completed.

Every medication order must be complete and include:

- Date
- Route
- Generic drug name
- Dose ordered in metric units & Arabic numerals
- Frequency (using only accepted abbreviations)
- Times (must be entered by the medical officer)
- Prescriber’s signature
- Prescriber’s name printed

It is appropriate to withhold the medicine if there is a known adverse drug reaction (ADR) to the prescribed medicine.

If the medication chart is full (ie there is no appropriate space to sign for administration) then the medication order is not valid. The chart must be re-written as soon as possible.

Generally medicines should not be withheld if the patient is pre-operative or nil by mouth (NBM)/fasting unless specified by the medical officer.

Remember the six R’s:

- The right drug
- The right dose
- The right route
- The right time
- The right patient
- The right documentation¹

¹ Nurses Board of Western Australia. Medication Management Guidelines for Nurses and Midwives.