Guidelines for the WA National Inpatient Medication Chart

Guidelines for use of the WA NIMC including the long stay NIMC

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

Version 5 – August 2012

Department of Health

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GUIDELINES FOR USE OF THE NATIONAL IN-PATIENT MEDICATION CHART

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

Exceptions: The National In-patient 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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ITEMS COVERED IN THIS GUIDELINE

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1. Introduction

The National In-patient Medication Chart (NIMC) is an initiative of the Australian Council for Safety and Quality in Health Care (Council), now known as the Australian Commission for Safety and Quality in Health Care. The Council considered the introduction of a standardised chart as a significant quality improvement strategy aimed at reducing patient harm resulting from errors in the medication documentation processes. Quality and safety improvements were proposed through standardising processes of communication, optimising workflow patterns and introducing functions to improve the safe, effective and efficient use of medicines.

The Council's National Medication Chart Working Group developed the NIMC based on the standardised chart developed by Queensland Health.

In developing its chart, Queensland Health undertook:
- an extensive literature review focusing on factors that cause prescribing and administration errors;
- learning from human factors and ergonomic;
- observational studies and work practice mapping;
- audits;
- pilots; and
- national focus groups

In April 2004, Australian Health Ministers endorsed the use of a common medication chart in all public hospitals to assist in standardisation and consistent documentation of medications.

In August 2004, following agreement on the design of the NIMC, the Council piloted the chart in a total of 31 sites across Australia (January – May 2005), including three sites in WA – Joondalup Health Campus, Broome-Kimberley Health Service and Kalgoorlie Regional Hospital.

Participating hospitals were required to conduct a pre and post implementation audit. The aim of the audits was to measure the impact of the implementation of the NIMC so as to inform the rollout of the chart nationally in accordance with the recommendations from the Australian Health Ministers. The *NIMC Pilot Aggregate Data Report* provides a comparison of baseline results with data following the implementation of the NIMC. The general trend of the data demonstrates improvement in medication documentation processes across the pilot sites. There is however, opportunity for improvement in most aspects of documentation.

The NIMC 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.

NIMC long-stay version
A long-stay version of the NIMC was developed for long-term, stable patients in acute care settings. For example, the NIMC long-stay version may be suitable for patients in spinal units and rehabilitation units. The NIMC long-stay version available on the Commission web site has 28.5 days of administration available although the number of administration days may be varied.

The NIMC long-stay version does not have variable dose or VTE prophylaxis pre-printed sections. Hospitals will need to ensure policies are in place so that those, or other, specialist drug therapies are stepped down for patients transitioning from the NIMC to the NIMC long-stay version.

Paediatric versions of the NIMC
In 2008, Australian Health Ministers endorsed paediatric versions of the NIMC (short and long stay). The paediatric NIMCs have additional features that support safe prescribing in the paediatric population including neonates. These charts should be used for all children aged 12 years and less. Hospitals may chose to use the chart in children up to the age of 18 years, particularly where weight based dosing is being used. Instructions on the use of the safety features specific to the Paediatric NIMCs are outlined in Section 6 of this guide. Unless otherwise indicated the general guide in Sections 2 through to 5 also apply to the Paediatric NIMCs.

2. General Instructions

The following are **general requirements** regarding use of the medication chart:

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

- The medication chart is to be completed for all admitted 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 immunosuppressive agents, epidural and regional infusion and patient controlled analgesia.

- **All orders are to be written legibly in ink.**

- No matter how accurate or complete an order is, it may be misinterpreted if it cannot be read.

- Water-soluble ink (e.g. fountain pen) should not be used.

- Black ink is preferred (Australian Standard for Paper-based health care records AS2828-1999). Local policy may allow for the use of a distinct pen colour for pharmacist annotations. This colour should be chosen to prevent confusion with the prescribers' orders and must be legible on photocopy or fax.

- A medication order is valid only if the medical officer enters all the required items.

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

- Only accepted abbreviations may be used. Refer to http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12476

- A separate order is required for each medicine.

- A separate order is required for each different route of a medication unless local guidelines direct otherwise.

- No erasers or whiteout can be used.

3. Front Page of Medication Chart (including top section of middle page visible when chart is closed)

3.1 Patient Location

Facility/Service: ....

Ward/Unit: ....

Consultant: ....

The patient's current location should be clearly marked on the medication chart. If patients move to a different ward or unit this new location should be indicated on the chart.

3.2 Identification of the Patient

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

UR No:

Family name:

Given names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

DOB: Sex ☐ M ☐ F

1st Prescriber to print patient name and check label correct:

....

Patient weight (kg): ....

Height (cm): ....

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

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 Patient Weight and Height

Patient weight (kg): ....

Height (cm): ....

Patient weight and height information should be documented in the space provided (it is important clinical information vital to confirming doses of certain medicines).

Rationale

The doses of many high risk drugs are calculated using the patient's body weight.

3.4 Numbering of the Medication Chart

MEDICATION Chart No. ....of ....

If more than one NIMC is in use, then this must be indicated by filling in the appropriate numbers using the spaces provided e.g. Medication Chart 1 of 2. NOTE: This count does not include specialised charts refered to below.

If additional charts are written, this information must be updated.

3.5 Additional (specialised) Charts

☐ IV Fluids   ☐ BGL/Insulin   ☐ Acute Pain   ☐ Variable Dose

☐ Palliative Care   ☐ Chemotherapy   ☐ Anticoagulation   ☐ Other

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

NOTE: Use of the **WA Anticoagulation Medication Chart** became mandatory in April 2010.
If anticoagulants are being prescribed (therapeutic **or** prophylactic), the above box **AND** the large box in the middle pages of the WA NIMC must be ticked.

3.6 Adverse Drug Reaction Alerts

Attach ADR Sticker

ALLERGIES AND ADVERSE DRUG REACTIONS (ADR)
☐ **Nil known**   ☐ **Unknown** (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

Sign: .... Print: .... Date: ....

If the patient is not aware of any previous Adverse Drug Reaction (ADR), then the <u>**Nil known**</u> box **must** be ticked and the person documenting the information must sign, print their name and date the entry.

If a previous allergy or 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"*)
  * Initial the entry

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*).
Once complete the person completing the ADR box must sign and complete their name and the date at the bottom of the ADR box.

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

c) Affix **large, red ADR alert sticker** to the front of the patient's medical record and complete the relevant information, if not already done.

d) Attach **red ADR alert bracelet** to patient's wrist. Details of the ADR should **not** be written on the bracelet. The bracelet is only to be used as an alert, for allergy details refer to the medication chart.

The bracelet must be annotated with the patient name, UR number and date of birth in legible print using a permanent marker or a computer generated label.

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

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.

Rationale

- Information about 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.

3.7 Once Only, Pre-Medication and Nurse/Midwife Initiated Medicines

ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES								
Date prescribed	Medication (print generic name)	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator		Given by	Time given	Pharmacy
					Signature	Print your name			

Once only and pre-medication orders:

The following must be documented for **once only** and **pre-medication orders**:
- Date prescribed
- Generic name of medicine
- Route of administration (accepted abbreviations may be used, refer to Section 4.2)
- 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
- Time medicine administered
- Pharmacy confirmation that medicine is safe to administer and requires supply (S) or is on imprest (I)

Nurse/Midwife initiated medicines:

The following must be documented for **nurse/midwife initiated medicines**:
- Date prescribed
- Generic name of medicine
- Route of administration (accepted abbreviations may be used, refer to Section 4.4)
- Dose to be administered
- Date and time medicine nurse initiated
- Nurse/midwife initiator to sign and print name
- Initials of person that administers the medicine

> *Note*
>
> Local hospital policy/guidelines will outline when nurses can initiate specific medicines and will specify a limitation on nurse initiated medicines such as 'for one dose only' or 'for a maximum of 24 hours only.'
>
> Generally the capacity applies to a limited list of medicines only. Typically this includes: simple analgesics, aperients, antacids, cough suppressants, sublingual nitrates, inhaled bronchodilators, artificial tears, sodium chloride 0.9% flush or IV infusion to keep IV line(s) patent as per local policy.

3.8 Telephone Orders

Date/ Time	Medication (print generic name)	Route	Dose	Frequency	Nurse/Midwife Initials 1st/2nd	Dr name	Dr sign	Date	RECORD OF ADMINISTRATION			
									Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

TELEPHONE ORDERS (to be signed within 24 hours of order)

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 4.4)
- Dose to be administered
- Frequency at which the medicine is to be administered
- Initials of two nursing officers/midwives to confirm that verbal order heard and checked (see example below)
- Name of doctor giving verbal order
- Time of administration

The telephone order MUST be signed and dated by the doctor giving the verbal order, 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.

3.9 Drugs Taken Prior to Admission

Medicines taken Prior to Presentation to Hospital (Prescribed, over the counter, complementary)			Own medications brought in? ☐ Y ☐ N Administration Aid (specify)		
Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration
GP:			Community Pharmacy:		
Documented by:	(Sign)		(Date)	Medicines usually administered by:	

The admitting medical officer, a pharmacist or other 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
- Whether the patient uses a dose administration aid (*e.g. WebsterPak or other blister pack*)
- Contact details for patient's community health providers (GP and Community Pharmacist)
- Whether the patient usually receives assistance to administer/manage their medicines

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

When a subsequent medication chart is required, prescribing officer is to write "refer to original NIMC for this admission" in the drugs taken prior to admission section.

Note

This section is included in the medication chart to facilitate quick and effective documentation of, and access to, medication history information and provides space for the **minimum** information that should be documented. At local levels, facilities may choose to implement a more comprehensive approach to documentation including documenting the indication for use and use of a checklist as a prompt to ensure a comprehensive history is obtained. If a separate medication history or action plan form is used, reference to it should be made on the medication chart. For more information about medication history documentation refer to local health service policy.

Rationale

Medication history provides an essential source of information for staff when making decisions about appropriate medication therapy. Current processes are disjointed and information often located in various parts of the record or with pharmacy staff. Having this information on the chart also facilitates communication back to the GP of changes made to a patient's medications during admission.

4. Middle Pages of the Medication Chart

4.1 Variable Dose Medicines (not relevant to the long stay NIMC)

For **each day of therapy**, the following information should be documented:
- Drug level results when required
- Time drug level taken

For **each dose**, the following information must be documented:
- Dose
- Prescriber's initials
- Initials of nurse that administers the dose – to be signed in the "Time to be given" row.
- Actual time of administration (this may be different from the dose time)

If a patient requires a **second variable dose medication** use, another chart or consider using the variable dose medication chart.
If patient requires **twice daily dosing**, prescribe in the regular section using the above format or consider using the variable dose medication chart.

Rationale

This section has been formatted to facilitate ordering of medicines that require variable dosing based on laboratory test results or as a reducing protocol *eg gentamicin and steroids*. If these agents are ordered in the regular ordering section, then there is no designated area to record drug levels and if they are ordered in the "once-only" ordering section, the risk of errors of omission is increased.

4.2 Regular Medicines

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

a) **Date -** date that the medication order was **written** should be entered; **NOT** the date that it was originally ordered. The prescriber will need to locate the original order date if required.

b) **Generic Drug Name -** because there may be several brands of one agent available, the generic name should be used. Local guidelines may allow the prescribing of certain brand names e.g. for some combination preparations such as *Seretide®, 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. This box should be ticked for medications which are enteric coated as this is classified as a modified release form which slows release until within the intestine.

d) **Route -** only commonly used and understood abbreviations should be used to indicate the route of administration. Acceptable abbreviations are listed below.

COMMONLY USED AND UNDERSTOOD ABBREVIATIONS			
Abbreviation	Meaning	Abbreviation	Meaning
IM	intramuscular injection	Eye Ointment	eye ointment
Intrathecal	intrathecal	PO	per oral / by mouth
IV	intravenous injection	PR	per rectum
MA	metered aerosol	PV	per vagina
MDI	metered dose inhaler	SUBCUT	subcutaneous
Neb	nebulised / nebuliser	SUBLINGUAL	sublingual
NG	nasogastric	top	topical

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to Avoid	Intended Meaning	Reason for Avoiding	Acceptable Alternative
S/C	subcutaneous	Mistaken for 'sublingual'	write subcut or subcutaneous
S/L	sublingual	Mistaken for S/C (subcutaneous)	write subling or under tongue
E	Ear or eye	Misinterpreted as the other organ	write ear or eye in full
IVI	Intravenous Injection / Infusion	Misread IVI as IV1 resulting in overdose (e.g. administration of 125mg of the intended medication rather than 25mg.)	Write 'IV' or 'Intravenous'

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 125micrograms 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.

COMMONLY USED AND UNDERSTOOD ABBREVIATIONS	
Abbreviation	**Meaning**
mL	Millilitre
L	Litre
g	Gram
mg	Milligram
microg (safer to write microgram in full)	Microgram
Unit(s)	International Unit(s)

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to Avoid	**Intended Meaning**	**Reason for Avoiding**	**Acceptable Alternative**
Ug, µg or mcg	microgram	mistaken for milligram when handwritten	write microg or write microgram
U or U/s	Unit or units	mistaken for 0	write unit(s)
IU or iu (*eg 3 IU*)	international unit	mistaken as iv (intravenous) or as 31u (thirty-one units)	write unit(s)
No zero before decimal point (eg .5mg)	0.5mg	Misread as 5mg	Write **0.5mg** or write **500microgram**
Zero after decimal point (eg 5.0mg)	5mg	Misread as 50mg	Do not use decimal points after whole numbers

f) **Frequency and Administration Times** - The medical officer writing the order **must** enter the frequency and administration time(s) when writing the medication order, this is to ensure no errors occur when interpreting the frequency prescribed. **If these details are not entered, the dose may not be administered by nursing staff.**

Acceptable frequency abbreviations are listed below.

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

RECOMMENDED ADMINISTRATION TIMES GUIDELINES ONLY					
Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800		2000	
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

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.
In the situation where a drug is prescribed more than six times per day the order should be written over two boxes to allow more than 6 times be entered.

COMMONLY USED AND UNDERSTOOD ABBREVIATIONS	
Abbreviation	**Meaning**
bd	Twice daily
mane	Morning
nocte	Night
qid	Four times a day
tds	Three times a day

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to Avoid	**Intended Meaning**	**Reason for Avoiding**	**Acceptable Alternative**
OD, od or d	Once a day Once daily	mistaken for twice a day d is easily missed	write mane, nocte or specific time
QD or qd	Every day	Mistaken as qid (four times a day)	write mane, nocte or specific time
m	Morning	Mistaken for n (night)	Write mane
n	Nocte	Mistaken for m (morning)	Write nocte
6/24	Every six hours	Mistaken for six times a day	Write q6h or 6 hourly
1/7	For one day	Mistaken for one week	Write for one day in full
X 3d	For 3 days	Mistaken as for three doses	Write for 3 days in full

g) **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** or **DD** to indicate a Schedule 8 medicine (stored in CD/DD cupboard)
- **Fridge** to indicate a medicine that is stored in the fridge
- Recommendations or instructions on the safe administration of the prescribed medicine.

Any annotations by the pharmacist should be easily identified as being distinct from the prescribers writing. Hospital policy may allow for the use of coloured ink pens, however these should be easily visible when charts are photocopied or faxed.

h) **Indication** - This section is for the medical officer to document the indication for use. This allows the order to be reviewed in the context of why the medicine was prescribed, reducing the risk of misinterpretation of the order (e.g. medicines with look-a-like names) or incorrect doses (e.g. where medicines have different doses for different indications).

i) **Doctor Signature and Print Name -** The signature of the medical officer must be written to complete each medication order. For each signature (prescriber), their name must be written at least once on the medication chart with a contact number to allow clarification if necessary.

4.3 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 <u>NOT</u> to be given**.**

4.4 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"**.

4.5 Administration Record

The medication administration record provides space to record **up to ten days** of therapy and up to **35 days** on the long stay NIMC. At the end of ten or 35 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 a valid/current prescription.

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

- 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.

4.6 Reasons for Not Administering

REASON FOR NURSE NOT ADMINISTERING Codes MUST be circled	
Absent	(A)
Fasting	(F)
Refused - notify Dr	(R)
Vomiting	(V)
On leave	(L)
Not available - obtain supply or contact Dr	(N)
Withheld - Enter reason in Clinical Record	(W)
Self Administering	(S)

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** this code. 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.

4.7 Clinical Pharmacist Review

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 credentialled 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.

4.8 Discharge Supply

Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:	Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:	Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:	Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:	Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:	Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty: ....

Prescriber's signature: _____ Print your name: _____ Contact No: _____ Date: _____ Pharmacist: _____ Date: _____

For **each drug** prescribed for an inpatient, the following information must be documented in the discharge supply section
- Continue on discharge? yes/no
- Discharge supply required? yes/no
- Duration in days and/or Quantity required to be dispensed. Note for schedule 8 medication the total quantity MUST be specified.

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 the discharge is prescribed
- Pharmacist signature
- Date discharge medication is dispensed

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 4.6) but indicated as being a required medication for discharge.

Hospitals may have local policy which required PBS or hospital prescriptions to be written for discharge medications rather than using the discharge supply section of the NIMC. Local policy should be followed in this situation.

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.

5.1 As required ("PRN") Medicines

Date	Medication (Print Generic Name)		Date										
Route	Dose Hourly Frequency **PRN**	Max Dose/24 hrs	Time										
Indication		Pharmacy	Dose										
			Route										
Prescriber Signature	Print Your Name	Contact	Sign										

Prescribing:
The medical officer **must** write:
- Dose and hourly frequency. "PRN" (pre-printed) alone is not sufficient
- Indication and maximum daily dose (ie Maximum dose in 24 hours) *eg Paracetamol 4g/24 hrs*

The 'Max dose/24 hours' prompt indicates the total amount of the medication which may be administered in 24 hours for PRN doses **only**. The maximum daily dosage should not be exceeded for that PRN medicine. Prescribers should exercise caution when prescribing PRN medicines and check the regular medications section for possible duplicate orders.

Administration:
The actual dose given **must** be recorded as well as confirming the route
The person administering each dose is responsible for checking that the maximum daily dosage will not be exceeded

Date 1/10/04	Medication (Print Generic Name) *Paracetamol*		Date 1/10	
Route O	Dose 1g Hourly frequency 6 hrly **PRN**	Max dose/24 hrs 4g	Time 1400	
Indication *Febrile*		Pharmacy	Dose 1g	
			Route O	
Prescriber Signature	Print Your Name B Good	Contact page 0004	Sign	

Prescribing PRN opioids

The sedation score may be specified in the 'Max Dose/24 hrs' section to indicate the maximum dose of drug to be administered when prescribing opioids in the PRN section.

Where sedation scores are used the hospital policy or guideline should specify a standard sedation scoring system and a process for recording the scores, and the record must be available at the point of care. Nursing and medical staff should be familiar with the sedation scale used.

In the example below, using the 4 point sedation scale of 0 to 3 published by the Victorian Quality Council (see below), the PRN order could specify "if sedation score is less than 2". The error-prone symbol $<$ should not be used.

Date 2/3/12	Medication (Print Generic Name) OXYCODONE (ENDONE)		Date 2/3								Continue on discharge? Yes / No
Route PO	Dose 5mg Hourly Frequency 4hrly **PRN**	Max Dose/24 hrs If Sedation score less than 2	Time 1400								Dispense? Yes / No Qty:
Indication Breakthrough Pain	Pharmacy		Dose 5mg								Duration: days
			Route PO								Date:
Prescriber Signature	Print Your Name M Smith	Contact 4721	Sign AN								

6. Special features of the PAEDIATRIC SHORT STAY Medication Chart

The paediatric versions of the NIMC incorporate additional features identified as important for facilitating safe medicines use in the paediatric and neonatal populations. These features include designated:
• Boxes for recording weight and date measured on front and back pages of chart;
• Spaces for recording body surface area and gestational age at birth (where relevant);
• Space for documenting the basis for dose calculation (e.g. mg/kg/dose); and
• Space for double signing when recording administration.

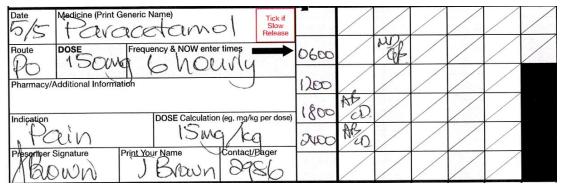## 6.1 Patient weight, date, height, and body surface area
The child's weight must be documented in the box on the front of the chart including the date weight was measured. The weight should also be documented on the back page when PRN medicines are ordered.
The height and body surface area should be documented for when body surface area (BSA) is used to calculate the dose of a medicine.

6.2 Gestational age at birth
There is space for recording gestational age at birth under the BSA and height box. This should be completed for premature infants.

6.3 Dose calculation
The prescriber must document the basis for the dose calculation in the dose calculation box (e.g. mg/kg/dose or microgram/m2/dose etc). This will assist pharmacists, nurses and other doctors in double-checking the dose to ensure that the intended and actual dose is calculated correctly.

The basis for the dose calculation should first be checked in a current paediatric dosing reference endorsed by the local Drug and Therapeutics Committee. The actual dose should be calculated using an accurate weight or BSA (up to usual adult dose).
If the child is obese or significantly oedematous, the ideal weight may be more appropriate.
All calculations should be double-checked.

6.4 Administration of medicines
There are two spaces for recording the administration of each dose of medicine to allow for the recording of two signatures, to document that the double checking process has occurred when required. (See example above)

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)
- **Medical officer's signature**
- **Medical officer'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 documentation**[1]

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

APPENDIX B - Ordering oral and enteral nutritional supplements on the NIMC

The WA NIMC is not designed for ordering and administration of oral nutritional supplements.

Its use for this purpose may result in:

• Confusion of nutritional supplements with medicines; (e.g. Pulmocare® mistaken for the corticosteroid inhaler Pulmicort® and aminoacid liquid Nepro® mistaken for the antiepileptic medication Keppra®)
• Potential for patients to receive unauthorised medicines;
• Delays in provision and administration of nutrition to patients if the NIMC is sent to the pharmacy for dispensing.

Health Services that choose to use the NIMC for ordering nutritional supplements should undertake a risk assessment and have a local policy/procedure on the ordering and administration of nutritional supplements on the NIMC. The same requirements for safer prescribing and administration of medicines apply to nutritional products.

The policy/procedure should include:

• who is responsible for ordering nutritional supplements on the NIMC (medical officer, authorised dietitian);
• where and how the nutritional supplement is ordered;
• the requirement to annotate "nutritional supplement" in the "Indication box" or next to the product name; and
• how to cease the product.

Example