

**National Inpatient Medication Chart (NIMC) Audit  
Frequently Asked Questions**

<b>Topic Question</b>	<b>Answer</b>
<b>Preparation for participating in NIMC Audit 2014</b>	<p>The best preparation for undertaking the audit is to read the NIMC Audit Guidelines and WA's FAQ list, and attend (where possible) the Train the Trainer workshop. If unable to attend, the education package will be made available online for reading.</p> <p>Sites must decide the method for collecting the data – e.g. collect on paper tool, then manually enter data (remember that you can only upload data once data for ALL patients have been entered), enter directly onto the web-based database (data can be entered per patient).</p> <p>If site is using paper tool, print off the required number of audit tools.</p> <p>It is also recommended that sites pilot the audit tool prior to the commencement of the audit period. A meeting involving all auditors may be necessary to ensure consistency in the interpretation of the information on the NIMCs and the audit questions.</p> <p>Sites will need to determine the number of charts that are going to be audited, and how the spread of charts will be managed. Sites will also need to determine the auditors involved, and any separate data entry personnel (if appropriate).</p> <p>Other materials that need to be compiled before commencement of the audit include:</p> <ol style="list-style-type: none"><li>1. List of approved trade names</li><li>2. List of error-prone abbreviations</li><li>3. Paediatric dosing reference (for sites which have paediatric patients)</li><li>4. A calculator to ensure doses are calculated correctly (for sites which have paediatric patients)</li></ol>
<b>Selection of sample patients Are we to pick patients at random from the wards, ie. current inpatients as opposed to looking at medical records of those who have already been discharged?</b>	<p>It is up to the individual sites how the quota of patients is selected for audit. It is usually done prospectively during the patients' admission. The NIMC Audit Guidelines have a recommended sample size depending on the number of beds at your facility.</p>

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

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### Time to complete survey per patient

I have calculated that we will need to audit 50 medication charts. From previous audits, or from other people's feedback, what is the approx time it takes to audit one medication chart?

It takes approx 1 hr per audit (with a generous buffer) – this is for data collection, and entering data onto the database.

RPH have tested the web-based application (i.e. where data is entered directly onto the database), and the time taken to audit and enter data started at about 35-45mins to start (1<sup>st</sup> patient audited, with range of 15-25 drug orders), and reduced to about 15-20mins with familiarisation. Using the web-based application could significantly reduce time required for data entry, and having to double check the entry.

### Health Care Facility Code

On the NIMC Audit Tool there is space for a “Healthcare Facility Code”. What is this?

Your Healthcare Facility Code is the Establishment ID.

You need the Establishment ID (9 digit code). If you are unsure of the ID for your hospital – email QICM unit and you will be sent the ID code for your facility.

### Patient weight

If a pharmacist completed the weight section in purple pen, is this Y or N?

It doesn't matter who fills in the weight - as long as it is done the answer is Yes.

Adult patients: The patient's weight should be documented on at least one medication chart, or in the general observations chart (also known as Adult Observation and Response Chart [AORC]).

### Adverse Drug Reaction (ADR) Details

(2.1) Would ADR documentation be considered incomplete if reaction details are not stated? E.g. drugs are listed such as penicillin, tramadol, but no reaction details are specified such as nausea, or anaphylaxis.

ADR documentation needs to be completed on all charts.

Record “Y” if the following are documented on all current medication charts:

- Nil known or unknown box ticked, OR adverse drug reactions (ADRs) documented
- Drug name and reaction documented, when the patient has had a previous ADR (if known)
- Clinician signature.

If the reaction detail is not documented, it is incomplete. Select “N”.

If the reaction documented is “patient unsure” or “patient can't remember”, it is considered completed. Select “Y”.

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## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

(2.2) The guide mentions asking the patient about their ADR history and recording data according to their response. Please clarify: if the patient recalls no ADR history but medical notes do, should we still record "Yes"?

If the medical notes have a record of an ADR and the patient recalls no ADR then you would need to seek further clarification as to whether the ADR record was warranted (ie what the reaction was, when/where it occurred)

If the cognitive function of the patient is of concern then I would suggest you record a "Y" for the ADR. If the patient is adamant that no ADR exists then it may need to be reviewed further. (and answer "N" for the audit)

I would say this scenario would be less likely than the situation when the patient has had an ADR and it was not documented. (Hopefully neither situation will eventuate!)

We have cases where the 2.1 is completed with actual ADR but the patient is unavailable therefore 2.2 is completed as "Unknown." The audit tool tells us to skip 2.3 and 2.4 because 2.2 is "Unknown" however, 2.3 and 2.4 are still relevant to these patients. Is this a case needing further investigation (ie. waiting for the patient to become available)? As that would considerably increase the time required to audit. Do we always ask the patient of their ADR details for question 2.2 despite on how 2.1 is completed (NKDA, not completed or actual ADR documented)? Please advise.

If ADR documentation (2.1) is completed on the NIMC, answer 2.2-2.4 according to this documentation.

If ADR documentation (2.1) is not completed, verbally confirm with patient/family/carer if the patient has had ADR(s), and document your answer to 2.2 accordingly.

Proceed to answer 2.3 and 2.4 accordingly.

We had a scenario where question 2.1 was completed (NKDA), but upon asking the patient for ADR details in question 2.2, the patient actually had allergies. How should section 2 be filled? This is how we filled it for the moment:

2.1 Y

2.2 Y

2.3 N

2.4 N

Comments: "ADR completed as NKDA but upon questioning patient, several adverse drug reactions were discovered."

I agree with what you have suggested.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

(2.3) This mentions 'similar' class drug whereas the guide explanation refers to 'same' class. Please clarify if this strictly refers to drugs of the same class such as flucloxacillin and amoxicillin, or similar classes such as cephalosporins and penicillins.

Also, if 'Yes' is recorded but a rationale is documented, should we also document that?

I think the intention for this question is for drugs that have similar class cross-reactivity (which cover both examples you have given, also the infamous "Sulfa" allergies which are not all the same class of drug (but have a similar chemical structure)).

If the patient is documented as having a previous ADR and the decision to re-expose is documented then write this information in the field provided.

(2.4) ADR Alert Stickers on all NIMC: Does this also apply to specialised charts?

Theoretically it should, but for this audit I would concentrate on the NIMC only.

### Medication Reconciliation

(3.1) If a medication history is documented but not completed (ie. does not include medication aid/pharmacy/administration by details or not signed by whoever completed the history), how complete/incomplete does this section need to be to warrant a Y/N answer?

The minimum amount of information that is required for a medication history to be considered completed is: Drug name, dose/strength and frequency.  
e.g. Atorvastatin 40mg daily.

If the patient does not take any regular medication, the documentation of "Nil regular" or similar is also considered a medication history.

The question does not target the accuracy of the medication history, neither whether the person documenting the medication history has signed the entry.

If the medication history is not present on any of the active charts, a cross reference should be made on the NIMC – e.g. "refer/see other med chart" or "refer/see MMP".  
In this case, the answer for 3.1 would be No, and 3.2 would be Yes.

### VTE Prophylaxis

(5.1) VTE Assessment: since we have not yet started to use the NIMC with the VTE assessment embedded into it, are we looking to see that any form of assessment has been done.

If your site has not implemented the (short stay) NIMC with integrated VTE risk assessment tool, select NA, and skip to Section 6.

Similarly, if auditing a long stay NIMC, paediatric NIMC or paediatric long stay NIMC, select NA, and skip to Section 6.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### Warfarin

(6.1) Please clarify what the "Warfarin Guidelines" refers to. Is this the pink anticoagulation chart? Also, our NIMC does not have a warfarin section. In its place is a tick box to indicate if warfarin or anticoagulant is in use. We use the anticoagulation chart for warfarin orders instead.

The National version of the NIMC has a dedicated warfarin prescription section. The WA NIMC does not as WA has a WA Anticoagulation Chart for all anticoagulant prescribing.

The Commission will not amend the audit tool for WA circumstances - therefore put NA for Q6.1 and then 0 for Q6.2 and go to Q7.1

(6.3 & 6.4) INR range: We are confused with these items as we believe an INR range need only be documented once (and the NIMC only has one box for it). Therefore, we can only record "0" or "1" in which case this item should have been a "Yes" or "No" type of record. Please elaborate.

If you have selected NA to 6.1, and entered "0" to 6.2, both these questions can be skipped.

### Prescribing and Administration

#### Annotation on NIMC (including ceased orders)

Are we auditing only what the prescriber has written on the NIMC or are we including pharmacist annotations?

The NIMC audit primarily looks at what has been annotated by the doctor – i.e. the medication order as it is intended, prior to pharmacist involvement. [Except Q11.11 – pharmacist annotation].

The NIMC audit looks at all aspects of use of the chart including prescribing (medical or nurse practitioner), administration (nursing) and pharmacy annotation for safe use of medicines.

There is a column in the audit tool determines whether the pharmacist has annotated the prescription.

Could you please confirm the following:

- Indication written in by pharmacist
- Dose/Frequency unclear but clarified in purple pen
- Route written as PO/IV but pharmacist has crossed out IV
- SR box is ticked by pharmacist, not by prescriber
- 11.10 (Indication) N, 11.11 (P'cist annotation) Y
- 11.5 (dose) U, 11.6 (frequency) U, 11.11 (P'cist annotation) Y
- 11.4 (route) U, 11.1 (P'cist annotation) Y
- 7.2 Consider ticked – irrespective of doctor or pharmacist annotation

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### Acceptable tradenames

(11.3) Do you have a list of acceptable trade names used statewide (re. 11.3 Drug Name)?

There is no existing list of acceptable brand names - this is left up to site policy/guidelines. ie OXYNORM would be acceptable to clarify formulation, some sites find it acceptable to use tradenames for some combination products (e.g. Panadeine Forte etc) or insulins (e.g. Novomix 30, Lantus). It is up to the site to decide what is acceptable.

### Clarification of Clear prescription example

(11.3/11.11) Prescriber has written: "Coversyl 5mg i mane" and in purple pen a pharmacist has written "Perindopril" to indicate the generic name. Are we auditing only what prescribers have written on the NIMC or are we including pharmacist annotations?

Do we complete item 11.3 as C (Clear) because the pharmacist has clarified the drug name or T (Tradename) because the original prescriber did not write the generic name?

You would need to answer "T" for tradename in Drug name column. Then in the pharmacist annotation section select "Y".

(11.5) Antibiotics such as Tazocin where the strength is written as 4.5g - is this considered unclear because it should be 4g/500mg or is clear/unclear status something that should be decided internally?

I think you will have to decide at a site level. Technically this is unclear, but it is commonly prescribed that way and may be deemed acceptable.

### Determining if dose is correct

(11.5) How much analysis is expected for us to determine if a dose is correct? Would doses falling under normal ranges be sufficient to be correct, or do we need to consider individual patient factors (eg. blood results, medical histories, adverse effects, treatment outcomes) to determine if the dose is correct?

This refers only to the documentation of the dose. Auditors will not need to check the appropriateness of the dose.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### Frequency

(11.6/11.14) If the frequency is missing, but times are charted (eg. 'bd' is missing but times for 0800 and 2000 are written) is that considered "missing" or "unclear"? Also, what is an example of incorrect frequency? We are not sure how a frequency can be incorrect, unless this refers to an irrationally unusual dose frequency for the particular drug.

It would also depend upon who wrote the times for administration (prescriber/nurse/pharmacist). I would hope that all prescriptions would have a frequency written as well as the times entered.

In this case, I would consider the frequency (11.6) "Missing" and frequency matches administration time (11.14) "No".

Unclear may be more to do with use of abbreviations that can be confused (ie od, 4<sup>o</sup> etc) or illegible writing.

"q4h" for Oxycontin may be deemed as incorrect if the prescriber is unaware he has prescribed the wrong formulation etc...

### Calculation for paediatric medication orders

(11.7/11.8) Where is the place to document calculations if calculations have been done on the NIMC?

The calculation question only relates to paediatric charts (if you use them at your hospital). If not auditing a paediatric NIMC (long or short stay), you need to answer NA.

### Roman numerals are not acceptable abbreviations as per Commission Guidelines

The NIMC guidelines note that Roman numerals should not be used. For the number of dosage units, we commonly see a variation of the Roman numerals written. A number of dots and vertical lines coinciding with the intended number are written on top of each other (dots on top), separated by a horizontal line. Is this acceptable?

Roman numerals are not acceptable abbreviations.

"ii" is often used for puffers and combination preparations, etc but as outlined in the *Recommendations for Terminology, Abbreviations, and Symbols used in the Prescribing and Administration of Medicines* document, it states - do not use Roman numerals. It should be written as "2".

### Indication box

If the Indication: is "DHx" or "regular meds" or similar be considered Y or N? We acknowledge them as improper indications but in a way this explains why the medication is charted.

The answer would be "N". The idea of documenting the indication is to ascertain why they are on the meds. "reg meds" or DHx does not suffice.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### Pharmacist annotation

How do we record partial annotations? For example, generic name or slow release box clarified in purple pen but pharmacy box has not been signed to confirm the order (as what happens at times when an ED pharmacist sees the chart but has not yet been seen by the ward pharmacist).

If you can identify the annotation as by a pharmacist (ie purple pen) then that is adequate. Any clarification or additional information to the drug order made by a pharmacist (indicated by purple pen) is considered an "annotation".

### Prescriber printing name

For 11.13, the auditing guide states that a prescriber must write their name at least once in a chart. Does this suggest we enter Y if the prescriber has clearly printed their name for *any* order in the chart or only enter Y if that particular order has the name printed?

Eg. a chart where one prescriber has written ten items, signed all orders, but only printed their name clearly on the first order. Should Q11.13 be Y for all orders? Or Y for the first order and N for the rest?

If the prescriber has printed his/her name once on the chart then 11.13 is Y for all orders. Each prescriber must print their name on the chart for at least one order on that chart.

### Clarity of orders

Is an order of "daily" considered unclear? In regards to Q11.14 do we still enter Y so long as only one administration time is specified? Or do we also need to document this in the comments? Documenting may be cumbersome as a whole chart can be written by a prescriber this way.

If a time has been indicated and daily prescribed then it would be Y, if no time specified by prescriber then it would be unclear. Documenting this as a special comment is unnecessary.

### Correct entry of administration times

Item 11.14: It would be difficult to determine whether a doctor or a nurse entered administration times incorrectly. Are we able to write "cannot determine whether doctor or nurse entered incorrect administration times"?

This requirement has been removed from the 2014 audit.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### Doses required and doses administered

What do we document for ceased regular medications where no doses have been given: same as above, we have written "0" for both "Doses Required" and "Doses Admin"

If medication was ceased before it was started (ie prescriber changed mind) then it would be 0 and 0. However, if several days have gone by and it should have been administered (but wasn't) then you need to add up the doses that should have been given (required) and have 0 as doses administered.

### Miscellaneous Issues

#### Data entry issue

Two columns revert to NA when I enter data: Freq. and Freq. Matches Admin Time. However the correct data is retained for this patient in 'Drug Ceased'.

The answer to those data columns is N/A if stat/once only orders. (as per Guide to Auditing NIMC)

### Stat/Once Only Orders

11.14 Frequency correlates with administration time - select "NA"

#### 11.15 Drug ceased

In most cases, the order (once given) would not be ceased, and therefore it would be a "N" as it is still an "active" order.

If the order has been crossed out prior to a dose being given, then it would be a "Y" as it has been ceased.

#### 11.16 Drug ceased correctly

If answered "Y" to 11.15, check to see if the drug has been ceased correctly ("Y"), or incorrectly ("N").

If not ceased, select "NA".

11.17 Doses required - answer "0",

11.18 Doses administered – answer "0"

11.19 Max PRN dose – select "NA"

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

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### PRN orders

PRN orders where the frequency is a time interval but the max dose in 24 hours is not in strength, but number of times the medication can be given.

Eg:

Drug name: Paracetamol

Route: PO

Dose: 1g

Hourly frequency: 4hrly

Max dose/24 hours: x4

Under 11.19, is this Y, N, or Y w/ comments?

The maximum number of doses has been stipulated - therefore Y. In this example, it should ideally be max 4g/24 hours, but documenting as "x4" is also acceptable as the dose is clear.

### Missing Date on prescription

How do we document a missing date for the prescription?

It is important to the legality of the prescription - so I would advise to document this in comments section.

### Orders with dose or frequency amendments.

Orders with dose or frequency amendments. Eg. Vancomycin 2g bd where 2g is then amended to 1.5g or bd amended to tds. We are under the impression that orders cannot be amended and should be rewritten as a new order. Does the strength/frequency (whichever is amended) be considered "unclear" for these examples? Or is there a better way to record these cases?

If the amended orders are clear enough to audit, I would audit them as separate orders.

However, if it is not possible to do so, I would only audit the "newest" order, and mark dose as "unclear".

e.g. If vancomycin 2g bd was changed to 1.5g bd, I would audit as 2 orders.

Ideally the order should be ceased and rewritten as a new order.

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## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

The following section contains information pertaining to discussions at the 2014 Workshop.

### Topic (post 2014 workshop) Question

### Answer

#### PATIENT ID

##### 1.2 Patient ID complete on ALL pages.

This is in relation to the use of patient ID labels on the NIMCs.

Does the prescriber need to handwrite/print the patient's name on the BOTH sides of the active med chart if there is no active order on the PRN page?

e.g. if only regular medications are prescribed, but nothing in the PRN section yet – does the patient's name need to be written on the PRN page (page 4)

1.2. If patient ID labels are used the prescriber needs to hand-write patient's name.

If there is no order on the PRN page, then it may be acceptable that this doesn't have patient ID on it.

##### 1.3 Weight documented

With respect to paed's, does the weight need to be recorded on both sides of ALL PNIMCs, even though there is no order on the PRN page?

i.e. does it need to be recorded on page 4 if there are no PRNs documented?

1.3. No. The weight should be documented on all PNIMCs currently in use. The audit does not specify the requirement for weight to be documented on all pages of the PNIMC.

#### ADVERSE DRUG REACTION DETAILS

##### 2.4 ADR Alert Stickers

Do the stickers also need to be in place where there is no active drug order – e.g. page 4 if no PRN orders?

2.4. Yes. All pages must have the ADR Alert Stickers adhered to them.

# National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

## PRESCRIBING AND ADMINISTRATION

### 11.5 Dose

### 11.7 Dose calculation documented

### 11.8 Dose calculation documented correctly

This is in relation to paediatric dosing, the appropriateness of the dose and the documentation of the dose calculation.

e.g. Oxycodone 3mg every 4-6 hours when required (patient weight = 25kg)

Dose calculation documented as: 0.1mg/kg/dose // Based on this, dose = 2.5mg

Dose calculation according to reference: 0.1-0.2mg/kg/dose // Based on this dose = 2.5-5mg

How are we supposed to answer these questions?

11.5 Dose = C or I (it is both clear, and SAFE according to the paed dosing reference, but not according to dose calculation documented on the order)

11.7 Dose calculation = Y

11.8 Dose calculation documented correctly = Y

11.5 Dose= C

The auditor needs to calculate the total dose using the paediatric reference and the weight or BSA of the patient documented on the chart. The auditor should not be using the dose calculation documented on the chart for this question.

11.7 Dose calculation= Y

The basis for the dose calculation has been documented by the prescriber in this example.

11.8 Dose calculation documented correctly= Y

### 11.7 Dose calculation documentation

Also, in relation to the documentation of dose calculation, does this need to be written as either mg/kg/dose or microgram/m<sup>2</sup>/dose?

Is it acceptable to write it in a different form – e.g. mg/kg/day, as long as the units are clear?

The requirement is for mg/kg/dose.

This is an unacceptable and unsafe form.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### 11.15 Drug ceased

According to the NIMC User Guide, the requirements for ceasing a medication include:

- a. Clear line through the medication order in both prescription AND administration record sections.
  - b. Reason for changing, date AND initials in prescription section.
- The question has been raised as to what the minimum requirements are for the order to be ceased correctly? Are there any?

OR

If the auditor decides that the order has been ceased clearly enough, would that suffice?

e.g. If there is a line through the administration record section, but not the prescription area.

e.g. If the Dr ceasing the order does not sign that the order has been ceased, but clearly marked that no further doses be given.

e.g. If it is clear that no further doses should be given, but no reason has been documented.

### 11.15 Drug Ceased

Auditors need to agree that the medicine has been ceased.

### 11.16 Ceased Correctly

To be correct, orders must be ceased as described in the 'Note' section for this question.

Note: When a medication is ceased, the original order must not be obliterated. The prescriber must draw a clear line through the order in both the prescription and the administration record sections, taking care that the line does not cross into other orders. The prescriber must write the reason for changing the order (e.g. cease, written in error, increased dose, etc) at an appropriate place in the administration record section and date and initial the entry.

### 11.17 Doses required

### 11.18 Doses administered

In the case of PRN meds, the Guide states to enter "0" for 11.17. Do we enter the actual number of doses administered (if any) for 11.18 despite answering "0" to 11.17? e.g. 11.17 = 0 (coz PRN) and 11.18 = 7 (if 7 doses given)

No. As you suggest, 11.17 and 11.18 are interrelated. The number for 11.18 should be documented as '0' also.

If a '0' is entered into the NIMC Audit System for question 11.17, then the system will calculate 0 for doses required/doses administered, even if the doses are counted for 11.18.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

### ADR Documentation

With respect to the documentation of ADRs on the NIMC:

- For ADR documentation to be “complete”, the drug(s) and reaction(s) need to be documented on ALL med charts. “See previous/other chart” will not suffice.
- If there is no ADR documentation on the NIMC prior to auditing, you will need to verbally confirm with patient/family/carer.
- If you are unable to verify ADR information from the patient/family/carer, you should not use documentation from previous admissions to answer the audit questions. If this is the case, select “Unk” for 2.2. (*The audit only looks at what is documented for the current admission, using the active charts*).
- If the patient has had a previous ADR and it has not been documented on the NIMC, indicate on the audit tool:
  - 2.1 (ADR documentation completed on ALL charts) = N (*do not change the answer to this question*)
  - 2.2 (Patient had previous ADR) = Y.
  - Answer 2.3 and 2.4 accordingly.
  - You are allowed to write new ADR information on the NIMC (for patient safety), but do not include this in the audit data.

### Medication History

- “Nil regular medications” (or similar) documented on the front of the NIMC is considered to be a medication history. If this has been documented:
  - 3.1 (Medication History documented on Med Chart) = Y
  - 3.3 (MMP form at “end of bed folder”) – this will depend on whether the WA MMP has been used to document “Nil regular meds” as well as the NIMC.
- WA MMP:  
If your site does not use the WA MMP, but has a different mechanism of recording medication history and reconciling medications, that is fine. However, for the purpose of the audit, we are only looking at what has been documented on the WA MMP – and therefore you will be unable to answer this section.

## National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions

If so, answer “N” to 3.3, and move on to section 4.

You could choose to add to the Comments section that your site is not currently using the WA MMP – the Commission may add an “NA” option in the future.

However, to meet Standard 4, your hospital will need to have a process in place to document a medication history, the sources that are used to confirm it and communication of medication reconciliation regarding discrepancies identified.

- If the WA MMP **has** been used:
  - 3.3 (MMP form at end of bed folder) = Y
  - 3.5 (No. of medications taken prior to admission) = “0”
  - 3.6 (No. of medications with Dr’s Plan on Admission) = “0”  
*(consistent WA answer)*
  - 3.7 (No. of medications with Reconcile column ticked) = “0”
- If the WA MMP **has NOT** been used:
  - 3.3 (MMP form at end of bed folder) = N *(then skip to Q4.1)*

### Pharmaceutical Review (10.1 ) occurred

As long as a pharmacist (irrespective of level) has reviewed the chart at least once, select “Y”.

## **National Inpatient Medication Chart (NIMC) Audit Frequently Asked Questions**

### **Error Prone Abbreviations**

Standardisation of terminology, abbreviations and symbols in the prescribing and administration of medicines (Operational Directive OD 0184/09) – see link below:

[http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ\\_ID=12476](http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=12476)

Please be aware that non-standard abbreviations such as “o”, “inh” and “top” should not be used. The correct abbreviations would be “PO”, “inhale” and “eye”/ “ear” (depending on where topical treatment should be applied) respectively.

*(This supercedes the information provided at the workshop).*

### **Doses Required / Doses Administered**

Documentation of Omissions : Please check your local guidelines or policies with regards to the time allowance for dose administration from the documented dosage time.

e.g. If dose was due at 0800, and it is now 0900 (time of audit), is this dose considered to be missed?

# National Inpatient Medication Chart (NIMC) Audit

## Frequently Asked Questions

### Issue relating to Paediatric NIMC and warfarin:

Please see the National version of the adult NIMC. There is a built-in order for warfarin on page 2.

Regular medicines																					
Year 20		Date and month																			
<b>Variable dose medicine</b>		Drug level																			
Date	Medicine (print generic name)	Time level taken																			
Route		<b>Dose</b>																			
Frequency		Prescriber																			
Prescriber to enter dose times and individual dose		Time to be given:																			
Indication		Pharmacy																			
Prescriber signature		Print your name	Contact																		
Time given																					
<b>VTE risk assessed: Yes <input type="checkbox"/> Prophylaxis not required <input type="checkbox"/> Contraindicated <input type="checkbox"/></b>		Signature:											Date:								
Date	Medicine (print generic name)																				
Route		Dose	Frequency and NOW enter times																		
Indication		Pharmacy																			
<b>VTE prophylaxis</b>		Prescriber signature	Print your name	Contact																	
Mechanical prophylaxis		AM check																			
Prescriber/NI signature		Print your name	Contact																		
Date		<b>Warfarin</b>	Marevan / Coumadin																		
Route		Prescriber to enter individual doses	Target INR Range	<b>Dose</b>	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	
Indication		Pharmacy	Prescriber	1600																	
Prescriber signature		Print your name	Contact	Initial 1																	
<b>PRESCRIBER MUST ENTER administration times</b>		Initial 2																			
Date	Medicine (print generic name)	Tick if slow release																			
Route		Dose	Frequency and NOW enter times																		
Indication		Pharmacy																			
Prescriber signature		Print your name	Contact																		

This Commission wants us to audit the use of the warfarin section in the NIMC for section 6.

As WA uses the WA Anticoagulation Medication Chart (Operational Directive OD 0522/14), the warfarin section is not relevant to us.

Hence, you would answer 6.1 as "NA" and 6.2 as "0".

As was mentioned, the WA Anticoagulation chart is not suitable for use in paediatric patients and hence the warfarin order tends to be written in the paediatric NIMC. Paediatric wards can still audit this order for warfarin, but only choose "R" for 6.2 (Drug order) and not "W" for warfarin. ("W" will not be used in WA).