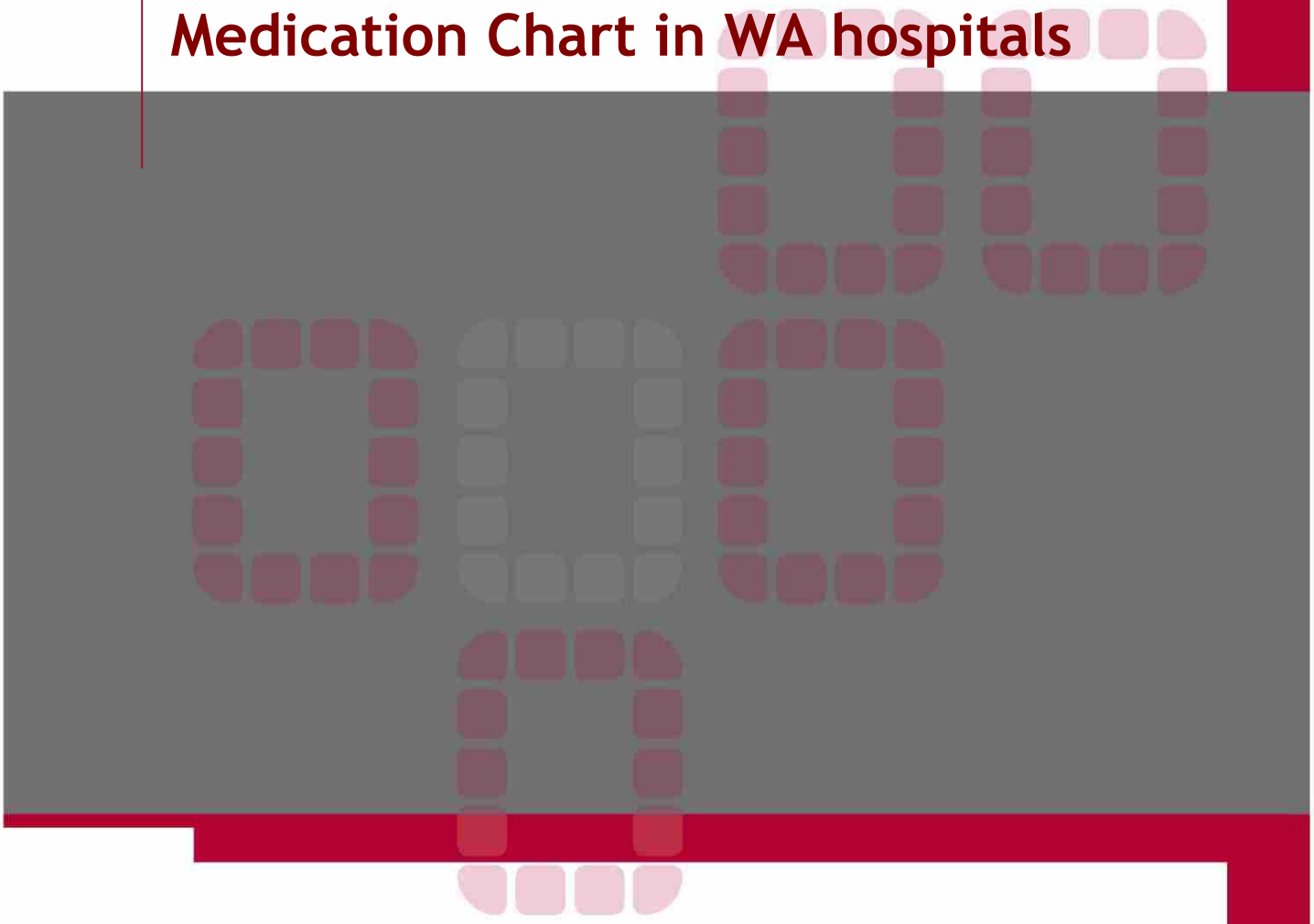
Guidelines for use of the Paediatric Inpatient (Short-Stay) Medication Chart in WA hospitals



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

August 2012

Department of Health

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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Copies of the document can be accessed electronically from the NIMC website:

http://www.safetyandquality.health.wa.gov.au/medication/nimc.cfm

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.

ITEMS COVERED IN THIS GUIDELINE

***** 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 immunosuppressive 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.
    - Black ink is preferred (Australian Standard for Paper-based health care records AS2828-1999).
    - 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/m^2, 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

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

3.2 Identification of the Patient

Every medication chart must have:

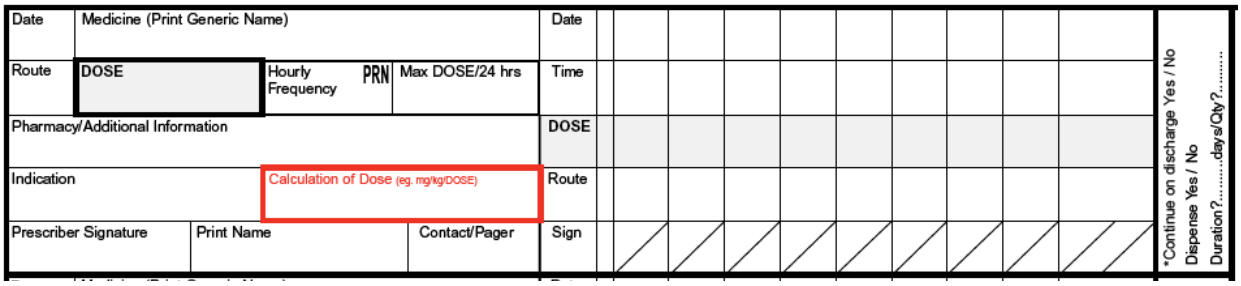
- EITHER the **current patient identification label**
- OR, as a minimum, the **patient name, UR number, date of birth** and **gender** written in **legible print**
- AND the first prescriber must print the patient's name and check that the identification label is correct

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

Rationale

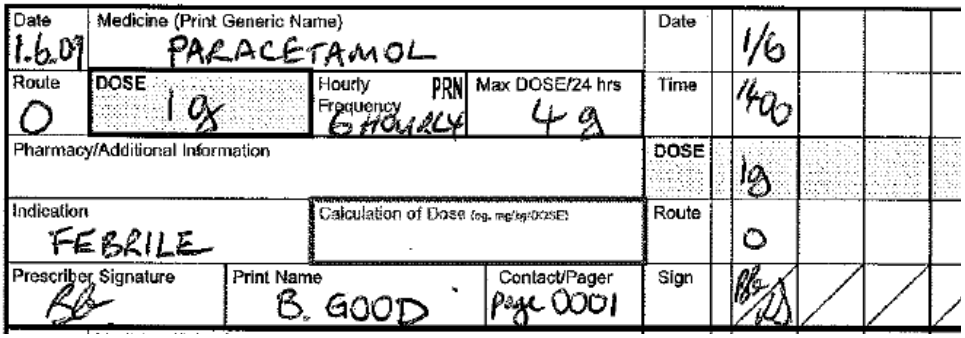
Patient identification guidelines and the printing of patient name will reduce the risk of wrong identification label being placed on the chart and the wrong patient receiving medication.

3.3 As required ("PRN") Medicines



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

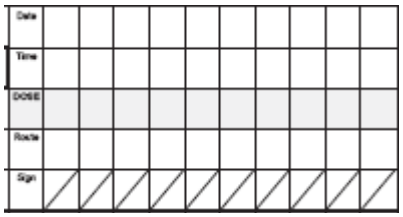
- **Date** that the medication order was started
- **Generic Drug Name**
- **Dose and hourly frequency**. "PRN" (pre-printed) alone is not sufficient
- **Indication and maximum daily dose** (ie maximum dose in 24 hours) *eg Paracetamol 4g/24 hrs*
- **Route -** only approved ***Commonly Used and Understood 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/m^2, 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

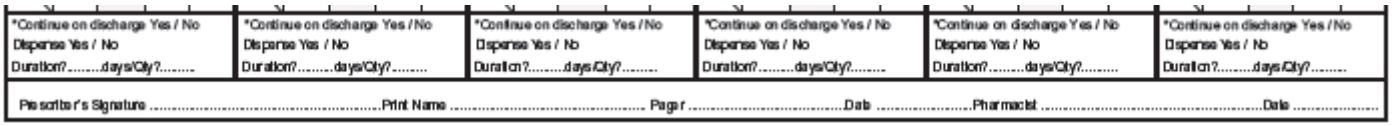


Administration:

- 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

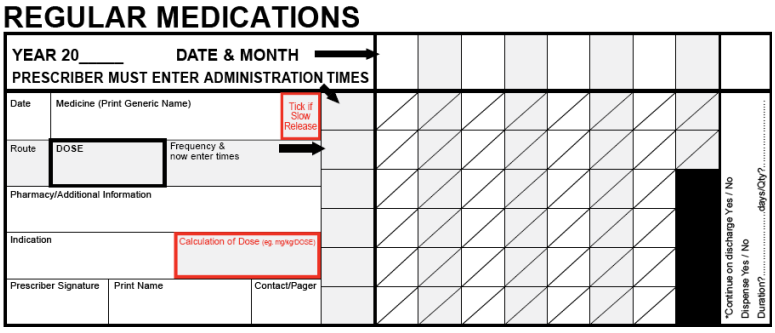
- Hospitals may have their own procedures in place for prescribing discharge supplies of schedule 8 medications which must be followed

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

Abbreviation	Meaning	Abbreviation	Meaning
Eye Ointment	Eye Ointment	PO	per oral / by mouth
IM	Intramuscular injection	PEG	Percutaneous enteral gastronomy
intrathecal	Intrathecal	PR	per rectum
IV	intravenous injection	PV	per vagina
intranasal	Intranasal	subcut	subcutaneous
intraarticular	Intraarticular	subling	sublingual
MA	metered aerosol	topical	Topical
MDI	metered dose inhaler	inhale / inhalation	Inhale/Inhalation
neb	nebulised / nebuliser	epidural	Epidural
NG	nasogastric	Irrigation	Irrigation

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 or e	Ear or eye	Misinterpreted as the other organ	write ear or eye in full
gtt or gutte	Drops	Latin abbreviation not universally understood	drops
IJ	Injection	Mistaken as 'IV' or 'intrajugular'	injection
IN	Intranasal	Mistaken as 'IM' or 'IV'	intranasal
IT	Intrathecal	Mistaken as Intravenous	intrathecal
Oc or Occ	Eye Ointment	Mistaken as eye drops	eye ointment
OJ	Orange Juice	Mistaken as 'OD' or 'OS' (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	orange juice
Mist	Mixture	Latin abbreviation not universally understood	mixture

Note

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	
Abbreviation	**Meaning**
mL	Millilitre
L	Litre
g	Gram
mg	Milligram
microg	Microgram
mmol	Millimol
m	Milli
unit(s)	Unit(s)
international unit(s)	International Unit(s)

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to Avoid	**Intended Meaning**	**Reason for Avoiding**	**Acceptable Alternative**
ug, mcg or µg	microgram	mistaken for milligram when handwritten	write mcg clearly 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 international 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. **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**:

RECOMMENDED ORAL 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	
Four times a day	QID	0800	1200	1700	2100

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	
Abbreviation	**Meaning**
bd	Twice daily
mane	Morning
nocte	Night
qid	Four times a day
tds	Three times a day
prn	As required
stat	Immediately

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 'daily' and specific time of day
QD or qd	Every day	Mistaken as qid (four times a day)	write 'daily' and specific time of day
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
qod or QOD	Every other day	Mistaken as qd (daily' or 'qid' (four times daily'	Write 'every second day' or 'on alternate days'
½	Half	Mistaken as 'one of two'	Write 'half'
TID	Three times a day	Mistaken as 'bd'	Write 'tds'
TIW	Three times a week	Mistaken as 'three times daily'	Write 'three times a week' and specify exact days in full
i/D	Once daily	Mistaken as 'id'	write 'daily' and specific time of day
Qh	Every hour	Not universally understood	Write 'hourly' or 'every hour'
Qhs	Nightly at bedtime	Mistaken as 'qhr' or evey hour	Write 'night' or 'daily at bedtime'
OW	Once a week	Not universally understood	Write 'once a week'
p/f	Per fortnight	Not universally understood	Write 'every two weeks' or 'per fortnight'
q6pm etc	Every evening at 6pm	Mistaken as every six hours	Write '6pm daily', 'every night at 6pm' or 'every day at 6pm'

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** to indicate a Schedule 8 medicine (stored in CD cupboard)
- **Fridge** to indicate a medicine that is stored in the fridge

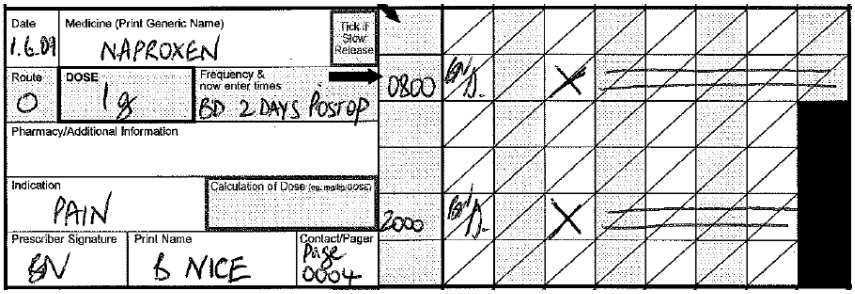
h) **Indication** - This section is for the medical officer to document the indication for use or pharmacist to add or clarify any specific details (*eg may be used to specify administration methods or rates etc*).

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.

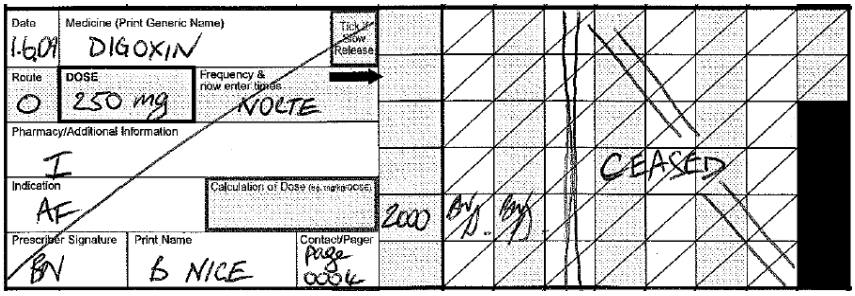
k) **Dose Calculation** – The medical officer or pharmacist must calculate the dose rate in accordance with Hospital policy (e.g. dose per mg/kg, mg/m^2, mg/kg per day). Staff must not use the dose calculation box unless the correct units of measurement are used.

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.

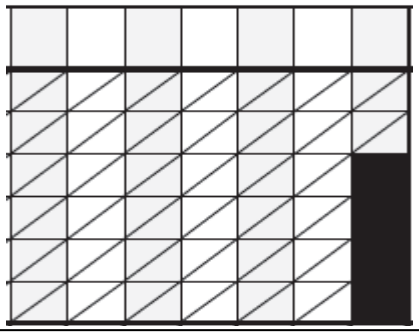
The medical officer must write the reason for changing the order (eg cease, written in error, increased dose etc) at an appropriate place in the administration record section.

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



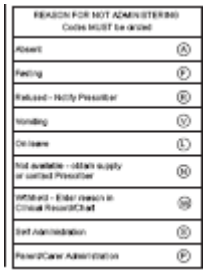
- The first person administering medication on any day must write the date in the box at the top of the column, this column is then for medications administered on this date only.

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.

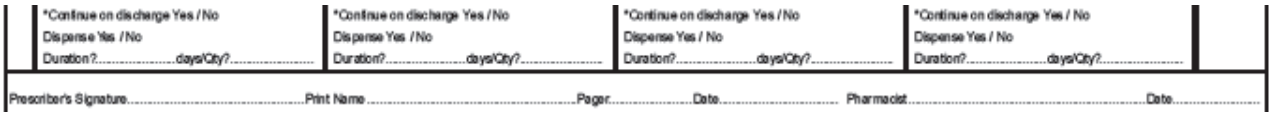
4.6 Clinical Pharmacist Review

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 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.

4.7 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

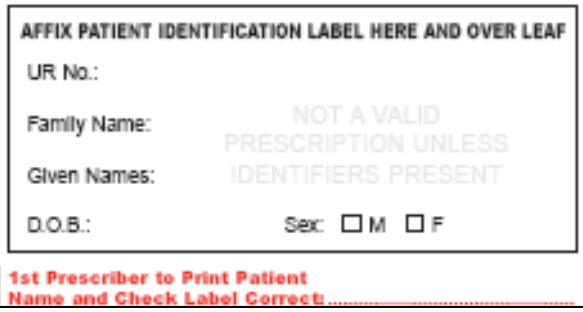
The discharge supply section is designed to facilitate the dispensing of discharge medication directly from the chart as a mechanism to avoid transcription errors.

5. Back Page of Medication Chart (including top section of left middle page)

5.1 Patient Location

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

5.2 Identification of the Patient



Every medication chart must have:

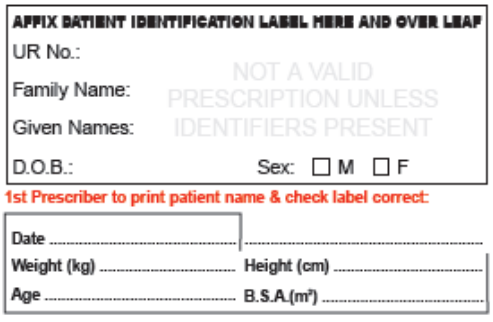
- EITHER the **current patient identification label**
- OR, as a minimum, the **patient name, UR number, date of birth** and **gender** written in **legible print**
- AND the first prescriber must print the patient's name and check that the identification label is correct

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

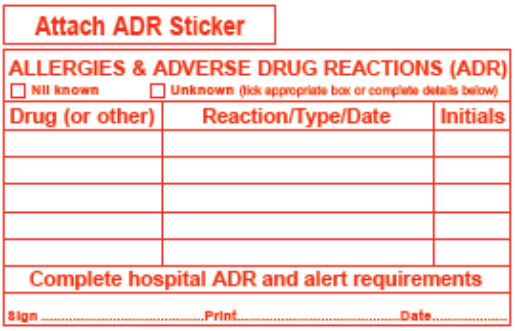
If more than one paediatric medication chart is in use, then this must be indicated by filling in the appropriate numbers using the spaces provided. E.g. Paediatric Medication Chart 1 of 2.

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:

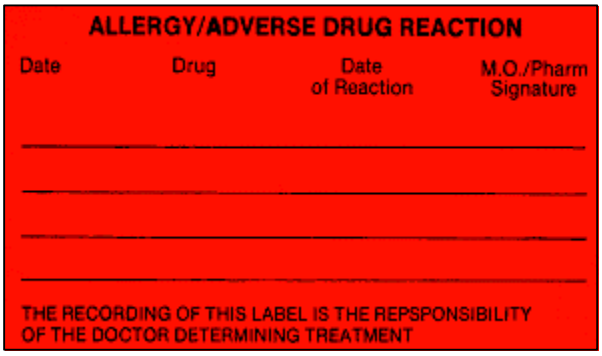
- Name of drug/substance (*include allergies to drugs, food, lotions, plaster, latex etc)*
- Reaction details (*e.g. rash*)
- Date that reaction occurred (or approximate timeframe *e.g. "20 years ago"*)
- Initials of person completing information

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 MEDICINES

Date Prescribed	Medicine (Print Generic Name)	Route	DOSE	Date/Time to be given	Prescriber		DOSE calc e.g. mg/kg per DOSE	Given by	Date/Time Given	Pharm
					Signature	Print Name				

(WA Paediatric Inpatient Medication Chart)

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)

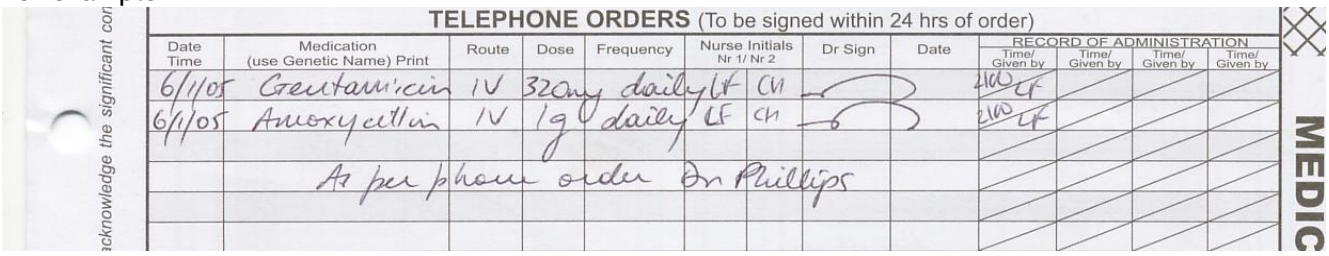
5.8 Telephone Orders

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



TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medication (use Genetic Name) Print	Route	Dose	Frequency	Nurse Initials Nr 1/ Nr 2		Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by
6/1/05	Gentamicin	IV	320mg	daily	LF	CH			2100 LF			
6/1/05	Amoxycillin	IV	1g	daily	LF	CH			2100 LF			
	As per phone order Dr Phillips											

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

INITIALS All staff please print name and designation beside your initials					
Initials	Print name and designation	Initials	Print name and designation	Initials	Print name and designation

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

Medicines Taken Prior to Presentation to Hospital (Prescribed, Over the Counter, Complementary) Own medicines brought in? ☐ Y ☐ N

Medicine & Formulation	Dose & Frequency	Duration	Medicine & Formulation	Dose & Frequency	Duration

Doctor/GP: Community Pharmacy:

Documented by: (Sign) (Date) Medicines usually administered by:

Medication reconciliation, including an accurate medication history, is to be conducted for all inpatients by an appropriately credentialled 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 credentialled 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 documentation**[1]

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