

National Inpatient Medication Chart Four A4 page version

User advice

Purpose

To provide guidance on use of the four A4 page version of the National Inpatient Medication Chart (NIMC)

Key points

1. A four A4 page version of the NIMC (the chart) has been approved for use by the NIMC Oversight Committee.
2. It is designed to assist general practitioners electronically prescribing for admitted patients primarily in rural and remote hospitals. The four A4 page version should assist GPs (without access to A3 printers) to provide medication orders in a format that complies with the NIMC
3. Although not essential, colour printing is preferred as the document has contrasting red as a safety device to highlight:
 - a. Allergies and ADR information;
 - b. Medicines taken prior to presentation (to distinguish from current medications);
 - c. Dedicated medications boxes (for variable dose medication and warfarin);
 - d. Warfarin education box.

Differences between the standard NIMC and the four A4 page version

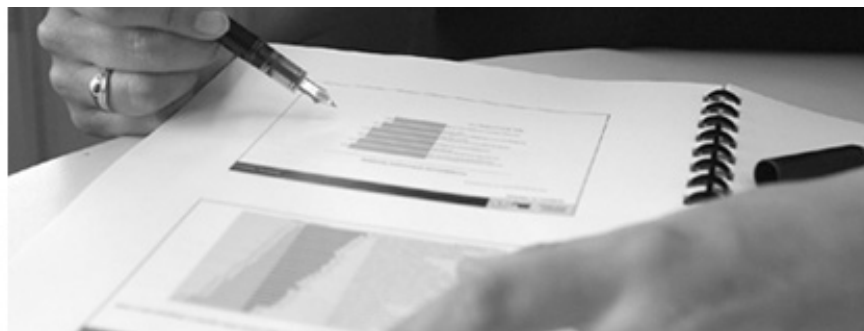
1. The current NIMC (2009 version) is a folded A3, double-side printed document. The four A4 page version has the following differences:
 - a. Each page requires full patient identification details (this should be automatically populated when the chart is printed) ;
 - b. Each page number is stated as part of the whole document, as in “Page 1 of 4”, Page 2 of 4” etc.;
 - c. Allergies and adverse drug reactions are detailed on page 1 and reference made to the page 1 details on successive pages;
 - d. Various boxed information (which is in the middle of pages 3 and 4 in the standard NIMC) has been moved to underneath the allergy/ADR and patient ID space on page 2 of the four A4 page NIMC.
 - e. As a result of the boxed information on page 2, there is one less regular medications space available than on the standard NIMC.

Key practice issues

1. The same use requirements for the four A4 page NIMC apply as for the standard NIMC with the following additional requirements:
 - a. All four pages constitute a single chart and should not be printed in part.
 - b. All pages of the chart must be kept together in the correct sequence.
 - c. If the document is printed single-sided and placed in a ring folder, then pages 2 and 4 are punched on the right side so that the Regular Medications section (across pages 2 and 3) can be seen and used as one page.
2. Hospitals and health services should develop local policies to manage introduction of this chart into their facilities.

Background

1. Implementation of the NIMC in 2006 and 2007 resulted in problems for some general practitioners who electronically generated prescriptions for admitted patients in rural and remote hospitals on non NIMC compliant charts. These orders had to be transcribed by hand onto a complying NIMC which created additional patient safety risks.
2. The summary rationale for the NIMC is attached for information. Further NIMC support materials are available on the Commission website www.safetyandquality.gov.au



Summary rationale for the National Inpatient Medication Chart

Ensuring hospital patients receive the best therapy in a safe and effective manner is a complex process involving many health professionals often working in teams. One critical component of this process is the communication of prescriptions to allow safe and accurate dispensing, administration and reconciliation of medicines. Evidence suggests that communication can be made safer through education of safe prescribing and administration principles and with standardisation of best practice to reduce the potential for errors.

Additional potential benefits in patient safety are derived from:

- standardisation of best practice throughout the medication management cycle, within and between healthcare organisations
- standardisation of undergraduate, postgraduate and continuing professional education in the medication management cycle.

Key principles

1. When a medication chart is first written up, the patient's name should always be handwritten at the top of the chart by the prescriber. This acts as a double check for pre-labelled charts and reduces the risk of ordering medication for the wrong patient.
2. When subsequent new prescriptions are written, the chart should be checked to ensure it is for the correct patient.
3. A medication chart should include a section for recording adverse drug reaction information. This section should enable documentation of whether a reaction has previously occurred, the nature of the reaction (if one has occurred previously), the date the reaction occurred and the signature of the healthcare professional recording the information. If no previous reactions have occurred, this should be explicitly documented (eg 'nil known'). If no information is available about previous reactions (eg if the patient is unable to communicate), this should also be documented (eg 'unknown') This section should be clearly visible where most regular prescriptions are written to reduce the risk of inadvertent exposure to a drug to which the patient is allergic.
4. A single chart should include a section for 'once only' and premedication orders so that they are neither on a separate chart nor included with regular orders. This minimises the risk of doses being missed or orders being continued inadvertently, as well as providing a more complete medication history on a single chart.
5. Telephone orders should be discouraged, unless essential due to work practice restrictions (for example, hospitals with no resident medical staff). Where telephone orders are unavoidable, the medication chart should contain a section that facilitates the safe practice of two staff independently receiving and reading back the order to the prescriber. These orders should allow no more than four doses to be administered before being signed by the prescriber.
6. There should be a section on the medication chart for recording medicines taken by the patient prior to admission, except when a facility uses a dedicated medication reconciliation chart that accompanies the current medication chart. The inclusion of this information on or with the medication chart, or on a dedicated chart, facilitates reconciliation of pre-admission medication with medications prescribed whilst the patient is in hospital and at transfer. It also

aids communication of changes to medication regimens made during admission to patients and primary care clinicians.

7. A medication chart must include a specific section for prescribing variable doses of drugs. This section should facilitate ordering and documentation of drug levels, as appropriate, to assist selection of suitable subsequent doses. It is recommended that this variable dose section be on the inside of the chart with other regular orders to reduce the risk of dose omissions.
8. A medication chart should include a specific section for prescribing warfarin. Warfarin is associated with adverse events both through underdosing and overdosing. The warfarin section should enable documentation of both the International Normalised Ratio (INR) target range and INR results to facilitate dosing decisions. Ideally, warfarin should be prescribed at 4pm to ensure morning results are reviewed and the next dose is ordered by medical staff familiar with the patient's medication management, rather than by 'after-hours' medical staff.
9. A medication chart should have a separate section for 'when required' (PRN) medications in order to distinguish them from medicines that need to be given regularly. The PRN orders should be unambiguous, with clearly defined doses or dose ranges, minimum hourly frequency of administration and a recommended maximum dose in 24 hours, together with the indication for use.
10. A medication chart should include a specific section for nurse-initiated medication, in accordance with state regulations and hospital practices.
11. Medication management review is aided by documenting medication starting dates rather than the date the chart is re-written. However, the date of the current order should take precedence if required by state regulations.
12. The chart should encourage prescribing using generic drug names. This is to reduce the risk of duplicate orders of the same drug being made because of unfamiliarity with different trade names. In addition, medication is usually stocked on the ward alphabetically by generic name, therefore generic prescribing facilitates location of the drug.
13. The chart should discourage the use of abbreviations, particularly those known to be error-prone. This reduces the risk of misinterpretation.
14. The chart should facilitate recording of the administration times by the prescriber, based on a hospital agreed standard. This reduces the potential for nurses to misinterpret prescribed administration frequency instructions.
15. The chart should include a section for clinical pharmacist annotation regarding optimal supply and administration. In addition, a section enabling pharmacists to sign the chart following pharmaceutical review facilitates peer review and improves communication with pharmacists covering the same ward.
16. The chart should facilitate dispensing of discharge medication directly from the medication chart, to avoid transcription errors. This may not be applicable for those sites using the PBS for discharge medications or where separate discharge prescriptions are used. In such cases, local procedures should be developed to ensure that transcription errors are minimised and full medication reconciliation at discharge is facilitated.
17. The chart should include a section for prescriber contact details (for example, pager number), so that they can be easily contacted.