

National Inpatient Medication Chart

# **Audit Tool - User Guide 2009**

For NIMC 2009, long-stay, private hospital and paediatric versions

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Other resources available from <http://www.safetyandquality.gov.au>:

National Inpatient Medication Chart 2009 national audit tool

National Inpatient Medication Chart 2009

National Inpatient Medication Chart long-stay version 2009

National Inpatient Medication Chart paediatric version 2009

National Inpatient Medication Chart long-stay paediatric version 2009

National Inpatient Medication Chart private hospital version 2009

National terminology, abbreviations and symbols to be used in prescribing and administering medicines in Australian Hospitals 2009

Guidelines for use of the National Inpatient Medication Chart 2009

Jurisdictional Guidelines for Local Management of the National Inpatient Medication Chart

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This document is based on a guide developed by the Safe Medication Practice Unit, Medication Services Queensland, Queensland Health for use in Queensland hospitals. The Australian Commission on Safety and Quality in Health Care acknowledges the significant work of Medication Services Queensland in the development of the original document and the support provided in the development of this document.

## 1. Introduction

### Auditing National Inpatient Medication Charts

Following implementation of the National Inpatient Medication Charts (NIMC), it is recommended that re-audits are completed at **yearly** intervals. However, if significant non compliance with the chart's safety features is identified during the audits, it is recommended that audits occur more frequently within a quality improvement cycle (e.g. Plan Do Study Act cycle) until such time as compliance with the safety features of the chart improves.

The objectives of the audits are to:

- Evaluate the effect of the medication chart, and the implementation process, on the safety and quality of prescribing and medication documentation;
- Identify further areas for improvement in medication management.

National auditing occurs in August each year.

## 2. Audit tool

**National Inpatient Medication Chart Audit Tool** (a scannable form) is available to use to collect audit data. The tool can be used to audit the NIMC and the paediatric versions of the chart. The tool is available on the Commission's website

([http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NIMC\\_001](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NIMC_001))

Local criteria can to be included in the audit, using the 'Comments' section on page 1 of the form to document the information e.g. height. (these additional criteria should also be listed on form A). In addition, the comments section of the form can be used to document examples of errors identified during the audit. This information can be included in the compiled audit report.

### Scanning the NIMC audit tool

The audit tool is designed to be scannable. If audit tool forms are to be scanned, original printed forms **must** be used to collect data – **DO NOT USE PHOTOCOPIES**.

Photocopies do not contain the embedded technology that allows them to be read by the scanner.

### Legend

A legend has been included to assist in determining the appropriate responses to each audit criteria.

## 3. Audit instructions

1. This Guide should be read by staff completing the audits. It is recommended the Australian Commission on Safety and Quality in Health Care *Guidelines for use of the NIMC 2009* are also read as it provides useful background material. The guidelines are available at:  
[www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/NIMC\\_002\\_MedicationsCharts](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/NIMC_002_MedicationsCharts)
2. Read local medication related procedures and guidelines e.g. the approved medicines brand names list. If local policies do not exist, a list of acceptable abbreviations should be developed to use for all audits. This will ensure consistency between auditors and

between audits. For guidance refer to the *National terminology, abbreviations and symbols*<sup>1</sup> document which is available at [www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/NIMC\\_002\\_MedicationsCharts](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/NIMC_002_MedicationsCharts)

3. The audit team should decide the number of charts to audit. Refer to section 1.4 'Number and type of charts to audit' for further information. Complete all details on Form A.
4. Enter the state, hospital, ward, date, gender, date of birth (DOB) reviewer(s) name(s) and unique record (UR) number on the front page of the NIMC audit tool.

**A response should be entered for each of the criteria,  
i.e. yes, no, unknown or a number.  
'N/A' should be recorded if the criterion is not relevant to the facility.**

### Number and type of charts to audit

#### Initial audit

Ideally, all available NIMCs should be reviewed. This allows the identification of errors that occur infrequently and in different patient types. Where time and resources are limited, as many medication charts as possible from each ward type (e.g. medical, surgical, critical care, geriatric, paediatric etc) should be reviewed in order to evaluate any significant changes to medication safety. To enable a large number of patient charts to be reviewed the data collection may take place over a number of weeks i.e. 5 charts per week for 1 month. See Table 1 for recommended minimum sample size\*.

**Table 1:**

Number of adult beds in hospital	Sample size
150 or more	20% of current patients
30-149	30 current patients
Less than 30	All current patients

#### **Subsequent Audits**

Where possible this should be identical to the initial audit to ensure a comparison of similar wards, patients and numbers. (However if the initial audit consisted of less than 20 charts, it is recommended that 20 charts are audited). Ideally the same team who completed the initial audit should also conduct reaudits to minimise variability in data collected.

#### **Who should complete the audit?**

To minimise observer bias the audit should be conducted by two people. A registered nurse must be involved as they are the key people who interpret the prescription and administration information. A pharmacist should assist where available, otherwise a medical officer or another nurse should be a part of the audit team.

It is recommended that all auditors complete the **NIMC Audit Education Package** prior to commencing the audit.

\* Suggested sample size derived from *Indicators for Quality Use of Medicines in Australian Hospitals*<sup>2</sup>

## 4. Data collection

### 1. Audit demographics

Some jurisdictions require a separate audit demographic form to be completed. If so, complete ONE copy ensuring that all details are completed.

### 2. National Inpatient Medication Chart audit tool

Complete one copy for each patient.

#### Page 1

Complete all the information requested in the top section of the page. I.e.:

- State
- Hospital
- UR No.
- Gender
- Ward
- Bed No.
- Audit Date
- Date of birth
- Name of reviewer 1
- Name of reviewer 2
- Chart type (e.g. NIMC, NIMC Paediatric version)

## 1. Patient Identification & Weight

### 1.1 Total current *Medication Charts* (i.e. charts in use)

Record total number of current medication charts i.e. charts in use on the day of the audit.

### 1.2 *Patient ID* complete on all pages (must include printed name if label used)

Each medication chart has **two** points where patient identification is required i.e. page 3 and page 4.

Identification details may be handwritten or a patient identification (ID) label (UR sticker) used. If a patient ID label is used the first prescriber **must** print the patient's name, ensuring that the identification label is correct. It is not required to print the patient's name if the patient details are handwritten.

To record a 'yes' the following patient identification information must be visible and correct on all pages of the medication chart:

- Unique Record (UR) number
- Patient name
- Patient address
- Date of birth
- If a patient ID label is used the first prescriber **must** print the patient's name

**Rationale:** *Incomplete patient identifiers or patient identification that is not visible on all sections of the chart may result in:*

- *an adverse drug event where the medication is administered to the incorrect patient*
- *a patient being prescribed or administered medication intended for another patient.*

*This is also a safety requirement for all hospital Pharmaceutical Benefit Scheme prescriptions. Medicare Australia identified that patients were at risk or receiving the wrong medicines from incorrect identification labels being placed on prescriptions.*

*Printing of the patient name under an identification label was introduced as a compulsory safety mechanism for the prescriber to ensure that the correct patient identification was placed on the medication chart/prescription.*

### 1.3 **Weight documented on a Medication Chart**

Record 'yes' if the patient's weight is documented on at least one medication chart currently in use.

For paediatric patients record 'yes' only if the patient's weight is recorded on **all** medication charts currently in use.

**Rationale:** *A number of high risk medications and the majority of paediatric doses are based on bodyweight. Inaccurate dosing may result when the actual weight is not readily available.*

## 2. Adverse Drug Reaction (ADR) Details

### 2.1 **ADR documentation complete on all charts (including nil known (NKDA) / unknown)**

Record 'yes' 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 where patient has had a previous ADR
- Clinician signature.

**Rationale:** *Omission of ADR information risks re-prescribing and administering a medicine that has previously caused an adverse reaction or a similar agent. Recording of the clinician's signature assigns accountability for the information.*

### 2.2 **Patient has previous ADR**

Ask the patient about their ADR history. Record 'yes' when the patient has a known previous ADR. If the patient is unavailable, document 'unknown'.

**If 'No' for question 2.2 proceed to section 3.**

### 2.3 **Similar class of medicine prescribed**

**(Document drug reaction and re-prescribed medicine in Comments section at bottom of page)**

Record 'yes' if the patient has a medication (or the same class of medication) prescribed that has been identified previously as causing an ADR.

Where 'yes' is recorded, specify in the comments section the criteria number (2), the name of the medicine documented as causing an ADR, the type of reaction previously experienced, the name of the re-prescribed medicine, and if any doses have been administered.

**Rationale:** *Documentation of ADR details and the use of ADR alerts should prevent patients being re-prescribed, dispensed or administered a medication to which they have previously had a reaction.*

### 2.4 **If a previous ADR, do all pages have ADR alert stickers in place?**

Each National Medication Chart has **two** points where an ADR alert sticker is required i.e. on pages 3 and 4. Record 'yes' if a patient has an ADR recorded, and all current medication charts have ADR alert stickers in place on pages 3 and 4.

**NB:** Only include ADR stickers where there is a **drug** allergy/ADR and not food, bee etc. allergies.

**Rationale:** *The use of ADR alerts is a physical reminder to reduce the risk of patients being re-prescribed, administered or dispensed a medicine to which they have previously experienced a reaction.*

### 3. Medication History

#### 3.1 Medication History documented

Record 'yes' if the patient's medication history (including 'nil regular meds') is recorded on at least one medication chart that is currently in use.

**Rationale:** *Accurate information on the medicines patients are taking prior to admission is an important component of the medication reconciliation process and forms a basis for future decisions about therapy*

#### 3.2 If 'No', is a Medication History cross-referenced on Medication Chart?

Record 'yes' if the patient's medication history is cross referenced on at least one medication chart that is currently in use i.e. see previous medication chart or refer to Medication Action Plan, medication history/reconciliation form.

#### 3.3 Medication Action Plan (MAP) Form in the 'end of bed' folder?

Record 'yes' if there is a MAP form in the end of bed folder.

**(If no, go to question 4.1)**

**Rationale:** *The 'Medication Action Plan' (or medication history/reconciliation form) can be used as an alternative to the medication chart to document: the patient's medication history as well as changes made to orders when checked with the medication chart (reconciliation) and issues identified during medication review. Documenting these processes contributes to an improvement in communication and medication management.*

#### 3.4 Allergies/ADR box completed on MAP Form

Record 'yes' if the Allergies/ADR box contains an allergy/ADR or the 'nil known' or 'unknown' box has been ticked.

**Rationale:** *Allergies/ADR information is obtained during the patient/carer medication history interview. New Allergies/ADR information may be obtained.*

**NB:** Any new information must be transferred to the medication chart.

#### 3.5 No. medicines taken prior to presentation to hospital recorded on the MAP Form

Indicate the number of **medicines** listed in the 'medicines taken prior to presentation to hospital' section of the MAP form. If no medicines were recorded (i.e. left blank) enter the value '0'.

**Rationale:** *Accurate information on the patient's medication prior to admission is an important component of the medication reconciliation process and forms a basis for future decisions about therapy.*

#### 3.6 No. medicines with Dr's Plan on Admission completed on MAP Form

Record the number of **medicines** listed in the 'medicines taken prior to presentation to hospital' section with the 'Dr's Plan on Admission' completed on the MAP / medication reconciliation form.

**Rationale:** *To complete the medication reconciliation process (checking the medicines taken prior to admission with the prescribed medicines), the care plan for each of the patient's 'prior to admission medicines' has to be known. Medication reconciliation ensures the patient receives all intended medicines and reduces common errors of transcription, omission, commission, duplication, drug-drug and drug-disease interactions.*

### **3.7 No. of medicines with *Reconcile* column ticked on MAP Form**

Record the number of **medicines** listed in the 'medicines taken prior to presentation to hospital' section with a tick in the '**Reconcile**' column of the MAP / medication reconciliation form.

**Rationale:** *Medication reconciliation ensures the patient receives all intended medicines and reduces common errors of transcription, omission, commission, duplication, drug-drug and drug-disease interactions. Placing a tick in the reconcile column communicates to other clinicians that the medication reconciliation process has been completed.*

### **3.8 More than one source indicated on MAP Form**

Record a 'yes' if more than one source has been ticked in the '**Sources of Medicine List**' box with or without annotation of who confirmed the information and date confirmed.

**Rationale:** *To ensure a complete and accurate list of 'medicines taken prior to presentation to hospital', confirmation with a second source is recommended. Documenting the source communicates to other clinicians the reliability of the information and enables further clarification to be made if required.*

## **4. Warfarin**

### **4.1 Warfarin Guidelines at end of the patient's bed or with Medication Chart**

Record 'yes' if the Warfarin guidelines are available at the end of the bed and /or with the medication chart for all adult beds excluding mental health, maternity, and gynaecology.

**Rationale:** *Warfarin prescribing guidelines should be available at the point of prescribing to reduce risk of unsafe prescribing.*

### **4.2 No. times patient prescribed Warfarin (Warfarin & Regular Order sections)**

Indicate the number of times warfarin is prescribed either in the *Warfarin* section or the *Regular* section of the chart.

**(If zero, go to question 5.1)**

### **4.3 No. of Target INR ranges documented if prescribed in Warfarin Section**

Indicate the number of times that a target INR range is documented when warfarin is prescribed in the *Warfarin* section.

**Rationale:** *Prompting at the point of prescribing for indication, target INR range and INR results will assist the attending team to make informed decisions on warfarin doses.*

### **4.4 No. of Target INR ranges documented if prescribed in Regular Section**

Record the number of times that a target INR range is documented when warfarin is prescribed in the regular section.

**Rationale:** *Prompting at the point of prescribing for indication, target INR and INR results will assist the attending team to make informed decisions on warfarin doses.*

#### **4.5 Warfarin Education record**

Record 'yes' if the *Warfarin Education Record* has been fully completed for patients prescribed warfarin.

**Rationale:** *All patients should receive counselling about the use of warfarin and should be given warfarin education materials to reduce risks associated with the use of warfarin. Education provided should be documented on the medication chart as a record of completion.*

**All other warfarin prescribing and administering information should be recorded on page 2 of the audit tool**

### **5. Variable Dose**

#### **5.1 No. of Variable Dose medications (Variable Dose & Regular Medications sections)**

Indicate the number of variable dose medicines prescribed in either the *Variable Dose Medication* section or the *Regular* section. (Include ceased orders, exclude Warfarin and PRN medications.)

If variable dose medicines are prescribed in *Regular* section, write criteria number, name and frequency of the medicine in the comments section of page 1 e.g. criteria 5 clozapine BD.

**(If nil go to question 6.1)**

**All other Variable Dose prescribing and administering information to be recorded on page 2 of the audit tool**

### **6. Sustained Release**

#### **6.1 No. Sustained Release medications ordered (Regular Medications section)**

Record the number of sustained release medications prescribed in the *Regular Medications* section of the chart. (Include ceased orders.)

**(If nil go to question 7.1)**

#### **6.2 No. Sustained Release medications with SR box ticked**

Record the number of sustained release medications documented in the *Regular Medications* section of the chart that have the SR box ticked.

**Rationale:** *If the sustained release form is not specified, then immediate release preparations may be administered in error (e.g. 3x80mg normal release administered when 1 x Verapamil 240mg SR intended).*

### **7. Intermittent Medications**

#### **7.1 No. Intermittent medications ordered (i.e. weekly, fortnightly, twice weekly),**

Record the number of medicines prescribed intermittently. (Include ceased orders and regular medication orders only.)

**(If nil, go to question 8.1)**

### **7.2 No. *Intermittent* medications ordered and 'boxed'**

Record the number of intermittent medications where all relevant boxes have been crossed out to flag dose(s) not to be administered.

**Rationale:** *Crossing out boxes reduces the risk of patients receiving unintended doses of medicines.*

## **8. Duplicated Orders**

### **8.1 Number of Duplicated orders**

Record the number of current *Once Only, Stat, Telephone, Regular, and PRN* medication orders duplicated for the same medication or class of medication, which would result in the patient receiving unintentional additional doses of the medication, e.g. ordering of captopril as well as lisinopril.

Where an order has been duplicated, document the criteria number and the names of the medicines in the comments section. (NB In many instances it is acceptable to have both regular and PRN medication orders eg Salbutamol. In such cases the orders need to be clearly cross referenced and have a maximum dose specified).

**Rationale:** *Patient are at risk of receiving excessive doses when duplicate orders exist.*

## **9. Clinical Pharmacy**

### **9.1 *Pharmaceutical Review* occurred (i.e. initial at bottom of chart)**

Record 'yes' if the *Pharmaceutical Review* section has been initialled at least once on the medication chart.

**Rationale:** *Review of medication charts by clinical pharmacists reduces the risk of patients experiencing harm from preventable prescribing and administering errors.*

### 10. Prescribing and Administration

The following information is required to be documented separately for each medication order i.e. *Once Only/Stat, Variable Dose, Warfarin, Regular* and *PRN*– **including ceased orders**

**Each column must have a response documented**

#### 10.1 Allocate a number to each order

E.g. the first order reviewed will be Order No. 1, second order reviewed – Order No. 2 etc.

#### 10.2 Drug Order (include ceased orders)

Enter the relevant code from the *Drug Order* legend to identify the **section** of the medication chart **where the medication is prescribed**:

**R=Regular**

**P=PRN**

**S=Stat/Once Only/telephone**

**V=Variable Dose**

**W=Warfarin**

**NB:**

- If warfarin is prescribed in the *Regular* section of the chart record as R, if prescribed in *Warfarin* section record as W
- If variable dose medication is prescribed in the *Regular* section record as R, if variable dose medication prescribed in *Variable dose* section record as V

#### 10.3 Drug Name (include ceased orders)

Enter the relevant code from the *Drug Name* legend.

**U=Unclear:** Use if the name of medicine is unclear to the reviewer(s) e.g. where the medication order might be interpreted as another product or is illegible. The name of the medicine must be clearly identified by both pharmacist/doctor and nurse undertaking the audit.

**Rationale:** *If the name of the medicine is unclear the clinician administering the medicine may misinterpret the order and administer the wrong medication.*

**T=Trade name:** Indicate if medication name is prescribed using an unacceptable trade name i.e. not on list of accepted drug trade names for your hospital. A list of acceptable trade names should be determined prior to the audit and used for future audits to ensure consistency between auditors and between audits.

**Rationale:** *The generic name should always be used when prescribing. For example, where Dicloclil<sup>®</sup>, Floxsig<sup>®</sup>, Timentin<sup>®</sup> or Augmentin<sup>®</sup> is written, it may not be recognised as penicillin which could be documented as causing an ADR. While trade names may be accepted for combination medications, using the generic name helps to identify that the medication contains penicillin and may be the cause of an ADR.*

*There may be different brands available for a single generic medication. Medicines are stored, labelled, dispensed and distributed by the generic name. Trade names that sound alike and look alike can lead to medication selection errors by nursing and pharmacy staff.*

**CL=Clear:** If medication name is clear and no potential for error identified.

#### 10.4 Route (include ceased orders)

Enter the relevant code from the *Route/Dose/Freq* legend.

**M=Missing:** No route documented

**U=Unclear:** Route is unclear e.g. SC can be mistaken for SL (and vice versa) - 'subcut' is acceptable. The practice of ordering two routes on the one order (e.g. IV/PO) is not considered safe as some medicines (e.g. ranitidine) have different doses depending on the route of administration.

**Rationale:** *Abbreviations may appear to be good time savers, but if unsafe abbreviations are used they can increase the potential for medication errors.*

**I=Incorrect:** Route documented is incorrect.

**CL=Clear:** If medication route is clear and no potential for error identified.

#### 10.5 Dose (include ceased orders)

Enter the relevant code from the *Route/Dose/Freq* legend.

**M=Missing:** No dose documented.

**U=Unclear:** Medication doses must be specified using metric and Arabic systems. Abbreviations should be avoided.

**Rationale:** *Many medicines come in multiple dosage forms. If the dose does not include the strength to be administered the wrong dose may be administered. E.g. 'enalapril – 1 tablet each morning' could be 2.5mg, 5mg, 10mg or 20mg. Use of abbreviations such as 'U' for units are can be misinterpreted as an extra zero e.g. 5000U when handwritten can look like 50000.*

**I=Incorrect:** Dose documented is incorrect. **Special note for paediatric charts** - The dose should be the safe, total dose (auditor to calculate using the patient's body weight or BSA and a current paediatric dosing reference endorsed by the local Drug and Therapeutics Committee).

**CL=Clear:** If medication dose is clear and no potential for error identified.

#### 10.6 Frequency (include ceased orders)

This field **must** be marked **Not Applicable** for **Stat/Once Only medication, Warfarin when prescribed in Warfarin section** and **Variable Dose medication when prescribed in the Variable Dose Section**

Enter the relevant code from the *Route/Dose/Freq* legend.

**M=Missing:** No frequency documented.

**Note:** For PRN medications, if *PRN* is all that is documented for the frequency this is considered a missing frequency e.g. morphine 10mg PRN **must** include a time interval i.e. morphine 10mg 4 hourly PRN.

**Rationale:** *If the frequency of a dose to be administered PRN is not stated, nursing staff may administer a medicine more frequently than recommended, resulting in the patient receiving an excessive dose. For example, morphine 10mg PRN could be administered at 15 minute intervals as no interval has been defined.*

**U=Unclear:** Frequency is unclear if illegible or unacceptable abbreviations are used (e.g. order is written using unsafe abbreviations i.e. 'frusemide 40mg qd' is not acceptable, it must be specified as 'frusemide 40mg mane'). The abbreviation OD is also unacceptable as it can be misinterpreted as 'BD' or 'QID'.

**Note:** Abbreviations such as BD, TDS or QID are considered unclear for *PRN* orders as hourly frequency is required. For example if metoclopramide is prescribed 10-20 mg TDS this may result in administration of doses every 8 hours, however it may be clinically acceptable to administer this medication more frequently and the nursing staff need adequate guidelines i.e. '10-20 mg 4-6 hourly'.

**Rationale:** Use of unclear frequencies can lead to administration errors and patient harm.

**I=Incorrect:** Frequency documented is incorrect.

**CL=Clear:** If medication frequency is clear and no potential for error identified

### 10.7 Dose Calculation Documented (include ceased orders)

**Circle Y** if basis for dose calculation is documented in dose calculation box (e.g. mg/kg/dose or microgram/m<sup>2</sup>/dose). **Circle N** if not documented. **Circle NA** if not auditing the NIMC paediatric versions.

**Rationale:** Incorrect dosing is the most common medication error reported in paediatric patients. The intended dose per kilogram body weight (or dose per body surface area) and the total calculated dose should appear on all orders for paediatric patients.

### 10.8 Dose Calculation Documented is Correct (include ceased orders)

**Circle Y** if dose calculation documented is correct based on the recommended dose in a current paediatric dosing reference endorsed by the local Drug and Therapeutics Committee. **Circle N** if dose calculation is incorrect. **Circle NA** if not auditing the NIMC paediatric versions.

**Rationale:** Incorrect dosing is the most common medication error reported in paediatric patients. The intended dose per kilogram body weight (or dose per body surface area) and the total calculated dose should appear on all orders for paediatric patients.

### 10.9 Error Prone Abbreviations used

Circle Y if an error prone abbreviation is used, N if error prone abbreviation not used

#### Error prone abbreviations

Uq, mcg ug = microgram

U or u = unit

Qd or QD = every day

o.d. or OD = once daily

SC, S/C = subcutaneous

SL, S/L = sublingual

O (degree symbol) = hourly frequency

No leading zero before a decimal point (eg .5mg) = 0.5mg

Trailing zero after decimal point (eg 1.0mg) =1mg

Hospitals may wish to develop more extensive lists of error prone abbreviations. Refer to the *National terminology, abbreviations and symbols for use in prescribing and administering medicines in Australian Hospitals.* <sup>1</sup>.

### 10.10 Indication Documented (include ceased orders)

This field **must** be marked **Not Applicable** for **Stat/Once Only medications**

**Circle Y** if indication is documented, **circle N** if not documented or **circle NA** for *Stat/Once Only* medication.

***Rationale:** The prescription can be reviewed in the context of why it was prescribed for that particular patient reducing the risk of medication errors from incorrect dosing or misinterpretation of an order. E.g. gabapentin may be used for neuropathic pain or epilepsy requiring different dosing, lasix® being misread as losec® and vice versa.*

### 10.11 Pharmacy Annotation (include ceased orders)

**Circle Y** if a pharmacist has annotated the order (e.g. clarified any ordering details including medication name, frequency, and administration information as well as supply information).

**Circle N** if no annotation is absent.

***Rationale:** Clarification of medication orders and provision of information by clinical pharmacists reduces the risk of patients experiencing harm from preventable prescribing and administering errors.*

### 10.12 Prescriber Signature (include ceased orders)

**Circle Y** if the medication order has been signed by the prescriber or **circle N** if not signed.

**Note:** A doctor's signature is required within 24hours of a telephone order.

***Rationale:** State and Territory legislation requires medication orders to be signed by a medical practitioner. This excludes standing orders and drugs approved for prescribing by nurse practitioners.*

### 10.13 Prescriber Name Clear (include ceased orders)

**Circle Y** if the prescriber's name is clear. Prescribers should print their surname at least once on the medication chart to enable other clinicians to identify their signature. **Circle N** if not clear.

***Rationale:** The prescriber must be identifiable in order to allow nursing, pharmacy or other medical staff to contact the prescriber should orders require clarification.*

#### 10.14 Frequency Correlates with Administration Time (include ceased orders)

This field **must** be marked **Not Applicable** for **Stat/Once Only, Warfarin when prescribed in Warfarin section**, and **PRN medications**

**Circle Y** if times correlate with frequency or **circle N** if times do not correlate with frequency e.g. prescriber ordered metoprolol TDS and administration times entered as BD.

If times do not correlate with frequency, write criteria number and who entered the administration times, doctor, nurse or pharmacist in comments section on page 1 e.g. criteria 10.12 nurse entered administration times incorrectly.

**NA=Not Applicable:** Stat/Once Only, Warfarin (when prescribed in *Warfarin* section) and PRN medications.

**Rationale:** *The administration times must be entered on the chart by the prescriber at the same time as the frequency. Many medication errors have been reported where nurses have interpreted the frequency ordered by the prescriber incorrectly, and written wrong times on the chart e.g. frequency ordered QID – times written as 0800, 1400 and 2200.*

#### 10.15 Drug Ceased

**Circle Y** if the drug has been ceased or **circle N** if still an active order.

#### 10.16 Drug Ceased Correctly (include ceased orders)

This field **must** be marked **Not Applicable** if medication **not ceased**

**Circle Y** if medication has been ceased correctly, **circle N** if incorrect and **circle NA** if medication not ceased.

**Note:** When a medicine 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 impinge on other orders. The medical officer 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, date and initial the entry.

**Rationale:** *If an order has not been clearly ceased additional dose/s may be administered.*

#### 10.17 Doses Required (include ceased orders)

This field **must** be marked '**0**' (**zero**) for **PRN medication**.

Record the number of doses that **should have been administered**. Count all doses that **should** have been administered from the commencement of the chart to the time of the audit by counting the administration boxes. Include Stat/Once Only medication.

#### 10.18 Doses administered (include ceased orders)

Record the number of doses that **have been administered**, including doses that have a 'reason for not administering' code documented.

**Note:** Administration record should be signed when the medication has been administered or an administration code (circled and un-circled) documented.

**Rationale:** *If a clinician administers a medicine but forgets to initial the chart, the next clinician will not know if the medicine has been administered or not. This can lead to double dosing or omission of a dose.*

#### **10.19 If PRN, Max dose documented (include ceased orders)**

This field **must** be marked **Not Applicable** for **Stat/Once Only, Variable Dose, Warfarin** and **Regular medications**

Circle Y if a *PRN* medication order has the maximum dose documented, N if no maximum dose documented and NA for Stat/Once Only, Variable Dose, Warfarin and Regular medication.

**Rationale:** *Some PRN medicines may need to be given frequently, but have a maximum dose that can safely to be given in any 24 hour period. For example, if diazepam 5-10mg is ordered every 2-3 hours for agitation, the prescriber might want to limit a patient to 40mg in every 24 hour period to prevent any adverse effects, e.g. respiratory depression.*

**Each column must have a response documented**

## References

1. Australian Commission on Safety and Quality in Health Care. National terminology, abbreviations and symbols to be used in the prescribing and administering of medicines in Australian hospitals., 2008.
2. NSW Therapeutic Advisory Group. *Indicators for Quality Use of Medicines in Australian Hospitals*, 2007.