AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NIMC (GP e-version) User Guide

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Australian Commission on Safety and Quality in Health Care *NIMC (GP e-version) User Guide*. ACSQHC, Sydney 2009

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This document should be read in conjunction with the NIMC User Guide.

Purpose

To provide guidance on use of the NIMC (GP e-version)

Key points

1. A four A4 page version of the NIMC (acute), the NIMC (GP e-version), was approved for use in 2009.
2. It is designed to assist general practitioners electronically prescribing for admitted patients primarily in rural and remote hospitals. The NIMC (GP e-version) should assist GPs (without access to A3 printers) to provide medicine orders for inpatients in a NIMC compliant format
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 medicines boxes (for variable dose medication and warfarin)
    d. warfarin education box.

Differences between the NIMC (acute) and the NIMC (GP e-version)

1. The NIMC (acute) is a folded A3, double-side printed document. The NIMC (GP e-version) has the following differences:
    a. Each page requires full patient identification details (and which 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 ADRs are detailed on page 1 and reference made to the page 1 details on successive pages.

       In instances where a patient has more than five allergies/ ADRs some versions of the NIMC (GP e-Version) with generate a fifth page (“Page 5 of 5”). The fifth page will contain the complete list of allergies and ADRs. All preceding pages will refer readers to the fifth page for the complete list of allergies and ADRs.
    d. Various boxed information (which is in the middle of pages 3 and 4 in the NIMC (acute) has been moved to underneath the allergy/ADR and patient ID space on page 2 of the NIMC (GP e-version).
    e. As a result of the boxed information on page 2, there is one less regular medicines space available than on the NIMC (acute).

Key practice issues

1. The same use requirements for the NIMC (GP e-version) apply as for the NIMC (acute) with the following additional requirements:
    a. All four pages (or five pages where an additional allergies/ADRs page has been generated), 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 Medicines 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 the NIMC (GP e-version) into their facilities.

Background

1. Implementation of the NIMC (acute) 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 NIMC Summary Rationale is attached for information.
3. Further NIMC support materials are available on the Commission website www.safetyandquality.gov.au

Date

14 August 2014

NIMC summary rationale

Ensuring 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 medicines orders 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 for ordering and administering medicines for an individual patient

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 medicine for the wrong patient.
2. When subsequent new medicine orders 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 (e.g. 'nil known'). If no information is available about previous reactions (e.g. if the patient is unable to communicate), this should also be documented (e.g. '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 medication 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, health service organisations 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 medicines with medicines prescribed whilst the patient is in care and at transfer. It also aids communication of changes to medicines made during admission to patients and primary care clinicians.
7. A medication chart must include a specific section for prescribing variable doses of medicines. 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 documenting venous thrombo-embolism (VTE) risk, prophylaxis appropriateness, ordering and recording administration of VTE chemo-prophylaxis and ordering and recording checking of mechanical prophylaxis. Hospital-associated VTE is a national safety and quality issue with research showing that medication chart prompts can improve the rate of VTE risk assessment and of appropriate prophylaxis prescribing.
9. A medication chart should include a specific section for prescribing warfarin. Warfarin is associated with adverse events both through under-dosing and overdosing. The warfarin section should enable documentation of both the International Normalised Ration (INR) target range and INR results to facilitate dosing decisions. Ideally, warfarin should be administered at 4 p.m. to ensure morning results are reviewed and the next dose is ordered by a prescriber familiar with the patient's medication management, rather than by 'after-hours' medical staff.
10. A medication chart should have a separate section for 'when required' (PRN) medicines 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.
11. A medication chart should include a specific section for nurse-initiated medicine, in accordance with state regulations and local practices.
12. Medicine orders should be dated from when the medication chart is rewritten, although medication management review is aided by documenting the date the medicine is started. It is useful to record in the National Medication Management Plan when medicines were commenced.
13. The chart should encourage prescribing using generic (active ingredient) medicine names. This is to reduce the risk of duplicate orders of the same medicine being made because of unfamiliarity with different trade (brand) names. In addition, medicines are usually stocked on the ward alphabetically by generic name, therefore generic prescribing facilitates location of the drug.
14. The chart should discourage the use of abbreviations, particularly those known to be error-prone. This reduces the risk of misinterpretation. Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines should be reflected in local health service organisation policy.
15. The chart should facilitate recording of the administration times by the prescriber, based on a locally agreed standard. This reduces the potential for nurses to misinterpret prescribed administration frequency instructions.
16. The chart should include a section for clinical pharmacist annotation regarding supply and administration. In addition, a section enabling pharmacists to sign the chart following review by a pharmacist facilitates peer review and improves communication with pharmacists covering the same ward or unit.
17. The chart should facilitate dispensing of discharge medicine directly from the medication chart, to avoid transcription errors. This may not be applicable for those sites using the PBS for discharge medicines 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.
18. The chart should include a section for prescriber contact details (for example, pager number), so that they can be easily contacted.