AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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| | |
|---|---|
| **Title:** | **National In-patient Medication Chart** |
| **Description:** | Guidelines for use of the National In-patient Medication Chart |
| **Target Audience:** | All Nursing, Medical and Pharmacy staff and Administrative and Allied Health staff that are authorised to access and use patient medication charts. |

**Exceptions:** The National In-patient Medication Chart is intended to be used to 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 PROCEDURE




**Acknowledgements:**
The Australian Council for Safety and Quality in Health Care would like to acknowledge the role of the Council's National In-Patient Medication Chart Working Group in consultation and development of the chart. We would also like to acknowledge the significant contribution of the Queensland Health Medication Management Services and the (QLD) Adverse Drug Event Prevention Project.

## 1. Purpose

**Consistent documentation allows accurate interpretation of orders**
The National In-Patient Medication Chart is an initiative of the Australian Council for Safety and Quality in Health Care (the Council).

Research shows that many adverse events reported in Australian hospitals are associated with medications. Research also demonstrates that improvements to medication chart design can improve the safety of medication processes in hospitals. The Council has developed this Medication Chart through a group of health care professionals (including nursing, medical, pharmacy and the private sector) from states and territories across Australia who have been involved in similar medication chart standardising projects within their own organisations.

Australian Health Ministers have endorsed the recommendation made by the Council that a Common In-Patient Medication Chart be in use in all public hospitals by June 2006 to assist in standardisation and consistent documentation of medications. Council's vision is that this chart will be used in health care facilities nationally, and that it will be a valuable precursor to the electronic health environment.

The 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 minimise the risk of adverse medication events.

The following are general requirements regarding use of the medication chart:

- All Medical Officers must order medicines for inpatients in accord with legislative requirements as required by state/territory Health (Drugs and Poisons) Regulations.

- The medication chart is to be completed for all admitted 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.

## 2. General Instructions

**All orders are to be written legibly in ink**

No matter how accurate or complete an order is, it may be misinterpreted if it cannot be read.

Water soluble ink (eg fountain pen) should not be used.

Black ink is preferred.

A medication order is valid only if the medical officer enters all the required items (refer Section 4.4).

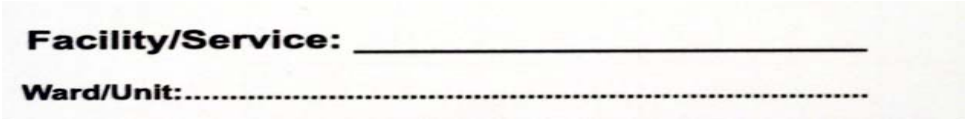
All information, including drug names, should be PRINTED.

Only accepted abbreviations may be used. Dangerous abbreviations must be avoided (refer Appendix A).

A separate order is required for each medicine.

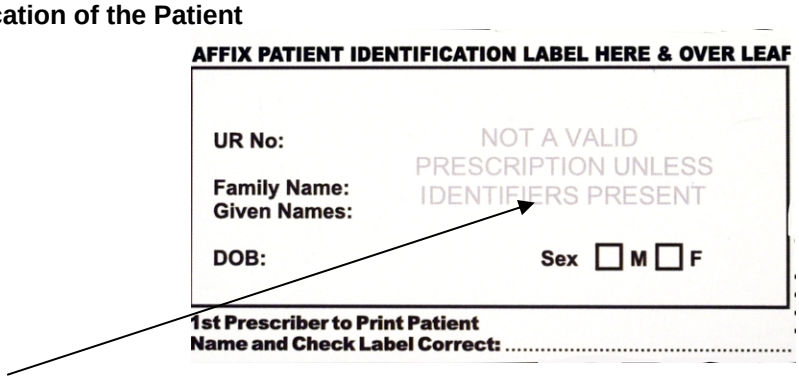
No erasers or "whiteout" can be used. Orders MUST be rewritten if **any** changes are made, especially changes to dose and/or frequency.

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



## 3. Front Page of Medication Chart (including top section of Page 3)

### 3.1 Identification of the Patient



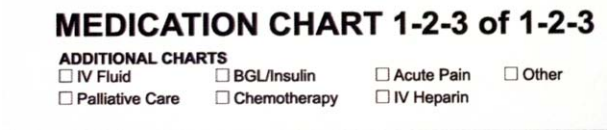

A watermark has been placed on the "patient identification section" as a reminder that a prescription is not valid unless the patient's identifiers are present, that is:

- EITHER the **current patient identification label**
- OR, as a minimum, the **patient name, UR number, date of birth** and **gender** written in **legible print.**

The first prescriber must print the patient's name. This will reduce the risk of wrong identification label being placed on the chart .

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

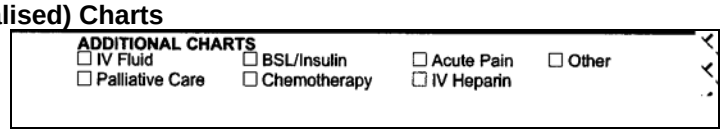
### 3.2 Numbering of the Medication Chart




If more than one general medication chart is in use, then this must be indicated by circling the appropriate numbers using the numbers provided.
*Eg: Medication Chart 1 of 2*

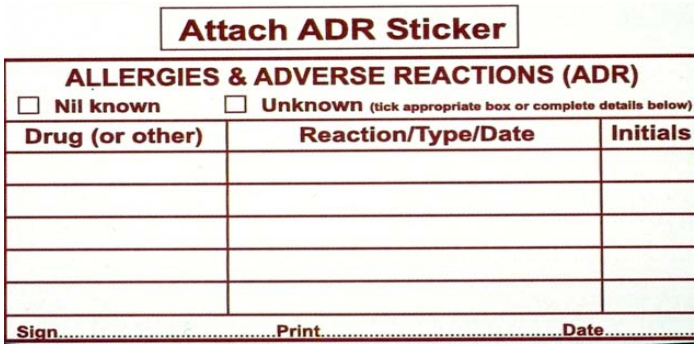
If additional charts are written, this information will need to be updated.

### 3.3 Additional (specialised) Charts




When additional (specialised) charts are written, this should be indicated by placing a tick or cross in the space provided.

### 3.4 Adverse Drug Reaction Alerts


Attach ADR Sticker

ALLERGIES & ADVERSE REACTIONS (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

| Drug (or other) | Reaction/Type/Date | Initials |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Sign..... Print..... Date.....

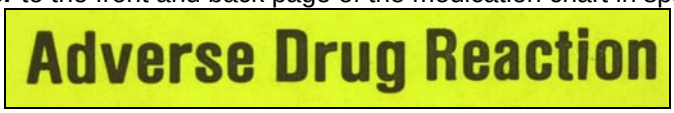
Medical Officers, Nursing Officers and Pharmacists are obliged to complete "Allergies and Adverse Drug Reactions (ADR)" details for all patients. (*Patients may be more familiar with the term allergy, than ADR, so this may be a better prompt*). Once the information has been documented, the person documenting the information must sign, print their name and date the entry.

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

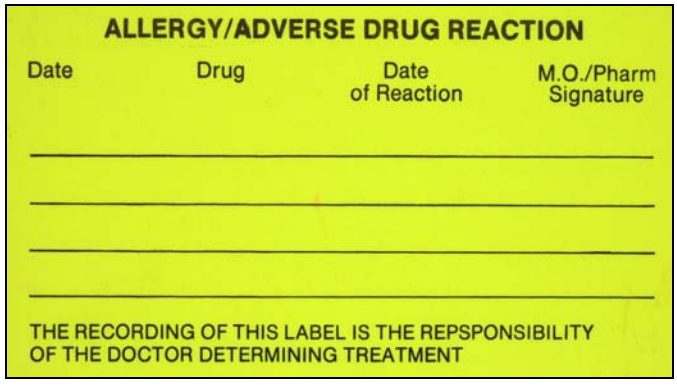
If the patient is not aware of any previous ADRs, then the **Nil known** box should be ticked and the person documenting the information must sign, print their name and date the entry.

**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
- Reaction details (*eg rash*)
- Date that reaction occurred (or approximate timeframe *eg "20 years ago"*)

**Note** this is the minimum information that should be documented. It is preferable to also document how the reaction was managed (eg "withdraw & avoid offending agent") and the source of the information (*eg patient self report, previous documentation in medical notes etc*)
**b)** Affix **ADR alert sticker** to the front and back page of the medication chart in space provided

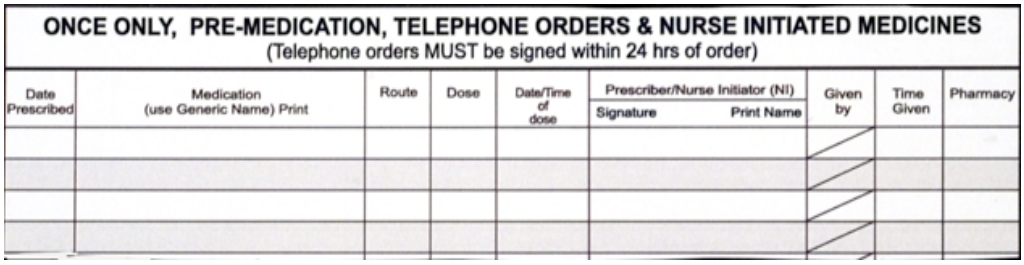



**c)** Affix **large, yellow ADR alert sticker** to front of patient's medical record and complete the relevant information




**d)** Attach **red ADR alert bracelet** to patient's wrist. Details of the ADR should **not** be written on the bracelet. The bracelet is only to be used as an alert , for allergy details refer to the medication chart
The bracelet may be annotated with the patient name, UR number and date of birth in legible print using a permanent marker, if this is required by local policy/procedure.

### 3.5 Once only, pre-medication, telephone orders and nurse initiated medicines



**ONCE ONLY, PRE-MEDICATION, TELEPHONE ORDERS & NURSE INITIATED MEDICINES**
(Telephone orders MUST be signed within 24 hrs of order)

| Date Prescribed | Medication (use Generic Name) Print | Route | Dose | Date/Time of dose | Prescriber/Nurse Initiator (NI) Signature | Prescriber/Nurse Initiator (NI) Print Name | Given by | Time Given | Pharmacy |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

**Once only and pre-medication orders**:

The following must be documented for **once only** and **pre-medication orders**:
- date prescribed
- generic name of medicine
- route of administration (accepted abbreviations may be used, refer Appendix A)
- 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
- time medicine administered
- pharmacy confirmation that medicine requires supply (S) or is on imprest (I)

**Nurse initiated medicines**

The following must be documented for **nurse initiated medicines**
- generic name of medicine
- route of administration (accepted abbreviations may be used, refer Appendix A)
- dose to be administered
- date and time medicine nurse initiated
- nurse initiator to sign and print name
- initials of person that administers the medicine

**Local hospital policy/guidelines** will outline when nurses can initiate medicines and will specify a **limitation** on **nurse initiated medicines** such as "for one dose only" or "for a maximum of 24 hours only". Generally the capacity applies to a **limited list of medicines** only. Typically this includes: simple analgesics, aperients, antacids, cough suppressants, sublingual nitrates, inhaled bronchodilators, artificial tears, sodium chloride 0.9% flush or IV infusion to keep IV line(s) patent as per local policy.

**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 Appendix A)
- 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

**The telephone order MUST be signed, or otherwise confirmed in writing, within 24 hours**

**Example**

**ONCE ONLY, PRE-MEDICATION, TELEPHONE ORDERS & NURSE INITIATED MEDICINES**
(Telephone orders MUST be signed within 24 hrs of order)

| Date Prescribed | Medication (use Generic Name) Print | Route | Dose | Date/Time of dose | Prescriber/Nurse Initiator (NI) Signature | Prescriber/Nurse Initiator (NI) Print Name | Given by | Time Given | Pharmacy |
|---|---|---|---|---|---|---|---|---|---|
| 26/9/04 | Metoclopramide | IV | 10mg | 26/9 2200 | | S BROWN RN | | 2205 | |
| | As per Phone order Dr Wash | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

### 3.6 Drugs taken prior to admission

**Medicines taken Prior to Presentation to Hospital**
**(Prescribed, over the counter, complementary)** Own medications brought in? ☐ Y ☐ N Administration Aid (specify) .....

| Medication | Dose & frequency | Duration | Medication | Dose & frequency | Duration |
|---|---|---|---|---|---|
| | | | | | |



**GP:** **Community Pharmacy:**

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

The admitting medical officer, a pharmacist or other 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
- whether the patient uses a dose administration aid (*eg Webster Pack or other blister pack*)
- contact details for patient's community health providers (GP and Community Pharmacist)
- whether the patient usually receives assistance to administer/manage their medicines

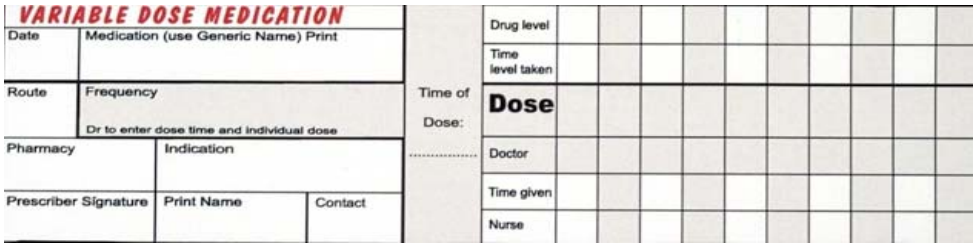
Any discrepancies noted by the person documenting the medication history must be brought to the attention of the attending medical officer.

**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 local health service policy.

**Note** 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.

## 4. Second & third page of medication chart

### 4.1 Variable dose medicines



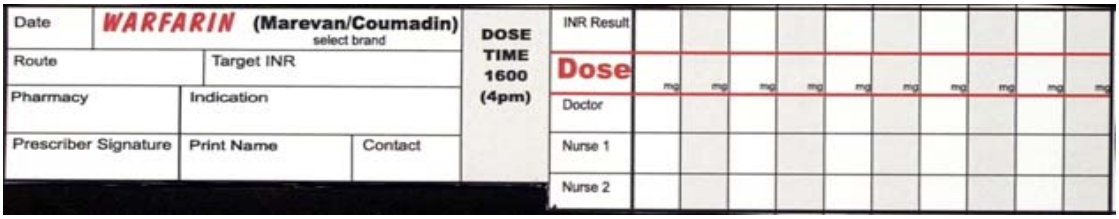

This section has been formatted to facilitate ordering of medicines that require variable dosing based on laboratory test results or as a reducing protocol *eg gentamicin and steroids.* If these agents are ordered in the regular ordering section, then there is no designated area to record drug levels and if they are ordered in the "once-only" ordering section, the risk of errors of omission is increased.

For **each day of therapy**, the following information should be documented:
- Drug level results
- Time drug level taken

**For each dose**, the following information must be documented:
- Dose
- Doctor's initials
- Actual time of administration (this may be different from the dose time)
- Initials of nurse that administers the dose

If a patient requires a second variable dose medication or twice daily dosing prescribe in the regular section using the above format

### 4.2 Warfarin ordering section




The warfarin ordering section is printed in red as an extra alert to indicate that it is an anticoagulant (and a high-risk medicine).

It is recommended that a laminated copy of the *Guidelines for Anticoagulation using Warfarin* is available to assist the doctor/pharmacist/nurse when a patient is commenced on warfarin. The *Guidelines* offer information about target INR, duration of therapy, dosing, management of excessive bleeding and drug interactions.

A standard dose time of 1600 hours (4pm) is recommended as this allows the medical team caring for the patient to order the next dose based on INR results, rather than leaving it for after-hours staff to do.

The indication and target INR (based on *Guidelines for Anticoagulation using Warfarin*) should be included when warfarin is initially ordered.

For **each day of therapy**, the following information should be documented:
- INR result
- warfarin dose
- doctor's initials
- initials of nurse that administers the dose and the checking nurse

### 4.3 Warfarin education record

Because of the well documented risks associated with use of warfarin, all patients should receive counselling about the use of warfarin and given a warfarin book (*available from Boots healthcare*). This section is included as a record that these risk mitigation activities have been completed.

**WARFARIN EDUCATION RECORD**

Patient Educated by:.....

Sign:.....

Date: .....

Given Warfarin Book:.....

Sign:.....

Date: .....

### 4.4 Regular medicines

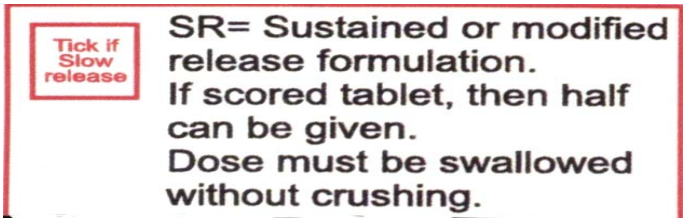
| | | | |
|---|---|---|---|
| Date | Medication (use Generic Name) Print | Tick if Slow release | |
| Route | Dose | Frequency & NOW enter times → | |
| Pharmacy | Indication | | |
| Prescriber Signature | Print Name | Contact | |

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 as below is in the margin of the medication chart




d) **Route**. Only commonly used and understood abbreviations should be used to indicate the route of administration. Acceptable abbreviations are listed below.

| COMMONLY USED AND UNDERSTOOD ABBREVIATIONS | |
|---|---|
| **Abbreviation** | **Meaning** |
| PO | per oral / by mouth |
| NG | nasogastric |
| SUBLINGUAL | sublingual |
| IV | intravenous injection |
| IM | intramuscular injection |
| SUBCUT | subcutaneous |
| IT | intrathecal |
| PR | per rectum |
| PV | per vagina |
| Gutt | eye drop |
| Occ | eye ointment |
| Top | topical |
| MA | metered aerosol |
| Neb | nebulised / nebuliser |

| 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 & interpreted as subcutaneous | write **subling** or **under tongue** |
| E | Ear or eye | Misinterpreted as the other organ | write **ear** or **eye** in full |

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.

**Note** In the case of **liquid medicines**, the **strength** and the **dose** in milligrams or micorgrams (not millilitres) must always be specified *eg morphine mixture (10mg/mL) Give 10mg every 8 hours*

**Note** The ward/clinical pharmacist will clarify when the strength supplied is different from that ordered *eg For 10mg, the pharmacist may write 2 x 5mg tablets or for 25mg, the pharmacist may write ½ x 50mg*

| COMMONLY USED AND UNDERSTOOD ABBREVIATIONS | |
|---|---|
| **Abbreviation** | **Meaning** |
| mL | Millilitre |
| L | Litre |
| g | Gram |
| mg | Milligram |
| mcg (safer to write **microgram** in full) | Microgram |
| Unit(s) | International Unit(s) |

| DANGEROUS ABBREVIATIONS NOT TO BE USED | | | |
|---|---|---|---|
| **Abbreviation to avoid** | **Intended meaning** | **Reason for avoiding** | **Acceptable alternative** |
| ug or µg | microgram | mistaken for milligram when handwritten | write **mcg** clearly or write **microgram** |
| U or U/s | unit or | 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 **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. This will prevent errors where the nurse misinterprets the frequency and writes down the wrong times. If these details are not entered, the dose may not be administered by nursing staff.

Acceptable abbreviations are listed below.

Times should be entered using the 24-clock (this nomenclature is the global standard)

Unless drugs must be given at specific times (eg some antibiotics, with/before food), they should be administered according to the **Recommended Administration Times**.

| RECOMMENDED 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 | |
| Antibiotic 6 hourly | 6 hrly | 0600 | 1200 | 1800 | 2400 |
| Antibiotic 8 hourly | 8 hrly | 0600 | 1400 | 2200 | |
| Four times a day | QID | 0600 | 1200 | 1800 | 2200 |

The ward/clinical pharmacist or nurse will clarify (and annotate the chart) the administration time if necessary to correctly administer the drug (in relation to food etc)

| COMMONLY USED AND UNDERSTOOD ABBREVIATIONS | |
|---|---|
| **Abbreviation** | **Meaning** |
| mane | Morning |
| nocte | Night |
| bd | Twice daily |
| tds | Three times a day |
| qid | Four times a day |
| unit(s) | International Unit(s) |

| DANGEROUS ABBREVIATIONS<br>NOT TO BE USED | | | |
|---|---|---|---|
| **Abbreviation to avoid** | **Intended meaning** | **Reason for avoiding** | **Acceptable alternative** |
| OD, od or d | Once a day<br>Once daily | mistaken for twice a day<br>**d** is easily missed | write **mane**, **nocte** or **specific time** |
| QD or qd | Every day | Mistaken as qid<br>(four times a day) | write **mane**, **nocte** or **specific time** |
| 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 |

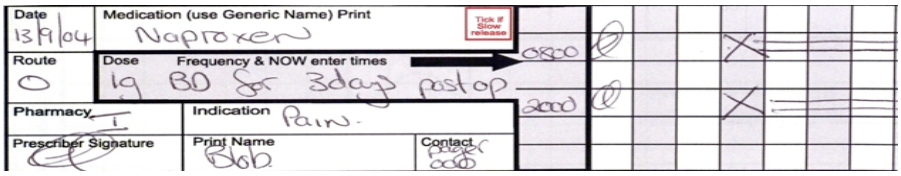
g) **Pharmacy**. This section is for use by the ward/clinical pharmacist. Annotations include:
**I** for medicines available on imprest
**S** for non-imprest items that will be supplied and labelled for individual use from the pharmacy
**Pts own** for medicines checked by the pharmacist and confirmed 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. For each signature (medical officer), the name must be written in print at least once on the medication chart.

**4.5 Limited duration and ceased medicines**

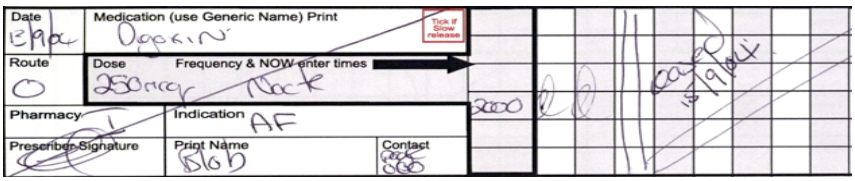
When a medicine is ordered for a **limited duration**, or only on **certain days**, this must be clearly indicated using crosses (**X**) to block out day/times when the drug is **NOT** to be given




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.

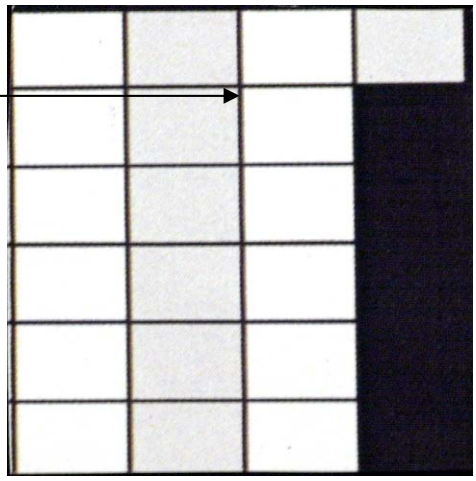
The medical officer must write the reason for changing the order (eg cease, written in error, increased dose etc) at an appropriate place in the administration record section.

**Note** the acronym "**D/C**" should not be used for ceased orders since this can be confused with "**DISCHARGE**". Always use "**CEASE**".




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.

### 4.6 Administration Record



The medication administration record provides space to record **up to eleven days** of therapy. At the end of eleven 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.

### 4.7 Reasons for not administering

| REASON FOR NURSE NOT ADMINISTERING<br>Codes MUST be circled | |
|---|---|
| Absent | A |
| Fasting | F |
| Refused - notify Dr | R |
| Vomiting | V |
| On leave | L |
| Not available - obtain supply or contact Dr | N |
| Withheld - Enter reason in Clinical Record | W |
| Self Administering | S |

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.

(Refer to Appendix B - Guidelines for Withholding Medicines)

### 4.8 Patient Weight and Height

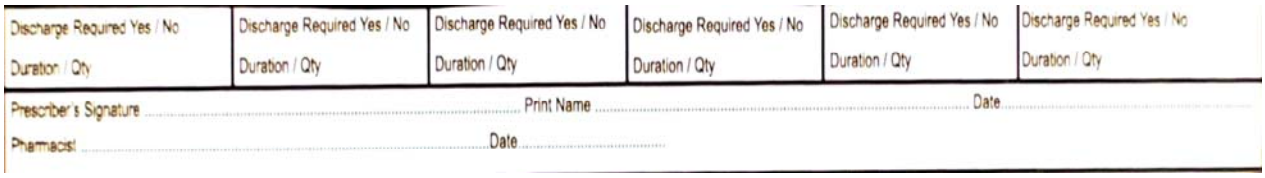
This information should be documented in the space provided (it is important clinical information, vital to confirming doses of certain medicines).

Patient Weight (kg).....Height (cm).....

### 4.9 Clinical pharmacist review


The clinical pharmacist will sign this section as a record that they have reviewed the medication chart (on that day) to ensure that all orders are clear, safe and appropriate for that individual patient, therefore the risk of an adverse drug event is minimised.

### 4.10 Discharge Supply




For sites not using the PBS system to supply discharge medications, the discharge supply section on the statewide medication chart should be used.

For **each drug** prescribed while an inpatient, the following information must be documented in the discharge supply section

- Discharge supply required yes/no
- Duration / Quantity

For **each page** the following information is only required to be documented once

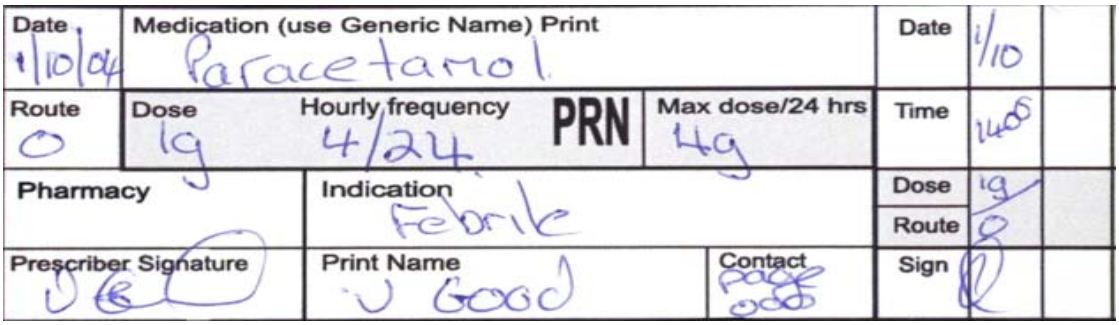
- Prescriber's signature
- Prescriber to print name
- Date discharge required
- Pharmacist signature
- Date discharge information completed

## 5. Back page of medication chart

### 5.1 As required ("prn") medicines

**Prescribing:**
The medical officer **must** write:
- 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*

**Administration:**
The actual dose given **must** be recorded
The person administering each dose is responsible for checking that the maximum daily dosage will not be exceeded



## APPENDIX A – DANGEROUS ABBREVIATIONS

| **Avoid these abbreviations** | **Intended Meaning** | **Why?** | **What should I use?** |
|---|---|---|---|
| OD<br>o.d.<br>d | Once daily | **OD** can be mistaken as twice a day<br>**d** can easily be missed | Preferably write the time of the day for administration<br>eg **mane**, **midday**, or **nocte** |
| TIW | Three times a week | Mistaken as three times a day | Write out in full and specify which days |
| SC | subcutaneous | Mistaken for sublingual | Use **subcut** or **subcutaneous** |
| q.d.<br>QD | every day | Mistaken as Q.I.D or four times a day | Specify time of day eg **mane**, **nocte** etc |
| IU<br>eg 3 IU | International unit | Misread as IV (intravenous) or misread as 31 U (ie 31 units) | Use **units** |
| Cc | cubic centimetres | Misread as **u** when handwritten | Use **mL** |
| µg<br>mcg | microgram | Mistaken as **milligram** when handwritten | Write out in full |
| x3d | For 3 days | Mistaken as three doses | Use **for three days** |
| > or < | Greater than or less than | Opposite of intended | Use **greater than** or **less than** |
| Zero after a decimal point<br>eg 5.0 | 5 mg | Misread as 50mg if decimal point not seen | Do not use decimal points after whole numbers |
| No decimal point before fractional dose eg .5mg | 0.5mg | Misread as 5 mg | Always use a zero before a decimal when dose is less than one |
| Chemical symbols<br>Eg MgSO4 | Magnesium sulfate | May not be understood or may be misunderstood eg morphine sulfate | Write out in full |
| Drug names<br>eg epo<br>(& many other examples!) | Erythropoietin<br>Epoetin alpha | Mistaken as **evening primrose oil** | Write all drug names out in full – generic name for single active ingredient, and trade name for combination drugs |
| 6/24 | Every six hours | Mistaken as six times a day | Use **q6h** or **6 hourly** |
| 1/7 | For one day | Mistaken for one week | Write **for one day** |
| E | **ear** or **eye** | Misinterpreted as the other organ | Write **ear** or **eye** |
| S/L | For sublingual | Mistaken for S/C - subcutaneous | Write **subling** or **sublingual** or **under tongue** |
| D/C | Discharge or discontinue | Misinterpreted as the other intention | Write out **discontinue** or **discharge** |

## APPENDIX B – GUIDELINES FOR WITHHOLDING MEDICINES

The medication chart is a legal document and therefore **must be** written in a clear, legible and unambiguous form.

Every nursing officer 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)
- **medical officer's signature**

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 five Rs:
- The **right drug**
- The **right dose**
- The **right route**
- The **right time**
- The **right patient**