Please note that the following document was created by the former Australian Council for Safety and Quality in Health Care. The former Council ceased its activities on 31 December 2005 and the Australian Commission for Safety and Quality in Health Care assumed responsibility for many of the former Council’s documents and initiatives. Therefore contact details for the former Council listed within the attached document are no longer valid.

The Australian Commission on Safety and Quality in Health Care can be contacted through its website at http://www.safetyandquality.gov.au/ or by email mail@safetyandquality.gov.au

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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.

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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

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 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

![Telephone Order Form]

3.6 Drugs taken prior to admission

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.
This section has been formatted to facilitate ordering of medicines that require variable dosing based on laboratory test results or as a reducing protocol e.g. 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.

4.4 Regular medicines

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO</td>
<td>per oral / by mouth</td>
</tr>
<tr>
<td>NG</td>
<td>nasogastric</td>
</tr>
<tr>
<td>SUBLINGUAL</td>
<td>sublingual</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous injection</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular injection</td>
</tr>
<tr>
<td>SUBCUT</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>IT</td>
<td>intrathecal</td>
</tr>
<tr>
<td>PR</td>
<td>per rectum</td>
</tr>
<tr>
<td>PV</td>
<td>per vagina</td>
</tr>
<tr>
<td>Gutt</td>
<td>eye drop</td>
</tr>
<tr>
<td>Occ</td>
<td>eye ointment</td>
</tr>
<tr>
<td>Top</td>
<td>topical</td>
</tr>
<tr>
<td>MA</td>
<td>metered aerosol</td>
</tr>
<tr>
<td>Neb</td>
<td>nebulised / nebuliser</td>
</tr>
</tbody>
</table>

DANGEROUS ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation to avoid</th>
<th>Intended meaning</th>
<th>Reason for avoiding</th>
<th>Acceptable alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>S/C</td>
<td>subcutaneous</td>
<td>Mistaken for &quot;sublingual&quot;</td>
<td>write subcut or subcutaneous</td>
</tr>
<tr>
<td>S/L</td>
<td>sublingual</td>
<td>Mistaken for S/C &amp; interpreted as subcutaneous</td>
<td>write subling or under tongue</td>
</tr>
<tr>
<td>E</td>
<td>Ear or eye</td>
<td>Misinterpreted as the other organ</td>
<td>write ear or eye in full</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>mL</td>
<td>Millilitre</td>
</tr>
<tr>
<td>L</td>
<td>Litre</td>
</tr>
<tr>
<td>g</td>
<td>Gram</td>
</tr>
<tr>
<td>mg</td>
<td>Milligram</td>
</tr>
<tr>
<td>mcg</td>
<td>Microgram</td>
</tr>
<tr>
<td>(safer to write microgram in full)</td>
<td></td>
</tr>
<tr>
<td>Unit(s)</td>
<td>International Unit(s)</td>
</tr>
</tbody>
</table>
DANGEROUS ABBREVIATIONS
NOT TO BE USED

<table>
<thead>
<tr>
<th>Abbreviation to avoid</th>
<th>Intended meaning</th>
<th>Reason for avoiding</th>
<th>Acceptable alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>ug or µg</td>
<td>microgram</td>
<td>mistaken for milligram when handwritten</td>
<td>write mcg clearly or write microgram</td>
</tr>
<tr>
<td>U or U/s</td>
<td>unit or</td>
<td>mistaken for 0</td>
<td>write unit(s)</td>
</tr>
<tr>
<td>IU or iu (eg 3 IU)</td>
<td>international unit</td>
<td>mistaken as iv (intravenous) or as 31u (thirty-one units)</td>
<td>write unit(s)</td>
</tr>
<tr>
<td>No zero before decimal point (eg .5mg)</td>
<td>0.5mg</td>
<td>Misread as 5mg</td>
<td>Write 0.5mg or write 500 microgram</td>
</tr>
<tr>
<td>Zero after decimal point (eg 5.0mg)</td>
<td>5mg</td>
<td>Misread as 50mg</td>
<td>Do not use decimal points after whole numbers</td>
</tr>
</tbody>
</table>

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](image)

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)

<table>
<thead>
<tr>
<th>COMMONLY USED AND UNDERSTOOD ABBREVIATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abbreviation</strong></td>
</tr>
<tr>
<td>man</td>
</tr>
<tr>
<td>noce</td>
</tr>
<tr>
<td>bd</td>
</tr>
<tr>
<td>tds</td>
</tr>
<tr>
<td>qid</td>
</tr>
<tr>
<td>unit(s)</td>
</tr>
</tbody>
</table>
DANGEROUS ABBREVIATIONS
NOT TO BE USED

<table>
<thead>
<tr>
<th>Abbreviation to avoid</th>
<th>Intended meaning</th>
<th>Reason for avoiding</th>
<th>Acceptable alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD, od or d</td>
<td>Once a day</td>
<td>Mistaken for twice a day d is easily missed</td>
<td>write mane, noce or specific time</td>
</tr>
<tr>
<td></td>
<td>Once daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QD or qd</td>
<td>Every day</td>
<td>Mistaken as qid (four times a day)</td>
<td>write mane, noce or specific time</td>
</tr>
<tr>
<td>m</td>
<td>Morning</td>
<td>Mistaken for m (night)</td>
<td>Write mane</td>
</tr>
<tr>
<td>n</td>
<td>Nocte</td>
<td>Mistaken for n (morning)</td>
<td>Write noce</td>
</tr>
<tr>
<td>6/24</td>
<td>Every six hours</td>
<td>Mistaken for six times a day</td>
<td>Write q6h or 6 hourly</td>
</tr>
<tr>
<td>1/7</td>
<td>For one day</td>
<td>Mistaken for one week</td>
<td>Write for one day in full</td>
</tr>
<tr>
<td>X 3d</td>
<td>For 3 days</td>
<td>Mistaken as for three doses</td>
<td>Write for 3 days in full</td>
</tr>
</tbody>
</table>

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

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).
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

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