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## Definitions and abbreviations

<table>
<thead>
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<th>Term/Acronym</th>
<th>Definition</th>
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<tr>
<td>ACSQHC (the Commission)</td>
<td>Australian Commission on Safety and Quality in Health Care</td>
</tr>
<tr>
<td>The Commission</td>
<td>Australian Commission on Safety and Quality in Health Care</td>
</tr>
<tr>
<td>Department of Health (the Department)</td>
<td>Australian Government Department of Health</td>
</tr>
<tr>
<td>DHS</td>
<td>The Department of Human Services</td>
</tr>
<tr>
<td>HSMEAG</td>
<td>Health Services Medication Safety Expert Advisory Group</td>
</tr>
<tr>
<td>National Inpatient Medication Chart (NIMC)</td>
<td>The national standardised paper medication chart designed by the Commission for hospital inpatients</td>
</tr>
<tr>
<td>NSQHSS</td>
<td>National Safety and Quality Hospital Service Standards</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme also taken to include Repatriation Pharmaceutical Benefits Scheme (RPBS) unless otherwise stated</td>
</tr>
<tr>
<td>PBS HMC</td>
<td>A national standard PBS/RPBS compliant hospital medication chart</td>
</tr>
<tr>
<td>RPBS</td>
<td>Repatriation Pharmaceutical Benefits Scheme under the <em>Veterans’ Entitlement Act 1986</em> includes all items on the Repatriation Schedule of Pharmaceutical Benefits and the PBS Schedule</td>
</tr>
</tbody>
</table>
About this guide
1 About this guide

The PBS HMC Implementation Guide aims to assist healthcare organisations to implement the PBS HMC at a local level.

It outlines:
- the general principles of PBS HMC implementation
- a summary of planning considerations for implementation
- links to relevant resources for implementation including training and stakeholder communication
- detailed guidance regarding the requirements for making alterations to the chart if required to support local clinical needs
- guidance regarding printing
- contacts for further information.

The overarching principle of implementation is that the PBS HMC should be used with little or no modification. This is consistent with the quality and safety goals of standardisation for medication charts. It is understood however that some modification will be necessary to support local clinical or administrative requirements.

A main focus of this guide is to set out the minimum requirements for the chart from a safety and legal point of view and provide detailed guidance on the scope of changes to the PBS HMC which can be authorised at local levels (i.e. state/territory, private health service chain/local hospital network and individual health service organisation).

The guide also describes the process for managing PBS HMC issues which cannot be managed locally and which need to be referred to the national level for consideration.

The document can be referred to when justifying decisions about modifications.
About the PBS HMC
2 About the PBS HMC

The Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC) is a national standardised medication chart that allows the prescribing, administration, claiming and supply of PBS and non-PBS medicines directly from the chart without the need for a separate paper prescription.

The PBS HMC was developed by the Commission and trialled in public and private hospitals across the country. The evidence-based chart builds on the National Inpatient Medication Chart (NIMC) and retains key safety features.

The PBS HMC use is supported for accreditation purposes. Health service organisations seeking accreditation against National Safety and Quality Health Service (NSQHS) Standard 4 Medication Safety are expected to demonstrate the use of a compliant standardised chart.

Non-conforming medication charts:
- cannot be used for PBS claiming purposes
- are not reflected in any nationally maintained support materials including education resources
- may create medico-legal risks for health service organisations in the event of patient harm related to medication misadventure.

Stewardship of the PBS HMC

The Commission is charged with maintaining the PBS HMC on behalf of the Australian Government Department of Health. Through the Health Services Medication Expert Advisory Group (HSMEAG), the Commission maintains an issues and communications log for the chart, provides guidance for effective implementation of the chart and support materials that support chart implementation.
Planning checklist and resources
Successful implementation of the chart relies on thorough planning and strong clinical engagement, as well as the establishment of monitoring and reporting mechanisms to ensure safe and effective implementation.

The following checklist summarises the main considerations for planning and the resources available to support the planning and implementation processes. They should form the basis of your project plan.

Need help?

**Contact the Commission**
For information about the implementation of the PBS HMC, including clinical and safety and quality aspects:

**Email:** PBSHospitalMedCha@safetyandquality.gov.au

**Web:** www.safetyandquality.gov.au

**Contact the Department of Health**
For more information about Commonwealth PBS policy or legislation / regulatory requirements relating to the PBS HMC:

**Email:** pbshmc@health.gov.au

For information about State or territory regulatory requirements contact your relevant jurisdiction.

**Contact the Department of Human Services**
For information about operational aspects regarding claiming from the PBS HMC:

**Phone:** 132 290

**Email:** pbs@humanservices.gov.au

For information about functionality with dispensing software, contact your software vendor.
# PBS HMC Planning Checklist

<table>
<thead>
<tr>
<th>Planning considerations</th>
<th>Tips and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project governance</strong></td>
<td>Implementation of the PBS HMC requires comprehensive oversight including high level involvement through an executive sponsor and involvement of relevant committees (Patient Safety and Quality Committee/Drug and Therapeutics Committee).</td>
</tr>
<tr>
<td><strong>Stakeholder engagement</strong></td>
<td>Key stakeholders to be involved in implementation include pharmacy, health information services, and medical and nursing personnel.</td>
</tr>
<tr>
<td><strong>Clinical leadership</strong></td>
<td>Strong clinical leadership is important to support change management and ensure implementation issues are addressed in a timely way.</td>
</tr>
<tr>
<td></td>
<td>Leadership at department and ward level should be considered, including the establishment of implementation champions to monitor and provide feedback.</td>
</tr>
<tr>
<td><strong>Implementation strategy</strong></td>
<td>The implementation strategy for each organisation should be carefully considered. Consider options such as piloting, phased implementation and service-wide implementation.</td>
</tr>
<tr>
<td><strong>Project management and resourcing</strong></td>
<td>Implementation of the PBS HMC is a complex project requiring appropriate project management and resourcing.</td>
</tr>
<tr>
<td></td>
<td>Implementation should be supported by a comprehensive project plan developed with input from stakeholders and endorsed at Executive level.</td>
</tr>
<tr>
<td></td>
<td>The project plan including the rationale for the change to the PBS HMC and the benefits realization statement should be recommended to the relevant local committee and formally endorsed for action</td>
</tr>
<tr>
<td><strong>Chart adaptation to local requirements</strong></td>
<td>This guide outlines the requirements for local adaptation including identifying which aspects of the chart may be altered. It should inform stakeholder consultation regarding local requirements.</td>
</tr>
<tr>
<td><strong>Chart production and printing</strong></td>
<td><strong>High resolution artwork and printer instructions</strong> are provided to ensure quality production of the chart.</td>
</tr>
<tr>
<td></td>
<td>The PBS HMC must be printed with the 8-digit Authority Prescription Number (APN) in the allocated space</td>
</tr>
<tr>
<td><strong>Pharmacy software readiness</strong></td>
<td>Pharmacy must liaise with the software provider regarding software functionality for PBS HMC.</td>
</tr>
</tbody>
</table>
3 Planning checklist and resources

PBS HMC Planning Checklist

<table>
<thead>
<tr>
<th>Planning considerations</th>
<th>Tips and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>A communication plan should be developed to support awareness and promote smooth implementation. The PBS HMC User Guide (<a href="http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/pbs-hospital-medication-chart/">http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/pbs-hospital-medication-chart/</a>) contains all relevant information and can be used as a source for local communications on various aspects. Two Fact Sheets are available to support communication with clinicians and other health service staff.</td>
</tr>
<tr>
<td>Education</td>
<td>The PBS HMC User Guide provides comprehensive guidance for use of the chart and is the basis for education of users including prescribers, nurses and pharmacists. The Fact Sheets summarise the main benefits and process requirements for users.</td>
</tr>
<tr>
<td>Monitoring and reporting</td>
<td>Change takes time and should be supported by a process of monitoring and feedback so that issues can be addressed in a timely way through communication, education and supervision. Monitoring also helps to communicate benefits arising from the implementation. Measures may include: chart completion, medication related incidents, transcription errors, clinician feedback, owing prescriptions.</td>
</tr>
</tbody>
</table>
Guidance for local chart preparation
4 Guidance for local chart preparation

4.1 Modifications to the chart

The overarching principle of implementation of the PBS HMC is that it should be used with little or no modification. This is consistent with the quality and safety goals of standardisation for medication charts.

While it is understood that some modification will be necessary to support local clinical or administrative requirements, the overall layout of the PBS HMC is not to be altered and there must be no impact on the four page layout of the chart or the capacity for the chart to be transmitted as a single document. Additional folds risk patient safety by obscuring patient identification and other critical information and do not constitute part of the agreed, standard PBS HMC.

This section sets out the minimum requirements for the chart from a safety and legal point of view and provides detailed guidance on the scope of changes to the PBS HMC which can be authorised at local levels (i.e. state/territory, private health service chain/local hospital network and individual health service organisation).

This section also describes the process for managing PBS HMC issues which cannot be managed locally and which need to be referred to the national level for consideration.

Elements of the chart that cannot be altered by local health organisations are summarised in Table 1A and detailed rationale is provided in Appendix 1. Jurisdictional policy should also be considered.

Elements of the chart that may be altered at a local level, following appropriate consultation and approval processes, are summarised in Table 1B. They include administrative formatting that is not related to the clinical use of the chart such as:

- Use of coloured strips for chart identification
- Use of other general colour (except in sections that use red as an alert)
- Inclusion of a medical record number or barcode
- Hospital identification details
- Pharmacy identification details

Other aspects that may be altered based on local requirements include:

- The number of days covered by the chart
- The number of additional charts referred to
- The recommended administration times

The local process for preparing the chart for production or printing should be undertaken in a robust manner, with appropriate oversight and documentation, preferably with reference to this guidance document.
### A) PBS HMC sections that cannot be altered (detailed rationale is provided in Appendix 1)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Requirement Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient identification</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged</td>
</tr>
<tr>
<td>Patient weight and height</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged</td>
</tr>
<tr>
<td>Hospital identification</td>
<td>• name and provider number must be included</td>
</tr>
<tr>
<td>Chart numbering</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged</td>
</tr>
<tr>
<td>Period of chart validity</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged</td>
</tr>
<tr>
<td>Authority Prescription Number</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged</td>
</tr>
<tr>
<td>Allergies and adverse drug reaction alerts</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged&lt;br&gt;• red must be used and must be visible when viewing drug orders</td>
</tr>
<tr>
<td>Once only, pre-medication orders and nurse initiated medicines</td>
<td>• must be included (not as a separate chart)&lt;br&gt;• format and content must remain unchanged</td>
</tr>
<tr>
<td>Telephone orders</td>
<td>• need not be included if telephone orders not permitted&lt;br&gt;• if included, format and content must remain unchanged</td>
</tr>
<tr>
<td>Medicines taken prior to presentation to hospital</td>
<td>• must be included&lt;br&gt;• format and content must remain unchanged&lt;br&gt;• if facility has a separate medicine reconciliation form this section should refer to that form and the requirement for it to be attached to the chart</td>
</tr>
<tr>
<td>Format for documenting order for Regular Medicines</td>
<td>• format and content must remain unchanged&lt;br&gt;• number of days for administration may be altered – see below&lt;br&gt;• recommended administration times may be altered – see below</td>
</tr>
</tbody>
</table>
## A) PBS HMC sections that **cannot** be altered
(detailed rationale is provided in Appendix 1)

<table>
<thead>
<tr>
<th>Section</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Format for documenting orders for PRN medications | • must be a separate section  
• format and content must remain unchanged |
| Brand substitution                   | • must be included  
• format and content must remain unchanged |
| Pharmaceutical review                | • must be included  
• format and content must remain unchanged |
| Prescriber details box               | • must be included  
• format and content must remain unchanged |
| Discharge supply                     | • must be included  
• format and content must remain unchanged |

## B) PBS HMC sections that **can** be altered

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital identification</td>
<td>Logo may be included</td>
</tr>
<tr>
<td>Pharmacy details</td>
<td>Organisations can add their pharmacy approval details to the designated area</td>
</tr>
<tr>
<td>Coloured strip</td>
<td>A coloured strip may be added to the PBS HMC to assist with rapid chart identification of the chart in the medical record</td>
</tr>
<tr>
<td>Colours</td>
<td>Red, black and grey have been used to alert and differentiate between sections of the chart. These colours may be varied, however, it is recommended that consideration be given to legibility after faxing and printing to ensure that safety is not compromised. Use of additional colours may generate additional printing costs.</td>
</tr>
<tr>
<td>Binding margin</td>
<td>The binding margin for the PBS HMC is located in the middle and for the PBS HMC long-stay on the left. Jurisdictions may choose to bind all medication charts from the left side.</td>
</tr>
<tr>
<td>Medical record number or bar code</td>
<td>A medical record number or bar code may be added to assist with identification and ordering of medication charts, in accordance with local hospital information service requirements</td>
</tr>
<tr>
<td>Recommended administration times</td>
<td>These may be altered in line with local practice</td>
</tr>
<tr>
<td>The number of days for administration</td>
<td>The number of days for administration may be adjusted to meet local requirements. The need for transcription should be minimised as this can increase the risk of medication error.</td>
</tr>
<tr>
<td>The list of additional charts may be increased</td>
<td>The list of ancillary charts may be amended to suit local needs. It is acknowledged that fewer charts will reduce the risk of prescribing and administration error.</td>
</tr>
</tbody>
</table>
4.2 Printing the chart

High quality production of the PBS HMC is important for ensuring patient safety.

High resolution print ready files may be downloaded from the Commission website together with detailed instructions for printing.

The high resolution PDF files should be sent to a professional printer.

The high resolution files are PDF files. Conversion to other file types is not recommended as it is likely to disrupt the layout.

Contact the Commission if you have any further questions about printing charts.

PBS requirements mean that the hospital approval and pharmacy approval numbers must be displayed on all PBS HMCs. A hospital organisation may choose to print their charts using any of the configurations shown – the last example with details printed onto the medication chart being the easiest.
Process for managing proposals for change to the PBS HMC
Changes to the PBS HMC will only be considered if they are evidenced based and address a clearly identified patient safety issue.

Proposals for changes to the PBS HMC, other than those that can be made locally (Table 1B), are managed through a jurisdictional process aimed at maintaining standardisation and version control and providing an efficient and robust approval process.

A jurisdictional oversight body (or the equivalent arrangement) should have responsibility for receiving and managing proposals for change in a timely manner, and assessing whether the proposals warrant consideration at a national level.

The oversight body should establish a structured approach to managing proposals for change, including:

- local policies and procedures outlining clear requirements for submissions for change;
- a register for PBS HMC change proposals; and
- systems and processes for communicating change decisions and implementing changes that are approved at a national level.

Where the jurisdictional oversight body considers that the proposal for change addresses a clearly identified patient safety issue and is supported by appropriate evidence (e.g. risk assessments, case reports, surveys, audits and incident reports) they will notify the Health Service Medication Expert Advisory Group (HSMEAG) and ask for consideration and possibly further evaluation of the proposal. The Health Service Medication Expert Advisory Group provides advice accordingly to the Commission.

Approved changes to the PBS HMC will be incorporated into the next scheduled version update (usually January of each year).
5 Process for managing proposals for change to the PBS HMC

Figure 1: Summary of processes for organisational, jurisdictional and national approval of PBS HMC changes

Organisation identifies changes to PBS HMC based on patient safety concerns

*Organisation manages proposal through local governance processes and implements revised chart*  

**Organisation submits proposal to jurisdictional body**

Jurisdictional body adds to register and initiates review process

**Jurisdictional body considers**

*Is there evidence of patient safety issue?*

*Is there evidence that change will address patient safety issue?*

YES

Jurisdiction submits report to HSMEAG

HSMEAG advises Commission

Commission accepts change?

Revisions incorporated into national standardised chart

NO

Change rejected by jurisdictional body

NO

Jurisdictional body notifies stakeholders

YES

Commission accepts change?
## Appendix 1:
Sections of the PBS HMC that must not be altered without national approval

<table>
<thead>
<tr>
<th>Section</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Patient identification**           | • Either a patient identification label should be attached, or the patient’s name, date of birth, gender and unit record number must be printed legibly.  
• If an identification label is used, the first prescriber must print the patient’s full name by hand under the label, to reduce the risk of ordering for the wrong patient.  
• Writing the patient’s name is in addition to attaching a label and acts as a double check for pre-labelled charts. |
| **Patient weight and height**        | • Patient weight and height must be documented to assist staff in calculating doses safely, especially for paediatric patients, and for certain high risk medicines. |
| **Hospital identification**          | • The name of the hospital is important for identifying the source of the prescription  
• The provider number must be present for claiming |
| **Chart numbering**                  | • The number of charts in use must be identified, for example chart 1 of 2.  
• Any additional ancillary charts must also be identified on the main chart. This is to provide an alert to minimise the risk of omission of medicine or inappropriate prescribing. |
| **Period of chart validity**         | • The PBS HMC is only valid as a PBS/RPBS prescription if the period of chart validity is documented. |
| **Allergies and adverse drug reaction alerts** | • The PBS HMC includes a section to record the medicine and the reaction, if known. This is to assist prescribing decisions.  
• The ADR section must be clearly visible whenever medicines are prescribed are written.  
• Red is used to draw attention to this important section. |
| **Once only and nurse initiated medicines and pre-medications** | • The PBS HMC includes a separate section for once only and nurse initiated medicines and pre-medications to distinguish them from regular medicines and therefore minimise the risk of unnecessary administration.  
• It is important that this section is included on the PBS HMC rather than a separate chart to minimise the risk of omission and to provide a complete medication history. |
| **Telephone orders**                 | • Telephone orders should generally be discouraged, unless they are essential due to work practice restrictions, such as rural and private hospitals and facilities without resident medical staff.  
• Some metropolitan sites have limited telephone orders to one dose, by blacking out the remaining three of the four boxes.  
• Where telephone orders are permitted, the medication chart must include capacity for two nurses to sign for a telephone order, which must be co-signed by the prescriber within 24 hours of the order. |
<table>
<thead>
<tr>
<th><strong>Section</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
</table>
| **Medicines taken prior to presentation to hospital** | • There should be space on the medication chart to record medicines taken by the patient prior to admission.  
• Some sites may record this information on a separate form which is designed to facilitate reconciliation and accompanies the medication chart. This will assist with the medication reconciliation process on admission, during transfer and at discharge.  
• Where dedicated medication reconciliation forms are used, sites may refer to the alternative form in the ‘medicines taken prior to presentation’ section. Dedicated medication reconciliation forms must be accessible along with the current medication chart at all times.  

| **Regular medications** | **Variable dose section:**  
  • The format of this section facilitates ordering of medicines that require variable doses based on pathology results or as a reducing protocol.  
  • The medicine level should be entered together with the date. The prescriber’s initials, actual administration time and the initials of the person administering the dose must accompany each dose.  
  • If a second variable dose medicine is required, or twice daily dosing is appropriate, the regular medicines section should be used following the format for variable dose orders described above.  

| **Warfarin section:** | • The warfarin section is highlighted in red to indicate that it is a high risk medicine.  
  • A recommended standard dose time (such as 1600 hours) allows the medical staff responsible for the care of the patient to review the INR (international normalised ratio) result and prescribe the dose, rather than an on-call doctor who may not be familiar with the patient’s medical history. This dose time may be modified to a later time for rural or private facilities, where a visiting medical officer cares for the patient.  
  • The indication and target INR range must be documented when warfarin is initially ordered.  
  • The INR should be documented at a frequency appropriate to the patient’s condition. The dose, prescriber’s initials, initials of the person administering the warfarin and the initials of the second person checking the administration should also be documented.  
  • The PBS HMC includes a warfarin education record to indicate that the patient has received verbal and written information, as appropriate.  

| **Regular medications section:** | • Prescribers should enter administration times, as this minimises the risk of errors that may result from incorrect interpretation of the instructions by the nursing staff.  
  • In addition to signing the order, prescribers must also print their name at least once on the chart and provide contact details, such as pager number or prescriber number in the prescriber details box, to minimise delays in clarifying orders (see below).  
  • Recommended administration times must be listed in the centre margin for easy reference. The suggested administration times may be amended to meet local needs. Health service organisations may find it helpful to ensure that administration times are standardised between wards.  

Appendix 1: Sections of the PBS HMC that must not be altered without national approval

<table>
<thead>
<tr>
<th>Section</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Regular medications (continued)** | **Regular medications section (continued):**  
  • A pharmacy box must be included to provide space for pharmacist’s annotation.  
  • An indication box must be included to provide clarity, especially where a medicine may be used for more than one indication.  
  • The red ‘tick if slow release’ box is included as a prompt to prescribers to consider whether a modified release or immediate release preparation is required.  
  • The administration record provides space to record up to eleven days of therapy. The last column is partially blocked out to ensure that a new chart is written during the day.  
  • Codes for not administering medicines must be listed in the centre of the chart for easy reference.                                                                                                                                                                                                                                                                                                                                 |
| **PRN (as required) medicines** | • A specific section must be included on the medication chart for PRN (as required) medicines, rather than including them in the regular medicines section, to minimise the risk of these being administered regularly.  
  • The prescriber must document the dose and hourly frequency, as ‘PRN’ does not provide sufficient information for the medicine to be administered correctly. Indication and maximum daily PRN dose (that is, maximum PRN dose in twenty four hours) must be provided to ensure safe and appropriate administration and to minimise the risk of overdose. The prescriber must check the regular medicines section for possible duplicate orders.  
  • Where appropriate, the prescriber may indicate the maximum number of doses to be administered or maximum duration for the order by crossing out parts of the administration section.  
  • Staff administering the medicine must document the actual dose given. The person administering each dose must check the maximum PRN dose in 24 hours and also check the timing of the previous dose (either PRN or regular).                                                                                                                                                                                                                           |
| **Pharmaceutical review** | • A section for clinical pharmacist review must be included to ensure that all orders are clear, safe and appropriate for that individual patient, to minimise the risk of an adverse drug event.                                                                                                                                                                                                                                                                                                                                 |
| **Prescriber details box** | • In addition to signing the order, prescribers must also print their name at least once on the chart and provide contact details, such as pager number or prescriber number in the prescriber details box, to minimise delays in clarifying orders.                                                                                                                                                                                                 |
| **Discharge supply** | • A section has been included on the chart to minimise the risk of transcription errors for discharge medicines. For each medicine, the prescriber should indicate whether discharge supply is required, including the duration/quantity. Prescribers must provide their signature, printed name and the date the discharge medicine is ordered. The pharmacist should ensure the discharge information is complete.  
  • When there is a change in dose for a discharge medicine, a new order should be written, the discharge section completed and the administration section crossed out.                                                                                                                                                                                                                                                                 |
Appendix 2: 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 chemoprophylaxis 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 Ratio (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.
Appendix 2: Key principles for ordering and administering medicines for an individual patient

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.