Government of **Western Australia**
Department of **Health**

Guidelines for the WA Hospital Medication Chart (Adult and Paediatric)

Includes the short stay and long stay versions of the WA Hospital Medication Chart (Adult) (Version 08/22) and the WA Paediatric Hospital Medication Chart (Version 08/22)

Medicines and Technology Unit, Patient Safety and Clinical Quality Directorate

health.wa.gov.au

Contents

Introduction

The Western Australian Hospital Medication Chart (WA HMC) and WA Paediatric Hospital Medication Chart are designed to assist in the safe and consistent communication of a patient's medication requirements. Endorsed for use by the Australian Commission for Safety and Quality in Health Care (ACSQHC), they build on the National Inpatient Medication Chart (NIMC), retaining key safety features to minimise the risk of adverse medication events. The charts incorporate standardised processes for documentation of medicines prescription, administration, and medication reconciliation in the inpatient setting.

Use of the WA HMC is mandatory for all WA public and private health services that provide publicly funded inpatient care.

The evidence-based safety features that are incorporated in the WA HMC are applicable across a range of hospital healthcare settings and it is strongly recommended that it also be used in WA private hospitals.

A standard medication chart ensures that health professionals are familiar with the chart and its medication management safety features when working in different healthcare settings across WA health services.

A component of health services' accreditation requires them to demonstrate use of a compliant standardised medication chart and the WA HMC is approved for this purpose.

The WA HMC incorporates components of the National Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC). It is approved by the Pharmaceutical Benefits Division of the Australian Department of Health and supply and reimbursement of medicines under the Pharmaceutical Benefits Scheme can be made directly from the chart.

The WA Medication Chart Policy mandates that Health Service Providers (HSPs) must use the WA HMC for adult patients (and the WA Paediatric Hospital Chart for children), alongside the WA Health Electronic Discharge Summary application (currently Notification and Clinical Summary (NaCS) application). Use of the WA HMC for discharge dispensing remains at the discretion of the Health Service Provider but must not replace the use of the WA Electronic Discharge Summary application for discharge reconciliation, prescription generation requirements at discharge, creation of consumer medication lists and discharge summaries.

The WA HMC forms part of the patient's medical record. It must be maintained and stored according to local hospital policy.

The most current versions of the WA HMC and WA Paediatric Hospital Medication Chart listed in this guideline can be accessed via the Patient Safety and Clinical Quality internet page - WA Medication Charts.

Under the direction of the Australian Commission of Safety and Quality on Health Care, a Health Service Medication Expert Advisory Group (HSMEAG) has been established to provide national governance for the standardised medication charts including the National Inpatient Medication Chart (NIMC), the paediatric NIMC (PNIMC) and the PBS Hospital Medication Chart (PBS HMC). This Group is responsible for maintaining the standardisation of the national medication charts across Australia and for considering proposals from States/Territories and hospitals to change the chart.

The WA HMC has been adapted from the PBS HMC to reflect local needs. In order to maintain the standard safety components and adhere to the underlying principle of standardisation to

optimise patient safety, sections of the chart other than the hospital logo and MR number are not to be changed without approval of the Medicines and Technology Unit, Patient Safety and Clinical Quality Directorate, Department of Health.

All major changes to the WA HMC and WA Paediatric Hospital Medication Chart need endorsement from the HSMEAG.

Recommendations for change to these charts should be lodged to the WA DoH Medicines and Technology Unit. Recommendations for change must be evidence based, with the primary objective of improving patient safety. MTU will screen these requests and escalate to HSMEAG where appropriate.

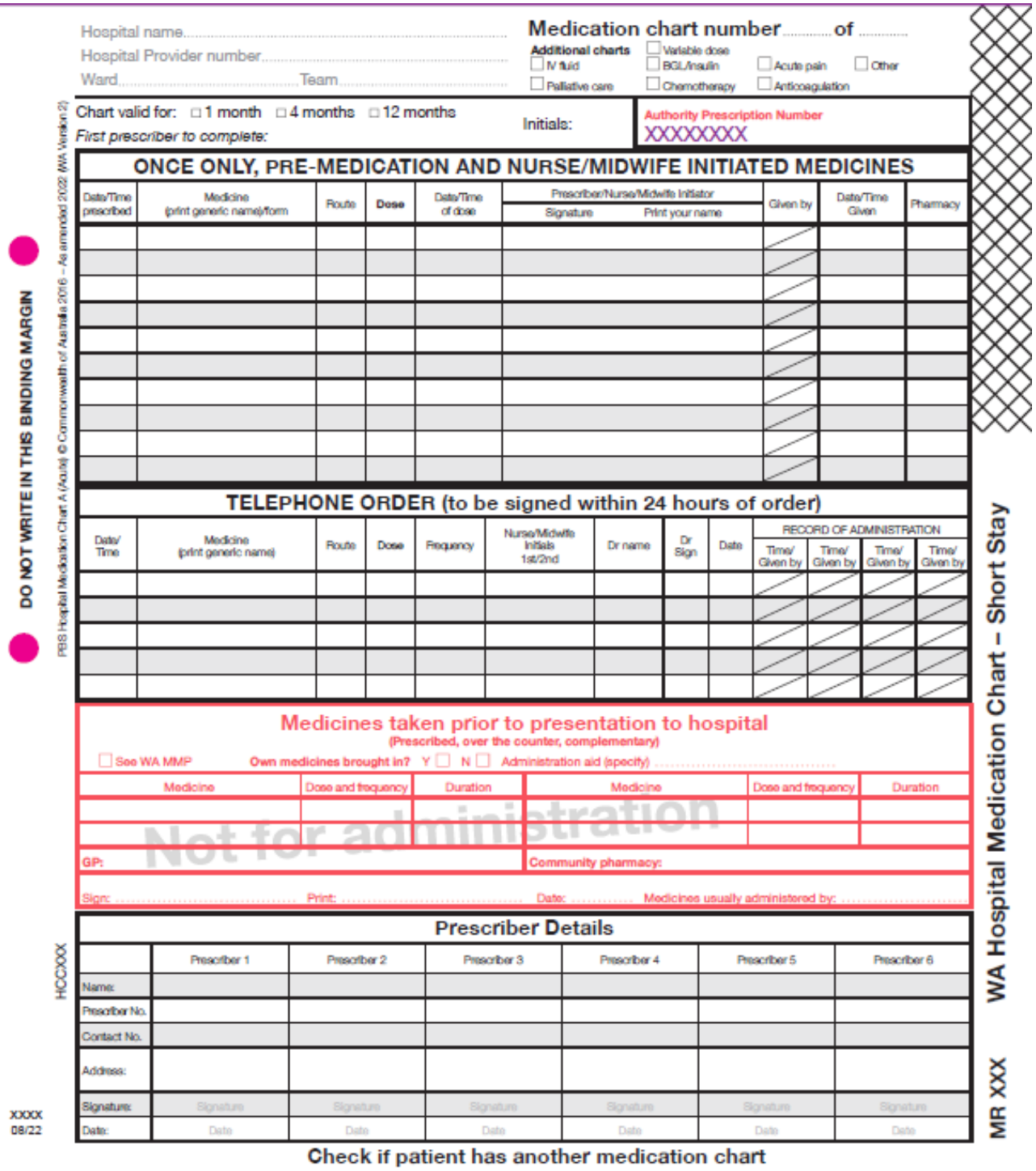
General Instructions

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

- All prescribers must order medicines for patients in accordance with the WA Medicines and Poisons Regulations 2016.
- The WA HMC or WA Paediatric Hospital Medication Chart is to be used for all admitted patients requiring medications and placed in the bedside folder, unless ward/unit procedures state otherwise. All active medications charts should be filed together.
- All medications should be reviewed regularly to monitor and ensure safe and appropriate therapy, and to discontinue (cease) medicines that are no longer required.
- Specific medication charts are required for specialised medication orders such as insulin, intravenous fluids, anticoagulants, parenteral cytotoxic agents, epidural and regional infusions and patient-controlled analgesia. These charts should be cross-referenced on the WA HMC or WA Paediatric Hospital Medication Chart.
- The WA HMC and WA Paediatric Hospital Medication Chart are legal documents and therefore prescriptions must be written in a clear, legible, indelible and unambiguous way.
- All medication orders must be written legibly in black or blue ink (black ink preferred).
    - Water-soluble ink (e.g. fountain pen) should not be used.
    - Black ink is preferred. Local policy may allow for the use of a distinct pen colour for pharmacists' annotations. This colour should be chosen to prevent confusion with the prescribers' orders and must be legible on photocopy, scanning or fax.
    - No matter how accurate or complete an order is, it may be misinterpreted if it cannot be read. (For safety purposes, if a medication order is not legible, the prescriber should be asked to rewrite the order to minimise risk of medication misadventure.)
    - Standing order prescriptions are not recommended, including the use of photocopies of a standardised template, stickers, or stamps to prescribe medications.
- A medication order is only valid if the prescriber enters all the required details (refer to Regular Medications).
- All information required to administer the medication, including medication names, should be PRINTED legibly.
- No erasers or 'whiteout' can be used. Orders must be rewritten if any changes are made, especially changes to dose and/or frequency.
- All instructions must be written in plain English.
- **Only acceptable abbreviations may be used.** Error-prone abbreviations, symbols and dose designations have a history of causing error and must be avoided.

Please refer to: Australian Commission for Safety and Quality in Health Care (ACSQHC) – Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines.

Front Page of Medication Chart



Hospital name.....
Hospital Provider number.....
Ward..... Team.....

Medication chart number..... of .....

Additional charts: ☐ Variable dose ☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other ☐ Palliative care ☐ Chemotherapy ☐ Anticoagulation

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months

First prescriber to complete:

Initials:

Authority Prescription Number XXXXXXXX

ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES

Date/Time prescribed	Medicine (print generic name)/form	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator: Signature / Print your name	Given by	Date/Time Given	Pharmacy

TELEPHONE ORDER (to be signed within 24 hours of order)

Date/ Time	Medicine (print generic name)	Route	Dose	Frequency	Nurse/Midwife Initials 1st/2nd	Dr name	Dr Sign	Date	RECORD OF ADMINISTRATION: Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary)

☐ See WA MMP Own medicines brought in? Y ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP: Community pharmacy:

Sign: ..... Print: ..... Date: ..... Medicines usually administered by: .....

Prescriber Details

	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart A (Adult) © Commonwealth of Australia 2016 – As amended 2022 (WA Version 2)

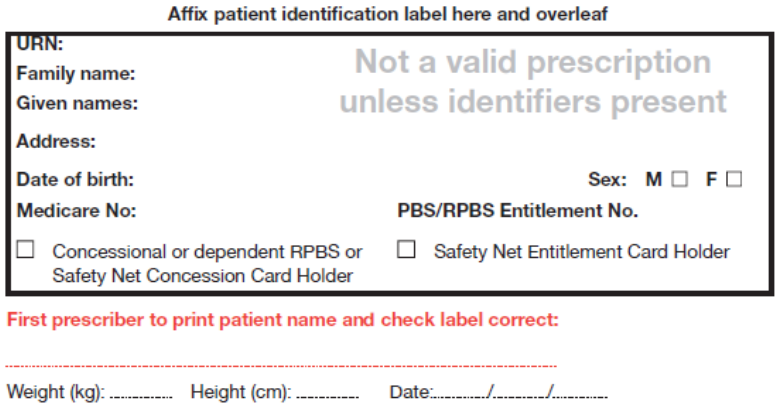
HCCXXX

XXXX 08/22

WA Hospital Medication Chart – Short Stay

MR XXX

Patient Identification


Affix patient identification label here and overleaf

URN:
Family name:
Given names:
Address:
Date of birth:
Sex: M ☐ F ☐
Medicare No:
PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder
☐ Safety Net Entitlement Card Holder

Not a valid prescription unless identifiers present

First prescriber to print patient name and check label correct:

Weight (kg): ..... Height (cm): ..... Date:...../...../.....

The patient's identity must be established before prescribing commences. To ensure that the medications are prescribed for the correct patient, each medication chart must have:

1. The patient's name, unique medical record number (UMRN), date of birth and gender written in legible print; OR
2. The current patient identification label (addressograph).
   Where the patient identification label has been used, the first prescriber must print the patient's name in the space provided below to document confirmation of the patient's identity.
   This is to confirm that the correct patient identification label has been placed on the medication chart.

Medications should not be administered if the prescriber has not documented the patient identification.

Rationale:
Patient identification guidelines and the printing of the patient's name will reduce the risk of the wrong identification label being placed on the chart, and the wrong patient receiving the wrong medication.

For a valid PBS/RPBS prescription the patient identification details required are:

- Patient's full name (as it appears on the patient's Medicare card)
- Patient's address
- Patient's Medicare number
- Any number specified on a card, issued by the Commonwealth, as an entitlement number for the patient.

Patient Location

Hospital name.....

Hospital Provider number.....

Ward..... Team.....

The patient's current location (ward or unit) within the hospital should be clearly marked on the medication chart.

If a patient moves to a different ward or unit, this new location should be indicated on the medication chart i.e. when a patient is transferred to a new ward, but is still using the current WA HMC or WA Paediatric Hospital Medication Chart, the previous ward should be crossed off, and the new ward should be written in its place.

Documenting the details of the patient's current location reduces the risk of the wrong medication chart being referred to when treating patients.

The Hospital Provider number is a PBS /RPBS requirement for hospitals using the WA HMC for discharge prescriptions.

Chart Validity

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months Initials:

First prescriber to complete:

The "Chart valid for" section on the WA HMC is only required to be completed if the hospital is utilising the WA HMC for PBS claiming of discharge prescriptions. Please refer to Discharge Supply for further information.

Patient Weight and Height

ADULT CHART

Weight (kg): ..... Height (cm): ..... Date:...../...../.....

Rationale:
Weight serves as important clinical information for correctly prescribing some medicines and for "at risk" patient groups, such as paediatric patients, and patients with either renal and/or hepatic impairment. Height is equally important in obese patients, to determine the patient's ideal body weight (IBW). The IBW is then used to calculate the appropriate dose of some medications.

Information about the patient's weight and height should be documented in the space provided.

WA Paediatric Hospital Medication Chart

Note: for paediatric patients, dose calculations are usually based on the current weight of the child (e.g. mg/kg/dose) and the child's weight and the date that the child is weighed should be documented on the chart.

Weight (kg):	.....
Date weighed:	Gestational age at birth (wks):
Height (cm):	Date:
B.S.A. (m^2):	Date:

Weight (kg):.....
Date weighed:.....

Number of Medication Chart(s)

Medication chart number ..... of .....

If there are more than one WA HMCs or WA Paediatric Hospital Medication Charts in use, then this must be indicated by filling in the appropriate numbers using the spaces provided – e.g. "Medication chart number 1 of 2."

If the number of medication charts in use changes (e.g. if additional charts are written, or if charts are ceased and thereby removed from use), this information must be updated. Failure to communicate that there is more than one active medication chart may result in missed doses, or duplicated prescribing. All medication charts should be kept together, preferably in a separate medication chart file.

Clinicians need access to all medication information to ensure safe treatment and care of patients.

Additional (specialised) Charts

When additional (specialised) charts are written, this should be indicated by placing a tick or cross in the space provided for each specialised chart in use. Failure to communicate additional specialised charts may result in missed doses or duplicated prescribing.

There are two sections on the chart that can be used to document when specialised charts are in use.

Front of chart:

Additional charts
☐ Variable dose
☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other
☐ Palliative care ☐ Chemotherapy ☐ Anticoagulation

Inside chart above regular order section.

Additional Charts – Tick if in use

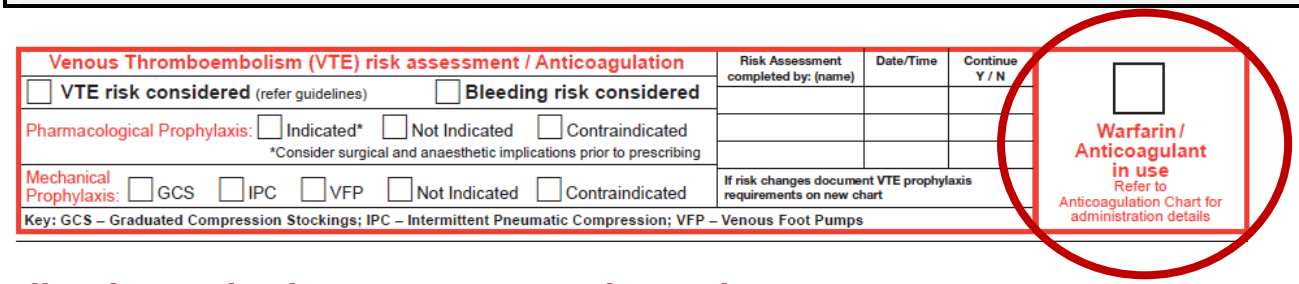
☐ Blood Glucose Level (BGL) monitoring (☐ Subcutaneous Insulin or ☐ Intravenous Insulin Infusion)

☐ Clozapine	☐ Intravenous (IV) Fluid	☐ Chemotherapy
☐ Agitation & arousal	☐ Palliative care	☐ Acute Pain
☐ Long acting injection	☐ Variable dose	☐ Other .....

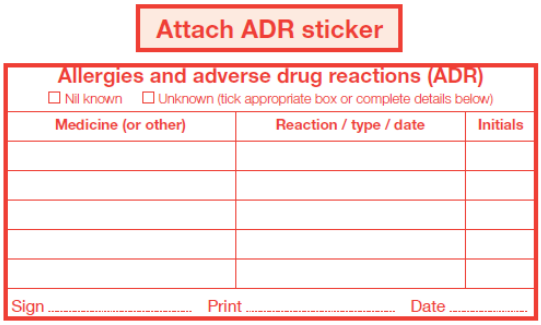
Note:

Use of the WA Adult Anticoagulation Medication Chart (WA AMC) is mandatory for prescription and administration of all anticoagulants.

If an anticoagulant is prescribed (for treatment or prophylaxis in an adult), the 'Anticoagulation' specialised chart box on front of chart (pictured above) and the 'Warfarin/Anticoagulant in use' box within the WA HMC (pictured below) must be ticked.



Allergies and Adverse Drug Reactions Alert



This section communicates the existence of previous allergies, adverse drug reactions (ADRs) and related information. Failure to communicate previous allergies or ADRs may result in re-prescribing of offending medications, and avoidable patient harm.

The following details must be completed:

1. Allergy status
    - Tick the 'Nil known' box if the patient is not aware of any previous allergies or ADRs, OR
    - Tick the 'Unknown' box if no information is available about previous reactions (e.g. if the patient is unable to communicate), OR
    - Details of previous allergies or ADRs – include medication and reaction details (refer below for more information)
2. Signature and printed name of person taking allergy/ADR history.
3. Date of initial documentation (by person above).

If a previous allergy or ADR exists, the following steps must be completed:

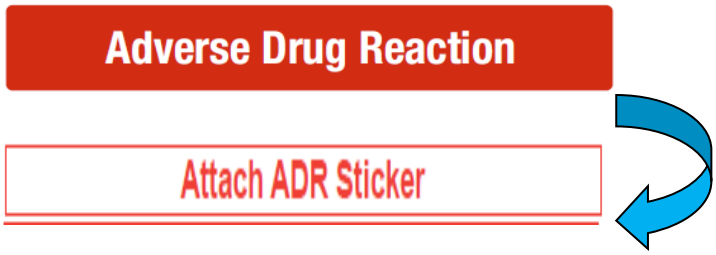
1. Document the following information in the space provided on the medication chart, and in the patient's medical record:

- Name of medication/substance (including allergies to medications, lotions, plasters, latex etc.). This section should be reserved for documentation of medication-related adverse drug reactions. Food and insect allergies should be documented elsewhere as per local hospital policy.
- Reaction details (e.g. rash, hallucinations etc.) and type (e.g. allergy, anaphylaxis).
- Date of when the reaction occurred (or approximate timeframe – e.g. “childhood allergy”, “20 years ago”).
- Initial/signature of the person taking the allergy/ADR history.

Note: This is the minimum information that must be documented.
It is preferable to also include how the reaction was managed (e.g., “withdraw and avoid offending agent”) and the source of the information (e.g. “patient self-report”, “previous documentation in medical record”, etc.).
If there are more than four previous allergies or ADRs to record, use the fifth line to refer other health professionals to the medical record for additional information.

Once completed, the person completing the allergy/ADR documentation must sign and print their name and date at the bottom of the allergy/ADR box (this assigns responsibility for the information obtained).

2. Affix the ADR alert sticker to the front and back page of the medication chart, in the space provided. This highlights the existence of previous allergies and ADRs recorded in the allergy/ADR section.



3. Affix a Patient Alert sticker to the front of the patient’s medical record and complete the relevant information, if not already done. Where hospitals are utilising the MR ALERT 1 form for patient alerts, document the ADR/allergy information on this form (as per Clinical Alert Policy MP 00531/17).

4. Attach the red ADR alert bracelet to patient's wrist. Details of the ADR(s) should not be written on the bracelet. The bracelet is only to be used as an alert. Health professionals must refer to the medication chart or medical record for allergy or ADR details.

The red ADR alert bracelet must be annotated with the patient's name, UMRN and date of birth in legible print using a permanent marker, or a generated patient identification label (addressograph).

NOTE:

- Doctors, nurses, midwives and pharmacists are required to complete the 'Allergy/Adverse Drug Reactions' documentation for all patients.
- Patients may be more familiar with the term 'allergy' than ADR, so this may be a better prompt to use when interviewing a patient about their allergy/ADR history.
- Once the information has been documented, the person documenting the allergy/ADR information must sign or initial their name, print their name and date the entry.

Rationale:

- Information about previous allergy/ADRs or allergies can assist staff in making decisions about medication therapy and avoid re-prescribing, dispensing and administering a medication involved in a previous ADR.
- By signing the ADR documentation, this assigns accountability for the information obtained.
- The use of alerts (e.g. stickers and bracelets) provides a physical reminder to help prevent the occurrence of ADRs.

Medicines Taken Prior to Presentation to Hospital

Medicines taken prior to presentation to hospital
(Prescribed, over the counter, complementary)

☐ See WA MMP **Own medicines brought in?** Y ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration
GP:			**Community pharmacy:**		
Sign: ..... Print: ..... Date: ..... Medicines usually administered by:					

The admitting medical officer, pharmacist or other clinician trained in medication history documentation may complete this section. A correct and complete medication history at the point of prescribing reduces the risk of medication misadventure.

This section is included on the medication chart to facilitate quick and effective documentation of, and access to, medication history information and **provides space for the minimum information that should be documented.**

NOTE: For the majority of patients, this information should be documented on the WA Medication History and Management Plan (WA MMP) form. For the most current version for WA Health refer to: Medication reconciliation

Where a WA MMP form exists for the patient, a notation should be made on the front cover of the WA HMC or WA Paediatric Hospital Medication Chart referring clinicians to the WA MMP.

The following must be documented on the WA MMP:

- A complete list of medications taken at home prior to being admitted to hospital (prescription and non-prescription medications – includes over-the-counter and complementary medicines), including drug identification details (generic name, strength and form) and dose and frequency.
- Whether the patient has brought their own medications with them to hospital.
- Whether the patient uses a dose administration aid (e.g. WebsterPak®, dosette box, or other dose administration aids (D.A.A.)).
- Contact details for the patient's community health providers (General Practitioner (GP) and community pharmacy).

Other useful information that could be included in this section:

- Whether the patient has a preferred dosage form (e.g. suspension for patients with swallowing difficulties or paediatric patients).
- Whether the patient receives assistance to administer or manage their medications.
- The indication for use of medications as a prompt to ensure a comprehensive history is obtained.

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

When a subsequent medication chart is required (i.e. additional medication chart in use or initial medication chart is re-written), the doctor or pharmacist should annotate to either:

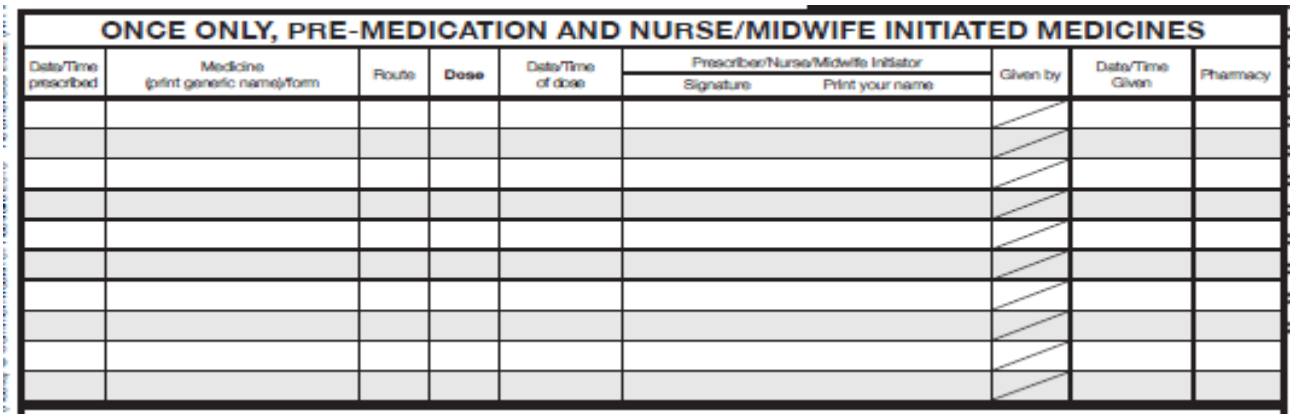
- Refer to the original WA HMC or WA Paediatric Hospital Chart for this admission – if the medication history has been documented on the front of the chart, OR
- Refer to the WA MMP (use tick box "See WA MMP") – if the medication history has been documented and reconciled on the WA MMP form.

It is also helpful to:

- Document the indication for each medication.
- Use a checklist (refer to checklist included on the WA MMP) as a prompt to ensure a comprehensive medication history is obtained.

For further information, refer to WA Medication History and Management Plan Guidelines.

Once Only, Pre-Medication and Nurse/Midwife Initiated Medicines



ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES								
Date/Time prescribed	Medicine (print generic name)/form	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator Signature / Print your name	Given by	Date/Time Given	Pharmacy

The following must be documented for once only, pre-medication and nurse/midwife-initiated medications:

- Date/time prescribed
- Generic medication name (trade names only to be used based on local policy or guidelines) – Nurses/midwives must refer to local policy or guidelines to determine if a medication can be nurse/midwife initiated, or if it needs to be prescribed by a doctor.
- Route of administration
- Dose to be administered
- Date and time the medication is to be administered
- Prescriber's signature and printed name OR nurse/midwife initiator's signature and printed name
- Initials of person that administers the medication
- Date and time medication administered

The ward/clinical pharmacist should:

- Confirm that the medication is safe to administer
- Annotate if the medication requires supply or is on imprest ("I"), a Schedule 8 (S8) or Restricted Schedule 4 (S4R) medication.

Nurse initiated medications are non-prescription medications that may be administered by a registered nurse or midwife or delegated to an authorised enrolled nurse in non-life-threatening situations without a prior written or telephone instruction from an authorised prescriber.

The medication must be listed on the health service organisation's approved list of nurse-initiated medications and administered in accordance with local policy. Some health service organisations do not permit nurse-initiated medicines to be administered to paediatric patients.

Local policy or guidelines will outline when nurses can initiate medications and will specify a limit on doses of nurse-initiated medications that can be given, for example for one dose only or for a maximum of 24 hours only.

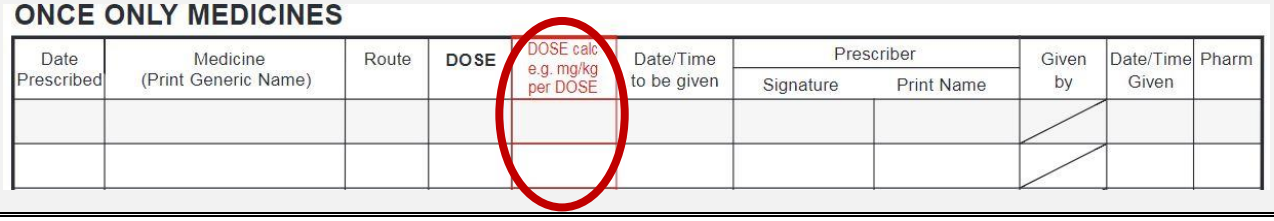
Generally, this applies to a limited list of unscheduled, Schedule 2 and Schedule 3 medications which may include (check with local policy):

- Antacids (e.g. Mylanta®, Gastrogel®)
- Laxatives (docusate sodium with sennoside, glycerol and bisacodyl suppositories)
- Non-medicated throat lozenges (e.g. Cepacol®)
- Oral Glucose Solution (e.g. Carbotest or equivalent product)
- Paracetamol (as a single product)
- Sodium Chloride 0.9% for flushing lines
- Unscheduled topical medications (e.g. lanolin, sorbolene)

Note:

For paediatric patients:

1. The dose to be administered must be accompanied by the dose calculation (e.g. mg/kg per DOSE), where appropriate.
2. Initials of a second person double checking the dose must be documented prior to the dose being administered.
3. This section is titled 'Once Only Medicines' – it does not allow for nurse/midwife-initiated medications or pre-medications



ONCE ONLY MEDICINES

Date Prescribed	Medicine (Print Generic Name)	Route	DOSE	DOSE calc e.g. mg/kg per DOSE	Date/Time to be given	Prescriber		Given by	Date/Time Given	Pharm
						Signature	Print Name			

Telephone Orders

TELEPHONE ORDER (to be signed within 24 hours of order)

Date/ Time	Medicine (print generic name)	Route	Dose	Frequency	Nurse/Midwife Initials 1st/2nd	Dr name	Dr Sign	Date	RECORD OF ADMINISTRATION			
									Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

The following must be completed for telephone orders:

- Date/time prescribed
- Generic medication name (trade names only to be used based on local policy or guidelines)
- Route of administration

- Dose to be administered
- Frequency at which the medication is to be administered
- Initials of two nurses/midwives to confirm that the verbal order has been heard and checked (see example below)
- Name of doctor giving verbal order

  The telephone order must be signed and dated by the doctor giving the verbal order, or otherwise confirmed in writing within 24 hours of the order.
- Date medication administered
- Time medication administered and initials of person that administers the medication

Local policy or guidelines will outline whether telephone orders are allowed, and under what circumstances they may be used.

Rationale:
Telephone orders are discouraged, as they are an error prone activity. To reduce the potential for error, telephone orders are to be countersigned by two nurses/midwives who have both independently heard/received and read back the order to the prescribing doctor.

Note:

For paediatric patients:

1. The dose to be administered must be accompanied by the dose calculation (e.g. mg/kg per DOSE), where appropriate.
2. Initials of a second person double checking the dose must be documented prior to the dose being administered.

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medicine (Print Generic Names)	Route	Dose	DOSE calc e.g. mg/kg per DOSE	Frequency	Nurse/Midwife Initials 1st/2nd		Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION		
											Time/Given by:	Time/Given by:	Time/Given by:

Prescriber Details

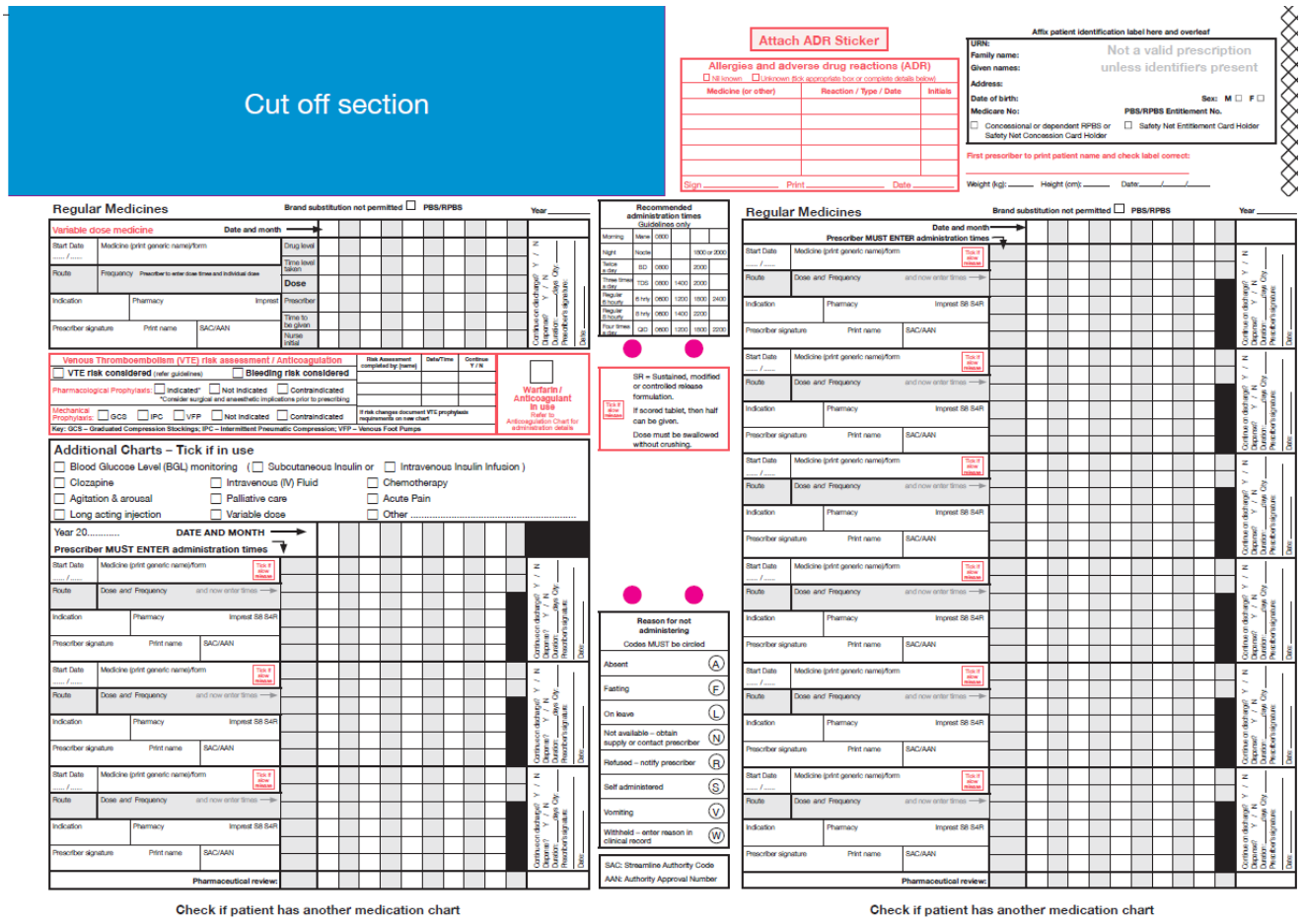
If the hospital is using the WA HMC for discharge prescriptions for PBS reimbursement, the details of the prescriber must be documented on the front of the WA HMC in the section below.

Prescriber Details						
	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

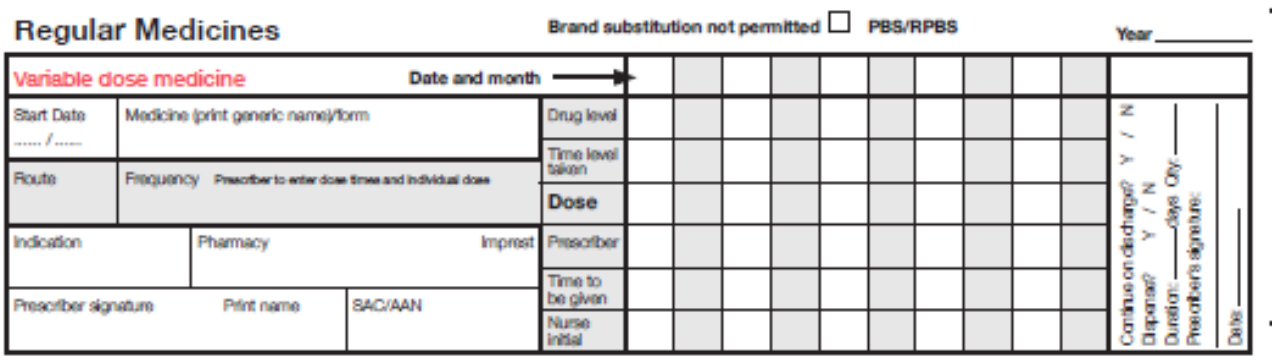
For a valid PBS prescription, the following prescriber details must appear on page one of the chart:

- Name
- PBS prescriber number
- Contact number (mobile or pager)
- Address of health service/organisation
- Signature and date

Middle Pages of the Medication Chart



Variable Dose Medicines



For each medication order, the following details must be documented:

- Start date of prescription – see under ‘Regular Medicines’ section for further details on ‘Start Date’
- Generic medication name
- Route of administration
- Frequency of administration
- Indication
- Prescriber’s signature and printed name

For each dose, the following information must be documented:

- Dose to be administered
- Time dose is to be administered (to be documented in the “Time to be given” row)
- Prescriber’s signature
- Initials of nurse that administers the dose in ‘Nurse Initial’ box and notes actual time dose is given in same box.

For each day of therapy, the following information must be documented:

- Date and month of therapy
- Drug level results, when required
- Time drug level taken

The ward/clinical pharmacist should:

- Confirm that the medication is safe to administer
- Annotate if the medication requires supply or is on imprest (“I”), a Schedule 8 (S8) or Restricted Schedule 4 (S4R) medication.

NOTE:

The date and month row on the top of the Variable Dose Medication section may not correlate with that of the regular medications, especially if the variable dose medication is to be given more frequently (e.g. twice daily, three times daily, etc.) or less frequently (every 2 days) than once daily.

If a patient requires a second variable dose medication, another medication chart should be used. Alternatively, there is a dedicated “Variable Dose Medication Chart” which may be considered for use.

NOTE:

The long stay HMC does not have dedicated variable dose medication section. Hospitals and health service organisation will need to ensure policies are in place so that variable dose medications are transferred accurately for patients transitioning from the short stay to the long stay HMC.

Rationale:
This section has been formatted to facilitate ordering of medicines that require variable dosing, based on laboratory test results (e.g., vancomycin) or as a reducing protocol (e.g., prednisolone).
If these agents are ordered in the 'Regular Medicines' section, there is no designated area to record drug levels.
If these medications are prescribed in the 'Once Only' section, the risk of errors of omission is increased.

SAC/AAN Section of medication prescriptions

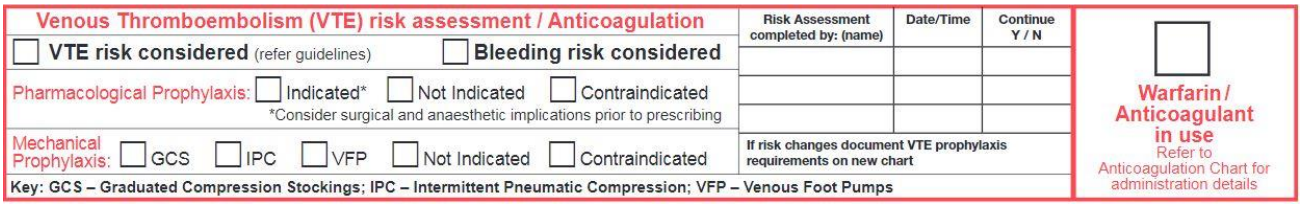
For hospitals using the WA HMC as a PBS prescription for discharge medications (please refer to Discharge Supply), the following information must be provided in the SAC/AAN section of the order.

Streamlined Authority Code (SAC) – If the prescribed medication is Authority Required (STREAMLINED), the prescriber must write the relevant four digit Streamlined Authority Code in the SAC/AAN box provided. Only the prescriber can provide this information.

Phone Authority – A single PBS WA HMC Authority Prescription Number is printed on the WA HMC and must be used by the prescriber to obtain prior authority approval for each authority required item.

The **Authority Approval Number (AAN)** provided by Department of Human Services (DHS) must be written on the WA HMC in the box provided. Only the prescriber can provide this information.

Venous Thromboembolism (VTE) Risk Assessment Documentation Section



Venous Thromboembolism (VTE) risk assessment / Anticoagulation	Risk Assessment completed by: (name)	Date/Time	Continue Y / N	
☐ VTE risk considered (refer guidelines) ☐ Bleeding risk considered				☐ Warfarin / Anticoagulant in use Refer to Anticoagulation Chart for administration details
Pharmacological Prophylaxis: ☐ Indicated* ☐ Not Indicated ☐ Contraindicated *Consider surgical and anaesthetic implications prior to prescribing				
Mechanical Prophylaxis: ☐ GCS ☐ IPC ☐ VFP ☐ Not Indicated ☐ Contraindicated	If risk changes document VTE prophylaxis requirements on new chart			
Key: GCS – Graduated Compression Stockings; IPC – Intermittent Pneumatic Compression; VFP – Venous Foot Pumps				

This VTE prophylaxis section is designed to prompt documentation of:

- VTE risk assessment
- Contraindications to VTE prophylaxis
- Ordering of pharmacological and mechanical VTE prophylaxis, if indicated.

Whoever is allocated responsibility for assessing a patient's VTE risk (usually the admitting medical officer or authorised prescriber) should do so according to local policy and then document the outcome on the WA HMC. (Not present on WA Paediatric Hospital Medication Chart)

All adult patients must have a VTE risk assessment completed within the specified timeframes as indicated in local policy, and the VTE risk assessment outcome must also be clearly documented within the patient's medical records.

The risk assessment should be completed consistent with local policy and in relation to the patient's clinical status at that point. For patients with multiple charts, the VTE risk assessment should be documented on the first chart.

Re-assessment of risk may be required depending on changes to clinical status, medications, or other circumstances, and should be documented in the VTE risk assessment section (The VTE Risk Assessment Tool in the WA HMC allows for up to 3 assessments to be documented if there is no change to the original assessment. If there is a change to Pharmacological Prophylaxis or Mechanical Prophylaxis, for example a change from indicated to contraindicated, then a new WA HMC VTE Risk Assessment Tool will need to be completed). In the case of re-assessment, it is important that the person completing this ensures that the date and time of documentation is recorded (to communicate when the re-assessment took place).

Although the VTE risk assessment outcome may be included within the integrated progress notes, WA Health strongly recommends documentation within the WA HMC as it:

- is easily accessible
- acts as a central point of reference for medical, nursing and pharmacy staff for review of ongoing management
- provides a consistent point of handover when the patient is transferred between wards and hospital settings.

The minimum requirements for VTE risk assessment documentation in the WA HMC are:

- document that the VTE risk (clotting risk) has been considered by ticking the "VTE risk considered" box
- document that the bleeding risk has been considered by ticking the "bleeding risk considered" box

- sign/initial the appropriate section to indicate the person who has conducted the VTE risk assessment
- document the date and time of the VTE risk assessment
- document the outcome of the VTE risk assessment:
    - whether pharmacological prophylaxis is indicated
    - whether mechanical prophylaxis is indicated
- tick the “Warfarin/Anticoagulant in use” box, if pharmacological prophylaxis is indicated and prescribed on the WA Anticoagulation Medication Chart (WA AMC)

NOTE:

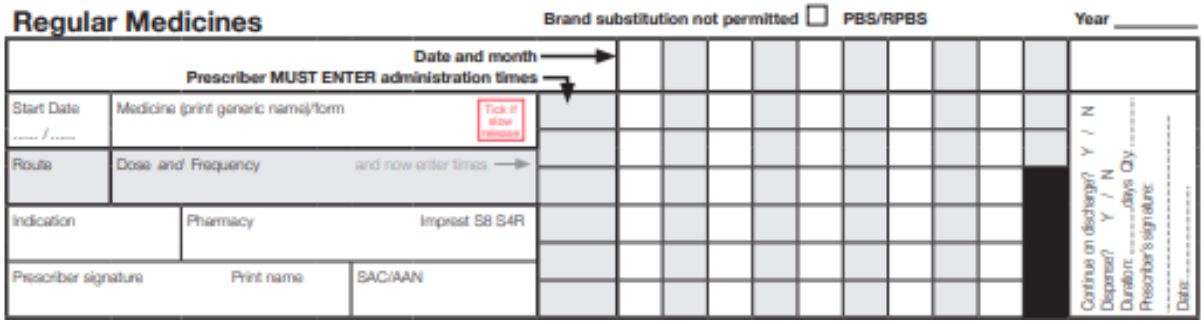
The risk of developing VTE depends on the patient’s intrinsic risk factors (patient-related) such as existing medical conditions, age or family history, and extrinsic risk factors (admission-related) such as surgical intervention, medical treatment or immobility.

Specific tools or guidelines which assist medical officers to determine the patient’s risk of clotting and bleeding, and therefore management of overall VTE risk must be implemented at each hospital or health service. For example, sites may choose to implement the National Health and Medical Research Council (NHMRC) or CHEST guidelines. Where other tools or guidelines are used, these must be based on best clinical knowledge and evidence.

Effective VTE prevention is achieved through both prompt assessment of risk factors, and the provision of appropriate prophylaxis.

It is recommended that the patient’s VTE risk be reassessed regularly (at least every 7 days) or as the patient’s clinical condition changes (e.g. unplanned surgery, changes in mobility, etc.). Clinicians must assess the need for prolonged prophylaxis on transfer of care or discharge. In such circumstances, the patient’s medical officer must develop a plan, and have this plan communicated in a timely manner to the patient’s care provider and explained to the patient/carer/family.

Regular Medicines



These are the minimum requirements that need to be documented by the prescriber for a medication order to be valid:

Start Date	The prescriber should enter the current date if administration of the medication is intended on this date or a date in the future when the prescriber wants the first administration of the medication. If transcribing/re-writing charts, the prescriber must enter the date of transcription. It is not the date that the medication was originally ordered. It may be useful for some medications (e.g. antibiotics) to include the date of first prescribing somewhere on the administration panel.
Generic medicine name	**Medications must be ordered preferably by their generic name** (active ingredient). **Medications must be prescribed by their full name**. **Medications must be written legibly in black or blue ink** (black ink preferred) **Medication names must never be abbreviated.** For example: ISMN – isosorbide mononitrate GTN – glyceryl trinitrate EPO – epoetin **Medications must not be prescribed by chemical names/symbols**. For example: KCl – potassium chloride **Local policy or guidelines may allow the use of trade names** (brand names) of combination products (e.g. Seretide®). Medication orders for insulin preparations (irrespective of whether it is a single or multiple ingredient product) should preferably be written in trade name – to minimise confusion between available products. It is also recommended to include the form of insulin device being used (i.e. NovoRapid Flexpen® 10 Units tds).

	The Australian Approved Name is the official terminology as per the Therapeutic Goods Administration (TGA) website **A separate order is required for each medication.** • To reduce the chance of error, in circumstances where a combination product is unavailable as a single product, but available in separate components, the medication order must be rewritten to reflect what is being administered. For example: Clopidogrel/Aspirin 75/100mg 1 tablet mane – rewritten as separate orders for: ○ Clopidogrel 75mg mane, AND ○ Aspirin 100mg mane
Route	Generally, each order is for one route only. Health services should be aware of risks associated with medication orders with multiple routes of administration, ensuring there is adequate documentation of the actual route administered and whether the dosing between routes is bioequivalent. Local policy or guidelines may allow multiple routes to be ordered together (e.g., where the dose required for different routes are the same – for example paracetamol 1g [PO or IV] qid). A health service-specific list of exceptions to the general rule should be determined in conjunction with the health service's Drug and Therapeutics Committee (DTC) or equivalent and appropriate risk mitigation strategies put in place. • Note: Writing a 'regular dose' order for multiple routes of medication does not allow the documentation of route used to administer the dose.
Dose	Only metric and Arabic numerals must be used. Roman numerals (e.g., i, ii, iii, iv, etc.) must be avoided. Always use a zero (0) before a decimal point e.g., 0.5g otherwise the decimal point may be missed. However, if possible, it is preferable to state the dose in whole numbers, not decimals. For example, write 500mg instead of 0.5g, or write 125 micrograms instead of 0.125mg. Never use a trialling zero ('.0') as it might be misread if the decimal point is missed e.g., 1.0 misread as 10. Do not use 'U' or 'IU' for units because the 'U' may be misread as zero. Always write units in full.

Note:

In the case of liquid medications, the strength and dose in milligrams or micrograms must always be specified (not in millilitres).

For example, for a medication order for 10mg of morphine liquid would read:

***Correct*:** Morphine mixture (10mg/mL) – Give **10mg** every 8 hours when required

Wrong: Morphine mixture (10mg/ml) – Give **1mL** every 8 hours when required

The amount in 'mL' can be annotated on the chart in addition to the strength to clarify the amount to be administered.

The clinical/ward pharmacist should clarify the order, where the strength of the medication supplied is different from that which has been ordered.

For example:

10mg dose: Pharmacist will write "2 x 5mg tablet"

25mg dose: Pharmacist will write "Half x 50mg tablet"

Frequency and

Administration time(s)

The prescriber must enter both the frequency AND administration time(s) for the medication. If not entered, the dose may not be administered by nursing staff.

Administration times should be entered using the 24-hour clock, a universal standard.

Recommended administration times
Guidelines only

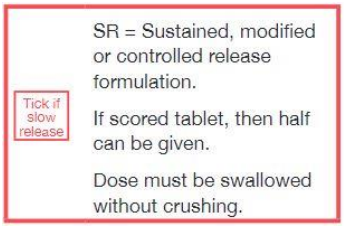
Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800		2000	
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

Medications should be administered according to the recommended administration times unless they must be given at specific times (e.g., some antibiotics, with/before food, Parkinson's disease medications) or, as in the case of children with variable meal and sleep schedules, a specific schedule is required.

If necessary, the clinical/ward pharmacist or nurse will clarify the administration time to correctly administer the medication (e.g., in relation to food) and annotate the chart to indicate that this has occurred. Nursing staff

	are authorised to change the times to meet local ward/hospital policy BUT, out of courtesy, should inform the prescriber of this action. In the situation where a medication is prescribed more than six times per day (e.g., eye drops requiring administration every 2 hours), the medication order should be written over two consecutive boxes to allow more than 6 dosage times to be entered.
Indication	This is critical information as it allows the order to be reviewed in the context of why it was prescribed, therefore reducing the risk of misinterpretation of the order (e.g. look alike sound alike [LASA] medications, incorrect doses, medications which have different doses for different indications). Recording the indication for each medication helps the health care team select the right medication.
Prescriber's signature and name (printed)	The signature of the prescriber must be documented to complete each medication order. For each signature (prescriber), their name must be printed at least once on that medication chart, preferably with a contact number to allow clarification, if necessary.

Other information/items that should be documented in the regular medications section are:

Slow-Release box	The "Tick if Slow Release" box is included as a prompt to prescribers to consider whether the standard release form of the medication is required. This box must be ticked to indicate a sustained or modified release form of an oral medication (e.g. verapamil SR, diltiazem CD, metformin XR, tramadol SR).  If not ticked, then it is assumed that the standard release form is to be administered. If the box has not been ticked, nursing staff may want to contact the ward/clinical pharmacist or prescriber to seek clarification of which form should be administered to the patient. Further explanation is included in the margin of the medication chart. This box should also be ticked for medications which are enteric coated, as this is classified as a modified release form (releases the medication slowly within the intestine). For more information, refer to: Department of Health "Don't Rush to Crush" poster. 

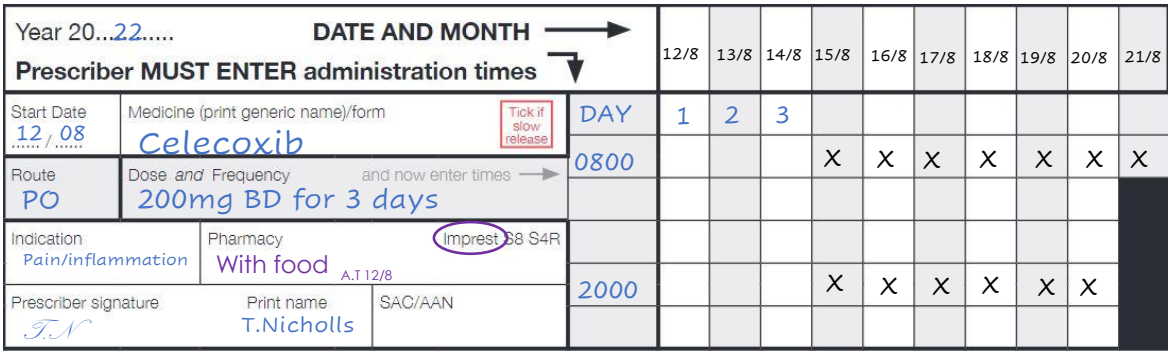
<table>
<tr><td>Pharmacy</td><td>This section is for use by the ward/clinical pharmacist. Annotations may include:<table>
<tr><td>Imprest</td><td>Medication available on imprest at ward level.</td></tr>
<tr><td>S</td><td>Non-imprest items that will be supplied, and labelled for individual patient use from the hospital pharmacy.</td></tr>
<tr><td>Pts own</td><td>Medications brought into the hospital by the patient (Patient’s Own), and checked by the pharmacist and confirmed to be acceptable for use during the patient’s admission.</td></tr>
<tr><td>S8 or S4R</td><td>Controlled drugs or drugs of dependence

Indicates a Schedule 8 or Schedule 4 restricted medication (stored in the S8/DD or S4R safe).</td></tr>
<tr><td>Fridge</td><td>Indicates the medication is stored in the fridge.</td></tr>
</table>The pharmacist may also include recommendations or instructions on safe administration of the prescribed medication.</td></tr>
</table>

Limited Duration Medicines

When a medication is ordered for a limited duration, this must be clearly indicated. The days or times when a medication is NOT to be given may be indicated by crosses (X) or a line through the appropriate administration day/time box.

Example:



Year 20...22..... DATE AND MONTH → / Prescriber MUST ENTER administration times ↓				12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8
Start Date 12 / 08	Medicine (print generic name)/form: Celecoxib	Tick if slow release	DAY	1	2	3							
Route: PO	Dose *and* Frequency: 200mg BD for 3 days	and now enter times →	0800				X	X	X	X	X	X	X
Indication: Pain/inflammation	Pharmacy: With food A.T 12/8	Imprest S8 S4R											
Prescriber signature: T.N	Print name: T.Nicholls	SAC/AAN	2000				X	X	X	X	X	X	

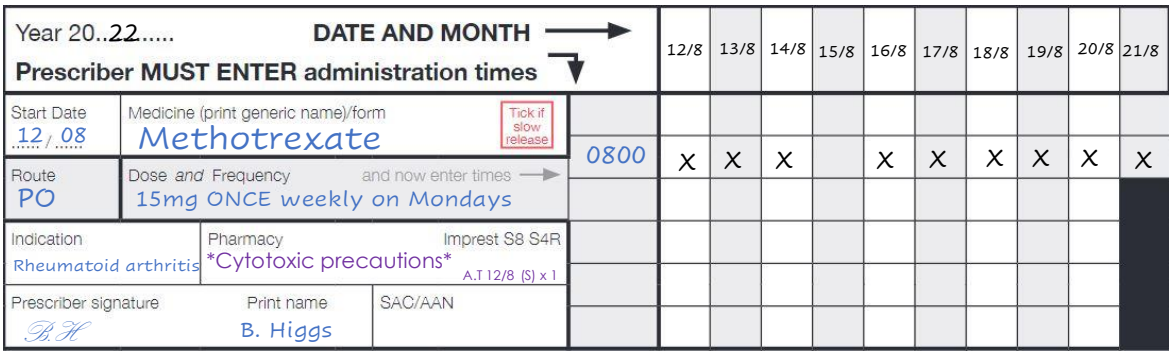
Medicines with Intermittent Doses

When a medication is ordered only on certain days, this must be clearly indicated by documenting the day of administration as part of the prescription order (i.e. stipulate Monday if that is the day the medication is to be taken). The medication order must clearly distinguish between when the medication is to be administered, and when it is not to be given.

Usually, the use of a box indicates the day/time when a medication is to be given.

The use of crosses (X) or a line through the other days indicates when a medication is NOT to be given.

Example:



Year 20..22..... DATE AND MONTH → / Prescriber MUST ENTER administration times ↓				12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8
Start Date 12 / 08	Medicine (print generic name)/form: Methotrexate	Tick if slow release											
Route: PO	Dose *and* Frequency: 15mg ONCE weekly on Mondays	and now enter times →	0800	X	X	X		X	X	X	X	X	X
Indication: Rheumatoid arthritis	Pharmacy: *Cytotoxic precautions* A.T 12/8 (S) x 1	Imprest S8 S4R											
Prescriber signature: B.H	Print name: B. Higgs	SAC/AAN											

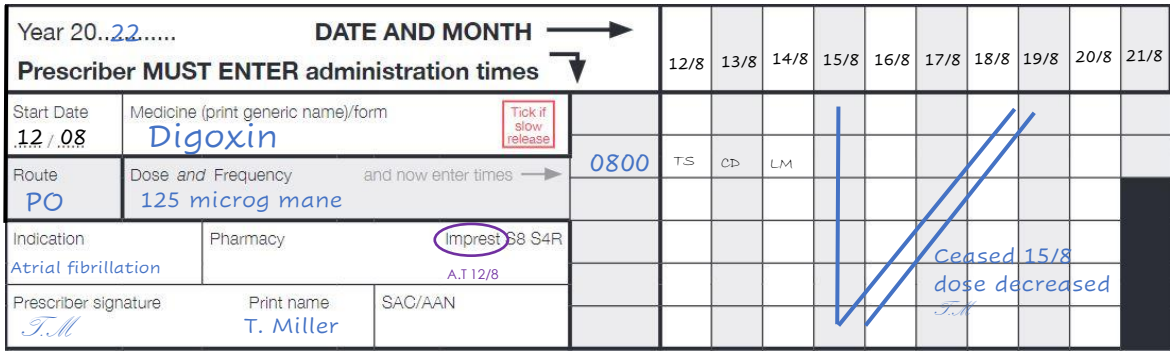
Ceased Medicines

Ceasing or changing medication chart prescriptions

- When ceasing a medication, the original prescription must NOT be removed or obscured. The prescriber must draw a clear diagonal line through the order in the prescription box and two diagonal lines through the administration record section, taking care that the lines do not impinge on other orders (as this may result in a second medication being inadvertently ceased). The prescriber must also write 'ceased', reason for ceasing medication, date and sign the ceased the order.
- If a change to a medication order is required, the prescriber must cease the current order on the WA HMC or WA Paediatric Hospital Medication Chart, as above, ***and complete a new entry on the chart*** reflecting the required change. The prescriber must write the reason for changing or ceasing the order (e.g. ceased, written in error, increased dose, duplicated order, etc.).
- Changes to medication orders (e.g., ceased, written in error, increased dose, duplicated order, etc.) must not be conveyed by altering an existing medication order.

Note:
The acronym 'D/C' should not be used for ceased orders since this can be confused with 'Discharge'. Always use 'Ceased'.

Example:

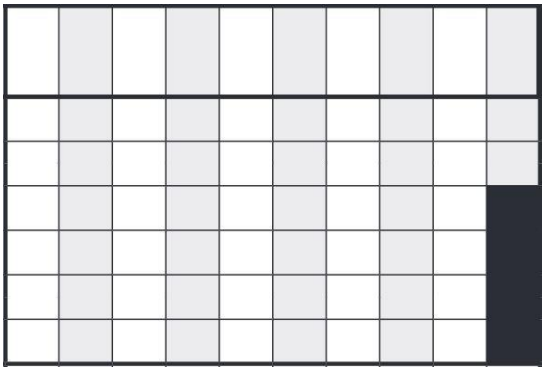


Administration Record

Every nurse/midwife has a responsibility to ensure they can clearly read and understand the order before administering any medications. For all incomplete or unclear (include illegible) orders, the prescriber must be contacted to clarify.

Assumptions should never be made about the prescriber's intent.

Every medication chart must have the patient's identification details completed. If the patient identification details are not completed, there is no confirmation that the medication was prescribed for the correct patient.



The medication administration record provides space to record up to ten (10) days of therapy on the short stay WA HMC, and up to thirty-five (35) days on the long stay WA HMC. At the end of the 10 or 35 days, a new chart should be written.

The last column (which is partially blocked out) is present only as a safety net, to prompt for a new order to be rewritten if required. If the medication chart is full, then the medication orders written in it should not be considered a valid/current prescription.

The shading of alternate columns is intended to reduce the risk of administering a medication on the wrong day.

The first person administering medications on any given day must write the date of that day in the appropriate box at the very top of each column ('Date and Month'). This column is to be used for medications administered on this day/date only. Note that the year should already have been specified by the prescriber in the 'Year' section.

Remember the six Rights:

- ✓ **The right patient**
  - ☐ Does the order match the patient? Ask the patient for their first and last name (3 identifiers are required to be confirmed, if possible).
  - ☐ Does the label on the dispensed medication match the patient?
- ✓ **The right medication**
  - ☐ Does the medication match the order? Be vigilant with look-alike sound alike medications.
  - ☐ Is it the correct medication for that particular condition?
- ✓ **The right dose**
  - ☐ Does the strength and dosage match the order?
  - ☐ Does the dose require either half, whole, or multiple tablets/capsules, etc.?
  - ☐ Is it safe for the patient?
- ✓ **The right time**
  - ☐ Does the administration time match the order? Consider special precautions for timing of dose (e.g. with food).
  - ☐ Does the frequency match the order?
  - ☐ Ensure specified time interval has passed before administering PRN medication
- ✓ **The right route**
  - ☐ Does the route match the order?
  - ☐ Is this route suitable for the patient?
  - ☐ Can this preparation be crushed (tablet), opened (capsule), or mixed in other substances?
  - ☐ Have old transdermal patches been removed prior to applying new patch?
- ✓ **The right documentation**
  - ☐ Ensure that the order is valid (dated and signed by the prescriber).
  - ☐ Document immediately after the medication has been administered.

☐ If dose is not administered, document the reason for this on the medication chart.

Reasons for Not Administering

Reason for not administering Codes MUST be circled	
Absent	A
Fasting	F
On leave	L
Not available – obtain supply or contact prescriber	N
Refused – notify prescriber	R
Self administered	S
Vomiting	V
Withheld – enter reason in clinical record	W

When it is not possible to administer the prescribed medication, the reason for not administering must be recorded by entering the appropriate code and circling this code. By circling the code, it will not accidentally be misread as someone's initials.

If a patient refuses a dose, the prescriber must be notified.

If a medication or dose is withheld, the reason must be documented in the patient's medical notes.

If the medication is not available on the ward, it is the nurse's responsibility to notify the pharmacy and/or obtain supply, or to contact the prescriber (or another doctor from the treating team) to advise that the medication ordered is not available.

Withholding Medications

- It is appropriate to withhold the medication if there is a known adverse drug reaction (ADR) to the prescribed medication.
- If the medication chart is full (i.e. there is no appropriate space to sign for administration), then the medication order is not valid. The medication chart must be rewritten as soon as possible. (Be mindful of time-critical medications)
- Generally, medications should not be withheld if the patient is pre-operative or nil by mouth (NBM) or fasting, unless specified by the medical officer.

Pharmaceutical Review

Pharmaceutical review:												

The clinical/ward pharmacist (or appropriately credentialed health professional for medication review) must sign this section as a record that they have reviewed the medication chart on that day.

Rationale:
Review by a clinical pharmacist will ensure that all orders are clear, safe and appropriate for that individual patient, therefore the risk of an adverse drug event is minimised.

Back Page of Medication Chart

URN:
Family name:
Given names:
Address:

Not a valid prescription unless identifiers present

Date of birth: Sex: M ☐ F ☐
Medicare No: PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

First prescriber to print patient name and check label correct:

Approved pharmacy details:

Pharmacy approval no:

Attach ADR sticker
See front page for details

As required PRN medicines

Brand substitution not permitted ☐ PBS/RPBS

Year

Start Date ...../...../..... | Medicine (print generic name)/form | Route | Dose and hourly frequency | PRN | Indication | Max PRN dose/24hr | SAC/AAN | Pharmacy | Imprint SB SAR | Prescriber signature | Print Name

Date | Time | Dose | Route | Sign

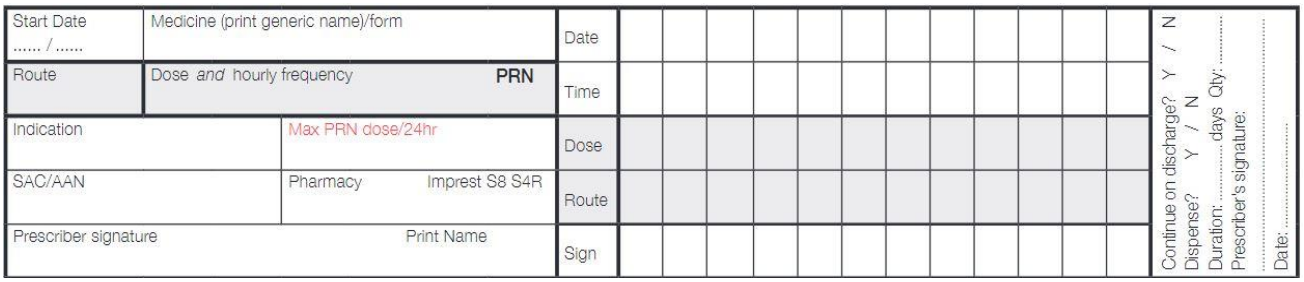
Continue on discharge? Y / N
Dispense? Y / N
Duration:..... days Qty.....
Prescriber's signature
Date:

Pharmaceutical review:

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

As required ("PRN") Medicines



Prescribing

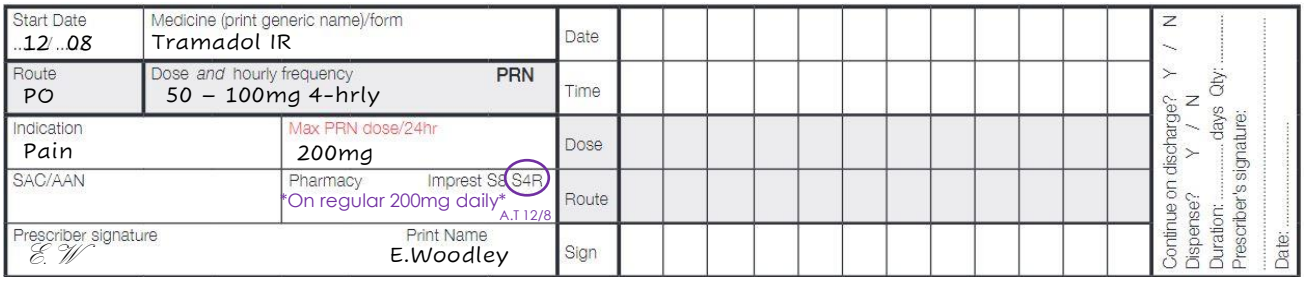
The prescriber must write the:

- Start date of prescription
- Generic medicine name (see under 'Regular Medicines' for further comments)
- Route of administration
- Dose AND hourly frequency. "PRN" (pre-printed) alone is not sufficient
- Indication and maximum daily dose (i.e. maximum dose in 24 hours)
  For example: Maximum of 4g paracetamol in 24 hours
  Maximum of 200mg in 24 hours
- Prescriber's signature, printed name and contact details

The 'Max PRN dose/24 hr' prompt indicates the total amount of the medication which may be administered for PRN doses only for that medication. The maximum daily dosage should not be exceeded for that PRN medicine.

Prescribers should exercise caution when prescribing PRN medications and check the regular medication section for possible duplicated orders. Where appropriate, ward or clinical pharmacists should annotate on the medication chart where a medication is prescribed in both the regular dose and PRN sections.

For example:



Administration

For each medication administration, document the:

- Date
- Time
- Dose administered
- Route
- Initial of person administering dose

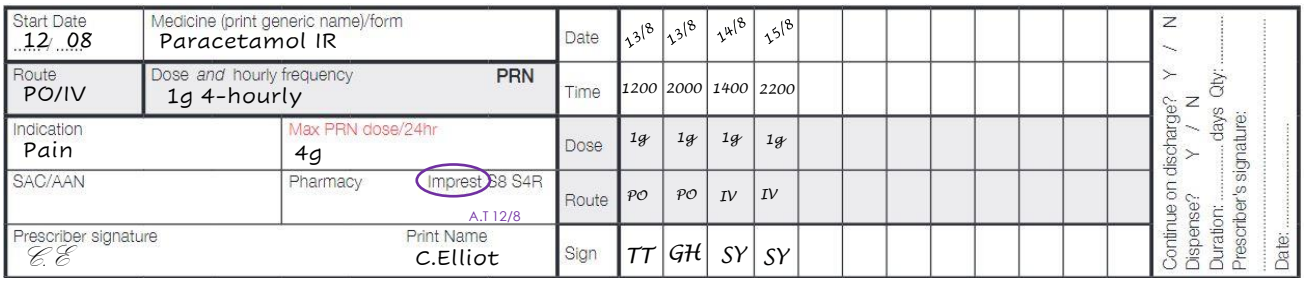
The person administering each dose is responsible for:

- checking that the maximum daily dosage will not be exceeded
- checking the timing of the previous dose (includes both regular and PRN dose)

For example:

Multiple Route Orders

Generally, medication orders should be written for ONE ROUTE only. However, local requirements may indicate other practices. Hospital and health service organisations should be aware of risks associated with medication orders with multiple routes of administration. A health service-specific list of exceptions to the general rule should be determined in conjunction with the health service's DTC or equivalent, and appropriate risk mitigation strategies put in place.



Note:

While it is recommended that only one route is prescribed per entry, local policy may allow certain medications to be prescribed as multiple routes, provided the dose and maximum dose/24 hours are the same for all routes allowed.

Prescribing PRN Opioids

The sedation score may be specified in the 'Max Dose/24 hr' section to indicate the maximum dose of drug to be administered when prescribing opioids in the PRN section.

Where sedation scores are used, the local hospital policy or guidelines should specify a standard sedation scoring system and a process for recording the scores, and the record must be available at the point of care. Nursing and medical staff should be familiar with the sedation score used.

For example, using the 4-point sedation scale below of 0 to 3, the PRN order should specify "if sedation score is less than 2".

0 = awake and alert

1 = mild, occasionally drowsy, easy to rouse

2 = moderate, constantly drowsy, easy to rouse

3 = severe, somnolent, difficult to rouse

Start Date 12/08	Medicine (print generic name)/form: Oxycodone IR		Date	12/8												Continue on discharge? Y / N			
Route: PO	Dose *and* hourly frequency: 5mg 4-hourly PRN		Time	1100												Dispense? Y / N			
Indication: Breakthrough pain	Max PRN dose/24hr: If sedation score less than 2		Dose	5mg												Duration: ..... days Qty:			
SAC/AAN	Pharmacy: Imprest S8 S4R A.T 12/8		Route	PO												Prescriber's signature:			
Prescriber signature: AJ	Print Name: A.Jones		Sign	HS												Date:			

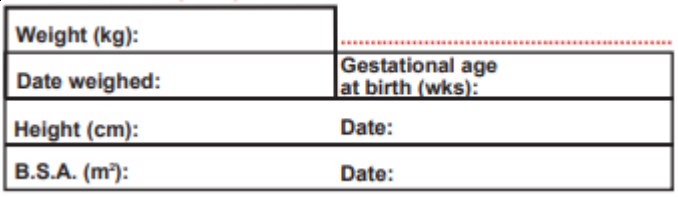
Rationale:
'PRN' medications are charted separately from the 'Regular Medicines' section, in order to reduce the risk of inadvertently giving them regularly. This section also includes additional information (e.g. maximum dose/24 hours) to prevent overdose.

Special Features of the WA Paediatric Hospital Medication Chart

The WA Paediatric Hospital Medication Chart (short stay and long stay versions) incorporate additional features identified as important for facilitating safe medications use in the paediatric and neonatal populations. These features include designated:

- Boxes for recording weight and date measured on front and back pages
- Spaces for recording body surface area (BSA) and gestational age at birth (where relevant)
- Space for documenting the basis of dose calculation (e.g., mg/kg/dose)
- Space for double signing when recording administration

Patient Weight, Height, Body Surface Area (BSA) and Gestational Age at Birth

Front page	Back page
	

The child's weight must be documented in the box on the front of the chart, including the date the weight was measured. The weight should also be documented on the back page, where PRN medications are ordered.

The height and BSA should be documented for when BSA is used to calculate the dose of a medication.

The gestational age at birth for premature infants should also be documented. This information may also be required to calculate the dose of a medication.

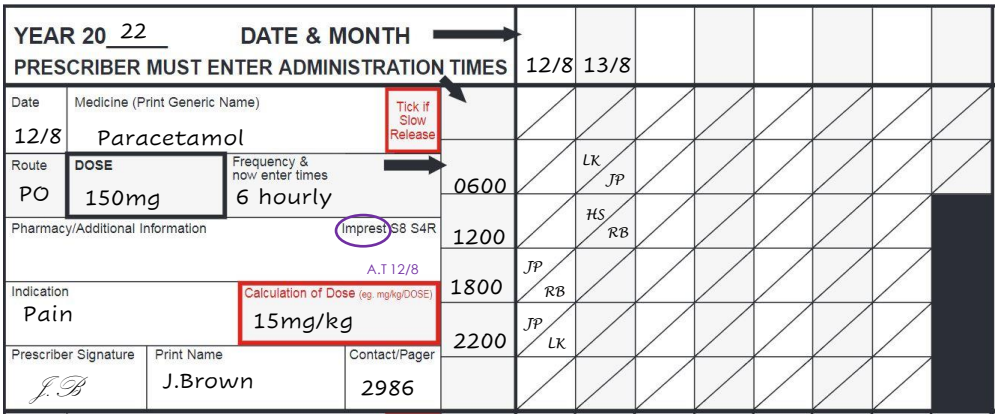
Dose Calculation

The prescriber must document the basis for the dose calculation in the dose calculation box (e.g. mg/kg/dose or microgram/m^2/dose, etc.).

This will assist pharmacists, midwives, nurses and other doctors in double checking that the dose that was intended and the actual dose were calculated correctly.

Regular Paediatric Medicines

An example of a medication order:



YEAR 20 22 — DATE & MONTH → 12/8, 13/8

PRESCRIBER MUST ENTER ADMINISTRATION TIMES

Date	Medicine (Print Generic Name)	Tick if Slow Release		
12/8	Paracetamol			
Route	DOSE	Frequency & now enter times		
PO	150mg	6 hourly		
Pharmacy/Additional Information		Imprest S8 S4R		
		A.T 12/8		
Indication		Calculation of Dose (eg. mg/kg/DOSE)		
Pain		15mg/kg		
Prescriber Signature	Print Name	Contact/Pager		
J.B	J.Brown	2986		

	12/8	13/8
0600		LK JP
1200		HS RB
1800	JP RB	
2200	JP LK	

Once Only Medicines

Date Prescribed	Medicine (Print Generic Name)	Route	DOSE	DOSE calc e.g. mg/kg per DOSE	Date/Time to be given	Prescriber		Given by	Date/Time Given	Pharm
						Signature	Print Name			

Telephone Orders

Date Time	Medicine (Print Generic Names)	Route	Dose	DOSE calc e.g. mg/kg per DOSE	Frequency	Nurse/Midwife Initials 1st/2nd		Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION		
											Time/Given by:	Time/Given by:	Time/Given by:

Initials

INITIALS All staff please print name and designation beside your initials

Initials	Print name and designation	Initials	Print name and designation	Initials	Print name and designation

The Paediatric HMC features a section for all staff who document in the NIMC to document their name and designation beside their initials.

As Required 'PRN Medicines

Date	Medicine (Print Generic Name)			Date										
Route	DOSE	Hourly Frequency	PRN Max PRN DOSE/24hrs	Time										
Pharmacy/Additional Information			Imprest S8 S4R	DOSE										
Indication		Calculation of Dose (eg. mg/kg/DOSE)		Route										
Prescriber Signature	Print Name	Contact/Pager		Sign										

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days/Qty: .....

The basis for dose calculations should first be checked in a current paediatric dosing reference endorsed by the local DTC. The actual dose should be calculated using an accurate weight or BSA (up to the usual adult dose).

If the child is obese, or significantly oedematous, the ideal body weight may be more appropriate. All calculations should be double checked.

Administration of Medicines

There are two spaces for recording the administration of each dose of medication to allow for two signatures, to document that the double-checking process has occurred when required.

This need for documentation is present for all types of medication orders (i.e. once only medications, telephone orders, regular dose medications and as required 'PRN' medications).

Reason for Not Administering

REASON FOR NOT ADMINISTERING	Codes MUST be circled	
Absent (A)	Not available - obtain supply or contact Prescriber (N)	Vomiting (V)
Fasting (F)	Withheld - Enter reason in Clinical Record / Chart (W)	On Leave (L)
Refused - Notify Prescriber (R)	Self Administration (S)	Parent / Carer Administration (P)

There is an additional 'Reason for Not Administering' medication code on the WA Paediatric Hospital Medication Chart. This code 'P' indicates that the medication was administered by the paediatric patient's parent or carer.

Transdermal Patch Sticker

Background

Transdermal medications in the form of patches are often prescribed on the medication chart. Although some patches are changed daily, others require intermittent changing, such as every three, four, or seven days. For patches that are changed less frequently than once daily, the chance of them falling off unnoticed prior to the next prescribed dose is possible and could potentially affect the patient's medical management. In addition, if an error in administration has been made, for example the wrong medication or strength being applied, it may go unnoticed until the patch is changed.

Some of the incidents reported to the Clinical Incident Management System (CIMS) that have occurred in relation to transdermal patch use include:

1. Using the wrong strength of patch
2. Missed dose
    - Patch removed and not replaced on schedule
    - Patch not in situ (fallen off or removed), and not noticed
3. Increased dose
    - Multiple patches being used simultaneously as older patch was not removed
    - Dose changed, but older patch was not removed
4. Wrong medication
    - Fentanyl patch used instead of buprenorphine (as prescribed)

Transdermal Patch Check Sticker

PATCH CHECK (each shift)	**AM**									
	PM									
	NIGHT									

The transdermal patch check sticker ("the sticker") was developed to prompt nursing staff to check that:

1. the prescribed medication patch is securely intact on the patient's body, and
2. the correct medication patch is in situ at each shift, and
3. the correct strength patch is in situ at each shift.

This sticker may be used for all medication patches that remain in situ for at least 24 hours including:

- opioids (including fentanyl and buprenorphine)
- oxybutynin
- rivastigmine
- rotigotine
- nicotine (where applied for 24 hours)
- hormone replacement (e.g. oestradiol, testosterone)

The sticker should not be used for patches that are applied for less than 24 hours. The need for a patch check in this situation may cause confusion (where application occurs during one shift and its removal occurs at another shift).

Examples where the sticker is **not appropriate** include:

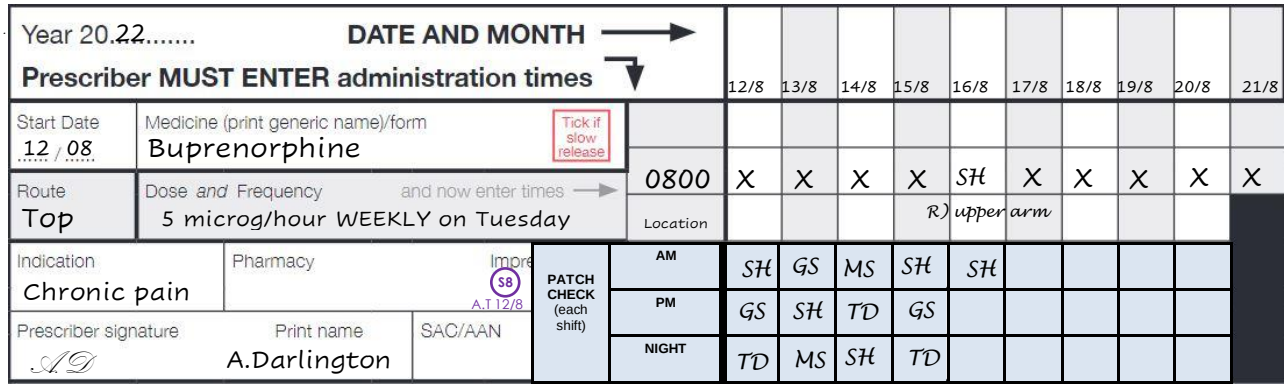
1. glyceryl trinitrate (applied for 12 hours of each day)
2. lignocaine (applied for 12 hours of each day)
3. nicotine (where these are applied for 16 hours, or removed at night)
4. prilocaine (time applied to skin depends on age)

Where should the stickers be placed?

The prescriber is to write the medication order for the patch and record the administration time on either the first or second line of that order.

The prescriber is to then place the sticker on the bottom three lines of the corresponding order (see example 1). The prescriber should see nursing staff if unaware of where stock of the stickers is stored on the ward.

If there are less than 3 lines remaining on the order, the prescription is to be rewritten. The sticker should not “overflow” into the following order (may lead to confusion) and should not obscure any pertinent information on the HMC.



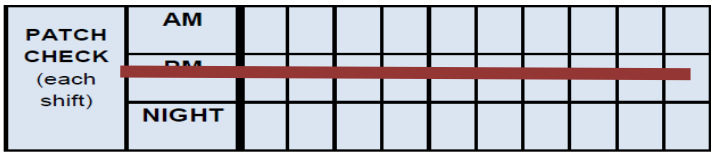
Year 20.22..... DATE AND MONTH → / Prescriber MUST ENTER administration times										
	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8
Start Date 12/08 — Medicine (print generic name)/form: Buprenorphine — Tick if slow release										
Route: Top — Dose and Frequency: 5 microg/hour WEEKLY on Tuesday — and now enter times → — 0800	X	X	X	X	SH	X	X	X	X	X
Location				R) upper arm						
Indication: Chronic pain — Pharmacy — Impre SB A.T 12/8 — PATCH CHECK (each shift) — AM	SH	GS	MS	SH	SH					
PM	GS	SH	TD	GS						
Prescriber signature: AD — Print name: A.Darlington — SAC/AAN — NIGHT	TD	MS	SH	TD						

Example 1: Transdermal patch check sticker is placed under the medication order/prescription. Nursing staff must initial or sign three times each day (each shift) to indicate the correct patch is present and intact. The location of patch application is documented by the nurse who applied the patch under their initial or signature on the medication order/prescription.

Nursing staff are to initial or sign under the relevant date and time during their shift, after confirming the medication and strength is correct, and that the patch is securely intact.

The location of patch application is to be documented by the nurse applying the patch. This is recorded under the nurse’s initial or signature at the time of application. This is to assist in locating the patch at each shift patch check. The patch location is not to be documented on the patch check sticker, as the location will change with each application. (Most patches require rotation of application sites to minimise site reactions). Nursing staff may refer to the medication order/prescription and administration section to see where the last patch has been applied.

If there are less than three nursing shifts per day, the “PM” check may be crossed off by drawing a line through the “PM”, leaving the “AM” and “NIGHT” rows.

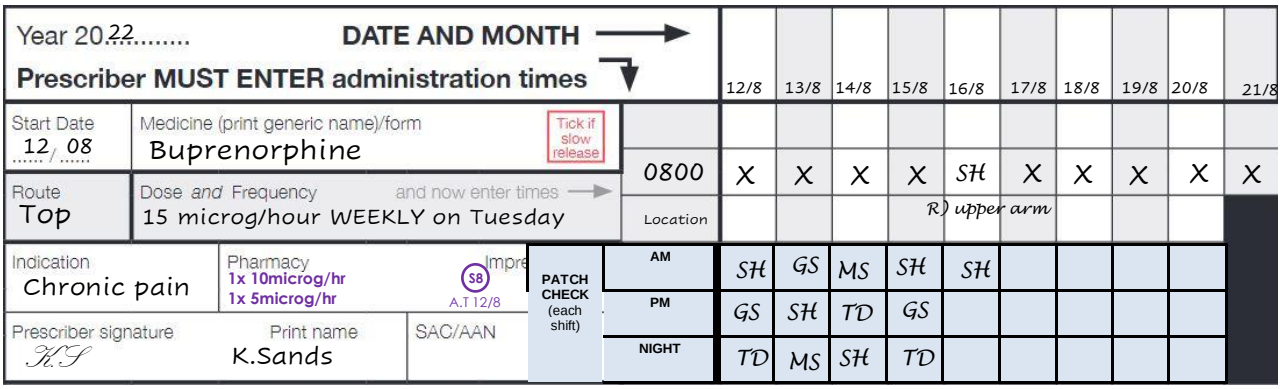


Example 2: Crossing off the “PM” check where there are less than three nursing shifts per day.

Multiple Patches

If multiple patches are required to administer a dose, the full dose should be prescribed, as a SINGLE ORDER. The patch check should be done for the TOTAL dose.

For example, if a patient was prescribed a dose of buprenorphine 15microgram/hour, it should be prescribed as a single medication order. The pharmacist would then endorse for nurses to use a 1 x 10microgram/hour patch AND 1 x 5 microgram/hour patch.



Example 3: Patch check sticker for a dose requiring 2 different strengths of patches, prescribed as single medication order.

NOTE: Where more than one patch is required to fulfil a dose, the nurse conducting the patch check should ensure all the patches:

i. are securely intact on the patient’s body,
ii. are of the correct medication, and
iii. add up to the correct dose.

In situations where at least one patch is either incorrect or not securely intact (or missing), the entire dose will need to be replaced.

Where there is intermittent dosing (i.e. not daily dosing), the medication order will need to be rewritten, with the day of the next patch change altered accordingly. This will minimise confusion in relation to changing different patches on different days.

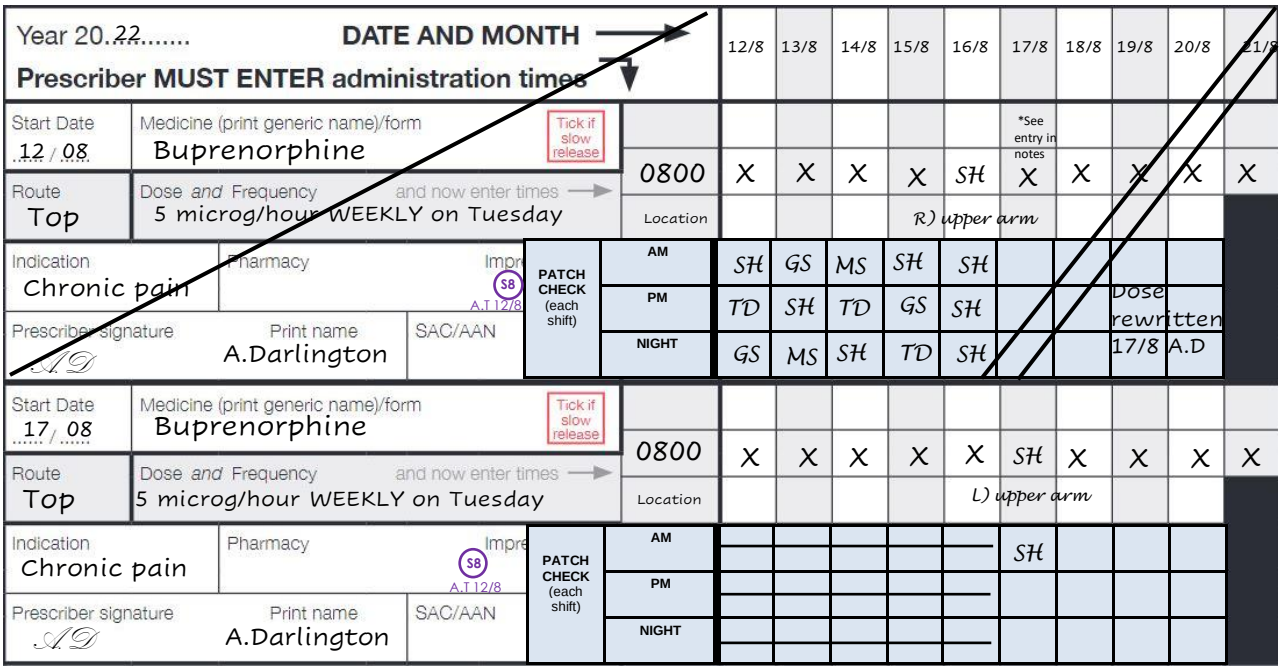
Unsecure or Missing Patches

If a patch is not securely in place, or cannot be located when conducting a patch check, a new patch should be applied (see example 4). The prescribing team should be informed, and the incident documented in the patient's medical record (integrated progress notes). The order would then need to be rewritten. The day of the next patch change would change accordingly. (The pharmacokinetics of each type of patch will need to be considered).

The patient's bed and surrounding area(s) (including shower) should be checked, and if the patch is found, it should be disposed of according to hospital policy.

If a patch is unable to be located during a routine patch check, a Clinical Incident Management System (CIMS) form should be completed.

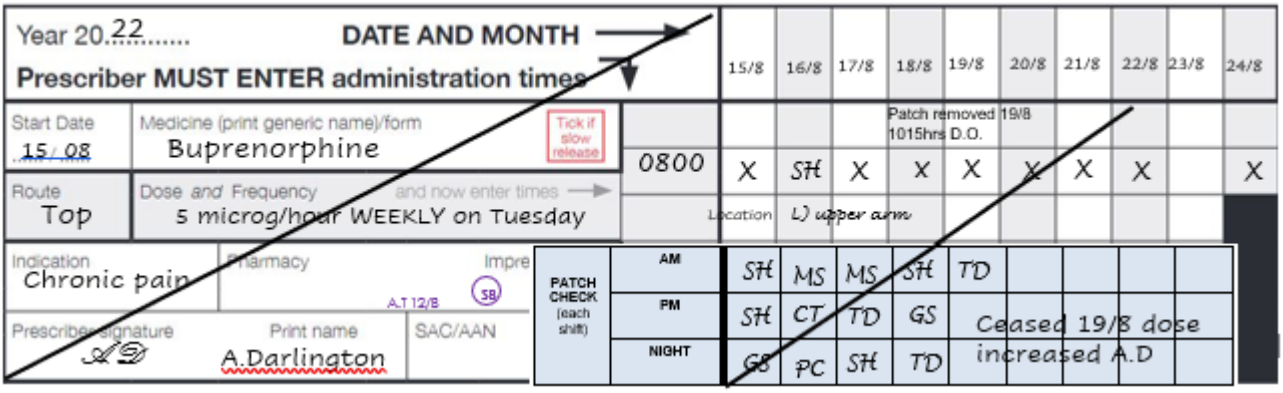
For Schedule 8 medication patches, this medication loss will require completion of Medicines Discrepancy Report Form, as per MP 0103/19 Reporting of Schedule 4 Restricted and Schedule 8 Medicines Discrepancies Policy.



Example 4: Medication order rewritten once a patch has been determined to be missing (where due date has changed)

Ceasing Patch Checks

When a medication order for a patch is ceased, the prescriber must cease the patch check as well (see example 5). If the prescriber has not ceased the patch check, but has ceased the medication order, a nurse or pharmacist may cease the patch check section. It should be clearly documented that the patch has been removed and disposed of, adjacent to the ceased medication order.



Example 5: Ceasing medication orders and patch checks.
Doctor has ceased the medication order and patch check, signed the cessation and provided the reason and the date of cessation. The nurse has confirmed the patch was removed on 19/8/22 at 10.15am. The nurse's initial or signature and date of patch removal must be documented on the medication order.

Ordering oral and enteral nutrition supplements on the WA HMC or WA Paediatric Hospital Medication Chart

The WA HMC or WA Paediatric Hospital Medication Chart is not designed for ordering and recording administration of oral and enteral nutritional supplements. Its use for this purpose may result in:

- Confusion of nutritional supplements with medications; e.g. *Pulmocare*® mistaken for the corticosteroid inhaler *Pulmicort*® and amino acid liquid *Nepro*® mistaken for the antiepileptic medication *Keppra*®.
- Potential for patients to receive unauthorised medications.
- Delays in provision and administration of nutrition to patients if the WA HMC or WA Paediatric Hospital Medication Chart is sent to the pharmacy for dispensing.

Some health services have a separate clinical nutrition chart for ordering and administration of nutritional products including nutritional supplements.

Example: Nutritional supplement charted by dietician

Year 20...22... DATE AND MONTH → / Prescriber MUST ENTER administration times ↓										
	11/8	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8
Start Date 11/08 — Medicine (print generic name)/form: TWOCAL HN — Tick if slow release										
Route: PO — Dose *and* Frequency: 60mL QID — and now enter times → 0800										
1200										
Indication: Nutritional supplement — Pharmacy — Imprest S8 S4R: From Stores — 1700										
2100										
Prescriber signature: AP (Dietician) — Print name: A.Pears — SAC/AAN										

Health services that choose to use the WA HMC for ordering nutritional supplements should undertake a risk assessment and have a local policy or procedure on ordering and recording the administration of nutritional supplements. The same requirements that apply to safer prescribing and administration of medications on the WA HMC should also apply to ordering and recording the administration of nutritional supplements on the WA HMC.

Local policies or procedures for ordering and recording the administration of nutritional supplements on the WA HMC or WA Paediatric Hospital Medication Chart should include:

- Who is responsible for ordering nutritional supplement on the chart (medical officer, authorised dietitian, etc.)
- The requirement for a dietitian to undertake training in the key principles of safe prescribing practices before ordering an approved nutritional supplement on the chart
- Where and how the nutritional supplement is ordered
- The requirement to annotate ‘nutritional supplement’ in the indication box or next to the product name
- How to cease the nutritional supplement

- Dietitian to regularly check the chart for transcription errors or orders
- Regular auditing of prescriptions of nutritional supplements.

Ordering and administering medical gases on the WA HMC

The WA HMC should not be used to order or administer medical gases, such as oxygen. These medications require specific features to safely order, administer and monitor their use. The necessary features are not included on the standard WA HMC.

It is recognised that some jurisdictions have systems in place to order and administer medical gases, such as specific ancillary charts.

Please contact the WA DoH Medicines and Technology Unit for information on recommended processes for documenting orders and administration of medical gases.

Discharge Supply

Use of the revised WA HMC for discharge dispensing remains at the discretion of the HSP but must not replace the use of the WA Electronic Discharge Summary Application (currently NaCS) for discharge reconciliation, prescription generation requirements at discharge, creation of consumer medication lists and discharge summaries.

Private contracted health entities that provide publicly funded inpatient care must implement this chart for PBS inpatient and discharge supply.

All approved PBS prescribers in accordance with local policy can use the WA HMC to prescribe eligible PBS/RPBS medications. An Approved Medical Practitioner cannot supply medications from a WA HMC. The WA HMC is only valid for PBS dispensing at the pharmacy attached to the hospital and must not be used outside of the hospital (i.e. community pharmacy). In this situation, a separate PBS/RPBS prescription will need to be prepared by the PBS prescriber for the patient to take outside the hospital for supply.

Supply from the WA HMC will occur at the pharmacy service attached to the hospital by whatever arrangement is in place. If a patient is discharged outside of normal pharmacy service business hours, a separate PBS/RPBS prescription will need to be prepared in this instance by the PBS prescriber discharging the patient.

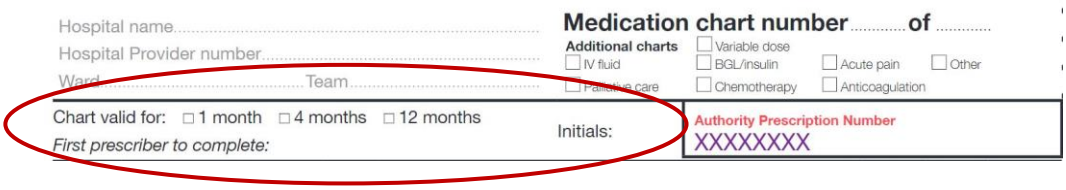
The WA HMC is designed to allow the prescribing and claiming of discharge medications. A PBS/RPBS quantity of medication may be supplied to a patient at discharge if:

- the WA HMC is still valid,
- an approved PBS prescriber has completed the discharge section for each medication and provided prescriber details on the front of the chart,
- the setting is appropriate for PBS/RPBS items to be dispensed and the patient is eligible to obtain the PBS/RPBS items.

For a valid PBS/RPBS prescription the following must be recorded on the WA HMC:

- hospital name and provider number (can be pre-printed onto the WA HMC)
- prescriber's name, PBS prescriber number, contact number (mobile or pager), address, signature and date (to be filled in by the prescriber)
- patient's full name as it appears on the patient's Medicare card, patient's address, Medicare number and any number specified on a card, issued by the Commonwealth, as an entitlement number for the patient.

The period of WA HMC validity for PBS dispensing is identified on page one (see image below) and must be filled out by the first prescriber.



- The period of validity starts on the date of prescribing the first medication order on the WA HMC. Supply cannot occur after the WA HMC expiry date.

- Up until the expiry date of the chart a PBS/RPBS medication can be dispensed as charted unless otherwise indicated in the individual medication orders. If the medications are not recharted, all orders on the WA HMC cease to be valid for PBS supply and for administration after the chart expiry.
- Prescribers should ensure that each medicine panel is completed in full.
    - Write clearly in blue or black pen using ball point pens only.
    - Write the word ‘private’ or ‘non-pbs’ where you do not intend a PBS or RPBS claim to be made.
    - Tick the brand substitution box if any or all of the medicines on the PBS HMC are not suitable for generic substitution – emphasise your instruction by specifying the brand name in each applicable medicine order.
    - Mark the appropriate ‘valid for’ period on the front of the chart (1, 4 or 12 months) and initial.
    - Refer to the User Guide for further information on the best practice use of the PBS HMC.
    - Prescribers must ensure that medicines are prescribed on the PBS HMC in accordance with jurisdictional regulations.

Requirements for a PBS prescription to be completed by prescriber:

Patient identification

- Patient’s full name (as it appears on their Medicare card)
- Patient’s address
- Patient’s Medicare number
- Any number specified on a card issued by the Commonwealth, as an entitlement number for the patient

Prescriber details

- Name
- PBS prescriber number
- Contact number (mobile / pager)
- Address
- Signature and date

Period of chart validity

- ‘Expiry date’ or the ‘Chart valid’ period (1, 4 or 12 months)

Medicine details

- PBS, RPBS or private (strike through those that do not apply)
- Medicine and form
- Dose
- Route
- Frequency
- SAC / AAN (Streamlined Authority Code or Authority Approval Number)
- Brand substitution
- Signature
- Start date

Discharge

- Continue on discharge?
- Dispense (Y/N)
- Duration
- Quantity

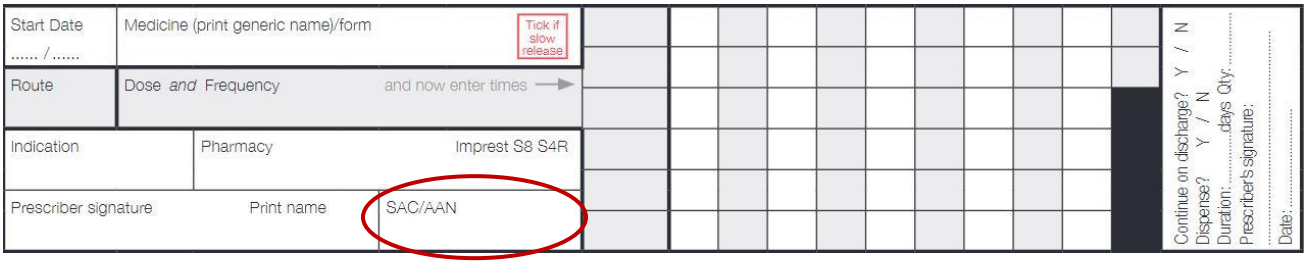
- Pharmacists are permitted to supply up to one PBS maximum quantity at a time with subsequent supplies as required to meet the prescriber's order until the WA HMC expiry date.
- When supplying a non-PBS/private supply for which a PBS maximum quantity does not apply, the pharmacist is permitted to dispense one 'smallest currently marketed registered pack' at a time, with subsequent supplies as required to meet the prescriber's order until the stop date or chart expiry date, whichever is earlier.

A single PBS Authority Prescription Number is printed on the WA HMC and can be used by the PBS prescriber to apply for one or more Authority required items as needed.

Pre-printing of this unique number on the chart MUST be organised by the health service if the chart is intended for PBS prescribing at discharge.

Streamlined Authority Code – If the prescribed medication is Authority Required (STREAMLINED), the prescriber must write the relevant four digit Streamlined Authority Code (SAC) in the box provided. Only the prescriber can provide this information.

Phone Authority – A single WA HMC Authority Prescription Number is printed on the WA HMC and must be used by the prescriber to obtain prior authority approval for each authority required item. The Authority Approval Number (AAN) provided by Department of Human Services (DHS) must be written on the WA HMC in the box provided. Only the prescriber can provide this information.



Written Authorities – A prescriber is required to obtain prior written authority approval in line with current requirements. If the WA HMC is used to obtain prior written authority approval – the original WA HMC along with usual supporting documentation must be submitted to the DHS.

Appendix 1

Table 1: Route-Related Acceptable abbreviations

ROUTE ACCEPTABLE ABBREVIATIONS			
Abbreviation	**Meaning**	**Abbreviation**	**Meaning**
IM	Intramuscular injection	Eye ointment	Eye ointment
Intrathecal	Intrathecal injection	PO	Per oral (by mouth)
IV	Intravenous injection	PR	Per rectum (inserted rectally)
MA	Metered aerosol	PV	Per vagina (inserted vaginally)
MDI	Metered dose inhaler	SUBCUT	Subcutaneous injection
Neb	Nebulised/nebuliser	SUBLINGUAL	Sublingual
NG	Nasogastric	Top	Topical

Table 2: Route-Related Error-Prone Abbreviations

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to avoid	**Intended meaning**	**Reason for avoiding**	**Acceptable alternative**
S/C, sc	Subcutaneous	Mistaken for “sublingual”	“subcut” or “subcutaneous”
S/L, sl	Sublingual	Mistaken for “subcutaneous”	“subling” or “sublingual”
E	Ear or eye	Misinterpreted for the other organ	“ear” or “eye” accordingly
IVI	Intravenous injection	Misread IVI as “IV1” resulting in overdose (e.g. administration of 125mg of intended medication, rather than 25mg)	“IV” or “intravenous”

Table 3: Dose-Related Acceptable Abbreviations

DOSE ACCEPTABLE ABBREVIATIONS			
Abbreviation	**Meaning**	**Abbreviation**	**Meaning**
mL	Millilitre	Mg	Milligram
L	Litre	Microg (safer to write "microgram" in full	Microgram
G	Gram	unit(s)	International Unit(s)

Table 4: Dose-Related Error-Prone Abbreviations

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to avoid	**Intended meaning**	**Reason for avoiding**	**Acceptable alternative**
ug, µg, or mcg	Microgram	Mistaken for "milligram" when handwritten	"microg" or "microgram"
U or U(s)	Unit or units	Mistaken for "0"	"unit(s)"
IU or iu	International units	Mistaken for "IV" (intravenous) or a larger dose (e.g. 3 IU may be mistaken as 31 u)	"unit(s)"
No zero before decimal point (e.g. ".5mg")	0.5mg	Misread as "5mg"	"0.5mg" or "500microgram"
Zero after decimal point (e.g. "5.0mg"	5mg	Misread as "50mg"	"5mg" (Do not write decimal points after whole numbers)

Table 5: Frequency-Related Acceptable abbreviations

FREQUENCY ACCEPTABLE ABBREVIATIONS			
Abbreviation	**Meaning**	**Abbreviation**	**Meaning**
bd	Twice daily	qid	Four times a day
mane	Morning	tds or tid	Three times a day
nocte	Night		

Table 6: Frequency-Related Error-Prone Abbreviations

DANGEROUS ABBREVIATIONS NOT TO BE USED			
Abbreviation to avoid	**Intended meaning**	**Reason for avoiding**	**Acceptable alternative**
OD, od or d	Once a day, once daily	Mistaken for twice daily "d" is easily missed	"mane", "nocte" or write the specific time
QD or qd	Every day	Mistaken as qid (four times a day)	"mane", "nocte" or write the specific time
M	Morning	Mistaken for n (night)	"mane"
N	Nocte	Mistaken for m (morning)	"nocte"
6/24	Every six hours	Mistaken for six times a day	"q6h" or "6 hourly"
1/7	For one day	Mistaken for one week	Write "for one day" in full
X 3d	For three days	Mistaken for three doses	Write "for 3 days" in full

This document can be made available in alternative formats on request for a person with a disability.