National Inpatient Medication Chart (NIMC) Audit

- Nationally coordinated NIMC audit that occurs every 2 years, starting from 1 Aug – 30 Sep 2012

- Using and auditing the NIMC are activities that can be used to demonstrate compliance with the NSQHS Standards for accreditation.
NIMC Audit

- Auditing the NIMC:
  - Provides baseline data for NIMC use and future quality improvement activities
  - Improves the safety of medication charting in hospitals
  - Evaluates the effect of NIMC safety features in hospitals.
NIMC Audit

- Objectives:
  - Evaluate the effect of the NIMC safety features
  - Evaluate the implementation process on the safety and quality of
    - prescribing
    - medication documentation
  - Identify further areas for improvement in medication management.
NIMC Audit

- Frequency of auditing will depend on:
  - staff changes,
  - risk of medication errors
  - other local factors.

- If significant non-compliance is identified: audit occur more frequently within a quality improvement cycle (PDSA), until compliance improves.
NIMC Audit Tools

- Paper based form, available at:

- Electronic versions (*NIMC Audit Spreadsheet*) and web based (*NIMC Audit System*) also available on [Commission website](http://www.safetyandquality.gov.au).
NIMC Audit Reports

Four types of audit reports can be generated:

- Audit Summary
- Audit Statistics
- Patient Audit Report
- Medication Report
Preparing for the NIMC Audit

- Refer to Commission’s:
  - Guide to Auditing the NIMC 2014
  - NIMC User Guide

- Read local medication related procedures and guidelines, e.g. approved list of tradenames, list of acceptable abbreviations

- Decide on the number of charts to audit

- Decide how data will be entered
Preparing for the NIMC Audit

- Some of the audit criteria require subjective judgement and interpretation:
  - determining unclear orders
  - assessing completeness of documentation.

- It is important that auditors meet up prior to the audit to discuss the parameters for these areas, as they are defined in the *Guide to Auditing the NIMC*.

- Conducting a pilot may be beneficial
  - Small sample of medication charts from different wards
Number and type of charts to audit

Initial audit

- Ideally all available active NIMC should be reviewed – allows identification of errors that occur infrequently and in different patient types.

- As many medication charts as possible should be reviewed to evaluate any significant changes to medication safety.

- To enable a large number of patient charts to be reviewed, data collection may take place over a number of weeks, e.g. 5 charts for each ward per week for one month.
Number and types of chart to audit

- Suggested initial audit sample size:

<table>
<thead>
<tr>
<th>Hospital bed numbers</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 or more</td>
<td>20% of current inpatients</td>
</tr>
<tr>
<td>30-149</td>
<td>30 current inpatients</td>
</tr>
<tr>
<td>Less than 30</td>
<td>All current inpatients</td>
</tr>
</tbody>
</table>

Subsequent audits

- Where possible, these should be identical to the initial audit to ensure a comparison of similar wards, patients and numbers.

Partial audits

- Hospitals may wish to target specific areas of concern where performance is suboptimal.
Audit teams

- Should be conducted by 2 people together:
  - To minimise observer bias
  - A registered nurse – interpretation of the prescription and administration information.
  - A pharmacist (or medical officer, or another nurse)

- The teams should be allocated and maintained for the audit period, to ensure consistency in the data collected.
Familiarisation with medication related policies and guidelines

- Local medication related procedures and guidelines – e.g. hospital’s list of approved trade names for prescribing

- If no local procedures or policies exist, auditors will need to agree on some audit parameters – e.g. acceptable abbreviations and trade names.
  - Establish consistency between auditors for current and subsequent audits.
Piloting data collection

- Teams should consider testing their data collection methods, using the NIMC Audit Form.

- NIMCs selected should include a variety of medicines which utilise different safety features of the chart.

- Pilot testing and correlating data collection decisions will help to achieve consistency between audit team members.

- Reflective discussion after pilot testing may also be helpful in situations where there is disparity between auditors.
# Completing the Audit Tool

![Audit Tool Form](image)

## National Inpatient Medication Chart Audit Tool

<table>
<thead>
<tr>
<th>Chart Type</th>
<th>NIMC</th>
<th>NIMC Long Stay</th>
<th>NIMC Paediatric</th>
<th>NIMC Paediatric Long Stay</th>
</tr>
</thead>
</table>

### 1. Patient Identification & Weight

1. Total current Medication Charts (in use) ____________
2. Patient ID complete on all pages (incl. hand-printed name if used) ____________
3. Weight documented on a Medication Chart (Points must be all charts) ____________

### 2. Adverse Drug Reaction (ADR) Details

1. ADR documentation complete on all charts (incl. NODA/Unknown) ____________
2. Patient has previous ADR ____________
3. Similar class of medication prescribed ____________
4. If previous ADR, do all pages have ADR Alert Stickers in place ____________

### 3. Medication History

1. Medication History documented on Medication Chart ____________
2. If No is a Medication History cross-referenced on Medication Chart ____________
3. Medication Management Plan (MMP) Form in ‘end of bed’ folder ____________
4. Allergies / ADR box completed on MMP Form ____________
5. No. medicines taken prior to presentation to hospital recorded on MMP Form ____________
6. No. medicines with Dr’s Plan on Admission completed on MMP Form ____________
7. No. medicines with Reconcile column ticked on MMP Form ____________
8. More than one source indicated on MMP Form ____________

### 4. Variable Dose

1. No Variable Dose medications (Variable Dose & Regular Order sections) ____________

### 5. Venous Thromboembolism (VTE) Prophylaxis

1. VTE Risk Assessment documented on any current medication ____________
2. VTE Prophylaxis prescribed (VTE & Regular sections) ____________
3. VTE Prophylaxis prescribed in VTE section ____________

### 6. Warfarin

1. Warfarin Guidelines at end of patient's bed or with Medication Chart ____________
2. No. times patient prescribed warfarin (Warfarin & Regular sections) ____________
3. No. Target INR ranges documented if prescribed in Warfarin section ____________
4. No. Target INR ranges documented if prescribed in Regular section ____________
5. Warfarin Education recorded ____________

### 7. Sustained Release

1. No. Sustained Release medications ordered (Regular section) ____________
2. No. Sustained Release medications with SR box ticked ____________

### 8. Intermittent Medications

1. No. Intermittent medications ordered (ie. weekly, fortnightly, twice weekly) ____________
2. No. Intermittent medications ordered & ‘boxed’ ____________

### 9. Duplicate Orders

1. No. Duplicated orders ____________

### 10. Pharmaceutical Review

1. Pharmaceutical Review occurred (in initial at bottom of chart) ____________

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**Comments:** ____________
Completing the Audit Tool

- Complete one audit tool per patient.
- Complete all fields on top of page 1.

- Ensure all appropriate fields are answered with a “Yes”, “No”, “Unknown” or a number. “NA” should only be used if appropriate.
Patient Confidentiality

- To ensure confidentiality, the UMRN and DOB will not be transmitted beyond the hospital.

- The electronic NIMC spreadsheet and web-based NIMC audit system will automatically assign individual ID, which de-identifies the patient.
Patient Identification & Weight

1.1 Total current Medication Charts

Count and record the total number of current medication charts in use (on the day of the audit).

Do not rely on the number indicated here. Only count the NIMCs in use. (i.e. do not include additional charts such as anticoagulation chart, insulin chart, or IV fluids chart, etc)
Patient Identification & Weight

1.2 Patient ID complete on all pages

Look at pages 3 and 4 of all medication charts.

YES if at least 3 are present on (visible and correct):

- Medical record number (UMRN)
- Patient name (family and given names)
- Date of birth
- Gender
- Patient address

If patient ID label is used, the first prescriber must print the patient’s name.
Patient Identification & Weight

1.3 Weight documented on a medication chart

YES if:

- **(Adult)** Weight documented on at least one medication chart, OR on general observations chart.

- **(Paediatric)** Weight documented on **ALL** pages of active medication charts.
Adverse Drug Reaction (ADR) Details

2.1 ADR documentation complete on all charts (incl. NKDA / Unknown)

YES if (on ALL medication charts):

- Nil known, unknown or ADR documented,
- Drug name and reaction documented
  - If reaction is unknown, a record of “patient unsure of reaction” (or similar) is required.
  - If no reaction is documented, it is not considered to be complete.
- Clinician signature
2.2 Patient has previous ADR

If ADR documentation is not completed:
Auditor(s) need to verbally confirm with patient if they have ADR(s), and what they are.

**NB:** If patient is unable to answer, (e.g. not available, intubated, non-English speaking etc) – check with family/carer.

Select **YES** or **NO** accordingly.
Select **Unknown (Unk)** if unable to verify.
2.2 Patient has previous ADR (continued)

If ADR documented has been completed: Select **YES** or **NO** accordingly.
2.3 Similar class of medicine prescribed

YES if: patient has a medication (or same class of medication) prescribed

Document in Comments section:
- Name of medicine recorded in allergy/ADR section
- Type of reaction recorded
- Name of the re-prescribed medicine
- If any doses of the re-prescribed medicine has been administered. If so, record number of doses given.
2.4 If previous ADR, do all pages have ADR alert stickers in place?

Look at page 3 and 4 of all medication charts.

**YES** if: ALL medication charts have ADR alert stickers in place.
(even if no active order on the page)

**NA if**: site does not use ADR alert stickers
Medication History

3.1 *Medication History* documented on front of the Medication Chart

**YES if:** Medication history (including “nil regular meds”) recorded on at least one chart

Is the medication history documented here?
Medication History

3.2 If “No”, is a Medication History cross-referenced on Medication Chart?

YES if: Medication history is cross-referenced on at least one chart (e.g. “See MMP” or “See previous chart”)
Medication History

3.3 Medication Management Plan (MMP)
Form in the “end of bed” folder

Refer to the WA Medication History and Management Plan (WA MMP) form.

YES if: WA MMP present in bedside folder.

NB: Either old or new version of the WA MMP is acceptable
Medication History

3.4 Allergies/ADR box completed on MMP form

YES if: Allergies/ADR box contains an allergy/ADR,
OR “Nil Known” or “Unknown” box has been ticked on WA MMP

ALLERGIES & ADVERSE DRUG REACTIONS (tick appropriate box)  ☐ Nil Known  ☐ Unknown  ☐ Reaction – refer to NIMC
Medication History

3.5 No. of medicines taken prior to presentation to hospital recorded on the MMP form

Indicate no. of medicines taken prior to admission. Include PRN and OTC medications if the patient is currently taking them.

If nil, enter “0”
Medication History

3.6 No. of medicines with Dr’s Plan on Admission completed on MMP form

This question is not relevant to WA.* Enter “0”.

(*This is different to Commission’s Guidelines)

3.7 No. of medicines with Reconcile column ticked on MMP form

Indicate number of medicines that have documentation (as per legend) in the Reconcile with NIMC column.*
Medication History

3.8 More than one source indicated on **MMP form**

**YES if**: More than one source has been ticked in the *Sources* section

**OR if** “Second Source deemed unnecessary”
Variable Dose

4.1 No. of Variable Dose medications

Look for medicines prescribed in both Variable Dose and Regular sections of the medication chart.

- Include ceased orders.
- Exclude warfarin and PRN medications.

If variable dose medication prescribed in Regular section, write name and frequency of the medicine in Comments section.
Venous Thromboembolism Prophylaxis

5.1 VTE risk assessment documented on any medication chart

**YES if (ALL present):**
- VTE Risk considered box ticked*
- Signature present
- Date of risk assessment documented

**NA if:** Auditing long stay, paediatric, paediatric long stay NIMC or if NIMC has no VTE Risk Assessment tool

* Consider surgical and anaesthetic implications prior to prescribing on Anticoagulation Chart

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Delivering a Healthy WA
VTE Prophylaxis

5.2 VTE prophylaxis prescribed

Refer to NIMC and WA Anticoagulation chart.*

**YES if:** Pharmacological VTE prophylaxis prescribed.

5.3 VTE prophylaxis prescribed in VTE section

Refer to WA Anticoagulation chart only.*

**YES if:** Pharmacological prophylaxis prescribed in prophylaxis section.
Warfarin

WA uses the WA Anticoagulation Medication Chart (WA AMC) for prescribing all anticoagulants. This section is not relevant to WA.

To keep WA data consistent:

Question 6.1 Select NA
Question 6.2 Enter “0”

Doing this will allow you to skip to section 7.
Sustained Release

7.1 No. of *Sustained Release* medications ordered (Regular medications section)

Indicate no. of SR medications prescribed in regular medications section (include ceased orders)

7.2 No. of *Sustained Release* medications with SR box ticked

Indicate no. of SR medications that have the SR box ticked (either doctor or pharmacist)
Intermittent Medications

8.1 No. of *Intermittent* medications ordered (e.g. weekly, fortnightly, twice weekly)

Indicate no. of medicines prescribed intermittently (include ceased and regular medications orders only).

8.2 No. of *Intermittent* medications ordered and “boxed”

Indicate no. of intermittent medications where all relevant boxes have been crossed out to flag dose(s) not to be administered.
Duplicated Orders

9.1 Number of Duplicated Orders

Indicate the no. of current *Once Only, Stat, Telephone, Regular and PRN* medication orders duplicated for the same medication or class of medication, which would result in the patient receiving unintentional additional doses of the medication.

If so, document names of the medicines in the *Comments* section.

Note: In some instances, this may be acceptable, e.g. salbutamol regular and PRN doses. Ensure regular dose is cross referenced to PRN dose, and max dose specified in PRN order.

Delivering a Healthy WA
Pharmaceutical Review

10.1 *Pharmaceutical Review* occurred
(i.e. Initial/s at bottom of chart)

**YES if:** there is at least ONE initial in the *Pharmaceutical Review* section on the medication chart (regardless of length of stay)
### National Inpatient Medication Chart Audit Tool

#### Legend
- **R:** Regular
- **P:** PRN
- **S:** Stat/Phono/Dose Only
- **V:** Variable Dose
- **W:** Wartten

#### Definitions: Error Prone Abbreviations
- **i**: ipg, ug, mg = microgram
- **u**: u = unit
- **d**: qd or OD = every day
- **q**: qd or OD = once daily

#### Data Columns
- **Order No.**
- **Drug Name**
- **Route**
- **Dose**
- **Frequency**
- **Date Given**
- **Documented**
- **Documented Correctly**
- **Corrected**
- **Corrected by**
- **Dispensed**
- **Dispensed Correctly**
- **Dosage**
- **Dosage Correctly**
- **Dosages Required**
- **Dosages Administered**
- **PRN, Max, Dose Doc.**

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*Delivering a Healthy WA*
Prescribing and Administration

This information is required to be documented separately for each medication order, i.e. *Once Only/Stat, Variable Dose, Regular* and *PRN* – including ceased orders.

Each column must have a response documented.

Focus on actual drug order
(i.e. Doctor’s documentation for this section, except question 11.11 – pharmacist annotation)
Prescribing and Administration

11.1 Allocate a number to each order
Only for paper audit tool. Excel and web based system will generate a number for each order.

11.2 Drug Order (include ceased orders)
This refers to the section of the chart where the medication has been prescribed.

<table>
<thead>
<tr>
<th>Drug Order Legend</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Regular</td>
<td>P</td>
</tr>
<tr>
<td>S</td>
<td>Stat/Once Only/Telephone</td>
<td>V</td>
</tr>
<tr>
<td>W</td>
<td>Warfarin <em>(Do not use this code in WA as warfarin not prescribed on NIMC)</em></td>
<td></td>
</tr>
</tbody>
</table>

NB: If variable dose medication is prescribed in Regular section, select “R”.
# Prescribing and Administration

## 11.3 Drug Name

<table>
<thead>
<tr>
<th>Drug Name Legend</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Unclear</td>
</tr>
<tr>
<td>T</td>
<td>Trade Name</td>
</tr>
<tr>
<td>C</td>
<td>Clear</td>
</tr>
</tbody>
</table>

### Drug Name Legend

**U**  Unclear

Drug name is illegible or may be interpreted as another product.

**T**  Trade Name

Drug is prescribed by UNACCEPTABLE trade name.

*Example: Timentin should be prescribed as Ticarcillin/Clavulanic Acid to identify as penicillin (NB: This may differ from site to site)*

**C**  Clear

Drug is prescribed clearly, and there is no potential for error identified.

Drugs may be prescribed in ACCEPTED trade name.

*Example: Trade names for insulins (to prevent error)*

*Example: OxyCONTIN vs OxyNORM*

Sites should have a list of acceptable trade names - refer to medication safety group (MSG)
# Prescribing and Administration

## 11.4 Route

<table>
<thead>
<tr>
<th>Route Legend</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C</strong> Clear and Correct</td>
<td>Route of administration is clear, correct and no potential for error.</td>
</tr>
<tr>
<td><strong>M</strong> Missing</td>
<td>No route documented.</td>
</tr>
</tbody>
</table>
| **U** Unclear | • Where route may be mistaken e.g. “SC” and “SL”  
• Where route is illegible  
• Where multiple routes have been ordered (where different doses are required depending on route chosen) |
| **I** Incorrect | Route documented is incorrect e.g. “po” for tiotropium |
## Prescribing and Administration

### 11.5 Dose

This refers only to the documentation of the dose. Auditors will not need to check the appropriateness of the dose.

<table>
<thead>
<tr>
<th>Dose Legend</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Clear and correct</td>
</tr>
<tr>
<td>M</td>
<td>Missing</td>
</tr>
<tr>
<td>U</td>
<td>Unclear</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Incorrect</td>
</tr>
</tbody>
</table>
Prescribing and Administration

11.5 Dose

*Paediatric Dose*

The dose should be the SAFE, total dose.

Auditors are required to calculate the dose using the patient’s weight or body surface area (BSA) according to the paediatric dosing reference endorsed by the site.

A calculator is recommended for this question.
Prescribing and Administration

11.6 Frequency

This refers to the dosing frequency as annotated by the doctor.

<table>
<thead>
<tr>
<th>Frequency Legend</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Clear</td>
</tr>
<tr>
<td></td>
<td>If medication frequency is clear, and there is no potential for error.</td>
</tr>
<tr>
<td>M</td>
<td>Missing</td>
</tr>
<tr>
<td></td>
<td>No frequency documented.</td>
</tr>
<tr>
<td>I</td>
<td>Incorrect</td>
</tr>
<tr>
<td></td>
<td>Frequency documented is incorrect.</td>
</tr>
<tr>
<td>U</td>
<td>Unclear</td>
</tr>
<tr>
<td></td>
<td>Frequency documented is illegible, or where an unacceptable abbreviation has been used. (See following slide for examples)</td>
</tr>
<tr>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>If <em>Stat/Once Only</em> medication or Variable dose medication prescribed in <em>Variable Dose</em> section</td>
</tr>
</tbody>
</table>
## Prescribing and Administration

### 11.6 Frequency (continued)

<table>
<thead>
<tr>
<th>Frequency Legend</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U</strong> Unclear</td>
<td>Frequency documented is illegible, or where an unacceptable abbreviation has been used.</td>
</tr>
</tbody>
</table>
| **Regular orders** | UNACCEPTABLE: Frusemide 40mg qd (or od)  
- Should be written as daily, or mane  
- **Frusemide 40mg mane ✓** |
| **PRN orders**   | UNACCEPTABLE: Morphine 10mg PRN  
- Should include a time interval for PRN orders  
- **Morphine 10mg 4hourly PRN ✓** |
| **PRN orders**   | UNACCEPTABLE: Metoclopramide 10-20mg tds PRN  
- May result in administration of doses every 8 hours, however may be clinically acceptable to administer more frequently.  
- **Metoclopramide 10-20mg 4-6 hourly PRN ✓** |
Prescribing and Administration

11.7 Dose Calculation Documented

**YES if:** Basis for dose calculation is documented in dose calculation box (e.g. mg/kg/dose or microgram/m²/dose)

**NB:** If written in different form (e.g. mg/kg/day) - this is considered unacceptable and unsafe.

**NO if:** Not documented

**NA if:** Not auditing the paediatric NIMC (PNIMC)

**OR** where dose calculation is not required (e.g. topical)
Prescribing and Administration

11.8 Dose Calculation Documented is Correct

YES if: Dose calculation documented is CORRECT based on the recommended dose in a current paediatric dose reference.

NO if: Dose calculation is incorrect.

NA if: Not auditing PNIMC
OR if dose calculation is not required for the medication (e.g. topical).
### 11.9 Error Prone Abbreviations

**YES if:** Error prone abbreviation is used.

<table>
<thead>
<tr>
<th>Error prone abbreviation</th>
<th>Intended meaning</th>
<th>Correct Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ug, mcg or μg</td>
<td>Microgram</td>
<td>Microgram or microg</td>
</tr>
<tr>
<td>U or u</td>
<td>Unit</td>
<td>Unit(s)</td>
</tr>
<tr>
<td>OD, od or d</td>
<td>Once daily</td>
<td>Daily, or specific time (e.g. mane, nocte)</td>
</tr>
<tr>
<td>QD or qd</td>
<td>Every day</td>
<td>Daily, or specific time (e.g. mane, nocte)</td>
</tr>
<tr>
<td>Q4H, q4h</td>
<td>Every 4 hours</td>
<td>Every 4hours, 4 hourly, 4hrly</td>
</tr>
<tr>
<td>SC or S/C</td>
<td>Subcutaneous</td>
<td>Subcut or subcutaneous</td>
</tr>
<tr>
<td>SL or S/L</td>
<td>Sublingual</td>
<td>Subling or sublingual</td>
</tr>
<tr>
<td>.5mg</td>
<td>0.5mg</td>
<td>0.5mg or 500microgram or 500microg</td>
</tr>
<tr>
<td>5.0mg</td>
<td>5mg</td>
<td>5mg</td>
</tr>
<tr>
<td>Drug name abbreviations</td>
<td>e.g. AZT = zidovudine</td>
<td>Do not use abbreviations for medicine names.</td>
</tr>
</tbody>
</table>
Prescribing and Administration

11.9 Error prone abbreviations (continued)

Refer to Commission’s

**Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines**

- Hospitals may wish to develop more extensive list of error prone abbreviations
Prescribing and Abbreviations

11.10 Indication Documented

YES if: Indication is documented

NO if: Indication is not documented

NA if: *Stat/Once Only* medication

What is this drug being used for?
Prescribing and Administration

11.11 Pharmacy Annotation

**YES if:** A Pharmacist has added or clarified any information on the medication order (usually indicated by purple pen). Also includes supply information.

**NO if:** No annotation is present

**NB:** Pharmacists initials alone are not considered “annotation”. Some medication orders (if clear) do not require further pharmacist annotation.

A pharmacist’s annotation may appear on other parts of the medication order (i.e. not reserved to just the Pharmacy section of the medication order).
Prescribing and Administration

11.12 Prescriber Signature

**YES if:** Medication order has been signed by the prescriber

**NO if:** Medication order has not been signed by the prescriber

Is the order signed?
Prescribing and Administration

11.12 Prescriber Signature (continued)

Note 1: A doctor’s signature is required within 24 hours of a *Telephone Order*.
*(Answer “Y” if ordered <24hours prior to audit)*

Note 2: A doctor’s signature is required for the original order (not the daily order)

Delivering a Healthy WA
Prescribing and Administration

11.13 Prescriber Name Clear

YES if: Prescriber’s name is clear.

NO if: Prescriber’s name is not clear.

Note: Prescribers should print their surname at least once on the medication chart to enable other clinicians to identify their signature.
Prescribing and Administration

11.14 Frequency Correlates with Administration Time

**YES if:** Administration time(s) correlates to frequency prescribed

**NO if:** Administrations time(s) does not correlate to frequency prescribed

e.g. Metoprolol 50mg TDS ordered, but administration times entered as BD

**NA if:** *Stat/Once Only* and PRN medications
Prescribing and Administration

11.14 Frequency Correlates with Administration time

Variable dose section:

Check that these match – especially important if more than once daily dosing
Prescribing and Administration

11.15 Drug Ceased

YES if: Order ceased

NO if: Still an active order

11.16 Drug Ceased Correctly

YES if: Order has been ceased correctly

NO if: Order has not been ceased correctly

NA if: Order has not been ceased

To be ceased correctly:

• Original order should not be obliterated.

• Clear line through order - prescription & administration section

• Reason for changing order (e.g. Ceased, increased, written in error)

• Date & initial the entry
Prescribing and Administration

11.17 Doses Required

Record the number of doses that **should have been administered** from the commencement of the order on the chart to the time of the audit.

Include *Stat/Once Only* medication.

Enter “0” for PRN medications.

11.18 Doses Administered

Record the number of doses that **have been administered**, including doses that have a “*reason for not administering*” code.

Enter “0” for PRN medications (even if doses have been given).
Prescribing and Administration

11.19 If PRN medication, Max dose documented

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication (Print Generic Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route</td>
<td>Dose</td>
</tr>
<tr>
<td>Indication</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Prescriber Signature</td>
<td>Print Your Name</td>
</tr>
</tbody>
</table>

Is this completed?

**YES if:** PRN medication has the maximum dose documented

**NO if:** No maximum dose documented

**NA if:** *Stat/Once Only, Variable Dose, Regular medication*

Delivering a Healthy WA
Comments Section

Document the following:

- 2.3: Drug & ADR, re-prescribed drug & no. of doses administered.
- 4.1: Name & frequency of variable dose medication prescribed in Regular section.
- 9.1: Duplicated drug orders (that are not cross-referenced)
Comments Section

Sites may wish to collect information on particular area(s) of practice for improvement, for example:

- Orders changed but not rewritten
  - e.g. Frusemide 40mg mane increased to 40mg bd on the existing order

- Orders prescribed in roman numerals
  - e.g. Timolol eye drops 0.5% i drop nocte
  - e.g. Paracetamol SR ii tid

- Orders using error-prone abbreviations
  - e.g. “sc” used to denote subcutaneous
Comments Section – Additional Information

Sites may also consider collecting data on:

- the number of orders that have not been annotated by the pharmacist, that should have been
- the percentage of NIMCs that do not have:
  - patient’s name printed if using the patient ID label
  - ADR documentation on ALL NIMCs
  - patient weight on ALL paediatric NIMCs

A report can be generated from this content. Commission will include this in national data.
**Recommendations**

- It is recommended that sites collect data on the paper audit form, and then upload the information onto the database (NIMC Audit System).

- Maintain a log of frequently occurring errors/issues
  - These can justify results for each site
    - e.g. “i-ii drops” – non-standard abbreviation, minimal impact
    - e.g. “U” (for units) – non-standard abbreviation, major impact
  - Can be used for education/improvement at each site
Recommendations

- Take de-identified photos of any major issues – present to site’s DTC or MSG
  - May be once-off event
  - May be part of a pattern

- Obtain a list of acceptable tradenames (may need to liaise with DTC or MSG)

- Determine the paediatric dosing reference used, and have it ready when auditing.

- Have a calculator handy – especially when auditing paediatric NIMCs
Acknowledgements

- Australian Commission on Safety and Quality in Health Care
  Resources available at: http://117.53.164.80/AustralianCommission/

- Armadale Kelmscott Memorial Hospital
Contact

For more information:

Quality Improvement and Change Management – Medication Safety
- Email: [waiseen.kee@health.wa.gov.au](mailto:waiseen.kee@health.wa.gov.au)
- Telephone: 08 9222 4170 (Thurs/Fri only)

Australian Commission on Safety and Quality in Health Care