Health Quality & Safety Commission New Zealand

Safe Medication Management Programme

MEDICATION CHARTING STANDARDS

SAFE MEDICATION MANAGEMENT PROGRAMME

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NOTES

INTRODUCTION

The medication charting standards are part of a wider Safe Medication Management (SMM) Programme. The SMM Programme is a clinician-led collaboration across 20 district health boards (DHBs), which has been put in place by the ministerial-appointed Quality Improvement Programme, as an initiative to improve safety by reducing harm to patients from adverse drug events.

The medication charting standards have been formulated by a multidisciplinary working group of clinical, quality, management, and information technology (IT) staff from across 20 DHBs.

Scope of application

The medication chartings standards are the minimum requirements for patient safety for prescribing, dispensing and administering of medications (either paper or electronic based).

Review period

It is intended that the medication charting standards continue to reflect the challenges and changes experienced by the sector. In order to achieve this, the document will be monitored and reviewed on an annual basis.

Explanation of terminology

Outcome The outcome is the overall goal of each standard.

Criteria The criteria are components of the service provision (inputs) that are required to be in place in order to achieve the outcome.

Guidance The guidance offers non-mandatory comments on the criteria, and how they could be managed.

SUMMARY OF MEDICATION CHARTING STANDARDS

The medication charting standards consist of three key areas, which are:

- Person details
- Medication details
- Document management.

Each area is separated into the required criteria to achieve compliance. For some of the criteria there is guidance to support understanding.

In summary, the medication charting standard requirements are detailed as follows:

Standard 1 **The details of all persons involved in the medication charting process are clearly documented on the medication chart.**

Standard 2 **Medication details are documented in a legal, legible and consistent manner.**

Standard 3 **Document management is clearly recorded.**

MEDICATION CHARTING STANDARDS

Outcome **Consumers receive medications in a safe and timely manner which complies with current legislative requirements and best practice guidelines.**

PERSON DETAILS

In this standard, a person will either be **identified** as a 'patient', 'prescriber', 'dispenser/pharmacist', or 'administrator'.

Standard 1 **All persons involved in the medication charting process are clearly documented on the medication chart.**

1A Patient

This is the person who the medication chart is for.

Criteria The criteria required to achieve this outcome will include the collection and documentation of the:

1.1 Patient's National Health Index (NHI) number

Guidance: the NHI number takes precedence over all other identifiers for consumers of health services in New Zealand.

1.2 Patient's family name

Guidance: the family name is also known as the surname.

1.3 Patient's given name(s)

Guidance: the given name(s) must accurately match the details on the patient's NHI number and written before the patient's family name.

1.4 Patient's gender

Guidance: this criterion is used to record the gender of the patient and should be registered as male, female, or undetermined.

1.5 Patient's date of birth

Guidance: the patient's date of birth should be recorded in day/month/year format.

1.6 Patient's name written by the first prescriber

Guidance: the first prescriber should confirm that the attached patient identification label is correct and contains all relevant patient details. The label should not be placed over the name that has been written by the first prescriber. The first prescriber will document the patient's given and family name.

1.7 Patient's height and date measured

Guidance: the patient's height will be documented in centimetres with the date it was measured in day/month/year format.

1.8 Patient's weight and date measured

Guidance: the patient's weight will be documented in kilograms with the date it was measured in day/month/year format.

1.9 Patient's allergies

Guidance: allergies are immune-mediated and can cause reactions ranging from mild to anaphylaxis. The substance that the patient is allergic to, and the type of reaction they experience, should be documented on the chart with the signature and date of the person who records the information.

1.10 Patient's adverse drug reactions

Guidance: adverse drug reactions are intolerances to medications administered in their usual doses. The medication that the patient has a reaction to, and the type of reaction they experience, should be documented on the chart with the signature and date of the person who records the information.

1.11 Patient's special care requirements:

(a) Breastfeeding;

(b) Pregnancy;

(c) Renal/hepatic;

(d) Other.

Guidance: 'Yes/No' boxes should be available to indicate impairment if a patient has a special care requirement. 'Other' is for describing specific details, e.g. dementia, that may influence medication prescribing.

1.12 Specialist requirements

Guidance: areas with specialist requirements may, in line with their DHB internal approval process, add information to the chart, for example height for paediatrics, to promote patient safety.

Standard 1 **All persons involved in the medication charting process are clearly documented on the medication chart** (continued).

1B Prescriber

This is the health practitioner who is responsible for generating the prescription.

Criteria The criteria required to achieve this outcome should include the collection and documentation of the:

1.13 Prescriber's registration number

Guidance: the registration number is the unique identifier provided by the registering body of the prescriber in New Zealand.

1.14 Prescriber's family and given name

Guidance: the family name is the name held by the registering body.

1.15 Prescriber's sample signature

Guidance: each prescriber documenting their signature on the chart should be easily identifiable. The prescriber can document this information on the medication chart.

1.16 Prescriber's designation

Guidance: designation is the prescriber's current role, e.g. house officer, register consultant, midwife.

Standard 1 **All persons involved in the medication charting process are clearly documented on the medication chart** (continued).

1C Dispenser/pharmacist

This is the health practitioner who is responsible for dispensing the prescription and advising on aspects of medication management.

Criteria The criteria required to achieve this outcome should include the collection of the:

1.17 Dispenser's/pharmacist's registration number

Guidance: the registration number is the unique identifier provided by the registering body of the dispenser/pharmacist in New Zealand.

1.18 Dispenser's/pharmacist's family and given name

Guidance: the family name is the name held by the registering body.

1.19 Dispenser's/pharmacist's sample initials

Guidance: each health practitioner documenting their initials on the chart should be easily identifiable. The dispenser/pharmacist can document this information on the medication chart.

1.20 Dispenser's/pharmacist's designation

Guidance: designation is the dispenser's/pharmacist's current role, e.g. pharmacy technician.

Standard 1 All persons involved in the medication charting process are clearly documented on the medication chart (continued).

1D Administrator

This is the health practitioner who is responsible for administering the medication to the patient.

Criteria The criteria required to achieve this outcome should include the collection and documentation of the:

1.21 Administrator's registration number

Guidance: the registration number is the unique identifier provided by the registering body of the administrator in New Zealand.

1.22 Administrator's family and given name

Guidance: the family name is the name held by the registering body.

1.23 Administrator's sample initials

Guidance: each health practitioner documenting their initials on the chart should be identifiable. The administrator can document this information on the medication chart.

1.24 Administrator's designation

Guidance: designation is the administrator's current role, e.g. charge nurse.

Standard 1 **All persons involved in the medication charting process are clearly documented on the medication chart** (continued).

1E Checker

This is the health practitioner who is responsible for checking the administration of the medication to the patient.

Criteria The criteria required to achieve this outcome should include the collection and documentation of the:

1.25 Checker's registration number

Guidance: the registration number is the unique identifier provided by the registering body of the checker in New Zealand.

1.26 Checker's family and given name

Guidance: the family name is the name held by the registering body.

1.27 Checker's sample initials

Guidance: each health practitioner documenting their initials on the chart should be identifiable. The checker can document this information on the medication chart.

1.28 Checker's designation

Guidance: designation is the checker's current role, e.g. clinical nurse specialist.

Outcome **Consumers receive medications in a safe and timely manner which complies with current legislative requirements and best practice guidelines.**

MEDICATION DETAILS

This section describes the detail required for a prescription item on the medication chart.

Standard 2 Medication details are documented in a legal, legible and consistent manner.

2A Verbal orders

This applies to all prescriptions which have been authorised verbally for once-only administration, and the required information which should be included.

Criteria The criteria required to achieve this outcome should include the collection of the following on the medication chart:

2.1 Date of prescription

Guidance: the date that the medication is prescribed should be recorded in day/month/year. A once-only verbal order should be signed within 24-hours of the verbal order being taken.

2.2 Time of prescription

Guidance: the time that the medication is prescribed should be recorded in hour(s)/minute(s) 24-hour format.

2.3 Medication name

Guidance: the medication name should be written in non-abbreviated capital letters with chemical abbreviations avoided. The generic name is preferred and the trade/ brand name should be avoided unless there are safety reasons that require the addition of the brand name.

2.4 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. Avoid the unnecessary use of decimal points with leading or trailing zeros. Refer to http://www.safeuseofmedicines.co.nz for current abbreviation guidelines.

2.5 Route to be administered

Guidance: the route describes the means or pathway by which the medication should be administered to the patient.

2.6 Specified individualised time for the medication to be administered

Guidance: the time that the medication is to be administered as a once-only event as specified by the prescriber. The time should be recorded in hour(s)/minute(s) 24-hour format.

2.7 Initials of first witness to verbal order

Guidance: the health practitioner who received the verbal order for the medication should document their initials and this should correspond to the details in the sample signature/initials section on the medication chart.

2.8 Initials of second witness to verbal order

Guidance: the second health practitioner to witness the received verbal order should document their initials and this should correspond to the details in the sample signature/initials section on the medication chart.

2.9 Prescriber's signature

Guidance: the prescriber's signature should correspond to the details in the sample signature/initials section on the medication chart.

2.10 Time of medication administration

Guidance: the time that the medication is administered should be recorded in hour(s)/minute(s) 24-hour format.

2.11 Administrator's initials

Guidance: the initials of the administrator of the medication should correspond to the details in the sample signature/initials section on the medication chart.

2.12 Checker's initials

Guidance: the health practitioners assisting with the medication administration procedure should record their initials to confirm that the correct medication and dosage is being administered. The initials of the checker of the medication should correspond to the details in the sample signature/initials section on the medication chart.

Standard 2 Medication details are documented in a legal, legible and consistent manner (continued).

2B Once-only medications

This applies to all prescriptions which are intended for a once-only administration and can include infusions and complex prescriptions.

Criteria The criteria required to achieve this outcome should include the collection and documentation of the following on the medication chart:

2.13 Date of prescription

Guidance: the date that the medication is prescribed should be recorded in day/month/year format.

2.14 Medication name

Guidance: the medication name should be written in non-abbreviated capital letters with chemical abbreviations avoided. The generic name is preferred and the trade/ brand name should be avoided unless there are safety reasons that require the addition of the brand name.

2.15 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. Avoid the unnecessary use of decimal points with leading or trailing zeros. Refer to http://www.safeuseofmedicines.co.nz for current abbreviation guidelines.

2.16 Route to be administered

Guidance: the route describes the means or pathway by which the medication should be administered to the patient.

2.17 Specified individualised time for the medication to be administered

Guidance: the time that the medication is to be administered as a once-only event as specified by the prescriber. The time should be recorded in hour(s)/minute(s) 24-hour format.

2.18 Special instructions

Guidance: these can outline how the medication should be administered and/or how the effects of the medication are to be monitored.

2.19 Prescriber's signature

Guidance: the prescriber's signature should correspond to the details in the sample signature/initials section on the medication chart

2.20 Pharmacy comment

Guidance: pharmacy comment provides the relevant instructions and clinical information about the medication.

2.21 Time medication commenced

Guidance: this identifies the actual time that the medication administration commenced. This should be recorded in hour(s)/minute(s) 24-hour format.

2.22 Administrator's initials

Guidance: the initials of the administrator of the medication should correspond to the details in the sample/initials signature section on the medication chart.

2.23 Checker's initials

Guidance: the health practitioner assisting with the medication administration procedure should record their initials to confirm that the correct medication and dose is being administered. The initials of the checker of the medication should correspond to the details in the sample signature/initials section on the medication chart.

2.24 Time medication completed

Guidance: if the medication is administered over a period of time, the administrator will document the actual time that the administration is completed, or the time that the medication was stopped. The time should be recorded in hour(s)/minutes(s) 24-hour format. The administrator's initials should correspond to the details in the sample signature section on the medication chart.

Standard 2 **Medication details are documented in a legal, legible and consistent manner** (continued).

2C Regular medications

This applies to all medications that are to be administered on a regular basis.

Criteria The criteria required to achieve this outcome should include the collection of the following on the medication chart:

2.25 Date of prescription

Guidance: the date that the medication is prescribed should be recorded in day/month/year format.

2.26 Medication name

Guidance: the medication name should be written in non-abbreviated capital letters with chemical abbreviations avoided. The generic name is preferred and the trade/ brand name should be avoided unless there are safety reasons that require the addition of the brand name.

2.27 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. Avoid the unnecessary use of decimal points with leading or trailing zeros. Refer to http://www.safeuseofmedicines.co.nz for current abbreviation guidelines.

2.28 Route to be administered

Guidance: the route describes the means or pathway by which the medication should be administered to the patient.

2.29 Predetermined time intervals for administration

Guidance: tick boxes are required to show when the medication should be administered, e.g.:

- 0800 hrs
- 1200 hrs
- 1800 hrs
- 2200 hrs
- additional interspersed boxes for the prescriber to write a specific time.

2.30 Special instructions

Guidance: these can outline how the medication is to be administered and/or how the effects of the medication should be monitored.

2.31 Prescriber's signature

Guidance: the prescriber's signature should correspond to the details in the sample signature/initials section on the medication chart

2.32 Date and time to cancel the medication, and the prescriber's signature

Guidance: outlines the date and time that the medication should no longer be administered to the patient. The prescriber's signature will correspond to the details in the sample signature/initials section on the medication chart.

2.33 Pharmacy comment

Guidance: pharmacy comment provides the relevant instructions and clinical information about the medication.

2.34 Date of medication administration

Guidance: the date should be recorded in day/month/year format.

2.35 Time of medication administration

Guidance: the time should be recorded in hour(s)/minute(s) 24-hour format.

2.36 Dose of medication administered

Guidance: the medication dose and units should describe measurement of the medication. Doses not administered as intended will be appropriately documented on the medication chart.

2.37 Administrator's initials

Guidance: the initials of the administrator of the medication should correspond to the details in the sample/initials signature section on the medication chart.

2.38 Checker's initials

Guidance: the health practitioner assisting with the medication administration procedure should record their initials to confirm that the correct medication and dose is being administered. The initials of the checker of the medication should correspond to the details in the sample signature/initials section on the medication chart.

Standard 2 **Medication details are documented in a legal, legible and consistent manner** (continued).

2D As required (PRN) medications

This applies to prescriptions which are intended for administration on an 'as-required basis'.

Criteria The criteria required to achieve this outcome should include the collection of the following on the medication chart:

2.39 Date of prescription

Guidance: the date that the medication is prescribed should be recorded in day/month/year format.

2.40 Medication name

Guidance: the medication name should be written in non-abbreviated capital letters with chemical abbreviations avoided. The generic name is preferred and the trade/ brand name should be avoided unless there are safety reasons that require the addition of the brand name.

2.41 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. Avoid the unnecessary use of decimal points with leading or trailing zeros. Refer to http://www.safeuseofmedicines.co.nz for current abbreviation guidelines.

2.42 Route to be administered

Guidance: the route describes the means or pathway by which the medication should be administered to the patient.

2.43 Special instructions

Guidance: these can outline how the medication is to be administered and/or how the effects of the medication should be monitored.

2.44 Indications for use

Guidance: describes the specific clinical circumstances for which the medication is being prescribed.

2.45 Frequency of administration

Guidance: this is the time interval in which the medication is to be safely administered. Ranges such as 4 – 6 hourly should be avoided.

2.46 Maximum dose in a 24-hour period

Guidance: this describes the maximum cumulative dose of the medication in a 24-hour period that can be safely administered.

2.47 Prescriber's signature

Guidance: the prescriber's signature should correspond to the details in the sample signature/initials section on the medication chart.

2.48 Date and time to cancel medication, and the prescriber's signature

Guidance: outlines the date and time that the medication should no longer be administered to the patient. The prescriber's signature should correspond to the details in the sample signature/initials section on the medication chart.

2.49 Pharmacy comment

Guidance: pharmacy comment provides the relevant instructions and clinical information about the medication.

2.50 Date of medication administration

Guidance: the date the medication is administered should be recorded in day/month/year format.

2.51 Time of medication administration

Guidance: the time the medication is administered should be recorded in hour(s)/minute(s) 24-hour format.

2.52 Dose of medication administered

Guidance: the medication dose and units should describe measurement of the medication.

2.53 Route of medication administered

Guidance: the route describes the means or pathway by which the medication was administered.

2.54 Administrator's initials

Guidance: the initials of the administrator of the medication should correspond to the details in the sample signature/initials section on the medication chart.

2.55 Checker's initials

Guidance: the health practitioner assisting with the medication administration procedure should record their initials to confirm that the correct medication and dosage is being administered. The initials of the checker should correspond to the details in the sample signature/initials section on the medication chart.

Outcome **Consumers receive medications in a safe and timely manner which complies with current legislative requirements and best practice guidelines.**

DOCUMENT MANAGEMENT

This section describes how the medication chart should be managed.

Standard 3 Document management is clearly recorded.

3A Medication charts

This applies to all medication charts and the required information which should be included.

Criteria The criteria required to achieve this outcome should include the collection of the following on the medication chart to ensure clear management:

3.1 Re-charting prescriptions

Guidance: when the medication chart is full and a new chart is required to continue the medication schedule for the period of the patient's admission, the prescriber should re-prescribe the medication(s) on a new chart. When carrying forward the original date of the prescription, this should be documented next to the new date.

3.2 Number of medication charts in use

Guidance: when multiple charts are in use they should be held together and numbered 1 of 2 and so on at the front of each chart to ensure that the most current chart is being operated.

3.3 Supplementary chart documentation

Guidance: any regular medication recorded on supplementary charts should be written onto the main medication chart in the regular medication section with instruction to refer to the supplementary chart for details.

3.4 Health practitioner's sample signature/initials section

Guidance: this ensures that all health practitioners who have documented the chart are identifiable by their registration number, family name, designation, and signature/initials.