DISTRICT HEALTH BOARDS MEDICATION CHARTING STANDARDS

SAFE MEDICATION MANAGEMENT PROGRAMME

ACKNOWLEDGEMENTS

The Chair of the Safe Medication Management Programme would like to acknowledge the assistance of the 21 District Health Boards throughout New Zealand and the many stakeholders from across the health and disability sector who are engaged in the Safe Medication Management Programme.

We particularly acknowledge the assistance of Safe Quality Use of Medicines group (SQUM) for its input and work, which established the basis for these standards.

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SAFE MEDICATION MANAGEMENT

INTRODUCTION

The medication charting standards are part of a wider Safe Medication Management Programme (SMMP). The SMMP is a clinician-led collaboration across 21 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.

This medication charting standards document has been formulated by a multidisciplinary working group of clinical, quality, management, and IT staff from across all 21 DHBs and approved by the SMMP Steering group.

The working groups are clinician-led with administrative, quality, and IT requirements being established to support clinical need.

Scope of application

The medication charting standards are intended to supplement the provision of assured quality and safe documentation procedures for medication management.

These standards are the minimum requirements to enhance patient safety for charting medication in all general and speciality clinical areas.

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 as-required basis.

Explanation of terminology

Outcome The outcome is the overall goal of each Standard. The outcome specifies the objective of the service or organisation.

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.

Informative references

For the purposes of this medication charting standards document, the word 'should' refers to practices that are advised or recommended.

SUMMARY OF MEDICATION CHARTING STANDARDS

The medication charting standards consist of three key areas which should allow the user to use all of the elements recommended in the medication process. The elements are:

- Person details
- Medication details
- Document management.

Each of the areas is separated into easily identifiable elements with the required criteria to achieve compliance detailed clearly. In order to ensure understanding of some of the criteria there are guidance boxes attached. These are intended to expand on the criteria and reduce any ambiguity.

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

Standard 1 Person details – All persons involved in the prescribing process are clearly recorded on the medication chart to ensure a safe and monitored level of care.

1A Patient

1.1 Patient's National Health Index (NHI) number
1.2 Patient's surname(s)
1.3 Patient's first name(s)
1.4 Patient's gender
1.5 Patient's date of birth
1.6 Patient's age
1.7 Patient's name written by the first prescriber
1.8 Patient's height
1.9 Patient's weight
1.10 Patient's allergies
1.11 Patient's adverse drug reactions
1.12 Patient's special care requirements to alert to the following:
  (a) Breastfeeding
  (b) Pregnancy
  (c) Special considerations/physiological dysfunction(s)
  (d) Other

1B Prescriber

1.13 Prescriber's registration number
1.14 Prescriber's surname(s)
1.15 Prescriber's first name(s)
1.16 Prescriber's sample signature and initials
1.17 Prescriber's designation

1C Dispenser/pharmacist

1.18 Dispenser's/pharmacist's surname(s)
1.19 Dispenser's/pharmacist's first name(s)
1.20 Dispenser's/pharmacist's sample signature and initials
1.21 Dispenser's/pharmacist's designation

1D Administrator

1.22 Administrator's surname(s)
1.23 Administrator's first name(s)
1.24 Administrator's sample signature and initials
1.25 Administrator's designation

Standard 2 Medication details – Prescription requirements are recorded in a legible and consistent manner to ensure that all elements of the prescription are met. Medications should be administered to consumers in a safe and consistent manner.

2A Once-only verbal orders

2.1 Date of prescription
2.2 Time of prescription
2.3 Medication name
2.4 Medication dose and units
2.5 Route of administration
2.6 Specified individualised time for the medication to be administered
2.7 Initials of first witness to verbal order
2.8 Initials of second witness to verbal order
2.9 Prescriber's signature and registration number
2.10 Time of medication administration
2.11 Administrator's initials
2.12 Checker's initials

Standard 2 Medication details (continued)

2B Once-only medications

2.13 Date of prescription
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2.15 Medication name
2.16 Medication dose and units
2.17 Route of administration
2.18 Specified individualised time for the medication to be administered (once only)
2.19 Special instructions
2.20 Prescriber's signature and registration number
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2.38 Dose of medication administered
2.39 Route of medication administration
2.40 Administrator's initials
2.41 Checker's initials

Standard 2 Medication details (continued)

2D As required (PRN) medications

2.42 Date of prescription
2.43 Time of prescription
2.44 Medication name
2.45 Medication dose and units
2.46 Route of medication administration
2.47 Special instructions
2.48 Indications for use
2.49 Minimum dose interval in a 24-hour period
2.50 Maximum dose in a 24-hour period
2.51 Prescriber's signature and registration number
2.52 Date and time to cease medication and the prescriber's initials
2.53 Pharmacy comment
2.54 Date of medication administration
2.55 Time of medication administration
2.56 Dose of medication
2.57 Route of medication administration
2.58 Administrator's initials
2.59 Checker's initials

Standard 3 Document management – Documentation management is structured, easy to follow, and clearly recorded.

3A Medication charts

3.1 Transcribed events
3.2 Number of medication charts in use
3.3 Ancillary chart documentation
3.4 Health professional's sample signature section
3.5 Specialist requirements

SAFE MEDICATION MANAGEMENT

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

PERSON DETAILS

This section describes the individuals involved in the prescribing process. In this standard a person will either be identified as a 'patient', 'prescriber', 'dispenser/ pharmacist', or 'administrator'.

Standard 1 **All persons involved in the prescribing process are clearly recorded on the medication chart to ensure a safe and monitored level of care.**

1A Patient
This is the person who receives the medication.

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

1.1 Patient's National Health Index (NHI) number

Guidance: the NHI number is the unique lifetime identifier for all New Zealanders. It takes precedence over all other identifiers, for consumers of health services in New Zealand.

1.2 Patient's surname(s)

Guidance: the surname(s) should always be placed first and written before the patient's first name(s).

1.3 Patient's first name(s)

Guidance: the first name(s) should accurately match the detail on the patient's NHI number.

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 age

Guidance: the patient's age should be expressed in weeks, months, or years.

1.7 Patient's name written by the first prescriber

Guidance: the first prescriber should check that any attached preprinted patient identity 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.

1.8 Patient's height

(a) Height in centimetres;

(b) Date measured.

1.9 Patient's weight

(a) Weight in kilograms;

(b) Date measured.

1.10 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 of the person who records the information. This allergy information should also be documented in a highly visible and easily accessible part of the patient's record.

1.11 Patient's adverse drug reactions

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

1.12 Patient's special care requirements to alert the following:

(a) Breastfeeding;

(b) Pregnancy;

(c) Special considerations/physiological dysfunction(s);

(d) Other.

Guidance: 'yes/no' boxes should be available for each special care requirement. A 'see notes' statement should be included alongside special considerations/physiological dysfunction(s). 'Other' is for describing specific details that may influence medication prescribing.

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Standard 1 **All persons involved in the prescribing process are clearly recorded on the medication chart to ensure a safe and monitored level of care** (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 surname(s)

Guidance: the surname(s) should be written before the prescriber's first names(s).

1.15 Prescriber's first name(s)

Guidance: the first name(s) should accurately match the detail on the prescriber's registration details.

1.16 Prescriber's sample signature and initials

Guidance: each medication chart should have a sample signature of each healthcare practitioner associated with the patient's medication in order to identify them.

1.17 Prescriber's designation

Guidance: designation is the prescriber's registered profession.

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:

1.18 Dispenser's/pharmacist's surname(s)

Guidance: the surname(s) should be written before the dispenser's/pharmacist's first name(s).

1.19 Dispenser's/pharmacist's first name(s)

Guidance: the first name(s) should accurately match the detail on the dispenser's/pharmacist's registration details.

1.20 Dispenser's/pharmacist's sample signature and initials

Guidance: each medication chart should have a sample signature of each dispenser/pharmacist associated with the patient's medication in order to identify them.

1.21 Dispenser's/pharmacist's designation

Guidance: designation is the dispenser's/pharmacist's registered profession.

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:

1.22 Administrator's surname(s)

Guidance: the surname(s) should be written before the administrator's first names(s).

1.23 Administrator's first name(s)

Guidance: the first name(s) should accurately match the detail on the administrator's registration details.

1.24 Administrator's sample signature and initials

Guidance: each medication chart should have a sample signature of each dispenser/pharmacist associated with the patient's medication in order to identify them.

1.25 Administrator's designation

Guidance: designation is the administrator's registered profession.

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 **Prescription requirements are recorded in a legible and consistent manner to ensure that all elements of the prescription are met. Medications should be administered to consumers in a safe and consistent manner.**

2A Once-only 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: where practical the generic non-abbreviated name of the medication should be used and chemical abbreviations should be avoided.

2.4 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. The use of abbreviations and decimal points should be avoided.

2.5 Route of administration

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: this applies to verbal orders that are to be administered at a specific time as a once-only event. 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 professional who received the verbal order for the medication should document their initials and this should correspond to the details in the sample signature section on the medication chart.

2.8 Initials of second witness to verbal order

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

2.9 Prescriber's signature and registration number

Guidance: if the registration number is used then this can identify the prescriber . The registration number is the unique identifier provided by the registering body of the prescriber in New Zealand.

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 section on the medication chart.

2.12 Checker's initials

Guidance: the health professional 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 section on the medication chart.

Standard 2 **Prescription requirements are recorded in a legible and consistent manner to ensure that all elements of the prescription are met. Medications should be administered to consumers in a safe 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 Time of prescription

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

2.15 Medication name

Guidance: where practical the generic non-abbreviated name of the medication should be used and chemical abbreviations should be avoided.

2.16 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. The use of abbreviations and decimal points should be avoided.

2.17 Route of administration

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

2.18 Specified individualised time for the medication to be administered (once only)

Guidance: this applies to medications prescribed to be administered at a specific time as a once-only event. The time should be recorded in hour(s)/minute(s) 24-hour format.

2.19 Special instructions

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

2.20 Prescriber's signature and registration number

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

2.21 Pharmacy comment

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

2.22 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.

2.23 Administrator's initials

Guidance: the administrator who commences administering the medication to the patient, and their initials should correspond to the details in the sample signature section on the medication chart.

2.24 Checker's initials

Guidance: the health professional 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 section on the medication chart.

2.25 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. Their initials should correspond to the details in the sample signature section on the medication chart.

Standard 2 **Prescription requirements are recorded in a legible and consistent manner to ensure that all elements of the prescription are met. Medications should be administered to consumers in a safe 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:

2.26 Date of prescription

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

2.27 Time of prescription

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

2.28 Medication name

Guidance: where practical the generic non-abbreviated name of the medication should be used and chemical abbreviations should be avoided.

2.29 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. The use of abbreviations and decimal points should be avoided.

2.30 Route to be administered

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

2.31 Predetermined time intervals for administration

Guidance: tick boxes are required to show when the medication should be administered. Use the following:

- 0800 hrs
- 1200 hrs
- 1800 hrs
- 2200 hrs
- additional interspersed boxes for free text time.

2.32 Special instructions

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

2.33 Prescriber's signature and registration number

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

2.34 Date and time to cease the medication and the prescriber's initials

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

2.35 Pharmacy comment

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

2.36 Date of medication administration

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

2.37 Time of medication administration

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

2.38 Dose of medication administered

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

2.39 Route of medication administration

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

2.40 Administrator's initials

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

2.41 Checker's initials

Guidance: the health professional 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 section on the medication chart.

Standard 2 **Prescription requirements are recorded in a legible and consistent manner to ensure that all elements of the prescription are met. Medications should be administered to consumers in a safe 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:

2.42 Date of prescription

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

2.43 Time of prescription

Guidance: the time that the medication is prescribed should be recorded in hours/minutes 24-hour format.

2.44 Medication name

Guidance: where practical the generic non-abbreviated name of the medication should be used and chemical abbreviations should be avoided.

2.45 Medication dose and units

Guidance: the medication dose and units should describe measurement of the medication. The use of abbreviations and decimal points should be avoided.

2.46 Route of medication administration

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

2.47 Special instructions

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

2.48 Indications for use

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

2.49 Minimum dose interval in a 24-hour period

Guidance: the time interval relates to the frequency in which the medication can be safely administered to reach the maximum dose in a 24-hour period.

2.50 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.

2.51 Prescriber's signature and registration number

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

2.52 Date and time to cease medication and the prescriber's initials

Guidance: this describes the date and time that the medication should no longer be administered to the patient. The initials of the prescriber should correspond to the details in the sample signature section on the medication chart.

2.53 Pharmacy comment

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

2.54 Date of medication administration

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

2.55 Time of medication administration

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

2.56 Dose of medication

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

2.57 Route of medication administration

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

2.58 Administrator's initials

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

2.59 Checker's initials

Guidance: the health professional 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 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 **Documentation management is structured, easy to follow, and 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 Transcribed events

Guidance: transcribing is required when the medication chart, or part thereof, is full and a new chart is required to continue the medication schedule for the period of the patient's admission. This should be documented with time, date, and identity of the transcriber.

3.2 Number of medication charts in use

Guidance: if there are multiple medication charts for a patient, they should be accordingly numbered 1, 2, 3 of 1, 2, 3 to ensure that the most current chart is being operated.

3.3 Ancillary chart documentation

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

3.4 Health professional's sample signature section

Guidance: this ensures that all health professionals who have documented their initials or signature on the chart are identifiable by their name and designation, on the sample signature section in order to identify them.

3.5 Specialist requirements

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

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