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

WA Hospital Medication Chart

Short Stay and Long Stay

better health ▪ better care ▪ better value

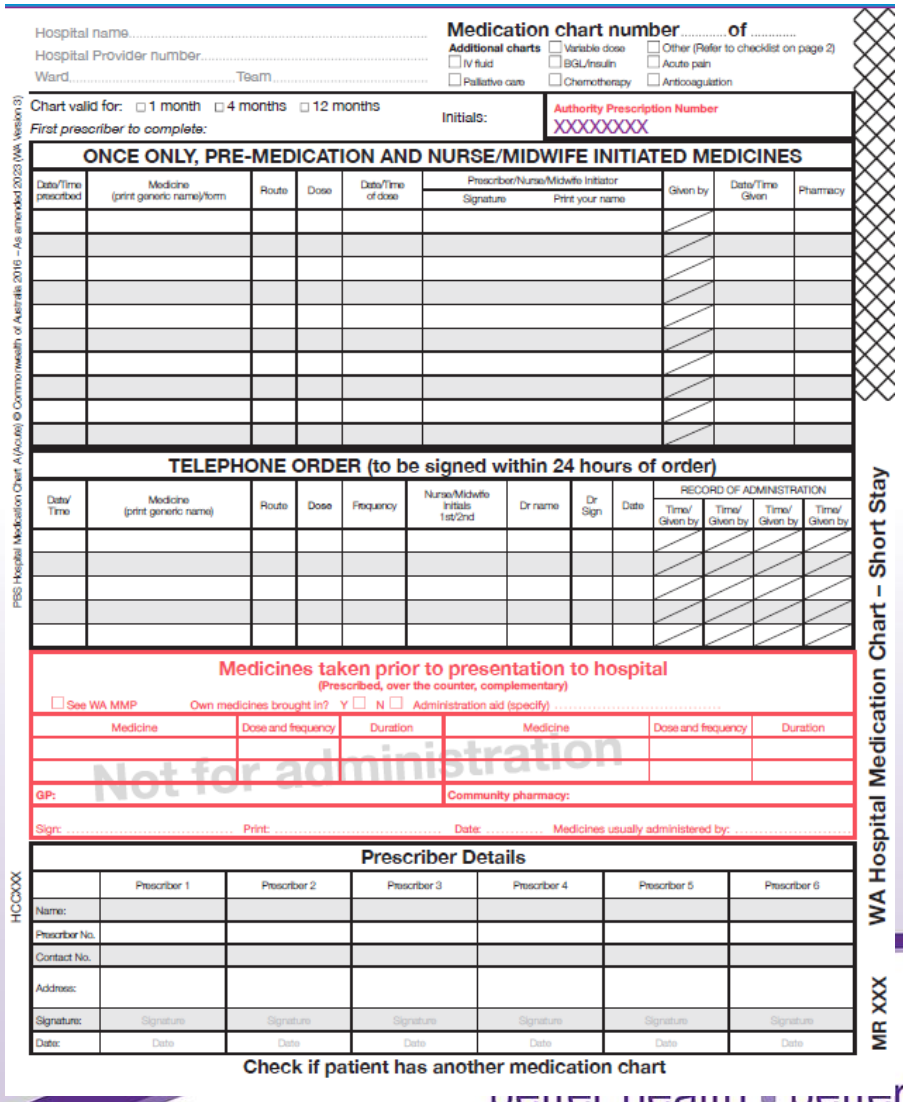
WA Hospital Medication Chart (WA HMC)

- The WA HMC is the national standardised medication chart designed to assist communication of a patient's medication requirements consistently between health professionals and to support the safe and quality use of medications.
- Use of the WA HMC is mandatory for all WA public and private health services that provide publicly-funded inpatient care.
- The WA HMC
  - supports requirements for accreditation purposes
  - builds on the key safety features of the NIMC
  - has been modified to adopt the format requirements of the National Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC)

- Health Service Providers (HSPs) must use the WA HMC for adult patients (WA Medication Chart Policy) alongside the WA Health Electronic Discharge Summary application
  - currently Notification and Clinical Summary (NaCS)

- Use of the WA HMC for discharge dispensing remains at the discretion of the HSP but must not preclude the use of the NaCS for discharge prescription.

Front page of WA HMC



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

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

Additional charts ☐ Variable dose ☐ Other (Refer to checklist on page 2)
☐ IV fluid ☐ BGL/Insulin ☐ Acute pain
☐ 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	Prescriber/Nurse/Midwife Initiator: 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

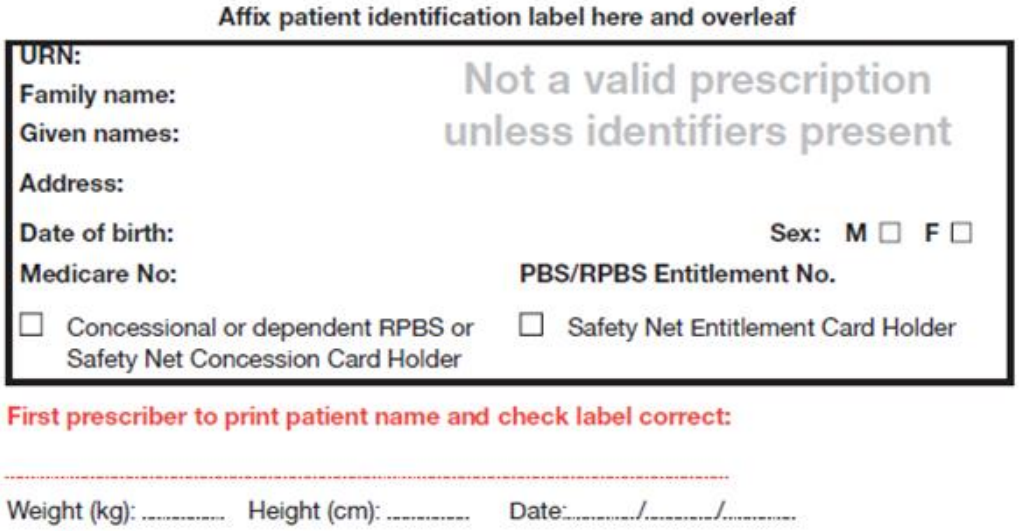
PBS Hospital Medication Chart A(Acute) © Commonwealth of Australia 2016 – As amended 2023 (WA Version 3)

HCCXXX

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

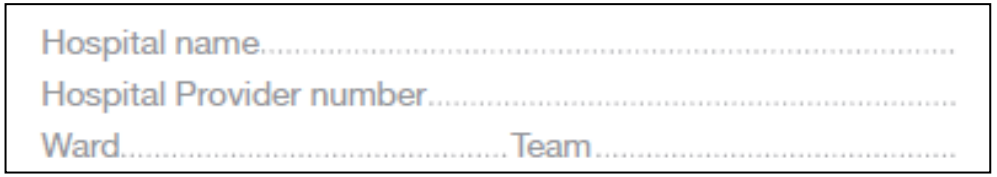
First prescriber to print patient name and check label correct:

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:
  - The patient's name, unique medical record number (UMRN), date of birth and gender written in legible print; OR
  - The current patient identification label (addressograph).

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

Patient Location & Number of Medication charts

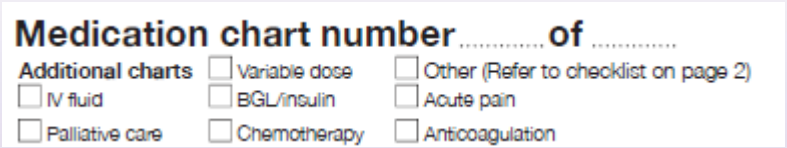


- The patient's current location (ward or unit) within the hospital should be clearly marked on the medication chart.
- If a patient moves to a different ward or unit, this new location should be indicated on the medication chart - the previous ward should be crossed off, and the new ward should be written in its place.
- If there are more than one WA HMC or WA Paediatric NIMC in use, then this must be indicated by filling in the appropriate numbers in the space provided

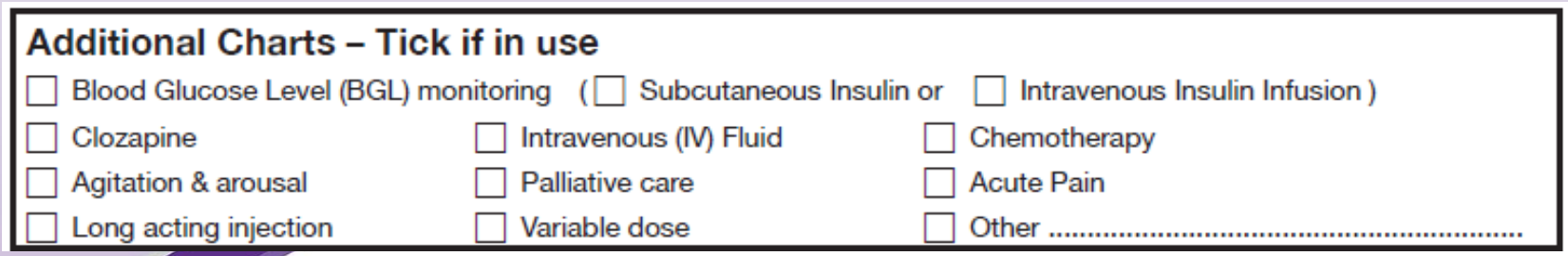
- If additional charts are written, or charts are ceased, this information should be updated

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:

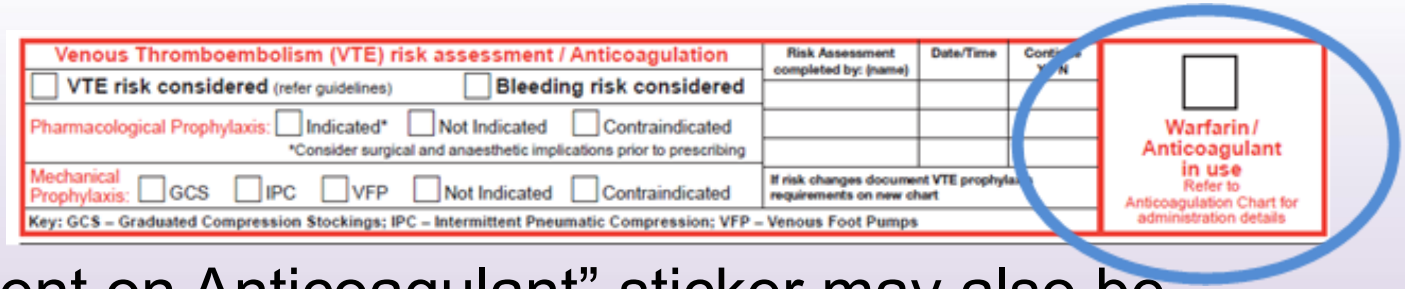


- Inside chart above regular medication order:



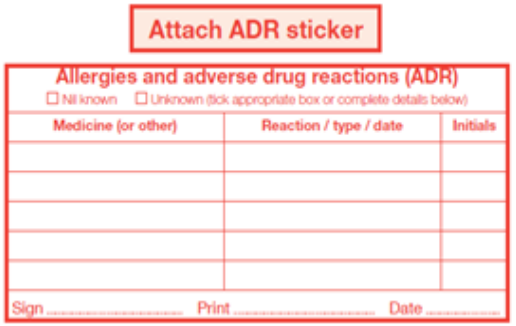
Anticoagulant prescribing

- Use of the WA Adult Anticoagulation Medication chart is mandatory for the prescription and administration of all anticoagulants
- If an anticoagulant is prescribed in adults the anticoagulation specialised chart box on front of chart and the ‘Warfarin/Anticoagulant in use’ box should be ticked.



- A “Patient on Anticoagulant” sticker may also be attached to the Warfarin/Anticoagulant in use box

Allergies and Adverse Drug Reaction Alert



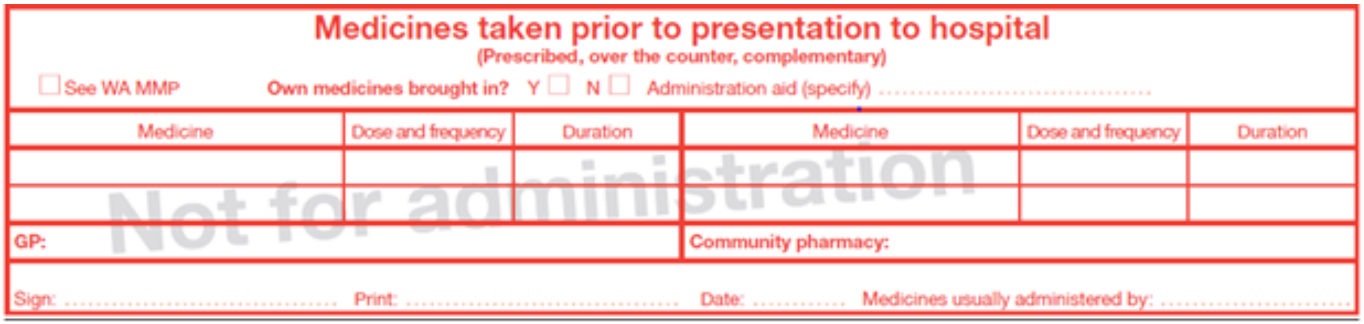
This section communicates the existence of previous allergies, adverse drug reactions (ADRs) and related information.

The following details must be completed:

- 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)
- Signature and printed name of person taking allergy/ADR history
- Date of initial documentation (by person above)
- If the patient has an ADR use the following sticker

Doctors, nurses, midwives and pharmacists are required to complete this documentation for ALL patients

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

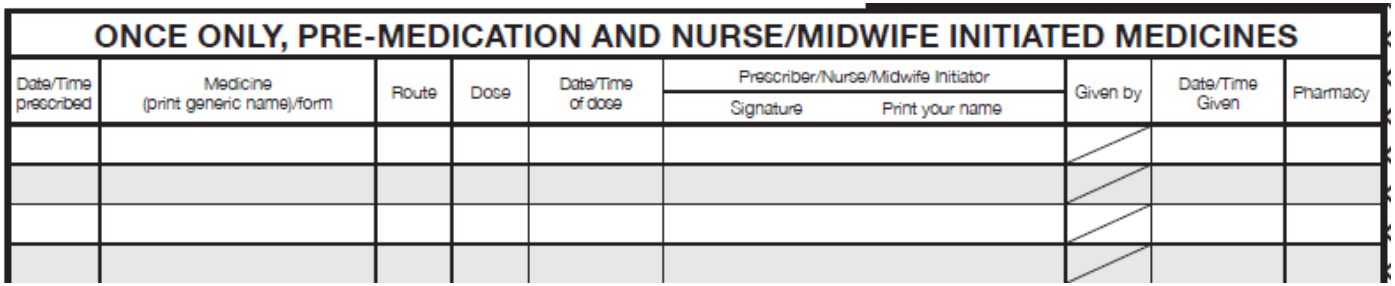
Not for administration

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.
- 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.
- For the majority of patients this information should be documented on the WA Medication History and Management Plan (WA MMP) form.

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

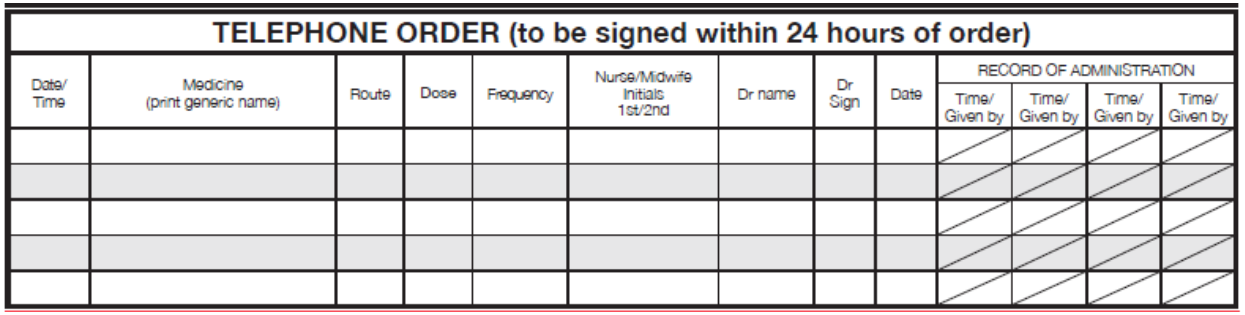


ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES								
Date/Time prescribed	Medicine (print generic name)/form	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator		Given by	Date/Time Given	Pharmacy
					Signature	Print your name			

- The following must be documented in this section:
  - Date/Time prescribed
  - Generic medication name
  - Route of administration
  - Dose to be administered
  - Date/Time to be administered
  - Prescriber's signature and printed name OR nurse/midwife initiator's signature and printed name
  - Initials of person that administered medication
  - Date/Time medication administered

- Ward pharmacist should confirm the medication is safe to administer and annotate if the medication requires supply or is on imprest (I), a Schedule 8 (S8) or Restricted Schedule 4 medication (S4R)

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

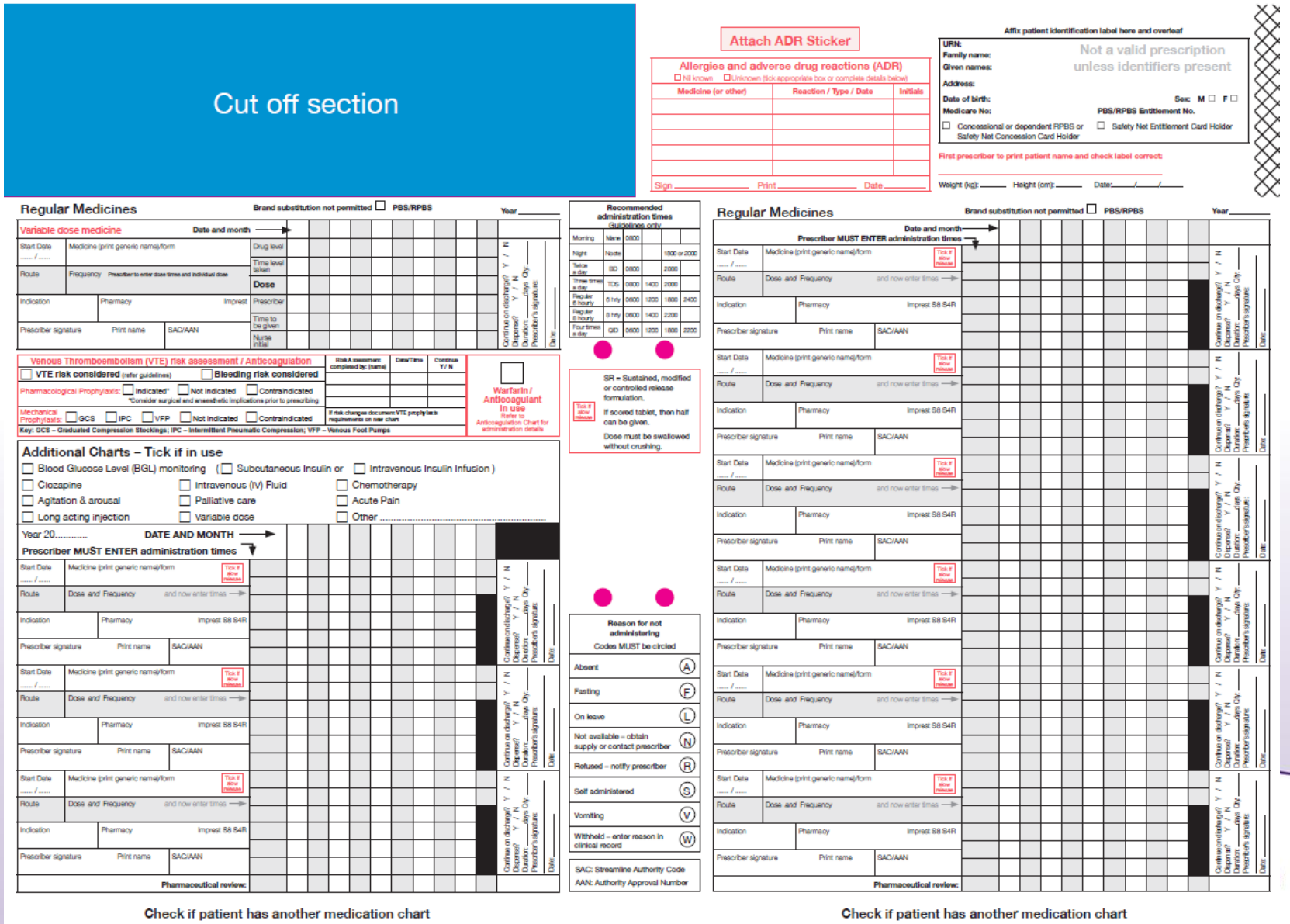
- Telephone orders are discouraged, as they are an error prone activity. To reduce the potential for error, telephone orders are to be countersigned by 2 nurses/midwives who have both independently heard/received and read back the order to the prescribing doctor
- The following must be completed:

- Date/time prescribed
- Generic medication name
- Route of administration
- Dose to be administered
- Frequency at which the medication is to be administered

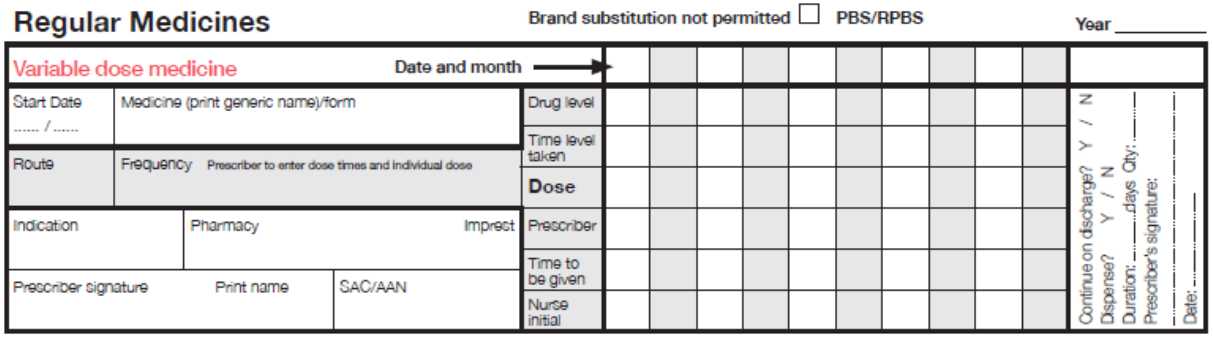
- Initial of two nurses/midwives to confirm that the verbal order has been heard and checked
- Name of doctor giving verbal order
- Initials of person that administers the medication
- Date and time medication administered

Middle Pages of the medication chart

Cut off section



Variable Dose Medicine Orders



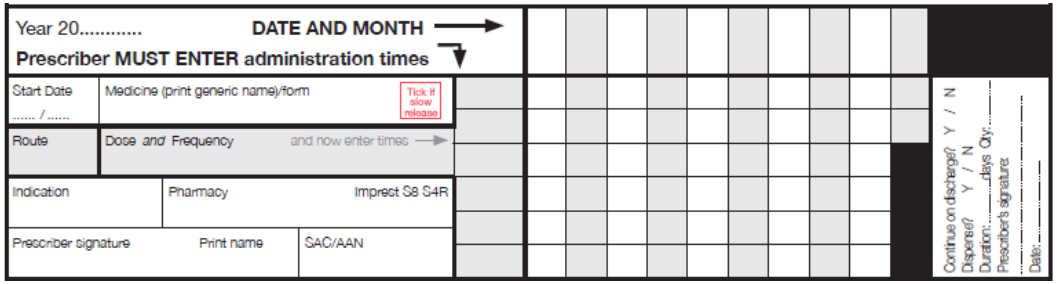
Regular Medicines Brand substitution not permitted ☐ PBS/RPBS Year _____

Variable dose medicine	Date and month →										
Start Date ..... /	Medicine (print generic name)/form	Drug level									
Route	Frequency Prescriber to enter dose times and individual dose	Time level taken									
		Dose									
Indication	Pharmacy Imprest	Prescriber									
		Time to be given									
Prescriber signature Print name SAC/AAN		Nurse initial									

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

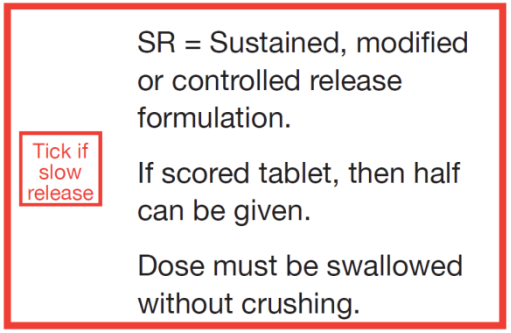
- This section has been formatted to facilitate ordering of medicines that require
  - **variable dosing, based on laboratory test results** (e.g. vancomycin) **or**
  - **as a reducing protocol** (e.g. prednisolone).
- For each medication order, the following details must be documented:
  - Start date - 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
  - 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:
  - Drug level results, when required
  - Time drug level taken

Regular Medicine Orders



- All regular medications must be prescribed in this section of the WA HMC
- For an order to be valid the following must be complete
  - Start date
  - Generic medicine name
  - Route of administration
  - Dose and Frequency
  - Indication
  - Prescriber's signature and name (printed)

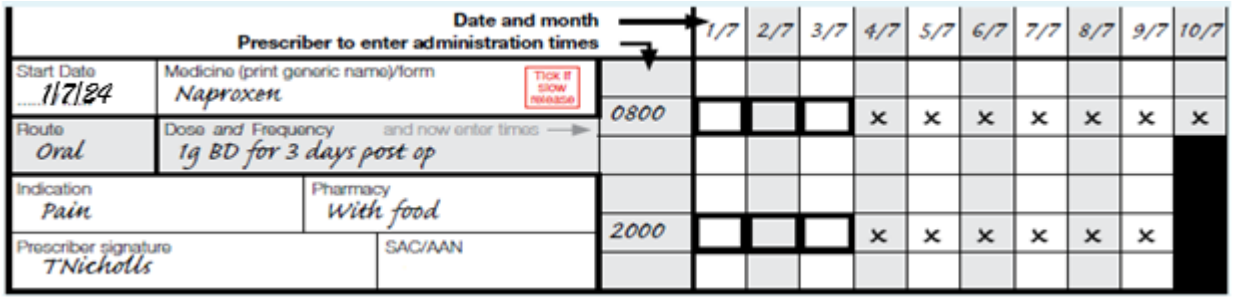
Slow Release box



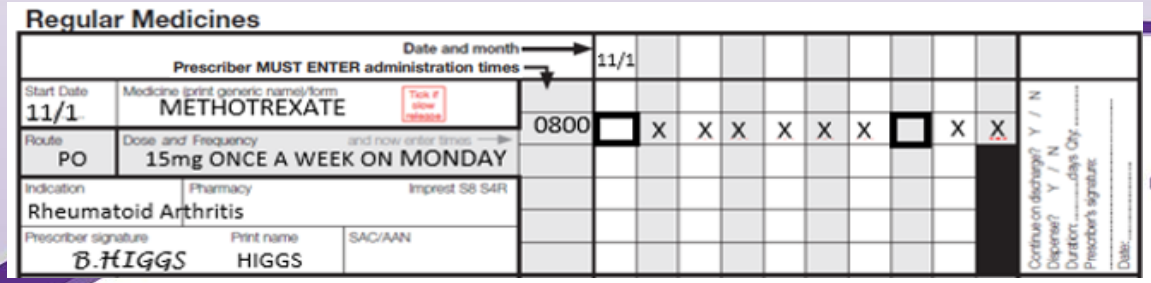
- The "Tick if Slow Release" box is included as a prompt to prescribers to consider whether or not the standard release form of the medication is required. This box must be ticked to indicate a sustained or modified release form of an oral medication (e.g. verapamil SR, diltiazem CD, metformin XR, tramadol 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.

Limited Duration or Intermittent Doses

- 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.



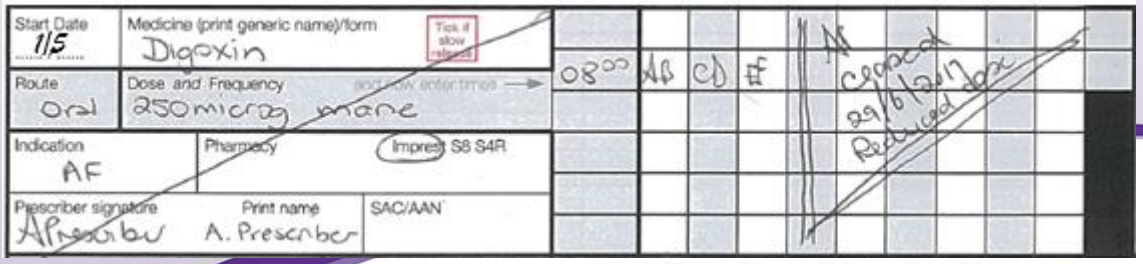
- When a medication is **ordered only on certain days**, this must be clearly indicated by documenting the day of administration as part of the prescription order (i.e. stipulate Monday if that is the day the medication is to be taken).
- The medication order must clearly distinguish between when the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



- better value

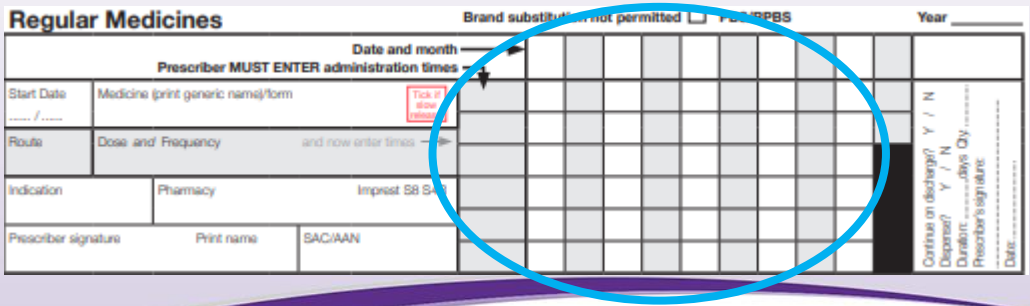
Ceased or changing medicines

- When ceasing a medication, the original prescription must NOT be removed or obscured.
- The prescriber must draw a clear diagonal line though the order and two diagonal lines through the administration record section
- Prescriber must write ‘ceased’, reason for ceasing, date and sign the ceased order.
- If a change to the medication order is required the above should be followed and complete a new entry on the chart



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.
- Remember the six Rights
  - The right **patient**
  - The right **medication**
  - The right **dose**
  - The right **time/frequency**
  - The right **route**
  - The right **documentation**



Reasons for Not Administering

- 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.
- The nurse/midwife is responsible for obtaining supply of a medication that is not available on the ward by contacting pharmacy
- The prescriber must be notified :
  - If a patient refuses a dose
  - If the medication is not available on the ward
- If a medication or dose is withheld, the reason must be documented in the patient's medical notes.

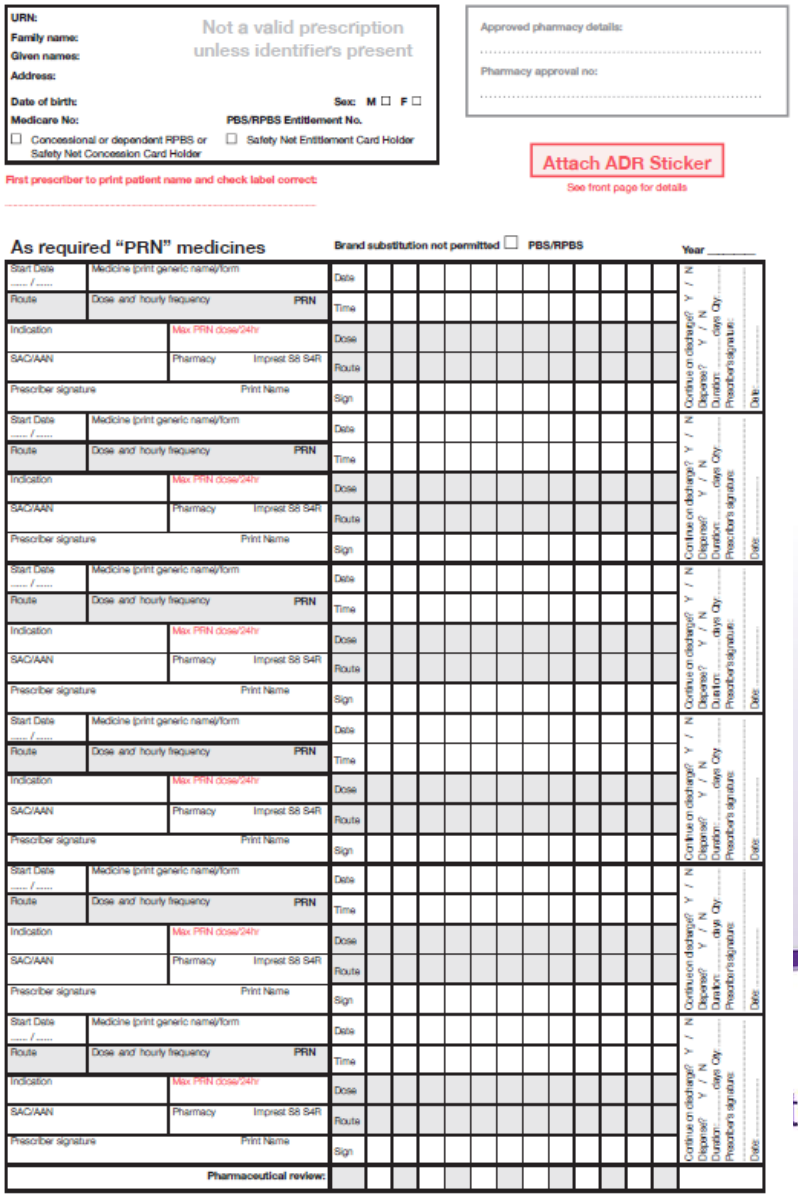
Reason for not administering Codes MUST be circled	
Absent	A
Fasting	F
On leave	L
Not available – obtain supply or contact prescriber	N
Refused – notify prescriber	R
Self administered	S
Vomiting	V
Withheld – enter reason in clinical record	W

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

- 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:
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

Approved pharmacy details:
Pharmacy approval no:

Attach ADR Sticker
See front page for details

First prescriber to print patient name and check label correct:

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 | Imprest S8 S4R
Prescriber signature | Print Name

(repeated)

Pharmaceutical review:

Date | Time | Dose | Route | Sign

Continue on discharge? Y / N
Dispense? Y / N Duration: ..... days Qty:
Prescribers signature:
Date:

Check if patient has another medication chart

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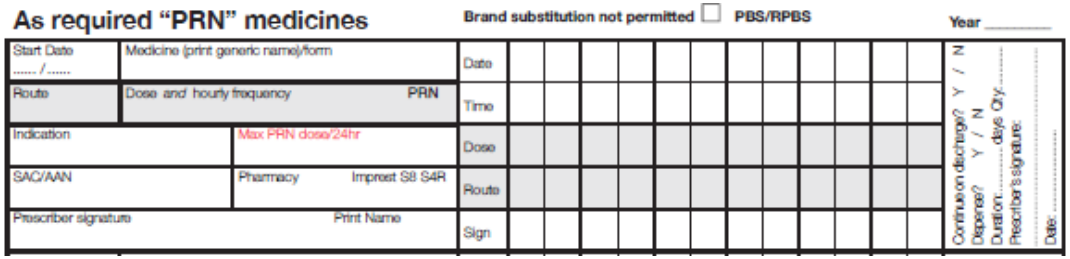
As required (PRN) Medicines

- Prescribing section must have the following complete:
  - Start date of prescription
  - Generic medicine name
  - Route of administration
  - Dose and hourly frequency
  - Indication and maximum daily dose
  - Prescriber's signature, printed name and contact details



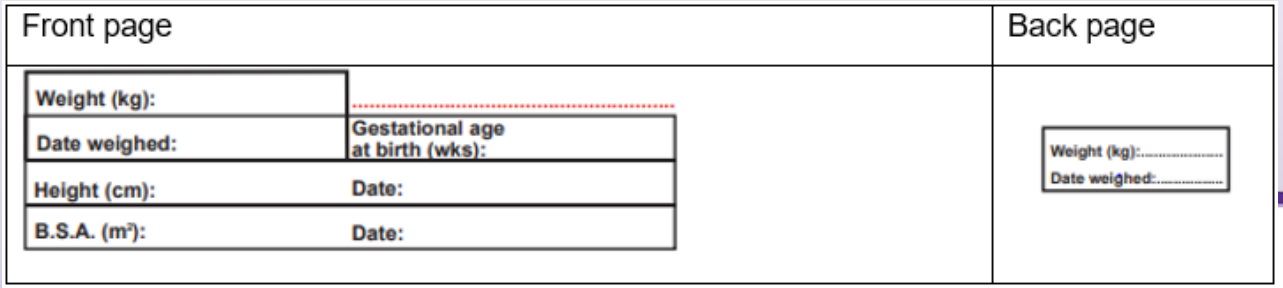
- Administration section the following must be documented:
  - Date
  - Time
  - Dose administered
  - Route of administration
  - Initial of person administering the dose
- Person checking each dose is responsible for
  - Checking maximum daily dose is not exceeded
  - Checking the timing of the previous dose

Multiple route orders

- Generally, medication orders should be written for ONE ROUTE only.
- 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 Drug and Therapeutics Committee (DTC) or equivalent, and appropriate risk mitigation strategies put in place

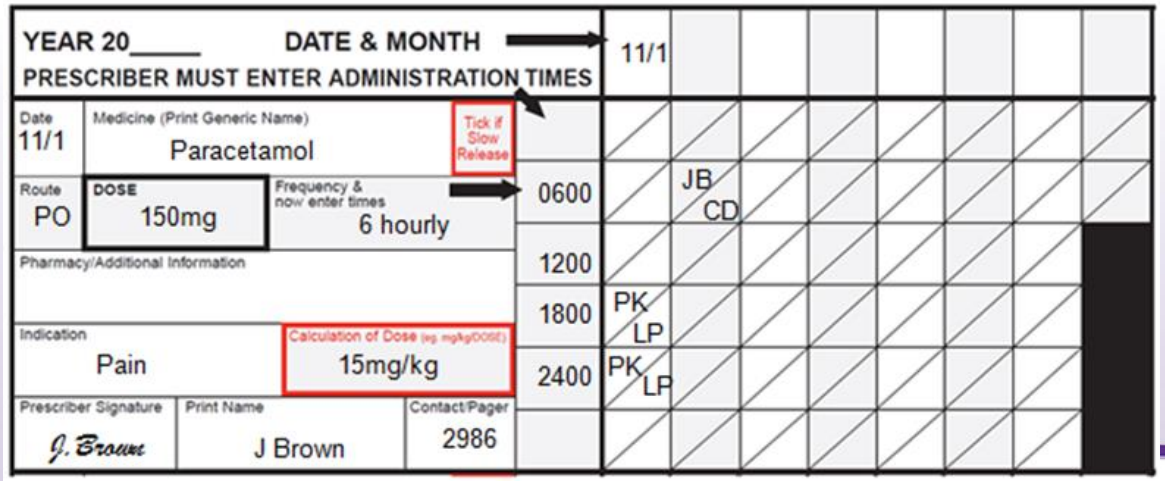
Special features of WA Paediatric NIMC

- The paediatric versions (both short stay and long stay versions) incorporate additional features identified as important for facilitating safe medications use in the paediatric and neonatal populations.
  - 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)



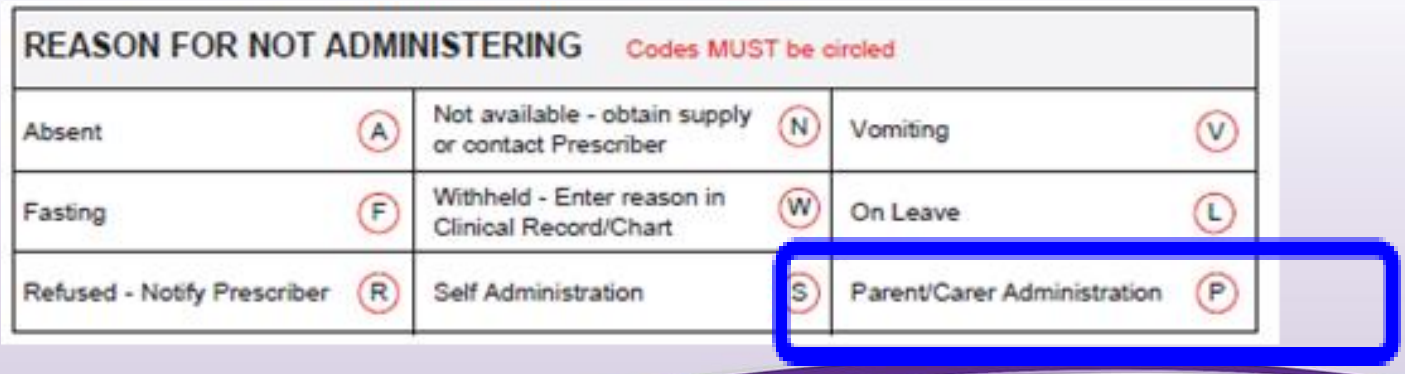
Special features of WA Paediatric NIMC

- Space for documenting the basis of dose calculation (e.g. mg/kg/dose)
- Space for double signing when recording administration



Special features of WA Paediatric NIMC

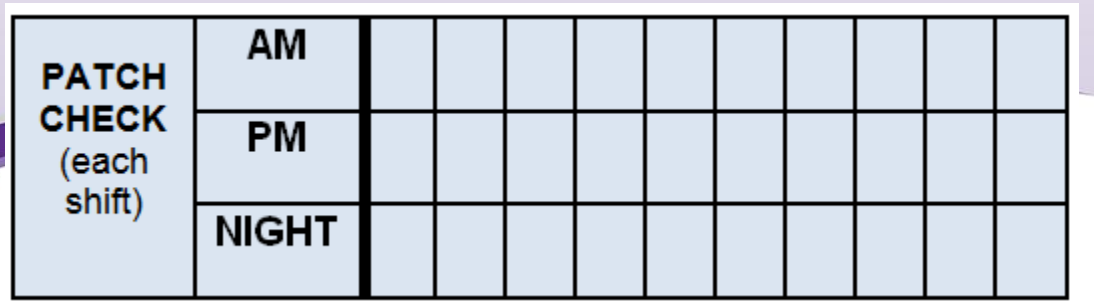
- Reason for Not Administering:
  - There is an additional code on the paediatric NIMC
  - This code indicates that the medication was administered by the paediatric patient's parent or carer



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

Transdermal Patch Check Sticker

- The transdermal patch check sticker ("the sticker") was developed to prompt nursing staff to check that:
  - the prescribed medication patch is securely intact on the patient's body, and
  - the correct medication patch is in situ at each shift, and
  - the correct strength patch is in situ at each shift.
- This sticker may be used for all medication patches that remain in situ for greater than 24 hours
- For further information please refer to the WA HMC user guide



Ordering and administrating miscellaneous products on the WA HMC

- The WA HMC or WA Paediatric NIMC is not designed for ordering and recording administration of nutritional supplements (oral or enteral).
- Some health services have a separate clinical nutrition chart for ordering and administering these products.
- 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 the ordering and recording administration of nutritional supplements.
- The WA HMC should not be used to order or administer medical gases such as oxygen, as these medications require specific features to safely order, administer and monitor their use.

Discharge Supply

- Use of the WA HMC for discharge dispensing remains at the discretion of the HSP.

- It **must not** preclude 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

Discharge Supply

- 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.
- 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.

PBS requirements

Prescribers should ensure that each medicine panel is completed in full.

- Write clearly in blue or black indelible pen (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.

PBS requirements

- 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:

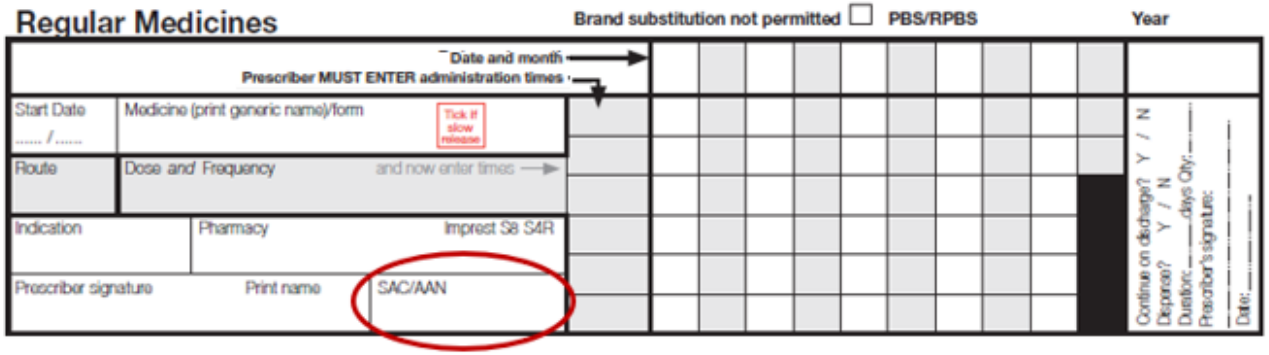
  - Is only required to be completed if the hospital is using the WA HMC for PBS claiming of discharge prescriptions

- Prescriber Details
  - For a valid PBS prescription this section MUST be completed

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

PBS requirements

- SAC/AAN



- **Streamline Authority Code (SAC)** – is the relevant 4 digit streamline code. Only the prescriber can provide this information

- Phone authority – a single PBS authority prescription number is printed on the WA HMC and must be used by the prescriber to obtain authority approval

- **Authority Approval Number (ANN)** –must be written in the box provided. Only the prescriber can provide this information.