

THE NATIONAL PAEDIATRIC INPATIENT MEDICATION CHART

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Clear communication about medication orders ensures that the right drug, in the right dose is given to the right patient at the right time. This will minimise harm to patients from preventable medication errors. Paediatric patients are particularly vulnerable.

To improve the safety and quality of medicines use nationally, the Australian Health Ministers Advisory Council (AHMAC) decided that all public hospitals in Australia would be using a common medication chart. The National Inpatient Medication Chart (NIMC) was developed by a multi-disciplinary national working party. Similarly, a nationally agreed paediatric version (paed-NIMC) has been developed, sharing many features with the original NIMC, but incorporating additional features important for facilitating safe medicines use in the paediatric population.

Short stay (5 days) and long stay (21 days) versions are available.

The Paediatric-NIMC is being implemented across all facilities providing paediatric care.

- A web-based self-directed education module is available to assist prescribers in familiarising themselves with general aspects of the NIMC at <http://nimc.nps.org.au/elearning/log/login.asp>
- This fact sheet highlights some of the more important new features of the Paed-NIMC for ready reference.
- Paediatric-specific educational resources are available.

What's different from the common NIMC being used in adults?

1. No designated section for ordering warfarin or variable dose medicines
2. Designated space for recording weight, height and BSA
3. Designated space for documenting basis for dose calculation (eg mg/kg/dose)
4. Need for double signing when recording administration, to document double checking

Clinicians providing both adult and paediatric services, should familiarise themselves with differences between the paediatric and adult versions of the NIMC.

Special features of the paediatric inpatient medication chart

1. **Patient details:** there are 2 areas on the **front and back** of the chart that need to be completed every time a new chart is used. If a patient addressograph label is used, the **1st prescriber must also print** the patient's name (below the label). This acts as a double check to ensure that the correct patient label has been attached.
2. **Adverse Drug Reaction (ADR)** information needs to be documented on the **front and back** of the chart. If there are no known drug reactions, then "nil known" should be documented on the chart. This section now requires details of any reaction to be documented so that more accurate information is available to all prescribers. This will ensure that a child is not re-exposed to a drug that may cause harm. (*see also SCH "Allergy and Adverse Drug Reaction (ADR) working party recommendations", Nov 2006*).

The documentation required includes:

- The **name** of the drug involved
- The **type of reaction** (eg anaphylaxis, diarrhoea) [*see SCH Table of ADR definitions and examples, Nov 2006*]
- **Date of reaction:** if a reaction has occurred more than 5 years ago, consider an immunology review of the patient's current allergy status
- **Who** has recorded this information. This is primarily the prescriber's responsibility (with nurses and pharmacists having an important supplementary role to ensure accuracy). Prescribers should endeavour to make sure that what is recorded here is appropriately verified ADR information. Information about who has verified the allergy/ADR (eg immunologist? GP? Other?) should be documented in the medical records.

3. There is a special box to document the patient's **accurate weight** just below the ID label. Check the ideal body weight if the patient is significantly overweight or oedematous. There is also space to document **height** and **body surface area** next to the weight.

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4. For regular medications, there are separate fields to enter the date (of the initial order), **printed generic name** of medicine, route, dose, frequency, **indication** (eg *co-trimoxazole for PCP prophylaxis or UTI*), prescriber signature, printed name and pager or contact number.
5. Additional important features of the new chart are:
 - Special box to document the **basis for the dose calculation** (eg mg/kg/dose or microgram/m²/dose etc). This dose should first be **checked in a current paediatric dosing reference** endorsed by the local DTC. e.g. [RCH Pharmacopoeia](#). Recording the dose here helps double-checking by pharmacists, nurses, and other doctors, ensuring that both the intended and actual dose calculated is correct.
 - The **actual dose** should be calculated using an **accurate weight or BSA** (up to the usual adult dose only).
 - Dose calculations should be double-checked using a calculator
 - Medication **administration times are now to be entered by the prescriber** at the time of prescribing. This is a major change in practice which is aimed to prevent errors in frequency of administration due to misinterpretation of the original order. Guidelines for recommended administration times are provided on the chart.
 - For infants and young children who have variable meal and sleep schedules, the prescriber should ideally **discuss with the patient's parent/carer and nurse** to determine an appropriate schedule for orally administered medicines for that patient before writing these on the chart.
 - This step will also further **enhance communication about the order**, which is important in preventing errors and harm.
 - Space for additional important information to be provided about the order (eg special advice from the **pharmacist** who has reviewed the order)
6. **Administration of the medicine**
 - is recorded by **two signatures, to document double-checking** process has occurred.
 - Reasons for nurse not administering the medicines should be recorded using the codes provided on the chart. e.g. "P" for administered by parent.
7. **To cease or change an order:**
 - draw a single line through the prescription (without obliterating it); and
 - a double diagonal line across the administration section; and
 - sign and date this section
 - include the reason for ceasing (eg changed dose, ceased, written in error etc)
8. When writing any prescription, use only standard **approved abbreviations**. Error-prone or dangerous abbreviations **MUST NOT** be used. The name of a medicine should **NOT** be abbreviated. See; *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines at NSWTAG at <http://www.ciap.health.nsw.gov.au/nswtag/publications/guidelines/TERMINOLOGY1206.pdf>*
9. There is a separate section for **PRN** medications on the **back** of the chart. In addition to the usual information, the **indication** for the order (eg *paracetamol for pain vs paracetamol for symptomatic fever > 38.5 °C*) and the **maximum daily dose** (eg *90 mg/kg/day vs 60 mg/kg/day*) should be recorded in the special boxes provided.
10. There are now also separate sections for once only, nurse initiated and telephone orders, as well as a section for recording medications given prior to hospital presentation (front of chart).
 - Please note that at SCH **telephone and verbal orders are not accepted**. However, verbal or phone orders from a prescriber who is onsite may be used in emergencies, for insulin, or during sterile procedures where ungloving would be impractical. In such cases, all of the relevant information in the "telephone orders" section of the chart should be documented for each order. This includes the need for **2 nurses to confirm and double check** the order.

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