Downtime - Documenting a Paper National Inpatient Medication Chart (NIMC) - PAEDIATRIC

Digital Health
CONNECTING BEST CARE

Digital Health
Quick Reference Guide

NIMC Overview (See Appendix A for full NIMC screenshots)

Section	Instruction
Patient Identification Affix patient identification label here and overleaf URN: Family name: Given names: Address: Not a valid prescription unless identifiers present Date of birth: Sex: M ☐ F ☐ First prescriber to print patient name and check label correct: Weight (kg): .... Height (cm):	Adhere patient identification label in the space provided (on ALL PAGES) or hand write the **patient name, UR number, date of birth** and **gender** in legible print
Patient weight and height Weight (kg): .... Date weighed: .... Height (cm): .... BSA (m²): .... Gestational age at birth (wks):	For a paediatric patient, also include when weight was measured, body surface area and gestational age at birth
Patient location Facility/service: .... Ward/unit:	Write patient's current location
NIMC numbering Medication chart number .... of	Write the number of NIMC in the sequence of active NIMCs e.g. 1 of 3
Additional charts Additional charts ☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other ☐ Palliative care ☐ Chemotherapy ☐ IV heparin	Indicate if additional specialist charts are in use
Allergies and ADR alert Attach ADR sticker Allergies and adverse drug reactions (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below) Medicine (or other) | Reaction / type / date | Initials Sign .... Print .... Date	Obtain and record allergies and ADRs in this section Tick **Nil known** if the patient is not aware of any previous ADRs or allergies. Tick **Unknown** if no information is available about previous reactions (e.g. if the patient is unable to communicate). Once completed, sign the space underneath, print name and date.

Once Only / STAT orders

Paediatric:

Once only medicines

Date prescribed	Medicine (print generic name)	Route	Dose	Date/time to be given	Prescriber: Signature	Prescriber: Print your name	Dose calc eg. mg/kg per dose	Given by	Date/time given	Pharm

Document once only orders with all relevant details in this section

Telephone Orders

Telephone orders (to be signed within 24 hours of order)

Date time	Medicine (print generic name)	Route	Dose	Frequency	Check initials N1	Check initials N2	Prescriber name	Pres. sign	Date	Record of administration: Time / given by	Time / given by	Time / given by	Time / given by
1/6/15	Frusemide	IV	20mg	Stat	AB	QT	P.Jones	PJones	2/6/15	10.00 AB			

Document telephone orders with all relevant details in this section

Variable Dose medicine

VARIABLE DOSE MEDICATION

Date | Medication (Print Generic Name)
Route | Frequency
Dr to enter dose time and individual dose
Indication | Pharmacy
Prescriber Signature | Print your surname | Contact

Drug level
When Level taken
Prescriber
AM: Dose / Time / Nurse initial / Time given
PM: Dose / Time / Nurse initial / Time given

Document variable dose medicine (e.g. prednisolone, levothyroxine) with all relevant details in this section

VTE Prophylaxis

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated: ☐
Surname: | Signature: | Date:
PRESCRIBER MUST ENTER administration times
Date | Medication (print generic name)
Route | Dose | Frequency & NOW enter times
Indication | Pharmacy
VTE prophylaxis
Prescriber Signature | Print your surname | Contact
Mechanical prophylaxis
Prescriber/NI Signature | Print your surname | Contact
AM Check
PM Check
Dispense? Yes / No

Medical staff need to complete VTE risk assessment as this is not checked on other charts

Check for other anticoagulants
Order chemo / mechanical prophylaxis if required
Nursing staff need to implement clinical intervention e.g. calf compression stockings or calf compressors
If no action is required, this must be acknowledged
Nurses need to check this section is completed

Warfarin

Date	WARFARIN (Marevan/Coumadin) select brand		DOSE TIME 1600 (4pm)	INR Result			
Route	Prescriber to enter individual doses	Target INR		Dose	mg	mg	mg
Indication		Pharmacy		Prescriber			
Prescriber Signature	Print your surname	Contact		Nurse 1			
				Nurse 2			

WARFARIN EDUCATION RECORD

Patient educated by: ....
Sign: ....
Date: ....
Given Warfarin book: ....
Sign: ....
Date: ....

Document warfarin order details within this section

Please review if patient have had recent education about Warfarin and their follow up INR review

Check which warfarin brand they are taking at this time

Regular Medications (except insulin)

Paediatric:

Date	Medicine (print generic name)		Tick if slow release		
11/1	Paracetamol				
Route	Dose	Frequency and NOW enter times		0600	JB/CD
PO	150mg	6 hourly			
Pharmacy/additional information				1200	
Indication	Dose calculation (eg. mg/kg per dose)			1800	PK/CD
Pain	15mg/kg			2400	PK/LP
Prescriber signature	Print your name	Contact/pager			
J. Brown	J. Brown	2986			

Document regular medications within this section (except for insulin).

Paediatric chart has an extra field to document the dose calculation. Prescriber must document the basis for the dose calculation in the dose calculation box (e.g. mg/kg/dose or microgram/m²/dose etc)

PRN Medications

Date	Medicine (print generic name)			Date	11/1
11/1/16	Paracetamol				
Route	Dose	Hourly frequency	Max PRN dose/24 hrs	Time	1400
PO	1g	4 hrly PRN	4g		
Indication	Pharmacy			Dose	1g
Pain	2 x 500mg I			Route	PO
Prescriber signature	Print your name	Contact		Sign	MS
M. Smith	M.Smith	8948			

Document PRN medications within this section

Insulin Orders

INSULIN ORDERS
Check supplemental/variable/stat orders
Contact HMO if BGL out of range
Mealtime insulin is given at start of meal

Time/Meal	Name of Insulin	Start date 18/2	Date of changed order (cross out previous dose) 19/2	/	/	/	YEAR 20 16 – Date and month of 18/2	19/2
0800	NOVORAPID	6 Units	6 Units	Units	Units	Units	6 Units	6 Units
Prescriber signature: Smith	Print your surname: SMITH	Pharmacy	Initial	Initial	Initial	Initial	AB	CD
1230	NOVORAPID	6 Units	6 Units	Units	Units	Units	6 Units	6 Units
Prescriber signature: Smith	Print your surname	Pharmacy	Initial	Initial	Initial	Initial	AB	CD
1730	NOVORAPID	6 Units	8 Units	Units	Units	Units	6 Units	8 Units
Prescriber signature: Smith	Print your surname	Pharmacy	Initial	Initial	Initial	Initial	EF	EF
0800	LANTUS	20 Units	20 Units	Units	Units	Units	20 Units	20 Units
Prescriber signature: Smith	Print your surname	Pharmacy	Initial	Initial	Initial	Initial	AB	CD
Time/Meal	Name of Insulin							

Document routine insulin orders within this section

Nurses to complete administration as per five rights of administration

Date and sign and write amount of insulin in the date and month section

Supplemental subcutaneous insulin

Supplemental subcutaneous insulin
Variable dose (sliding scale) insulin alone is NOT recommended - consider basal insulin requirements. If unsure, seek advice.

Name of insulin: NOVORAPID
Surname: SMITH
Sign: Smith
Frequency: ☑ With meals only ☐ 6 hourly ☐ Other (specify)

If BGL (mmol/L) is in range below then administer additional insulin	Start date 18/2	Date of changed order (Cross out previous order) /	/	/	/
0 - 4 or	0 Units	0 Units	0 Units	0 Units	0 Units
4.1 - 8 or	0 Units	Units	Units	Units	Units
8.1 - 12 or	2 Units	Units	Units	Units	Units
12.1 - 16 or	4 Units	Units	Units	Units	Units
16.1 - 20 or	6 Units	Units	Units	Units	Units
Pharmacist					

Align supplemental 'Date and month of Administration' to date above

Date	18/2
Time	1730
Dose	4 Units
Initial	EF

If patient is using a Continuous subcutaneous insulin infusion (CSII) pump: Insulin: carbohydrate ratio .... Insulin sensitivity factor .... Basal rate (units/hour) ....
Patient to self-administer insulin via CSII pump
Prescriber signature .... Print your surname .... Date ....

Document supplemental insulin within this section

Nurses to complete administration as per five rights of administration

Nurses need to review this section in conjunction with Blood Glucose

Please enter the date, time, number of units and initials post administration (pertaining to the amount insulin administered off this order)

Pharmaceutical Review

Pharmaceutical review:

This section is for pharmacist to Review the NIMC to ensure that all orders are clear, safe and appropriate for the patient and initial the space on the correct day.

Reference:
[National Inpatient Medication Chart (NIMC) - User Guide | Australian Commission on Safety and Quality in Health Care]

Appendix A

Paediatric NIMC:

Affix patient identification label here

URN:
Family name:
Given names:
Address:
Not a valid prescription unless identifiers present
Date of birth: Sex: ☐M ☐F
First prescriber to print patient name and check label correct:

Attach ADR sticker
See front page for details

As required PRN medicines

Weight (kg):
Date weighed:
Ward/unit:

Cut off section

Paediatric Medication chart number ___ of ___
Facility/service:
Ward/unit:
Additional charts: ☐IV fluid ☐BGL/insulin ☐Acute pain ☐IV heparin ☐Inhalation ☐Palliative care ☐Chemotherapy ☐Other

Once only medicines

Telephone orders (to be signed within 24 hours of order)

Medicines taken prior to presentation to hospital (prescribed, over the counter, complementary) Own medicines brought in? ☐Y ☐N

Not for administration

Paediatric Medication Chart

WHAD271.3

Not a valid order unless legible

DO NOT WRITE IN THIS BINDING MARGIN

ALL AND PROOF

Cut off section

Attach ADR sticker

Allergies and adverse drug reactions (ADR)
☐Nil known ☐Unknown

Affix patient identification label here and overleaf

Regular medicines

Year 20__ Date and month
PRESCRIBER MUST ENTER administration times

Recommended administration times (Guidelines only)

SR = Sustained, modified or controlled release formulation. If scored tablet, then half can be given. Dose must be swallowed without crushing.

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

Pharmaceutical review: