

Downtime - Documenting a Paper National Inpatient Medication Chart (NIMC) – ADULT (>16 years)



NIMC Overview (See Appendix A for full NIMC screenshots)

<p>Patient Identification</p> <p>Affix patient identification label here and overleaf</p> <p>URN:</p> <p>Family name: Not a valid prescription unless identifiers present</p> <p>Given names:</p> <p>Address:</p> <p>Date of birth: Sex: M <input type="checkbox"/> F <input type="checkbox"/></p> <p>First prescriber to print patient name and check label correct: Weight (kg): Height (cm):</p>	<p>Adhere patient identification label in the space provided or hand write the patient name, UR number, date of birth and gender in legible print</p>															
<p>Patient weight and height</p> <p>Adult:</p> <p>Weight (kg): Height (cm):</p>	<p>Document patient's weight and height</p>															
<p>Patient location</p> <p>Facility/service:</p> <p>Ward/unit:</p>	<p>Write patient's current location</p>															
<p>NIMC numbering</p> <p>Medication chart number of</p>	<p>Write the number of NIMCs in the sequence of active NIMCs</p> <p>e.g. 1 of 3</p>															
<p>Addition charts</p> <p>Additional charts</p> <p><input type="checkbox"/> IV fluid <input type="checkbox"/> BGL/insulin <input type="checkbox"/> Acute pain <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Palliative care <input type="checkbox"/> Chemotherapy <input type="checkbox"/> IV heparin</p>	<p>Indicate additional specialist charts in use</p>															
<p>Allergies and ADR alert</p> <p>Attach ADR sticker</p> <p>Allergies and adverse drug reactions (ADR)</p> <p><input type="checkbox"/> Nil known <input type="checkbox"/> Unknown (tick appropriate box or complete details below)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Medicine (or other)</th> <th style="width: 40%;">Reaction / type / date</th> <th style="width: 30%;">Initials</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Sign Print Date</p>	Medicine (or other)	Reaction / type / date	Initials													<p>Obtain and record previous allergies and ADRs in this section</p> <p>Tick Nil known if the patient is not aware of any previous ADRs or allergies.</p> <p>Tick Unknown if no information is available about previous reactions (e.g. if the patient is unable to communicate).</p> <p>Once completed, sign the space underneath, print name and date.</p>
Medicine (or other)	Reaction / type / date	Initials														



Once Only / STAT orders

Adult:

Once only and nurse initiated medicines and pre-medications									
Date prescribed	Medicine (print generic name)	Route	Dose	Date/time of dose	Prescriber/Nurse Initiator (NI)		Given by	Time given	Pharmacy
					Signature	Print your name			

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		Prescriber name	Pres. sign	Date	Record of administration					
					N1	N2				Time / given by	Time / given by	Time / given by	Time / given by		
1/6/15	Frusemide	IV	20mg	Stat	AB	QT	P. Jones	P. Jones	2/6/15	10.00	AB				

Document telephone orders with all relevant details in this section

Variable Dose medicine

VARIABLE DOSE MEDICATION			Drug level						
Date	Medication (Print Generic Name)		When Level taken						
			Prescriber						
Route	Frequency <small>Dr to enter dose time and individual dose</small>		Dose						
			Time						
			Nurse initial						
Indication	Pharmacy		Time given						
			Dose						
			Time						
Prescriber Signature	Print your surname	Contact	Nurse initial						
			Time given						

Document variable dose medicine 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: **VTE prophylaxis** Pharmacy: _____

Prescriber Signature: _____ Print your surname: _____ Contact: _____

Mechanical prophylaxis: _____ AM Check: _____ PM Check: _____

Dispensed? 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) <small>select brand</small>		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				

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

WARFARIN EDUCATION RECORD	
Patient educated by:	
Sign:	
Date:	
Given Warfarin book:	
Sign:	
Date:	

Regular Medications (except insulin)

Adult:

Date	Medicine (print generic name)	<input type="checkbox"/> Tick if slow release						
Route	Dose	Frequency and NOW enter times						
Indication	Pharmacy							
Prescriber signature	Print your name	Contact						

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

Paediatric:

Date	Medicine (print generic name)	<input type="checkbox"/> Tick if slow release						
Route	Dose	Frequency and NOW enter times	0600					
Pharmacy/additional information			1200					
Indication	Dose calculation (eg. mg/kg per dose)		1800					
Prescriber signature	Print your name	Contact/pager	2400					

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					
Route	Dose	Hourly frequency	Time	1400				
Indication	Pharmacy		Dose	1g				
Prescriber signature	Print your name	Contact	Route	PO				

Document PRN medications within this section

