Medication Safety Audit Tools Definitions

The following definitions and examples apply to the Medication Safety Audit Tools:

1. National Inpatient Medication Chart (NIMC), Paediatric National Inpatient Medication Chart (PNIMC) and Medication Action Plan (MAP)
2. Medication History
3. Allergies and Adverse Drug Reactions (ADR)
4. VTE Risk Assessment
5. Prescribing Intravenous Fluids and Electrolytes for Adults (4th Edition)
6. Guidelines for Anticoagulation using Warfarin (Version 7)
7. IV Line Labelling
8. Consumer Medicine Information (CMI)

1. National Inpatient Medication Chart (NIMC), Paediatric National Inpatient Medication Chart (PNIMC) and Medication Plan (MAP)

There are a number of questions on the audit tools targeted at documented evidence on the NIMC, PNIMC or MAP. Screen shots of each of the 3 documents are displayed below.
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value 1</td>
<td>Value 2</td>
<td>Value 3</td>
</tr>
<tr>
<td>Value 4</td>
<td>Value 5</td>
<td>Value 6</td>
</tr>
<tr>
<td>Value 7</td>
<td>Value 8</td>
<td>Value 9</td>
</tr>
<tr>
<td>Value 10</td>
<td>Value 11</td>
<td>Value 12</td>
</tr>
</tbody>
</table>

*Note: This is a sample table to illustrate the format.*
2. Medication History

Questions 1.0 & 1.1 on the patient audit tool require evidence of a medication history. The Medication History can be documented in the Medicines Prior to Presentation to Hospital section located either at the bottom of page 1 of the NIMC OR, alternatively, in the Medication Action Plan (MAP) form.

**NIMC - Medicines Prior to Presentation to Hospital section**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose &amp; frequency</th>
<th>Duration</th>
<th>Speciation</th>
<th>Dose &amp; frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Not for administration*

**MAP - Medicines Prior to Presentation to Hospital section**

For the medication history section to be complete, the Medicines Prior to Presentation to Hospital section needs to be recorded on at least one medication chart or MAP form that is in current use.

A complete medication history requires:

- drug identification details (generic name, strength and form)
- dose and frequency
- duration of therapy, i.e. when started
- the person documenting the history has signed, printed their name and dated the entry
3. Allergies and Adverse Drug Reactions (ADR)

Questions 3.0 & 3.1 on the patient audit tool require evidence of medication allergies and adverse drug reactions.

The allergies and adverse drug reactions section is located in the top left corner of the NIMC.

For this section to be complete, either:

- ‘Nil Known’ box is ticked
- OR the ‘Unknown’ box is ticked
- OR the name of the drug / substance, the reaction details (e.g. rash, nausea) and the date the reaction occurred or approximate timeframe (e.g. “20 years ago”) is documented.

In the case where an adverse reaction is documented, an ADR alert sticker must also be attached on the front and back page of the NIMC and the person documenting the ADR status must have signed, printed their name and dated the entry on all NIMCs in use.
4. VTE Risk Assessment

Questions 7.0 & 7.1 on the patient audit tool require evidence of a Venous Thromboembolism (VTE) risk assessment. VTE comprises deep vein thrombosis (DVT) and pulmonary embolism (PE). It is a significant problem for medical and surgical patients, leading to an increased risk of morbidity and mortality. Options for thromboprophylaxis include anticoagulants and mechanical prophylaxis.

The NIMC facilitates the prescribing of these prophylaxis methods by providing:

- an area to document that the patient’s VTE risk has been assessed and to record contraindications to VTE prophylaxis as relevant
- a designated section for prescribing of anticoagulants for VTE prophylaxis
- a designated section for the prescribing of mechanical prophylaxis such as graduated compression stockings or intermittent pneumatic compression devices

For this section to be complete:

- the VTE risk assessed box is signed and dated on the NIMC/medication chart
- the VTE risk assessment is clearly documented on a site specific chart.

An example of a site specific chart for documenting VTE risk assessment
5. Prescribing Intravenous Fluids and Electrolytes for Adults (4th Edition)

Question 5.0 on the patient audit tool requires evidence of the ‘Prescribing Intravenous Fluids and Electrolytes for Adults’ guideline at the bedside.
6. Guidelines for Anticoagulation using Warfarin (Version 7)

Question 6.0 on the patient audit tool requires evidence of the ‘Guidelines for Anticoagulation using Warfarin’ at the bedside.
7. IV Line Labelling

Questions 9.0 and 9.1 on the patient audit tool requires the correct line labelling for all peripheral IV lines.
Labelling of injectable medicines and fluids, and the devices used to deliver them, has been identified as a patient safety issue. The ACSQHC has developed National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines (the Labelling Recommendations) to improve safety in this important practice area.

**Intravenous Lines**
When auditing, check if the line labels (as pictured below) are applied to all of the patient’s intravenous line(s).

For the line label question to be complete, the label should be positioned near the line’s injection port on the patient side (see photo), for ALL peripheral IV lines.

![Label near the injection port on the patient side.](image)

*All peripheral IV lines should include this label*
8. Consumer Medicine Information (CMI)

Question 7.0 on the ward/unit audit tool and Question 12.0 on the patient audit tool are associated with the provision of medicine information leaflets, such as consumer medicine information (CMI). An example of a CMI on Aspalgin is displayed below.

Further information can be found at:


- Queensland Health staff can access information on Medication Safety via the Queensland Health intranet Medication Services Queensland website.
We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a ‘Work in Progress’, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.

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