SAFE PRESCRIBING GUIDELINES - SCH

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- These guidelines outline the use of safe and standardised prescribing practices to minimise medication errors and their impact on patient safety at SCH-Randwick.

CHANGE SUMMARY

- Replaces SCH.C.20.12 – Safe Prescribing Guidelines and SCH.C.5.1 Prescribing Medications.
- Inclusion of requirements for:
  - Best Possible Medication History (BPMH),
  - Medication reconciliation
  - External prescriptions including PBS Authority

READ ACKNOWLEDGEMENT

- The following staff are to read and acknowledge this document:
  - All staff of SCH-R who are involved in the provision of medications.
  - Department Heads and Nursing Unit Managers at SCH-R.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure & Guideline Committee	SCH MAG, July 2012
Date Effective:	1st October 2016	**Review Period:** 3 years
Team Leader:	Senior Pharmacist	**Area/Dept:** Medicines Advisory Group

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This Guideline may be varied, withdrawn or replaced at any time.

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Background

Clear communication of medication orders minimises medication errors. Prescribers are encouraged to use these simple and standardised prescribing guidelines in order to ensure medication orders are clear and that the right drug in the right dose is given to the right patient at the right time, all the time.

General Safe Prescribing Tips

Gather Information

- Take a comprehensive medication history
- Know the patient's current drug therapy and reason for using each drug
- Access adherence to current and past medications and reasons for any non-adherence

Decision Making and Communication

- Check potential drug interactions, co-morbidities and side effects before prescribing a new medication
- Be specific, identify the drug, form, route, dose, frequency and duration of treatment
- Write legibly in ball point pen (printing in CAPITALS is ideal)
- Indicate the timing of any drug levels required
- Do not use verbal orders
- Minimise the number of active medication charts per patient.

  If there are multiple charts, annotate "1 of 2, 2 of 2…etc" and modify appropriately as therapy changes.
- Communicate decisions to other health care professionals and patients

Monitor and Review

- Review control of symptoms and signs, patient's outcomes, and drug levels

Medication History

Best Possible Medication History (BPMH)

The BPMH should be initiated by medical, nursing or pharmacy staff as soon as possible in the episode of care to ensure timely appropriate medication management. BPMH includes:

- A list of medications including recently started, ceased or changed medication (generic name, dose, route, strength and formulation, date of initiation and indication, over the counter and complementary medications)
- The source(s) of the information (at least two sources)
  - E.g. an interview with the patient and/or their carer confirmed using another available source.

Medication Reconciliation

The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care the verified information is transferred to the next care provider

For information on BPMH and Medication Reconciliation see Medication Reconciliation Procedure-SCHN

National Inpatient Medication Chart (NIMC)

Patient Information

Each Medication Chart Should Clearly Show:

- Patient's name and Medical Record Number
- Name of Admitting Medical Officer
- Date of birth

If addressograph sticker is used the first prescriber **must** print the patient's name on the chart in the space provided.

Adverse drug reactions (ADR)

Verified ADRs including allergies, must be documented by writing the medication name, type of reaction and date of occurrence in the ADR box (Figure 1).

The ADR sectionof the chart must not be left blank.

If ADR status is unknown, or there are nil known ADRs this must be documented.

- Tick Unknown if no information is available about previous reactions (e.g. if the patient is unable to communicate
- Tick Nil known if the patient is not aware of any previous ADRs or allergies.

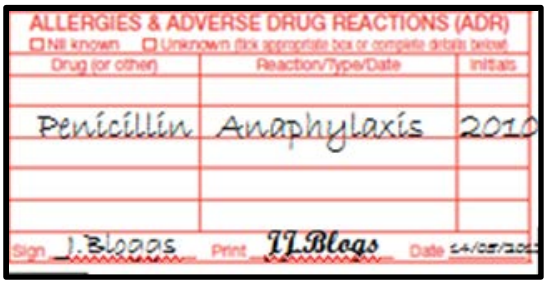


Figure 1 ADR documentation requirements for medication charts

Weight and Body Surface Area

- Document accurate weight or body surface area (BSA) including the date the weight was measured.
- Weight must also be documented on the back page of the chart where PRN medicines are ordered.

If a patient is overweight or oedematous ideal body weight should be checked.

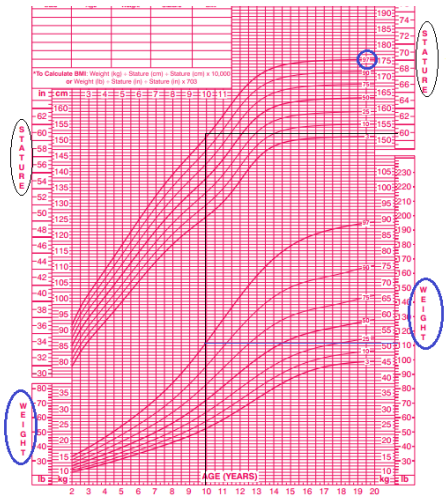


Figure 2 Sample Growth Chart

For ideal body weight where the age and height are known:

- Use a stature-for-age growth chart to find the patient's percentile.
- Use the percentile on the weight-for-age chart together with the age chart to read the "ideal" weight. (Figure 2)
- If the patient's height is not known or cannot be measured use the 50th percentile as a rough guide.

For underweight children drug dosing should be based on total body weight (TBW) taking into consideration general nutritional status and precautions regarding possible altered drug clearance e.g. renal and hepatic function

Gestational Age

- Gestational age at birth should be documented for premature infants under the BSA and height box.

Medication Order Requirements:

Date of prescription or amendment

Medication name

- Use generic medication name unless a combination product is used e.g. Pentavite®
- Do NOT use abbreviations for medication names eg MTX (write out methotrexate), AZA (write out azathioprine), GCSF (specify filgrastim, lenograstim, pegfilgrastim etc)
- Chemical names eg KCL can be easily confused or misread and should never be used. Chemical names should be written out in full eg "potassium chloride"
- Clarify form and strength (e.g. hydrocortisone 1% cream vs eye drops)
- Use the *Tick if Slow Release* box to indicate a sustained, modified or controlled release form of an oral drug (*e.g. verapamil SR, Diltiazem CD*).

Route

- Only commonly used and understood abbreviations should be used to indicate the route of administration.

Error prone abbreviations associated with routes of administration should NEVER be used
Use subcut OR write out subcutaneous, DO NOT USE SC
Use subling OR write out sublingual, DO NOT USE SL

Indication

- Indication must be specified for all medication orders. It ensures effective communication to other staff and allows the order to be reviewed in the correct context, reducing the risk of misinterpretation.
  - e.g. PRN medication (e.g. paracetamol for symptomatic fever > 38.5°C)
  - e.g. trimethoprim sulfamethoxazole for PCP prophylaxis or UTI

Dose

- Check doses in a current local guideline or paediatric dosing reference available from the SCHN clinical resources page OR CIAP eg:
  - Australian Medicines Handbook Children's Dosing Companion
  - British National Formulary for Children
  - Uptodate©
  - Children's Hospital Westmead Drug Doses Guide (note: recommendations may vary with local SCH guidelines)
- Calculate the dose using accurate weight or BSA (up to the maximum adult dose) with consideration of the most appropriate weight (ideal or actual). See SCH Drug Dosing in Obesity Guideline for recommendations on the appropriate dosing weight for commonly prescribed medications
- Round doses to allow practical administration eg consider whether safe to round to nearest whole number or dosage unit
- Include the basis for dose calculation in the dose calculation box (e.g. 15mg/kg/dose) to assist pharmacists, nurses and other doctors in double-checking the dose to ensure that the intended and actual dose is calculated correctly. ***Prescribers must double check their calculations***.
- Adjust dose for renal or hepatic impairment if needed.

Error Prone Prescribing : Dose

NEVER use trailing zeros which can lead to ten-fold errors

ALWAYS use leading zeros

e.g. 0.1 mg NOT .1 mg; 15 mg NOT 15.0 mg

NEVER use "mcg" or "µ" or "ug"

ALWAYS use "microg" OR write out micrograms in full

NEVER use IU or U which have been known to cause significant harm and admission to hospital

ALWAYS use "units" written out in full

- Give specific dosage instructions – dose strength, route and frequency
- Express dosage strength in exact units (not mL or number of tablets)
  - e.g. carbamazepine 100 mg, rather than 5 mL or i tablet
- Use words or numbers (1, 2, 5 etc) rather than roman numerals (i, ii, v)

Frequency and administration times

- The prescriber writing the order **must** enter the **frequency** and **administration time(s)** when writing the medication order.
- Administration times should be entered using the 24-clock (e.g. 18:00)
- Once daily medication times should specified in the prescription eg 'morning', 'midday', at night' based on patient preference, timing of food and other medications and the nature of the medication

Error Prone Prescribing: Frequency

If 'daily' is used this should be written out in full. Abbreviations OD or QD are ambiguous and must not be used

Avoid fractions eg 1/7 may be understood to mean one seventh, once a day, for one day, once a week, for one week

Medications which are not given every day (Figure 3)

- If medications are given once or twice a week, the actual days should be stated. e.g. methotrexate on MON only
- Cross out days when drug is not to be given on the administration record section of the chart.

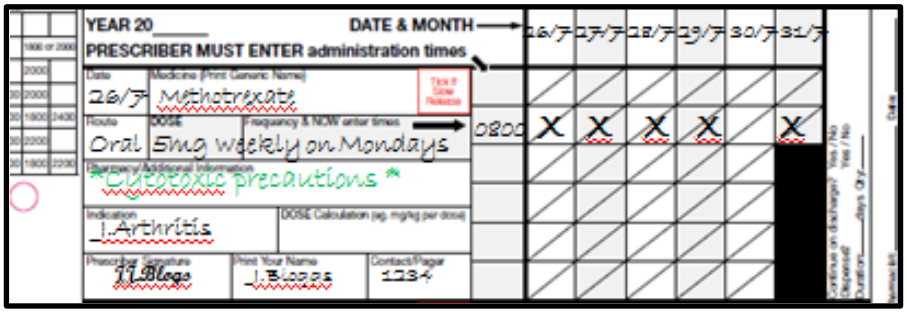


Figure 3 Forcing function for non-administration days

Duration of therapy

- Specify the duration intended on the medication chart where relevant
- Cross out subsequent days if the stop date is definitive OR note the time for review on the medication chart (e.g. intended duration for a course of antibiotics)

Prescriber identification

- Sign each order separately
  - **Print** surname and **pager number** next to signature on each page of the medication chart

As required (PRN) orders

Medications charted on the back section of the NIMC for use as required must include:

- Hourly frequency (prn alone is not sufficient)
- Maximum number of doses in 24 hours
- Maximum number of doses, or the maximum duration of treatment (except where the order is intended for the duration of the medication chart)
    - e.g. morphine 5 mg IV prn for severe pain x 10 doses

Prescribers should carefully check medication charts for duplications on either additional PRN charts OR regular orders

Ceasing /changing orders

- Regularly review the medication chart and discontinue orders no longer needed
- To cease an order (See Figure 4);
    - The original order must not be obliterated
    - draw a single line through the order; and
    - a line across the administration section ensuring that the line does not impinge on other orders; and
    - write the reason for changing the order (eg cease, written in error, dose increase etc) at an appropriate place in the administration record section
    - sign and date this section
- To change an order, cease the first order and re-write a new order

Note: The acronym D/C should not be used for ceased orders since this can be confused with discharge. Always use Cease or Ceased

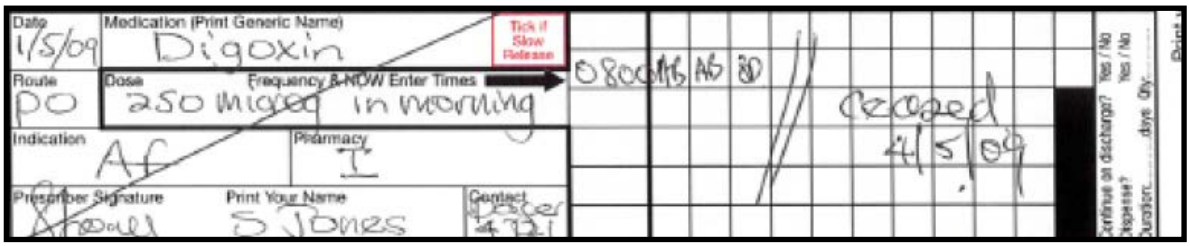


Figure 4 Ceased medication order

Verbal medication orders

Verbal orders are restricted to two situations:

- **Insulin orders prescribed over the phone by the Endocrine team**

Nursing staff who receive insulin orders by telephone must have the prescriber repeat and verify the order to a second nursing staff member.

This is then documented with dual initials on the insulin order chart.

- **Emergency resuscitation**

The verbal order is documented by the nurse and the medication order is confirmed again with the prescriber immediately before the medication is given.

All verbal orders need to be identifiable and subsequently physically signed off by the prescriber who should complete this as soon as practical.

Discharge and Outpatient Prescriptions

Clearly indicate the number of tablets, capsules, etc. required and the number of repeats needed, and **do not use** abbreviations such as 'Max. Qty', 'M.Q.', or 'M.R.'.

Medication Supplied from Sydney Children's Hospital Pharmacy

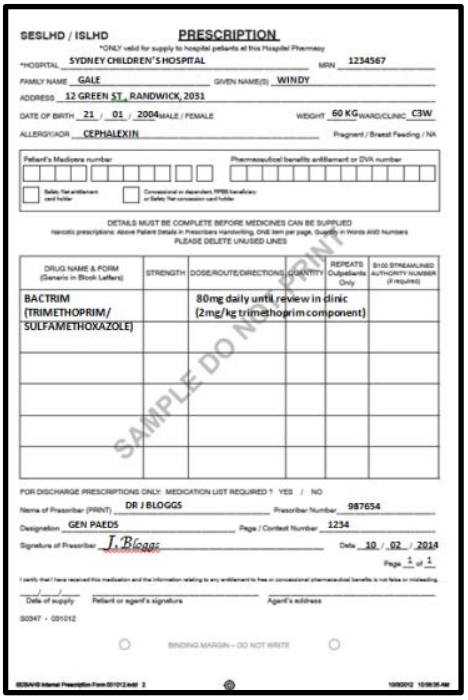
On discharge SCH pharmacy will provide up to one week of supply for new regular medications available on the pharmaceutical benefits scheme (PBS). The pharmacy can supply up to one week of regular, continuing medications if needed.

Ongoing supply of PBS items is to be obtained from the patient's local pharmacy.

Non-PBS items including oral liquids manufactured by SCH may be obtained from SCH on an ongoing basis where use is concordant with the hospital formulary.

Hospital discharge or outpatient prescriptions (Figure 5) cannot be used externally with PBS reimbursement but may be used as a private prescription.

Fees associated with private prescriptions are determined by individual pharmacies.


SESLHD / ISLHD PRESCRIPTION

*HOSPITAL SYDNEY CHILDREN'S HOSPITAL MRN 1234567

FAMILY NAME GALE GIVEN NAME(S) WINDY

ADDRESS 12 GREEN ST, RANDWICK, 2031

DATE OF BIRTH 21 / 01 / 2004 MALE / FEMALE WEIGHT 60 KG WARD/CLINIC C3W

ALLERGY/ADR CEPHALEXIN Pregnant / Breast Feeding / NA

Patient's Medicare number Pharmaceutical benefits entitlement or DVA number

DETAILS MUST BE COMPLETE BEFORE MEDICINES CAN BE SUPPLIED

PLEASE DELETE UNUSED LINES

DRUG NAME & FORM (Generic in Block Letters)	STRENGTH	DOSE/ROUTE/DIRECTIONS	QUANTITY	REPEATS Outpatients Only	S100 STREAMLINED AUTHORITY NUMBER (If required)
BACTRIM (TRIMETHOPRIM/ SULFAMETHOXAZOLE)		80mg daily until review in clinic (2mg/kg trimethoprim component)			

SAMPLE DO NOT PRINT

FOR DISCHARGE PRESCRIPTIONS ONLY: MEDICATION LIST REQUIRED ? YES / NO

Name of Prescriber (PRINT) DR J BLOGGS Prescriber Number 987654

Designation GEN PAEDS Page / Contact Number 1234

Signature of Prescriber J. Bloggs Date 10 / 02 / 2014

Page 1 of 1

Date of supply Patient or agent's signature Agent's address

S0047 - 051012

BINDING MARGIN – DO NOT WRITE

Figure 5 SCH Discharge/ Outpatient Prescription

Schedule 8(S8) Prescription Requirements

Pre-printed 'addressograph' labels cannot be used for S8 prescriptions

Each S8 medications must be written on an individual prescription. Prescriptions for S8 medications must not include any other orders eg regular medications or another form or strength of the same Schedule 8 medication

Each prescription must include:

The patient's name and address written by hand by the prescriber

- The quantity of medication in both figures and words
    - Eg *20 (twenty) tablets OR 20mL (twenty millilitres) for a liquid*
- The interval for repeat dispensing (if applicable)
- Prescription for dexamphetamine or methylphenidate require additional authority.
- Refer to NSW Health Policy Directive "Medication Handling in NSW Public Health Facilities" for more information

PBS prescribing

There are instances where a prescription must be filled by an external pharmacy. In this scenario prescribers must ensure prescriptions meet the requirements of a PBS prescription (Figure 6) including:

1. Name and practice address
2. Prescriber number
3. Patient's name and address
4. Indicate the box that is relevant to your patient (ie PBS)
5. Name, strength and form of medicine
6. Dose or instructions for use
7. Quantity and number of repeats, no abbreviations
8. Your signature
9. Date prescription is written – *forward or back dating is not permitted*
10. If appropriate, tick 'Brand substitution not permitted' box
11. Medicare and concession card numbers

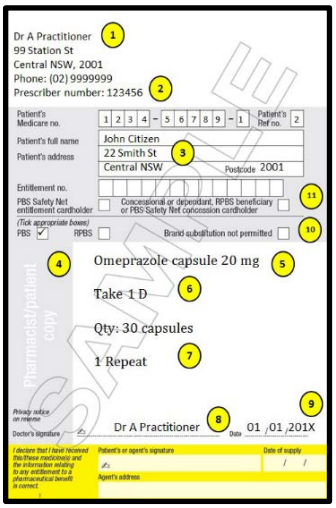


Figure 6 PBS Prescription

A maximum of 3 items from the "unrestricted" or "restricted" schedule may be written on each prescription.

If the maximum PBS quantity is insufficient to provide one month of therapy, or repeats are insufficient for 6 months due to higher than normal dose the prescriber may apply for a PBS Authority by telephone.

Authority PBS Prescriptions

Each Authority required PBS item must be written on an Authority PBS prescription form, one item per form.

In order to be processed the authority prescriptions require (Figure 7):

12. Authority prescription number – this is used by the pharmacy as a reference when dispensing an approved PBS authority prescription and any repeats from that prescription. You will be required to quote the authority prescription number when applying for telephone approvals

13. Authority approval number – this is the approval number given by the PBS and is essential for Authority required medicines. For Authority required (STREAMLINED) medicines, write the 4 digit streamlined authority code from the Schedule

If authority is granted via telephone the prescriber must notify the PBS if the medication is ceased. A single patient cannot have multiple telephone authorities for the same product at any one time.

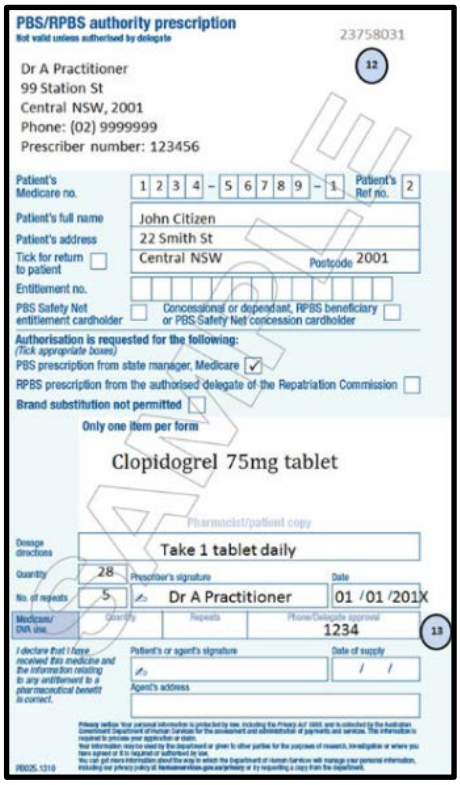


Figure 7 Authority PBS prescription

For more information on PBS prescribing see the Pharmacuetical Benefits Scheme Website

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