Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC)

User Guide

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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Definitions and abbreviations

Term/Acronym	Definition
ACSQHC (the Commission)	Australian Commission on Safety and Quality in Health Care
APN	Authority Prescription Number
Approved Hospital Authority	A hospital authority (for a private or public hospital) approved under section 94 of the *National Health Act 1953* (or otherwise approved under that Act) to supply pharmaceutical benefits
Approved Medical Practitioner (APM)	A medical practitioner approved under section 92 of the *National Health Act 1953* to supply pharmaceutical benefits (dispensing doctor)
Approved Pharmacist (AP)	A pharmacist approved under section 90 of the *National Health Act 1953* to supply pharmaceutical benefits (community pharmacy)
Approved Supplier	Approved Hospital Authority and Approved Pharmacist, being the only approved PBS HMC suppliers
Claiming	Claims lodged by an approved hospital authority or an approved pharmacist for payment of PBS/RPBS claims for listed PBS/RPBS items, for PBS/RPBS eligible patients in PBS/RPBS appropriate settings only
The Commission	Australian Commission on Safety and Quality in Health Care
Controlled Drug (Schedule 8 item)	A substance that should be available for use, but requires restriction of supply to reduce abuse, misuse and physical or psychological dependence as defined under the *Poisons Standard 2010*. These items include pharmaceutical benefits that attract a Dangerous Drug fee.
Department of Health (the Department)	Australian Government Department of Health
DHS	The Department of Human Services
National Inpatient Medication Chart (NIMC)	The national standardised paper medication chart designed by the Commission for hospital inpatients
NHA	*National Health Act 1953*
PBS	Pharmaceutical Benefits Scheme also taken to include Repatriation Pharmaceutical Benefits Scheme (RPBS) unless otherwise stated
PBS HMC	A national standard PBS/RPBS compliant hospital medication chart
PBS Prescriber	An Approved Medical Practitioner, participating dental practitioner, authorised optometrist, authorised nurse practitioner or authorised midwife who is approved to prescribe PBS medicines under the *National Health Act 1953*
PBS Schedule	Schedule of Pharmaceutical Benefits – means the pharmaceutical benefits declared under section 85 of the *National Health Act 1953*
RPBS	Repatriation Pharmaceutical Benefits Scheme under the *Veterans' Entitlement Act 1986* includes all items on the Repatriation Schedule of Pharmaceutical Benefits and the PBS Schedule

About this guide

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1 About this guide

Introduction

The Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC) is a national standardised medication chart that allows the prescribing, administration, claiming and supply of PBS and non-PBS medicines directly from the chart without the need for a separate paper prescription.

The PBS HMC was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) and trialled in public and private hospitals across the country. The evidence-based chart builds on the National Inpatient Medication Chart (NIMC) and retains key safety features.

The PBS HMC is supported by a range of nationally consistent and maintained resources. These include resources for health professional education and guidance on use of the PBS HMC. A list of resources for the PBS HMC can be found in Appendix 1.

Background

The Commission has identified improving the safety and quality of medication usage in Australia as one of its priorities and as a National Safety and Quality Health Service (NSQHS) Standard. Reducing error and harm from medicines through safe and quality use is an important element of the Commission's work and contributes to it achieving its over-arching objective of leading and coordinating national safety and quality improvements in health care.

There is a risk of harm associated with the use of medicines, which are Australia's most prevalent form of health therapy. For example, an error in the delivery of medicines, such as the wrong medicines being prescribed or used, or the right medicines being used inappropriately, can lead to patients being harmed.

Between 2%–5% of Australian medication charts contain prescribing errors and administration errors in prescribing occur at a rate of between 5% and 18%[1]

Standardisation of medication charts is an important strategy for overcoming adverse medicine events in acute care[2]. In April 2004 Australian Health Ministers agreed that all public hospitals should use a common medication chart to support standardisation and medication safety and appointed the Commission to develop and implement the NIMC, which has reduced the incidence of prescribing errors in the medication management cycle in Australia.[3]

Following implementation of the NIMC, the Commission was engaged by the Australian Government Department of Health (the Department) to develop a new standard chart for use in residential aged care facilities (the National Residential Medication Chart (NRMC)). The NRMC was designed to meet the specific requirements of this different clinical setting and enable medication ordering, supply, administration and Pharmaceutical Benefits Scheme (PBS) claiming in a single form. The NRMC was also developed to improve safety through the inclusion of standard fields, layout and intuitive design. The successful phased implementation of the NRMC resulted in considerable improvements in safety and quality for residents in aged care facilities.

The NRMC reduced the paperwork burden on pharmacists and clinicians and improved efficiencies by allowing PBS claiming through the single form, removing the need to issue a separate prescription.

1 Roughead E SS, Rosenfeld E. Literature Review: Medication Safety in Australia 2013. 2014.

2 Australian Council for Safety and Quality in Health Care. Second National Report on Patient Safety – Improving Medication safety. Canberra: Australian Council for Safety and Quality in Healthcare, 2002.

3 Coombes I, Reid C, McDougall D, et al. Pilot of a National Inpatient Mediation chart in Australia: Improving prescribing Safety and Enabling Prescribing Training. Br J Clin Pharmacol 2011; 72(2): 338–349

A review of chemotherapy funding arrangements in 2012 highlighted the degree of administrative burden related to medication charting and prescribing in other clinical settings. As a result of this, coupled with the successful implementation of the NRMC, the Australian Government proposed to simplify a number of processes to reduce the administrative burden faced by prescribers, pharmacists and hospitals when prescribing, dispensing and claiming for PBS medicines.

The Department's PBS Hospital Medication Chart (PBS HMC) initiative aims to allow the supply and claiming of PBS medicines directly from medication charts without the need for a separate hardcopy PBS prescription. The Commission was appointed to develop the PBS HMC for use in public and private hospitals and to pilot and test the safety and effectiveness of the new chart. The PBS HMC is based on the NIMC, used in public and private hospitals nationally.

Limitations of this guide

The PBS HMC User Guide provides guidance and best practice advice to health service organisations on the use of the PBS HMC.

The Commission recognises that some jurisdictions will make state-wide modifications to the standard PBS HMC in a similar way to the changes made to the NIMC. For information regarding these changes, the relevant representative from the Health Services Medication Expert Advisory Group (HSMEAG) or health department should be contacted.

Legislative requirements for prescribing, administering, dispensing and claiming medicines vary between jurisdictions. Health service organisations should make contact with their state department to confirm that jurisdictional requirements are met as part of their project planning for the implementation of the PBS HMC.

PBS requirements

Table 1 lists the elements that are required for a valid PBS prescription.

Table 1: PBS and RPBS prescription requirements

Patient identification
Patient's full name as it appears on their Medicare card
Patient's address
Patient's Medicare number
Any number specified on a card, issued by the Commonwealth, as an entitlement number for a patient
Prescriber details
Name
PBS Prescriber Number
Contact number (mobile/pager)
Address
Signature and date
Hospital details
Hospital name
Hospital provider number
Period of chart validity
'Expiry date' or 'chart valid' period
Medicine details
PBS, RPBS or private
Medicine and form
Dose, route and frequency
Streamlined Authority/Authority Approval Number/Authority Prescription Number
Brand substitution not permitted
Signature
Date of prescribing

Frequently asked questions

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2 Frequently asked questions

Implementing the PBS HMC

What is the PBS HMC?

The PBS HMC is a national standard PBS/RPBS compliant hospital medication chart developed by the Commission in conjunction with the Department to be used in public and private hospitals for prescribing, supply, administering and claiming purposes. The chart can be used for claiming listed PBS items for eligible patients in PBS appropriate settings.

Is the PBS HMC a mandatory chart?

Use of the PBS HMC is not mandatory.

Why has the PBS HMC been developed?

The PBS HMC is an Australian Government initiative announced in the 2014–15 Budget to reduce the administrative and regulatory burden of supplying PBS/RPBS medicines in public and private hospitals.

What are the benefits of the PBS HMC?

The PBS HMC reduces the administrative and regulatory burden of supplying PBS/RPBS eligible medicines in public and private hospitals.

An approved supplier is able to supply listed PBS/RPBS medicines from the PBS HMC to eligible patients in selected public and private hospitals in PBS appropriate settings. Where the chart is used for supply, the approved supplier will no longer need a prescription from the prescriber, which reduces duplication of effort for prescribers, and ensures that the medicine supplied accords with the prescriber's most recent intentions.

The PBS HMC is expected to contribute to improved patient safety.

What is the difference between the NIMC and the PBS HMC?

The PBS HMC is based on the NIMC and retains the safety elements of the NIMC. It allows for prescribing, supply and claiming of eligible PBS/RPBS medications, without the need for a separate prescription.

Who has been involved with the development of the PBS HMC for trial?

The Commission has worked with stakeholders from the states and territories, peak bodies and representatives from public and private hospitals to develop the PBS HMC. A reference group of key experts has provided guidance and advice to the Commission during the development phase.

2 Frequently asked questions

Q Who can use the PBS HMC?

A Any public or private hospital with a valid hospital provider number can use the PBS HMC.

Q Who owns the PBS HMC?

A The PBS HMC forms part of a patient's medical record at the hospital. It must be maintained and stored according to state and territory legislation and local hospital policy.

Q What is the governing legislation relevant to this initiative?

A Supply and claiming for PBS items is subject to Australian Government legislation. Amendments to *National Health (Pharmaceutical Benefits) Regulations 1960* and *National Health (Claims and under co-payment data) Rules 2012* enable supply of medicines directly from medication charts in public and private hospitals.

Prescribing and supply of all medicines, and special requirements for medicines supplied as private or non-PBS, are subject to the regulatory requirements of the relevant state or territory. Users should check the relevant provisions in their state or territory and consult any specific information developed within their jurisdiction.

Prescribing and supplying with the PBS HMC

Q Who can use the PBS HMC to prescribe medicines?

A All approved PBS prescribers can use the PBS HMC to prescribe eligible PBS/RPBS medicines.

Q Who may supply and claim eligible items using a PBS HMC?

A Approved Pharmacists (community pharmacy) and Approved Hospital Authorities are eligible to supply and submit claims for listed PBS/RPBS items prescribed on the PBS HMC. An Approved Medical Practitioner (AMP) cannot supply medicines from a PBS HMC.

Q Are all PBS medicines eligible to be prescribed, dispensed and claimed on the PBS HMC?

A PBS/RPBS subsidised items normally supplied from a prescription can be prescribed, supplied and claimed from the PBS HMC. Usual PBS/RPBS rules apply.

In addition to the PBS HMC, specific ordering charts may be required for specialised medicine orders such as insulin, intravenous fluids, anticoagulants, parenteral cytotoxic and immunosuppressive agents, epidural and regional infusion and patient-controlled analgesia.

Q Can the PBS HMC be used to prescribe and dispense medicines for discharge?

A Yes. If needed, the PBS HMC is designed to allow the prescribing and claiming of discharge medications. A PBS/RPBS quantity of a medicine may be supplied to a patient at discharge if:

- the PBS HMC is still valid
- an approved PBS prescriber has completed the discharge section for each medicine.
- the setting is appropriate for PBS/RPBS items to be dispensed and the patient is eligible to obtain PBS/RPBS items.

Q Can Controlled Drugs (Schedule 8 medicines) be prescribed, dispensed, administered and claimed on the PBS HMC?

A Yes. Controlled Drugs or Schedule 8 medicines can be prescribed and claimed for on the PBS HMC if in accordance with state and territory regulation for the supply of these medicines. Their administration is also recorded on the PBS HMC.

Q Can the PBS HMC be used for Highly Specialised Drugs?

A Yes. Highly Specialised Drugs can be prescribed on the PBS HMC however all usual PBS/RPBS rules apply.

Q How will 'Authority Required' items be prescribed under this initiative?

A A single PBS HMC Authority Prescription Number is printed on the PBS HMC and can be used by the PBS prescriber to apply for one or more Authority Required item as needed.

Streamlined Authority Code – If the prescribed medicine is Authority Required (STREAMLINED), the prescriber must write the relevant four digit Streamlined Authority Code (SAC) in the box provided. Only the prescriber can provide this information.

Phone Authority – A single PBS HMC Authority Prescription Number is printed on the PBS HMC and must be used by the prescriber to obtain prior authority approval for each authority required item. The Authority Approval Number (AAN) provided by DHS must be written on the PBS HMC in the box provided. Only the prescriber can provide this information.

Written Authorities – A prescriber is required to obtain prior written authority approval in line with current requirements. If the PBS HMC is used to obtain prior written authority approval –the original PBS HMC along with usual supporting documentation must be submitted to DHS.

Q Will there be any changes to the PBS Schedule, drug listings and item codes under this initiative?

A No. There are no changes to the PBS Schedule, drug listings and item codes.

2 Frequently asked questions

Q Will there be any changes to patient eligibility and entitlements?

A No. The existing arrangements will apply to eligibility and entitlements, co-payments and Safety Net benefits.

Regulation 25 will apply under this initiative for private hospitals as per current PBS arrangements.

Q Will owing prescriptions be allowed?

A No. As the PBS HMC is the prescription this initiative removes the need for an additional prescription to be written. The PBS HMC does have provision for telephone orders.

Q Will same day prescribing or supplying be allowed?

A Yes. Same day prescribing will be allowable for eligible PBS/RPBS items under the PBS HMC arrangements. The supply must be consistent with state and territory law.

Each item may be supplied and claimed using the same date of prescribing up to a maximum period of 1, 4 or 12 months from the date the item is prescribed.

Q Will 'deferred supplies' be allowed?

A No. Deferred supply from the PBS HMC is not allowed.

Q Will 'repeat supplies' be allowed?

A The PBS HMC allows for ongoing supply up to the HMC expiry date as authorised by the prescriber. The re-supply of items from the PBS HMC is not managed through the use of repeat authorisation forms.

Original supplies of up to the maximum quantity of an item may be supplied and claimed on an ongoing basis from the PBS HMC:

- Using the same date of prescribing for the item, and
- Until the PBS HMC expires.

Q Will Regulation 24 apply?

A Regulation 24 does not apply under these PBS HMC arrangements. (Regulation 24 means that a doctor can write a PBS prescription so that all the repeats are supplied at the same time, in certain circumstances.)

Q Should the Medication Management Plan be used?

A The PBS HMC should be used in conjunction with the Medication Management Plan.

Q How will medications be ordered from the hospital pharmacy?

A Once a medication order has been completed by an approved prescriber, the original PBS HMC (or a copy) should be sent to the pharmacy subject to local policy. An approved supplier can then dispense the required medicines up to the relevant PBS quantities.

Where can medicines prescribed on the PBS HMC be dispensed?

Supply from the PBS HMC will occur at the pharmacy service attached to the hospital by whatever arrangement is in place. Section 94 (approved hospital authorities) and Section 90 (approved pharmacists) are eligible to supply and submit claims for eligible PBS/RPBS items from the PBS HMC.

Can PBS medications be dispensed from the PBS HMC at PBS approved community pharmacies?

PBS approved community pharmacies can only dispense from the PBS HMC if contracted to provide pharmacy services to the hospital at which the PBS HMC is used.

What will happen if a patient is discharged outside of normal pharmacy service business hours?

A separate PBS/RPBS prescription will need to be prepared in this instance by the PBS prescriber discharging the patient (as per the current practice).

My patient would prefer to attend their local pharmacy. Can I give them a copy of the PBS HMC with the discharge section completed to take to their local pharmacy?

No. A separate PBS/RPBS prescription must be prepared by the PBS prescriber discharging the patient. The PBS HMC is only valid at the pharmacy attached to the hospital.

Claiming from the PBS HMC

Can a copy of the PBS HMC be taken to a community pharmacy to have a discharge order dispensed?

No. A separate PBS/RPBS prescription must be prepared by the PBS prescriber discharging the patient. The PBS HMC is only valid at the pharmacy attached to the hospital.

How does a pharmacy provide Supply Certification when using a PBS HMC?

Where dispensing software functionality has incorporated 'DHS Streamlined PBS and RPBS Claiming', an approved supplier can close their claim electronically, which prompts an electronic certification.

Where dispensing software functionality does not have the facility to close a claim electronically, an approved supplier must send in a paper Supply Certification Form to DHS.

What is the claiming process for claiming PBS/RPBS items from a PBS HMC?

The electronic claim for each PBS/RPBS benefit item supplied from a PBS HMC and claimed from DHS must contain the usual claim information. The approved supplier is not required to send the PBS HMC to DHS.

Which claiming channels are available?

Electronic claims must be submitted through current Online Claiming for PBS.

2 Frequently asked questions

Q Will Approved Pharmacists be required to transmit the entire PBS HMC in their electronic claim?

A No. Approved Pharmacists will not be required to submit the PBS HMC to DHS for the purposes of a claim. However, these must be retained for a period of two (2) years and be available on request by DHS.

Q Will there be any changes to the PBS payment advice forwarded to the pharmacy?

A No. There will be no change to the PBS payment advice.

Q Will my claims be subject to audit by the Department?

A Yes. Current arrangements remain unchanged.

Storage of the PBS HMC

Q My hospital currently uses a non-conforming medication chart – can this be adapted to allow for PBS claiming?

A No. The PBS HMC will be the approved form for all prescribing, supplying and claiming. Other forms cannot be used.

Q Where will the PBS HMC be stored in the hospital?

A The original PBS HMC for each patient will be stored at the point of care while in use, and then with the patient's medical record as per local policies and in accordance with state and territory regulations.

Q How long will I have to keep copies of the PBS HMC?

A The original PBS HMC for each patient will be stored by the hospital with the patients' medical record for a minimum of seven years.

Copies of the PBS HMC used by the approved supplier as a direction to supply and the PBS HMC supply record must be kept by the approved supplier for two years for regulatory and audit purposes.

Printing the PBS HMC

How do I arrange the printing of the PBS HMC?

The PBS HMC can be printed through any commercial printing company. All of the instructions are contained in the print read files (PDF). Your organisation may have a contract in place with a commercial printing company or you may have to arrange one specifically for the PBS HMC. The Commission does not recommend or keep a record of commercial printing companies.

What is an Authority Prescription Number (APN)?

The APN is a number that will need to accompany any authority items on the PBS HMC. It is a legislated PBS input element. Pharmacy services attached to the hospital should generate their own APNs and provide these to their chosen printing service.

How do I generate an APN?

An APN contains 8 (numeric) digits. The first seven digits form the basis of the APN and should be selected at random. The eighth digit is called the 'check digit' and is calculated by adding the first seven digits and dividing this answer by 9. The resulting remainder digit becomes the 'check digit' or the eighth digit in the APN.

For example, APN 52738492 is generated by:

1. Seven digits are selected at random
2. These seven digits are then added to produce a total (5 + 2 + 7 + 3 + 8 + 4 + 9 = 38)
3. The sum of the first seven digits is then divided by 9 (38 ÷ 9 = 4.2, with a remainder digit of 2)
4. 2 becomes the eighth digit in the APN, otherwise known as the 'check digit.'

Is the APN unique?

No the APN is not a unique number. One APN can be used to prescribe and claim more than one PBS authority benefit.

Can I use an APN more than once?

Yes an APN can be used more than once. For example, a batch of APNs can be used for multiple print runs of the PBS HMC.

I have two different pharmacy suppliers – can I have two approval numbers printed on the back of the PBS HMC?

If you have a contract for services with more than one pharmacy supplier you can have both approval numbers printed on the chart.

Instructions for using the PBS HMC

3

3 Instructions for using the PBS HMC

The PBS HMC has multiple sections designed to communicate clearly the essential medication information and to minimise medication errors.

This section of the guide provides general instructions on completion of the PBS HMC as well as specific guidance for the various sections. Details include the purpose of each section, the rationale in terms of risk management and requirements relating to PBS prescribing and supply.

Visual examples provide further guidance.

A 'medication chart prescription' is a 'completed item' in a 'medication chart' (not the whole medication chart).

3.1 General requirements

Writing orders

The PBS HMC is a legal document and therefore must be written in a clear, legible and unambiguous way.

- All entries on the PBS HMC must be written legibly in ink.
- Water soluble ink (e.g. fountain pen) should not be used.
- Black ink is preferred.
- A medicine order is valid only if the prescriber enters all the required items.
- All information, including medicine names, should be printed.
- No erasers or 'whiteout' can be used. Orders must be rewritten if any changes are made, especially changes to dose and/or frequency.
- All instructions must be written in plain English.

Abbreviations, symbols and terminology

Australia has agreed national standards for terminology, abbreviations and symbols used in the prescribing and administration of medicines. It provides:

- principles for consistent prescribing terminology
- a set of recommended terms and acceptable abbreviations
- a list of error-prone abbreviations, symbols and dose designations that have a history of causing error and must be avoided.

Please refer to: Recommendations for Terminology. Abbreviations and Symbols used in the Prescribing and Administration of Medicines.

Prescribing requirements

a) Start Date

- The prescriber should enter the current date if administration of the medicine is intended on this date or a date in the future when the prescriber wants the first administration of the medicine.
- If transcribing charts, the prescriber must enter the date of transcription. It may be useful for some medicines to include the date of first prescribing somewhere on the administration panel.

b) Generic (active ingredient) medicine name, form and strength

- Medicines should be prescribed by generic name unless specified otherwise in the local protocol. Examples where generic names may not be appropriate include, where combination products are ordered or insulins are prescribed. The Australian Approved Name is the official terminology as per the Therapeutic Goods Association (TGA) website http://www.tga.gov.au/acronyms-glossary

c) Route

- Only commonly used and understood abbreviations should be used to indicate the route of administration.
- Generally, medicine orders should be for one route only. However, local requirements may indicate other practice. Health services should be aware of risks associated with medicine orders with multiple routes of administration. A health service-specific list of exceptions to the general rule should be determined in conjunction with the health service's drug and therapeutics committee or equivalent and appropriate risk mitigation strategies put in place.

d) Dose

- Doses must be written using metric and Arabic e.g. 1, 2 ,3. Roman numerals must not be used e.g. i, ii, iii, iv.
- Always use zero (0.) before a decimal point e.g. 0.5g otherwise the decimal point may be missed. However, if possible it is preferable to state the dose in whole numbers, not decimals, e.g. write 500mg instead of 0.5g or write 125microgram instead of 0.125mg.
- Never use a trailing zero (.0) as it might be misread if the decimal point is missed e.g. 1.0 misread as 10.
- Do not use U or IU for units because it may be misread as zero. Always write units in full.

e) Frequency and administration times

- The prescriber must document the frequency and administration time(s). This will prevent errors where the person administering the order misinterprets the frequency and writes down the incorrect times. If these details are not entered, the dose may not be administered by nursing staff.
- Times should be entered using the 24 hour clock, a universal standard.
- Medicines should be administered according to the recommended administration times unless they must be given at specific times (e.g. some antibiotics, with/before food) or, as in the case of children with variable meal and sleep schedules, a specific schedule is required.
- If necessary, the ward or clinical pharmacist or nurse will clarify the administration time to correctly administer the medicine (e.g. in relation to food) and annotate the chart to indicate this has occurred.

f) Indication

- Most order spaces require the prescriber to document the indication. Indication is important clinical information for other health professionals involved in medicines management. It allows the order to be reviewed in the context of why the medicine was prescribed, reducing the risk of misinterpretation of the order. For example a common source of error occurs when medicines with look-a-like or sound-a-like names (known as LASA medicines) are prescribed. Recording the indication for each medicine helps the health care team select the right medicine.

g) Ceasing or changing medication chart prescriptions

- When ceasing a medicine, the original prescription must not be removed or obscured. The prescriber must draw a clear diagonal line through the order in the prescription box and another diagonal line through the administration record section, taking care that the lines do not impinge on other orders. The prescriber must also write 'ceased', the reason for ceasing the order, date and sign (see Section 3.2.16).
- If a change to a medication order is required, the prescriber must cease the current order on the PBS HMC, as above, and complete a new entry on the chart reflecting the required change. Changes to medication orders (drug, frequency, etc.) must not be conveyed by altering an existing medication order.
- The pharmacy should be notified and supplied with the most current copy of page one and the most current copy of the page where the medicine being requested is ceased or changed.

Administration requirements

a) Check the order

- Accurately recording medicines administration is a critical part of safe medication management and can reduce the risk of medication error through inadvertent under or over-dosing.
- The administering health professional has a responsibility to ensure they can clearly read and understand the order before administering any medicines.
- Always ensure prescribing requirements are met before administering a medicine. For all incomplete or unclear orders, the prescriber should be contacted to clarify. Never make any assumptions about the prescriber's intent.
- Medicines should be administered according to the recommended administration times unless they must be given at specific times (e.g. some antibiotics, with or before food) or, as in the case of children with variable meal and sleep schedules, a specific schedule is required.
- Those administering medicines also play an important role in identifying prescribing and supply errors before they reach the patient. Remember the following safety checking list:
  - **Right medicine** (that matches the order and the patient's condition)
  - **Right dose** (that matches the order and is safe for the patient)
  - **Right route** (that matches the order and is appropriate for the medicine and the patient)
  - **Right time** (that matches the order and its frequency and administration time directions)
  - **Right patient** (that matches the patient ID on the chart, the label on the dispensed medicine and is confirmed by the patient using three identifiers if possible).
- If the medication chart is full (i.e. there is no appropriate space to sign for administration) then the medication order is not valid. The chart must be re-written as soon as possible.

b) Reasons for non-administration

- Reasons for not administering should be recorded in the chart using the codes indicated. The codes must be circled.

  A Absent

  F Fasting

  L On leave

  N Not available – obtain supply or contact prescriber

  R Refused – notify prescriber

  S Self-administered

  V Vomiting

  W Withheld – enter reason in clinical record

- It is appropriate to withhold the medicine if there is a known adverse drug reaction (ADR) to the prescribed medicine.
- Generally medicines should not be withheld if the patient is pre-operative or nil by mouth (NBM) or fasting unless specified by the authorised prescriber.

3 Instructions for using the PBS HMC

Supply requirements

a) Communicating the medication order

- The pharmacist must have systems in place to ensure the pharmacy has access to contemporaneous copies of the medication chart at all times.
- A copy of the PBS HMC is provided to the pharmacy.
- When a patient's PBS HMC is faxed, scanned and emailed or photocopied for delivery to the pharmacy, the front page of the chart containing the prescriber's details must always be included.
- A copy of the chart must be sent to the pharmacy as a complete unit when first charted, with all pages kept together
- Supply cannot occur unless the pharmacy is in possession of a copy of each page on which the medicine being requested is prescribed as well as a copy of the front page that details the prescriber information.

b) Chart validity period

- The period of PBS HMC validity is identified on page one of the PBS HMC (see Section 3.2.6). The prescriber chooses a time period that best matches the episode of care, for example, one month is an appropriate period for an acute admission. The maximum duration is 12 months.
- The period of validity (1, 4 or 12 months) starts on the date of prescribing of the first medication order on the PBS HMC.
- Supply cannot occur after the PBS HMC expiry date.
- Up until the expiry date of the chart, a PBS medicine can be dispensed as charted unless otherwise indicated in the individual medication orders (see below). If the medicines are not re-charted, all orders on the PBS HMC cease to be valid for PBS supply and for administration after the chart expiry date.
- The administration of the last quantity or single quantity supplied from the PBS HMC may over-run the PBS HMC validity period. For example, if the medicine is required on the last day of the chart's validity, the pharmacist is authorised to dispense a full PBS maximum quantity. This is the same logic as for a regular prescription, where a full PBS maximum quantity can be dispensed on the expiry date of the prescription even though the quantity dispensed will last beyond that date. This does not apply where a 'stop date' is indicated, as the quantity supplied in this case must only be the quantity sufficient for administration to the patient up to and including the stop date, and not beyond that date.
- Pharmacists are permitted to supply up to one PBS maximum quantity at a time, with subsequent supplies as required to meet the prescriber's order until PBS HMC expiry date. The quantity required to be supplied on each occasion, and the number of supplies required throughout the validity period of the PBS HMC, will be determined by the prescribed dose and frequency of administration, the date of prescribing or start date of administration.

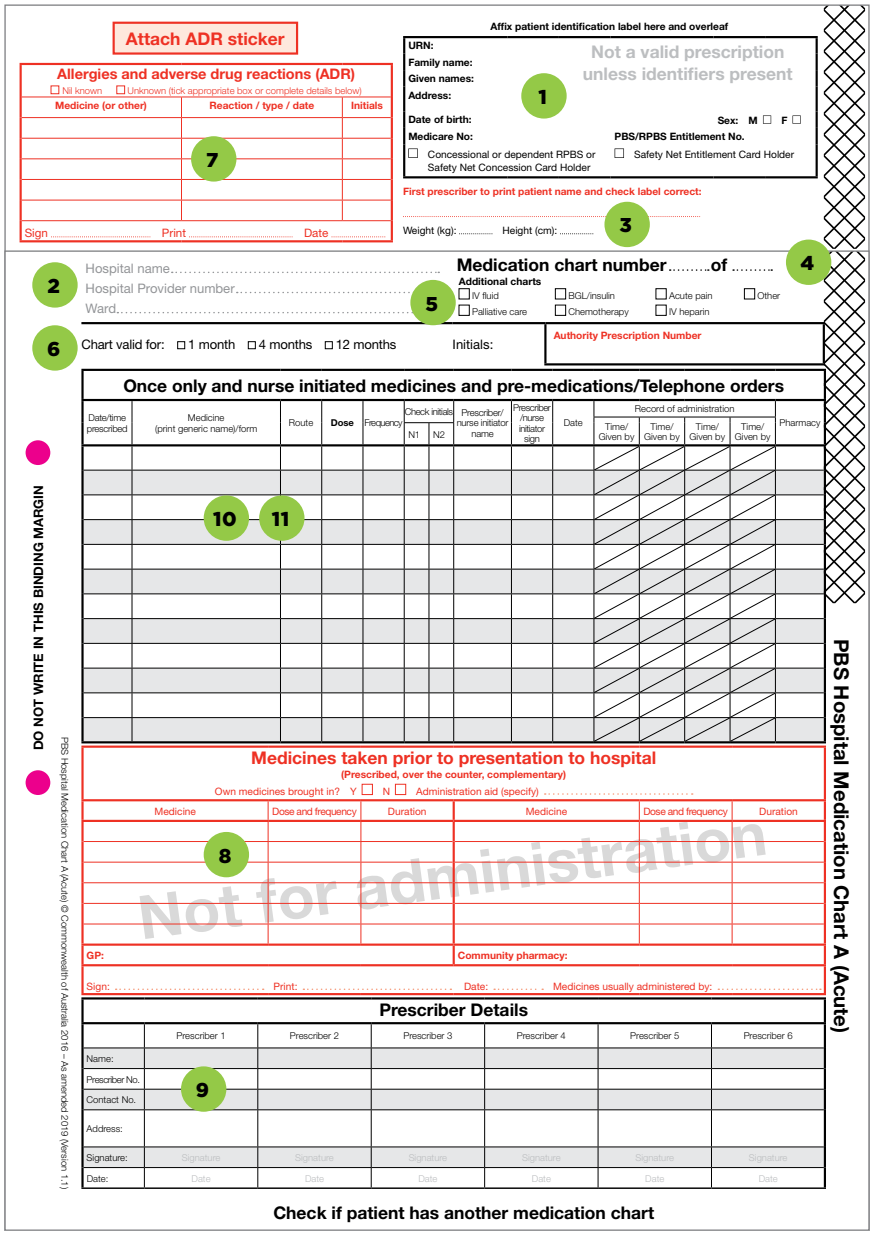
c) Other supply considerations

- Each supply from the PBS HMC is treated as an 'original supply' and repeat authorisation forms are not required.
- When there is more than one PBS maximum quantity available, the lesser maximum quantity must be dispensed unless the patient is entitled to a larger quantity due to their medical condition.
- When supplying a non-PBS/private supply for which a 'PBS maximum quantity' does not apply, the pharmacist is permitted to dispense one 'smallest currently marketed registered pack' at a time, with subsequent supplies as required to meet the prescriber's order until the stop date or chart expiry date, whichever is earlier.

3.2 Section by section instructions

This section provides detailed guidance for completion of each section of the PBS HMC based on the legend below.

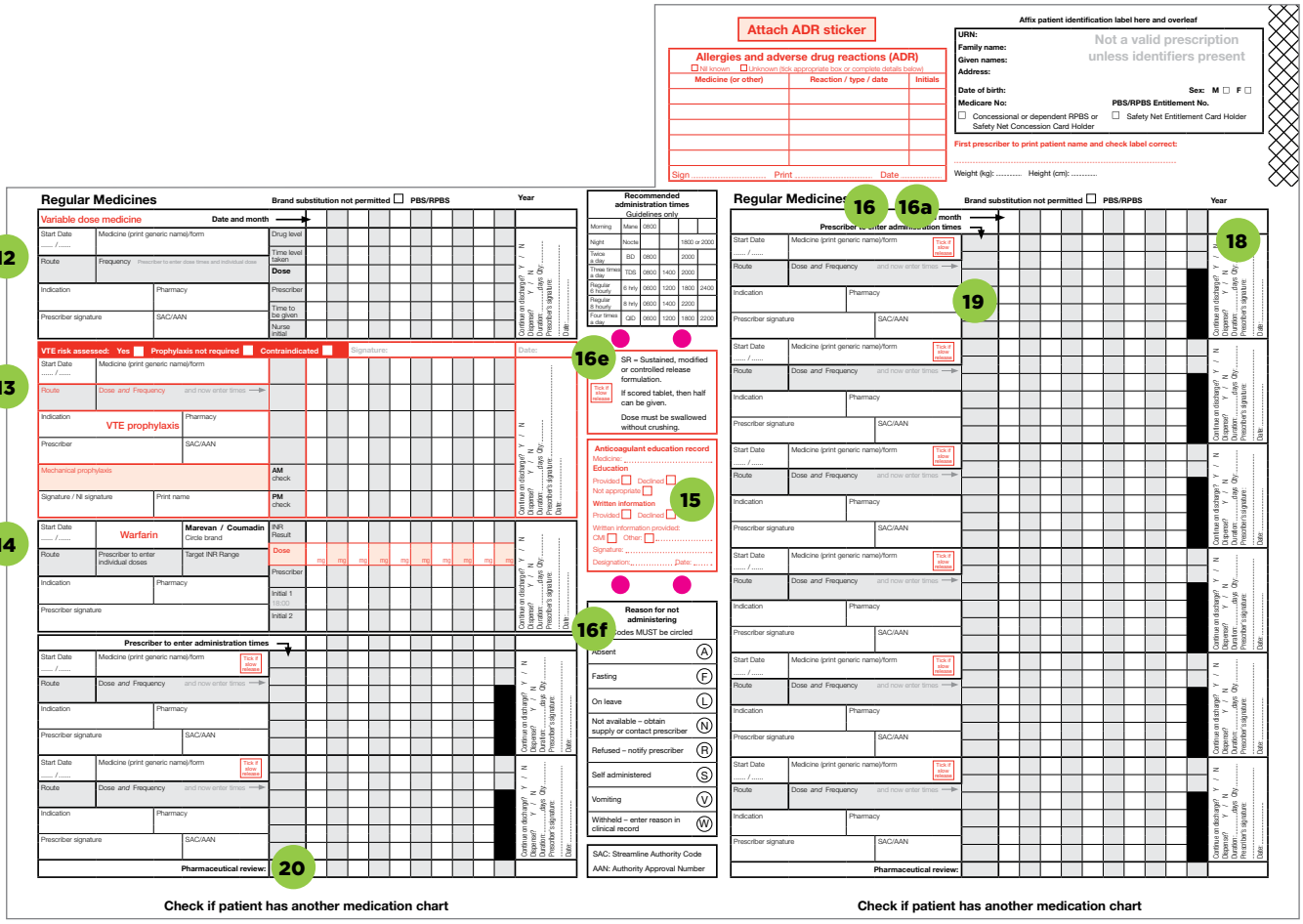
FRONT PAGE



1. Patient identification
2. Hospital details and patient location
3. Patient weight and height
4. Chart numbering
5. Additional charts
6. Chart period of validity
7. Allergies and ADR alerts
8. Medicines taken prior to presentation to hospital
9. Prescriber details
10. Once only and nurse initiated medicines and pre-medication (non PBS)
11. Telephone orders

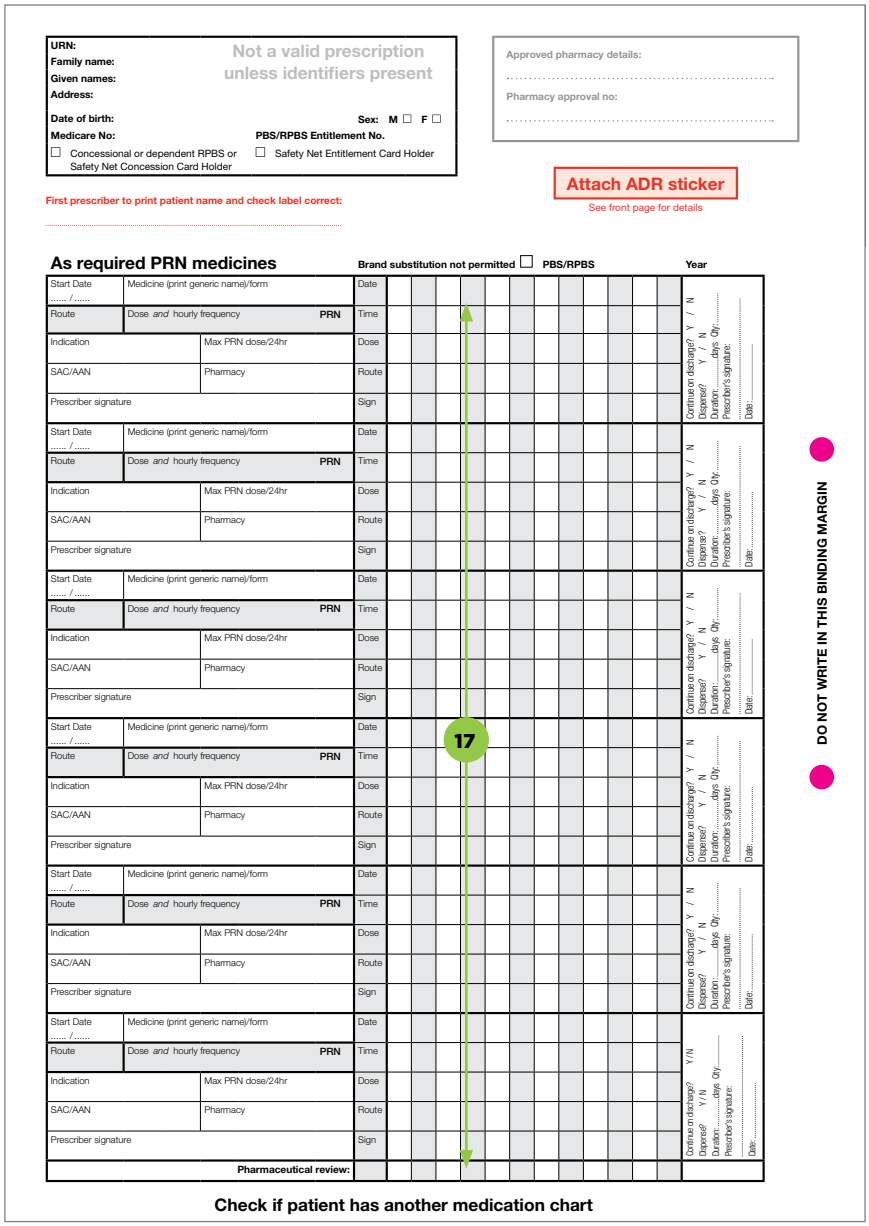
3 Instructions for using the PBS HMC

MIDDLE PAGES (2 & 3)



- 12 Variable dose medicine orders
- 13 VTE prophylaxis orders
- 14 Warfarin orders
- 15 Anticoagulant education
- 16 Regular medicine orders
  - 16a Limited duration medicines
  - 16b Medicines intended for next day administration – not shown
  - 16c Medicine orders prescribed on an additional specialty chart – not shown
  - 16d Ceased medicines/changes to medication orders – not shown
  - 16e Slow release medicines
  - 16f Reasons for not administering
- 18 Discharge supply
- 19 Pharmacy annotation
- 20 Pharmaceutical review

BACK PAGE (PAGE 4)



URN:
Family name:
Given names:
Address:

Not a valid prescription unless identifiers present

Date of birth: Sex: M ☐ F ☐
Medicare No: PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

Approved pharmacy details:
Pharmacy approval no:

Attach ADR sticker
See front page for details

First prescriber to print patient name and check label correct:

As required PRN medicines — Brand substitution not permitted ☐ PBS/RPBS — Year

Start Date ..../..../.... | Medicine (print generic name)/form | Date
Route | Dose *and* hourly frequency PRN | Time
Indication | Max PRN dose/24hr | Dose
SAC/AAN | Pharmacy | Route
Prescriber signature | Sign

Continue on discharge? Y / N
Dispense? Y / N
Duration: ....days Qty: ....
Prescriber's signature:
Date: ....

17

DO NOT WRITE IN THIS BINDING MARGIN

Pharmaceutical review:

Check if patient has another medication chart

17 PRN orders

3 Instructions for using the PBS HMC

3.2.1 Patient identification

Purpose:

To establish the patient's identity before prescribing commences.

Risk addressed:

Not correctly identifying patients can result in missed and incorrect doses.

Using three approved patient identifiers to establish patient identity satisfies NSQHS Standard 4.

PBS requirements:

For a valid PBS/RPBS prescription the patient identification details required are:

- Patient's full name (as it appears on the patient's Medicare card)
- Patient's address
- Patient's Medicare number
- Any number specified on a card, issued by the Commonwealth, as an entitlement number for the patient.

Instruction:

- The attending health professionals must ensure a patient identification (ID) label is adhered in the space provided or hand written. If hand written it must be written in legible print.
- The first prescriber must check the patient's identity and write the patient's name to document confirmation. This should occur on the front and back page where ID labels are adhered.
- Medicine orders should not be administered if the prescriber does not document the patient identification.

Figure shows the chart identification section.

URN: 123 456
Family name: Sample Person
Given names:
Address: Lovely St NSW 0000

Not a valid prescription unless identifiers present

Date of birth: 15/1/1978 **Sex:** M ☒ F ☐
Medicare No: 123456 7 1 **PBS/RPBS Entitlement No.**

☐ Concessional or dependent RPBS or Safety Net Concession Card Holder

☐ Safety Net Entitlement Card Holder

First prescriber to print patient name and check label correct:
Sample person

3.2.2 Hospital details and patient location

Purpose:

To record the patient's location (hospital and ward) on the medication record.

Risk addressed:

Hospital details including the hospital provider number are essential for processing PBS prescriptions.

Patient location details reduce the risk of the wrong chart being used.

PBS requirement:

For a valid PBS/RPBS prescription the hospital name and Provider Number must be recorded on the PBS HMC.

Instruction:

Attending health professionals should ensure the hospital name, Hospital Provider Number and ward are recorded in the space provided.

Figure shows the patient location section.

Hospital name..... Caring Hospital
Hospital Provider number..... 12345X
Ward..... Waratah

Chart valid for: ☑ 1 month ☐ 4 months ☐ 12 months

3.2.3 Patient weight and height

Purpose:

To ensure the patient's weight and height are available at the point of prescribing.

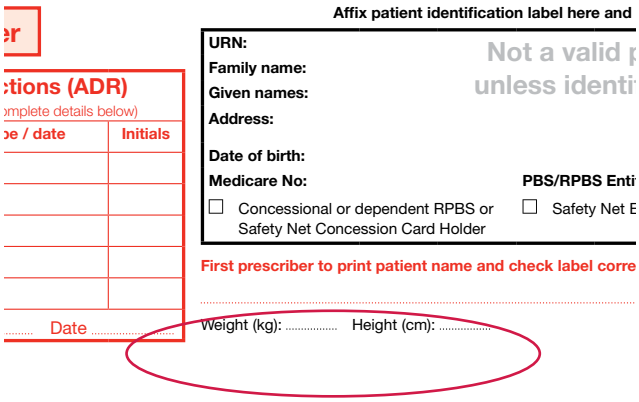
Risk addressed:

Weight is important clinical information for correctly prescribing some medicines and for at-risk patients such as those with renal impairment.

Instruction:

Attending health professionals should record the patient's weight and height in the space provided.

Figure shows the weight and height recording section.



3.2.4 Chart numbering

Purpose:

To communicate the use of more than one active chart.

Risk addressed:

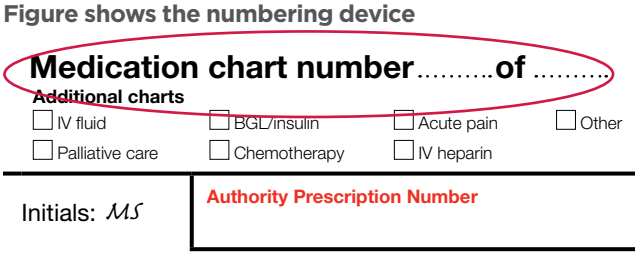
Failure to communicate that there is more than one active chart can result in missed doses or duplicate prescribing.

Clinicians need access to all medicines information to ensure safe treatment and care of patients.

Instruction:

Attending health professionals must write the number of the chart in the sequence of active charts e.g. Medication chart number **1** of **2**. The information must be updated if additional active charts are created.

Figure shows the numbering device



3 Instructions for using the PBS HMC

3.2.5 Additional charts

Purpose:

To communicate the use of other specialist charts.

Please also refer to section 3.2.16 MEDICINE ORDERS: Regular medicine orders: Further information – Medicine orders prescribed on an additional (specialty) chart.

Risk addressed:

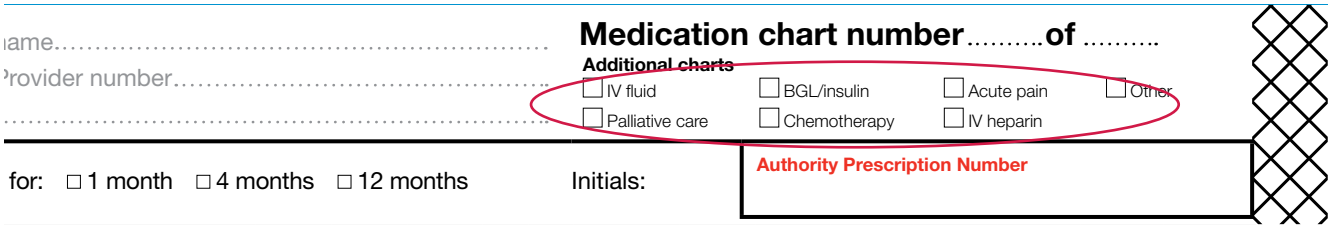
Failure to communicate additional specialist charts may result in missed doses or duplicate prescribing.

Instruction:

If additional specialist charts are in use a tick or cross must be placed in the space provided to indicate which charts are in use, including:

- IV fluid chart
- BGL/insulin chart
- Acute pain chart
- Palliative care chart
- Chemotherapy chart
- IV heparin chart
- Other – specify the nature of the chart in the space provided or in the clinical notes if insufficient room.

Figure shows the additional charts section.



3.2.6 PBS requirements

The chart validity section must be completed by an approved prescriber.

Purpose:

To communicate how long the chart is valid for supply and claiming purposes.

Risk addressed:

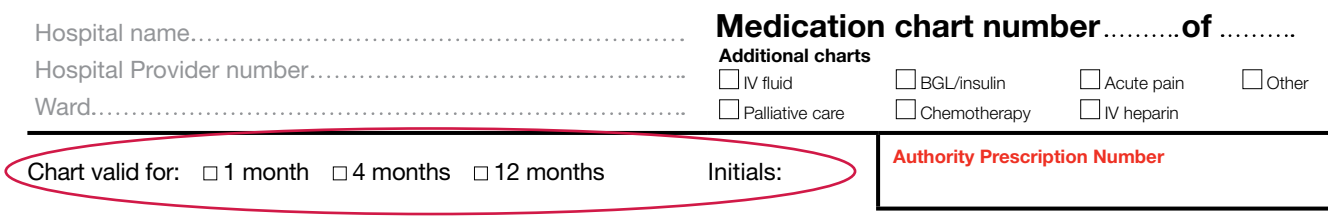
Limiting the chart validity period is one means of limiting or controlling patients' exposure to medicines and ensuring patient safety.

Instruction:

The prescriber is required to choose a time period that best matches the episode of care, for example, one month is an appropriate period for an acute admission.

The PBS HMC can be used for supply and claiming purposes for the period starting from the date entered in the 'start date' box. Up until the expiry date of the chart, a PBS medicine can be dispensed and administered as charted.

Figure shows the chart validity section.



3.2.7 Allergies and ADR alert

Purpose:

To communicate the existence of previous allergies, adverse drug reactions (ADRs) and related information.

Risk addressed:

Failure to communicate previous allergies or ADRs can result in re-prescribing of offending medicines and avoidable patient harm.

Instruction:

Attending health professionals must obtain and record previous allergies and ADRs including:

- the medicine (or substance)
- reaction details (e.g. rash, diarrhoea) and type (e.g. allergy, anaphylaxis)
- date that it occurred or approximate time frame (e.g. 20 years ago).

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).

If there are more than four previous allergies or ADRs to record, use the fifth line to refer other health professionals to the health record for additional information.

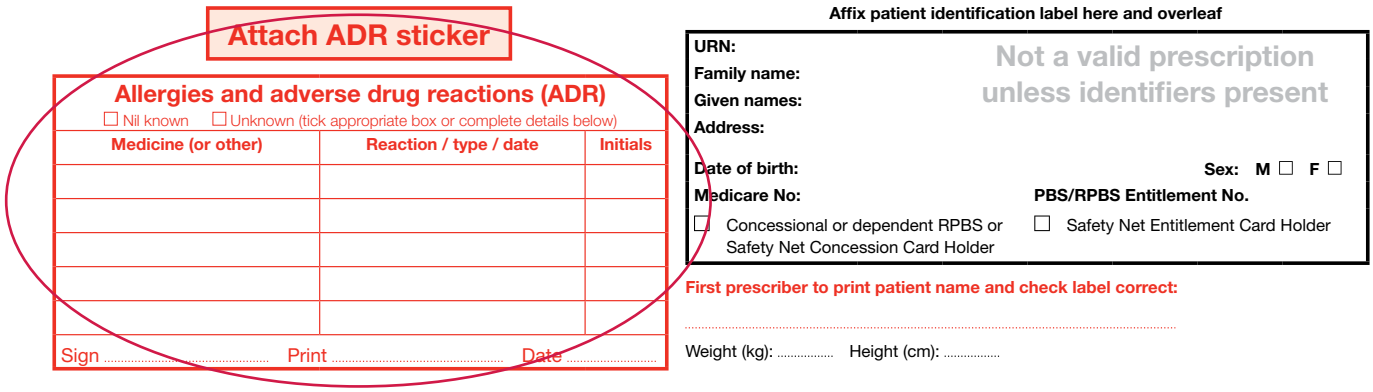
Once completed, sign the space underneath, print name and date.

Affix an ADR alert sticker to the front and back page of the chart in the spaces provided if alert stickers are available in your facility.

Note: This is the minimum information that should be documented. It is preferable to also document how the reaction was managed (e.g. withdraw and avoid offending agent) and the source of the information (e.g. patient self-report, previous documentation in health record etc.).

Any information added after the initial recording needs to be initialled in the side column.

Figure shows the allergies and adverse drug reaction section.



3.2.8 Medicines taken prior to presentation to hospital

Purpose:

To record and communicate the patient's medication history.

Risk addressed:

A correct and complete medication history at the point of prescribing reduces the risk of medication misadventure.

Instruction:

A health professional trained to take a best possible medication history must document:

- A complete list of all medicines taken normally at home (prescription, non-prescription and complementary medicines) including drug identification details (generic name, strength and form), dose and frequency, and duration of therapy or when therapy started.
- Whether the patient:
  - has their own medicines with them
  - uses a dose administration aid (e.g. Webster Pak)
  - has a preferred dosage form (e.g. suspension for paediatric patients)
  - receives assistance to administer or manage their medicines.
- Contact details for the patient's community health providers (general practitioner and community pharmacy).

Any unintentional discrepancies between the medication history and the medicine orders must be brought to the attention of the prescriber.

Use a separate medication history form (such as the Medication Management Plan) for patients presenting with more than 12 medicines.

Note: It is also helpful to document the indication for use and to use a checklist as a prompt to ensure a comprehensive history is obtained.

Figure above shows the medication history section.

Medicines taken prior to presentation to hospital
(Prescribed, over the counter, complementary)

Own medicines brought in? Y ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP:	Community pharmacy:

Sign: ..... Print: ..... Date: ..... Medicines usually administered by: .....

Recording medication history: Further information

Patient medication history may also be recorded on:

1. National Medication Management Plan form
2. Local medication history form.

If a separate form is used, it should be noted in the 'Medicines taken prior to presentation' section and the separate form should be kept with, or next to, the PBS HMC.

Medication Management Plan (MMP) Form

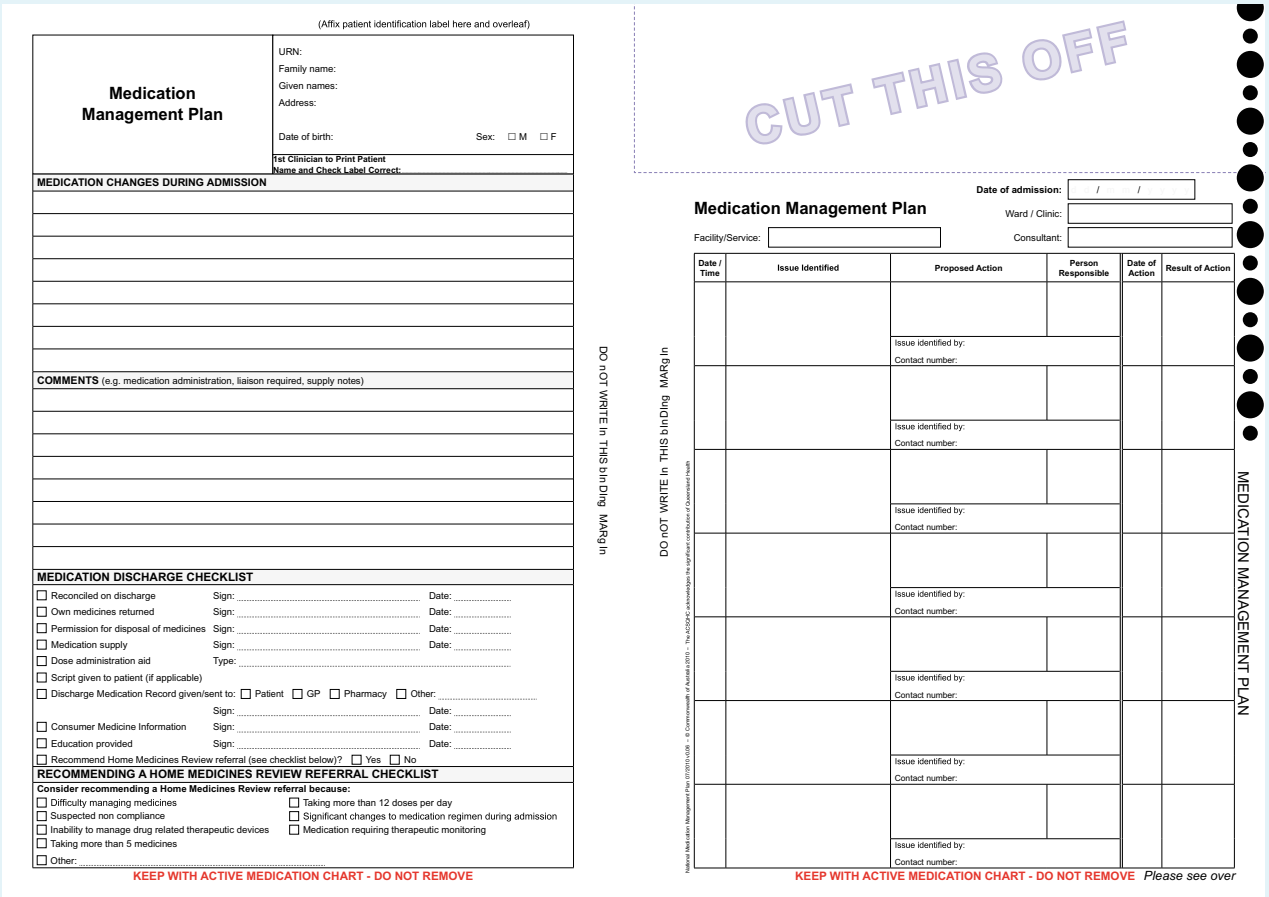
The MMP provides health service organisations with a standardised form that can be used by nursing, medical, pharmacy and allied health staff to improve the accuracy of information recorded on admission and available to the clinician responsible for therapeutic decision making.

A standardised form to record the medicines taken prior to presentation at the health service organisation and used for reconciling patients' medicines on admission, intra-health service transfer and at discharge is considered essential for the medication reconciliation process. The MMP provides Australian health service organisations with a form designed specifically for these purposes. The MMP is designed for use in adult and paediatric patients.

The MMP aligns with the Australian Pharmaceutical Advisory Council's Guiding principles to achieve continuity in medication management. It incorporates the minimum data set for a medication history outlined in Guiding Principle 4: Accurate medication history.

The MMP, Medication Management Plan User Guide and other implementation resources are available from the Commission's web site at www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/medication-management-plan.

http://www.safetyandquality.gov.au/wp-content/uploads/2010/01/Medication-Management-Plan.pdf



(Affix patient identification label here and overleaf)

Medication Management Plan

URN:
Family name:
Given names:
Address:

Date of birth: Sex: ☐ M ☐ F

1st Clinician to Print Patient Name and Check Label Correct:

MEDICATION CHANGES DURING ADMISSION

COMMENTS (e.g. medication administration, liaison required, supply notes)

MEDICATION DISCHARGE CHECKLIST

- ☐ Reconciled on discharge Sign: ..... Date: .....
- ☐ Own medicines returned Sign: ..... Date: .....
- ☐ Permission for disposal of medicines Sign: ..... Date: .....
- ☐ Medication supply Sign: ..... Date: .....
- ☐ Dose administration aid Type: .....
- ☐ Script given to patient (if applicable)
- ☐ Discharge Medication Record given/sent to: ☐ Patient ☐ GP ☐ Pharmacy ☐ Other: .....
  Sign: ..... Date: .....
- ☐ Consumer Medicine Information Sign: ..... Date: .....
- ☐ Education provided Sign: ..... Date: .....
- ☐ Recommend Home Medicines Review referral (see checklist below)? ☐ Yes ☐ No

RECOMMENDING A HOME MEDICINES REVIEW REFERRAL CHECKLIST

Consider recommending a Home Medicines Review referral because:

- ☐ Difficulty managing medicines
- ☐ Suspected non compliance
- ☐ Inability to manage drug related therapeutic devices
- ☐ Taking more than 5 medicines
- ☐ Taking more than 12 doses per day
- ☐ Significant changes to medication regimen during admission
- ☐ Medication requiring therapeutic monitoring
- ☐ Other: .....

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE

DO nOT WRITE In THIS bInDIng MARg In

CUT THIS OFF

Medication Management Plan

Date of admission: / /
Ward / Clinic:
Facility/Service:
Consultant:

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			

DO nOT WRITE In THIS bInDIng MARg In

MEDICATION MANAGEMENT PLAN

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE *Please see over*

3.2.9 Prescriber details

Purpose:

To document details and signatures of all prescribers and provide sample signatures to accurately verify medicines.

Risk addressed:

Full prescriber details are required in order to confirm their authority to prescribe and to provide contact details if follow-up is required.

PBS requirements:

For a valid prescription, the following prescriber details must appear on page one of the chart:

- Name
- PBS prescriber number
- Contact number (mobile or pager)
- Address
- Signature and date.

Instruction:

The prescriber does not have to personally complete their name, address and PBS prescriber number on the front page of the chart, but these fields must be completed for orders on the chart to be considered valid prescriptions. However, the prescriber must sign the front page of the chart (in the box containing their details), and must sign their name in the prescription box for each medication order written on the chart.

Figure shows the prescriber details section.

Presc

	Prescriber 1	Prescriber 2	Presc
Name:	A Doctor		
Prescriber No.	1122334		
Contact No.	0404123123		
Address:	1 Sunny Dale Pleasantville 8001		
Signature:	ADoctor	Signature	Sign
Date:	1/4/18	Date	D

3.2.10 Once only and nurse initiated medicines and pre-medications

Purpose:

To document once only and nurse initiated medicines and pre-medications.

Risk addressed:

Ensuring patients receive timely medicines requires a structured system of authorisations to mitigate potential patient safety risks.

Instruction:

Once only medicines and pre-medications

Document the following for once only and pre-medication orders:

- date prescribed
- generic name of medicine
- route of administration
- dose to be administered including the dose calculation (e.g. mg/kg/dose) for paediatric orders
- date and time medicine is to be administered
- prescriber's signature and printed name
- initials of person that administers the medicine, and initials of a second person to document double checking of the dose for paediatric orders
- time medicine administered
- pharmacist review of orders.

Standing orders

Document standing orders the same as once only medicines and pre-medications (see above) and consistent with the relevant local health service organisation policy or guidelines.

Nurse initiated medicines

Document nurse initiated medicines the same as once only medicines and pre-medications (see above) and consistent with the relevant local health service organisation policy or guideline.

Figure shows the once only and nurse initiated medicines and pre-medications section (page 1 of PBS HMC).

Once only and nurse initiated medicines and pre-medications/Telephone orders														
Date/time prescribed	Medicine (print generic name)/form	Route	**Dose**	Frequency	Check initials		Prescriber/ nurse initiator name	Prescriber /nurse initiator sign	Date	Record of administration				Pharmacy
					N1	N2				Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by	

Nurse initiated medicines: Further information

Nurse initiated medicines are non-prescription medicines that may be administered by a registered nurse or midwife, or delegated to an authorised enrolled nurse in non-life threatening situations without a prior written or telephone instruction from an authorised prescriber.

The medicine must be listed on the health service organisation's approved list of nurse initiated medicines and administered in accordance with local policy. Some health service organisations do not permit nurse initiated medicines to be administered to paediatric patients.

Local policy or guidelines will outline when nurses can initiate medicines and will specify a limit on doses of nurse initiated medicines that can be given such as for one dose only or for a maximum of 24 hours only. Generally this applies to a limited list of unscheduled, Schedule 2 and Schedule 3 medicines. Typically this list includes:

- analgesics
- laxatives
- antacids
- cough suppressants
- sublingual nitrates
- inhaled bronchodilators
- artificial tears
- sodium chloride 0.9% flush
- IV infusion to keep IV line(s) patent as per local policy.

3.2.11 Telephone orders

Purpose:

To document telephone orders.

Risk addressed:

Ensuring patients receive medicines in a timely manner in the absence of a prescriber requires a structured system of authorisations to reduce risk of errors from verbal orders.

Instruction:

Local policy and guidelines will outline whether telephone orders are allowed and under what circumstances they are to be used.

When a telephone order is required, the prescriber telephones the hospital and two registered nurses confirm the order with the prescriber.

The telephone order MUST be signed and dated, or otherwise confirmed in writing (e.g email, fax) by the prescriber, within 24 hours.

The telephone order section of the chart should be completed as follows:

- date prescribed
- generic name and form of medicine
- route of administration
- dose to be administered including the basis for the dose calculation (e.g. mg/kg/dose) for paediatric orders
- frequency with which the medicine is to be administered
- initials of the two nursing staff to confirm the verbal order was heard and double checked
- name of the prescriber giving the verbal order
- date and time medicine is to be administered
- initials of person that administers the medicine, and initials of a second person to document double checking of the dose for paediatric orders
- time medicine was administered
- prescriber's signature and printed name (within 24 hours or followed by another written confirmation of the order that complies with jurisdictional regulations).

Note: If the prescriber does not sign the order within seven days, the pharmacist must advise the Duty Pharmaceutical Officer at the Pharmaceutical Services Unit in the relevant jurisdiction.

Figure shows the telephone orders section with order recorded, checked and signed.

Once only and nurse initiated medicines and pre-medications/Telephone orders

Date/time prescribed	Medicine (print generic name)/form	Route	**Dose**	Frequency	Check initials		Prescriber/ nurse initiator name	Prescriber /nurse initiator sign	Date	Record of administration				Pharmacy
					N1	N2				Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by	
1/6/18	Frusemide	IV	20mg	Stat	AB	QT	P.Jones	P.Jones	2/6/15	10.00 AB				

3.2.12 MEDICINE ORDERS: Variable dose medicines

Purpose:

To document variable dose medicine orders that require laboratory test results or are prescribed as a reducing protocol (e.g. gentamicin or steroids).

Risk addressed:

There is no designated area to record drug levels if these agents are ordered in the regular ordering section.

The risk of omission is increased if variable dose medicines are ordered in the once only ordering section.

Instruction:

The prescribing clinician should document the following:

- generic name of medicine
- form and strength of medicine
- dose
- frequency of administration
- route of administration
- Streamlined Authority Code (if applicable)
- prescriber signature and date signed
- start date
- times medicine to be administered
- indication.

The attending health professional should document the following for each day of therapy:

- drug level results for medicines requiring therapeutic monitoring
- time drug level was taken.

The prescribing clinician should document the following for each dose:

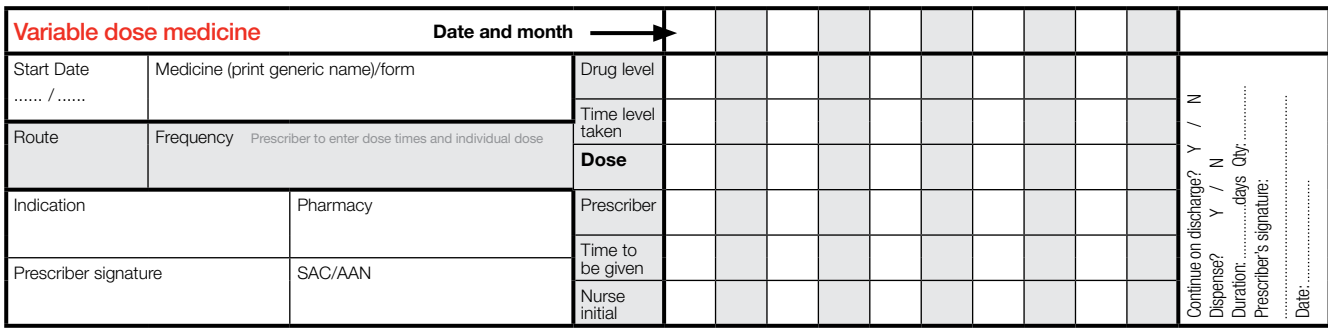
- dose
- pathology results where appropriate
- prescriber's initials.

The administering clinician should document the following for each dose:

- initials of the person who administers the dose (written in the time to be given row)
- actual time of administration which may be different from the dose time (written in the time given row).

If a patient requires a second variable dose medicine, or twice daily dosing, prescribe the second medicine or the second dose in a regular medicine space using the same format as in the variable dose medicine section.

Figure shows the variable dose medicine section.



3.2.13 MEDICINE ORDERS: Venous thromboembolism prophylaxis

Purpose:

To document venous thromboembolism (VTE) risk, contraindication and prophylaxis orders.

Risk addressed:

Healthcare-associated VTE is a national health safety and quality issue. Research demonstrates that including a prompt for VTE risk assessment and for prophylaxis prescribing improves the rate of VTE risk assessment and of appropriate prophylaxis prescribing.

Instruction:

Assessing VTE risk and pharmacological and mechanical prophylaxis contraindication

The attending health professional should assess patient's VTE risk and:

- tick the 'VTE risk assessed' box
- tick the 'prophylaxis not required' box if appropriate
- tick the 'contraindicated' box if appropriate and document in the health record (and strike out pharmacological and/or mechanical prophylaxis sections as appropriate)
- sign and date.

VTE pharmacological prophylaxis

The prescribing clinician should document the following:

- generic name of medicine
- form and strength of the medicine
- dose
- route of administration
- frequency of administration
- date and time medicine is to be administered
- prescriber's signature and date
- start date for medicine.

Three dose time sections allow these medicines to be administered up to three times a day.

The indication section is pre-printed with 'VTE prophylaxis'

If the dose of VTE prophylaxis medicine needs to be changed, a new order should be prescribed on a subsequent chart.

The administering clinician should document the following:

- their initials on administration.

VTE mechanical prophylaxis

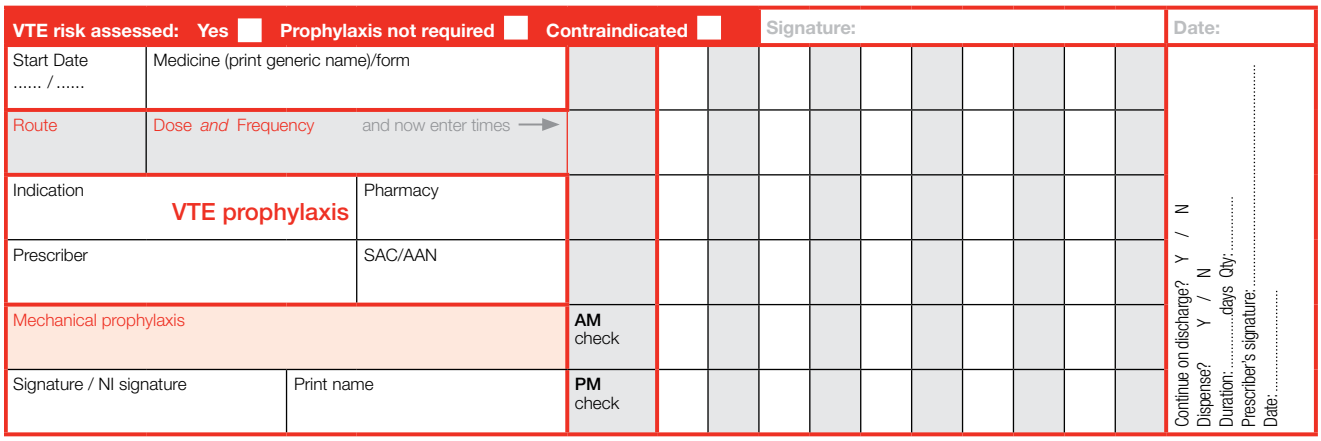
The prescribing clinician should document the following:

- type of mechanical prophylaxis required e.g. graduated compression stockings
- prescriber's signature.

Nursing staff may have responsibility for ordering mechanical prophylaxis depending on local policy.

'am and 'pm' have been pre-printed in the administration space to encourage checking and documenting that patients receive mechanical prophylaxis correctly.

Figure shows the VTE prophylaxis section.



VTE prophylaxis section: Further information

This VTE prophylaxis section is designed to prompt documentation of:

- VTE risk assessment
- contraindications to VTE prophylaxis
- ordering of pharmacological and mechanical VTE prophylaxis, if indicated.

The VTE prophylaxis section is placed above the dedicated warfarin section to assist in recognising patients who are already receiving therapeutic anticoagulation and do not require VTE prophylaxis.

The clinician responsible for assessing patients' VTE risk should do so according to local policy and then document the outcome.

In some health service organisations, documentation of the risk assessment will be done by the admitting medical officer or authorised prescriber. In others, it will be the responsibility of the nursing staff. The risk assessment should be completed consistent with local policy and in relation to the patient's clinical status at that point. For patients with multiple charts, the VTE risk assessment should be documented on the first chart. Reassessment of risk may be required depending on changes to clinical status, medicines and other circumstances and should be documented in the VTE risk assessment section on one of the subsequent charts.

If the dose of VTE prophylaxis medicine needs to be changed, a new order should be prescribed on a subsequent chart.

VTE therapy/treatment

If VTE therapy is required, e.g. for a pre-existing DVT, it should be ordered in the regular medicines space and not in the pre-printed VTE prophylaxis section.

3.2.14 MEDICINE ORDERS: Warfarin

Purpose:

To document warfarin orders and record INR results.

Risk addressed:

Warfarin is a medicine with a high risk of patient harm from missed or duplicate doses and from prescribing not linked to international normalised ratio (INR) results. The integrated and dedicated warfarin space incorporates warfarin prescribing with INR result recording to reduce these risks.

Instruction:

The prescribing clinician should document the following:

- start date
- route
- required brand name (circle)
- dose to be administered (prescriber enters individual doses)
- target INR range
- indication
- prescriber's signature and date signed.

For **each day of therapy**, document the following information:

- INR result
- warfarin dose
- prescriber's initials
- initials of the person that administers the medicine, and initials of a second person to document double checking of the dose.

Warfarin section: Further information

The warfarin ordering section is printed in red as an extra alert to indicate that it is an anticoagulant (and a high-risk medicine).

It is recommended that a copy of guidelines for anticoagulation using warfarin is available for health professionals to assist when a patient is commenced on warfarin. The guidelines should include information about target INR, duration of therapy, dosing, management of excessive bleeding and drug interactions.

A standard warfarin administration time is recommended and the PBS HMC includes a pre-printed standard time of 18:00. However, services may choose an alternate standard time to pre-print on the PBS HMC, such as 16:00, to ensure the team caring for the patient orders the next dose (based on INR results) during usual business hours.

Figure shows the warfarin section.

Start Date ..... /	Warfarin	**Marevan / Coumadin** Circle brand
Route	Prescriber to enter individual doses	Target INR Range
Indication	Pharmacy	
Prescriber signature		

INR Result											
Dose	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	
Prescriber											
Initial 1 18:00											
Initial 2											

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty: .....
Prescriber's signature: .....
Date: .....

3.2.15 Anticoagulant education record

Purpose:

To document education provided at the initiation of anticoagulant therapy prescribed for ongoing treatment.

Risk addressed:

Anticoagulants are medicines with high risk of patient harm if not taken correctly. Documenting that an education session was conducted with the patient ensures all healthcare staff know the patient has been instructed on how to manage their anticoagulant medicine safely, including any required monitoring and dose adjustment for ongoing use.

This section records a key risk mitigation activity, educating patients on how to manage their anticoagulant medicine.

Instruction:

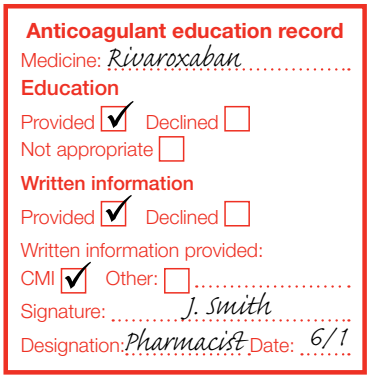
The health professional who intends to provide the education should document:

- the name of the anticoagulant (medicine) prescribed for ongoing treatment
- whether education for the anticoagulant was provided, declined or was not considered appropriate for the patient. The choice of 'not appropriate' should be in line with local policy. It may include instances where the patient has taken the medicine before or where the patient is cognitively impaired.
- whether written information about the anticoagulant was provided or whether it was declined by the patient
- what written information was provided to the patient; Consumer Medicine Information (CMI) and/or other (specify)
- health professional signature
- their designation, for example nurse, pharmacist or doctor
- date signed.

Anticoagulant education record: Further information

Anticoagulants are high risk medicines. To safeguard against potential harms, all patients initiated on oral or injectable anticoagulants such as warfarin, direct oral anticoagulants (e.g. rivaroxaban) or low molecular weight heparins (e.g. enoxaparin) for ongoing treatment must receive education and written information about their new medicine..

Figure shows a completed example of the anticoagulant education record.



3 Instructions for using the PBS HMC

3.2.16 MEDICINE ORDERS: Regular medicine order

Purpose:

To document regular medicine orders.

Risk addressed:

Standardising medicines prescribing and administering, and presentation of related information, reduces the risks of error through slips and lapses, the greatest causes of medicine error in health service organisations.

Instruction:

The prescribing clinician should document the following:

- start date (date of prescribing or transcribing)
- generic medicine name
- form and strength
- whether slow release (tick box if appropriate)
- route
- dose
- frequency and enter administration times
- indication
- prescriber signature and date signed.

The administering clinician should document their initials to the relevant administration panel on the PBS HMC.

Figure shows a regular medicine panel.

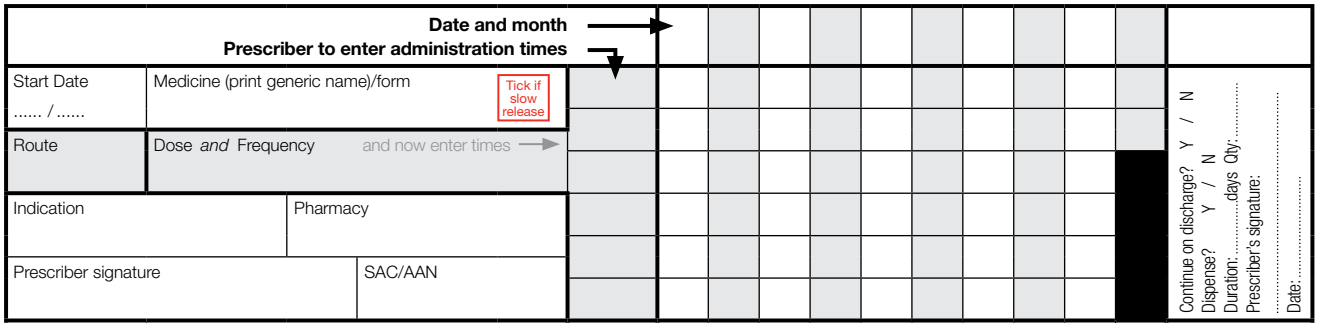
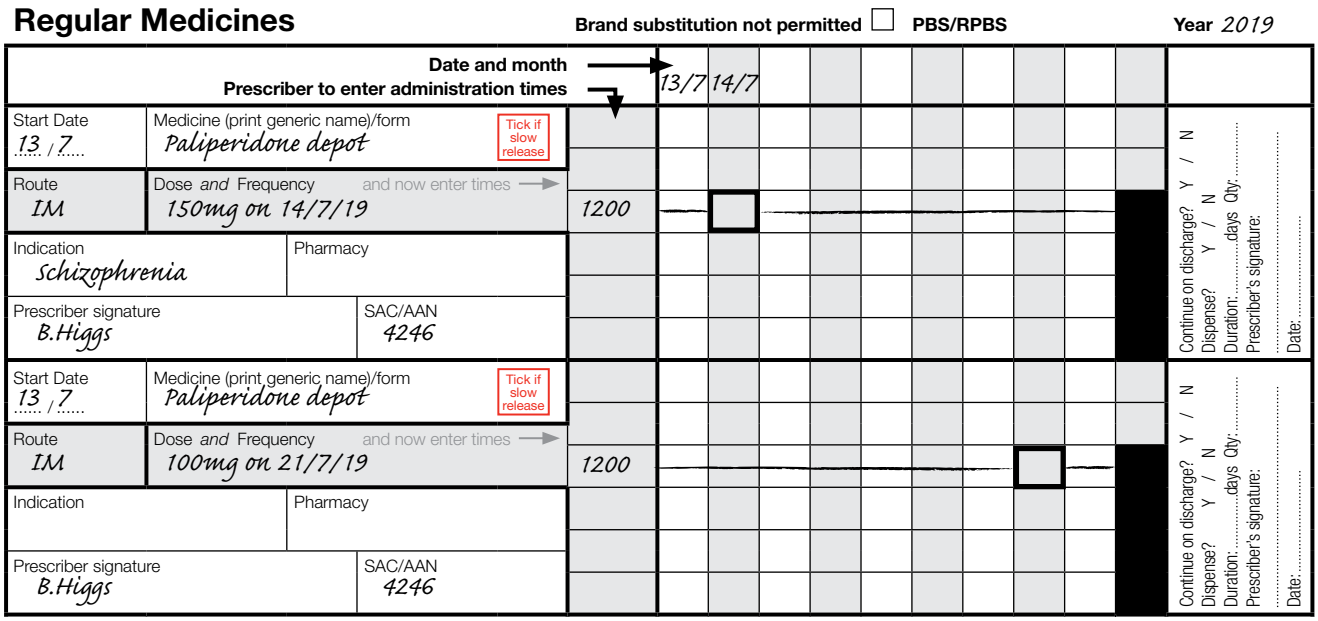


Figure shows a complete medicine order including how an intermittent medicine can be charted.

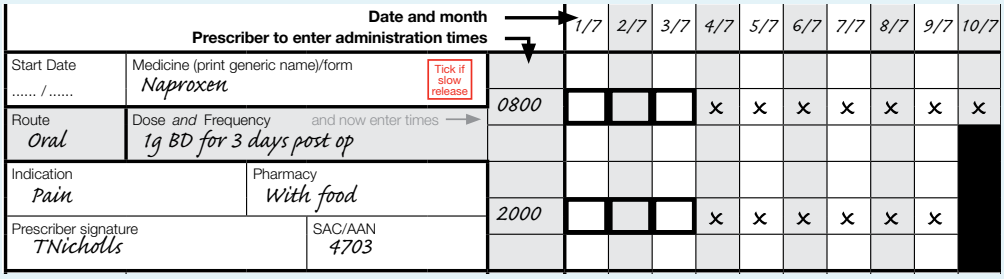


Regular medicine orders: Further information

a) Limited duration medicines

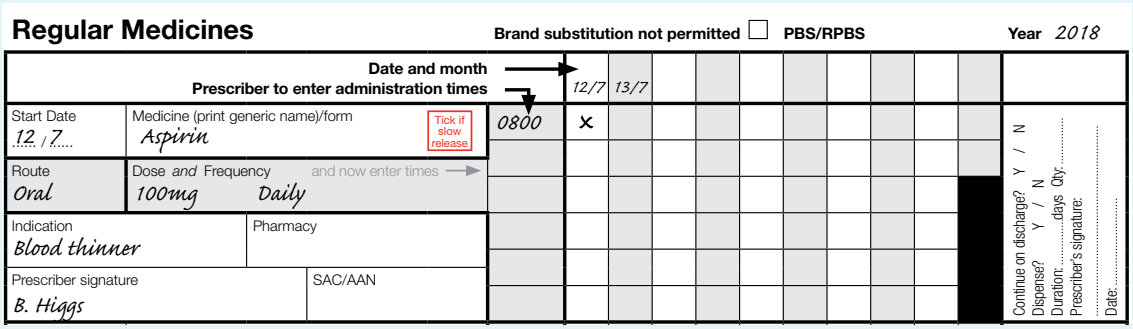
When a regular medicine is ordered for a limited duration, or only on certain days, this must be clearly indicated using crosses (**X**) to block out day/times when the medicine is NOT to be given.

Orders for antimicrobials must include a cease or review date.



b) Medicines intended for next day administration

Prescribers ordering medicines intended for next day administration should clearly cross out the days/times when the medicine is NOT to be given.



c) Medicine orders prescribed on an additional (specialty) chart

Regular medicines prescribed on specialty charts should be documented in the regular medicines section of the PBS HMC. The date and name of the medicine should be written into the 'Medicine (print generic name)' field for the medicine order with a reference in the administration section indicating which specialty chart should be referred to along with the initials of the prescriber. Administration of the medicine should be documented on the specialty chart to correspond with the medicine order. The specialty chart can not be used for claiming.

Please also refer to section 3.2.5, Additional charts.

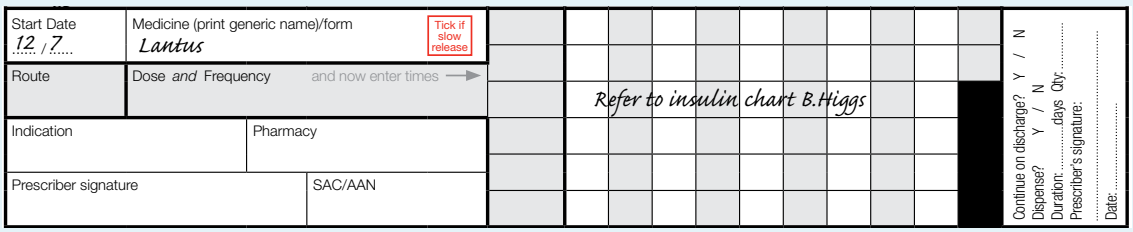


Figure above demonstrates how to cross-reference a regular medicine prescribed on an additional (specialty) chart.

d) Ceased medicines/changes to medication orders

When stopping a medicine, the original order must not be obliterated. The prescriber must draw a clear line through the order in both the prescription and the administration record sections, taking care that the line does not impinge on other orders.

The prescriber must write the reason for changing the order (e.g. cease, written in error, increased dose etc), the date and their initials in the administration record section.

When a medicine order needs to be changed (e.g. drug, form, strength, frequency), the prescriber must not over write the order. The original order must be ceased and a new order written.

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

The changes must be promptly communicated to pharmacy by sending each page of the chart on which a medication change has occurred and a copy of the front page of the chart.

e) Slow release medicines and other non-standard formulations

The *Tick if Slow Release box* is included in regular medicine spaces as a prompt to prescribers to consider whether or not the standard release form of the medicine is required. This box must be ticked to indicate a **sustained, modified or controlled** release form of an oral medicine (e.g. verapamil SR, diltiazem CD). If not ticked, then it is assumed that the standard release form is to be administered.

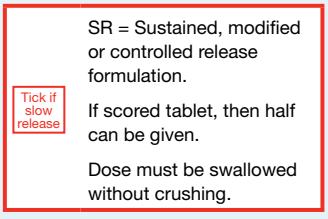


Figure shows the Slow release and legend box found in the middle of the acute charts and on the right hand side of the long-stay chart.

f) Reasons for not administering

When it is not possible to administer the prescribed medicine, the reason for not administering must be recorded by entering the appropriate code (see figure below) and circling. By circling the code it will not accidentally be misread as someone's initials.

If a patient refuses medicine(s), then the prescriber must be notified. If medicine(s) are withheld, the reason must be documented in the patient's medical notes.

If the medicine is not available when required, it is the responsibility of the person administering to notify the pharmacy and/or to obtain supply or to contact the prescriber to advise that the medicine ordered is not available.

Figure shows reasons for not administering box found in the middle of the chart.

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

3.2.17 MEDICINE ORDERS: PRN orders

Purpose:

To provide a separate section for ordering PRN (as required) medicines.

Risk addressed:

Mistaking PRN orders for regular orders is a risk to patient safety. Separating PRN from regular orders reduces the risk of error.

Instruction:

Prescribing clinicians should exercise caution when prescribing PRN medicines and check the regular medicines section for possible duplicate orders.

The prescribing clinician should document the following for each medicine prescription:

- medicine (generic name)
- form and strength of medicine
- route
- dose (PRN (pre-printed) alone is not sufficient)
- hourly frequency (PRN (pre-printed) alone is not sufficient)
- maximum daily dose (i.e. maximum PRN dose in 24 hours) e.g. paracetamol 4g
- indication
- prescriber signature.

Administering clinicians should check the maximum PRN dose in 24 hours and also check the timing of the previous dose (either PRN or regular).

The administering clinician should document the following for each medicine administration:

- date
- time
- dose given
- route
- initial.

PRN (as required) medicines: Further information

a) Max PRN dose/24 hrs

The Max PRN dose/ 24 hours prompt indicates the total amount of the medicine which may be administered in 24 hours for PRN doses only. The maximum daily dosage should not be exceeded for that PRN medicine.

b) Multiple route orders

Generally, medicine orders should be for one route only. However, local requirements may indicate other practice. Health service organisations should be aware of risks associated with medicine orders with multiple routes of administration. A health service-specific list of exceptions to the general rule should be determined in conjunction with the health service's drug and therapeutics committee or equivalent and appropriate risk mitigation strategies put in place.

The figure shows the PRN order section.

Start Date 1 / June	Medicine (print generic name)/form Paracetamol	Date													
Route Oral	Dose *and* hourly frequency 500mg Every 6 hours **PRN**	Time													
Indication Pain relief	Max PRN dose/24hr 1g	Dose													
SAC/AAN	Pharmacy	Route													
Prescriber signature A Doctor		Sign													

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature: .....
Date: .....

c) Prescribing PRN opioids

The sedation score may be specified in the 'Max Dose/24 hrs' section to indicate the maximum medicine amount to be administered when prescribing opioids in the PRN section.

When sedation scores are used, the local policy or guideline should specify a standard sedation scoring system and a process for recording the scores, and the record must be available at the point of care. Nursing and medical staff should be familiar with the sedation scale used.

For example, using the 4 point sedation scale of 0 to 3 published by the Victorian Quality Council, the PRN order could specify 'if sedation score is less than 2'. The error-prone symbol < should not be used.

The Victorian Quality Council 2007 Acute Pain Management Measurement Toolkit is available from www.health.vic.gov.au/qualitycouncil/downloads/apmm_toolkit.pdf

The figure below details a sedation scale.

Victorian Quality Council sedation scale	
0	awake, alert
1	mild sedation, easy to rouse
1s*	asleep, easy to rouse
2	moderate sedation, easy to rouse, unable to remain awake
3	difficult to rouse

* may not be used in some centres where a score of 1 is used whether or not the patient is asleep as a sedation score of 2 could be missed.

3.2.18 MEDICINE ORDERS: Discharge supply

Purpose:

To order discharge supply of medicines.

Risk addressed:

Poor continuity of care, including ongoing medicines supply, risks patient recovery and safety. Prescribing discharge medicines directly from the medication chart reduces the risk of transcription error.

Instruction:

The prescribing clinician should document the following for each medicine:

- Continue on discharge? Circle yes if medicine is to be continued on discharge
- Dispense? Circle yes if the medicine is to be dispensed by the health service organisation pharmacy on discharge.
- Duration …days. Number of days the medicine is required on discharge.
- Qty……..Quantity of the medicine to be supplied.
- Prescriber's signature and date.

Figure shows the discharge supply space which is displayed vertically in the regular medicine section and in the PRN medicine section.

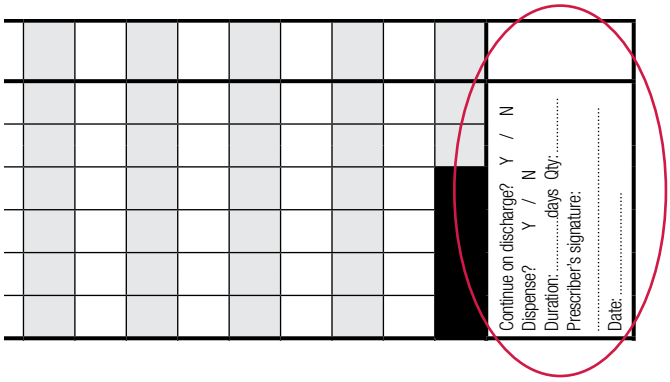
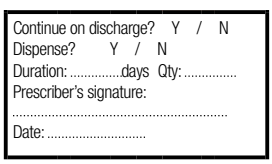


Figure shows the detail of the discharge section.



3.2.19 MEDICINE ORDERS: Pharmacy annotation

Purpose:

To supplement prescribing information during review by a pharmacy. This could be completed by a pharmacist or another member of the pharmacy staff.

Risk addressed:

Unclear or ambiguous medicine orders can risk patient safety. Ensuring ongoing availability of medicines reduces risks of omitted doses or delayed administration.

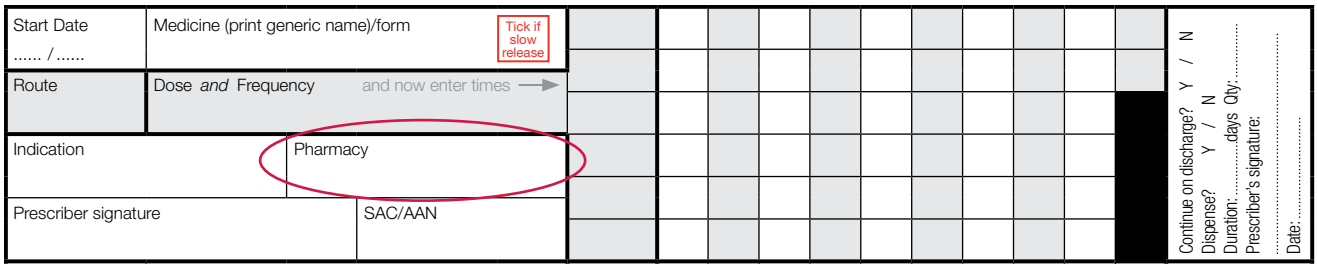
Instruction:

- The PBS HMC includes space for use by the ward/clinical pharmacist to clarify the medication chart prescription, indicate source of supply or provide administration instructions. Annotations in the space can include:

I	Medicines available on imprest
S	Non-imprest items that will be supplied and labelled for individual use from the pharmacy
Pts own	Medicines brought in by the patient that have been checked by the pharmacist and confirmed to be acceptable for use during the patient's admission
CD, S8	Controlled Drug (Schedule 8 medicine stored in CD safe)
Fridge	A medicine that is stored in the refrigerator

The pharmacist should review the chart to ensure that all orders are clear, safe and appropriate for the patient, and accordingly initial the space on the correct day.

Figure shows the pharmacy annotation space.



3.2.20 MEDICINE ORDERS: Pharmaceutical review

Purpose:

To document the clinical review of medicine orders by a pharmacist.

Risk addressed:

Unclear, unsafe and inappropriate medicine orders can risk patient safety.

Instruction:

Review medicine orders on the PBS HMC to ensure that all orders are clear, safe and appropriate for the patient. Initial the space on the correct day.

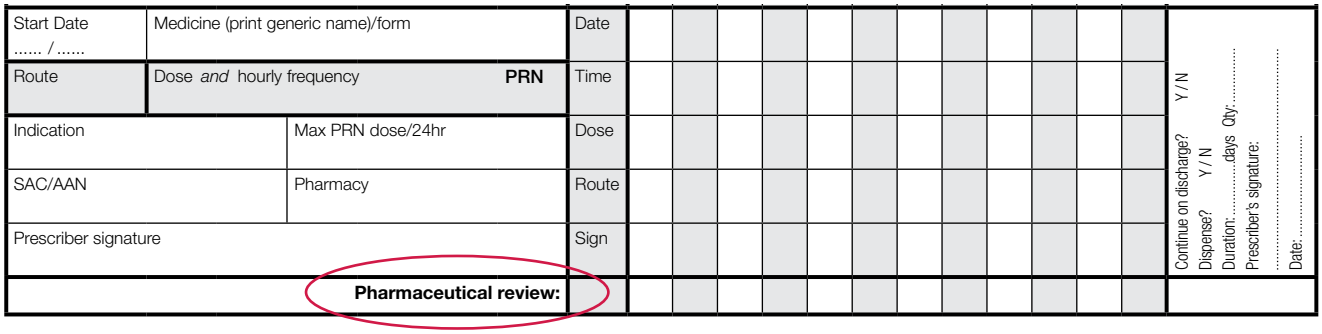


Figure above shows an example of the Pharmaceutical review space that can be found at the base of the regular medicines and PRN sections of the chart.

Appendices

4

4 Appendices

Appendix 1: PBS Hospital Medical Chart resources

1. Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines www.safetyandquality.gov.au/publications-and-resources/resource-library/recommendations-terminology-abbreviations-and-symbols-used-medicines-documentation
2. Medication Management Plan form and support materials www.safetyandquality.gov.au/publications/medication-management-plan
3. High risk medicines resources www.safetyandquality.gov.au/our-work/medication-safety/medication-alerts
4. National Standard Medication Chart auditing www.safetyandquality.gov.au/our-work/medication-safety/nsmc-audit

Appendix 2: Guidelines for administering and withholding medicines

The PBS HMC is a legal document and therefore must be written in a clear, legible and unambiguous form.

Every nurse has a responsibility to ensure they can clearly read and understand the order before administering any medicines. For all incomplete or unclear orders, the prescriber should be contacted to clarify. Never make any assumptions about the prescriber's intent.

Every medication chart must have the patient's identification details completed.

Every medicine order must be complete and include:

- **Date**
- **Route**
- **Generic medicine name**
- **Dose ordered in metric units & arabic numerals**
- **Frequency** (using only accepted abbreviations)
- **Times** (must be entered by the authorised prescriber)
- **Prescriber's signature**

If the medication chart is full (i.e. there is no appropriate space to sign for administration) then the medicine order is not valid. The chart must be re-written as soon as possible.

Withholding medicines

It is appropriate to withhold the medicine if there is a known adverse drug reaction (ADR) to the prescribed medicine.

Generally medicines should not be withheld if the patient is pre-operative or nil by mouth (NBM) / fasting unless specified by the authorised prescriber.

Remember the five Rs:

- The **right medicine**
- The **right dose**
- The **right route**
- The **right time**
- The **right patient**

Appendix 3: Ordering oral and enteral nutrition supplements on the PBS HMC

The PBS HMC is not designed for ordering and recording administration of oral and enteral nutritional supplements. Its use for this purpose may result in:

- Confusion of nutritional supplements with medicines; (e.g. *Pulmocare* mistaken for the corticosteroid inhaler *Pulmicort* and amino acid liquid *Nepro* mistaken for the antiepileptic medicine *Keppra*)
- Potential for patients to receive unauthorised medicines
- Delays in provision and administration of nutrition to patients if the PBS HMC is sent to the pharmacy for dispensing.

Some health services have a separate clinical nutrition chart for ordering and administration of nutritional products including nutritional supplements.

Health services that choose to use the PBS HMC for ordering nutritional supplements should undertake a risk assessment and have a local policy or procedure on ordering and recording administration of nutritional supplements. The same requirements that apply to safer prescribing and administration of medicines on the PBS HMC should also apply to ordering and recording administration of nutritional products on the PBS HMC. Local policies or procedures for ordering and recording administration of nutritional supplements on the PBS HMC should include:

- Who is responsible for ordering nutritional supplement on the PBS HMC (medical officer, authorised dietitian, etc.)
- The requirement for a dietitian to undertake training in the key principles of safe prescribing practices before ordering an approved nutritional supplement on the PBS HMC
- Where and how the nutritional supplement is ordered
- The requirement to annotate 'nutritional supplement' in the indication box or next to the product name
- How to cease the nutritional product
- Dietitian to regularly check PBS HMC for transcribing errors in nutritional product
- Regular auditing of prescriptions of nutritional supplements.

Appendix 4: Ordering and administering medical gases on the PBS HMC

The PBS HMC should not be used to order or administer medical gases, such as oxygen. These medicines require specific features to safely order, administer and monitor their use. The necessary features are not included on the standard PBS HMC.

It is recognised that some jurisdictions have systems in place to order and administer medical gases, such as specific ancillary charts. Please contact your jurisdiction's Health Services Medication Expert Advisory Group representative or health department for information on recommended processes for documenting orders and administration of medical gases.

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