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COMMISSION NEW ZEALAND  
*Kupu Taurangi Hauora o Aotearoa*

his<sup>o</sup>

Health Information Standards Organisation  
PAEREWA PĀRONGO HAUORA

# Medication Charting **STANDARD** VERSION 3, SEPTEMBER 2012

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## New Zealand Legislation

The following legislation is referred to within this Standard. They may be consulted, if required, in order to further clarify this Standard.

Health Practitioners Competence Assurance Act 2003  
Medicine Act 1981  
Medicines Regulation 2005  
Health and Disability Services (Safety) Act 2001  
Privacy Act 1993  
Health (Retention of Health Information) Regulations 1996



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# 1 Introduction

The Medication Charting Standard was initially developed by the Safe Medication Management (SMM) Programme. The SMM Programme was a clinician-led collaboration across 20 district health boards (DHBs), which was put in place by the ministerial-appointed Quality Improvement Programme, as an initiative to improve safety by reducing harm to patients from adverse drug events. Medication safety is now the responsibility of the Commission.

The Standard details the minimum requirements for documentation of each person involved in the medication charting process, the minimum requirements for a prescription item on the medication chart and how the documentation should be managed.

The details of all persons involved in the medication charting process must be clearly documented on the medication chart. The key persons involved are: patient, prescriber, dispenser/pharmacist, administrator, checker and other healthcare practitioners, eg, a dietician or certified diabetes educator, who sees a patient based on a referral from another healthcare practitioner.

The definitions for each of the key healthcare practitioners can be found in the glossary in Appendix A.

The expected outcome of the Standard is for patients to receive medicines in a safe and timely manner which complies with current legislative requirements and best practice guidelines.

## 1.1 SCOPE OF APPLICATION

This Standard explains the minimum requirements for patient safety for prescribing, dispensing and administering of medicines (either paper or electronic based) within the New Zealand health and disability sector.

## 1.2 REVIEW PERIOD

This Standard provides a consistent framework for medication charting across the New Zealand health and disability sector. It is intended that the Standard continues to reflect the challenges and changes experienced by the sector. In order to achieve this, the Standard will be reviewed every two years from the date of publication unless required sooner.

## 1.3 INTERPRETATION

Within the text of this document, the words 'shall' and 'will' refer to practices that are mandatory for compliance with this Standard. The words 'should' and 'may' refer to practices that are advised or recommended.

## 2 Summary of the Medication Charting Standards

The Medication Charting Standard consists of three key areas.

Each area has an overall aim and specific requirements which need to be met in order to achieve the outcomes of the Standard. The objectives for each key area are listed below. To ensure further understanding of these objectives and to reduce any ambiguity, further specificity is included underneath the objective requirements.

Key area	Objectives
Person Details	The details of all persons involved in the medication charting process must be clearly documented on the medication chart. The requirements for each person/role are listed in this section.
Medication Details	This section describes the detail required for a prescription item on the medication chart and also to ensure the medicine details are documented in a legal, legible and consistent manner.
Document	This section describes how the medication chart should be managed.



## 3 Person Details

In this Standard, a person is identified as either a 'patient', 'prescriber', 'dispenser/pharmacist', 'administrator' or 'checker'.

There are different requirements for what is recorded for each of the key persons.

### 3.1 PATIENT IDENTIFICATION DETAILS

This section records the details required for the patient.

#### 3.1.1 Patient's National Health Index (NHI) number

The NHI number is the unique lifetime identifier for consumers of health services in New Zealand and takes precedence over all other identifiers.

#### 3.1.2 Patient's family name

The family name must accurately match the details associated with the patient's NHI number. The family name may consist of more than one name and could be hyphenated. The family name is also known as the surname.

#### 3.1.3 Patient's given name(s)

The given name(s) must accurately match the details associated with the patient's NHI number.

#### 3.1.4 Patient's gender

The gender of the patient must be recorded as male, female, or undetermined.

#### 3.1.5 Patient's date of birth

The patient's date of birth must be recorded in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974.

#### 3.1.6 Patient's name written by the first prescriber

Before prescribing any medication, the first prescriber will document the patient's given and family name and then confirm that the patient identification label is correct and contains all relevant patient details before affixing it to the chart. When the label is placed on the medication chart, it should not be placed over or obscure the patient's name as written by the first prescriber. This provides a double check that the correct label has been attached to the correct medication chart.

#### 3.1.7 Patient's weight, and date measured

The patient's weight will be documented in kilograms with the date it was measured in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974.

### 3.1.8 Patient's height, and date measured

The patient's height will be documented in centimetres with the date it was measured in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974 when required.

### 3.1.9 Patient's allergies

Allergies are immune-mediated and can cause reactions ranging from mild to anaphylaxis. When documenting allergies record the following:

- the substance and, if medicine, the formulation
- the type, severity and date of onset (if known) of reaction. Document 'no known allergies' if they have none, or 'unknown' if not known
- the signature of the person who records the information and date.

### 3.1.10 Patient's adverse drug reactions

Adverse drug reactions (ADRs) are responses which are noxious and unintended and which occur at doses normally used in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function. When documenting ADRs, include the following:

- the medicine name and formulation
- the type, severity and date of onset (if known) of reaction. Document 'no known ADR' if they have none, or 'unknown' if not known
- the signature of the person who records the information and date.

### 3.1.11 Patient's special care requirements

Any special care requirements relating to medicines should be recorded, eg,

- breastfeeding
- pregnancy
- renal/hepatic
- other.

A 'No' box should be available to indicate if a patient has no special care requirements. 'Other' is for describing specific details, eg, dementia, that may influence medicine prescribing.

### *Additional specialist requirements*

Some specialist areas will require space for additional details to be documented eg, paediatrics, oncology.

### 3.1.12 Patient's body surface area measured

The body surface area is the measured or calculated surface of the person's body. The patient's body surface area will be documented in square metres (m<sup>2</sup>) when required.

### 3.1.13 Patient's gestational age at birth

The patient's gestational age at birth will be documented in weeks, eg, 24 weeks for neonates when required.

## 3.2 HEALTHCARE PRACTITIONER DETAILS

This section records the required details of all healthcare practitioners involved in the medication process: the prescriber, dispenser/pharmacist, administrator and checker. See Appendix A for detailed descriptions of these roles.

### 3.2.1 Registration number

The registration number is the unique identifier of all registered healthcare practitioners, provided by the relevant New Zealand registering body.

### 3.2.2 Family and given name

The family and given name is the name held by the registering body.

### 3.2.3 Prescriber's sample signature

Only the prescriber is required to document their signature. Each prescriber documenting their signature on the chart should be easily identifiable. The prescriber documents this information on the medication chart. Sample signatures will or can be replaced by electronic signatures if legal dispensation has been granted.

### 3.2.4 Sample initials

The dispenser/pharmacist, administrator and checker must record their initials on the medication chart. Each healthcare practitioner documenting their initials on the chart should be easily identifiable. Sample initials will or can be replaced by electronic signatures if legal dispensation has been granted.

### 3.2.5 Designation

Designation is the current role of the healthcare practitioner, eg, house officer, registrar, consultant, midwife, pharmacy technician, charge nurse, clinical nurse specialist.

# 4 Medication Details

This section describes the details required for a prescription item on the medication chart. Medication details are to be documented in a legal, legible and consistent manner.

## 4.1 TYPES OF PRESCRIPTIONS

**Regular medicines** – all prescriptions that are to be administered on a regular basis.

**Verbal orders** – all orders which have been authorised verbally for once-only administration, and the required information which should be included.

**Once-only medicines** – all prescriptions which are intended for a once-only administration. Can include infusions and complex prescriptions.

**As required (PRN) medicines** – all prescriptions that are intended for administration on an 'as required' basis.

## 4.2 REQUIRED FOR ALL TYPES OF PRESCRIPTIONS

The following details are required on all types of prescriptions:

### 4.2.1 Date of prescription

The date that the medicine is prescribed must be recorded and should be in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974. A once-only verbal order should be signed within 24 hours of the verbal order being taken.

### 4.2.2 Medicine name

The medicine name should be written in non-abbreviated capital letters with chemical abbreviations avoided. The generic name is preferred and the trade/brand name should be avoided unless there are safety reasons that require the addition of the brand name.

### 4.2.3 Medicine dose and units

The medicine dose and units must describe measurement of the medicine. Avoid the unnecessary use of decimal points with leading or trailing zeros. Refer to the Commission's website [www.hqsc.govt.nz](http://www.hqsc.govt.nz) for current abbreviation guidelines.

### 4.2.4 Route to be administered

The route must describe the means or pathway by which the medicine should be administered to the patient.

### 4.2.5 Prescriber's signature

The prescriber's signature or electronic signature (if legal dispensation has been granted) must correspond to the details in the sample signature/initials section on the medication chart or the login for the prescriber.

#### 4.2.6 Administrator's initials

The initials or the electronic signature (if legal dispensation has been granted) of the administrator of the medicine must correspond to the details in the sample signature/initials section on the medication chart or the login for the administrator.

#### 4.2.7 Checker's initials

When a second checker is required, the healthcare practitioners assisting with the medicine administration procedure should record their initials or electronic signature (if legal dispensation has been granted) to confirm that the correct medicine and dosage is being administered. The initials of the checker of the medicine must correspond to the details in the sample signature/initials section on the medication chart or the login for the checker.

In addition to the above requirements, the criteria below specifically apply to the following prescriptions.

### 4.3 REGULAR MEDICINE-ONLY REQUIREMENTS

#### 4.3.1 Predetermined time intervals for administration

Tick boxes are required to show when the medicine should be administered, eg,

- 08:00 hrs
- 14:00 hrs
- 18:00 hrs
- 22:00 hrs
- additional interspersed boxes for the prescriber to write a specific time.

#### 4.3.2 Special instructions

These can outline how the medicine is to be administered and/or how the effects of the medicine should be monitored.

#### 4.3.3 Date and time to cancel the medicine, and the prescriber's signature

Outlines the date and time after which the medicine must no longer be administered to the patient. The prescriber's signature or electronic signature (if legal dispensation has been granted) will correspond to the details in the sample signature/initials section on the medication chart or the login for the prescriber.

#### 4.3.4 Pharmacy comment

Pharmacy comment provides the relevant instructions and clinical information about the medicine.

#### 4.3.5 Date of medicine administration

The date must be recorded and should be in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974.

4.3.6 Time of medicine administration

The time must be recorded in hour(s):minute(s) in 24-hour format (hh:mm).

4.3.7 Dose of medicine administered

The medicine dose and units should describe measurement of the medicine. Doses not administered as intended will be appropriately documented on the medication chart.

## 4.4 VERBAL ORDER ONCE-ONLY REQUIREMENTS

4.4.1 Date of prescription

The date that the medicine is prescribed must be recorded and should be in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974. A once-only verbal order should be signed within 24-hours of the verbal order being taken.

4.4.2 Time of prescription

The time that the medicine is prescribed must be recorded in hour(s):minute(s) 24-hour format (hh:mm).

4.4.3 Specified time for the medicine to be administered

The time that the medicine is to be administered as a once-only event as specified by the prescriber. The time must be recorded in hour(s):minute(s) 24-hour format (hh:mm).

4.4.4 Initials of recipient of verbal order

The healthcare practitioner who received the verbal order for the medicine must document their initials or electronic signature (if legal dispensation has been granted) and this should correspond to the details in the sample signature/initials section on the medication chart or the login for the healthcare practitioner.

4.4.5 Initials of witness to verbal order

The second healthcare practitioner who witnesses the received verbal order (by the prescriber repeating the order to the witness) must document their initials or electronic signature (if legal dispensation has been granted) and this should correspond to the details in the sample signature/initials section on the medication chart or the login for the witness.

4.4.6 Time medicine commenced

This identifies the actual time that the medicine administration commenced. This must be recorded in hour(s):minute(s) 24-hour format (hh:mm).

#### 4.4.7 Time medicine completed

If the medicine is administered over a period of time, the administrator will document the actual time that the administration is completed, or the time that the medicine was stopped. The time should be recorded in hour(s):minutes(s) 24-hour format (hh:mm). The administrator's initials or electronic signature (if legal dispensation has been granted) must correspond to the details in the sample signature section on the medication chart or the login for the individual administrator.

## 4.5 ONCE-ONLY MEDICINE REQUIREMENTS

#### 4.5.1 Specified date and time for the medicine to be administered

The date and time that the medicine is to be administered as a once-only event as specified by the prescriber. The date should be recorded in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/197. The time must be recorded in hour(s):minute(s) 24-hour format (hh:mm).

#### 4.5.2 Special instructions

These can outline how the medicine should be administered and/or how the effects of the medicine are to be monitored.

#### 4.5.3 Pharmacy comment

Pharmacy comment provides any relevant instructions and clinical information about the medicine.

#### 4.5.4 Time medicine commenced

This identifies the actual time that the medicine administration commenced. This must be recorded in hour(s):minute(s) 24-hour format (hh:mm).

#### 4.5.5 Time medicine completed

If the medicine is administered over a period of time, the administrator will document the actual time that the administration is completed, or the time that the medicine was stopped. The time must be recorded in hour(s):minutes(s) 24-hour format (hh:mm). The administrator's initials or electronic signature (if legal dispensation has been granted) must correspond to the details in the sample signature section on the medication chart or the login for the individual administrator.

## 4.6 AS REQUIRED (PRN) MEDICINE-ONLY REQUIREMENTS

### 4.6.1 Special instructions

These can outline how the medicine is to be administered and/or how the effects of the medicine should be monitored.

### 4.6.2 Indications for use

Describes the specific clinical circumstances for which the medicine is being prescribed.

### 4.6.3 Frequency of administration

This is the time interval in which the medicine is to be safely administered. Ranges such as 4 – 6 hourly should be avoided.

### 4.6.4 Maximum dose in a 24-hour period

This describes the maximum cumulative dose of the medicine in a 24-hour period that can be safely administered.

### 4.6.5 Date and time to cancel medicine, and the prescriber's signature

Outlines the date and time after which the medicine must no longer be administered to the patient. The prescriber's signature must correspond to the details in the sample signature/initials section on the medication chart or the prescriber's individual login.

### 4.6.6 Pharmacy comment

Pharmacy comment provides the relevant instructions and clinical information about the medicine.

### 4.6.7 Date of medication administration

The date the medicine is administered must be recorded and should be in day/month/year (dd/mmm/yyyy) format, eg, 02/Jul/1974.

### 4.6.8 Time of medicine administration

The time the medicine is administered must be recorded in hour(s):minute(s) 24-hour format (hh:mm).

### 4.6.9 Dose of medicine administered

The medicine dose and units must describe measurement of the medicine.

### 4.6.10 Route of medicine administered

The route describes the actual means or pathway by which the medicine was administered.



# 5 Document Management

This section describes how the medication chart should be managed and clearly recorded.

## 5.1 MEDICATION CHARTS

The collection of the following information applies to all medication charts to ensure clear management.

### 5.1.1 Re-charting prescriptions, date recharted

When the medication chart is full and a new chart is required to continue the medication schedule for the period of the patient's admission, the prescriber should re-prescribe the medicine(s) and the date of recharting on a new chart. When carrying forward the original date of the prescription, this should be documented next to each medicine.

### 5.1.2 Number of medication charts in use

When multiple charts are in use they should be held together and numbered 1 of 2 and so on at the front of each chart to ensure that all charts are being used.

### 5.1.3 Supplementary chart documentation

Any regular medicines recorded on supplementary charts should be written onto the main medication chart in the regular medicine section with instruction to refer to the supplementary chart for details.

### 5.1.4 Healthcare practitioner's sample signature/initials section

This ensures that all healthcare practitioners who have documented on all the relevant charts are identifiable by their registration number, family name, designation, and signature/initials. In an electronic system, all healthcare practitioners would be identified by their individual login.

# Appendix A – Glossary

<b>TERM</b>	<b>DEFINITION</b>
Administrator	A healthcare practitioner who, for the purposes of this model, has administered a medicine to a patient. This could include a healthcare practitioner, the patient themselves (self-administered), or a parent or other caregiver in a household situation.
Authorised prescriber	A registered medical practitioner, midwife, dentist, nurse, optometrist or other healthcare practitioner who has the rights to prescribe specified prescription medicines as set out in Section 2(1) of the Medicines Act 1981 and Medicines Regulations 2005 relating to scope of practice in New Zealand.
Certification	Mandatory requirements by the Ministry of Health, introduced under the Health and Disability Services (Safety) Act 2001 and based on the health and disability regulations and legislations, which establish the minimum level of care that should be expected of any healthcare practitioner within New Zealand.
Checker	The healthcare practitioner responsible for checking the administration of the medicine to the patient when there is a requirement for a checker.
Designation	Current role of the healthcare practitioner.
Dispenser/pharmacist	A 'dispenser', who is usually a pharmacist, but could be a general practitioner, dentist, or other healthcare practitioner (as defined in relevant legislation). In general terms, it would be the pharmacist or the prescriber as permitted in legislation.
Guidance	Non mandatory information to assist with the implementation of the standard.
Healthcare practitioner	A person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession.
Patient	The patient is the person whose medicines are documented on the medication chart.
Prescribe	In medical practice, the act of authorising an order to supply or administer a substance used or capable of being used to prevent, treat, or palliate a disease, or the symptoms or effects of a disease for the purpose of clinical treatment of a patient under the authorising person's care.
Prescription item	Refers to each individual medicine prescribed.  In a hospital situation on a medication chart, this is an order to administer.
PRN	Latin for Pro re nata 'when necessary' (as required).
Supplementary chart	A supplementary chart may be used for medicines that require complex prescribing or specialised monitoring and are usually pre-formatted.



