We will work with patients, healthcare professionals and organisations to ***reduce patient harm associated with medicines or their omission***

Medication Record Templates for Adult Acute Hospitals

Explanatory notes

National Medication Safety Programme (Safermeds)
HSE Quality Improvement Division

March 2017

safermeds

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

We are delighted to make the national Medication Record templates for adult acute care available to you on www.safermeds.ie The Medication Record is the medication prescription and administration record, drug kardex or drug chart.

The templates are intended to be used as an aid in the development or revision of local Medication Records. They incorporate good and safe practice, however they should not be regarded as a definitive national standard that must be implemented. **Ensuring that each hospital's Medication Record is designed, tested, used and revised appropriately and safely is the responsibility of that hospital.**

This document introduces the background to development of the templates, for whom and how to use them and important design and printing aspects. Key features of each template are briefly described, together with an indication as to whether the template is considered essential, recommended (and if so, if it should be in the Medication Record only, or whether it may be in an alternative location), or optional. Hospitals may choose to use some or all of the templates as we have suggested, or adjust their Medication Record to incorporate some of the template elements.

Background

Extensive work went into designing and testing a Medication Record from 2010-2013, in a project led by Mr Tim Delaney under the guidance of the National Medication Safety Advisory Group chaired by Professor Joe Harbison. This included national consultation and piloting in Portiuncula, Naas, Beaumont and Cork University hospitals. The HSE Quality Improvement Division (QID) Medication Safety Programme, with assistance from Ms Anna Seoighe, has now updated and redesigned the Record in the form of templates for each section.

The templates have been developed for use for adult medical and surgical in-patients in acute hospitals. The templates may be useful as a point of reference for staff in other settings when developing or revising their medication records.

Each template is a section of the Medication Record, based on sections in use in some or all hospitals when surveyed. Specialist sections such as diabetes/insulin, chemotherapy, blood products may also be in use, however they are usually a separate chart/form and we have not produced templates for these records. Where medication is prescribed on a separate chart/ form, this should be indicated in the regular prescriptions section, e.g. Insulin, See Diabetes Chart, and the appropriate box ticked in the "Other medication records in use" box on the cover. National projects are underway to develop electronic records for maternity, neonatal and oncology chemotherapy.

Printing and design aspects of the Medication Record templates

Each hospital must follow local purchasing/procurement procedures when engaging with printers for design and printing of their Medication Record. We worked with Dalcon Print on the design and printing of this document.

Dalcon Print Ltd, Unit B3 JFK Trading Centre, JFK Road, Dublin 12.
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When using/adapting this record for local use, consider the following factors:

- Paper thickness and quality: Cover at least 200 grm card/paper, interior pages at least 100 grm

- Hole punched: 2 holes, or as required for local hospital binders

- **Cut-out (safety feature):** We recommend an A4 cover with a cut-out at the top of all internal pages. This means that patient ID is visible when using any page, but only needs to be written (or an addressograph attached) on the cover pages, rather than on every page. This is an important safety feature and improves efficiency as it requires less rewriting.

- No cut-out: If a hospital chooses not to use the cut-out format, each left-hand page must be redesigned with the same header as the template header for page 2 (addressograph and Codes for recording omitted doses). Each right-hand page must be redesigned with a header consisting of an addressograph and a reminder to check the patient's allergy status. Blank header pages are available as templates to facilitate this.

- Page numbering and order: If changing the order, ensure any left-hand pages are aligned to leave room for hole punch and binding on the right, and right-hand pages are aligned to leave room for the hole punch on the left. Page numbering also needs to be altered as appropriate.

- **Binding (safety feature):** at least 3 staples, or stitched using stitch wire of 1.5-2 mm thickness. Ensure binding is suitable for filing in the hospital chart and any other location it is stored. It is crucial that the central cut-out pages do not fall out, as there would be no patient ID on them. Piloting to ensure the chart is robust is required.

- Colour: We recommend full colour for differentiation and to ensure optimum readability. For the recommended chart (28 page, A4 cover, cut-outs internally, hole punched, 3 or more staples binding), printing in black and one other colour would be cost approximately 4% less and black and white 14% less than printing in full colour, for a print run of 5,000 charts.

What is included in the templates?

The Medication Record templates are described below. We have suggested a 28 page record format (for adult medical/surgical in-patients), and an 8 page Short Stay chart (an example of what might be included in a medication record for shorter stays, e.g. day case surgery). The templates are listed below, together with the page numbers they are on for the 28 page and 8 page chart.

Template	Comment	Page number	
		28 page	8 page
Cover	**Essential**: Addressograph, Other records in use, Weight, height and CrCl, Allergies and ADRs, Index **Recommended**: How to use this Medication Record, Oral Medication in Surgical Pre-Operative Patients, Patient Conditions Affecting Oral Doses. All are suggested safety features. May adjust according to local needs/policy	1	1
Communication Record	**Optional**. May not be needed if another shared record is used.	2	2
Signature Record	**Recommended**	2	2
Pre-Admission Medication and Medication Reconciliation	**Recommended (in Medication Record or other location)**. A form like this should be in use to record the pre-admission medication history and/or medication reconciliation. It may be located in the Medication Record, the Clinical Notes, or other location accessible to the multidisciplinary team.	3	3
Once Only and Depots	**Recommended**	4	4
Variable Dose Prescriptions	**Optional**. Likely to facilitate safer prescribing. May also be used instead of other variable prescriptions, e.g. warfarin, infusions.	4	4
VTE Prophylaxis Protocol	**Recommended (in Medication Record or other location)**. It is recommended that the hospital has a VTE prophylaxis protocol. This template must be modified for local use, particularly the drug choice in Step 3. The VTE protocol may be included in the Medication Record as a guideline for reference or as a form to be filled in. Alternatively, the protocol may be elsewhere (e.g. hospital formulary/guidelines, posters, in a wallet card, in an admission document, in the Clinical Notes), as a protocol/guideline, or as a form to be filled in.	5	-

Regular Prescriptions Thrombo-prophylaxis	**Recommended**. The first two Regular Prescriptions are designated Pharmacological and Mechanical Thromboprophylaxis, to be filled in if indicated for the patient and they have no contra-indications.	6	-
Regular Prescriptions	**Essential**. Hospitals may adjust the number of Regular Prescriptions required, and the duration of administration, if needed. The long duration of administration in the templates minimises the need for multiple rewrites. Safety features are incorporated, including Frequency being next to the times, with the prescriber to circle times.	6	5
As Required (PRN) Prescriptions	**Essential**. Hospitals may adjust the number of prescriptions required and the duration of administration if needed.	-	6
Antimicrobials requiring Therapeutic Drug Monitoring	**Essential**. This is a component of the national antimicrobial medication record, contains many important features and should be incorporated. The guidance section at the top may be adjusted if local guidance differs.	24	-
Surgical Antimicrobial Prophylaxis	**Essential**. This is a component of the national antimicrobial medication record, contains many important features and should be incorporated.	25	-
Antimicrobial Prescriptions	**Essential**. This is a component of the national antimicrobial medication record, contains many important features and should be incorporated. The number of prescriptions may be adjusted if necessary.	25	-
Oxygen Therapy	**Recommended**. This incorporates many features to facilitate safe and effective use of oxygen, in line with best practice guidelines.	27	-
Fluid +/- Electrolytes	**Essential (in Medication Record or other location)**. Some hospitals may have this as a separate form.	28	8
Warfarin	**Optional**. May alternatively be prescribed in variable or regular prescription sections.	-	-
Drug Infusions	**Optional**. May alternatively be prescribed in the regular or variable prescription sections.	-	-
Other sections	**Optional.** Some hospitals may include additional sections in their Medication Record.	-	-