

Victorian Quality Use of Medicines Network (VQUMN)

National inpatient medication chart (NIMC) implementation in specific patient groups – a snapshot of practices August 2006

Request:

Helen Leach, Senior Advisor, Victorian Medicines Advisory Committee, Quality Use of Medicines Program, Quality and Safety Branch, Department of Human Services, Victoria

'As the majority of you will be aware, in a joint communiqué, dated 23 April 2004, Australian Health Ministers stated a commitment to the implementation of a standard national medication chart in public hospitals, by June 2006, to reduce harm from medication errors.

In Victoria we have prioritised implementation into general medical and surgical areas, acknowledging that specialist charts are currently being developed for specific patient groups, including paediatrics and palliative care.

Implementation or a commitment to implementation of the NIMC, by January 2007, has been stated by all rural and regional health services (except residential aged care facilities and sites using electronic prescribing) and all major metropolitan health services.

To respond to questions from Victorian health services, we are now keen to identify which sites have implemented the NIMC in the following areas:

- Intensive care units
- Emergency departments
- Short stay units
- Mental Health units

What barriers were addressed in those areas of implementation? How were these barriers addressed?

This information will assist us in exchanging information and ideas for best practice between sites'.

Responses:

Peter Stuchberry, Director of Pharmacy, The Northern Hospital, Victoria

'As per our telephone conversation a week or so ago, The Northern Hospital and Bundoora Extended Care Centre plan to roll out the NIMC in September 2006. The roll out will include intensive care and mental health units. At this stage the day procedure unit will only use the chart if the patient is to be admitted. The emergency department will also use the chart for those patients that are to be admitted'.

Dianne Inglis, Kyneton District Health Service, Kyneton, Victoria

'Kyneton District Health Service does not have an intensive care unit or mental health unit. The charts are not used in the emergency department unless the patient is to be admitted to the ward. The day procedure unit does not use the NIMC either. The chart is used for post-surgical and overnight stay patients'.

Sharon Goldsworthy, Clinical Pharmacy Team Leader, Pharmacy Services, The Queen Elizabeth Hospital and Health Service, Woodville, S.A

'We use the chart in our mental health unit and in the next few weeks plan to also introduce the long stay chart there as well. There are major problems in our area getting suitable accommodation for some people. As a result the length of stay blows out for some of our more vulnerable people and has resulted in us implementing a long stay chart.

We use the NIMC in the emergency department once a decision has been made to admit the patient.

Our short stay unit (up to 23 hours) uses the NIMC'.

Kenneth Chng, Pharmacy Manager, West Gippsland Healthcare Group, Warragul, Victoria

'As you are aware we have implemented the chart throughout our hospital. We do not have an intensive care unit nor a mental health unit. It is in place in our high dependency unit. The NIMC is used in the emergency department if the patient is to be admitted or is likely to be admitted to the hospital'.

Sharon Godleman, Director Clinical Services, Seymour District Hospital, Seymour, Victoria

'We have now educated staff and implemented the NIMC across the acute sector of our organisation. It has not been implemented in the residential aged care or community section.

There have been a few teething problems however we are pushing ahead'.

Graham Chesterton, Pharmacist, Latrobe Regional Hospital, Traralgon, Victoria

'Latrobe Regional Hospital implemented the NIMC in all the mentioned areas at the same time. In the emergency department it is used for those patients to be admitted to a ward or who require multiple medications otherwise we use the emergency department triage chart, which includes only a small section for prescribing.

The main barrier was education of staff before the introduction. We used sample charts to aid this process. We involved both pharmacy staff and the staff development unit to help overcome this problem. The type of query we got was "what do we do with Ventolin® nebules"? The answer was usually to "do what you used to do."

In the end implementation was not really a great drama it will assist in exchanging ideas between sites and promote best practice'.

Jan deClifford, Senior Clinical Pharmacist, Project Officer for NIMC Implementation, Frankston Hospital, Victoria

'We have implemented the NIMC in all the areas outlined in your email.

In intensive care units the main barrier has been resistance from nursing staff. This may have been aggravated by the fact that our new intensive care unit nurse unit manager had come from Queensland and just said "yes we can do it and yes it will work in the intensive care unit". The major practical problem has been the number of charts required per patient and high requirements for once only orders. There is not enough room on the chart for these and we end up with second or third charts often with "once only" orders on them. Also nursing staff found the "folded over" chart got tatty with a lot of handling and it became difficult to follow all the regular orders once there was more than one chart. We now lay the charts flat to see the regular orders and they turn it over for the "when necessary" and "once only" orders. This has been an improvement but remains a problem. My feeling is the chart is not ideal for the intensive care unit but it is workable.

In the emergency department we use the chart for all patients that are to be admitted. For those patients who are not admitted and attend for only a few hours we continue with our pre-existing paperwork, that is, the medical record for non-admitted patients. As soon as it is determined that a patient will be admitted they are referred to the appropriate treating team who then attend the emergency department and fill out a NIMC for the patient. This works quite well.

Short stay units use NIMC for any patients staying beyond twenty-four hours. Otherwise we use a short stay patient record, which was our pre-existing form.

In the mental health unit the NIMC was introduced at the same time as the general hospital. There were two major barriers. The first was safe prescribing of depot injections and the other was prescribing and recording medications for overnight or weekend leave. We designed a separate form with depot injections on one side and leave medications on the other in order to deal with these problems.

We use the NIMC in paediatrics with no problems. We have not introduced the NIMC into the palliative care unit but are trialling its use in a very small number of patients at our Rosebud site. I have previously raised my concerns about the palliative care chart especially in reference to the doses being administered as a volume and millimetre on a syringe driver rather than as a dose of drug'.

Swee Wong, Director of Pharmacy, Royal Women's Hospital, Melbourne.

'The Royal Women's Hospital is implementing the NIMC from 14 August 2006 in adult patients only. We have no adult intensive care unit, no mental health unit and we are not implementing it in the emergency department as they have their own twenty-four hour chart which records all medications given in the emergency department including intravenous fluids. In the short stay unit, that is, the day surgery unit, they also have their own charts, which include intravenous fluids'.

Anne McGrath, Austin Health, Victoria

I wish to share some feedback from clinicians regarding the NIMC since a workshop held at the Austin Hospital in November 2005. A lot of what I have to say was covered at the Department of Human Services workshop in December 2005 however I know you are seeking information regarding the NIMC in specialist areas.

We have not implemented the NIMC at the Austin Hospital. Our intensive care unit and mental health unit have expressed concern regarding the chart at a forum held at Austin Hospital.

The intensive care unit have expressed the following:

- There is less space for drugs
- There is less ability to visualise "once only" drugs easily and within the context of the entire chart
- There is less ability to visualise "when necessary" orders within the entire context of the chart
- Our current intensive care chart contains a non-drug section for dressings, blood tests and other non-drug orders. This section is heavily used and provides a comprehensive treatment plan. Losing this section will be a major obstacle to the successful uptake of the chart
- A period of ten days is probably too long.

Our mental health unit note:

- There are insufficient days for long stay patients.

I will understand if these comments are not suitable for inclusion in your report as we have not actually implemented the NIMC'.

**Responses compiled by Harry Wendt, Quality Use of Medicines Project Officer.
17 August 2006**

Please note that all information and policies are current only at the time the response is sent and individual hospitals should be contacted to ascertain current policies and practices. The responses received are only representative of the hospitals participating in the discussion at the time and do not necessarily indicate a complete picture of all current practices. Information sharing occurs on the understanding that due acknowledgement will be given to the original source and that the information will not be quoted or used out of the context of the discussion. Permission should be sought from the original source before any policy, protocol or guideline is used in another setting.