

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**

TRIM D16-38121

Guide to Using the NIMC Audit Spreadsheet

February 2017

Contents

Introduction	3
1. Accessing the <i>NIMC Audit Spreadsheet</i>	3
2. Using the <i>NIMC Audit Spreadsheet</i> for the first time.....	4
3. Entering hospital information.....	5
4. Entering patient audit data in the <i>NIMC Audit Spreadsheet</i>	6
4.1 Entering patient data for Sections 1 to 10.....	6
4.2 Entering data for Section 11: Prescribing and Administration.....	8
5. New Patient	9
6. Saving the Data.....	9
7. Exporting and uploading the data to the <i>NIMC Audit System</i>	10

Introduction

The *Guide to using the National Inpatient Medication Chart (NIMC) Audit Spreadsheet* is a resource designed to assist data entry into a 'NIMC Audit Tool' that is simply an excel spreadsheet.

The purpose of the excel spreadsheet is to create an electronic file of your NIMC Audit that can later be uploaded to the web-based NIMC Audit System to produce summary and comparison reports of the audit. **Please note that the Audit System also enables patient audits to be entered directly online and therefore it is not absolutely necessary to use the spreadsheet.** Auditors have the choice of either using the online system or the excel spreadsheet. The difference between the two is that the online system requires the user to be connected to the internet while entering the data. Alternatively, the excel spreadsheet enables the user to enter the data offline and then upload the file at a later date. Auditors may like to experiment with the two options and choose their preference.

Specific explanatory notes about answering each of the questions in the audit can be found in the *Guide to Auditing the NIMC*. All the audit tools, and guidance on how to use them, are available on the Commission's web site at: www.safetyandquality.gov.au/nimcaudit.

Only use one spreadsheet per hospital per audit. If you use multiple spreadsheets for the same hospital, you will be unable to upload these spreadsheets to the same audit.

The spreadsheet cannot be used for 'partial' audits. Partial audits are audits conducted with only a subset of the audit questions (which can be selected at the time of setting up your audit in the web-based NIMC Audit System).

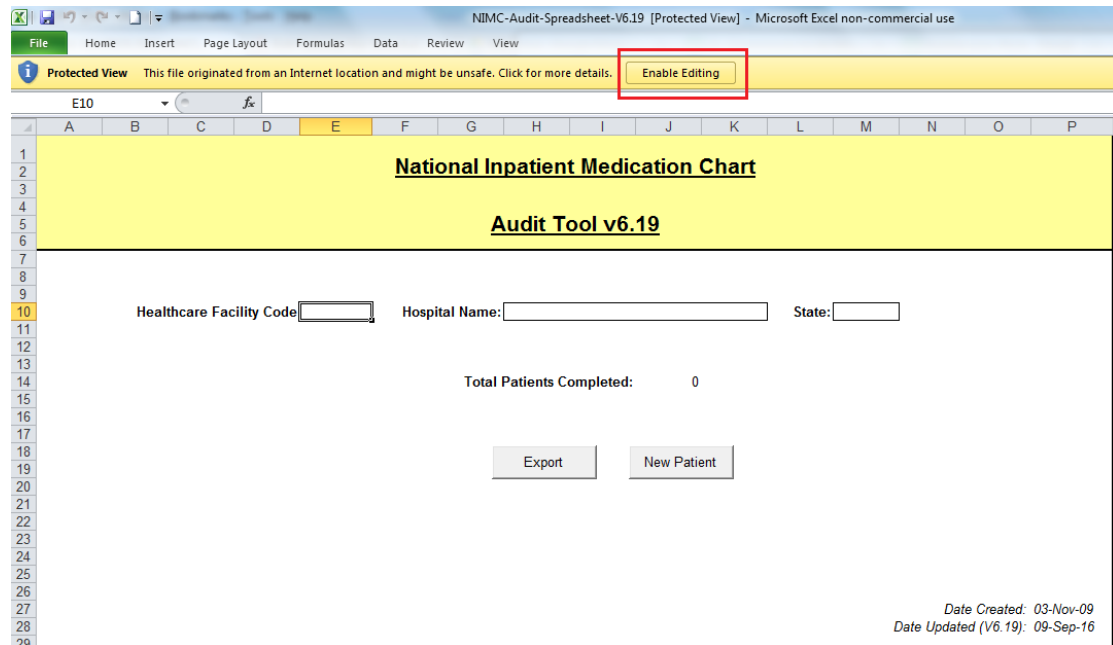
1. Accessing the NIMC Audit Spreadsheet

1. Navigate to the NIMC audit website by typing the following in your web browser:
<http://www.safetyandquality.gov.au/nimcaudit>
2. Scroll down the screen and find the dotpoint:
 - [NIMC Audit Spreadsheet](#)
3. Click on this link and save the file to your computer.
4. Some web browsers will save the file directly to your downloads folder, whereas other web browsers will let you choose where to save the file. Be sure to save the file somewhere you can easily find it. **Always use the latest version of the NIMC audit spreadsheet. Always download the spreadsheet from the above location before commencing an audit, instead of referring to earlier versions of the spreadsheet which may no longer be compatible with the online system.**

2. Using the NIMC Audit Spreadsheet for the first time

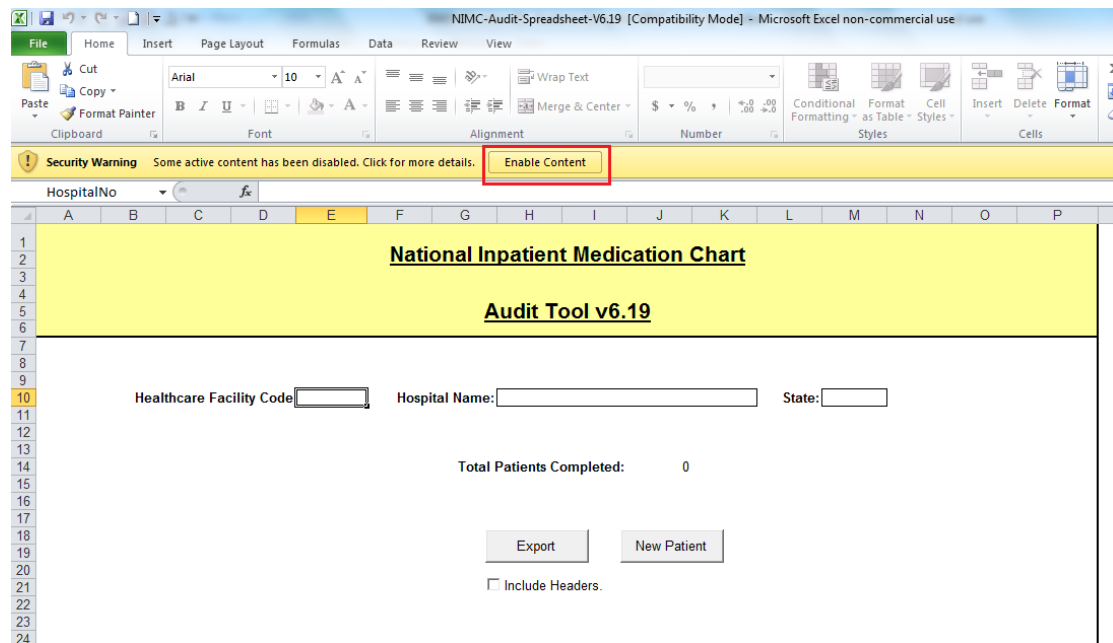
When opening the *NIMC Audit Spreadsheet* for the first time, you will need to click “Enable Editing”. See Figure 1 below.

Figure 1 – NIMC audit spreadsheet, the view when you open the file



After you click enable editing, you may also get a security warning on the screen. Click “Enable Content”. See Figure 2 below.

Figure 2 – Security warning



3. Entering hospital information

When you open the spreadsheet, you will see the hospital worksheet. Please ensure you are using the latest version available from the NIMC Audit System home page at www.safetyandquality.gov.au/nimcaudit. The version number and date updated are shown on the hospital worksheet. (Figure 3)

Figure 3 – Version number

The screenshot shows the 'National Inpatient Medication Chart' interface. At the top, the title 'National Inpatient Medication Chart' is centered, with 'Audit Tool v6.19' circled in red below it. The form includes three input fields: 'Healthcare Facility Code', 'Hospital Name', and 'State'. Below these fields, it displays 'Total Patients Completed: 0'. There are two buttons: 'Export' and 'New Patient'. In the bottom right corner, the text 'Date Created: 03-Nov-09' and 'Date Updated (V6.19): 09-Sep-16' is circled in red. The browser window title is 'Hospital'.

You are required to enter the Healthcare Facility Code (otherwise known as the Establishment ID, consisting of nine alpha-numeric characters for a public hospital and eight alpha-numeric characters for a private hospital), Hospital Name and State or Territory before you start entering patient details.

Hospital facility codes are available from your State or Territory representative or you may contact the Commission to obtain your facility code. Email nimc.audit@safetyandquality.gov.au to obtain your code if required. Please allow up to 3 business days for replies from the nimc audit inbox.

The State field is entered via a drop-down list. When you click on the State field, a button with a down arrow will appear (Figure 4).

Figure 4 – State drop down

A close-up of the 'State:' field, which is a drop-down menu with a small downward-pointing arrow on the right side.

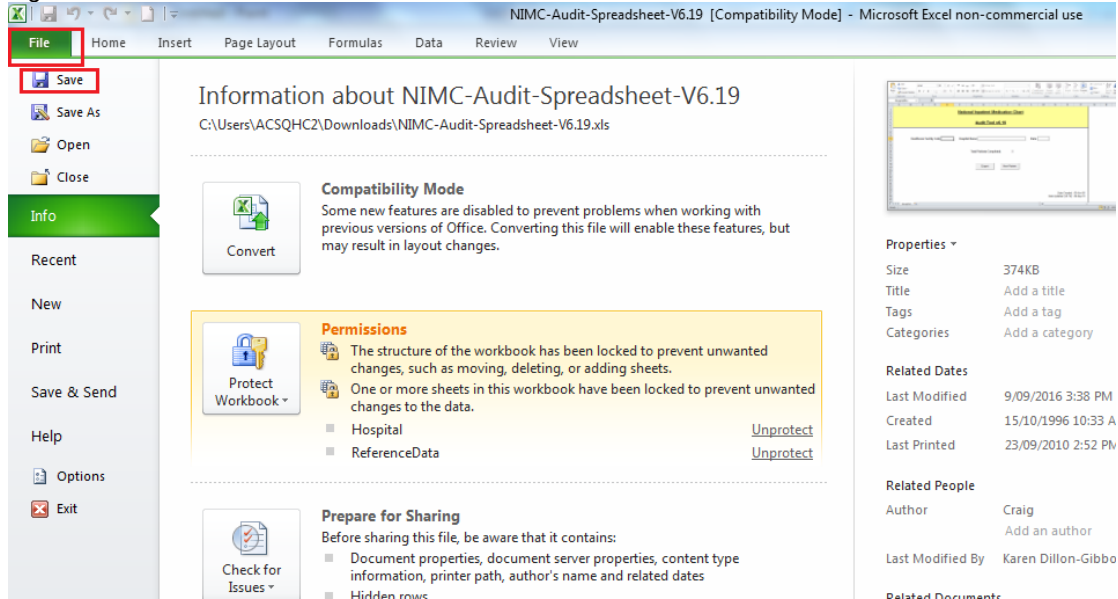
Click on the down arrow button, and a list of options will drop down for you to select. (Figure 5)

Figure 5 – State drop down showing list when the arrow button is clicked

A close-up of the 'State:' field with the drop-down list open. The list contains the following options: NSW, VIC, QLD, SA, WA, NT, TAS, and ACT. The 'NSW' option is highlighted in blue.

Once you have completed the three fields, **save the application file**. Do this by clicking the “File” tab and then the Save icon. The File tab and Save icon are highlighted with red boxes in Figure 6 below.

Figure 6 – File tab and save icon



4. Entering patient audit data in the NIMC Audit Spreadsheet

Only use one spreadsheet per hospital per audit. If you use multiple spreadsheets for the same hospital, you will be unable to upload these spreadsheets to the same audit.

4.1 Entering patient data for Sections 1 to 10

On the Hospital worksheet, there is a [New Patient] button. To add a new patient audit worksheet, click on this button (Figure 7), and a new patient userform will be created. (Figure 8) The userform will automatically generate a 'Patient Audit Number' (e.g. EXL1).

Figure 7: Hospital worksheet

Healthcare Facility Code Hospital Name: State:

Total Patients Completed: 1

Figure 8: Patient userform

Main Patient Details

Patient Audit Number: Gender: Chart Type: Audit Date: (Enter in dd/mm/yy format)

Bed Number: Ward: Reviewer 1: Reviewer 2:

1. Patient Identification & Weight

1.1 Total Current Medication Charts (ie Charts in use)

1.2 Patient ID complete on ALL pages (include hand-printed name if label used)

1.3 Weight documented on a Medication Chart (Paeds must be ALL charts)

2. Adverse Drug Reaction (ADR) Details

2.1 ADR documentation complete on ALL charts (include NDA / unknown)

2.2 Patient has previous ADR (if no, go to Q3.1)

2.3 Similar class of medication prescribed (Document Drug, Reaction & Represcribed Drug here)

2.4 If previous ADR, do ALL pages have ADR Alert Stickers in place

3. Medication History

3.1 Medication History documented on Medication Chart (if yes, go to Q 3.3)

3.2 If 'No', is a Medication History cross-referenced on Medication Chart

3.3 Medication Management Plan (MMP) Form in 'end of bed' folder (if no, go to Q 4.1)

3.4 Allergies/ADR box completed on MMP Form

5. Venous Thromboembolism (VTE) Prophylaxis

5.1 VTE Risk Assessment documented on ANY medication chart

5.2 VTE Prophylaxis prescribed (VTE & Regular sections) (if no, go to Q6.1)

5.3 VTE Prophylaxis prescribed in VTE section. (if multiple VTE Prophylaxis orders, at least one in VTE section)

6. Warfarin

6.1 Warfarin Guidelines at end of patient's bed or with Medication Chart

6.2 Number of times patient prescribed warfarin (Warfarin & Regular Order sections) (if nil/zero, go to Q 7.1)

6.3 Number of Target INR ranges documented if prescribed in Warfarin section

6.4 Number of Target INR ranges documented if prescribed in Regular section

6.5 Warfarin Education recorded

7. Sustained Release

7.1 Number of Sustained Release medications ordered (Regular Order Section) (if nil/zero, go to Q 8.1)

7.2 Number of Sustained Release medications with SR box ticked

8. Intermittent Medications

8.1 Number of Intermittent medications ordered (ie Weekly, fortnightly, twice weekly) (if nil/zero, go to Q 9.1)

8.2 Number of intermittent medications ordered and 'boxed'

You are now ready to enter data for the first patient. First, enter the patient details at the top of the page (Figure 9).

Figure 9: Patient details

Main Patient Details

Patient Audit Number: Gender: Chart Type: Audit Date: (Enter in dd/mm/yy format)

Bed Number: Ward: Reviewer 1: Reviewer 2:

Reviewers dropdown menu options: NIMC, NIMC Long Stay, NIMC Paediatric, NIMC Paediatric Long Stay

Then, following the instructions in the *Guide to Auditing the NIMC*, enter data into the fields in Sections 1-10. You will need to scroll down to get to all the fields.

Most questions are mandatory except for data fields; 'Reviewer 2' and 'Bed Number'.

You can navigate quickly to the next data field using [Tab] or [Enter] key. To go back, use the [Shift + Tab] key.

Most fields have drop downs to assist in data entry. You can also enter the letters Y, N, NA (if applicable) using your keyboard instead of the drop down menus and the mouse. Enter numbers in those fields requesting numbers. You can type in additional information in text boxes provided. A series of warning messages have been programmed to appear if you enter a value that is not valid.

To save time and maximise accuracy of data, selecting an answer to preceding data fields may automatically grey out certain data fields where an answer is not required. This would leave only those fields that require answers.

Once you have completed Sections 1-10, scroll down to Section 11.

4.2 Entering data for Section 11: Prescribing and Administration

You are now ready to enter a drug order within a Table where the spreadsheet will automatically generate an order number starting from order number 1. (Figure 10)

Figure 10: Prescribing and Administration

On each row of this new order, enter under each column a relevant code shown in the legend.

Once you have completed the first drug order, you must click the 'Add/Update Order' button. This will automatically generate a new row with drug order number 2. You can create as many drug orders as required. If no further drug orders are required, simply click 'Submit'.

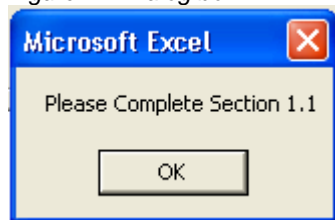
To view orders that have already been entered, you can browse through the 'Order No.' drop down menu and select the order number and it will display the corresponding values. To edit a data field, you can change those values and click [Add/Update Order].

To delete an order, select the 'Order No.', then click the [Delete Order]. (Figure 10)

The [Cancel] button will close the patient userform.

When you click on the [Submit] button at the end of the final section, the sections that are mandatory will be identified. A dialog box will pop up and identify the section still to be completed. (Figure 11)

Figure 11: Dialog box



On selection of [OK], you will automatically navigate to the first mandatory section.

Once you have completed entering data for one patient, click the [Submit] button to populate the details from the patient userform into an excel worksheet. This will automatically generate an excel worksheet named 'Patient1' pre-populated with that patient's data. (Figure 12)

Figure 12: Populated excel sheet for Patient1

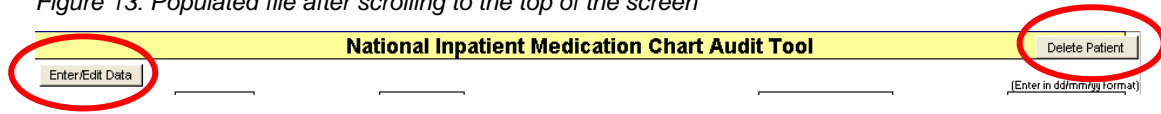
11. Prescribing and Administration																			
Legend										Definitions: Error Prone Abbreviations									
Drug Order	Drug Name	Route/Dose	Frequency	Others															
R = Regular	U = Unclear	C = Clear & Correct	C = Clear	Y = Yes															
P = PRN	T = Trade	M = Missing	M = Missing	N = No															
S = Stat/Phone/Once Only	C = Clear	U = Unclear	U = Unclear																
V = Variable Dose		I = Incorrect	I = Incorrect																
W = Warfarin			NA = Not Applicable																
					mcg, µg, ug = microgram U or u = unit qd or QD = every day o.d. or OD = once daily SC, SIC = subcutaneous SL, SIL = sublingual o (degree symbol) = hourly frequency No leading zero before a decimal point (eg. .5mg) = 0.5mg Trailing zero after decimal point (eg. 1.0 mg) = 1mg														
Order No.	Drug Order	Drug Name	Route	Dose	Frequency	Dose Calc'n Documented	Dose Calc'n Documented Correctly	Error Prone Abbrev'ns Used	Indication Documented	Pharm. Annot.	Pres. Signed	Pres. Clear	Freq. Matches Admin Time	Drug Ceased	Ceased Correctly	Doses Required	Doses Admin	# PRN, Max Dose doc.	
1																			
74	1	S	U	C	C	NA	NA	NA	Y	NA	Y	Y	Y	NA	Y	Y	2	2	NA
75	2	R	U	C	C	C	NA	NA	N	Y	Y	Y	Y	N	NA	NA	3	3	NA
76																			
77																			

At this point, you have the opportunity to review the data that you have entered in all sections.

Scroll to the top of the screen to see all the data. To edit a data field, click the [Enter/Edit Data] button located at top left hand corner of the worksheet and change any data fields in the patient userform page and click [Submit]. (Figure 13)

To delete a patient, click [Delete Patient] button located at top right hand corner. (Figure 13)

Figure 13: Populated file after scrolling to the top of the screen



Tip: You should frequently save your work while you're auditing. Simply click the File tab and save at any time, whether you have completed the audits or not.

5. New Patient

Once you have finished each patient audit, click on the "hospital" tab at the bottom of the screen to go back to the hospital screen and add a new patient. See Figure 14 below.

Figure 14 – Populated spreadsheet with Hospital tab highlighted

National Inpatient Medication Chart Audit Tool				Delete Patient			
Enter/Edit Data				(Enter in dd/mm/yyyy format)			
Patient Audit Number:	EXL1	Gender:	Female	Chart Type:	NIMC Acute	Audit Date:	01-Jan-16
Bed Number:	1	Ward:	ly	Reviewer 1:	kw	Reviewer 2:	kw
1. Patient Identification & Weight				5. Venous Thromboembolism (VTE) Prophylaxis			
1.1	Total Current Medication Charts (ie. Charts in use)	1		5.1	VTE risk assessment documented on NIMC Acute chart (If N/A, go to q 6.1)		Y
1.2	Patient ID complete on all pages (include hand-printed name if label used)	Y		5.2	VTE Prophylaxis prescribed (VTE & Regular sections) (If No, go to q 6.1)		N
1.3	Weight documented on a Medication Chart (Paeds must be all charts)	Y		5.3	VTE Prophylaxis prescribed in VTE section. (If multiple VTE Prophylaxis orders, at least one in VTE section)		
2. Adverse Drug Reaction (ADR) Details				6. Warfarin			
2.1	ADR documentation complete on all charts (include NKDA / unknown)	Y		6.1	Warfarin Guidelines at end of patient's bed or with Medication Chart		Y
2.2	Patient has previous ADR (if no, go to Q 3.1)	Y		6.2	Number of times patient prescribed warfarin (Warfarin & Regular Order sections) (If nil/zero, go to q 7.1)		0
2.3	Similar class of medication prescribed (Document Drug, Reaction & Represcribed Drug here)	Y		6.3	Number of Target INR ranges documented if prescribed in Warfarin section		0
	y			6.4	Number of Target INR ranges documented if prescribed in Regular section		0
2.4	If previous ADR, do all pages have ADR Alert Stickers in place	Y		6.5	Warfarin Education recorded		
3. Medication History				7. Sustained Release			
3.1	Medication History documented on Medication Chart (if yes, go to Q 3.3)	Y		7.1	Number of Sustained Release medications ordered (Regular Order section) (If Nil / Zero, go to Q 8.1)		0
3.2	If 'No', is a Medication History cross-referenced on Medication Chart			7.2	Number of Sustained Release medications with SR box ticked		0
3.3	Medication Management Plan (MMP) Form in 'end of bed' folder (if no, go to Q 4.1)	Y		8. Intermittent Medications			
				8.1	Number of Intermittent medications ordered (ie. Weekly, fortnightly, twice weekly) (If nil/zero, go to Q 8.1)		0
				8.2	Number of Intermittent medications ordered and 'boxed'		0

6. Saving the Data

You MUST save the excel spreadsheet before closing, whether you have completed the audits or not. It is recommended that you back up the file so that you do not lose the data. This is particularly important if you are collecting the data over several weeks.

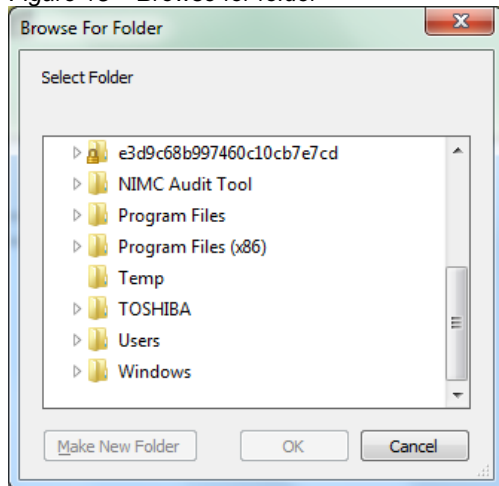
Tips: You should save the application before closing, whether you have completed the audits or not.
 Use only one NIMC Audit Spreadsheet per hospital. Patient worksheets from one spreadsheet cannot be copied and pasted into a new audit spreadsheet. This process will corrupt the excel file format and result in failure to upload your data to the NIMC Audit System.

7. Exporting and uploading the data to the NIMC Audit System

Once you have finished entering all the patient audit data, save the file. Click back to the first tab of the spreadsheet called "Hospital".

Now click on the [Export] button to create export (CSV (CSV= comma-separated values)) files. A dialog box "Browse For Folder" (Figure 15) will appear asking you to select a folder/directory to save the files. A second dialog box will confirm the directory/location of where the export files are saved.

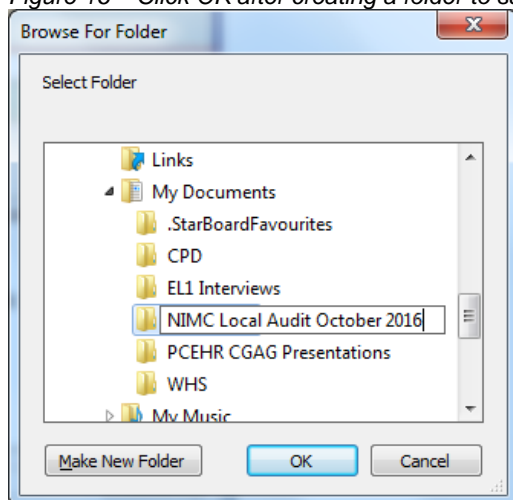
Figure 15 – Browse for folder



Browse for a location to save the exported files. It is good practice to create a new folder each time data is exported with the name and the date of the audit clearly visible on the folder. Every time you create exported files from the NIMC audit spreadsheet, they have identical names, so the folder is the only way to differentiate the exported files created from audits conducted in different time periods.

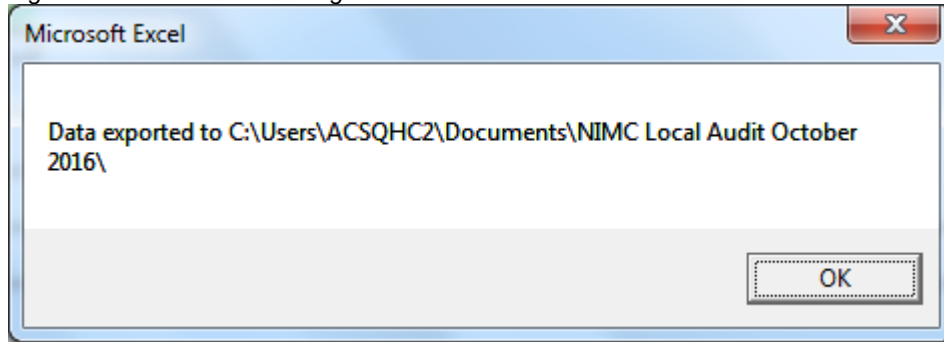
Click OK once the location is chosen (Figure 16).

Figure 16 – Click OK after creating a folder to save the files in



The following dialog box confirming the creation of the exported files will appear (Figure 17).

Figure 17 – Confirmation dialog box

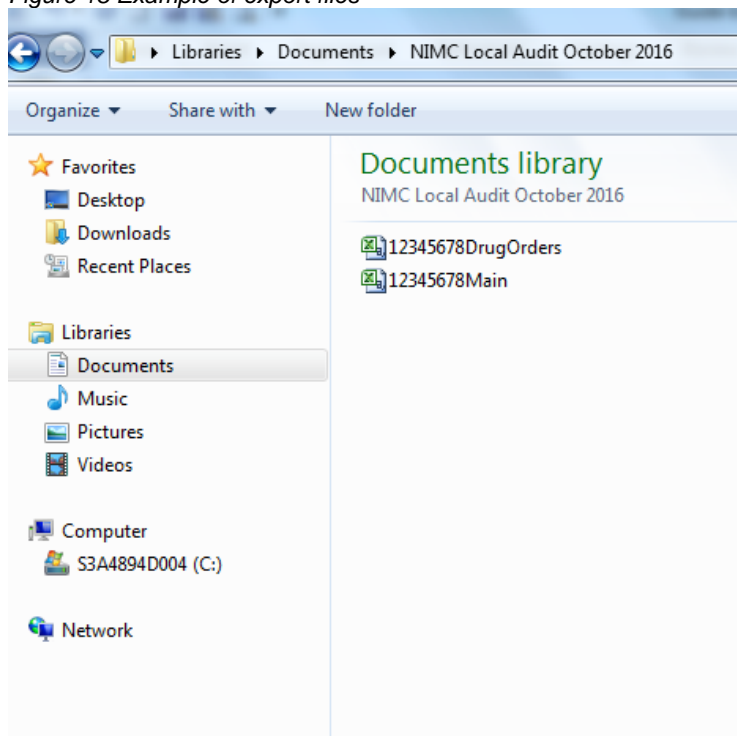


The two export files will be called:

- XXXXXXXXMain; and
- XXXXXXXXDrugOrders.

where XXXXXXXX is the Healthcare Facility Code that you have entered on the first tab of the spreadsheet. See example in Figure 18.

Figure 18 Example of export files



You are now ready to upload the CSV files created by the export, to the *NIMC Audit System* at www.safetyandquality.gov.au/nimcaudit. Please refer to the *NIMC Audit System User Guide*, Chapter 10: *Uploading Patient Audits using the Audit Spreadsheet*.

Tips: The data within the exported CSV files should never be modified and resaved. This will result in changes to the file format and failure to upload the data to the *NIMC Audit System*. Edit the data in the audit spreadsheet and click export. Please note that clicking export after editing will overwrite previously exported files. Therefore, do not use the excel spreadsheet for a second audit until the first two files have been saved.