National Standard Medication Chart (NSMC) audit form

i) Hospital name: .....

ii) Date of audit: .....

Information for local use only

a) UR number: .....

b) Ward: .....

Chart type and age of patient

iii) Please specify chart type(s) being audited:

- ☐ NIMC (acute)
- ☐ NIMC (long-stay)
- ☐ NIMC (paediatric)
- ☐ NIMC (paediatric long-stay)
- ☐ PBS HMC (acute)
- ☐ PBS HMC (long-stay)

iv) The patient is aged 12 years or under **Y** / **N**

Only include charts that are 'active' and in current use at the time of audit (i.e. do not include charts where all orders have been ceased or have otherwise expired)

Section 1 Patient identification

1.1 Patient identification section is completed using:

- ☐ handwritten patient details
- ☐ printed patient identification labels
- ☐ a mix of printed patient identification labels and handwritten details

1.2 Patient identification section is completed on all pages of all active charts
Y / **N**

1.3 Handwritten patient details are legible and complete (i.e. at least 3 patient identifiers documented)
Y / **N** / **NA**

1.4 Patient's name is handwritten under patient identification label(s) by first prescriber
Y / **N** / **NA**

Section 2 Prescriber details

{PBS HMC only}

2.1 All prescribers who have ordered a medicine for the patient are listed in the prescriber details section of the PBS HMC
Y / **N [if N, go to Q3.1]**

2.2 The prescriber details section of the PBS HMC is legible and complete
Y / **N**

Section 3 Weight documentation

{Patients aged 12 years or under and using NIMC paediatric only}

3.1 Weight is documented on all charts
Y / **N [if N, go to Q4.1]**

3.2 Date weighed is documented with weight on all charts
Y / **N**

Section 4 Adverse drug reactions (ADR)

4.1 The following has been documented in the ADR section:
(select **one** option only)

- ☐ details of any medicine (or other) allergies or ADR(s) **[go to Q4.2]**
- ☐ 'Nil known' or 'unknown' box marked with signature, name and date on all active charts **[go to Q5.1]**
- ☐ none of the above apply **[go to Q5.1]**

4.2 The medicine (or other) section and reaction type has been documented on all active charts
Y / **N**

4.3 The ADR documentation includes signature, name and date on all active charts
Y / **N**

Section 5 Medication history

5.1 Medication history for the current episode of care is:
(select **one** option only)

- ☐ documented on the chart **[go to Q6.1]**
- ☐ documented elsewhere according to local procedure **[go to Q5.2]**
- ☐ not documented **[go to Q6.1]**

5.2 Where medication history is documented elsewhere according to local procedure, it has been cross-referenced on the chart[a]
Y / **N**

Section 6 VTE risk assessment and VTE prophylaxis

{NIMC acute & PBS HMC acute only}

6.1 The following has been documented in the VTE risk assessment section:
(select **all** that apply)

- ☐ 'yes' box marked
- ☐ 'prophylaxis not required' or 'contraindicated' box marked
- ☐ signature and date documented
- ☐ none of the above apply

6.2 VTE prophylaxis has been prescribed
Y / N [if N go to Q7.1]

6.3 Section in which VTE prophylaxis was prescribed:
(select one option only)

- ☐ the VTE prophylaxis order section only
- ☐ the regular medicines order section only
- ☐ both the VTE prophylaxis and regular medicines sections

Section 7 Pharmaceutical review

7.1 Pharmaceutical review has been documented at least once on all charts (i.e. clinician initials are recorded in the pharmaceutical review box under the regular medicines section)
Y / N

Section 8 Chart numbering

8.1 All charts for the patient are correctly numbered
Y / N

Section 9 Anticoagulant education record

{NIMC acute, NIMC long-stay, PBS HMC acute & PBS HMC long-stay only}

9.1 The patient has been initiated on an anticoagulant for ongoing treatment
Y / N [if N, go to section 10]

9.2 The anticoagulant education record has been completed
Y / N

Section 10 Regular medicine orders

		No.
10.1	Total number of regular medicine orders[b] **[If '0', go to section 11]**	☐
10.2	Record the number of **orders** in this section where the following errors are identified:[c]	
	order **not** legible	☐
	order contains one or more error-prone abbreviation(s)	☐
	medicine name **not** complete and correct	☐
	route **not** complete and correct	☐
	dose **not** complete and correct	☐
	frequency **not** complete and correct	☐
	prescriber name **not** legible on the chart[d]	☐
	order **not** signed by prescriber	☐
10.3	How many regular medicine orders contain one or more of the above errors?[e]	☐
10.4	Total number of SR medicine orders[f]	☐
10.5	Number of orders where SR box is **not** ticked for SR medicines	☐
10.6	Number of orders where indication is **not** documented	☐
10.7	Number of orders where dose calculation is **not** documented for patient aged 12 years or under {NIMC paediatric only}	☐
10.8	Total number of required **doses** prescribed in the regular medicines section[g]	☐
10.9	How many doses were **missed** without a reason for not administering specified?[h]	☐

Section 11 PRN medicine orders

		No.
11.1	Total number of PRN medicine orders[b] **[If '0', go to section 12]**	
11.2	Record the number of orders in this section where the following errors are identified:[c]	
	order **not** legible	☐
	order contains one or more error-prone abbreviation(s)	☐
	medicine name **not** complete and correct	☐
	route **not** complete and correct	☐
	dose **not** complete and correct	☐
	hourly frequency **not** complete and correct	☐
	maximum PRN dose in 24 hours **not** documented	☐
	prescriber name **not** legible on the chart[d]	☐
	order **not** signed by prescriber	☐
11.3	How many PRN medicine orders contain one or more of the above errors?[e]	☐
11.4	Number of orders where indication is **not** documented	☐
11.5	Number of orders where dose calculation is **not** documented for patient aged 12 years or under {NIMC paediatric only}	☐

Section 12 Once only, nurse initiated & phone orders

No.

12.1 Total number of once only and nurse initiated **orders**[b] ☐

12.2 Total number of phone **orders**[b] ☐
[If '0' for both Q12.1 and Q12.2, go to section 13]

12.3 Record the number of orders in this section where the following errors are identified:[c]

- order **not** legible ☐
- order contains one or more error-prone abbreviation(s) ☐
- medicine name **not** complete and correct ☐
- route **not** complete and correct ☐
- dose **not** complete and correct ☐
- frequency **not** complete and correct {phone orders only} ☐
- double signature **not** complete {phone orders only} ☐
- prescriber name **not** legible on the chart[d] ☐
- order **not** signed by prescriber ☐

12.4 How many once only, nurse initiated and phone orders contain one or more of the above errors?[e] ☐

12.5 Total number of required **doses** prescribed in the once only, nurse initiated and phone order section[g] ☐

12.6 How many doses were **missed** without a reason for not administering specified?[h] ☐

Section 13 Variable dose medicine orders

No.

{NIMC acute & PBS HMC acute only}

13.1 Total number of variable dose medicine orders[b] ☐
[If '0', go to section 14]

13.2 Record the number of **orders** in this section where the following errors are identified:[c]

- order **not** legible ☐
- order contains one or more error-prone abbreviation(s) ☐
- medicine name **not** complete and correct ☐
- route **not** complete and correct ☐
- dose **not** complete and correct for each day of administration ☐
- frequency **not** complete and correct ☐
- time to be given **not** documented ☐
- prescriber name **not** legible on the chart[d] ☐
- order **not** signed by prescriber ☐

13.3 How many variable dose medicine orders contain one or more of the above errors?[e] ☐

13.4 Number of orders where indication is **not** documented ☐

13.5 Total number of required **doses** prescribed in the variable dose section[g] ☐

13.6 How many doses were **missed** without a reason for not administering specified?[h] ☐

Section 14 Orders in warfarin section

No.

{NIMC acute, NIMC long-stay, PBS HMC acute & PBS HMC long-stay only}

14.1 Total number of orders in the warfarin section[b] ☐
[If '0', go to Q14.9]

14.2 Record the number of **orders** in this section where the following errors are identified:[c]

- order **not** legible ☐
- order contains one or more error-prone abbreviation(s) ☐
- brand name has **not** been selected ☐
- route **not** complete and correct ☐
- daily warfarin dose **not** documented and signed[i] ☐
- prescriber name **not** legible on the chart[d] ☐
- order **not** signed by prescriber ☐

14.3 How many orders in the warfarin section contain one or more of the above errors?[e] ☐

14.4 Number of orders where INR result(s) are **not** documented at least once on the chart ☐

14.5 Number of orders where INR target range is **not** documented ☐

14.6 Number of orders where indication is **not** documented ☐

14.7 Total number of required **doses** prescribed in the warfarin section[g] ☐

14.8 How many doses were **missed** without a reason for not administering specified?[h] ☐

14.9 How many warfarin orders are prescribed in the regular medicines section? ☐

Explanatory notes

a) Where medication history is recorded elsewhere (e.g. MMP or eMR), record Y if the patient's medication history is cross-referenced on at least one active chart. Note that this is not the same as reconciling medication history.

b) Record the total number of orders in the specified section. If reviewing more than one chart for the patient, ensure that all medicine orders for each section (on all 'active' charts in current use) are included in the total.

c) Reviewing all the orders in this section, record the number of orders where the specified error has been identified. Take care to record number of orders where the errors occur, not total number of errors. Put a 0 in the box if there are no orders with the specified error.

d) Record any orders where prescriber identity cannot be determined from the chart with a legible name clearly printed. (Prescriber name needs to be printed only once on the chart).

e) Record the total number of orders with one or more errors, not total number of errors.

f) Record the number of medicine orders that are slow release (SR), regardless of whether the SR box has been ticked. Note that this is a subset of the total number of regular medicine orders.

g) Record the total number of doses that are required to have been administered since the order was written, considering the current date and time.

h) Record the number of doses that have been missed without an appropriate code for not administering documented.

i) If one or more doses in the Warfarin section are not documented and signed, count this as one incorrect order only.