National Standard Medication Chart (NSMC) audit form

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  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
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
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

12.1 Total number of once only and nurse initiated orders:

12.2 Total number of phone orders:

12.3 Record the number of orders in this section where the following errors are identified:
- 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
- order not signed by prescriber

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

12.5 Total number of required doses prescribed in the once only, nurse initiated and phone order section

12.6 How many doses were missed without a reason for not administering specified?

Section 13 Variable dose medicine orders

(NIMC acute & PBS HMC acute only)

13.1 Total number of variable dose medicine orders:

13.2 Record the number of orders in this section where the following errors are identified:
- 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 for each day of administration
- time to be given not documented
- prescriber name not legible on the chart
- order not signed by prescriber

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

13.4 Number of orders where indication is not documented

13.5 Total number of required doses prescribed in the variable dose section

13.6 How many doses were missed without a reason for not administering specified?

Section 14 Orders in warfarin section

(NIMC acute, NIMC long-stay, PBS HMC acute & PBS HMC long-stay only)

14.1 Total number of orders in the warfarin section:

14.2 Record the number of orders in this section where the following errors are identified:
- 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
- prescriber name not legible on the chart
- order not signed by prescriber

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

14.4 Number of orders where INR results 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

14.8 How many doses were missed without a reason for not administering specified?

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 each 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.