



Government of **Western Australia**
Department of **Health**

National Standard Medication Chart (NSMC) Audit Form – WA Statewide Audit November 2026

Health Service: (follow the prompts to select appropriate HSP, hospital group or WACHS site and hospital)		
Date of audit:		
Patient UMRN: (for auditor reference purposes only)		
Ward:		
Chart type and age of patient		
Chart type		
☐ WA Adult HMC* (acute)	☐ WA Paediatric HMC* (acute)	☐ Neonatal Chart
☐ WA Adult HMC* (long-stay)	☐ WA Paediatric HMC* (long-stay)	•
Is the patient aged 12 years or under		Y / N

Section 1 Adverse drug reactions (ADR) (Medicine or treatment related ADRs only)

1.1 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 question 1.2)	
☐ "Nil known" or "unknown" box marked (go to question 1.4)	
☐ None of the above apply (go to section 2)	
1.2 If ADR has been identified for the patient, has the medicine (or other) section and reaction type been documented on ALL active charts	Y / N
1.3 If ADR has been identified for the patient, has an "Adverse Drug Reaction" sticker been affixed to the ADR box on ALL active charts	Y / N
1.4 The ADR documentation includes signature, name and date on ALL active charts	Y / N
Additional comments	

Section 2 VTE risk assessment and VTE prophylaxis (WA Adult HMC acute and long-stay)

2.1 The following has been documented in the VTE risk assessment section: (select ALL that apply)	
☐ "Indicated" box marked	☐ Signature and date documented
☐ "Not Indicated" or "Contraindicated" box marked	☐ None of the above apply
2.2 VTE prophylaxis has been prescribed (if N is selected, go to question 2.4)	Y / N
2.3 Section in which VTE prophylaxis was prescribed:	
☐ The VTE prophylaxis order section only (WA Anticoagulation Chart)	
☐ The regular medicines order section only (WA Hospital Medication Chart)	
☐ Both the VTE prophylaxis and regular medicines sections	
☐ Other (please specify)	
2.4 Where has the VTE Risk Assessment been documented?	
☐ WA HMC	
☐ Other (go to question 2.5)	
☐ No documentation of VTE Risk Assessment	
2.5 If 'Other' in Q 2.4, please specify where VTE Risk Assessment is documented.	
Additional comments	

Section 3 Regular Medicine Order

3.1 Total number of regular medicine orders (If '0', go to section 4)	
3.2 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)	
Annotate the error-prone abbreviations	
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	
Order not signed by prescriber	
3.3 How many regular medicine orders contain one or more of the above errors?	
3.4 Total number of SR medicines orders	
3.5 Number of orders where SR box is not ticked for SR medicines	

3.6 Number of orders where indication is not documented	
3.7 Number of orders where dose calculation is not documented for patients aged 12 years or under (Paediatric HMC, Neonatal chart or patient is 12 years and under)	
3.8 Total number of required doses prescribed in the regular medicines section	
3.9 How many doses were missed without a reason for not administering specified?	

Section 4 PRN medicine orders

4.1 Total number of PRN medicine orders (If '0', go to section 5)	
4.2 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)	
Annotate the error-prone abbreviations	
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	
Order not signed by prescriber	
4.3 How many PRN medicine orders contain one or more of the above errors?	
4.4 Number of orders where indication is not documented	
4.5 Number of orders where dose calculation is not documented for patients aged 12 years or under (Paediatric HMC, Neonatal chart or patient is 12 years and under)	

Section 5 Once only, nurse initiated and phone orders

5.1 Total number of once only and nurse-initiated orders	
5.2 Total number of phone orders (If '0' for both Q 5.1 and Q5.2, go to section 6)	
5.3 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)	
Annotate the error-prone abbreviations	
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 signatures not complete (phone orders only)	
Prescriber name not legible on the chart	
Order not signed by prescriber	
5.4 How many once only, nurse initiated and phone orders contain one or more of the above errors?	
5.5 Total number of required doses prescribed in the once only, nurse initiated and phone order section	
5.6 How many doses were missed without a reason for not administering specified?	

Section 6 Option to complete non-mandatory sections of audit

Do you wish to complete any of the non-mandatory sections of the audit	Y / N
If you select Y, you will be prompted to add additional data in the non-mandatory sections of the audit	
If you select N, you will be prompted to complete the audit.	

Non-Mandatory questions (Section 7-15)

Section 7 Patient Identification

Questions 7.1 to 7.3 only relate to the Patient Identification Box (addressograph box) located on page 3 and 4 of the WA Hospital Medication Chart.

Question 7.4 relates to the section just below the Patient Identification Box, where the first prescriber must handwrite the patient's name if using printed labels.

7.1 Patient identification section is completed using:	☐ Handwritten patient details ☐ Printed patient identification labels ☐ A mix of printed patient identification labels and handwritten details
7.2 Patient identification is completed on all pages of ALL active charts	☐ Yes ☐ No
7.3 Where handwritten, are patients details legible and complete (i.e. at least 3 patient identifiers documented such as UMRN, patient name – family and given name, DOB, gender or address)	☐ Yes ☐ No
7.4 Patient's name is handwritten under patient's identification label(s) by first prescriber?	☐ Yes ☐ No
Additional Comments:	

Section 8 Prescriber Detail (WA PBS HMC only)

8.1 All prescribers who have ordered a medicine for the patient are listed in the prescriber details section of the PBS HMC	☐ Yes ☐ No
8.2 The prescriber details section of the PBS HMC is legible and complete	☐ Yes ☐ No

Section 9 Weight Documentation

9.1 Weight is documented on all charts	☐ Yes ☐ No
9.2 Date weighed is documented with weight on all charts	☐ Yes ☐ No

Section 10 Medication History

10.1 Medication history for the current episode of care is: (select ONE option only)	☐ Documented on the chart [Go to next section] ☐ Documented elsewhere according to local procedure [Go to Q10.2] ☐ No documented [Go to next section]
10.2 Where medication history is documented elsewhere according to local procedure, it has been cross-referenced on the chart	☐ Yes ☐ No

Section 11 Pharmaceutical Review

11.1 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).	☐ Yes ☐ No
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Section 12 Chart Numbering

12.1 All charts for the patient are correctly numbered	☐ Yes ☐ No
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Section 13 Anticoagulant education record

13.1 The patient has been initiated on an anticoagulant for ongoing treatment.	☐ Yes ☐ No [Go to next section]
13.2 The anticoagulant education record has been completed (refer to WA AMC).	☐ Yes ☐ No

Section 14 Variable dose orders

14.1 Total number of variable medicine orders [If '0', go to next 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)	
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	
Order not signed by prescriber	
14.3 How many variable dose medicine orders contain one or more of the above errors?	
14.4 Number of orders where indication is not documented	
14.5 Total number of required doses prescribed in the variable dose section	
14.6 How many doses were missed without a reason for not administering specified?	

Section 15 Warfarin order section (Refer to WA Anticoagulation Medication Chart [WA AMC])

15.1 Total number of doses in the warfarin section [If '0', go to Q15.9]	
15.2 Record the number of orders in this section where the following errors are identified:	
Order not legible (This relates to any handwritten information on the order that may be hard to read, e.g. dose, or INR range)	
Brand name has not been selected	
Daily warfarin dose not complete and correct	
Prescriber name not legible on the chart	
Order not signed by prescriber	
15.3 How many orders in the warfarin section contain one or more of the above errors?	
15.4 Number of orders where INR result(s) are not documented at least once on the chart	
15.5 Is the INR target range documented?	☐ Yes ☐ No
15.6 Is warfarin indication documented?	☐ Yes ☐ No
15.7 Total number of required doses prescribed in the warfarin section	
15.8 How many doses were missed without a reason for not administering specified?	
15.9 How many warfarin orders are prescribed on the WA AMC?	

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