



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

National Standard Medication Chart (NSMC) Audit 2026

WA Quick Reference Guide and
Frequently Asked Questions (FAQs)

General Instructions

Complete one audit tool per patient.

NOTE: The REDCap® audit tool uses branching logic, therefore some questions will only appear if they are relevant to the responses entered into the audit.

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:

Select the appropriate health service/hospital name by following the prompts when using the REDCap® audit tool and enter the date the chart was audited.

Record patient's Unique Medical Record Number (UMRN) and 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		

- Adult patients in public hospitals – select either WA Adult Hospital Medication Chart acute or long-stay version.
- Paediatric patients in public hospitals – select either WA Paediatric Hospital Medication Chart acute or long-stay version.

Mandatory section (1-5)

Section 1 Adverse drug reactions (ADR) (Mandatory)

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	

Review page 3 of ALL active charts.

1.1 This section aims to identify if the ADR details have been completed fully, partially or not at all.

- Select ONE option only. Then follow prompts to next appropriate question.
- If the prescriber has ticked the "Nil known" and included their signature but no name or date, then this would be considered the third option "none of the above apply".

- The ADR section can be used to document all allergies/ADRs based on local policy, however the focus for the NSMC audit is to identify medicine-related ADRs as a patient safety feature related to prescribing of medicines on the medication chart.
- Refer to additional information in the “Frequently Asked Questions (FAQ)” section of this document.

1.2 Documentation needs to include medicine (or other) AND reaction type.

- If reaction is documented as “patient unsure” or “patient can’t remember”, select YES.1.3
- Check that an “Adverse Drug Reaction” sticker has been affixed to the ADR box on ALL active charts.
- Please also refer to the back page (page 4) of the WA HMC to see if the sticker has been affixed here.

1.4 Documentation requires signature/initial and name of the person documenting the ADR(s) and date of documentation on ALL active charts.

Section 2 VTE risk assessment and VTE prophylaxis (Mandatory)

This section is only applicable if auditing the WA Adult HMC acute and long-stay charts.

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 (<i>if N is selected, go to question 2.4</i>)	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	

2.1 Refer to the VTE risk assessment tool within the WA HMC. Look specifically at the pharmacological prophylaxis section of the tool.

VTE risk assessment needs to be documented within at least ONE of the active charts (if multiple charts are present). Select all options that apply:

- If “**Indicated**” box is marked, select this option.
- If either the “**Not indicated**” or “**Contraindicated**” box is marked, select this option.
- If prescriber has signed AND dated the VTE risk assessment tool, select “signature and date documented”
- If VTE risk assessment tool has not been completed for at least ONE of the active charts, select “None of the above apply”

2.2 Refer to the pharmacological (not mechanical) VTE prophylaxis section only of WA Anticoagulation Medication Chart (WA AMC) and cross check the WA HMC.

- Select YES if pharmacological prophylaxis prescribed.

2.3 Confirm the section where VTE prophylaxis has been prescribed.

- Select “The VTE prophylaxis order section” if a pharmacological VTE agent has been prescribed on the VTE prophylaxis section of the WA AMC.
- Cross check the WA HMC to confirm no VTE prophylaxis has been charted here and select the appropriate option.
- If VTE prophylaxis is prescribed elsewhere select “Other” and then specify location.

2.4 Confirm where the VTE Risk Assessment has been documented.

- Select “WA HMC” if this is documented in the VTE Risk Assessment section of the chart.
- Select “Other” if your site has a separate tool to document VTE Risk Assessment.
- If your site uses the Digital Medical Record (DMR) to record VTE Risk Assessment refer to additional information in the “Frequently Asked Questions (FAQ)” section of this document.

2.5 If you selected “Other” in Q2.4, you will be prompted in this section to specify where this has been documented.

Section 3 Regular Medicine Order (Mandatory)

Applies to all medicine orders in the regular sections of all active charts in current use at time of auditing. Excludes ceased medications.

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)	
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?	

3.1 Record the total number of regular medicine orders currently prescribed.

- 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.
- If there are no regular medicine orders currently prescribed, record 0 for this question.

User will automatically be taken to Section 4 if '0' is entered for this question.

3.2 Reviewing all the orders in the regular medicines section, record the number of orders where the specified error has been identified.

- Take care to record the number of orders where the errors occur, not the total number of errors. Put a 0 in the box if there are no orders with the specified error.
- *Note: Each answer should contain a number, if none of the orders contain errors, record 0.*
 - **Order not legible** - Record the number of orders that are not legible to both auditors, with risk of misinterpretation identified. Legibility is referring to the handwriting only.
 - **Order contains one or more error-prone abbreviation(s)** - Record the number of orders that contain one or more error-prone abbreviations.
 - *Note: See the National Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines and local policy.*
 - *A separate non-mandatory question immediately following this has been included for sites who may wish to annotate the type of error-prone abbreviations identified during the audit.*
 - **Medicine name not complete and correct** - Record the number of orders where the medicine name is not complete and correct, with potential for error identified. *Note: refer to local policy to determine if generic or brand name is considered correct.*
 - **Route not complete and correct** - Record the number of orders where the route is not complete and correct, with potential for error identified.
 - **Dose not complete and correct** - Record the number of orders where the dose is not complete and correct, with potential for error identified. *Note: where reviewing orders for paediatric patients, consider correctness and consistency with any dose calculations documented on the chart.*
 - **Frequency not complete and correct** - Record the number of orders where the frequency is not complete and correct, with potential for error identified.
 - **Prescriber name not legible on the chart** - Record the number of orders where the prescriber's name is not legibly written somewhere on the chart containing the order. Prescriber name needs to be printed at least once on the chart.
 - **Order not signed by the prescriber** - Record the number of orders where the prescriber has not signed the order.

3.3 How many regular medicine orders contain one or more of the above errors?

- Record the number of regular medicine orders where one or more of the errors listed in Q3.2 were identified.
- Do not record the total number of errors.

3.4 Total number of SR medicine orders.

- Record the total 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.
- Please see below table for examples of other terms that can be used to mean slow release.

Abbreviations used for slow release products include:

Abbreviation	Meaning	Example
SR	Sustained/slow release	Veracaps SR (verapamil)
MR	Modified release	Diamcron MR (gliclazide)
LA	Long acting	Ritalin LA (methylphenidate)
XL	Extended release	Toprol XL (metoprolol)
XR	Extended release	Diabex XR (metformin)
ER	Extended release	Felodur ER (felodipine)
CR	Controlled release	Tegretol CR (carbamazepine)
CD	Controlled delivery	Cardizem CD (diltiazem)

3.5 Number of orders where SR box is not ticked for SR medicines.

- Record the number of orders where prescriber has not ticked the SR box.

3.6 Number of orders where indication is not documented.

- Record the number of orders where the prescriber has not documented the indication.

3.7 Number of orders where dose calculation is not documented for patient aged 12 years or under. (NIMC paediatric and patients aged 12 years and under only)

- Record the number of orders where the prescriber has not documented a dose calculation.
- Note: Dose calculations should refer to a dose from an appropriate reference and specify the dose per body weight (for example, in mg/kg) or per body surface area (for example, microgram/m² /dose).*

3.8 Total number of required doses prescribed in the regular medicines section.

- Record the total number of doses in the regular medicines section that are required to have been administered since the order was written, considering the current date and time.

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

- Record the number of required doses in the regular medicines section that appear to have been missed, that is, have not been documented as administered and a code for not administering has not been specified.

Section 4 PRN Medicine Order (Mandatory)

Applies to all medicine orders in the PRN sections of all active charts in current use.

Excludes ceased medications.

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)	
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)	

4.1 Total number of PRN medicine orders.

- Record the total number of PRN medicine orders currently prescribed.
- 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.
- If there are no PRN medicine orders currently prescribed, record 0 for this question.
- User will automatically be taken to Section 5 if '0' is entered for this question.

4.2 Record the number of orders in this section where the following errors are identified.

- Reviewing all the orders in the PRN medicines section, record the number of orders where the specified error has been identified.
- Take care to record the number of orders where the errors occur, not the total number of errors. Put a 0 in the box if there are no orders with the specified error
- *Note: Each answer should contain a number, if none of the orders contain errors, record 0.*
 - **Order not legible** - Record the number of orders that are not legible to both auditors, with risk of misinterpretation identified. Legibility is referring to the handwriting only.
 - **Order contains one or more error-prone abbreviation(s)** - Record the number of orders that contain one or more error-prone abbreviations. *Note: See the National Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines and local policy.* A separate non-mandatory question immediately following this has been included for sites who may wish to annotate the type of error-prone abbreviations identified during the audit.
 - **Medicine name not complete and correct** – Record the number of orders where the medicine name is not complete and correct, with potential for error identified. *Note: refer to local policy to determine if generic or brand name is considered correct.*
 - **Route not complete and correct** - Record the number of orders where the route is not complete and correct, with potential for error identified.
 - **Dose not complete and correct** - Record the number of orders where the dose is not complete and correct, with potential for error identified. *Note: where reviewing orders for paediatric patients, consider correctness and consistency with any dose calculations documented on the chart.*
 - **Hourly frequency not complete and correct** - Record the number of orders where the hourly frequency is not complete and correct, with potential for error identified.
 - **Maximum PRN dose in 24 hours not documented** - Record the number of orders where the maximum PRN dose in 24 hours is not documented.
 - **Prescriber name not legible on the chart** - Record the number of orders where the prescriber's name is not legibly written somewhere on the chart containing the order. Prescriber name needs to be printed at least once on the chart.
 - **Order not signed by prescriber** - Record the number of orders where the prescriber has not signed the order.

- 4.3 How many PRN medicine orders contain one or more of the above errors?
- Record the number of PRN medicine orders where one or more of the errors listed in Q4.2 were identified.
 - Do not record the total number of errors.*
- 4.4 Number of orders where indication is not documented.
- Record the number of orders where the indication has not been documented by the prescriber.
- 4.5 Number of orders where dose calculation is not documented for patient aged 12 years or under. (NIMC paediatric only)
- Record the number of orders where a dose calculation has not been documented by the prescriber.
 - Note: Dose calculations should refer to a dose from an appropriate reference and specify the dose per body weight (for example, in mg/kg) or per body surface area (for example, microgram/m² /dose)*

Section 5 Stat, nurse initiated and phone order (Mandatory)

This section applies to all medicine orders in the once only, nurse-initiated and phone order sections of all active charts in current use.

5.1 Total number of once only and nurse-initiated orders	
5.2 Total number of phone orders (If '0' for both Q5.1 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)	
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?	

- 5.1 Total number of *once only and nurse-initiated orders*.
- Record the total number of once only and nurse-initiated medicine orders.
 - 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.
 - If there are no once only and nurse-initiated medicine orders currently prescribed, record 0 for this question.
- 5.2 Total number of *phone orders*.
- Record the total number of phone orders.

- 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.
- If there are no phone orders currently prescribed, record 0 for this question.
- User will automatically be taken to Section 6 if '0' is entered for both 5.1 and 5.2.

5.3 Record the number of orders in this section where the following errors are identified.

- Reviewing all the orders in the once only, nurse-initiated and phone orders medicines section, record the number of orders where the specified error has been identified.
- Take care to record the number of orders where the errors occur, not the total number of errors. Put a 0 in the box if there are no orders with the specified error.
- *Note: Each answer should contain a number, if none of the orders contain errors, record 0.*
 - **Order not legible** - Record the number of orders that are not legible to both auditors, with risk of misinterpretation identified. Legibility is referring to the handwriting only.
 - **Order contains one or more error-prone abbreviation(s)** - Record the number of orders that contain one or more error-prone abbreviations. *Note: See the National Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines and local policy. A separate non-mandatory question immediately following this has been included for sites who may wish to annotate the type of error-prone abbreviations identified during the audit.*
 - **Medicine name not complete and correct** - Record the number of orders where the medicine name is not complete and correct, with potential for error identified. *Note: refer to local policy to determine if generic or brand name is considered correct.*
 - **Route not complete and correct** - Record the number of orders where the route is not complete and correct, with potential for error identified.
 - **Dose not complete and correct** Record the number of orders where the dose is not complete and correct, with potential for error identified.
 - **Frequency not complete and correct (phone orders only)** Looking only at the phone orders, record the number of orders where the frequency is not complete and correct, with potential for error identified.
 - **Double signature not complete (phone orders only)** Looking only at the phone orders, record the number of orders where the double signature of two clinicians receiving the order is not complete.
 - **Prescriber name not legible on the chart** Record the number of orders where the prescriber's name is not legibly written somewhere on the chart containing the order. Prescriber name needs to be printed at least once on the chart.
 - **Order not signed by prescriber** Record the number of orders where the prescriber has not signed the order. *Note: Each answer should contain a number, if none of the orders contain errors, record 0.*

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

- Record the number of once only, nurse-initiated and phone orders where one or more of the errors listed in question 5.3 were identified.
- Do not record the total number of errors.

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

- Record the total number of doses in the once only, nurse-initiated and phone order section that should have been administered since the order was written, considering the current date and time.

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

- Record the number of required doses in the once only, nurse-initiated and phone order section that appear to have been missed – that is, the orders which are not signed as administered and/or do not contain a code for not administering.

Section 6 Option to complete non-mandatory sections of audit (Mandatory)

This section enables the user to either finish the audit or complete other sections (non-mandatory) of the audit.

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
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- Select 'No' if you want to finish the audit.
- Select 'Yes' if you want to complete other non-mandatory sections of the audit.
- User will then be enabled to view all relevant questions based on the chart type selected at the beginning of the audit.

Non Mandatory questions (section 7-15)

Section 7 Patient Identification (Non-mandatory section)

Section 7: Patient Identification

Question 7.1 to 7.3 only relates 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
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7.2 Patient identification is completed on all pages of ALL active charts?	☐ Yes ☐ No
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7.3 Where handwritten, are patient details legible and complete (i.e. at least 3 patient identifiers documented such as UMRN, patient name - family and given, DOB, gender, or address)	☐ Yes ☐ No
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7.4 Patient's name is handwritten under patient's identification label(s) by first prescriber?	☐ Yes ☐ No
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Additional comments

Review ALL pages of ALL active medication charts.

7.1 Select ONE option.

7.2 Select YES or NO accordingly.

7.3 Wherever patient ID is handwritten, select YES if at least three identifiers are present on the WA HMC (visible and correct).

- These identifiers include: UMRN, patient name – family and given names, DOB, gender, or address.

7.4 Select YES if first prescriber has handwritten patient's name. Select NO if it is a different prescriber, or pharmacist who has handwritten patient's name.

- Please feel free to write any additional comments if applicable.

Section 8 Prescriber Detail (Non-mandatory section)

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

This section is only applicable for the WA PBS HMC

8.1 Select YES if all prescribers who have ordered a medicine for the patient are listed in the prescriber details section of the active WA PBS HMC(s) containing the prescriber's current medicine orders. Otherwise record No. If no, go to next applicable section.

8.2 The prescriber details section of the WA PBS HMC is legible and complete.

This question only applies to patients with a WA PBS HMC where yes was selected for Q8.1. Record YES if all the details below are recorded and legible for each prescriber in the prescriber details section on the WA PBS HMC:

- Name
- PBS prescriber number
- Contact number
- Address
- Signature
- Date.

Otherwise record 'No'.

Section 9 Weight Documentation (Non-mandatory section)

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

This question applies to all patients aged 12 years and under using WA Paediatric Chart or Neonatal Chart.

9.1 Select YES if the weight field is complete on ALL active charts in current use.

Select NO if the weight field is not complete on one or more charts. If no, go to next applicable section.

9.2 Select YES if the date has been completed with the corresponding weight on ALL active charts in current use. Select No if the date weighed field is not complete on one or more charts.

Section 10 Medication history (Non-mandatory section)

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 the next section]
☐ documented elsewhere according to local procedure [go to Q10.2]
☐ not documented [go to the next section]

10.2 Where medication history is documented elsewhere according to local procedure, it has been cross-referenced on the chart?

- ☐ Yes
☐ No

10.1 Select ONE option only.

- Select how the medication history for the current episode of care is documented (including 'nil regular meds' or equivalent).
- Record only one option above that applies to at least one of the patient's active charts. If the first response is selected, move to the next applicable section of the audit.
- If the second response is selected, move to the next question (Q10.2); and if the last response is selected, move to the next applicable section.

10.2 Select ONE option only.

Section 11 Pharmaceutical review (Non-mandatory section)

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

11.1 Select YES if a clinician's initials are recorded in the pharmaceutical review box at least once on all active charts in current use, regardless of patient length of stay.

Select NO if there are no pharmacist initials in the pharmaceutical review box on one or more of the charts.

Note: Pharmaceutical review is not the same as pharmacy annotation of individual medicine orders.

Section 12 Chart Numbering (Non-mandatory section)

Section 12 Chart numbering

12.1 All charts for the patient are correctly numbered

- ☐ Yes
☐ No

12.1 Select YES if the chart number and the total number of active charts in current use for the patient (such as '1 of 1', or '1 of 2' and '2 of 2') are correctly documented in the space provided on all charts.

Select NO if the chart number and the total number of active charts in current use for the patient are not documented in the space provided on one or more charts, or if the chart numbering is not correct on one or more charts.

Note: Chart numbering must be updated when extra charts are written, or charts are ceased.

Section 13 Anticoagulant education record (Non-mandatory section)

Section 13 Anticoagulant education record

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

☐ Yes
☐ No

13.2 The anticoagulant education record has been completed

☐ Yes
☐ No

Refer to the WA Anticoagulation Medication Chart for this question. This question only relates to patients that have been **INITIATED** on an anticoagulant during their hospital admission.

13.1 Select YES if the patient has been initiated on an anticoagulant for ongoing treatment during this episode of care.

Select NO if the patient has not been initiated on an anticoagulant for ongoing treatment during this episode of care. If no, go to next applicable section.

13.2 Select YES if a clinician has completed all fields in the anticoagulant education record on at least one active chart in current use. Otherwise select No.

Section 14 Variable Dose Orders (Non-mandatory section)

- Total number of orders = active orders on current charts (i.e. not ceased medications)
- When reviewing all of the orders in the specified section, record the **number of orders** where the specified error has been identified. Record the number of orders where one or more errors have occurred, not the total number of errors.

Section 14 Variable dose medicine orders

14.1 Total number of variable dose 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 (Non-mandatory section)

Refer to 'Warfarin Variable Dose Order' section of the WA Anticoagulant Medication Chart (WA AMC)

15.1 If warfarin is prescribed, record 1

15.2 Order not legible = 0 (unless actual dose prescribed is illegible)

Route not complete and correct = 0

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

15.9 This should be 0. Record 1 if warfarin order has been documented on the WA HMC.

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

15.1 Total number of orders 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 like 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 HMC?

National Standard Medication Chart (NSMC) Audit - Frequently Asked Questions (FAQ)

Topic Question	Answer
General information	
Preparation for participating in WA NSMC Audit 2026	The WA NSMC 2026 audit will be coordinated via REDCap®. 1. Site Coordinators will require access to REDCap® to be able to run reports for their site. 2. Register for access to REDCap® – Complete the registration form 3. Site Coordinators will then need to email MTU to ask for specific access to the National Standard Medication Chart Audit 2026 REDCap® project. 4. Auditors can either: • Enter data via the REDCap® link , OR • Alternatively, they can request access to the National Standard Medication Chart Audit 2026 REDCap® Project if deemed appropriate by their site coordinators following the above steps. This local WA NSMC Audit 2026 has been adapted from the Australian Commission on Safety and Quality in Health Care NSMC Audit. The WA NSMC Audit 2026 is a targeted audit that focuses on: • adverse drug reactions (ADRs) , • venous thromboembolism (VTE) risk assessment, • regular medicine orders, • PRN medicine orders and, • Stat, nurse initiated and phone order. The audit period will run from Tuesday 20 October to Tuesday 10th November 2026. MTU has developed this Quick Reference Guide document, and a Train-the-Trainer presentation to assist WA auditors in completing the audit. Refer to the WA Health Safety and Quality website for further information. Sites must decide the method for collecting the data either by: i. Collecting data on the paper based tool, which then needs to be entered into REDCap®. ii. Entering the data directly into REDCap® using the REDCap® <u>National Standard Medication Chart Audit Tool</u> (an electronic version of the Audit Form) via the following link, or through the REDCap® project. It is recommended that auditors become familiar with the audit questions and the electronic REDCap® audit tool. • Sites will need to determine the number of patients that are going to be audited, and how the spread of charts will be managed. Sites will also need to determine the auditors involved, and any separate data entry personnel (if appropriate). • Print off the required number of paper audit tools. Multiple uploads of data can occur from one site as each auditor can use the REDCap® audit tool link to enter data simultaneously.

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Selection of sample patients	- The audit must be conducted on medication charts that are active and in current use. Therefore, the audit should be done prospectively and not retrospectively (i.e. patients must be current inpatients and not recently discharged). - It is up to the individual sites how the quota of patients is selected for audit. - The guidelines recommend that as many medication charts as possible are audited from each ward type, however if not all charts can be audited ensure charts are chosen at random.								
Number of charts to be audited	The ACSQHC have provided a recommended sample size (Table 1) which is dependent on the number of beds at your facility. WA Health supports this recommendation to ensure that sample sizes across NSMC audits are consistent. However, as mentioned previously, it is recommended that as many medication charts are audited (as feasible based on resources and time). Table 1: Suggested audit sample size* <table> <tr> <th>Number of adult beds in hospital</th><th>Sample size</th></tr> <tr> <td>150 or more</td><td>20% of current patients</td></tr> <tr> <td>30 -149</td><td>30 current patients</td></tr> <tr> <td>Less than 30</td><td>All current patients</td></tr> </table> * Suggested sample size derived from Indicators for Quality Use of Medicines in Australian Hospitals²	Number of adult beds in hospital	Sample size	150 or more	20% of current patients	30 -149	30 current patients	Less than 30	All current patients
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Time to complete survey per patient	Fully trained and experienced auditors will work more quickly than poorly trained or inexperienced auditors. To enable adequate numbers of patients charts to be reviewed, the data collection may take place over several days. For example, if your hospital needs to audit a total of 40 charts - this can be done over the 2 week period by auditing 20 charts per week, or 3 charts per day. This only accounts for the time required for data collection. Consideration needs to be given to time required to enter patient data into the REDCap® audit tool.								
Section 1 Adverse Drug Reaction (ADR)									
Question 1.1	A. This section has been amended to identify if the ADR details have been completed fully, partially or not at all. Select only 1 option that applies. B. What happens if the prescriber has ticked the ‘Nil known’ and included their signature but no name or date? This would be considered the third option “none of the above apply” C. What about the ADR sticker should we consider this section completed in the audit only if the ADR sticker is affixed the chart? This audit does not make reference to auditing the ADR sticker and is not assessed as part of the audit tool. Your hospital may want to collect information on the use of the ADR sticker at the same time as the NSMC audit data is collected or as a separate audit. What about non-medication allergies? The ADR section can be used to document all allergies/ADRs based on local policy, however the focus for the NSMC audit is to identify medicine or treatment -related ADRs as a patient safety feature related to prescribing of medicines on the medication chart.								

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	- Documentation of ADRs should avoid patient harm by preventing the prescribing, dispensing or administration of a medicine, or one similar to it, that has previously caused an ADR. - Recording the clinician's signature assigns accountability for the information and allows for follow up if required. If the ADR box contains information on a non-medication or treatment related allergy such as a dietary allergy or intolerance then complete the audit as per the following: - In question 1.1 select "None of the above apply (go to section 2)" - Add the following comments in the additional comments section at the end of Section 1 "Non-medicine or treatment related ADR documented in the ADR box" When reporting on ADR completion any of the audits that contain the above information will be excluded in the evaluation of this section to ensure only medication and/or treatment related ADRs are audited.
Question 1.2	Would ADR documentation be considered incomplete if reaction details are not stated? (for example medicines are listed such as penicillin, tramadol, but no reaction details are specified such as nausea, or anaphylaxis.) This question is only applicable if 'details of any medicine (or other) allergies or ADRs' box was selected in 1.1. If the reaction detail is not documented, it is incomplete. Select "N". If the reaction documented is "patient unsure" or "patient can't remember", it is considered completed. Select "Y".
VTE prophylaxis	
Prescription of anticoagulants	What if my hospital doesn't use the WA Anticoagulation Medication Chart (WA AMC) to prescribe anticoagulants? The recent Medication Chart Policy mandates the use of the WA Anticoagulation Chart to prescribe all anticoagulants.
Separate/ different VTE risk assessment tool	What if my hospital has a separate VTE risk assessment tool? If your site has a separate form/tool to document the patient's VTE Risk Assessment, select "Other" for Q2.4. You will then be prompted to specify where the VTE risk assessment has been documented in Q2.5. In this scenario, document your site specific VTE risk assessment tool. It may be helpful to identify where this tool is kept, so please provide information – e.g. in the Medical Records or with the Medication Chart folder.
Digital Medical Record	My Hospital uses a Digital Medical Record - how to assess and answer VTE Risk Assessment documentation? VTE risk assessment should be completed for all inpatients and reassess every 7 days as per the Clinical Care Standard. Therefore, identifying if a VTE Risk Assessment has been completed for a patient should be quick. If your hospital uses a Digital Medical Record (DMR) for recording VTE Risk Assessment, you may have to search within the DMR. Potential ways to search if a VTE Risk Assessment in the DMR: Refer to the eform where the VTE Risk Assessment is documented with in the DMR

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	• If the audit date is close to patient's admission – review the medical progress notes corresponding to the date of admission or possibly the day after • If VTE prophylaxis has been prescribed – review the medical progress note entries in DMR on the date of prescription You should not spend more than a realistic amount of time to identify if a VTE risk assessment has been completed and documented in the DMR. If the search takes more than a few minutes, select the option “<i>No documentation of VTE Risk Assessment</i>”. It is suggested to make a comment in the additional comments section that no VTE Risk Assessment was identified in the DMR. Proposed wording for entry into comments section “ DMR search, No VTE Risk Assessment found” This process is only for sites where there are local policies, procedures and/or guidelines to document VTE Risk Assessment elsewhere than the recommended documentation on the WA HMC.
Sections 3 to 5	Are we auditing only what the prescriber has written on the NIMC/WA HMC or are we including pharmacist annotations? The NSMC audit primarily looks at what has been annotated by the doctor – i.e. the medication order as it is intended, prior to pharmacist review. Therefore, when auditing the medication order, consider the prescription prior to pharmacist annotation for appropriateness and legibility. Are Roman numerals acceptable? (e.g. i, ii, iii) Roman numerals are not acceptable abbreviations as per Commission Guidelines The NSMC guidelines note that Roman numerals should not be used. "ii" is often used for puffers and combination preparations, etc but as outlined in the Recommendations for Terminology, Abbreviations, and Symbols used in the Prescribing and Administration of Medicines document, it states that Roman numerals should not be used. Instead it should be written as "2". Acceptable tradenames - Is there a list of acceptable trade names used statewide? There is no existing statewide list of acceptable brand names - this is left up to site policy/guidelines. It is recommended that insulin products are prescribed by trade name. Some hospitals recommend that the trade name is prescribed alongside the generic name to differentiate the product formulation (ie Oxynorm® would be acceptable to clarify formulation of oxycodone), some sites find it acceptable to use tradenames for some combination products such as inhalers (e.g. Seretide®, Symbicort®) and for some liquid preparations such as Mylanta®. It is up to the site to decide what is acceptable. Antibiotics such as Tazocin® where the strength is written as 4.5g – would this mean the dose is considered complete and correct or is this something that should be decided internally? Technically this is unclear, and it should list the two components – piperacillin (4g) + tazobactam (500mg), so that clinicians are aware of what is in Tazocin® (especially when assessing allergy status and if the brand changes). So ideally the answer would be 'N'. A decision will need to be made at a hospital level as to whether prescribing Tazocin® 4.5g is considered appropriate.

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	Dose not complete and correct question: How much analysis is expected for us to determine if a dose is correct? Would doses falling under normal ranges be sufficient to be correct, or do we need to consider individual patient factors (eg. blood results, medical histories, adverse effects, treatment outcomes) to determine if the dose is correct? This refers only to the <u>documentation of the dose</u>. Auditors will not need to check the appropriateness of the dose. Record the number of orders where dose is not complete and correct, with potential for error identified. Note: where reviewing orders for paediatric patients, consider correctness and consistency with any dose calculations documented on the chart. Frequency question: • If the frequency is missing, but times are charted (e.g. 'bd' is missing but times for 0800 and 2000 are written) is that considered "complete" or "clear"? • Also, what is an example of incorrect frequency? In this case, the frequency would be considered not complete and clear as it does not include the frequency documented in the prescription order section. An example of 'unclear frequency' may be use of error-prone abbreviations (i.e. 'od, '4' etc.) or illegible writing. An example of 'incorrect' frequency' may be the prescription "q4h" for Oxycontin® may be deemed as incorrect if the prescriber is unaware he has prescribed the wrong formulation (e.g. slow release instead of immediate release). I have an order where the prescriber has written 'every 4 hours' however the dosage times have been written by a nurse. Would this be considered an error? Yes, when auditing the medicine order section, it is the prescriber's responsibility to document the times a medication should be administered. If a nurse or a pharmacist has annotated these times this order would be considered incomplete. Is an order of "daily" considered complete and correct? If a time has been indicated and daily prescribed, then it would be considered 'Y' complete and correct in regard to frequency. Ideally a time of day should be specified when prescribing the medication – i.e. mane, midday, nocte. Prescriber printing name as part of medication order The auditing guide states that a prescriber must write their name next to their signature for at least one prescription on a medication chart to ensure that the prescriber can be contacted if there is an issue with a prescription. (E.g. a chart where one prescriber has written ten items, signed all orders, but only printed their name clearly on the first order.) Each prescriber must print their name on the chart for <u>at least one order on that chart</u>. If this has occurred and the name is legible then answer 0 for this question. What happens if the second prescriber has prescribed medications on the medication chart but has not printed their name next to one of the orders? How would I answer this?

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	In this instance, the number of orders prescribed by the second prescriber would be considered an error. For example, if the second prescriber charted three orders and none of these orders had a printed prescriber name then the number of orders with errors for this question would be '3'. SR medications question: The chart has an order for Metformin however the SR box is not ticked. How do I know that this is the immediate release formulation and not the slow release formulation? As an auditor you need to assess whether there is any potential for confusion/ misinterpretation, however it is not your role to investigate whether this order has been charted correctly. If it can be easily obtained by looking at the annotations on the chart like 'swallow whole' or 'do not crush' then it may be safe to assume the order should be a SR. However, if there is no annotation on the order, refer to the MMP for further clarification. What happens if the pharmacist has ticked the SR box can these be counted as ticked? (Q10.4 + 10.5) Answer 'Yes' if a pharmacist or another clinician has ticked the SR box. You will need to count all the medicine orders that do not have this box ticked when the medicine prescribed is a SR formulation. Indication box If the Indication: is "DHx" or "regular meds" or similar would this be considered documented? The answer would be "N". The idea of documenting the indication is to ascertain why they are on the medications. "reg meds" or DHx does not suffice. Doses required, and doses missed Record the number of required doses in the regular medicines section that that should have been given and then record the number that appear to have been missed, that is, have not been documented as administered and a code/reason for not administering has not been specified. What do we document for ceased regular medications where no doses have been given? The audit only focuses on active charts and not ceased orders. Do not audit cease orders.
Calculation for paediatric medication orders	Where is the place to document calculations if calculations have been done on the NIMC? The calculation question only relates to paediatric charts. If not auditing a paediatric NIMC (long or short stay), you will not need to answer this question.
Section 5: Once only, nurse initiated and phone orders	The 'route' column in these sections of the chart is very small which make it difficult for the prescriber to clearly document acceptable abbreviations. Can the prescriber write outside of this box to clearly annotate the correct route? Yes the prescriber can go outside the box to clarify the correct route, however it should be written as either 'subcut'

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Section 7 Patient Identification	
Handwritten patient details are legible and complete?	If there are no printed ID labels, are the handwritten patients details complete and legible and have <u>AT LEAST 3</u> patient identifiers: • Patient Name, • Date of birth • Medical record number (UMRN) • Gender • Patient address
Patient's name is handwritten under the patient ID label(s) by the first prescriber?	The guideline clearly indicates that handwriting the patient's name under the addressograph must be completed by the first prescriber. If a pharmacist or a second prescriber completed this section, then chose 'N'. Record NA if no printed patient identification labels are used.
Section 8 – Prescriber Details	This section is only relevant if your hospital uses the PBS claiming component of the chart (WA private hospitals) This section is not applicable for WA public hospitals as no public hospital uses the WA HMC for PBS prescriptions. Ensure you select 'NIMC acute' or 'NIMC long-stay' option for WA public hospitals.
Section 9: Patient weight Date weighed is documented with weight on all charts	A. If a pharmacist completed the weight section in purple pen, is this Y or N? This is only applicable to patients aged 12 years or younger AND using a paediatric NIMC (acute or long-stay). It doesn't matter who fills in the weight - as long as it is documented on ALL active charts. If documented by a pharmacist or nurse on all active charts answer 'Y'. B. This is a new question in the audit. The patient's weight must be documented on ALL active charts
Section 10: Medication history	For this question, you will have to refer to the WA Medication History and Management Plan (WA MMP) form. A. My chart states to “see WA MMP” but I can't find it? You will need to find the MMP to ensure that the medication history is documented on this form. Double check the medical record to ensure that the MMP hasn't been filed in here accidentally. If you cannot find the MMP then select “not documented” B. I have three active charts, but the MMP is only referenced on one chart, so how do I answer this question? As long as the MMP is cross referenced on one active chart at the time of audit then 5.2 will be a “Yes”. C. What happens if the medication history is documented in the medical notes only and not on the MMP? For this audit, WA will only be referring to the medication chart or the MMP to answer this section.

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	D. I work in a maternity hospital so how will I answer this question for all the newborn patients? There is a section on the medication chart to document either 'nil regular medication' or similar. If there is no documentation, then the 'not documented' option should be selected. E. What if the cross-referencing between the NSMC/NIMC and the MMP was done on a NSMC/NIMC that has been filed from the beginning of the admission as it is no longer current? There must be documentation on one current chart that a MMP exists for the answer to be 'Y'.
Section 11: Pharmaceutical Review	Refers to a clinician - what happens if this is signed by another health care professional? This section is usually completed by the ward pharmacist, although it can be completed by another appropriately credentialed professional. As long as it is documented at least once on ALL ACTIVE charts select the 'Yes' option. Note: Pharmaceutical review is NOT the same as pharmacy annotation of individual medicine orders.
Section 12: Chart Numbering	Does this refer to other specialised chart or only the WA Hospital Medication Charts? The auditors should count the number of active hospital medications charts (WA HMC, NIMC) and no other specialised charts like Insulin, Fluid Order or Anticoagulation Chart.
Section 13: Anticoagulant education record	Question 9.1 makes reference to the patient being initiated on an anticoagulant for ongoing treatment How will I know if the anticoagulant was initiated during this admission and if this is for ongoing treatment? To work out if the anticoagulant therapy is for ongoing treatment look at the 'therapeutic doses' or the 'warfarin variable dose order' section on the WA Anticoagulation Chart. a. Warfarin Refer to the dose at admission section and see if this is complete or whether the 'Not applicable' box is ticked. b. Other anticoagulants Refer to the MMP to see if this is a new medication? Otherwise see if there is any annotation of the anticoagulant chart to suggest this is a new medication.
Section 15: Warfarin orders	The National version of the hospital medication chart has a dedicated warfarin prescription section. WA has a dedicated statewide WA Anticoagulation Chart for prescribing of all anticoagulant medications. Please refer to the WA Anticoagulation Chart for Section 15 questions. The first prescriber has completed the warfarin order section, however a subsequent prescriber has prescribed a warfarin dose, where would this prescriber print their name clearly and is this considered an error? There is no section on the Anticoagulant Chart for other prescribers to clearly print their name. This will not be counted as an error.

This document can be made available in alternative formats on request for a person with disability.

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