KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

TOOL 11: PAEDIATRIC CARE RECORD AUDIT

Facility Name:		IP Nº		Year:	

1 This is a combined audit to be completed by nursing and medical team.
2 Audit a minimum of 5 records per month (60 records in the year).
3 Record the final score on the monthly clinical and record audit summary tool.

Not applicable (NA):	Does not apply to the unit, or individual assessment.
Non-Compliant (NC):	<50% compliance. The required standard is not present or is present less than 50% of the time.
Partially Compliant (PC):	50 - 79% Compliance. The required standard is present but incomplete or present less than 80%.
Compliant (C):	80 -100% Compliance. The required standard is completed fully or is present more than 80%.

	ASSESSMENT AND PLANNING - Admission	NA	NC	PC	C	COMMENT
1	Triage performed					
2	Date and time of admission					
3	Date and time of the assessment at the nursing station					
4	Assessed by an MO within 1 hr of admission					
5	Enquiry of priority problems (IMCI)					
History obtained included:						
6	• Presenting problem					
7	• Family's medical (TB & HIV status)					
8	• Child's medical					
9	• Nutritional					
10	• Immunisations					
11	Social background, home circumstances & household income assessed					
12	Physical assessment performed					
13	Neurological assessment performed					
14	Developmental assessment performed (milestones & schooling)					
15	Nutritional assessment performed including growth parameters					
16	Details of medical findings leading to a diagnosis are recorded					
17	Immediate management given					
18	Visitation rights discussed					
19	HCT/PICT offered					
	ASSESSMENT AND PLANNING – Admission totals (19)					

	ASSESSMENT AND PLANNING - Medical					
20	Surgical patients assessed by surgical team within 12 hours of admiss.					
21	Details of medical findings leading to a diagnosis are recorded					
22	ICD 10 coding done					
23	Consultation times of doctor recorded					
24	Problem list updated, examination, assessment and management plan for **each problem** reviewed daily by MO					
25	On admission or if unstable - child reviewed twice daily					
26	Treatment prescribed, in notes, and on prescription sheets					
27	Any emergency treatment clearly ordered(eg Nebs, stat antibiotics)					
28	HIV testing and staging completed					
29	Evidence of repeated TB screening done					
30	Results sheet complete with signatures for all results/ investigations					
ASSESSMENT AND PLANNING - Nursing						
31	Paediatric standardised nursing care plan initiated on admission and updated if condition changes/ new problem identified					
32	Observations (PEWS score) completed 6 hourly					
33	Age appropriate PEWS score used					
34	General condition and colour assessed 6 hourly					
35	Respiratory condition and oxygen monitored 4 hourly for all children with respiratory conditions. (Respiratory monitoring chart)					
36	Oxygen administered and increased in stepwise fashion if Sats ($Sp0_2$) not maintained ≥ 92%. (Respiratory monitoring chart)					

37	Glucose monitored on admission then 3 hourly for 24 hours if in High care or SAM ward (Hypoglycaemia management chart)					
38	Glucose checked if hypothermic/ unresponsive or having seizures/ nil per mouth/ vomiting /not taking or tolerating feeds well					
39	Hydration assessed 2 hourly for any child with diarrhoea and vomiting (Hydration check chart)					
40	Frequency, type, duration, location and management of any seizures recorded (Seizure management chart)					
41	Level of consciousness assessed daily for any child with abnormal neurological signs (Children's coma scale chart)					
42	Circulation (warmth, colour, mobility) of distal limb assessed if any circumferential dressing/POP/traction/splint present					
43	Wound assessment performed at every dressing change - signs of infection, size, shape, exudate, epithelisation etc					
44	Site, type and frequency of pain assessed 6 hourly when indicated					
45	Danger signs assessed 3 hourly if admitted in High Care or has respiratory distress, SAM, burns, diarrhoea or dehydration					
46	Growth assessed & plotted on admission and as indicated.					
47	Maternal condition and care of child assessed daily					
48	Actions documented for abnorm. assessments & reassessed in 1 hour					
	ASSESSMENT AND PLANNING – Medical & Nursing totals (29):					

IMPLEMENTATION						
General Care- Nursing		**NA**	**NC**	**PC**	**C**	**COMMENT**
49	MO informed immediately if condition changes or danger signs present					
50	Child's hygiene maintained - bath, hair, eyes, mouth, nails, buttocks					
51	Child's skin integrity maintained - pressure part & buttock /skin care					
52	Pain management given before procedures and as ordered					
53	Lines/tubes changed/removed as ordered or per care plan					
54	Immunisations given as indicated					
55	All doctor's orders are implemented					
56	Telephonic orders are signed by 2 nurses - at least one a PN					
57	Standing orders are signed and dated when implemented					
58	Management for any emergency/priority signs clearly documented					
59	In any emergency/adverse event-date & time doctor notified & arrived is recorded					
General Care - Medical						
60	Child reviewed within 30 minutes if condition changes or danger signs present					
61	Details of any procedures performed clearly documented					
62	Reviewed immediately by doctor if any emergency/priority signs noted					
63	Consultations with referral centre clearly documented (including name of Doctor and hospital, problem and management plan					
64	Telephonic orders are counter signed within 24 hours					
	IMPLEMENTATION- General care totals (16):					

Medications						
65	M.O's signature, name, qualifications & contact details					
66	Sample signatures on reverse of medication chart					
67	Commencement and completion dates					
68	Legibly written					
69	Dates only recorded in date column					
70	Current day of treatment recorded each day					
71	Stat orders ordered at the bottom of med chart and signed once administered					
72	All medications administered at correct times/as ordered – with signature and designation					
73	Reason given if medication not given eg NPO					

74	Administration of non-routine medications entered in nursing process and underlined					
75	Schedule drugs - correct N^{o} of doses given					
76	Schedule drugs given correspond with drug register					
	IMPLEMENTATION - Medications totals (12):					

Nutrition and growth		**NA**	**NC**	**PC**	**C**	**COMMENT**
77	Mother received education re benefits & Mx of breastfeeding					
78	Seen by dietician at least weekly					
79	Age appropriate diet ordered					
80	Total daily fluid requirements assessed and calculated (ml/kg/day)					
81	IV fluid volume administered reviewed regularly					
82	Total daily fluid intake and output calculated					
83	Intake (oral and IV when indicated) prescribed in notes and intake/output sheet					
84	Feeds/fluids administered as ordered					
85	IV site checked hourly if on IV fluids. If not on IV fluids, as per IV medication frequency (site and condition recorded)					
86	If child not taking 80% of the amount prescribed is fed by nasogastric tube					
87	How well child is eating/tolerating feeds assessed					
88	Output documented including vomiting, urine and type of stool					
89	Weight assessed daily if a neonate, malnourished or has renal/cardiac condition					
90	Weight gain/loss calculated daily if has one of above conditions					
	IMPLEMENTATION - Nutrition and growth totals (14)**:**					

Informed Consent						
91	Procedure explained in caregiver's/child's language by doctor					
92	Correct operation/procedure and site recorded					
93	Signatures of caregiver and x 2 witnesses					
Early childhood development (ECD) and Family Centred care						
94	Family visiting documented					
95	Caregivers had unrestricted access					
96	Child played outside daily					
97	Child played inside daily					
98	If bedbound - comfort item available					
99	Caregiver/child are fully informed re diagnosis, problems, on-going condition and prognosis					
100	Caregiver/child are fully informed of management/ treatment plan					
101	Caregiver/child participate in decision-making relating to treatment					
102	Caregiver/child receive adequate health education including orientation, hygiene, care of devices, discharge etc					
103	Health education signed for by caregiver/child					
104	Health promotion given by multidisciplinary team					
	IMPLEMENTATION - Consent & ECD/Family Centred care totals (14):					

Discharge and transfer						
105	Observations continued while awaiting transfer					
106	Condition on transfer recorded					
107	HIV status of mother and baby known before discharge and treatment initiated					
108	Baby immunised prior to discharge if immunisation status not up to date					
109	Discharge education/advice given					
110	Discharge authorised by doctor					
111	Discharge entry in nursing process including date and time of departure and that all invasive devices were removed					
112	Referral/transfer letter given to caregiver					
113	RTHB updated (indicated in discharge summary)					
114	A detailed discharge/transfer summary – included:					

115	the receiving MO/ward & reason for the transfer					
116	current and resolved problem list with ICD codes					
117	management given					
118	the condition of child at discharge					
119	discharge medication (including dose)					
120	follow up plan- including places and dates					
121	follow up plan agreed by caregivers					
122	referral to CCG/WBOT					
Dying and death						
123	Special/Advance care plan in place including pain management and resuscitation plans (discussed with caregivers)					
124	Caregiver/child was seen by a social worker/psychologist/ religious leader					
125	Caregiver present with child & offered an opportunity to hold child					
126	Death entry written by PN includes date and time of death, body taken to mortuary and notification of doctor and caregivers					
IMPLEMENTATION - Discharge/transfer/death totals (22):						

DOCUMENTATION						
127	This paediatric patient record reflects comprehensive, quality care					
128	Record compiled according to the Good record keeping guideline					
129	Clinical notes are legible					
130	Patient name and initials recorded on every page					
131	Hospital number recorded on every page					
132	Date of birth recorded wherever indicated					
133	Identifiable name, signature and designation for every entry					
134	Primary care giver name & contact details recorded as indicated					
135	Every admission is clearly recorded including brief summary					
136	Clinical notes, including referral letters, in chronological order					
137	Every referral to other services is recorded clearly					
138	The findings and plans of other services involved in the patient's care are clearly documented					
139	Abbreviations are kept to a minimum or defined					
Documentation totals (13)						

NB. Bring forward **ALL** subtotals including sections marked not applicable (NA). Subtract these (NA x 2) sections from the Total score.

Subtotals brought forward	NA	NA x 2	PC	C	C x 2	Column A PC+ (C x 2)	Column B Total Possible Score	A / B	X 100
Admission							38		%
Medical & Nursing assess.							58- (NA x 2)		%
Medical & Nursing care							32- (NA x 2)		%
Medications							24- (NA x 2)		%
Nutrition							28- (NA x 2)		%
ECD/Family centred care							28- (NA x 2)		%
Discharge/transfer/Death							44- (NA x 2)		%
Documentation							26		%
Final Score:							278- (NA x 2)		%

Assessed by:			
Sign:		**Print:**	
Registration Nº		**Date:**	
Sign:		**Print:**	
Registration Nº		**Date:**	