



PAEDIATRIC RECORD AUDIT

DATE: _____

HOSPITAL: _____

DATE OF PATIENT'S ADMISSION: _____

PATIENT'S DIAGNOSIS: _____

Check each document for the following:

Paediatric Patient Record				
A. PATIENT'S DETAILS:	N/C	P/C	C	COMMENTS
Name and Initials recorded on every page				
Hospital number recorded on every page				
Date of birth recorded wherever indicated				
Name and contact details for primary care giver clearly recorded wherever indicated				
C. DOCUMENTATION				
Standardised Paediatric Record Keeping system used				
Record compiled exactly according to policy				
Clinical notes, including referral letters, in chronological order				
Clinical notes, including referral letters are legible				
Identifiable name on every entry				
Cover page filled in				
Second page (background information) filled in				
Weight plotted on growth chart				
Results sheet filled in				
Signature on all results/reports of investigations e.g. bloods, x-rays, etc.				
HIV testing and staging filled in				
Admission times recorded				
Consultation times recorded				
Appropriate history taken				
Appropriate clinical examination performed				
Requests of special diagnostic tests documented				
Details of medical findings leading to a diagnosis are recorded				
An assessment of the child's problems is recorded				
A comprehensive problem list is recorded				
A plan is made for each problem				
Treatment prescribed, in notes, and on prescription sheets				
Intake (oral and IV when indicated) in notes and intake/output sheet				
Nursing orders are clearly documented				
Every consultation/clinical encounter with patient is recorded				
Every referral to other services is recorded clearly				
The findings and plans of other services involved in the patient's care are clearly documented				
Abbreviations are kept to a minimum or made clear				

D. INFORMATION FOR PARENTS / CARE GIVER	N/C	P/C	C	COMMENTS
Carer/child is informed of diagnoses and problems and this is documented				
Carer/child is informed of management/treatment plan and this is documented				
Carer/child is informed of prognosis and this is documented				
Patient and carer participate in decision-making relating to treatment, and same documented				
Informed consent is obtained when necessary and this is documented				
E. DISCHARGE OF PATIENTS				
Unresolved problems at discharge are clearly stated and documented				
Follow-up plans (including places and dates) for each problem are agreed with patients and carers by doctors prior to discharge and documented				
Discharge medication (drugs and dosing) clearly documented in the discharge letter				
Discharge summary in the paediatric patient record and a copy filed in the ward				
Adequate Health Education is given to caregivers during hospitalisation and on discharge				
GENERAL OVERVIEW / COMMENTS				
This paediatric patient record reflects quality medical care				
This paediatric patient record reflects comprehensive care				
The guideline on quality paediatric record keeping was followed				
If this was my own child, I would be happy with this clinical record				

Auditor's name: _____

Signature: _____

Outcome of audit

Reported by: _____

Reported to: _____

Date: _____

Rating:

Non-compliant (n/c) = 0
Partially compliant (p/c) = 1
Compliant (c) = 2