KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

SKILLS AUDIT: SHOCK RESUSCITATION

Facility Name:		**Year:**						
Doctor assessed:		**Rank:**	EN		PN Gen		PN Spec	
Non-Compliant:	<80% compliance		CSO		MO Gr1		MO Gr 2	
Compliant:	80-100% Compliance		Specialist					

Equipment required:		
1 Infant Mannequin	2 Nasal Prong Oxygen	3 Non-rebreathing mask with reservoir bag
4 Oxygen tubing	5 Volume extension sets	6 Giving sets
7 Jelcos	8 IO Needles	9 Fluids – MRL/Saline (220ml), NNL(200ml)
10 Syringes 5ml/10ml/20ml	11 Blood tubes, culture bottles	12 50% Glucose
13 Alcohol swabs	14 Glucometer	

Scenario

State: "A 4-month-old baby boy weighing 5kg and length of 55cm is has been admitted from casualty with a one- day history of fever, and vomiting. He was started on ORS in casualty and sent to the ward for overnight observation. The mother reported that he was becoming less active, started breathing fast and developed copious amount of watery stools in the ward."

N°	INDICATOR	NC	C	Comment
Communicates with mother				
1	Introduces herself			
2	Asks the mother how are she and the baby			
Assessment and management of the airways and breathing				
3	Sprays hands			
4	Looks for chest movement			
5	Listens for breath sounds			
6	Feels for air movement			
State"The child is breathing fast however there are no other signs of respiratory distress."				
7	Commences nasal prong oxygen at 1L			
Assesses circulation				
8	Checks warmth of the hands			
9	Checks capillary refill time			
10	Checks central pulses			
11	Counts heart rate			
State "The baby has cool hands, a prolonged CRT of 6 sec and thready weak femoral pulses. The heart rate of 180/min."				
Supports circulation				
12	Inserts an IV line or an IO after cleaning with alcohol swabs			
13	Administers fluid bolus at 20 ml/kg of saline or MRL fast			
14	Takes bloods for glucose, blood gas (if available), FBC and U&E (if enough blood) and culture			
Assesses Nutritional status and other danger signs				
15	Looks for oedema			
16	Looks for visible severe wasting			
17	Assesses level of consciousness			
18	Checks glucose levels			
19	Warms the baby			
State "The baby is well nourished. He is responsive to pain and the glucometer reading is normal."				
Reassessment on completion of the bolus				
20	Reassess: Airways and breathing			
21	Reassess circulation (warmth, CRT, pulse rate and volume)			
22	Reassess the level of consciousness			
State "The perfusion has improved however the CRT is 4sec and the pulse is 160/min.				
Assesses for features of fluid overload				
23	Counts heart rate			
24	Listens for extra heart sounds			
25	Feels for hepatomegaly			
State "There are no features of fluid overload."				
26	Administers 2nd bolus of 20 ml/kg			
State "The baby has improved. The heart rate is 130/min and CRT 2sec. What would you do next?				

GROWING KWAZULU-NATAL TOGETHER

Provides further management		NC	C	Comment
27	Prescribes maintenance fluids – ½ DD at 10 ml/kg /hr over 4 hours			
28	Updates mother on condition of her baby			
	Totals			
	Compliant total / 28			
	Final Percentage X 100 =	%		

In Discussion with the Individual:	
Gaps Identified:	
Action Plan:	

Assessed by:					
Sign:		**Print:**		**Desig:**	