TOOL 11: PAEDIATRIC CARE AUDIT

Facility Name:		IP Nº		Year:	

1 This is a combined audit to be completed by nursing and medical team.
2 A minimum of 5 records must be audited 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	Date and time of admission					
2	Assessed by an MO within 1 hr of admission					
3	Nutritional assessment performed					
4	Physical assessment performed					
5	Neurological assessment performed					
6	Immediate management given					
7	HCT/PICT offered					
8	Visitation rights discussed					
9	Consent for procedures obtained					
ASSESSMENT AND PLANNING - Medical						
10	Surgical patients assessed by surgical team within 12 hours of admission					
11	Details of medical findings leading to a diagnosis are recorded					
12	ICD 10 coding done					
13	Problem list updated, examination, assessment and management plan for each problem reviewed daily by MO					
14	On admission or if unstable - child reviewed twice daily					
15	Treatment prescribed, in notes, and on prescription sheets-					
ASSESSMENT AND PLANNING - Nursing						
16	Paediatric standardised nursing care plan initiated on admission and updated if condition changes/ new problem identified					
17	Observations (PEWS score) completed 6 hourly					
18	Age appropriate PEWS score used					
19	General condition and colour assessed 6 hourly					
20	Respiratory condition and oxygen monitored 4 hourly for all children with respiratory conditions. (Respiratory monitoring chart)					
21	Oxygen administered and increased in stepwise fashion if Sats (S_p0_2) not maintained ≥ 92%. (Respiratory monitoring chart)					
22	Glucose monitored on admission then 3 hourly for 24 hours if in High care or SAM ward (Hypoglycaemia management chart)					
23	Glucose checked if hypothermic/ unresponsive or having seizures/ nil per mouth/ vomiting /not taking or tolerating feeds well					
24	Hydration assessed 2 hourly for any child with diarrhoea and vomiting (Hydration check chart)					
25	Frequency, type, duration, location and management of any seizures recorded (Seizure management chart)					
26	Level of consciousness assessed daily for any child with abnormal neurological signs (Children's coma scale chart)					
27	Circulation (warmth, colour, mobility) of distal limb assessed if any circumferential dressing/POP/traction/splint present					
28	Wound assessment performed at every dressing change - signs of infection, size, shape, exudate, epithelisation etc					
29	Site, type and frequency of pain assessed 6 hourly when indicated					
30	Danger signs assessed 3 hourly if admitted in High Care or has respiratory distress, SAM, burns, diarrhoea or dehydration					
31	Maternal condition and care of child assessed daily					

IMMPLEMENTATION						
General Care- Nursing		**NA**	**NC**	**PC**	**C**	**COMMENT**
32	Actions documented for abnorm assessments & reassessed in 1 hour					
	ASSESSMENT AND PLANNING Totals (32):					
33	MO informed immediately if condition changes or danger signs present					
34	Child's hygiene maintained - bath, hair, eyes, mouth, nails, buttocks					
35	Child's skin integrity maintained - pressure part & buttock /skin care					
36	Pain management given before procedures and as ordered					
37	Lines/tubes changed/removed as ordered or per care plan					
38	Immunisations given as indicated					
39	All doctor's orders are implemented					
40	Telephonic orders are signed by 2 nurses - at least one a PN					
41	Standing orders are signed and dated when implemented					
42	Management for any emergency/priority signs clearly documented					
43	In any emergency/adverse event-date & time doctor notified & arrived is recorded					
General Care - Medical						
44	Child reviewed within 30 minutes if condition changes or danger signs present					
45	Details of any procedures performed clearly documented					
46	Reviewed immediately by doctor if any emergency/priority signs noted					
47	Consultations with referral centre clearly documented (including name of Doctor and hospital, problem and management plan					
48	Telephonic orders are counter signed within 24 hours					
	Medical and Nursing general care Totals (16):					
Medications						
49	M.O's signature, name, qualifications & contact details					
50	Sample signatures on reverse of medication chart					
51	Commencement and completion dates					
52	Legibly written					
53	Dates only recorded in date column					
54	Current day of treatment recorded each day					
55	Stat orders ordered at the bottom of med chart and signed once administered					
56	All medications administered at correct times/as ordered – with signature and designation					
57	Reason given if medication not given eg NPO					
58	Stat orders signed once given					
59	Administration of non routine medications entered in nursing process and underlined					
60	Schedule drugs - correct N^{o} of doses given					
61	Schedule drugs given correspond with drug register					
	Medications totals (13):					
Nutrition and growth						
62	Mother received education re benefits & Mx of breastfeeding					
63	Seen by dietician at least weekly					
64	Age appropriate diet ordered					
65	Total daily fluid requirements assessed and calculated (ml/kg/day)					
66	IV fluid volume administered reviewed regularly					

Nutrition and growth - continued		NA	NC	PC	C	COMMENT
67	Total daily fluid intake and output calculated					
68	Intake (oral and IV when indicated) prescribed in notes and intake/output sheet					
69	Feeds/fluids administered as ordered					
70	IV site checked hourly if on IV fluids. If not on IV fluids, as per IV medication frequency (site and condition recorded)					
71	If child not taking 80% of the amount prescribed is fed by nasogastric tube					
72	How well child is eating/tolerating feeds assessed					
73	Output documented including vomiting, urine and type of stool					
74	Weight assessed daily if a neonate, malnourished or has renal/cardiac condition					
75	Weight gain/loss calculated daily if has one of above conditions					
	Nutrition and growth totals (14):					
Informed Consent						
76	Procedure explained in caregiver's/child's language by doctor					
77	Correct operation/procedure and site recorded					
78	Signatures of caregiver and x 2 witnesses					
Early childhood development (ECD) and Family Centred care						
79	Family visiting documented					
80	Caregivers had unrestricted access					
81	Child played outside daily					
82	Child played inside daily					
83	If bedbound - comfort item available					
84	Caregiver/child are fully informed re diagnosis, problems, on-going condition and prognosis					
85	Caregiver/child are fully informed 0f management/ treatment plan					
86	Caregiver/child participate in decision-making relating to treatment					
87	Caregiver/child receive adequate health education including orientation, hygiene, care of devices, discharge etc					
88	Health education signed for by caregiver/child					
89	Health promotion given by multidisciplinary team					
	Consent & ECD/Family Centred care totals (14):					
Discharge and transfer						
90	Observations continued while awaiting transfer					
91	Condition on transfer recorded					
92	HIV status of mother and baby known before discharge and treatment initiated					
93	Baby immunised prior to discharge if immunisation status not up to date					
94	Discharge education/advice given					
95	Discharge authorised by doctor					
96	Discharge entry in nursing process including date and time of departure and that all invasive devices were removed					
97	Referral/transfer letter given to caregiver					
98	A detailed discharge/transfer summary – including:					
99	the receiving MO/ward & reason for the transfer					
100	current and resolved problem list with ICD codes					
101	management given					
102	the condition of child at discharge					
103	discharge medication (including dose)					
104	follow up plan including places and dates					
105	follow up plan agreed by caregivers					
106	referral to CCG/WBOT					

Dying and death						
107	Palliative care plan in place including pain management and resuscitation plans (discussed with caregivers)					
108	Caregiver/child was seen by a social worker/psychologist/ religious leader					
109	Caregiver was present with child and offered an opportunity to hold child					
110	Death entry written by PN includes date and time of death, body taken to mortuary and notification of doctor and caregivers					
	Discharge/transfer/death totals (21):					

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 Score	A / B	X 100
Assessment & planning							- (NA x 2)		%
Medical & Nursing care							- (NA x 2)		%
Medications							- (NA x 2)		%
Nutrition							- (NA x 2)		%
ECD/Family centred care							- (NA x 2)		%
Discharge/transfer/Death							- (NA x 2)		%
Final Score:							- (NA x 2)		%

Assessed by:			
Sign:		**Print:**	
Registration N^{o}		**Date:**	
Sign:		**Print:**	
Registration N^{o}		**Date:**	