KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

TOOL 12: RECORD AUDIT GENERAL CASE

Facility Name:		IP N°		Year:	

1 This is a combined audit to be completed by nursing and medical team.
2 Use together with Tool 11 (Paediatric care) to 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%.

Has the following information been recorded and management given?

A. PATIENT'S DETAILS:		NA	NC	PC	C	Comment
1	Patient name and initials recorded on every page					
2	Hospital number recorded on every page					
3	Date of birth recorded wherever indicated					
4	Name and contact details for primary care giver recorded wherever indicated					
A TOTALS	**(4)**					

B. DOCUMENTATION:		NA	NC	PC	C	Comment
5	Standardised paediatric record keeping system used					
6	Record compiled exactly according to policy					
7	Documentation that a triage process has taken place					
8	Clinical notes, including referral letters, in chronological order					
9	Clinical notes are legible					
10	Identifiable name, signature and designation for every entry					
11	Social background recorded (marital status, education, number of children)?					
12	Household circumstances recorded – place, size, water source, electricity?					
13	Household finances documented - employment, income, grants etc.?					
14	Family medical history, including TB & HIV status?					
15	Child's development – milestones or schooling?					
16	Record of child's immunisations?					
17	Child's past medical history?					
18	Nutritional history?					
19	Growth parameters measured (weight & height/length)					
20	Weight plotted on growth chart					
21	Results sheet filled in					
22	Signature on all results/reports of investigations eg.bloods, x-rays, etc.					
23	HIV testing and staging filled in					
24	Evidence of repeated TB screening done					
25	Every admission is clearly recorded including brief summary					
26	Every referral to other services is recorded clearly					
27	The findings and plans of other services involved in the patient's care are clearly documented					
28	Abbreviations are kept to a minimum or made clear					
B TOTALS	**(24)**					

C. CURRENT PROBLEM:		NA	NC	PC	C	Comment
29	Date and time of the assessment at the nursing station recorded					
30	Consultation times of doctor recorded					
31	Appropriate history of presenting problem taken					
32	Enquiry of priority problems (IMCI)					
33	Systematic history taken					
34	Appropriate clinical examination performed					
35	Results of special diagnostic tests documented					
36	Details of medical findings leading to a diagnosis are recorded					

C. CURRENT PROBLEM CONTINUED:		NA	NC	PC	C	Comment
37	An assessment of the child's problems is recorded					
38	A comprehensive problem list is recorded					
39	A plan is made for each problem					
40	Treatment prescribed clearly					
41	Any emergency treatment clearly ordered(eg Nebs, stat antibiotics)					
42	Nursing orders are clearly documented					
C. TOTALS	**(14)**					

D. INFORMATION FOR PARENTS/CAREGIVER		NA	NC	PC	C	Comment
43	Carer/child is informed of diagnoses and problems and this is documented					
44	Carer/child is informed of management/treatment plan and this is documented					
45	Carer/child is informed of prognosis and this is documented					
46	Informed consent is obtained when necessary and this is documented					
D. TOTALS	**(4)**					

E. FOLLOW UP OF PATIENTS		NA	NC	PC	C	Comment
47	RTHB update on this visit indicated in the notes					
48	Follow-up plans (including places and dates) for each problem are agreed with patients and carers by doctors prior to leaving the consultation					
49	Adequate health education is given to caregivers					
E. TOTALS	**(3)**					

F. GENERAL OVERVIEW/COMMENTS		NA	NC	PC	C	Comment
50	This paediatric patient record reflects quality medical care					
51	This paediatric patient record reflects comprehensive care					
52	The guideline on quality paediatric record keeping was followed					
53	If this was my own child, I would be happy with this clinical record					
F. TOTALS	**(4)**					

NB. Bring forward **ALL** subtotals.

Subtotals brought forward	NA	(NAx2)	PC	C	(Cx2)	Column A PC+ (Cx2)	Column B Total Score	A/B	X100
Patient's details							8-(NA x2)		%
Documentation							48-(NA x2)		%
Current problems							28-(NA x2)		%
Parents/caregiver info							8-(NA x2)		%
Follow up of patients							6-(NA x2)		%
Overview/comments							8-(NA x2)		%
Final Score:							106-(NA x2)		%

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