KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

RECORD AUDIT: EPILEPSY

Instruction: Assess all relevant information of two patients that have been seen in the POPD with a chronic condition on more than 3 occasions

Record I/D: …….. Date. ……

Not applicable (NA) Non-Compliant (NC) Partially Compliant (PC) Compliant (C)

Has the following information been recorded and management given?

	NA	NC	PC	C	Comment
A. PATIENT'S DETAILS:					
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					
B. DOCUMENTATION:					
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 HCW name on every entry					
11 Social background & home circumstances updated					
12 Child's immunisations updated					
13 Developmental milestones updated					
14 Family medical history, including TB & HIV exposure?					
15 Nutritional history?					
16 Growth parameters measured (weight & height/length)					
17 Weight plotted on growth chart					
18 Results sheet filled in					
19 Signature on all results/reports of investigations eg.bloods, x-rays, etc.					
20 HIV testing and staging filled in					
21 Evidence of repeated TB screening done					
22 Every admission is clearly recorded including brief summary					
23 Every referral to other services is recorded clearly					
24 The findings and plans of other services involved in the patient's care are clearly documented					
25 Abbreviations are kept to a minimum or made clear					
B TOTALS					
C. HISTORY – EPILEPSY					
26 Date and time of the assessment at the nursing station recorded					
27 Consultation times of doctor recorded					
28 Description of seizures					
29 Details of investigations					
30 Details of diagnosis					
31 Details of treatment					
32 Enquiry about treatment compliance					
33 Enquiry about breakthrough seizures					
34 Enquiry about ongoing development or schooling					
C. TOTALS					
D. EXAMINATION AND MANAGEMENT					
35 General condition					
36 Neurological assessment					
37 Assessment of comorbidities					
38 Assess behavioural problems					
39 Review of fit chart					
40 Follow up of results – neuroimaging; drug levels etc					
41 Antiepileptic – correct drug for seizure type/age					
42 Correct dose for weight					
43 Correct frequency					
D. TOTALS					

E. COUNSELLING OF CARER						
44 Evidence that carer counselled re epilepsy						
45 Evidence of ongoing education of carer re – first aid for seizures						
46 Follow up arranged						
E. TOTALS						
PATIENT'S DETAILS:	**A**					
DOCUMENTATION:	**B**					
HISTORY:	**C**					
EXAMINATION AND MANAGEMENT:	**D**					
COUNSELLING OF CARER:	**E**					
TOTALS						

A. Total the number of NA (x 2); PC (x 1) and C (x 2) items	**X 2 =**	**X 0 = 0**	**X 1 =**	**X 2 =**
B. Maximum total possible	**92**			
C. Subtract the number of NA (x 2) items from the total in B	92 - (NA x 2) =			
D. Add the total PC and C together and divide C: Total	/			
E. Multiply by 100: Percentage	%			