KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

RECORD AUDIT: ASTHMA

Facility Name:		Year:	

1. This is a clinical audit of asthma. To be completed by the nursing and medical team.
2. Only one chronic condition needs to be audited each month. Audit at least 2 records with this condition. The patient should have been seen in POPD at least 3 times.
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%.

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					
PATIENT'S DETAILS TOTALS (8)					

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					
DOCUMENTATION TOTALS (42)					

HISTORY					
26 Date & time of the assessment at the nursing station recorded					
27 Consultation times of doctor recorded					
28 Details of diagnosis					
29 Details of investigations					
30 Details of treatment					
31 Enquiry re daytime symptoms					
32 Enquiry re night time symptoms					
33 Enquiry re exercise tolerance					
34 Enquiry re school attendance/absenteeism					
35 Enquiry about treatment					
36 Enquiry about response to rescue medicine					
HISTORY TOTALS (22)					

EXAMINATION AND MANAGEMENT	NA	NC	PC	C	Comment
37 General condition					
38 Nutritional assessment					
39 Pertinent respiratory examination					
40 Pertinent ENT examination					
41 Assessment for atopy					
42 Assess inhaler technique					
43 PEAK flow					
44 Assessment of severity of asthma					
45 Correct medicine prescribed					
EXAMINATION AND MANAGEMENT TOTALS (18)					

COUNSELLING OF CARER					
46 Evidence that carer counselled re asthma					
47 Evidence of ongoing health education					
48 Follow up arranged					
COUNSELLING OF CARER TOTALS (6)					

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:							42-(NA x2)		**%**
HISTORY:							22-(NA x2)		**%**
EXAMINATION & MGMT:							18-(NA x2)		**%**
COUNSELLING OF CARER:							6-(NA x2)		**%**
Final Score:							96-(NA x2)		**%**

Assessed by:			
Sign:		**Print:**	
Registration Nº		**Date:**	
Sign:		**Print:**	
Registration Nº		**Date:**	