KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

RECORD AUDIT: CEREBRAL PALSY

Facility Name:		Year:	

1. This is a clinical audit of cerebral palsy. 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 Description of cerebral palsy					
29 Details of vision and hearing					
30 Details of cognitive ability					
31 Details of functional ability (gross motor, fine motor, communication)					
32 Enquiry about seizures					
33 Enquiry about feeding					
34 Enquiry about behaviour					
35 Enquiry about rehab programme					
HISTORY TOTALS (20)					

EXAMINATION AND MANAGEMENT					
36 General condition					
37 Nutritional assessment					
38 Assessment of comorbidities					
39 Assess behavioural problems					
40 Check for complications – pressure sores, dislocations etc					
41 Follow up of results – neuroimaging; drug levels etc					
42 Baclofen if indicated (severe spasticity)					
43 Antiepileptic if indicated					
EXAMINATION AND MANAGEMENT TOTALS (16)					

COUNSELLING OF CARER					
44 Evidence that carer counselled re cerebral palsy					
45 Evidence of ongoing education of carer re multidisciplinary care					
46 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:							20-(NA x2)		**%**
EXAMINATION & MGMT:							16-(NA x2)		**%**
COUNSELLING OF CARER:							6-(NA x2)		**%**
Final Score:							92-(NA x2)		**%**

Assessed by:			
Sign:		**Print:**	
Registration N°		**Date:**	
Sign:		**Print:**	
Registration N°		**Date:**	