KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CLINICAL & RECORD AUDIT: WELL TERM

1. This is a combined audit with nursing and medical team.
2. This audit captures sentinel indicators. It is not necessarily a review of all required care.
3. A minimum of 2 (District) or 4 (Reg/Tert.) audits must be completed per month.
4. Record total achieved on the monthly well new-born audit summary.

Date:		**Unit:**	
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%.		

RECORDS:	**Name:**		**IP No:**	

Quality of records		**NA**	**NC**	**PC**	**C**	**COMMENT**
1.	Patient details/sticker on all documents					
2.	Date, time, signature, designation & printed name-all entries					
3.	Corrections ruled out and signed					
4.	Black pen for all entries					
5.	All notes legible and in chronological order					

HISTORY		**NA**	**NC**	**PC**	**C**	**COMMENT**
Maternal information:						
6.	Ante natal history					
7.	Delivery mode and problems					
8.	Maternal HIV status					
9.	RPR and Rh					
Baby information:						
10.	Date & time of birth					
11.	Weight, COH, Length					
12.	Gest. age assessed using LMP, early ultrasound & palpation					
13.	Apgar score 1 and 5 mins					
14.	Details of immediate care and resuscitation (HBB)					
15.	Condition of placenta					
16.	Maternal & Perinatal risk factors/problems identified & classified					
Essential Newborn Care						
17.	Baby identified at birth					
18.	IMI Konakion given at birth					
19.	Antibiotic eye treatment at birth					
20.	Cord cleaned with Chlorhexidine					
21.	Put to breast within 30 mins of birth (LCSC-1 hour)					
	RECORDS & HISTORY totals (21):					
ADMISSION ASSESSMENT –POSTNATAL WARD						
22.	Temperature recorded on arrival					
23.	First examination documented					
24.	Any abnormalities reported and acted upon					
25.	Weight, length and COH plotted on percentile chart					
26.	Abnormal foetal growth identified (SGA/LGA/AGA)					
27.	At risk baby-assessed by MO					
ONGOING ASSESSMENT AND CARE						
28.	ID bands checked daily					
29.	Baby assessed 12hrly if no risk factors					
30.	Temp maintained 36^{5}-37°C					
31.	Action was taken for any temp. <36.5°C					
32.	Condition and care of cord documented					
33.	Baby cleansed with a warm cloth once temp. >36^{5}°C					
	ASSESSMENT & CARE totals (12):					

At Risk Babies/ Minor Problems		NA	NC	PC	C	COMMENT
34.	Seen daily by MO if at risk					
35.	Baby assessed 6hrly if risk factors present					
36.	Blood glucose monitored hourly until stable if at risk /cold/ maternal diabetes					
37.	Action taken for any blood glucose < 2.6mmol/					
38.	Phototherapy commenced immediately if jaundice observed					
39.	TSB taken immediately jaundice observed and daily					
40.	Position changed 3hrly if under phototherapy					
41.	Referred to neonatal unit if Jaundice levels climbing					
42.	PCR taken if HIV exposed					
43.	HIV prophylaxis commenced within 24hrs if HIV exposed					
44.	Short line checked 6hrly for patency/signs of phlebitis/perfusion					
45.	Antibiotics administered as ordered					
46.	Benzathine penicillin given to baby if mother RPR +					
47.	Anti D given if mother Rh neg.					
48.	At risk baby observed for at least 24hrs before discharge					
	At Risk Babies totals (15):					
Feeding and growth						
49.	Mother received education on breastfeeding					
50.	Baby breast fed on demand (1-4hrly)					
51.	Ability of baby to suck recorded					
52.	Reason recorded for non-breast feeding					
53.	Mother supported with breast feeding					
54.	Passing of urine and stool monitored					
	Feeding and growth totals (6):					
DISCHARGE/TRANSFER						
55.	BCG and polio immunisations given					
56.	Passing of urine and stool confirmed prior to discharge.					
57.	Assessed for jaundice prior to discharge					
58.	Mother received adequate health education & discharge advice					
59.	Road to Health book (RtHB) completed					
60.	RtHB given to mother prior to discharge					
61.	HIV(mother), RPR and RH results known before discharge					
62.	Baby was referred to a CCG on discharge.					
63.	Follow up (FU) appointments and management plan recorded					
64.	FU appointments & management plan discussed with mother					
65.	Baby discharged by advanced midwife if no risk factors					
66.	Baby discharged by MO if risk factors present					
	Discharge/transfer totals (12)					

NB. Bring forward **ALL** subtotals including sections marked not applicable (NA). Subtract these (NAx2) sections from the Total score.

Subtotals brought forward	NA	NAx2	PC	C	Cx2	A	B	A/B	X100
						PC+ (Cx2)	Total Score		
Records & History							42- (NA x2)		%
Assessment & care							24- (NA x2)		%
At Risk Babies							30- (NA x2)		%
Feeding and growth							12- (NA x2)		%
Discharge/transfer							24- (NA x2)		%
Final Score:							132- (NA x2)		%

Assessed by:			
Sign:		**Print:**	
Practice No.		**Date:**	
Sign:		**Print:**	
Practice No.		**Date:**	