KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CLINICAL & RECORD AUDIT: SICK & SMALL (2°)

1. This is a combined audit to be completed by nursing and medical team.
2. A minimum of 5 records must be audited per month (60 records in the year)
3. Record the final score on the monthly clinical and record audit summary tool for sick and small babies.
4. Section A is a record audit. Section B is a clinical audit. Complete all sections in Section A and all applicable sections in Part B.

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%.		

SECTION A

Quality of records		**NA**	**NC**	**PC**	**C**	**COMMENT**
1.	Patient details/sticker on all documents					
2.	Date, time, signature, designation & stamp/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.	HIV exposure					
9.	RPR and RH recorded					
Baby information:						
10.	Date & time of birth, Weight, COH, Length					
11.	Gestational age assessed using LMP, early ultrasound, palpation					
12.	Apgar scores at 1 and 5 mins. minimum					
13.	Details of immediate care and resuscitation (HBB) recorded					
14.	Cord/arterial blood gas recorded if 5min Apgar <7					
15.	Condition of placenta recorded					
16.	Maternal & Perinatal risk factors & problems identified & classified					
Essential New-born Care						
17.	Baby identified with 2 ID bands at birth					
18.	IMI Konakion given at birth					
19.	Chloramphenicol eye ointment at birth					
	RECORDS & HISTORY Totals (19):					

ASSESSMENT AND PLANNING-Admission						
20.	Condition & vital signs on arrival					
21.	First examination (NA if transfer in)					
22.	Gestational age at birth/current- Assessed					
23.	Within 24hrs of birth (NA if transfer in)					
24.	Using Ballard score (NA if transfer in)					
25.	Assessed by an MO within 1 hr of admission/birth					
26.	FBC, CRP and blood culture taken on admission					
27.	Mother received orientation to the unit					
28.	Social & economic status of mom assessed					
29.	Admission checklist completed					

ASSESSMENT AND PLANNING-Nursing		NA	NC	PC	C	COMMENT
30.	Management Checklists reviewed daily –each one completed and new ones initiated according to identified problems					
31.	Current gestational age recorded daily					
32.	Emergency /Priority signs assessed and documented					
33.	Baby assessed/observed as indicated on chart and PRN					
34.	Temp maintained 36^{5}-37°C					
35.	Incubator temp /Heater output monitored 3hrly and adjusted					
36.	Saturations maintained 90-94% in oxygen; 90-100% no oxygen					
37.	Blood glucose recorded as indicated on chart and PRN					
38.	Glucose maintained 2.6-8mmol					
39.	Urine dipstix recorded as indicated					
40.	Pain assessed 3-6hrly on all ICU/HC babies					
41.	Pain management and response recorded					
42.	Actions documented for abnorm. assessments & reassessed within 1hr					
43.	Maternal condition and care of baby assessed daily					
ASSESSMENT AND PLANNING - Medical						
44.	Problem list updated, examination, assessment and management plan reviewed daily by MO					
45.	On admission or if unstable -baby reviewed twice daily					
46.	On admission, and if baby required HC/ICU, reviewed by consultant daily					
47.	CRP repeated at 48hrs to assess cessation of antibiotics					
48.	Diagnostic tests (laboratory/radiological/other) documented					
	ASSESSMENT AND PLANNING Totals (29)**:**					

IMPLEMENTATION						
General Care-Medical						
49.	Reviewed by doctor if any emergency/priority signs noted					
50.	Consultations with referral centre clearly documented (including name of Doctor and hospital, problem and management plan					
51.	Results of diagnostic tests recorded					
General Care-Nursing						
52.	Safety checklist completed at start of each shift					
53.	ID bands checked twice daily					
54.	Eyes cleaned 3hrly if sticky/swollen/discharging					
55.	Mouth cleaned 3-6hrly					
56.	Cord cleaned 6hrly					
57.	Skin care given					
58.	Developmentally supportive care given					
59.	Invasive procedures documented					
60.	EBM/Sucrose and non-nutritive sucking given prior to painful procedures.					
61.	Lines/tubes changed /removed as stipulated					
62.	Birth immunisations given					
63.	6 week immunisations given (if still admitted)					
64.	Multidisciplinary team input /referral recorded (management checklist)					
	Nursing and Medical care Totals (16):					

Family Centred care						
65.	Family visiting documented					
66.	Parents are fully informed/counselled re diagnosis, findings and on-going condition of baby					
67.	Informed consent in writing obtained for invasive procedures					
68.	Parents received adequate health education including infection control, care of the newborn, KMC etc					
69.	Intermittent KMC commenced within 48hrs if possible					
	Family centred care Totals (5):					

Medications		**NA**	**NC**	**PC**	**C**	**COMMENT**
70.	Pen G/Ampicillin and Gentamycin ordered on admission (NA for transfer in)					
71.	Correct dose and frequency prescribed (NA for transfer in)					
72.	Time ordered recorded					
73.	Commenced within 1 hr					
74.	Antibiotics discontinued after 72 hrs if baby is well, CRP & FBC normal and no growth on culture					
75.	Meds. ordered in clinical record & prescribed on prescription chart					
76.	M.O's signature , name, qualifications & contact details					
77.	Commencement and completion dates.					
78.	Legibly written					
79.	Dates only recorded in date column.					
80.	Current day of treatment recorded each day.					
81.	Stat orders ordered at the bottom and signed once administered					
82.	All medications administered at correct times/as ordered					
83.	Sample signatures on reverse of medication chart					
84.	All IV/IMI meds countersigned					
	Medications Totals (15):					

Nutrition						Mx =management
85.	Received oral or NG colostrum within 6hrs of birth					
86.	Feeding readiness /transition tools guide feeding advancement					
87.	Mother received education re benefits & Mx of breastfeeding					
88.	Seen by dietician at least weekly					
89.	Total daily fluid requirements assessed and calculated (ml/kg/day)					
90.	Feeds/ fluids ordered on fluid balance page					
91.	Feeds / fluids administered as ordered					
92.	IV site checked hourly (site and condition recorded)					
93.	IV fluid volume administration recorded hourly					
94.	Total daily fluid intake and output calculated					
95.	Last stool occurrence documented daily					
96.	NPO for 1st 24hrs if severe respiratory distress					
97.	Kept NPO for no longer than 3 days without TPN					
98.	Only a dietician and consultant order TPN					
99.	Arterial/umbilical line –distal perfusion checked hourly-3hrly					
100.	PICC/CVP flushed 6hrly with hep. Saline (Reg/Tert)					
101.	Breast milk only given					
Growth monitoring						
102.	Weight plotted on weight chart and clinical record daily					
103.	Weight gain /loss calculated daily					
104.	Growth (Length, weight and COH) assessed weekly and plotted					
105.	After 1st week of life-no weight gain for 3 days-dietician consult					
106.	FM85 only commenced with dietician consult					
	Nutrition Totals (22):					

Discharge/Transfer		NA	NC	PC	C	COMMENT
107.	HIV (mother and baby), RPR and RH known before discharge					
108.	Discharge education/ advice given					
109.	A detailed discharge/transfer summary –including					
110.	✓ the baby's initial condition on arrival					
111.	✓ maternal history and birth details					
112.	✓ current and resolved problem list with ICD codes					
113.	✓ management					
114.	✓ the condition of baby at discharge					
115.	✓ discharge meds. (including dose)					
116.	✓ follow up plan and CCG linkage					
Dying and Death						
117.	Palliative care plan in place including pain management and resuscitation plans (discussed with parents)					
118.	Mother is seen by a social worker/ psychologist/ religious leader					
	Discharge/Transfer/Death Totals: (12)					

SECTION B. SPECIFIC CONDITIONS-MARK ALL APPLICABLE						
Prematurity		**NA**	**NC**	**PC**	**C**	**COMMENT**
119.	Prematurity appropriately diagnosed -gestational age <37 weeks.					
120.	Antenatal steroids-2 doses received					
121.	Caffeine loading and maintenance dose ordered on Day 1 (if <35 weeks). Aminophylline if Nil Per Os (NPO)					
122.	Caffeine discontinued at 34 weeks.					
123.	Multivitamins 0.3-0.6mls given daily from 14 days/ full feeds.					
124.	Vit D 400iu given daily from 14 days/ full feeds.					
125.	Folate 2.5mg given weekly from 14 days/ full feeds.					
126.	Iron given 0.3-0.6mls given daily from 21 days					
127.	Baby admitted to 24hr KMC when off oxygen & IV fluids and gaining weight. (May be earlier if supportive environ. available)					
128.	Baby observed 12hrly and PRN in KMC unit					
129.	Baby in KMC position with wrap tied tightly at every observation.					
130.	Feeding readiness assessed					
131.	Transitioned from NG feeds to breast feeds without cup feeding					
132.	If baby <1500g/32 weeks at birth screened at least once for ROP					
133.	Baby assessed at least once for hearing loss					
134.	Cranial ultrasound done at least once to screen for IVH					
135.	KMC Discharge assessment score sheet completed daily					
136.	Baby discharged once score 19 or more and weight 1800g. (Weight may be more or less based on home circumstances)					
	Prematurity Totals (18):					

Nosocomial sepsis		NA	NC	PC	C	COMMENT
137.	Nosocomial sepsis appropriately diagnosed: Acquired after 72hrs, WCC raised /lowered and haemodynamic instability					
138.	Correctly assessed-suspected/ confirmed and system					
139.	Full septic screen-FBC, culture, LP, urine, X-Ray, CRP					
140.	Culture results documented					
141.	2nd line antibiotics started, appropriate to identified/unit bacteria					
142.	Correct dose and frequency prescribed					
143.	Supportive management commenced promptly for severe sepsis					
	Sepsis Totals (7)**:**					

Respiratory distress						
144.	Signs of respiratory distress noted and progress monitored					
145.	Blood gas done within 1 hr					
146.	Chest X-Ray done within 1 hr					
147.	Severity assessed (mild, moderate, severe)					
148.	Cause identified (Diagnosis)					
149.	Correct treatment given (Antibiotics/Surfactant)					
150.	Oxygen therapy commenced if Sats <90%					
151.	Oxygen weaned if saturations >94%					
152.	Flow & percentage of oxygen recorded (ie blender/venturi used)					
153.	CPAP commenced within 1hr of birth for prem. with any respiratory distress					
154.	CPAP commenced immediately for any mod. to severe resp. distress					
155.	$FI0_2$ & humidifier temp monitored 3hrly on CPAP					
156.	PEEP maintained at $5cmH_20$. Flow of 8L/min					
157.	Nasal perfusion monitored 3 hourly					
158.	If baby requiring >40% FiO_2 on CPAP in and out Surfactant administered within 1hr					
159.	Appropriate sedation (morphine and midazolam) administered prior to intubation for surfactant administration					
160.	Suctioned 3-6hrly					
161.	Colour and consistency of secretions recorded					
	Respiratory Totals (18)**:**					

HIV Exposure						
162.	Mother received ARVs					
163.	Mother's viral load known					
164.	If HIV exposed or mother never tested birth PCR done					
165.	PCR result documented					
166.	Baby received ARVs					
167.	Co-timoxazole prescribed and administered (from 4-6 weeks)					
	HIV Totals (6)**:**					

Necrotising entero colitis (NEC)						
168.	Clinical signs present: Systemic instability, abdominal distention, Feeding intolerance, abnormal stools					
169.	Necrotising entero colitis (NEC) confirmed on X-Ray					
170.	NEC managed appropriately- Triple antibiotics					
171.	NPO- 3/7/14 days as indicated and TPN					
172.	NG placed on free drainage and aspirated 3hrly					
173.	Abdominal girth measured daily					
174.	Surgical consultation if not responding to med. Management					
	NEC Totals (7)**:**					

Anaemia						
175.	Baby transfused if HB<10gm/dl and symptomatic					
176.	10-20ml/kg leucocyte depleted packed cells transfused over 4hrs					
177.	Baby observed appropriately using blood transfusion chart					
178.	Furusemide given half way through transfusion					
	Anaemia Totals (4)**:**					

Jaundice		**NA**	**NC**	**PC**	**C**	**COMMENT**
179.	Phototherapy commenced **immediately** jaundice noted					
180.	Efficacy of lights checked-hours & blue lights					
181.	TSB measured when jaundice noted					
182.	Baby's Group and Coombs assessed					

Jaundice cont.		NA	NC	PC	C	COMMENT
183.	Cause of jaundice assessed					
184.	Severity assessed (Graph used)					
185.	Eyes covered and nappy open					
186.	Position changed 3hrly					
187.	Bilirubin (TSB) levels monitored every 12-24hrs					
188.	If TSB continued to climb- double lights commenced					
189.	reviewed by consultant					
190.	Need for exchange transfusion assessed--chart, clinical, anaemia					
191.	Breast milk given via NGT if TSB near exchange levels					
192.	160ml/kg (term) / 180ml/kg (prem) whole blood exchange transfusion performed if required					
193.	Kept NPO for 4 hrs. post transfusion					
194.	Glucose monitored 3hrly for 24hrs					
195.	FBC, bilirubin, Ca taken 4hrs post transfusion					
196.	Phototherapy discontinued when TSB 50 mmol/l below the line					
	Jaundice Totals (18)**:**					
Ventilation						
197.	Appropriate sedation (morphine and midazolam) administered prior to intubation and during ventilation					
198.	Size and depth of ET tube correct -confirmed on X-Ray					
199.	Ventilator settings and monitored values recorded hourly.					
200.	Air entry, sounds and chest movement assessed hourly					
201.	Nasal perfusion monitored hourly					
202.	Expired tidal volumes calculated and maintained at 4-6ml/kg					
203.	Blood gas performed at least 12hrly					
	Ventilation Totals (7)**:**					
Surgery						
204.	Informed consent obtained by surgeon					
205.	Seen by anaesthetist prior to surgery					
206.	Relevant blood results FBC, INR, U&E and crossmatch) noted					
207.	Pre-op SOP completed					
208.	Fluids administered during surgery					
209.	Detail of surgery performed					
210.	Blood loss recorded					
211.	Anaesthetic administered					
212.	Wound closure and dressing applied					
213.	Condition assessed before leaving theatre					
214.	Condition assessed on arrival in unit					
215.	Theatre and Unit nurses sign transfer/receipt of baby					
216.	Post-operative analgesia and/ or epidural ordered					
217.	Hourly observations recorded (including TPR, BP, Sats, pain)					
218.	Epidural site checked hrly-dressing intact no leakage					
219.	Pain assessed and analgesia administered as ordered					
220.	Type of epidural mixture and rate/dose documented					
221.	Initial wound assessment performed					
222.	Wound assessment and dressing changes recorded					
223.	Wound drainage monitored					
224.	Post-operative and maintenance fluids ordered & administered					
225.	Urinary output monitored					
226.	TOF:- NG/ET tube (silastic) **not** removed/reinserted					
227.	Gastroschisis: Abdominal pressure monitored					
228.	Jejunal tube: Only continuous feeds administered					
229.	Choanal atresia: stents suctioned regularly					
	Surgery Totals (26)**:**					

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)	Column A PC+ (Cx2)	Column B Total Score	A/B	X100
Records & History							38-(NA x2)		%
Assessment & planning							58-(NA x2)		%
Nursing & Medical care							32-(NA x2)		%
Family centred care							10-(NA x2)		%
Medications							30-(NA x2)		%
Nutrition							44-(NA x2)		%
Discharge/Death							24-(NA x2)		%
Prematurity							36-(NA x2)		%
Nosocomial Sepsis							14-(NA x2)		%
Respiratory Distress							36-(NA x2)		%
HIV exposure							12-(NA x2)		%
NEC							14-(NA x2)		%
Anaemia							8- (NA x2)		%
Jaundice							36-(NA x2)		%
Ventilation							14-(NA x2)		%
Surgery							52-(NA x2)		%
Final Score:							458-(NA x2)		%

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