KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CLINICAL & RECORD AUDIT: SICK & SMALL (1°)

Date:		Unit:	

1. This is a combined audit to be completed by 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 records must be audited per month (24 records in the year).
4. Record the final score on the monthly clinical and record audit summary tool for sick and small babies.
5. Section A is a record audit. Section B is a clinical audit. Complete all sections in Section A & all applicable sections in Part B.

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%.

RECORD AND GENERAL CARE AUDIT						
QUALITY OF RECORDS		**NA**	**NC**	**PC**	**C**	**COMMENT**
1.	Patient details 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.	Antenatal history					
7.	Delivery mode and problems					
8.	Maternal HIV status					
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 Newborn Care						
17.	Baby identified with 2 ID bands at birth					
18.	IMI Konakion given at birth					
19.	Antibiotic eye treatment at birth					
	RECORDS & HISTORY Totals (19):					

ASSESSMENT AND PLANNING-Admission to Neonatal Unit						
20.	Condition & vital signs on arrival					
21.	First examination (NA if transfer in)					
22.	Gestational age at birth/current assessed using Ballard score					
23.	Assessed by an MO within 3 hr of admission/birth					
24.	FBC, CRP and blood culture taken on admission/birth					
25.	Admission checklist completed					
26.	Management Checklists reviewed daily –each one completed and new ones initiated according to identified problems					
27.	Emergency /Priority signs assessed and documented					
28.	Baby assessed/observed as indicated on chart and PRN					

ASSESSMENT AND PLANNING- Nursing cont.		NA	NC	PC	C	COMMENT
29.	Actions documented for abnorm. assessments & reassessed in 1hr					
30.	Incubator temp. /Heater output monitored 3hrly & adjusted					
31.	Urine dipstix recorded as indicated					
ASSESSMENT AND PLANNING - Medical						
32.	Problem list updated, examination, assessment and management plan reviewed daily by MO					
33.	If unstable -baby reviewed twice daily					
34.	CRP repeated at 48hrs to assess cessation of antibiotics					
	ASSESSMENT AND PLANNING Totals (15):					

IMPLEMENTATION - General Care-Medical		NA	NC	PC	C	COMMENT
35.	Reviewed by doctor if any emergency/priority signs noted					
36.	Consultations with referral centre clearly documented (including name of Doctor and hospital, problem and management plan					
37.	Results of diagnostic tests recorded					
General Care-Nursing						
38.	Safety checklist completed at start of each shift					
39.	Developmentally supportive care given					
40.	EBM/Sucrose and non-nutritive sucking given prior to painful procedures.					
41.	Lines/tubes changed /removed as stipulated					
42.	Immunisations given as per EPI schedule					
43.	6 week immunisations given (if still admitted)					
44.	Multidisciplinary team input/referral recorded (management checklist)					
	Nursing and Medical care Totals (10):					

IMPLEMENTATION - Family Centred care		NA	NC	PC	C	COMMENT
45.	Orientation and ongoing education received					
46.	Social & economic status of mom assessed					
47.	Maternal condition and care of baby assessed daily					
48.	Parents are fully informed/counselled re diagnosis, findings and on-going condition of baby					
49.	Parents received adequate health education including infection control, care of the newborn, KMC etc					
50.	Intermittent KMC commenced within 48hrs if possible					
	Family centred care Totals (6):					

IMPLEMENTATION - Medications		NA	NC	PC	C	COMMENT
51.	Meds. ordered in clinical record & prescribed on prescription chart					
52.	M.O's signature , name, qualifications & contact details					
53.	Commencement and completion dates.					
54.	Specimen signatures recorded on prescription chart					
	Medications Totals (4):					

IMPLEMENTATION - Fluids and feeds		NA	NC	PC	C	COMMENT
55.	Total daily fluid requirements assessed and calculated (ml/kg/day)					
56.	Feeds/ fluids orders recorded in daily plan and fluid balance page					
57.	Total fluid intake and output for previous 24hrs documented					
58.	IV site checked hourly (site, condition and perfusion recorded)					
59.	Received oral or NG colostrum within 6hrs of birth					
60.	Feeding readiness /transition tools guide feeding advancement					
61.	Breast milk only given					
62.	Kept NPO for no longer than 3 days					
63.	Seen by dietician at least weekly					

IMPLEMENTATION - Growth monitoring		NA	NC	PC	C	COMMENT
64.	Weight plotted on weight chart and clinical record daily					
65.	Weight gain /loss calculated daily					
66.	Growth (Length, weight and COH) assessed weekly and plotted					
67.	After 1st week of life-no weight gain for 3 days-dietician consult					
	Fluids, feeds, growth Totals (13):					

DISCHARGE/TRANSFER		NA	NC	PC	C	COMMENT
68.	HIV (mother and baby), RPR and Rh known before discharge					
69.	Discharge education/ advice given					
70.	Standardised discharge/transfer summary completed					
Dying and Death						
71.	Palliative care plan in place including pain management and resuscitation plans (discussed with parents)					
72.	Mother is seen by a social worker/ psychologist/ religious leader					
	Discharge/Transfer/Death Totals (5):					

CLINICAL AUDIT OF SPECIFIC CONDITIONS-MARK ALL APPLICABLE						
PREMATURITY		**NA**	**NC**	**PC**	**C**	**COMMENT**
73.	Prematurity appropriately diagnosed -gestational age <37 weeks.					
74.	Caffeine loading and maintenance dose ordered on Day 1 (if <35 weeks). Aminophylline if Nil Per Os (NPO)					
75.	Caffeine discontinued at 34 weeks.					
76.	Supplements given as per management checklist (Inpatient support pack)					
77.	Baby observed at least 12hrly and PRN in KMC unit					
78.	Baby in KMC position with wrap tied tightly at every observation					
79.	Transitioned from NG feeds to breast feeds without cup feeding					
80.	If baby <1500g/32 weeks at birth booked for ROP screening					
	Prematurity Totals (8)**:**					

HOSPITAL ACQUIRED INFECTION (HAI)		NA	NC	PC	C	COMMENT
81.	HAI suspected: Acquired after 48hrs, WCC raised /lowered and haemodynamic instability					
82.	Full septic screen-FBC, culture, LP, urine, X-Ray, CRP					
83.	Culture results documented					
84.	Antibiotics commenced					
85.	Antibiotics changed if unresponsive after 24hrs or according to culture results					
	Sepsis Totals (5)**:**					

RESPIRATORY DISTRESS		NA	NC	PC	C	COMMENT
86.	Signs of respiratory distress noted and progress monitored					
87.	Severity assessed (mild, moderate, severe)					
88.	Oxygen therapy commenced if Sats <90%					
89.	Blood gas done initially and at least daily if on respiratory support					
90.	Chest X-Ray done					
91.	Cause identified (Diagnosis)					
92.	Respiratory support commenced according to gestation and severity					
93.	Flow & percentage of oxygen recorded (ie blender/venturi used)					
94.	Oxygen weaned if saturations >94%					
95.	PEEP initiated at ≥ 5cmH_20.					
96.	If baby requiring ≥ 30% FiO_2 on CPAP- in and out Surfactant administered as soon as possible					
97.	Appropriate sedation (morphine and midazolam) administered prior to intubation					
98.	Nasal perfusion monitored					
99.	Respiratory condition (including sats & effort) & support monitored					

RESPIRATORY DISTRESS cont.		NA	NC	PC	C	COMMENT
100.	If baby requiring >60% FiO_2 on CPAP 1hr after admin of surfactant assessed for possible transfer					
	Respiratory Totals (15)**:**					

JAUNDICE		NA	NC	PC	C	COMMENT
101.	TSB measured when jaundice noted & at least daily					
102.	Cause of jaundice assessed: Early-Coombs test. Late-Septic screen					
103.	Severity assessed (Graph used)					
104.	Phototherapy commenced when jaundice noted					
105.	Efficacy of lights checked-hours & blue lights (See Safety checklist)					
106.	Eyes covered and nappy open					
107.	Position changed 3hrly					
108.	Breast milk feeds continued					
109.	Phototherapy discontinued when TSB 50 mmol/l below the line					
	Jaundice Totals (9)**:**					

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							30-(NA x2)		**%**
Nursing & Medical care							20-(NA x2)		**%**
Family centred care							12-(NA x2)		**%**
Medications							8-(NA x2)		**%**
Fluids, Feeds, Growth							26-(NA x2)		**%**
Discharge/Death							10-(NA x2)		**%**
Prematurity							16-(NA x2)		**%**
HAI							10-(NA x2)		**%**
Respiratory Distress							30-(NA x2)		**%**
Jaundice							18-(NA x2)		**%**
Final Score:							218-(NA x2)		**%**

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