NSW KIDS + FAMILIES

NSW GOVERNMENT | Health

AUDIT TOOL FOR THE GUIDELINE:

Infants and Children:

Initial management of fever or suspected infection in oncology and stem cell transplantation patients

Instructions for Completing the Audit:

1. This is a medical record audit.
2. The following patients can be included in the audit:
   Patients aged up to and including 18yrs, presenting with fever > 38°C OR unwell OR with parental concerns who meet ANY of these criteria:
   - Patients on treatment for cancer
   - Patients who ceased treatment for cancer within the last three months
   - Recipients of Stem Cell Transplantation (SCT) within the last 12 months and / or on immunosuppressive therapy
   - Oncology or SCT patients with Central Venous Access Devices (CVAD) in situ.
3. LHDs/SHNs can decide how they make use of this audit tool. NSW Kids and Families suggest including 30% of patients over a 12 month period who meet the requirements set out in (2) above.

DRAFT

1. Facility: ______________________________ **2. Ward:** ______________________________ **3. Auditor's Name:** ______________________________	***Affix patient label here OR record MRN***

4. (a) Date of Triage / Presentation: _ _ / _ _ / _ _ _ _

4. (b) Time of Triage / Presentation (in 24hr clock): ______________________________

5. At the initial assessment, the patient was assessed as:

☐ Clinically stable ☐ Clinically unstable

☐ Severe sepsis / shock ☐ Not documented

6. If the patient was assessed as severe sepsis / shock <u>AND</u> the facility is in a rural or regional area:

a) Was the senior local paediatrician contacted?

☐ Yes ☐ No ☐ Unclear ☐ Not documented

b) Was NETS contacted?

☐ Yes ☐ No ☐ Unclear ☐ Not documented

THIS IS NOT A MEDICAL RECORD FORM

NSW KIDS + FAMILIES

AUDIT TOOL FOR THE GUIDELINE:
Infants and Children:
Initial management of fever or suspected infection in oncology and stem cell transplantation patients

NSW GOVERNMENT | Health

Affix patient label here OR record MRN

7. List all observations documented at the initial assessment:

a) Respiratory rate: __________ / min

b) Respiratory distress:

☐Normal ☐mild ☐mod ☐severe

c) O2 saturation: __________ %

d) Blood pressure: __________ mmHg

e) Heart rate: __________ / min

f) Capillary refill:

☐<3secs ☐≥3secs

g) Level of consciousness (GCS): __________

h) Any signs of **cold** shock (diminished pulses, prolonged capillary refill, hypotension)?

☐ Yes ☐ No ☐ Not documented

i) Any signs of **warm** shock (bounding pulses, flash – very rapid capillary refill, wide pulse pressure)?

☐ Yes ☐ No ☐ Not documented

8. (a) Which antibiotics were prescribed (tick all that apply)?

☐ Gentamicin ☐ Piperacillin / Tazobactam ☐ Vancomycin

☐ Other: ____________________________ ☐ Not documented

8. (b) What route was used?

☐ CVAD ☐ Peripheral ☐ Not documented

9. (a) Date when administration of the first antibiotic started: _ _ / _ _ / _ _ _ _

9. (b) Time when administration of the first antibiotic started (in 24hr clock): ____________________________

10. At the initial assessment, what tests were ordered (tick all that apply)?

☐ Blood Culture
☐ FBC
☐ EUC
☐ LFT
☐ BGL
☐ Lactate

11. Any further comments?

THIS IS NOT A MEDICAL RECORD FORM

DRAFT