

AUDIT TOOL
Infants and Children: Acute Management of Seizures

Facility: _____ Ward: _____	(affix patient label here)
Time of Triage/Presentation	Time: ___:___ (24 hour clock) Date: ___/___/___ (DD/MM/YY)
Time of onset of seizure	Time: ___:___ (24 hour clock)
Time of first dose of anti-seizure medication	Time: ___:___ (24 hour clock)
What anti-seizure medication was prescribed for first dose?	<input type="checkbox"/> Midazolam <input type="checkbox"/> Diazepam <input type="checkbox"/> Phenyton <input type="checkbox"/> Levetiracetam <input type="checkbox"/> Phenobarbitone
Time of cessation of seizure if resolved	Time: ___:___ (24 hour clock)
Time of second dose of anti-seizure medication	Time: ___:___ (24 hour clock)
What anti-seizure medication was prescribed for second dose?	<input type="checkbox"/> Midazolam <input type="checkbox"/> Diazepam <input type="checkbox"/> Phenyton <input type="checkbox"/> Levetiracetam <input type="checkbox"/> Phenobarbitone
Time of cessation of seizure if resolved	Time: ___:___ (24 hour clock)
Time of third dose of anti-seizure medication	Time: ___:___ (24 hour clock)
What anti-seizure medication was prescribed for third dose?	<input type="checkbox"/> Midazolam <input type="checkbox"/> Diazepam <input type="checkbox"/> Phenyton <input type="checkbox"/> Levetiracetam <input type="checkbox"/> Phenobarbitone
Time of cessation of seizure if resolved	Time: ___:___ (24 hour clock)
Escalation	
If unstable Escalated as per local CERS Time of Escalation	Time: ___:___ (24 hour clock) N/A <input type="checkbox"/>
Time of intubation if required	Time: ___:___ (24 hour clock)
Time of cessation of seizure if resolved	Time: ___:___ (24 hour clock)
Comments:	
Signature: _____	Designation: _____

THIS IS NOT A MEDICAL RECORD FORM

COMPLETING THE AUDIT TOOL

This audit tool accompanies the Infants and Children Acute Management of Seizures Clinical Practice Guideline 3rd edition

- ✓ **All dates are in DD/MM/YY format.**
- ✓ **All times are in HH:MM 24 hour clock format.**
- ✓ **Patient label must be attached to each sheet.**
- ✓ **All fields are mandatory and N/A is provided where required.**
- ✓ **Please use the comments box to record information which may assist in the data analysis. This includes explanations of blank fields etc. Do not use the comments box as a pathology or medical record.**
- ✓ **The signature and designation boxes are to record the name of the person completing the form.**