**Appendix 2 B (supplemental digital content)**

**Analysis of documentation carried out on a completed patient file.**

Dept. /Ward: Date:

Case number: Controller:

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| **1** | **Medical Anamnesis / Indication**  Following content exists in written form: | yes | part. | no | comments |
| 1.1 | Current ailment |  |  |  |  |
| 1.2 | Risks, allergies, infections  (Entry or „not known“) |  |  |  |  |
| 1.3 | Current medication (at time of admittance).  Amount and dosage |  |  |  |  |
| 1.4 | Vital signs (at time of admittance) |  |  |  |  |
| 1.5 | Reason for hospitalization / Suspected diagnosis) |  |  |  |  |
| 1.6 | Further diagnoses (main and ancillary diagnosis) |  |  |  |  |
| 1.7 | Medical justification for case type and admission indication is documented (AEP) |  |  |  |  |
| 1.8 | Diagnostic findings of initial physical examination |  |  |  |  |
| 1.9 | Planned medical procedure (goals / therapy) |  |  |  |  |
| 1.10 | Date, signature of admitting doctor |  |  |  |  |

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| 2 | **Nursing / Care Anamnesis** | yes | part. | no | comments |
| 2.1 | Collected within 24 hrs. after admission; |  |  |  |  |
| 2.2 | Wishes/expectations of patient recorded |  |  |  |  |
| 2.3 | Problems/resources and support effort systematically recorded (assigned to categories: e.g. hygiene/nutrition/ excretion/mobilisation/breathing/etc.) |  |  |  |  |
| 2.4 | Decubitus risk assessed at admission/resp. at time of ascertainment (also post op) |  |  |  |  |
| 2.5 | Risk of falling assessed at time of admission (also post op) |  |  |  |  |
| 2.6 | Pneumonia risk assessed at admission (also post op) |  |  |  |  |
| 2.7 | Additional risks assessed at admission (e.g. thrombosis, contractures, etc.) |  |  |  |  |
| 2.8 | Intolerances (nourishment) are recorded (or „none“) |  |  |  |  |
| 2.9 | Degree and acuteness of an existing decubitus is recorded (or “skin condition in good order”) |  |  |  | If no decubitus ,  does not apply (=**yes**) |
| 2.10 | Date and signature of admitting person are present |  |  |  |  |

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| 3 | **Care Planning**  (Documentation of goal oriented planning and execution) | yes | part. | no | comments |
| 3.1 | Plan was created within 24 hrs after admission? (see date of first administered measure). |  |  |  |  |
| 3.2 | Measured were planned based on risks and restrictions determined during care anamnesis |  |  |  |  |
| 3.3 | Are type, scope, and frequency of planned measures apparent? (reference to standards, treatment path, etc.) |  |  |  |  |
| 3.4 | Is it apparent when (date/time stamp) and by whom (initials) measures were undertaken? |  |  |  |  |
| 3.5 | Is it apparent who administered the medication |  |  |  |  |
| 3.6 | If additional forms are referenced (check boxes), have these been created and processed (e.g. risk scales, monitoring sheet, daily logs, wound documentation, exercise plan, etc.) |  |  |  |  |

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| 4 | **Record of care relevant supplementary diagnoses (pND) according to ICD 10 GM and procedures (OPS)** | yes | part. | no | comments |
| 4.1 | Is data collection sheet in place (with patient name or patient sticker) |  |  |  |  |
| 4.2 | Care relevant supplementary diagnoses/procedures are documented or “none exist” is checked |  |  |  |  |
| 4.3 | Justification for care relevant supplementary diagnoses/procedures according to DKR exists (the documented note (care relevance) can be found in the documentation). |  |  |  |  |

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| 5. | **Medical Orders** | yes | part. | no | comments |
| 5.1 | The doctor’s orders together with their elaboration are dated and initialled. |  |  |  |  |
| 5.2 | Does order for medication on demand contain specifications for indication, frequency, amount, and daily maximum permissible dose? (Also for direct documentation/transfer in to the Patient documentation chart  Not only: “as required....”) |  |  |  | If none,  does not apply **(=yes)** |

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| 6. | **Patient documentation chart** | yes | part. | no | comments |
| 6.1 | Vital signs are recorded with time stamp (also daily protocol, as available) |  |  |  |  |
| 6.2 | Administration of injections is recorded with time stamp and initials (also medical log, as available) |  |  |  | If none,  does not apply (=yes) |
| 6.3 | Administration of infusions is recorded with time stamp and initials (also medical log, as available) |  |  |  | If none,  does not apply (=yes) |
| 6.4 | Carried out diagnostic and consultant reports are recorded in daily column? |  |  |  |  |
| 6.5 | Carried out measures of the treatment team are recorded with brief description, time stamp and initials (e.g. visits, therapies, conversations, and consultations, etc.) |  |  |  |  |

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| 7 | **Progress documentation /progress report / care report** | yes | part. | no | comments |
| 7.1 | Doctor and care personnel conjointly document in this sheet with initial and time stamp? |  |  |  |  |
| 7.2 | Progress report contains documented results, changes, reasons for changes, and important observations? (no new description of measures!) |  |  |  |  |
| 7.3 | Progress report contains regular\* medical assessment regarding patient’s condition? (e.g. severity of ailment, intensity of treatment, results of visits, etc.)  \*entry for every visit |  |  |  |  |
| 7.4 | Course of treatment is visible (content, overview) |  |  |  |  |
| 7.5 | Report is concise, precise and uses medical terminology  (avoidance of discriminatory statements?) |  |  |  |  |

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| 8 | **Discharge and transfer documentation** | yes | part. | no | comments |
| 8.1 | For patients with post-stationary treatment and care requirements a discharge plan exists.  (Date and type of subsequent treatment ; support requirement; e.g. documentation in special forms, checklists or defined form fields for discharge planning) |  |  |  | If post-stationary treatment not required  Does not apply(=yes) |
| 8.2 | The medical discharge letter contains the following:   * Diagnoses/presumed diagnoses * Administered diagnostic and therapies * Summary of ailment process * Recommended therapy   Doctor’s signature |  |  |  |  |
| 8.3 | For patients with post-stationary treatment or care requirements a discharge report/care transition report exists. |  |  |  | If post-stationary treatment not required  Does not apply **(=yes)** |
| 8.4 | Execution of discharge conversation is documented (incl. expressed suggestions and behavioural hints). |  |  |  |  |

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| 9 | **Formal** | yes | part. | no | Comments |
| 9.1 | All forms can be uniquely associated to a patient (name/birthdate or sticker) |  |  |  |  |
| 9.2 | Only indelible writing material was used (no pencils) |  |  |  |  |
| 9.3 | Original text remains legible after correction (no white-out, glue overs, or strike-thru) |  |  |  |  |
| 9.4 | Hand written entries in forms are legible |  |  |  | If no, which form: |
| 9.5 | Phrasing is non-judgmental |  |  |  |  |
| 9.6 | Phrasing is comprehensible |  |  |  |  |