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

Requirements for the Clinical Documentation / Patient Documentation regarding Quality of Structure, Process and Results at the Asklepios Clinics

1. **Quality of Structure**

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| 1 | The clinic has a written governance regarding patient documentation (including governance of responsibilities) |
| 2 | A sample and/or a manual for producing patient documentation exists. |
| 3 | All departments use common and standardized forms for the collection of the relevant information (e.g. anamnesis, clinical findings, patient documentation chart etc.).  Required specialisation for the individual departments are adjusted to the structure of the base documentation. |
| 4 | The standard documentation / base set (general station) includes  Form for patient master data (possibly incorporated in anamnesis form)  Anamnesis and clinical findings  Medical prescription  Questionnaire on nursing requirements  Care plan/Proof of execution  Form for nursing relevant ancillary diagnosis  Report of process |
| 5 | The documentation of all occupational groups is collated in the system envelope or the components of the documentation are accessible for all occupational groups at any time. |
| 6 | Relevant data/information (e.g. patient safety) is documented in predefined fields and are listed at the top of the first sheet (fields for important information, allergies, infections, diagnoses, orientation, risk stratification of falling, decubitus ulcer, thrombosis, contracture etc.) |
| 7 | The form and fields are created in a manner permitting unique answers, meaning there is always a options to negate (field example: “no”, “none”, not applicable”, “unknown”, etc.  No ambiguities arise due to fields without entries. |

**II. Quality of Process**

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| 1 | The representation of the complete treatment process is ensured:  Patient documentation begins with emergency acceptance at the emergency ward.  Incl. urgency assessment (e.g. Manchester-Triage-scale /MTS), central in-patient admission or admission in to a ward  Transmission of information following a change in treatment unit (e.g. ward – OP – intensive care) is ensured.  Documentation at completion of treatment is performed (discharge and/or transfer documentation). |
| 2 | Patient documentation is undertaken across all occupational groups,  All occupational groups involved in the treatment process document in to a common patient file (medical, custodial and therapeutic documentation, mutual procedural documentation on one sheet or into a document which is agreed upon by all occupational groups regarding). |
| 3 | Maintenance of a complete and comprehensible documentation is ensured.  Guidance and trainings regarding the usage of the documentation system according to the requirements take place (all occupational groups). |
| 4 | An up-to-date list of initials of all involved employees is kept. |
| 5 | A process to check the patient documentation according to a checklist is established. |

**III. Quality of Results**

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| 1 | **Medical Anamnesis / Indication Sheet of the Specialist Ward**  The following information is available in written form: |
| 1.1 | Current medical condition and complaints |
| 1.2 | Risks, allergies, infections  (field entry or “none known”) |
| 1.3 | Current medication (at time of admission) specification of mount and dosage |
| 1.4 | Vital signs (at time of admission) |
| 1.5 | Hospitalisation diagnosis/tentative diagnosis |
| 1.6 | Additional diagnoses (main and supplementary diagnosis) |
| 1.7 | Medical justification for type of case and admission indication is documented. |
| 1.8 | Finding of initial physical examination |
| 1.9 | Planned medical process (goal/therapy) |
| 1.10 | Date, signature of admitting doctor |

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| 2 | **Care Anamnesis / Care Requirements Survey** |
| 2.1 | Care anamnesis is performed within 24 hrs after admission (at minimum initial assessment). Patients accepted for an operation receive an initial assessment at admission, followed by an extensive care requirement survey/care anamnesis postoperative. |
| 2.2 | Wishes and expectations of patients have been recorded. |
| 2.3 | Problems/resources and support requirements have been systematically recorded  (assignment to categories, e.g. hygiene, nourishment, excretion, mobilisation, respiration, etc.) |
| 2.4 | Risk of decubitus at time of admission resp. at time of survey has been assessed (also postoperative). |
| 2.5 | Risk of falling at time of admission resp. at time of survey has been assessed (also postoperative). |
| 2.6 | Risk of pneumonia at time of admission resp. at time of survey has been assessed (also postoperative). |
| 2.7 | Additional risks at time of admission resp. at time of survey has been assessed (also postoperative), e.g. thrombosis, contractures etc. |
| 2.8 | Intolerances (dietary) are recorded (or “none”). |
| 2.9 | Degree and state of an existing decubitus ulcers are documented (or “skin condition intact”) |
| 2.10 | Date and signature of accepting care staff exist. |

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| 3 | **Care Plan**  (Documentation of goal oriented plan and its execution) |
| 3.1 | Plan was established within 24 hrs after admission. (Documentation of date of creation or date of first measure) |
| 3.2 | Based on risks and restrictions assessed during care anamnesis, measures are planned. |
| 3.3 | Type, scope and frequency of individual planned measures are apparent. (also: reference to standards, treatment paths, etc.) |
| 3.4 | It is evident when (date / time) and by whom measures where undertaken. |
| 3.5 | It is evident who administered medication. (possibly also in the patient documentation chart) |
| 3.6 | If additional forms are referenced (checkbox), these have been created and processed  (e.g. risk scales, monitoring forms, daily logs, trauma documentation, exercise plan) |

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| 4 | **Recording care relevant Supplementary Diagnosis**  According to ICD 10 GM and Procedures (OPS) |
| 4.1 | A registration form is in place (with patient name and patient sticker) |
| 4.2 | Care relevant supplementary diagnoses are documented (or entry “none exist” is checked) |
| 4.3 | Justification for care relevant supplementary diagnoses / procedures according to DKR are present. (The documented reference (“care relevant”) can be found in documentation. |

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| 5 | **Medical Directives** |
| 5.1 | Medical directives together with their elaborations are documented with date and signature/initials. |
| 5.2 | Prescription and documentation of required medication contain specifications regarding indication, frequency, dose and daily maximum permissible dose (including direct documentation/transcription into patient documentation chart  Example: “Trauma pain 4x daily 5mg XXX drops”; not merely “as required…”) |

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| 6 | **Patient documentation chart** |
| 6.1 | Vital signs documented with time stamp (also daily log, if available) |
| 6.2 | Administration of injections documented with time stamp and signature/initials (also on medication log, if available) |
| 6.3 | Administration of infusions documented with time stamp and signature/initials (also on medication log, if available) |
| 6.4 | Performed diagnostic and consults are documented in daily columns. |
| 6.5 | Performed measures of the treatment team are documented including brief description, signature/initials, and time stamp (e.g. visitation, therapies, conversations, case reviews, etc.). |

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| 7 | **Progress Documentation /Progress Report/ Care Report** |
| 7.1 | Doctor, care (and possibly additional occupational groups) document the progress of treatment in a mutual sheet with signature/initials and time stamp. |
| 7.2 | Progress report contains the following points (not a description of measures!):  All daily observations relevant for treatment progress  Regular medical assessment of patient’s condition (e.g. degree of ailment, intensity of treatment, results of visits (entry for every visit)  Description of changes/modifications and the associated additional effort (medical / care)  Reason for discontinuation of change of measures  Peculiarities during administering of measures/ effect of measures  Perception in dealing with patient  Result of dialogue with patient, agreements, visits, case reviews, etc. |
| 7.3 | Treatment progress of patient is visible (content, overviews) |
| 7.4 | Report is short, precise and uses medical terminology (avoidance of discriminatory statements?) |

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| 8 | **Discharge and Transfer Documentation** |
| 8.1 | For patients requiring post stationary (out-patient) treatment or care, a discharge planning is available. (Date and type of additional treatment, support requirement; e.g. documentation of special forms, checklists, or defined form fields for discharge planning) |
| 8.2 | Medical discharge letter contains the following:  Diagnosis/ probable diagnoses  Conducted diagnostic and treatment  Summary of course of illness  Suggestions for therapy  Doctor’s signature |
| 8.3 | For patients requiring post stationary (out-patient) treatment or care, a discharge/transition of care report is available. |
| 8.4 | Execution of discharge conversation is documented (including stated suggestions and behavioural advice) |

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| 9 | **Formal** |
| 9.1 | All forms can be uniquely assigned to the patient. (name/birth date or sticker) |
| 9.2 | Only indelible writing materials were used (no pencil). |
| 9.3 | Given corrections, the original text remains legible (no whiteout, glue over, total strikeout) |
| 9.4 | Handwritten entries into the forms are legible. |
| 9.5 | Statements are value neutral |
| 9.6 | Statements are comprehensible. |