



Qualità e Risk Management

Annex 1- Overall analysis of each individual criterion

Survey 2016: Results expressed as a percentage of compliance frequency (YES and PE ^) or non-compliance with the criterion (NO).

ID	CRITERION	PERCENTAGE %	
		YES	NO
1	Is the hospital discharge data (HDD) present in the record?	87,4	12,6
1a	Has the HDD been signed by the responsible	89,5	10,5
	doctor?		
2	Is present the privacy form (signed and dated always)?	33,4	66,6
3	Is the personal data of the patient complete?	100,0*	0,0
4	Does the patient enter into a "fragile" category?	62,3	37,7
5	Is the patient's occupation recorded?	55,1	44,9
6	Is the file organized chronologically? (always)	8,9	91,1
7	Is the diagnosis upon reception into hospital recorded? (always)	96,1	3,9
8	Was the evaluation of the patient carried out within 24 hours of their admission? (always)	99,2	0,8
9	Does the initial evaluation include the following aspects? (history, objective tests, prescription of therapy, the request for diagnostic test)	98,2*	1,8
10	The fall risk: was the patient evacuate according to the Conley Scale within 72 hours of admission (when applicable)?	50,8*	49,2
11	Is the diet the patient has to follow present?	41,9	58,1
12	Are the details about the patient's lifestyle (smoking, alcohol, education, etc)?	85,9*	14,1
13	Does the file contain information about allergies?	84,5	15,5
14	Is the history present? (always) (do not evaluate PS file)	97,3	2,7
14a	Is the history written in legible handwriting? (always)	99,8	0,2
15	Is the physical examination present?	89,7	10,3
15a	Does the physical examination include an evaluation of the state of consciousness, the functioning of the respiratory & cardiovascular systems and the location of any identified problems (do not evaluate PS file)?	94,3*	5,7
15b	Is the physical examination conducted on admission signed/initialed? (always)	34,2*	65,8
15c	Is the physical examination conducted on admission dated? (always)	61,3	8,7
15d	Is the physical examination legible? (always)	99,8	0,2
16	All the vital signs are measured?	82,7*	17,3







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	38,9*	61,1
Is pain intensity assessed in the file? (only if the	25, 4	74,6
evaluation of pain scale is present)		
Is pain intensity assessed on a daily basis?	76,8*	23,2
Is there an evaluation of the water balance? (at	40,2	59,8
least one day)		
Is the daily diary present? (always)	96,7	3,3
· · · · · · · · · · · · · · · · · · ·	86,0	14,0
day in hospital? (always)		
Are the annotations in the daily diary	48,7	51,3
, ,		
	8,9	91,1
		27,1
	, _,,	_,,_
	49.2	50,8
	17,2	70,0
	90.5*	9,5
	70,7	7,7
	00.7	0.2
		0,3
	92,9**	7,1
	· ·	
1	93,7*	6,3
• •		
	96,4*	3,6
	80,9	19,1
1 0		
the wards where they are adopted)		
Has the nurse signed or initialed to confirm the	91,2	8,8
	64, 3	35,7
management?		
Is the patient's informed consent specific for a	92,9	7,1
transfusion present? (at least a copy		
If the patient received a transfusion is the card	72,8	27,2
for the transfusion received present?		
Are the labels from the transfusion bags present	92,9	7,1
·	40,7	59,3
1 0 0 1		
Is the informed consent of the patient for the	97,4	2,6
	evaluation of pain scale is present) Is pain intensity assessed on a daily basis? Is there an evaluation of the water balance? (at least one day) Is the daily diary present? (always) Is the daily diary present and annotated for each day in hospital? (always) Are the annotations in the daily diary signed/initialed? (always) Is the nursing card present in the clinical file? If the nursing card is present is it annotated for each day in hospital? If yes are the annotations on the nursing card signed/initialed? (in the wards where they are adopted) Is the order sets paper (for medication therapy management) present? Is the order sets paper legible? The prescription or suspension of pharmaceuticals are signed or initialed by a doctor? Are the date and time of the prescription recorded? (in the wards where they are adopted) Are the date and time of the administration recorded? Has the nurse signed or initialed the non-administration explaining the reason with an appropriate key e.g. V=vomit, A=absent, etc (in the wards where they are adopted) Has the nurse signed or initialed to confirm the administration? (in the wards where they are adopted) Are the allergies reported on medication therapy management? Is the patient's informed consent specific for a transfusion present? (at least a copy If the patient received a transfusion is the card	All the vital signs are measured daily? Is pain intensity assessed in the file? (only if the evaluation of pain scale is present) Is pain intensity assessed on a daily basis? Is there an evaluation of the water balance? (at least one day) Is the daily diary present? (always) Is the daily diary present and annotated for each day in hospital? (always) Are the annotations in the daily diary signed/initialed? (always) Is the nursing card present in the clinical file? If the nursing card is present is it annotated for each day in hospital? If yes are the annotations on the nursing card signed/initialed? (in the wards where they are adopted) Is the order sets paper (for medication therapy management) present? Is the order sets paper legible? Are the date and time of the prescription recorded? (in the wards where they are adopted) Are the date and time of the prescription recorded? (in the wards where they are adopted) Are the date and time of the administration recorded? Has the nurse signed or initialed the nonadministration explaining the reason with an appropriate key e.g. V=vomit, A=absent, etc (in the wards where they are adopted) Has the nurse signed or initialed to confirm the administration? (in the wards where they are adopted) Are the allergies reported on medication therapy management? Is the patient's informed consent specific for a transfusion present? (at least a copy If the patient received a transfusion is the card for the transfusion received present? Are the labels from the transfusion bags present in the clinical diary?







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24a	Is the signature of the patient present on the informed consent form? (if a surgical procedure was undertaken)	99,6	0,4
24b	Is the signature of the surgeon present on the informed consent form? (if a surgical procedure was undertaken)	76,1	23,9
24c	On the informed consent form for the surgical procedure was the type of procedure undertaken clearly stated? (if a surgical procedure was undertaken)	96,5	3,5
24d	On the informed consent form for the surgical procedure was the date of the procedure stated? (if a surgical procedure was undertaken)	95,8	4,2
25	Is an informed consent form for anesthetic present? (if a surgical procedure was undertaken)	94,8	5,2
25a	Is the signature of the patient present on the informed consent form for anesthetic? (if a surgical procedure was undertaken)	99,2	0,8
25b	Is the signature of the anesthetist present on the informed consent form for anesthetic? (if a surgical procedure was undertaken)	61,4	38,6
25c	On the informed consent form for the anesthetic is the type of anesthetic clearly stated? (if a surgical procedure was undertaken)	57,2	42,8
25d	On the informed consent form for the anesthetic is the date of the anesthesia clearly stated? (if a surgical procedure was undertaken)	94,5	5,5
26	Did the patient undergo an invasive procedure?	27,9	72,1
27	Is the informed consent of the patient for the invasive procedure present?	84,7	15,3
27a	Is the signature of the patient present on the informed consent form for an invasive procedure? (if an invasive procedure was undertaken)	98,1	1,9
27b	Is the signature of the doctor present on the informed consent form for an invasive procedure? (if an invasive procedure was undertaken)	65,8	34,2
27c	On the informed consent form for the invasive procedure was the type of procedure undertaken clearly stated? (if an invasive procedure was undertaken)	93,5	6,5
27d	On the informed consent form for the invasive procedure was the date of procedure clearly stated? (if an invasive procedure was undertaken)	96,8	3,2





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28	Is an informed consent form for anesthetic	67,5*	32,5
	present? (if an invasive procedure was		
	undertaken)		
28a	Is the signature of the patient present on the	100,0	0,0
	informed consent form for anesthetic? (if an		
	invasive procedure was undertaken)		
28b	Is the signature of the anesthetist present on the	63,0	37,0
	informed consent form for anesthetic? (if an		
	invasive procedure was undertaken)		
28c	On the informed consent form for the	59,3	40,7
	anesthetic is the type of anesthetic clearly stated?	,-	
	(if an invasive procedure was undertaken)		
28d	On the informed consent form for the	98,1	1,9
204	anesthetic is the date of the anesthesia clearly	70,1	1,7
	stated? (if an invasive procedure was		
	undertaken)		
29	Is a cardiology assessment present?	90,7	9,3
30	Is the anesthesia documentation or file present	84,1	15,9
30	or attached?	04,1	13,3
30a	In the anesthesia, documentation or file is the	98,8	1,2
30a		70,0	1,2
	intra-operative monitoring included (if an anesthetic was administered)?		
21	·	07.4	2.6
31	In the operating report is the first surgeon	97,4	2,6
22	identifiable? (the name must be legible?)	00.0	2.0
32	In the operating report is the date of the	98,0	2,0
	procedure clearly stated		
33	In the operating report is the type of the	98,0	2,0
- /	procedure undertaken clearly stated?		
34	Is the anatomical pathology report present? (if a	87,3	12,7
	request for a surgical or biopsy procedure was		
	made)		
35	Is an operating theatre security checklist present?	78,7	21,3
35a	If yes, is the operating theatre security checklist	89,1	10,9
	signed or initialed by the surgeon?		
35b	If yes, is the operating theatre security checklist	91,9	8,1
	signed or initialed by the anesthetist?		
35c	If yes, is the operating theatre security checklist	95,7	4,3
	signed or initialed by the nurse?		
36	Was a thromboembolic prophylaxis performed	66,5	33,5
	on the patient who underwent the surgical		
	procedure?		
36a	If NO is a reason clearly stated on file?	22, 8	77,2
37	Is the discharge summary present? (always)	81,2	18,8
37a	Is the discharge summary dated? (always)	99,2	0,8
37b	Is the reporting doctor identifiable (legible)?	82,6	17,4





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ID	CRITERION	PERCEN	TAGE %
		YES	NO
37c	Is there a descriptive summary of the Medical history? (always)	86,1	13,9
37d	On the discharge card is the reason for hospitalization clearly stated?	99,6	0,4
37e	Does the discharge card include details of the physical examinations and the development of the clinical situation?	79,1*	20,9
37f	Does the discharge card include the diagnosis upon discharge and co-morbidity?	89,9*	10,1
37g	Does the discharge card include the diagnostic and therapeutic procedures followed?	96,5	3,5
37h	Does the discharge card describe the patient's condition upon discharge?	77,9	22,1
37i	Does the discharge card detail the pharmaceutical therapy to be taken at home?	99,2	0,8
371	Does the discharge card specify eventual follow-up?	97,1	2,9
38	Does the clinical file include Consultant referrals and/or reports?	75,8	24,2
38a	Are any consultant reports signed legibly and stamped with the Consultant's name?	98,3*	1,7
38b	Are consultancy reports legible?	99,0	1,0

Legend: ^PARTIAL EVALUATION; *The result include YES and PARTIAL EVALUATION.