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 doctor?	89,5	10,5
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

16a	All the vital signs are measured daily?	38,9*	61,1
17	Is pain intensity assessed in the file? (only if the evaluation of pain scale is present)	25, 4	74,6
17a	Is pain intensity assessed on a daily basis?	76,8*	23,2
18	Is there an evaluation of the water balance? (at least one day)	40,2	59,8
19	Is the daily diary present? (always)	96,7	3,3
19a	Is the daily diary present and annotated for each day in hospital? (always)	86,0	14,0
19b	Are the annotations in the daily diary signed/initialed? (always)	48,7	51,3
20	Is the nursing card present in the clinical file?	8,9	91,1
20a	If the nursing card is present is it annotated for each day in hospital?	72,9	27,1
20b	If yes are the annotations on the nursing card signed/initialed? (in the wards where they are adopted)	49,2	50,8
21	Is the order sets paper (for medication therapy management) present?	90,5*	9,5
21a	Is the order sets paper legible?	99,7	0,3
21b	The prescription or suspension of pharmaceuticals are signed or initialed by a doctor?	92,9*	7,1
21c	Are the date and time of the prescription recorded? (in the wards where they are adopted)	93,7*	6,3
21d	Are the date and time of the administration recorded?	96,4*	3,6
21e	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)	80,9	19,1
21f	Has the nurse signed or initialed to confirm the administration? (in the wards where they are adopted)	91,2	8,8
21g	Are the allergies reported on medication therapy management?	64, 3	35,7
22	Is the patient's informed consent specific for a transfusion present? (at least a copy	92,9	7,1
22a	If the patient received a transfusion is the card for the transfusion received present?	72,8	27,2
22b	Are the labels from the transfusion bags present in the clinical diary?	92,9	7,1
23	Did the patient undergo a surgical procedure?	40,7	59,3
24	Is the informed consent of the patient for the surgical procedure present?	97,4	2,6

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

28	Is an informed consent form for anesthetic present? (if an invasive procedure was undertaken)	67,5*	32,5
28a	Is the signature of the patient present on the informed consent form for anesthetic? (if an invasive procedure was undertaken)	100,0	0,0
28b	Is the signature of the anesthetist present on the informed consent form for anesthetic? (if an invasive procedure was undertaken)	63,0	37,0
28c	On the informed consent form for the anesthetic is the type of anesthetic clearly stated? (if an invasive procedure was undertaken)	59,3	40,7
28d	On the informed consent form for the anesthetic is the date of the anesthesia clearly stated? (if an invasive procedure was undertaken)	98,1	1,9
29	Is a cardiology assessment present?	90,7	9,3
30	Is the anesthesia documentation or file present or attached?	84,1	15,9
30a	In the anesthesia, documentation or file is the intra-operative monitoring included (if an anesthetic was administered)?	98,8	1,2
31	In the operating report is the first surgeon identifiable? (the name must be legible?)	97,4	2,6
32	In the operating report is the date of the procedure clearly stated	98,0	2,0
33	In the operating report is the type of the procedure undertaken clearly stated?	98,0	2,0
34	Is the anatomical pathology report present? (if a request for a surgical or biopsy procedure was made)	87,3	12,7
35	Is an operating theatre security checklist present?	78,7	21,3
35a	If yes, is the operating theatre security checklist signed or initialed by the surgeon?	89,1	10,9
35b	If yes, is the operating theatre security checklist signed or initialed by the anesthetist?	91,9	8,1
35c	If yes, is the operating theatre security checklist signed or initialed by the nurse?	95,7	4,3
36	Was a thromboembolic prophylaxis performed on the patient who underwent the surgical procedure?	66,5	33,5
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)? (always)	82,6	17,4

ID	CRITERION	PERCENTAGE %	
		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
37l	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.