

Assessing levels of documentation performance of the medical records during the first and third COVID-19 pandemic waves in Egypt

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Supplementary data

Physician assessment form

1. Patients and their families are informed of the consequences of refusing or not continuing treatment?
2. Patients and their families are made aware of their responsibilities to refuse or discontinue treatment?
3. Patients are informed of the available care and treatment alternatives?
4. All diagnoses are recorded and updated in the patient's medical file according to the results of examinations and re-evaluation?
5. Medical history and examination are completed in full and recorded in the patient's medical file within 24 hours from the time of admission according to the hospital policy?

6. The doctor's notes regarding the development of patients with acute diseases are recorded at least once a day?
7. Physician's notes regarding the progression of patients with chronic diseases are recorded once a day?
8. A specific process is performed to obtain a complete list of the patient's current treatment upon admission, and document this with the patient's participation?
9. The patient gets a complete list of the treatment he should take after discharge from the hospital?
10. The presence of a doctor's order regarding the type of food, as well as the presence of a label on the type of nutrition on the first page of the file?
11. Patients near death model (in intensive care unit): Dealing with the needs and desires of dying patients (pain and psychological needs) is implemented and documented?
12. Restriction and isolation are used based on an order from the treating physician restriction order?
13. Restriction orders made for medical and surgical reasons must be renewed every 24 hours at least, based on the continued need for them (restriction order)?
14. The process of giving blood and its derivatives is carried out and followed up in accordance with the policies and procedures?
15. Process steps for receiving verbal and telephone orders and reports of critical examination results (oral order form) are applied?

16. The patient gets a list of the treatment that he should take after the referral or transfer outside the hospital, in order to present it to the follow-up to providing health care services to him outside the hospital?
17. The medical file for each patient includes at least the following: (the time of the patient's arrival and the time of discharge, the final results at the end of treatment, the patient's condition upon discharge, the patient's destination upon discharge, the medical care instructions for following up on the patient's condition?)

Nurse assessment form

1. Declaration form of consent to hospitalization and treatment and the rights and duties of the patient?
1. Patients are informed of their rights in a way that they can understand?
2. Patients are informed of their duties and agreed to abide by them?
3. A general acknowledgment is taken of the patient's consent to receive treatment upon admission to the hospital?
4. When a declaration of consent is taken from a person other than the patient, this is done in accordance with the laws and regulations and is documented?
5. The nursing assessment is recorded in the patient's medical file during the shift during which he entered?
6. A nursing reassessment including pain assessment, general condition, vital signs, and skin condition is recorded every shift?
7. Each patient's fall risk is assessed, including the potential risk associated with the patient's treatment regimen, and this assessment is regularly reassessed?

8. The patient's risk of developing bedsores is assessed and documented?
9. All patients are examined for the extent of pain at least once in each shift or as ordered by the attending physician?
10. The type, location and severity of the pain are evaluated and recorded in the patient's medical file if pain is present?
11. X-ray and Lab reports are available at the appointed times?
12. All lab results and reports have a specific reference range (normal ranges) for each age and sex; if applicable?
13. The process of giving blood and its derivatives is followed up in accordance with the policies and procedures?
14. Doctor's order to give blood, consent declaration for blood transfusion, blood transfusion follow-up form)?
15. Each drug dose that was given is recorded (Medication Sheet Form)?
16. There is a medical file with a unified number for each patient who underwent examination and treatment?
17. At least two methods are used to identify the patient: (patient's full name and file number on all medical file papers)?
18. Process steps for receiving verbal and telephone orders and reports of critical examination results (the oral order form) are applied?
19. Patients subject to restriction for medical and surgical reasons are followed up at least every two hours and this is recorded?

20. Patients with urgent and urgent needs shall have the priority of evaluation and treatment according to the specifications (the presence of the color of the classification on the emergency ticket)?
21. The medical file for each patient includes at least the following: (patient's arrival time and discharge time, final results at the treatment end time, patient's condition upon discharge, patient's destination upon discharge, medical care instructions for the following up on the patient's condition, the discharge order is documented by the treating physician)?