**Inpatient Medical Record Quality Scoring Table**

Name: Branch: Bed No.: Inpatient No.: Ward:

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Record Content | | Department self-evaluation | Hospital Score |
| 1. Home Page and Fascia Column (5 points) | |  |  |
| Two, admission records (20 points) | |  |  |
| 3. Course record 40 minutes | 1. First Chronology (6 points) |  |  |
| 2. Records of ward rounds by superior doctors (including records of first ward rounds by superior doctors and records of daily ward rounds by superior doctors) (10 points) |  |  |
| 1. General course records (including daily course records, invasive diagnosis and treatment operation records, consultation records, difficult case discussion records, rescue records, shift records, transfer records, stage summary, nursing records of critically ill and critically ill patients) (12 points) |  |  |
| 1. Perioperative records (including preoperative summary, preoperative discussion, preoperative visit records, anesthesia records, surgical records, surgical safety verification records, surgical inventory records, postoperative course records, postoperative visit records) (12 points) |  |  |
| 4. Discharge records or death records (including death records and death case discussion records) (8 points) | |  |  |
| 5. Medical informed consent and proxy (10 points) | |  |  |
| 6. Medical orders, auxiliary examinations and body temperature sheets (12 points) | |  |  |
| Seven, other basic writing requirements (5 points) | |  |  |
| Total score: 100 | | Department score:  Fen | Hospital score:  Fen |
| Signature of department assessor: Signature of hospital assessor: | | | |

**Rules for scoring the quality of inpatient medical records (total score of 100 points)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (1) First page of medical record: 5 minutes | | | | | | | | | | | | |  |
| Writing Items | Inspection Requirement | | | | Deduction Standard | | | | | | | | Deduction Score  /Rating |
| First page of medical record | All items are completed completely, correctly and regularly. | | | | The name, sex, ID number, contact person and contact method, address, blood type and other important information in the front page are wrongly written or omitted. | | | | | | | | 2 |
| Diagnostic and surgical operation names are not filled in or filled in incorrectly | | | | | | | | 5 |
| Left and right errors in the front page and medical records lead to serious consequences. | | | | | | | | Class C |
| Other items are not filled in or filled in incorrectly or not standardized. | | | | | | | | 0.2 Per Office |
| The first page lacks the signature of the head of the department or treatment team. | | | | | | | | 1 |
| (II) admission records: 20 MINUTES | | | | | | | | | | | | | |
| Writing Items | | | Inspection Requirement | | | | | | Deduction Standard | | Deduction Score  /Rating | | |
| Admission Record | | | The admission record shall be completed by the medical practitioner within 24 hours after the patient's admission. The written form shall meet the requirements. | | | | | | Absence of admission records (or failure to complete within 24 hours) or non-practicing physician writing | | Class C | | |
| Writing form does not meet the requirements | | 1 | | |
| 1. General 2. Project | | | Complete and accurate filling | | | | | | Missing items or errors or irregularities | | 0.5/item | | |
| 2. Principal complaint | | | (1) Not more than 20 words, capable of deriving a first diagnosis | | | | | | More than 20 words, no first diagnosis exported | | 1 | | |
| (2) Symptoms and duration, in principle, do not need to replace the name of the diagnosis. | | | | | | The chief complaint is not standardized or replaced by a diagnosis and symptoms are found in the current medical history. | | 1 | | |
| 3. Present medical history | | | (1) Incidence: Record the time, place, onset, prodromal symptoms, possible causes or incentives. | | | | | | Lacking an item | | 1/Term | | |
| (2) The characteristics of the main symptoms and their development and changes: Describe the location, nature, duration, degree, alleviating or aggravating factors of the main symptoms according to the sequence of occurrence, and the evolution and development of the main symptoms. | | | | | | Lacking an item | | 1/Term | | |
| (3) Concomitant symptoms: Record the concomitant symptoms and describe the relationship between the concomitant symptoms and the main symptoms. | | | | | | Lacking an item | | 1/Term | | |
| (4) The course and results of diagnosis and treatment since the onset of the disease: Record the detailed course and effect of examination and treatment in the hospital and outside the hospital from the onset of the disease to the admission. | | | | | | An item does not meet the requirements. | | 0.5/item | | |
| (5) The general situation since the onset of the disease: briefly record the mental state, sleep, appetite, urine and stool, weight and so on after the onset of the disease. | | | | | | An item does not meet the requirements. | | 0.5/item | | |
| (6) Other diseases that are not closely related to the disease but still need to be treated shall be recorded in a separate paragraph after the current medical history. | | | | | | An item does not meet the requirements. | | 0.5/item | | |
| 4. Past History | | | Record general health, history of disease, infectious disease, vaccination, surgical trauma, blood transfusion, food or drug allergy, etc. | | | | | | Lack of content | | 1/Term | | |
| Defective recording | | 0.5/item | | |
| 5. Personal history, marriage and childbearing history, menstrual history and family history | | | (1) Record the place of birth and long-term residence, living habits and hobbies such as smoking, alcohol and drugs, occupation and working conditions, contact history of industrial poisons, dust and radioactive substances, and travel history. | | | | | | Lack of personal history or omission of personal history related to diagnosis and treatment | | 1/Term | | |
| Defective recording | | 0.5/item | | |
| (2) Marital status, age at marriage, health status of spouse, children, etc. The age of menarche, days of menstruation, days of interval, time of last menstruation (or age of amenorrhea), amount of menstruation, dysmenorrhea and fertility were recorded in female patients. | | | | | | History of lack of marriage and childbearing and history of menstruation | | 1/Term | | |
| Defective recording | | 0.5/item | | |
| (3) The health status of parents, brothers and sisters, whether they have similar diseases with patients, and whether they have familial hereditary diseases. | | | | | | Family History Deficiency | | 1/Term | | |
| Missing items or deaths in the family, no cause of death described | | 0.5/item | | |
| 6. Physique  Check | | | (1) Complete items, including body temperature, pulse, respiration, blood pressure; general information, skin, mucosa, superficial lymph nodes of the whole body, head and organs, neck, chest (chest, lungs, heart, blood vessels), abdomen (liver, spleen, etc.), rectum and anus, external genitalia, spine, limbs, nervous system, etc. | | | | | | Lack of any examination records of head, neck, chest, abdomen, spine, limbs and nervous system | | 0.5 ~ 1/Term | | |
| (2) The physical examination items related to the present medical history of the chief complaint are described emphatically, and the physical examination items related to differential diagnosis are sufficient. | | | | | | Insufficient physical examination items related to this hospitalization | | 2/Term | | |
| (3) The examination was comprehensive and correct. Detailed physical signs related to differential diagnosis were recorded. | | | | | | Missing important positive signs and missing negative signs with differential diagnostic significance | | 2/Term | | |
| 1. Auxiliary   Check | | | Record the main examination related to this disease and its results before admission. State the date of examination, and indicate the name and number of the examination hospital. | | | | | | There is no record of the auxiliary inspection results or the record is defective. | | 1/Term | | |
| 8. Preliminary diagnosis, admission diagnosis | | | The diagnosis is reasonable, the name of the disease is standardized, and the primary and secondary diagnosis is clear. | | | | | | Lack of preliminary diagnosis | | 2 | | |
| Irrational, irregular, or defective diagnosis; diagnosis is replaced only by symptoms or signs. | | 1 | | |
| The patient was admitted to the hospital within 48 hours of diagnosis by the attending physician. | | | | | | Absence of admission diagnosis (or failure to complete within 48 hours of admission) | | 4 | | |
| 1. Doctor   Signature | | | Written and signed by a licensed physician in our hospital | | | | | | No doctor's signature | | 1 | | |
| (3) Course record: 40 minutes | | | | | | | | | | | | | |
| Writing  Project | Inspection Requirement | | | | | | Deduction Standard | | | | Deduction/Rating | | |
| 1. First Course Record | (1) It is completed by the doctor on duty or the doctor on duty within 8 hours of the patient's admission. | | | | | | Absence of first course notes or not completed within 8 hours of admission or non-practicing physician writing first course notes | | | | Class C | | |
| (2) Characteristics of the case: The characteristics of the case, including the positive findings and the negative symptoms and signs with differential diagnostic significance, etc., should be written after a comprehensive analysis, induction and collation of the medical history, physical examination and auxiliary examination. | | | | | | One item was missing or the contents of the hospital admission records were not summarized and refined. | | | | 2/Term | | |
| (3) Diagnostic basis and differential diagnosis (analysis of proposed diagnosis): according to the characteristics of the case, put forward the preliminary diagnosis and diagnostic basis; write out the differential diagnosis and analysis of the unknown diagnosis; analyze the next step of diagnosis and treatment measures; analyze the next step of diagnosis and treatment measures | | | | | | A writing defect (insufficient analysis and discussion, insufficient differential diagnosis, no specific content of the diagnosis and treatment plan, no evaluation content, etc.) | | | | 2/Term | | |
| (4) Diagnosis and treatment plan: put forward specific examination and treatment measures. | | | | | |
| 2. Daily course notes | (1) Critical patients write at any time according to the change of their condition, at least once a day, and the time is recorded to minutes. Serious patients record at least once every 2 days. Stable patients record at least once every 3 days. | | | | | | Critical patients did not record the course of disease according to the regulations. | | | | 2/4 | | |
| The patients with stable condition did not follow the prescribed course record. | | | | 1/Times | | |
| (2) The course of disease was recorded continuously for three days after the new patient was admitted. | | | | | | Course of disease of new patient was not recorded continuously for 3 days after admission. | | | | 2/4 | | |
| (3) Record the patient's condition change, including the patient's conscious symptoms and signs, and analyze the reasons. | | | | | | No timely recording of changes in the condition, observation records without pertinence, no analysis and treatment of new positive findings. | | | | 1/Times | | |
| (4) Recording the important auxiliary examination results and their clinical significance | | | | | | Failure to record important or abnormal inspection results or to analyze, judge and deal with them | | | | 1/Times | | |
| (5) Record the medical measures taken, the contents of the doctor's orders and the reasons for the changes. | | | | | | No record of the treatment measures adopted, no description of the change of drugs and treatment methods | | | | 1/Times | | |
| (6) Record the important matters and wishes of informing the patients and their close relatives, and ask the patients to sign if necessary. | | | | | | No notification to patients was recorded | | | | 1/Times | | |
| (7) The course record written by the intern must be signed and corrected by the superior doctor according to the prescribed time limit. | | | | | | Failure to sign within the prescribed time limit | | | | 0.5 per session | | |
| (8) On the day of blood transfusion, the course of disease, the type and amount of blood transfusion, and whether there were transfusion reactions were recorded. | | | | | | No record or defective record in the course record | | | | 1/Times | | |
| (9) The course of the disease should be evaluated and agreed by the superior physician within 24 hours before discharge. | | | | | | No discharge history and evaluation content. | | | | 2/4 | | |
| 3. Record of the first ward round by a superior physician | (1) The patient completes the ward round record of the superior doctor within 48 hours of admission. | | | | | | Absence of records of first rounds by superior physicians or failure to complete within 48 hours of admission | | | | Class B | | |
| (3) Record the name, professional and technical position, supplementary medical history and signs of the superior doctor, and analyze the causes. | | | | | | No ward rounds by superior doctors were recorded, or there were no supplementary contents for medical history and signs, and no evaluation contents for the condition. | | | | 2/Term | | |
| (5) Record the analysis of the diagnosis basis and differential diagnosis and the diagnosis and treatment plan of the superior doctors. | | | | | | No necessary analysis and discussion, no differential diagnosis. | | | | 2/Term | | |
| Insufficient analysis or copy of first course notes | | | | 1 ~ 2/Term | | |
| 4. Record of routine superior physician rounds | Record the doctor's name, professional and technical position, analysis of the condition and opinions on diagnosis and treatment, etc. | | | | | | No content, no analysis, no diagnosis and treatment opinions | | | | L ~ 2/Times | | |
| 5. Record of invasive diagnosis and treatment | Write immediately after the completion of the operation, including the operation name, operation time, operation steps, results and the general situation of the patient, record whether the process is smooth, whether there are adverse reactions, postoperative precautions and whether to explain to the patient, the operator's signature | | | | | | No record of invasive procedure | | | | Class B | | |
| Intimely or incomplete recording | | | | 0.5 ~ 1/time | | |
| 6. Record of consultation | (1) Regular consultation should be completed within 48 hours, emergency consultation should be attended within 10 minutes, and consultation records should be completed immediately after consultation. | | | | | | Consultant's orders, no record of consultation | | | | Class B | | |
| (2) Record of application for consultation: The patient's condition and diagnosis and treatment, the reason and purpose of applying for consultation, and the signature of the doctor applying for consultation shall be briefly stated. | | | | | | There are omissions or defects in the writing of the consultation record. | | | | 1 ~ 2 times | | |
| (3) Consultation records: including consultation opinions, the name of the department or medical institution where the consultant is located, the consultation time and the signature of the consultant, etc. | | | | | |
|
| (4) The doctor applying for consultation should record the implementation of the consultation opinion in the course record. | | | | | | Failure to record the implementation of the consultation opinion in the course record | | | | 1 ~ 2 times | | |
| 7. Notes of discussion of difficult cases | To discuss the cases with difficulty in diagnosis or inexact curative effect in time, including the date of discussion, the host (department director or doctor above the deputy high school), the names and professional and technical positions of the participants, the specific discussion opinions and the summary opinions of the host, etc. | | | | | | Cases with difficulty in diagnosis or uncertain efficacy were not discussed. | | | | Class B | | |
| The content of the record is simple or without analysis or the content is obviously defective. | | | | L ~ 2/Times | | |
| 8. Rescue Records | Six hours after the completion of the rescue. The contents include the changes of the patient's condition, the rescue time and measures, the names and professional titles of the medical staff participating in the rescue, etc. The time should be recorded in minutes. | | | | | | There is no record of rescue or rescue is not completed within 6 hours after the end of rescue. | | | | Class B | | |
| The writing is defective. | | | | 1/Times | | |
| Evaluation of emergency condition of critically ill patients after emergency treatment | | | | 2/4 | | |
| 9. Shift handover records, transfer records, stage details | (1) Handover record: The handover doctor and the handover doctor respectively summarize the patient's condition and diagnosis and treatment, the handover record is completed before the handover, and the handover record is completed within 24 hours after the handover, and the contents meet the requirements. | | | | | | Absence and handover records, transfer records, stage summaries or not completed on time or handover and handover, transfer and transfer records are the same. | | | | 2/4 | | |
| (2) Transfer record: The transfer record is completed before the transfer, and the entry record is completed within 24 hours after the patient enters the department, and the content meets the requirements. | | | | | |
| (3) stage summary: The patient stays in hospital for a long time, and the doctor must summarize the patient's condition every month, including the date of admission, the date of discharge, the patient's name, sex, age, chief complaint, admission situation, admission diagnosis, diagnosis and treatment process, current situation, current diagnosis, diagnosis and treatment plan, doctor's signature, etc. | | | | | | Summary of missing stages | | | | Class B | | |
| Lack of content or writing defects in the assessment of illness | | | | 1 ~ 2 times | | |
| 10. Care of seriously (critically) ill patients | (1) Written by nurses according to the nursing characteristics of corresponding specialties | | | | | | Lack of nursing records for seriously ill (critically ill) patients | | | | Class C | | |
| (2) The contents shall include the patient's name, department, inpatient's medical record number (or medical record number), bed number, page number, record date and time, fluid volume, body temperature, pulse, respiration, blood pressure and other observation of the patient's condition, nursing measures and effects, and the nurse's signature, etc. The record time shall be specified to minutes. | | | | | | Missing or nonstandard | | | | 0.5/item | | |
| 11. Preoperative summary | The summary of the patient's condition by the physician before the operation of grade 1 or above, including the brief condition, preoperative diagnosis, surgical indications, names and methods of the operation to be performed, methods of anesthesia to be applied, matters needing attention, and recording the relevant situation of the patient before the operation | | | | | | PREOPERATIVE SUMMARY OF ABSENCE | | | | 5 | | |
| Defect, omission, etc | | | | 0.5 per session | | |
| 12. Minutes of preoperative discussions | (1) The preoperative discussion of grade 1 and above should be completed within 24 hours before operation. The preoperative discussion of grade 1 ~ 2 should be carried out by the treatment group according to the situation, and the preoperative discussion of grade 3 ~ 4 and above should be carried out by the critical, disabled, new operation and special operation. | | | | | | Those who did not have the required preoperative discussion or surgery did not participate. | | | | Class C | | |
| (2) to discuss the operation mode, the possible problems and the corresponding measures. | | | | | | Insufficient discussion on surgical methods or intraoperative possible problems and countermeasures | | | | 2/4 | | |
| (3) The contents include preoperative preparation, surgical indications, surgical schemes, possible accidents and preventive measures, names and professional and technical positions of participants in the discussion, specific discussion opinions and summary opinions of the moderator, date of discussion, signature of the recorder, etc. | | | | | | Missing entries or defective records | | | | 0.5 per session | | |
| (4) Special, major and new operations must be applied for by the department and submitted to the Medical Affairs Department for examination and approval. | | | | | | Lack of approval | | | | Class B | | |
| (5) Consultation or operation with experts outside the hospital must be applied for by the department and submitted to the Medical Affairs Department for examination and approval. | | | | | | Lack of approval | | | | Class B | | |
| 13. Surgical records | (1) Written by the operator and completed within 24 hours after the operation; under special circumstances, when written by the first assistant, the operator must sign. | | | | | | Missing surgical records or not completed within 24 hours after surgery | | | | Class C | | |
| An assistant writes the signature of the missing surgeon. | | | | 5/Times | | |
| (2) Including general items (patient's name, gender, department, ward, bed number, hospitalization record number or case number), operation date, preoperative diagnosis, intraoperative diagnosis, operation name, operator and assistant name, anesthesia method, operation process, intraoperative situation and treatment, etc. | | | | | | Missing or nonstandard | | | | 0.5/item | | |
| (3) The medical records of those who use human implants should include the registration form for the use of implanted medical devices (including bar codes). | | | | | | Registration Form for Use of Implanted Medical Devices (including Bar Code) | | | | Class C | | |
| 14. First postoperative history | (1) It was completed by the doctor who participated in the operation immediately after the operation and recorded for three consecutive days. | | | | | | Absence of First Postoperative Course Record | | | | Class B | | |
| Three postoperative absence of postoperative course record. | | | | 2/4 | | |
| (2) The contents include operation time, intraoperative diagnosis, anesthesia mode, operation mode, brief course of operation, postoperative treatment measures, and matters needing special attention and observation after operation, etc. | | | | | | Missing or nonstandard | | | | 0.5/item | | |
| 15. Anesthesia preoperative interview record | (1) Grade 1 and above operations are performed by an anesthesiologist. Preoperative visits and preanesthesia evaluations are performed. | | | | | | Anesthesia preoperative interview record | | | | Class C | | |
| Anesthesia Absence Assessment Record | | | | 2 | | |
| (2) Including name, sex, age, department, case number, patient's general condition, brief medical history, auxiliary examination results related to anesthesia, mode of operation to be performed, mode of anesthesia to be performed, anesthesia indication and problems to be paid attention to in anesthesia, preoperative anesthesia doctor's order, anesthesiologist's signature and date to be filled in | | | | | | Missing or nonstandard | | | | 0.5/item | | |
| 16. Anesthesia records | (1) The operation of grade 1 or above shall be performed by the anesthesiologist and the patient's condition shall be evaluated during anesthesia. | | | | | | Lack of anaesthesia record | | | | Class C | | |
| Assessment of Anesthesia Deficiency | | | | 2 | | |
| (2) The content includes the general situation of the patient, the special situation before operation, the medication before anesthesia, the diagnosis before operation, the diagnosis during operation, the mode and date of operation, the mode of anesthesia, the time of anesthesia induction and the beginning and end of each operation, the name, mode and dose of medication during anesthesia, the special or unexpected situation and treatment during anesthesia, the time of operation starting and ending, the signature of anesthesiologist, etc. | | | | | | Missing or nonstandard | | | | 0.5/item | | |
| 17. Records of post-anaesthetic visits | (1) The operation of grade 1 or above is completed by the anesthesiologist after operation, and the condition of the patient is evaluated after anesthesia. | | | | | | Postoperative interview record of anaesthesia | | | | Class C | | |
| Post-anaesthesia assessment record | | | | 2 | | |
| (2) Including name, sex, age, department, case number, general condition of the patient, recovery of anesthesia, awake time, doctor's order after operation, whether to remove tracheal intubation, etc., if there are special circumstances, detailed records should be recorded, and the date signed and filled in by the anesthesiologist. | | | | | | Missing or nonstandard | | | | 0.5/item | | |
| 18. Record of surgical risk assessment | (1) The surgeon, anesthesiologist and itinerant nurse shall evaluate the risk of operation within 24 hours before operation, and sign in the corresponding column after evaluation. | | | | | | Lack of surgical risk assessment records | | | | Class C | | |
| (2) The standard of surgical risk is calculated according to the three variables of surgical incision cleanliness, anesthesia grade and surgical duration. | | | | | | Incomplete items or irregular records | | | | 0.5/item | | |
| 19. Record of surgical safety checks | (1) Check, confirm and sign by the surgeon, anesthesiologist and itinerant nurse before the implementation of anesthesia, before the start of operation and before leaving the room. | | | | | | Absence of operation safety check record | | | | Class C | | |
| (2) Check the patient's identity, surgical site, surgical method, anesthesia and surgical risk, and count the items used in the operation. Patients with blood transfusion should also check the blood type and blood volume. | | | | | | Missing party verification signature/verification item is incomplete or record is not standardized | | | | 0.5/item | | |
| 20. Inventory of surgical articles and instruments | (1) Intracavitary surgery must have an inventory record of surgical articles and instruments, which shall be completed immediately by the operator, the instrument nurse and the itinerant nurse before the end of the operation. | | | | | | Lack of inventory records of surgical articles and instruments | | | | Class C | | |
| 21. Notice of critical illness (serious) | The critical (serious) notice should be completed in two copies, one for the patient and one for the medical record. | | | | | | Notice of doctor's advice without serious illness (serious illness) | | | | Class B | | |
| Fill in nonstandard or missing items | | | | 0.2 Per Office | | |
| (4) Discharge records, death records (death case discussion records and related records) 8 points | | | | | | | | | | | | | |
| (1) Discharge records are completed within 24 hours after discharge. | | | | | | | Absence of discharge records or failure to complete within the prescribed time | | | | | Class C | |
| (2) The death record is completed within 24 hours after the death of the patient. | | | | | | | Lack of death records or failure to complete within the prescribed time | | | | | Class C | |
| (3) The discharge (death) records include the date of admission, the time of discharge (death), the situation of admission, the diagnosis of admission, the course of diagnosis and treatment, the diagnosis of discharge (death), the situation of discharge and the doctor's order (cause of death), etc. | | | | | | | Missing or nonstandard | | | | | 0.5/item | |
| The discharge doctor's order is not specific (the name, dosage, usage, total amount of medication, follow-up requirements and matters needing attention are not specified). | | | | | 1 ~ 2/Term | |
| (3) The basis of discharge diagnosis is sufficient, the diagnosis is comprehensive and clear, and the discharge doctor's advice is reasonable and standardized. | | | | | | | Defective recording | | | | | 1 ~ 2 points | |
| (4) The discharge (death) record should be signed by the superior physician. | | | | | | | Lack of signature of superior physician | | | | | 2 | |
| (5) The record of case discussion should be completed within one week after the death of the patient. | | | | | | | Lack of a record of death discussions or failure to complete them within the prescribed time | | | | | Class C | |
| (6) The discussion record of the death case shall be presided over by the director of the department or a doctor with a deputy high school or above, and the contents shall include the date of discussion, the names of the moderator and the participants, the professional and technical positions, the specific discussion opinions and the summary opinions of the moderator, and the signature of the recorder, etc. | | | | | | | Insufficient analysis and discussion | | | | | 2 | |
| Record nonstandard or defective | | | | | 1 | |
| (7) The deathbed electrocardiogram must be included in the death case history, and the bed number, name, sex and time must be indicated. | | | | | | | Dying electrocardiogram | | | | | 2 | |
| (8) Death medical certificate must be included in the death medical record. | | | | | | | Lack of Medical Certificate of Death | | | | | Class B | |
| (9) The time of death records of patients in death medical records are consistent (death rescue records, doctor's advice, temperature records, death records, critical patient care records, death electrocardiogram, death medical certificates, death discussion records, etc.) | | | | | | | There is a time inconsistency. | | | | | Class B | |
| (V) Informed consent: 10 points | | | | | | | | | | | | | |
| Writing Items | | | | Inspection Requirement | | Deduction Standard | | | | | | Deduction/Rating | |
| Informed Consent | | | | (1) All medical activities requiring written consent of patients, such as operation, anesthesia, blood transfusion, radiotherapy, chemotherapy and special examination (treatment), shall be carried out with the informed consent signed by the patients. | | Lack of informed consent | | | | | | Class C | |
| Only the patient signed wuhuanfang signed the opinion. | | | | | | 5 | |
| (2) Specification for recording of informed consent for operation, anesthesia, blood transfusion, radiotherapy, chemotherapy and special examination (treatment), including project name, possible complications, risks, patient's opinion and signature, doctor's signature, etc. | | Lack of items or content is not comprehensive, writing is not standardized. | | | | | | 1 ~ 2/Term | |
| (3) Because of the limitation of the protective medical system, the patient himself can not sign the informed consent, he must authorize the client to sign the informed consent, but he must have the power of attorney. | | Lack of requisite power of attorney | | | | | | Class C | |
| The signature of the relative or related person is inconsistent with the signature of the power of attorney. | | | | | | Class B | |
| (6) 12 points for doctor's orders, auxiliary examination reports and temperature sheets | | | | | | | | | | | | | |
| Writing Items | | Inspection Requirement | | | | Deduction Standard | | | | Deduction/Rating | | | |
| 1. Medical Advice Sheet | | (1) The contents of medical orders shall be accurate, clear and standardized, and each medical order shall contain only one content, and the contents of non-medical orders shall be prohibited. | | | | One does not meet the requirements. | | | | 0.5 percent | | | |
| (2) Each doctor's order shall have a clear time for issuance, termination and execution. It shall be signed by the doctor and the nurse. | | | | Missing Signature | | | | Class B | | | |
| (3) When it is necessary to cancel the doctor's order, mark the word "cancel" in red ink and sign it. | | | | Cancellation of doctor's orders is not standardized | | | | 0.5 percent | | | |
| 2. Auxiliary inspection report form | | (1) The auxiliary examination report sheet is consistent with the doctor's order, and the report sheet is complete without omission. | | | | Inconsistent or missing reports of significant value to the diagnosis and treatment | | | | Class B | | | |
| (2) The auxiliary examination results of other recognized hospitals shall be the original or photocopy of the report form in the medical records. | | | | Missing a report card | | | | 1 | | | |
| (3) Routine examination items (blood routine, liver function, blood type, hepatitis items, HIV antibody, syphilis antibody) should be given to patients who have received blood transfusion (including blood preparation). | | | | Lack of routine examination items before blood transfusion | | | | Class C | | | |
| (4) Complete routine auxiliary examination items (blood, urine and stool routine, bleeding and clotting time, virus items, liver and kidney functions, electrocardiogram, chest radiograph, etc.) Before operation in surgical cases. | | | | Related check items not completed | | | | 0.5/item | | | |
| (5) Each auxiliary inspection report sheet has complete items, standardized contents and pasted specifications. | | | | Incomplete or irregular content of report form | | | | 0.5/sheet | | | |
| 3. Body temperature | | Body temperature list complete, complete content, writing norms. | | | | There is a defect in the temperature record. | | | | 0.5 percent | | | |
| (7) Basic requirements for writing: 5 points | | | | | | | | | | | | | |
| Writing  Project | Inspection Requirement | | | | | | | Deduction Standard | | Deduction/Rating | | | |
| Writing  Basic  Request | 1. It is strictly forbidden to alter or forge the contents of medical records. The medical records printed by the computer meet the requirements of medical records writing. It is strictly forbidden to copy errors. | | | | | | | Serious errors caused by altering or falsifying the contents or copies of medical records. | | Class C | | | |
| 2. Obstetric medical records must have the footprints of the newborn and the right thumb of the mother, with accurate gender marking. | | | | | | | Lack of neonatal footprints and mother's right thumb prints, or neonatal gender error | | Class C | | | |
| 6. All kinds of records (including medical records printed by computer) shall be signed by the writing physician, and shall not be imitated or substituted. All kinds of records written by non-practicing physicians of our hospital shall be reviewed, revised and signed by practicing physicians of our hospital. | | | | | | | Missing Handwritten Signature | | Class B | | | |
| 3. Standardize the use of medical terminology; clear handwriting, smooth sentences, correct punctuation, standardized format; label page numbers, neat pages, each page has basic information such as patient name, case number, etc. Sort correctly, complete content, no lack of pages, few pages | | | | | | | Full page missing | | Class C | | | |
| Writing is not standardized, page sorting is wrong, page is not neat, etc. | | 0.5 percent | | | |
| 4. The content of the medical record is objective, and the same medical record must not be contradictory. | | | | | | | There are contradictions in the contents of the medical records. | | 1/2 | | | |
| 5. Date and time shall be written in Arabic numerals and recorded in a 24-hour system. Emergency medical records, course records of critically ill patients, rescue time, time of death and time of issuance of doctor's orders shall be recorded to minutes. | | | | | | | Records do not meet requirements | | 0.2 Per Office | | | |
| 7. When modifying, mark the wrong words with double lines, keep the original record legible, indicate the date of modification, and sign the modifier's signature. | | | | | | | Modify nonstandard | | 0.2 Per Office | | | |
| 8. Use a blue or black ink ballpoint pen with carbon black or blue black ink. Use a red ink pen to cancel the doctor's order. Use a red ink pen to review changes and sign. No more than three changes per page. | | | | | | | The color of the pen does not conform to the regulations. | | 0.2 Per Office | | | |