ORGANIZATIONAL MODEL IN FIRST AID: THE COORDINATOR, PROFESSIONAL GUIDE FOR THE ORGANIZATION AND MANAGEMENT OF ASSISTANCE, IN RELATION TO THE DESIGN, DRAFTING AND INTRODUCTION OF THE NURSING RECORD

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ABSTRACT

The reason why we have undertaken this type of work comes from having become aware of the profound state of discomfort experienced, and therefore it is possible to find the strength to take the real path, overcoming the current patterns, which unfortunately, still see the profession . for homework.
The multicentre study, carried out on the topic of Nursing Records, significantly accelerates the timing of this historic step, so that the culture of innovation, creativity and change is enhanced and embraced.
Analyzing the nursing work situation, I noted the need together with a group of colleagues and a coordinator, belonging to the same Hospital, to propose the inclusion of an innovative Nursing Record, so that a professional contribution was formed by the staff nursing and, from this, the activation of multidisciplinarity and, at the same time, the recognition of the usefulness of the role of the nursing figure and of the valid collaboration within the health team took off.
The working group was formed on a specific project, focused on the design and drafting of the Nursing Record, an operational tool designed and managed by the nurse (in collaboration with the coordinator), used to collect useful information regarding each patient individually.
This tool was indispensable for the elaboration of an assistance plan that takes into account the social, cultural and welfare context in which it is developed, guaranteeing the continuity of services.
Since it appears necessary for a Nursing Record to be built by the team , the need arises to have common indications regarding its design and drafting.

INTRODUCTION

The nurse is a professional figure who responds to the patient's evident and latent needs for assistance; to carry out these tasks he uses various tools.
Among these tools, the one that contributes most to the carrying out of the mission is the Nursing Record . This integrative, continuous and formally recognized tool is crucial for verifying the quality of the nursing services provided.
With the Nursing Folder we want to document which are the problems of the user, which are the interventions undertaken, which and how many are those carried out and with the achievement of which results.
This tool supports the need to control the relationship between demand for assistance (what are the levels of patient need) and response for assistance.
Furthermore, the law n. 43 of February 1, 2006, "Provision regarding the nursing, midwifery, rehabilitation, technical-health, prevention professions , delegation to the Government for the establishment of the related professional associations", opened a new and further season to the meaningful path of growth that nursing has had in the last decade.
There are many contents of this law that have recognized a new condition of nurses.
The first is the delegation that with article 3 is made to the Government so that the new professional Orders are created and the existing Colleges are transformed into Orders.

Premise

The reason why we have undertaken this type of work comes from having become aware of the profound state of discomfort experienced, and therefore it is possible to find the strength to take the real path, overcoming the current patterns, which unfortunately, still see the profession. for homework.
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History Of The Nursing Briefcase:
All those who work or have had work experience in the past in a
any hospital ward, they will have noticed how important it is to write down everything
it concerns every hospitalized patient. The annotation of the daily parameters, the recording
the diagnostic procedures carried out and the prescribed therapy are in fact essential for
have a complete and up-to-date picture on the state of well-being of patients e above all, they constitute an excellent method of communication between all the personnel responsible for their assistance and care at various levels.
It therefore emerges how important it is that this communication between doctors and nurses o between nurses on consecutive shifts is effective and occurs quickly, concise and always understandable using precise and detailed information.
In the 1980s, there were three tools used by the healthcare staff of each department to record all the data concerning the general state of the patients, various diagnostic tests prescribed and therapy: the notebook of the nursing report, the clinical diary and the medical record.
In the nursing report notebook, which was used only by staff nursing, therapy was copied (from the clinical diary), deliveries were reported nursing and all the procedures scheduled for the day were noted. Such instrument, in which sometimes there could be errors was not attached to the medical record.
The clinical diary, on the other hand, was used by both doctors and nurses, the latter there
they recorded vital signs (body temperature, pulse, blood pressure, alvus and diuresis while the doctors recorded the therapy, a summary of the visit, and the programming of the patients' procedures.
Finally, the medical record collected the remote pathological anamnesis, the next one, the
reason for hospitalization, data relating to the first visit, medications used at home and diagnosis
at the entrance. Each medical record in paper form corresponded to one in form IT: it consisted of a software that collected all the data of the original file, and at the time of discharge gave the possibility to print a letter of discharge which summarized: the diagnosis of entry, the procedures carried out during hospitalization the diagnosis of discharge and the therapy to be continued at home.
One last proposal for the future of the integrated medical-nursing record it concerns the entry of our country among those of the European union. It would be interesting indeed that this new medical record model was also introduced in other European hospitals.
The method of collecting patient data could thus be standardized as much as possible communication tool between doctors and nurses and allow for easier comparison e immediate between hospitals in countries other than ours in the management of clinical cases. This could furthermore, involve further modifications and improvements of this instrument brought about by the contribution of several health workers from different and consequently more varied working realities.

The concepts of "protocol", "standard", and "guidelines" are used in the context of nursing service documents with the following meanings:
- PROTOCOL: indicates a pre-defined pattern of diagnostic, therapeutic assistance, etc.

It refers to a sequence of very well defined behaviors as occurs within a clinical research program.
It is a rather rigid tool for explaining the lines of conduct considered
- STANDARD: refers to the threshold values (minimum or maximum) of a specific indicator or frequency of offer of a certain service or, again, of performance for a specific intervention. It has assumed a normative value which is frequently associated with an explicit judgment of the quality of assistance.

For example, there is an expected (standard) number of patients falling out of bed: if it is exceeded, the assistance or safety regulations in that context are probably not adequate.
- GUIDELINES: are recommendations of clinical behavior, produced through a systematic process with the aim of assisting healthcare personnel and assisted persons in deciding which are the most appropriate assistance modalities in specific clinical circumstances.

They are less rigid tools than protocols as they help the clinical decision, which is in any case left to the professional.
They are presented as a synthesis of available scientific information critically evaluated according to principles shared by professionals.

Objectives Of The Nursing Record
1) Systemic and written documentation of data, completeness of information.
2) Continuity of assistance.
3) Written care planning.
4) Quality assessment.
5) Application of a conceptual model.
6) Uniqueness and care planning.
7) Professional responsibility of the nurse.
8) Team integration.
9) Preservation of history.
10) Improve the relationship between the nurse and the patient.

Project:
Achieve the goal of having in the Emergency Department of the Hospital, a paper tool to fully document the care needs of patients and the answers that the

nursing staff provides.
The project consists in the introduction of the Nursing Record which guarantees a better management of information relating to the patient's path, from the moment of taking charge until his discharge.
The terms and sequences used make it possible to standardize the behavior between the different professionals and the standardization of some steps of the path itself, the terminology used also leads to standardize some assessments and judgments by building a shared professional language.
The Nursing Record of the Emergency Department of the Hospital Unit allows you to have complete, homogeneous and precise information available, as well as the monitoring of the nursing activity carried out on the patient, since the Nursing Record is in fact a very detailed work tool, so its insertion appears to be strategic.
A broader perspective on the evolution of the profession and the affirmation of Nursing as an autonomous discipline, the use of a nursing documentation system, even if customized according to the needs of the individual department and / or patient, guarantees nurses a clear reference framework. and common, supporting them in the assistance and organizational activities.
Once fully operational, the Nursing Record will allow the production and archiving of very efficient documentation, and will be a stimulus for operators to acquire new knowledge and skills to be able to intervene and solve problems, for the benefit of the patient, quality and 'organization.
This project is particularly significant for the Emergency Department of the Hospital as it represents a decisive step towards the creation of an information flow, aimed at improving professional quality.

I Study:
Identify the strategies that increase the knowledge, skills and timeliness of the nurse and allow him to collaborate in group work, in order to provide appropriate assistance with attention to the real needs of the patient.
Research:
is practiced in the Emergency Department of the hospital, the nursing staff is invited for a period of about a month, to follow information courses, where the Coordinator of this unit in collaboration with a nurse gives information on the use of the nursing record, opens a debate on the subject, and invites the staff to elucidate them on the problems that arise at work.

Phases of the research:

- Training courses, where the Coordinator of this unit in collaboration with a nurse gives information on the use of the nursing record, opens a debate on the subject, and invites the staff to elucidate them on the problems that arise at work.

Questionnaire;
which shows personal data, gender, age, qualification, years of service, professional experience in the basic training field. As well as the degree of preparation of the nurses who serve in the FIRST AID, and what are the difficulties that arise daily in the working context taking into account the users and the problems related to the strategic position of the Presidium.

QUESTONARY

Last name……..
First name…….
Born in ……on …….
Age …….
Gender: M F
Qualification ……
Work experiences ……
……
Service time provided in the Aversa Emergency Department: ……
……

1) **What are the difficulties facing the professional nurse in the emergency room?** _____

2) **Is the environment where assistance is provided suitable for the work?** _____

3) **Does the nurse feel prepared, ready, and protected for the service to be performed in the emergency room?** _____

4) **There is a need to change culture and assistance techniques .** _____

5) **Is staff training practiced with due consideration?** _____

6) **How does communication take place between the emergency room operations team?** _____

7) **The nurse is available for the introduction of a paper communication.** _____

8) **Is the use of the Nursing Record shared with, and accepted by, the Emergency Room Operations Team**_____

Expected Result

The nursing record makes it possible to appropriate a common language by guaranteeing nurses a clear and uniform framework of reference supported in the assistance and organizational activity; giving the possibility to the nursing team operating in the emergency room to establish greater collaboration with uniform assistance. One of the long tools provided for the nurse's activities is undoubtedly the nursing record, but its relatively recent practical utilization .The nursing record allows a regular and systematic collection of data for each patient, avoids the dispersion or distortion of information so frequent in purely verbal transmission within such an enlarged team, highlights the most important aspects that emerged during even a brief hospital stay in the emergency room. Numerous data and information are often dispersed in the context of a convulsive activity, while the possibility of collecting them and highlighting them on the nursing record not only allows their clinical and assistance use but stimulates the nurse to reflect more deeply on their work. The professional growth of the figure of the nurse allows today a greater capacity for evaluation and operational autonomy: the record can tangibly sanction the effective acquisition of these prerogatives.

Greater collaboration between fellow nurses, with a marked reduction in staff illness, since the nursing record allows them to appropriate a common language, guaranteeing nurses a clear and common reference framework, supporting them in their care and organizational activities; reducing the physical and emotional workload, since the use of the nursing record has enriched both professionally and personally, and is shared by the Emergency Aid Operations Team

Professional profile AND FUNCTION of the coordinator

The current figure of the coordinator following the abrogation of Legislative Decree n ° 52/92, actually provides for the formation of coordination courses at university level.

With the subsequent legislation CCNL 2000/01, and Presidential Decree No. 220/01, the previous legal status is effectively abrogated.

The managerial coordination function described by law No. 229/99, with the extension of the degree of autonomy of "intermediate roles", is not concretely reflected in the functions performed by the current coordination figures, especially if they are included in category "D" corresponding to a declaration inadequate to the role played and often declined within complex operational units.

With regard to the foregoing, the agenda of the Senate Health Committee under law no. 251/2000, provided that the nursing coordinator was considered to be a nursing manager in the U. OC, this agenda was disregarded.

The law n ° 43 of 1/02/2006, reforms the professional orders, recognizes a new condition of nurses, the first delegation is made to the Government with article 3, so that new professional orders are created, and the existing Colleges are transformed into Orders.

The exercise of the function of coordinator is carried out by those who are in possession of the following requisites:

- First level Master in Management for coordination functions in the area of belonging.
- At least three years of experience in the membership profile.

After the reform of art. 17 of the constitution approved with Law 3/2001 is presented in new juridical terms.

In matters of concurrent legislation, the new Article 17 states - the power is vested in the regions, except for the determination of the fundamental principles reserved for state legislation.

The state may eventually feel it has to legislate on some principle features in the nursing coordination sector.

Functions of the coordinator *:*

The coordinator is the one who possesses a certain competence, that is the legal and professional capacity that allows him to take on some functions and take charge of some activities.

He is able not only to apply a technique to a problematic situation but also to know how to adapt on the pitch, to move with skill and personal commitment towards the solution of the problem, taking on the responsibility of getting out of that situation with strategies aimed at a result.

The coordinator has the fundamental task of giving a sense of disciplinary belonging to the profession and of managing the professional group through a mental orientation to group work; he guides and stimulates change by promoting the growth of the group with specific training courses, investing in their skills seen from an innovative perspective, combination, skills and individual characteristics that interact with each other.

Furthermore, he guarantees complete monitoring of all planned initiatives, guides the path and the appropriate choices in carrying out the teaching function, evaluates the feasibility and convenience.

- elaborates specific models,
- draws up memoranda of understanding for development and direct assistance.
- Identify and schedule training for nursing staff
- It disseminates information relating to the plan and the approved initiatives
- Identify the information needs of health professionals
- Ensures the involvement of nurses.
- Promote training
- Check and verify directly.

In order to correctly carry out his training competence it is essential that the coordinator is aware of his role, understood as a correct perception of himself with respect to others and the reference context, in fact he is considered a strategic figure since he acts as a link between the organizational objectives on the one hand and the needs and skills on the other, because it is ungrateful to influence a numerically significant part of the human heritage. Given that he relates to adults, the coordinator regulates adult learning by taking into consideration the experiences of the subjects and their need to know, active research education centered on real everyday problems, the need to know, why it is necessary to learn before undertaking, the learning of oneself, the concept of oneself, it is necessary to be considered and treated by others as people capable of managing independently and responsible for their own life decisions

Aspects Of The Communication-Relationship.

The Communication is a bi-directional flow, which requires an awareness and, great job responsibility requires a clear and simple language, without haste and ambiguities; it is the ability to make common and participatory, to be aware of what we intend to communicate and, at the same time, to ensure that the message has been clearly received.

It is necessary to create meeting points, and satisfaction in the interlocutor for the result of the common work.

The coordinator detects the functioning of a person or a group and intervenes effectively on it, making room for what they propose with the optimization of study processes.

The latter allow:

- the activation of new individual and group energies, for change projects,
- the development of human skills, leadership skills, a sense of responsibility and personal and professional revitalization;
- increasing self-awareness and the ability to read one's own behavior;
- the improvement of the management skills of decision-making processes, of problem-solving, of the planning / implementation relationship
- improving communication skills and increasing tolerance for diversity
- accompany and support staff in order to identify training and / or professional paths suited to their personal potential, characteristics, interests, motivations.

An element of great importance is the relationship that is established within the group which is based on collaboration and relational and communication skills. The coordinator defines the objective in a clear and realistic way with obtainable solutions, with the convocation of the working group, that there is an adequate justification of the quality of energy necessary to achieve the objective.

Systemic Analysis Of The First Aid Operating Unit

The emergency room is located in the hospital, which reaches a large catchment area.

Access to the emergency room varies, while on weekends they are always much higher due to the closure of the GP's and PLS offices.

Organizational Functions

They are divided into:

- Direct assistance: therapy administration, transfer.
- Indirect assistance: registration, education, information on directives, prevention.
- Staff:
- Refresher courses.
- Equipment.
- Presidium.
- Study
- Improvement project of the assistance provided.
- Advice from the staff of the external operating unit: RX, Cardiology; Surgery, Otorino; Orthopedics.

Input

Resources:

- Technologies: saturator, monitor, aspirators, pumps, laryngoscopes, endotracheal tubes, ambu bag, defibrillator, scissors, blades, portable x-ray .
- Preparations for reception: Oxygen, ECG, Fax, photocopier, computer, gluco-test, lancets, urotest.

Human: head physician, coordinator, doctors, nurses, OSS, cleaner.

Economic: budget.

Time: Hours of service 24h on "4h divided into three shifts; 36 hours per week.

Morning: 8.00 / 14.20; Afternoon: 14.00 / 20.20; Night at 20.00 / 8.20.

Beds available: 10 stretchers.

Basic structure.

- environments:

The emergency room operating unit is located north of the Hospital, it is accessed through a large room, where there is a divider and adjacent to it a counter, where a professional nurse is accompanied by an auxiliary operator. that welcome the patient.

The TRIAGIST nurse welcomes the user by attributing the TRIAGE code and invites him to explain the problem, after which he evaluates the vital parameters, observes carefully and implements a short anamnesis to assign the appropriate code; inviting the patient to wait in the waiting room.

In the waiting room there is a bathroom for users, the judicial office, rooms used as deposits.

Adjacent to the triage counter there is a door that allows access to the Emergency Department, followed by a box used as a Red Code, in front of a box used as

a White Code, on the left follows a corridor where a box is used for Yellow Code, followed by a Pediatric box, a box used for orthopedic services, and a further central box with more stretchers used as a Green Code, a room for doctors, a nursing room, finally a rather large room used for brief observation , and a small room that serves as a deposit and, where the sterilizer is placed.

Request:
users who arrive in the emergency room have various needs, from small emergencies such as wounds, trauma, colic, to emergencies such as poly-trauma, cardio-respiratory diseases.
Functions of the nurse:
They take place over three shifts, morning, afternoon and night.
The emergency room nurse provides a waiting service, so at the beginning of the shift if he is not busy with the patients, he arranges for the reordering of the various codes; supplying them with materials and drugs, he checks the functionality of the pumps, monitors, cardiac devices, oxygen inlets and aspirators.
Provides and collaborates with the doctor for diagnostics, assists the doctor during the visit, collects information for an accurate diagnosis, administers the therapy, providing for the application of the venous catheter, carries out ECG , and medically. Carefully takes care of the interpersonal relationship with the patient in a short time in order to contribute to correct assistance.
Operational mechanisms;
Decision-making criteria: they start from the primary and are followed by doctors, coordinators, nurses;
the whole of the staff evaluates and then decides how to operate, usually it takes action according to written protocols and provided by the head physician.
Training system
Refresher courses are organized by the hospital for all staff, with the issue of a certificate.
Social processes The staff is made up of 25 nursing units, divided into 5 per shift , of which one unit is intended for Triage, holidays and illnesses are replaced by nurses who are readily available, placing the staff at an excessive workload.
There are also on average three auxiliary health workers per shift.
As regards the medical staff, there will be three units per shift, one of which during the night shift, must also provide for the emergency medicine department.

Conclusions / Reason for the study
The organization present in the Emergency Department of the Hospital, places health personnel at excessive work rates that cause physical and mental damage, forgetting that the work of the nurse is above all a work of concentration, as it has to do with the people's lives and a moment of distraction could be irrecoverable, so faced with such emotional and physical stress, the coordinator together with a group of nurses identified the need for a nursing record to pay better attention to the patient's needs . It allows you to plan a continuous and detailed assistance plan, which has a sequence, to allow the Team to effectively service the service .
The nursing coordinator is explicit in guiding and directing the operators towards a correct use of the introduction training to the nursing record.
Develop a training program that aims to achieve complex learning, resulting in a change in the professional culture.
The program is characterized by:

- periodic meetings of the emergency room staff
- creation and administration of a questionnaire to identify the training needs of the group of nurses working in the emergency room.

The questionnaire will be administered to 25 nurses, in the period from March 20 to April 30, of the current year.

Organizational Function:
the importance of an organization is reviewed below the first aid is an emergency operating unit, provides a service that responds at any time within 24 hours to requests for urgent medical assistance, has a staff composed of by nurses who work on a 24-hour shift arranged 5 per shift of which one unit is intended for triage, holidays and illnesses are replaced by nurses who are readily available, there are three doctors and three health auxiliaries per shift placing the staff to an excessive workload. Forgetting that the work of the nurse is above all a work of concentration, as it deals with people's lives and a moment of distraction could be irretrievable. The staff as a whole evaluates and then decides how to operate, usually it takes action according to written protocols and provided by the Director of the Emergency Department the decision-making criteria start from the Director after together with the COORDINATOR and DOCTORS they detect the need for the nursing record to pay more attention to needs of the patient and to allow the planning of a continuous and detailed assistance plan to allow the operational team to be able to operate effectively. Develop a training program that aims to achieve complex learning, resulting in a change in the professional culture. The program includes periodic meetings of the emergency room staff, the creation and administration of a questionnaire for the identification of training needs and for himself and the nurses who work in the emergency room. The questionnaire is given to a number of 25 nurses.

Nursing record
The nursing record is a paper support tool, designed to contain the recording of data and the set of documents pertaining to nursing on the case / user. Certifies and organizes with logic and effectiveness all the information and assistance activities of the person, collected and carried out by the nurse, favoring their accountability.
It is used for the preparation of anamnesis, for the definition of the assistance objectives, for the annotation of the interventions carried out and for the evaluation of the results.
With it we want to document which are the problems of the person, the interventions we have decided, which and how many we have carried out and what result we have achieved.
It is the tool that makes the nursing care process and the application of the specific content of the nurse's professional profile visible, observable, measurable, evident . The core of the nursing record is the personalized care plan.
Formally recognized by art. 69 of Presidential Decree

384/90, is legally considered as a public act, as it is compiled by a person in charge of a public service; although it does not have the same probative value, for greater completeness of the health documentation it must be archived as an integral part of the medical record.

Reasons for studying the nursing record.

There are various reasons: scientific reasons, such as the collection of data to carry out research (retrospective data analysis); medico-legal reasons, document the work carried out by care professionals in an objective way (subject to all the rules of health documentation), professional reasons, organizational reasons. With the tools used up to now, the attention was placed on what had been done on the patient, that is, it was a descriptive documentation of the nurse's executive activity , so much so that in most of the deliveries it read: practiced, administered, performed; with poor description of the patient's problems or needs. The intervention carried out was reported directly , without documenting why and, above all, the decision-making process used to reach those conclusions. Furthermore, much of the documentation referred exclusively to medical prescriptions and not to the peculiarity of the nursing activity.

Today the evolution of assistance, the recognition of a greater centrality of the person in the care path and the affirmation of nursing as an independent discipline means that the nurse is increasingly aware of the diagnostic reasoning that leads him to identify the problems of the person or to feel the need for a new and more complete instrument. The international nursing experience has led to the introduction of nursing diagnoses as elements of critical judgment calibrated on the problems of the assisted person. The nursing diagnosis is: declaration of a real or potential problem of the assisted person, correlated to reasons that determine it or that can determine it;

it is a written expression with concise language.

- it is centered specifically on the person, and not on a treatment or nurse's activity.
- it is the basis for autonomous nursing interventions;
- it is based on the set of data collected;
- it is an element that helps to reflect the person's health condition.

Care planning process used by the nursing record.

The nursing record uses the nursing process, which is several stages away.

Initial Assessment:

Assessment is the phase of the nursing care process that allows information to be collected, to identify people's problems and their underlying motivations, and therefore aims to identify what the current situation of people is.

The initial assessment opens with the collection of useful elements to identify the patient safely and quickly frame his situation: personal data, reasons for admission, diagnosis of entry, etc…; in addition to personal data, it is advantageous to collect useful information for communicating with family members, relatives or in any case with other significant persons for the patient (telephone numbers to contact in case of urgent need or necessity are particularly useful).

It is evident that in emergency situations the data to be collected immediately are those to ascertain the patient's clinical conditions and all data must be postponed over time.

The second part of the assessment is constituted by the assessment of the needs and problems that the patient presents upon accessing the facility; the methods used are the most varied and diversified, both in terms of form and content.

The form can be totally standardized with already coded entries, or totally open and the nurse must write all the information he collects from the patient; often the form is intermediate.

The contents are strongly influenced by the type of department or structure in which it operates.

The evaluation of the patient's problems is often accompanied by the collection of medical-surgical information, such as the patient's taking specific therapies, the presence of allergies to drugs or other substances, the use of prostheses and others medical-surgical aids or aids.

When collecting patient data, pay particular attention to how information is collected, bearing in mind that it must be collected in a completely confidential manner, not only out of respect for the most elementary rules on privacy, but for the need to maintain professional secrecy.

Subsequently, the collection of data develops into a continuous assessment which aims to periodically or constantly evaluate the improvement / deterioration of the patient or the occurrence of new situations.

The conclusion of the initial assessment leads to the identification of the problems of the assisted person that will guide the subsequent phase of care planning.

Assistance planning

Planning is linked to the need to define the methods of responding to the specific assistance needs of each patient or each type of patient.

It allows the integration of care modalities over time (between multiple shifts) and between multiple professionals.

The most used form of planning is that of diagnostic-therapeutic prescriptions, created by the doctor to allow the execution of services by other professionals such as nurses or rehabilitation therapists or others.

It is a continuous phase that takes into account the patient's daily observations and variations. Two planning methods are spreading: on the one hand, the use of plans made on the basis of the specific problems identified on the patient with the description of the objective and the progress / regress of the patient over time; on the other hand, the use of lists of nursing problems or diagnoses made on the basis of the experiences gained by the department itself.

Implementation of assistance.

Implementation of care requires specific space within the nursing record for two main reasons:

- it is necessary to document the implementation of assistance interventions
- it is also necessary to transcribe the evaluation of the patient's problems and the relative modifications.

Furthermore, in the implementation phase, the implementation of diagnostic and in particular therapeutic treatments is also documented, for this purpose it is

advantageous to use a single form both to document the prescription and the implementation of the therapeutic interventions; implementation is typically a continuous phase.

The evaluation.

The evaluation phase includes two aspects:

- the continuous evaluation, which is in fact carried out in the part of the documentation relating to the implementation of the assistance regardless of the use of deliveries or structured cards or diaries.
- The final evaluation, which is formulated in a specific form or in other parts of the documentation.

With regard to the final evaluation, the use of transfer and discharge forms has spread in many departments, which contain many elements of evaluation on the needs of patients and on the continuation of treatments, paying little attention to the informative, educational, and planning aspects of the treatment. discharge.

Criteria for the construction of the nursing record.

The introduction of the nursing record as a tool for individualized assistance involves inevitable changes in daily work habits; for this reason it is not possible to identify "model paths" and it is for this reason that each group of professionals, within their own reality, must undertake a path suitable to their context, to the specific needs of the type of patient who assists human resources and structural that are present.

Its use allows to promote:

- The definition of common objectives for the team, through which it is possible to obtain a better cohesion between the people who make up the group;
- A dialogue and constant listening to the assisted person;
- Better integration with medical staff and other specialized healthcare professionals who are involved in patient care
- A different organization of nursing care with the consequent continuity of 24-hour care and their total vision;
- Nursing research activities and to foster greater integration of trainees.

The Nursing Record being a support tool for the care process, in its structuring two main requirements must be taken into consideration:

1) must refer to explicit and shared theoretical models,
2) it must include all stages of the process;
   these phases are divided:
   - Assessment,
   - Care planning,
   - Implementation of interventions,
   - Assessment.

In the operational implementation there is a tendency to favor a card structure that can be changed according to the operative units and the types of patients.

Parts Of The Nursing Folder
ASSESSMENT: data collection and identification sheets of patient problems

TO) PERSONAL DATA FOR ADMISSION

Personal data for admission:

TO) DATA ON PROBLEMS

Data on levels of dependence and problems or nursing diagnoses

PLANNING: Service planning sheet

TO) OBJECTIVES AND INTERVENTIONS

PLANNING:

IMPLEMENTATION: implementation / observation form or nursing diary and accessory forms

B) DIARY OF URGENCY:

DIARY OF URGENCY:

ATTACHMENTS:

COLLABORATIVE SHEETS:
EMERGENCY THERAPY CARD;
DIAGNOSTIC CARD;
VITAL PARAMETERS SHEET;

PROJECT

Project title

"THE NURSING RECORD AS CLINICAL-ASSISTENTIAL SUPPORT STRATEGIES AND IMPROVEMENT IN FIRST AID ASSISTANCE :

guided for nursing staff

1) Definition of the problem **: Train the nursing staff on the new path with the integration of the nursing record . Each change always brings new difficulties within a group and / or work team. The health professionals are always ready to modify and integrate the training course in order to provide assistance to the patient who arrives in the emergency room in a state of emergency and / or urgency to provide adequate assistance to the case.**
2) Definition of the causes: **The lack of knowledge on the part of the staff concerned, of the various roles, skills and integrations that they can exploit in order to interact with each other and improve the assistance to the patient who comes to the emergency room often even alone I have in one state of unconsciousness.**
3) Expected skills: **Streamline expectations, improve relations between the emergency room and the wards where the patient is transferred after being stabilized. The nursing record is used to create a connection network and to provide the staff receiving the patient with a complete view of all the maneuvers practiced in the emergency room and the therapies practiced in urgency. to have a clear picture of the degree of participation and awareness of the patient, and to continue the clinical assistance path by colleagues in the hospital ward.**
4) Profile of training needs
……
…… ……..
5) Skills expected

DEGREE	Intellectual	Manual	Relational
1			
2			
3			

6) Skills observed

DEGREE	Intellectual	Manual	Relational
1		Patient management	
2			
3			

7) Training needs

DEGREE	Intellectual	Manual	Relational
1	**Through a training course aimed at deepening the knowledge for a correct application of protocols and guidelines**	**Verify the quality of care in patient management.**	
2			
3			

8) Definition of general objectives: **These aregiven to us by a field research in a short time to implement the assistance plan appropriate tothe specific case.**
9) Definition of specific learning **objec-tives** : **The specific objective is given precisely by the emergency.**
10) Evaluation Planning: **Planning and evalu-ation is implemented through research and staff training.**
11) Program definition: **ECM training is of ut-most importance to both the nursing and medical teams. It is thus possible to coordinate and evaluate the quality of care, and the strategies to be implemented during the emergency.**
12) Training path, defined by the guidelines:

……

FIRST AID HOSPITAL
In collaboration with:
The Medical Managers of FIRST AID
THE COORDINATOR
Corso ECMLA CARTELLA INFERMIERISTICA COME SUPPORTO CLINICO ASSISTENZIALE

Connotation of the intervention
Course title:
Professional figure covered by the course: ***Nurses***
Credits: Total expected duration: ***2 days, total 16 hours***
Total number of students: 18 internal students
Total cost: Zero cost
ECM course dates: February 2010 Implementing body: HOSPITAL ....

Characteristics of the implementing body

Denomination: HOSPITAL
Project subjects First aid coordinator
Course director: Medical Director of the emergency room:
Organizing Secretariat: CPSI ***Dr. Olimpia Cimmino***

Intended recipients: Nurses

Number	Credits
18 interiors	**Compulsory course for CPSI**

Operational headquarters

Body	Secretariat	Site
Hospital ……	**Street 081**	**room 80123 AVERSA**

Motivation of the training intervention

The study aims to provide various assistance management tools to the patient who comes to the emergency room, in order to be able to operate in various situations. The training and introduction of the nursing record will serve the health staff to reduce complications, analyzing through the study of an operational reality such as the emergency room, trying to correct the defects and understand the problems. Care has been defined by the World Health Organization as the possibility of providing the patient with those services and tools that contribute to maintaining the highest level of well-being, health and function. With the nursing record, the quality of care provided in the future will be a constant signal, the skills, the complexity and the continuous evolution of the technical knowledge make the problems of the patient assisted easy to manage.

Course objectives

The purpose of this training event is that it can stimulate all professionals to develop and improve clinical care strategies with the best knowledge and scientific skills in the emergency field. Ministerial Decree 739 of 1994 tells us that nursing professionals take responsibility for assistance in its entirety and introduce the foundations for taking charge of the patient throughout his hospital stay by implementing scientific evidence based on efficacy evidence and using operational information tools. cutting edge.
The knowledge to be obtained is:

- **Personalized assistance in emergencies.**
- **Develop new approaches to the problem of innovations with the support of the nursing record. Provide new scientific and technical-rehabilitative knowledge**
- **To concretely develop assistance in the critical moment of the patient**
- **Ensure assistance aimed at reducing the acute state**
- **Establish a relationship and connection with doctors and colleagues in the hospital ward.**
- **Guarantee an educational action designed to foster the ability to care.**

Context

The nurse who is to operate in an emergency must provide assistance to people who present clinical evidence of considerable complexity, the intensity of the nursing intervention on the patient must have professional value but also a confirmation of the operation itself all this is possible with the nursing record.

Course structure

1: Assessment of initial prerequisites: Multiple choice test
2: Description of the didactic intervention in relation to the indicated objectives

EDUCATIONAL MODULES	TEACHING UNITS	Hours
1st day Monday 26-02-2010	**Notes on the nursing record Evolution of the nursing profession** **The ethical aspects** **Technology to help** **The nursing organization of the Emergency Room Operating Unit** Description of the nursing record Nursing skills Construction of the training event	1.5 theoretical hours 30 theoretical min 30 theoretical min 1 theoretical hour 1.5 theoretical hours 1 theoretical hour 1,5 theoretical hours 30 theoretical min
2nd day Tuesday 02-27-2010	**The autonomy of the Nursing Coordinator** **The preparation of the nurse** **The nursing organization before and during the emergency or urgency phase** **The quality of patient care** **Support of the care pathway** **Insertion and maintenance of the new procedure** **Presentation of the project for the improvement of care by the coordinator**	1 theoretical hour 1.5 theoretical hours 30 theoretical min 1 theoretical hour 30 theoretical min 1.5 theoretical hours 30 theoretical min 1.5 theoretical hours

3: Course duration: total 16 hours
4: Attendance of the modules: Attendance of the days is compulsory
5: Methods and tools for measuring and controlling learning / teaching processes
6: Discussion and debate at the end of the daily section, with delivery of questionnaires before and after the didactic course.

- Teaching methods: Frontal lessons, discussion.
- Methods and tools for measuring and controlling learning / teaching processes: Multiple choice test
- Professional resources used: 1 teacher
- Study material: handouts.
- Didactic material used: handouts, personal computers.

Feasibility condition

The project is made possible if the following conditions are met:

- **Explicit mandate for the realization of the project**
- **Sharing of responsibilities with top management and the FIRST AID Director**
- **Sharing of objectives by the medical staff and the coordinator.**
- **Availability of human, instrumental and internal structural resources.**
- **Project realization times**
- **Collaboration / comparison between nurses and speakers.**

Evaluation system

The evaluation system includes:

- **assessment of access requirements for nursing staff**
- **assessment of learners' learning**
- **remote evaluation of the effectiveness of the course for healthcare professionals in order to ascertain the acquisition of skills and professional autonomy over time.**

Risk / success factors

The dominant factors for the success of this course are:

- **the availability of the operators involved (nurses)**
- **the budget (cost, internal resources)**
- **operator satisfaction**
- **the efficiency of the use of internal human and material resources available**
- **The increase of the offer by the medical team**
- **The implementation of the lessons by the coordinator own activities, and taking responsibility for basic and continuing training.**

Conclusions:
In this paper we have tried to describe the procedures related to the activity in the emergency room by placing the entire training program that leads the nurse from the base to carry out direct assistance to the patient and to highlight the problems related to it. In reality, the nursing record collects and contains the work of the nurse, in order to face the patient's needs with safety and giving the right quality, structuring a management path in several phases, defining the processes with responsibility for each phase. The management of the nursing record serves to give stability to the assistance elements, guaranteeing in full compliance with ethical principles, and adequate professionalism for the entire path. Over the last few decades, the care needs have increased with greater responsibility than in the past, patients and their families ask for more and more professional quality this gives rise to a more important care complexity, which made it appropriate to carry out this training event and to introduce of the nursing record. In order to facilitate communication between health professionals , doctors propose the establishment of a scientific guarantor for the information and description of the project "NURSING CLINICAL RECORD AS A CLINICAL ASSISTANCE SUPPORT " identified as a professional the coordinator with the insertion also a monthly space where to deepen the knowledge and the importance of the document as adopted in other regions eg. EMILIA ROMAGNA. The proposals made in this project may succeed in activating the active participation of other hospitals.

THERAPY SHEET
INTRAVENOUS:
INTRAMUSCULAR:
ORAL THERAPY:
SUBCUTANEOUS THERAPY:

DIAGNOSTIC SHEET:
NURSING HISTORY :

VITAL PARAMETERS SHEET **P / A F / C SATURATION**
POSITIONING OF NEEDLE / VENOUS CANULA
MONITORING OF DIURESIS AFTER CATHETERIZATION
EMATOCHEMICAL / EMERGENCY TESTS;
ECG TRACE
RADIOLOGICAL EXAMINATIONS
DRESSINGS:

DIMISSION AND / OR TRANSFER SHEDA **DETECTIONS OF THE PATIENT'S DEGREE OF AUTONOMY**	**EVALUATION: RESIGNATION AND / OR TRANSFER FORM** E) EVALUATION WITH RESPECT TO THE OBJECTIVES

Patient problem identification and data collection card.

In the card used for the nursing history, it is essential that the following data appear:
patient identification,

- identifiers of significant persons to be contacted in cases of need,
- data about the type of hospitalization (including dates of movement),
- for the evaluation of the patient's autonomy in satisfying basic needs or in carrying out life activities including vital parameters,
- other data responding to the needs of the operating units such as scales or measuring instruments for the assessment of specific needs or risks for the patient.

Depending on the other documentary tools present and used in the operational unit, other types of data can be collected such as:

- diagnosis and / or reason for hospitalization,
- previous pathologies,
- drug history
- other diagnostic-therapeutic elements considered useful.

Graphically, the data collection and identification form of the patient's problems can be created using closed or open questions; in both cases there are pros and cons.
In the first case, the assessment is detailed and guided, but it is not very flexible and can be impersonal in extreme situations.
In the second case it requires a greater effort in the compilation and more time available, but allows you to collect many elements of customization.
Data collections are often used in a mixed way, ie a part is carried out with closed questions and a part with open questions; this allows to structure a form with identical modules for all the operating units of the same area and some differentiated by specialist sectors. This sheet can end with a section in which the patient's problems , both nursing and collaborative, or nursing diagnoses are formulated .
In many cases, the formulation of problems or diagnoses is returned directly to the planning sheet to avoid unnecessary transcriptions.

Service Planning Sheet:

The planning should include the list of actual and potential nursing problems or diagnoses , their priorities, the objectives to be achieved with the relative deadlines, the planned nursing interventions.
In operational realities, two settings are basically used that respond to different needs.
The first is based on a standardized plan that describes the nursing problems / diagnostics related to a pathology or type of treatment and provides the series of necessary interventions / measures and possibly the expected results for each area of intervention or day of hospitalization.
The second uses a personalized tool in which an ad hoc care plan is drawn up for each patient on the basis of the specific nursing problems / diagnoses identified. In this case, protocols or reference guidelines can be used for each type of problem / diagnosis.
Forms are also spreading that allow the use of standardized planning, for the most recurring problems, and a free part in which to plan the resolution of the specific problems of that patient.

Implementation / observation form or nursing diary

The implementation / observation form or nursing diary is the part of the nursing record where everything that has been achieved and happened to the patient during the day or during the single shift of service is reported.
This form is also essential to report the elements of continuous evaluation of the patient, such as new clinical pictures, new problems, changes in physical or mental conditions, changes in vital parameters, etc.

Therapy card

The current legislation assigns the therapeutic prescription to the competence of the doctor, while, to the nurse assigned the administration of the prescribed drugs: "guarantees the correct application of the diagnostic-therapeutic prescriptions (Ministerial Decree of 14 September 1994 n.739).
The therapeutic prescription is complete when it indicates:

- the type of drug;
- the dosage;
- the timing and route of administration,
- the pharmaceutical form;
- The doctor's signature;
- The date;

If the prescription is incomplete or illegible, it is a source of responsibility for the doctor. Any damage resulting from the nurse's error in transcribing the medical prescription is a source of responsibility for the nurse himself, and it is therefore advisable to avoid transcriptions. Error, as an act of negligence, can give rise to disciplinary, civil and criminal proceedings.
The management of the drug is instead assigned to the responsibility of the nurse, as well as the judgment on **whether to** administer it, in relation to the symptoms presented by the patient, for example at the
of the administration of a drug such as digitalis, if the patient has bradycardia, the nurse is required to communicate the clinical change to the doctor before starting the administration itself.
Feature particular assumes, however, the therapeutic prescription indicated with the term " **in need** " in which it is entrusted nurse its judgment as well as to **whether** also to **when** administering the drug
This introduces the concept of responsibility into the correctness of the evaluation of the patient's need.
This type of prescription allows the need to define the concept of "need" in the context of the prescription itself; that is, when to administer the administration and any limits to the administration itself.
The completeness of the prescription must be such as to allow the nurse a certain assessment of the appeal of the state of need.
For example, administer antipyretic if the temperature exceeds 38.5 ° C. or administer the painkiller when pain appears but do not repeat for four hours.
Obviously, as in the case of ordinary administration also for the therapeutic prescription as needed, the appearance of signs and symptoms not foreseen in the prescription itself must be reported to the doctor.
Regardless of the care organization present in the structure, it is necessary, in collaboration with the medical team, to identify a procedure for prescribing, administering and evaluation of the therapy in a single form that allows both the registration of the prescrip-

tion and the administration.
The therapy card thus becomes that part of the clinical documentation that assumes the
following functions:

- Administration of the drug by the nurse;
- Verification of the effects.

At the time of discharge or transfer, the form must be combined with the remaining clinical documentation.
Graphically, the therapy sheet must provide spaces for:

- The complete prescription of the therapy, including the date of prescription;
- The documentation of the administration, or the causes of non-administration.

Given that the therapeutic administration must be documented by the nurse who performed it, depending on the care and organizational model of the structure, two graphic methods can be used:

- The first is based on the affixing of the signature (also in the form of initials) at the end of the administration for each patient;
- The second is based on the signature of the therapeutic administration for the patients entrusted.

In the first hypothesis, reference is made to the structures where one works for tasks or "rounds", in the second one takes into consideration the structures where one works by "sectors" or small "teams" with responsible assignment of a certain number of patients to every nurse.
A further graphic element to consider is the documentation of some patient parameters that allow an immediate clinical evaluation of the effects of the administered therapy. This aspect is strongly influenced by the type of department concerned as the parameters change in relation to the clinical discipline involved.

Accessory Cards Such As:

- VITAL PARAMETERS;
- DIAGNOSTICS;
- WATER BALANCE;
- PROCESSING PROTOCOLS;

A wide range of other technical data sheets can be inserted in the nursing card file, which allow a quick and timely response to the specific needs of the various operating units.
Not all and in all types of department are necessary .
It is not convenient to disperse the information in a multitude of files if there is a real need because the phenomenon to be managed is complex and recurring.
Among the most popular cards we note:

- Vital Signs Card:

it allows to report in a unitary way all the main vital parameters detected in short time sequences.
In addition to the detection date and times, the items mainly reported are:

- Heart rate (HR);
- Respiratory rate (FR);
- Temperature (T);
- Onsente blood pressure (PA);
- Quantity of urine produced;
- Central Venous Pressure (PVC);

They are used where the monitoring of parameters is a widespread and constant datum.

- Diagnostic card:

it allows to maintain a unitary vision of the urine, bacteriological and diagnostic blood tests generally requested and performed by the patient.

- Water balance sheet:

reports in detail the quantities of liquids entering and leaving the patient to allow rapid and precise monitoring of the patient's water balance.

- Diabetic patient management sheet:

it allows to report in a unitary way the programming and the diagnostic, therapeutic and dietetic implementation of the patient.
Results of blood and urine tests, amounts of insulin, diet administered, etc.

- Catheters / drains and dressings tab:

it allows to manage in a unitary way the different catheters and drainages that the patient may have, such as: nasogastric tube, bladder catheter, central and / or peripheral venous catheter, epidural catheter, wound drainage, etc; allows you to monitor the dates of application and replacement and the related dressings.
In the case of the management of complex wounds it is useful to describe the evolution of the healing process and related treatments.

- Treatment cards:
- it allows you to directly introduce specific care protocols to the nursing record to which the nurse must comply over the course of the various days.

For example: protocol for the management of the patient immobilized in the bed (postural plan) or protocol for the management of the post-operative liver transplant, etc.

Discharge or transfer form

The transfer card is a card that is used to transmit data relating to the period of patient care by an operating unit or to a territorial unit and there is a need for a continuation of nursing treatment.
The discharge form, on the other hand, must allow for the final evaluation of the patient's problems.
In the first case, in addition to the patient's personal data, the set objectives and their total or partial achievement, the proposals for continuation of the treatments.
In the second case we focus in particular on the synthetic assessment of the objectives set and their total or partial achievement.
Also in this case the card can be structured with a series of coded entries or free.

Nursing Weight Assessment Sheet

The Nursing Care Weight Score Sheet is used to determine the patient's nursing care needs.
It can be completed at the time of access to the facility of the assisted person, or at the time of taking charge, as well as at discharge. The access detection allows you to program the resources necessary to assist the patient; that repeated in different moments of the hospitalization allows to compare the assistance provided to that specific patient over time and, at the same time, the different patients with each other.

CONCLUSIONS

The nursing record or care dossier is therefore a "formal", flexible, adaptable, susceptible, continuously updated documentary tool capable of highlighting the professionalism of each health worker, in carrying out his / her activities and correct documentary behavior at any time.
It must be simple to use, easy to compile and consult, and must also have the following characteristics:

- specifies: the data must be entered correctly, distinguishing the objective from the subjective, use abbreviations only if only understandable.
- Clear: legible and visible.
- Truthfulness: (otherwise the nurse incurs a false public document, pursuant to art. 476-479 of the Italian Criminal Code).
- The formal correctness, that is the legibility and the absence of legible and unsigned erasures, and also the dating of the writings.
- Complete.
- Timely.
- Contextual.
- Reserved.

It should be considered a public act in the broad sense since it is drawn up by a person in charge of a public service.
It should be considered an integral part of the medical record, because it helps to make the subject's documentation complete, therefore kept for convenience in a diversified way, but assembled for the archive.
The head physician is in charge of the Medical Record, the head nurse of the filing that can be brought back to the Nursing Record.
When the citizen is discharged, the file must be delivered to the archive, where the obligation of custody falls on the Health Director and on all the staff.

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