Taken Care Of Nursing In Cardiology: Integrating Ethics And Quality

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The Cardiological Patient. Specific Characteristics
The cardiovascular disease is turning into an authentic plague into the developed world, there being had his more spectacular summit between 1900 and 1950, as consequence of the adoption of habits of life that we might consider to be "harmful" and that are directly related to the culture of the well-being (increase of the consumption of fats and carbohydrates, smoking, sedentary life, stress...); this one situation, far from disappearing, has been restored by more force in the modern current life, provoking among other things, a showy increase of the obesity, with a direct repercussion in the numbers of mortality, very importantly.

It is the first reason of death in the developed world and it estimates that in approximately 15 years, it will happen to be worldwide and all this in spite of the development of therapies increasingly effective and of the use increasingly generalized of desfibrillator semiautomatic, that together with other technologies (cardiac surgery, development of technologies hemodynamics, cellular transplant, regeneration of fabrics myocardial necrotized...), have contributed and they help to diminish of important form the above mentioned morbi-mortality (current investigations suggest that in a few years, it will be possible to store in banks of fabrics, cells of newborn children's bony marrow, for his later utilization along the life of this individual.

it) gives the Dr. Valentín Fuster, when he(she) says: "Unfortunately we are treating patients, but we are not preparing(anticipating) the disease". With the application of the advances developed in the multiple investigations(researches) in the matter, "one" has managed "to "delay" the climbing of the coronary disease, but for really, to be able to think about the possibility of stopping(detaining) this epidemic, it would be necessary to bring together of determined form, the involution of the investigation(research), with the education of the population and the necessary boarding of the prevention (previous unification of criteria on the part of the groups of experts).

For the correct managing of the coronary patient, it is necessary to know and to be able to apply a series of knowledge and specific skills, which include specific material (ECG, monitoring, desfibrillators...), invasive technologies (skills) (catheterization venous and arterial, collaboration in other medical technologies(skills)...), administration of typical medication (fibrinolytic, anticoagulative, analgesic ...) and as(like) not, knowledge of fisiopathologic cardiovascular; bearing in mind, that in all the cases, the evolution of the treatments and therefore the changes in the boarding and managing, are constant and permanent, for what it needs an overstrain of permanent update.

They are in the habit of being common characteristics in patients with coronary disease, some of the following circumstances:

- Hypertension · Habit smoking
- Hyperlipemia
- Hypercholesterolemia
- sedentary Life
- Obesity
- Stress
- easily irritable Character
- Diabetes
- Other associate pathologic
- Other toxic habits
The advances in the clinical treatments and the present cares of infirmary facilitate that the discharges are more and more precocious and the limitations (morbidity) smaller; the fact that this pathology appears every time in younger people, raises the necessity to make the sanitary education from early ages to try to inculcate healthier habits of life, than they can prevent the disease. As far as the greater ones of 70 years, to comment that the age has stopped being a criterion of exclusion to be able to benefit as much from the enter units of high technology (UCI, Hemodynamic...), like for the access to certain specific treatments (fibrinolytic); this group such deserves well-taken care of that any other young patient, since surpassed the acute phase, the rehabilitation is good and its quality of acceptable life; the exclusion criterion focuses to the situation of basal standard of life of the patient (those patients in situation would be excluded from general deterioration).

According to Hennekens's study, the abandon of the tobacco in the population of low risk, you reduce up to 50% the appearance of coronary crises; the reduction of 10% in the plasmatic levels of cholesterol, it would be translated in a decrease of cardiovascular 30% in the episodes. Likewise the decrease of 6 mmHg in the pressure diastolic, there am (she) would suppose to reduction of 16% of cardiac diseases and of brain-vascular 42% in the appearance of accidents.

But so that the boarding can be really effective, we will have to consider all the implied factors. We know that the cultural inheritance exerts a great influence in the behavior of the individual, and this does not exclude the sanitary scope either. The terms "blame", "commitment" and "responsibility", to which so many times sanitary professional reference in the relation "patient - patient" is made, means different things according to the territorial scope and/or social of which we speak and they also interpret of different form based on the social group, particular experiences or other causes that affect the patient; in addition, at the time of transmitting that information to the patient (sanitary education), "the culprit" style has demonstrated to be even inferior placebo.

Changes that would be needed are then of such openwork, that they would require a global effort, being his success dependent of multiple factors, beginning by own atmosphere, that at the moment could to consider toxic, since it favours the appearance of conditioners that we know for sure are detrimental, like the sedentary and the obesity:

- Ample sensorial Supply of foods
- Prevail dwell and rich dwell fat foods and calories (proliferation of the premises of fast food) The publicity you induce to to massive and indiscriminate consumption (the rations was uncreating considerably) Publicizes (Advertises) and is generated to stimulus of pleasing, related to the food Increases the supply (spending machines ...)  
- More and more conditioners induce to remain quiet, generating a sensation of subjective comfort:
  - Remote Control of generalized use and in all the imaginable situations
  - Use of motor vehicles for any displacement or similar Proliferation of mechanical stairs or systems
  - The moments of leisure tie more and more to isolation situations, in which prime the use of electronic devices and virtual realities.
  - The sports happen to considered a spectacle, more than necessary exercise... nor so at least is precise to rub 2 branches to be able to fire.

Because they interfere like we are seeing, manifold cultural, social and economic reasons, on whom the single individual has a small parcel of autonomy, reason why to center the prevention in the to accused of the people is at least an incomplete strategy, that demonstrates a tremendous ignorance of the construction of the habits and that it loads to the patient with a responsibility very difficult to control and that surely it will perpetuate the high rates of failure that today exist in cardiovascular prevention.

It is known that the prevalent origin corresponds to arterial Hypertension, excessive caloric Ingestion with obesity, elevated cholesterol Levels, Sedentary, Habit to smoke and alcohol Consumption; and that all of them, would be on the other hand susceptible of modification. Every time more is based international the scientific consensus, as far as which the preventive strategies of the coronary diseases must begin in the childhood, indeed because is in this age where many of the precursory circumstances of the cardiological disease settle down. It is necessary to identify to the children with elevated risk, to modify those factors and thus to prevent the future injuries:

"To promote a healthy boy, it is the base to have a healthy adult"

The five factors of risk better identified in children, ploughs the tobacco, dislipemias hypertension, obesity and sedentary. The values of oily fractions, the arterial corporal pressure and the index of mass (IMC) in children, ploughs predicting of cardiovascular risk in the adult. The measures then to consider in any person with risk of cardiological disease would be centered in the reeducation of habits in adults and the educative programs for the children

- Electronic Reduction of dedicated times to television and games
- To promote spaces for the game and the sport (preferably outdoors)
- Promotion of one dwells to dwell healthful feeding: less coal fats and hydrates, replacing them by dwells(dwell) fruits and vegetables (scholastic educative programs).
- To moderate the salt consumption. To avoid negative advertising element
- To educate to avoid the use and abuse of alcohol and tobacco
- To promote the physical activity in general (besides to elevate hormones "endorphins", that will produce pleasant sensation, fortify the immune system and the defenses).
- The essential fatty acids like Omega 3 (present in blue seaweed, seafood and fish) improve the variability of the heart rate and have certain protective effect against the arrhythmias.

In the patients who already have had a cardiological event, it will have, on the other hand, that to increase the efforts, but has demonstrated that to make a pursuit regulate and near, supporting with information (education), and making pursuit on the fulfillment of the prescribed treatment and the indicated guidelines. Another one of the aspects that worry to the cardiological patients more (and not very often demanded), after to have had a crisis cardiac, is the maintenance of the sexual activity (mainly in men); reason why we have to approach this question of natural form.

Cardiovascular disease and sexual dysfunction, usually go very frequently sometimes even, because they share the origin substrate and the factors of risk (age, sex, hypertension, diabetes, hipercolesthrolemia, smoking and depression), to which there would be to add certain interactions of the cardiological treatments (the diuretic, antihypertensive and antiarrhythmic can be inductive of sexual dysfunction, among others). A 75% of patients vary or leave their sexual activity after an infarct; by fear (44%); others by inhibition of the sexual desire derived from the disease or the treatment (48%). Of that they resume it, a 65% undergo diverse upheavals that act like conditioners of the social and labour restoration, the quality of life and, even, the morbid-mortality cardiac.

Although the patient ones as soon as they consult (16.5%), if they are interested in receiving sexual direction and specific sanitary education, that supported by new oral drugs effectiveness in most of the cases has demonstrated.

For that reason cardiologists and nurses we would have to become familiar with all the aspects that base the sexual advice to the cardiovascular patient and his actually daily application.

**Integrating Ethical and Quality**

The necessity to always improve the administered cares is the main axis of the philosophy of the continuous improvement of the quality.

The term Quality, is a relative, cultural and different concept (it implies a judgment of individual or collective value). It is also a polysemic term, that supposes different meanings, as much in the time, as based on whom it uses it: "It is the set of inherent properties to a thing that allow to appreciate it like equal, or better worse than the rest of its species".

The management of the quality of the cares of nursing, must foment a style of work based on the continuous improvement, from the Planning, Development, Evaluation and Improvement of the quality. The welfare quality is the result of the sanitary policies, to do the correct thing of correct way, and the satisfaction of the organization, professionals and receiving users of the cares. Their high-priority objectives are:

- To be enough medical assistance of agreed with science
- To manage well-taken care of that satisfies the patient
- To assure the continuity the cares

It the conclusion that is not come off the relation between ethics and quality is very narrow and that without the one, the other will be possible either.

There are two forms to focus the quality from any scope, toilet or no, one like internal client (professional/used), and another one like external client (usuary client/). Therefore the quality is, without a doubt, something more than the guarantee of not committing errors, is an integral and unconditional commitment between the usuary client/; this commitment has an ethical root that the client ties to the supplier with the own given commitment.

The following definition of quality will help us to include/understand better east concept:

"Quality is to equip with identity the pronoun we. It is to tame to the beast of the involuntary variations.
It is to locate under benign and well-meaning control the force of complete production that hides in the organization,
of way of each productive step, each investment in resources, each request made to each individual worker serves the common objectives".

(Donald Berwick, 1992)

Really, the quality is an ethical commitment and all we have to be able to acquire ethical commitments respect to our work and our patients, but we needed to perceive that that commitment is shared by all. Single interrelating ethical and quality with the cares that we gave, we will be really at readiness to guarantee that our patients receive not only good well-taken care of ones of infirmary, but the best possible cares.

The formation which we received during the nursing studies, is destined, in general, to the theoretical knowledge acquisition and the training in necessary practical abilities for its correct application. One trains the professionals to reduce to the times and the costs and thus to improve the answer capacity, but with too much frequency, the user perceives that basic problems subsist such, those that are related to their more intimate necessities, since they lack, information, warmth, respect, Privacy..., really, often exists the sensation which he is not being with people (DEHUMANIZATION).

Ethics comes to be code of conduct, that regulates the relations between the patient and the sanitary professional and as well between the own professionals, who develop and accept specific norms of formation, competition and conduct professional, whose fulfillment guards the deontologic committees.

Traditionally the predominant attitude was the "charitable-paternalist", cradle in the ethical principle basic "primum non nocere", (first of all not to harm); the ill person does not know or knows her disease, its cause and the way to cure itself bad. The doctor has the knowledge, knows what it happens to him to the patient and tries to cure to him without it is necessary the intervention of the own patient.

Here the ethical function of the sanitary professional era to take care of the patient still against its will, always based on the benefit of the patient. With the development of the bioetics, objective criteria settle down on which to put to us in agreement; thus four ethical principles or criteria have been defined that are applicable to the sanitary scope:

**Nonslander:** "Primum non nocere". "It is not possible to be done badly (damage) to another one, although it requests it". This principle does not depend on the will of the people and forces not only not to do badly, but also to deal to the people with equal consideration and respect. With respect to the information, it demands to contact good with the taken care person and to offer a truthful, comprehensible and continued information to him in the time. Everybody would agree in which to strike or to give a beating, is I mistreat physical evident that precise moral and even penal sanction, but for example that to a old one incapacitated is deprived to him of an adapted hygiene, of necessary the postural changes or that the risks of falls or hospitable infection do not consider to him, also is I mistreat physical, but in this case, default, laziness or negligence.

**Justice**
The principle of Justice forces to deal to all the people with equal consideration and respect. The discrimination, marginalization or segregation of the patients are unjust and immoral. The access to the sanitary services must be equitable and these must lend a level of attendance adapted to the necessities of the population and the resources available.

So unjust is abandonment therapeutic (to do without resources of vital support or high technology, conditional by the social pressure of resources that we know that they are limited), like the over treatment that also takes place when we tried to delay the death at all costs available, call "therapeutic fierceness".

The aim never must be the prolongation of the biological life like so, but the profit of a natural and total life. The ethical exigency that must be fulfilled is the one to take care of the patient. Still in many cases, it is not absolutely clear, the line that separates the attention of quality at those final moments of the life, of the therapeutic fierceness.

**Charity**
"One is due to make the people well who request it"; but the affluent concept, is subjective and different for each person; it always depends on the system of own values, (the charity principle is subjective unlike both previous that are objective). This principle is inseparable of the principle of Autonomy, both talk about to the scope of concrete and particular it of each person, therefore it is precise to communicate with the patient to know his concept "good" and to respect it. The good to another one against its will cannot be done, although yes there is obligation of not doing to him badly.
With respect to the information, it demands to offer alternatives and to inform correctly on them, so that the patient can choose closest with knowledge to his own concept of good. When the taken care of person cannot decide by itself, also it is necessary to do either, understanding to him by or, which expresses who know him and speaks by her.

**Autonomy**

It is the ability to act with knowledge of cause and without coaction. All independent person is able to make her own decisions, even when she is ill. The respect to the autonomy implies the no interference in the rights, duties and values and the acceptance of the options that declare to us.

But there are other aspects also intimately related to the ethical perspective of the cares, as much in cardiological patients, as in any other, who we do not have to let mention; thus, we will speak of the information, the professional secret, the professional attitude before the death or the registries:

- All person has right to being informed on its situation, alternatives and treatments, having favored its decision making and respecting these. In the sanitary scope, to inform and to request the consent are to consider the right of the people to decide on themselves and to respect its autonomy. The informed consent is not an isolated act of exchange of information so that the patient signs an authorization; it entails a bidirectional state, where the toilet must offer information and recommendations on which in his opinion he is more advisable and to receive from the patient, the impressions and decisions on which he understands that he is better for him.

The ethical nurse therefore has to be a moral construction that orients the attitudes and the behaviors of the professionals towards the provision of taken care of which they promote the health, they prevent its alterations, they contribute to its recovery and rehabilitation and help to live or to die with dignity when the improvement or the recovery is not possible and all it from the recognition of the human being in its totality and the respect of the social

- The professional secret. In our activity, one assumes implicit, the values, commitment of not disclosing the well-known in the exercise of the profession. In the sanitary relation, the patient frequently reveals his privacy that is necessary to receive the sanitary attention. The professional of the health is forced to respect the secret and the secret that has received; single the social interest of the health can force to keep awake it. The registries are the graphical support of the work made in each turn and simultaneously they suppose means by which to value the quality and effectiveness of the given cares. In the legal scope, in addition, they constitute the professional information contributed by the infirmary personnel to the clinical history of the patient and like so, they represent the best test of than we arrange, to clarify any susceptible situation of legal investigation (legal defense).

The nursing registries must include objective, clear and precise data that they inform on the state, evolution or any other data relative to the patient, that we consider important to review (signs, symptoms, analgesia and reason, as well as if it has been effective, aspect of wounds, drainages, etc.). It is responsibility of each professional of nursing to register the observations of each patient and simultaneously to consider registered by others companions; all it in the vend saves time and guarantees a greater security in the given attendance.

- The death is not conceived like a mere event that we must accept with respect; but that nowadays one is to delay, almost obsessively, this fact. From this perspective, it is the ethical responsibility in the deal with the disease and the quality of the cares, the one that without a doubt has to take part to avoid excesses. Frequently the welfare personnel does not have time, availability, nor formation to confront the emotional overload of the terminal patients. All it contributes to increase the anguish of the patient; the nonverbal language is very important, (fugitive answers, shorter visits, silence, sensation of frightening); in addition the family in many cases cannot be permanently with him (hour strict or other causes), when what needs she is:

  - Frequent Visits
  - Control of symptoms (pain)
  - To speak to him
  - To touch to him
  - To favor support

**As we Must Act**

In general the coronary patient, but specially when she enters by a cardiological event, she is scared and he is anxious, is possibly incapable to speak, reason why she cannot formulate questions; all it
does not make but increase the level of stress; they are far from its normal, isolated habitat, can that immobilized, overloaded with lights and strange sounds, without entertainment means, that is only that can do is to reflect on itself and its state. In order to fight this, first it will be to inform to him about its immediate surroundings, where it is and so that, what is all the apparatuses that it has around, using simple and comprehensible words; to prepare it for any alarm that can sound, explaining that they suppose a change in the state or a necessity to him to review the apparatus, not unavoidably a danger for its life. To also explain the limitations to him of the units of critical cares, and its special, hour norms of visit, rest, to go or not to the WC, television, flowers, etc. Another added problem is of the dream pattern, that often between stress, the noises and the own pathology can become an unattainable feat; the prolonged deprivation of dream even reduces the vital energy that the patient needs for his treatment and jeopardizes his reestablishment, being able to give rise to sensorial upheavals, disorientation, aggressiveness etc., reason why we have to take all the measures possible to favor that the patient can sleep (to diminish intensity of the light, volume of apparatuses and alarms, to adapt schedules as far as possible, to favor relaxation by means of massages, suitable hygiene, change of clothes frequents and favoring that express its doubts and fears trying to explain it to it.

We have to consider that ignorance is a dangerous ally of the anxiety that will increase the disquiet in the patient and his family, even making difficult the administration of some specific therapies. The fear and insecurity sensation that can perceive the patient to be in “a strange” atmosphere, surrounded by personnel whom it does not know, of apparatuses and noises (overload of stimuli), added to the ignorance of their problem, can cause to a sensation of important fear and insecurity.

The nursing personnel, in our attempt to integrate ethics, well-taken care of and quality, we must be able to detect these situations and to mainly handle to the anxiety and the stress that produce, individualizing the cares, dealing to the patient and family with attention and respect, contributing to the attainment of a information permanent and adapted (understandable and adapted the interlocutor) and harnessing the mutual confidence. The suitable attitude of the professionals usually has more effectiveness in this field, who the administration of many tranquillizers.

- To receive to the patient with amiability, identifying to us with our name and estate and directing us to him, also by its name.
- To inform to him into its location, norms that must consider (control of the bed, lights, stamps...) and any doubt that can raise to us.
- To try its tranquillity, explaining its situation: nakedness (for fast performance in case of emergency), connection to cables (permanent observation), norms of visits (restriction), use of electronics devices or telephony (limitation), in bed (rest necessity, without being able to rise, at least, temporarily), origin and cause of the sounds which it perceives (the alarms not always supposes episodes of gravity), etc.
- As far as the family, to inform exhaustive (at an understandable level by the interlocutor), to explain situation of the patient and norms of the unit for the visits, information..., (preferably in oral and written form).
- To notice that the telephone information must be exceptional (impossibility to identify the interlocutor)
- In summary, to create an suitable, and surely comfortable atmosphere, that on the other hand will also result in a greater satisfaction of the welfare equipment.

An aspect to consider is the suitable adjustment of the limits of alarm of the used apparatuses. The main function of the alarms, she is the one of which goes personal toilet immediately to value the situation and thus to be able to detect and to solve the causes; for that reason to intensity and frequency it varies based on the gravity of the same ones. The alarm messages usually are of several types, based on their gravity, using luminous and acoustic signals:

- **Red**: It indicates top priority by possible situation of vital risk (asystole, ventricular fibrillation...); it is accompanied by a very acute sonorous alarm and that is repeated of intermittent but very fast form.
- **Yellow**: It indicates average priority. One corresponds with the preformed limits of alarm for events that do not suppose vital risk and intermittent average is accompanied frequently by more serious sonorous alarm and.
- **Green**: Indicates low priority and usually they correspond to technical situations (loose cable, impossibility to make measurement...); in this case the sonorous alarm is of less volume and intensity and its frequency of intermittence is low.
In the units of Critical Cares, all the patients must easily be observable (by direct vision) from the infirmary control, since otherwise we would lose one of the main sources of intelligence (the direct observation). If the physical structure of the unit did not allow it, can be precise to install systems of closed circuit of television. In these cases it is necessary to always notice to patients and relatives, (and to even disconnect it if it is solicitd) not to violate his right to the privacy.

The practical nurse necessarily has to sustain his bases in the scientific method, using instruments validated and own of nursing:
- Applying registries of initial valuation of infirmary (Basic Necessities, Functional Patterns of health...)
- Establishing diagnoses validated nurses (North American Nursing Diagnosis Association - NANDA).
- Restoring taken care of plans of that establish and develop to validated interventions nurses (Nursing Interventions Classification- NIC).
- Establishing objective and making pursuit and evaluation of the plans of established cares, through
parameters of validated results (Nursing Outcomes Classification - NOC) • Making information of continuity of cares, that make possible the transmission of information between the different welfare levels, to the time that guarantee, the continuity and the quality of the established cares.

**The Plan of cares has to consist of four fundamental elements:**

1. Valuation from infirmary to the entrance, that will derive in the identification from problems nurses (infirmary diagnoses) whom the patient presents/displays.
2. Planning of the objectives that we try and of the actions (interventions), that we will program to carry out them.
3. Execution or accomplishment of the interventions and planned treatments. Administration of planned cares.
4. Evaluation: degree of attainment of the objectives and of what and like we have applied the plan of taken care of (if he is being useful or if on the contrary it would be necessary to again value the situation of the patient).

"The nurse must be able to also appreciate not only the necessities of the patient but the pathological circumstances and states that they alter" (to Virginia Henderson to them. The nature of nursing (August 1964). American Journal of Nursing 64:62 - 68).

The valuation to the entrance, will be the base for the elaboration of the Diagnoses Nurses, reason why it must as far as possible be concrete and agile, so that we compile the useful information, but optimizing the time of cover.

Traditionally it has been thought that at the most information is registered, greater will be legal protection than we will have, but one has demonstrated that this does not have because to be certain; amount not always is synonymous of quality, reason why if we followed a system coordinated, possibly more excellent data are registered, in less space and less time.

To formulate Diagnoses nurses requires to make a situation analysis of the patient, to synthesize the most important findings, exactitude when interpreting and giving sense to the observed clinical data. It is a process of critical thought, that allows us (it enables) to make decisions on the results that we wished to obtain and the interventions necessary to obtain them. The use of a language validated and standardized diagnosis provides a common frame to us of reference, for that reason it must easily be comprehensible for all the members of the health equipment.

The objectives that we consider must be clear, feasible and realistic, otherwise we fall in the risk of which the plan of cares is unrealizable. For its exposition we will ask ourselves that results we try to obtain with the patient; to it we also have validated tools: NOC (Nursing Outcomes Classification) or Classification of Results of Nursing, that we will explain more ahead in the evaluation section.

As far as the interventions, also a validated classification exists; the Classification of Interventions of Nursing (NIC) is a standardized classification and completes of all the interventions that the infirmary personnel makes. It categorized, standardizes and describes of systematic form everything what the nurses for the care do of their patients, as much of independent form, as in collaboration, raising taken care of as much direct as indirect. The classification includes the competitions of all the scopes of infirmary, being able to be used in all the situations, (critical cares, domiciliary hospitalization, cares and primary attention) Many even require special formation and some suitable degree; Others describe to basic measures of hygiene and comfort that in some cases can be delegated in the aid, but whose planning and evaluation on the part of an nursing professional continue being

- An intervention defines as "any treatment, based on the clinical necessary criterion and knowledge, that an nursing professional makes, to increase the results of the patient."

The use of standardized language does not inhibit the practice; rather it communicates the essence of the cares from nursing to others and it helps us to improve the practice through the investigation. When using this language, we will be at readiness of being able to compare and to evaluate the effectiveness of the cares administered in multiple situations and by different professionals from nursing.

Arrived east moment, it is necessary to evaluate the degree of effectiveness of the plan of cares established and administered; if we used the traditional method, we will evaluate the attainment of the objectives, and therefore the consequent validity of the plan and of since we have applied it.

To the valuation of results that have been reached with the patient through plan of cares we also have validated tools: NOC (Nursing Outcomes Classification), standardizes of systematic form and provides test to measure the results of the Interventions of nursing carried out the patients (results).

The results of the patient serve like criterion to measure the success of an intervention nurse. They
describe the state, conducts, answers and feelings of a patient, derivatives of the administered cares (other variables that can influence are: the process used in the provision of the care, environmental variables of organization or).

The NOC includes individual, familiar and communitarian results influenced by independent interventions of infirmary and collaboration. A result is defined as "a state, conduct or variable perception of a patient or familiar, sensible to interventions of nursing and conceptualized caretaker at mean levels of abstraction".

Each result NOC has a label, a definition, a list of indicators to evaluate the state of the patient in relation to the result, a scale of Likert of five points, to measure the state of the patient and a brief list of references used in the development of the result (Examples: 1 = extremely jeopardizes to 5 = it do not jeopardize; 1 = never declared to 5 = always demonstrated).

The scales allow to measure the state of the result in each point of a continuous process, from most negative to most positive, as well as the identification of changes in the state of the patient in different points.

Unlike the information provided by the attainment of an objective (an objective is satisfied or not), results NOC can be used to control the progress or absence of progress throughout a process of well-taken care of and through different surroundings from cares; They are developed to be used in any surroundings and any specialty.

The Taxonomy NANDA and Classifications NIC and NOC, can be used jointly or separately, although together and interrelated, they represent the scope of performance of infirmary in all its amplitude.

**Continuity of Cares**

Once the patient is registered, or must be transferred by some reason, it is necessary to emit the consequent Report of Discharge of Infirmary, in which they must go reflected the pending problems to solve, so that the personnel of destiny infirmary (he is of Attention Prioritized or of another hospitable center), can to guarantee a suitable continuity of cares.

The Discharge of nursing would have to begin from the himself moment of the entrance, thus allowing for planning, according to the detected necessities, those formatives actions (or rehabilitation) that the patient will need to develop the sufficient abilities, that they allow him to be able to recover, as far as possible, his own autonomy.

Thus we will have to value if it is precise to be forming in techniques of cures, techniques of subcutaneous injection, taken care of the diabetic foot, type of diet and feeding, level of recommended and/or allowed exercise...

The discharge report, allows in addition that the patient arranges, at any moment, of an official document where to be able to consult any doubt on the indications who has received, and it guarantees in addition the continuity to cares, when informing to the destiny professional, on all those excellent aspects of the process that has undergone the patient, which will allow him to optimize, as well, the cares to administer.

**Importance of the Registries**

According to some studies, the nurses happen between 35 and 14 minutes writing, (he depends on the complexity of the state of the patient and in question service), but also he has seen that in fact long time is dedicated to repeat annotations of the cares and observations of routine. In order to be able to optimize the time and that the registries are adapted, we must follow a series of basic guidelines:

- To complete and to register the information of the valuation as soon as possible (the lateness can go to forgetfulnesses and mistakes).
- To write with clear letter and indelible ink (not to use pencil); certifying date and shift.
- If it is necessary to correct something, there must not be used correctors (tipp - ex TM); it is necessary to put the paragraph or line in brackets, correct with an alone line and write to the side "MISTAKE".
- It is not necessary to reflect backward information and if it is necessary to reflect something important that one has forgotten the previous day, specify it of the same form.
- Annotating the activities or information immediately that take place (are produced), we will avoid forgetfulnesses.
- It is indispensable to sign always, later of the last written word, with the signature.
It is necessary to avoid the use of symbols or not standardized abbreviations.
- Judgments(reasons) of value must be included neither on situations or patients, nor negative connotations.
- It is necessary to avoid use the records to solve discussions or to award you blame third persons.
- The subjective information as pain must include complementary information as type, intensity, n° of episodes, duration, way of relieving it, etc.
- In general it is important to include any realized observation that we consider to be relevant in the evolution of the patient.
- There must not be included contents that could suggest risk or neglectful practice (routes exist to denounce these cases).
- The signature(company) must go rightly later of the last word or written line.
- Lines must never be left in white(target) between records.
- To try(get) to be brief, precise and concrete in the exhibition

The elimination of the repetitive and narrative records, it will help to reduce the time of record without reducing his quality, deriving in turn, in a coordinated record that integrates the whole process of nursing, from the revenue of the patient up to the discharge. The system use and software computerized, it can facilitate very much this job, at the time that it guarantees the confidentiality of the information.

We must REMEMBER that the records:
- Is a legal obligation, regulated by specific laws.
- Not written, to legal effects, is not done.

In order to conclude, to insist on which cares of quality are not possible, without an absolute respect to the ethical and professional values, of equal way that are impossible that we respect the ethical values in our welfare work, if we are not applying criteria of quality and professional excellence.

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