Specific nursing documentation at the Department of Intensive Cardiac Care, University Hospital Centre Rijeka

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Nursing documentation has become a crucial aspect of the nursing duties in Croatia following the adoption of the Nursing Act in 2003 and the establishment of the Croatian Chamber of Nurses. According to this legal framework, nurses are required to document all procedures performed for each patient, 24 hours a day, 365 days a year. This documentation provides a clear overview of all procedures carried out, ensuring the delivery of high-quality and safe healthcare. Precise record-keeping minimizes the risk of errors, such as double medication administration, missed procedures, or improper monitoring of vital signs, thereby protecting both the patient and the healthcare staff. At the Department of Intensive Cardiac Care, University Hospital Centre Rijeka, nursing documentation has specific requirements tailored to the needs of patients in critical conditions. This documentation includes: 1. monitoring of vital signs: pulse, blood pressure, heart rhythm, fluid intake and output (intravenous and oral), urine output, vomiting, as well as recording sweating and bowel movements; 2. detailed documentation of interventions such as coronary angiography, monitoring radial wristbands, and recording the administration of therapy (oral, intravenous, and intramuscular); 3. patient categorization, evaluation through scales, and continuous monitoring, which not only ensures medical protection for patients but also provides legal security for nurses and staff. This type of documentation is a fundamental tool for maintaining continuity of care, and accurate record-keeping is essential for preventing errors and ensuring legal protection within complex cardiac procedures.[1]

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LITERATURE

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