# Nursing documentation in cardiac care – the importance of standardization

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Although medical records date back to ancient Egypt, the systematic importance of nursing documentation began with Florence Nightingale, who recognized it as a foundation for nursing to evolve into a profession. In modern cardiology, patients are at risk of sudden clinical deterioration and require continuous monitoring, structured and accurate documentation is essential[1]. We synthesized current evidence on the role of standardized nursing documentation in cardiology, with a focus on patient safety, continuity of care, and digital transformation.

Recent studies demonstrate that standardized nursing documentation in cardiology improves early detection of clinical deterioration, enhances patient safety, ensures consistency of care, and reduces rehospitalization rates. The integration of digital technologies further advances documentation processes by enabling structured recording, facilitating interdisciplinary communication, and supporting decision-making. Amid current workforce shortages, standardization reduces errors and safeguards the registration of vital parameters. The three most important components of standardization today are: structured documentation templates, implementation of digital/electronic health records, and continuous staff education and training.

Nursing documentation in cardiology serves not only as a communication tool but also as a clinical instrument directly influencing patient outcomes. The adoption of standardized forms, systematic training, and digitalization are key steps for improving quality of care in cardiac nursing practice.

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## LITERATURE

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