Evaluation of form of documentation of nursing adult patients of treated in Cardiac Surgery Ward of the Military Medical Academy University Teaching Hospital - Central Veterans Hospital in Lodz**.**

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 Doctoral Dissertation – abstract

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**Introduction**

The recent decades there have occurred very significant changes related to hospital treatment documentation. Records regarding patients observation, diagnosis and treatment process have became considerably extended and elaborated. It enables a study of medical problems, among others, from the point of view of taken actions' effectiveness.

**Aim**

Verification of the nursing documentation forms applied so far from the point of view of coherence of recorded observations and nursing procedures.

An attempt to develop a standardized nursing documentation.

**Material and Methods**

Studies on the existing documentation have been carried out among nurses working on cardiac surgery and cardiology wards of the Military Medical Academy University Teaching Hospital - Central Veterans Hospital in Lodz by application of survey and assessment of its results. The survey group included 50 respondents.

**Results**

The survey proves that, in general, the existing nursing documentation forms have a lot of drawbacks. What the respondents particularly emphasized was duplication of information and figures and necessity of giving sometimes needlessly detailed information. What was also stressed was too little information regarding the specialized specificity of clinics. The nurses taking part in the survey also notice that it is necessary to keep a standardized and continuous nursing documentation regardless of where the patient stays.

**Conclusions**

Standardization of nursing documentation templates on the ward/ in the cardiac surgery clinic provides an opportunity to maintain continuity of records on observations and full documentation of continued nursing and treatment procedures.