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Editorial

We must start the path with the "basics". Related to this concept, the "Real Academia de la Lengua Española" states that is something "Belonging or related to the base or bases on which something fundamental is sustained".

The above mentioned concept used like an adjective acquires a special importance in two areas: Education and Research.

In this first number we will focus on the "Basic Research" that consolidates on the paths traced by those who preceded us conceptualizing the importance of Care.

The academic source mentioned before defines the concept of researching as "doing formalities to discover something"; and the basic research as that one "aiming to increase the scientific knowledge, without pursuing, at first, any practical application".

This definition places such research in a higher level, the applied research.

Ultimately, if we concrete the above mentioned basic research on care, we will assume that the same one is "basic" in the way of the comprehension of caring of people: the "what", always goes beyond the "how".

Conceptualizations of Care...

The health care records (I): Definition, Structutral analysis and normalization.

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Key words

Healthcare records, clinical history, health records, nursing records.

Abstract

Healthcare records included in clinical history are based on the selfcare deficit theory. They provide data about basic determining factors, their influence into the agency and demand of selfcare, the deficit that its misalignment generates and the nursing system used for its resolution.

Thanks to the implementation of electronic support, the standardization of this sort of records and the health history is showing a great advance. However, some experiences, including those under this support, show a basic degree of development.

Introduction

Health professionals use the health history of users to make notes or to consult previous information about the care process of the treatment of some health problem.

The consulted literature highlights the importance of taking notes about the carried out activities.

It is increasingly common to find records in electronic support, the situation has changed sensitively. When thinking about taking care not only records created ad hoc must be taken into account for this purpose. It is possible to think that the whole history, or just a part, is useful to provide care. It is necessary to distinguish between the records filled out by the nurse and those useful or necessary to provide adequately such care.

In the past, the records used by nurses were imported from records of other health disciplines. The reason might be in a lack of own language.

Some times the patterns of thinking and confrontation of people with care problems responded to models outside the nursing discipline.

The use of the languages belonging to the different branches of knowledge is not exclusive of professionals involved. The visibility of a discipline also depends on the use of its own language by the scientific community.

Aims

To define the healthcare records in a legislative context and to approach the analysis of its structure.

Analysis results

The legislative bench marks are placed in several different planes, standing out in our country "la Constitución Española", "La Ley General de Sanidad" (1) and "la Ley 41/2002" (2), several state sanitary laws, rules of the autonomous communities and finally, and without legislation, the codes of ethics of doctors and nurses.

Referents in terms of the discipline are based on Orem's selfcare deficit model.

Question 1: How to define the records filled out by nurses?

Nurses transcribe to a set of records included in the health history the result of a sanitary assistance.

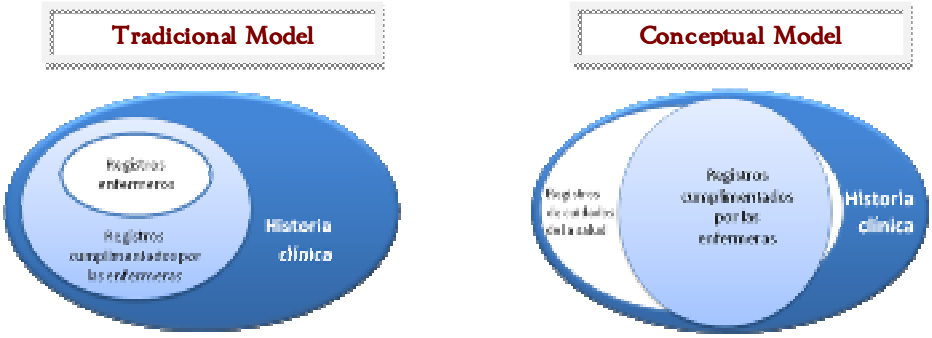
This fact of filling out some records does not imply the impossibility of use the rest of the included in the history to diagnose and plan care.

Question 2: Which are the differences between records filled out by nurses and health care records?

Records filled out by nurses are described as nursing records or nursing files.

We have added the terms filled out and healthcare records. if from the Orem's self-care deficit a part of the records included in the clinical history can give us data about the care determining factors, such records will be useful to diagnose and plan care.

Healthcare records are integrated as a wide and relevant part of the set of health records. It is also necessary take into account the records filled out by nurses, obviating the usefulness that the rest of the history has for these professionals.



Graphc 1 Traditional model versus Conceptual model in the health care records

Question 3: Which is the difference between health record and clinical history?

Both terms can be considered as synonymous. Clinical history implies pathology, a health problem or self-care deficit.

Health record adds to the stated above information related to the user and linked to the promotion of the health and the prevention. With the incorporation of the electronic support this term tends to be used as electronic health record (EHR).

Question 4: Which are the health care records?

All files included in the health history are useful in the accomplishment of care. The Law 41/2002 (2) indicates a set of records including the term nursing. In article 15 of this Law it is established the basic minimum content of the clinical history.

Table 1 Minimum content of the clinical history (Law 41/2002)

Necesary and essential documents	*Necesary and essential documents to ADD in hospitalitation prodess*
Documentation relative to a clínical estadistic sheet.	
	Authorization of revenue
	Report of urgency
Anamnesis and physical exploration	
Evolution	
Medical orders	
Interconsultation sheet	
Reports of complementary explorations.	
	Anformed consent
	Anesthesia report
	Report of operating room or registry of the childbirth
	Report of pathological anatomy
The evolution and planning of nursing care	
The therapeutic application of nursing	
	Signs chart
	Clinical report of discharge

In the clinical practice there are other files filled out by nurses, such as the signs chart. When it is used the term "nursing files" or "nursing records" usually refers to those including assessment, diagnosis and nursing care plans.

Curiel Blacksmith (3) describes, in accordance to the Law, the files included in the clinical history. Inside these there is included the sheet of infirmary urgencies, the initial valuation, the successive valuations, evaluation of infirmary, report of nursing to the discharge, short stays, graph of infirmary, daily, graphical graph of the awakening, sheet of follow-up flooroperating room and sheet of follow-up operating room - plant, sheet of administration of medication, sheet of follow-up of tests. The real situation can differ.

Question 5: Which is the structure of content of records filled out by nurses?

It is necessary to make clear the distinction among conceptual and professional models. Conceptual models define the reason for the object of the nursing discipline, caring, and they are indispensable to develop the professional models. Within the professional models they can be distinguished professional models of process and process of language, where the taxonomies are of particular relevance In nursing

practice is very common to find sub-models of evaluation, based on conceptual models (D. Orem) philosophies (V. Henderson) and valuation structural models (Functional patterns of M. Gordon). In practical nurse is frequent to find submodels of valuation, based on conceptual models (D.Orem), on philosophies (V. Henderson) and in structural models of valuation (functional Bosses of M. Gordon).

The diagnosis sub-model is usually tackled from professional models of language such as the diagnostic taxonomy NANDA. In other submodels there are also aims or results and the interventions.

The variety of orientations of the records is extensive. We must keep in mind that under certain models most of the clinical history consists of health care records since it includes basic conditioning factors that influence when determining a nursing diagnosis and the subsequent care plan.

Question 6: Which standardization do health care records have?

Law 41/2002 (2) suggests the need for a single clinical history per patient and center.

The ISO international level, specifically one of its technical committees ISO/TC 46 is in charge of setting standards in the files field. CEN/CT 251 is related to the European area of standardization in the field of health information. When the meeting took place on June 29th, 1999 it was passed the pre-rule ENV13606 for the Electronic Healthcare Record Communication which collects the structures, terminology, access and distribution rules and messages to a safe communication (Electronic Healthcare Record Communication).

In the international standardization is also notable HL7 (Health Level Seven). It is one of the standards development organizations involved in the health system belonging to the American National Standards Institute (ANSI). Its scope is the clinical and administrative data. The Reference Information Model (RIM) is the cornerstone of the third version of HL7. The RIM is a wide representation of the clinical data (domains) relating them to each other and allowing the use of multimedia information

On a local level, the implementation of the standards is linked to the commission of clinical histories of each hospital and to the technicians responsible for the primary care environment. This process began in the 80s and, as López (11) says, it was when habits and values of health management began to be implemented.

They were started up laws such as the Order 221/1984 (12) which regulates the discharge report to be compulsory for all patients who have been at least once in a health-care establishment, according to the article 3 of the "Real Decreto 2177/1978 ". In addition, it came up the need of creating indicators based on the medical diagnosis

and on their corresponding treatments for a more accurate measurement of the health care activities carried out.

The groups related to the diagnosis (GRDs) arisen in 1983 in the USA MEDICARE as a payment system for patients. It influences the information systems of hospitals, so it emerged the idea of filling out in the clinical history a minimum data set (MDS)

In this process of change towards the quality improvement and the standardization of files the LGS (1) in chapter 1, title 1, article 1, establishes the right of the patient with regard to the different health-care public administrations to record all the process in writing. In chapter 3, article 3; it sets the criterion of a single history per patient, at least within each health-care institution. This law establishes the existence of a set of files integrated on the clinical history that are subject to legal requirements in terms of its design: autopsy report, organ extraction and transplantation and clinical trials (Tests).

In 1987 the "Consejo Interterritorial del SNS" recommended the implementation and use of MDS (H) at discharge. It is compulsory to have established the MDS for each admission and discharge of patients in hospitals. It is made up by the patient's personal data collected by the Admitting office in its master file of patients. These data is complemented with the clinical data provided by the codification of the health-care process at discharge.

The ability to analyze the quality of care has noticeably improved; although as López (11) notes, ambulatory health-care has had a lower development. Although there is no such a MDS in primary health care, some authors have developed a number of possible items that could be considered as the MDS at the first level of care, based on studies on the frequency of occurrence of data in primary health care clinical histories (13) (14)

Lack of normalization is a frequent fact. Let's take Dixon's (15) study as an example; he relates the analysis of clinical files in 6 different University Hospitals where he found 900 different designs. After a process of homogenization and normalization this impossible volume of files was reduced to 20. In Spain they have been also analyzed the processes of normalization in certain centers and services. According to Ribal Prior (16) results obtained are not too encouraging when talking about the problem of acronyms and abbreviations in the clinical history. Something similar happens to the study published by Ruiz Cárdaba (17); he detects in the same hospital that the case history, exploration and development files are filled by 60 ; the admission order by 87.5 and over 90 the chart files, nursing observations and medication sheets.

Romero de San Pio et al. (18) in their study on the nursing record in a hospital ICU they set out the identified problems when filling out the records: succinct

records, unsigned, with no evolutionary changes on the sick person, incomprehensible, repetitive, with no recognizable abbreviations, comments unrelated to the treatment or with non significant tags and the absence or records. The latter two were detected more frequently (16 and 13.4 respectively). Authors describe the level as medium-high but it could be highly improved.

This and other studies capture the real difficulty in maintaining in an accurate way the clinical history according to the law and again, how the use of an electronic device can be an opportunity to improve. According to this idea some authors (8) choose the need of all the information to be recorded in a single point and available to all who need it.

This one and other studies reflect the real) difficulty to support in a suitable way the clinical history according to the legislation and how, again, the utilization of the electronic format can be an opportunity of improvement. In agreement with this idea, some authors (8) are praised (decanted) by the need of that all the information is registered in an alone point and availably for all those who need it.

Analysis conclusions

The term nursing records may be incomplete when it is referring to those health records related to health care.

This categorical statement is easily explainable if, for example, under the self-care deficit theory we expect deal with a problem related to care. In this sense, the conditioning factors influencing the demand are not only those including the "nursing assessment" (such as data requested and filled out by a nurse), diagnosis and care plans; but the information provided from other records and that serve to evaluate such abilities.

In the quotations and bibliographic references underlie the idea of conceiving the clinical history as a kind of documentation linked to the hospital, being omitted the primary health care field. Another idea is the absence of the nurse in the design, the care responsibility, in the record, etc... being this professional figure under the denomination "other health professionals involved in the care of the patient".

Finally, the standardization of the records is a task has undergone significant changes: single clinical histories per hospital and per primary health care area, implementation of the electronic support with applications compatible with care levels among other achievements.

However, there are other issues to be determined; such as achieve single health histories per user in wider care and geographical environments and a wider conception of the records included in the health histories by the nurse.

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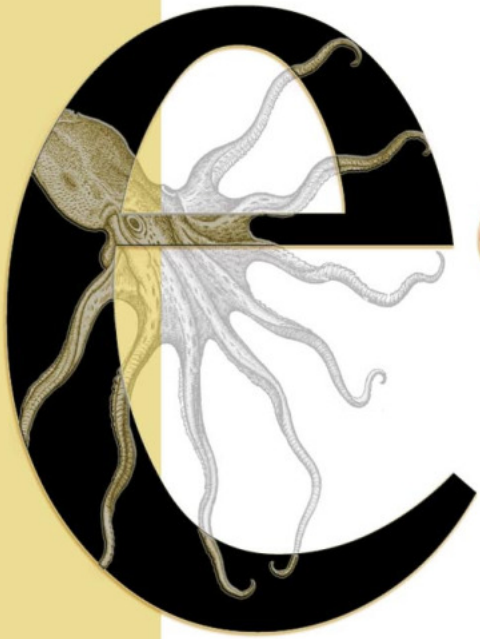

Eduction of Care

Research protocol for the Eduction of Knowledge about Care Taxonomies.

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Key words

Eduction, Taxonomies, Care, Research.

Abstract

Knowledge eduction constitutes a form of its *acquisition* which is centered in obtaining the information from experts of certain knowledge.

The lack of normalization in this type of investigation, which is necessary for the knowledge *conceptualization* at any environment and specially for the knowledge of people care, has forced to the Department of Methodology of FUDEN (Foundation for the Development of Nursing) to approach this normalization so that the developments realised about the care taxonomies incorporate the knowledge of the experts of the care (the clinical ones: in those who reside people direct care) about the same.

Introduction

The present study describes the research protocol for the eduction of knowledge about the existing taxonomies about any of the phases, relating to the nursing care process.

It has been validated through the Department of Methodology FUDEN, demonstrating its usefulness by means of publications from which they stem different doctoral theses focused on the formalization of the knowledge of care.

The publication of this protocol has a double intention: the spread to the scientific community of an effective normalization method of the language of care. On the other hand, it expects to indicate the structure required for the publication in this section of researches about taxonomic eduction..

Results

Below they will be detailed the phases of the research protocol designed and validated for the knowledge eduction that clinicians have about the taxonomic language of care.

This protocol includes a pre-eduction phase.

Phase 0 or Phase "extraction of knowledge ".

The aim of this phase is the acquisition of knowledge from written sources.

Sub-phase 0.1: Information collection sub- phase.

Determination of that updated existing bibliography incorporating knowledge about taxonomies of care.

Sub-phase 0.2 Initial conceptual analysis and clustering sub-phase.

Analysis of the information taking into account the available level of evidence, both for its degree and for the existing conformity in between different sources.

For this analysis, it has been proposed one of the most popular and used techniques: the Structural Analysis of Texts. It consists in seeking the fundamental structures that transmit the knowledge residing in the written language.

This analysis allows establishing::

- *Definitions:* they introduce a new concept in the text.
- *Statements:* they are the phrases or sentences establishing a truth.
- *Laws:* they establish the basic principles of a domain and the rules that mark the functioning of domain objects.
- *Procedures:* they establish the steps to solve problems in the domain

Sub-phase 0.3: Base documentation sub-phase.

It finishes the process of knowledge extraction.

A "Base document" is generated bringing together the knowledge, in a certain moment, on a specific area of the language of care.

Phase 1 or Phase of "knowledge eduction".

To detect the knowledge experts have. The starting point will be the Base Document.

To educt this knowledge it is required the participation in work groups made up of expert nurses specialized in health care.

Subphase 1.1: Sub-phase of creation of the experts' panel.

The characteristics of the experts' panels:

- The members must be expert nurses in health care.
- The number of members can be varied, but in any case it can be less than 8 people.
- They can carry out remote working or work on site.

- A member that carries out the Coordinator's figure of Experts whose mission will consist in:
  - Distribution and receipt of documentation.
  - Explanation of doubts about functioning and dynamics.
  - Monitoring and support for meeting the deadlines of work.
  - Production of the provisional documentation in the process of eduction.
  - Ensuring the fulfillment of the rules based on the rigor of the obtained data.
  - Ensuring that the contributions carried out by experts are limited to the analyzed phase of the process.

Sub-phase 1.2: Procedural eduction sub-phase.

In order to ensure the validity of the obtained results it is used the "Delphy" methodology at "n" returns, with a minimal time of one month and a maximum of three, with three clearly distinct periods:

- *First Period of Grupal Situation:* each one will analyze the knowledge about the aspect of the language to approach, collected in the Base Document.
- *Second Period of Individual Contribution:* the expert will incorporate his/her knowledge on aspects defined by means of extraction in Phase1.

  It must be done based on his professional experience as a caregiver and justified with all available evidence:
  - In the case of books: last editions, including page and chapter.
  - In the case of scientific journals and periodicals (independently of the format, with ISSN or ISBN): last five years, including page and section.
  - In the case of conference reports: last five years, including page and title of the research. En el caso de memorias de congresos: cinco últimos años, indicando página y título de la investigación.
- A second phase of teamwork, where they will be analyzed the contributions made by the members, preparing provisional documents until there is unanimity, moment in which the work concludes.

Conclusions

Although it is not the subject of the article, the obtaining of this protocol has required readjustments for the obtained results to be improving in relation to criteria of effectiveness and efficiency.

The present research protocol has enabled the extension of knowledge about languages of care, demonstrating new research lines and areas of knowledge about this kind of languages not approached up to this moment.

The above protocol is a result of investigation but it will have to be updated and renewed constantly.

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Axioms of Care

As it was stated at the beginning of this paper it is necessary to begin with the "basics".

For the clarity and evidence of the above mentioned statement, it constitutes an axiom by itself that is to say, one of those "fundamental and unprovable principles on which a theory is built".

This idea leads to the existence of a "basic" principle about care, an initial care axiom on which it is possible to build all the explanatory theories: both about its "Why " and its "How".

This "basic" care axiom may be unnoticed, however:

"... care is part of reality... "

The implications inferred from this axiomatic principle are: as part of reality, care can be studied and understood scientifically.

There are other axioms of care, but there are even more not evidenced yet, and therefore not available to the people in charge of studying people care it is a task of each one of the readers of this publication to collaborate in bringing them out into the light.

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