The three automatic actions — and how each one is undone

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Settings fixed by the nurse coordinator, log of set-asides and field closures · fictional document

Fictional document — demonstration example

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Fictional document, produced for the demonstration. **Three actions, not one more, and all three come undone. None of the three writes a clinical item nobody observed, and none closes a field in the nurse's place.**

The three actions

Action	Trigger	What happens	How it is undone
Opening a named field	An item a protocol expects is missing at the expected time	**The field opens in the note: name of the item, time expected, protocol that expects it**	**It closes by itself as soon as the item is entered or read from a device; the nurse can also close it with a word and a reason, which goes back to the protocol**

Action	Trigger	What happens	How it is undone
Timestamped recording of a vital sign	A reading appears in the memory of a unit device	**The value enters the record with the device, the time and the reading identifier**	**The nurse sets it aside with a word and a reason — and the discrepancy stays visible with BOTH values, which is what lets someone read the series six months later**
Completeness flag on a prescription	One of the four elements of art. R4311-7 is missing or illegible	**The document is marked « to be completed » and the request to the prescriber is PREPARED**	**Nothing goes out without the nurse's validation, and they dismiss the flag with a word**

The first action renders a service you only see the following quarter: every field closed with a reason produces **the list of protocol expectations that no longer match the resident. That is how 23 monitoring protocols were identified as describing a rhythm that is no longer the resident's** — the work is proposed, not carried out. **A system that does not record its closures never improves.**

Everything else waits for a named decision

Act	Who takes it	Record
Clinical assessment	**The registered nurse — art. R4311-3 and following**	Care record
Decision to give care, actual order of the round	**The registered nurse**	Care plan, handover note
Validation of a handover note	**The registered nurse**	Care record: name, date, time

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Act	Who takes it	Record
Prescription, and any change to any of its elements — dose, frequency, time	**The physician — art. R4311-7 and L4161-1**	Written, dated, signed prescription
Bringing a consistency rule into service	**The nurse coordinator**	Rule register, dated version
Changing a unit protocol	**The nurse coordinator**	Protocol register, dated version
Disclosing information to a third party	**The registered nurse — art. L1110-4**	Log of disclosures to third parties

Settings for the three actions fixed by the nurse coordinator, on: _____

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