INTRODUCTION

Comprehensive documentation is very important in health care today. This importance cannot be minimized. If a client's record is misplaced on a nursing unit, a vital line of communication is blocked.[1]

During the last decade, much within the literature has been devoted to the enhancement of professionalism in nursing. Many issues have been addressed regarding communication of professional practice through documentation.[2] Documentation reflects the character, the competency and the caring of the nurse. Just like other aspects of nursing have to be learned, practiced and refined, so does documenting.[3]

Quality care depends on the practitioner's ability to handle a large amount of information about the patient. To demonstrate the contribution nursing makes to patient outcomes, nurses need to integrate all clinical data.[4] The quality of client care depends on caregiver's ability to communicate information with one another.[5]

The quality of care deserved by the clients, standards of regulatory agencies, reimbursement structure in the health care system, and the legal guidelines for nursing practice make documentation one of the most important functions of a nurse.[5] Regulatory agencies such as the Joint

Commission on Accreditation of Healthcare Organization (JCAHO) establish standards for nursing service that include several standards related to nursing care and documentation.[6] Also, the American Nurse Association Standards of Nursing Practice (1973) reflect the importance of recording of client data. In addition, the information should be retrievable and confidential.[7]

Current regulations demand that the quality and appropriateness of patient care provided by nursing departments be monitored and evaluated as a part of the hospital's quality assurance program.[8] Such monitoring requires a thorough review of the documentation in a client's medical record.[5] Quality assessment and improvement activities are an essential part of nursing practice, and depend heavily on documentation of nurse-patient interactions and patient outcomes.[9]

In the 125 years separating Nightingale and Benner, the context within which nursing practice, education and the needs of the consumer of nursing services have changed. Nursing has been and remains client-centered. As professionals, we are required to critically examine our services and validate their effectiveness. Quality management may depend on existing records, or the collection of specific data to describe nursing care as it is delivered. The data are then compared to standards of care or predetermined thresholds of acceptable care. When nurses do not record what they do for patients, it is impossible to claim a stake in the positive outcomes of care. More importantly, absence of documentation may associate the nurse with poor outcomes.[10]

The increasing acuity among hospital patients, the complexity of their care, and the expending responsibilities of the staff nurse place a heavy burden on the documentation and communication skills of the nurse. Presently, there is a need for nurses to have timely and accurate data on which to base their clinical judgements.[10] All members of the health care team depend on recorded accurate information which ensures continuity and quality of care.[5]

JCAHO audits clients' records yearly, and encourages hospitals to set-up on-going quality assurance programs. If deficiencies are detected, educational programs can be designed to improve outcomes in these areas.[11]

Despite the publication of a detailed report by the World Health Organization (WHO, 1983) regarding the aim, methods, principles and recommendations for record writing, difficulties still persist.[12] Nurses openly acknowledge problems with accuracy, completeness, and timeliness.[13]

Improving documentation can be approached in four ways: using a nursing assessment tool, change, education, and evaluation.[14] Development of a documentation system should follow standards dictated by the JCAHO, reflect the philosophy of the department, and the way nursing care is given to clients.[11, 15] Change process requires overcoming the problems of documenting care, and inherent in the development and implementation of new system.[2] Educational process serves as the foundation for the implementation of new documentation system, and enhances the change process.[2, 10] Evaluation provides an effective indicator of in-service

education, and justifies staffing requirements or changes.[2, 14] This can be done through nursing audit and patient questionnaire.[16] Retrospective nursing audit is easy, economic, and provides a good global perspective. Phaneuf developed an audit that suggests audit using problem-oriented records.[17] Another evaluation method is patient questionnaire, which surveys patient's general satisfaction in order to detect problems areas, and obstacles to effective patient care retrospectively.[16, 18, 19]

Several research efforts have been used in USA on problem-oriented record system of documentation. The audit results show that the use of this system improved the documentation of nursing care.[14, 20, 21]

However, studies done in this field in Egypt are limited. The results show that nursing documentation system lacks some of its components in both medical and surgical units. Record writing is a particular problem in most of the Egyptian hospitals.[22, 23, 24, 25, 26, 27]

Therefore, there is a need to develop a nursing documentation system that has all principles of good documentation and to prepare the staff to use it, through change process and educational program. This would be followed by evaluation of the effect of introducing this system on the quality of documentation and quality of care. It is our hope that the nurse appreciates the importance of recording as an essential component of professional nursing, and strives to develop the requisites of knowledge and skills in these aspects of professional practice.