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EDITORIAL

THE NURSING PROCESS: INTERFACES WITH
THE HOSPITAL ACCREDITATION PROCESS

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Improvement in patient safety and the quality of healthcare have received special attention worldwide and are a top priority for the World Health Organization (WHO)[1,2]. In this respect, many hospitals recognize the need to develop strategies that prevent or minimize the chances of errors and failures in their services by implementing the hospital accreditation standards of the Joint Commission International (JCI).

The JCI offers the international community objective processes based on healthcare assessment standards, aimed primarily at promoting continuous and sustained improvement in these institutions[3]. Thus, the pursuit of qualification and safety in healthcare, combined with its growing complexity in the face of factors such as scientific and technological advances, challenges nurses to develop intellectual, technical and interpersonal skills for performing systemic activities aimed at reducing undesirable outcomes.

In conjunction with the accreditation process, the nursing process (NP) is an important guide in the organization and documentation of professional practice, with a view to qualifying nursing care[4,5]. As stipulated in the Nursing Code of Ethics[6] and Resolution COFEN 358/2009[4], recording inherent information essential to care on patients' medical charts is a professional obligation and forms part of the NP: data collection, diagnosis, planning, intervention and evaluating results. In turn, when recorded fully and accurately, the information generated by the NP can ensure the continuity of care and promote patient safety, as stipulated by the WHO and JCI.

The JCI manual of Hospital Accreditation Standards is divided into two main sections, the most noteworthy of which is "Patient-Centered Standards". This section includes a chapter on the Assessment of Patients (AOP), which consists of three basic processes: data collection, data and information analysis, and developing a care plan[3]. These activities are also included in some phases of the NP, which identify the need to gather information from the patient on which to base your diagnosis and in order to plan care. Similarly, the Care of Patients (COP) chapter focuses on establishing basic care activities according to the goals to be achieved[3]. Once again, this point is closely related to the planning, intervention and result assessment stages of the NP.

Thus, considering the hospital accreditation scenario, the search for quality care is also based on recording coherent information, which is decisive to the adoption of measures that increase safety. To that end, it is important to reorganize work processes, continuously train staff to value and adhere to the recommended standards, and create instruments that support rather than hamper patient care records. Information management must be dynamic and form part of a whole. In this regard, information technology and nursing classification systems are excellent tools that facilitate the application of the nursing process, as well as optimizing and lending visibility to healthcare records[7], which improve the safety and quality of care. We therefore reiterate the interface between the nursing process and hospital accreditation, given that records are one of the most important testaments to safe care.

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