Ministry of Higher Education

& Scientific Research

University of Babylon

College of Nursing

Nursing Documentation of Hygiene Practices for Unconscious Patients in Intensive Care Unit at Neurosurgical Hospital in Baghdad

A Thesis Submitted

By

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To

College of Nursing, University of Babylon

in Partial Fulfillment of the Requirements for the Degree of

Master in Nursing Sciences

Supervised by

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September 2022 A.D Safar 1444 A.H

بِسْمِ اللهِ الرَّحْمَنِ الرَّحِيمِ

ن وَالْقَلَمِ وَمَا يَسْطُرُونَ

صدق الله العلي العظيم

سورة القلم

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Supervisor Certification

I certify that this thesis, entitled **Nursing Documentation of Hygiene practices for Unconscious Patients in Intensive Care Unit at Neurosurgical Hospital in Baghdad)**, submitted by **Kadhim Hussein Jassim** was prepared under my supervision and guidance at the Department of Adult Health Nursing, College of Nursing, University of Babylon as a partial fulfillment of the requirement for the Degree of Master in Nursing Sciences.

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Certification

We, the examining committee, certify that we have read this dissertation **(Nursing Documentation of Hygiene practices for Unconscious Patients in Intensive Care Unit at Neurosurgical Hospital in Baghdad)**, which is submitted by **Kadhim Hussein Jassim** from the department of Adult Health Nursing, and we have examined the student in its contents, and what is related to it and we decide that it is adequate for awarding the degree of (Master) in nursing Sciences with specialty of (Adult Health Nursing) .

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Dedication

To the Grandson of the prophet (peace be upon him) our guide and leader Al-Imam Al-Mahdi

(peace be upon him).

To the our heroes on the battle field.

To the pure souls of our martyrs.

To my idol in life, who gave me her blood, soul and love… My Mother.

To the pure spirit whom I carry his name proudly... My Father.

To my amazing wife.

To my brothers and my lovely children.

Acknowledgements

Praise to the Almighty Allah, the glorious creator of the universe, for his kindness and mercy, and blessing upon Mohammad the prophet our first master.

I would like to express my sincere thanks to Prof. Dr.Ameen A. Yasir

, Dean of the College of Nursing, University of Babylon for his support.

It is a pleasure to express my deep appreciation to my supervisor. Prof. Dr. Shatha Saadi Mohammed for her valuable guidance, assistance, co-operation and motivation throughout the course of my thesis preparation.

I thank also all the distinguished panel of experts who have arbitrated the study tool.

Thanks and gratitude is also extended to all teachers in my college and experts for their help, advices and comments regarding the study. Thanks is also extended to all teachers in College of Nursing, University of Baghdad. Finally, I would like to express my appreciation to all employees of intensive care units in Neurosurgery Teaching Hospital in Baghdad for facilitating my research and completing the study.

Abstract

Nursing documentation is part of nurses' medical notes and a source of basic and essential information in health care, a patient record containing all written information about a patient's condition and needs, and nursing tasks as it serves many different purposes. The aims of the study are to assess the nursing documentation of hygiene practice for unconscious patients in the intensive care unit at the neurosurgical hospital in Baghdad and to find out the relationship between nurses' documentation of unconscious patient hygiene practice and their demographic characteristics. The study was conducted for the period from 9th of February 2022 to 26 June 2022.The observational checklist has been applied by researcher to a convenience (non-probability) method of (107) nurses was selected to carry out the study who are work in intensive care unit at Neurosurgical Teaching Hospital regarding to the Al-Rusafa Health Baghdad Directorate . The questionnaire consists of (51)items. The study was conducted to observe the nursing documentation of the nurse's related hygiene of the unconscious patients. The instrument of the study was built to achieve the desired study objectives. The instrument has been tested for validity and reliability. The findings reveal that most of the sample patients were male, the age ranged from (30-39) years, and the (65.4%) of nurses exhibited poor documentation of hygiene practices for unconscious patients, the most of the study sample hadn't training sessions related to documenting in nursing. The study participants illustrate significant differences in nurses' documentation of hygiene for unconscious patients with socio-demographic data such as (education level, years of experience, and training course). While there were no significant differences in nurses' documentation of hygiene for these participants with (age and gender). The findings revealed that overall assessment for the documentation of the

nursing staff was poor. It reveals that there is a significant difference in nurses' documentation of hygiene for unconscious patients with their education level, years of experience, and training course. Regarding to the recommendations, nurses should be given training sessions as a unique challenge to demonstrate the importance of documentation and recording nursing activities. Developing multidisciplinary electronic nursing documentation tools to assist with patient care implementation.

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List of Abbreviations and Symbols

Item	Meaning
ANOVA	Analysis of Variance
CBE	Charting By Exception
CCU	Critical Care Unit
CT scan	A computerized Tomography
E.C.G.	Electro-Cardio-Graphy
et al.,	And others
F	Frequency
H0	Null Hypothesis
H1	Alternative Hypothesis
HS	High Significant
ICU	intensive care unit
IPH	Interventional Patient Hygiene
M.R.I.	Magnetic Resonance Imaging
MS	Mean Score
No.	Number
NS	No Significant
OH	Oral Hygiene
PPE	Personal Protection Equipment
RNs	Register nurses
S.O	Source-oriented
SD	Standard Deviation
SDVs	. Descriptive Statistic of Socio-Demographic Variables
SPSS	Statistical Package for Social Sciences and and
T	t- test
US	United State
VAP	Ventilator-associated Pneumonia
WHO	World Health Organization
X-Ray	Roentgen ray
≤	Less or Equal
<	Less Than
≥	More or Equal

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Chapter One

Introduction

Chapter One

1.2. Introduction

Nursing documentation is part of nurses' medical notes and a source of basic and essential information in health care, a patient record containing all written information about a patient's condition and needs, and nursing tasks as it serves many different purposes (Inan & Dinç, 2013).

The goal of nursing documentation study is to show that the organization maintains written evidence for its planning, implementation, evaluation, and evaluation of patient care, it is also considered as a source of knowledge for aspiring nurses and possibly for the development of nursing theory (Wang et al., 2011). Whereas previous writings provided evidence of patient progress, this one should include rationale and basic critical thinking for clinical decisions, interventions, and nursing staff evaluations, as well as conform to established standards (Hameed & Allo, 2014).

The medical record is a legally binding document that can be used for a variety of purposes. In legal terms, it is a critical component in defending against potential legal challenges arising from carelessness or professional misconduct. From admission to discharge, the medical record is the only permanent record of the patient's care (Wang et al., 2020). A well-maintained record aids healthcare providers in better managing patient care, but a poorly maintained record raises the chance of medical errors. Consider medication errors caused by illegible handwriting or a lack of documentation of a drug's administration. While the medical record can be used for a variety of purposes, its primary function is to facilitate patient care continuity. Always keep in mind that the patient is at the core of all you do (Johnson et al., 2010).

Furthermore, documentation on a customer's health record, alike sheet, electronic, audio, or visual, is utilized to monitor a customer's advance and communication with other care providers, as well as for else aims like quality assurance, legal purposes, health planning, resource allocation, nursing research, and development to achieve these goals (Demirci et al., 2017).

As a result, documentation in nursing is considered a vital tactic for communicating patients' information to nurses and other care providers, but it can be rough for busy nurses to clarify patients' information by notes and studied through research (Cheevakasemsook et al., 2006).

In addition, an Australian study proved that the implementation of standards resulted in a significant improvement in nursing documentation. The goal of this project was to create and experience a quick audit tool for assessing the implementation of documentation requirements and to monitor nurses' written documentation of their treatment on a continual basis (Saranto et al., 2009).

Hygiene indicates a set of practices that are carried out in order to maintain the health of an individual. Hygiene, according to the WHO, signifies conditions and activities that help in the preservation of health and prevent the transmission of illnesses. While hygiene is commonly equated with "cleanliness" in popular culture, its complete and original definition encompasses all situations and tactics, lifestyles matters, premises, and commodities that contribute to a safe and wholesome environment (Inan & Dinç, 2013).

Whilst present-day medical science has established a pack of cleanliness criteria for various settings, what is deemed hygienic or not varies among cultures, genders, and ethnic groups (Lindo et al., 2016). Regular hygienic

behaviors are might be regarded as good habits in society, whereas hygiene ignoring may be regarded as repulsive, insulting, or even dangerous. Medical hygiene refers to the procedures that are used in the delivery of medicine and medical treatment to prevent or reduce disease and disease transmission (Abd Alraheem, 2020).

Correct nursing documentation is considered one of the pillars of hygiene for unconscious patients, because it is considered a link between the health team that rotates patients in the intensive care units, and it is a working guide to follow up personal hygiene and without it, a complete qualitative nurse intervention and even effective patient care are impossible (Ioanna et al 2007)

One of the most common personalized nursing care actions is saving patients' hygiene, which is normally decided solely by the caring nurse's discretion. When patients are mechanically ventilated or confined to bed with life-threatening conditions, it is frequently performed in critical care units such as neurology clinics or intensive care units (Inan & Dinç, 2013). Patient hygiene offers numerous benefits, including removing bacteria and perspiration from the skin, lowering infection risk, boosting blood circulation, offering relaxation and comfort, and enhancing the patient's self-image and mental health. (Nisser, & Ycaza, (2017).

Furthermore, if documented, providing sanitary care to patients is considered from a visible nursing care activity. Some of the studies have shown, however, that nurses' hygienic care actions are similarly badly documented. Nursing work can be hampered by insufficient proper and/or poor documentation, which can have a detrimental influence on patients' care and the efficiency, goodness, and clarity of nursing work. As a result,

there is a paucity of empirical evidence of nursing documentation of patient health care (Menon et al., 2020).

In addition, unconsciousness is described as an inability to respond with people or activities. Doctors refer to this as a comatose or being in a coma. Other changes in cognition can occur even if you are not unconscious. Alteration in mental status is the term for this (Puggina et al., 2012).

1.2. Importance of the study:

Documentation is of great importance in the delivery of care services and through which we can develop the services provided to the patient as well as the changes that occur in the patient and know the extent of his or her response to nursing interventions and is viewed as a means of communicating with the patient Health team. Detailed care documentation in the medical record provides legal evidence that the care provided complies with recognized care standards (Choi, 2021).

Furthermore, it is regarded as a necessary matter in the profession of nursing, as it provides the structural, harmonic, and effective communication wanted for the submission of high-quality care for patients that meet legal and professional standards, where the nurses spend nearly (15%) to (25%) from each turn of duty for documenting patients' care (Wang et al., 2011).

Where there are a number of aspects that can influence the goodness of documentation, including staffing levels, nurses' education, and training (Blake- Mowatt et al., 2013).

Since the time of Florence Nightingale, documentation has been considered from the most significant duty of nurses because it backs up varied and different purposes. Documentation is required nowadays in the

healthcare systems to assure the continuation of care, provide a legal record of the care process, and aid in the appraisal of the patients quality care (Cheevakasemsook et al., 2006).

As a result, nurses are encouraged to examine their documentation processes critically in order to guarantee that the documentation is understandable to readers both within and outside the field. The documentation, on the other hand, is more important because it serves as a communication tool for all health-care personnel (Choi, 2021).

There are various impediments to documentation, like ambiguous language or the utilization of unofficial acronyms, where the patient's status, care, and response to care should be documented using defined nursing documentation principles (Jefferies et al., 2012).

Furthermore, a slew of studies has emphasized the need for nursing recordkeeping. Accurate documentation, for example, enhances communication and cooperating, Assists with the legal aspect of the process and treatment outcomes, assists patients in decision-making and safety, and adheres to professional standards and practice (Blake- Mowatt et al., 2013).

Florence Nightingale was the first to recognize documentation as an important part of a nurse's professional practice. It is still considered one of the major core competencies today (Lindo et al., 2016).

Nursing documentation, on the other hand, reflects the entire sequence of nurse processes, from assessments of nursing and diagnosis of nursing to nursing interventions, nursing implementation and evaluation, and, finally, response of patient and results.(Austin, 2011).

Nurses in the United States and around the world are concerned about the goodness of documentation. Documentation must, but oftentimes doesn't demonstrate the rationalistic and critical thinking that underpins

clinical decisions and actions whilst giving a documented record of the patient's development (Choi, 2021). Some of the frameworks presently available to help in the documentation include (problem-oriented approaches, narrative charting, focus notes, and clinical pathways). A lot of staff of nursing, on the other hand, continues to struggle with keeping correct and legally sound paperwork (Blair& Smith, 2012).

More than half of hospitals in the United States still employ paper-based paperwork. Similarly, paper-based documentation is still widely used in parts of Germany, the United Kingdom, and the majority of low- and middle-income countries (Nakate et al., 2015).

Another study conducted in the ICUs of an academic hospital in the Western Cape found that nursing documentation in the intense unit is insufficient within the first 48 hours of arrival. Where poor documentation jeopardizes patient safety and necessitates immediate improvement (Hector, 2010)

Similarly, the paperwork in the Jamaican healthcare system is mostly centered on a paper based on the health record system. As a result, developing policies to manage nursing documentation and emphasizing the prominence of "documentation and record-keeping quality in nursing practice, nursing education, and nurse continuing education" can't be overstated (Inan, & Dinç, 2013).

While in Brazil, documentation became a major focus of evaluation at institutions, both organizationally and in terms of aid. As a result, the accuracy of computerized nursing documentation plays a critical role in securing hospital accreditation (Nomura et al., 2016).

On the other hand, in most cases in Iran, documentation standards are not considered, and for example, healthcare services provided to

patients are not always recorded completely in the patient's medical file; as a result, one out of every four cases of patient care negligence is attributed to nursing documentation errors (Tajabadi et al., 2020). When inadequate documentation of nursing care has a substantial impact on the diagnosis and management of critical clinical problems. The most typical sorts of documentation flaws are failing to document critical caring issues, documentation at inopportune periods, use of jargon or deceptive material, and the existence of uncertainty in reports (Choi, 2021).

Furthermore, according to a 2013 study conducted in Turkey, the consistency amidst real patients' sanitary treatment and their documentation was (77.6%). Where nursing recordings were of inferior quality and insufficient for reflecting individualized nursing care. Whereas the findings show that, in order to improve the evidential value of nursing records, more focus on their quality should be placed on nursing practice and education (Inan & Dinç, 2013).

1.3. Statement of problem:

Nursing documentation of hygiene practices for unconscious patients in intensive care unit at neurosurgical hospital in Baghdad.

In the intensive care unit nurses have a great responsibility for caring for the patients. Every day they need more time to monitor the status of unconscious patients, also pay great attention to the aspect of their hygiene. Therefore, they need scientific knowledge and practices to manage this matter and document it, which is reflected in the quality of care provided to these patients, so the documentation is considered an important matter

1.4. Objectives of a study:

1. To assess the nursing documentation of hygiene practice for unconscious patients in intensive care unit at neurosurgical hospital in Baghdad.

2. To find out the relationship between nurses' documentation toward unconscious patient hygiene practice and their demographic characteristics, e.g.: age, gender, education level, experiences years in nursing, experiences years in intensive care unit.

1.5. Definition of terms:

1.5.1. Nursing documentation:

Theoretical definition:

The written record of care that is delivered by nursing staff or health care to patients under the guidance of a competent nurse, where is considered the most significant provenance of clinical data for meeting legal and professional standards in nursing. Also, it is a significant facet of safe, ethical, and effective nursing practice, whether carried out manually or electronically. Whereas it must adhere to all legal requirements for the documenting of nursing care (De Groot, et al., 2019).

Operational definition:

Under the steering of a qualified nurse, documentation is considered records of the nursing care that nursing staff or health care plan and administer for specific patients. Nursing documentation is the major source to clinical information to meet legal and professional standards.

1.5.2. Unconscious Patients:

Theoretical definition:

The patients who are in a coma for a long time due to situations such as stroke, brain tumor, or head injury are all considered to be in a clinical condition (Maas et al., 2017).

Operational definition:

The comatose patient is complete bed rest in the ICU at the Hospital Neurosurgery Teaching which needs to meet daily requirements such as personal hygiene by the ICU nurses.

1.5.3. Intensive Care Units (ICUs):

Theoretical definition:

The most stressful parts of a hospital are the intensive care units. ICU workers must often unravel a complicated web of causal elements while making several treatment options in quick succession to restore organ function and general health in patients with acute life-threatening illnesses (Azoulay, et al., 2009).

Operational definition:

Is a unique unit for comatose patients or those with disabilities in the ICU of a teaching neurosurgical hospital in Baghdad that contains several teams and skilled nursing personnel that give high-quality treatment?

1.5.4. Hygiene

Theoretical definition:

Cleanliness is the practice or principles of keeping oneself and one's surroundings clean in order to maintain health and avoid disease (McCreary, (2009).

Operational definition:

The personal responsibility of the patient in the event of the ability to meet this need and the caretakers of the unconscious patient in the hospital by the nurses in the ICU of the for-neurosurgery teaching hospital.

Chapter Two

Literature Review

Chapter Two

Literatures Review

2.1. Historical background

2.1.1. Documentation in time Hippocrates (460-377) before birth:

The first historical references to Hippocrates received in the Analects of the Greek philosopher Plato with (Phaedrus) Alobaqrati discussions of education, and in the dialogue (Protagoras), Socrates says to his companion: "If you paid money to Hippocrates, and asks why people pay him this money, what you would answer, he said: I give money to it Doctor (Miles, 2004).

Needless to say, he cannot talk about the history of human medicine in the world, without talking to Hippocrates as was the first to record observations, and the owner of the oldest medical books in history. Apart from the humanitarian papyri Paranoiac, and before the Hippocratic Medicine in Greece was limited to family as aglbius that Hippocrates was one of them, and inherited the family medicine industry, even less than in the time of Hippocrates, As feared that Livni Medicine of the world aware of strangers medicine, and began writing books on the side of brevity (Tofiq, 1996).

2.1.2. Miss Nightingale Writings:

Throughout her lifetime, Florence Nightingale worked extensively about hospitals, Sanitation, ventilation, health and health statistics, and especially about nursing education, but she contributed little on documentation and record nursing observation (Ellis and Hertley, 2001).

Nutting and dock (2000), mention about Nightingale writings:

"the most important practical lesson that can be given to nurses is to teach them what to observe, how to observe, what symptom indicate improvement what the reverse", which is of very important importance note to be taken by medical wards nurses in documenting the nursing intervention and outcome. Also the information and facts must be recorded accurately in patient charting.

Florence Nightingale thought, and in all of her efforts throughout her life, that the administrator could only succeed if he was directed by documented statistical knowledge. Too often, the legislator, let alone the politician, fails due to a lack of expertise. She went even further: she believed that the cosmos, including human communities, was unfolding in accordance with a divine purpose, which he should try to understand and govern his actions in accordance with. But, she claimed, we must study statistics in order to comprehend God's thinking, because statistics are the measure of his intent. As a result, studying documentation statistics was a holy obligation for her (Schuyler, 1992).

2.2. Guideline for quality documentation and record

To improve efficient, tailored patient care, quality documentation and reporting are required. Nova Scotia's College of Registered Nurses (2012); Koizer and other (2004); Smiltzer and Bare (2002); Smith and other (2004); Potter and Perry (2003); Smith and Duell (2000); Moffet and Hill (2000); Potter and Perry (2000) stated that are many important guidelines which must be followed for quality documentation and reporting (Davies et al., 2019).

2.2.1. Factual basis:

Information documentation about patient and their care should be actual. Goal information based on firsthand experience, the nurse's assessment, and the client understands of their requirements. What a nurse sees, hears, feels, and smells should be recorded in a descriptive, objective manner. Furthermore, documentation should clearly clarify the nurse's observations of the patient's behaviors rather than interpreting those (Amwar et al., 2002).

2.2.2. Accuracy:

The patient record must be accurate so that precise documentation is sustained. The use of exact measurement ensures that a record is accurate. Information that is clear and easy to comprehend and contains details that are important to the client, as well as variations in the client's response to treatment. Furthermore, if the documentation is to be used fully, either clinically or for search, accuracy is critical (Olawaleeta et al.,2015).

It is critical for good documentation to utilize descriptive, factual terminology to chart exactly what was observed or done, with perfect spelling. It is also important to use abbreviations that will not be misinterpreted. Furthermore, nurses must never chart for others or allow others to chart for them, and any descriptive note in a patient's record must conclude with the caregiver's full name and status (Paans et al.,2011).

2.2.3. Completeness:

Complete, succinct, and thorough information should be included in any record entry or report. Information that adequately reflects the client's care requirements, nurse interventions, and anticipated outcomes. When reports are incomplete communication is compromise and when concise data is easy to understand and clear, succinct working makes interpretation

easier, while a long report wastes time and is often boring. Furthermore, a good report or record is essential to protect both the patient and the nurse (Lai et al.,2019).

2.2.4. Currentness:

Information that is current and was recorded during or shortly after the intervention or encounter took place. In the patient's contemporaneous care, prompt entries are critical; delays in documentation can lead to major omissions and untimely delays in patient care.

The following activities or findings must be communicated at the correct time:-

1. Vital indicators.
2. Medication and treatment administration
3. Diagnostic test or surgery preparation.
4. Changes in the patient's condition.
5. The patient's admission, transfer, discharge, or death.
6. Treatment for a patient's rapid change in condition.
7. The patient's reaction to the intervention.

Many agencies utilize military time, a 24-hour system that uses a digit number to determine morning, afternoon, and evening hours, while others use civil time. (Am,Pm) (Cabitza, & Gesso,2010).

2.2.5. Organization:

The nurse presents information in a logical sequence. When information is delivered in the order in which it occurred, health care team members grasp it better. And keep track of the information in a logical order so that nursing decisions, actions, and client reactions to those activities may be seen. Furthermore, it was mentioned that every entry

should begin with the date and time, and that data should be charted in a timely manner to avoid omission of important information.

The chaotic not is strewn together and does not clarify what happened to the patient first. Furthermore, disorganized notes can cause misunderstanding regarding whether or not sufficient care was provided (Bond et al.,2018).

2.2.6. Confidentiality:

A confidentiality communication information given by one person to another with trust and confidence that such information will not be disclosed. The low protect information about patient that is gathered by examination (Stablein et al., 2018). Information is reflect of the delivery of safe, competent, ethical and compassionate nursing care and consistent with standards of practice, so it is the nurse's responsibility to protect the privacy and confidentiality of patient interaction assessment and care given. Furthermore, in many institutions, particularly teaching hospitals, patient records may be used for education or research purposes, that user should not break confidentiality, as long as the records are used as specified and permission that is granted from hospital internal review boards (Hecker & Edwards 2014).

2.3. Methods of documentation.

The documentation system selected by the nursing service should reflect the philosophy of the department and the way the nursing care is implementation. The two most common types of documentation are documentation by inclusion and documentation by exception. All assessment results, nurse actions, and client outcomes are documented on a regular basis in inclusion documentation. By contrast, documenting by

exception documents unfavorable outcomes and is completed after the evaluation is concluded (**Blair**, 2012).

Healthcare professionals have been required to adhere to societal norms, expert standards of practice, legal and regulatory standards, and institutional policies and standards; consequently, systems for recording and reporting data pertinent to client care have primarily evolved in response to these requirements. Current documentation systems reflect the many needs and preferences of today's healthcare professionals (**Blair**, 2012).

Client care needs and the environment of practice must be reflected in the documentation technique used within an agency or practice setting. Various documentation approaches and formats may be combined by some agencies. If an agency wishes to update its documentation or expectations method or format, it's vital that this happens as part of a well-thought-out plan that involves nurse engagement and education. Nurses are responsible for documenting client assessments, interventions, and the effect of interventions on client outcomes, regardless of the technique utilized. Clients who are terminally sick, at high risk, or who have several medical issues need more detailed, in-depth, and regular reporting (Bose, 2019).

2.3.1. Narrative documentation:

The conventional technique of nursing documentation, narrative charting, is a tale structure that describes the client's state, interventions and treatments, and treatment response. This was the only way to document care before the invention of flow sheets. During an 8-hour shift, nurses spent about 30% of their time on narrative charting (Moss et. al., 2007)

In emergency scenarios where a clear, chronological arrangement is required, narrative documentation is straightforward to employ. However, it

is impossible to resist being subjective in this form of recording, and there is usually a lack of analysis and critical decision-making on the side of the nurse. Because the flow of care is disordered, narrative charting is being supplanted by other styles. It's tough to demonstrate a link between data and critical-thinking abilities (Byrne et al, 2012).

2.3.2. Source-oriented charting

Source-oriented (S.O.) chart is described as each member of the health care team (source) documenting a narrative on separate records. Care is typically fragmented, and communication across specialists takes time since each specialty retains its own record. S.O. charting has comparable benefits and drawbacks to narrative charting since nurses utilize an unstructured technique of reporting in progress notes (Chowdhry et al, 2017).

Source-oriented documentation is a type of narrative documentation in which each member of the health team keeps their own narrative notes, usually in their own records, with little or no multidisciplinary information sharing. This is a conventional technique of collecting records, but it can lead to fragmented treatment and time-consuming information sharing meetings. Many organizations have abandoned this method of documentation (Lockwood, 2020).

2.3.3. Problem- oriented charting

The patient's problems are the emphasis of the problem-oriented charting system. It, too, begins with a medical history and assessment of the patient. Based on the patient's assessment, a problem list is generated, and a care plan is created that outlines how the health team will handle each concern. At the end of each shift, progress notes are written, and a discharge report is created for the patient (Saletnik et al., 2008).

2.3.5. Focus charting

It's a type of charting that addresses a patient's problems or requirements and includes a column that summarizes the entry's topic. It's meant to put the client and their worries and strengths at the center of care. It is a system for arranging health information in a person's file. A systematic method to documentation is called focus charting (Blair &Smith, 2012).

The nurse determines a "focus" based on client concerns or behaviors recognized during the evaluation, a current client worry or behavior, including such decreased urinary output, a transition in a patient's case or behavior, such as dizziness to time, place, and person, and a major event in the client's diagnosis, such as the client's return from surgical procedure. The assessment of focus charting. (Alvarez, 2018).

2.3.6. Charting by exception

It's a novel way to streamline documentation, requiring the nurse to only capture deviations from pre-determined standards. St. Luke Medical Center in Milwaukee implemented it in 1983 to address the problem of long, repetitive notes and to make the identification of patterns in patient condition more visible. It is also mentioned that it is a shorthand approach for documenting normal finding and regular treatment based on specified nurse evaluations and intervention criteria and explicitly established professional standards (Kerr, 2011).

In addition, the form comprises the teaching record and discharge notes, implying that the parts of the (CBE) system have three main components.

1. Flow sheets: emphasize key findings and set evaluation parameters and outcomes.

2. Reference documentation: is related to nursing practice standards. (Unless otherwise specified, all criteria are met.)

3. Accessibility at the bedside: this is linked to the documentation forms. The nurse is required by CBE to document any significant discoveries or deviations from specified norms.

2.3.7. Computerized documentation:

To better monitor hospital finances, administrators began to invest in electronic systems in the late 1960s and early 1970s to handle accounting systems (accounts payable, accounts receivable, admissions, discharges, and transfers). Department directors began to find applications for computers within their specialty departments as computerization capabilities grew: laboratory, radiology, pharmacy, and, of course, nursing. Some of the first computerized nursing systems were adopted from order entry or financial systems. These systems were designed primarily for financial purposes and, secondarily, for nursing (Saletnik et al, 2011).

In response to the high need for clinical, administrative, and regulatory information, the modern health-care system has urged nursing leaders to build computerized records. "The health-care business has learnt from other industries that computers make communication faster, information more accurate, and information storage, retrieval, and revision easier" (Paans, W et al,).

Thorough computerized documentation is a prerequisite for optimal patient care, an important component of clinical documentation, and a vehicle for effective interdisciplinary communication and collaboration. (Korihara et al., 2001).

The use of computers Nursing Informatics: An Open Access Journal Page 3 of 20 is becoming more popular as a means of enhancing efficiency, care quality, and documentation accuracy (Chand, 2014).

Nursing documentation has an impact on hospital reimbursement, which means that, unlike other professions, what nurses' document or leave out has an effect on the bottom line.

Type of information's stored in the computerized clinical records includes the following:-

- Intake record.
- Assessment.
- Care plan.
- Nursing clinical vital notes.
- Physician order request.
- Discharge summary.
- Laboratory results.
- Therapeutic clinical documentation.

Some computer software companies developed a system that can effectively computerized and integrate some or all the following:-

- Admission data.
- Nursing history.
- Medical record obstructs.
- Nursing diagnosis.
- Patient acuity.
- Diagnosis-related group assignment.
- Nursing order.
- Individualized nursing care plan.
- Automated kardex.

- Nursing goals.
- Measurable patient outcome.
- Nursing intervention.

2.3.7.1. Learning a Computerized nursing information system:

An overview of the system can help a nurse get started. Before employing the nursing information system on the nursing unit, the best way to learn how to use a computerized information system is to enroll in a structured training session followed by supervised practice. What types of forms are included in the clinical record, how does data flow, and how is data shared with other parts of the clinical record? The nurse should read about how to care for the hardware, understand the software screen progression and how to move from one screen to the next, understand what the icon or processing buttons imply, and watch a demonstration of what to do or who to call. (Saletnik et al, 2011).

2.4. Categories of documentation forms in a clinical record system.

Patient information in clinical record is documented within four basic categories of forms:

2.4.1. Assessment and data base forms; that include:

1) Intake or admission record.
2) Nursing history and assessment.
3) Medical history and physical examination.
4) Test results:

- Laboratory.
- X-Ray.
- E.C.G.
- M.R.I.
- CT scan

- Diagnostic test result data.

2.4.2. Plan of care forms; that include:

1) Orders from the doctor.

2) Plan of care for patients, including medical directives.

3) An assessment medical plan or patient records documenting a multidiscipline comprehensive care plan.

4) Plans for testing that may be distinct or integrated. into a treatment strategy

5) Kardex.

2.4.3. A record of progress; that include

a) Documentation of clinical report form by all specialties involved in the patient's treatment.

b) A record kept by the medical staff.

c) Reports on how things turned out.

- The weekly overview of the narrative findings.
- A record of the outcomes of the nursing strategy.
- Outcomes recorded in accordance with predetermined standards.

2.4.4. The basis of long-term care; that include

a) Record's teaching.

b) Progress report.

c) Transfer the forms.

d) Summary discharge.

(Park et al, 2019).

2.5. Documentation nursing activities:

Nurses utilize a number of forms throughout the clinical record to document evidence of the nursing process, which should explain the

patient's current status and reflect the full range of the nursing process (Kozier et al, 2018).

2.5.1. Admission Nursing Assessment:

When a patient is admitted to the nursing unit, a full entrance evaluation, also known as an initial database, nursing history, or nursing assessment, is done. A nurse should do an admission evaluation with a parent or care giver as soon as possible after arrival to the ward or preadmission, but no later than 24 hours after admission. On the nursing admission form, the admission assessment must be documented. The patient's privacy must be respected at all times (Toney-Butler, & Unison-Pace, 2018).

2.5.2. Nursing Care Plan:

A patient's nursing care will be offered. It is a collection of measures taken by the nurse to address nursing issues highlighted during the evaluation. The planning stage of the nursing process is an intermediate one. It assists in the provision of continuing nursing care and in the evaluation of such care. Traditional and standardized nursing care plans are the two types of nursing care plans. The traditional care plan is developed for each patient, and the form differs from agency to agency depending on the patient and department requirements. The majority of forms include three columns: one for nursing diagnosis, one for expected outcome, and one for nursing intervention. The standardized care plan was created to help people save time (Shala, et al ., 2021).

2.5.3. Kardexes:

Kardex (kar-deks) was the initial name for a proprietary file system for nursing records and orders that was kept centrally on the ward and contained all of the nursing information and observations of patients

obtained during their hospital stay. Despite the fact that this system is no longer utilized for nursing records, because care plans are now kept at the patient's bedside rather than centrally, the term 'kardex' is still used to refer to certain centrally maintained patient record systems. (McFerran, 2014)

A quick worksheet with basic client care information that isn't usually included in medical records. During the shift and then at the end of the shift, there will be reports, the Kardex is used as a reference. It is available in a variety of sizes, forms, and varieties, including computer-generated versions. The following information is frequently found in the Kardex: Name, birth date, gender, marital status, religion, and physician's contact information are required. (including phone of the number). Medical diagnosis are prioritized. Prioritized list of nursing diagnoses Allergies Activities allowed: functional limits, support required in daily activities, and safety precautions (Chanyagorn et al., 2016).

2.5.4. Flow sheet:

Recording date, time, assessment data, and treatment information in vertical and lateral columns makes it simple to track changes in the client's condition. The flow sheet also includes special equipment for client teaching and IV therapy. Because they have minimal areas for recording data, these forms frequently incorporate legends identifying the permitted acronyms for charting data (Jasemi et al, 2013).

2.5.5. Progress Notes:

Keep note of the client's health, concerns and complaints in addition to interventions and the client's response to interventions as well as the consequences of these actions there are a variety of papers that come under the umbrella of nurse's proforma. These include personal care flowing sheets, education records, vitals documents, fluid intake types, and

speciality forms (such as a diabetes flow sheet or even a neurological evaluation form). (Blair & Smith, 2012).

2.6. Documentation of nursing:

2.6.1. The qualities of nursing documentation:

It is described as "recording pertinent patient data in a clinical record" as a nursing intervention (Aghdam,, et al., 2009). Any electronic or any written information on a patients who describe the treatment or care delivered to a patients is referred to as a patient record.

Medical records on computers, faxes, e-mails, video or audio recordings, and photographs are examples of health records that can be paper or electronic. Nurses communicate these observations, judgments, results and actions for patients through documentation. Documentation is a detailed record what happened and where it happened. It helps nurses and other health-care professionals to communicate around the services they provide. Documentation aids nurses in satisfying professional and legal standards and promotes appropriate nursing care. (Akhu- Zaheya et al., 2018)

In the nursing profession, the terms 'nursing documentation' and' record keeping' are interchangeable. When there is a disagreement within the healthcare team about how the patients must be treated, over all qualified professions, keeping records is tied to standards and codes of conduct. (Aghdam,, et al., 2009)

2.6.2. Objective of the nursing documentation

Nurses and another care provider can communicate about the healthcare they deliver thanks to documentation. Documentation also encourages effective nursing care and allows nurses to adhere to professional and regulatory requirements. Nurses are encouraged to document even if they are unsure whether it is appropriate to do so. They need to remember who,

where, when, and why. They also must solely document events and views based on facts. Nurses should record the patient's objective, not subjective, behaviors, facts, and interventions. The most crucial weapon in avoiding malpractice is comprehensive documentation, which can save both the nurse and the patient (Asaro et al., 2004).

2.6.3. The conditions of effective nursing documentation

Comprehensive and complete documentation, according to the Nurses Board of South Australia (2006), should have been a clear, succinct, and comprehensive record of nursing; it should be factually correct, truthful, and honest. ; It should be factually correct, truthful, and honest. Professional observations and assessments should be documented in a timely, legible, and permanent manner. It ought to be a current record for caregiver, complete with date and time, to avoid data duplication and to name the person who administered or registered the therapy. (Ammenwerth et al., 2003).

According the Nursing profession Board of South Australia, nursing documentation must also define the type of data, such as information given by another caregiver,, other medical provider or provider, or relatives; contain meaning and purpose and important data; and avoid meaningless words (2006:np). Nursing professionals can monitor recording by nursing practitioners and other licensed healthcare professionals since nursing documentation should contain minimum data transcription, be simple to read through time, and avoid abbreviations. (Perry et al.,2009)

Muller (2001) listed five (5) areas of concern when it comes to clinical record keeping. These include insufficient, incomplete, or absent documentation, missing all or part of the clinical record, record

manipulation, Clinical record manipulation and even record invention are possible.

2.6.4. **Effects of the poor nursing profession**

Nursing data, such as care plans, is commonly entered into a patient's medical record on the beginning of their hospital stayed and subsequently forgotten. As a result, problems such as insufficient documentation arise. A patient care, the institution, and the nursing profession all suffer when nursing documentation is not up to standard. (Smith et al., 2012).

Acute care mistakes and delays in patient care may occur when the nursing process is disrupted. (Potter et al., 2004).

According to the Audit Commission, the shortcomings revealed a lack of proper documentation was found in Pullen and Loudon (2006), who concluded that. Among them are:

- The necessity of good record-keeping is undervalued;
- A lack of information sharing between professions and work units;
- A tendency to treat records as personal rather than corporate assets;
- A lack of coordination between paper and electronic information and strategies; and the need to maintain confidentiality while legitimately freeing information (Ndenje-Sichalwe, 2010).

2.6.5. Clinical nursing is governed by nursing regulations and. documentation

Clinical records management is a professional duty that may lead to lawsuit if it is not properly completed. Only the documenting of the patient's clinical record can provide evidence of care (Pesut et al., 2019). A legal record is created by recording observations, management, and related data. Nursing paperwork must not be taken for granted, according to the South African Nursing Council, which governs the nursing profession in

South Africa (Searle, 2000& 2005). The nursing code, acts and exclusions related to the nursing competence, and the professional boundaries control the registered nurses in South Africa (Kroezen et al., 2013).

It is stipulated by the South African Nurses Association in its rule on the Area of Work for registered nurses that they are obligated to assess, diagnose, plan, implement and evaluate the treatment plan for their patients. The evaluation should collect information for nursing care. In order to come up with a nursing assessment that focuses just on patient's requirements, some information should be gathered. Nurses may use the diagnosis to build a treatment plan which will be executed and evaluated on a regular basis. The following items should be included in the nursing care plan's execution:

• Prescriptions and instructions from a doctor

• Health education

• Overall the health care coordination

• Assisting with surgical, diagnostic, and the therapeutic procedures

• Maintaining an atmosphere that promotes patient recovery and disease prevention.

Patients' progress and responses to therapy must be documented and monitored constantly by a certified nurse. The greatest strategy for avoiding an unfavorable legal outcome is to utilize skilled nursing care, critical thinking, and a sound recording technique. A hospital's vicarious liability allows a patient to sue both the individual nurse and the institution as a whole for damages caused by the carelessness of one of its employees. It is possible for a patient's legal counsel to claim that the hospital care was not delivered at a specific location since there is no paperwork to verify this. (Prideaux, 2011).

Failure to adequately monitor and analyze the patient's status, as well as failure to appropriately supervise a patient, are the most prominent causes of malpractice cases against nurses. As long as their records indicate that they took every precaution to prevent damage, including consulting with others, nurses are exempt from culpability. (Lindo et al., 2016). If something is not recorded during an investigation, it will be handled as if it never happened because there will be no proof that it did. It is important to preserve accurate records since no health care professional can predict all treatment outcomes or medication side effects.

2.7. Documentation relationships in nursing practice

Depicts the relationship between nursing documentation and treatment collaboration, communication, accountability, responsibility, and decision-making. Patients' care is coordinated by nurses who act as care coordinators, who provide effective care management and the transmission of vital nursing information (Blair& Smith, 2012). Two of the most important reasons to record are professional obligation and accountability. The practitioner's duty to the patient, his organization, the professional, and society may be put in writing if the practitioner so chooses (Törnvall & Wilhelmsson,2008).

2.7.1. Coordination

The professional nurse is responsible for analyzing, planning, executing, and assessing the care of patients and their loved ones as a leader and coordinator of care. In hospitals, nurses play a critical role in the coordination and communication of patient care. In an acute care setting, nurses are the primary point of communication between multidisciplinary care providers, patients, and family members, relaying patient status and treatment responses. (Jørgensen & Kollerup, 2022). A multidisciplinary

team method to coordination can include many persons and disciplines, the direct interaction between two caregivers who share a shift report, as well as. As a critical care unit, we rely on documented evaluations and well-planned nurse care. (Björvell et al., 2003). The methodical synchronization of diverse tasks in an ICU in the order to preserve concentration and unity of the goal accomplishment, as well as to increase quality, efficiency, and effectiveness, is referred to as coordination. (Blair& Smith, 2012).

Documentation refers to the written history of interactions by and among healthcare workers, patients, their relatives, and healthcare institutions. This involves performing diagnostic tests, treatments, and treatments, as well as providing client education and reporting on the results of diagnostic testing and interventions. In addition, documentation offers written records of the patient care provided based on the data analysis as well as the patient's reaction to treatments. All information on the patient's health previous to the intervention, as well as the patient's reaction to the intervention and prognosis, must be documented (Prideaux, 2011).

2.8. Documentation of the nursing in the (ICU)

Intensive treatment is branch of nursing that deals with a person's reaction to life-threatening events is known as critical care nursing. These life-threatening problems demand constant monitoring and rigorous therapeutic methods and interventions. The critical care nurse's role is to provide critically ill patients and their families with the best possible care (Jonsson et al., 2011). An individual's level of critical illness increases the likelihood that they will be severely vulnerable, unpredictable, and have a wide range of health problems, demanding careful and vigilant nursing care plus, as a result, more documentation (Ritmala- Castren et al, 2017).

Central venous catheters are inserted into the veins of more than 50% of ICU patients at some time during their stay. Patients' health is jeopardized by these surgical treatments. (Pronovost, Wu & Sexton, 2004). Patients in (ICU) were in a critical state, and even the smallest medical error can result in serious consequences (Li, 2016).

Critically ill patient's very unwell patients require intensive nursing care and could be at greater risk of harm owing to their condition. In the critical care context, Rothschild investigated the frequency and nature of adverse occurrences and significant errors. Adverse events and significant errors that harm critically ill patient are common and frequently life-threatening, according to the findings. The inability to appropriately carry out required nursing care was the most prevalent kind of mistake observed(Jonsson et al., 2011).

It is important for ICU nurses caring for critically sick patients to accurately record their observations, actions, as well as the patients' reactions to those treatments in addition to providing effective patient care. Carelessness might emerge from a failure to properly and accurately record any aspect of care, which could result in legal action. Although delivering nursing care in an (ICU) could be extremely stressful and demanded, documentation is essential in these situations (Li, 2016).

In order to minimize problems, nurses in high-dependency nursing care must be able to analyze, extrapolate, and critically assessment the data obtained, the management and treatments are undertaken, and a nursing care delivered using their knowledge and abilities (Munyisia et al, 2011).

The intensive care nurse operates autonomously when conducting the nursing protocol. The critical care unit needs a high level of nursing attention as well as a considerable amount of paperwork. This nurse's role

include not only providing care, but also making decisions about the patient's care and implementing strategies to keep the patients healthy. Every one of this intensive care nurse responsibilities relies on and is helped by good nursing documentation (Jonsson et al., 2011).

Patients with arrhythmias or who are mechanically ventilated are also monitored extensively and continuously in acute or critical care. These procedures need round-the-clock observation in order to catch any potential complications early enough to use medicine, cardioversion, or defibrillation to keep the patient stable, improve their prognosis, and preserve vital organ function in the long term. These patients need a lot of nursing care because of the high prevalence of arrhythmias. Patient requirements are assessed by the critical care nurse, who delivers treatment that makes use of the most up to date monitoring and therapeutic technologies.

There is a lot of healthcare data to manage and choices that affect patient and family directly as a nurse in emergency and critical care. Documented (Azevedo et al , 2019).

In the first 48 hrs and later in in-hospital therapy of unstable angina underlines that the earliest particular therapeutic actions are geared at preventing thrombolytic artery blockage, reducing myocardial oxygen demand, and improving coronary blood flow. Arrhythmias, which are common consequences of severe cardiac ischemia, are one of them (Jonsson et al., 2011).

2.9.1. Unconscious Patient and Intensive Care Unit:

According to Hollaar et al. (2015), the nursing staff looks after multiple neurologically unwell hospitalized patients. Self-care is challenging with oral motor deficits, apraxia, and hemianopia due to a lack of limb function. Oral motor dysfunction is not always treated with

rehabilitation. Physical and dental dysfunctions might jeopardize oral health, making daily oral hygiene self-care impossible. As a result, oral care for neurological patients is typically completed by nurses. Oral health is not a nursing priority due to conflicting priorities. Hand hygiene habits must vary during hospitalization or illness. Customers care about personal cleanliness and mental health. Patients in hospitals and intensive care units have to take care of personal cleanliness due to their illness. Nurses are essential in meeting people's hygiene needs. ICU nurses must provide basic hygiene while respecting patients' preferences and only providing services that patients are unable or unwilling to provide. Nurses should be mindful of their patients' physical, mental, and emotional conditions while delivering care. ICU nurses must connect health care technologies with patient requirements as a result of these issues (Baird, 2009).

2.9.2. The Priorities of Intensive Care Nursing:

Prioritizing patient hygiene when unwell and unstable, according to Coyer et al. (2011), is a clinical problem. For some individuals, optimal sleep, hemodynamic stability, and temperature regulation may be more important than other treatment objectives. The frequency of bathing is determined by the patient's pyrexia, continence, and overall stability.

Priorities differ in the ICU. In addition to everything else, ICU care, as well as all elements of nursing care, requires a lot of attention. Because cleanliness is an active process, critical care nurses concentrate on it (Comisso et al., 2018). Prioritizing patient hygiene when unwell and unstable, according to Coyer et al. (2011), is a clinical problem. For some individuals, optimal sleep, hemodynamic stability, and temperature regulation may be more important than other treatment objectives. The

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2.10.1. Hygiene and Hygiene Overview:

According to Vandyke et al. (2004) of Kananga Hospital, hygiene is a personal responsibility and an important element of staying healthy. Individual hygiene, whether sick or well, is a very personal idea that can be influenced by traditions, conventions, family values, and other cultures.

According to Lawton and Shepher (2019), bedridden patients, as well as their caregivers and caretakers, must be aided so that whole body hygiene, including hair shaving, can be supplied within the bed, as well as the minimal necessities for hygiene.

2.10.2. Hygiene for Unconscious Patient in Intensive Care Unit:

Florence Nightingale, a theorist, addressed the need of the nurse and the patient bathing to bring comfort, remove sweat, fat, and grime, increase

blood circulation, and rejuvenate patients with impairments (King et al., 2010).

According to El-Soussi and Asfour (2016), hospitalized patients are more likely to be infected with drug-resistant bacteria that cause dermatosis and colonization. People in critical condition require a strict hygiene regimen, particularly in the bed and bathroom, because inadequate hygiene can lead to infection. The care nurse has the last say on whether or not to bathe in bed. Economic resources, a lack of equipment, a lack of policies, and insufficient information are all factors that limit bed bath operations.

Ullman et al. conducted an observational research.

2.10.3. Concept of Hygiene:

According to Pegram et al. (2007), hygiene is critical for a patient's best health. A caregiver or nurse plays a crucial role in ensuring that handicapped patients' hygiene requirements are satisfied.

Hygiene, according to Salmon et al. (2015), is the process of preserving or improving personal health. Cleaning and refreshing the environment The importance of hygiene in our daily lives cannot be overstated. These are generally referred to as hygiene and are used to promote excellent health.

Personal hygiene, according to Pehlivan et al. (2011), includes things like bathing, hand cleaning, nail cutting, and wearing clean clothes. It is also necessary to keep the area around the patient bed clean of microorganisms.

2.10.4. Concept of Personal Hygiene:

According to Downey and Loyd (2008), Yoost, (1991) clarified the patient's right to cleanliness, not merely for amusement. He also stated that hygiene is a bodily act in which the person or his assistants clean the skin apparatus.

Hand hygiene, regular tooth brushing, washing the nose, eyes, and oral cavity are all behaviors that can be applied to a patient who is sleeping due to a specific nerve illness, according to Rasool (2012). To the unconscious patient in bed, all natural actions must be used.

In an article, Lawton (2019) stated that people should make an effort to keep their bodies clean, but that maintaining one's self-esteem and overall quality of life is also important. A fundamental responsibility

2.10.5. Evidence- Based Nursing to Interventional Patient Hygiene (IPH):

IPH, according to Comisso et al. (2018) and McGuckin et al. (2008), is an organized, evidence-based technique for reducing infection. Nurses' approach focuses on improving the epidermis, oral, and genital cleanliness of the patient. IPM originally included all procedures for managing beds, teeth, and wounds, as well as mobilizing patients, addressing bladder problems, and placing urinary catheters. Hygiene is a nursing requirement (Fundamental). Hygiene is the act or practice of keeping one's body in good health.

2.10.6. Component of Hygiene:

Many factors contribute to hygiene, thus following these guidelines can help you become more hygienic: Mouth, hair, eyes, ears, nose, face, neck, fingernails, and toenails should all be washed and cleaned, as should hygiene around the mouth, arms, hands, chests, abdomens, legs, feet, and perineum (Dingwall, 2010).

2.10.7. Hygiene: Basic Care that Promotes Comfort in Bedrest Patient:

According to Coyer et al. (2011), one of the primary goals of bathing is to keep unconscious patients healthy and clean, but there are numerous additional health benefits as well. Baths also help to eliminate sweat, oil,

grime, and bacteria from the face and neck, as well as reducing the risk of sickness.

In their study, which included three qualitative studies, twenty-seven quantitative (descriptive) studies, a mixed study, and forty documentaries, researchers Carrascal and Ramirez (2015) proved that hygiene is the foundation of nursing action for the patient in bed. The research's foundation is an important focus of hygiene.

2.10.8. Important of Hygiene for Unconscious Patient.

Miranda, (2016); and Pegram et al. (2007) stated that hygiene is very important for the unconscious patient because blood circulation is active, and for the nurses because they can use their special skills to perform nursing care to meet patient needs such as hair care, shaving, haircuts, skin care, and showering. To enhance respiration and the patient's overall appearance, one of the most important nursing and medical procedures within the hospital, especially in the critical care unit, is to take care of the unconscious patient's mouth.

According to Brady et al. (2006), the majority of stroke patients require more oral hygiene than others, not just to remove unpleasant odors from the mouth, but also because it is a necessary daily task. The medical staff

2.10.9. Hygiene Practices:

According to Lillis et al. (2010), there is a strong and significant link between excellent cleanliness and health behaviors; nevertheless, inappropriate hygiene practices for unconscious individuals may induce health problems.

The nursing performance of patient's oral and bodily care is a mainstay in the ICU of comatose patients, according to researchers Costello and Coyne (2008) at Ireland's General Hospital. The study shows that nurses need to

be trained and that the care unit needs to be strengthened with tools and resources for cleaning the patient's body.

2.10.10. Factors Affecting Hygiene:

The equipment used in critical care to clean the body, particularly oral cleaning equipment such as toothbrushes and fluoride toothpaste, is one of the most essential aspects that determine the performance of hygiene for the unconscious patient (Costello & Coyne, 2008).

Diaz et al. (2017) and Dougherty and Lister (2015) both stated that the difference in performance between nurses in terms of hygiene must be respected in further investigations. Hygiene practices differ from country to country, and there is a large range of countries. Many elements influence the patient's hygiene and the one based on meeting hygiene, including culture, the number of times a day he swims, his physical and social condition, and his level of development from infancy to maturity, which means he takes more risks.

2.10.11. Providing Scheduled Hygiene Care:

According to Sucre and Nicola (2009), nursing work has privacy and respect for the time and date of washing the patient, and this is mostly dependent on the hospital's processes. Parents and nurses must assist the unconscious patient in critical care with basic needs, including hygiene, such as bed bathing. For numerous reasons, including artificial respiration, excessive intracranial pressure, palpitations, electrical tachycardia, and cardiac arrest, the patient must be closely observed during and after bathing.

On top of being hospitalized, Ashkenazi et al. (2013) found that more than three-quarters of intensive care nurses use toothpaste, salt water, and a fluid

extraction equipment to clean the patient's teeth three times a week in the morning.

2.10.11.1. Early Morning Care:

Early start time in the morning to clean the unconscious patient by the intensive care nurses before giving feeding, washing the face, hands and sometimes mouth.

2.10.11.2. Morning Care:

Time for the day after nasogastric feeding the tube, the nurse follows a hygiene procedure on the bed for the patient with impaired motion. This helps the patient wash mouth, hair, shave, and cleanse their skin and soreness.

2.10.11.3. Afternoon Care:

The afternoon period is one of the important periods to complete the nursing work of the morning nursing team to complete the care of the patient, such as making the bed, washing the body and changing the diapers of the comatose patient.

2.10.11.4. Hour of sleep Care:

Although the patient is asleep throughout the period of lying in bed and not moving and active, one of the duties of the health and nursing team is to massage a warm wet cloth on the patient’s body to stimulate blood circulation, maintain the integrity of the skin and provide comfort to the patient, especially at the beginning of the night.

2.10.11.5. As Needed:

Hygiene at times as needed, such as cleaning the internal areas of the axillary, genitals and mouth every two hours at least. Hygiene as needed is not scheduled within the daily program to meet the needs of patients (Lillis et al., 2010).

2.10.12. Scientific Knowledge Base:

Patients in a coma lose the feeling of pressure imposed on them by staying for a long time without changing the position, so the important basic daily need of bathing must be fulfilled and completed.

2.10.12.1. Skin:

The health of the skin, hair and nails is just as important as skin care. The nurse first needs to understand the functions of the structure, the expected evaluation results, and potential differences in order to provide more appropriate nursing care (Nugent & Vitale, 2014).

The skin is a dynamic organ that acts as an excellent shield and a vehicle for secretion and temperature regulation. Since healthy skin acts as the body's first line of defense against microorganisms that may invade the body's internal environment, it is considered a vital component of the body. Infections from viruses, bacteria, fungi, or large parasites are most commonly spread on the skin. In addition, sweating and skin oil are potential sources of microorganisms that can damage or harm the skin's protective barrier function. Dehydrated skin cannot retain excess body secretions, and they must be removed but not at the cost of drying the skin. It is especially important to take care of the skin so that it functions optimally (Collins & Hampton, 2003).

Starks (2009) at University of Wisconsin Pres mentioned that there are approximately two million sweat glands in human anatomy. Sweat and dead skin cells combine to form dirt that sticks to your skin and underwear. Bacteria break down from sweat, causing odor and irritation. This appears in the groin, underarms, and feet, as well as in sweat-drenched clothing. Poor body hygiene leads to scabies, blisters, and ringworm.

2.10.12.2. Mouth:

Bonetti (2015) reported that the brushing and flossing the teeth are routine components of good oral health; they have a detrimental effect on patients' health. Follows patient's oral hygiene protocols to clean the gums, teeth, tongue, lips, and dentures.

The mouth is the body part most prone to bacterial growth and infection. Our mouth breaks food mechanically. This process leaves food debris on our gums and teeth. Our mouth cavity is a breeding ground for bacteria (Horne et al., 2015).

According to the study by Rumagihwa (2017) at University of Rwanda reported that all unconscious patients in the adult intensive care unit should receive routine oral care. Particular caution should be exercised in patients with a platelet count of less than 30/L as there is a greater risk of bleeding. Every 12 hours, registered nurses must perform an oral assessment of critically ill patients to determine their level of oral impairment and give them personalized care. If an oral Candida infection or ulcer is found, the patient should be referred to medical staff. Brushing should be done by two nurses while one is suctioning the mouth.

Lin et al. (2011) stated that the practicing good oral hygiene is an essential nursing care activity that everyone needs. The refactors as well. There are many factors that make it difficult to provide proper oral hygiene in the intensive care unit, especially for critically ill patients.

Haresaku et al. (2018) asserted that the nursing assists in performing these routine oral health examinations for elderly patients. Nurses are an effective referral link for patients who require specialized care for their oral health needs.

2.10.12.3. Hair:

Draelos (2010) concerning the dandruff and skin infections can be related to hair hygiene issues. Dandruff is dead skin that flakes off the scalp and contains oils secreted by the sebaceous glands. In the case of severe lice infestation, shaving the head of hair is an option.

2.10.12.4. Eyes, Ears, and Nose:

Kwok et al. (2015) showed that the daily hygiene of ICU patients the eyes is the most crucial part of facial hygiene. Protective fluids excreted by the eyeball can dry up and build up. Upon awakening, they are visible. Fly trachoma and conjunctivitis are spread by organic matter in eye secretions.

Oladeji et al. (2015) reported that the standardized questionnaire was administered to health staff in a tertiary hospital in Nigeria. The participants' knowledge of the effect of ear self-cleaning was scored as low, fair, or good. Out of 150 people polled, 10.7% knew a lot about ear wax and the health risks of self-cleaning, whereas 51.3% knew nothing. The knowledge score was strongly associated with 2 occupations (x =24.113, P=0.007), but not with ear self-cleaning practice. Most responders were unaware of the importance of ear wax and the dangers of self-cleaning. Thus, public education on the practice's complexities is required.

Researchers Alshehri et al. (2020) and Alruwaili et al. (2021) reported that the interviewed Saudi teens from the north of Saudi Arabia to see if there was a link between crucifixion and religious extremism. A predesigned questionnaire was used to assess self-ear cleaning knowledge, attitudes, and practices. 63% of participants were men. Approximately 93.1% of participants knew about and used ear cleaning regularly. To remove earwax was the most common reason for self-cleaning (41.55 percent). Other factors included cleanliness (34.3%), itching (16.5%), and dirt removal

(34.3%). (2.1 %). The most common tools were cotton buds (77.7%), tissue (11.2%), and keys (2.4%). 93.1 percent of participants clean their own ears regularly. Encourage more large-scale studies on safe ear self-cleaning techniques and public health education on this issue.

2.10.12.5. Feet, Hands, and Nails:

Ferreira et al. (2018) stated that the podoconiosis (mossy foot) requires good foot hygiene. A nail is a growing hard tissue. Long fingernails tend to collect dirt underneath. Despair or contact with contaminated surfaces can cause dirt. Weekly nail care is essential for good health. Closely trim nails to avoid damaging skin. Nails are cut with razor blades or fingernail cutters. Nail cutters must be kept private.

The body parts are become wet and sweaty and our sweat becomes pungent and may offend others. It is imperative that the armpits and the buttocks are washed daily. Hygienic practice of cleaning the anus after defecation is known as anal cleansing. A clean piece of toilet paper or similar type of paper product may be used to cleanse the anus and buttocks. It is okay to use water (Takehara, 2011).

2.10.13. Nursing Skills Related to Hygiene for Unconscious Patient (As Priorities)

2.10.13.1. Domain: Oral Hygiene for Unconscious Patient.

The study by Perrie and Scribante (2011), at South African showed that the ICU is a place where critically ill patients who require care and support are cared for. Nursing interventions that are ordinary and taken for granted must be extensively examined as of the basic nursing standards that require extra scrutiny because they have become routine and have not been tested for adequate care. In critically ill patients, using oral hygiene is supported by evidence could help to lower occurrence of (VAP). This survey reveals

what ICU practices are like in South Africa, and this information should be useful in influencing changes.

• Steps of Hygiene Performance.

Mattson et al. (2016) mention that:

- Wash hands and wear clean gloves.
- The patient is placed sideways with his head tilted towards the nurse.
- Places a towel under the patient's head.
- Places the renal vessel under the patient's jaw.
- Carefully open the patient's mouth with a mouth opening tube or wrap a piece of gauze with a tongue depressor.
- Cleans and moisturizes the mouth by using a moisturizing stick with a spongy end or toothbrushes with saline or solution or a small amount of toothpaste and warm water
- Brushes the teeth from the inside and outside, washes the gums and wipes the sides of the mouth from the inside
- Gently cleans the tongue from the top, bottom and sides
- Operate the oral fluid suction device and place the end of the suction tube inside the patient's mouth from the lower side near the bed pillow, then wash and rinse the mouth by pushing a little warm water or saline solution through the syringe from the upper side of the mouth and withdrawing water from the mouth after washing and rinsing with a device fluid withdrawal
- Dry the lips of the water after washing and apply a lip balm
- Removes mouthwashes
- The patient is placed in a supine position on the back
- Remove the gloves.

- Recording the patient's oral hygiene care procedures.

2.10.13.2. Domain: Hair Hygiene for Unconscious Patient:

Lillis et al. (2010) stated that showering with a mild shampoo and brushing the hair regularly keeps the hair clean and distributes oil at the root. Brushing also improves circulation in the scalp. Curly hair is difficult to comb. If the patient's hair hasn't been combed in a day or more, each strand may need to be combed separately. Hair must be washed frequently if it is dirty or greasy. Clean the hairbrush and comb after each use.

• Steps of Hygiene Performance:

- Wearing medical gloves
- Inspection of the patient's hair and scalp
- The patient is placed in a lying position on the back without a pillow and the patient's head is near the end of the head of the bed
- Put a rolled towel under the patient's neck
- Puts a bath towel on the patient's chest
- Place a nylon tablecloth (waxed) under the shoulder, neck and head of the patient with its sides rolled up and put its end in a bucket to collect the drainage of water
- Mix warm water in a bowl
- Moisturizing the hair and scalp with warm water
- Apply the shampoo or liquid soap in an appropriate amount and massage the hair and scalp with the fingers of the hand in a circular motion
- Comb the hair with shampoo or liquid soap, starting from front to back
- Rinse the hair with warm water and dry it well with a towel

- Wrap the patient's hair and scalp with a towel in a turban manner
- Removes hair cleaning tools
- Remove gloves when finished (Nugent & Vitale, 2013).

2.10.13.3. Shaving the hair of the unconscious patient:

Use a disposable razor blade:

- Prepare shaving equipment by the bed
- Prepare a bowl of warm water and dip a towel or a large piece of gauze in it
- The patient is placed in a supine position on the back
- Wearing clean gloves
- Place a bath towel or a shaving cloth on the patient's chest and under the head
- Puts a towel or a large piece of gauze after immersing it in warm water and squeezing it well, and then puts it on the patient’s hair area to be removed for several minutes
- Apply an appropriate layer of shaving cream or liquid soap to the area to be shave
- Hold the razor blade with the hand we always use and pull the skin with the other hand against the direction of the blade
- Carefully shave the hair using downward motions in the direction of hair growth and at an angle of 45° relative to the skin
- Remove shaving cream, soap and hair removed after shaving from the razor blade into a bowl of warm water to shave again.
- After shaving the hair completely, rinse the shaving cream and liquid soap from the shaved area using a washcloth and warm water
- Dry the area well and apply a moisturizing lotion, if available

- Remove shaving tools
- Remove gloves when finished (Yoost and Crawford 2019).

Using an electric razor:

Mention by Legesse and Argaw (2014):

- Prepare shaving equipment by the bed
- The patient is placed in a supine position on the back
- Wearing clean gloves
- Places a bath towel or a shaving cloth on the chest and under the patient's head
- Holding the razor with the hand always use
- Shave the hair to be removed gently and use appropriate movements in the direction of hair growth
- Gently remove the hair from the skin using a towel or a large piece of gauze moistened with warm water
- Clean the electric shaver well after each area is completed
- Remove the shaving tools after finishing
- Remove the gloves

2.10.13.4. Domain: Eyes, Ears, Nose, Face, and Neck Hygiene for Unconscious Patient:

The study by Lillis et al. (2010) reported that recording that the corneal blink reflex is absent or diminished; the patient should be seen every four hours. Corneal ulceration can occur due to inadequate eye moisture. Nursing measures include lubricating the eye with saline or artificial tears and shielding it. Enough cleaning of the outer ears for routine ear care Dry the ears with a soft towel to remove excess water and cerumen (wax). It helps to force a towel into the ear canal. Any of these items will work to

safely remove wax from your ears. Gently blowing your nose cleans it. Make sure both nostrils are open. Widening one nostril increases the risk of obstructing the Eustachian tubes. Irrigations should be avoided if the irrigate could enter the sinuses. Gently blowing on your nose cleans it. Open both nostrils. Single-nasal use increases the risk of Eustachian tube blockage. The risk of foreign matter entering the sinuses outweighs the potential benefits. The crust softens and breaks off when the external nares are heated. Sniffing paper tissues is advised.

Steps of Hygiene Performance.

- Wash hands thoroughly.
- Wearing clean gloves.
- Prepare a piece of gauze moistened with saline solution or clean warm water.
- Wipe the eye with a gauze pad and in one direction from the corner of the eye near the nose to the corner far from the nose and gently.
- Repeat the scanning of the eye again and with a new piece of gauze (the process of scanning for the other eye is repeated in the same way).
- Puts drops of a sterile solution or eye moisturizer after washing is completed.
- Close and cover the patient's eyes after cleaning with a gauze pad.
- Clean the ear from the outside and the back with a piece of gauze or a towel moistened with warm water and liquid soap or a wet cleans.
- Gently clean the patient's forehead and then the cheeks and palate by wiping in the form of the letter 3 in English and repeating the cleaning again.

- Clean the nose by wiping from top to bottom, as well as cleaning the nose from the inside.
- Wipe the neck with a piece of gauze or a towel moistened with warm water with a cleaning agent or a damp tissue.
- Remove the gloves (Potter et al., 2009).

2.10.13.5. Domain: Arms, Hands, and Fingernails Hygiene for Unconscious Patient:

• Steps of Hygiene Performance.

Berman et al. (2010) stated that:

- Wearing clean gloves.
- Exposes the arm to be washed completely from the hand to the armpit.
- Puts a towel under the arm or Elisa.
- Dip a towel or a large piece of gauze in warm water and liquid soap or any cleaning material suitable for the patient and squeeze it well.
- Start by washing the fingers of the hand and between the fingers and the arm by wiping in a circular motion up to the armpit.
- Rinse the arm of the detergent with a large piece of gauze or a towel moistened with warm water.
- Dry the arm well.
- Dip the palm of the hand in a bowl of warm water for 3-4 minutes and then wash the hand and fingers and between the fingers and nails.
- Remove the wash bowl and dry the hand thoroughly
- Wash, rinse and dry the other arm with the same washing steps above
- Removes the washing tools for the arms
- Cover the arms after drying them
- Remove the gloves

2.10.13.6. Domain: Legs, Feet, and Toenails Hygiene for Unconscious Patient.

Dingwall (2010); Lillis et al. (2010) stated that the foot care is important whether you're talking about shoes or not. A decrease in blood circulation to the lower extremities may occur as people age. Patients should be encouraged to walk around the clinic. Include planned walks in the patient's care plan if the patient requires assistance to move. People who regularly exercise their feet should do so at least once a day.

• **Steps of Hygiene Performance.**

- Wearing clean gloves.
- Preparing the necessary tools for washing, rinsing and drying the patient's legs
- Expose and expose the leg to be washed by lifting the cover above it.
- Puts a towel or Elisa under the patient's leg.
- Dip a washcloth and a large piece of cloth in warm water and wring it out well.
- Put a small amount of liquid soap or detergent on a washcloth or large piece of gauze.
- Washing the patient's leg from the ankle joint area and up to the knee, and then washing the thigh to the pubic area in a circular motion.
- Rinse the leg with liquid soap or detergent, and then dry the leg well
- Dip the feet in a bowl of warm water for 3-4 minutes, and then wash the feet, toes, and between toes and nails.
- Dry the feet well.
- Wash, rinse and dry the other leg with the same washing steps above
- Cover the legs after drying them.

- Removes the washing tools for the legs (Comisso et al., 2018).

2.10.13.7. Domain: Perianal Hygiene for Unconscious Patient.

It is dealt with in a matter-of-fact and dignified manner. The majority of patients do not find it offensive or embarrassing to see a provider of the opposite gender. Following perennial care, the indwelling catheter is typically cared for on a daily basis. Catheter care for the indwelling (Dingwall, 2010).

An embarrassment for many patients, perineum care is performed in bed Starting with patients of the opposite sex can be embarrassing for a nurse. Assisting patients with advanced tasks, such as self-battery, is not required. On occasion, a nurse will use a moistened washcloth and soap, hand it to the client to wash and dry it, and finally provide a towel. A nurse must be quick to provide effective perianal care. Gloves should be worn while providing this care to increase client comfort and protect the nurse from infection (Berman et al., 2018).

• Steps of Hygiene Performance.

- Make sure the blinds are lowered and the door is closed.
- Wearing clean gloves
- Places a tarpaulin absorbent cloth (Elisa) under the patient's seat and under his diaper.
- Open the patient's diaper tape and lower it from the pubic region side down.
- Changing the patient's position to a sitting position on the back with the knee bent.
- Cleaning the perineum of the male patient: Washing the opening and beginning of the urinary tract with a piece of wet tissue or a piece of

gauze moistened with warm water and liquid soap by wiping in a circular motion from all sides.

- Washing the head of the penis with a wet tissue or a clean piece of gauze moistened with warm water and liquid soap in a circular manner for one time.
- Washing the body of the penis with a wet tissue or a clean piece of gauze moistened with warm water and liquid soap by wiping longitudinally from front to back for one time.
- Washing the scrotum with a wet tissue or a clean piece of gauze moistened with warm water and liquid soap by wiping method.
- Wash, rinse and dry the pubic and genital parts.
- Removes the patient's diaper with fecal material from under the patient's seat if fecal material is found.
- Change gloves with other clean gloves.
- Changing the patient's position to the side position after the doctor's approval.
- Cleaning the anus with a wet tissue or a large piece of gauze moistened with warm water and liquid soap by wiping from front to back towards the back and for one time and it is damaged.
- Repeated washing and rinsing by wiping with a piece of gauze or a wet tissue on all sides until the area is cleaned well.
- Remove the water-absorbent tarpaulin from under the patient's seat and put it in the wastebasket.
- Change gloves with other clean gloves.
- Put on a clean diaper for the patient and then remove the gloves (Kozier et al., 2018).

2.10.13.8. Domain: Back Hygiene for Unconscious Patient:

It is imperative that all bodily regions be cleansed in order to effectively remove sweat, dirt, and microorganisms. It is especially important to make note of the patient's face, oral cavity, hands, armpits, and perineum, as well as the patient's malodor and discomfort (Leslie, 2009).

2.11. Study previous

2.11.1. First study

A Study conducted by Mst Thomina et al., 2020 "Nursing Documentation in Intensive Care Units at Bangladesh's Tertiary Level Public Hospitals" The goal of this study is to look into the present nursing documentation practice and standard for ICU patients in two tertiary public hospitals in Bangladesh. Their conclusion was that ICU patients in Bangladesh had poor nursing documentation. To ensure continuity and quality of treatment, policymakers and administrators should take the lead in implementing a consistent nursing documentation system across the country.

2.11.2. Second Study

A study conducted by Nisser, & Ycaza, 2017 “Nurses' Hygiene Knowledge and Practices in the Care of Comatose Patients at a Government Hospital in Jordan's Surgical and Medical Ward” The purpose of this study is to evaluate nurses' hygiene knowledge and practice in the treatment of comatose patients in a Jordanian government hospital. According to the findings, the individual has a moderate to good level of knowledge. This study concluded that nurses should attend courses and trainings on comatose patient hygiene in order to improve their practice.

2.11.3. Third Study

A study conducted by (Asmirajanti et al., 2019) based on documentation, nursing care activities Based on the paperwork produced, the goal of this study is to identify nurse actions in the delivery of nursing care. Conclusions: Within the hospital, nursing actions are vital and must address the patient's challenges. Every nursing action should result in documentation of critical thinking. Nursing care assessment and inter-professional communication cannot be ideal if nursing documents are not clear and proper. A nurse manager's job is to direct, supervise, and evaluate nursing activities and documentation on a regular basis. Nursing activities should always be of high quality to increase patient enjoyment, patient safety, and cost-effectiveness.

2.11.4. Fourth Study

A study conducted by Jebur & Mohammed, 2016 which was titled as "Evaluation of Nursing Staffs' Documentation Standard Related to Nursing Procedures at Medical Wards in Al-Najaf Al-Ashraf Governorate," he aimed to evaluate nursing staffs' documentation standard in medical wards, as well as discover the relationship between nursing staffs' documentation and sociodemographic characteristics of the patients (age, gender, education level, and years of experience).

The researcher concluded that the overall evaluation of nursing staff documentation is moderate, so he suggested that the modified documentation system be implemented in all Iraqi medical wards, and that training sessions for nurses be held as a unique challenge for demonstrating the importance of documentation and documenting nursing activities.

2.11.5. Fifth Study

A study conducted by Inan & Dinc, 2013 “Evaluation of nursing documentation on patient hygienic care”. The purpose of this study was to assess nursing documentation on patient sanitary care and to examine the consistency between real nurse care and that recorded in the nursing record.

Chapter Three

Methodology

Chapter Three

Methodology

Scientific research methodology is a set of specific scientific standards, criterion and controls that are followed during the work of scientific research. Therefore, scientific research methodology is one of the important matters on which it builds and organizes good scientific research. One of the most important controls of scientific research is that it should be organized and accurate, so that everyone who reads it and looks at its lines benefits from it, therefore we should address the various scientific research methods that the researcher can use during the work of a well-structured scientific research. In this chapter, the study design and all other scientific steps that were followed by the researcher from the beginning of the study until its completion will be covered.

3.1. Design of Study

Descriptive cross-sectional approach is done by observing the study participants (nurses) about their documentation about hygiene practices.

The descriptive cross-sectional study design is done through the limit includes the following:

Objective limits: The subject of the study was to assess the nursing documentation of hygiene practices for unconscious patients in intensive care unit at neurosurgical hospital in Baghdad.

Spatial limits: The spatial boundaries of the study were limited to the intensive care unit at neurosurgical hospital in Baghdad.

Time limits: The study was conducted for the period from 9th of February 2022 to 26 June 2022.

Human limits: The study was conducted on nurses who are work at to the intensive care unit at neurosurgical hospital in Baghdad.

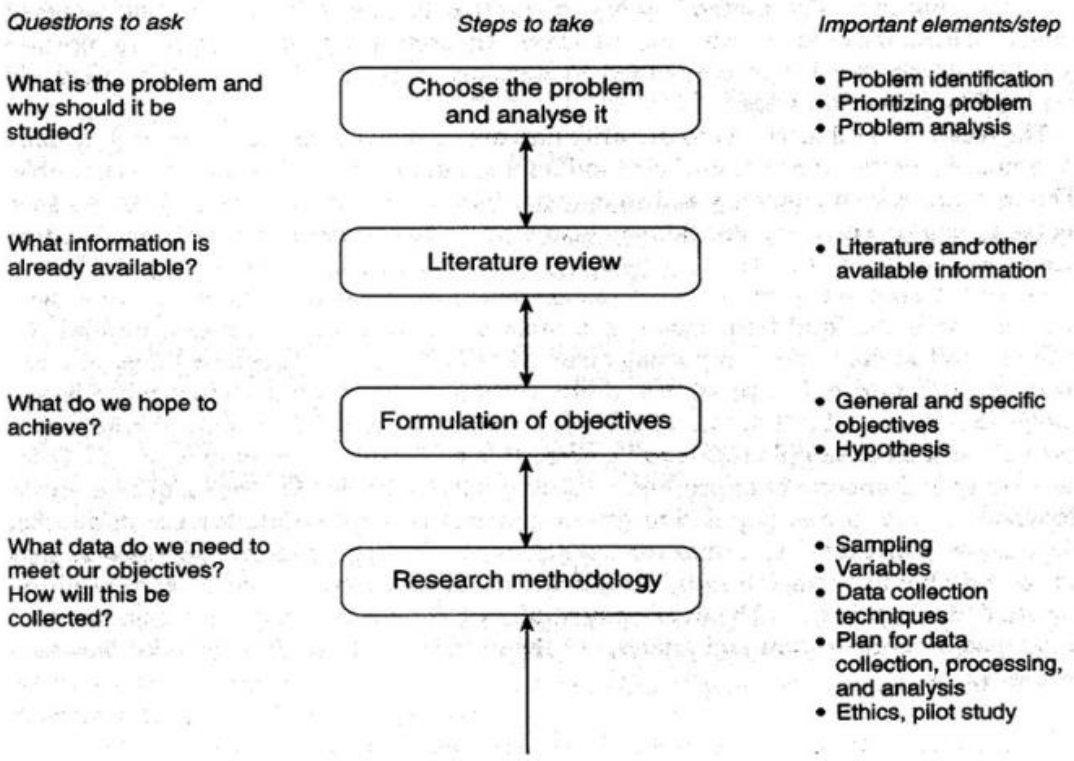


Figure 3-1: Steps of conducted cross sectional study design (Elisabeth, 2021).

3.2. Administrative Arrangements

The official permissions were obtained from relevant authorities before collecting the study data as follow:

1. Approval from the Research Ethical Committee at the Nursing College, Babylon University (Appendix C).

2. Official approvals were received from the Al-Rusafa health Baghdad administrative (Appendix C).

3.Official permission has been obtained from Neurosurgical Teaching Hospital.

3.3. Setting of the Study

Study conducted at NICU, Neurosurgical Department. at a Neurosurgical Hospital in Baghdad**.**

3.3.1. Neurosurgery Teaching Hospital

Neurosurgery Teaching Hospital is the mother hospital for neurosurgery in Iraq. It is the first hospital in the country since it was established in 1970 and specializes in brain and spinal cord surgery, and it is one of the teaching hospitals. The hospital is located in Baghdad on Port Said Street near Al Tayaran Square in Al Bab Al Sharqi, and it is adjacent to the Ministry of Interior. The bed capacity is 145 beds and is prepared for 135 beds. It contains three main corridors: the wards for mothers and children, and the male's ward, and the intensive care unit prepared for 18 beds. It contains a consulting clinic, radiology, neurophysiology and physiotherapy, as well as About that it is a training center for postgraduate students. The hospital also contains 4 operating theaters, and the hospital receives patients from all over the country.

3.4. Study Sample:

Using convenience (non-probability) method of (107) nurses was selected to carry out the study who are work in ICU. They were selected according to the following criteria include:

This questionnaire consists of two parts; sociodemographic sheet and nurses' feedback questionnaire deals with nursing documentation of hygiene practices for unconscious patients in intensive care unit at Neurosurgical Hospital in Baghdad.

Part I: This section contain of the socio-demographic information's who are included: nurses age, gender, education level, marital status, years of experience, years of experiences in surgical wards and number of training sessions related to communication skills (Appendix B).

Part II: This section deals with nursing nurses' documentation of general information. This sheet is a part of the tool which consists of general information including (age, gender, doctor name, admission date, body temperature, respiratory rate, pulse rate and blood pressure for the patient, high and weight of the patient, bowel pattern, noticeable secretions, NG tube to the patient).

Part III: This section deals with documentation of general preparations by the nurse before starting hygiene and includes the following:

It was composed of (11) item include (wearing Personal Protective equipment, close the room door and windows and put the blinds, adjust the room temperature and water so that is suitable for the patient's body, place the bed at an appropriate height for patient usually at the height of the nurse

elbow form the bed, bring appropriate Personal hygiene items to the patient on the bedside or dresses cart near the patient, clean disposable gloves, Big size swimming pool, try washing a small size , large & small size medical gauze, wet tissue and fluid suction device with accessories such as suction tube) which were rated as (3) apply always, (2) apply sometimes, and (1) for not apply answer.

Part IIII: This section deals with documentation of patients hygiene care for unconscious patients and include the following:

It was composed of (6) domains include caring for the unconscious patient's mouth, hair, shaving the hair, eye, ear, nose, face, neck, arms, hands, nails, chest, abdominal, leg, foot, toe, nail, perineum, and back hygiene and (28) items. The items were (apply and not apply questions) with three observations for each item (Appendix B).

3.6. Questionnaire Validity

The questionnaire validity the mean making certain that it will measurement what it was prepared to measure, as is meant by truthful (the questionnaire's inclusion of all aspects that must be included in the analysis, and on the other, the clarity of its paragraphs and terminology, so that it is intelligible to everyone who uses it)

To ensure that the questionnaire was valid, it was submitted to 12 specialists in various departments of nursing. (Appendix A). Experts were asked for this opinions and comments on all of the study's questionnaire items in the term of linguistic appropriate, relationship within the

dimensions of study difference to assigned, and proper of a study population.

The experts' responses indicated that some changes should be done in the main domains like demographical variables(age, years of experiences) add years after dash, and some of the items related to documentation' hygiene practices so the researcher change it according to their suggestions, then the final draft was completed to be ready for conducting the study.

3.7. Pilot Study

This preliminarily study was conducted to determine the stability and credibility of the study tool, clarity and its efficiency which confirmed, and standard time required to collect data for each subject which can estimated during the interview procedures and to difficulties identification that may encounter. A pilot study was done at three weeks throughout the period from 22th of February 2022 to 14th of March 2022.

The pilot study aimed to achieve the following objectives.

1. Developing and evaluating the effectiveness of research instruments.
2. Assessing the instrument's viability.
3. Examining the recommended data analysis techniques for disadvantages.
4. Estimate the time during collected data by the researcher.

Results of pilot study

1. The questionnaire is reliable.
2. The time required for conducting observational checklist ranged from (20-40) minutes.
3. The instrument items were clarifying and understood the phenomenon underlying of the study

Presenting the questionnaire to the supervisor to express her opinion and observations in developing the questionnaire and modifying it based on her observations.

1. Presenting the questionnaire to a number of panels of experts to express their opinion and observations in developing the questionnaire and modifying it based on what they submitted.
2. Conducting a reliability test on it by distributing the questionnaire to a sample of 10 nurses.
3. Writing the questionnaire in its final form, then printing, reviewing and distributing it.

Questionnaire Reliability:

The reliability of study instruments refers to the assurance that the answer will be almost identical when administered to the same persons at different times. The 10 nurses were collected at neurosurgical hospital in Baghdad by two investigators (researcher and well trained person).

Together the researcher and one students (Master of Science in Nursing), College of Nursing, Babylon University, were used the instrument for each nurse in the same time and place.

Table3-1: Reliability of the Studied Questionnaire

No items	Cronbach's Alpha	Assessment
51	.87	Pass

3.8. Ethical Considerations

Ethical obligations are one of the most important things that the researcher must follow and abide it when doing the study. The researcher distributed an informed consent sheet to all participating intensive care unit nurses in order to obtain their permission to participate in the current study.

3.9. Methods of Data Collection

The data was carried out 17th March 2022, to 15th May 2022, The observational checklist has been applied by researcher to a convenience (non-probability) method of (107) nurses was selected to carry out the study who are work in ICU. sample of nurses. The researcher examined the documentation of hygiene practices of nurses to the patients in ICU by using direct observation as an average data collection. The researcher monitored nurses during their work and the care that provided to patients who were staying in ICU. There was a time interval between each view for almost 10 days.

The rating and scoring system stated as; 3 accurate documentation out of 3 observations were rated as always, 2 accurate documentation out of 3 observations was rated as sometimes, and 1 correct documentation out of 3 observations was rated as never.

3.10. Methods of Statistics Data Analysis

The researcher utilizes the SPSS ver-20 plus Microsoft Office excel (2010) programs to analyze the data and handle with all of it statistically, to determine the links between both the variables, and to produce the final conclusions of the study based on a series of statistical tests.

3.10.1. Descriptive approach

Descriptive statistics include a set of mathematical and statistical methods that are adopted to describe the main features of a data quantitatively by using tables and charts. Descriptive statistics always aim to present and describe the data which is required to be processed, organized, summarized and categorized, as well as presenting them in a simple and clear manner that makes it easier for the recipient to recognize and understand its content. The analysis performed through use:

A. Statistical tables "Frequencies and percent" which are:

$$\% = \frac{\boldsymbol{Frequency}}{\boldsymbol{Sample\ Size}}\ x100$$

B. Mean of scores "*M*±".

The average score can be calculated by using the following:

$$M.S = \frac{\sum \text{ri} = 1\text{Fi x Si}}{\sum \text{ri} = \ 1\text{Fi}}\ x100$$

The overall responses of Nursing Documentation of Hygiene according to total mean of score which follow:

M= 28-46 refers to Poor.

M=47-65 refers to Fair.

M=66-84 refers to Good.

C. Standard Deviation test ±*SD*.

$$SD = \sqrt{\frac{1}{n-1}\sum_{i=1}^{n}(Xi - \bar{\chi})^2}$$

D. It uses a correlational coefficient "Cronbach alpha" used in estimating the internal consistency of the study tool, which can be calculated by using the following:

$$\alpha = \frac{K}{K-1}\left[1 - \frac{\sum_{i=1}^{K}\sigma_{ii}}{\sum_{i=1}^{K}\sum_{j=1}^{K}\sigma_{ij}}\right]$$

2.10.2.Inferential approach

1. **Analysis of Variance**

For equality of means, is used (ANOVA test when the mean parameter varies).

Source of variance	Sum of square	d.f	Mean square	F
Between Groups	$SS_B = \sum \frac{(\sum xP1)^2}{n} - \frac{(\sum xP)^2}{n}$	$df_B = K\text{-}1$	$\frac{MS\beta}{MS\beta}$	
Within Groups	$SS_w = \sum \frac{(\sum xP1)^2}{N} - \frac{(\sum xP)^2}{N}$	$df_w = N\text{-}k$	$\frac{SSw}{DFw}$	$\frac{MSB}{MSW}$
Total	$SS_T = \sum \frac{(\sum xP1)^2}{N} - \frac{(\sum xP)^2}{N}$	$df_T = N\text{-}1$		
P-value (≤0.05)				

2. Independent Sample t-test

The t Test compares the means of two clusters to discover whether the related population means differ significantly statistically.

$$t = \frac{\mu_A - \mu_B}{\sqrt{\left[\frac{\left(\Sigma A^2 - \frac{(\Sigma A)^2}{n_A}\right) + \left(\Sigma B^2 - \frac{(\Sigma B)^2}{n_B}\right)}{n_A + n_B - 2}\right] \cdot \left[\frac{1}{n_A} + \frac{1}{n_B}\right]}}$$

$(\Sigma A)^2$: Sum of data set A, squared (Step 2).
$(\Sigma B)^2$: Sum of data set B, squared (Step 2).
μ_A: Mean of data set A (Step 3)
μ_B: Mean of data set B (Step 3)
ΣA^2: Sum of the squares of data set A (Step 4)
ΣB^2: Sum of the squares of data set B (Step 4)
n^A: Number of items in data set A
n^B: Number of items in data set B

The following are shortcuts for measuring important in comparison to the level:

(1) **NS**: *Non significantly at probability-value>0.05*.

(2) **S**: *Significantly at probability-value <0.05*.

Chapter Four

Results

Chapter Four

Results of the Study

Under the objectives of current study findings, the descriptive and inferential statistic approaches are organized in tables and figures that includes the followings:

Table 4-1. Descriptive Statistic of Socio-Demographic Variables (SDVs)

SDVs	Classification	Freq.	%
Age/years	20-29 years old	48	44.9
	30-39 years old	49	45.8
	40-49 years old	10	9.3
Gender	Male	59	55.1
	Female	48	44.9
Education level	School Nursing	37	34.6
	Institute Nursing	42	39.3
	College and above	28	26.2
Years of experience	<5 years	44	41.1
	5-10 years	47	43.9
	>10 years	16	15.0
Training courses	No	48	44.9
	1-2 sessions	29	27.1
	>2 sessions	30	28.0

Finding show participants demographic information, the age 30-39 years old were recorded the highest percentage (45.8%). In regards with gender, more than half of study sample were male (55.1%) as compared with those who are female. Respected to the education level, the highest percentage for those who are institute graduated (39.3%) and small percent for those who are college graduated. Years of experience related findings, most of nurses exhibited 5-10 years (43.9%) and small ratio expressed >10 years. In terms of training courses, the not participated in training were

mostly among nurses (44.9%) as compared with those who had 1 to 2 sessions and more.

Table 4.2. Nurses Documentation of General Information

List	General Information Items	Class	Freq.	%	*M.s*	*Ass.*
1	Patient's age	Not record	18	16.8	*1.83*	*Always*
		Record	89	83.2		
2	Patient's sex	Not record	4	3.7	*1.96*	*Always*
		Record	103	96.3		
3	Name the physician	Not record	58	54.2	*1.45*	*Sometime*
		Record	49	45.8		
4	Date of admission	Not record	2	1.9	*1.98*	*Always*
		Record	105	98.1		
5	Temperature	Not record	5	4.7	*1.95*	*Always*
		Record	102	95.3		
6	Pulse	Not record	4	3.7	*1.96*	*Always*
		Record	103	96.3		
7	Breathing	Not record	32	29.9	*1.70*	*Always*
		Record	75	70.1		
8	Blood pressure	Not record	28	26.2	*1.73*	*Always*
		Record	79	73.8		
9	Weight & height	Not record	69	64.5	*1.35*	*Sometime*
		Record	38	35.5		
10	Any changes in bowel pattern of diarrhea or constipation	Not record	54	50.5	*1.49*	*Sometime*
		Record	53	49.5		
11	Any noticeable secretions such as vomiting	Not record	64	59.8	*1.40*	*Sometime*
		Record	43	40.2		
12	NG	Not record	51	47.7	*1.52*	*Sometime*
		Record	56	52.3		

In terms of statistical mean, this table demonstrats that the nurses recorded the general information of unconscious patients at all studied items of documentation except, nurses were sometime documented the physician name, weight & height, changes in bowel pattern, noticeable secretions such as vomiting and NG.

Table 4-3. Documentation of General Preparation by the Nurse before Starting Hygiene

List	General Preparation Items	Responses	Freq.	%	*M.s*	*Ass.*
1	Wearing Personal Protective equipment (Gown, Mask, head cover clean Gloves ect.)	Never	44	41.1	*1.88*	*Fair*
		Sometime	31	29.0		
		Always	32	29.9		
2	Close the room door and windows and put the blinds	Never	44	41.1	*1.67*	*Fair*
		Sometime	54	50.5		
		Always	9	8.4		
3	Adjust the room temperature and water so that is suitable for the patient's body	Never	21	19.6	*2.01*	*Fair*
		Sometime	63	58.9		
		Always	23	21.5		
4	Place the bed at an appropriate height for patient usually at the height of the nurse elbow form the bed	Never	55	51.4	*1.66*	*Poor*
		Sometime	33	30.8		
		Always	19	17.8		
5	Bring appropriate Personal hygiene items to the patient on the bedside or dresses cart near the patient	Never	20	18.7	*2.14*	*Fair*
		Sometime	51	47.7		
		Always	36	33.6		
6	Clean disposable gloves	Always	31	29.0	*1.97*	*Fair*
		Sometime	48	44.9		
		Never	28	26.2		
7	Big size swimming pool	Never	18	16.8	*2.33*	*Fair*
		Sometime	35	32.7		
		Always	54	50.5		
8	Try washing a small size	Never	26	24.3	*1.94*	*Fair*
		Sometime	61	57.0		
		Always	20	18.7		
9	Large & small size medical gauze	Always	15	14.0	*2.55*	*Good*
		Sometime	18	16.8		
		Never	74	69.2		
10	Wet tissue	Always	37	34.6	*2.05*	*Fair*
		Sometime	27	25.2		
		Never	43	40.2		
11	Fluid suction device with accessories such as suction tube	Always	51	47.7	*1.88*	*Fair*
		Sometime	17	15.9		
		Never	39	36.4		
Overall		Always	21	19.6	*2.01*	*Fair*
		Sometime	57	53.3		
		Never	29	27.1		
		Total	107	100.0		

In terms of statistical mean of scores, findings demonstrated that the (53.3%) of nurses showed a fair preparation to hygiene practices for unconscious patients.

4.4. Documentation of Nursing Hygienic Care for Unconscious Patients

Table 4-4-1. Care of Hair Steps Documenting

List	Care of Hair Items	Responses	Freq.	%	*M.s. ± SD*	*Ass.*
1	Shaving	Never	73	68.2	*1.48±0.769*	*Poor*
		Sometime	16	15.0		
		Always	18	16.8		
		Total	107	100.0		
2	Shampooing	Never	64	59.8	*1.47±0.634*	*Poor*
		Sometime	35	32.7		
		Always	8	7.5		
		Total	107	100.0		
Total		Never	78	72.9	*1.48±0.549*	*Poor*
		Sometime	17	15.9		
		Always	12	11.2		
		Total	107	100.0		

In terms for statistical mean and standard deviation, this table illustrats that the nurses expressed a poor practice regards care of hair for unconscious patients at all studied items as indicated by low mean scores (*M≤1.66*).

Table 4-4-2. Mouth care Steps Documenting

List	Mouth Care Items	Responses	Freq.	%	*M.s ± SD*	*Ass.*
1	Inspecting and the mouth daily for dryness inflammation and crusting	Never	55	51.4	*1.71±0.812*	*Fair*
		Sometime	28	26.2		
		Always	24	22.4		
		Total	107	100.0		
2	Cleansing the mouth daily and rinsed	Never	49	45.8	*1.84±0.859*	*Fair*
		Sometime	26	24.3		
		Always	32	29.9		
		Total	107	100.0		
3	Brush teeth /denture, gums and tongue twice daily	Never	72	67.3	*1.50±0.781*	*Poor*
		Sometime	16	15.0		
		Always	19	17.8		
		Total	107	100.0		
4	To avoid drying from excess toothpaste, rinse after wads and suction with a soft-tipped catheter.	Never	62	57.9	*1.57±0.741*	*Poor*
		Sometime	29	27.1		
		Always	16	15.0		
		Total	107	100.0		
Total		Never	54	50.5	*1.65±0.595*	*Poor*
		Sometime	40	37.4		
		Always	13	12.1		
		Total	107	100.0		

In terms for statistical mean and standard deviation, this table illustrated that the nurses expressed a poor practices regards mouth care in terms of inspecting and the mouth daily for dryness inflammation and

crusting and cleansing the mouth daily and rinsed as indicated by moderate mean scores (M=1.67-2.33) and poor practices in terms of brush teeth /denture, gums and tongue twice daily and rinse after wads to avoid drying from excess toothpaste, rinse after wads and suction with a soft-tipped catheter as indicated by low mean scores (*M≤1.66*).

By the overall practices related to mouth care, the findings depict (50.5%) of nurses were poor practices as described by low average *1.65 (±0.595)*.

Table 4-4-3. Eye Care Steps Documenting

List	Eye Care Items	Responses	Freq.	%	*M.s ± SD*	*Ass.*
1	Cleaning the eye with cotton balls moister with normal slain every 8 hours	Never	63	58.9	*1.58±0.776*	*Poor*
		Sometime	25	23.4		
		Always	19	17.8		
		Total	107	100.0		
2	Using of artificial tears every 2 hours	Never	64	59.8	*1.61±0.820*	*Poor*
		Sometime	20	18.7		
		Always	23	21.5		
		Total	107	100.0		
3	Monitoring and recording any sign of eye irritation or inflammation	Never	65	60.7	*1.57±0.789*	*Poor*
		Sometime	22	20.6		
		Always	20	18.7		
		Total	107	100.0		
4	Closuring of eyelids with eye shields	Never	65	60.7	*1.47±0.649*	*Poor*
		Sometime	33	30.8		
		Always	9	8.4		

		Total	107	100.0		
Total		Never	67	62.6	*1.56±0.599*	*Poor*
		Sometime	22	20.6		
		Always	18	16.8		
		Total	107	100.0		

In terms for statistical mean and standard deviation, this table illustrates that the nurses expressed a poor practice regards eye care for unconscious patients as indicated by low mean of scores (*M≤1.66*).

By the overall practices related to eye care, the findings depict (62.6%) of nurses were poor practices as described by low average *1.56 (±0.599)*.

Table 4-4-4. Nose Care Steps Documenting

List	Nose Care Items	Responses	Freq.	%	*M.s ± SD*	*Ass.*
1	Cleaning the nose daily with normal saline	Never	69	64.5	*1.57±0.825*	*Poor*
		Sometime	15	14.0		
		Always	23	21.5		
		Total	107	100.0		
2	Placing sterile cotton in the nose if there is sign of rhinorrhea	Never	70	65.4	*1.50±0.757*	*Poor*
		Sometime	20	18.7		
		Always	17	15.9		
		Total	107	100.0		
3	Avoid remove nose clot	Never	44	41.1	*1.83±0.794*	*Fair*
		Sometime	37	34.6		
		Always	26	24.3		
		Total	107	100.0		
Total		Never	74	69.2	*1.63±0.621*	*Poor*

	Sometime	20	18.7		
	Always	13	12.1		
	Total	107	100.0		

In terms for statistical mean and standard deviation, this table illustrates that the nurses expressed a poor practice regards nose care for unconscious patients as indicated by low mean of scores (*M≤1.66*) and fair care in terms of *avoid remove nose clot* (moderate mean of scores).

By the overall practices related to nose care, the findings depict (69.2%) of nurses were poor practices as described by low average *1.63 (±0.621)*.

Table 4-4-5. Ear Care Steps Documenting

List	Ear Care Items	Responses	Freq.	%	*M.s ± SD*	*Ass.*
1	Clean the ear daily	Never	51	47.7	*1.75±0.810*	*Fair*
		Sometime	31	29.0		
		Always	25	23.4		
		Total	107	100.0		
2	Place sterile cotton in the ear if there is sign of otorrhea	Never	75	70.1	*1.42±0.700*	*Poor*
		Sometime	19	17.8		
		Always	13	12.1		
		Total	107	100.0		
Total		Never	69	64.5	*1.58±0.643*	*Poor*
		Sometime	18	16.8		
		Always	20	18.7		
		Total	107	100.0		

Findings depicted (64.5%) of nurses were poor practices related to ear care as described by low average *1.58 (±0.643)*.

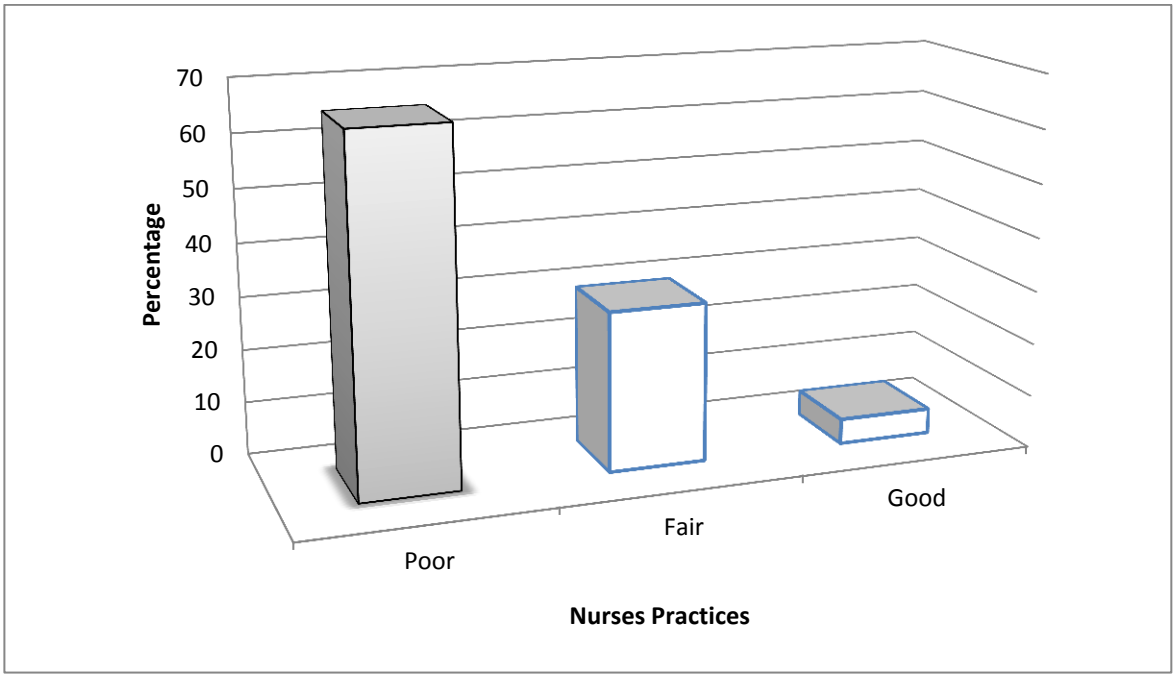
Table 4-4-6. Skin and joint integrity Steps Documenting

List	Skin and Joint Care Items	Responses	Freq.	%	*M.s ± SD*	*Ass.*
1	Bathing the patient daily with soap and warm water	Never	41	38.3	*1.93±0.838*	*Fair*
		Sometime	32	29.9		
		Always	34	31.8		
2	Turning the patient each 2 hours	Never	67	62.6	*1.57±0.802*	*Poor*
		Sometime	19	17.8		
		Always	21	19.6		
3	Inspecting the skin for pressure ulcer	Never	56	52.3	*1.84±0.933*	*Fair*
		Sometime	12	11.2		
		Always	39	36.4		
4	Using passive exercise of the extremities	Never	69	64.5	*1.57±0.825*	*Poor*
		Sometime	15	14.0		
		Always	23	21.5		
5	Using splints or foam boots aid to prevent foot drop	Never	73	68.2	*1.50±0.793*	*Poor*
		Sometime	14	13.1		
		Always	20	18.7		
6	Using trochlear roll to support the hip joint	Never	69	64.5	*1.57±0.825*	*Poor*
		Sometime	15	14.0		
		Always	23	21.5		
7	Lubricate skin with emollient lotions	Never	69	64.5	*1.60±0.866*	*Poor*
		Sometime	11	10.3		
		Always	27	25.2		
8	Keeping patient skin and under patient linen tight and dry	Never	66	61.7	*1.45±0.633*	*Poor*
		Sometime	33	30.8		
		Always	8	7.5		
9	Clip patient nails	Never	55	51.4	*1.63±0.731*	*Poor*
		Sometime	36	33.6		
		Always	16	15.0		
10	Hygiene for the legs, feet and nails of Unconscious patients	Never	64	59.8	*1.46±0.619*	*Poor*
		Sometime	36	33.6		
		Always	7	6.5		
11	Hygiene for the chest abdomen of Unconscious patients	Never	68	63.6	*1.39±0.545*	*Poor*
		Sometime	36	33.6		
		Always	3	2.8		
12	Hygiene for the Back of Unconscious patients	Never	75	70.1	*1.38±0.639*	*Poor*
		Sometime	23	21.5		
		Always	9	8.4		
13	Hygiene for Genital of Unconscious patients	Never	60	56.1	*1.54±0.676*	*Poor*
		Sometime	36	33.6		
		Always	11	10.3		
Total		Never	68	63.6	*1.57±0.436*	*Poor*
		Sometime	35	32.7		
		Always	4	3.7		
		Total	107	100.0		

In terms for statistical mean and standard deviation, this table illustrates that the (63.6%) of nurses showed a poor practices related to skin and joint integrity for conscious patients as described by low average *1.57 (±0.436)*.

Table 4-5: Nursing Documentation of Hygiene Practices for Unconscious Patients

Nurses Practices	*Freq.*	*%*	*M ± SD*
Poor (*M=28-46*)	70	65.4	*44.41 ± 11.27*
Fair (*M=47-65*)	32	29.9	
Good (*M=66-84*)	5	4.7	
Total	107	100.00	



Findings demonstrat that the (65.4%) of nurses exhibited a poor documentation of hygiene practices for unconscious patients as described by low total mean of scores and SD *44.41* (*±11.27*).

4-1.Overall Nurses Documentation of Hygiene

4.6. Association between Nurses Documentation of Hygiene with Socio-Demographic data

Table 4-6-1: Statistical Differences in Nurses Documentation of Hygiene with regards their Age (*n=107*)

Age	Variance Source	Squares Sum	d.f	Mean of Square	*F*	*p-value*
Documentation of Hygiene	Between Groups	.499	2	.250	1.555	.216
	Within Groups	16.692	104	.161		
	Total	17.191	106			

The study found that there have been no significantly different in nurses documentation for hygiene for unconscious patient with regards age groups (*p=0.216*).

Table 4-6-2: Statistical Differences in Nurses Documentation of Hygiene with regards their Gender (*n=107*)

Variables	Gender	m	s/ d	t-v	D/f	*p.value*
Documentation Hygiene	Male	1.5696	.41185	.468	105	*.641*
	Female	1.6064	.39458			

Findings demonstrate that there were never significantly differences in nurses documentation of hygiene for unconscious patients with regards those who are male and female nurses (*t=0.468*; *p=0.641*).

Table 4-6-3: Statistical Differences in Nurses Documentation of Hygiene with regards their Education Level (*n=107*)

Education Level	Variance Source	Squares Sum	df	Mean of Square	*F*	*p-value*
Documentation of Hygiene	Between Groups	4.112	2	2.056	16.347	.001
	Within Groups	13.080	104	.126		
	Total	17.191	106			

The study found that there have been considerable variances in nurses documentation for hygiene for unconscious patient with regards education level (*p=0.001*). It was observed that the nurses who are graduated college and above is significantly associated higher documentation of hygiene practices, unlike those who are school nursing (Fig. 4-2).

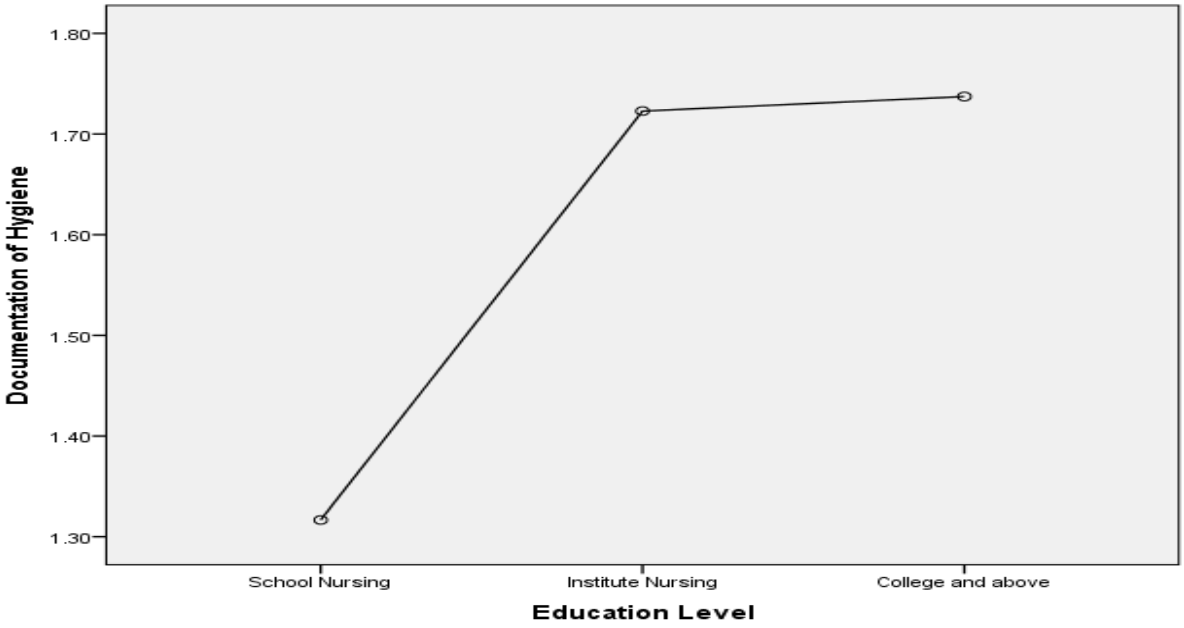


Figure 4-2.Distribution of Nursing Documentation of Hygiene according to Education Level

Table 4-6-4: Statistical Differences in Nurses Documentation of Hygiene with regards their Years of Experience (*n=107*)

Years of Experience	Source of variance	Sum of Squares	d.f	Mean Square	*F-statistic*	*p-value*
Documentation of Hygiene	Between Groups	6.816	2	3.408	34.161	.001
	Within Groups	10.375	104	.100		
	Total	17.191	106			

The study found that there have been considerable variances in nurses documentation for hygiene for unconscious patient with regards years of experience (*p=0.001*). It was observed that the more years of experience is significantly associated higher documentation of hygiene practices (Fig. 4-3).

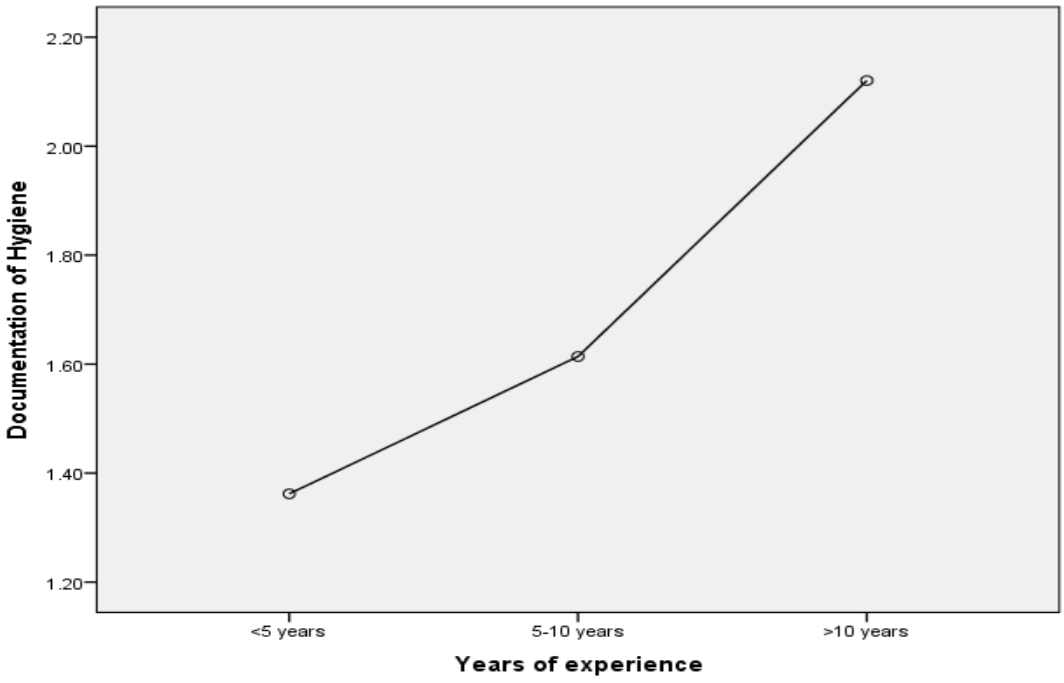


Figure 4-3.Distribution of Nursing Documentation of Hygiene according to Years of Experience

Table 4-6-5:Statistical Differences in Nurses Documentation of Hygiene with regards their Number of Training (*n=107*)

Years of Experience	Source of variance	Sum of Squares	d.f	Mean Square	*F-statistic*	*p-value*
Documentation of Hygiene	Between Groups	5.085	2	2.543	21.842	.000
	Within Groups	12.106	104	.116		
	Total	17.191	106			

The study found that there have been considerable variances in nurses documentation for hygiene for unconscious patients with regards number of training sessions (*p=0.001*). It was observed that the significant training associated higher documentation of hygiene practices (Fig. 4-4).

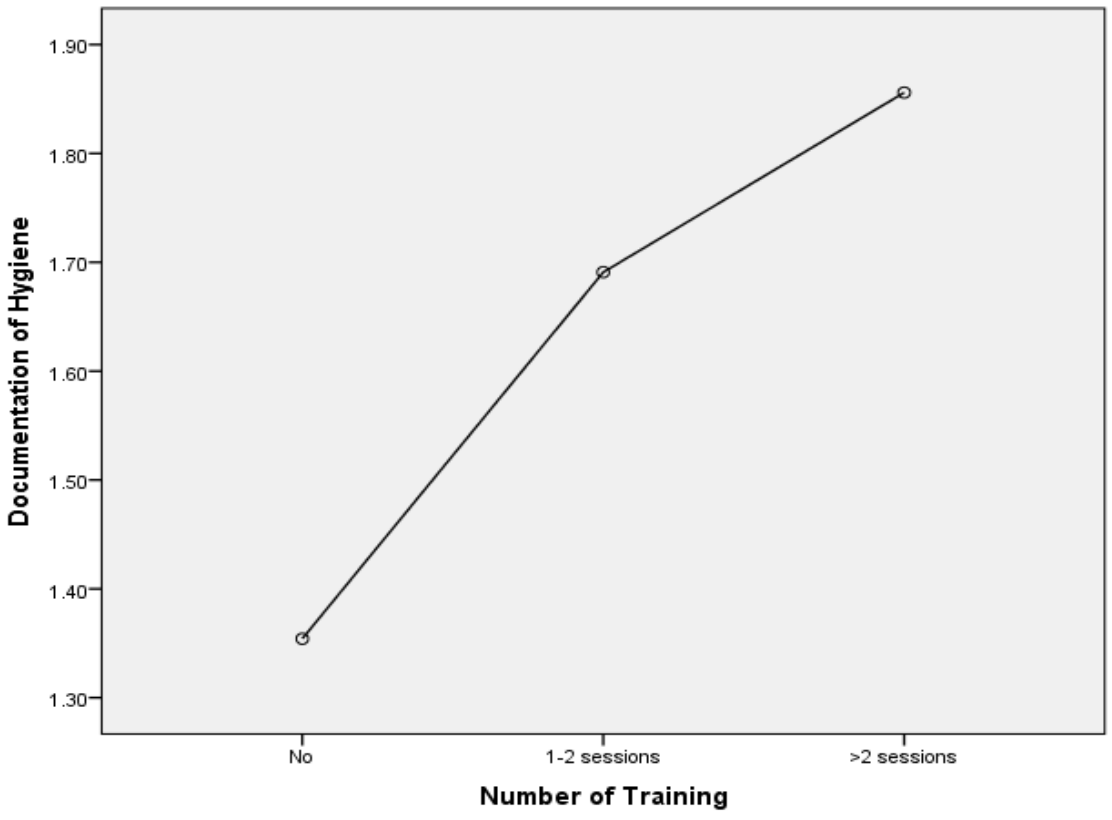


Figure 4-4.Distribution of Nursing Documentation of Hygiene according to Number of Training Courses

Chapter Five

Discussion of the Study Results

Chapter Five

Discussion of the Study Results

Nursing must demonstrate that the care nurses deliver is connected with optimal patient outcomes, as well as a high degree of quality and safety, in the age of evidence-based healthcare. Nursing documentation is the process of generating evidence connected to nursing practice. It can be a useful measure of the quality of treatment given to patients in hospitals. Nursing documentation is so critical to providing high-quality, effective, and safe nursing care. Its quality, accuracy, and growth necessitate monitoring and evaluation, which can be accomplished through documentation.

5.1. Socio-demographic Factors of Descriptive Statistic

The Findings represent the distribution of the nurses by their demographic characteristic in term of frequency with percentage. The groups of studied ages are the subjects in these study were (30-39) yrs., and they made up (45.8%) of the total number of participants. Because of the nature of their duties, surgical wards require young nurses. This age group is capable of offering nursing interventions swiftly and effectively.

This result matches the result of the study conducted by (Karthiga. 2016) who found in their study that the majority of the study subject's age younger than 40 years.

Regarding the gender, 59 % are male nurses predominated and accounted for more than half of all nurses, as opposed to 48 female nurses, who account for (44.9%) of the total number of participants. These results

agree with (Mohaithef, 2020) which they found that the about more than half of participants (51.9%) of their study sample were (male).

The data show that approximately less than half of the study sample had diplomas (39.3 %), that is due to the large number of institutions that offer such degrees. This conclusion is also based on the fact that hospital wards are totally depend on nurses who have graduated from nursing institutes, despite the fact that nurses who have graduated from nursing colleges are still in the minority when compared to other nurses. This finding has not match the result conducted by (Aboalizm‹. et al., 2016). Who found that that approximately less than half of the study sample (45%) had diplomas.

According to the data collected from research participants, (41.1 percent and 34.9 percent, respectively) have less than 10 years of experience in their profession and in ICU. This is due to the fact that a lot of nurses think working in ICU requires a great amount of effort and a considerable measure of sensitive and skilled care when dealing with the unconscious patients, as well as dealing with patients' families and relatives by providing them the needed information and education regarding patients' health conditions. Alternatively, the few years of nursing experience in certain wards might be explained by nurses rotating from one unit to another within the hospital. This finding matches with the study of (Abid, et.al 2018) who mentioned that the majority of their study samples were has less than 10 years of experience.

The findings show that half of the study participants were not trained (48.0%). This is because most of the nurses are new employees who have not yet had the opportunity to attend training sessions on

nursing documentation and the lack of interest of some nurses in the training sessions held by the continuing education units in the hospitals. These results are compatible with a result obtained from (Ali, 2014) study that states that the half of the study participants didn't have communitive training and account for (50%).

5.2. Nurses Documentation of General Information for the patinas

Table (4.2) shows that nurses recorded general information on unconscious patients in all studied documentation items, but sometimes omitted the physician's name, weight, height, changes in bowel patterns, and observed secretions such as vomiting and NG.

This is due to overwork and the ratio of nurses to patients is disproportionate. The researcher believes that nursing documentation can be improved through better nursing staff, better peer mentoring, and continuing education.

These results are compatible with a result obtained from (Asmirajanti, et al., 2019) study that states that more than 95% had recorded general information of patients include I. Patient Identification which comprise the patient's name, age, weight, and height, as well as their health record number. Initial Evaluation, which includes a thorough check of the patient's outer appearance, state of consciousness, vitals, histories of allergies, and nutritional testing.

5.3. Documentation of General Preparation by the Nurse before Starting Hygiene

Results indicate that the (53.3%) of nurses showed a fair preparation to hygiene practices for unconscious patients. The rationale for these

results includes “a low level of education, inadequate effective training, and nurses’ few years of experience". (Researcher)

These results correspond to (Asmirajanti, et al., 2019) study results that show that shows that the majority of respondents, (95%) are aware of the policy on documentation of physical assessment and preparation to hygiene practices for unconscious patients.

5.4. Documentation of Nursing Hygienic Care for Unconscious Patients

5.4.1. Care of Hair Steps Documentation:

The findings in table (4.4.1) illustrated that the nurses expressed a poor practices regards care of hair for unconscious patients at all studied items.

These findings were supported by study conducted by (Kadhim, & Khudur, 2021).Who revealed that there was a low level of nurses Performances regarding hair care of unconscious patient.

Furthermore, these result may explain their practice regarding nursing documentation, and discovered that the performance of nurses with respect to the aims of documentation was superior than their practice with regard to the rules of documentation, however there was deficit for improvement with regard to the what and how to record.(Researcher)

5.2.4. Mouth care Steps Documentation:

The findings in the table (4.4.2) showed that the nurses expressed a poor performance regards mouth care in terms of inspecting and the mouth daily for dryness inflammation and crusting and cleansing the

mouth daily and rinsed as indicated by moderate mean scores (M=1.67-2.33) and poor practices in terms of brush teeth /denture, gums and tongue twice daily and rinse after wads to prevent drying, from Excess toothpaste, then suction, with soft tipped catheter as indicated by low mean scores (M≤1.66).

By the overall practices related to mouth care, findings depicted (50.5%) of nurses were poor practices as described by low average 1.65 (±0.595).

The findings agree with Khudhair (2014) . The findings of the his study showed that the nurses have inadequate practices in all items concerning mouth care accept hand wash.

The results for this previous study show the nursing documentation for communication and evaluation of care, weaknesses, and deficiencies in the nursing records, such as difficulties in finding important information due to a large number of routine notes.

5.4.3. Eye Care Steps Documentation:

In terms of statistical mean and standard deviation, the findings demonstrate that In the nurses expressed poor practices regards eye care for unconscious patients as indicated by low mean scores (M≤1.66).

By the overall practices related to eye care, findings depicted (that 62.6%) of nurses were poor practices as described by a low average of 1.56(±0,599).

These findings were inconsistent with a study by (Inan & Dinç 2013). Which pointed out that there was more than half of the participants (57.2) had documented the care of eye .

This is related to several reasons. Besides the few years of experience, and the educational attainment of the study sample, most of them hold a diploma, which makes their experience in presenting and sharing information in innovative ways, such as displaying images and videos of the surgical procedure to unconscious patients, limited. In addition, nurses lack knowledge of modern technology and its uses in transferring information to patients and its limited availability to health institutions.(Researcher)

5.4 4.Nose Care Steps Documentation:

Table 4.4.4 illustrated that the nurses expressed poor practices regards nose care for unconscious patients as indicated by low mean scores (M≤1.66) and unsuitable care in terms of avoiding removing nose clots.

By the overall practices related to nose care, findings depicted that (69.2%) of nurses have poor practices recorded by a low average of 1.63 (±0,621).

These findings were reinforced by (Abid et al., 2018). In recording practices related to nose care documenting which include intake and output of fluids most items that weren't recorded were included, In addition to intravenous fluid, nasogastric tubes, and gastrostomies, oral fluid administration accounts for (64%) of all fluid administration (88 percent) All of the items have been removed (88 percent) all of the items

have been removed (88 percent) Nursing paperwork is devoid of every item on this list.

Some nurses think that documentation is not important and it's not their responsibility. While in fact, it is an integral part of ICU nursing care. In addition, nursing documentation effectively requires good practices and skills; novice nurses face difficulty when documenting such procedures.(Researcher)

5.4.5. Ear Care Steps Documentation:

Findings in the table (4.4.5) depict that most nurses (64.5%) had bad practices related to ear care as described by a low average of 1.58 (±0,643) .

These findings are supported by (Kadhim& Khudur 2021) in the study that revealed there was a low level of hygiene care documentation practices for the ENT and face of unconscious patients.

Unfortunately, nurses in this study do not pay attention to these important duties due to a lack of experience and knowledge of their importance. (Researcher)

5.4.6. Skin and joint integrity Steps Documenting

According to findings in table 4.4.6 in terms of statistical mean and standard deviation, this table illustrates that the (63.6%) of nurses showed a poor practice related to skin and joint integrity for conscious patients as described by a low average of (1.5).

These findings disagree with Ali, (2014) because his study showed that more than two-thirds of the study group provides patient skin care and

protect it from pressure ulcer by changing the patient's position every two hours which mean nurses have good practice to prevent pressure ulcer while assessing hydration level, more than two-thirds of the target study group have good knowledge and (25%) of them have satisfied knowledge.

5.5. Nursing Documentation of Hygiene Practices for Unconscious Patients

Findings in table(4.5) demonstrated that the (65.4%) of nurses exhibited poor documentation of hygiene practices for unconscious patients as described by low total mean scores and SD 44.41(±11,27).

These findings were inconsistent with a study by Inan & Dinç (2013). In this survey hygiene practices such as brushing teeth, flossing, most frequent, followed washing hands , feet and care of the perianal came in second .

This result found that the patients in care units are more vulnerable to oral and skin infections because of their medical and/or situations, and this study's findings are important since providing hygienic care is one of the most essential nursing duties.

According to the findings of this research, audited data demonstrate that, although certain patient hygiene cares were unrecorded while being done by nurses, relative consistency among nursing cleaning care as well as its recording was (77.6 percent).

5.6. Socio-Demographic Variables Associated with Nurses Practices Concerning Nursing Documentation of Hygiene

There were only nurse's education level, years of experience, and training courses as a factor associated with their practices of nursing documentation of hygiene which are discussed as the following:

5.6.1. Nurses Practices of Nursing Documentation of Hygiene and their Age

The analysis of variance showed that there were no significant differences in nurses' documentation of hygiene for unconscious patients with regard to age groups (p=0.216) (table 4-6-1). In other words, age is considered a non-influencing factor in nursing practices, as there were no differences between nurses of young ages (20 years) and nurses over (40 years) of age. Thus, it is not possible to work on the age variable in improving nursing practices. These findings are supported by Inan and Dinç (2013), who stated that the age of nurses is considered a non-influencing factor on their performance in documentation hygiene. Also, da Silva Rodrigues et al. (2016), emphasized there were no differences in nursing documentation of oral hygiene for unconscious patients according to their age groups.

5.6.2. Nurses Practices of Nursing Documentation of Hygiene and their gender

The mean of nursing documentation of hygiene for male nurses is 1.56 (±0.411) and the mean of nursing documentation of hygiene for female nurses is 1.60 (±0.394) (table 4-6-2). Through these results, comparing male and female nurses with regard to practices of nursing documentation of hygiene for unconscious patients, the results show that female nurses are better than men in performance with no statistically

significant difference (t=0.468; p=0.641). The no significant differences in the preference of female nurses considering that gender is a factor ineffective, and this cannot be considered in these wards. Based on those regards, Dagnew et al. (2020), confirmed that the nurses female were more positive attitudes toward nursing documentation of oral hygiene for unconscious patients than the male nurses.

5.6.3. Nurses Practices of Nursing Documentation of Hygiene and their Education Level

The study found that there have been considerable variances in nurses' documentation for hygiene for unconscious patient with regard to education level (p=0.001) (table 4-6-3). Through these significant differences, the educational level is an influential factor in the practices of nursing documentation of hygiene.

It was observed that the nurses who graduated college and above are significantly associated with higher practices of nursing documentation of hygiene for unconscious patients, followed by those who are nursing institute graduates unlike those who are in school nursing (Fig. 4-2).

There was a significant correlation (positive) between nurses' education qualifications and their practices of nursing documentation this was evident in the study by (Coke et al., 2015) .

The interpretation of the direct correlation between educational level and practices in (Coke and other), studies indicates that the lower the educational level, the lower the level of practices.

Severgnini et al. (2016), illustrated in their studies that whenever there are high educational levels in the care of unconscious patients it will give a better quality of patient care.

Health departments and decision-makers should take into consideration that in order to raise the level of care in critical care units, relying on nurses who graduated from college gives better results in nursing care related to unconscious patients. (Researcher)

5.6.4. Nurses Practices of Nursing Documentation of Hygiene and their Years of Experience

The study found that there have been considerable variances in nurses' documentation for hygiene for unconscious patient with regard to years of experience (p=0.001) (table 4-6-4). The years of experience in the critical care unit are considered a challenge in nurses' practices (Deldar et al., 2018). The significant differences were in favor of those who had ≥10 years of experience, as they recorded the highest average nursing documentation of hygiene practices, unlike those who had <5 years (Fig. 4-3). This variable (years of experience) can be worked on by improving documentation practices by relying on experienced nurses. (Researcher)

5.6.5.Nurses Practices of Nursing Documentation of Hygiene and their Training Courses

The study found that there have been considerable variances in nurses' documentation for hygiene for unconscious patient with regard

number of training sessions (p=0.001) (table 4-6-5). The current research discovered that more nearly half of a nurses evaluated (44.6 percent) did not participate in nurses documentation of cleanliness in ICU training programs (table 4-1). This might be owing to a dearth of in-service instructional sessions on this issue inside hospitals. Elgazzar and Keshk (2018) performed a research and discovered that its majority of the surveyed nurses did not attend the training course addressing patients' safety following cardiac catheterization with significant differences between attended training and not attendant.

It was observed that the significant training was associated with higher documentation of hygiene practices (Fig. 4-4). Training programs including the proposed rules for documentation of patient in ICU should be adopted for nurses depending on their needs evaluation, and their impact on their performances must be evaluated. (Abdallah et al., 2020).

Finally, nurses at all level of education do not care about documentation which give a relational for their poor levels in all domains of this issue.

Chapter Six

CONCLUSION AND RECOMMENDATIONS

Chapter Six

6.1. Study Conclusions:

6.1.1. The results of study showed that the majority of the participants were male, with age group (30-39) years, graduated from nursing institutes.

6.1.2. In fact (44.9%) of the nurses had no training sessions related to documenting in nursing, but (43.9%) of them had (5-10) years of experience in the work of NICU.

6.1.3. The majority of the sample recorded the general information of unconscious patients at all studied items of documentation.

6.1.4. Overall assessment of the documentation of the nursing staff is poor.

6.1.5. The study sample showed significant differences in nurses' documentation of hygiene for unconscious patients with socio-demographic data such as (education level, years of experience, and training course). While there were no significant differences in nurses' documentation of hygiene for these participants with (age and gender).

6.2. Recommendation

Based on the results and the conclusion of the current study the researcher suggested the following recommendations

6.2.1. Scheduled training sessions should be delivered at a time that is most convenient for employees. In fact, several employers pay nurses to attend training on their own time.

6.2.2. Continuous educational sessions and programs to applied for enhance nurses' documentation skills when dealing with critical patients during their care in ICU.

6.2.3. Developing multidisciplinary electronic nursing documentation tools to assist with patient care implementation. In addition, nurses in Iraq must be using an electronic documentation system as part of their work.

6.2.4. Reassessment and follow-up for nurses are required following an education session to monitor, evaluate, and promote their skills in order to ensure their application in the work.

6.2.5. Impose sanctions on nursing staff who fail to use nursing documentation tools.

6.2.6. Further researches should be carried out that may contribute to improving nurses' documentation skills.

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Appendices

Appendix A

Panel of Experts

ت	اسم الخبير	اللقـــــب العلمي	الاختصاص	مكان العمل	سنوات الخبرة
١	د. راجحة عبد الحسن حمزة	**أستاذ**	**تمريض صحة البالغين**	**كلية التمريض جامعة الكوفة**	٣٧سنة
٢	د. صباح عباس احمد	**أستاذ**	**تمريض صحة البالغين**	**كلية التمريض جامعة بغداد**	٣٤سنة
٣	د. سحر ادهم علي	**أستاذ**	**تمريض صحة البالغين**	**كلية التمريض جامعة بابل**	٢٧سنة
٤	د. خالدة محمد خضر	**استاذ**	**تمريض صحة البالغين**	**كلية التمريض جامعة بغداد**	٢٠سنة
٥	د. فاطمة مكي محمود	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة كربلاء**	٢٧سنة
٦	د. تحسين رجب محمد	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة بغداد**	٢٢سنة
٧	د. حسام عباس داود	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة بابل**	٢٠سنة
٨	د. حسن عبدالله عذبي	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة كربلاء**	١٩سنة
٩	د. ابراهيم علوان كاظم	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة الكوفة**	١٦سنة
١٠	د محمد عبد الكريم مصطفى	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة الكوفة**	١٣سنة
١١	د. جهاد جواد كاظم	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة الكوفة**	١٣سنة
١٢	د .صادق عبدالحسين	**أستاذ مساعد**	**تمريض صحة البالغين**	**كلية التمريض جامعة بغداد**	١١سنة

Appendix B1

Questionnaire

Part I: Demographical data

1-Age

20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐

2-Gender

Male ☐ Female ☐

3-Level of education

School of nursing ☐

Preparatory of nursing ☐

Institute of nursing ☐

College of nursing ☐

4-Years of experiences

5-10 ☐ 11-20 ☐ 21-30 ☐

5- Participation of the nurses in turning courses in nursing documentation

Yes ☐ No ☐

If yes

Internal Iraq ☐ external Iraq ☐

Number of turning

1-3 ☐ 4-6 ☐ 7-9 ☐ 10-over ☐

Appendix B1

Part II:

General information which documented by the nurses:

No	Information	Record	Not record
1	Patient's age		
2	Patient's sex		
3	Name the physician		
4	Date of admission		
5	temperature		
6	pulse		
7	breathing		
8	blood pressure		
9	Weight & height		
10	Any changes in bowel pattern of diarrhea or constipation		
11	Any noticeable secretions such as vomiting		
12	NG		

Appendix B1

Part III:

General Preparation by the Nurse before Starting Hygiene:

general preparation & equipment before starting Hygiene		Always	Sometime	Never
1	Wearing Personal Protective equipment (Gown, Mask, head cover clean Gloves ect.)			
2	Close the room door and windows and put the blinds.			
3	Adjust the room temperature and water so that is suitable for the patient's body			
4	Place the bed at an appropriate height for patient usually at the height of the nurse elbow form the bed			
5	Bring appropriate Personal hygiene items to the patient on the bedside or dresses cart near the patient			
6	Clean disposable gloves			
7	Big size swimming pool			
8	Try washing a small size			
9	Large & small size medical gauze			
10	Wet tissue			
11	Fluid suction device with accessories such as suction tube			

Appendix B1

Part IV:

Dominos of patient hygienic care:

	1-Care of Hair for Unconscious patients	Always	Sometimes	Never
a	Shaving			
b	Shampooing			
2-Mouth care				
a	Inspecting and the mouth daily for dryness inflammation and crusting			
b	Cleansing the mouth daily and rinsed			
c	Brush teeth /denture, gums and tongue twice daily			
d	Rinse after wads to prevent drying, from Excess toothpaste, then suction, with soft tipped catheter			
3-Eye Care				
a	Cleaning the eye with cotton balls moister with normal slain every 8 hours			
b	Using of artificial tears every 2 hours			
c	Monitoring and recording any sign of eye irritation or inflammation			
d	Closuring of eyelids with eye shields			
4-Nose Care				
a	Cleaning the nose daily with normal saline			
b	Placing sterile cotton in the nose if there is sign of rhinorrhea			

Appendix B1

c	Avoid remove nose clot			
5-Ear care				
a	Clean the ear daily			
b	Place sterile cotton in the ear if there is sign of outorrea			
6-Skin and joint integrity				
a	Bathing the patient daily with soap and warm water			
b	Turning the patient each 2 hours			
c	Inspecting the skin for pressure ulcer			
d	Using passive exercise of the extremities.			
e	Using splints or foam boots aid to prevent foot drop			
f	Using trochlear roll to support the hip joint			
g	Lubricate skin with emollient lotions			
h	Keeping patient skin and under patient linen tight and dry			
i	Clip patient nails			
j	Hygiene for the legs, feet and nails of Unconscious patients			
k	Hygiene for the chest abdomen of Unconscious patients			
l	Hygiene for the Back of Unconscious patients			
m	Hygiene for Genital of Unconscious patients			

Appendix B2

((استبانة))

الجزء الأول: البيانات الديموغرافية للممرضين

١ – العمر: ٢٠-٢٩ ☐ ٣٠ -٣٩ ☐ ٤٠-٤٩ ☐ ٥٠ -٥٩ ☐

٢-الجنس: ذكر ☐ انثى ☐

٣- المستوى التعليمي:

دورة التمريض ☐ اعدادي التمريض ☐

معهد التمريض ☐ كلية التمريض ☐

٤- سنوات من الخبرة:

٥ -١٠ ☐ ١١-٢٠ ☐ ٢-٣٠ ☐

٥-مشاركة الممرضين في دورات التوثيق التمريضي:

نعم ☐ لا ☐

اذا نعم

داخل العراق ☐ خارج العراق ☐

عدد الدورات

١-٣ ☐ ٤-٦ ☐ ٧-٩ ☐ ١٠-اكثر ☐

Appendix B2

الجزء الثاني:

توثيق الممرضين للمعلومات العامة

التسلسل	**المعلومات**	موثق	**غير موثق**
١	عمر المريض		
٢	جنس المريض		
٣	اسم الطبيب		
٤	تاريخ الدخول		
٥	درجة الحرارة/ درجة سليزية		
٦	النبض/ نبضة بالدقيقة		
٧	معدل التنفس/ نفس بالدقيقة		
٨	ضغط الدم/ملم زئبق		
٩	الطول والوزن		
١٠	أي تغيرات في نمط حركة الأمعاء من الإسهال أو الإمساك		
١١	أي إفرازات ملحوظة مثل القيء		
١٢	أنبوب أنفي معدي		

Appendix B2

الجزء الثالث:

توثيق التحضير العام من قبل الممرض قبل البدء في النظافة:

	الفقرات الموثقة	دائما	بعض الاحيان	أبدا
١	ارتداء معدات الحماية الشخصية (صدرية ، قناع ، غطاء الرأس ، قفازات نظيفة إلخ...)			
٢	أغلق باب الغرفة ونوافذها وضع الستائر.			
٣	ضبط درجة حرارة الغرفة والماء بما يتناسب مع جسم المريض			
٤	ضع السرير على ارتفاع مناسب للمريض عادة على ارتفاع مرفق الممرض من السرير			
٥	إحضار أدوات النظافة الشخصية المناسبة للمريض على جانب السرير أو عربة الملابس بالقرب من المريض			
٦	القفازات النظيفة التي تستخدم لمرة واحدة			
٧	حمام سباحة كبير الحجم			
٨	جرب غسل حجم صغير			
٩	شاش طبي كبير وصغير الحجم			
١٠	منديل مبلل			
١١	جهاز شفط السوائل مع ملحقات مثل أنبوب الشفط			

Appendix B2

:الجزء الرابع

:توثيق العناية بنظافة المريض فاقد الوعي

	١-الخطوات الموثقة للعناية بالشعر	مشاهدة ١		مشاهدة ٢		مشاهدة ٣	
		يفعل	لا يفعل	يفعل	لا يفعل	يفعل	لا يفعل
أ	الحلاقة						
ب	الغسل بالشامبو						
	٢- الخطوات الموثقة للعناية بالفم						
أ	يفحص الفم يوميا من الجفاف والالتهاب والتقشر						
ب	تطهير الفم يوميا وشطفه						
ج	غسل الأسنان / طقم الأسنان واللثة واللسان مرتين يوميًا						
د	شطف بعد الحشوات لمنع الجفاف ، من معجون الأسنان الزائد ، ثم الشفط باستخدام قسطرة ناعمة الرأس						
	٣- الخطوات الموثقة للعناية بالعيون						
أ	تنظيف العين بالكرات القطنية الرطبة بمحلول ملحي عادي كل (٨) ساعات						
ب	استخدام الدموع الصناعية كل ساعتين						
ج	مراقبة وتسجيل أي علامة على تهيج أو التهاب في العين						
د	إغلاق الجفون باستخدام واقيات العين						
	٤- الخطوات الموثقة للعناية بالأنف						
أ	تنظيف الأنف يومياً بمحلول ملحي عادي						
ب	هناك علامة على وضع قطن معقم في الأنف إذا كانت سيلان الأنف						
ج	تجنب إزالة جلطة الأنف						

Appendix B2

٥- الخطوات الموثقة للعناية بالأذن						
أ	نظف الأذن يوميًا					
ب	ضع قطنًا معقمًا في الأذن إذا كانت هناك علامة على ظهور الافرازات					
٦- الخطوات الموثقة لسلامة الجلد والمفاصل						
أ	الحمام اليومي للمريض بالصابون والماء الدافئ					
ب	يقلب المريض كل ساعتين					
ج	فحص الجلد لقرحة الضغط					
د	.استخدام التمارين السلبية للأطراف					
ه	يساعد استخدام الجبائر أو الأحذية الرغوية في منع سقوط القدم					
و	استخدام لفافة البكر لدعم مفصل الورك					
ز	دهن الجلد بمستحضرات الترطيب					
ح	الحفاظ على جلد المريض ووضع كتان تحت المريض مشدودًا وجافًا					
أ	قص أظافر المريض					
ي	فاقد الوعي مرضى نظافة أرجل وأقدام وأظافر					
ك	نظافة الصدر والبطن للمرضى الفاقد للوعي					
ل	الفاقدين الوعي المرضى لظهر النظافة					
م	فاقدين الوعي للمرضى النظافة للأعضاء التناسلي					

Appendix C

University of Babylon
College of Nursing
Research Ethics Committee

جـامـعة بـــابـل
كـــلية التمريـض
لجنة اخلاقيات البحث العلمي

Issue No:

Date: / /2022

Approval Letter

To,

Kadhim Hussein Jassim

The Research Ethics committee at the **University of Babylon, College of Nursing** has reviewed and discussed your application to conduct the research study entitled **" Nursing Documentation of Hygiene practices for Unconscious Patients in Intensive Care Unit at Neurosurgical Hospital in Baghdad.**

The Following documents have been reviewed and approved:

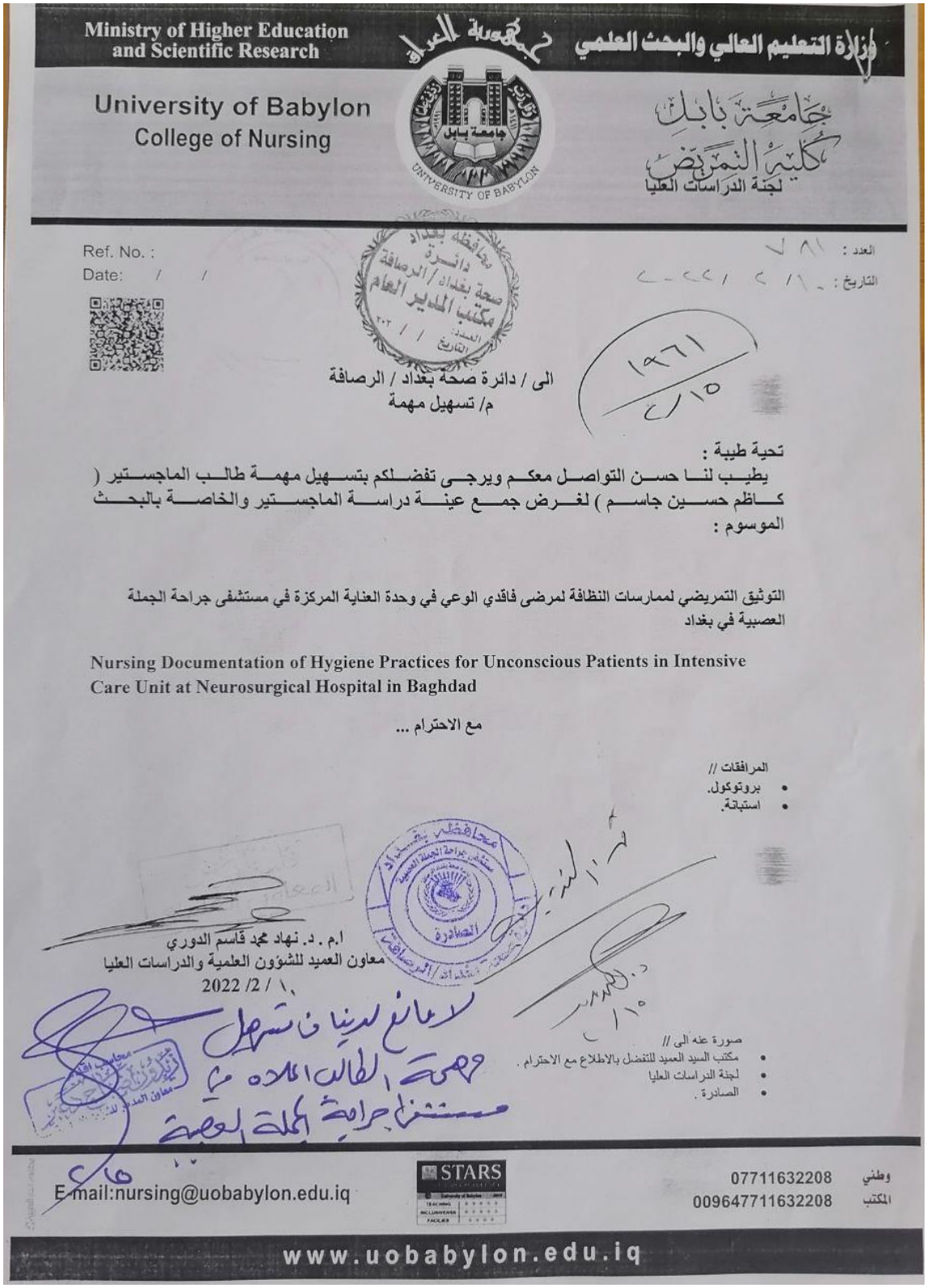
1. Research protocol
2. Research instrument/s
3. Participant informed consent

Committee Decision.

The committee approves the study to be conducted in the presented form. The Research Ethics committee expects to be informed about any changes occurring during the study, any revision in the protocol and participant informed consent.

Prof. Dr. Salma K. Jehad
Chair Committee
College of Nursing
Research Ethical Committee
9 / 2 /2022

Appendix C



Ministry of Higher Education and Scientific Research

وزارة التعليم العالي والبحث العلمي

جمهورية العراق

University of Babylon
College of Nursing

جامعة بابل
كلية التمريض
لجنة الدراسات العليا

Ref. No. :
Date: / /

العدد : ٨١٧
التاريخ : ١٠ / ٢ / ٢٠٢٢

محافظة بغداد
دائرة صحة بغداد / الرصافة
مكتب المدير العام
العدد: / /
التاريخ: ٢٠٢

١٩٦١
١٥/٢

الى / دائرة صحة بغداد / الرصافة
م/ تسهيل مهمة

تحية طيبة :

يطيب لنا حسن التواصل معكم ويرجى تفضلكم بتسهيل مهمة طالب الماجستير (كاظم حسين جاسم) لغرض جمع عينة دراسة الماجستير والخاصة بالبحث الموسوم :

التوثيق التمريضي لممارسات النظافة لمرضى فاقدي الوعي في وحدة العناية المركزة في مستشفى جراحة الجملة العصبية في بغداد

Nursing Documentation of Hygiene Practices for Unconscious Patients in Intensive Care Unit at Neurosurgical Hospital in Baghdad

مع الاحترام ...

المرافقات //
- بروتوكول.
- استبانة.

محافظة بغداد
مستشفى جراحة الجملة العصبية
الصادرة

أ.م . د. نهاد محمد قاسم الدوري
معاون العميد للشؤون العلمية والدراسات العليا
2022 /2/ ١٠

لا مانع لدينا في تسهيل مهمة الطالب المذكور مع مستشفى جراحة الجملة العصبية

صورة عنه الى //
- مكتب السيد العميد للتفضل بالاطلاع مع الاحترام .
- لجنة الدراسات العليا
- الصادرة .

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STARS

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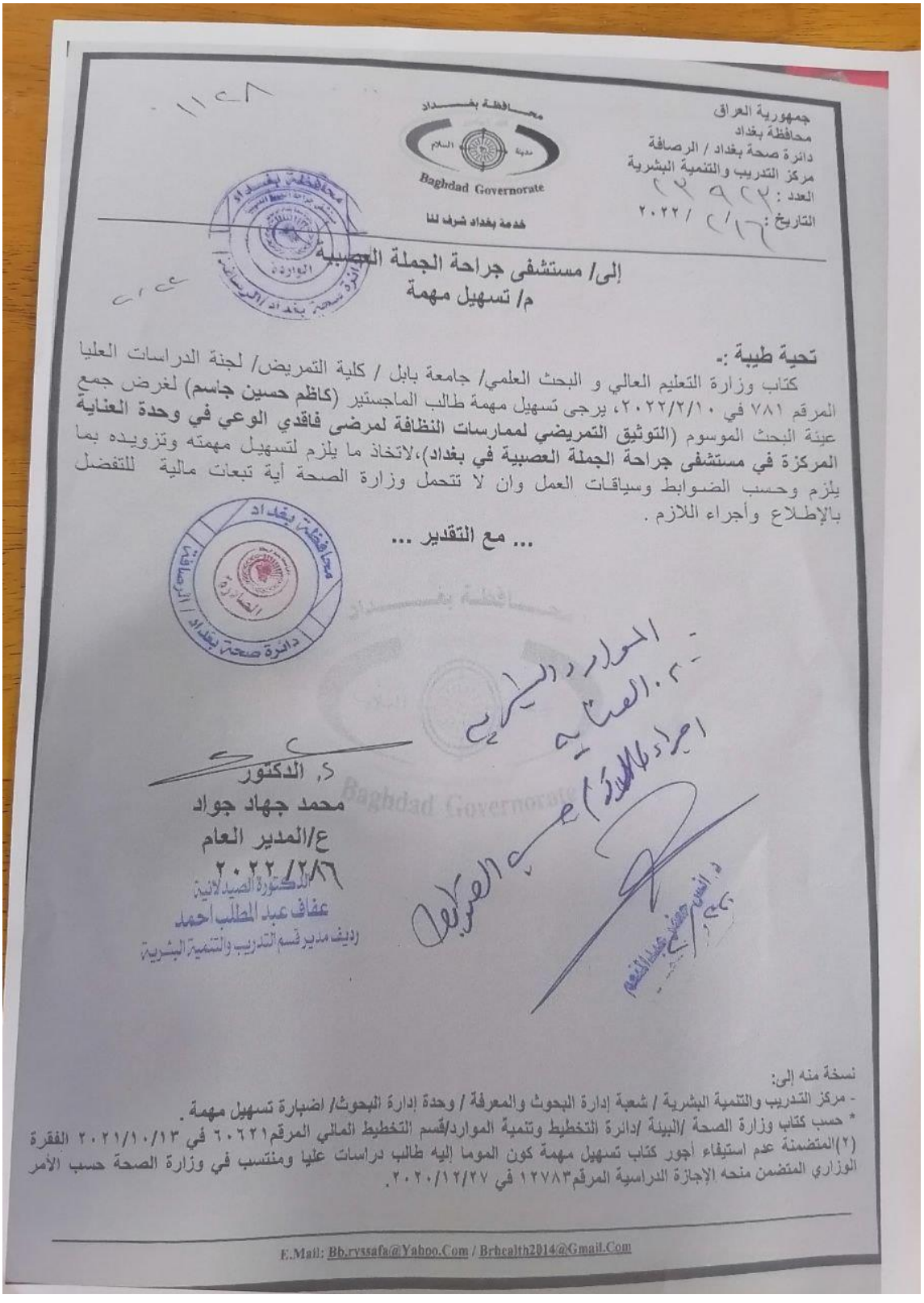
Appendix C



جمهورية العراق
محافظة بغداد
دائرة صحة بغداد / الرصافة
مركز التدريب والتنمية البشرية
العدد : ٢٢٩٢٢
التاريخ : ١٦/ ٢/ ٢٠٢٢

محافظة بغداد
Baghdad Governorate
خدمة بغداد شرف لنا

إلى/ مستشفى جراحة الجملة العصبية
م/ تسهيل مهمة

تحية طيبة :-

كتاب وزارة التعليم العالي و البحث العلمي/ جامعة بابل / كلية التمريض/ لجنة الدراسات العليا المرقم ٧٨١ في ٢٠٢٢/٢/١٠، يرجى تسهيل مهمة طالب الماجستير (**كاظم حسين جاسم**) لغرض جمع عينة البحث الموسوم (**التوثيق التمريضي لممارسات النظافة لمرضى فاقدي الوعي في وحدة العناية المركزة في مستشفى جراحة الجملة العصبية في بغداد**)،لاتخاذ ما يلزم لتسهيل مهمته وتزويده بما يلزم وحسب الضوابط وسياقات العمل وان لا تتحمل وزارة الصحة أية تبعات مالية للتفضل بالإطلاع وأجراء اللازم .

... مع التقدير ...

محافظة بغداد / الرصافة / دائرة صحة بغداد

ك. الدكتور
محمد جهاد جواد
ع/المدير العام
٢٠٢٢/٢/١٦

الدكتورة الصيدلانية
عفاف عبد المطلب احمد
رديف مدير قسم التدريب والتنمية البشرية

نسخة منه إلى:
- مركز التدريب والتنمية البشرية / شعبة إدارة البحوث والمعرفة / وحدة إدارة البحوث/ اضبارة تسهيل مهمة .
* حسب كتاب وزارة الصحة /البيئة /دائرة التخطيط وتنمية الموارد/قسم التخطيط المالي المرقم٦٠٦٢١ في ٢٠٢١/١٠/١٣ الفقرة (٢)المتضمنة عدم استيفاء اجور كتاب تسهيل مهمة كون الموما إليه طالب دراسات عليا ومنتسب في وزارة الصحة حسب الأمر الوزاري المتضمن منحه الإجازة الدراسية المرقم١٢٧٨٣ في ٢٠٢٠/١٢/٢٧.

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وزارة التعليم العالي والبحث العلمي
جمهورية العراق
Ministry of Higher Education and Scientific Research

جامعة بابل
كلية التربية للعلوم الانسانية

University of Babylon
College of Education for Human Sciences

العدد : ٦٣٦٣
التاريخ : ٢٠ / ٦ / ٢٠٢٢

Ref. No :
Date:

المعاون العلمي

الى/جامعة بابل / كلية التمريض

مكتب السيد معاون العميد للشؤون العلمية المحترم

م/أعادة رسالة

تحية طيبة :

اشارة الى كتابكم المرقم (٢٢٦٠) في ٢٠٢٢/٦/٢٨، نعيد إليكم رسالة طالب الدراسات العليا / الماجستير (**كاظم حسين جاسم**) بعد تقويمها لغوياً من قبل **(أ.م.د. حسين حميد معيوف) من قسم اللغة الانكليزية في كليتنا**، وقد ثبت الملاحظات على متن الرسالة يرجى من الباحث الالتزام بها .

*** مع الاحترام ***

أ.د. اسامة كاظم عمران
معاون العميد للشؤون العلمية
والدراسات العليا

نسخة منه إلى //
- الدراسات العليا .
- الصادرة

البريد الالكتروني bad_edu_humsci@yahoo.com
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الخلاصة

التوثيق التمريضي هو جزء من الملاحظات الطبية للممرضين ومصدر للمعلومات الأساسية والضرورية في مجال الرعاية الصحية ، وهو سجل للمريض يحتوي على جميع المعلومات المكتوبة حول حالة المريض واحتياجاته ، ومهام التمريض لأنه يخدم العديد من الأغراض المختلفة. تهدف الدراسة إلى تقييم التوثيق التمريضي لممارسة النظافة للمرضى الفاقدين للوعي في وحدة العناية المركزة في مستشفى جراحة الأعصاب في بغداد ومعرفة العلاقة بين توثيق الممرضين لممارسات نظافة المريض الفاقد للوعي وخصائصهم الديموغرافية. أجريت الدراسة في الفترة من ٩ فبراير ٢٠٢٢ إلى ٢٦ يونيو ٢٠٢٢ ، وقد تم تطبيق قائمة الملاحظات الرقابية من قبل الباحث على طريقة ملائمة (غير احتمالية) لعدد (١٠٧) ممرضين لإجراء الدراسة من العاملين فيها. وحدة العناية المركزة في مستشفى جراحة المخ والأعصاب التعليمي التابع لمديرية صحة الرصافة في بغداد. الاستبانة مكونة من (٥١) فقرة. أجريت الدراسة لمراقبة التوثيق التمريضي لممارسة النظافة للممرضين ذات الصلة للمرضى الفاقدين للوعي. تم بناء أداة الدراسة لتحقيق أهداف الدراسة المرجوة. تم اختبار الأداة للتأكد من صحتها وموثوقيتها. تظهر النتائج أن معظم مرضى العينة كانوا من الذكور ، وتراوحت أعمارهم بين (٣٠-٣٩) سنة ، وأن (٦٥,٤٪) من الممرضين أظهروا توثيقًا ضعيفًا لممارسات النظافة للمرضى الفاقدين للوعي ، ومعظم عينة الدراسة لم تكن كذلك. دورات تدريبية خاصة بالتوثيق في التمريض. يوضح المشاركون في الدراسة اختلافات كبيرة في توثيق الممرضين للنظافة للمرضى الفاقدين للوعي مع البيانات الاجتماعية والديموغرافية مثل (المستوى التعليمي ، سنوات الخبرة ، والدورة التدريبية). بينما لم تكن هناك فروق ذات دلالة إحصائية في توثيق الممرضين للنظافة لهؤلاء المشاركين (العمر والجنس). أظهرت النتائج أن التقييم العام لتوثيق طاقم التمريض كان ضعيفًا. يكشف عن وجود اختلاف كبير في توثيق الممرضين للنظافة للمرضى فاقدي الوعي مع مستوى تعليمهم وسنوات خبرتهم ودوراتهم التدريبية. فيما يتعلق بالتوصيات ، ينبغي إعطاء الممرضين جلسات تدريبية كتحدي فريد لإثبات أهمية التوثيق وتسجيل أنشطة التمريض. تطوير أدوات توثيق التمريض الإلكترونية متعددة التخصصات للمساعدة في تنفيذ رعاية المرضى.

جمهورية العراق
وزارة التعليم العالي والبحث العلمي
جامعة بابل
كلية التمريض

التوثيق التمريضي لممارسات النظافة لمرضى فاقدي الوعي في وحدة العناية المركزة في مستشفى جراحة الجملة العصبية في بغداد

رسالة مقدمة من قبل

كاظم حسين جاسم

الى

مجلس كلية التمريض/ جامعة بابل

جزء من متطلبات نيل درجة ماجستير في علوم التمريض

بإشراف

أ. د. شذى سعدي محمد

ايلول ٢٠٢٢ ميلادي صفر ١٤٤٤ هجري