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Effect of the Nursing Documentation Educational Program on Nurse's Knowledge and Attitude in Al-Furat Al-awsatt Teaching Hospital

A Dissertation

Submitted to the Council of College of Nursing, University of Babylon

By

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Fulfillment of the Requirements for the Doctorate Degree of Philosophy in Nursing

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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

ن وَالْقَلَمِ وَمَا يَسْطُرُونَ

صَدَقَ اللَّهُ الْعَلِيُّ الْعَظِيمُ

سورة ألقلم/ الآية (1

Supervisor Certificate

This is to certify that the dissertation entitled: **Effect of the Nursing Documentation Educational Program on Nurse's Knowledge and Attitude in Al-Furat Al-awsatt Teaching Hospital**, submitted by **Hayder Ghaleb Jebur** to the University of Babylon, College of Nursing in partial fulfillment of the requirements for the Degree of Doctor of Philosophy in Nursing. The dissertation work was carried out by the student under my supervision and guidance.

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Committee Certification

We, the members of the Dissertation Discussion Committee, certify that the we have reviewed the dissertation entitled **‘‘Effect of the Nursing Documentation Educational Program on Nurse's Knowledge and Attitude in Al-Furat Al-awsatt Teaching Hospital**” carried out by **Hayder Ghaleb Jebur** and examined the student in its contents and what is related to it on / /2022.

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Dedication

To

- ***Praise be to Allah Almighty first.***
- ***Thanks to my parents for their constant prayers for me.***
- ***I thank my dear wife for her patience and encouragement.***
- ***Finally, a special thanks to my friends for their continued support.***

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I was pleased with the nurses' participation in this study despite the difficult conditions they are going through in under Covid -19 of the pandemic, as I was inspired by their eagerness to gain knowledge, develop their practices and change their attitudes towards nursing documentation.

Also, I would like to recognize the positive efforts and invaluable assistance of the library staff in the College of Nursing.

Abstract

Background: Nursing documentation is the record of nursing care that is planned and delivered to individual patients by qualified nurses or other caregivers under the direction of a qualified nurse . and it is principal clinical information source to meet legal and professional requirements.

Methods: Quasi-experimental design carried out to evaluate the effect of the documentation program on the nurses knowledge and attitudes from September 21, 2020 to March 7, 2022, at Al-Furat Al-Awsat Teaching Hospital in Al-Najaf City.

A total of (50) nurses were randomly assigned to two groups and enrolled using non-probability deliberate selection procedures. The study group was attended the program sessions, while the control group remain with out any intervention, both groups were exposed to pre and post test.

Results: Participants from both groups showed in pre test insufficient knowledge (56% for the study and 72%for the control) and had indifferent attitudes of nursing documentation (76% for the study and 80% for the control). While participants in the study group were compared after executing the program, (post-tests) demonstrated a significant improvement in their knowledge (68%), and attitudes (80%). The control group, showed knowledge and attitudes deficit with a modest decline in nursing documentation.

Conclusion: furthermore, the education program was shown to be effective to improve the nurses' documentation knowledge and attitude. according to the study. Furthermore, a method like this is useful in shielding nurses from being documented.

Recommendation: Nurses' benefits for documentation may be taken and consideration by establishing special educational training programs to improve competence.

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List of Abbreviation Symbols

Items	Meaning
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADL	Activity daily living
Am	Ara- somni
ANA	American nursing association
ANOVA	Analyse of Variances
ARBs	Acute respiratory therapy
Ass	Assessment
B C	Before Christ
C.C	Contingency Coefficients
C.S	Comparison significant
CBAR	Case,Background,Assessment,Recommendation
CBE	Charting by exception
CCU	Cardiac care unit
CDS	Computerized documentation system
CRNBC	College of Register Nurse of British Columbia
CT	Computerised Tomography
d.f.	Degree of freedom
DH	Department of health
ECG	Electro cardiograph

EHR	Electric Heart Record
EoLC	End of life care
et. Al	Italia (others)
Fi	Fisher Information
Fig	Figure
Fre	Frequency
H.S	High-significant
HR	Heart rate
HRQOL	Health related quality of life
Hrs	Hours
I.V	Intravenous
ICN	International council of nursing
ICU	Intensive care unit
IT	Information Techonology
KAP	Knowledge, Attitude, Practices
M.S	Mean of scores
MRI	Magnetic resonance image
MS	Medical surgical
MT	Med Take
N	Number of Cases
N	Total Number of Cases
N.S	Non-significant

NANDA	North American nursing diagnosis association
NAO	National audit office
No	Number
PIE	Problem, intervention, evaluation
Pm	Post- somni
PR	Pulse rate
QoL	Quality of life
R	Alpha correlation coefficient
R.S	Relative sufficiency
Ri	Correlation
RR	Respiratory rate
RT	Respirotory thearpy
RT	Respiratory therapy
S	Significant
S.O	Source oriented
SD	Standard Deviation
SDVs	Socio-Demographic Variables
Si	Statistical Inference
Sig	Signifacant
SOAPIER	Subject, object, assessment, plan, intervention, evaluation, revision
SPSS-16.0	Statistical Package of Social Sciences-Version 16

UN	United nations
WHO	World health organization
χ2	Chi- square
%	Percentage
<	Less than
>	Greater than
χ^2	Chi- square

Chapter One

Introduction

Chapter One

1.1.Introduction

Nursing documentation is a component of clinical notes completed by nurses, and it is one of the most basic and fundamental sources of information in health care. A patient's record is a collection of all written information about a patient's condition and needs, and it is one of the most important functions of nurses because it serves so many different purposes (White et al, 2017).

Nursing documentation is important for a variety of reasons, including identifying members of the treatment team, ensuring continuity of care, reminding nurses of their professional duties and responsibilities, evaluating therapeutic interventions, calculating health care costs, upholding and protecting patients' and nurses' legal rights, and providing research and training details (Hameed & Allo, 2014).

The quality and coordination of care in modern healthcare systems is dependent on communication between different caregivers concerning their patients. Nurses and other caregivers use documentation as a means of exchanging information held in medical records. Good nursing documentation improves personalised continuity of care and patient safety by ensuring orderly, consistent, and effective communication between caregivers (Al Najafi, 2009).

Patient safety incidents have been attributed to a poor of communication in the healthcare system. The engagement of many team members using a variety of communication means, professional hierarchies that inhibit collaboration, and the frequent shift of healthcare team members owing to change and schedule changes may all contribute to poor communication in today's complicated healthcare system. The Case, Background, Assessment, and Recommendation (CBAR) tool is one

interprofessional communication technique that has been proposed to improve quality and safety by reducing some of these barriers (Dawood et al, 2018).

The first stage in the nursing documentation process is to assess the patient, and it is critical to obtain information that will aid the nurse in making a nursing diagnosis, planning and implementing nursing managment, than evaluating. Regardless of the practice scenario, the ability to assess a patient's status is one of the most crucial abilities a nurse may have. Obtaining a comprehensive health history and employing proper assessment skills are crucial in all scenarios where nurses contact with patients to discover their physical and psychological problems and concerns (Al Botany and Gorges, 2007).

Documentation in a client's health record can be used for quality assurance, legal goals, health planning, resource allocation, caring, and as research (Timby, 2021).

Documentation of the patient's specific disease facts; used as a treatment planning tool for the patient Medical records must be retained and maintained for a variety of reasons, including facilitating communication between the various health care providers and assisting in the protection of patients and healthcare providers' legal rights. It's also one of the most important nursing responsibilities. Health records describe the patient's health, status needs, nursing managment, and response to care; nevertheless, it does not reflect the holistic nature of nursing practice and function. These clinical records make it easier to provide care, increase continuity of care, and coordinate treatment and evaluation for patients (Tola, 2017).

1.2.Importance of the Study

Nursing documentation must be rational, informative, and easy to understand. Medical personnel' documentation processes have gotten a lot of attention in recent years. Accurate and complete nursing documentation promotes efficiency, enhances communication among members of the patient care team, and allows for care continuity. The reduction of errors is supposed to be achieved by simplifying and standardizing processes such as documentation (Steel, et al 2019).

Nursing practices and documents were also linked, according to Yoost (2015), in order to give clients with safe and effective therapy. The paperwork acts as a legal record, proving that all components of the nursing process, as well as professional standards of care, regulatory regulations, and agency guidelines, were performed appropriately.

Furthermore, health-care providers employ reporting and recordkeeping as key communication tools to help clients make informed decisions and preserve treatment continuity. The medical record, which also functions as a legal document, records all client activities that have been examined and conducted by the healthcare practitioner (Kohar, 2020).

A health care organization's policies and processes should have been linked with the appropriate state and federal laws, regulations, and accepted standards. A breach of the standard of care could occur if a company's policies and procedures are not followed. Organizational rules and procedures should serve as a set of recommendations for nurses, but they should not be used to replace independent nursing judgment. If rules and procedures are not followed, documentation should offer fasts to support the nursing judgment (Diana et al, 2020).

Nurses are expected to keep track of their patients' progress, evaluate which interventions are useful and which are not, and to identify and document any necessary adjustments to the treatment plan. The documentation can be helpful in making financing decisions, managing resources, and conducting nursing research, all of which have the potential to improve nursing practice and client care. Individual nurses can assess their practices and make improvements based on information such as accident data or outcome data (CRNBC, 2013).

The medical record is a legally binding document that can be used for a variety of purposes. In a legal sense, it is an essential component of a defense against any potential negligence or malpractice lawsuit. The medical record is the only permanent record of the patient's care from the time of admission to the time of discharge. A well-maintained record assists healthcare providers in better managing patient care, but a poorly managed record raises the risk of medical error. Consider the medication errors that arise as a result of illegible handwriting or a failure to document the administration of a drug. While the medical record can serve a variety of objectives, its primary function is to ensure patient care continuity. Always keep in mind that the patient is the center of all paperwork (ACSQHC, 2017).

Documentation is of great importance in the provision of nursing services and also through which we can develop the services provided to the patient as well as the to know the changes that occur to the patient and the extent of its response to the interventions of nursing and is considered as a way to communicate with the health team. Detailed documentation of care in the medical record serves as legal proof that the care provided complies with accepted standards of care.

The problem of the study on nursing documentation was chosen because it is considered one of the effective means of communication within the health institution, if not the most important one, because it represents a link between the members of the health team, as well as for excellence in job performance through participation in the nursing staff evaluation committees and their follow-up. And also a specific problem related to nursing documentation and thinking about solving it in a scientific way, where the nursing staff lacks a rigorous application of nursing fundamentals and needs guidance and follow-up, which can be achieved by doing research and solving problems in a scientific way.Since scientific research is an ongoing process, this study came to complement what I started in my master's study of research on a problem related to nursing documentation (The researcher).

1.3.Statement of the Study

An Educational Program on Nurses Knowledge, Attitude and Practices toward Documentation in Al-Furat Alawsatt Teaching Hospital

1.4.Objectives of the Study

This study aims at:

1. To assess the pre-test knowledge, attitudes, and practices of the nurses documentation.
2. To determine the effectiveness of the planned teaching program upon study groups knowledge, attitudes, and practices regarding documentation.
3. To find the association between post-test levels of knowledge, attitudes, and practices with participants socio-demographic variables.

1.5..Hypothesis:

- **H0:** There is no significant differences in knowledge, attitude and practice of nurses documentation between study and control groups at post test.
- **H1:** There is significant differences in knowledge, attitude and practice of nurses documentation between study and control groups at post test.

1.6.Definition of Terms:

1.6.1.Educational program:

A. Theoretical:

An educational program is a systematic developed and designed educational intervention (for instance as learning-teaching strategies, instructional materials, presentations and programs,) as solutions for complex problems in educational practice, which also targets at progressing human knowledge toward selected issue (Plomp, 2010).

B. Operational:

It refers to a planned educational program that is constructed systematically to provide knowledge and information about the documentation of nurses to increase their knowledge levels and to influence their attitudes toward this issue.

1.6.2.Knowledge:

A. Theoretical:

Any information that is acquired through education or practical experience (Al-Tameemi, 2016).

B. Operational:

Nurses' information about the documentation which is measured by their ability to answer correctly the self-administered questionnaire.

1.6.4.Attitude:

A. Theoretical:

The definition of attitudes is a general framework, in which a human regulate his feelings and knowledge about a subject, matter or person according to it.. Attitudes can also be referred to as the process of evaluating an individual, either positively or negatively, toward a group or individual, a particular issue, or even a particular object. Therefore, attitudes issues short judgments, resulting from feelings, knowledge, or actions emanating from the target objects. (Videbeck, 2020a; VandenBos, 2015)

B. Operational:

Attitudes of the nurses about documentation in the current study measured by their responses to the attitude questionnaire, which will be either in a negative or positive direction.

1.6.6.Documentation:

A. Theoretical:

Anything written or generated electronically about a customer's condition, care, or services (Potter &Perry, 2020).

B. Operational:

A written record of nursing notes that reflects the quality of care provided to the patient.

Chapter Two

Review of Litrature

Chapter Two

Review of Literature

Throughout this chapter, the previous literature related to "the nursing documentation" will be reviewed.

It is worth noting that the literature review is a summary of most of the applied and theoretical sources and references related to the problem under study, with the aim of forming a perception about the available knowledge on the subject and the aspects that are not studied at all or not adequately researched, and thus clarify the research problem in a better way and prepare Available knowledge for use in the application of the study (Bomer-Norton, 2018; Nieswiadomy and Bailey, 2018).

Throughout the present study, the previous literature was reviewed and written according to the sections shown in the following list of subjects:

2-1 Historical Background

- Documentation in time Hippocrates(460-377 BC)
- Documentation in Muslim culture
- Miss Nightingale Writings

2-2 Guideline for Quality Documentation and Record

2-2-1 Factual Basis

2-2-2 Accuracy

2-2-3 Completeness

2-2-4 Currentness

2-2-5 Organization

2-2-6 Confidentiality

2-3 Methods of Documentation.

2-3-1 Narrative Documentation

2-3-2 Source-Oriented Charting

2-3-3 Problem- oriented Charting

2-3-3-1 Database

2-3-3-2 The Problem List:

2-3-3-3 Initial Plan

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2-3-6 Charting by Exception

2-3-7 Computerized Documentation

2-3-7-1 Learning a Computerized Nursing Information System

2-4 Categories of Documentation Forms in a Clinical Record System

2-4-1 Assessment and Data Base Forms

2-4-2 Plan of Care Forms

2-4-3 Progress Notes Forms

2-4-4 Continuity Care Forms

2-5 Documentation Nursing Activities

2-5-1 Admission Nursing Assessment

2-5-2 Nursing Care Plan

2-5-3 Kardexes

2-5-4 Flow Sheet

2-5-5 Progress Notes

2-6 Overview of the Nursing Process

- Dynamic
- Analytical
- Organized

- Collaborative
- Adaptable
- Outcome Oriented

2-6-1 Assessment

2-6-1-1 Collecting Data

2-6-1-2 Organizing Data:

2-6-1-3 Validating Data

2-6-1-4 Prioritizing Data

2-6-2 Nursing Diagnosis

2-6-2-1 Type of Nursing Diagnosis:

2-6-2-2 Comparison of Medical and Diagnostic Process

2-6-3 Planning:

2-6-4 Implementation

2-6-5 Evaluation

3- Medical Ward Round:

3-1- Job Description:

4- Previous Study:

2.1.Historical Background

Documentation in Hippocrates Time (460-377) BC:

The Hippocratic Corpus consists of some 60 medical treatises, the majority of them conventionally dated to the later decades of the fifth century B.C., or to the early decades of the fourth; that is to say, at the culmination of the "Classical .Hippocrates from the island of Cos was known as a famous physician, (Theofanidis & Krepia, 2015).

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 (Kentikelenis A et al, 2014).

Documentation in Muslim Culture:

From the Islamic period to the present age, history has been marked by a turbulent past marked by cultural boundaries and societal pressures. The lack of medical record made the task of nursing in early Islamic culture, which is commonly considered in the context of Muhammad, and the Islamic era's historical evolution to modern society, a tumultuous past fraught with cultural hurdles and societal constraints, difficult (Francis and Davies, 2016).

Although there is little information about nursing in the pre-Islamic period, a thorough understanding of the cultural and theological paradigms in place throughout Muhammad's reign can provide light on the roles and expectations of nurses in ancient times. In sharp contrast to Christian idea that sickness is a divine punishment for man, Muslims place a high value on body cleaning, regular prayer, and rigorous diets (Jonathan, 2013).

Medicinal care during Mohammed's time was generally performed solely by doctors and nurses, such as rufiad al aslamia, who was a nurse during the prophet Mohammed's time. With the prophet's approval, she learned a variety of nursing skills, including diagnosing abnormalities and administering medications to individuals who needed them. Nurses were limited in their duties to providing physical comfort and mental support because the majority of a patient's biological and physiological obligations were placed solely on the doctor's shoulders (Al Najafi et al, 2009).

Miss Nightingale Writings:

Throughout her life, Florence Nightingale worked in hospitals, cleanliness, ventilation, health statistics, and especially nursing education, albeit she contributed little to documentation and nursing observation records (McDonald, 2018).

Ellis and Hertley, (2012), mention about Nightingale writings:

The most important practical lesson for nurses to learn is what to notice, how to observe, and what symptoms suggest improvement and reversal, which is crucial for nurses on medical wards to consider when documenting nursing interventions and

outcomes. In addition, the facts and information must be accurately recorded in the patient charts.

It was mentioned in the same source Ellis and Hertley, (2012), that Florence Nightingale believed and acted on the assumption that the administrator could only be successful if he was directed by documented statistical knowledge in all of her acts. Too frequently, the lawmaker, to say nothing of the politician, has failed due to a lack of information. She went even further: she believed that the cosmos, including human communities, was evolving in accordance with a divine purpose, which he should try to understand and govern his actions in accordance with. However, she claimed that in order to comprehend God's thoughts, we must study statistics, as they are the measure of his intent. As a result, studying documentation statistics was a holy obligation for her.

2.2.Quality Documentation and Record-Keeping Guidelines

To improve efficient, tailored patient care, high-quality documentation and reporting are required.

College of Registered Nurses of Nova Scotia (2012); Koizer and other (2014); Smiltzer and Bare (2002); Smith and other (2014); Smith and Duell (2010); Moffet and Hill (2010); Potter and Perry (2020) stated that are many important guidelines which must be followed for quality documentation and reporting.

2.2.1.Factual basis:

Actual information regarding the patient and their care should be documented. Descriptive goal information based on personal experience, the nurse's assessment, and the client's appraisal of their own 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 them.

2.2.2.Accuracy:

In order to maintain correct paperwork, the patient's history must be accurate. Accurate recording is ensured by the use of exact measurement. Clear, easy-to-understand information about the client's important components and the variances in the client's treatment response. Furthermore, if the documentation is intended to be utilized for clinical or research purposes, accuracy is necessary.

The use of factual descriptive phrases to illustrate exactly what was observed or done, with perfect spelling, is critical to good documentation. It's also critical to employ acronyms that are difficult to misunderstand. Nurses must also never plan for others or allow others to plan for them, and any descriptive remark in a patient's record must conclude with the caregiver's full name and condition.

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.

2.2.4.Currentness:

During or soon after the intervention or interaction, current data was captured. Timely admittance is crucial in today's patient care; delays in paperwork can lead to serious omissions and unnecessary delays in patient treatment.

The following are some of the activities or discoveries that should be communicated at the appropriate time:

1. Checking vital signs.
2. Medication and treatment administration
3. Getting ready for a diagnostic test or surgery.
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. Patient response to intervention.

Many agencies use military time, a 24-hour system that uses a digit number to medicate morning, afternoon and evening time, while others use civilan times (Am).

2.2.5.Organization:

The nurse communicates information in a logical form or order. Health care team members understand information better when it is given in the order in which it occurred and keep track of the information in a logical order so that nursing decisions, actions, and client reactions can 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 disorganized not is fragment and does not clearly explain what happened first to the patient. Moreover, poorly

organized notes can lead to confusion about whether proper care was given or not.

2.2.6.Confidentiality:

Confidentiality communication is information communicated by one person to another with the expectation that it would not be revealed. Patient information gathered during screening is not adequately protected. Nurses are required by ethical norms to treat all patient information, including the patient's record, with confidentiality and professionalism. The data shows the delivery of nursing care that is safe, competent, ethical, compassionate, and compliant with industry standards. Furthermore, because the written documentation contained in a patient's file is the legal record of care, nurses should not discuss a patient's condition with other patients or staff members not involved in the patient's care. As a result, it is the nurse's responsibility to keep all patient contacts, assessments, and care private and confidential. Furthermore, patient records may be utilized for instruction or research in many institutions, particularly teaching hospitals, and such users are not required to violate confidentiality as long as the records are used as directed and with consent from hospital internal review boards.

2.3.Methods of Documentation

The Nursing Service Documentation System is intended to reflect the department's attitude and the manner in which nursing care is delivered. Authentication by inclusion and documentation by exception are the two most frequent methods of authentication. All assessment findings, nursing interventions, and client outcomes are documented on a regular basis as part of the inclusion process. Documentation by exception, on the other hand, keeps track of

unfavorable outcomes and ends after the evaluation is over (Abbas, 2013).

Compliance with societal and professional standards of practice, legal and regulatory requirements, and institutional policies and procedures has prompted the evolution of customer care data collection and reporting systems. Many of today's healthcare practitioners' demands and preferences are reflected in current documentation systems (Abbas, 2013).

Exceptions should only be used when evaluation criteria or standards of care are clearly specified and available inside the agency. Exception documentation is never appropriate in the context of medication management (Abbas, 2013).

The documentation technique employed within an agency or practice environment should reflect the needs of client care and the practice environment. Some organizations may mix and match parts of several documentation methodologies and formats. If the agency wants to update its documentation or the process or structure of its projections, it must do so as part of a comprehensive plan that involves nurse engagement and education. Regardless of the method employed, nurses are responsible for recording client evaluations, interventions, and the impact of interventions on client outcomes. Clients who are terminally sick, at high risk, or who have a range of health concerns require more detailed, in-depth, and regular reporting (CRNBC, 2013).

2.3.1.Narrative Documentation:

A narrative chart is a form of story that details a patient's disease, interventions, therapies, and treatment response. It's a tried-and-true method of nursing drawing. This was the only way to document care prior to the invention of flow sheets. During an 8-

hour shift, the nurses spent roughly 30% of their time in the narrative chart (Kitson et al, 2012)

In an emergency where a clear chronological order is necessary, narrative documentation is simple to employ. However, being subjective in this form of recording is unavoidable, and the nurse's ability to analyze and make key decisions is frequently weak. The narrative graph is being phased out in favor of alternate formats since the flow of care is unstructured. Establishing a link between data and critical thinking abilities is tough. Each nurse has a particular writing style, making it difficult to determine care continuity. It also doesn't represent the nursing procedure. Tasks take precedence over data for evaluation or progress toward goals. It takes a long time to complete. Because the paragraphs flow easily, it takes longer to record and interpret the exact facts for others, and retrieving the information is more difficult. It's tough to track a customer's progress because the same issues may not be addressed from one transformation to the next. Auditors frequently refuse to pay costs for equipment and supplies since consistent use cannot be detected and is the most typical means of documenting for most carers. It's written in a straightforward paragraph structure so that caregivers can keep track of what's going on (Zeru et al, 2020).

2.3.2.Source-Oriented Charting

A source-oriented (SO) graph is a story in which each member of a healthcare team (source) is described independently in separate records. Because each specialization has its own record, sponsorship is frequently fragmented, and communication between professionals takes time. Consequently. Because nurses take an

unstructured approach to reporting in progress diaries, charts and narrative graphs offer similar advantages and limitations (Timby, 2021).

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. This sort of documentation is no longer used by many institutions (Lockwood, 2014).

2.3.3.Problem- Oriented Charting

The problem oriented graphical system is a visual system that focuses on patient difficulties. A medical history and patient evaluation are also required. A list of problems is established based on the patient's assessment, and a plan of treatment is developed to identify how the health team will handle each problem. Progress notes are made at the end of each shift, and a patient discharge report is created. Data is inserted into the schema using the SOAP, SOAPIE, and SOAPIER formats. Subjective data (what the patient says), objective data (data gathered via observation and testing), assessment data (conclusion is based on subjective and objective data), and a plan (approach to dealing with the patient's condition) are all components of SOAP. SOAPIE is the same as SOAPIE, except instead of explaining intervention (the actions took to care for the patient), explain assessment (the effectiveness of the intervention). The SOAPIER Framework takes care of the final stage of the review (Plan Adjustments). In acute, home, and long-

term care settings, as well as mental health and rehabilitation institutes, problem-solving systems are applied (Richards & Keogh, 2017).

• S: subjective information (what the client or family states).

• O: objective data (what is observed/inspected).

•A: evaluation (a decision based on information such as a client's problems or a nursing diagnosis).

•P: Plan (steps to be taken to address a customer's issue) SOAPIE and SOAPIER are two terms for data-rich formats.

• I: The questioning (measures to achieve an expected result).

• E: Average evaluation (effectiveness of interventions).

• R: Represents the act of rewriting (changes from the original plan of care).

If an issue is not resolved or the client's health changes, a comprehensive observation should be performed every 24 hours, and continuity of care is demonstrated when the care plan and interventions are implemented at the same time. Some clinicians utilize this format when making progress notes (abbas, 2013).

The problem oriented record consists of four component including:

2.3.3.1.Database:

The patient's profile, history, physical, and laboratory investigations make up the data base, which is the first set of information gathered. Listing the body systems that are normal and the body systems that are abnormal can help to organize facts in a

more meaningful way. The most important consideration is that the data base be as comprehensive and consistent as possible (Zsolt et al, 2018).

2.3.3.2.The Problem List:

The problem list is a meticulously produced and numbered list of all the issues found in the database. Diagnostic entities, clinical signs, physical findings, and aberrant laboratory findings are all employed, depending on what the recorded data supports; diagnostic guesses and impressions are not used. The problem list is one of the most essential concepts in the problem-oriented medical record, and its accuracy is directly related to the plan's quality and relevancy, as well as the follow-thoroughness. up's As a result, the first problem list must be thorough and accurate. A priority list should be made while creating the problem list so that the most serious issues are examined first (Virginie et al, 2021).

2.3.3.3.Initial plan:

A treatment plan is created based on the concerns uncovered during the admissions process. Patients are asked questions about their medical history, physical abilities, functional abilities, psychological concerns, and discomfort during a personalized assessment. The assessment's goal is to determine what kind of care, therapy, and services the patient requires (Harris, 2012).

2.3.3.4.Progress Notes:

Members of the medical team use them to track and document the progress of a patient's condition. Every concern should be explored in normal times. The frequency with which observations are made is a variable that is determined by the

conditions surrounding each encounter. The frequency of reassessment (daily, hourly, or on an ongoing basis) is determined by how quickly the condition has changed and how critical it is to healing (Hassan, 2019).

2.3.4.PIE Charting

This is a streamlined method of concentrating on the client's issues, interventions, and assessments. Flow sheets and progress notes are used instead of the care plan in this documentation format. Nursing diagnoses are used as the problem in the progress notes. Each problem is reviewed at least once during each shift, and a number of distinct problems (with interventions and responses) may be recorded and numbered sequentially (Lockwood, 2014).

When SOAP charting became popular in 1984, Craven Regional Medical Center introduced the problem, intervention, and evaluation (PIE) strategy to expedite recording. PIE charting is based on a nursing approach, while SOAP is based on a medical model. PIE stands for problem, intervention, and evaluation in nursing care. Assessment flow sheets and nurse progress notes are key components of this system, which work together to develop an integrated care plan that eliminates the need for a separate plan of care. Each customer complaint is categorized and numbered for ease of reference. When interventions are utilized to address a client concern, the problem number is determined. This technique substitutes the standard care plan by adding an ongoing care plan in the daily enrollment (*Taiye, 2015).*

2.3.5.Focus Charting

It's a form of chart that deals with a patient's problems or needs and includes a column that highlights the most important

points of input. It strives to put the client, with their worries and strengths, at the center of care. It's a system for organizing health data in a person's file. A focus scheme is a technique of documenting that adheres to a set of rules (vera, 2011).

The nurse determines the client's 'focus' based on the client's concerns or behaviors identified during the evaluation, the client's current concerns or behavior, such as decreased urine output, or a change in the client's condition or behavior, such as confusion about when, where, or Who to contact, and a major event in the client's treatment, such as returning from surgery. In the framework of data, action, and response concerns, the focus scheme organizes the assessment of the client's position, the interventions done, and the influence of the interventions on client outcomes. Flow sheets and checklists are commonly used to document personal care, vital signs, uptake and outcomes, and other routine and continuous evaluations and observations. In progress notes, there is no need to repeat information from flowsheets or checklists (CRNBC, 2013).

2.3.6.Charting by Exception

Only infractions from pre-determined regulations should be documented by the nurse, which is a novel way to reduce paperwork. It was carried out in 1983 at Milwaukee's St. Luke's Medical Center to address the issue of long and repetitive observations and to make patterns in the patient's condition more evident. It's also described as a reductive strategy to documenting routine detection and care based on clearly defined practice standards, nurse evaluation, and action criteria (vera, 2011).

Besides, the form also contains the teaching record and discharge notes, from that, The elements of the (CBE) classification

are shown to include three important components, according to the findings.

1.**Flow sheets:** are used to highlight important findings and to describe assessment parameters and results.

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 notable results or deviations from specified norms.

Reporting in documentation

Reporting is the verbal or written communication of data regarding the client's health status needs, treatments, outcomes, and responses. Reporting facilitates clinical decision-making, continuity of care, and coordination among health team members. and the used in the hospital setting usually are change-of-shift reports, transfer reports and Incident reports (Daniel, 2012).

Change-of-Shift Reports it may be given orally in person by audio taping, recording, or during rounds at the client's besides some of the points to be kept in mind while giving reporting such as basic information that must be obtained from the patient but not reviewed in all routine care procedures or tasks (Golestan, 2018).

Reports patients will frequently be transferred from one unit to another to receive different levels of care. When giving a transfer request, the nurse should include the following information,(Client's name, age, primary doctor, and medical diagnosis, current health status - physical and psycho-social, Etc) (Chatterjee, 2019)

Nurses usually become involved in client-related incidents as some points in their careers. They must understand the purpose of incident reports and the correct way to report information.while incident reporting to be kept in mind.And she has to describin es in concise form what happens in specially objective terms and does not interpret or attempt to explain the cause of the incidence (Guoyi, 2019).

2.3.7.Computerized Documentation:

Administrators began investing in computerized accounting systems in the late 1960s and early 1970s to better monitor hospital expenditures (accounts payable, accounts receivable, admissions, disbursement, and transfers). Department managers began defining computer applications inside their specialty departments as computing capabilities expanded: laboratory, radiology, pharmacy, and, of course, nursing. Order entry and finance systems were among the first computerized systems developed for nursing. The majority of these systems were designed with money in mind, with nursing being a distant second (Turpin, 2015).

The modern healthcare system has encouraged nursing executives to create electronic records in response to the increased need for clinical, administrative, and organizational data. As other sectors have found, computers improve connectivity, improve information accuracy, and make data storage, retrieval, and review easier for healthcare businesses (Ahn et al, 2016).

One of the first "made for nurses" systems was the Med TakeTM system. This hardware and software package was designed to provide a point-of-care scoring system for nurses working in normal hospital medical and surgical units. This system's software

allowed vital signs to be typed into a bedside computer using a specially developed keyboard and plotted automatically in a variety of ways depending on the hospital's preferences. The nurse used the same keyboard to record patient care, selecting phrases from a list to construct sentences for data entry. The keypad was used to enter inputs and outputs, and the system calculated totals by shift, day, and duration of stay. Despite the fact that blueprint samples could be generated from a central printing station, the system's appearance was distinctive. All entries are time-stamped and electronically signed with a secure access code provided by the nurse (Turpin, 2015).

Thorough computerized recording is a prerequisite for optimal patient care, an essential component of clinical documentation, and a vehicle for effective interdisciplinary communication and collaboration (Graham, 2018).

Nursing Informatics (Information Technology): An Online Journal is a publication dedicated to the study of nursing informatics. Page 3 of 20 is increasingly being used to increase efficiency, care quality, and documentation accuracy (Gregory, 2013).

Nursing documentation has a positive or negative impact on hospital reimbursement, which means that, unlike other professions, what nurses document or leave out has an impact on the bottom line (Sonnenberg, 2017).

As a result of risk management concerns, practice standards, and evolving expectations of external regulating agencies such as Medicare and the Joint Commission, documentation needs continue

to climb. Compliance with these evolving regulations, regardless of record type, can be daunting for bedside nurses (Barr, 2012).

Type of information 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 obstruct.
- Nursing diagnosis.
- Patient acuity.
- Diagnosis-related group assignment.
- Nursing order.
- Individualized nursing care plan.
- Automated kardex.
- Nursing goals.
- Measurable patient outcome.
- Nursing intervention.

2.4.Categories of Documentation forms in a Clinical Record System

Patient information is recorded in the clinical record using four different types of forms:

2.4.1.Assessment and Data Base Forms; that include:

- Admissions or intake records.
- Nursing history and evaluation
- A medical history is taken, as well as a physical examination.
- Results of the tests:
- Laboratory.
- X-Ray.
- E.C.G.
- M.R.I.
- CT scan
- Information about the results of diagnostic tests.

2.4.2.Plan of Care Forms; that include:

1. Medical directives.
2. A nursing care plan with nursing orders is included.
3. Multidiscipline eatery Assessment care plan or progress notes should include discipline-specific plans.
4. Testing plans, which could be separate or combined. into a treatment plan

2.4.3.Progress Notes Forms; that include

a) All specialties providing care must document clinical progress notes.

a) A record of medical administration.

b) Reports on the results.

• Notes on the weekly narrative outcome summary.

• A record of the nursing plan's outcome.

• A record of outcomes depending on criteria.

2.4.4.Continuity Care Forms; that include

a) Teaching experience.

b) A summary of the progress made.

c) Forms to be transferred.

d) A summary of the discharge (Cameron et al, 2019).

2.5.Documentation Nursing Activities:

Nurses document evidence of the nursing process using a variety of forms in the clinical record, which must describe the patient's current status and reflect the full spectrum of the nursing process(Kozier et al, 2014).

2.5.1.Admission Nursing Assessment:

When a patient is admitted to the nursing unit, a full entry assessment, also known as a master database, nursing history, or nursing assessment, is performed. A nurse should conduct an admission evaluation with a parent or caregiver as soon as feasible after arriving on the ward or before to admission, but no later than 24 hours following admission. The admission assessment must be provided on the Nursing Admission Form. At all times, patient privacy must be protected (Tammy et al, 2021).

2.5.2.Nursing Care Plan:

The nursing care that will be provided to the patient. It is a set of measures taken by the nurse to resolve the nursing issues that were discovered during the evaluation. In the nursing process, designing a plan is a phase that occurs in the middle. Assists in the delivery of continuing nursing care and the evaluation of such care. there are two type of nursing care plan: They are standardized and

customary. Each patient's typical care plan is developed, and the form differs from agency to agency depending on the patient's and department's needs. Nursing diagnosis, predicted outcome, and nursing intervention are the three columns in most models. The Standardized Care Plan was created to save time and can be based on the organization's standards of practice. It aids in the delivery of high-quality nursing care (potter and, perry 2020).

2.5.3.Kardexes:

Was the initial name for a proprietary file system for nursing records and orders that was housed centrally on the ward and held all of a patient's nursing data and notes obtained during their hospital stay. The name "kardex" is still used to describe to some centrally situated patient registration systems, even though this technology is no longer utilized for nursing records because care plans are now recorded at the patient's bedside rather than centrally (Diana, 2020).

A quick worksheet that contains basic client care information that isn't usually kept in the medical record. Throughout the shift and at change-of-shift reports, the Kardex is used as a reference. It is available in a variety of sizes, forms, and varieties, including computer-generated versions. Name, age, marital status, religious preference, medical contact information, and family contact information are typically contained in the Kardex (including phone number). The importance of medical diagnoses is listed first. The nursing diagnoses are presented in ascending order of importance. Allergies Allowable activities include functional limitations, the need for assistance in ordinary activities, and safety considerations (Abbas, 2013).

2.5.4.Flow Sheet:

Use vertical or horizontal columns to record date, time, evaluation data, and intervention information to keep track of client changes in a case. 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 (Duncan and Baumle, 2011).

2.5.5.Progress Notes:

They're used to keep track of the client's condition, difficulties, and complaints, as well as interventions, the client's response to the interventions, and the outcome. Nurse progress notes encompass a wide range of documents such as nurse notes, personal care flow sheets, instructional records, vital sign records, input/output forms, and specialty forms (eg, diabetes flow sheet or neurological assessment form) (Duncan & Baumle, 2011).

2.6.Overview of the Nursing Process:

The nursing process involves clinical judgment to build an epistemological balance between personal interpretation and research data, in which critical thinking may play a part, in order to categorize a client's case and course of action. Nursing provides a wide range of learning modalities, and since the 1970s, nursing knowledge has encouraged diversity (Reed et al, 2019).

Several authors have advocated mind mapping or reasoning as a feasible alternate strategy for arranging care. Intuition plays a role for seasoned nurses (Lowenstein, 2010).

It's all about a series of events that lead to a specific goal. The nursing process is a well-organized set of problem-solving procedures for identifying and treating clients' health problems. This guideline has been developed by the American Nurses Association as an accepted standard for clinical practice. In all healthcare settings, the nursing process is the framework of nursing care. Clients receive high-quality treatment in the shortest period of time and with the greatest efficiency when following the nursing procedure (Lefevre, 2014).

The procedure provides as a foundation for organizing nursing practices. Assessment, nursing diagnosis, planning, execution, and evaluation are all stages conducted by a nurse caring for a patient. Each step's rationale is based on nursing theory. The procedure necessitates a systematic approach to the person's situation, beginning with an assessment and continuing with an examination and reconciliation of the person's, family's, and nurse's perceptions. After that, a strategy for the nursing actions to be performed may be established, and the plan can be set with the help of the individual and his or her family. The plan that was made with the person and his or her family is subsequently put into action. The outcome is discussed with the individual and his or her family. At the start of the procedure, the steps are sequential, but in some cases, they may need to be completed simultaneously. The procedure does not always end with an evaluation. The processes are repeated, providing for ongoing evaluation of the assessment, strategy, and objectives (Funnel, 2019).

Furthermore, it is a technique that emphasizes systematic thinking, analysis, and planning while working with patients to decide what to do (white,et al 2012).

So, The goal of the nursing process is to deliver personalised, holistic, effective, and efficient patient care (Delauna and Lander, 2014).

Moreover, it was mentioned by (Kozer et al, 2014)that the nursing diagnosis purposes centered around the following:

1. To improve delivery of care.
2. To facilitate inter-professional communication.
3. To validate nursing function.
4. To measure workloads.
5. To increase autonomy.

Lydia Hall is the one who brings it up first. The term "nursing as a process" was coined in a magazine article in 1955, although it was not widely used until the late 1960s (Edelman & Mandle, 1994). Orlando (1960) and Wiedenbach (1963) characterized the 'nursing process' as a synthesis of only three steps: evaluation, planning, and assessment. It was 1967 at the time. The nursing process, according to Leora Walsh, consists of four steps: assessment, planning, implementation and review.

Make advantage of Frey in 1953, created the term "nursing diagnostic" to describe a step in the development of a nursing care plan. Over the next two decades, nursing diagnoses are only cited infrequently in the literature. However, since 1973 (when the National Nursing Diagnostic Classification Group first met) to the present, the number of nursing diagnoses has expanded tenfold (Singh, 2010).

Fry (1953) was the first to employ nursing diagnostics, but Gaber and Lavigne did not consider it a separate and distinct stage in the nursing process until 1974, after the North American Nursing

Diagnostic Association held its first conference (NANDA). As a consequence, the nursing diagnosis was originally included in the first stage, assessment. Following the publication of the ANA Guidelines, a number of nations changed their nursing practice legislation to incorporate a clear outline of the nursing process. In 1991, the Afghan National Army modified the boundaries to separate the planning phase from the ultimate decision. Today's nursing procedures include evaluation, diagnosis, outcome, identification, planning, implementation, and evaluation. The American Nurses Association's Standards of Practice include every area of nursing (Smeltzer and Bare, 2014).

Yoost and Crawford (2015) Revealed that, Nurses must recognize and understand some fundamental elements of the nursing process in order to apply it successfully to nursing practice. Nurses are required to think critically as part of the nursing process. It is dynamic, well-organized, and collaborative, and it may be used in a variety of health-care settings. These characteristic include its:

DYNAMIC. Dynamic, evolving over time in response to the unique needs of each patient. Each stage's data feeds into the next, and the assessment results feed back into the evaluation. In both circumstances, the nursing diagnosis is intense pain. A patient's care plan, on the other hand, is tailored to their specific needs, changing needs, interaction environment, and time. It's feasible because of the dynamic nature of the nursing process.

ANALYTICAL. Nurses are required to think critically and analytically as part of the nursing process. To provide safe treatment, nurses must be able to accurately assess patients and then organize and analyze their findings. Nurses must address problems at each stage of the process, such as whether the data collection is

thorough and accurate, and whether the outcomes are specific and feasible for the individual patient. Critical thinking necessitates the use of logic. The nursing process is evolutionary, allowing nurses to adapt to changing patient needs. As the demands of the patients vary, so must the care plans.

ORGANIZED. Following the nursing process phases ensures that patient care is well-organized and comprehensive. Nurses all across the world are familiar with the nursing process, which provides a systematic approach of addressing patient requirements. Nurses use the nursing process as a foundation for developing a personalized plan of care because of its methodical character.

OUTCOME ORIENTED. The nursing processes that are centered on the patient and are meant to accomplish particular, well-defined results. Patient care plans are created to satisfy the individual goals of each patient, not the goals of standardized patients or members of the health care team, such as the nurse. The effectiveness of nursing interventions and medical treatments in satisfying a patient's recognized need and desired results is considered when making decisions about which to use. To better address the patient's concerns, the nurse must apply critical thinking skills, knowledge, and the nursing process to adapt the plan.

COLLABORATIVE. Collaboration between diverse members of the healthcare team is frequently required to completely address a patient's needs. To accomplish patient-centered objectives and outcomes, nurses frequently combine primary care provider requests, nurse involvement, and input from others, such as physical therapists, social workers, or respiratory therapists. The nurse may make a list of measures taken by the patient or the patient's family

to address the patient's goals. This is especially true when the patient is in a serious state and requires at-home care.

ADAPTABLE. The nursing process can be tailored to develop care plans for people who are in the hospital, or who are getting care in an outpatient, long-term care, or at-home context. It's also a good way to address the requirements of a certain group of people. In a community environment, the nursing procedure is customizable. Depending on a variety of considerations, such as cost and availability of professionals to perform treatments, the strategy may need to be revised at each step. The universal nature of the nursing process, on the other hand, allows for this adaptability. In all settings, enlisting the assistance of others in a collaborative discussion on how to best achieve patient or community goals can substantially enhance outcomes.

Consequently, it is imperative that the steps of any procedure, especially those that are complicated or personalized to the patient, are to be documented in details on the patient care plan. So each nursing intervention completed by different nurses has the same positive result, and that by the patient experience a feeling of reassurance that may not be achieved if each nurse attempts a totally different set of intervention to reach the same objective (Smith et al, 2014).

2.6.1.Assessment:

It is the first step in the nursing process, is the systematic collection of facts or data (LeFevre, 2014).

The nurse gathers information regarding the patient's psychological, physiological, social, and spiritual well-being throughout this stage. This information can be gathered in a variety of ways. Nurses are typically

the ones who interview the patient. Physical examinations, medical histories, family histories, and general observation may be utilized to gather data for assessment. During this time, patient contact is usually at its highest (Delauna & Ladners, 2014).

The first stage in providing nursing care is evaluation, which is a systematic, dynamic technique for collecting and evaluating data about a client. In addition to physiological data, psychological, social, spiritual, economic, and lifestyle factors are considered. A nurse assessing a patient in pain in a hospital, for example, considers not only the physical causes and manifestations of pain, but also the patient's response - inability to get out of bed, refusal to eat, withdrawal from family members, anger directed at hospital staff, or requests for more pain relievers(Koizer et al, 2014).

Furthermore, because patient evaluation is the first step in the nursing process, it is critical to gather information that will allow the nurse to construct a nursing diagnosis, define and implement nursing treatments, and assess their success (Smeltzer and Bare, 2012).

There are four activities that make up the assessment process:

2.6.1.1.Collecting Data:

Kozier (2014) defined data collection as the process of getting information regarding a person's health status. To avoid omission of important data and to represent a person's changing health state, it must be both systematic and continuous. The patient's data can be collected in one of two ways:

- **Subjective Data** refers to information gathered from the client's perspective, such as feelings, perceptions, and concerns. The interview is the most common approach for gathering subjective data. The nurse gathers information for the client database by using therapeutic interviewing techniques.
- **Observable and Measurable Data** produced during a medical examination utilizing conventional evaluation techniques and diagnostic tests is referred to as objective data. The most common method of acquiring objective data is through a physical examination, which offers information about the function of the body's systems.

They also noted that the information might have originated straight from the patient, who is known as the primary data source. Information from family members, other supporting individuals, other health professionals, records and reports, laboratory and diagnostic analyses, and relevant literature are examples of secondary or indirect sources.

According to Potter and Perry, the key data collection procedures include observation, interviews, and examination (2008). Observation is a method of gathering information via the use of one's senses. When the nurse is in contact with the patient or supporting people, it is an intentional and purposeful skill that is learned through effort and a structured approach; it occurs when the nurse is in contact with the patient or supportive individuals. Some of the most typical purposes for interviewing are taking a nurse's health history, examination, and interview, which is a structured dialogue or conversation for a specific purpose. A physical examination, also known as a physical assessment, is a form of data collecting that entails monitoring for health concerns that aren't

being addressed. In reality, the nurses are examining patients using all three processes at the same time.

2.6.1.2.Organizing Data:

The information should be organized in such a way that it is useful to both the health care provider and anybody else involved in the client's care. A nurse can piece together related pieces of information to develop a picture of a client's issues and strengths. After you've completed it. The relevant data provides clues that will assist you in identifying any current or potential issues. After you've recognized these cues, group all of the cues that support a problem into a "cluster." Data is given significance when it is clustered with other pertinent data (Dillon, 2017).

Orem's self-care model, Roy's adaption model, King's system model, Yura and Walsh's human need model are all examples of traditional nursing models. The Watson human care model, Newman's health model, and Gordon's function health pattern all give a holistic framework for assessment and a database for generating a wide range of nursing diagnoses. In addition to the fact that the nurse collects data on both functional and nonfunctional behavior, the pattern of the word is used to denote a series of repetitive behavior. Thus, by organizing data using the Gordon framework, nurses can identify emerging patterns. Among these functions is the health pattern.

1. **Health Perception – Health Management Pattern.**

- Perceived pattern of health, well-being.
- Knowledge of preventive health practices.
- Knowledge of lifestyle and relationship to health.

- Following medical and nurse prescriptions.

2. **Nutritional – Metabolic Pattern.**

- Consumption of meals and fluids in a regular rhythm.
- Food types, fluid intake, etc.
- Your current weight, as well as any weight loss or gain.
- Appetite and personal preferences.

3. **Elimination Pattern.**

- Changes in bowel elimination.
- Changes in the way the bladder eliminates waste.
- Keep difficulties under control.
- The use of assistive technology.
- Medication use.

4. **Activity – Exercise Pattern.**

- Exercise, activity, leisure, and recreation patterns.
- The ability to carry out daily activities.

5. **Sleep Rest Pattern.**

- Sleep and rest patterns.
- Quantity and quality perceptions.

6. **Cognitive – Perception Pattern.**

- Vision, hearing, tasting, touching, and smelling
- Language proficiency.
- Memory.
- A pattern of decision-making abilities.
- Discomfort complaints.

7. **Self-Awareness:**

- Self-esteem and a sense of value.
- Perception of one's own ability.

- Emotional Trajectory.
- Define your body image.

8. Role – Relationship Pattern is Number Eight.

- Relationship pattern.
- Responsibilities in each role.
- Contentment with one's relationship and responsibilities.

9. Reproductive Pattern in Sexuality

- Reproductive and menstrual history
- Satisfaction with one's sexual identity and connection.
- A issue that is either premenopausal or postmenopausal.
- Sex education accuracy.

10. Stress Tolerance is number ten on the list of coping skills.

- ☒ The ability to deal with stress.
- ☒ Understanding of stress tolerance.
- ☒ A source of assistance.
- ☒ The number of stressful life events experienced in the previous year.

11. Belief Pattern – Value

- Beliefs, values, and goals
- Spiritual exercises.

Values conflicts that are perceived (Kozier and other, 2014;Smeltzer and bare, 2012; Potter and Perry, 2020).

In order to standardize language related to client needs, the North American Nursing Diagnostics Association (NANDA) has created a taxonomy of Nursing Diagnostics (NANDA, 2009). Focus on the individual's health, which is considered as an open system that interacts with its surroundings. The initial categorization, which included 31 diagnostic categories, was completed in 1973. Over

100 diagnosis categories have resulted from this taxonomy, which is organized in a hierarchical structure based on nine human response patterns. This concept contends that a person's health state may be inferred from observable occurrences that can be classified into one of several human reaction patterns, which can then be utilized to collect data (DeLaune & Ladner, 2014). These human response patterns include:

1. **Exchange**: a human reaction pattern characterized by reciprocal giving and receiving.
2. **Communication**: Sending massages is a human response pattern.
3. **Relating:** a human response pattern that involves the formation of bonds.
4. **Valuing**: a human response pattern in which relative merit is assigned.
5. **Choosing**: a human reaction pattern incorporating alternative selection.
6. **Moving:** an activity-based human response pattern.
7. **Perceiving**: a human reaction pattern including information perception
8. **Knowing**: a pattern of human behavior including the interpretation of information.
9. **Feeling:** a pattern of human reaction involving subjective awareness

2.6.1.3.Validating Data:

Validation might happen at the same time as the evaluation Although validating every piece of data is impossible, you should do so whenever you spot a discrepancy or have doubts about your findings. Validating data can be done in a variety of ways. You can check your data using the same sources that you used to gather it. Validate subjective findings by comparing them to objective findings while you do the physical examination. The subjective and objective results should be complementary. Family members, other healthcare providers, previous health records, and diagnostic testing are all possible sources of validation (Dillon, 2017).

It's the process of double-checking or verifying data to make sure it's accurate, complete, and up-to-date. Make use of your colleagues' knowledge to back up your claims. For instance, you may believe you hear an odd heart sound but are unsure. Double-check with a colleague. You will gain confidence in the correctness of your assessment as you gain expertise. Even experienced nurses will rely on colleagues to corroborate assessment findings if they are significantly out of the ordinary (Bickley and Szilagyi, 2013).

2.6.1.4.Prioritizing Data:

Data organization will aid you in prioritizing the patient's issues. Consider the severity of the problem, the patient's perception of the problem, and the current situation when prioritizing. Place life-threatening concerns at the top of the list, followed by problems affecting basic needs that require immediate treatment, and then problems impacting psychosocial needs. Airway difficulties, for example, are a top-priority or primary problem that can be fatal. Secondary issues, such as pain, must be addressed quickly to avoid

your patient's health from deteriorating further. Third-level issues such as instructional requirements, while significant, do not require urgent care and can be handled once your patient's condition has stabilized (Davis, 2017).

2.6.2.Nursing Diagnosis

A clinical opinion regarding a person's, family's, or community's reactions to actual or potentially serious health problems, wellness difficulties, or syndromes is referred to as a nursing diagnosis. This step gave context to the information gathered and structured throughout the evaluation. The obtained data will need to be further analysed (broken down into bits that can be inspected) and synthesised (put together in a new way). It's also the outcome of identifying individual patient reactions to existing and anticipated health problems (Potter and Perry, 2020).

A nursing diagnosis is a clinical judgment about an individual's, family's, or community's response to existing or anticipated health problems or life processes, according to the North American Nursing Diagnostic Association (NANDA). The diagnosis suggests that the patient is suffering from both pain and anxiety as a result of his ordeal. Nursing diagnoses are standardized terminology that enable all nurses grasp the diagnosed condition. The nursing diagnosis serves as the foundation for establishing the steps that must be followed in order to attain the intended result (White et al, 2017).

The official organization in charge of defining the classification of nursing diagnoses and formulating accepted nursing diagnoses for research is the North American International Nursing Diagnostic Association (NANDA). NANDA International

collects and categorizes Certified Nursing Diagnostics into a categorization that is updated on a regular basis to keep it current. The diagnostic labels identified by NANDA International (2008) have gained widespread acceptance, but it is recommended that they be validated, improved, and expanded based on clinical use and research (Tola, 2017).

2.6.2.1.Type of Nursing Diagnosis:

Timpy , (2021); and Dillon, (2017); state that there are five types of nursing diagnosis.

1. The real diagnosis is the patient's state at the time of the nurse assessment. It all depends on whether or not there are any other symptoms or indicators.
2. A risk nursing diagnosis is a clinical assessment that there is no problem, but the existence of risk factors implies that a problem will develop unless the nurses intervene.
3. A healthy nursing diagnosis depicts the human's responses to his or her current state of health when the patient is ready for improvement.
4. When there is insufficient or ambiguous evidence of a health concern, a probable nursing diagnosis is made. To confirm or deny a possible diagnosis, more evidence is required.
5. A nursing diagnosis is a term that refers to a condition that is linked to a variety of other diagnoses.

2.6.2.2.Comparison of Medical and Diagnostic Process:

Ralph and Taylor,(2015), describe the difference between a nursing diagnosis and medical diagnostics as follows:

It's critical to grasp the difference between a nursing diagnostic and a medical diagnosis.

In pathology, a medical diagnosis is particular. It concentrates on the sickness. On the other hand, nursing diagnosis focuses on the patient's physiological and psychological responses. The doctors who make medical diagnoses come up with a diagnostic that will treat the medical condition, but a nursing diagnosis is centered on the care for the patient who is suffering from the sickness. Finally, a medical diagnosis is focused on the etiology, or cause, whereas a nursing diagnostic is focused on the care**.**

A nursing diagnosis*:* based on the patient's response to the medical situation This is why it's called a 'nursing diagnostic,' because it's something that requires nurses to take particular action. Nurses deal with everything that has to do with a person's reaction to a disease when it comes to the patient. This includes any type of bodily, emotional, or spiritual reaction. Simply said, a nursing diagnosis is one that focuses on the patient's health.

A medical diagnosis: It, on the other hand, concentrates on the patient's health. A physician's diagnosis or conclusion is based on the patient's physiological or medical condition. A physician's diagnosis is also focused on the sickness itself. The physician will next treat the clinical entity that may be the likely cause of the sickness as carefully and exactly as possible, culminating in the correct prescription being issued for the cure of the disease, based on his experience and understanding.

2.6.3.Planning:

Based on the assessment and diagnosis, Setting goals and results are part of the planning step. You're ready to construct a personalised plan of care for your patient once you've prioritized your diagnoses. You start by setting goals and determining measurable outcomes. You also determine which nursing interventions are required to achieve the desired goals and outcomes. Then, to preserve continuity of care and ensure success, you explain your plan to both the patient and other individuals involved in the plan of care (Dillon, 2017).

Prioritizing nursing diagnoses and collaborative challenges, identifying specific nursing interventions appropriate to achieve outcomes, documenting nursing diagnoses, collaborative issues, expected outcomes, nursing objectives, nursing interventions in the nursing care plan, and communicating with nursing diagnoses are all part of planning the nursing process. an item. In the nursing care plan, all collaborative issues, expected outcomes, nursing goals, and interventions are all included (Potter and Pery, 2020).

2.6.4.Implementation:

The nursing process implementation step entails carrying out the recommended nursing care plan. The nurse is in charge of coordinating and carrying out the activities of everyone involved in the implementation, including the patient, family, other members of the nursing team, and other members of the healthcare team, so that the patient's recovery is aided by the activity schedule. The nursing care plan acts as a road map for implementation. Nursing interventions are created with short-, medium-, and long-term goals in mind (Potter and Pery, 2020).

2.6.5.Evaluation:

The process of evaluation entails determining the efficacy of your plan and ensuring that your objectives and outcomes are met. and evaluate your patient's response using the criteria you've established for the outcome If your patient's goals and outcomes were not fulfilled, you'll need to reconsider your strategy and go through the process again to come up with a more effective plan of care for them (Dillon, 2017).

3. Job Description:

Nurses' job duties include assessing health conditions and patient requirements, developing and implementing nursing care plans, and keeping track of medical data. Providing nursing care to sick or elderly people. In addition to case management, patients may receive health counseling and illness prevention. Medical patients may have complex diagnoses and consequently complex requirements. Medical-surgical nurses are expected to be flexible and agile in delivering holistic care to patients in this area, ranging from ambulatory to total care. The types of patients that medical nurses deal with are listed below. Patients and their families with acute to chronic conditions that require therapy, as well as those with complex and multiple co-morbidities (Taylor, 2008).

4.Previous study:

First Study: The study which carried out in 2021 by Ali et al, to examine nurses' knowledge, attitude, and performance, as well as to look into the elements that influence nursing records in the Al-Jomhori hospital authority in Sana'a, Yemen.

A cross-sectional study was undertaken with 115 nurses from the Al-Jumhuri Hospital Authority in Sana'a, Yemen. The participants were chosen using the standard random sampling method. According to Cronbach's Alpha, data were obtained using a validated questionnaire with an internal reliability of 72.5 percent for items of knowledge, performance, and behavior. SPSS version 23 was used for the analysis.

According to the findings, the overall response percentage was 100%. Around 46.01 percent of the 115 respondents had extensive knowledge, 68.2 percent had a positive attitude (agree), and 36.78 percent did poorly on nursing documentation (always). Gender and training were found to be statistically significant in the KAP for nurses.

Nurses working in Sana'a public hospitals had low knowledge, performance, and behavior when it came to nursing documentation, according to the study. Every public hospital must hire trained nurses and implement a training continuity strategy to handle this issue.

Second study: Previous work done in 2021 by Aylele et al**.** to look at how nurses in Hawassa City Administration General Hospitals in southern Ethiopia felt about paperwork and other related difficulties.

From March 1 to March 30, 2020, a cross-sectional survey including 422 nurses was undertaken. The study participants were chosen using a simple random sampling method. For the purpose of analysis, the data was collected via a self-administered questionnaire. Multivariate logistic regression analysis was used to evaluate the association between nurses' attitudes regarding

documentation and the covariates. A p-value of less than 0.05 was considered statistically significant.

The findings revealed In the study, 58.8% of the 413 nurses had a positive attitude toward documentation [95 percent confidence interval: 54.5 percent to 63.7 percent]. The work setting had a considerable influence on nurses' attitudes toward documentation [AOR=1.94 (95 percent CI:1.23-3.05)]. [AOR = 3.28 (95 percent CI:2.08-5.16)] and knowledge [AOR=3.28 (95 percent CI:2.08-5.16)].

Third study: A study for measuring in 2019 to examine documentation of client education and discharge planning in an urban Jamaican hospital's medical wards, done through Abdul-Kareem et al.

A 131 records from six hospital wards were audited. The audit tool assessed the completeness of the assessment, use of the nursing process, client instructions, and discharge planning and was developed in accordance with Jamaican Department of Health standards. The use of quota sampling made it simple to locate medical records that met the inclusion criteria.

Of 88 adult (67.2%) and 43 (32.8%) pediatric records were reviewed, with 89.3 percent of clients diagnosed with at least one noncommunicable disease. 14percent of records showed recorded evidence of a client's education during the first 72 hours of admission. Only 18.3 percent accurately reflect a client's education on the day of layoff. Because only6.9 percent of records contained written evidence, nurses rarely began planning discharge within the first 24 hours of hospitalization. These trends were seen in both the adult and pediatric departments..

Fourth study: A recent paper done by Gizaw et al, in 2018 amid to evaluate nursing documentation practices and related characteristics among nurses at Jimma University Medical Center.

The research was carried out with the use of institution-based cross-sectional technology. A self-contained questionnaire and a standard nursing care checklist were used to collect data. A initial graft was provided to 10% of the nurses sampled at the Shenen Gibe Hospital. A basic random sampling approach was used to collect the sample. Epidata version 3.1 was used to enter the data. Descriptive statistics and binary logistic regression were utilized by the authors..

The survey found that 48.6% of nurses practice good nursing documentation. The practice of nursing care documentation was substantially connected with the adequacy of documenting formats, time, supervisor motivation, training, and acquaintance with operational standards of nursing documentation.

Nursing documentation practice was found to be inadequate (51.4 percent) among the nurses in the study. Nursing leaders should inspire staff to improve their documentation practices and provide the appropriate documentation supplies, and the institution should promote awareness and conduct close monitoring and evaluation.

Fifth study: At earlier time, during 2018 by Andualem et al, to amid Nurses at West Gojjam-Zone public hospitals in Amhara Ethiopia were evaluated for their knowledge, attitude, practice, and other criteria related to nursing care documentation.

A cross-sectional study of 246 nurses in public hospitals in West Gugam district was conducted from February to March 8,

2018. To choose study participants, the primary random sampling approach was used. Cronbach's alpha values for knowledge, attitudes, and practice were 0.912, 0.784, and 0.713, respectively, for a self-organized, pre-tested, and validated questionnaire. Descriptive statistics and a two-way logistic regression model were utilized by the authors.

The findings of this study demonstrated that general hospital nurses in the West Gojjam area have poor nursing care documentation knowledge, conduct, and practice. As a result, in order to address this issue, every hospital must hire nurses in order to ensure that the hospitals are adequately staffed. It is advised that every hospital have standards/guidelines for documenting nursing care and that training be provided on them. To increase the quality of nursing care documentation, multi-site research, particularly qualitative studies, is also advised.

Sixth study: Correspondingly, at same year (2018) by Bizimana and Bimerew to two Burundi hospitals, researchers looked at nurses' patient record-keeping knowledge, attitudes, and impediments to improving patient record-keeping quality.

A quantitative descriptive survey approach and a self-administered questionnaire were used to collect data from 121 nurses in two district public hospitals. According to the findings, 82.6 percent of nurses (n = 100) scored above 80% on the knowledge scale, showing adequate knowledge, whereas 17.4 percent (n=21) scored below 80%, indicating insufficient knowledge. In terms of attitudes, 64% of nurses (n = 78) scored above 80% on the scale, indicating positive attitudes, whereas 36% (n=43) scored less than 80%, suggesting negative attitudes. Patients' records are of poor quality due to a lack of training in record

keeping (n=99), high workload, inhibition (81.3 percent, n=99), lack of time (46, n=38percent), and unsuitable management practices (55.4 percent, n=67). The X2 test demonstrated a statistically significant link between respondents' knowledge of the benefits of good patient record-keeping (2 = 19.182,p=.000724) and their knowledge of the benefits of good patient record-keeping (2=19.182, p=.000724). On the trends scale, respondents' views on the advantages of storing patient records properly were connected to their educational level (2 = 22.674, p =.001).

Despite the abundance of knowledge and good views about the benefits of keeping great patient records, the study found impediments that contributed to the poor quality of patient record keeping in the institutions studied. Nurses' judgments of the benefits of keeping good patient records were influenced by their gender, years of experience, and level of education. The consequences of the findings were looked into.

Seventh study: A research applied in 2013 Juliet and Sudha, to determine staff nurses' perceptions and attitudes concerning electronic health records (EHR).

Sri Ramakrishna Hospital served as the study's location, 134 staff nurses were chosen for the study using a suitable sampling procedure. A questionnaire was used to gather information. The survey included demographic information as well as questions on nurses' attitudes toward electronic health records. The nurses' attitudes were measured using the Modified Stronge and Brodt Attitude Scale.

According to the conclusions of the study, the vast majority of nurses (95.5%) believe that digital documentation would be quite

advantageous in the health-care system. 67.9% of nurses believe that using an EHR will help them save time, and 73.1 percent believe that electronic documentation will reduce their burden. The majority of nurses (91.8 percent) had a positive view about EHR, according to the survey.

Nurses with advanced degrees, nurses who took short-term computer training courses, and nurses who used computers as a subject in core nursing curricula all demonstrated a positive relationship between attitudes and demographic characteristics.

Eighth study: Consistently, Al-Najafi in 2009, to From the 10th of October 2007 to the 30th of August 2008, A purposeful sample of (50) nurses was selected from the ICUs of Baghdad's major teaching institutions (Special Surgeries, Baghdad teaching hospital, Al Kadimia, Al Yarmmok, Ibn Al Naffis hospital).

The instrument was separated into two sections: one kept the nurses' demographic data, and the other included the initial assessment documentation tool, which consisted of eight parts, including the general information form and the initial assessment form. The data was analyzed using descriptive and inferential statistical methods. The tool parts and flow sheets were tested and retested for instrument reliability, and the tool's validity was certified by a panel of specialists.

The majority of the study sample came from special surgeries and the Baghdad teaching hospital, according to the findings. They were married while studying for a diploma and a bachelor's degree. They show a high proportion of application to eight sections of a documentation tool despite not having participated in any I.C.U. training courses in Iraq or in a broad.

Ninth study: Previous work don in 2007 by Gugerty, to describes the challenges and opportunities in nursing care documentation of patients. Based on the results of the focus groups and the competence of the work group, a nursing documentation of patient care questionnaire was created. Other nurses replied to Emil's invitation to submit the poll by returning the completed questionnaire to the Maryland Nurses Association.

Respondent demographics are used to display quantitative data from the survey. This poll reveals that a significant portion of a nurse's day is spent recording patient care. The work group believes that achieving two goals in three years is feasible:

1.Reduce the amount of time each working nurse spends documenting each shift.

2.Overtime for nurses and the institution can be provided for the purpose of documenting patient care.

Tenth study: Another research by Al Botany accomplished in Iraq in 2006, Between April 15, 2004 and April 15, 2006, a deliberate sample of 65 nurses from the intensive care units of Baghdad's major teaching hospitals (Al-Karama, Al-Kindi, Kadhimiya, Yarmouk, Baghdad Teaching Hospital, Ibn Al-Nafis Hospital) and Ibn Al-Bitar Hospital were recruited.

The instrument was divided into two sections: one for the nurses' demographic information and the other for the initial assessment documentation tool, which was divided into two parts: a general information form and a preliminary evaluation form. The data was analyzed using descriptive and inferential statistical methods. In addition to a panel of experts determining the tool's

validity, the instrument's dependability for the tool parts was tested, and it was found to be reliable (0.85).

The findings revealed that the majority of the study participants were young males who had graduated from nursing school and were working with minimal experience ranging from 1 to 5 years in general and CCU. Despite this, none of them received any instruction on how to record their activities.

Eleventh study: A recent paper done by Rifaie and Rami, in 2006 amid to Lasted from June to October of 2011. The sample included (150) nurses who worked in the governorate of Nineveh's two main teaching hospitals. (Al-Jamhori and Al-Salam) After studying numerous related literatures, a self-administered questionnaire was created.

The tool's validity was determined by consulting seven experts, and its reliability was determined using the split-half technique to determine internal consistency (r = 0.87). The tool's final draft is divided into two parts: principles and purposes. Each tool item has two choices (No = 0; Yes = 1).

To collect data, an interview method was used. None of the other objects received a high level of expertise, but they all received a reasonable level of knowledge. More over half of the items (53.97 percent) about principles and (28.57 percent) about purposes were given a level of knowledge, while the rest were given a moderate level of knowledge, but none were given a high level of knowledge. Nurses' educational levels were strongly associated to aspects of documentation.

Twelveth study: The study which carried out in 2004 by Sadia, aimed to determine the reporting and recording of clinical observations by nurse midwives in Babylon Governorate hospitals.

Purposefully selected samples of (50) nurse midwives were questioned using a questionnaire designed specifically for this study.

The study reveals that nurse midwives' clinical observation recording and reporting were suboptimal, affecting the sort of care provided to patients. Nurse-midwives do not record 47.5 percent of clinical observations related to patient status, none of nurse-midwives do not document clinical observations related to fetus status, and 69.2 percent of nurse-midwives do not record clinical observations related to drug delivery.

The study suggests that during specific training programs for nurse-midwives, a focus be placed on practices connected to the recording and reporting process, and that they be encouraged to conduct research on recoding and reporting.

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 be organized and accurate, so that everyone who reads it and looks at its lines benefits from it, and 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

To fulfill the study's objectives, a quasi-experimental study design was utilized, with a pre- and post-test method for both the studied and control groups, and it was carried out for a period of "10th September 2021 to 7th March 2022"

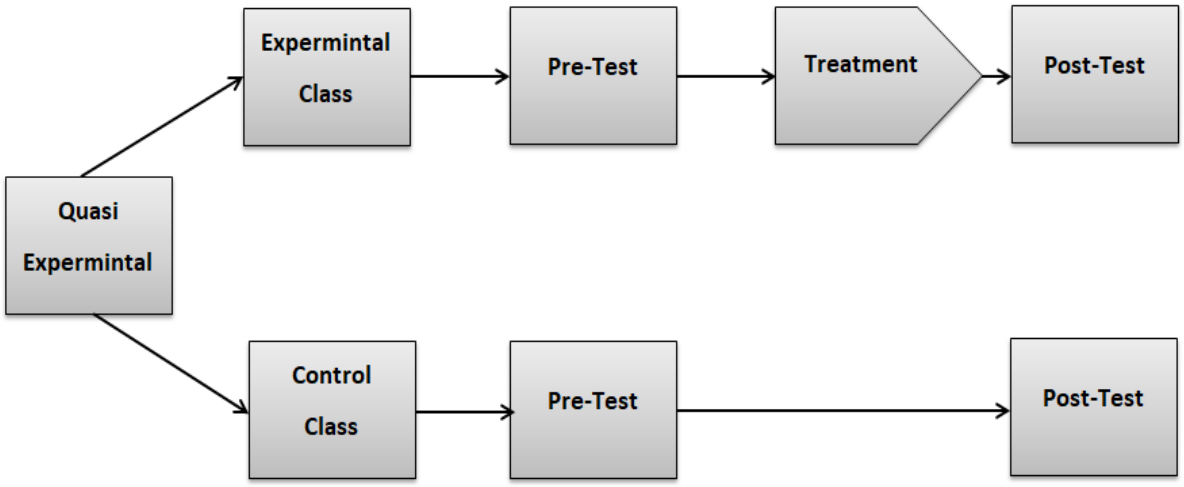

Figure3-1: Steps of quasi-expermintal study (Dinardo,2008)

3.2.Administrative Arrangements

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

1. Approval from the College of Nursing in the University of Babylon to start the thesis
2. Approval from the Training and Development Center in the Al Najaf Alashraff Health Directorate.
3. Approval from Al-Furat Al-Awsat Teaching Hospital to implement the educational program

3.3.Ethical Considerations

Ethical obligations are one of the most important things that the researcher must follow and abide it when doing the study. Before the starting of collect the data from the community that has been identified for the study, the researcher should clarify the main purpose and desired goal of conducting this study for the sample to be including in the study, as well as adhere to the strict confidentiality of the data taken from the study sample and pledge to use it for scientific purposes related to the study only.

Before the starting of gathering the data from the sample who are participating in the study, the researcher given a brief explanation about the scientific background of the research and the purpose of conducting it and what is the role of the nurses who participate in this study, to give them a complete and clear picture about the study to be carried out.

On the other hand, the researcher emphasized that all nurses who are participating in the study had the right to not complete their participation and withdraw from this study in the event that they felt uncomfortable or annoyed with some of the items in the

questionnaire that was prepared as a research tool or the researcher's method of collecting data or anything else.

3.4.Setting of Study

The study is being carried out at Al-Furat Al-Awsat Teaching Hospital in order to acquire accurate and thorough data.

3.5.Sampling of study

To gather representative and reliable data, a "purposeful" non-probability sample of (50) nurses was chosen. The sample size was 50 female nurses, who were split into two groups: (25) in the experimental group and (25) in the control group. The study group is exposed to a nursing documentation instructional program, while the control group is not.

3.5.1. Criteria for Acceptance:

1.nurses working at Al-Furat Al-Awsat Teaching Hospital.

2.Nurses with at least one year of experience, both male and female.

3.Nurses who received a score of less than 60% on the pre-test (Appendix - B).

3.5.2. Criteria for Exclusion:

1.Nurses with a pre-test score of 60% or higher.

2.Newly licensed nurses with less than a year of experience.

3.Nurses who declined to participate in the research.

4.Nurses who are chosen for the pilot study and assessment must be able to work independently.

3.6.Steps of the Study

The present study was conducted at the following steps:

3.6.1.Preliminary assessment of the nurses knowledge, attitudes and practices about the nursing documentation

The goal of this evaluation was to analyze nurses' knowledge, attitudes, and practices regarding nursing documentation. The researcher employed an open questionnaire format to complete this section of the investigation. The format's content was based on a review of pertinent literature as well as subjective responses to the questions about knowledge, attitudes, and practices. A test was performed on a group of five nurses. A questionnaire is required for the evaluation of nurses. Each nurse was given a time limit of 15 to 20 minutes to respond to the questions. The assessment found that the majority of nurses (38 percent) lacked knowledge, attitudes, and practices related to nursing documentation.

3.6.2.The Constructed of the Educational Program

The training program was created using data from a nurse needs assessment, as well as information gleaned from a review of relevant scientific literature, past studies, and the researcher's own experience. Experts in several fields of nursing sciences assessed the content of the curriculum (Appendix - C). Based on the views and suggestions of these specialists, the contents of the program form were revised. They agreed that the training was well-designed to increase nurses' knowledge and attitudes in relation to nurse documentation. The instructional program was created to help nurses improve their knowledge and attitudes when it came to nursing documentation (Appendix- B).

3.7. Educational Program

First session include:

1- Introduction on the nursing documentation.

2- Importance of the Documentation and historical background

3- Guideline for quality documentation and record

Time: 60 minutes

Teaching strategies:Lecture and discussion

Second session include:

1- Factors that emerged providers accountability for the documentation of services.

2- Purposes of Health Care Documentation.

3- Principles of effective documentation.

4- Elements of Effective Documentation.

Time: 60 minutes

Teaching strategies:Lecture and discussion

Third session include:

1- Methods of documentation.

Time: 60 minutes

Teaching strategies:Lecture and discussion

Fourth session include:

1- categories of documentation forms in a clinical record system.

2- Documentation nursing activities:

Time: 60 minutes

Teaching strategies:Lecture and discussion

3.8.Study Instrument

The questionnaire is one of the means to help collect data that contribute to achieving the results expected by the study, so the researcher designed this questionnaire, which aims to clarify the study's objectives and significance by obtaining answers to the study's questions.

The researchers used two tools to collect data from study participants as following:

Part one is the socio-demographic variables such as (age, gender, level of education, years of experiences, training session)

Part two is the knowledge and attitudes towards nursing documentation, it was constructed by the researcher through review of literature, which are include:

1. **The nurses knowledge toward documentation:**

The knowledge scale contains 20 questions to demonstrate nurses' knowledge about nursing documentation.

2. **The nurses attitude toward documentation:**

This part contains a 24-question scale to show nurses' attitudes towards nursing documentation, through which it shows whether nursing documentation has a positive, neutral or negative impact on the care provided to the patient.

3.9.Validity of the Questionnaire

The ability of the questionnaire to measure what it claims to measure, as assessed by honesty, determines its validity (include in the questionnaire all the elements that must be included in the analysis on the one hand, and the clarity of its paragraphs and vocabulary on the other, so that they are understandable to all its users).

To improve the validity of the questionnaire, it was submitted to 12 experts from various nursing specialist. Experts were asked for their opinions and comments on each of the study questionnaire's items in terms of linguistic appropriateness, relationship with the dimension of study variables to which it was assigned, and suitability for the study population.

Minor changes to several elements were suggested by the experts, and these were made in accordance with their ideas, before the final document was finished in order to perform the study.

3.10.Pilot Study

This preliminarily study was conducted to determine the stability and credibility of the study, 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.

The pilot study aimed to achieve the following objectives.

1. Developing and evaluating research tools for appropriateness.
2. Analyzing the instrument's viability.
3. Identifying logistical issues that may arise as a result of the proposed solutions.
4. Identifying potential issues with the proposed data analysis approaches.
5. Estimate the time during collected data by the researcher .

Results of pilot study

1. The questionnaire is reliable.
2. The time required for answering the questionnaire ranged from (20-25) minutes.

3. The instrument items were clarify and understood the phenomenon underlying of the study (Table 3-1).

Before the questionnaire reached its final form, it went through the following stages:

1. Determining the data that will be collected through the questionnaire according to the study questions.
2. Determining the method and format of the questionnaire.
3. Determining the type of criterion that determines the type of answer in the questionnaire.
4. Presenting the questionnaire to the supervising to express his opinion and observations in developing the questionnaire and modifying it based on his observations.
5. Presenting the questionnaire to a number of panel of experts to express their opinion and observations in developing the questionnaire and modifying it based on what they submitted.
6. Conducting a reliability test on it by distributing the questionnaire to a sample of 5 nurses.
7. Writing the questionnaire in its final form, then printing, reviewing and distributing it in a same formula before and after education program.

Reliability of the Questionnaire:

The reliability of the study instruments entails ensuring that the result will be almost identical if it is administered to the same persons multiple times at different times.

The same people the second time, after confirming the apparent validity of the study tool, the researcher applied it to a random exploratory sample of 5 nurses, using the test-retest method, where each nurses from the sample was given a number from 1 to 5 and the questionnaire was

distributed to them without prior known of them that they are a sample to measure the stability of the tool, and after an interval of about two weeks, 5 questionnaires were redistributed to the same exploratory sample, where the members of this sample were later excluded from the original sample on which the final study was conducted. Reliability coefficient using the sample coefficient of Alpha Cronbach as shown below.

Table 3-1: Reliability of the Studied Questionnaire

Scale	Reliability Technique	N	No. of Items	Test	Retest	Accepted Value	evaluation
Knowledge	(Test/Re-Test)	5	20	0.832	0.881	0.70	Reliable
Attitudes		5	24	0.761	0.783	0.70	Reliable

3.11.Measurements at Pre-Test (base line) and a 1-Month Follow up After the Educational Program (post-test)

A pre–test was introduced before to the execution of the built program to examine the nurses' knowledge, attitudes, and practices (Appendix - B) was used to create a list of 20 items for knowledge and 24 for attitudes. The same items were used in a post–test administered two weeks after the program was implemented.

3.12.Methods of Data Collection

The implementation was carried out in the Al Najaf Alashraff Health Directorate. throughout the period from 6th July to 22nd August 2021.

The following were included in the implementation of the program that was presented to the study group:

3.12.1.In the experimental and control groups, each nurses filled out a demographic data form.

3.12.2.A pre-test was given to all of the nurses in the study to assess their knowledge, attitudes and practices on an individual basis, the pre-test lasted (20-25) minutes.

3.12.3.They were summoned to the same classroom sessions to take part in an educational program.

3.12.4.There were (63) questions on the nurses knowledge, attitudes and practices test. Both the experimental and control groups were given various alternatives. The examination was designed to evaluate the nurses knowledge, attitudes and practices towards nursing documentation.

3.12.5.Each class will take 60-90 minutes to complete.

3.12.6.In this study, all nurses in the experimental and control groups were given a post-test right at the end of the program.

3.12.7.The control group had the same procedures as the experimental group, with the exception of the educational program.

3.12.8.These sessions included the following teaching materials: (classroom, lectures, white board, computer, data show, book late demonstrate, not book).

3.13.Rating Scores

In order to statistically analyze the score rating includes the following:

For Nurses Knowledge

1 × Incorrect responses

2 × Correct responses

For Nurses Attitudes

1 ×Strongly Disagree

2 ×Disagree

3 ×Neutral

4 ×Agree

5 ×Strongly Agree

3.14.Statistical Analysis Approach

In order to statistically analyze the data collected from the study sample to arrive at the results, the researcher used the SPSS version (20) and Microsoft Excel (2010) program to analyze this data and deal with it statistically, to find the relationships between the variables, and obtain the final results of the research based on a set of statistical tests.

3.14.1.Descriptive approach

Descriptive statistics includes 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:

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

N. Rose Marie (2018).

B. Statistical Mean of Score (*MS*).

The average score can be calculated by using the follow

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

N. Rose Marie (2018).

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

For Nurses Knowledge

Poor Knowledge = 20-26

Moderate Knowledge = 27-33

Good Knowledge =34-40

For Nurses Attitudes

Negative Attitudes = 24-55

Neutral Attitudes= 56-87

Positive Attitudes=88-120

For Nurses Practices

Inadequate = 19-25

Fair Practices = 26-32

Adequate Practices =33-38

C. Standard Deviation (±*SD*).

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

N. Rose Marie (2018).

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:

$$\alpha = \frac{K}{K-1}\left[1 - \frac{\sum_{i=1}^{K}\sigma_{ii}}{\sum_{i=g1}^{K}\sum_{j=1}^{K}\sigma_{ij}}\right]$$

N. Rose Marie (2018).

3.14.2.Inferential approach

1. **Sample Independent *t-test***

A. Paired Sample *t-test*

To assess the significance difference between pre-test and post-test in one group, such as pre-post study group.

B. Independent Sample *t-test*

To assess the significance difference between two groups of measurement, such as pre-test of intervention group and pre-test of control group.

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

$(\Sigma A)^2$: 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

N. Rose Marie (2018).

2. Analysis of Variance

"For equality of Means (testing for coincidence when the mean's parameter is different), use analysis of variance (ANOVA)".

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	$SS_W = \sum (\sum xP1)^2 - \frac{(\sum xP)^2}{N}$	$df_w = N\text{-}k$	$\frac{SSw}{DFw}$	$\frac{MSB}{MSW}$
Total	$SS_T = \sum (\sum xP1)^2 - \frac{(\sum xP)^2}{N}$	$df_t = N\text{-}1$		
P-value (≤0.05)				

N. Rose Marie (2018).

Chapter Four

Results

Chapter Four

Results of the Study

The finding of data analysis systematically in figures and tables , which are corresponded with the objectives of the study as follows:

Table 4-1:Descriptive Statistic of Socio-Demographic Variables (SDVs) of the *experimental -Control* Groups

Table4-1-1:Distribution of Study Sample by their Age Groups

	Classification	Experimental		Control		*p-value*
		Freq.	%	Freq.	%	
Age /years	20-29 years old	16	64.0	15	60.0	*0.230*
	30-39 years old	6	24.0	3	12.0	
	40-49 years old	3	12.0	6	24.0	
	50-59 years old	0	00.0	1	4.0	
	Total	25	100.0	25	100.0	
	Mean± SD	*29.2 ± 7.694*		*30.76 ± 9.024*		

Findings show participants age, the mean age for nurses in study group is 29, the age 20-29 years old were recorded the highest percentage among nurses in Experimental group (*n=16*; 64.0%). While, the mean age for nurses in control group is 30, the age 20-29 years old were recorded the highest percentage among nurses in control group (*n=15*; 60%). There were no-significant differences in age groups for nurses in both groups (*p=0.230*).

Table4-1-2:Distribution of Study Sample by their Gender

	Classification	Experimental		Control		*p-value*
		Freq.	%	Freq.	%	
Gender	Male	14	56.0	12	48.0	*0.203*
	Female	11	44.0	13	52.0	
	Total	25	100.0	25	100.0	

Respect to the gender, the male were predominated among nurses in Experimental group (*n=14*; 56%) compared with female in control group (*n=13*; 52%). There were significant differences in gender for nurses both groups (*p=0.203*).

Table4-1-3:Distribution of Study Sample by their Level of Education

	Classification	Experimental		Control		*p-value*
		Freq.	%	Freq.	%	
Level of Education	Graduate school of nursing	1	4.0	0	00.0	*0.757*
	Graduate preparatory of nursing	7	28.0	10	40.0	
	Graduate institute of nurse	14	56.0	10	40.0	
	Graduate college of nursing	3	12.0	5	20.0	
	Total	25	100.0	25	100.0	

In regard with education level, most of nurses were institute graduated in Experimental group (*n=14*; 56%). While, most of nurses in control group were distributed a institute and preparatory of nursing graduated (*n=10*; 40%) for each them. There no-significant differences in educational level for both groups (*p=0.757*).

Table4-1-4:Distribution of Study Sample by their Years of Experience

	Classification	Experimental		Control		*p-value*
		Freq.	%	Freq.	%	
Years of Experience	<5 years	19	76.0	15	60.0	*0.460*
	5-10 years	4	16.0	7	28.0	
	>10 years	2	8.0	3	12.0	
	Total	25	100.0	25	100.0	

Concerning years of experience, nurses in Experimental and control groups expressed a less than 5 years of experience (*n=19*; 76%) and (*n=15*; 60%) respectively. There no-significant differences in years of experience of nurses for both groups (*p<0.460*).

Table4-1-5:Distribution of Study Sample by their Participant in training sessions

	Classification	Experimental		Control		*p-value*
		Freq.	%	Freq.	%	
Training	Yes	9	36.0	5	20.0	*0.794*
	No	16	64.0	20	80.0	
	Total	25	100.0	25	100.0	

Training sessions related findings, nurses expressed no attending training sessions in Experimental and control groups (*n=16*; 64%) and (*n=20*; 80%) respectively. There no-significant differences in training sessions of nurses for both groups (*p=0.794*).

Table 4-2:Nurses' Knowledge towards Nursing Documentation (*Study and Control Groups*)

Table 4-2-1:Nurses Knowledge Responses at Pre-test Regarding to Nursing Documentation (*Study Group*)

Item		Pre-test study Group	
		M ± SD	Ass.
1	The first scientist to record medical notes in history?	1.40±0.500	Fair
2	That the information documents about the patient, his care, and descriptive information about the target be based on direct knowledge and evaluation of the disease?	1.16±0.374	Fail
3	Clear and easy-to-digest information that contains important details for the patient	1.12±0.331	Fail
4	The information in the patient record entry must fully describe patient care needs and nursing interventions	1.04±0.200	Fail
5	Information recorded during or shortly after the occurrence of the interference or interaction in a timely manner is necessary in concurrent patient care?	1.28±0.458	Fail
6	Does the nurse communicate the recorded information in a logical way?	1.40±0.500	Fair
7	The recorded information reflects the provision of safe, competent, ethical and compassionate nursing care that conforms to the standards of professional practice?	1.64±0.489	Fair
8	Documenting information continuously and regularly and recording all evaluation results, patient interventions and outcomes?	1.56±0.506	Fair
9	The traditional method of nursing documentation, which is a story describing the patient's condition, interventions, treatments and responses?	1.40±0.500	Fair
10	Easy-to-use documentation in emergency situations, as it requires a simple chronological arrangement. Usually, there is a lack of analysis and critical decision-making on the part of the patient?	1.36±0.489	Fair
11	What are the reasons for replacing the narrative documentation style with other formats?	1.20±0.408	Fail
12	A form of narrative documentation in which each member of the health team keeps separate narrative note	1.08±0.276	Fail
13	Documentation focuses on the patient's problems starting from the patient's medical history and evaluation?	1.20±0.408	Fail
14	When entering information in the patient's record using the formatting of subjective and objective data with the addition of the plan and review that refers to the amendment	1.24±0.435	Fail
15	In the primary data that has been collected and consists of the patient's profile, history, laboratory and physical examinations?	1.40±0.500	Fair
16	Information changing a diagnostic entity, clinical relationship, physical result, or abnormal laboratory result?	1.20±0.408	Fail
17	Patients receive an individual assessment of physical, functional, psychosocial and pain history. The goal is to determine appropriate patient care?	1.20±0.408	Fail
18	Observing and recording observations and patients' problems and reassessing them at appropriate intervals?	1.28±0.458	Fail
19	A simple approach to focus on patient problems and interventions but ignore the nursing care plan documentation?	1.36±0.489	Fair
20	Using this documentation method, the nurse determines the "focus" based on the patient's problems or behaviors that were identified during the evaluation?	1.32±0.476	Fail

"Level of Assessment (Fail=1-1.33, Fair=1.34-1.67, Pass≥1.68"

Findings demonstrated assessment of the study sample responses at the pre-test with regard knowledge towards nursing documentation. The

results indicate that the nurses at the pre-test in Experimental group are fail at all studied items (*M=1-1.33*) except, the items number (1, 6, 7, 8, 9, 10, 15 and 19) the responses were fair knowledge (*M=1.34-1.67*).

Table 4-2-2.Overall Nurses Knowledge about Nursing Documentation at Pre-test for Study Group

Weighted	Freq.	%	*M ± SD*
Poor Knowledge	14	56.0	*25.84 ± 3.715*
Moderate Knowledge	9	36.0	
Good Knowledge	2	8.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a poor level of knowledge with regard nursing documentation at the pre-test period of measurement (*n=14*; 56.0%).

Table 4-2-3:Nurses Knowledge Responses at Post-test Regarding to Nursing Documentation (*Study Group*)

Item		Post-test Study Group	
		M ± SD	Ass.
1	The first scientist to record medical notes in history?	1.72±0.458	Pass
2	That the information documents about the patient, his care, and descriptive information about the target be based on direct knowledge and evaluation of the disease?	1.80±0.408	Pass
3	Clear and easy-to-digest information that contains important details for the patient	1.60±0.500	Fair
4	The information in the patient record entry must fully describe patient care needs and nursing interventions	1.72±0.458	Pass
5	Information recorded during or shortly after the occurrence of the interference or interaction in a timely manner is necessary in concurrent patient care?	1.88±0.331	Pass
6	Does the nurse communicate the recorded information in a logical way?	1.80±0.408	Pass
7	The recorded information reflects the provision of safe, competent, ethical and compassionate nursing care that conforms to the standards of professional practice?	1.72±0.458	Pass
8	Documenting information continuously and regularly and recording all evaluation results, patient interventions and outcomes?	1.67±0.476	Fair
9	The traditional method of nursing documentation, which is a story describing the patient's condition, interventions, treatments and responses?	1.48±0.509	Fair
10	Easy-to-use documentation in emergency situations, as it requires a simple chronological arrangement. Usually, there is a lack of analysis and critical decision-making on the part of the patient?	1.72±0.458	Pass
11	What are the reasons for replacing the narrative documentation style with other formats?	1.72±0.458	Pass
12	A form of narrative documentation in which each member of the health team keeps separate narrative note	1.76±0.435	Pass
13	Documentation focuses on the patient's problems starting from the patient's medical history and evaluation?	1.72±0.458	Pass
14	When entering information in the patient's record using the formatting of subjective and objective data with the addition of the plan and review that refers to the amendment	1.80±0.408	Pass
15	In the primary data that has been collected and consists of the patient's profile, history, laboratory and physical examinations?	1.68±0.476	Pass
16	Information changing a diagnostic entity, clinical relationship, physical result, or abnormal laboratory result?	1.72±0.458	Pass
17	Patients receive an individual assessment of physical, functional, psychosocial and pain history. The goal is to determine appropriate patient care?	1.80±0.408	Pass
18	Observing and recording observations and patients' problems and reassessing them at appropriate intervals?	1.88±0.331	Pass
19	A simple approach to focus on patient problems and interventions but ignore the nursing care plan documentation?	1.80±0.408	Pass
20	Using this documentation method, the nurse determines the "focus" based on the patient's problems or behaviors that were identified during the evaluation?	1.88±0.331	Pass

Findings demonstrated assessment of the study sample responses at the post-test with regard knowledge towards nursing documentation. The results indicate that the nurses at the post-test in study group are pass at all studied items (*M≥1.68*) except, the items number (3, 8 and 9) the responses were fair knowledge (*M=1.34-1.67*).

Table 4-2-4.Overall Nurses Knowledge about Nursing Documentation at Post-test for Study Group

Weighted	Freq.	%	*M ± SD*
Poor Knowledge	4	16.0	*34.88 ± 5.166*
Moderate Knowledge	4	16.0	
Good Knowledge	17	68.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a good level of knowledge with regard nursing documentation at the post-test period of measurement after application of education program (*n=17*; 68.0%).

Table 4-2-5:Statistical Significant Difference between Pre and Post Test by Overall Responses to the Knowledge Scores for Study Group

	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
Study Group Knowledge	Pre-test	1.29	0.185	7.944	24	*0.000*	*HS*
	Post-test	1.74	0.258				

Findings illustrated that there is a highly statistical significant difference in knowledge scores in two periods of measurements pre-test (*M ± SD=1.292±0.185*) and post-test (*M ± SD=1.74±0.258*) at *p-value <0.01*.

Table 4-2-6:Nurses Knowledge Responses at Pre-test Regarding to Nursing Documentation (*Control Group*)

Item		Pre-test Control Group	
		M ± SD	Ass.
1	The first scientist to record medical notes in history?	1.24±0.435	Fail
2	That the information documents about the patient, his care, and descriptive information about the target be based on direct knowledge and evaluation of the disease?	1.36±0.489	Fair
3	Clear and easy-to-digest information that contains important details for the patient	1.20±0.408	Fail
4	The information in the patient record entry must fully describe patient care needs and nursing interventions	1.28±0.458	Fail
5	Information recorded during or shortly after the occurrence of the interference or interaction in a timely manner is necessary in concurrent patient care?	1.20±0.408	Fail
6	Does the nurse communicate the recorded information in a logical way?	1.40±0.500	Fair
7	The recorded information reflects the provision of safe, competent, ethical and compassionate nursing care that conforms to the standards of professional practice?	1.48±0.509	Fair
8	Documenting information continuously and regularly and recording all evaluation results, patient interventions and outcomes?	1.36±0.489	Fair
9	The traditional method of nursing documentation, which is a story describing the patient's condition, interventions, treatments and responses?	1.20±0.408	Fail
10	Easy-to-use documentation in emergency situations, as it requires a simple chronological arrangement. Usually, there is a lack of analysis and critical decision-making on the part of the patient?	1.20±0.408	Fail
11	What are the reasons for replacing the narrative documentation style with other formats?	1.24±0.435	Fail
12	A form of narrative documentation in which each member of the health team keeps separate narrative note	1.08±0.276	Fail
13	Documentation focuses on the patient's problems starting from the patient's medical history and evaluation?	1.16±0.374	Fail
14	When entering information in the patient's record using the formatting of subjective and objective data with the addition of the plan and review that refers to the amendment	1.40±0.500	Fair
15	In the primary data that has been collected and consists of the patient's profile, history, laboratory and physical examinations?	1.36±0.489	Fair
16	Information changing a diagnostic entity, clinical relationship, physical result, or abnormal laboratory result?	1.24±0.435	Fail
17	Patients receive an individual assessment of physical, functional, psychosocial and pain history. The goal is to determine appropriate patient care?	1.40±0.500	Fair
18	Observing and recording observations and patients' problems and reassessing them at appropriate intervals?	1.12±0.331	Fail
19	A simple approach to focus on patient problems and interventions but ignore the nursing care plan documentation?	1.16±0.374	Fail
20	Using this documentation method, the nurse determines the "focus" based on the patient's problems or behaviors that were identified during the evaluation?	1.44±0.506	Fair

Findings demonstrated assessment of the study sample responses at the pre-test with regard knowledge towards nursing documentation. The results indicate that the nurses at the pre-test in control group are fail at all studied items (*M=1-1.33*) except, the items number (2, 7, 8, 14, 15 and 17) the responses were fair knowledge (*M=1.34-1.67*).

Table 4-2-7.Overall Nurses Knowledge about Nursing Documentation at Pre-test for Control Group

Weighted	Freq.	%	*M ± SD*
Poor Knowledge	18	72.0	*25.52 ± 3.652*
Moderate Knowledge	6	24.0	
Good Knowledge	1	4.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a poor level of knowledge with regard nursing documentation at the pre-test period of measurement (*n=18*; 72.0%).

Table 4-2-8:Nurses Knowledge Responses at Post-test Regarding to Nursing Documentation (*Control Group*)

Item		Post-test Control Group	
		M ± SD	Ass.
1	The first scientist to record medical notes in history?	1.48±0.509	Fair
2	That the information documents about the patient, his care, and descriptive information about the target be based on direct knowledge and evaluation of the disease?	1.20±0.408	Fail
3	Clear and easy-to-digest information that contains important details for the patient	1.44±0.506	Fair
4	The information in the patient record entry must fully describe patient care needs and nursing interventions	1.24±0.435	Fail
5	Information recorded during or shortly after the occurrence of the interference or interaction in a timely manner is necessary in concurrent patient care?	1.16±0.374	Fail
6	Does the nurse communicate the recorded information in a logical way?	1.12±0.331	Fail
7	The recorded information reflects the provision of safe, competent, ethical and compassionate nursing care that conforms to the standards of professional practice?	1.28±0.458	Fail
8	Documenting information continuously and regularly and recording all evaluation results, patient interventions and outcomes?	1.20±0.408	Fail
9	The traditional method of nursing documentation, which is a story describing the patient's condition, interventions, treatments and responses?	1.16±0.374	Fail
10	Easy-to-use documentation in emergency situations, as it requires a simple chronological arrangement. Usually, there is a lack of analysis and critical decision-making on the part of the patient?	1.40±0.500	Fair
11	What are the reasons for replacing the narrative documentation style with other formats?	1.16±0.374	Fail
12	A form of narrative documentation in which each member of the health team keeps separate narrative note	1.34±0.476	Fair
13	Documentation focuses on the patient's problems starting from the patient's medical history and evaluation?	1.28±0.458	Fail
14	When entering information in the patient's record using the formatting of subjective and objective data with the addition of the plan and review that refers to the amendment	1.44±0.506	Fair
15	In the primary data that has been collected and consists of the patient's profile, history, laboratory and physical examinations?	1.28±0.458	Fail
16	Information changing a diagnostic entity, clinical relationship, physical result, or abnormal laboratory result?	1.36±0.489	Fair
17	Patients receive an individual assessment of physical, functional, psychosocial and pain history. The goal is to determine appropriate patient care?	1.32±0.476	Fail
18	Observing and recording observations and patients' problems and reassessing them at appropriate intervals?	1.16±0.374	Fail
19	A simple approach to focus on patient problems and interventions but ignore the nursing care plan documentation?	1.36±0.489	Fair
20	Using this documentation method, the nurse determines the "focus" based on the patient's problems or behaviors that were identified during the evaluation?	1.36±0.489	Fair

Findings demonstrated assessment of the study sample responses at the post-test with regard knowledge towards nursing documentation. The results indicate that the nurses at the post-test in control group are fail at all

studied items (*M=1-1.33*) except, the items number (1, 3, 10, 12, 14, 16, 19 and 20) the responses were fair knowledge (*M=1.34-1.67*).

Table 4-2-9.Overall Nurses Knowledge about Nursing Documentation at Post-test for Control Group

Weighted	Freq.	%	*M ± SD*
Poor Knowledge	17	68.0	*25.72 ± 5.303*
Moderate Knowledge	5	20.0	
Good Knowledge	3	12.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a poor level of knowledge with regard nursing documentation at the post-test period of measurement (*n=17*; 68.0%).

Table 4-2-10:Statistical Significant Difference between Pre and Post Test by Overall Responses to the Knowledge Scores for Control Group

	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
Control Group Knowledge	Pre-test	1.27	0.182	0.145	24	*0.886*	*NS*
	Post-test	1.28	0.265				

Findings illustrated that there were no statistical significant difference in knowledge scores in two periods of measurements pre-test (*M ± SD=1.27±0.182*) and post-test (*M ± SD=1.28±0.265*) at *p-value >0.05*.

Table 4-2-11:Independent Sample t-test between the Study and Control Group responses at pre-post test Knowledge related to Nursing Documentation

	Weighted	Mean	S.D	t-value	f	p≤ 0.05	Sig
Pre-test Knowledge	Experiment	1.29	0.185	0.307	٤	*0.760*	*NS*
	Control	1.27	0.182				
Post-test Knowledge	Experiment	1.74	0.258	6.186	٤	*0.000*	*HS*
	Control	1.28	0.265				

This table shows that there is a no statistical significant difference between Study (*M ± SD= 1.29±0.185*) and control (*M ± SD= 1.27±0.182*) groups in the pre-test period of measurement (*p=0.760*). While there is a highly statistical significant difference between the Study (*M ± SD= 1.74±0.268*) and control (*M ± SD= 1.28±0.265*) groups at the post-test period of measurement (*p=0.000*).

Table 4-3:Nurses' Attitudes towards Nursing Documentation (*Study and Control Groups*)

Table 4-3-1:Nurses Attitudes Responses at Pre-test Regarding to Nursing Documentation (*Study Group*)

Item		Pre-test Experimental Group	
		M ± SD	Ass.
1	Nursing documents have a positive impact on the care provided.	2.96±1.368	Neutral
2	Nursing documents affect patient safety	2.76±1.331	Neutral
3	The nurses should spend the time documenting the reports	2.96±1.206	Neutral
4	Nursing documentation depends on training	2.88±1.201	Neutral
5	Accurate documentation enhances professional independence	2.96±1.206	Neutral
6	Nursing documents are legally valid documents	2.96±1.337	Neutral
7	Nursing documents enhance the healing process	2.80±1.190	Neutral
8	Nursing documentation improves patient care time	3.04±1.240	Neutral
9	Nursing documentation is an important discipline for nursing practice	3.04±1.171	Neutral
10	Nursing documents help nursing staff to gain knowledge about patients	3.04±1.098	Neutral
11	Nursing documentation can protect the rights of both the nurse and the patient	2.88±1.166	Neutral
12	Nursing documents are a source for study	2.80±1.224	Neutral
13	Nursing documentation improves interactions between members of the medical team	2.72±1.100	Neutral
14	Nursing documents make discharge from hospital go smoothly	2.68±1.107	Neutral
15	Nursing documents lead to professional independence	2.84±1.247	Neutral
16	It would be better to focus on nursing care rather than documentation	1.88±1.394	Disagree
17	Nursing documentation reduces work pressure on nurses	2.52±1.388	Neutral
18	It is essential to document all nursing interventions	2.88±1.129	Neutral
19	Documentation can help speed up the decision and increase patient satisfaction	2.68±1.107	Neutral
20	Nursing documentation improves the quality of nursing care	2.92±1.115	Neutral
21	Nursing documents help speed up patient delivery	2.84±1.106	Neutral
22	Nursing documents enable the medical staff to discover changes in the patient's condition	2.64±1.075	Neutral
23	Documentation can help enhance knowledge of nursing	2.88±1.129	Neutral
24	Documenting nursing interventions is a valuable skill	2.84±1.106	Neutral

Findings demonstrated assessment of the study sample responses at the pre-test with regard attitudes towards nursing documentation. The results indicate that the nurses at the pre-test in Experimental group are neutral at all studied items (*M=2.60-3.39*) except, the items number (16) the responses were disagree (*M=1.80-2.59*).

Table 4-3-2.Overall Nurses Attitudes about Nursing Documentation at Pre-test for Study Group

Weighted	Freq.	%	*M ± SD*
Negative	5	20.0	*76.4 ± 22.42*
Neutral	19	76.0	
Positive	1	4.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a neutral level of attitudes with regard nursing documentation at the pre-test period of measurement (*n=19*; 76.0%).

Table 4-3-3:Nurses Attitudes Responses at Post-test Regarding to Nursing Documentation (*Study Group*)

Item		Post-test Study Group	
		M ± SD	Ass.
1	Nursing documents have a positive impact on the care provided.	4.08±1.077	Agree
2	Nursing documents affect patient safety	4.28±0.890	Strongly agree
3	The nurses should spend the time documenting the reports	4.08±1.077	Agree
4	Nursing documentation depends on training	2.84±1.863	Strongly agree
5	Accurate documentation enhances professional independence	4.24±1.128	Strongly agree
6	Nursing documents are legally valid documents	3.88±1.423	Neutral
7	Nursing documents enhance the healing process	4.24±1.164	Strongly agree
8	Nursing documentation improves patient care time	4.24±1.164	Strongly agree
9	Nursing documentation is an important discipline for nursing practice	4.16±1.143	Agree
10	Nursing documents help nursing staff to gain knowledge about patients	4.32±1.144	Strongly agree
11	Nursing documentation can protect the rights of both the nurse and the patient	3.56±1.685	Agree
12	Nursing documents are a source for study	4.08±1.382	Agree
13	Nursing documentation improves interactions between members of the medical team	3.96±1.368	Agree
14	Nursing documents make discharge from hospital go smoothly	3.92±1.255	Agree
15	Nursing documents lead to professional independence	4.08±1.222	Agree
16	It would be better to focus on nursing care rather than documentation	2.69±1.604	Neutral
17	Nursing documentation reduces work pressure on nurses	2.96±1.836	Neutral
18	It is essential to document all nursing interventions	4.24±1.164	Strongly agree
19	Documentation can help speed up the decision and increase patient satisfaction	4.32±1.144	Strongly agree
20	Nursing documentation improves the quality of nursing care	4.32±1.180	Strongly agree
21	Nursing documents help speed up patient delivery	4.12±1.129	Agree
22	Nursing documents enable the medical staff to discover changes in the patient's condition	3.56±1.386	Agree
23	Documentation can help enhance knowledge of nursing	4.16±1.143	Agree
24	Documenting nursing interventions is a valuable skill	3.88±1.332	Agree

Findings demonstrated assessment of the study sample responses at the post-test with regard attitudes towards nursing documentation. The results indicate that the nurses at the post-test in Experimental group are agree to strongly agree at all studied items (*M=3.40-4.19 and M*≥4.20) respectively except, the items number (16 and 17) the responses were neutral (*M=2.60-3.39*).

Table 4-3-4.Overall Nurses Attitudes about Nursing Documentation at Post-test for Study Group

Weighted	Freq.	%	*M ± SD*
Negative	2	8.0	*93.88 ± 21.343*
Neutral	3	12.0	
Positive	20	80.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a positive attitudes with regard nursing documentation at the post-test period of measurement (*n=20*; 80.0%).

Table 4-3-5:Statistical Significant Difference between Pre and Post Test by Overall Responses to the Attitudes Scores for Study Group

	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
Study Group Attitudes	Pre-test	2.80	0.934	4.422	24	*0.000*	*HS*
	Post-test	4.14	0.930				

Findings illustrated that there is a highly statistical significant difference in attitudes scores in two periods of measurements pre-test (*M ± SD=2.80±0.934*) and post-test (*M ± SD=4.14±0.930*) at *p-value <0.01*.

Table 4-3-6:Nurses Attitudes Responses at Pre-test Regarding to Nursing Documentation (*Control Group*)

Control Group Attitudes		Pre-test Control Group	
		M ± SD	Ass.
1	Nursing documents have a positive impact on the care provided.	2.76±1.090	Neutral
2	Nursing documents affect patient safety	2.52±1.294	Disagree
3	The nurses should spend the time documenting the reports	2.64±1.113	Neutral
4	Nursing documentation depends on training	2.68±1.375	Neutral
5	Accurate documentation enhances professional independence	2.96±0.978	Neutral
6	Nursing documents are legally valid documents	3.36±1.150	Neutral
7	Nursing documents enhance the healing process	2.8±1.154	Neutral
8	Nursing documentation improves patient care time	2.88±1.092	Neutral
9	Nursing documentation is an important discipline for nursing practice	3.04±1.171	Neutral
10	Nursing documents help nursing staff to gain knowledge about patients	3.04±1.135	Neutral
11	Nursing documentation can protect the rights of both the nurse and the patient	3.16±1.106	Neutral
12	Nursing documents are a source for study	2.36±1.319	Neutral
13	Nursing documentation improves interactions between members of the medical team	2.72±1.173	Neutral
14	Nursing documents make discharge from hospital go smoothly	3.04±1.135	Neutral
15	Nursing documents lead to professional independence	2.24±1.331	Neutral
16	It would be better to focus on nursing care rather than documentation	1.20±0.645	Strongly disagree
17	Nursing documentation reduces work pressure on nurses	1.32±0.748	Strongly disagree
18	It is essential to document all nursing interventions	2.64±1.036	Neutral
19	Documentation can help speed up the decision and increase patient satisfaction	2.96±1.019	Neutral
20	Nursing documentation improves the quality of nursing care	3±1.154	Neutral
21	Nursing documents help speed up patient delivery	2.08±1.320	Neutral
22	Nursing documents enable the medical staff to discover changes in the patient's condition	2.88±1.092	Neutral
23	Documentation can help enhance knowledge of nursing	2.04±1.368	Neutral
24	Documenting nursing interventions is a valuable skill	3.2±1.224	Neutral

Findings demonstrated assessment of the study sample responses at the pre-test with regard attitudes towards nursing documentation. The results indicate that the nurses at the pre-test in control group are neutral at all studied items (*M=2.60-3.39*) except, the items number (2, 16 and 17) the responses were agree to strongly disagree (*M=1.80-2.59 and M=1-1.79*) respectively.

Table 4-3-7.Overall Nurses Attitudes about Nursing Documentation at Pre-test for Control Group

Weighted	Freq.	%	*M ± SD*
Negative	4	16.0	*63.52 ± 16.047*
Neutral	20	80.0	
Positive	1	4.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a neutral level of attitudes with regard nursing documentation at the pre-test period of measurement (*n=20*; 80.0%).

Table 4-3-8:Nurses Attitudes Responses at Post-test Regarding to Nursing Documentation (*Control Group*)

Control Group Attitudes		Post-test Control Group	
		M ± SD	Ass.
1	Nursing documents have a positive impact on the care provided.	2.92±0.996	Neutral
2	Nursing documents affect patient safety	2.56±1.227	Neutral
3	The nurses should spend the time documenting the reports	2.64±1.036	Neutral
4	Nursing documentation depends on training	2.72±1.339	Neutral
5	Accurate documentation enhances professional independence	3.12±0.832	Neutral
6	Nursing documents are legally valid documents	3.14±1.083	Neutral
7	Nursing documents enhance the healing process	3.04±0.978	Neutral
8	Nursing documentation improves patient care time	2.96±0.978	Neutral
9	Nursing documentation is an important discipline for nursing practice	3.2±1.040	Neutral
10	Nursing documents help nursing staff to gain knowledge about patients	3.2±1.000	Neutral
11	Nursing documentation can protect the rights of both the nurse and the patient	3.28±0.979	Neutral
12	Nursing documents are a source for study	2.48±1.262	Neutral
13	Nursing documentation improves interactions between members of the medical team	2.96±1.098	Neutral
14	Nursing documents make discharge from hospital go smoothly	3.08±1.077	Neutral
15	Nursing documents lead to professional independence	2.28±1.307	Neutral
16	It would be better to focus on nursing care rather than documentation	1.4±0.816	Strongly disagree
17	Nursing documentation reduces work pressure on nurses	2.72±0.890	Neutral
18	It is essential to document all nursing interventions	3.12±0.881	Neutral
19	Documentation can help speed up the decision and increase patient satisfaction	3.16±1.027	Neutral
20	Nursing documentation improves the quality of nursing care	2.24±1.331	Neutral
21	Nursing documents help speed up patient delivery	3±0.957	Neutral
22	Nursing documents enable the medical staff to discover changes in the patient's condition	2.08±1.351	Neutral
23	Documentation can help enhance knowledge of nursing	3.4±1.080	Neutral
24	Documenting nursing interventions is a valuable skill	2.26±1.324	Neutral

Findings demonstrated assessment of the study sample responses at the post-test with regard attitudes towards nursing documentation. The results indicate that the nurses at the post-test in control group are neutral at all studied items (*M=2.60-3.39*) except, the items number (16) the responses were strongly disagree (*M=1-1.79*).

Table 4-3-9.Overall Nurses Attitudes about Nursing Documentation at Post-test for Control Group

Weighted	Freq.	%	*M ± SD*
Negative	3	12.0	*66.2 ± 14.722*
Neutral	21	84.0	
Positive	1	4.0	
Total	25	100.0	

Findings illustrated that the nurses expressed a neutral level of attitudes with regard nursing documentation at the post-test period of measurement (*n=21*; 84.0%).

Table 4-3-10:Statistical Significant Difference between Pre and Post Test by Overall Responses to the Attitudes Scores for Control Group

	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
Control Group Attitudes	Pre-test	2.64	0.668	1.452	24	*0.160*	*NS*
	Post-test	2.75	0.613				

Findings illustrated that there were no statistical significant difference in attitudes scores in two periods of measurements pre-test (*M ± SD=2.64±0.668*) and post-test (*M ± SD=2.75±0.613*) at *p-value >0.05*.

Table 4-3-11:Independent Sample t-test between the Study and Control Group responses at pre-post test Attitudes related to Nursing Documentation

	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
Pre-test Attitudes	Experiment	2.80	0.934	0.703	48	*0.485*	*NS*
	Control	2.64	0.668				
Post-test Attitudes	Experiment	3.91	0.889	5.338	48	*0.000*	*HS*
	Control	2.75	0.613				

This table shows that there is a no statistical significant difference between study (*M ± SD= 2.80±0.934*) and control (*M ± SD= 2.64±0.668*) groups in the pre-test period of measurement (*p=0.485*). While there is a highly statistical significant difference between the Study (*M ± SD= 3.91±0.889*) and control (*M ± SD= 2.75±0.613*) groups at the post-test period of measurement (*p=0.000*).

4.5.Statsitical Differences in Two Test Knowledge of Nurses towards Nursing Documentation with regards their Socio-demographic Characteristics (*Study Group*)

Table 4-5-1:Significant Differences in knowledge and nurses age (*n=25*)

Age	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test knowledge	Between Groups	.130	2	.065	2.053	.152 No-sig.
	Within Groups	.698	22	.032		
	Total	.828	24			
Post-test knowledge	Between Groups	.014	2	.007	.096	.909 No-sig.
	Within Groups	1.588	22	.072		
	Total	1.602	24			

Findings illustrated there were no significant differences in nurses knowledge about nursing documentation with regard age groups at pre-test (*p=0.152*) and post test (*p=0.909*) after education program.

Table 4-5-2:Significant Differences in knowledge and nurses gender (*n=25*)

	Gender	Mean	S.D	t-value	d.f	*p≤ 0.05*	Sig
Pre-test knowledge	Male	1.30	0.176	0.238	23	*0.814*	No-sig.
	Female	1.28	0.205				
Post-test knowledge	Male	1.76	0.248	0.358	23	*0.723*	No-sig.
	Female	1.72	0.280				

Findings illustrated there were no-significant differences in nurses knowledge about nursing documentation at two period of measurement pre-test (*p=0.814*) and post tests (*p=0.723*) after education program with regard male and female nurses.

Table 4-5-3:Significant Differences in knowledge and nurses education level (*n=25*)

Education Level	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test knowledge	Between Groups	.162	3	.054	1.708	.026 Sig.
	Within Groups	.666	21	.032		
	Total	.828	24			
Post-test knowledge	Between Groups	.030	3	.010	.134	.938 No-sig.
	Within Groups	1.571	21	.075		
	Total	1.602	24			

Findings illustrated there were significant differences in nurses knowledge about nursing documentation with regard educational level at pre-test (*p=0.026*) and no significant differences in knowledge at post test (*p=0.938*) after education program.

Table 4-5-4:Significant Differences in knowledge and nurses experiences (*n=25*)

Experience	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test knowledge	Between Groups	.037	2	.019	.520	.602 No-sig.
	Within Groups	.791	22	.036		
	Total	.828	24			
Post-test knowledge	Between Groups	.108	2	.054	.794	.464 No-sig.
	Within Groups	1.494	22	.068		
	Total	1.602	24			

Findings illustrated there were no significant differences in nurses knowledge about nursing documentation with regard years of experience at pre-test (*p=0.602*) post test (*p=0.464*) after education program.

Table 4-5-5:Significant Differences in knowledge and nurses experiences (*n=25*)

Experience	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test knowledge	Between Groups	.013	1	.013	.362	.553 No-sig.
	Within Groups	.816	23	.035		
	Total	.828	24			
Post-test knowledge	Between Groups	.053	1	.053	.792	.383 No-sig.
	Within Groups	1.548	23	.067		
	Total	1.602	24			

Findings illustrated there were no significant differences in nurses knowledge about nursing documentation with regard training at pre-test (*p=0.553*) post test (*p=0.383*) after education program.

4.6.Statsitical Differences in Two Test Attitudes of Nurses towards Nursing Documentation with regards their Socio-demographic Characteristics (*Study Group*)

Table 4-6-1:Significant Differences in Attitudes and nurses age (*n=25*)

Age	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test Attitudes	Between Groups	1.243	2	.622	.694	.510 No-sig.
	Within Groups	19.715	22	.896		
	Total	20.958	24			
Post-test Attitudes	Between Groups	.446	2	.223	.265	.770 No-sig.
	Within Groups	18.534	22	.842		
	Total	18.980	24			

Findings illustrated there were no significant differences in nurses attitudes about nursing documentation with regard age groups at pre-test (*p=0.510*) and post test (*p=0.770*) after education program.

Table 4-6-2:Significant Differences in Attitudes and nurses gender (*n=25*)

	Gender	Mean	S.D	t-value	d.f	*p≤ 0.05*	Sig
Pre-test Attitudes	Male	3.07	0.662	1.664	23	*0.110*	No-sig.
	Female	2.46	1.140				
Post-test Attitudes	Male	4.16	0.341	1.699	23	*0.103*	No-sig.
	Female	3.58	1.238				

Findings illustrated there were no-significant differences in nurses attitudes about nursing documentation at two period of measurement pre-test (*p=0.110*) and post test (*p=0.103*) after education program with regard male and female nurses.

Table 4-6-3:Significant Differences in Attitudes and nurses education level (*n=25*)

Education Level	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test Attitudes	Between Groups	1.758	3	.586	.641	.597 No-sig.
	Within Groups	19.200	21	.914		
	Total	20.958	24			
Post-test Attitudes	Between Groups	.643	3	.214	.245	.864 No.sig.
	Within Groups	18.337	21	.873		
	Total	18.980	24			

Findings illustrated there were no significant differences in nurses attitudes about nursing documentation with regard educational level at pre-test (*p=0.597*) and at post test (*p=0.864*) after education program.

Table 4-6-4:Significant Differences in Attitudes and nurses experiences (*n=25*)

Experience	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test Attitudes	Between Groups	1.711	2	.855	.978	.392 No-sig.
	Within Groups	19.248	22	.875		
	Total	20.958	24			
Post-test Attitudes	Between Groups	1.767	2	.884	1.129	.341 No-sig.
	Within Groups	17.213	22	.782		
	Total	18.980	24			

Findings illustrated there were no significant differences in nurses attitudes about nursing documentation with regard years of experience at pre-test (*p=0.392*) post test (*p=0.341*) after education program.

Table 4-6-5:Significant Differences in Attitudes and nurses experiences (*n=25*)

Experience	Source of variance	Sum of Squares	d.f	Mean Square	F	*p≤ 0.05*
Pre-test Attitudes	Between Groups	.179	1	.179	.199	.660 No-sig.
	Within Groups	20.779	23	.903		
	Total	20.958	24			
Post-test Attitudes	Between Groups	2.392	1	2.392	3.316	.082 No-sig.
	Within Groups	16.589	23	.721		
	Total	18.980	24			

Findings illustrated there were no significant differences in nurses knowledge about nursing documentation with regard training at pre-test (*p=0.660*) post test (*p=0.082*) after education program.

Chapter Five

Discussion

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.

Nurse's knowledge, attitudes, and practices questionnaire items for nursing documentation, using MCQ questionnaire's items technique for knowledge and practices, which were classified in to two categories responses, such as "False, and True, and Liker's scale for attitudes, such as (strongly agree, agree, neutral, disagree, and strongly disagree)" along studied (Pre, and Post) periods due to application of an educational program for experimental group, as well as controlled group, are analyzed.

The results of significant testing with reference to questionnaire items are mostly highly significant differences at P-value 0.05, which assigned effectiveness of the studied educational program by raising knowledge, attitudes, and practices grades regarding nurse staff in the experimental group, and that be able to confirm the importance or success of implementing the suggested program. When there are no significant differences at P-value >0.05 and the suggested program cannot be used, vice versa.

1.5.Socio-demographic Characteristics of the Study Sample

Table 4-1-1 shows participant age, with the mean age for nurses in the experimental group being 29 and the mean age for nurses in the control group being 30, with the age 20-29 years old accounting for the biggest percentage of nurses in both groups. There were no significant variations in age groups for nurses in both groups (p=0.230), indicating that the sample is homogeneous in both. We locate them in the young group because the majority of them have diplomas. According to Andualem et al. (2019), the average age of participants (nurses) is 29.5, with the age group of 20-30 years old accounting for the majority of the data.

In terms of gender, male nurses predominated in the experimental group compared to female nurses in the control group. Both groups of nurses had significant gender disparities (p=0.203) (table 4-1-2). The lack of a significant difference indicates a strong argument in favor of the educational program for comparison purposes. This is in line with the findings of Akhu-Zaheya et al. (2018), who discovered that female nurses outnumbered male nurses in their study. In the current study, men nurses were more likely to participate in the education program than female nurses.

In terms of educational attainment, the majority of nurses were institute graduates in the research group. While the majority of the nurses in the control group were assigned to a nursing institute and graduated from nursing preparatory school. Due to the high number of institutions that award such degrees, there were no significant variations in educational level for both groups (p=0.757), since diploma degrees were deemed the primary proportion of staff nurses in health organizations (table 4-1-3). Hassan (2018), who evaluated nurses' awareness of documentation in Mansoura University Hospital, came to similar conclusions. Their results

revealed that their nursing certification was a diploma. The majority, on the other hand, had a secondary nursing diploma, while the rest obtained a technical institute diploma. As demonstrated by Hameed and Allo (2014) in their study in Iraq, this could have an impact on their understanding and practice of nursing documentation. However, no such difference was seen in the current study, which is likely due to the essentially identical nursing documentation curricula in both diploma programs.

Nurses in both the experimental and control groups had fewer than 5 years of experience, and there were no statistically significant variations in years of experience between the two groups (p0.460). (table 4-1-4) This could be because the nurses are young and new to the institute, so they have fewer years of experience. This research is based on the findings of Tasew et al. (2019), who studied nursing documentation practices and associated factors among nurses working in public hospitals. According to their findings, a higher percentage of nurses with less than 5 years of experience (34.5 percent) had fewer than 5 years of experience. Those findings are also in line with those of Tamir et al. (2021), who found that out of 50 nurses with fewer than 5 years of experience, 52.1% had less than 5 years of experience.

Findings linked to training sessions revealed that nurses in both the experimental and control groups did not attend training sessions. There were no significant differences in nurse training sessions for both groups (p=0.794)(table 4-1-5), indicating the importance of ongoing education in nursing documentation. According to Myklebust et al. (2018), the majority of nurses did not attend any training sessions since hospital policy was unconcerned about this.

5.2.Nurses' Knowledge towards Nursing Documentation

5.2.1.Nurses' Knowledge towards Nursing Documentation at Pre-Test for both Groups (Study and Control)

A total of 20 multiple choice questions were used to assess respondents' knowledge of nursing documentation, with a mean score of 34-40 indicating a higher level of knowledge, 27-33 indicating a moderate level of knowledge, and 20-26 indicating a lower level of knowledge. Nurses in both the study group (M SD= 25.84 3.715) (table 4-2-2) and the control group (M SD= 25.52 3.652) showed a low level of knowledge about nursing documentation during the pre-test period of measurement (table 4-2-7). Given the importance of documentation in nursing practice and its importance in providing quality patient care, this is a concerning conclusion.

In the pre-test period of measurement (p=0.760), there was no statistically significant difference between the experimental (M SD= 1.29±0.185) and control (M SD= 1.27±0.182) groups in terms of knowledge about nursing documentation (table 4-2-11). In terms of the statistical mean, the study results show that the nurses' knowledge scores in the pre-test experimental group did not improve when compared to the pre-test control group. Because both sides (experimental and control) have the same knowledge levels.

The findings of this study are consistent with those of other investigations, which found that nurses have similar levels of awareness of documentation. As a result, Hassan (2018) found that most nurses had insufficient understanding, with less than two-fifth of the nurses having total satisfactory knowledge of documentation.

In a study conducted in Uganda, Nakate et al (2015) discovered that more than two-thirds of the nurses in the study sample had inadequate

documentation knowledge. In a similar vein, Yearous (2011) found that between one-third (29.9%) and two-fifths (41.4%) of nurses in three separate hospitals had inadequate knowledge of nursing documentation.

On the contrary, Taiye (2015) found that all of the nurses in the sample had appropriate knowledge of nursing documentation in a research in Nigeria. This could be related to the latter study's ongoing staff development efforts.

In fact, a lack of understanding of the need of documentation would lead to a hesitant attitude and consequent undesirable behavior. In contrast, due to ongoing education training, the majority of nurses in a Danish survey showed a good understanding of the value of nursing documentation (Søndergaard et al., 2017).

According to the findings of the current study, nurses' "knowledge of documentation" was lowest in the area of documentation. As a result, more than half of them lacked sufficient documentation expertise. In fact, if the nurses are unfamiliar with the documentation, they will never be able to perform it correctly. The findings are consistent with Hameed and Allo (2014), who found that the lowest nurses' understanding of documentation was related to its basic concepts and how to record in northern Iraq (Nineveh).

Tasew et al. (2019) found that more than half of nurses did not document their nursing care due to a lack of understanding. Employing institutions should give training on nursing care documentation to improve understanding and raise awareness about nurses' documentation among nursing directors and chief executive officers, in addition to hiring more nurses.

5.2.2.Nurses' Knowledge towards Nursing Documentation at Post-Test for both Groups (Study and Control)

According to the results of the current study, nurses had a satisfactory level of knowledge about nursing documentation during the post-test measurement phase (M SD= 34.88±5.166) after completing the education program (table 4-2-4). At the post-test measurement period, nurses in the control group had a low level of knowledge (M SD= 25.72±5.303) about nursing documentation (table 4-2-9). This finding indicates that an educational program is beneficial, as nurses in the study group felt satisfaction.

At the post-test period of assessment (p=0.000), there is a very statistically significant difference in knowledge of nursing documentation between the experimental (M SD= 1.74±0.268) and control (M SD= 1.28±0.265) groups (table 4-2-11). In terms of the statistical mean, the study results show that after implementing the education program, the experimental group's knowledge scores improved when compared to the control group.

This finding is comparable to that of Sabeghi et al. (2012), who found that there were significant differences in knowledge (P =0.000), attitude (P=0.000), and performance (P=0.001) regarding documentation between nurses in the intervention and control groups. In terms of demographic factors, the data revealed that there was no statistically significant difference between the two groups. The findings of this study imply that continuing education programs improve nurses' documentation knowledge, attitude, performance, and competency. It is suggested that more research be done on learning stability after using this strategy and comparing it to other educational methods.

Attending a regular nursing documentation training program was linked to a positive outcome. This finding is similar to that of research

conducted in Ghana (Asamani et al., 2014), Uganda (Nakate et al., 2015), and Gondar (Asamani et al., 2014). (Kebede et al., 2017). This could be because training increases their familiarity with operational documentation standards, improves their knowledge of documentation, and increases their value in recording what they've done. As a result, training will be beneficial in improving documentation practices.

There is accepted hypothesis that states "*There were significant differences in nurses knowledge between study group and control group*), nurses in the study group achieved considerable benefit from educational program concerning nurses knowledge towards nursing documentation (*t-test= 6.186; p=0.000*) (poor to good knowledge".

5.2.3.Statistical Differences in Two Test Knowledge of Nurses towards Nursing Documentation with regards their Socio-demographic Characteristics (Study Group)

5.2.3.1.Nurses Knowledge and Age group

There were no significant variations in nurses' understanding of nursing documentation between age groups at pre-test (p=0.152) and post-test (p=0.909) after the education program, according to the findings (table 4-5-1). This research implies that nurses' knowledge of documentation is unaffected by their age groups, implying that nurses of all ages have the same level of expertise. Melkie (2020) stated that nurses aged 25-30 years old had the same knowledge scores as nurses aged 40-45 years old, and that the knowledge scores were not affected by the nurses' age groups.

5.2.3.2.Nurses Knowledge and Gender

There were no significant variations in nurses' understanding of nursing documentation between male and female nurses at pre-test (p=0.814) and post-test (p=0.723) after the education program, according to the findings (table 4-5-2). Male nurses' mean knowledge scores in the pre-post test (1.30 and 1.76) were the same as female nurses' knowledge

scores in the pre-post exam (1.28 and 1.72). That is, there is no difference between male and female nurses in terms of weak knowledge (pre-test) and good knowledge (post-test) after educational programs. In other words, nurses' knowledge of documentation is determined by their school program rather than their gender. In addition, Okaisu et al. (2014) found that the gender of nurses had no effect on their knowledge of the value of nursing documentation.

5.2.3.3.Nurses Knowledge and Education Level

There were significant variations in nurses' knowledge regarding nursing documentation with reference to educational level at pre-test (p=0.026) but no significant differences in knowledge at post-test (p=0.938) following the education program, according to the findings (table 4-5-3). These findings show that nurses' documentation knowledge is significantly reliant on their educational level. A high level of education resulted in significantly higher knowledge ratings. Hameed & Allo (2014), who investigated documentation knowledge among nurses working in two key teaching hospitals in Nineveh governorate, backed with these findings. The educational level of nurses was found to have a strong relationship with components of documentation (Principles and Purposes).

5.2.3.4.Nurses Knowledge and Years of Experience

There were no significant changes in nurses' understanding of nursing documentation based on years of experience at pre-test (p=0.602) or post-test (p=0.464) after the education program, according to the findings (table 4-5-4). This finding agrees with Kelley et al. (2011), who found no significant relationship between nursing knowledge and years of experience. These findings show that nursing knowledge does not differ based on years of experience, but rather based on another variable (educational program) that might increase or decrease. It makes no difference whether the number of years of experience has increased or

reduced in terms of executing an educational program to improve documentation expertise.

5.2.3.5.Nurses Knowledge and Training Courses

There were no significant variations in nurses' understanding of nursing documentation between pre-test (p=0.553) and post-test (p=0.383) after completing the education program (table 4-5-5). This study is consistent with the findings of Abell et al. (2015), who found that training sessions had little effect on nurses' knowledge of how to apply medical records. Because training courses alter practices, they are not considered a factor affecting nurses' knowledge of documentation. According to our findings, the majority of nurses (64 percent) did not attend training courses (table 4-1-5), which they discovered in the pre-test (low knowledge), while their knowledge did not differ only in its increase when they attended the educational program. That is, whether or not they have training courses, educational programs expand their knowledge.

5.3.Nurses' Attitudes towards Nursing Documentation

5.3.1.Nurses' Attitudes towards Nursing Documentation at Pre-Test for both Groups (Study and Control)

Nurses' attitudes were measured using a Likert scale with item scores ranging from strongly agree (5) to strongly disagree (1), with a potential total mean score of 120 at the highest level and 24 at the lowest level. Nurses in both the experimental group (M SD= 76.4 22.42) (table 4-3-2) and the control group (M SD= 63.52 16.047) indicated neutral attitudes regarding nursing documentation during the pre-test period of measurement (table 4-3-7).

In the pre-test period of measurement (p=0.485), there was no statistically significant difference in attitudes about nursing documentation between the experimental (M SD= 2.80±0.934) and control (M SD= 2.64±0.668) groups (table 4-3-11). In terms of the statistical mean, the

study results show that the nurses' knowledge scores in the pre-test study group did not improve when compared to the pre-test control group.

Furthermore, this result was consistent with research undertaken in Indonesia (83.3%) (Mote, 2016), Iran (85.8%) (Mohajjel Aghdam et al., 2012), India (98.8%) (Juliet & Sudha, 2013), South Africa (71.7%) (Olivier, 2010), and Gondar (60.7%). (Kebede, 2017). This resemblance could be owing to nurses' neglect of nursing documentation as part of their professional obligations and responsibilities. It could be owing to the heavy workload, given the low nurse-to-patient ratio in the country. It could also be a lack of documentation training in the workplace.

According to Ayele et al. (2021) in Southern Ethiopia, more over half of the study participants had a Simi-favorable attitude about documentation. Nurses' attitudes toward nursing care documentation were linked to their education and training. To improve nurses' attitudes toward documentation, it is recommended that they develop their understanding of documentation and efficiently manage working units.

Nurses with good knowledge may be more aware of the importance of nursing care documentation and the consequences of poor documentation. There are two possible explanations for this. The first is that they place a high value on paperwork. The second issue is that these nurses are unable to recognize documentation due to a lack of knowledge. This is the most likely explanation, given the study's findings revealed that a much higher number of nurses with inadequate expertise had poor agreement on the relevant views.

5.3.2.Nurses' Attitudes towards Nursing Documentation at Post-Test for both Groups (Study and Control)

Following the implementation of the education program, nurses indicated good attitudes toward nursing documentation at the post-test

assessment period (M SD= 93.88±21.343). (table 4-3-4). At the post-test period of measurement, nurses in the control group had neutral opinions toward nursing documentation (M SD= 66.2 1±4.722) (table 4-3-9).

At the post-test period of measurement (p=0.000), there is a very statistically significant difference in attitudes about nursing documentation between the experimental (M SD= 3.91±0.889) and control (M SD= 2.75±0.613) groups (table 4-3-11). In terms of the statistical mean, the study results show that after implementing the education program, the attitudes scores of the experimental group improved when compared to the control group.

According to Namayanja (2016), the respondents in this study had a positive attitude toward documentation, with the majority believing that documentation was not a waste of time, 61 percent believing that not all patients have the same information, 46 percent believing that failure of some nurses to record was not due to the belief that they could not forget a daily practice, and 52 percent believing that not all patients were supposed to know what they were supposed to know. This is due to effective nursing education training, and nurses have stated that it has benefited them.

When compared to nurses who were not motivated, nurses who were motivated to participate in documentation training were more likely to have good attitudes toward documentation (Tasew et al., 2019). Similarly, this evidence is consistent with the findings of the Jimma investigation (Gizaw et al., 2018). This could be because nurses who participate in training programs have a more positive attitude regarding nursing documentation and are more likely to document their work.

There is accepted hypothesis that states "*There were significant differences in nurses attitudes between study experimental and control group*), nurses in the experimental group achieved considerable benefit

from educational program concerning nurses attitudes towards nursing documentation (*t-test= 5.338; p=0.000*) (neutral to positive attitudes".

5.3.3.Statistical Differences in Two Test Attitudes of Nurses towards Nursing Documentation with regards their Socio-demographic Characteristics (Study Group)

5.3.3.1.Nurses Attitudes and Age groups

There were no significant differences in nurses' views regarding nursing documentation between age groups at pre-test (p=0.510) and post-test (p=0.770) after the education session, according to the findings (table 4-6-1). This conclusion is backed up by Ayele et al. (2021), who found no link between nurses' documentation attitudes and their age. The nurses' age before and after the schooling program had no bearing on their attitudes. Rather, the documentation knowledge element is regarded a direct influencing factor, as their attitudes were neutral and did not differ according to his age, while their attitudes after completing the program were positive and did not differ according to their ages.

5.3.3.2.Nurses Attitudes and Gender

There were no significant changes in nurses' attitudes toward nursing documentation between male and female nurses at two points in time: pre-test (p=0.110) and post-test (p=0.103) after the education program (table 4-6-1). This finding is backed up by Ayele et al. (2021), who found no link between nurses' views toward documentation and their gender. Male nurses' mean attitudes scores in the pre-post test (1.07 and 4.14) were the same as female nurses' attitudes scores in the pre-post test (2.46 and 3.58). That is, there is no difference between male and female nurses' neutral attitudes (pre-test) or positive attitudes (post-test) after educational programs. In other words, nurses' views toward documentation are determined by their educational program rather than their gender.

5.3.3.3.Nurses Attitudes and Education Level

At pre-test (p=0.597) and post-test (p=0.864) after the education session, there were no significant variations in nurses' opinions towards nursing documentation based on educational level (table 4-6-3). This finding is backed up by Ayele et al. (2021), who discovered no link between nurses' documentation attitudes and their educational background. Nurses' attitudes about nursing documentation are unaffected by their educational degrees since they lack knowledge as a result of their neutral views prior to performing an education program. Their attitudes after completing the educational program, on the other hand, do not differ merely in terms of enhancing their attitudes, regardless of their educational degrees. So, nurses' attitudes towards documentation depend on educational programs and not on educational levels.

5.3.3.4.Nurses Attitudes and Years of Experience

There were no significant variations in nurses' attitudes toward nursing documentation based on years of experience at pre-test (p=0.392) or post-test (p=0.341) after the education session, according to the findings (table 4-6-4). This research supports the findings of Andualem et al. (2019), who found no significant variations in attitudes between those with more and less experience. Nurses' attitudes toward documentation do not differ based on years of experience, as those with less than 5 years of experience are similar to those with more than 10 years, so nurses' attitudes are determined by their understanding of the importance of nursing documentation, regardless of how much or how little experience they have.

5.3.3.5.Nurses Attitudes and Training Courses

There were no significant variations in nurses' understanding of nursing documentation between pre-test (p=0.660) and post-test (p=0.082) after completing the education program (table 4-6-5). This research supports the findings of Andualem et al. (2019), who found no significant

variations in attitudes between those who are trained and those who are not. Whether or not training courses alter the nurses' views is unrelated to their attendance or non-attendance at the training sessions.

Chapter Six

Conclusion and Recommendation

Chapter Six

Conclusions and Recommendations

6.1.Conclusion:

In light of the results discussion and their interpretations, our study concludes that:

6.1.1. In terms of nursing documentation, nurses lacked knowledge and attitudes.

6.1.2. In the pre-test, there were no differences in knowledge, attitudes, or practices between the study and control groups.

6.1.3. Nurses' knowledge and attitudes, improved after the post-test for the study group as a result of the educational program on nursing documentation. During the pre- and post-test, the control group did not show any improvement in their knowledge and attitudes

6.1.4. Staff training is accomplished by the implementation of an education program that aids in the development of their knowledge and attitudes related to nursing documentation.

6.1.5. Rejecting the null hypothesis and demonstrating that nurses in the research group benefited significantly from a nursing documentation educational program.

6.2.Recommendations:

The present study could recommend, based on the above stated conclusion, that:

6.2.1. Nurses' benefits for documentation may be taken and consideration by establishing special educational training programs to improve competence.

6.2.2. It is suggested that nurses be recruited until hospitals are fully staffed, and that a system be put in place to track and monitor how staff members apply nursing care documentation, as well as provide feedback to those who have had difficulties.

6.2.3. Nurses' knowledge and attitudes of nursing care documentation should be studied in multisite studies, particularly qualitative studies (to make the study more representative and reduce bias).

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Appindices

Appindix-A

Administrative Arrangements

Appendix- A.....(1)

السيـــــــد المعـــــاون العلمـــــي المحتـــــرم.

السيـــد رئيـــس فـرع تمريـــض البالغيـــن المحتـرم.

السادة اعضاء اللجنة العلمية والأخلاقيات البحث المحترمون.

م/ اخـــلاقيـــات البحـــث

يرجى التفضل بالموافقة على عرض موضوع (**الدكتوراه**) على اللجنة العلمية واخلاقيات البحث العلمي عن موضوع **اطروحتي** الموسومة:

باللغة العربية:

(برنامج تعليمي حول معارف واتجاهات وممارسات الممرضين باتجاه التوثيق في مستشفى الفرات الاوسط التعليمي).

واللغة الإنكليزية:

(An Educational Program on Nurses Knowledge, Practices and Attitude toward Documentation in Al-Furat Alawsatt Teaching Hospital).

مع التقدير

اسم المشرف وتوقيعـه: أ.م. د. شذى سعدي محمد

اسم الطالب وتوقيعـــه: حيـدر غالـب جبـر

رئيس الفرع وتوقيعه: أ.م. د. شذى سعدي محمد

المـعاون العلمـي

الدكتور
حسام عباس داود

ملاحظة: ترفق جميع الاستمارات الخاصة بلجنة اخلاقيات البحث مع الطلب. (Ethical form 1, Ethical (form2, Ethical Form3

Appendix- A.....(2)

University of Babylon
College of Nursing
Research Ethics Committee

جـامـعة بـابـل
كـلية التمريـض
لجنة اخلاقيات البحث العلمي

Issue No: 58
Date: 10 /05 /2021

Approval Letter

To,
HAYDER GHALEB JABUR

The Research Ethics committee at the **University of Babylon, College of Nursing** has reviewed and discussed your application to conduct the research study entitled " **An Educational program on Nurses Knowledge, Practice, and Attitude toward Documentation in Al-Furat Alawsat Teaching Hospital.**"

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
10 / 5 /2021

Appendix- A.....(3)

Ministry of Higher Education and Scientific Research

وزارة التعليم العالي والبحث العلمي

University of Babylon
College of Nursing

جامعة بابل
كلية التمريض
لجنة الدراسات العليا

العدد: ١٤٨٨
التاريخ: ١٠ / ٥ / ٢٠١٧

Ref. No. :
Date: /

الى / مستشفى الفرات الاوسط التعليمي

م/ تسهيل مهمة

تحية طيبة :

يطيب لنا حسن التواصل معكم ويرجى تفضلكم بتسهيل مهمة طالب الدكتوراه (حيدر غالب جبر حمزة) لغرض جمع عينة دراسة الدكتوراه والخاصة بالبحث الموسوم :

برنامج تعليمي حول معارف واتجاهات ممارسات الممرضين باتجاه التوثيق في مستشفى الفرات الاوسط التعليمي.

An Educational Program on Nurses Knowledg,Practices and Attitude toward Documentation in AL-Furat ALawsatt Teaching Hospital.

مع الاحترام ...

المرافقات //
- بروتوكول .
- استبانة .

ا.م.د. ماهر خضير هاشم
العميد وكالة
١٠ / ٥ / ٢٠١٧

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

E-mail:nursing@uobabylon.edu.iq

STARS

وطني 07711632208
المكتب 009647711632208

Appendix- A.....(4)

Republic of Iraq
Al-Najaf Al-Ashraf Governorate
Najaf Health Directorate
Training and Human Development Center
No.
Date:

جمهورية العراق
محافظة النجف الأشرف
دائرة صحة النجف
مركز التدريب و التنمية البشرية
العدد: ١٧٢٩٥
التاريخ: ١١/٥/٢٠٢١

إلى/ جامعة بابل / كلية التمريض
م / تسهيل مهمة

تحية طيبة ...
إشارة إلى كتابكم ذي العدد 1490 في ٢٠٢١/٥/١٠ بخصوص تسهيل مهمة الباحث طالب /الدكتوراه (**حيدر غالب جبر حمزة**) للحصول على الموافقة الاخلاقية للبحث الموسوم:

برنامج تعليمي حول معارف واتجاهات ممارسات الممرضين بأتجاه التوثيق في مستشفى الفرات الاوسط التعليمي

حصلت موافقة اللجنة العلمية للبحوث في مركز دائرتنا على إجراء البحث في **(مستشفى الفرات الاوسط لتعليمي)** مع التأكيد على الالتزام الكامل بتعليمات السلامة الحيوية والضوابط الاخلاقية والحصول على موافقة المشاركين قبل الشروع بالبحث والحفاظ على خصوصيتهم وعدم افشاء البيانات او استخدام العينات لغير اغراض البحث العلمي ... على أن لا تتحمل دائرتنا أية تبعات مادية .. مع الاحترام.

ملاحظة :
تم استيفاء أجور جباية البحوث والبالغة (١٠٠٠٠) عشرة الاف دينار بموجب الوصل المرقم (884849) في ٢٠٢١/٥/١١

دائرة صحة النجف
الصادر
قسم الامور الادارية والمالية والتكنولوجيا

الدكتور
رضوان كامل الكندي
المدير العام
١١ / ٥ / ٢٠٢١

نسخة منه الى /
مكتب المدير العام / للعلم مع الاحترام .
مركز التدريب و التنمية البشرية / مع الأوليات .
مستشفى الفرات الاوسط لتعليمي ..... للتفضل بالاطلاع وتسهيل مهمة اجراء البحث مع التقديـــر

Appindix-B1

Figures

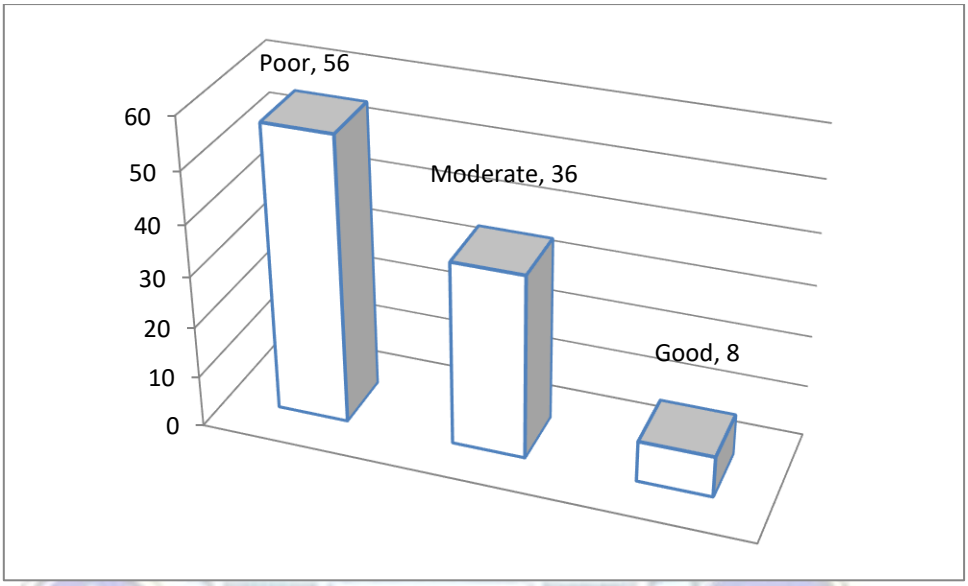

Fig. 4-1-1:Nurses Knowledge about Nursing Documentation at Pre-test for Experimental Group

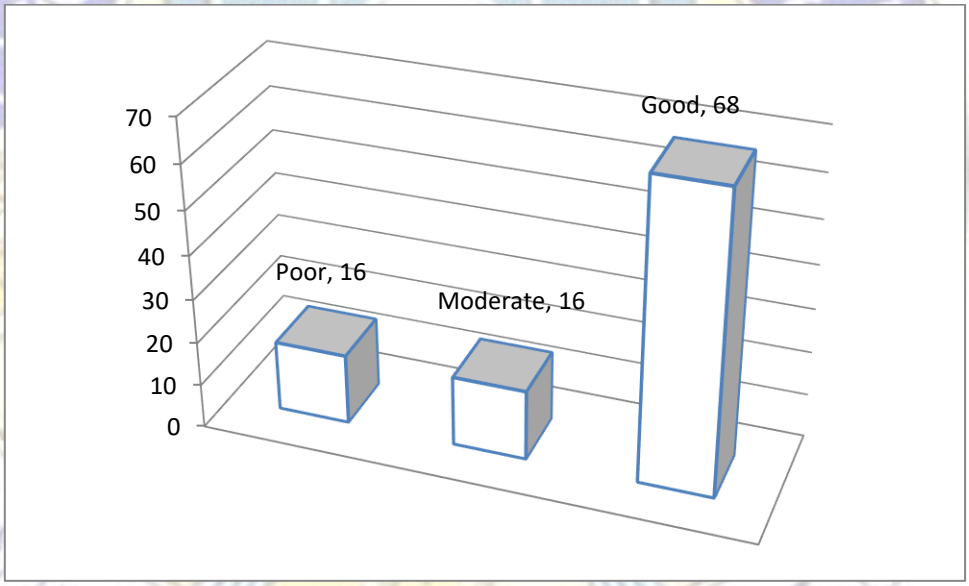

Fig. 4-1-2:Nurses Knowledge about Nursing Documentation at Post-test for Study Group

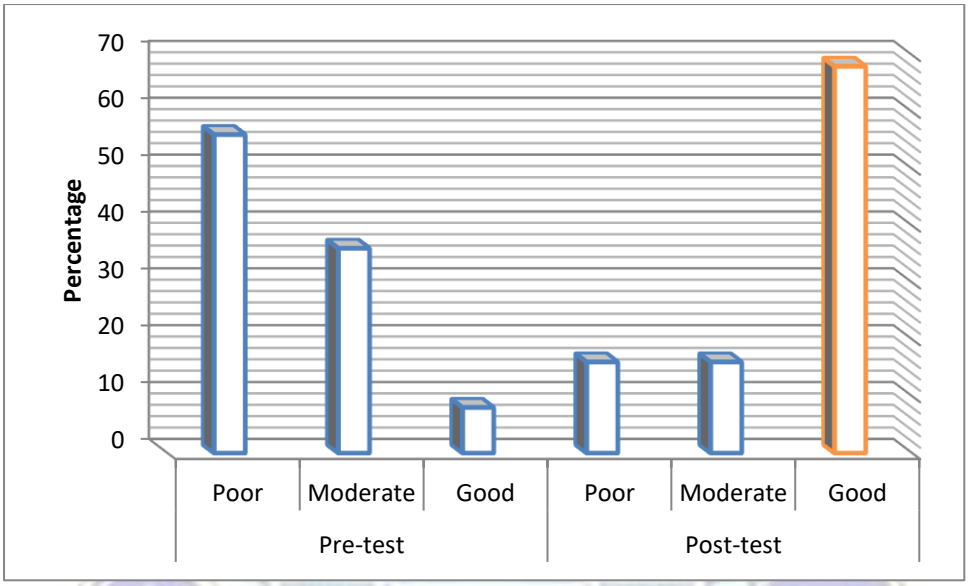

Figure 4-1-3:Comparison between the Overall Responses at Two Levels of Measurement for Study Group (pre-test and post-test)

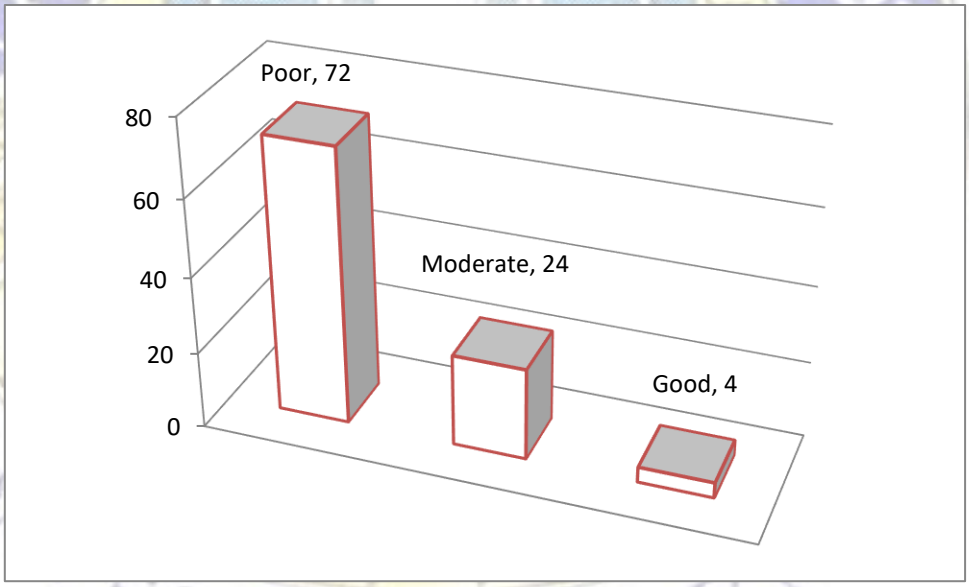

Fig. 4-1-4:Nurses Knowledge about Nursing Documentation at Pre-test for Control Group

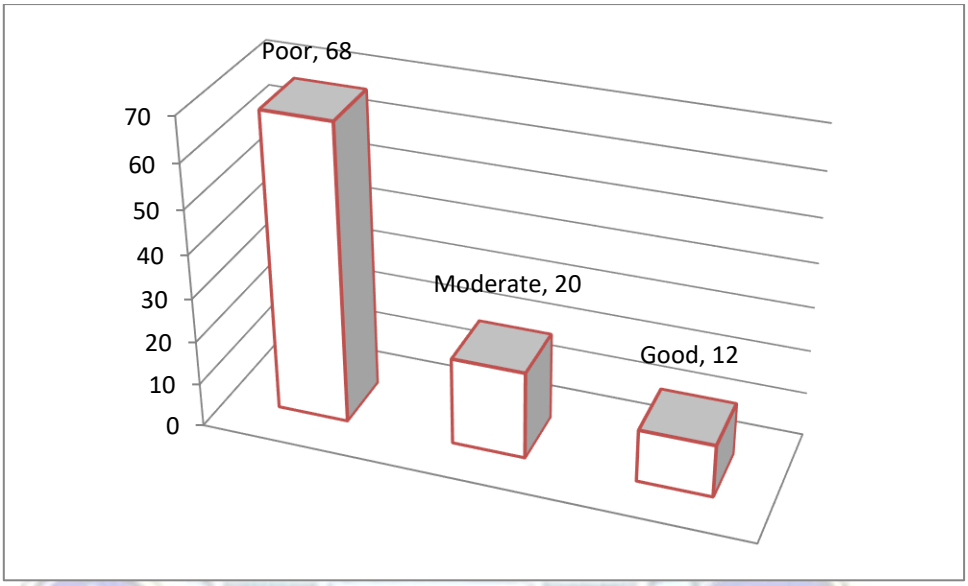

Fig. 4-1-5:Nurses Knowledge about Nursing Documentation at Post-test for Control Group

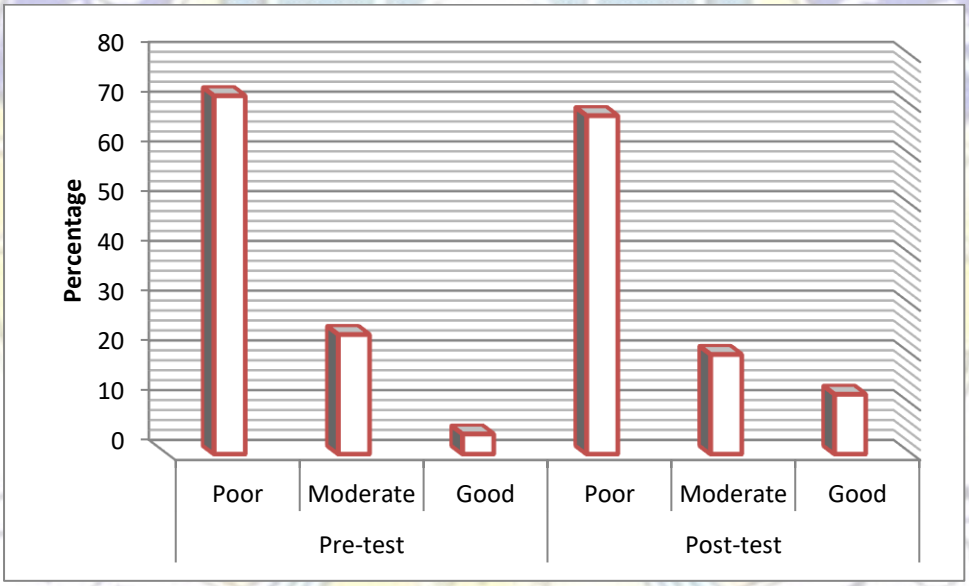

Figure 4-1-6:Comparison between the Overall Responses at Two Levels of Measurement for Control Group (pre-test and post-test)

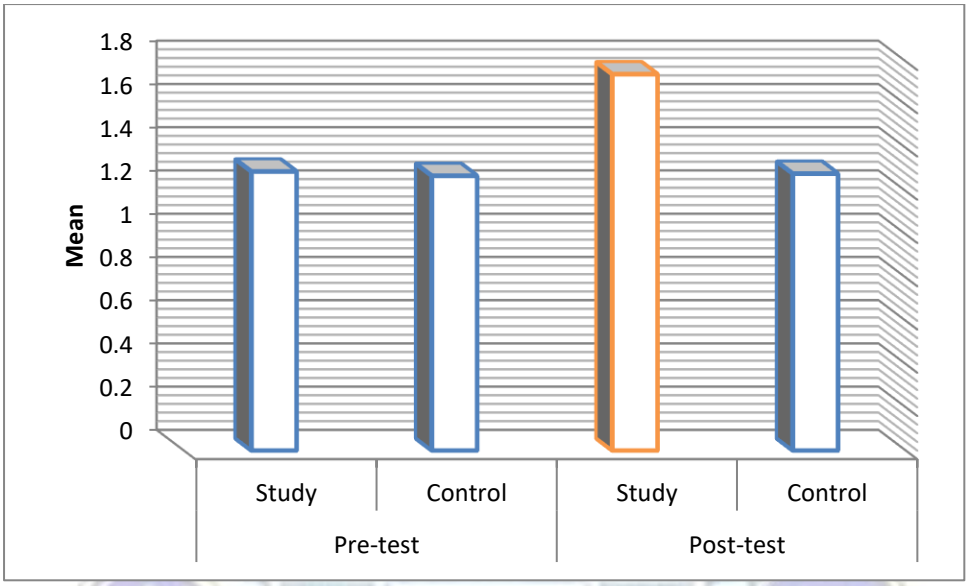

Figure 4-1-7:Comparison between the Overall Experimental and Control Groups Responses at Two Levels of Measurement (pre-test and post-test)

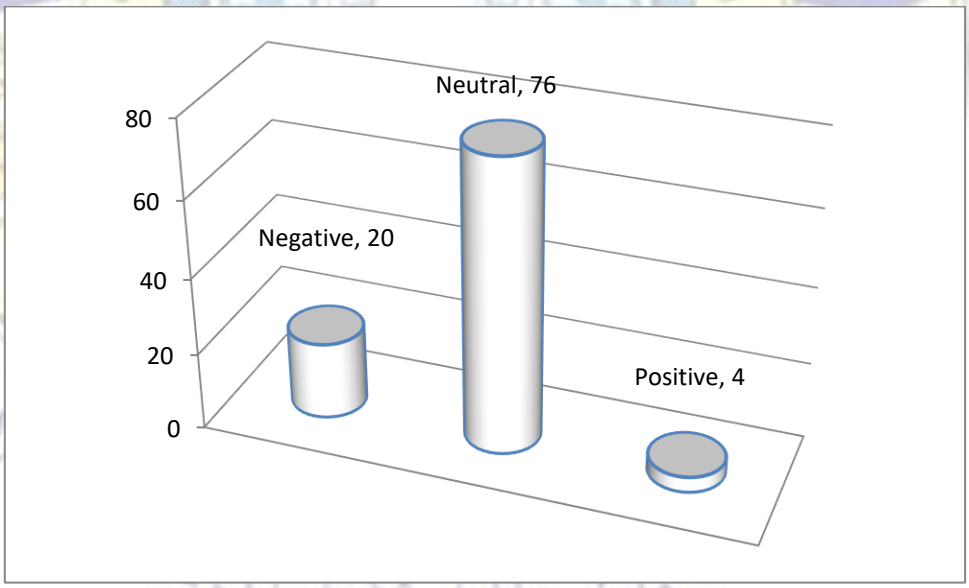

Fig. 4-2-1:Nurses Attitudes about Nursing Documentation at Pre-test for Study Group

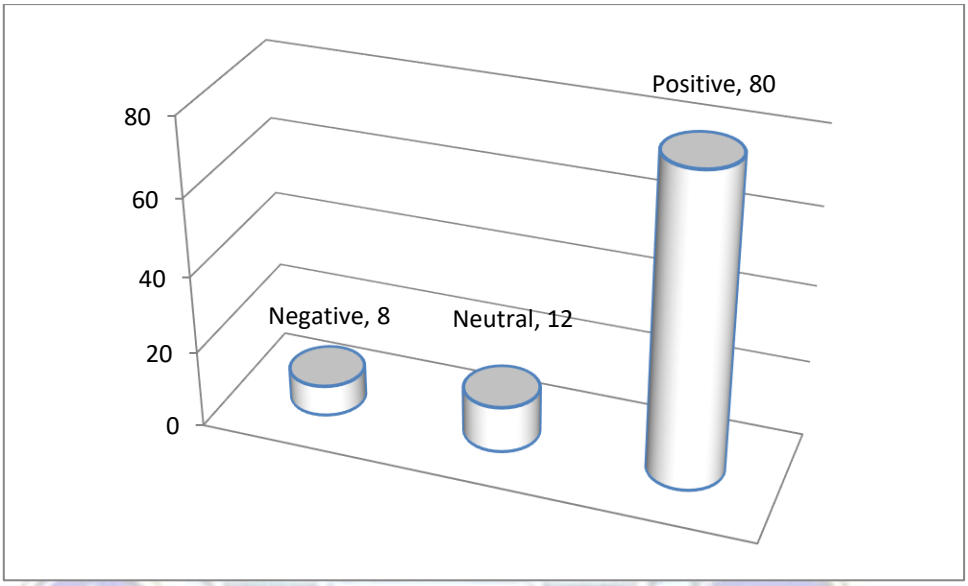

Fig. 4-2-2:Nurses Attitudes about Nursing Documentation at Post-test for Experimental Group

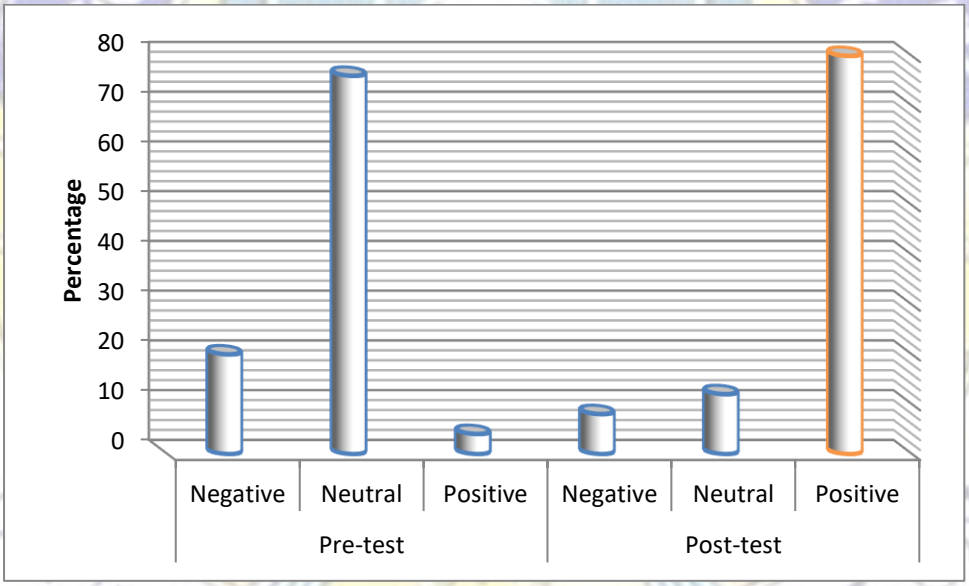

Figure 4-2.3:Comparison Attitudes between the Overall Responses at Two Levels of Measurement for Control Group (pre-test

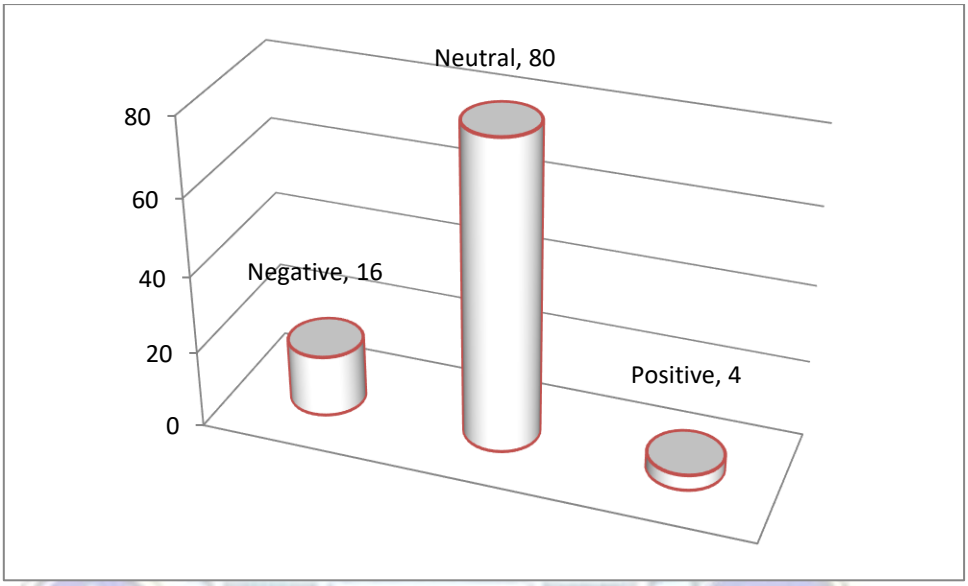

Fig. 4-2-4:Nurses Attitudes about Nursing Documentation at Pre-test for Control Group

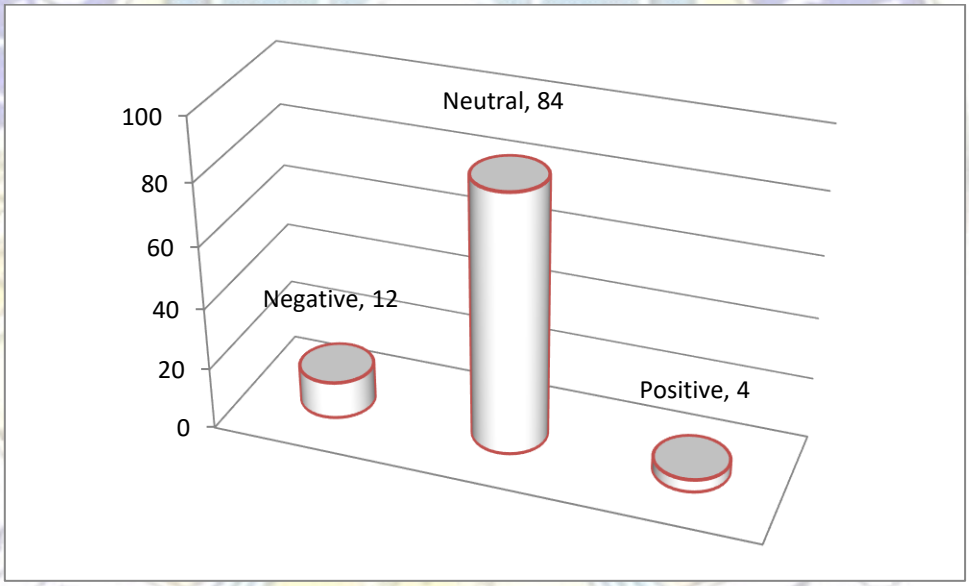

Fig. 4-2-5:Nurses Attitudes about Nursing Documentation at Post-test for Control Group

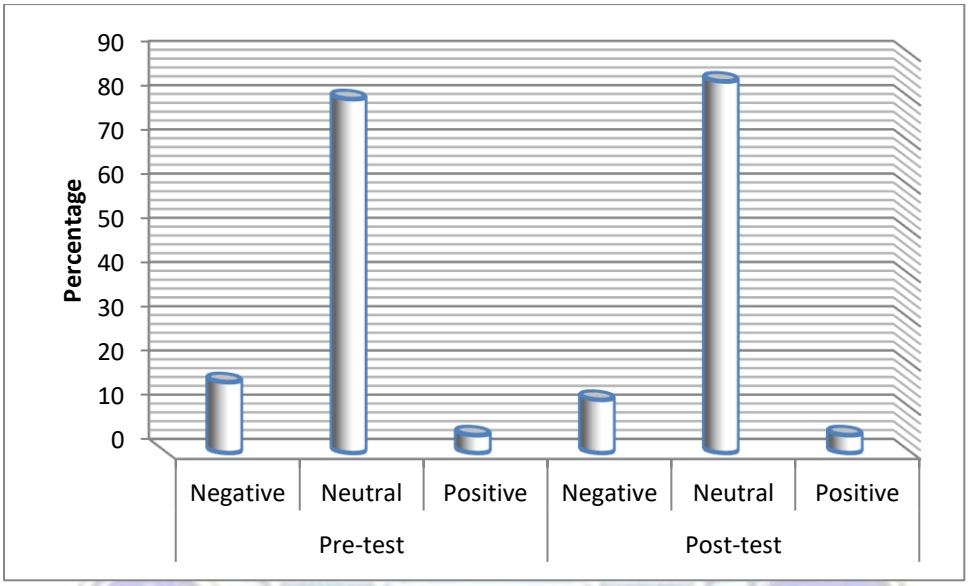

Figure 4-2.6:Comparison Attitudes between the Overall Responses at Two Levels of Measurement for Control Group (pre-test and post-test)

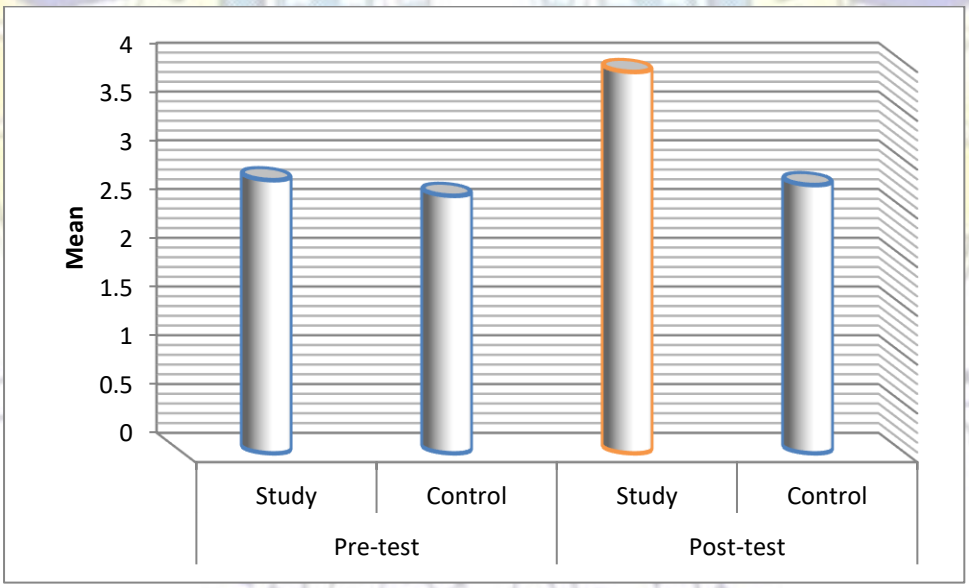

Figure 4-2-7:Comparison between the Overall Study and Control Groups Responses at Two Levels of Measurement (pre-test and post-test)

Appindix-B2

(1) English and Arabic Questionnaire.

(2) Constructed program in Arabic.

.

Demographic information for nursing staffs

No

Age

☐ Years

Gender

Male ☐ Female ☐

Level of education

Graduate turning of nursing ☐ Graduate school of nursing ☐
Graduate preparatory of nursing ☐ Graduate institute of nurs ☐
Graduate college of nursing ☐ Graduate high education of nursing ☐

Years of Survieces in Nursing

☐ Years

Participation of the nurse in truning regarding nursing documentation

Yes ☐ no ☐

Number of truning

1-3 ☐ 4-6 ☐ 7-9 ☐ 10-Over ☐

Duration of truning sessions

☐ Days

English questionaire: three parts: knowledge, attitudes and practices (63)

Question.

First part - Nurses' knowledge about nursing documentation

1. **The first scientist to record medical notes in history?**

A. Hippocrates
B. Phaedrus
C. Protagors
D. Astratos

2. **That the information documents about the patient, his care, and descriptive information about the target be based on direct knowledge and evaluation of the disease?**

A. Realistic basis
B. Precision
C. Completeness
D. Organization

3. **Clear and easy-to-digest information that contains important details for the patient**

A. Realistic basis
B. Precision
C. Completeness
D. Organization

4. **The information in the patient record entry must fully describe patient care needs and nursing interventions**

A. Realistic basis
B. Accuracy
C. Completeness
D. Regulation

5. **Information recorded during or shortly after the occurrence of the interference or interaction in a timely manner is necessary in concurrent patient care?**

A. Realistic basis
B. Precision
C. Completeness
D. Modernity

6. **Does the nurse communicate the recorded information in a logical way?**

A. Realistic basis
B. Precision
C. Completeness
D. Organization

7. **The recorded information reflects the provision of safe, competent, ethical and compassionate nursing care that conforms to the standards of professional practice?**

A. Organization
B. Confidentiality

C. Modernity
D. Completeness

8. **Documenting information continuously and regularly and recording all evaluation results, patient interventions and outcomes?**

A. Embedding
B. The exception
C. Completeness
D. Organization

9. **The traditional method of nursing documentation, which is a story describing the patient's condition, interventions, treatments and responses?**

A. N - Documentation
B. SOC
C. POC
D. SOAP

10. **Easy-to-use documentation in emergency situations, as it requires a simple chronological arrangement. Usually, there is a lack of analysis and critical decision-making on the part of the patient?**

A. N - Documentation
B. SOC
C. POC
D. SOAP

11. **What are the reasons for replacing the narrative documentation style with other formats?**

A. Each nurse documents in a unique manner, which makes it difficult to determine continuity of care
B. The nursing process does not reflect an emphasis on tasks without an emphasis on data or outcomes
C. The documentation does not take longer to record the accurate data and read it by others

12. **A form of narrative documentation in which each member of the health team keeps separate narrative notes?**

A. N - Documentation
B. SOC
C. POC
D. SOAP

13. **Documentation focuses on the patient's problems starting from the patient's medical history and evaluation?**

A. N - Documentation
B. SOC
C. POC
D. SOAP

14. **When entering information in the patient’s record using the formatting of subjective and objective data with the addition of the plan and review that refers to the amendment to the plan?**

A. SOAPIER

B. SOAPIE
C. POC
D. SOAP

15. In the primary data that has been collected and consists of the patient's profile, history, laboratory and physical examinations?

A. Database
B. List of problems
C. Initial plan
D. A note about progress

16. Information changing a diagnostic entity, clinical relationship, physical result, or abnormal laboratory result?

A. Database
B. List of problems
C. Initial plan
D. A note about progress

17. Patients receive an individual assessment of physical, functional, psychosocial and pain history. The goal is to determine appropriate patient care?

A. Database
B. List of problems
C. Initial plan
D. A note about progress

18. Observing and recording observations and patients' problems and reassessing them at appropriate intervals?

A. Database
B. List of problems
C. Initial plan
D. A note about progress

19. A simple approach to focus on patient problems and interventions but ignore the nursing care plan documentation?

A. PIE graph
B. SOAP
C. Initial plan
D. Focus on the graph

20. Using this documentation method, the nurse determines the "focus" based on the patient's problems or behaviors that were identified during the evaluation?

A. PIE graph
B. SOAP
C. Initial plan
D. Focus on the graph

Second part - Nurses' attitudes about nursing documentation

1. **Nursing documents have a positive impact on the care provided**.

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

2. **Nursing documents affect patient safety**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

3. **The nurses should spend the time documenting the reports**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

4. **Nursing documentation depends on training**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

5. **Accurate documentation enhances professional independence**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

6. **Nursing documents are legally valid documents**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

7. **Nursing documents enhance the healing process**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

8. **Nursing documentation improves patient care time**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

9. **Nursing documentation is an important discipline for nursing practice**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

10. **Nursing documents help nursing staff to gain knowledge about patients**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

11. **Nursing documentation can protect the rights of both the nurse and the patient**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

12. **Nursing documents are a source for study**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

13. **Nursing documentation improves interactions between members of the medical team**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

14. **Nursing documents make discharge from hospital go smoothly**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

15. **Nursing documents lead to professional independence**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

16. **It would be better to focus on nursing care rather than documentation**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

17. **Nursing documentation reduces work pressure on nurses**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

18. **It is essential to document all nursing interventions**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

19. **Documentation can help speed up the decision and increase patient satisfaction**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

20. **Nursing documentation improves the quality of nursing care**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

21. **Nursing documents help speed up patient delivery**

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

22. Nursing documents enable the medical staff to discover changes in the patient's condition

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

23. Documentation can help enhance knowledge of nursing

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

24. Documenting nursing interventions is a valuable skill

Strongly disagree	Disagree	Do not know	Agree	Strongly agree

Third part - the performance of nurses on nursing documentation

1. **Which of the following practices could lead to malpractice? Select all that apply**

   A- Charting interventions in advance to save time
   B-Documenting incorrect data
   C-not charting the correct time when events took place
   D- deleting incorrect entries and crossing them out with a horizontal line
   E- not recording verbal orders or not having them signed

2. **What kind of notes are taken when charting by exception? Select all that apply**
   A- additional treatments done or planned treatments withheld
   B- standing orders and physical history
   C- new concerns
   D- changes in patient condtion

3. **In the SOAPE format, a briefer adaptation of the POMR, where is Intervention (I) included?**
   A It is not mentioned in this kind of documentation
   B-Included in the notations under PLANNING
   C- Included under assessment
   D It belongs to another format

4. **Which of the following are considered the principal sections of a problem-oriented medical record? Select all that apply.**
   A-Database
   B-Problem list
   C-Care plan
   D-Physical examination and diagnostic tests
   E Referral form

5. **Preprinted guidelines used to care for patients with similar health problems.**
   A-Nursing Care Plan
   B-Kardex
   C Common illness index
   D Health intervention reference

6. **What kind of documentation is the following? Pain scale 0/10, hand and leg strong to right, weak to left. Skin pink, warm and dry, turgor good, incision to Rt. anterior chest wall erythema or edema.**
   A Kardex
   B- Narrative
   C- Nurse's Notes
   D Shift report

7. **Which of the following does not refer to the process of adding written information to a health care record?**
   A Recording
   B Charting
   C-Data entry
   D- Documenting

8. **Which of the following statements are true regarding basic rules for documentation. Select all that apply.**
   A-Use direct quotes for objective assessments
   B-If a charting error is made, draw one line through the faulty information
   C-Chart only your own care even when someone else calls you for a late entry.
   D-Chart after care is provided, as soon as possible, and as often as needed
   E Sign each block of charting with full legal initials and title

9. **When is it unnecessary to chart a narrative note? Select all that apply.**
   A Each time you give a medication
   B Each time a bath is given
   C Each time a decubitus ulcer changes in appearance
   D Each time you assess vital signs

10. **In the SOAPE format, if ever there is a need for changes, where will the REVISIONS (R) be included?**
    A REVISIONS belong to another format of documentation
    B REVISIONS are not part of this documentation
    C REVISIONS are noted in the EVALUATION section
    D REVISIONS are noted in the ASSESSMENT section

11. **Which of the following statements about documenting is not true?**
    A Involves recording the interventions carried out to meet the patient's needs.
    B Done in a proper way, it reflect the nursing process.
    C Necessary to prove that nursing work was done.
    D Nursing documentation can be accepted in both verbal and written form

12. **When does discharge planning ideally begin?**
    A During admission
    B After admission
    C Before admission
    D Without admission

13. **Choose based on SOAPIER, which abbreviation applies to the following:** You have a 48-year-old patient who says, "I feel like I can't breathe." . Then the patient grabs his chest and says, "My chest hurts so badly, please help!" Ask the patient to rate the pain on a scale from 0 to 10, with 10 being the worst pain of all. The patient replies, "10, it hurts me so badly!" Then she asks the patient to describe what the pain is feeling, and inform the patient that his pain is like pressure?

A- S
B- O
C- A
D- P
E- I
F- E
G- R

14- Choose based on SOAPIER, which abbreviation applies to the following: You have a 48-year-old patient whose respiratory rate is 28 breaths per minute and their heart rate is 115 beats per minute. . Then your patient will start to become sweaty and pale. You take an EKG that shows a sinus tachycardia. The pulse oximeter shows 100% on room air and patient blood pressure 120/80 mm Hg?

A- S B- O C- A D- P E- I F- E G- R

15- Choose based on SOAPIER, which acronym applies to the following: Information obtained from patients, including demographic data in the assessment, year of birth, gender, social status, economic level, the country from which they came, and the ethnic groups to which the patients belong?

A- S B- O C- A D- P E- I F- E G- R

16- Choose based on SOAPIER which abbreviation applies to the following: The nurse encourages the patient to cough / deep breathing, and to use an incentive spirometer. Helping the patient to navigate the bathroom and hallways. Use pain reliever as needed for pain when moving / walking. Keep monitoring vital signs and lab results?

A- S B- O C- A D- P E- I F- E G- R

17- Choose based on SOAPIER, which abbreviation applies to the following: A 62-year-old patient complains of shortness of breath with a cough accompanied by secretions, as the patient interferes with nursing in keeping the airway clean by encouraging the patient to fill his secretions with a successful cough. This facilitates Adequate disposal of secretions. And the suction of secretions as necessary. This is to clear the blockage in the airway. While staying with the patient during acute attacks of respiratory distress. This will reduce the patient's anxiety, thus reducing the need for oxygen. Helping the patient to move around as permitted by the doctor's orders three times a day. Can ambulation lead to more break-up and triggering of secretions that clog the airways?

A- S B- O C- A D- P E- I F- E G- R

18-Choose based on SOAPIER, which abbreviation applies to the following: A nurse enters the patient's room and starts a conversation. During this time, the nurse assesses whether the patient is following a new diet. The nurse also decides to evaluate the patient's expectations about care. The appropriate statement to evaluate the patient's expectations of care? On a scale from 0 to 10, evaluate your nausea level. The nurse weighs the patient as well, asks the nurse, "Do you think you've received the information you need to follow your diet"?

A- S B- O C- A D- P E- I F- E G- R

19-Choose based on SOAPIER, which abbreviation applies to the following: When visiting the patient x and assessing his health condition, the nurse noticed that the severity of the patient's pain did not decrease as required, so he informed the doctor as well. Who determines the adjustments to be made in the nursing care plan?

A- S B- O C- A D- P E- I F- E G- R

المعلومات الديموغرافية للملاك التمريضي

الرقم :

☐

العمر:

☐ سنة

لجنس:

ذكر ☐ أنثى ☐

المستوى التعليمي:

خريج دورة تمريض ☐ خريج مدرسة تمريض ☐ خريج إعدادية تمريض ☐

خريج معهد تمريض ☐ خريج كلية تمريض ☐ دراسات عليا ☐

سنين الخدمة في التمريض:

☐ سنة

اشترك الممرض بدورات تخص التوثيق التمريضي

نعم ☐ لا ☐

عدد الدورات:

3-1 ☐ 6-4 ☐ 9-7 ☐ 10- فاكتر ☐

مدة الدورة :

☐ يوم

اولا- معارف الممرضين حول التوثيق التمريضي

1. اول من سجل الملاحظات الطبيه في التاريخ؟
   أ. ابقراط
   ب. فايدروس
   ج. بروتاغورس
2. ان تكون وثائق المعلومات حول المريض ورعايته فعليه ومعلومات وصفيه عن الهدف تستند الى المعرفه المباشره تقييم المرض؟
   أ. الاساس الواقعي
   ب. الدقة
   ج. الاكتمال
   د. التنظيم

3. معلومات واضحه و سهله الفهم تحتوي على تفاصيل ذات اهميه للمريض او تباينات في استجابة المريض للرعاية
   أ. الاساس الواقعي
   ب. الدقة
   ج. الاكتمال
   د. التنظيم

4. المعلومات الوارده في ادخال سجل المريض يجب ان تصف بشكل كامل احتياجات رعايه المرضى والتداخلات التمريضية
   1. الاساس الواقعي
   2. الدقة
   3. الاكتمال
   4. التنظيم
5. المعلومات التي تم تسجيلها اثناء او بعد وقت قصير من حدوث التداخل او التفاعل في الوقت المناسب ضروريه في رعايه المريض المتزامنه؟
   أ. الاساس الواقعي
   ب. الدقة
   ج. الاكتمال
   د. الحداثة
6. يقوم الممرض بايصال المعلومات المسجله بشكل او ترتيب منطقي؟
   أ. الاساس الواقعي
   ب. الدقة
   ج. الاكتمال
   د. التنظيم
7. المعلومات المسجله تعكس تقديم رعايه تمريضيه امنه ومختصه واخلاقيه ورحيمه تتوافق مع معايير ممارسه المهنه؟
   أ. التنظيم
   ب. السرية
   ج. الحداثة
   د. الاكتمال
8. توثيق المعلومات بشكل مستمر ومنتظم ويدون جميع نتائج التقييم وتداخلات المريض والنتائج؟
   أ. التضمين
   ب. الاستثناء
   ج. الاكتمال
   د. التنظيم
9. الطريقه التقليديه للتوثيق التمريضي وهي عباره عن قصه يصف حاله المريض والتداخلات والعلاجات والاستجابات؟
   أ. N - Documentation
   ب. SOC
   ج. POC
   د. SOAP
10. توثيق سهل الاستخدام في حالات الطوارئ خيث يتطلب ترتيبا زمنيا بسيطا وعادتا ما يكون هناك نقص في التحليل و اتخاذ القرارات الحاسمه من جانب المريض؟

أ. N - Documentation
ب. SOC
ج. POC
د. SOAP

11- من اسباب استبدال اسلوب التوثيق السردي بتنسيقات اخرى؟
أ. يوثق كل ممرض باسلوب فريد مما يجعل صعوبة تحديد استمرارية الرعاية
ب. لا تعكس عملية التمريض ينصب التركيز على المهام دون التركيز على البيانات او النتائج
ج. لايستغرق التوثيق وقت اطول لتسجيل البيانات الدقيقة وقرأها الاخرون

12- شكل من اشكال التوثيق السردي حيث يحتفظ كل عضو في الفريق الصحي بملاحظات سرديه منفصله؟
أ. N - Documentation
ب. SOC
ج. POC
د. SOAP

13- يركز التوثيق على مشاكل المريض يبدا من التاريخ الطبي للمريض وتقييمه؟
أ. N - Documentation
ب. SOC
ج. POC
د. SOAP

14- عند ادخال المعلومات في سجل المريض باستخدام تنسيق البيانات الذاتيه والموضوعيه مع اضافه الخطه والمراجعه التي تشير الى التعديل على الخطه؟
أ. SOAPIER
ب. SOAPIE
ج. POC
د. SOAP

15- في البيانات الاوليه التي تم جمعها و تتالف من الملف الشخصي للمريض والتاريخ والفحوصات المختبريه والجسديه؟
أ. قاعدة البيانات
ب. قائمة المشاكل
ج. الخطة الاولية
د. ملاحظة حول التقدم

16- معلومات تغيير كيان تشخيصي او علاقه سريريه او نتيجه ماديه او نتيجه مختبريه غير طبيعيه؟
أ. قاعدة البيانات
ب. قائمة المشاكل
ج. الخطة الاولية
د. ملاحظة حول التقدم

17- يتلقى المرضى تقييما فرديا يتناول التاريخ الصحي جسدي والوظيفي والنفسي الاجتماعي والالم والهدف هو تحديد رعايه مناسبه للمريض؟
أ. قاعدة بيانات
ب. قائمة مشاكل
ج. الخطة الاولية
د. ملاحظة حول التقدم

18- مراقبه وتسجيل الملاحظات و مشاكل المرضى و اعاده تقييمه على فترات مناسبة؟
أ. قاعدة بيانات

ب. قائمة مشاكل
ج. الخطة الاولية
د. ملاحظة حول التقدم

19- نهج بسيط للتركيز على مشاكل المرضى والتداخلات ولكنه يتجاهل توثيق خطة الرعاية التمريضية؟

أ. الرسم البيانيPIE
ب. SOAP
ج. الخطة الاولية
د. التركيز على الرسم البياني

20- باستخدام طريقة التوثيق هذه ، يحدد الممرض "التركيز" بناءً على مشاكل المريض أو سلوكياته التي تم تحديدها أثناء التقييم؟

أ. الرسم البيانيPIE
ب. SOAP
ج. الخطة الاولية
د. التركيز على الرسم البياني

ثانيا- أتجاهات الممرضين حول التوثيق التمريضي

1. وثائق التمريض لها تأثير إيجابي على الرعاية المقدمة.					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
2. وثائق التمريض تؤثر على سلامة المريض					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
3. يجب على الممرضات قضاء الوقت الكافي لتوثيق التقارير					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
4. توثيق التمريض يعتمد على التدريب					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
5. توثيق دقيق يعزز الاستقلالية المهنية					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
6. وثائق التمريض هي وثائق صالحة قانونا					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
7. وثائق التمريض تعزز عملية الشفاء					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
8. توثيق التمريض يحسن وقت رعاية المريض					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
9. توثيق التمريض هو اختصاص مهم لممارسة التمريض					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
10. تساعد وثائق التمريض الملاكات التمريضية على اكتساب المعرفة حول المرضى					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
11. توثيق التمريض يمكن أن يحمي حقوق الممرض و المريض معا					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
12. وثائق التمريض هي مصدر للدراسة					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
13. توثيق التمريض يحسن التفاعل بين أعضاء الفريق الطبي					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
14. وثائق التمريض تجعل الخروج من المستشفى يسير بسلاسة					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	
15. وثائق التمريض تؤدي إلى الاستقلال المهني					
لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة	

16. سيكون من الأفضل التركيز على الرعاية التمريضية بدلاً من التوثيق

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

17. يؤدي توثيق التمريض إلى تقليل ضغط العمل على الممرضات

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

18. من الضروري توثيق جميع التدخلات التمريضية

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

19. يمكن أن يساعد التوثيق في تسريع القرار و زيادة رضا المريض

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

20. توثيق التمريض يحسن جودة الرعاية التمريضية

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

21. وثائق التمريض تساعد في تسريع تسليم المرضى

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

22. وثائق التمريض تمكن الطاقم الطبي من اكتشاف التغيرات في حالة المريض

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

23. يمكن أن يساعد التوثيق في تعزيز المعرفة بالتمريض

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

24. توثيق التدخلات التمريضية مهارة قيّمة

لا اوافق	لا اوافق بشدة	لا اعلم	اوافق	اوافق بشدة

ثالثا- أداء الممرضيين حول التوثيق التمريضي

1- أي من الممارسات التالية يمكن أن يؤدي إلى سوء التصرف؟ اختر كل ما ينطبق؟

أ. رسم المداخلات مسبقاً لتوفير الوقت
ب. توثيق بيانات غير صحيحة
ج. عدم رسم الوقت الصحيح لوقوع الأحداث
د. حذف المدخلات غير الصحيحة وشطبها بخط أفقي
ه. عدم تسجيل الأوامر الشفوية أو عدم التوقيع عليها

2- ما نوع الملاحظات التي يتم تدوينها عند التخطيط بالاستثناء؟ اختر كل ما ينطبق؟

أ. علاجات إضافية تم إجراؤها أو حجب العلاجات المخطط لها
ب. الأوامر الدائمة والتاريخ المادي
ج. اهتمامات جديدة
د. تغيرات في حالة المريض

3- في تنسيق SOAPE ، تعديل موجز لمقياس الأداء ، أين يتم تضمين التدخل (I)؟

أ. لم يرد ذكره في هذا النوع من الوثائق
ب. مدرج في الملاحظات تحت التخطيط
ج. مشمول تحت التقييم
د. ينتمي إلى تنسيق آخر

4- أي مما يلي يعتبر الأقسام الرئيسية في السجل الطبي الموجه للمشكلات؟ اختر كل ما ينطبق؟

أ. قاعدة البيانات
ب. قائمة المشاكل
ج. خطة العناية
د. الفحص البدني والاختبارات التشخيصية
ه. استمارة الإحالة

5- تستخدم الإرشادات المطبوعة مسبقًا لرعاية المرضى الذين يعانون من مشاكل صحية مماثلة؟

أ. خطة الرعاية التمريضية

ب. كارديكس
ج. مؤشر المرض الشائع
د. مرجع التدخل الصحي

-6 ما نوع التوثيق التالي؟ مقياس الألم 10/0 ، اليد والساق قوية إلى اليمين ، ضعيفة إلى اليسار. الجلد وردي ، دافئ وجاف ، لديه تورم ، جرح في الطرف الأيمن من جدار الصدر الأمامي محمر ومتوذم؟

أ. كارديكس
ب. السرد
ج. ملاحظات الممرضة
د. تقرير التحول

-7 أي مما يلي لا يشير إلى عملية إضافة معلومات مكتوبة إلى سجل الرعاية الصحية؟

أ. تسجيل
ب. الرسوم البيانية
ج. إدخال البيانات
د. التوثيق

-8 أي من العبارات التالية صحيح فيما يتعلق بالقواعد الأساسية للتوثيق. اختر كل ما ينطبق؟

أ. استخدام الاقتباسات المباشرة للتقييمات الموضوعية
ب. إذا حدث خطأ في الرسم البياني ، ارسم خطًا واحدًا من خلال المعلومات الخاطئة
ج. الرسم البياني فقط رعايتك الخاصة حتى عندما يتصل بك شخص آخر لدخول متأخر.
د. يتم توفير Chart بعد الرعاية ، في أسرع وقت ممكن ، وكلما دعت الحاجة
ه. قم بالتوقيع على كل من المخططات بالأحرف الأولى من اسمك القانوني الكامل والعنوان الوظيفي

-9 متى يكون من غير الضروري رسم ملاحظة سردية؟ اختر كل ما ينطبق؟

أ. في كل مرة تعطي فيها دواء
ب. في كل مرة يتم فيها اعطاء حمام
ج. في كل مرة يتغير مظهر قرحة الاستلقاء
د. في كل مرة تقوم فيها بتقييم العلامات الحيوية

-10 في تنسيق SOAPE ، إذا كانت هناك حاجة للتغييرات ، فأين سيتم تضمين المراجعات (R)؟

أ. المراجعات تنتمي إلى شكل آخر من الوثائق
ب. المراجعات ليست جزءًا من هذه الوثائق
ج. تمت الإشارة إلى المراجعات **R** في قسم التقويم
د. المراجعات مذكورة في قسم التقييم

-11 أي من العبارات التالية حول التوثيق غير صحيح؟

أ. يشمل تسجيل التدخلات التي يتم تنفيذها لتلبية احتياجات المريض.
ب. تمت بطريقة سليمة وتعكس عملية التمريض.
ج. ضروري لإثبات أن العمل التمريضي قد تم.
د. يمكن قبول وثائق التمريض في شكل شفهي وكتابي

-12 متى يبدأ التخطيط لخروج المريض بشكل مثالي؟

أ. أثناء القبول
ب. بعد القبول
ج. قبل القبول
د. بدون قبول

13- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: لديك مريض يبلغ من العمر 48 عامًا يقول: "أشعر أنني لا أستطيع التنفس." . ثم يمسك المريض بصدره ويقول: "صدري يؤلمني بشدة ، الرجاء المساعدة!" تطلب من المريض تقييم الألم على مقياس من 0 إلى 10 ، حيث يكون الألم 10 هو أسوأ ألم على الإطلاق. فيجيب المريض: "10 ، يؤلمني بشدة!" ثم تطلب من المريض أن يصف ما يشعر به الألم ، ويبلغ المريض أن ألمه يشبه الضغط؟**

أ. **S** ب. O ج. A د. P ه. I و. E ز. R

14- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: لديك مريض يبلغ من العمر 48 عامًا ، معدل التنفس 28 نفسًا في الدقيقة ومعدل ضربات القلب لديهم 115 نبضة في الدقيقة. . ثم يبدأ مريضك في أن يصبح معرقًا وشاحبًا. أنت تأخذ مخطط كهربية القلب الذي يظهر عدم انتظام دقات القلب الجيبي. يظهر مقياس التأكسج النبضي 100٪ على هواء الغرفة وضغط دم المريض 80/120 مم زئبق؟**

أ. S ب. **O** ج. A د. P ه. I و. E ز. R

15- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: معلومات يتم اخذها من المرضى تشمل البيانات الديموغرافية في التقييم سنة الميلاد ، والجنس ، والاحالة الاجتماعية والمستوى الاقتصادي والبلد الذي أتوا منه ، و المجموعات العرقية التي ينتمي إليها المرضى؟**

أ. S ب. O ج. **A** د. P ه. I و. E ز. R

16- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: يقوم الممرض بتشجيع المريض على السعال / التنفس العميق ، واستخدام مقياس التنفس التحفيزي. مساعدة المريض على التنقل في الحمام وفي الممرات. استخدم مسكنات الألم حسب الحاجة للألم عند التحرك / المشي. استمر في مراقبة العلامات الحيوية ونتائج المختبر؟**

أ. S ب. O ج. A **د. P** ه. I و. E ز. R

17- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: مريض يبلغ من العمر 62 عاما يشكو من ضيق في التنفس مع سعال مصحوب بافرازات حيث قام الممرض بالتداخل التمريضي في الحفاظ على مجرى الهواء نظيفًا عن طريق تشجيع المريض على تعبئة إفرازاته مع السعال الناجح هذا يسهل التخلص الكافي من الإفرازات. وشفط الإفرازات حسب الضرورة. هذا لإزالة الانسداد في مجرى الهواء. مع البقاء مع المريض أثناء النوبات الحادة من الضائقة التنفسية. سيؤدي ذلك إلى تقليل قلق المريض ، وبالتالي تقليل الحاجة إلى الأكسجين. ومساعدة المريض على التنقل كما هو مسموح به بأمر الطبيب ثلاث مرات يوميًا. يمكن أن يؤدي التمشي إلى مزيد من التفتيت وتحريك الإفرازات التي تسد الشعب الهوائية؟**

أ. S ب. O ج. A د. P **ه. I** و. E ز. R

18- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: ممرضة تدخل غرفة المريض وتبدأ محادثة. خلال هذه المرة ، تقوم الممرضة بتقييم هل يتبع المريض نظامًا غذائيًا جديدًا. تقرر الممرضة أيضًا تقييم توقعات المريض حول الرعاية. البيان المناسب لتقييم المريض توقعات الرعاية؟ على مقياس من 0 إلى 10 قيم مستوى الغثيان لديك,. الممرضة تزن المريض كذلك تسأل الممرضة ، "هل تعتقد أنك تلقيت المعلومات التي تحتاجها لاتباع نظامك الغذائي؟"**

أ. S ب. O ج. A د. P ه. I **و. E** ز. R

19- **اختر بناءا على SOAPIER اي الاختصار ينطبق على الاتي: عند زيارة المريض x وتقييم حالته الصحية لاحظ الممرض ان شدة الم المريض لم تنخفض بالشكل المطلوب فقام باخبار الطبيب وكذلك. قام بتحديد التعديلات التي يجب إجراؤها في خطة الرعاية التمريضية؟**

أ. S ب. O ج. A د. P ه. I و. E **ز. R**

برنامج تعليمي لتوثيق التمريض

مقدمة:

توثيق التمريض هو جزء من الملاحظات السريرية التي يتم إجراؤها من قبل الممرضات وهو أحد المصادر الأساسية للمعلومات في مجال الرعاية الصحية ، وهو سجل المريض الذي يحتوي على جميع المعلومات المكتوبة المتعلقة بظروف المريض واحتياجاته ، وهو أمر مهم للغاية وظائف الممرضات لأنها تخدم أغراضًا متعددة ومتنوعة (White et al، 2011).

تهدف وثائق التمريض إلى إثبات أن المنظمة تحتفظ بأدلة مكتوبة شاملة لتخطيطها وتقديمها وتقييمها لرعاية المرضى. إنه مصدر لمعرفة للممرضيين المبتدئين وربما لتطوير نظرية التمريض. على الرغم من أن توثيق التمريض يقدم دليلًا مكتوبًا على تقدم المريض ، إلا أنه يجب أن يتضمن المبررات والتفكير النقدي الكامن وراء القرارات والتدخلات والتقييمات السريرية لمقدمي الرعاية ويجب أن يمتثل للمعايير المعمول بها.

الأهداف العامة:

- توضيح أهمية التوثيق في تقديم وتطوير الخدمات التمريضة المقدمة للمريض.
- تحديد المسؤولية القانونية للممرض في التوثيق.
- دعم جودة الرعاية من خلال التوثيق.
- تقليل المخاطر في الوثائق.
- التحقق من المصداقية من خلال التوثيق.
- مقارنة الوثائق الورقية مقابل التوثيق الإلكتروني.
- كيفية استخدام عملية التمريض في التوثيق.

الجلسة الأولى: مقدمة وأهمية التوثيق

مقدمة:

توثيق التمريض له دور مهم للغاية فيما يتعلق بأعضاء فريق تقديم الخدمات الطبية ، واستمرارية الرعاية ، وتذكير الممرضات ومشاركتهم في الواجبات والمسؤوليات المهنية ، وتقييم التدخلات العلاجية ، وتحديد تكاليف الرعاية الصحية ، ودعم وحماية الحقوق القانونية للمرضى والممرضات ، و توفير تفاصيل البحث والتدريب.

أهداف خاصة:

1- أهمية التوثيق والخلفية التاريخية

- التوثيق في زمن أبقراط (460-377 قبل الولادة):
- التوثيق في الثقافة الإسلامية:
- توثيق فلورنس نايتنجل:

2-دليل لتوثيق وتسجيل الجودة

2-1 الأساس الوقائعي:

2-2 الدقة:

3-2 الاكتمال:

4-2 الحالية:

5-2 التنظيم:

6-2 السرية:

المحتوى:

أهمية التوثيق:

يجب أن تكون وثائق التمريض منطقية ، ويجب أن يكون لها معنى ، ويجب أن تكون طريقة للتواصل.

تم إيلاء اهتمام كبير في السنوات القليلة الماضية لممارسات التوثيق للموظفين الطبيين. يعمل التوثيق الدقيق والكامل للرعاية التمريضية على تحسين الكفاءة ، ويساعد على التواصل بين أعضاء فريق رعاية المرضى ، ويسهل استمرارية الرعاية. توحيد وتبسيط العملية ؛ مثل التوثيق الذي يُعتقد أنه يقلل من عدد الأخطاء (Akhtar and Rubenfeld، 2003)

التوثيق له أهمية كبيرة في تقديم خدمات التمريض وأيضاً يمكننا من خلالها تطوير الخدمات المقدمة للمريض وكذلك معرفة التغيرات التي تحدث للمريض ومدى استجابته لتدخلات التمريض و تعتبر وسيلة للتواصل مع الفريق الصحي. يوفر التوثيق الدقيق للرعاية في السجل الطبي دليلًا قانونيًا على أن الرعاية المقدمة تلبي معايير الرعاية المعتمدة.

أبقراط ، أبو الطب السريري

أبقراط كوس (460-377 قبل الميلاد) الحياة والفلسفة الطبية لأبقراط أبقراط كوس معروف عالميًا كأب للطب الحديث ، والذي يقوم على ملاحظة العلامات السريرية والاستنتاجات العقلانية. قبله ، كانت المحاولات العلاجية مبنية على معتقدات دينية أو سحرية وكان يمارسها عادة الكهنة والمعالجون الروحيون وأطباء السحرة.

تتميز مساهمته في الممارسة الطبية بقواعد السلوك الأخلاقية ، والمراقبة الدقيقة للأعراض السريرية ، وعقل متفتح لأية أفكار ، والاستعداد لشرح سبب الأمراض.

التوثيق في الثقافة الإسلامية:

على الرغم من وجود وثائق نادرة جدًا لتاريخ التمريض في فترة ما قبل الإسلام ، إلا أن الفهم الصحيح للنماذج المجتمعية والدينية خلال فترة حكم محمد يعطي نظرة ثاقبة لأدوار وتوقعات الممرضات في العصور القديمة. في تناقض واضح مع التفسير المسيحي السائد للمرض كعقاب إلهي للإنسان ، يحتل المسلم قيمة عالية للغاية في طقوس تطهير الجسم ، ومواعيد الصلاة اليومية ، والنظام الغذائي الصارم.

فلورنس نايتنجل:

"أهم درس عملي يمكن إعطاؤه للممرضات هو تعليمهم ما يجب ملاحظته ، وكيفية الملاحظة ، وما هي الأعراض التي تشير إلى التحسن والعكس" ، وهو أمر مهم للغاية يجب مراعاته من قبل ممرضات الأجنحة الطبية في توثيق التدخل التمريضي والنتيجة. أيضًا ، يجب تسجيل المعلومات والحقائق بدقة في الرسوم البيانية للمرضى الداخليين.

دليل لتوثيق وتسجيل الجودة

يعد التوثيق والتقارير عالي الجودة ضروريين لتعزيز رعاية المرضى الفردية والفعالة.

إرشادات مهمة يجب اتباعها لتوثيق الجودة وإعداد التقارير:

1. الأساس الوقائعي:

*يجب أن تكون وثائق المعلومات حول المرضى ورعايتهم فعلية. معلومات وصفية عن الهدف تستند إلى المعرفة المباشرة وتقييم الممرضة وتصور العميل لاحتياجاتهم. يجب أن يتضمن السجل معلومات وصفية وموضوعية حول ما تراه الممرضة وتسمعه وتشعر به وتشمه. بالإضافة إلى ذلك ، يجب أن تشرح الوثائق بوضوح ملاحظة الممرضة لسلوكيات المريض وألا تفسر تلك الملاحظة.

2. الدقة:

يجب أن يكون سجل المريض دقيقًا بحيث يتم الحفاظ على التوثيق الدقيق. يضمن استخدام القياس الدقيق دقة السجل. *معلومات واضحة وسهلة الفهم تحتوي على تفاصيل ذات أهمية للعميل و / أو تباينات في استجابة العميل للرعاية. علاوة على ذلك ، تعد الدقة أمرًا بالغ الأهمية إذا كان التوثيق سيستخدم بالكامل إما سريريًا أو للبحث.

3. الاكتمال:

*يجب أن تكون المعلومات الواردة في إدخال السجل أو التقرير كاملة وموجزة وشاملة. المعلومات التي تصف بشكل كافٍ احتياجات رعاية العميل وتدخلات التمريض والنتائج المتوقعة. عندما تكون التقارير غير مكتملة ، يتم اختراق الاتصال وعندما يكون من السهل فهم البيانات الموجزة وواضحة ، فإن العمل المقتضب يجعل التفسير أسهل ، بينما يضيع التقرير الطويل الوقت وغالبًا ما يكون مملاً. علاوة على ذلك ، يعد التقرير أو السجل الجيد ضروريًا لحماية كل من المريض والممرضة.

4. الحداثة:

*المعلومات المحدثة والتي تم تسجيلها أثناء أو بعد وقت قصير من حدوث التدخل أو التفاعل. تعتبر الإدخالات في الوقت المناسب ضرورية في رعاية المريض المتزامنة ؛ يمكن أن يؤدي التأخير في التوثيق إلى إغفال خطير وتأخير غير مناسب في رعاية المرضى الداخليين.

من اهم الأنشطة التي نوثقها في الوقت المحدد تشمل ما يلي: -

1) العلامات الحيوية.

2) إعطاء الدواء والعلاج.

3) تحضير الفحص التشخيصي أو الجراحة.

4) تغيرفي حالة المرضى الداخليين.

5) إدخال أو نقل أو خروج أو وفاة المريض.

6) علاج التغيير المفاجئ في حالة المريض.

7) استجابة المريض للتدخل.

تستخدم العديد من الوكالات التوقيت العسكري ، وهو نظام 24 ساعة يستخدم رقمًا رقميًا للعلاج في الصباح وبعد الظهر والمساء ، بينما يستخدم البعض الآخر الأوقات المدنية (صباحًا ، مساءً)

5. التنظيم:

*تقوم الممرضة بتوصيل المعلومات في شكل أو ترتيب منطقي. يفهم أعضاء فريق الرعاية الصحية المعلومات بشكل أفضل عند تقديمها بالترتيب الذي حدثت به. وتسجيل المعلومات بطريقة زمنية معقولة بحيث تكون قرارات التمريض والإجراءات وردود العميل على الإجراءات واضحة. إلى جانب ذلك ، ذكر أنه لبدء كل إدخال بالتاريخ والوقت ورسم المعلومات في الوقت المناسب لتجنب إغفال البيانات ذات الصلة.

6. السرية:

تم تقديم معلومات الاتصال السرية من قبل شخص لآخر مع الثقة والثقة بأن هذه المعلومات لن يتم الكشف عنها. يتم جمع معلومات الحماية المنخفضة عن المرضى عن طريق الفحص.
*تنعكس المعلومات على تقديم رعاية تمريضية آمنة ومختصة وأخلاقية ورحيمة ومتوافقة مع معايير الممارسة.

الجلسة الثانية: أغراض توثيق الرعاية الصحية.

مقدمة:

يعزز التوثيق التمريضي الجيد مصالح المرضى والمصالح الفضلى لأسباب مختلفة. يساعد تسجيل جميع المعلومات ذات الصلة برعاية المريض الممارسين على مراقبة ما تم إنجازه ، ويقلل من مخاطر تسلل الأخطاء إلى عملية العلاج. كما أن الاهتمام الدقيق بالتفاصيل يقلل أيضًا من احتمالية عودة المرضى للعلاج الإضافي. تتطلب العملية أيضًا درجة عالية من التقييم الذاتي وهو أمر ضروري لتعزيز الممارسات السريرية الجيدة ، فضلاً عن التطوير المهني للممارس.

أهداف خاصة:

1- العوامل التي ظهرت مساءلة مقدمي الخدمات عن توثيق الخدمات.

2- أغراض توثيق الرعاية الصحية.

1. المسؤولية المهنية والمساءلة.
2. عملية للتواصل ،

3. عملية تعليمية
4. البحث أو المراجعة أو الإحصاء.
5. تلبية ممارسة المعاييرالقياسية والقانونية.

3- مبادئ التوثيق الفعال.

4- عناصر التوثيق الفعال.

محتوى:

العوامل التي أظهرت مسؤولية مقدمي الخدمات عن التوثيق التمريضي:

أ. استجابة للتغيرات في تقديم الرعاية الصحية.
ب. التكنولوجيا المتقدمة والمؤثرة على توقعات التوثيق.
ج. أنشطة المقارنة المعيارية في تحسين الجودة واحتواء التكلفة.
د. التغييرات في المستهلك ، والمساءلة عن الأعراف المجتمعية.
ه. التوقعات القانونية ، وأنظمة الدولة.
و. المعايير المهنية للممارسة.
ز. السياسات والمعايير المؤسسية.
ح. نتائج البحث.

أغراض توثيق الرعاية الصحية:

1. المسؤولية المهنية والمساءلة.
2. التواصل ،
3. التعليم ،
4. البحث أو المراجعة أو الإحصاء.
5. تلبية المعايير القانونية والممارسة ،

1. المسؤولية المهنية والمساءلة: يوفر التوثيق أدلة مكتوبة على مساءلة الممارس أمام العميل والمؤسسة والمجتمع.

2. التواصل: الإبلاغ والتسجيل هي تقنيات الاتصال الرئيسية المستخدمة من قبل مقدمي الرعاية الصحية لتوجيه عملية صنع القرار على أساس العميل واستمرارية الرعاية والتحقق من صحة الرعاية المقدمة للعميل. يعمل السجل الطبي كوثيقة قانونية لتسجيل جميع أنشطة العميل التي تم تقييمها والمبادرة بها من قبل ممارسي الرعاية الصحية.

3. التعليم: يمكن استخدام السجل الطبي للعميل لغرض التعليم. يستخدم طلاب التمريض السجل الطبي كأداة للتعرف على عمليات المرض والمضاعفات والتشخيص الطبي والتمريضي والتدخلات. توفر نتائج

الفحص البدني والاختبارات المعملية والتشخيصية معلومات قيمة فيما يتعلق بالتشخيصات والتدخلات المحددة.

4. البحث: يعتمد الباحثون بشكل كبير على السجلات الطبية للعملاء كمصدر للبيانات السريرية لتحديد ما إذا كان العملاء يستوفون معايير البحث الخاصة بالدراسة.

5. المعايير القانونية والممارسة: السجل الطبي للعميل هو مستند قانوني ، وفي حالة وجود دعوى قضائية ، يكون السجل بمثابة وصف لما حدث للعميل بالضبط.

الموافقة المستنيرة: وهذا يعني أن العميل يفهم سبب ومخاطر التدخل المقترح ويوافق على العلاج. عادة ما تكون هذه المستندات نسخًا مكررة: يتم إدخال النسخة الأصلية في السجل الطبي ، وتعطى النسخة للعميل ، ويجب توقيع الموافقة المستنيرة من قبل العميل وشهدها.

مبادئ التوثيق الفعال:

يجب أن تكون ملاحظات التمريض منطقية ومركزة وذات صلة بالرعاية ، ويجب أن تمثل كل مرحلة في عملية التمريض. تختلف متطلبات التوثيق حسب:

أ. مرفق الرعاية الصحية (مستشفى ، دار رعاية المسنين ، وكالة صحة منزلية).

ب. الإعداد داخل المؤسسة (على سبيل المثال ، غرفة الطوارئ ، الوحدة الطبية الجراحية).

ج. مجتمع العينة (على سبيل المثال ، التوليد وطب الأطفال ودار المسنين).

عناصر التوثيق الفعال: يتطلب التوثيق الفعال:

1. استخدام مفردات شائعة (الاستخدام السليم للتهجئة والقواعد).
2. التعرف على متلقي الخدمات والكتابة بالحبر.
3. الوضوح والدقة.
4. استخدام الاختصارات والرموز المصرح بها فقط.
5. تنظيم واقعي ومتسلسل زمنياً.
6. تضمين أي أخطاء حدثت بدقة.

1. **استخدام المفردات الشائعة:** تعكس ممارسة التمريض استخدام مصطلحات متعددة لتدخلات التمريض ، مما يمنع المقارنات بين المؤسسات للرعاية التمريضية. ستعمل الجهود الحالية الجارية لإنشاء تصنيف لتدخلات التمريض التي تحددها تشخيصات تمريضية محددة على تعزيز جودة التوثيق ودعم جهود الباحثين. سيؤدي استخدام المفردات الشائعة أيضًا إلى تحسين التواصل داخل الفريق وتقليل الفرصة

2. **حدد هوية العميل ، واكتب بالحبر:** يجب أن يكون على كل صفحة من صفحات سجل العميل اسم العميل. ويجب أن تكون كل وثيقة ومعلومات مخططة بالحبر أو مطبوعة من الكمبيوتر.

3. **الوضوح:** كل ما تم رسمه يجب أن يكون سهل القراءة ، دون أي فرصة للخطأ. إذا كان خط يدك غير قابل للقراءة ، اطبع. إذا أخطأت ، فلا تمسحها أو تمحوها ؛ ارسم سطرًا واحدًا خلال الإدخال الخاطئ وحدد سبب الخطأ ، ثم قم بتوقيع وتاريخ التصحيح.

4. **الاختصارات والرموز:** عادة ما يكون للمنشآت قائمة بالاختصارات والرموز المقبولة ، المعتمدة من قبل لجنة السجلات الطبية ، لاستخدامها عند توثيق المعلومات في سجل العميل. تجنب الاختصارات التي يمكن أن يساء فهمها.

5. **منظمة واقعية ومتسلسلة زمنياً:**

أ. ابدأ كل إدخال بالتاريخ والوقت.

ب. رسم بياني في بيانات تقييم الترتيب الزمني والملاحظة والتدخل والتقييم.

ج. الامتثال للإطار الزمني المشار إليه في إرشادات المؤسسة للتوثيق: على سبيل المثال ، تواتر ملاحظات الرسوم البيانية للعميل مع القيود أو الإطار الزمني الذي يجب أن يتم خلاله إكمال تقييم القبول.

د. التخطيط في الوقت المناسب لتجنب إغفال البيانات ؛ ليس من الجيد الانتظار حتى نهاية التحول لرسم خريطة لجميع العملاء.

ه. قم برسم الأدوية مباشرة بعد الإعطاء لتجنب الأخطاء.

و. وقّع باسمك بعد كل إدخال.

ز. عندما تنسى الممرضة توثيق البيانات المهمة ، فمن المناسب والمستحسن تضمين هذه البيانات في تاريخ لاحق.

5. **الدقة:** تعد البيانات الدقيقة والموضوعية أمرًا بالغ الأهمية إذا كان التوثيق مفيدًا إما من الناحية السريرية أو للبحث. استخدم المصطلحات الواقعية والوصفية لرسم ما تم ملاحظته أو فعله بالضبط ؛ على سبيل المثال ، استخدم التدقيق الإملائي والنحوي الصحيح ، واكتب جمل كاملة.

الجلسة الثالثة: طرق التوثيق.

مقدمة:

تُستخدم عدة طرق للتوثيق لتنظيم ملاحظات الممرضة ، والتي يشار إليها أحيانًا باسم ملاحظات التقدم. قد تعتمد القرارات المتعلقة بالطريقة التي يجب استخدامها على المؤسسة التي تعمل بها ، والتي تحدد أحيانًا طرقًا معينة. خلاف ذلك ، عادة ما تكون مسألة تفضيل شخصي.

أهداف خاصة:

1- طرق التوثيق.

1-1 التوثيق السردي:

1-2 رسم بياني موجه نحو المصدر

1-3 رسم بياني موجه نحو حل المشكلات

1-3-1 قاعدة البيانات:

1-3-2 قائمة المشاكل:

1-3-3 الخطة الأولية:

1-3-4 ملاحظات التقدم:

1-4 رسم بياني

1-5 التركيز على الرسم البياني

1-6 التخطيط عن طريق الاستثناء

1-7 التوثيق المحوسب:

1-7-1 تعلم نظام معلومات التمريض المحوسب:

محتوى:

طرق التوثيق.

يجب أن يعكس نظام التوثيق المختار من قبل خدمة التمريض فلسفة القسم وطريقة تنفيذ الرعاية التمريضية. تنقسم معظم طرق التوثيق إلى فئتين: التوثيق عن طريق التضمين والتوثيق بالاستثناء. *يتم التوثيق عن طريق التضمين على أساس مستمر ومنتظم ويدون جميع نتائج التقييم وتدخلات التمريض ونتائج العميل. التوثيق بالاستثناء ، من ناحية أخرى ، يجعل ملاحظة النتائج السلبية ويكتمل عند تقييم النتائج

1 - التوثيق السردي(Narratine Documentation- N-DOC):

الرسم البياني السردي ، *الطريقة التقليدية لتوثيق التمريض ، عبارة عن تنسيق قصة يصف حالة العميل والتدخلات والعلاجات واستجابة العميل للعلاجات. قبل ظهور أوراق التدفق ، كانت هذه هي الطريقة الوحيدة لتوثيق الرعاية. تم قضاء حوالي 30٪ من وقت الممرضين ، خلال فترة عمل مدتها 8 ساعات ، في الرسم البياني السردي *ولذلك يوثق كل ممرض باسلوب خاص يزيد من صعوبة التركيز على المشكلة الصحية وتحديد رعايتها الامر الذى ادى الى استبدال هذا الاسلوب بتنسيقات اخرى

2. الرسوم البيانية المصدر(Sorce-Oriented- S-O-C)

يوصف الرسم البياني الموجه نحو المصدر (S.O.) *بأنه تسجيل سردي من قبل كل عضو (مصدر) من فريق الرعاية الصحية في سجلات منفصلة. نظرًا لأن لكل تخصص سجل منفصل ، غالبًا ما تكون الرعاية مجزأة ويصبح الاتصال بين التخصصات مستهلكًا للوقت. وبالتالي. الرسوم البيانية لها مزايا وعيوب مماثلة للرسم البياني السردي حيث تستخدم الممرضات نهجًا غير منظم في توثيق ملاحظات التقدم (Timby et al، 2005).

التوثيق الموجه نحو المصدر هو شكل من أشكال التوثيق السردي حيث يحتفظ كل عضو في الفريق الصحي بملاحظات سردية منفصلة ، عادةً في سجلات منفصلة بحيث يكون هناك القليل من المعلومات متعددة التخصصات أو منعدمة. هذه طريقة تقليدية لحفظ السجلات ، ولكنها قد تؤدي إلى رعاية مجزأة واجتماعات تستغرق وقتًا طويلاً لمشاركة المعلومات. ابتعدت العديد من المؤسسات عن هذا النوع من الوثائق

3. تخطيط حل المشكلات (Problem-Oriented Charting - POC)

*يركز نظام الرسوم البيانية الموجه نحو المشكلات على مشاكل المريض. يبدأ أيضًا بالتاريخ الطبي للمريض وتقييمه. يتم إنشاء قائمة بالمشكلات بناءً على تقييم المريض ويتم تطوير خطة رعاية توضح بالتفصيل كيفية تعامل الفريق الصحي مع كل مشكلة. * تتم كتابة ملاحظات التقدم في كل فترة ويتم إعداد ملخص الخروج عند خروج المريض. يتم إدخال المعلومات في المخطط باستخدام تنسيقات SOAP أو SOAPIE أو SOAPIER.

- **S:** بيانات ذاتية (ما يقوله العميل أو العائلة).
- **O:** بيانات موضوعية (ما يتم ملاحظته / فحصه)
- **A:** التقييم (استنتاج تم التوصل إليه على أساس البيانات التي تمت صياغتها على أنها مشاكل العميل أو تشخيص التمريض)
- **P:** الخطة (الإجراءات التي يجب اتخاذها للتخفيف من مشكلة العميل) يشير SOAPIE و SOAPIER إلى التنسيقات التي تضيف
- **I:** التدخل (تدابير لتحقيق نتيجة متوقعة)
- **E:** التقييم (فعالية التدخلات)
- **R:** مراجعة (تغييرات من خطة الرعاية الأصلية)

يتكون السجل الموجه نحو المشكلة من أربعة مكونات تشمل: -

- **قاعدة البيانات Data Base:**

* قاعدة البيانات هي البيانات الأولية التي تم جمعها وتتألف من الملف الشخصي للمريض وتاريخه والفحوصات المخبرية والجسدية. يمكن تحسين التنظيم الهادف للبيانات من خلال سرد أنظمة الجسم الطبيعية وأنظمة الجسم غير الطبيعية. الشاغل الأساسي هو أن قاعدة البيانات كاملة ومتسقة قدر الإمكان (Weed، 2009).

- **قائمة المشاكل The Problem List:**

قائمة المشكلات عبارة عن قائمة مُرقمة ومجمَّعة بعناية لجميع المشكلات المحددة في قاعدة البيانات. *يتم التعبير عن المشاكل إما على أنها بنية تشخيصية ، أو علامة سريرية ، أو نتيجة مادية ، أو نتيجة مختبرية غير طبيعية ، اعتمادًا على ما ستدعمه البيانات المسجلة ؛ لا يتم

استخدام التخمينات التشخيصية وانطباعات. تعد قائمة المشكلات من أهم مفاهيم السجل الطبي الموجه للمشكلات ولسلامته تأثير مباشر على جودة وملاءمة الخطة وشمولية المتابعة. على هذا النحو ، يجب أن تكون قائمة المشاكل الأولية كاملة ودقيقة. عند صياغة قائمة المشكلات ، يجب وضع قائمة أولويات حتى يتم تقييم المشكلات الأكثر أهمية أولاً (Hurst، 2006).

- **خطة أولية Initial Plan:**

* يتم وضع خطة رعاية باستخدام المشكلات التي تم تحديدها أثناء عملية القبول. يتلقى المرضى تقييمًا فرديًا يتناول التاريخ الصحي والجسدي والوظيفي والنفسي والاجتماعي والألم ، وما إلى ذلك. الهدف من التقييم هو تحديد الرعاية والعلاج والخدمات المناسبة لتلبية احتياجات المريض (Harris، 2012).

- **ملاحظات التقدم Progress Notes:**

هم من قبل أعضاء فريق الرعاية الصحية * لمراقبة وتسجيل التقدم المحرز في مشاكل المريض. يجب إعادة تقييم كل مشكلة على فترات مناسبة. تواتر الملاحظة هو عامل متغير ، يعتمد على طبيعة كل حالة على حدة. يعتمد تكرار إعادة التقييم (يوميًا ، كل ساعة ، باستمرار) على مدى سرعة تغير المشكلة وأهمية المشكلة فيما يتعلق بالتعافي

4. الرسم البياني PIE

* هذا نهج مبسط للتركيز على مشاكل العميل والتدخلات والتقييمات. يتجاهل تنسيق التوثيق هذا خطة الرعاية ولكنه يستخدم أوراق التدفق وملاحظات التقدم. تستخدم ملاحظات التقدم تشخيصات التمريض على أنها مشكلة. يمكن تسجيل عدد من المشكلات المختلفة (مع التدخلات والاستجابة) وترقيمها بالتسلسل ، ويتم تقييم كل مشكلة مرة واحدة على الأقل خلال كل وردية (Lockwood، 2014).

بعد أن اكتسب مخطط SOAP شعبية كبيرة ، تم إنشاء نظام المشكلة والتدخل والتقييم (PIE) في مركز كرافن الطبي الإقليمي في عام 1984 لتبسيط التوثيق. في حين تم تطوير SOAP على نموذج طبي ، فإن مخطط PIE له أصل تمريضي. PIE هو اختصار للمشكلة والتدخل وتقييم الرعاية التمريضية. المكونات الرئيسية لهذا النظام هي أوراق تدفق التقييم وملاحظات التقدم للممرضات مع خطة رعاية متكاملة تلغي الحاجة إلى خطة رعاية منفصلة. يتم تمييز كل مشكلة عميل وترقيمها للرجوع إليها بسهولة. عندما يتم تنفيذ التدخلات لإدارة مشكلة العميل ، يتم تحديد رقم المشكلة. يلغي هذا النظام خطة الرعاية التقليدية من خلال دمج خطة رعاية مستمرة في الوثائق اليومية (دانيلز ، 2004).

5. التركيز على الرسوم البيانية

* إنها طريقة للتخطيط تعالج مشاكل المريض أو احتياجاته وتتضمن عمودًا يلخص تركيز الإدخال المقصود به جعل اهتمامات العميل والعميل وقوتهما محور الرعاية. إنها طريقة لتنظيم المعلومات الصحية في سجل الفرد. التركيز على الرسوم البيانية هو نهج منظم للتوثيق

6. التخطيط عن طريق الاستثناء Charting by Exception CBE

إنـه نهـج مبتكـر لتبسـيط التوثيـق ويتطلـب مـن الممرضـة توثيـق الانحـراف الوحيـد عـن المعـايير المحـددة مسـبقًا. تأسسـت فـي 1983 مـن قبـل مركـز سـانت لـوك الطبـي فـي ميلـووكي للتغلـب علـى المشـكلة المتكـررة المتمثلـة فـي الملاحظـات الطويلـة والمتكـررة ولتمكـين تحديـد الاتجاهـات فـي حالـة المـريض بشـكل أكثـر وضـوحًا. يُـذكر أيضًـا أنهـا طريقـة مختصـرة لتوثيـق الاكتشـاف الطبيعـي والرعايـة الروتينيـة بنـاءً علـى معـايير محـددة بوضـوح للممارسـات ومعـايير محـددة مسـبقًا لتقيـيم التمريض والتدخل (فيرا وآخرون ، 2011).

إلـى جانـب ذلـك ، تحتـوي الاسـتمارة أيضًـا علـى سـجل التـدريس ومـذكرات الخـروج ، ومن ثم خلصت إلى أن عناصر نظام (CBE) تتكون من ثلاثة مكونات رئيسية.

1. أوراق المتابعة: تسليط الضوء على النتائج الهامة وتحديد معايير التقييم والنتائج.
2. مصـادر التوثيـق حسـب معـايير ممارسـة التمـريض. (يـتم اسـتيفاء جميـع المعـايير مـا لـم يـتم توثيـق خلاف ذلك.)
3. امكانيـة التوثيـق المتعلـق بالمعيـار التقريبـي الصـحيح : تتعلـق بنمـاذج التوثيـق بالاسـتثناء مـن الممرض توثيق النتائج المهمة أو الاستثناءات من المعايير المحددة مسبقًا

7. تعلم نظام معلومات التمريض المحوسب:

يمكـن للممرضـة أن تبـدأ الـتعلم مـن خـلال إلقـاء نظـرة علـى نظـرة عامـة علـى النظـام. أفضـل طريقـة لـتعلم كيفيـة اسـتخدام نظـام المعلومـات المحوسـب هـي المشـاركة فـي برنـامج تـدريبي رسـمي يتبعـه ممارسـة خاضـعة للإشـراف ، قبـل اسـتخدام نظـام معلومـات التمـريض فـي وحـدة التمـريض. مـا هـي النمـاذج المدرجـة فـي السـجل السـريري ، ومـا هـو تـدفق البيانـات وأيـن يـتم مشـاركة البيانـات فـي جـزء آخـر مـن السـجل السـريري. يجـب أن تقـرأ الممرضـة كيفيـة العنايـة بـالأجهزة ؛ تعلـم تقـدم شاشـة البرنـامج وكيفيـة الانتقـال مـن شاشـة إلـى أخـرى ؛ تعـرف علـى معنـى الرمـز أو أزرار المعالجـة ؛ تعلـم كيفيـة تجنـب الخطـأ الشـائع ومشـاهدة عـرض توضـيحي لمـا يجـب فعلـه أو بمـن تتصـل عند حدوث خطأ أو حدوث مشكلة (Smith et al، 2004).

الجلسة الرابعة: أصناف التوثيق.

مقدمة:

تسمح المعلومات الواردة في السجل الطبي لمقدمي الرعاية الصحية بتحديد التاريخ الطبي للمريض وتقديم رعاية مستنيرة. يعمل السجل الطبي كمستودع مركزي لتخطيط رعاية المرضى وتوثيق التواصل بين المرضى ومقدمي الرعاية الصحية والمهنيين الذين يساهمون في رعاية المريض. الغرض المتزايد من السجل الطبي هو ضمان توثيق الامتثال للوائح المؤسسية أو المهنية أو الحكومية.

تجمع السجلات الصحية الشخصية بين العديد من الميزات وإمكانية النقل ، مما يسمح للمريض بمشاركة السجلات الطبية عبر مقدمي الرعاية وأنظمة الرعاية الصحية.

أهداف خاصة:

1- فئات نماذج التوثيق في نظام السجل االسريري.

1-1 التقييم وأشكال قواعد البيانات

2-1 خطة أشكال الرعاية

3-1 نماذج ملاحظات التقدم

4-1 استمارات الرعاية المستمرة

2- توثيق أنشطة التمريض:

1-2 القبول في التمريض:

2-2 خطة الرعاية التمريضية:

3-2 Kardexes:

4-2 مخطط انسيابي

5-2 ملاحظات حول التقدم:

محتوى:

1- فئات نماذج التوثيق في نظام السجل السريري.

يتم توثيق معلومات المريض في السجل السريري ضمن أربع فئات أساسية من النماذج:

1-1- نماذج التقييم وقاعدة البيانات. يتضمن:

1) سجل دخول وخروج المرضى.

2) التاريخ التمريضي والتقييم.

3) التاريخ الطبي والفحص البدني.

4) نتائج الاختبار:

- التحاليل المختبرية.
- الأشعة السينية.
- E.C.G.
- الرنين النغناطيسي.
- الاشعة المقطعية (المفراس الحلزوني)
- بيانات نتيجة الاختبار التشخيصي.

1-2- خطة أشكال الرعاية. التي تشمل:

1) أوامر طبية.

2) خطة الرعاية التمريضية بما في ذلك أوامر التمريض.

3) خطة رعاية مطعمة متعددة التخصصات أو خطط خاصة بالانضباط موثقة في خطة رعاية التقييم أو ملاحظات التقدم.

4) خطط الاختبار ، والتي يمكن أن تكون منفصلة أو قد تكون مدمجة. في خطة رعاية

5) كارديكس.

1-3- نماذج ملاحظات التقدم ؛ يتضمن

توثيق ملاحظات التقدم السريري من قبل جميع التخصصات التي تقدم الرعاية.

ب) سجل الإدارة الطبية.

ج) تقارير النتائج.

• مذكرات موجزة عن النتائج السردية الأسبوعية.

• سجل نتائج خطة التمريض.

• سجل النتائج القائم على المعايير.

1-4- أشكال الرعاية المستمرة. التي تشمل

أ) سجل التدريس.

ب) ملخص التقدم.

ج) نماذج التحويل.

د) ملخص الخروج.

1-2- توثيق أنشطة التمريض:

يجب أن يصف سجل المريض حالة المريض المستمرة ويعكس النطاق الكامل لعملية التمريض ، وتستخدم مجموعة متنوعة من الأشكال في جميع أنحاء السجل السريري من قبل الممرضات لتوثيق الأدلة على عملية التمريض (Kozier et al، 2004).

1-2-1- قبول تمريض القبول:

يُشار أيضًا إلى تقييم القبول الشامل بقاعدة البيانات الأولية أو تاريخ التمريض أو تقييم التمريض عند قبول المريض في وحدة التمريض. يجب إكمال تقييم القبول من قبل الممرضة مع أحد الوالدين أو مقدم الرعاية ، بشكل مثالي عند الوصول إلى الجناح أو القبول المسبق ، ولكن يجب إكماله في غضون 24 ساعة من القبول. يتم توثيق تقييم القبول في استمارة قبول التمريض. يجب مراعاة خصوصية المريض في جميع الأوقات (Carpnito، 2002).

1-2-2- خطة التمريض:

الرعاية التمريضية التي يجب تقديمها للمريض. إنها مجموعة من الإجراءات التي ستقوم الممرضة بتنفيذها لحل مشاكل التمريض التي حددها التقييم. يعد وضع الخطة مرحلة وسيطة في عملية التمريض. وهو يوجه في توفير الرعاية التمريضية المستمرة ويساعد في تقييم تلك الرعاية. هناك نوعان من خطط الرعاية التمريضية: تقليدية وموحدة. تتم كتابة خطة الرعاية التقليدية لكل مريض ، ويختلف النموذج من وكالة إلى وكالة وفقًا للمريض واحتياجات القسم. تحتوي معظم النماذج على ثلاثة أعمدة ؛ الأول للتشخيص التمريضي ، والثاني للنتيجة المستثناة ، والثالث للتدخل التمريضي. تم تطوير خطة الرعاية الموحدة لتوفير الوقت وقد تستند إلى معايير الممارسة للمؤسسة ، مما يساعد على توفير رعاية تمريضية عالية الجودة (بيري وبوتر ، 2002).

1-2-3- كارديكسيس:

كارديكس (كار ديكس) ن. كان أصليًا ، وهو الاسم المملوك لنظام حفظ سجلات وأوامر التمريض التي تم الاحتفاظ بها مركزيًا في الجناح وتحتوي على جميع تفاصيل التمريض وملاحظات المرضى التي تم الحصول عليها أثناء إقامتهم في المستشفى. على الرغم من أن هذا النظام لم يعد مستخدمًا لسجلات التمريض ، نظرًا لأن خطط الرعاية يتم الاحتفاظ بها الآن بجانب سرير المريض بدلاً من مركزها ، يستمر استخدام مصطلح "kardex" بشكل عام ، لبعض أنظمة تسجيل المرضى التي يتم الاحتفاظ بها مركزيًا. (قاموس التمريض ، 2008).

ورقة عمل مختصرة تحتوي على معلومات أساسية عن رعاية العملاء والتي لا تعد عادةً جزءًا من السجل الطبي. يتم استخدام Kardex كمرجع طوال فترة التحول وأثناء تقارير تغيير الوردية. يأتي بأحجام وأشكال وأنواع مختلفة ، بما في ذلك التي تم إنشاؤها بواسطة الكمبيوتر. تحتوي Kardex عادةً على المعلومات التالية

هـ ، العمر ، الحالة الاجتماعية ، التفضيل الديني ، الطبيب ، الاتصال الأسري برقم الهاتف. التشخيصات الطبية: مدرجة حسب الأولوية. تشخيصات التمريض: مدرجة حسب أولويات الحساسية الأنشطة المسموح بها: القيود الوظيفية ، المساعدة المطلوبة في أنشطة الحياة اليومية ، واحتياطات السلامة (عباس ، 2013).

1-2-4- ورقة التدفق:

باستخدام أعمدة رأسية أو أفقية لتسجيل التاريخ والوقت وبيانات التقييم ومعلومات التدخل ، اجعل من السهل تتبع تغييرات العميل في الحالة. المعدات الخاصة المستخدمة في تعليم العميل والعلاج الوريدي هي أجزاء أخرى من ورقة التدفق. تحتوي هذه النماذج عادةً على وسائل إيضاح تحدد الاختصارات المعتمدة لبيانات المخططات نظرًا لاحتوائها على مساحات صغيرة للتسجيل (Duncan and Baumle، 2011).

1-2-5- ملاحظات حول التقدم:

تُستخدم لتوثيق حالة العميل ومشاكله وشكاوي ؛ التدخلات. استجابة العميل للتدخلات ؛ وتحقيق النتائج. تشمل المستندات التي تندرج تحت العنوان العام لملاحظات تقدم الممرضة ملاحظات الممرضة ، وأوراق تدفق العناية الشخصية ، وسجلات التدريس ، وسجلات العلامات الحيوية ، ونماذج الاستيعاب والمخرجات ، ونماذج التخصص (على سبيل المثال ، ورقة تدفق مرض السكري أو نموذج التقييم العصبي) (Duncan and Baumle، 2011).

Appindix-C

Panel of Experts

قائمة الخبراء

ت	اسم الخبير	اللقب العلمي	الاختصاص الدقيق	مكان العمل	سنوات الخبرة
1	د.فخرية جبر محيبس	أستاذ	تمريض البالغين	جامعة بابل /كلية التمريض	41
2	د. وداد كامل محمد	أستاذ	تمريض البالغين	جامعة بغداد /كلية التمريض	37
3	د. هدى باقر حسن	استاذ	تمريض البالغين	جامعة بغداد /كلية التمريض	34
4	د. صباح عباس احمد	استاذ	تمريض البالغين	جامعة بغداد /كلية التمريض	34
5	د. راجحة عبد الحسن حمزة	أستاذ	تمريض البالغين	جامعة الكوفة/ كلية التمريض	32
6	د. حسين جاسم محمد	أستاذ	تمريض صحة الأسرة والمجتمع	جامعة بابل /كلية التمريض	29
7	د. سحر ادهم	أستاذ	تمريض البالغين	جامعة بابل /كلية التمريض	25
8	د.خالدة محمد خضر	استاذ	تمريض البالغين	جامعة بغداد /كلية التمريض	17
9	د. ضياء كريم عبدعلي	أستاذ مساعد	تمريض البالغين	جامعة العميد/ كلية التمريض	15
10	د .جهاد جواد كاظم	أستاذ مساعد	تمريض البالغين	جامعة الكوفة/ كلية التمريض	13
11	د. صادق عبد الحسين	استاذ مساعد	تمريض البالغين	جامعة بغداد /كلية التمريض	12
12	د. حيدر حمزة علي	أستاذ مساعد	تمريض الصحة النفسية	جامعة الكوفة/ كلية التمريض	12

الخلاصة

الخلفية: توثيق التمريض هو سجل الرعاية التمريضية التي يتم التخطيط لها وتسليمها للمرضى من قبل الممرضين المؤهلين أو غيرهم من مقدمي الرعاية الصحية. وهو مصدر المعلومات السريرية الرئيسي لتلبية المتطلبات القانونية والمهنية.

الطريقة: تم تنفيذ تصميم شبه تجريبي لتقييم أثر برنامج التوثيق على معرفة واتجاهات الممرض من 21 سبتمبر 2020 إلى 7 مارس 2022 في مستشفى الفرات الأوسط التعليمي بمدينة النجف الأشرف.

تم تعيين ما مجموعه (50) ممرض بشكل عشوائي لمجموعتين وتم تسجيلهم باستخدام إجراءات اختيار متعمدة غير احتمالية. حضرت مجموعة الدراسة جلسات البرنامج ، بينما بقيت المجموعة الضابطة دون أي تدخل ، تعرضت المجموعتان للاختبار القبلي والبعدي.

النتائج: أظهر المشاركون من كلا المجموعتين في الاختبار الأولي معرفة غير كافية (56٪ للدراسة و 72٪ للمجموعة الضابطة) وكان لديهم مواقف غير مبالية من توثيق التمريض (76٪ للدراسة و 80٪ للمجموعة الضابطة). بينما تمت مقارنة المشاركين في مجموعة الدراسة بعد تنفيذ البرنامج ، أظهرت (الاختبارات اللاحقة) تحسنًا ملحوظًا في معارفهم (68٪) ، ومواقفهم (80٪). أظهرت المجموعة الضابطة نقصًا في المعرفة والمواقف مع انخفاض متواضع في توثيق التمريض.

الاستنتاج: أظهر برنامج التعليم فعاليته في زيادة المعرفة التوثيقية للممرضين ، والمواقف ، والسلوكيات ، وفقًا للدراسة. علاوة على ذلك ، فإن طريقة كهذه مفيدة في حماية الممرضين من التوثيق.

التوصية: بناءً على النتائج المذكورة أعلاه ، يمكن أن تشير الدراسة الحالية إلى انه يمكن أخذ وثائق الممرضين والنظر فيها من خلال إنشاء برامج تدريب تعليمية خاصة لتحسين الكفاءة.

جمهورية العراق
وزارة التعليم العالي والبحث العلمي
جامعة بابل
كلية التمريض

أثر البرنامج التعليمي للتوثيق التمريضي على معارف واتجاهات الممرضين في مستشفى الفرات الأوسط التعليمي

أطـــروحـــة

مـــقـــدمـــة الـــى مـجـــلـــس كـــلـــيـــة الـــتـــمـــريـــض

جـــامـــعـــة بـــابـــــل

مـــن قـــبـــل

حيـــدر غالـــب جبـــر

مـــن مـتـطـلـــبـات نـيـــل درجـــــة الـــــدكـتوراه

فـــلـــسـفـــة فـــــي الـتـمـريـض

بأشـــــراف

الاستاذ الدكتورة شـذى سعـدي محـــمد

اذار / 2022 ميلادي **شعبان / 1443هجري**