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Educational program on nurses attitude toward documentation in Al-Furat Alawsatt teaching hospital

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***Abstract*---**Nursing documentation's purpose is to show that an organization maintains thorough written record of its planning, delivery, assessment, and evaluation of patient care, as well as to serve as a source of information for new nurses and maybe for nursing theory development.It contains all written information related to the patient's condition and needs.From September 21, 2020 to March 7, 2022, the researcher at Al-Furat Al-Awsat Teaching Hospital in Al-Najaf City used a quasi-experimental design with two groups and two evaluation stages to assess the effectiveness of the educational program in improving attitudes, and practices related to nursing documentation. A total of (50) nurses were randomly assigned to two groups and enrolled using non-probability deliberate selection procedures. To the control group,which maintained the same level of attitudes, and practices with a modest decline in nursing documentation attitudes, and practices. Furthermore, the education program was shown to be effective in increasing nurses' documentation attitudes, and behaviors, according to the study. Furthermore, a method like this is useful in shielding nurses from being documented.Based on the above-mentioned findings, the current study suggest that the Ministry of Health should consider nurses' benefits. It should adjust training on nursing care documentation standards and direct Health Department to encourage nurses to do their activities and document.

***Keywords*---**educational program, nurses, attitude, documentation.

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Introduction

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. Despite the fact that the importance of good nursing documentation is widely recognized and efforts are being made to improve it, there are differences in the definition of good nursing documentation across countries and settings, which are based on different local requirements, documentation systems, and terminology. A number of audit instruments were employed in the research settings to assess the quality of nursing documentation, with diverse criteria reflecting how researchers viewed quality (Hameed & Allo, 2014).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, defining and implementing nursing treatments, and evaluating their success. 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 and give therapy to discover 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, nursing development, and research, to name a few (Timby, 2021).Physicians have been keeping medical records since Hippocrates' time. Health-care organizations are now obligated by law to keep a medical record for each patient, whether inpatient or outpatient, in accordance with acknowledged professional standards and procedures. Documentation of the patient's specific disease facts; usage 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 involved in a patient's care. giving information to third-party billing and regulatory organizations; and, last but not least, assisting in the protection of patients' and health-care providers' legal rights. It's also one of the most important nursing responsibilities. It is a section of the clinical record where nurses describe the patient's health, nursing needs, nursing treatment, 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).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).

Methodology

A quasi-experiment is a pilot interventional study in which the causal effect of an intervention (educational program) on the target population is determined without using random assignment (nurses). Quasi-experimental research lacks randomized processing and task control, despite its resemblance to traditional experimental designs or randomized controlled trials. Quasi-experimental designs, on the other hand, allow the researcher to affect the treatment case assignment using a factor other than random assignment. The Sitting of the Study is being carried out at Al-Furat Al-Awsat Teaching Hospital in order to acquire accurate and thorough data.The researchers used two tools to collect data from study participants as following: First one is the socio-demographic variables such as (age, gender, level of education, years of experiences, training session). Second part included attitude towards documentation This part contains a 24-question scale to show nurses' attitudes and 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 as the questions were in a case study manner to make the participants answer the questions they need critical thinking. The researcher adhered to the rules of writing the questionnaire due to the importance of the type of information that the researcher is keen to be sufficient and comprehensive for all aspects of the problem and can be relied upon and trusted. To vague and complex answers. The type of questions was of the closed type, which required answering with reference to what was appropriate. The researcher use program (SPSS 25) for data analysis include descriptive statistics(mean ,standard deviation, frequency and percentage).

Results

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

Study Group Attitudes		Pre-test Study 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 study 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 2:Nurses Attitudes Responses at Post-test Regarding to Nursing Documentation (*Study Group*)

Study Group Attitudes		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	3.56±1.685	Agree

	the nurse and the patient		
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 study 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 3:Statistical Significant Difference between Pre and Post Test by Overall Responses to the Attitudes Scores for Study Group

Study Group Attitudes	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
	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:Statistical Significant Difference between Pre and Post Test by Overall Responses to the Attitudes Scores for Control Group

Control Group Attitudes	Weighted	Mean	S.D	t-value	d.f	p≤ 0.05	Sig
	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*.

Discussion

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 study group (M SD= 76.4 22.42) (table 1) .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.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 . 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.

Conclusion

This study concluded that the nursing documentation, nurses lacked attitude, in the pre-test, there were no differences in attitude, between the study and control groups and Nurses' attitude, 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 attitudes.

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