Deanship of Graduate Studies

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The Quality of Nursing Documentation at Pediatric` Departments in Governmental Hospitals in Gaza Governorates, Palestine

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The Quality of Nursing Documentation at Pediatric Departments in Governmental Hospitals in Gaza Governorates, Palestine

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Dedication

First and foremost, I would want to praise Allah, the Almighty, who has given me innumerable blessings, opportunities, and knowledge, allowing me to finally finish this thesis.

Also I dedicate this work to my beloved prophet Mohammed (May Allah preserve and protect him), who taught us the meaning of life.

To the soul of my martyr brother Muhammad, and to all the martyrs of my family and Gaza.

To my beloved mother and father who, for months past, they encouraged me attentively with their fullest and truest attention to accomplish my work with truthful self-confidence.

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To my academic teachers and supervisors who guided and supported me.

To my friends who supported and encouraged me.

To everyone who has provided me with guidance and encouragement.

To all Palestinian children.

Nehal Tayseer Hassan Shabat

Declaration

I certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and this study or any its parts has not been submitted for a higher degree to any other university or institution.

Signed

Nehal Tayseer Hassan Shabat

Date: 16/12/2024

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Abstract

Nursing documentation is an important part of ensuring good quality patient care, particularly in departments of pediatric. Timely documentation reflects the nursing care provided by healthcare professionals and decreases risks such as medical errors and malpractice entitlements. Inadequacies in nursing documentation can affect patient safety and quality of care quality. The purpose of the study was to assess the quality of nursing documentation at pediatric departments of governmental hospitals in GS, Palestine. A quantitative descriptive research, cross-sectional design was applied. The study sample was 90 nurses and 200 pediatric medical records. A structured questionnaire was designed for data collection. The statistical analysis was analyzed by using SPSS version 25. The results showed that overall perception about the level of quality of nursing documentation in pediatric departments in governmental hospitals in GS was good (72.33%) also the moderate overall score about quality of nursing documentation was high (84.67%). The highest hospital quality of nursing documentation was El-Najar Hospital 92.07% followed by Al-Aqsa Martyrs Hospital (84.67%), Al-Durra Children's Hospital (83.58%) while the lowest one Al- Rantisy-Hospital (77.94%). Most of the participants were female (80%), while only 20% were male. The study concluded that the quality of nursing documentation in pediatric departments in government hospitals in Gaza ranged from moderate to high. Implement regular, structured training programs for nurses in pediatric hospitals to improve their documentation process, especially focusing on weakness areas that are illustrated in the results like pain assessment forms and discharge planning.

Keywords: Quality, Nursing Documentation, Pediatric Hospitals and Gaza Governorates.

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List of abbreviations

%:	Percentage
%Mean:	Percentage of the mean score
ANOVA:	Analysis of Variance
EU:	Emergency Unit
F:	One-way ANOVA
GS:	Gaza Strip
ICU:	Intensive Care Unit
IV:	Intravenous
JBI:	Joanna Briggs Institute
Med.	Medication
MoH:	Ministry of Health
N:	Number of subjects or patients
N:	Number of subjects or cases
NGO:	Non-Governmental Organization
PCBS:	Palestinian Central Bureau of Statistics
PMoH:	Palestinian Ministry of Health
P-value:	Probability value
Q:	Question
Q-DIO	Quality of Nursing Diagnoses, Interventions, and Outcomes
R:	Correlation coefficient
SD:	Standard Deviation
SPSS:	Statistical Package for the Social Sciences
t	Independent t-test
UNRWA:	United Nations Relief and Works Agency
VIPSL:	Variety, Impact, Prevention, and Support

Chapter One

Introduction

Nursing documentation is the process of creating a comprehensive record of handwritten or electronic evidence about a patient's care, including nursing assessment, nursing care plan, interventions, education, and discharge planning. Accurate, timely, and detailed documentation demonstrates the scope and quality of nursing care provided. Appropriate nursing documentation indicates nursing knowledge and judgment abilities and establishes a professional accountability. It also reflects that the patient was treated in accordance with the institution's policies, standards, and state regulations (American Nurses Association 2010).

In hospital settings, nurses are involved in several activities from the time a patient is admitted to the time he or she is discharged, helping patients to meet their needs. They provide continuous patient care 24 hours a day, seven days a week, through different shifts. Each activity should be properly documented as authentic and important proof (Asmirajanti et al., 2019).

Patient care is a multifaceted and complicated process It entails a large number of people and professionals whose activities may vary. However, not all of the care providers are always present at each contact with the patients to determine whether or not care was provided and this creates a situation in which the patients may experience overdose, under dose, or neglect of certain activities therefore the documentation is a method to avoid this issue (Wasini & Okoronkwo, 2020). Nursing documentation of high quality has the potential to improve patient safety and care quality. Nursing records do not always correspond to these documentation criteria, despite the fact that high-quality nursing documentation entails a full documentation of the nursing process (Moldskred et al., 2021).

Therefore, nursing documentation is critical in health care settings because it reflects a variety of factors, including nurses' awareness of their roles in providing high-quality health care (Alkouri et al., 2016). Pediatric departments are considered one of the most critical departments of the hospital so the nursing reports require high accuracy in providing the care to the pediatric patients (Delnavaz et al.,2018).

Nurses are legally obligate to document (Lapum et al. n.d.). Thus in nursing practice it is considered that what is not documented has not been done (Marinič &Milena, 2015).

1.1 Problem Statement

Nursing is a profession which depend on lots of information about patients and their care processes, there is a serious need to have a simplified documentation format that will motivate nurses to document all that they do (Wasini & Okoronkwo 2020).

Despite the importance of proper nursing documentation, the results of various studies over the years, indicate that the quality of nursing documentation has been reported as inadequate (Tasew et al., 2019, Akhu-Zaheya et al., 2018, and Blair & Smith, 2012). Various studies have shown that there is a relationship between nursing documentation and patient mortality (Collins et al. 2013).

Low quality nursing records can indicate serious problems, which affect directly the quality of care and patient safety, involving not only health care personnel, but also managers, researchers and teachers (Azevedo & Cruz 2021). Nursing documentation is critical as well for effective communication between nurses themselves and with other health care workers (American Nurses Association 2010). A few simple documentation errors can result in treatment errors for a patient, which could lead to malpractice claims (American Service Association, 2022). Therefore, poor communication between health care professionals is one factor for medical errors. Most of nursing care are not documented or not properly documented and thus form a major problem when evaluate of client care (Hussainat T, 2015). In Gaza, inadequate nursing documentation remains a significant factor contributing to medical errors. Overburdened healthcare staff, lack of proper training, and limited resources often result in incomplete or inaccurate records. Proper documentation is essential for evaluating patient care, ensuring accountability, and improving healthcare outcomes in challenging and resource-limited environments.

Based on the researcher experience at work in the pediatric departments of many governmental hospitals in GS, it was noticed that there were problems in nursing documentation as inaccurate, inappropriate, incomplete and disorganized charts and nursing notes. Therefore the current study was conducted to assess the quality of nursing documentation at pediatric departments of governmental hospitals in GS to provide some recommendations for policy makers in the Palestinian Ministry of Health

(PMoH) to adopt potential strategies to improve quality of nursing documentation and improve the productivity of nurses to improve patient safety based on proper documentation.

1.2 Significance of the study

The sharing of information between a health care providers which mostly happens through the completion of patient records, is essential for continuity of treatment. Inadequate communication could put patients' safety at risk and compromise the standard of treatment given.(Valera et al., 2017).

Nursing documentation is consider as a central clinical source of the patient's condition, and it plays a major role in evaluating the effectiveness of nursing care ; therefore, it should be based on scientific nursing knowledge which is fundamental for the nursing profession (Noureldin et al., 2014).

Health care documentation is very complex, especially for pediatric care thus early documentation of health status serves as a baseline throughout the continuum of care for coming years (Kamil, 2018).

1.2.1 Study objectives

1.2.2 General objective

To assess the quality of nursing documentation at pediatric departments of governmental hospitals in GS, Palestine.

1.2.3 Specific objectives

The Objectives of study were to:

1. Determine the level of quality of nursing documentation at pediatric departments of governmental hospitals in GS.
2. Identify the underlying factors that affect the quality of nursing documentation at pediatric departments.
3. Determine the relationship between nursing work environment and the quality of nursing documentation at pediatric departments.

4. Identify the perception of the nurses regarding existing barriers affect quality of nursing documentation practices at pediatric departments.
5. Determine the differences in quality of nursing documentation related to nurses' socio demographic characteristics at pediatric departments.

1.3 Research Questions:

This study was answered these questions:

1. Is the quality of nursing documentation at pediatric department meet the standard criteria of nursing documentation?
2. What are the underlying factors that affect the quality of nursing documentation at pediatric departments?
3. Is there a relationship between nursing work environment and the quality of nursing documentation at pediatric departments?
4. What is the perception of the nurses regarding existing barriers to nursing documentation practices?
5. Is there a difference in quality of nursing documentation related to nurses' socio demographic characteristics at pediatric departments?

1.4 Definition of Terms

1.4.1 Theoretical definitions:

1.4.1.1 Nursing documentation

Is defined as a record of the nursing care organized and provided to specific patients and clients by qualified nurses or other caregivers working under a licensed nurse's supervision (Alkouri et al., 2016).

1.4.1.2 Quality of nursing documentation:

The level of the quality of documentation includes completeness, accuracy, timing, permanence nursing care which reflect assessments, changes in clinical state, care provided and pertinent patient information to support the multidisciplinary team. (American Nurses Association, 2010).

1.4.1.3 Nursing work environment:

Work environment is defined as the organizational characteristics of a work setting that facilitate or impede professional nursing practice (Arsat et al. 2022).

1.4.2 Operational definitions:

1.4.2.1 Nursing documentation:

It is an essential part of nursing practice which is a written or electronic information about provided care to the pediatric patients in governmental hospitals by assigned nurses.

1.4.2.2 Quality of nursing documentation:

Reflect a degree of accurate, accessible, complete, legible, readable, and timely nursing documentation which meet the standardized criteria and PMoH principles, to deliver proper care to the patients at pediatric departments. Accurate, accessible, complete, legible, readable, and timely nursing documentation is essential for delivering high-quality care in pediatric departments. It ensures effective communication, supports clinical decision-making, and enhances patient safety. Regular audits, staff training, and adherence to standardized guidelines are critical for maintaining documentation quality and compliance with healthcare standards.

1.5 Context of the study

1.5.1 Geographical context

Historical Palestine had a total size of 27,009 square kilometers, whereas the area of the proposed State of Palestine on the areas that were occupied in 1967 AD (the West Bank and Gaza Strip) is 6,209 square kilometers, or 22.95% of the land of historical Palestine.5,844 km2 or 21.6% of historical Palestine is made up of the West Bank. The Gaza Strip covers 365 square kilometers, or 1.35% of all of historical Palestine (PCBS, 2022).

1.5.2 Demographic context:

The current population of Palestine based on Central Bureau of Statistics (PCBS) is 5,483,450 million. In comparison to the Gaza Strip, where the estimated population was 2.23 million including 1.13 million male and 1.10 million female, the West Bank was anticipated

to have a population of roughly 3.25 million, consisting of 1.65 million male and 1.60 million female (PCBS, 2022).

1.5.3 Gaza Strip

The Gaza Strip is a coastal region along the Mediterranean Sea. Its width ranges from six to twelve kilometers, and its private space is 360 square meters. Its length is around 41 kilometers. There are five governorates inside it: North, Gaza, Mid-zone, Khan Yunis, and Rafah. There are fourteen communities and eight refugee camps there. The Arab Republic of Egypt borders the Gaza Strip on the southwest and Egypt on the east. The governorates of the Gaza Strip now have a population density of 6,017 people per km2, with Khan Younis having the lowest density and Gaza having the highest. The Gaza Strip's population growth rate has somewhat slowed down from 2.8 in the year 2022 to 2.8 in the year 2021. The population under 15 years old makes up 40.5% of the entire population, while the population over 60 years old makes up 4.8% (PCBS, 2022).

1.5.4 Health care system in Palestine

There are four main sectors that make up the Palestinian health system: the government sector (the Palestinian Ministry of Health and Military Medical Services), the United Nations Relief and Works Agency UNRWA, non-governmental organizations, and the private sector. These several sectors are involved in providing citizens with health care services at all levels: primary, secondary, and tertiary. The continuity of the Palestinian healthcare system and the provision of all citizens with comprehensive, high-quality healthcare services are very important to the PMoH (PMoH, 2022).

There are 159 PHC centers in the Gaza Strip, of which 52 (32.7%) are managed by the PMoH, 22 (13.8%) by UNRWA, and 80 by NGOs. Of these, 19 centers (12%) offer PHC services in accordance with PMoH standards, and the remaining centers offer specialized medical care. Military Medical Services is in charge of five PHC facilities (3.1%) (PCBS, 2022).

1.5.5 Hospitals in Gaza Strip

In Gaza strip, 35 hospitals are now operational in the Gaza Strip, 13 of which are managed by PMoH, 17 by NGOs, 2 by the Ministry of Interior and National Security, and 3 by the private sector (PCBS, 2022).

1.5.6 Al Dora Children's hospital

It is located in the Al Toffah district on Salah Uddin Street in the northeast of Gaza City. In the year 2000, It was established on an area of 1600 square meters, to serve the areas of Shujaiya, Al -Shafa, and Al -Darg neighborhood. Al -Zaytoun neighborhood and Al -Tafah neighborhood. It has 110 beds in four internal departments (two medical pediatric departments, intensive care unit, emergency department, pharmacy, laboratory, outpatient clinics, X-ray and ultrasonic department, and others of logistic departments). It serves about 500,000 people and provides internal medicine for children between the ages of one month and twelve years (PMoH, 2022).

1.5.7 Al-Rantisy-Nasser Pediatric Hospital

Is the oldest and largest children's hospital in the Gaza Strip, with a capacity of (132) beds. It is located in Al-Nasr neighborhood and serves a large area of Gaza City and some of its services extend to the central and northern region, so the improvement of its service is reflected in the level of pediatric services in the GS. Note that Al-Nasr Hospital for Children was established in 1962 with an area of 4400 m (PMoH, 2022)

1.5.8 Nasser Medical complex Hospital

Was one of Palestine's biggest hospitals located in the Gaza Strip with a capacity of 665beds. The British Mandate authority had built a hospital for febrile diseases and quarantine on the site, and in 1957, during their rule of the Gaza Strip, the Egyptians built Nasser Hospital. The hospital bears Gamal Abdel Nasser's name, having opened its doors in 1960 (PMoH, 2022).

The hospital closed in 1972 so that construction could be done to quadruple its 112 bed capacity. In February 1974, it reopened. In December 1984, the Israeli authorities closed

down the orthopedic department owing to pollution and transferred its services to Al-Shifa Hospital (PMoH, 2022).

1.5.9 Al-Aqsa Martyrs Hospital

The hospital was established in 2001 in response to an emergency plan developed by the Palestinian Ministry of Health to treat the wounded during the Second Palestinian Intifada. It later developed, its departments expanded, and its bed capacity increased. It is located in Deir al-Balah, is a large government hospital in Gaza's Middle Governorate (PMoH, 2022).

1.5.10 El-Najar Hospital

The hospital opened in 2000 after converting the building's prior primary care clinic. The facility has an area of 4,000 square metres. The facility contains 65 beds and two operating rooms. The emergency room offers 9 beds. Due to the hospital's limited capacity, there was a call to establish another hospital nearby, which Qatar answered in 2020. Qatari philanthropic groups announced a gift to fund the hospital's construction, which will be overseen directly by the Qatar Committee for the Reconstruction of Gaza and carried out in collaboration with the Palestinian Ministry of Health (PMoH, 2022).

Chapter Two

Conceptual Framework and Literature Review

The quality of nursing documentation is influenced by a combination of sociodemographic factors, nursing work environment factors, and organizational factors, each playing a critical role in ensuring accurate and effective record-keeping. Sociodemographic factors, such as nurses' perceptions and knowledge regarding barriers to documentation, significantly impact their ability to maintain thorough records. Nurses who lack proper training or face barriers, such as insufficient understanding of documentation protocols, may struggle to meet quality standards. Additionally,

2.1 Conceptual Framework

This conceptual framework demonstrates all associations between variables of the study:

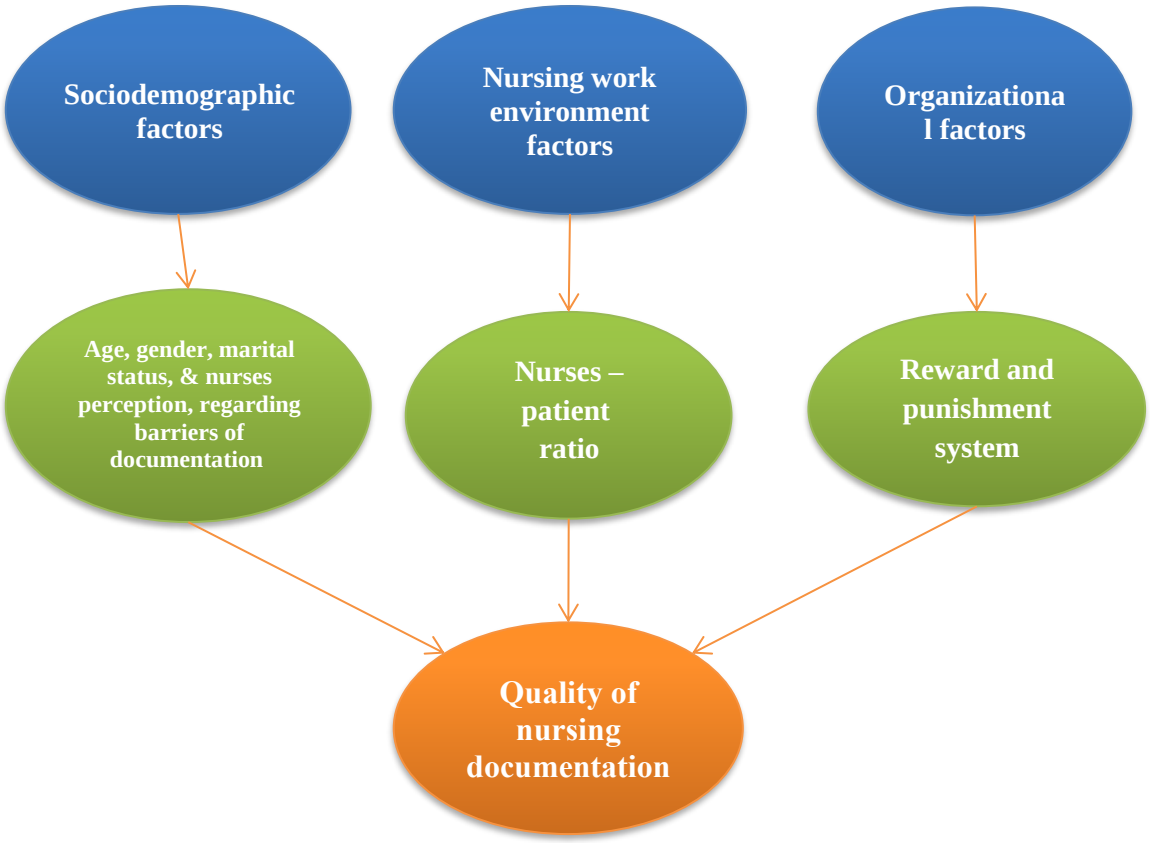

Figure 2.1: Diagram of conceptual framework (self-developed 2022)

The diagram clarifies the independent variables which are sociodemographic factors of nurses, nursing work environment and organizational factors while the quality of nursing documentation concider as dependant variable.

2.1 Background

2.1.1 Nursing Documentation from a Historical Perspective

Nursing documentation plays a critical role in the healthcare system as it serves as a primary means of communication between healthcare providers. The importance of nursing documentation was first recognized by Florence Nightingale, who established its early development as a vital part of nursing practice and patient care management. Nightingale emphasized that proper documentation ensures continuity of care, allows for the assessment of treatment efficacy, and enables health practitioners to make informed decisions (Chelagat et al., 2013).

In the context of pediatric departments, nursing documentation is even more crucial. Pediatric patients are highly vulnerable due to their developmental stages and unique health needs. Accurate and thorough documentation in pediatric nursing is essential to capture every aspect of patient care, from vital signs to the administration of medication, and to monitor any changes in a child's condition. Studies have shown that quality documentation in pediatric settings directly influences treatment outcomes and patient safety, which is paramount in managing the sensitive needs of this patient demographic (Abd El Rahman, 2021).

In Gaza Governorates, where healthcare systems face numerous challenges, the quality of nursing documentation becomes a matter of utmost importance. The unique political, economic, and infrastructural constraints faced by healthcare facilities in Gaza impact both the availability and quality of resources, including human resources. Nurses working in governmental hospitals often deal with high patient loads, inadequate staffing, and limited access to continuous professional development. These factors may hinder effective documentation practices, which in turn affects the quality of patient care provided (Al-Albelbeisi, 2024).

Quality nursing documentation in pediatric departments encompasses several components: adherence to standard protocols, accurate and complete recording, and timely updates to patient records. Research indicates that poor documentation can lead to a range of adverse outcomes, including medical errors, miscommunication, and even potential harm to patients. Therefore, it is essential for healthcare systems to prioritize training and support for nurses to improve their documentation skills. In Palestine, where resources are limited, understanding the barriers and enablers to high-quality nursing documentation is crucial for the development of sustainable healthcare improvements (Chelagat et al., 2013; De Groot et al., 2019).

This study explores the factors that influence the quality of nursing documentation within pediatric departments of governmental hospitals in Gaza. Specifically, it aims to assess how sociodemographic factors, the nursing work environment, and organizational policies impact the quality of documentation. Understanding these associations provides insights into how healthcare providers in challenging environments can improve documentation practices and, consequently, patient care outcomes. This focus is aligned with global healthcare quality standards that advocate for the accurate, complete, and timely recording of patient information as a benchmark for patient safety and care quality (World Health Organization, 2021).

Previous studies have identified various factors impacting nursing documentation quality, such as workload, perception of the importance of documentation, and availability of documentation tools. For instance, Chelagat et al. (2013) found that a lack of proper training and excessive workload are major barriers to effective documentation in nursing. Additionally, organizational support, including a reward and punishment system, can serve as a motivator for nurses to adhere to documentation standards (Al-Khateeb & Abdeen, 2018). In pediatric departments, where patient turnover may be high and cases are often complex, ensuring high-quality documentation is particularly challenging.

Furthermore, this sets the stage for a comprehensive examination of these factors by discussing the importance of quality documentation in pediatric departments and the challenges faced by healthcare professionals in Gaza Governorates. Given the constraints on the healthcare system in Gaza, this study also highlights the critical role of nursing documentation in managing pediatric cases effectively despite limited resources. By evaluating current documentation practices and identifying key areas for improvement, the

study aims to contribute valuable insights to both local healthcare policy makers and international organizations interested in supporting healthcare advancements in Palestine.

The quality of nursing documentation is essential for ensuring effective communication among healthcare providers, standardizing patient care, and improving patient outcomes. In pediatric departments, where patients require specialized care, high-quality documentation is indispensable. This study, therefore, seeks to explore the multi-faceted aspects of nursing documentation quality in Gaza's governmental hospitals, examining how sociodemographic, work environment, and organizational factors interact to influence the standard of care provided to pediatric patients. Through this examination, the study aims to contribute to the body of knowledge on nursing documentation in resource-constrained settings, offering practical recommendations to enhance documentation practices.

2.1.2 Definition of nursing documentation

Nursing documentation is a set of written information on the patient's health and care status that is communicated in the form of a document (Delnavaz et al., 2018). Also, Nursing documentation is a systematic process of recording patient care details, which enables nurses to communicate effectively with other healthcare providers, ensuring continuity and quality of care. Documentation serves as a record of the nursing process, reflecting the assessment, planning, intervention, and evaluation phases of patient care (Akhu-Zaheya et al., 2018). It is essential for accountability, legal evidence, and the facilitation of accurate decision-making (Alkouri et al., 2016).

Nursing documentation consists of recording in detail all of the clinical activities, assessments, and judgments related to the care of patients that are many and varied. El Rahman et al. (2021) point out "that the nature of the activities and the time frame over which they should be recorded have a direct influence on the quality of the documentation." Nursing documentation can be simple or complex but must always be accurate and complete to ensure patient safety. Poor documentation can lead to unsafe situations, while good documentation is vital for nurses and all healthcare team members to be able to deliver safe and effective care to patients. Furthermore, in many settings, written patient records are the only way to demonstrate that nursing has had an impact on a patient's health.

The concept of nursing documentation has evolved over time, with a shift from traditional paper-based systems to electronic health records. Akhu-Zaheya et al. (2018) compared paper-based and electronic documentation systems, highlighting that digital systems can enhance the clarity and accessibility of records, although they may also introduce challenges, such as increased time spent on documentation tasks.

In challenging environments like Gaza, nursing documentation can face additional barriers due to factors like occupational stress and resource limitations. Albelbeisi et al. (2024) identified occupational stress as a significant factor impacting nurses' ability to document effectively. This cross-sectional study in Palestine sheds light on the challenges that nurses encounter in maintaining high-quality documentation under stressful conditions.

Documentation is not merely a clerical task; it reflects a nurse's responsibility and professional integrity in providing high-standard care. Ali et al. (2020) explored nursing documentation practices in selected hospitals in Sudan, identifying common barriers that can compromise documentation quality. Inadequate training, lack of support, and high workload were among the factors that contributed to poor documentation practices.

Nursing documentation is fundamental for the delivery of safe and effective patient care. It not only serves as a communication tool but also acts as a legal document and a critical part of the healthcare quality assurance process. Proper documentation requires both institutional support and a conducive working environment to be implemented effectively (Alston-Jackson, 2022; Bjerkan et al., 2021). As healthcare systems evolve, continuous improvements in nursing documentation practices are necessary to ensure patient safety and care continuity.

2.1.3 The importance of nursing documentation

Nursing documentation is critical in health care settings because it reflects a variety of factors, including nurses' awareness of their duties in providing high-quality health care (Alkouri et al., 2016).

Nursing documentation is a critical component of healthcare practice, essential for maintaining the quality, continuity, and safety of patient care. It provides a written account of the nursing care provided to patients, capturing both the subjective and objective elements of patient interactions, including assessments, diagnoses, interventions, and outcomes.

Nursing documentation serves as a record that ensures accountability, communication, and support for clinical decisions (Akhu-Zaheya et al., 2018). By accurately recording patient information, nursing documentation facilitates effective communication across multidisciplinary teams, enabling healthcare professionals to make informed decisions (Albelbeisi et al., 2024).

Documentation plays a vital role in patient safety, as it serves as an essential source of information for healthcare providers to access and understand the patient's medical history, current status, and ongoing care needs. Abd El Rahman et al. (2021) highlight that the quality of nursing documentation has a direct impact on the continuity of care, as complete and accurate records enable seamless transitions between shifts, departments, and healthcare settings. In the absence of thorough documentation, the risk of medical errors increases, potentially leading to adverse outcomes for patients (Bjerkan et al., 2021).

Furthermore, nursing documentation serves as a legal document that can protect healthcare providers and institutions from potential legal issues. Proper documentation is often viewed as evidence of the care provided, and it can be used in court proceedings if necessary to verify the actions taken by healthcare staff (Ali et al., 2020). The American Nurses Association (2010) reinforces the notion that documentation must be accurate, comprehensive, and reflective of the nursing process, emphasizing that poor documentation can be interpreted as inadequate care.

The role of nursing documentation extends beyond legal protection; it also supports quality improvement initiatives within healthcare settings. By documenting nursing care accurately, healthcare organizations can identify trends, assess compliance with clinical guidelines, and implement improvements in patient care practices. For instance, studies have shown that facilities with robust documentation systems are better equipped to track patient outcomes and optimize care processes (Chelagat et al., 2013; Bunting & de Klerk, 2022). Documentation, therefore, serves as a data source for continuous quality improvement efforts and enhances healthcare service delivery standards.

In high-stress environments like Gaza, where nurses face occupational challenges such as excessive workload and limited resources, the importance of nursing documentation is further amplified. Albelbeisi et al. (2024) reveal that occupational stress among nurses significantly impacts the quality of documentation, with stressed nurses more likely to make

errors or skip documentation altogether. Addressing such challenges can improve documentation practices and, consequently, the quality of care provided to patients.

One of the most critical functions of nursing documentation is its role in communication. Nursing documentation serves as a bridge for effective communication between nurses, doctors, and other healthcare professionals. It allows for the accurate handover of patient information and ensures that all team members are aware of the patient's status and care plan. This communicative role is particularly essential in emergency settings, where prompt information sharing can be life-saving (Andualem et al., 2019). Asmirajanti et al. (2019) found that nursing documentation is a fundamental aspect of nursing care activities, directly influencing patient outcomes.

Another significant aspect of nursing documentation is its contribution to educational and research purposes. Nursing records are often used as data sources in research studies aimed at improving healthcare practices and policies. According to De Groot et al. (2019), documentation quality is crucial for reliable data collection in nursing research, and the use of standardized documentation practices can enhance the validity of research findings. Additionally, nursing students and new practitioners rely on documented records to understand patient care procedures and develop clinical skills, highlighting the educational value of high-quality documentation.

In addition to research and education, nursing documentation enables healthcare providers to perform audits and assess compliance with clinical guidelines. Quality audits are critical in identifying areas for improvement within healthcare facilities, and robust documentation provides the necessary data for these evaluations. Bail et al. (2020) conducted a record audit study that underscored the importance of comprehensive nursing documentation in identifying patient risks and evaluating interventions. Audits not only help to maintain compliance with established guidelines but also support the implementation of best practices in nursing.

Nursing documentation is indispensable for patient care quality, safety, and accountability. It serves multiple functions, including legal protection, quality improvement, research, education, and audit support. Effective documentation ensures the continuity of care, enhances communication among healthcare providers, and provides a basis for informed decision-making. As healthcare settings continue to evolve and adopt electronic health

records, the focus on quality documentation will only increase, with ongoing efforts required to train nurses and support them in adhering to documentation standards (Jefferies et al., 2010). Emphasizing the importance of documentation can lead to improved patient outcomes, reduced errors, and a safer healthcare environment overall.

2.2 Literature Review

There are limited number of studies about nursing documentation of pediatric patients have been reported globaly and in Palestine. Thus in this part of the study, previous studies which are related will be represent.

2.2.1 Evaluation the quality of nursing documentation:

Evaluating the quality of nursing documentation is essential to ensure that it meets the standards required for patient safety, continuity of care, and legal accountability. High-quality nursing documentation is characterized by accuracy, completeness, timeliness, and adherence to professional standards. Various methods have been developed to assess these attributes, with specific criteria designed to identify deficiencies and areas for improvement in documentation practices and one widely used approach in evaluating nursing documentation is auditing, which involves reviewing records to check for compliance with established standards and guidelines (De Groot et al. 2019). According to Bail et al. (2020), record audits play a significant role in assessing the quality of nursing documentation by identifying patient risks and evaluating the effectiveness of nursing interventions. These audits reveal how well nurses follow documentation protocols and provide insights into areas where documentation can be improved to enhance patient care outcomes.

Quality criteria such as accuracy and completeness are fundamental in evaluating nursing documentation. De Groot et al. (2019) conducted a systematic review to identify the quality criteria, instruments, and requirements for nursing documentation, concluding that thorough and accurate documentation minimizes errors and supports effective decision-making. Completeness in documentation ensures that all necessary information regarding patient care is recorded, while accuracy guarantees that the documented information is a true reflection of the care provided (Abd El Rahman et al., 2021).

The use of standardized documentation tools and formats can also improve the quality of nursing documentation. Akhu-Zaheya et al. (2018) highlight that electronic health records

(EHRs) can enhance documentation quality by providing a structured format for nurses to record patient information systematically. However, the transition to electronic documentation presents challenges, including increased time required for documentation, which can impact overall efficiency (Ali et al., 2020).

Timeliness is another important criterion in evaluating documentation quality. Timely documentation allows for real-time updates of patient information, enabling healthcare providers to respond promptly to patient needs. According to Bjerkan et al. (2021), delays in documentation can lead to communication breakdowns within healthcare teams, increasing the risk of medical errors. Timeliness is particularly critical in emergency care settings, where immediate access to patient information can significantly affect outcomes.

In high-stress environments, such as those experienced by nurses in Gaza, occupational stress can negatively impact the quality of nursing documentation. Albelbeisi et al. (2024) explored this aspect, showing that stress among nurses leads to decreased documentation quality. Under such conditions, evaluation efforts must also consider external factors like workload and resource limitations, which may hinder nurses' ability to maintain high-quality records.

Educational programs and training are critical in improving documentation practices, as they equip nurses with the skills needed to meet quality standards. Andualem et al. (2019) found that knowledge, attitude, and practices towards documentation significantly influence quality outcomes. By addressing gaps in knowledge and reinforcing the importance of documentation, healthcare institutions can improve overall compliance with documentation standards.

A comprehensive approach to evaluating nursing documentation involves the use of quality indicators, which serve as measurable elements that reflect the quality of documentation. Asmirajanti et al. (2019) suggest that regular evaluation using these indicators can help healthcare facilities identify trends, monitor compliance, and implement targeted interventions to improve documentation standards.

In conclusion, the quality of nursing documentation can be effectively evaluated using a combination of record audits, adherence to accuracy, completeness, and timeliness criteria, as well as the use of standardized tools. Addressing factors such as occupational stress and

providing ongoing education are essential to maintaining high-quality documentation. Evaluations based on these criteria help ensure that nursing documentation supports patient safety, continuity of care, and quality improvement initiatives within healthcare settings (Chelagat et al., 2013; Jefferies et al., 2010).

The achievement and maintenance of excellent standards of clinical documentation remain a challenge in the health profession despite ongoing and consistent advise from professional bodies and quality-improvement programs over a number of years (Alkouri et al., 2016).

The study was conducted by Delnavaz to assess the quality of nursing documentation in Urmia's Shahid Motahari Hospital's pediatric wards in 2017. The researchers used a descriptive study, in which all of the hospital's nursing staff was included who have at least three months of work experience, a bachelor's degree or higher, and direct clinical work with patients. Data was collected by using a demographic questionnaire and a checklist to assess the quality of nursing documentation. Researchers found that nursing documentation had a desirable quality, and examining the relationship between demographic variables and the quality of documentation, it was determined that documentation quality decreases with increasing age and experience (Delnavaz et al., 2018).

At Yasuj Shahid Beheshti Hospital, a study was conducted by Zabolypour with the goal of determining the quality of nursing documentation in various sections and the causes for the lack of accurate nursing reports. The samples consisted of 120 records of admitted patients and 100 nurses who were chosen at random. The check-list of common reports, admission, discharge, and pre-postoperative records were all used as research methods. Other check-lists were shown to be the source of inaccurate nursing paperwork. The SPSS 16 software was used to examine the data. On admission, 56 percent of records were right, 82 percent were correct at discharge, 44 percent were correct before surgery, and 68 percent were correct after surgery. The most important reasons for proper recording were the nurses' lack of time, high workload, and exhaustion (Zabolypour et al. 2017).

In 2017 a descriptive and quantitative study was conducted to check whether the nursing records of patients hospitalized in Pediatric Intensive Care Units are accurate through documentary research into the nursing records of 92 medical records from three Units of Pediatric Intensive Care hospitals. The study found that 21.8% of records had erasures and 26.1% had no complete identifier for care providers. According to the safety

recommendations, the records were satisfactory, although several areas were still lacking in connection to nursing standards (Valera et al., 2017).

A cross-sectional study was conducted in three Jamaican hospitals' medical wards to evaluate the quality of nursing documentation of client history, biological data, client assessment, nursing standards, discharge planning, and teaching by using an auditing instrument. In 90% of the records, a physical assessment had been done within 24 hours of admission, and entries had been timed, dated, and signed by a nurse, according to the audit. Less than 5% of dockets contained documentation of patient education, and 13.5% contained proof that discharge planning had been carried out within 72 hours of admission (Lindo et al. 2016).

The purpose of the study was to evaluate nursing care documentation practice and the related factors among nurses who were working at the University of Gondar Hospital's by using a cross-sectional design from 20 March to 30 April, 2014, among 220 nurses working in the inpatient wards of the University of Gondar Hospital. A pre-tested structured self-administered questionnaire was used to collect data. Descriptive statistics were used, as well as bivariate and multivariate logistic regression analyses. Also Epi Info version 7 was used to enter the data, and SPSS version 20 was used to analyze it. The study showed the percentage of nurses who documented their patient care well was 37.4% and the nursing care documentation practice was influenced by the nurse-to- patient ratio, in-service training, nurses' knowledge, and their attitudes regarding nursing care documentation (Kebede et al., 2017).

The purpose of the study was to evaluate the nursing documentation of the medical, surgical, and obstetrical wards of a Rizal secondary private hospital. Completeness, accuracy, timeliness, permanency, and timing all factor towards the level of documentation quality. This study specifically attempted to ascertain the level of nursing documentation quality, the demographic profile of the respondents in terms of age, sex, and education, and the significance of the association between the demographic factors and the overall standard of the nursing documentation. Data were gathered using a purposeful sample technique and a descriptive correlational method through an altered Nursing Documentation Audit Tool created by the Center's Quality Assurance Committee, Wroten and Associates. The questionnaire was split into two sections: the first section comprises the respondents' demographic information, and the second section is a twenty-one (21) item assessment

instrument that will gauge the level of documentation quality. The results of the study demonstrated a strong correlation between the respondents' demographic characteristics and the overall quality of nursing documentation (Rosales et al. 2022).

The quantitative and descriptive study was conducted to describe the quality of nurse documentation at Tallinn Children's Hospital. A sample was taken from nursing records both before and after nurses received NANDA-I nursing diagnostic training. The patient had to be hospitalized for at least three days and have a personalized nursing care plan, according to the selection criteria. From September 2016 to March 2017, data were gathered. We used the 4-score Likert scale and the D-Catch tool. Data analysis methods included the t-test, descriptive statistics, means, and SPSS 19.0.The study showed the significance of NANDA training in the implementation of new documentation standards in nursing practice (Smart 2018).

At the CURE Children's Hospital of Uganda, the project sought to improve nurses' recording of their patient assessments in order to raise the standard of nursing practice. An action research technique was utilized to identify best practice approaches in this setting for enhancing nurses' efficacy in documenting evaluations in the patient record, using repeated cycles of preparation, intervention, reflection, and adjustment. Data was acquired by the researchers through chart audits, literature studies, and key informant interviews. These data guided three cycles of system and practice modifications to increase the quality of documentation through analysis and critical reflection. The initial cycle demonstrated that staff training alone was insufficient to meet the project's goal. To improve documentation, larger adjustments were required, such as developing a critical mass of competent people, redesigning orientation and ongoing education, redesigning documentation forms, changing the nurse skill mix, and providing constant leadership support (Okaisu et al. 2016).

In five hospitals in the Tamale Metropolis, a descriptive retrospective cross-sectional quantitative study was conducted to evaluate the nurses' current nursing documentation practice by using a customized pre-coded audit tool, 500 patient records were examined. For analysis, extracted data were entered into SPSS v20. At general, nurses' documentation practices at the five hospitals under review were appalling. The failure of nurses to sign each entry in the nurses' notes was the most frequent error, accounting for 99.8% of all errors in nursing documentation (Buunaaisie et al. 2018).

A retrospective descriptive study was used to assess the quality of nursing documentation on medical records from patients at a university hospital in Sao Paulo, Brazil. From November 2006 to January 2007, 424 medical records of patients from medical and surgical units were evaluated. Medical records were obtained from individuals who had been discharged from the hospital (56.1%) or who had died (43.9%). The review focused on the demographic and background information, operating room flow sheet, nursing progress notes, nursing diagnosis, nursing orders, nursing order implementation, medical orders, nursing documentation, discharge documentation, and death documentation. 64.7% of nursing documentation was deemed satisfactory. Only 8.7% of the nursing records were of high quality. The remainder of the documentation for nursing was subpar (26.7%). It is significant to remark that the nursing care outcomes that are indicated in the medical records' nursing documentation were challenging to measure. Quality of care and patient safety may be impacted by this (Setz & D'Innocenzo 2009).

Throughout the descriptive study, a quasi-experimental design was used to examine nurses' knowledge of nursing documentation at pediatric surgical wards in Baghdad City. The research was carried out between the 23rd of December 2021 and the 20th of July 2022 by using pre- and post-tests for one group of pediatric surgery ward nurses, In the study group, there were three tests: baseline, post-test 1, and post-test 2. According to the result of this study, Nurses in pediatric surgery wards have limited expertise of nursing documentation. There is a link between nurses' knowledge and their (gender, education level, years of experience, and primary source of information) (Ibraheam & Khudhair 2022).

A descriptive cross-sectional study was conducted at major in-patient units of Jigme Dorji Wangchuck National Referral Hospital to assess quantitative completeness and quality of nursing documentation by using of D-catch tool. Data from 317 randomly selected patient records from six large in-patient units were added into the EpiData file. Descriptive statistics and multivariate analyses were performed using STATA version IC/14. The overall quantitative completeness of the nursing documentation was greater than the quality of the papers kept. Basic and less time-consuming information, such as admission data and vital signs charting, is better documented than more time-consuming and complex documentation, such as the nursing care process (Zangmo et al. 2019).

A systemic review study aimed to determine the effective strategies for improving clinical nursing documentation in the acute hospital setting. For quasi-experimental investigations, the Joanna Briggs Institute (JBI) critical evaluation was used. The data collected in each study were added to a Summary of Data (SOD) spreadsheet. Pre intervention and a post intervention percentage compliance scores were calculated for each study where possible. Each study was analyzed thematically in terms of the intervention strategies used. Compliance rates and the interventions used were compared to determine if any strategies were effective in achieving a meaningful improvement in compliance. When attempting to improve the quality of nursing documentation, documentation audits with personal input should be considered as one of the tactics to be used (Bunting & de Klerk 2022).

Observational study was conducted to assess the quality of nursing documentation by comparing the periods before and after hospital accreditation preparation, using the Quality of Nursing Diagnoses, Interventions, and Outcomes - Brazilian Version. Nursing documentation from 112 medical records before and after hospital accreditation was compared using the Q-DIO instrument - Brazilian version. The data was statistically examined. The quality of nursing documentation improved significantly. There was a dedication to cultural change through the interventions carried out, which resulted in the conquest of the Joint Commission International quality stamp (Nomura et al., 2016).

A descriptive, quantitative research study with data collecting backed by the institution's published quality assurance reports in nursing from 2002 to 2009 was conducted to evaluate the quality of nursing documentation in a university hospital. The division of inpatient satisfaction attained in 2007, with 82.2% of the documentation completed. The intensive care units did not meet any of the criteria. In 2009, the Maternal-Child Health Division had 90.7% of its records completed (Borsato et al. 2011).

To obtain an overview of available evidence on quality criteria, instruments, and nursing documentation needs, systemic review study was conducted. Two reviewers chose the reviews independently using a stepwise technique, assessed the methodological quality of the selected reviews, and extracted the data using a preset extraction format. The adoption of standard terminologies, as well as user friendly formats and procedures, appear to be vital for high quality nursing documentation. The absence of evidence based quality indicators complicates the pursuit of high quality nursing documentation. There is confusion in nursing

practice regarding which criteria must be completed in order to generate high quality documentation (De Groot et al. 2019).

The study's objectives were to evaluate current nursing care recording practices and create projects for their development. The project was carried out in 2014 from January to March. It was built around the core ideas of assessment, planning, implementation, and evaluation. a form of prospective cross-sectional analysis used to assess nursing "Focus Chart" materials. Using the hospital's assessment instrument, the documentation of two nurses per unit per day for two weeks was evaluated and examined from all units. Results revealed that 980 nurses are directly caring for patients and documenting that care in patients' charts. Six units are using various types of recording, 10 units are using narrative, and fifty percent of the units (n=16) have begun focus charting. To address the documentation issue, a package for improving documentation was designed, and procedures were implemented. Following a review of the nursing care plan, patient assessment, and activity flow sheets, nursing administration was advised to employ a multidisciplinary approach to create policies and guidelines for nursing documentation. Additionally, offer nurses with consistent chances for ongoing training on the effectiveness of documentation (Machudo, & Mohidin, 2015).

Descriptive research with a quantitative method was conducted to describe the terms nurses use when recording patients' progress in written records. 148,200 nursing documentations of patient development were examined between 2010 and 2012 at a university hospital in Curitiba, Paraná, using a software program to extract phrases linked to the documents. If necessary, the terms were standardized for spelling, gender, number, and tense before being categorized for analysis into a corpus of 2.638 items. The results showed that were problems with identifying the records, using trade names to identify objects used in nursing practice, using nonstandard acronyms and abbreviations, and using colloquial terminology. There were records of terminology used in the standardized language of nursing diagnostics (Gomes et al. 2016).

A purpose of this study was to compile all relevant material concerning nursing documentation and highlight the important features of great nursing documentation. A total of 177 papers were examined for their applicability to the clinical query. Two researchers read 28 publications in all. By comparing commonalities, information supporting the clinical query was retrieved and organized into essential themes. It was determined what the seven main themes (essentials) of high-quality nursing documentation were. The seven crucial

elements of high-quality nursing documentation have been identified after a review of recent literature, scientific data, and regional regulations (Jefferies et al., 2010).

A study was carried out to assess the effectiveness and quality of the nursing care documentation for patients who are hospitalized at one Rwandan hospital. 45 patient file documents were included in the sample. Twenty files were chosen at random from the medical departments, and twenty-five from the surgical departments. The data were evaluated using a quality measurement checklist. The statistics demonstrated that nurses devote greater attention to the medical prescription charts than to the nursing care plans. The analysis found that 48.7% of the records were preserved permanently. It was discovered that a significant portion (68%) of patients' vital signs were not collected at the time of admission. The investigation discovered that the patients' pupil reaction, skin tone, and mental states were not noted upon arrival. Also this study discovered that, within 24 hours of patients' admittance to the hospital, assessments of their fundamental needs were included in all (100%) of the paperwork (Mbabazi & Cassimjee, 2006).

2.2.2 Factors affecting nursing documentation:

Several local and international studies have highlighted the most important factors affecting the quality of nursing documentation. Several barriers to nursing documentation encountered by nurses have been discussed broadly in previous studies. There have been reports that a number of factors influence the practice of nursing documentation in developing countries(Seidu et al., 2021).

A cross-sectional study was conducted by Tamir, Geda and Mengistie to assess documentation practices among nurses in six government hospitals and identify associated factors. A simple random selection of nurses and charts was conducted after each hospital's total sample size had been allocated proportionately. Documentation was practiced poorly due to the identified factors. Age, attitude, in-service training, nurse-to-patient ratio, motivation, and acquaintance with nursing documentation standards were all found to have a statistically significant positive relationship with documentation practice (Tamir et al., 2021).

And according to Jeihooni and Seyyed Hannan (2016), the most major variables impacting inadequate nursing documentation, according to nurses, are a lack of personnel (72.7 percent), a lack of time (57.1 percent), and fatigue (54.5 percent). The most critical characteristics in the area of wards were a large number of patients (70.1 percent) and a large volume of work on the ward (62.3 percent). The most crucial factors in nursing management were reported to be a lack of a punishment and reward system (39.5 percent) and a lack of constant monitoring and evaluation (35.1 percent). The purpose of a study is to identify influencing factors that are not appropriately identified by licensed nursing professionals**.** The descriptive-analytic research of 80 nurses working in a hospital in Fasa, who were chosen based on their availability, and their perspectives on the variables causing the lack of proper nursing documentation. SPSS-19 was used to analyze the data (Jeihooni & Seyyed Hannan 2016).

A purpose of the study was to determine documentation practice and the factors that influence them among nurses working in public hospitals in Tigray, Ethiopia. A quantitative descriptive cross-sectional study design was used by Tasew. All nurses working in government-owned hospitals in Tigray served as the study's source population. The total number of people in the study was 317. A structured self-administered questionnaire was designed to collect data on nurse documentation practice and its associated factors. The findings of this study revealed that the documentation of practice nursing care was insufficient (47.8 percent). more than half of nurses were not documented their nursing care (Tasew et al., 2019).

The main results of a descriptive qualitative study where was conducted in an urban hospital in Indonesia to identify the issues that make it difficult for nurses to follow the correct documentation procedure were inadequate nursing documentation supervision, competency concerns in documentation, and lack of confidence and motivation in documenting . Head nurses and staff participated in focus group discussions through a simple random technique, nurses with more than a year of work experience were recruited. 35 people took part in the activity. The nursing documentation process-related open-ended questions were given out. The head nurses and their staff conducted separate discussions in groups once for each of the two teams. Content analysis techniques were used to identify the data for this study (Kamil et al., 2018).

Also another qualitative study was conducted in one of the Iranian hospitals to identify obstacles to improving nursing documentation services. 20 participants from various nursing grades participated in this qualitative study, including 17 nurses, 1 head nurse, and 2 committee members for accreditation. Semi-structured interviews were used to gather the data, together with an interview guide and field notes. Research data have been categorized into four main themes: qualification of documentation, including sub-categories of the need for effective training, the need for training in documentation standards, and the necessity of reporting skills; job burnout, including sub-categories of job stress and work pressure; perceived control, including sub-categories of planned control and effective monitoring and control; and intra-organizational coordination, including sub-categories of planned control and effective monitoring and control (Vafaei et al., 2018).

Investigating nurses' perceptions of the significance of nursing documentation was the goal of a study which was conducted in ten Slovenian hospitals through a quantitative non-experimental research approach. The survey's questions were all closed-ended. Data were gathered between June 1, 2012, and March 31, 2013. The response rate was 44.95 percent. 592 respondents in all took part in the study, with secondary education making up 47.3% and an undergraduate degree making up 52.7%.The results of this study showed the nursing professionals with at least a bachelor's degree gave documentation a higher priority than those with only a secondary education (p 0.001). No connection with statistical significance was found ($p = 0.98$). However, a negative association between the amount of time spent documenting and a favorable attitude toward documentation was found ($p = 0.04$) (Petkovšek-G &Skela-S, 2015).

In the Vhembe district of the Limpopo Province of South Africa, specific public hospitals were the focus of this study in order to explore and characterize the difficulties nurses faced with relation to record-keeping. The research design was descriptive, and qualitative. Semi-structured interviews with nurses employed by a few public hospitals were done until data saturation was reached after they had been purposefully chosen. The Tesch's open-coding technique was used to analyze the data. The main results of this study showed that a number of issues, such as a lack of time to complete the records, an increase in patient admissions, and a lack of recording materials make keeping records difficult for nurses working in public hospitals (Mutshatshi et al., 2018).

With regard to nursing care documentation, the cross-sectional study sought to evaluate nurses' knowledge, attitudes, practices, and related factors in West Gojjam Zone public hospitals in Amhara Ethiopia among 246 nurses working in public hospitals from February to March 8, 2018. Simple random sampling was used to choose the study subjects. Data were gathered using a self-administered, pre-tested, and validated structured questionnaire with internal reliability values of 0.912, 0.784, and 0.713 for knowledge, attitude, and practice items, respectively. For data entry and analysis, respectively, Epi Data version 3.1 and SPSS version 20 were utilized. We utilized a binary logistic regression model and descriptive statistics. The findings of this study revealed that West Gojjam zone public hospital nurses had low knowledge, attitudes, and practices regarding nursing care documentation. Also nursing care documentation practice was significantly influenced by work environment, work history, and nurse expertise. The availability of operating standards, nurses' knowledge and attitudes, and their practice of nursing care documentation all had a significant impact (A et al., 2019).

In Ghana, at Tamale Teaching Hospital the cross-sectional study examined the socio-demographic variables of nursing documentation practice among 278 nurses. A questionnaire was used to collect data, and descriptive and inferential analyses were performed to determine the factors impacting nurse documentation practice. The majority of nurses' knowledge of nursing documentation was determined to be adequate, and nursing schools were the participants' primary source of knowledge. Participants also had positive opinions toward nursing documentation, and the practice of documenting was reported to be frequent and more likely to be adequate for the majority of participants (Seidu et al., 2021).

A study was carried out in January 2017 at a hospital in Surabaya, Indonesia to analyze the relationship between nurses compliance and their knowledge, attitude and motivation and nursing documentation. Compliance with nursing care documentation is inversely related to knowledge. This is due to knowledge being the basic information capital of documentation compliance. Because attitude is a type of reaction to determine decision making in nursing documentation, it has a rather low link with nurse compliance. Unlike the preceding two criteria, motivation has a reasonable relationship to compliance since motivation is an inducement to behave in accordance with nursing documentation (Nyarmi et al., 2020).

The goal of the study was to examine factors associated to nurse behavior in recording nursing care in the Emergency Unit (EU) by using the Theory of Planned Behavior. The study is planned as an observational analysis with a cross-sectional methodology. Emergency nurses from emergency department of Level II Hospital Dr. Soepraoen, Panti Waluya Sawahan Hospital, and Islamic Hospital. The attitude of nurses is related to the purpose of documenting nursing care in the EU with a positive connection direction. The subjective norm has nothing to do with the objective of documenting nursing care in the EU ((Corresponding author) et al. 2018).

Data gathered from 2018 to 2019 in two urban locations of Iran were used in a qualitative study that used a qualitative content analysis to examine nursing documentation-related factors from the standpoint of the nurses. The primary focus of this study was "unsafe documentation." The development of 12 subcategories and two categories, "types of errors in reporting" and "reasons of errors in reporting," reflecting elements impacting nursing documentation in the Iranian nursing setting. Nursing documentation in Iran was often influenced by individual, organizational, and national variables thus the quality of nursing documentation should be improved in this regard by hiring more nurses, implementing changes to the healthcare management structure, creating appropriate rules for the division of labor, continuously educating healthcare staff, establishing clinical governance, enhancing interpersonal relationships, developing hardware and software techniques for documentation, and offering support (Tajabadi et al., 2020).

A purpose of the study was to investigate the factors that contribute to a lack of optimal nursing care documentation in an outpatient unit. A fish bone analysis approach was used in the study to determine the source of problems with documenting nursing treatment in an outpatient unit. This study was carried out in an outpatient section of Jakarta's Children's and Mother's Hospital. This study used questionnaires, observations, and interviews with the head of the room, Clinical Instructors, implementing nurses, Case Managers, and Nursing Fields to collect data. Several findings emerge from the analysis. Nurses, clinical instructors, high-demand activities, and rules and procedures for assessment and monitoring are insufficient. There are no effective procedures or mechanisms in place to supervise nursing care documentation and manual paperwork (Kurniawati et al., 2019).

A descriptive, correlational, cross-sectional study was conducted in East Java, Indonesia, at two government hospitals from December 2018 to February 2019 to examine the impact of nurses on the level of documentation in a hospital context. The sample was made up of nurses with a minimum of six months of work experience, regardless of age or gender. The quality of nursing care documentation was the variable dependent, while individual characteristics identified were gender, education, age, duration of service, knowledge and motivation of the nurses. An observation sheet for nursing documentation and a questionnaire about the knowledge and motivation of nurses were used to gather the data. There is evidence that the nurses' training, expertise, and motivation have an impact on the high quality of their documentation (Wahyuni et al., 2023).

The objectives of the study were to determine whether the keywords in a nursing documentation model, known as the VIPS model, were appropriate for use in pediatric nursing care, clarify the content represented by the keywords and suggest based on the study's findings, the addition of additional text to the key word descriptions to make the VIPS model more appropriate for use in pediatric nursing care. Pediatric case studies, pediatric nurse surveys, and examinations of nursing records were some of the research approaches used. In the case studies, the nurses provided written descriptions of the various VIPS model key terms and the type of treatment they required to note in the records of the children. Three times, nurses interested in nursing documentation both those with formal responsibilities for developing nursing documentation and those working on a volunteer basis were sent questionnaires that were quite different from one another. 81 nurses in all responded to the questionnaires. The examination of the documents revealed that the majority of notes in the section of nursing history related to the child's medical history, social background, and reasons for contact or admission. Nutritional requirements and respiratory issues were the most prevalent nursing status issues. The key phrase "special care" in the context of nursing interventions refers to interventions that are initiated by or prescribed by nurses, such as examinations, the administration of medications, and care related to tubes, drains, or pain treatment. Observer agreement was evaluated and deemed to be appropriate (Engvall, 1997).

2.2.3 Relationship between nursing documentation and pediatric patients' outcomes

The practice of documentation has been cited as crucial to the provision of healthcare services and advancements in treatment results (Mathioudakis et al. 2016).

A study was conducted to examine the relationship between the quality of the nursing documentation system and patient care continuity at Tanta University Hospitals. A descriptive correlational design study was conducted by Abd El Rahman (2021) at Tanta University Hospitals, which are linked with the Ministry of Health (MoH). In intensive care units, a handy sample of 80 nurse supervisors and a simple random sample of 80 staff nurses were used. The data was obtained using two instruments that the investigator had customized. The first instrument was a questionnaire about the quality of nursing documentation and the auditing continuity of patient care checklist was the second tool. There was a statistically significant positive link between nursing documentation quality and patient care continuity (Abd El Rahman et al., 2021).

According to the findings of a qualitative, exploratory study which conducted by a Bjerkan, Valderaune, and Olsen (2021) which aimed to understand healthcare professionals' and students' perceptions of existing barriers to patient safety through the use of documentation practices, there were a number of obstacles had a detrimental impact on information sharing and documenting practices, which could put primary care patients in a precarious and exposed position. Six focus group interviews were done with nurses and social educators (n = 12) active in primary care practice, as well as nursing and social educator bachelor's degree students from a University College (n = 11). The data was evaluated qualitatively using content analysis (Bjerkan et al., 2021).

Also, this study was conducted to examine the relationship between nursing documentation and patients' mortality. Electronic nursing documentation from a big, urban academic medical facility was analyzed using data-mining approaches over a 15-month period. For a random group of patients and patients who experienced a cardiac arrest during their stay, mortality rates, the frequency of vital sign measurements, and optional nursing remark documentation were studied. The results of the study showed that the nurses' documentation has a signal that provides information about the patient's condition and may be helpful in foretelling cardiac arrest and death. The clinical judgment of nurses and doctors regarding the severity of an illness at the time of admission has been linked to patient mortality, and

the signal of increased documentation is a sign of the nurses' clinical judgment to increase surveillance and monitoring for patients thought to be at risk of deterioration (Collins et al., 2013).

A mixed methods intervention study was carried out to investigate nurses' knowledge and attitudes regarding documentation, including an assessment of nurses' responses to a specified nursing documentation form. A convenience sample of forty participants was drawn from six wards of a Ugandan health facility. The study intervention consisted of training nurses the value of documenting and use the trial documentation tool. Organizational concerns, insufficient documentation knowledge, a lack of training, and a lack of motivation were identified as impediments to successful nursing documentation. The study's findings have implications for pre- and post-service training, documentation policies, and organizational supports for nursing documentation (Nakate et al., 2015).

Simply, the findings of these studies show that the quality of nursing documentation, particularly in pediatric departments, need further investigation and monitoring.

2.3 Assessment of current documentation practices in pediatric departments

2.3.1 Existing Documentation Practices in Governmental Pediatric Departments

Documentation practices in pediatric departments of governmental hospitals vary widely based on institutional policies, available resources, and the training provided to nursing staff. In many governmental settings, nurses face challenges such as high patient loads, resource limitations, and time constraints, which can impact the quality and thoroughness of documentation.

Ali et al. (2020) identify common barriers to effective documentation, including inadequate training and lack of managerial support. Such barriers contribute to inconsistent documentation practices that may not meet the required quality standards. Standardized documentation tools and templates, such as those provided in EHRs, are instrumental in promoting consistency and accuracy in records; however, they are not always available in resource-limited settings.

Andualem et al. (2019) emphasize that the attitudes, knowledge, and practices of nurses toward documentation significantly influence the quality of records. In pediatric departments, this is particularly important as documentation plays a key role in monitoring the health status of young patients. Providing regular training and support can help nurses understand the importance of documentation and improve compliance.

2.3.2 Methods for evaluating the quality of nursing documentation

Evaluating nursing documentation involves various methodologies aimed at determining compliance with standards, assessing completeness and accuracy, and identifying areas for improvement. Common methods include audits, quality indicators, and standardized evaluation tools. Bail et al. (2020) discuss the use of record audits to assess the quality of documentation, noting that these audits help to identify patterns, evaluate the consistency of documentation, and monitor compliance with clinical guidelines.

Another approach involves the use of quality criteria, such as accuracy, completeness, and timeliness, which are critical in ensuring that nursing documentation reflects the actual care provided (Groot et al., 2019).

Electronic health records (EHRs) have also been introduced as a tool to improve documentation quality by providing a structured format that ensures consistency in data entry. Akhu-Zaheya et al. (2018) compare the effectiveness of EHRs with paper-based systems, suggesting that digital records enhance the clarity and accessibility of patient information, though they may introduce challenges related to the increased time spent on documentation.

In Gaza, the unique socio-political and economic challenges impact the healthcare system, including documentation practices in pediatric departments. Nurses in Gaza often face high patient loads, limited resources, and occupational stress, which can affect their ability to document care accurately and consistently (Albelbeisi et al., 2024). These challenges create barriers to quality documentation, as nurses may lack the time or support needed to complete documentation tasks thoroughly.

2.3.3 Previous studies and findings on documentation quality in similar settings

Research on nursing documentation in similar healthcare settings provides valuable insights into the challenges faced and the methods used to improve documentation quality. In Ethiopia, Andualem et al. (2019) investigated the knowledge, attitudes, and practices of nurses regarding documentation and found that limited training and high workloads were major barriers to effective documentation. Abd El Rahman et al. (2021) examined the impact of documentation quality on patient care continuity and highlighted the need for regular training to enhance nurses' documentation skills.

In a comparative study, Akhu-Zaheya et al. (2018) analyzed the differences between paper-based and electronic documentation systems in nursing practice. Their findings suggest that EHRs improve data accessibility and reduce documentation errors, but they also noted that electronic systems might increase the time required for documentation, potentially impacting nurses' workflow.

The effect of occupational stress on documentation quality has also been documented. Albelbeisi et al. (2024) conducted a survey on occupational stress among nurses and discovered a strong link between stress and poor documentation practices. Addressing stressors in the workplace, such as high workloads and limited staffing, could lead to significant improvements in documentation quality.

Auditing and quality indicator assessments are recommended methods for evaluating documentation quality. Bail et al. (2020) advocate for regular audits to ensure compliance with documentation standards, which can help identify gaps and areas needing improvement. In pediatric departments, accurate and timely documentation is crucial for patient safety and care quality, making audits and quality assessments integral to documentation practices.

Evaluating the quality of nursing documentation in pediatric departments of governmental hospitals requires a comprehensive approach that considers both quantitative and qualitative factors. Methods such as audits, quality indicators, and electronic health record systems offer different perspectives on documentation quality. Current practices in governmental hospitals face challenges related to high workloads, limited training, and inconsistent use of standardized tools, which impact the quality of documentation. Previous studies indicate that

addressing these challenges through targeted interventions, such as training and workload management, can lead to significant improvements.

The findings from studies emphasize the importance of accurate, complete, and timely documentation for patient safety and care continuity. By implementing evidence-based practices and fostering a supportive work environment, healthcare providers in pediatric departments can enhance documentation quality and ensure high standards of care for young patients. Ongoing efforts to assess and improve documentation practices will be crucial for advancing healthcare outcomes and optimizing patient care quality (Ali et al., 2020).

2.4 Impact of Documentation Quality on Patient Outcomes in Pediatric Care

Documentation quality is a cornerstone of effective pediatric care, influencing patient outcomes through accurate and complete recording of nursing care, treatments, and observations. In pediatric care, the importance of documentation quality is particularly pronounced due to the vulnerable nature of the patient population and the complex nature of pediatric health needs. This document examines the impact of documentation quality on patient outcomes in pediatric care, focusing on the relationship between documentation quality and patient safety, case studies demonstrating the effects, and implications for pediatric recovery and continuity of care (Ramgopal et al., 2024).

2.4.1 Relationship between Documentation Quality and Patient Safety

The relationship between documentation quality and patient safety is well-established in the literature, with high-quality documentation being essential for effective communication, clinical decision-making, and the prevention of medical errors. De Groot et al. (2019) emphasize that documentation accuracy and completeness are critical for ensuring patient safety, as they provide healthcare professionals with a reliable source of patient information. In pediatric care, where patients are often unable to communicate their symptoms or needs, accurate documentation becomes even more crucial for safeguarding against potential risks.

Research conducted by Akhu-Zaheya et al. (2018) illustrates the impact of documentation on patient safety, noting that (EHRs) can enhance documentation quality by providing structured templates for data entry. However, EHRs also present challenges, such as increased documentation time, which may lead to information being recorded hastily or

inaccurately. Ali et al. (2020) further highlight that poor documentation can result in miscommunication among healthcare teams, leading to preventable adverse events and compromising patient safety.

In pediatric settings, timely and accurate documentation is essential for monitoring vital signs, tracking medication dosages, and noting any changes in patient condition. Abd El Rahman et al. (2021) found that high-quality documentation in pediatric departments reduces the likelihood of medication errors and enhances the ability of healthcare providers to respond promptly to patient needs, ultimately supporting safer patient outcomes.

2.4.2 Case Studies or Examples Demonstrating Impact

Case studies and real-world examples underscore the importance of documentation quality in pediatric care, revealing how deficiencies in documentation can directly impact patient outcomes. Bail et al. (2020) conducted a record audit that identified numerous instances where incomplete or inaccurate documentation led to delays in treatment, misdiagnosis, and in some cases, adverse patient outcomes. Their study demonstrates the potential for documentation audits to identify gaps in record-keeping and support quality improvement initiatives.

In one documented case, the failure to document a child's allergy led to the administration of a contraindicated medication, resulting in an adverse reaction (Chelagat et al., 2013). This example illustrates the severe consequences that can arise from lapses in documentation quality, particularly in pediatric care where young patients may be more sensitive to certain medications. Bjerkan et al. (2021) also describe instances where inadequate documentation of vital signs and patient observations resulted in missed opportunities to detect early signs of deterioration, compromising patient safety. Such cases highlight the need for consistent and accurate documentation practices, supported by continuous training and adherence to established guidelines. Ali et al. (2020) suggest that incorporating case-based training on documentation practices can improve nurses' understanding of documentation importance and reduce the risk of documentation-related errors.

2.4.3 Implications for Pediatric Patient Recovery and Care Continuity

High-quality documentation plays a vital role in ensuring the continuity of care, which is critical for the recovery of pediatric patients. Continuity of care depends on accurate, up-to-date information that allows healthcare providers to understand the patient's history, ongoing needs, and response to treatment. Abd El Rahman et al. (2021) emphasize that documentation quality directly impacts care continuity, as incomplete records can lead to lapses in treatment or misinterpretation of patient needs

In pediatric settings, continuity of care is essential due to the need for regular monitoring, follow-up appointments, and adjustments in care plans as children grow and their medical needs evolve. Akhu-Zaheya et al. (2018) discuss how electronic health records enhance continuity by making information accessible across departments and to various healthcare providers, thereby reducing the risk of miscommunication. Additionally, De Groot et al. (2019) highlight the importance of standardized documentation formats that enable seamless transitions between care teams and ensure that critical information is readily available. The recovery of pediatric patients is influenced by the quality of care they receive, and documentation quality is an integral part of that care. Poor documentation practices can lead to missed interventions, delayed diagnoses, and suboptimal treatment plans. Studies suggest that high-quality documentation supports timely decision-making and effective care planning, which are essential for the recovery process (Chelagat et al., 2013; Bjerkan et al., 2021). As pediatric patients often require ongoing care for chronic or complex conditions, maintaining accurate records over time ensures that each provider involved in the child's care has a comprehensive understanding of their medical history and care needs.

The quality of nursing documentation is a key determinant of patient outcomes in pediatric care, influencing patient safety, care continuity, and recovery. This assessment highlights the critical relationship between documentation quality and patient safety, demonstrating through case studies and examples the consequences of poor documentation practices. As the healthcare sector increasingly adopts electronic documentation systems, it is essential to balance the benefits of structured and accessible records with the potential challenges, such as increased documentation time (Ramgopal et al., 2024).

Ensuring high-quality documentation in pediatric care requires adherence to established standards, regular audits, and continuous training. By focusing on improving documentation

quality, healthcare institutions can support safer and more effective pediatric care, ultimately enhancing patient outcomes and supporting long-term health and recovery. Ongoing research and quality improvement initiatives are necessary to address the barriers to quality documentation and to develop strategies that promote best practices in pediatric healthcare documentation (Tang & Li 2024).

Research by Sammour et al. (2023) highlighted that Al-Rantisi Nasser Hospital had a notably high percentage of nursing participants in their study, reflecting the hospital's significant representation in nursing research within pediatric care. Similarly, Qasim et al. (2021) reported that the percentage of female nurses exceeded male nurses in pediatric hospitals, aligning with global trends in nursing demographics. Despite this, Jasem et al. (2024) and Hockenberry et al. (2023) indicated that nurses' attendance in training programs related to documentation remains consistently low, contributing to persistent gaps in documentation quality. Additionally, Ogboenyiya et al. (2020) and Ramgopal et al. (2023) emphasized the limited availability of standardized nursing record forms, further hindering effective documentation practices. These challenges are compounded by frequent staff turnover, understaffing, and a lack of robust monitoring systems, which create inconsistencies in documentation quality. Studies by Nool et al. (2023), Jasem et al. (2024), and Fatmawati et al. (2024) suggest that standardized documentation protocols and institutional policies can mitigate the effects of sociodemographic variations, leading to more uniform documentation practices. Supporting this, Bjerkan et al. (2021), Oliveira et al. (2021), Melnick et al. (2021), and Ruiz-Fernández et al. (2020) reinforced the importance of protocol adherence and regular training in achieving consistency. Finally, Moy et al. (2021) noted that variations in documentation quality often stem from differences in personnel qualifications, institutional policies, and access to technology, underscoring the multifaceted nature of improving documentation standards in pediatric nursing.

2.5 Summary

Nursing documentation is a core element in healthcare, initially emphasized by Florence Nightingale for supporting continuity of care, assessing treatment efficacy, and guiding informed clinical decisions. Its role is especially vital in pediatric care, where detailed, accurate documentation supports the safety and tailored treatment needs of vulnerable patients. In challenging environments like Gaza, where nurses face high patient loads and limited resources, maintaining consistent documentation is difficult, underscoring the need for robust training and support.

Documentation serves multiple functions: it records patient health and care status, facilitates communication among healthcare providers, and upholds accountability and legal standards. With the shift from paper to (EHRs), documentation has become clearer and more accessible, although time demands have increased, adding to nurses' workloads. The quality of documentation reflects the nurse's role in delivering responsible care, yet high stress, limited staffing, and resource constraints can hinder its effectiveness.

Evaluating nursing documentation quality involves audits and criteria focused on accuracy, completeness, and timeliness. Regular audits help monitor compliance, identify patterns, and improve documentation practices, especially critical in pediatric settings where patient safety depends on detailed and timely records. In resource-constrained areas like Gaza, factors like occupational stress and high patient volumes further challenge documentation standards.

To enhance documentation quality, healthcare facilities must prioritize a supportive work environment, manageable workloads, and continuous training. Standardized tools, like EHRs, promote consistency, while training on documentation standards encourages adherence. High-quality documentation is integral to patient safety, enabling better treatment decisions and reducing medical errors. In pediatric care, where continuity and accuracy are essential, improved documentation practices lead to safer, more effective patient care, fostering positive outcomes in even the most challenging healthcare settings.

Chapter Three
Methodology

3.1 Study Design

The quantitative descriptive cross-sectional study was conducted to assess the quality of nursing documentation in selected pediatric governmental hospitals in GS. This type of design was used because it is conducted over a short period of time and on a large population. It looks at relationships between many factors, and it's affordable, quick, and simple to use (Mohajan & Haradhan, 2020).

3.2 Setting of the study

The study was conducted in the pediatric departments of five governmental hospitals, which represent all five governorates of GS.

1. Al-Aqsa Martyrs Hospital, Middle governorate.
2. Al-Durra Children's Hospital, North Gaza governorate.
3. Al-Rantisy-Nasser Pediatric Hospital, Gaza governorate.
4. Nasser Medical complex Hospital, South Gaza governorate (Khan Younis).
5. El-Najar Hospital, South Gaza governorate (Rafah).

3.3 Nurses number in pediatric departments

Nursing staff who working in pediatric departments of selected hospitals at the time of the study who's total number 140 nurses and pediatric patients' medical record. The selection of 140 nursing staff and pediatric patients' medical records ensures a representative sample for evaluating documentation practices in pediatric care. This approach provides comprehensive data, combining nurses' insights and objective record analysis, enabling accurate assessment of adherence to PMoH standards and identifying areas for improvement in documentation quality.

Table 3.1: Nurses number in pediatric departments

Hospital Name	Nurses Number
Kamal Adwan Hospital	33
Al-Durra Children's Hospital	34
Al-Rantisy-Naser Pediatric Hospital	33
Nasser Medical complex Hospital	25
El-Najar Hospital	15
Total	140

3.4 Sample size and sampling process

Mixed sample of pediatric patients' medical records and nurses who work in pediatric departments of governmental hospital were used. Non-probability purposive sampling (also called judgmental sampling) is a non-probability sampling method where researchers intentionally select participants based on specific characteristics or criteria relevant to the study's objectives. The current study to recruit pediatric patients' medical record and nurses who work in the selected pediatric departments. The sample size required for a population survey with 95% confidence and 50% expected frequency is 90 nurses. This is calculated by epi info with an acceptable margin of error of 5%, design effect of 1.0. and 200 pediatric patients' medical records. The sampling process involved two steps: The first step includes the selection of nurses who meet the eligibility criteria from selected governmental hospitals. Second step include selection of pediatric patients' medical records which meet the eligibility criteria.

3.5 Data collection methods

Data were obtained through structured self-administered demographic questionnaire which was distributed by a researcher, and the participants were returned the answered structured questionnaires after 15 minutes, Also, a checklist for reviewing the pediatric patients' medical records which was developed based on standard nursing documentation principles, reviewing the research literature and standards developed by the PMoH.

3.6 Eligibility criteria

Nurses who working in the pediatric departments at selected hospitals and having at least 6 months of work experience, having a diploma degree at least and direct clinical work with the patient, work full time schedule, also being available at the time of the documentation exercise and willingness to participate in the study. Pediatric patients' medical records of patients with a hospital stay at least three days.

3.7 Instrument of the study

A structured self-administered questionnaire was developed to collect data regarding nursing documentation practice and its associated factors based on the national and PMoH guideline, numerous books authored of nursing documentation, and literatures connected to the topic were used to develop practice and knowledge of nursing documentation questions.

First Instrument: "Quality of nursing documentation questionnaires. It was adapted from Abdelwahab et al., (2021). This instrument aimed to assess the quality of nursing documentation It is consisted of two parts: First part: demographic data of nurse supervisors as gender, years of experience, educational level, residence, and job position. Second part: It covered (10) domains with 78 items as follow: types of nursing records formats availability (15 items), the reasons of unavailability of formats (3 items), types of nursing records formats kept in patient's file after patient discharge (15 items), responsibilities of reviewing recorded nursing format (3items), standards of nursing documentation quality (14 items), attendance of training programs related to nursing documentation(3 items), factors lead to poor documentation (8 items), importance of nursing documentation quality (8 items), importance of continuity of patient care from nurse`s point of view (6 items) and responsibility of writing shift report (3 items). The levels of Quality nursing documentation was classified as high or good=80-100, moderate=60-79.9, and low or poor=less than 60 (Ali et al., 2020) .

Auditing continuity of patient care checklist. The aim of this instruments to assess continuity of patient care by auditing checklist (observational checklist).

3.8 Pilot study

Before starting the actual data collection phase, the questionnaire was pretested among the nurses on 10% of the sample in order to provide feedback, ensure consistency of the questionnaire as well as identify areas of confusion during data collecting. It also aided in estimating the time required to complete the questionnaire sheets. The pilot study was conducted on 10% of the subjects (10) nurses. Based on the findings of the pilot study, some questions were rephrased to ensure clarity and ease of understanding for nurses. It was expected that each nurse would need 15 minutes to complete the questionnaires.

3.9 Validity and Reliability:

3.9.1 Validity:

The questionnaire was submitted to the experts in the field for ensuring the instrument's suitability and determine whether the questions aligned with the scope of the items and the extent to which these items reflected the research problem's and to check for redundant, unclear, or leading questions in the questionnaire.

3.9.2 Reliability:

The internal consistency of structured questionnaire was measured through Cronbach's alpha coefficient which was computed by using SPSS and should be in acceptable range 0 .7 or higher.

3.9.2.1 Reliability of the instrument

The reliability of an instrument is the degree of consistency with which it measures the attribute it is intended to measure. The test is administered to the same sample of individuals on two separate occasions, and the scores obtained are compared by calculating a reliability coefficient. One common method to calculate reliability is by using Cronbach's Alpha coefficient. Table 3.1 displays the values of Cronbach's Alpha for each domain of the questionnaire administered to the participants. The table illustrates the reliability of the domains, with a Cronbach's Alpha value of 0.951 for the entire questionnaire in the pilot sample, indicating good reliability for the entire questionnaire.

Table 3.2: Reliability of the research for each domain of the questionnaire

No.	Domains	No. of item	Cronbach's Alpha
D1	Types of nursing records formats availability	13	0.989
D2	Staff nurse's attendance of training programs related to nursing documentation	3	0.907
D3	Factors lead to inappropriate documentation ®	14	0.965
D4	Auditing continuity of patient care related to nursing intervention and vital signs	21	0.943
Total		**51**	**0.951**

3.9.2.2 Half-Split Method

As indicated in Table 3.2, the correlation between forms was 0.922, the unequal length Spearman-Brown Coefficient was 0.960, and the Guttman Split-Half Coefficient was 0.960. These findings demonstrate the high reliability of the questionnaire.

Table 3.3: Split and half for each domain of the questionnaire

Split half			R
Cronbach's Alpha	Part 1	Value	0.810
		N of Items	26
	Part 2	Value	0.807
		N of Items	25
	Total N of Items		51
Correlation Between Forms			0.922
Spearman-Brown Coefficient	Equal Length		0.960
	Unequal Length		0.960
Guttman Split-Half Coefficient			0.960

3.10 Data Analysis

The data was analyzing by using descriptive and inferential statistics through SPSS version 25 to assess the quality of nursing documentation in pediatric departments in selected governmental hospitals.

3.11 Ethical Consideration

Before conduct the study, approval was obtained from Al-Quds University, and an application letter was sent to the Helsinki Committee to obtain moral approval for the study. Also getting approval from PMoH to complete the study. In addition, clarifying the voluntary nature of participation, the right to withdraw at any time, and the purpose of the study with measures to preserve confidentiality.

3.12 Period of the study

The study was conducted between January and October 2023.

Chapter Four

Results

This chapter displays the outcomes of the assessment concerning the standards of nursing documentation in the pediatric wards of the governmental hospitals in Gaza strip Palestine. The respective headings in this section correspond to the sections where the information on the assessed quality of documentation is gathered, such as statistical similarities and major outcomes. This chapter describes the characteristics of the studied population in demographic and the results of various statistical analyses aimed at estimating and assessing the quality and patterns of documentation.

4.1 Quality of nursing documentation

4.1.1 Sample distribution according to socio-demographic data among nurses

The present cross-sectional study involved 90 nurses of pediatric department in five main governmental hospitals and delved into an assortment of socio-demographic variables, such as setting of work, gender, age in years, marital status, qualifications, years of experience in nursing and working time

4.1.1.1 Distribution of the study population according to the hospital (n=90)

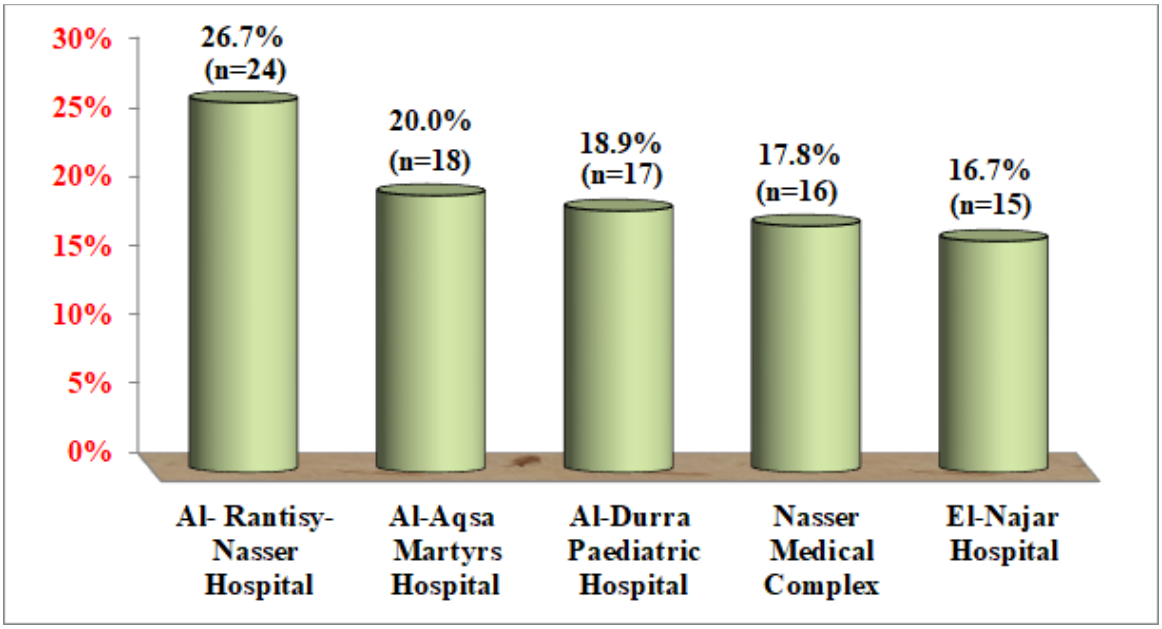

Figure 4.1: Distribution of the study population according to the hospital

Figure 4.1 Distribution of the study population according to the hospital. The dataset consists of ninety cases in total. Notably, the results showed that highest frequency was Al-Rantisy-Nasser Hospital (26.7%), followed by Al-Aqsa Martyrs Hospital at (20.0%). While Al-Durra Children's Hospital, El-Najar Hospital, and Nasser Medical Complex was 18.9%, 16.7%, and 17.8% of the dataset, respectively.

4.1.1.2 Distribution of the study population according to the gender

Figure 4.2 shows the distribution of the study population according to the gender. The results showed that the majority of participant was females (80.0%) while 20.0% was males

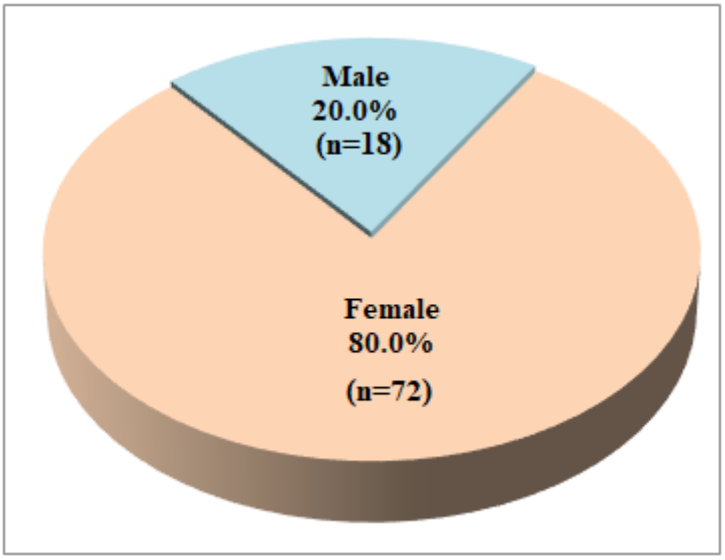

Figure 4.2: Distribution of the study population according to the gender

4.1.1.3 Distribution of the study population according to their socio-demographic information

Table 4.1: Distribution of the study population according to their socio-demographic information

Socio-demographic information	Categories	N	%
Age in years	Less than 35	47	52.2%
	35 or more	43	47.8%
Marital Status	Married	48	53.3%
	Single	42	46.7%
Qualifications	Diploma	28	31.1%
	Bachelor degree	54	60.0%
	Professional diploma	3	3.3%
	Master degree	5	5.6%
Years of experience in nursing	10 or less	51	56.7%
	More than 10	39	43.3%
Working time	Straight morning	44	48.9
	Rotated shifts	46	51.1

The present table furnishes a comprehensive dissection of the distribution of the study population based on their socio-demographic attributes. The socio-demographic variables include age, marital status, qualifications, years of experience in nursing, and working time. In terms of age distribution, the participants are categorized as being either less than 35 or 35 or more years old, with a distribution of 52.2% and 47.8%, respectively. Moving to marital status, more than half of the population, representing 53.3%, are classified as married, followed by 46.7% being single, and a minority of 1.1% being Others.

The educational composition of the participants is delineated through their qualifications. The spectrum spans from Diploma with a representation of 31.1%, escalating to a Bachelor's degree at 60.0%, and descending through a Professional diploma (3.3%) and Master's degree (5.6%), Transitioning to the metric of Years of experience in nursing, the participants are stratified into two categories: 10 or less and more than 10, with percentages of 56.7% and 43.3% respectively, illuminating a diverse range of nursing experience within the study population. The final socio-demographic facet elucidates the participants' Working time. Under this categorization, 48.9% of the participants are engaged in Straight morning shifts, while the remaining 51.1% working rotated shifts.

4.1.1.4 Scores of items measuring the level of types of nursing records formats availability

Table 4.2: Scores of items measuring the level of types of nursing records formats availability

SN	Items	Available and used n(%)	Available but not used n(%)	Not available n(%)	Mean	SD	Mean%	Rank
1.	Nursing notes form	90(100)	0(0)	0(0)	2.00	-	100.0	1
2.	Medication administration sheet	90(100)	0(0)	0(0)	2.00	-	100.0	1
3.	Vital signs sheet	88(97.8)	2(2.2)	0(0)	1.98	0.15	99.0	3
4.	Fluid balance sheet	65(72.2)	10(11.1)	15(16.7)	1.56	0.77	78.0	9
5.	Patient assessment on admission form	75(83.3)	3(3.4)	12(13.3)	1.70	.69	85.0	7
6.	Paediatric nursing care plan form	50(55.6)	7(7.8)	33(36.6)	1.19	.95	59.5	11
7.	Discharge planning form	2(2.2)	6(6.7)	82(91.1)	0.11	0.38	5.5	13
8.	Informed consent form	71(78.9)	11(12.2)	8(8.9)	1.70	.63	85.0	7
9.	Pain assessment form	36(40)	12(13.3)	42(46.7)	0.93	0.93	46.5	12
10.	Paediatric insulin administration form	56(62.2)	6(6.7)	28(31.1)	1.31	0.92	65.5	10
11.	Handover form	81(90)	5(5.6)	4(4.4)	1.86	0.46	93.0	5
12.	Incident report form	76(84.4)	8(8.9)	6(6.7)	1.78	0.56	89.0	6
13.	Kardex	85(94.4)	2(2.2)	3(3.4)	1.91	0.39	95.5	4
	Total				**1.54**	**0.41**	**77.01**	

Table 4.2 shows the distribution of nurses according to their responses about the level of types of nursing records formats availability. The table shows that the weighted mean for the overall perceptions about the level of types of nursing records formats availability was 77.01%. According to the results, the highest paragraph was the number (1) " Nursing notes form " and number (2) " Medication administration sheet" with a weighted mean equal to 100.0%. While the lowest paragraph (7) " Discharge planning form " with a weighted mean equal to 5.5%, followed by paragraph was the number (9) " Pain assessment form " with a weighted mean equal to 44.5%.

4.1.1.5 Staff nurse's attendance of training programs related to nursing documentation

Table 4.3: Staff nurse's attendance of training programs related to nursing documentation

SN	Items	Yes n (%)	No n (%)	Rank
1.	In the department	75(83.3)	15(16.7)	1
2.	In the hospital	72(80)	18(20)	2
3.	Outside the hospital	38(42.2)	52(57.8)	3
	Total	**68.5**	**31.5**	

Table 4.3 shows the distribution of nurses according to their responses about Staff nurse's attendance of training programs related to nursing documentation. The table shows that the weighted mean for the overall perceptions about the level of staff nurse's attendance of training programs related to nursing documentation was 68.5%. According to the results, the highest paragraph was the number (1) " In the department " with a weighted mean equal to 83.3% followed by number (2) " In the hospital " with a weighted mean equal to 80.0 While the lowest paragraph (3) " Outside the hospital " with a weighted mean equal to 42.2%.

4.1.1.6 Scores of items measuring the factors lead to inappropriate documentation

Table 4.4: Scores of items measuring the factors lead to inappropriate documentation

SN	Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	% Mean	Rank
1.	Lack of good monitoring system	29(32.2)	28(31.1)	14(15.6)	14(15.5)	14(5.6)	2.31	1.23	46.2	14
2.	lack of punishment and reward system	23(25.6)	21(23.3)	13(14.4)	28(31.1)	28(5.6)	2.68	1.31	53.6	5
3.	Lack of nursing documentation policies in pediatric departments	27(30)	33(36.7)	6(6.7)	19(21)	19(5.6)	2.36	1.27	47.2	12
4.	Lack of familiarity with operational standards of nursing documentation	17(18.9)	35(38.9)	16(17.8)	17(18.8)	17(5.6)	2.53	1.16	50.6	9
5.	Not dating, timing and signing entries	31(34.4)	29(32.2)	5(5.6)	17(18.9)	17(8.9)	2.36	1.36	47.2	13
6.	Use of inappropriate abbreviations	22(24.4)	26(28.9)	10(11.1)	25(27.8)	25(7.8)	2.66	1.33	53.2	6
7.	Leave blank lines between sentences in the documentation form	25(27.8)	25(27.8)	15(16.7)	19(21.1)	19(6.7)	2.51	1.28	50.2	11
8.	Entering information into the wrong chart	27(30)	26(28.9)	7(7.8)	21(23.3)	21(10)	2.54	1.39	50.8	8
9.	Documentation takes a long time	26(28.9)	24(26.7)	14(15.6)	19(21)	19(7.8)	2.52	1.32	50.4	10
10.	Nursing shortage	22(24.4)	10(11.1)	9(10)	26(28.9)	26(25.6)	3.20	1.55	64	2
11.	Excessive work load and fatigue	15(16.7)	14(15.6)	6(6.7)	27(30)	27(31)	3.43	1.48	68.6	1
12.	Poor physical work environment	17(18.9)	17(18.9)	17(18.9)	21(23.3)	21(20)	3.07	1.41	61.4	3
13.	Illegible handwriting	18(20)	17(18.9)	17(18.9)	25(27.8)	25(14.4)	2.98	1.37	59.6	4
14.	Inadequate documenting sheets	24(26.7)	20(22.2)	18(20)	19(21.1)	19(10)	2.66	1.34	53.2	6
	Total (mean*20= %mean)						**2.70**	**0.90**	**54.0**	

Table 4.4 shows the distribution of nurses according to their responses about the factors lead to inappropriate documentation. The table shows that the weighted mean for the overall perceptions about level of factors lead to inappropriate documentation was 54.0%.

According to the results, the highest paragraph was the number (11) " Excessive work load and fatigue " with a weighted mean equal to 68.6% followed by number (10) " Nursing shortage " with a weighted mean equal to 64.0%. While the lowest paragraph (14) " Lack of good monitoring system " with a weighted mean equal to 46.2%, followed by paragraph was the number (5) " Not dating, timing and signing entries " with a weighted mean equal to 47.2%.

4.1.1.7 Scores of items measuring the auditing continuity of patient care related to nursing intervention and vital signs

Table 4.5: Scores of items measuring the auditing continuity of patient care related to nursing intervention and vital signs

Items	Done and recorded properly	Done and not recorded	Not applicable	Mean	±SD	%Mean
Morning shift	89.7	3.0	7.3	1.83	0.39	91.50
Temperature	90 (100)	0 (0)	0 (0)	2.00	0.00	100.00
Pulse	82 (91.1)	3 (3.3)	5 (5.6)	1.86	0.49	93.00
Respiration	77 (85.6)	4 (4.4)	9 (10)	1.76	0.62	88.00
Blood pressure	74 (82.2)	4 (4.4)	12 (13.4)	1.69	0.70	84.50
Evening shift	84.5	5.8	9.7	1.75	0.47	87.50
Temperature	88 (97.8)	2 (2.2)	0 (0)	1.98	0.15	99.00
Pulse	75 (83.3)	7 (7.8)	8 (8.9)	1.74	0.61	87.00
Respiration	71 (78.9)	6 (6.7)	13 (14.4)	1.64	0.72	82.00
Blood pressure	70 (77.8)	6 (6.7)	14 (15.5)	1.62	0.74	81.00
Night shift	85.3	6.1	8.6	1.77	0.45	88.50
Temperature	89 (98.9)	1 (1.1)	0 (0)	1.99	0.11	99.50
Pulse	76 (84.4)	6 (6.7)	8 (8.9)	1.76	0.61	88.00
Respiration	73 (81.1)	5 (5.6)	12 (13.3)	1.68	0.70	84.00
Blood pressure	69 (76.7)	10 (11.1)	11 (12.2)	1.64	0.69	82.00
Nursing interventions	88.7	7.0	4.3	1.84	0.24	92.00
Hygienic care	71 (78.9)	11 (12.2)	8 (8.9)	1.70	0.63	85.00
Health education	84 (93.3)	6 (6.7)	0 (0)	1.93	0.25	96.50
Nursing observation	83 (92.2)	5 (5.6)	2 (2.2)	1.90	0.37	95.00
Changing position	73 (81.1)	8 (8.9)	9 (10)	1.71	0.64	85.50
Physical & psychological assessment	72 (80)	9 (10)	9 (10)	1.70	0.64	85.00
Patient complaints	86 (95.6)	2 (2.2)	2 (2.2)	1.93	0.33	96.50
Care of IV lines	84 (93.3)	3 (3.3)	3 (3.4)	1.90	0.40	95.00
Care of tubes	76 (84.4)	12 (13.3)	2 (2.3)	1.82	0.44	91.00
Administer ordered medications	89 (98.9)	1 (1.1)	0 (0)	1.99	0.11	99.50
Total				**1.80**	**0.33**	**90.00**

Table 4.5 shows the distribution of nurses according to their responses about level of auditing continuity of patient care related to nursing intervention and vital signs. The table shows that the weighted mean for the overall perceptions about level of auditing continuity of patient care related to nursing intervention and vital signs was 90%. According to the results, the

highest paragraph was the number (4) " Nursing interventions " with a weighted mean equal to 92.0% followed by number (1) " Morning shift " with a weighted mean equal to 91.5%. While the lowest paragraph (2) " Evening shift " with a weighted mean equal to 87.5%, followed by paragraph was the number (3) " Night shift " with a weighted mean equal to 88.5%.

4.1.1.8 Scores measuring of domains level of total quality of nursing documentation at pediatric departments of governmental hospitals in the Gaza Strip

Table 4.6: Scores measuring domains level of total quality of nursing documentation at pediatric departments of governmental hospitals in the Gaza Strip

No.	Domains	%Mean	SD	Rank
1	Types of nursing records formats availability	77.01	14.92	2
2	Staff nurse's attendance of training programs related to nursing documentation	68.5	32.14	3
3	Factors lead to inappropriate documentation ®	54.0	18.01	4
4	Auditing continuity of patient care related to nursing intervention and vital signs	90.0	16.57	1
	Total	**72.33**	**11.28**	

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; & ®: Reverse domain

Table 4.5 shows the distribution of nurses according to their responses about level of total quality of nursing documentation at pediatric departments of governmental hospitals in Gaza Strip. The table shows that the weighted mean for the overall perceptions about level of total quality of nursing documentation at pediatric departments of governmental hospitals in the Gaza Strip was 72.33 %. According to the results, the highest domain was the number (4) " Auditing continuity of patient care related to nursing intervention and vital signs " with a weighted mean equal to 90.0% followed by number (1) " Types of nursing records formats availability " with a weighted mean equal to 77.01%. While the lowest domain (3) " Factors lead to inappropriate documentation " with a weighted mean equal to 54.0%, followed by domain was the number (2) " Staff nurse's attendance of training programs related to nursing documentation " with a weighted mean equal to 68.5%.

4.1.2 Mean difference of studied domains related to demographic data

4.1.2.1 Mean difference of studied domains related to gender

Table 4.7: Mean difference of studied domains related to gender

Domains	Gender	N	%Mean	SD	T	P-value
Types of nursing records formats availability	Male	18	3.70	0.82	-0.978	0.331
	Female	72	3.89	0.73		
Staff nurse's attendance of training programs related to nursing documentation	Male	18	3.24	1.76	-0.545	0.587
	Female	72	3.47	1.58		
Factors lead to inappropriate documentation	Male	18	2.71	0.73	0.054	0.957
	Female	72	2.70	0.94		
Auditing continuity of patient care related to nursing intervention and vital signs	Male	18	4.37	0.94	-0.661	0.510
	Female	72	4.52	0.80		
Total	Male	18	3.51	0.65	-0.933	0.353
	Female	72	3.64	0.54		

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; t**:** independent t test & ®: Reverse domain

Table 4.7 presents the mean differences in the studied domains between genders. An independent t-test was conducted to examine if there were any statistically significant differences in the average mean scores of the studied domains. The analysis revealed no statistically significant variations among males and females among nurses in the average of studied domain as types of nursing records formats availability, staff nurse's attendance of training programs related to nursing documentation, factors lead to inappropriate documentation and auditing continuity of patient care related to nursing intervention and vital signs (P>0.05).

4.1.2.2 Mean difference of studied domains related to age

Table 4.8: Mean difference of studied domains related to age

Domains	Age (years)	N	%Mean	SD	t	P-value
Types of nursing records formats availability	Less than 35	47	3.93	0.71	1.031	0.305
	35 or more	43	3.77	0.79		
Staff nurse's attendance at training programs related to nursing documentation	Less than 35	47	3.40	1.80	-0.133	0.894
	35 or more	43	3.45	1.38		
Factors lead to inappropriate documentation	Less than 35	47	2.58	0.90	-1.338	0.184
	35 or more	43	2.83	0.90		
Auditing continuity of patient care related to nursing intervention and vital signs	Less than 35	47	4.46	0.88	-0.375	0.709
	35 or more	43	4.52	0.78		
Total	Less than 35	47	3.59	0.60	-0.422	0.674
	35 or more	43	3.64	0.53		

*Significant at P≤0.05; P>0.05: Not significant; n: number of subjects; SD: standard deviation; t: independent t test & ®: Reverse domain

Table 4.8 illustrates the mean differences in the investigated domains across different age groups. An independent t-test was employed to assess whether there existed statistically significant disparities in the mean scores of the examined domains. The conducted analysis demonstrated no statistically significant differences between individuals aged below 35 years and those aged 35 years or older among nurses, concerning the average scores in the studied domains. These domains encompassed aspects such as the availability of various nursing records formats, participation of staff nurses in training programs about nursing documentation, factors contributing to inadequate documentation, and the continuity audit of patient care concerning nursing interventions and vital signs ($p > 0.05$).

4.1.2.3 Mean difference of studied domains related to working time

Table 4.9: Mean difference of studied domains related to working time

Domains	Working time	N	%Mean	SD	t	P-value
Types of nursing records formats availability	Straight morning Rotated shifts	44 46	3.82 3.88	0.81 0.69	-0.323	0.747
Staff nurse's attendance of training programs related to nursing documentation	Straight morning Rotated shifts	44 46	3.52 3.33	1.58 1.65	0.557	0.579
Factors lead to inappropriate documentation ®	Straight morning Rotated shifts	44 46	2.43 2.96	0.90 0.83	-2.892	0.005
Auditing continuity of patient care related to nursing intervention and vital signs	Straight morning Rotated shifts	44 46	4.62 4.37	0.76 0.88	1.420	0.159
Total	Straight morning Rotated shifts	44 46	3.60 3.63	0.53 0.60	-0.299	0.765

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; & **t:** independent t test. and ®: Reverse domain

Table 4.9 pointed out the mean differences within the analyzed domains related to working time. An Independent t-test was employed. The analysis conducted indicated the average of factors leading to inappropriate documentation was higher statistically significant in distinctions among Rotated shifts compared to Straight morning (59.16% vs. 48.60, respectively, $p<0.05$). while no different in the average of other domain domains including the availability of diverse nursing record formats, participation of staff nurses in training programs related to nursing documentation, factors contributing to suboptimal documentation, as well as the ongoing audit of patient care continuity in relation to nursing interventions and vital signs ($p > 0.05$).

4.1.2.4 Mean difference of studied domains related to years of experience in nursing

Table 4.10: Mean difference of studied domains related to years of experience in nursing

Domains	Years of experience in nursing	N	%Mean	SD	t	P-value
Types of nursing records formats availability	10 or less More than 10	51 39	3.97 3.69	0.70 0.79	1.825	0.071
Staff nurse's attendance at training programs related to nursing documentation	10 or less More than 10	51 39	3.46 3.38	1.76 1.40	0.256	0.799
Factors lead to inappropriate documentation	10 or less More than 10	51 39	2.62 2.81	0.91 0.89	-0.992	0.324
Auditing continuity of patient care related to nursing intervention and vital signs	10 or less More than 10	51 39	4.53 4.43	0.74 0.94	0.557	0.579
Total	10 or less More than 10	51 39	3.65 3.58	0.53 0.61	0.586	0.559

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; & **t:** independent t test.

Table 4.10 pointed out the mean differences within the analyzed domains across distinct years of experience among nursing groups. To assess the presence of statistically significant variations in the mean scores across these domains, an independent t-test was employed. The analysis conducted indicated an absence of statistically significant distinctions between individuals with less than 10 years of experience in nursing and those with more than 10 years of experience, concerning the scores within the domains under study. These domains encompassed various facets including the availability of diverse nursing record formats, participation of staff nurses in training programs related to nursing documentation, factors contributing to suboptimal documentation, as well as the ongoing audit of patient care continuity in relation to nursing interventions and vital signs ($p > 0.05$).

4.1.2.5 Mean difference of studied domains related to marital Status

Table 4.11: Mean difference of studied domains related to marital Status

Domains	Marital Status	N	%Mean	SD	t	P-value
Types of nursing records formats availability	Married	48	3.89	0.70	0.539	0.591
	Single	42	3.81	0.80		
Staff nurse's attendance of training programs related to nursing documentation	Married	48	3.37	1.70	-0.363	0.717
	Single	42	3.49	1.51		
Factors lead to inappropriate documentation ®	Married	48	2.73	0.86	0.310	0.757
	Single	42	2.67	0.95		
Auditing continuity of patient care related to nursing intervention and vital signs	Married	48	4.36	0.93	-1.563	0.122
	Single	42	4.63	0.67		
Total	Married	48	3.59	0.62	-0.524	0.602
	Single	42	3.65	0.49		

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; & **t:** independent t test. and ®: Reverse domain

Table 4.11 pointed out the mean differences within the analyzed domains related to marital Status. The analysis conducted indicated no statistically significant distinctions between married individuals and single, concerning the scores within the domains under study. These domains encompassed various facets including the availability of diverse nursing record formats, participation of staff nurses in training programs related to nursing documentation, factors contributing to suboptimal documentation, as well as the ongoing audit of patient care continuity in relation to nursing interventions and vital signs ($p > 0.05$).

4.1.2.6 Mean difference of studied domains related to qualifications

Table 4.12: Mean difference of studied domains related to qualifications

Domain	Education levels	N	%Mean	SD	F	P-value
Types of nursing records formats availability	Diploma	28	4.05	0.69	1.617	0.191
	Bachelor degree	54	3.80	0.78		
	Professional diploma	3	3.27	0.19		
	Master degree	5	3.58	0.69		
Staff nurse's attendance of training programs related to nursing documentation	Diploma	28	3.33	1.76	0.548	0.651
	Bachelor degree	54	3.46	1.55		
	Professional diploma	3	4.44	0.96		
	Master degree	5	3.00	1.83		
Factors lead to inappropriate documentation	Diploma	28	2.67	1.01	0.569	0.637
	Bachelor degree	54	2.66	0.86		
	Professional diploma	3	3.21	1.24		
	Master degree	5	3.01	0.49		
Auditing continuity of patient care related to nursing intervention and vital signs	Diploma	28	4.53	0.89	1.219	0.308
	Bachelor degree	54	4.54	0.75		
	Professional diploma	3	4.21	0.39		
	Master degree	5	3.85	1.34		
Total	Diploma	28	3.64	0.63	0.449	0.719
	Bachelor degree	54	3.62	0.51		
	Professional diploma	3	3.79	0.30		
	Master degree	5	3.36	0.88		

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; & **F:** One-way ANOVA.

Table 4.12 pointed out the mean differences within the analyzed domains related to qualifications. The analysis conducted indicated no statistically significant distinctions regarding qualifications, concerning the scores within the domains under study. These domains encompassed various facets including the availability of diverse nursing record formats, participation of staff nurses in training programs related to nursing documentation, factors contributing to suboptimal documentation, as well as the ongoing audit of patient care continuity in relation to nursing interventions and vital signs ($p > 0.05$).

4.1.2.7 Mean difference of studied domains related to a hospitals

Table 4.13: Mean difference of studied domains related to a hospitals

Domains	Hospitals	N	%Mean	SD	F	P-value	Post Hoc test
Types of nursing records formats availability	Al-Aqsa Martyrs Hospital	18	3.93	0.67	0.818	0.517	
	Al-Durra Children's Hospital	17	3.90	0.80			
	Al- Rantisy-Nasser Hospital	24	3.65	0.80			
	El-Najar Hospital	15	3.81	0.73			
	Nasser Medical Complex	16	4.05	0.72			
Staff nurse's attendance of training programs related to nursing documentation	Al-Aqsa Martyrs Hospital	18	3.61	1.18	2.050	0.095	
	Al-Durra Children's Hospital	17	3.43	1.25			
	Al- Rantisy-Nasser Hospital	24	2.78	1.88			
	El-Najar Hospital	15	4.22	1.07			
	Nasser Medical Complex	16	3.44	2.06			
Factors lead to inappropriate documentation	Al-Aqsa Martyrs Hospital	18	2.94	0.75	2.592	0.042	El-Najar Hospital < others *
	Al-Durra Children's Hospital	17	2.48	0.66			
	Al- Rantisy-Nasser Hospital	24	2.93	1.01			
	El-Najar Hospital	15	2.16	0.81			
	Nasser Medical Complex	16	2.82	0.99			
Auditing continuity of patient care related to nursing intervention and vital signs	Al-Aqsa Martyrs Hospital	18	4.71	0.45	0.965	0.431	
	Al-Durra Children's Hospital	17	4.22	1.05			
	Al- Rantisy-Nasser Hospital	24	4.42	0.98			
	El-Najar Hospital	15	4.46	0.74			
	Nasser Medical Complex	16	4.65	0.71			
Total	Al-Aqsa Martyrs Hospital	18	3.80	0.39	1.443	0.227	
	Al-Durra Children's Hospital	17	3.51	0.40			
	Al- Rantisy-Nasser Hospital	24	3.44	0.73			
	El-Najar Hospital	15	3.66	0.32			
	Nasser Medical Complex	16	3.74	0.71			

*Significant at P≤0.05; P>0.05: Not significant; **n:** number of subjects; **SD**: standard deviation; & **F:** One-way ANOVA.

Table 4.13 highlights the mean differences observed within the assessed domains relevant to various hospitals.

The analysis performed revealed statistically significant disparities among the hospitals concerning the scores within the domain of "factors contributing to suboptimal documentation." Upon conducting post hoc analysis, it becomes evident that Al-Durra Children's Hospital exhibits an average percentage of 2.48 out of 5. Al-Rantisy-Nasser Hospital shows an average percentage of 2.93, El-Najar Hospital presents an average percentage of 2.16 out of 5 and Nasser Medical Complex displays an average percentage of 2.82 out of 5.. The post hoc test further indicates that El-Najar Hospital's scores are notably lower compared to the other hospitals in a statistically significant manner. Conversely, no significant differences were observed among the hospitals with respect to other domains, including the availability of diverse nursing record formats, staff nurses' participation in training programs related to nursing documentation, factors contributing to suboptimal documentation, and the ongoing audit of patient care continuity in relation to nursing interventions and vital signs ($p > 0.05$).

4.2 The quality of nursing documentation at pediatric departments according to PMoH policy & American Nursing Association

4.2.1 Sample distribution according to socio-demographic data among nurses

The present cross-sectional study involved a cohort of 200 medical records of pediatric department in five main governmental hospitals and delved into an assortment of socio-demographic variables, which encompassed elements like age of patient, hospital, diagnoses, duration of admission and outcome of admission.

4.2.1.1 Distribution of the study population according to the hospital

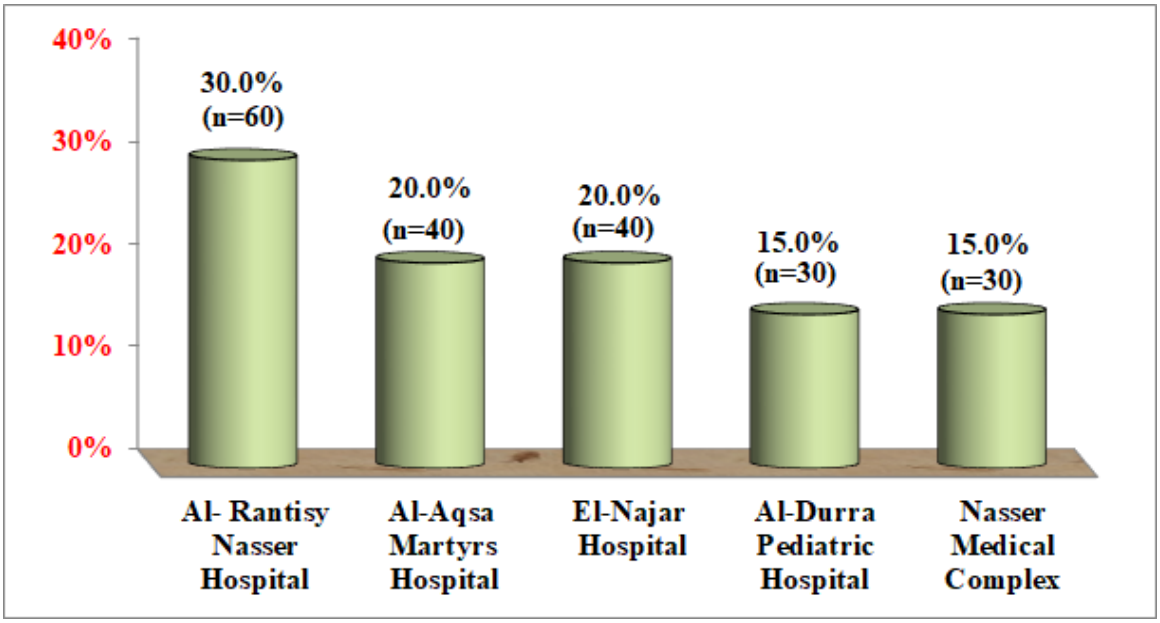

Figure 4.3: The distribution of the study population by hospital

The distribution of the study population by hospital was displayed in Figure 4.3. The participants were divided among several hospitals, The highest Hospital was Al-Rantisy-Nasser Hospital (30.%) followed by Al-Aqsa Martyrs Hospital (20.0%), El-Najar Hospital (20.0%) while the lowest percentage was Al-Durra Children's Hospital (15.0%) and Nasser Medical Complex (15.0%).

4.2.1.2 Distribution of the study population according to the diagnosis

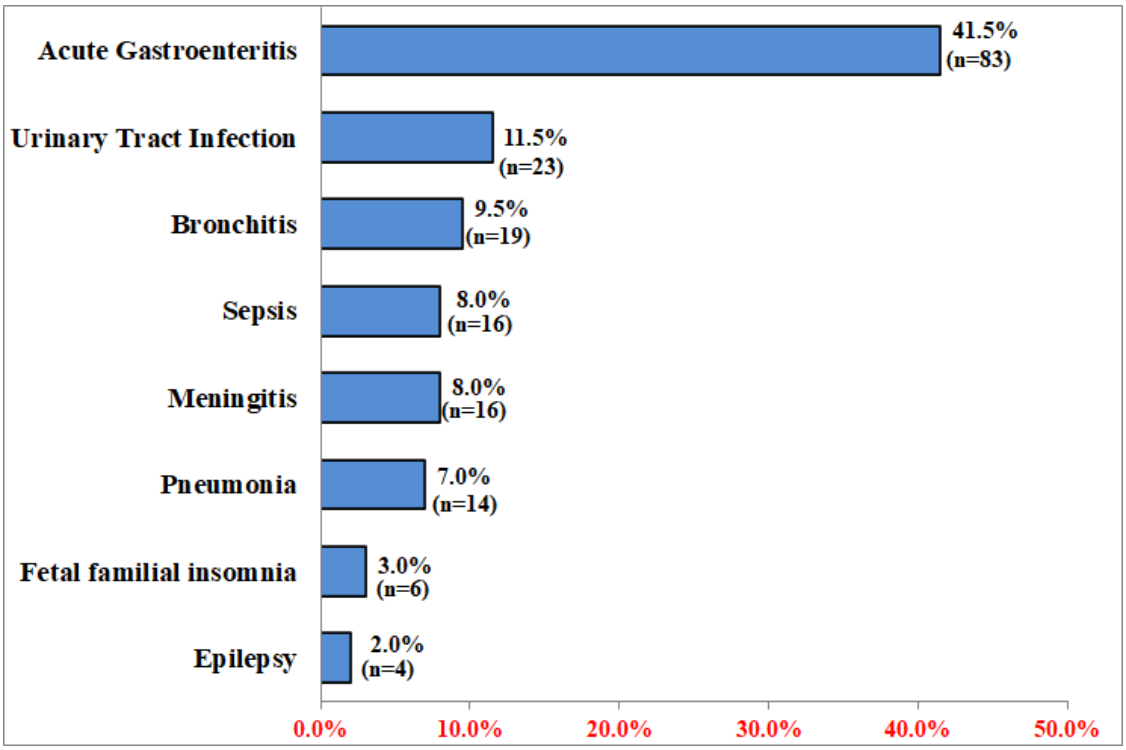

Figure 4.4: Distribution of the study population according to the diagnosis

Distribution of the study population according to the diagnosis showed in Figure 4.4. Acute Gastroenteritis was the highest prevalent diagnosis (41.5%) followed by Urinary Tract Infection (11.5%), and Bronchitis with 9.5%. Meningitis and Sepsis was 8.0% while Pneumonia and Fetal Familial Insomnia constituted 7.0% and 3.0%, respectively. Epilepsy had a lower representation (2.0%). Additionally, 9.5% of cases fell under the 'Others' category such as Pharyngitis, Viral Infection, Vein Thrombosis (DVT), AOM and CHD, and Asthma and Wheezy Chest.

4.2.1.3 Distribution of the study population according to their socio-demographic information

Table 4.14 showed the distribution of the study population (medical records) based on their socio-demographic characteristics. The majority age of patients (54.0%) was less than 1 year old, followed by 29.5% were aged between 1 to 3 years and 15.5% of patients aged from 4 to 9 years of the population, and 1.0% aged within the 10 to 12 years. Regarding the duration of admission 30.0% of patients had a hospital stay less than 3 days, 46.5% were stayed for 4 - 5 days, 15.0% stayed from 6 - 7 days, and 8.5% had an stayed duration 8 days or more. The outcomes of the admission showed the majority (77.0%) of patients experienced a full recovery while (6.0%) sadly passed away during their hospitalization and 3.0% were transferred to other medical facilities, while none of the patients absconded. Finally, 14.0% of patients were still under admission at the time of data collection.

Table 4.14: Distribution of the study population (medical records) according to their socio-demographic information

Socio-demographic information	Categories	N	%
Age of patient	< 1yr	108	54.0%
	1-3yrs	59	29.5%
	4-9yrs	31	15.5%
	10-12 yrs	2	1.0%
Duration of Admission	3 days	60	30.0%
	4-5 days	93	46.5%
	6-7 days	30	15.0%
	≥8 days	17	8.5%
Outcome of admission	Full recovery	154	77.0%
	Died	12	6.0%
	Transferred	6	3.0%
	Absconded	0	0.0%
	Still admission	28	14.0%

4.2.2.1 Scores of items measuring the level of quality of nursing documentation

Table 4.15: Scores of items measuring the level of quality of nursing documentation

	Items	Largely	Moderately	Low degree	Mean	SD	Mean%	Rank
Quality of nursing documentation Medication admin.								
1.	Q1 record is fully completed and signed	137(0.7)	58(0.3)	5(0)	2.66	0.53	88.67	10
2.	Q2 Is there a patient history?	75(0.4)	119(0.6)	6(0)	2.35	0.54	78.33	23
3.	Q3 Is there a nursing assessment: On admission?	125(0.6)	73(0.4)	2(0)	2.62	0.51	87.33	13
4.	Q4 Updated?	59(0.3)	139(0.7)	2(0)	2.29	0.47	76.33	24
5.	Q5 At discharge?	32(0.2)	63(0.3)	105(0.5)	1.64	0.75	54.67	31
Does the nursing documentation demonstrate:								
6.	Q6 Skilled observation and monitoring?	132(0.7)	66(0.3)	2(0)	2.65	0.50	88.33	11
7.	Q7 Assessment of the pediatric pt.?	75(0.4)	124(0.6)	1(0)	2.37	0.49	79.00	22
8.	Q8 Proper evaluation dates and follow-ups?	118(0.6)	81(0.4)	1(0)	2.59	0.50	86.33	17
Is the documentation of nursing care:								
9.	Q9 Accurate?	45(0.2)	152(0.8)	3(0)	2.21	0.44	73.67	25
10.	Q10 Concise and comprehensive?	41(0.2)	158(0.8)	1(0)	2.2	0.41	73.33	26
11.	Q11 Accurate, relevant and consistent?	43(0.2)	152(0.8)	5(0)	2.19	0.45	73.00	28
12.	Q12 Auditable?	42(0.2)	155(0.8)	3(0)	2.2	0.43	73.33	27
13.	Q13 Clear, and kcomplete?	102(0.5)	94(0.5)	4(0)	2.49	0.54	83.00	21
14.	Q14 Readable?	125(0.6)	72(0.4)	3(0)	2.61	0.52	87.00	15
15.	Q15 Thoughtful?	6(0)	189(0.9)	5(0)	2.01	0.24	67.00	29
16.	Q16 Timely, contemporaneous and sequential?	100(0.5)	99(0.5)	1(0)	2.5	0.51	83.33	20
17.	Q17 Reflective of the nursing process?	114(0.6)	85(0.4)	1(0)	2.57	0.51	85.67	18
		Mostly	**sometimes**	**Rare**				
18.	Q18 Written properly in terms of language and grammar	134(0.7)	62(0.3)	4(0)	2.65	0.52	88.33	11
19.	Q19 Vital signs are properly charted	131(0.7)	59(0.3)	10(0.1)	2.61	0.58	87.00	16
20.	Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital	139(0.7)	59(0.3)	2(0)	2.69	0.49	89.67	9

Table 4.15: Scores of items measuring the level of quality of nursing documentation…Continued

	Items	Largely	Moderately	Low degree	Mean	SD	Mean%	Rank
21.	Q21 Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments	126(0.6)	70(0.4)	4(0)	2.61	0.53	87.00	14
22.	Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)	94(0.5)	4(0)	102(0.5)	1.96	0.99	65.33	30
23.	Q23 Dated and time-stamped by the nurses who created the documentation	197(1)	3(0)	0(0)	2.99	0.12	99.67	1
24.	Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ?	197(1)	3(0)	0(0)	2.99	0.12	99.67	1
25.	Q25 Retrievable on a permanent basis in a nursing-specific manner	183(0.9)	17(0.1)	0(0)	2.92	0.28	97.33	8
26.	Q26 The patient's full name was written clearly and completely	186(0.9)	13(0.1)	1(0)	2.93	0.28	97.67	7
27.	Q27 The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record	118(0.6)	72(0.4)	10(0.1)	2.54	0.59	84.67	19
28.	Q28 There is no leaving empty lines between the sentences or any other documentation	194(1)	5(0)	1(0)	2.97	0.21	99.00	4
29.	Q29 Respiratory, feeding pump equipment labeled/tagged.	196(1)	4(0)	0(0)	2.98	0.14	99.33	3
30.	Q30 IVs dated, labeled.	191(1)	8(0)	1(0)	2.95	0.24	98.33	5
31.	Q31 Wound dressings, IV site dated and signed	186(0.9)	14(0.1)	0(0)	2.93	0.26	97.67	6
Total					**2.54**	**0.20**	**84.67**	

Table 4.15 shows the scores of items measuring the level of quality of nursing documentation. The table shows that the weighted mean about level of quality of nursing documentation was 84.67%. According to the results, the highest paragraph was the number (23) " Dated and time-stamped by the nurses who created the documentation " and number (24) " It was documented by the same nurse who provided the nursing care and not by another nurse?" with

a weighted mean equal to 99.67%. While the lowest paragraph (5) " Quality of nursing documentation Medication admin at discharge" with a weighted mean equal to 54.67%, followed by paragraph was the number (22) " Ink pen was used and appropriate colours according to the nursing shift were used for documentation (black, blue and red)" with a weighted mean equal to 65.33%.

4.2.1.4 Scores of items measuring the level of quality of nursing documentation in Al-Aqsa Martyrs Hospital

Table 4.16: Scores of items measuring the level of quality of nursing documentation in Al-Aqsa Martyrs Hospital

	Items	Largely	Moderately	Low degree	Mean	SD	Mean %	Rank
Quality of nursing documentation Medication admin.								
1.	Q1 record is fully completed and signed	0(0)	3(7.5)	37(92.5)	2.93	0.27	97.50	12
2.	Q2 Is there a patient history?	1(2.5)	26(65)	13(32.5)	2.30	0.52	76.67	26
3.	Q3 Is there a nursing assessment: On admission?	0(0)	9(22.5)	31(77.5)	2.78	0.42	92.50	17
4.	Q4 Updated?	0(0)	31(77.5)	9(22.5)	2.23	0.42	74.17	27
5.	Q5 At discharge?	37(92.5)	2(5)	1(2.5)	1.10	0.38	36.67	30
Does the nursing documentation demonstrate:								
6.	Q6 Skilled observation and monitoring?	0(0)	8(20)	32(80)	2.80	0.41	93.33	16
7.	Q7 Assessment of the pediatric pt.?	0(0)	34(85)	6(15)	2.15	0.36	71.67	28
8.	Q8 Proper evaluation dates and follow-ups?	0(0)	14(35)	26(65)	2.65	0.48	88.33	19
Is the documentation of nursing care:								
9.	Q9 Accurate?	0(0)	18(45)	22(55)	2.55	0.50	85.00	22
10.	Q10 Concise and comprehensive?	0(0)	18(45)	22(55)	2.55	0.50	85.00	22
11.	Q11 Accurate, relevant and consistent?	0(0)	17(42.5)	23(57.5)	2.58	0.50	85.83	21
12.	Q12 Auditable?	0(0)	21(52.5)	19(47.5)	2.48	0.51	82.50	24
13.	Q13 Clear, and complete?	0(0)	15(37.5)	25(62.5)	2.63	0.49	87.50	20
14.	Q14 Readable?	0(0)	2(5)	38(95)	2.95	0.22	98.33	8
15.	Q15 Thoughtful?	0(0)	40(100)	0(0)	2.00	0.00	66.67	29
16.	Q16 Timely, contemporaneous and sequential?	0(0)	21(52.5)	19(47.5)	2.48	0.51	82.50	24
17.	Q17 Reflective of the nursing process?	0(0)	7(17.5)	33(82.5)	2.83	0.38	94.17	15
18.	Q18 Written properly in terms of language and grammar	0(0)	2(5)	38(95)	2.95	0.22	98.33	8

Table 4.16: Scores of items measuring the level of quality of nursing documentation in Al-Aqsa Martyrs Hospital…Continued

	Items	Largely	Moderately	Low degree	Mean	SD	Mean %	Rank
19.	Q19 Vital signs are properly charted	0(0)	3(7.5)	37(92.5)	2.93	0.27	97.50	12
20.	Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital	0(0)	0(0)	40(100)	3.00	0.00	00.00	1
21.	Q21 Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments	0(0)	12(30)	28(70)	2.70	0.46	90.00	18
22.	Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)	39(97.5)	1(2.5)	0(0)	1.03	0.16	34.17	31
23.	Q23 Dated and time-stamped by the nurses who created the documentation	0(0)	0(0)	40(100)	3.00	0.00	100.00	1
24.	Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ?	0(0)	0(0)	40(100)	3.00	0.00	00.00	1
25.	Q25 Retrievable on a permanent basis in a nursing-specific manner	0(0)	2(5)	38(95)	2.95	0.22	98.33	8
26.	Q26 The patient's full name was written clearly and completely	0(0)	0(0)	40(100)	3.00	0.00	100.00	1
27.	Q27 The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record	0(0)	1(2.5)	39(97.5)	2.98	0.16	99.17	6
28.	Q28 There is no leaving empty lines between the sentences or any other documentation	0(0)	0(0)	40(100)	3.00	0.00	100.00	1
29.	Q29 Respiratory, feeding pump equipment labeled/tagged.	0(0)	1(2.5)	39(97.5)	2.98	0.16	99.17	6
30.	Q30 IVs dated, labeled.	0(0)	2(5)	38(95)	2.95	0.22	98.33	8
31.	Q31 Wound dressings, IV site dated and signed	0(0)	6(15)	34(85)	2.85	0.36	95.00	14
Total					**2.62**	**0.13**	**87.37**	

Table 4.16 shows the scores of items measuring the level of quality of nursing documentation in Al-Aqsa Martyrs Hospital. The table shows that the weighted mean about level of quality of nursing documentation in Al-Aqsa Martyrs Hospital was 87.37. According to the results, the highest paragraph was the number Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric and patients which approved and recognized in the hospital and Q23 Dated and time-stamped by the nurses who created the documentation and Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ? and Q26 The patient's full name was written clearly and completely and Q28 There is no leaving empty lines between the sentences or any other documentation with a weighted mean equal to 100.0%. While the lowest paragraph (5) " Quality of nursing documentation Medication admin at discharge" with a weighted mean equal to 36.67%, followed by paragraph was the number (22) " Ink pen was used and appropriate colours according to the nursing shift were used for documentation (black, blue and red)" with a weighted mean equal to 34.17%.

4.2.1.5 Scores of items measuring the level of quality of nursing documentation in Al-Durra Children's Hospital

Table 4.17: Scores of items measuring the level of quality of nursing documentation in Al-Durra Children's Hospital

	Items	Largely	Moderately	Low degree	Mean	SD	Mean%	Rank
Quality of nursing documentation Medication admin.								
1.	Q1 record is fully completed and signed	0(0)	4(13.3)	26(86.7)	2.87	0.35	5.56	11
2.	Q2 Is there a patient history?	0(0)	21(70)	9(30)	2.30	0.47	76.67	20
3.	Q3 Is there a nursing assessment: On admission?	0(0)	1(3.3)	29(96.7)	2.97	0.18	98.89	4
4.	Q4 Updated?	0(0)	25(83.3)	5(16.7)	2.17	0.38	72.22	23
5.	Q5 At discharge?	14(46.7)	15(50)	1(3.3)	1.57	0.57	52.22	29
Does the nursing documentation demonstrate:								
6.	Q6 Skilled observation and monitoring?	0(0)	3(10)	27(90)	2.90	0.31	96.67	8
7.	Q7 Assessment of the pediatric pt.?	0(0)	11(36.7)	19(63.3)	2.63	0.49	87.78	12
8.	Q8 Proper evaluation dates and follow-ups?	0(0)	3(10)	27(90)	2.90	0.31	96.67	8
Is the documentation of nursing care:								
9.	Q9 Accurate?	0(0)	24(80)	6(20)	2.20	0.41	73.33	21
10.	Q10 Concise and comprehensive?	0(0)	25(83.3)	5(16.7)	2.17	0.38	72.22	23
11.	Q11 Accurate, relevant and consistent?	0(0)	24(80)	6(20)	2.20	0.41	73.33	21

Table 4.17: Scores of items measuring the level of quality of nursing documentation in Al-Durra Children's Hospital…continued

	Items	Largely	Moderately	Low degree	Mean	SD	Mean%	Rank
12.	Q12 Auditable?	0(0)	28(93.3)	2(6.7)	2.07	0.25	68.89	25
13.	Q13 Clear, and complete?	0(0)	13(43.3)	17(56.7)	2.57	0.50	85.56	13
14.	Q14 Readable?	0(0)	14(46.7)	16(53.3)	2.53	0.51	84.44	17
15.	Q15 Thoughtful?	0(0)	29(96.7)	1(3.3)	2.03	0.18	67.78	27
16.	Q16 Timely, contemporaneous and sequential?	0(0)	14(46.7)	16(53.3)	2.53	0.51	84.44	17
17.	Q17 Reflective of the nursing process?	0(0)	14(46.7)	16(53.3)	2.53	0.51	84.44	17
18.	Q18 Written properly in terms of language and grammar	1(3.3)	11(36.7)	18(60)	2.57	0.57	85.56	13
19.	Q19 Vital signs are properly charted	1(3.3)	26(86.7)	3(10)	2.07	0.37	68.89	25
20.	Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital	0(0)	13(43.3)	17(56.7)	2.57	0.50	85.56	13
21.	Q21 Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments	2(6.7)	9(30)	19(63.3)	2.57	0.63	85.56	13
22.	Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)	25(83.3)	1(3.3)	4(13.3)	1.30	0.70	43.33	30
23.	Q23 Dated and time-stamped by the nurses who created the documentation	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
24.	Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ?	0(0)	1(3.3)	29(96.7)	2.97	0.18	98.89	4
25.	Q25 Retrievable on a permanent basis in a nursing-specific manner	0(0)	4(13.3)	26(86.7)	2.87	0.35	95.56	11
26.	Q26 The patient's full name was written clearly and completely	0(0)	1(3.3)	29(96.7)	2.97	0.18	98.89	4
27.	Q27 The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record	8(26.7)	18(60)	4(13.3)	1.87	0.63	62.22	28
28.	Q28 There is no leaving empty lines between the sentences or any other documentation	1(3.3)	1(3.3)	28(93.3)	2.90	0.40	96.67	8
29.	Q29 Respiratory, feeding pump equipment labeled/tagged.	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
30.	Q30 IVs dated, labeled.	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
31.	Q31 Wound dressings, IV site dated and signed	0(0)	1(3.3)	29(96.7)	2.97	0.18	98.89	4
Total					**2.51**	**0.13**	**3.58**	

Table 4.17 shows the scores of items measuring the level of quality of nursing documentation in Al-Durra Children's Hospital. The table shows that the weighted mean about the level of quality of nursing documentation in Al-Durra Children's Hospital was 83.58%. According to the results, the highest paragraph was the number Q23 Dated and time-stamped by the nurses who created the documentation and Q29 Respiratory, feeding pump equipment labeled/tagged and Q30 IVs dated, labeled with a weighted mean equal to 100.0%. While the lowest paragraph (5) " Quality of nursing documentation Medication admin at discharge" with a weighted mean equal to 52.22%, followed by paragraph was the number (22) " Ink pen was used and appropriate colours according to the nursing shift were used for documentation (black, blue and red)" with a weighted mean equal to 43.33%.

4.2.1.6 Scores of items measuring the level of quality of nursing documentation in Al-Rantisy-Hospital

Table 4.18: Scores of items measuring the level of quality of nursing documentation in Al-Rantisy-Hospital

	Items	Largely	Moderately	Low degree	Mean	SD	Mean%	Rank
Quality of nursing documentation Medication admin.								
1.	Q1 record is fully completed and signed	0(0)	4(13.3)	26(86.7)	2.10	0.48	70.00	17
2.	Q2 Is there a patient history?	0(0)	21(70)	9(30)	2.23	0.56	4.44	14
3.	Q3 Is there a nursing assessment: On admission?	0(0)	1(3.3)	29(96.7)	2.22	0.45	73.89	15
4.	Q4 Updated?	0(0)	25(83.3)	5(16.7)	2.02	0.22	7.22	22
5.	Q5 At discharge?	14(46.7)	15(50)	1(3.3)	1.73	0.52	57.78	31
Does the nursing documentation demonstrate:								
6.	Q6 Skilled observation and monitoring?	0(0)	3(10)	27(90)	2.08	0.33	69.44	18
7.	Q7 Assessment of the pediatric pt.?	0(0)	11(36.7)	19(63.3)	2.03	0.18	67.78	21
8.	Q8 Proper evaluation dates and follow-ups?	0(0)	3(10)	27(90)	2.05	0.29	68.33	19
Is the documentation of nursing care:								
9.	Q9 Accurate?	0(0)	24(80)	6(20)	1.98	0.29	66.11	27
10	Q10 Concise and comprehensive?	0(0)	25(83.3)	5(16.7)	2.02	0.22	67.22	22
11	Q11 Accurate, relevant and consistent?	0(0)	24(80)	6(20)	1.95	0.29	65.00	28
12	Q12 Auditable?	0(0)	28(93.3)	2(6.7)	1.95	0.22	65.00	28
13	Q13 Clear, and complete?	0(0)	13(43.3)	17(56.7)	2.00	0.37	66.67	26
14	Q14 Readable?	0(0)	14(46.7)	16(53.3)	2.05	0.39	68.33	19
15	Q15 Thoughtful?	0(0)	29(96.7)	1(3.3)	1.93	0.25	64.44	30
16	Q16 Timely, contemporaneous and sequential?	0(0)	14(46.7)	16(53.3)	2.02	0.22	67.22	22

Table 4.18: Scores of items measuring the level of quality of nursing documentation in Al-Rantisy-Hospital…continued

	Items	Largely	Moderately	Low degree	Mean	SD	Mean%	Rank
17.	Q17 Reflective of the nursing process?	0(0)	14(46.7)	16(53.3)	2.02	0.13	67.22	22
18.	Q18 Written properly in terms of language and grammar	1(3.3)	11(36.7)	18(60)	2.15	0.48	71.67	16
19.	Q19 Vital signs are properly charted	1(3.3)	26(86.7)	3(10)	2.28	0.69	76.11	11
20.	Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital	0(0)	13(43.3)	17(56.7)	2.28	0.49	76.11	11
21.	Q21 Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments	2(6.7)	9(30)	19(63.3)	2.25	0.44	75.00	13
22.	Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)	25(83.3)	1(3.3)	4(13.4)	2.93	0.31	97.78	8
23.	Q23 Dated and time-stamped by the nurses who created the documentation	0(0)	0(0)	30(100)	2.98	0.13	99.44	2
24.	Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ?	0(0)	1(3.3)	29(96.7)	2.97	0.18	98.89	4
25.	Q25 Retrievable on a permanent basis in a nursing-specific manner	0(0)	4(13.3)	26(86.7)	2.87	0.34	95.56	9
26.	Q26 The patient's full name was written clearly and completely	0(0)	1(3.3)	29(96.7)	2.95	0.22	98.33	6
27.	Q27 The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record	8(26.7)	18(60)	4(13.3)	2.53	0.54	84.44	10
28.	Q28 There is no leaving empty lines between the sentences or any other documentation	1(3.3)	1(3.3)	28(93.4)	2.95	0.22	98.33	6
29.	Q29 Respiratory, feeding pump equipment labeled/tagged.	0(0)	0(0)	30(100)	2.97	0.18	98.89	4
30.	Q30 IVs dated, labeled.	0(0)	0(0)	30(100)	2.98	0.13	99.44	2
31.	Q31 Wound dressings, IV site dated and signed	0(0)	1(3.3)	29(96.7)	3.00	0.00	100.00	1
Total					**2.34**	**0.11**	**77.94**	

Table 4.18 shows the scores of items measuring the level of quality of nursing documentation in Al- Rantisy-Hospital. The table shows that the weighted mean about the level of quality of nursing documentation in Al- Rantisy-Hospital was 77.94%. According to the results, the highest paragraph was the number (30) " Wound dressings, IV site dated and signed" weighted mean equal to 99.44 and number (23) Dated and time-stamped by the nurses who created the documentation and

Q30 IVs dated, labelled " with a weighted mean equal to 99.44%. While the lowest paragraph (15) " Thoughtful?" with a weighted mean equal to 64.44%, followed by paragraph was the (5) " Quality of nursing documentation Medication admin at discharge" with a weighted mean equal to 57.78%.

4.2.1.7 Scores of items measuring the level of quality of nursing documentation in El-Najar Hospital

Table 4.19: Scores of items measuring the level of quality of nursing documentation in El-Najar Hospital

	Items	Largely	Moderately	Low degree	Mean	SD	Mean %	Rank
Quality of nursing documentation Medication admin.								
1.	Q1 record is fully completed and signed	4(6.7)	46(76.7)	10(16.7)	3.00	000	100.00	1
2.	Q2 Is there a patient history?	4(6.7)	38(63.3)	18(30)	2.75	0.44	91.67	23
3.	Q3 Is there a nursing assessment: On admission?	1(1.7)	45(75)	14(23.3)	2.95	0.22	98.33	14
4.	Q4 Updated?	1(1.7)	57(95)	2(3.3)	2.98	0.16	99.17	11
5.	Q5 At discharge?	18(30)	40(66.7)	2(3.3)	2.53	0.78	84.17	25
Does the nursing documentation demonstrate:								
6.	Q6 Skilled observation and monitoring?	1(1.7)	53(88.3)	6(10)	3.00	0.00	100.00	1
7.	Q7 Assessment of the pediatric pt.?	0(0)	58(96.7)	2(3.3)	2.98	0.16	99.17	11
8.	Q8 Proper evaluation dates and follow-ups?	1(1.7)	55(91.7)	4(6.7)	3.00	0.00	100.00	1
Is the documentation of nursing care:								
9.	Q9 Accurate?	3(5)	55(91.7)	2(3.3)	2.25	0.44	75.00	27
10.	Q10 Concise and comprehensive?	1(1.7)	57(95)	2(3.3)	2.23	0.42	74.17	28
11.	Q11 Accurate, relevant and consistent?	4(6.7)	55(91.7)	1(1.7)	2.23	0.42	74.17	28
12.	Q12 Auditable?	3(5)	57(95)	0(0)	2.38	0.49	79.17	26
13.	Q13 Clear, and complete?	4(6.7)	52(86.7)	4(6.7)	2.93	0.27	97.50	20
14.	Q14 Readable?	3(5)	51(85)	6(10)	2.95	0.22	98.33	14
15.	Q15 Thoughtful?	4(6.7)	56(93.3)	0(0)	2.10	0.30	70.00	30

Table 4.19: Scores of items measuring the level of quality of nursing documentation in El-Najar Hospital…Continued

	Items	Largely	Moderately	Low degree	Mean	SD	Mean %	Rank
16.	Q16 Timely, contemporaneous and sequential?	1(1.7)	57(95)	2(3.3)	3.00	0.00	100.00	1
17.	Q17 Reflective of the nursing process?	0(0)	59(98.3)	1(1.7)	3.00	0.00	100.00	1
18.	Q18 Written properly in terms of language and grammar	3(5)	45(75)	12(20)	2.95	0.22	98.33	14
19.	Q19 Vital signs are properly charted	8(13.3)	27(45)	25(41.7)	3.00	0.00	100.00	1
20.	Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital	1(1.7)	41(68.3)	18(30)	2.95	0.22	98.33	14
21.	Q21 Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments	0(0)	45(75)	15(25)	2.90	0.44	96.67	21
22.	Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)	1(1.7)	2(3.3)	57(95)	1.15	0.53	38.33	31
23.	Q23 Dated and time-stamped by the nurses who created the documentation	0(0)	1(1.7)	59(98.3)	2.95	0.22	98.33	14
24.	Q24 It was documented by the same nurse who provided the nursing care and not by another nurse?	0(0)	2(3.3)	58(96.7)	3.00	0.00	100.00	1
25.	Q25 Retrievable on a permanent basis in a nursing-specific manner	0(0)	8(13.3)	52(86.7)	3.00	0.00	100.00	1
26.	Q26 The patient's full name was written clearly and completely	0(0)	3(5)	57(95)	2.73	0.51	90.83	24
27.	Q27 The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record	1(1.7)	26(43.3)	33(55)	2.85	0.36	95.00	22
28.	Q28 There is no leaving empty lines between the sentences or any other documentation	0(0)	3(5)	57(95)	2.98	0.16	99.17	11
29.	Q29 Respiratory, feeding pump equipment labeled/tagged.	0(0)	2(3.3)	58(96.7)	3.00	0.00	100.00	1
30.	Q30 IVs dated, labeled.	0(0)	1(1.7)	59(98.3)	2.95	0.32	98.33	14
31.	Q31 Wound dressings, IV site dated and signed	0(0)	0(0)	60(100)	3.00	0.00	100.00	1
Total					2.76	0.07	92.07	

Table 4.19 shows the scores of items measuring the level of quality of nursing documentation in El-Najar Hospital. The table shows that the weighted mean about the level of quality of nursing documentation in El-Najar Hospital was 92.07%. According to the results, the highest paragraph was the Q1 record is fully completed and signed and Q6 Skilled observation and monitoring? and Q8 Proper evaluation dates and follow-ups? and Q16 Timely, contemporaneous and sequential? and Q17 Reflective of the nursing process? and Q19 Vital signs are properly charted and Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ? and Q25 Retrievable on a permanent basis in a nursing-specific manner and Q29 Respiratory, feeding pump equipment labeled/tagged. and Q31 Wound dressings, IV site dated and signedwith a weighted mean equal to 100.0%. While the lowest paragraph (15) " Thoughtful?" with a weighted mean equal to 70.00%, followed by paragraph was the number (22) " Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)" with a weighted mean equal to 38.33%.

4.2.1.8 Scores of items measuring the level of quality of nursing documentation in Nasser Medical Complex

Table 4.20: Scores of items measuring the level of quality of nursing documentation in Nasser Medical Complex

	Items	Largely	Moderately	Low degree	Mean	SD	Mean %	Rank
Quality of nursing documentation Medication admin.								
1.	Q1 record is fully completed and signed	1(3.3)	5(16.7)	24(80)	2.77	0.50	92.22	15
2.	Q2 Is there a patient history?	1(3.3)	24(80)	5(16.7)	2.13	0.43	71.11	26
3.	Q3 Is there a nursing assessment: On admission?	1(3.3)	16(53.3)	13(43.4)	2.40	0.56	80.00	21
4.	Q4 Updated?	1(3.3)	25(83.3)	4(13.4)	2.10	0.40	70.00	27
5.	Q5 At discharge?	29(96.7)	1(3.3)	0(0)	1.03	0.18	34.44	31
Does the nursing documentation demonstrate?								
6.	Q6 Skilled observation and monitoring?	1(3.3)	2(6.7)	27(90)	2.87	0.43	95.56	10
7.	Q7 Assessment of the pediatric pt.?	1(3.3)	20(66.7)	9(30)	2.27	0.52	75.56	22
8.	Q8 Proper evaluation dates and follow-ups?	0(0)	9(30)	21(70)	2.70	0.47	90.00	19
Is the documentation of nursing care:								
9.	Q9 Accurate?	0(0)	25(83.3)	5(16.7)	2.17	0.38	72.22	25
10.	Q10 Concise and comprehensive?	0(0)	27(90)	3(10)	2.10	0.31	70.00	27
11.	Q11 Accurate, relevant and consistent?	1(3.3)	25(83.3)	4(13.4)	2.10	0.40	70.00	27

Table 4.20: Scores of items measuring the level of quality of nursing documentation in Nasser Medical Complex…continued

	Items	Largely	Moderately	Low degree	Mean	SD	Mean %	Rank
12.	Q12 Auditable?	0(0)	24(80)	6(20)	2.20	0.41	73.33	24
13.	Q13 Clear, and complete?	0(0)	11(36.7)	19(63.3)	2.63	0.49	87.78	20
14.	Q14 Readable?	0(0)	3(10)	27(90)	2.90	0.31	96.67	8
15.	Q15 Thoughtful?	1(3.3)	28(93.3)	1(3.4)	2.00	0.26	66.67	30
16.	Q16 Timely, contemporaneous and sequential?	0(0)	7(23.3)	23(76.7)	2.77	0.43	92.22	15
17.	Q17 Reflective of the nursing process?	1(3.3)	5(16.7)	24(80)	2.77	0.50	92.22	15
18.	Q18 Written properly in terms of language and grammar	0(0)	2(6.7)	28(93.3)	2.93	0.25	97.78	7
19.	Q19 Vital signs are properly charted	1(3.3)	3(10)	26(86.7)	2.83	0.46	94.44	12
20.	Q20 Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital	1(3.3)	3(10)	26(86.7)	2.83	0.46	94.44	12
21.	Q21 Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments	0(0)	4(13.3)	26(86.7)	2.87	0.35	95.56	10
22.	Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation(black, blue and red)	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
23.	Q23 Dated and time-stamped by the nurses who created the documentation	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
24.	Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ?	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
25.	Q25 Retrievable on a permanent basis in a nursing-specific manner	0(0)	3(10)	27(90)	2.90	0.31	96.67	8
26.	Q26 The patient's full name was written clearly and completely	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
27.	Q27 The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record	1(3.3)	21(70)	8(26.7)	2.23	0.50	74.44	23
28.	Q28 There is no leaving empty lines between the sentences or any other documentation	0(0)	0(0)	30(100)	3.00	0.00	100.00	1
29.	Q29 Respiratory, feeding pump equipment labeled/tagged.	0(0)	1(3.3)	29(96.7)	2.97	0.18	98.89	6
30.	Q30 IVs dated, labeled.	0(0)	5(16.7)	25(83.3)	2.83	0.38	94.44	12
31.	Q31 Wound dressings, IV site dated and signed	0(0)	7(23.3)	23(76.7)	2.77	0.43	92.22	15
Total					**2.58**	**0.19**	**86.09**	

Table 4.20 shows the scores of items measuring the level of quality of nursing documentation in Nasser Medical Complex. The table shows that the weighted mean about the level of quality of nursing documentation in Nasser Medical Complex was 86.09%. According to the results, the highest paragraph was the number Q22 Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red) and Q23 Dated and time-stamped by the nurses who created the documentation and Q24 It was documented by the same nurse who provided the nursing care and not by another nurse ? and Q26 The patient's full name was written clearly and completely and Q28 There is no leaving empty lines between the sentences or any other documentation with a weighted mean equal to 100.0%. While the lowest paragraph (31) " Thoughtful?" with a weighted mean equal to 66.67%, followed by paragraph was the number (5) " At discharge?" with a weighted mean equal to 34.44%.

4.2.2 Mean difference of studied domains related to socio-demographic data

Table 4.21: Mean difference of quality of nursing documentation level related to socio-demographic data

		level of quality of nursing documentation			Statistical Analysis	
		n	% Mean	SD	F	P-value
Hospital	Al-Aqsa Martyrs Hospital	40	87.37	4.26	1.323	0.148
	Al-Durra Children's Hospital	30	83.58	4.31		
	Al- Rantisy-Nasser Hospital	60	77.94	3.54		
	El-Najar Hospital	40	92.07	2.36		
	Nasser Medical Complex	30	86.09	6.45		
Diagnoses	Acute Gastroenteritis	83	85.80	7.02	1.113	0.331
	Urinary Tract Infection	23	85.83	7.31		
	Bronchitis	19	83.08	6.42		
	Meningitis	16	82.33	5.37		
	Pneumonia	14	84.41	7.72		
	Sepsis	16	80.71	3.57		
	Epilepsy	4	85.75	6.23		
	Fetal familial insomnia	6	90.14	2.30		
	Others	19	83.98	5.22		
Age of patient	< 1yr	108	83.85	6.68	1.386	0.113
	1-3yrs	59	84.24	6.30		
	4-9yrs	31	88.69	5.40		
	10-12 yrs	2	84.41	12.93		
Duration of Admission	3 days	60	84.37	6.23	0.987	0.489
	4-5 days	93	85.63	6.43		
	6-7 days	30	83.55	7.66		
	≥8 days	17	83.05	6.83		
Outcome of admission	Full recovery	154	85.26	6.33	1.466	0.078
	Died	12	85.84	7.83		
	Transferred	6	85.84	6.92		
	Still admission	28	81.03	6.70		

*Significant at P≤0.05; P>0 05: Not significant; **n:** number of subjects; **SD**: standard deviation; & **F:** One-way ANOVA.

Table 4.21 displays the mean differences of the studied domains concerning quality of nursing documentation level related to socio-demographic data. The one-way ANOVA test revealed that there was no statistically significant difference among the different among socio-demographic data as age of patient, hospital, diagnoses, duration of admission and outcome of admission. ($P>0.05$).

Chapter Five
Discussion

This chapter describes in detail the results of the study on the nursing documentation quality in the pediatric wards of governmental hospitals located in the Gaza Strip, Palestine. This section builds on the results presented in Chapter 4 and performs data interpretation while attempting to feel the anchors of the existing literature and practices.

The discussion begins with an overview of the principal results which will be in turn interpreted in light of already existing research and its developments. It addresses comprehensively the effects of certain determinants on the quality of documentation and the chapter also evaluates how these findings relate to nursing practice and standards holders and documentation intervention.

In combining the findings with a broad overview, the researcher attempts to illustrate how documentation can be improved regarding the quality of nursing documentation in pediatric areas, as well as what measures in practical outlook would be reasonable and possibly useful for the improvement of nursing documentation.

The distribution of the study participants showed that Al Rantisy Nasser Hospital had the highest percentage. several studies showed that Al Rantisy Nasser Hospital is specialized and a largest pediatric hospital in the Gaza Strip compared to others such as Al-Durra Pediatric Hospital, El-Najar Hospital, and Nasser Medical Complex. The current results conducted with Sammour et al., (2023), The authors showed that Al Rantisy Nasser Hospital had an elevated percentage of nursing participants in the study. The gender distribution among the study participants was females higher than males among the study population. Qasim et al., (2021) showed that the percentage of nursing females is higher than that of males in children hospitals. The researcher believes that the results highlight the significance of Al-Rantisy Nasser Hospital as the largest and most important pediatric hospital in Gaza. Additionally, the increasing percentage of female participants reflects the general trend in the nursing profession in this field in paediatric department.

Regarding age, the results showed that most participants were less than 35 years old, and more than half of the study population was classified as married. The educational levels showed that the highest is a Bachelor's degree at 60.0%, and more than half participants have

years of experience 10 or less and have rotated shifts. Albelbeisi et al., (2024) and Seda (2020) showed that most nurses in pediatric departments were married, had Bachelor's degrees, and had rotated shifts. The researcher notes that most of the participants fall under the relatively young category of the nursing workforce, with a large segment being under 35. The high percentage of married nurses, along with a Bachelor's degree being the most common form of educational attainment, really paint the picture of a professional atmosphere in pediatric departments. Also, with most having less than ten years of experience and many working rotating shifts, "staff stability and continuity of care" could be better in these departments.

The table shows that the weighted mean of the overall perceptions about the quality of nursing documentation was moderate (77.01%) and the highest items were "nursing notes form" and "medication administration sheet" with higher levels. However, the items "discharge planning form" and "pain assessment form" had lower levels. The present findings are consistent with another study that showed that the documentation quality was moderate in children's hospitals (Nool et al., 2023; Tang et al., 2024). In my opinion, this study showed that the moderate quality of nursing documentation was due to higher workloads with lower training. Also, limited resources causing stressful work, and inadequate policy would lead to moderate documentation quality.

The distribution of nurses according to their responses about staff nurses' attendance at training programs related to nursing documentation pointed out the overall perceptions about the level of staff nurses' attendance at training programs related to nursing documentation was low. According to the results, the items (in the department) and (in the hospital) received the highest good weight, while the items (outside the hospital) received a low weighted average of 42.2%. This result is consistent with previous studies that also showed that the distribution of nurses according to their responses about the attendance of working nurses in training programs related to nursing documentation was low (Jasem & Younis, 2024) (Hockenberry et al., 2023). In my opinion, this study illustrated that low participation among nurses in training programs in pediatric hospitals that often a result of insufficient resources and heavy workloads.

The level of availability of nursing record forms in pediatric hospitals was low (54.0%) and the two highest items were (overload and fatigue) and (lack of nursing) with moderate levels. In contrast, the lowest item was (lack of a good monitoring system) with low levels.

Ogboenyiya et al., (2020) and Ramgopal et al., (2023) demonstrated the low levels of level of availability of nursing record forms in pediatric hospitals. In my opinion, availability of nursing record forms in pediatric hospitals was low due to computerized documents in the last years.

Scores for the auditing continuity of patient care related to nursing intervention and vital signs were high (90%). the highest item for this domain was " Nursing interventions " and morning shift " with a high level while low scores of " Evening shift " and " Night shift " items. Such as in earlier research, high scores the auditing continuity of patient care related to nursing intervention and vital signs (Ramgopal et al., 2023 and Bail et al., 2020). In my opinion, addressing the disparities between shifts is essential to ensure uniform quality in patient care across all nursing interventions.

The current research showed that moderate level of total quality of nursing documentation at pediatric departments of governmental hospitals in the Gaza governorates (72.33 %). As seen in other studies, moderate quality documentation in pediatric departments of governmental hospitals is due to several factors such as lack of adequate training in proper documentation practices, leading to disorganized records. In addition, the presence of legacy systems such as paper records can contribute to inefficient documentation and increase the rate of errors. Frequent staff turnover or understaffing can also affect the quality of documentation. Finally, the absence of clear protocols for documentation in hospitals can lead to relatively uneven quality. (Nool et al., 2023, Jasem &Younis ., 2024 and Fatmawati et al., 2024). The results revealed no statistically significant variations in the studied domain as types of nursing records formats availability, staff nurse's attendance of training programs related to nursing documentation, factors leading to inappropriate documentation and auditing continuity of patient care related to nursing intervention and vital signs and domain as a total regarding gender and age, years of experience in nursing, marital status, and qualifications. In my opinion, addressing the identified deficiencies in training and establishing clear documentation protocols are crucial for enhancing nursing documentation quality.

The outcome aligns with other studies that showed that a lack of statistically significant variations in the quality of nursing documentation at pediatric hospitals regarding sociodemographic data due to standardized protocols and institutional policies will reduce the influence of personal demographics data on nursing documentation practices (Bjerkan et

al., 2021; Oliveira & Peres, 2021; Melnick et al., 2021 and Ruiz-Fernández et al., 2020). The current study showed that the average of factors leading to inappropriate documentation was higher and associated significantly with distinctions among rotated shifts compared to straight morning with no difference in the other domains. The current result corresponds with previous findings by Alston-Jackson et al., (2021) and Cnattingius et al., (2023) which showed that the reasons factors leading to inappropriate documentation were higher associated significantly with distinctions among rotated shifts compared to Straight morning include fatigue of nursing, and poor communication during rotating shifts, which lead to elevated documentation errors. On the other hand, the results revealed significant differences among hospitals in the domain of "factors contributing to suboptimal documentation". Al-Rantisy-Nasser Hospital had the highest hospital average, while El-Najar Hospital pointed out the lowest with significantly differing from other hospitals. In contrast, no significant differences were found in other studied domains. Hospitals may face challenges such as increased patient volume, nursing staff shortages, or inadequate nursing documentation protocols in pediatric departments that cause documentation errors. The lack of differences in other domains suggests greater standardization of record formats. As seen in other studies by Bunting et al., (2022) showed significant differences regarding hospitals in the factors contributing to suboptimal documentation domain. In my opinion, improving communication and addressing staff fatigue during shifts are vital for enhancing the accuracy of nursing documentation.

The study quality of nursing documentation at pediatric departments according to PMoH policy & American Nursing Association, the researcher had a cross-sectional study involving a cohort of 200 subjects of pediatric departments in five main governmental hospitals. The highest group was from Al-Rantisy-Nasser Hospital (30.%) due to specialization or resource constraints followed by Al-Aqsa Martyrs Hospital, El-Najar Hospital) while the lowest percentage was Al-Durra Children's Hospital and Nasser Medical Complex. Acute Gastroenteritis was the highest prevalent diagnosis (41.5%) followed by urinary tract infection and bronchitis, meningitis and sepsis, pneumonia and fatal familial insomnia, and epilepsy, respectively. These outcomes are consistent with another study by Jasem & Younis., (2024) that showed acute Gastroenteritis was the most prevalent diagnosis because of its high transmission, common causes of infections, and contaminated food among children. The majority age of patients (54.0%) was less than 1 year old, and the duration of admission 46.5% were stayed for 4 - 5 days. The outcomes of the admission

showed the majority (77.0%) of patients experienced a full recovery and 14.0% of patients were still under admission at the time of data collection. Such as in previous investigations by Delnavaz et al., 2018 which pointed out that most patients experienced a full recovery due to effective treatment protocols and timely medical intervention. While few cases are still under admission that require more time in treatment and that reflect the complexity of their conditions. This outcome is consistent with other study by Stotts et al., (2020). In my opinion, the high recovery rate reflects the importance of proper documentation and treatment in achieving positive health outcomes for pediatric patients.

The current study shows the level of quality of nursing documentation was high (84.67%) and that reflects good training, adherence to protocol with good monitoring systems in pediatric hospitals. the highest paragraph was " Dated and time-stamped by the nurses who created the documentation " and "It was documented by the same nurse who provided the nursing care and not by another nurse?" with a high level. The lowest paragraph " Quality of nursing documentation medication admin at discharge" followed by the paragraph " Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)" had low levels. Similar to other findings by Dinari et al., (2023) that demonstrate that stringent training programs, adherence to set criteria, and frequent audits result in high-quality nursing documentation. Mainz et al., (2023) showed that these elements guarantee complete and accurate recording, which enhances overall documentation procedures and pediatric care. Also, the enhanced by the nursing staff's ability to good communicate. In my opinion, the high documentation quality underscores the importance of continuous training and effective communication among nursing staff to maintain these standards.

The results show that the high level of the overall perceptions about of quality of nursing documentation. However, the quality of nursing documentation in pediatric hospitals was raged from moderate to good such as Al-Aqsa Martyrs Hospital (high, 87.37%), Al-Durra Children's Hospital (high, 83.58%), Al- Al-Rantisy-Hospital (moderate, 77.94%.), El-Najar (high, 92.07%), Nasser Medical Complex (high, 86.09%). The current results correspond with previous reports by Hariyati et al., (2020) that highlighting the variation in nursing documentation quality among pediatric hospitals can be credited to several factors such as limited resources, softer training, or inconsistent documentation procedures. Another study by Moy et al., (2021) showed that disparate percentages can be caused by variations in

personnel qualifications, hospital policies, and technological accessibility. In my opinion, addressing these discrepancies through targeted training and resource allocation is essential for standardizing documentation practices across hospitals.

Chapter Six
Conclusion and Recommendations

6.1 Conclusion

The study revealed that the quality of nursing documentation in pediatric departments across government hospitals in Gaza varied between moderate and high levels. While Al-Rantisi Nasser Hospital exhibited moderate documentation quality, hospitals like Al-Najjar and Nasser Medical Complex demonstrated higher standards. Factors contributing to moderate quality included heavy workloads, limited training opportunities, outdated paper-based documentation systems, and resource constraints. Additionally, rotating shifts and inadequate resources significantly increased documentation errors in certain hospitals. However, hospitals with structured training programs and effective monitoring systems, such as Al-Najjar, achieved notable improvements in documentation quality. Regular audits and strict adherence to standardized nursing protocols emerged as key determinants of high-quality documentation.

The study also identified barriers, including low participation in training programs and limited availability of nursing record forms, which impeded documentation improvement efforts. Interestingly, no significant differences were observed in documentation quality concerning sociodemographic factors like age, gender, or years of experience, highlighting the importance of uniform institutional policies in standardizing documentation practices. These findings align with previous research, underscoring the critical role of clear documentation protocols and ongoing staff training in enhancing nursing documentation quality and, ultimately, improving patient care outcomes.

6.2 Recommendationns

Recommendations to Children's Hospital

Implement regular, structured training programs for nurses in children's hospital to improve their documentation process, especially focusing on weakness areas that are illustrated on the results like pain assessment forms and discharge planning.

Elevated the availability of up-to-date, computerized documentation systems to replace paper-based methods because that will be reducing random and systematic errors and improve documentation efficacy.

Create routine audits and monitoring of documentation practices to ensure adherence to policy and improve quality.

Recommendations to Decision Makers:

Allocating more resources within pediatric hospitals to ensure that there is sufficient nurse to reduce the workload on the team, that directly affects the documentation quality inside departments.

Developing policies at the hospital to control documentation procedures in pediatric departments inside hospitals to lower gaps and improve documentation. Prioritizing investments in digital documentation systems and increasing continuous training programs among nurses to ensure that all nurses can use digital documentation tools.

Future Research:

Assessment of the long-term effect of modern digital documentation systems on the quality of nursing documentation in pediatric departments.

Explore the relationship between documentation errors and nurse’s workload in pediatric departments.

Examine the effects of regular, structured training programs among nurses about quality of documentation.

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Annexes

Annex (1): Consent Form for Questionnaire

Dear participant:

Firstly, I would introduce myself, my name is **Nehal Tayseer Hassan Shabat** a master's student in Master Degree of Science in Pediatric Nursing at Faculty of Health Profession, Nursing Department, I am conducting this research as a major health requirement of obtaining the Master's degree.

Dear Participant:

Good nursing documentation is essential for the continuity and coordination of nursing care. Therefore, this questionnaire will be used to assess the quality of nursing documentation at pediatric departments of governmental hospitals in the Gaza Strip, Palestine.

Please answer all the questions below, no need to write the name. Your participation in this study is voluntary. All responses you provide for this study will be completely confidential and only for research purposes. The time required to fill out the questionnaire is 15 minutes. If you have any questions before you complete this questionnaire, please contact me.

Researcher: Nehal Tayseer Hassan Shabat
Phone No :0597240634
Shnihal2020@gmail.com

Annex (2): Quality of Nursing Documentation Questionnaire

Socio-demographic characteristics of the study respondents:

1-	Setting:	☐ Al-Aqsa Martyrs Hospital ☐ Al-Durra Pediatric Hospital ☐ Al- Rantisy-Nasser Hospital ☐ El-Najar Hospital ☐ Nasser Medical Complex
2-	Gender:	☐ Male ☐ Female
3-	Age in years:	☐ ……Years
4-	Marital Status:	☐ Married ☐ Single ☐ Others
5-	Qualifications	☐ Diploma ☐ Bachelor degree ☐ Professional diploma ☐ Master degree ☐ Doctoral degree
6-	Years of experience in nursing	☐ ……Years
7-	Working time	☐ Straight morning ☐ Rotated shifts: -Morning- Evening- Night -Evening-night

I. Quality of nursing documentation at pediatric departments:

1-Types of nursing records formats availability

No.	Items	Available and used	Available but not used	Not available
1	- Nursing notes form			
2	- Medication administration sheet			
3	- Vital signs sheet			
4	- Fluid balance sheet			
5	- Patient assessment on admission form			
6	- Pediatric nursing care plan form			
7	- Discharge planning form			
8	- Informed consent form			
9	- Pain assessment form			
10	- Pediatric insulin administration form			
11	- Handover form			
12	- Incident report form			
13	- Kardex			

2-Staff nurse's attendance of training programs related to nursing documentation

No.	Items	Answer	
		Yes	No
1	- In the department		
2	- In the hospital		
3	- Outside the hospital		

3-Factors lead to inappropriate documentation

No.	Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	-Lack of good monitoring system					
2	- lack of punishment and reward system					
3	-Lack of nursing documentation policies in pediatric departments					
4	-Lack of familiarity with operational standards of nursing documentation					
5	-Not dating, timing and signing entries					
6	-Use of inappropriate abbreviations					
7	-Leave blank lines between sentences in the documentation form					
8	-Entering information into the wrong chart					
9	-Documentation takes a long time					
10	-Nursing shortage					
11	-Excessive work load and fatigue					
12-	-Poor physical work environment					
13-	-Illegible handwriting					
14-	-Inadequate documenting sheets					

4-Auditing continuity of patient care related to nursing intervention and vital signs

Items	Done and recorded properly	Done and not recorded	Not applicable
Morning shift			
-Temperature			
- Pulse			
-Respiration			
Blood pressure			
Evening shift			
-Temperature			
- Pulse			
-Respiration			
-Blood pressure			
Night shift			
-Temperature			
- Pulse			
-Respiration			
-Blood pressure			
Nursing interventions			
-Hygienic care			
-Health education			
-Nursing observation			
-Changing position			
-Physical& psychological assessment			
-Patient complaints			
-Care of IV lines			
-Care of tubes			
-Administer ordered medications			

Thank you for your cooperation

أنا الطالبة/ **نهال تيسير حسن شبات** ، طالبة ماجستير في جامعة القدس أبو ديس/ بكلية المهن الصحية ، تخصص تمريض أطفال، أنا أعمل على أطروحة الماجستير الخاصة بي والتي تعد مطلبًا لإكمال برنامج الماجستير.

عزيزي المشارك:

التوثيق التمريضي الجيد ضروري لاستمرارية الرعاية التمريضية وتنسيقها. لذلك سيتم استخدام هذا الاستبيان لتقييم جودة التوثيق التمريضي في أقسام الأطفال في المستشفيات الحكومية في قطاع غزة، فلسطين. يرجى الإجابة على جميع الأسئلة أدناه، ولا داعي لكتابة الاسم. مشاركتك في هذه الدراسة اختيارية وستكون جميع الردود التي تقدمها لهذه الدراسة سرية ولغرض البحث فقط. الوقت المطلوب لملء الاستبيان قد يستغرق من 15-20 دقيقة, و اذا كانت لديك أي أسئلة قبل إكمال هذا الاستبيان ، فيرجى الاتصال بي.

أولاً : البيانات الشخصية والاجتماعية:

1	**اسم المستشفى**	☐ مستشفى الدرة للأطفال ☐ مستشفى النصر للأطفال ☐ مستشفى شهداء الأقصى ☐ مستشفى النجار ☐ مجمع ناصر الطبي
2	**الجنس**	☐ ذكر ☐ انثى
3	**العمر بالسنوات**	☐ ..... سنة
4	**الحاله الاجتماعيه**	☐ اعزب ☐ متزوج ☐ غير ذلك
5	**المؤهلات العلميه**	☐ دبلوم متوسط ☐ بكالوريوس ☐ ماجستير / دكتوراه
6	**سنوات الخبرة**	☐ ..... سنة
7	**فترة الدوام**	☐ صباحي ☐ مسائي ☐ سهر ☐ مسائي–سهر

ثانيا: جودة التوثيق التمريضي في أقسام الأطفال

1. <u>توافر أنواع تنسيقات سجلات التمريض</u>

الرقم	الفقرات	متاح ومستخدم	متاح وغير مستخدم	غير متاح
1	نموذج ملاحظات التمريض			
2	نموذج صرف و اعطاء الدواء			
3	ورقة متابعة العلامات الحيوية			
4	ورقة متابعة السوائل			
5	نموذج تقييم المريض عند الدخول			
6	نموذج خطة رعاية تمريض الأطفال			
7	استمارة تخطيط الخروج			
8	نموذج الموافقة			
9	نموذج تقييم الالم			
10	استمارة إعطاء الأنسولين للأطفال			
11	نموذج الاستلام والتسليم			
12	نموذج تقرير الحوادث			
13	نموذج متابعة المرضى (الكاردكس)			

2. حضور الممرضين البرامج التدريبية المتعلقة بالتوثيق التمريضي

الرقم	الفقرات	الاجابة	
		نعم	لا
1	داخل القسم		
2	داخل المستشفى		
3	خارج المستشفى		

3. العوامل التي قد تؤدي الى ضعف التوثيق التمريضي في أقسام الاطفال

الرقم	الفقرات	لا أوافق بشدة	لا أوافق	محايد	أوافق	أوافق بشدة
1	- عدم وجود نظام مراقبة جيد					
2	- عدم وجود نظام للعقاب والثواب					
3	- عدم وجود سياسات التوثيق التمريضية في أقسام الأطفال					
4	- عدم الإلمام بالمعايير التشغيلية لوثائق التمريض					
5	- عدم كتابة التاريخ والوقت والتوقيع					
6	- استخدام الاختصارات غير الصحيحة					
7	- ترك اسطر فارغة بين الجمل في نموذج التوثيق					
8	- تدخيل البيانات في النموذج الغير مناسب					
9	- التوثيق يستغرق وقت طويل					
10	- نقص في الكادر التمريضي					
11	- عبء العمل الزائد والتعب					
12	-بيئة عمل غير ملائمة					
13	-نقص في مهارات الكتابة اليدوية					
14	نقص في نماذج التوثيق					

4. <u>تدقيق استمرارية رعاية المرضى فيما يتعلق بالتدخل التمريضي والعلامات الحيوية</u>

العناصر	تم عمله وتم تسجيله	تم عمله ولم يتم تسجيله	غير قابل للتطبيق
- دوام الفترة الصباحية			
- درجة الحرارة			
- معدل النبض			
- معدل التنفس			
- ضغط الدم			
- دوام الفترة المسائية			
- درجة الحرارة			
- معدل النبض			
- معدل التنفس			
- ضغط الدم			
- دوام الفترة الليلية			
- درجة الحرارة			
- معدل النبض			
- معدل التنفس			
- ضغط الدم			
التدخلات التمريضية			
- العناية الصحية			
- التثقيف الصحي			
- المراقبة التمريضية			
- تغيير الوضعية للمريض			
- التقييم الجسدي والنفسي للمريض			
- شكاوي المريض			
- العناية بالكانيولات			
- العناية بالأنابيب الموصولة بالمريض			
-اعطاء الادوية الموصوفة			

Annex (3): An auditing checklist for reviewing the quality of nursing documentation at pediatric departments according to PMoH policy & American Nursing Association

An auditing checklist for reviewing the quality of nursing documentation at pediatric departments according to PMoH policy & American Nursing Association

Part 1 – Patient demographic data:

1. Hospital
   - ☐ 1.Al-Aqsa Martyrs Hospital
   - ☐ 2.Al-Durra Pediatric Hospital
   - ☐ 3.Al- Rantisy-Nasser Hospital
   - ☐ 4.El-Najar Hospital
   - ☐ 5.Nasser Medical Complex

2. Age of patient: < 1yr [ ] 1-3yrs1 [ ] 4-9yrs2[ ]10-12 yrs3 [ ]
3. Duration of Admission: 3 days1 [ ] 4-5 days2 [ ] 6-7 days3 [ ] ≥8 days4 [ ]
4. Outcome of admission: Full recovery1[ ] Died [ ] Transfered3 [ ] Absconded4 [ ] Still admitted5[ ]
5. Medical Diagnoses**: ……**

Part 2– Quality of nursing documentation

•Medication admin. record is fully completed and signed

Largely ☐ Moderately ☐ low degree

•Is there a patient history?

☐ Largely ☐ Moderately ☐ low degree

•Is there a nursing assessment:

-On admission?

☐ Largely ☐ Moderately ☐ low degree

- Updated?

☐ Largely ☐ Moderately ☐ low degree

-At discharge?

☐ Largely ☐ Moderately ☐ low degree

•Does the nursing documentation demonstrate:

Skilled observation and monitoring?

☐ Largely ☐ Moderately ☐ low degree

Assessment of the pediatric pt.?

☐ Largely ☐ Moderately ☐ low degree

Proper evaluation dates and follow-ups?

☐ Largely ☐ Moderately ☐ low degree

•Is the documentation of nursing care:

Accurate?

☐ Largely ☐ Moderately ☐ low degree

Concise and comprehensive?

☐ Largely ☐ Moderately ☐ low degree

Accurate, relevant and consistent?

☐ Largely ☐ Moderately ☐ low degree

Auditable?

☐ Largely ☐ Moderately ☐ low degree

Clear, and complete?

☐ Largely ☐ Moderately ☐ low degree

Readable?

☐ Largely ☐ Moderately ☐ low degree

Thoughtful?

☐ Largely ☐ Moderately ☐ low degree

Timely, contemporaneous and sequential?

☐ Largely ☐ Moderately ☐ low degree

Reflective of the nursing process?

☐ Largely ☐ Moderately ☐ low degree

Written properly in terms of language and grammar

☐ Mostly ☐ sometimes ☐ Rarely

Vital signs are properly charted

☐ Mostly ☐ sometimes ☐ Rarely

•Using universal abbreviations and terminologies that include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of pediatric patients which approved and recognized in the hospital

☐ Mostly ☐ sometimes ☐ Rarely

•Nurse document all information related to the patient's care, observations, treatments, procedures and nursing interventions include the appropriate form used in the pediatric departments

☐ Mostly ☐ sometimes ☐ Rarely

•Ink pen was used and appropriate colors according to the nursing shift were used for documentation (black, blue and red)

☐ Mostly ☐ sometimes ☐ Rarely

•Dated and time-stamped by the nurses who created the documentation

☐ Mostly ☐ sometimes ☐ Rarely

•It was documented by the same nurse who provided the nursing care and not by another nurse ?

☐ Mostly ☐ sometimes ☐ Rarely

•Retrievable on a permanent basis in a nursing-specific manner

☐ Mostly ☐ sometimes ☐ Rarely

•The patient's full name was written clearly and completely

☐ Mostly ☐ sometimes ☐ Rarely

•The patient's age, diagnosis, file number, room and bed number were written on each form in the medical record

☐ Mostly ☐ sometimes ☐ Rarely

•There is no leaving empty lines between the sentences or any other documentation

☐ Mostly ☐ sometimes ☐ Rarely

•Respiratory, feeding pump equipment labeled/tagged.

☐ Mostly ☐ sometimes ☐ Rarely

•IVs dated, labeled.

☐ Mostly ☐ sometimes ☐ Rarely

•Wound dressings, IV site dated and signed

☐ Mostly ☐ sometimes ☐ Rarely

Annex (4): MOH Approval

State of Palestine
Ministry of health

دولة فلسطين
وزارة الصحة

السيد : هاني سلطان الوحيدي المحترم

التاريخ:17/07/2023

رقم المراسلة 1310145

مدير عام بالوزارة /الإدارة العامة للوحدات الإدارية المساعدة /وزارة الصحة

السلام عليكم ,,,

الموضوع/ تسهيل مهمة الباحثة نهال تيسير حسن شبات

التفاصيل //
السلام عليكم
نهديكم أطيب التحيات ونود منكم تسهيل مهمة الباحث/ة نهال تيسير حسن شبات الملتحق/ة ببرنامج ماجستير تمريض الأطفال – جامعة القدس ابو ديس في اجراء بحث بعنوان:
The Quality of Nursing Documentation at Pediatric Departments of Governmental Hospitals in Gaza Governorates, Palestine
حيث الباحث/ة بحاجة لتعبئة استبانة من عدد من العاملين في مرافق وزارة الصحة (مستشفى النصر للأطفال – مستشفى الدرة – مستشفى النجار – مجمع ناصر الطبي – مستشفى شهداء الأقصى) والاطلاع على عدد من ملفات المراجعين دون اجراء أي تدخل طبي او سحب عينات دم ، وبما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية، نأمل توجيهاتكم لذوي الاختصاص بضرورة الحصول على الموافقة المستنيرة من المشاركين.

وتفضلوا بقبول التحية والتقدير

ملاحظات /
تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 3 أشهر من تاريخه.
يرجى التأكد من توافق الاستبانة المرفقة والتي يتم تعبئتها ميدانيا على ان لا يتم أي إضافة او تعديل على الاستبانة المرفقة

يجب اطلاع دائرة البحث الصحي على النتائج قبل النشر

علي حسن البلبيسى
رئيس قسم اداري

التحويلات

■ علي حسن عبد القادر البلبيسي(رئيس قسم اداري)	← هاني سلطان ارميح الوحيدي(مدير عام بالوزارة)	إجراءاتكم بالخصوص(17/07/2023)

المرفقات

■ ادوات البحث نهال تيسير حسن شبات.pdf

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عنوان الدراسة: جودة التوثيق التمريضي في أقسام الأطفال في المستشفيات الحكومية في قطاع غزة, فلسطين

الطالبة: نـهال تيسير حسن شبات

إشراف: د. محمد الجرجاوي ، د. أشرف الجدي

الملخص:

توثيق التمريض جزء مهم لضمان جودة رعاية المرضى، خاصة في أقسام الأطفال. يعكس التوثيق في الوقت المناسب الرعاية التي يقدمها مقدمو الرعاية الصحية ويقلل من المخاطر مثل الأخطاء الطبية والمطالبات بالتقصير. يمكن أن يوثر نقص التوثيق في سلامة المرضى وجودة الرعاية. تهدف هذه الدراسة إلى قياس جودة توثيق التمريض في أقسام الأطفال بالمستشفيات الحكومية في قطاع غزة. تم تطبيق تصميم بحث وصفي كمّي وعرضي للتحقق من جودة التوثيق في خمسة مستشفيات حكومية في قطاع غزة. كانت عينة الدراسة 90 ممرضًا و200 سجل طبي للأطفال. تم تصميم استبيان منظم لجمع البيانات. تم تحليل البيانات باستخدام SPSS النسخة 25. أظهرت النتائج أن التصورات العامة عن مستوى جودة توثيق التمريض في أقسام الأطفال بالمستشفيات الحكومية في قطاع غزة كانت جيدة (72.33%). كما أن الدرجة الإجمالية المعتدلة لجودة توثيق التمريض كانت مرتفعة (84.67%). كانت أعلى جودة لتوثيق التمريض في مستشفى النجار (92.07%) يليه مستشفى شهداء الأقصى (84.67%)، مستشفى الدرة للأطفال (83.58%)، بينما كانت الأدنى في مستشفى الرنتيسي (77.94%). معظم المشاركين كانوا من الإناث (80%)، بينما كان 20% فقط من الذكور. خلصت الدراسة إلى أن جودة توثيق التمريض في أقسام الأطفال بالمستشفيات الحكومية في غزة تتراوح بين المتوسطة إلى العالية. من الضروري تنفيذ برامج تدريب منتظمة ومنظمة للممرضين في مستشفيات الأطفال لتحسين عملية التوثيق، مع التركيز على مجالات الضعف التي أبرزتها النتائج مثل استمارات تقييم الألم وخطة خروج المريض.

الكلمات المفتاحية: الجودة، توثيق التمريض، مستشفيات الأطفال، محافظات غزة.