

上海地区医院护理文书使用现况调查与分析

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摘要:目的 调查上海地区医院护理文书使用的现况, 为规范区域性标准化护理文书提供依据。方法 采用自行设计的《上海地区医院护理文书现况调查问卷》, 选取上海地区 29 所医院的护理文书使用现况进行调查分析。结果 体温单、入院护理评估单、一般护理记录单、转运交接单、压疮风险评估单及跌倒/坠床风险评估单是各医院最基本的护理文书(100%), 其中体温单、入院护理评估单为目前常用的电子护理文书(>90%)。体温单、医嘱单、手术护理记录单等护理文书在急诊留观室、急诊抢救室和日间病房的使用情况波动较大(13.8%~79.3%), 责任护士每日护理书写时间为 30~90 min(34.5%~37.9%)。结论 上海地区医院护理文书使用现状存在一定差距, 电子护理文书有待进一步开发与利用, 需构建标准化护理文书, 进一步规范护理文书书写。

关键词: 护理文书; 上海地区; 现况调查

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Status quo investigation and analysis of use of nursing documents in hospitals of Shanghai (1. Shanghai General Hospital, Shanghai Jiao Tong University, Shanghai 200080, China; 2. Zhongshan Hospital, Fudan University, Shanghai 200032, China; 3. Shanghai Tenth People's Hospital, Tongji University, Shanghai 200072, China; 4. Shanghai Ninth People's Hospital, Shanghai Jiao Tong University School of Medicine, Shanghai 200011, China; 5. Ruijin Hospital, Shanghai Jiao Tong University School of Medicine, Shanghai 200025, China; 6. Renji Hospital, Shanghai Jiao Tong University School of Medicine, Shanghai 200127, China; 7. Yueyang Hospital of Integrated Traditional Chinese and Western Medicine, Shanghai University of Traditional Chinese Medicine, Shanghai 200437, China)

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Abstract: Objective To understand the status quo of use of nursing documents in hospitals of Shanghai so as to provide evidences for standardizing the nursing documents. **Methods** Self-designed Nursing Documents Questionnaire was adopted to investigate the use of nursing documents in 29 hospitals in Shanghai. **Results** The most basic nursing documents were temperature chart, admission nursing assessment form, general nursing recording sheet, transfer receipt, pressure sore risk assessment list, and fall risk assessment list in all hospitals (100%). The current commonly used electronic nursing documents were temperature chart and admission nursing assessment form (>90%). The usage rate of nursing documents fluctuated obviously in emergency observation room, resuscitation room and day ward (13.8%-79.3%), including temperature chart, physician's order sheet, operational nursing record sheet, etc. Primary nurse spent 30 to 90 min per day to write nursing documents (34.5%-37.9%). **Conclusion** There are big gaps in the use of nursing documents among

hospitals. The value of electronic nursing documents remains to be further developed and utilized, and standardized nursing documents should be built to regulate nursing documents writing.

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