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# An Overview of Comprehensive Integration of Development Records and Nursing Documentation for Patients with Diabetes Mellitus

**Citra Suraya[1], Tukimin bin Sansuwito[2], Regidor III Dioso[3], Aris Citra Wisuda[4]**
[1,2,3,4]Faculty of Nursing, Lincoln University, Malaysia
[1,4]Faculty of Nursing, Sekolah Tinggi Ilmu Kesehatan Bina Husada Palembang, Indonesia
Email: citrasuraya.edu@gmail.com, tukimin@lincoln.edu.my, duke@lincoln.edu.my, ariscitrawisuda.edu@gmail.com

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**ABSTRACT**

Integrated patient development records form an integral part of nursing Integrated patient development records and Documentation, serving as a tangible representation of nurses' responsibility and accountability in executing their duties through interprofessional collaboration, while also offering authentic records of professional nursing care management. This study aims to elucidate the description of patient progress records and the completeness of nursing care Integrated patient development records and Documentation for Diabetes Mellitus patients in the Inpatient Ward of Siti Khadijah Islamic Hospital, Palembang. Employing a descriptive analytical approach with a cross-sectional design, the research involved purposive sampling, encompassing a total of 36 respondents. The findings revealed that among the respondents, 9 medical records (25%) were categorized as good, while 27 (75%) were classified as poor. Diagnosis results indicated that 28 medical records (77.8%) were deemed good, while 8 (22.2%) were rated as bad. Intervention records demonstrated that 3 respondents' medical records (8.3%) were assessed as good, whereas 33 respondents' records (91.7%) were categorized as poor. Implementation data showed that 26 respondents' medical records (72.2%) were in the good category, while 10 (27.8%) were in the bad category. Assessment outcomes showed that 5 respondents' medical records (13.9%) were considered good, while 31 (86.1%) were regarded as poor. Overall, Integrated patient development records and Documentation practices were observed among nurses in the inpatient ward at Siti Khadijah Islamic Hospital, Palembang; however, the implementation remains suboptimal. Statistical analysis of 36 medical records revealed that 24 (66.7%) were categorized as poor, whereas 12 (33.3%) were rated as good. Consequently, it is recommended to conduct standardized Integrated patient development records and Documentation training for both experienced and novice nurses, spanning across vocational and professional levels. Additionally, there is a necessity to establish and enhance nursing care instruments in alignment with standards, ensuring the optimal implementation of nursing process Integrated patient development records and Documentation

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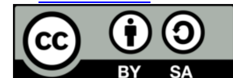

***Corresponding Author:***
Citra Suraya
Faculty of Nursing, Lincoln University,
Wisma Lincoln, No. 12-18, Road SS 6/12, 47301 Petaling Jaya, Selangor Darul Ehsan, Malaysia.
Program Studi Ilmu Keperawatan, Sekolah Tinggi Ilmu Kesehatan Bina Husada Palembang, Indonesia
Email: citrasuraya.edu@gmail.com

## 1. INTRODUCTION

Integrated patient development records and documentation serves as a vital communication tool among healthcare professionals, crucial for patient recovery and health improvement. In the absence of accurate and clear Integrated

patient development records and Documentation, the nursing services rendered by a professional nurse cannot be properly acknowledged, hindering efforts to enhance nursing service quality and elevate patient health in hospital settings (1). Medical record Integrated patient development records and Documentation establishes effective communication channels among healthcare providers, aiming to prevent misinformation, foster interdisciplinary coordination, avoid redundant information, and assist nurses in efficient time management. A clear indication of inadequate communication among healthcare disciplines is the persisting use of separate medical Integrated patient development records and Documentation for recording patient conditions, distinct from treatment documents and other health professional records (2).

Precise and consistent Integrated patient development records and documentation of nursing care stands as a fundamental responsibility for nurses (3). This obligation is stipulated in the Regulation of the Minister of Health Number 148 of 2010, which addresses permits and the execution of nursing practice. Article 12, paragraph 1, explicitly states that nurses are required to systematically record nursing care and adhere to established standards (4).

Integrated patient development records and Documentation serves as proof of nurses' responsibility and accountability in the execution of their duties, constituting an authentic record within the realm of professional nursing care management. Professional nurses are expected to undertake actions that are both accountable and verifiable through Integrated patient development records and Documentation. In case of any issues related to the nursing profession, Integrated patient development records and Documentation can be utilized as legal evidence in court proceedings (5).

The thoroughness of nursing care Integrated patient development records and Documentation stands as a determinant of the quality of nursing services (6). The quality of nurses' performance is assessed based on the completeness of nursing care, adhering to standard nursing processes tailored to the patient's disease status. This is particularly crucial for patients with chronic diseases necessitating ongoing care, emphasizing the importance of systematic recording of nursing Integrated patient development records and Documentation (7). This assertion aligns with (8), highlighting that chronic conditions like respiratory disorders (asthma), cardiovascular issues (coronary heart disease), and endocrine disorders (diabetes mellitus) demand continuous and systematic treatment.

Following a preliminary investigation conducted on March 9, 2023, in the Medical Records section of Siti Khadijah Islamic Hospital Palembang, an analysis of medical record data for Diabetes Mellitus patients revealed a consistent pattern. In 2021, there were 501 patients, while 2022 witnessed an increase to 682 patients. For the ongoing year, specifically from January to May 2023, there have been 287 patients. This data serves as the foundation for the researchers' focus on Diabetes Mellitus cases, as it is one of the ten most frequently occurring diseases on a monthly basis at Siti Khadijah Islamic Hospital, Palembang. Given its nature as a metabolic disease, effective interdisciplinary communication becomes imperative to ensure precision and completeness in the nursing process, adhering to established standards.

The study conducted by (9) revealed that the management of nursing care Integrated patient development records and documentation for individuals with diabetes mellitus fell into the poor category (48%), followed by moderate (35%) and good (17%). In alignment with this, research by (10) at Kelet Jepara Hospital demonstrated that the implementation of nursing care Integrated patient development records and Documentation was categorized as good (58.1%) and not good (41.9%). Another study by (11) indicated that the implementation of diabetes mellitus nursing care Integrated patient development records and Documentation was categorized as good (70%), quite good (20%), and not good (10%). The assessment of nursing care Integrated patient development records and Documentation implementation revealed that Integrated patient development records and documentation was only filled in 25%, nursing diagnosis Integrated patient development records and documentation was at 50%, planning Integrated patient development records and documentation at 37.5%, implementation Integrated patient development records and Documentation at 35.5%, and evaluation Integrated patient development records and documentation at 25%.

Based on the data gathered from the hospital in April 2023, the completeness percentages for nursing care Integrated patient development records and documentation were as follows: assessment 55%, diagnosis 53.3%, planning 65%, implementation 40%, and evaluation 50%. The average overall yield was 53.21%. These figures indicate that the completeness of nursing care Integrated patient development records and documentation is categorized as poor. In interviews conducted on April 13, 2023, with four nurses from Siti Khadijah Islamic Hospital Palembang, two nurses expressed that Integrated patient development records and documentation consumes considerable time, energy, and mental effort. Conversely, the other two nurses mentioned that they consider Integrated patient development records and documentation less important, emphasizing that meeting the client's needs is the top priority. These nurses prioritize direct patient care and, as a result, may not give sufficient attention to nursing care Integrated patient development records and documentation.

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## 2. RESEARCH METHOD

This study adopts a quantitative research approach with an analytical descriptive design. Analytical descriptive research is characterized by its aim to provide detailed descriptions of research variables (12). The design is employed to depict the Integrated patient development records and Documentation of nursing care for Diabetes Mellitus patients, covering assessment, nursing diagnosis, intervention, implementation, and evaluation in the inpatient ward of Siti Khadijah Islamic Hospital, Palembang, throughout the year 2023. The research was conducted within the inpatient ward of Siti Khadijah Islamic Hospital, Palembang, spanning from May to June 2023.

## 3. RESULTS AND DISCUSSION

### 3.1. RESULT

#### 3.1.1. Characteristics of Respondents

**Table 1**
**Frequency distribution of the characteristics of the respondents**

| No | Characteristics of Respondent | f | % |
|---|---|---|---|
| **1.** | **Age (year)** | | |
| | 23 – 35 | 22 | 61,1 |
| | 36 – 45 | 10 | 27,8 |
| | 46 – 55 | 4 | 11,1 |
| **2.** | **Gender** | | |
| | Laki-laki | 13 | 36,1 |
| | Perempuan | 23 | 63,9 |
| **3.** | **Education** | | |
| | Vocational (Diploma) | 26 | 72,2 |
| | Profesional (Bachelor) | 10 | 27,8 |
| | **Total** | **36** | **100** |

Table 1 above regarding the frequency distribution of the characteristics of the respondents shows that of the 36 respondents, it is known that more than half are aged 23-35 years (61.1%), more than half are female (63.9%) and most have vocational education (72.2%).

#### 3.1.2. Nursing Assessment

**Table. 2**
**Frequency Distribution of Nursing Care Integrated patient development records and Documentation Diabetes Mellitus Patients**

| Assessment | f | % |
|---|---|---|
| Good | 9 | 25 |
| Not Good | 27 | 75 |
| **Total** | **36** | **100** |

Table 2 above shows that the Integrated patient development records and Documentation of nursing care from the aspect of assessment on 36 medical records found that most were not good, namely as much as 75%.

#### 3.1.3. Nursing Diagnoses

**Table 3**
**Frequency Distribution of Nursing Care Integrated patient development records and Documentation**

| Diagnose | f | % |
|---|---|---|
| Good | 28 | 77,8 |
| Not Good | 8 | 22,2 |
| **Total** | **36** | **100** |

Table 3 above shows that the Integrated patient development records and Documentation of nursing care from the aspect of diagnosis in 36 medical records shows that most of them are not good, namely 77.8%.

### 3.1.4. Nursing Planning

**Table 4**
**Frequency Distribution of Nursing Integrated patient development records and Documentation in Diabetes Mellitus Patients**

| Planning | F | % |
|---|---|---|
| Good | 3 | 8,3 |
| Not Good | 33 | 91,7 |
| Total | **36** | **100** |

Table 4 above shows that the Integrated patient development records and Documentation of nursing care from the planning aspect of 36 medical records shows that most of them are not good, namely 91.7%.

### 3.1.5. Nursing Implementation

**Tabel 5**
**Frequency Distribution of Diabetes Mellitus Nursing Care Integrated patient development records and Documentation**

| Implementation | F | % |
|---|---|---|
| Good | 26 | 72,2 |
| Not Good | 10 | 27,8 |
| **Total** | **36** | **100** |

Table 5 above shows that the Integrated patient development records and Documentation of nursing care from the aspect of action in 36 medical records shows that the majority are not good, namely 72.2%.

### 3.1.6. Nursing Evaluation

**Table 6**
**Distribution of the Frequency of Diabetes Mellitus Nursing Care Integrated patient development records and Documentation**

| Evaluation | F | % |
|---|---|---|
| Good | 5 | 13,9 |
| Not Good | 31 | 86,1 |
| **Total** | **36** | **100** |

Table 6 above shows that the Integrated patient development records and Documentation of diabetes mellitus nursing care from the evaluation aspect of 36 medical records shows that most of them are not good, namely 86.1%.

### 3.1.7. General Description of Nursing Care Integrated patient development records in Diabetes Mellitus Patients

**Table. 7**
**Distribution Description of Nursing Care Integrated patient development records and Documentation in Diabetes Mellitus Patients**

| Integrated patient development records | F | % |
|---|---|---|
| Good | 12 | 33,3 |
| Not Good | 24 | 66,7 |
| **Total** | **36** | **100** |

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Table 7 above shows that the distribution of the description of diabetes mellitus nursing care Integrated patient development records and Documentation from 36 medical records shows that more than half are not good, namely 66.7%.

## 3.2. DISCUSSION

### 3.2.1. Nursing Assessment

Table 2 above shows that the Integrated patient development records and Documentation of nursing care from the aspect of assessment on 36 medical records found that most were not good, namely as much as 75%, because based on the results of statistical tests found 32 medical records of the assessment covering the assessment covering physical examination, 14 medical records of the assessment covering the client's psychosocial-spiritual status, 16 medical records of the assessment covering the client's lifestyle, 4 medical records of the complete assessment carried out 24 hours after the client entered.

The nursing assessment criteria encompass several components: (1) Data collection involves both subjective data, acquired from clients/patients as their opinions on situations and events, and objective data, observed and measured by nurses. The focus of data collection spans the history of past and current health status, coping patterns, function, previous and current responses to medical therapy and nursing interventions, identification of risks for potential problems, and identification of elements serving as sources of encouragement or strength for the client. (2) When collecting data to support nursing diagnoses, it is imperative that the characteristics are complete, accurate, real, and relevant. (3) Data collection extends beyond the client and may include information from the closest person (family), client records, past medical history, consultations with therapy, diagnostic examination results, medical records, and relevant literature (13).

The findings of this study diverge from the research conducted by (14), wherein the majority of assessment documents were categorized as Good, comprising approximately 81 documents (98.8%). The study results reveal suboptimal enthusiasm among nurses in performing assessments. The majority of nursing care Integrated patient development records and Documentation in the assessment aspect exhibits poor quality, with assessment files being incomplete, specifically in documenting health status and norms of life functions. Incomplete assessments can consequently impact the nursing diagnosis stage. This phenomenon is influenced by the knowledge and skills of nurses, particularly since a considerable number of them in the room are nursing graduates, potentially affecting their expertise.

From the researchers' findings, it can be inferred that nurses perceive Integrated patient development records and Documentation as straightforward and less significant, leading them to neglect completing comprehensive patient assessments. Although the assessment Integrated patient development records and Documentation process is undertaken by the executing nurse in the internal care room, it falls short of achieving optimal standards. In contrast to other departments like surgery, obstetrics, and pediatrics, the assessment stage in nursing Integrated patient development records and Documentation remains predominantly unfilled. This observation is supported by the clear absence of information in the Integrated patient development records and Documentation records within the room.

### 3.2.2. Nursing Diagnosis

Table 3 above shows that the Integrated patient development records and Documentation of nursing care from the aspect of diagnosis in 36 medical records shows that most of them are not good, namely 77.8%. Because based on statistical test results found 36 medical records of nursing diagnoses in accordance with the priority of the client's problems at that time, 5 medical records of nursing diagnoses covering the problem of Not Good Knowledge of the client at that time, 28 medical records of nursing diagnoses formulated correctly (PE/PES).

Nursing diagnosis involves analyzing subjective and objective data acquired through assessments. It requires a meticulous thought process based on information collected from clients, families, and other healthcare providers (15). When this aspect of the nursing care process is not executed properly, the overall quality of nursing services diminishes, leading to patient and family dissatisfaction (16). Nursing diagnosis is a statement outlining actual or potential responses to a client's health issues (17). This study contrasts with (18), indicating that the nursing diagnosis stage in the inpatient room is suboptimal. At this stage, nurses are expected to make decisions describing the patient's condition, including data grouping, analysis, and formulating potential, actual, and risk diagnoses.

The study's findings led the researchers to infer that the elevated percentage of nursing care Integrated patient development records and Documentation in the diagnosis aspect can be attributed to nurses possessing a relatively strong knowledge of documenting nursing diagnoses and maintaining a high awareness of the significance of such Integrated patient development records and Documentation.

#### 3.2.3. Nursing Planning

Table 4 above shows that the Integrated patient development records and Documentation of nursing care from the planning aspect of 36 medical records shows that most of them are not good, namely 91.7%. Because based on the results of statistical tests it was found that 15 medical records of nursing care plans included collaborative actions, 6 medical records of nursing care plans included actions that described client/family participation.

The objective of nursing interventions and activities is to mitigate, eliminate, and prevent nursing issues for clients. The care process criteria involve devising a nursing care action plan to tackle problems and enhance health, encompassing planning with priorities, goals, and strategies for nursing actions. When preparing nursing action plans, collaboration with clients is essential, tailoring the planning to the individual circumstances or needs of the client. Integrated patient development records and Documentation of nursing plans is a crucial aspect of this process (19).

The nursing care plan serves administrative goals by identifying individual or family nursing focuses, distinguishing the responsibilities of nurses from other health professionals, and assessing nursing care success based on set criteria. It also involves client classification criteria. On the clinical front, the plan provides guidelines for communicating nursing care to be implemented with other nurses, detailing what will be taught, observed, and done. It develops outcome criteria for evaluating the success of nursing care, along with specific and direct intervention plans for nurses to implement interventions for clients and their families (20). The planning stage encompasses the formulation of client-focused, measurable, clear, concise, observable, realistic, time-targeted goals that involve the client.

The findings of this study differ from the research conducted by (18), where 78 filled documents in the planning aspect are categorized as good, accounting for 95.1%.

From the research findings, the conclusion is drawn that nurses perceive Integrated patient development records and Documentation as straightforward and insignificant, leading to incomplete planning Integrated patient development records and Documentation for patients.

#### 3.2.4. Nursing Implementation

Table 5 above shows that the Integrated patient development records and Documentation of nursing care from the aspect of action in 36 medical records shows that the majority are not good, namely 72.2%. Because based on the results of statistical tests it was found that 34 medical records of nursing observation actions were documented, 26 medical records of nursing therapy actions carried out were documented, 4 medical records of health education actions carried out were documented, 21 medical records of collaborative actions carried out were documented, 22 medical records of client responses nursing actions are documented.

The findings of this study align with the research conducted by (21), indicating that in the implementation aspect, 66 documents (80.5%) fall into the Good category.

The outcomes of the research, which analyzed 36 medical records focusing on nursing care Integrated patient development records and Documentation in the aspect of actions, revealed that 10 medical records (27.7%) fell into the Not Good category. The statistical test results indicate that 2 records lacked Integrated patient development records and Documentation of nursing observation actions, 10 records lacked Integrated patient development records and Documentation of medical therapy nursing actions, 32 records lacked Integrated patient development records and Documentation of health education actions, 15 records lacked Integrated patient development records and Documentation of collaborative actions, and 14 records lacked Integrated patient development records and Documentation of client responses to nursing actions.

The criteria for implementing actions encompass: engaging the client in executing nursing actions, collaborating with other healthcare teams, conducting nursing actions to address the client's health, imparting education to clients and families on self-care skills, and assisting clients in modifying their environment. Additionally, it involves reviewing and evaluating the implementation of nursing actions based on client responses (15).

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According to the findings of this study, the researchers inferred that the elevated percentage of nursing care Integrated patient development records and Documentation in the diagnosis aspect could be attributed to (1) nurses' relatively strong knowledge regarding the Integrated patient development records and Documentation of nursing implementation and (2) the heightened awareness among nurses regarding the significance of documenting nursing implementation.

### 3.2.5. Nursing Evaluation

Table 6 above shows that the Integrated patient development records and Documentation of diabetes mellitus nursing care from the evaluation aspect of 36 medical records shows that most of them are not good, namely 86.1%. Because based on the results of statistical tests found 28 medical records of nursing diagnoses evaluated every day according to SOAP, seen in 8 medical records of nursing diagnoses that have been resolved.

Nursing evaluation involves comparing the outcomes of implemented nursing actions with predetermined goal norms or criteria. It constitutes the final step in the nursing process, assessing the attainment of goals outlined in the treatment plan. The evaluation aims to determine the effectiveness of nursing interventions or care strategies, providing insights into whether nursing actions have been successful and assessing patient progress in addressing health problems (22).

In contrast to (23) which indicated that 83.3% of the evaluated nursing care Integrated patient development records and Documentation in six general inpatient rooms was deemed adequate, with 16.7% classified as Not Good. However, the current research on 36 medical records focusing on nursing care Integrated patient development records and Documentation at the evaluation stage revealed that 31 records (86.1%) fell into the Not Good category. This classification resulted from statistical tests uncovering instances where eight daily evaluations of nursing diagnoses did not align with SOAP, and 28 medical records failed to display resolved nursing diagnoses in the Integrated patient development records and Documentation, contrary to expectations.

From the findings of the conducted research, it can be inferred that nurses perceive Integrated patient development records and Documentation as trivial and insignificant. Consequently, nurses tend to neglect documenting a comprehensive patient evaluation. This observation is substantiated by the apparent absence of the SOAP method (Subjective, Objective, Analysis, and Planning) in the existing Integrated patient development records and Documentation practices within the room.

### 3.2.6. Integrated patient development records of Nursing Care for Diabetes Mellitus Patients

Table 7 above shows that the distribution of the description of diabetes mellitus nursing care Integrated patient development records and Documentation from 36 medical records shows that more than half are not good, namely 66.7%. Because based on the results of statistical tests there were 9 assessment medical records in the Good category, 28 nursing diagnoses medical records in the Good category, 3 intervention (planning) medical records in the Good category, 26 implementation medical records in the Good category, 12 evaluation medical records in the Good category.

The results of research conducted on 36 medical records based on Integrated patient development records and Documentation of nursing care showed that 24 medical records (66.7%) were in the Not Good category, because based on the results of statistical tests there were 27 medical records for assessment in the Not Good category, 8 medical records for nursing diagnoses in the category Not Good, 33 intervention (planning) medical records in the Not Good category, 10 implementation medical records in the Not Good category, 24 evaluation medical records in the Not Good category.

As a vital part of the healthcare team, it is imperative for nurses to communicate client information accurately. The proficiency in communication among team members directly reflects the quality of client care. Integrated patient development records and Documentation serves as a crucial means of communication among healthcare professionals involved in the client's health recovery process. Nurses bear the responsibility and accountability for accurately documenting their actions. The effectiveness of nursing service activities, aimed at enhancing the quality of care and improving the client's health status, hinges on the precision and clarity of Integrated patient development records and Documentation (24).

Delivering professional nursing care involves administering care to clients grounded in nursing knowledge and a "humane" approach. This approach encompasses a holistic perspective, addressing bio-

psycho-social/cultural and spiritual aspects, alongside a focus on the client's objective needs. This constitutes a form of scientific nursing practice, emphasizing a comprehensive and compassionate methodology (25).

Nurses and their practice are portrayed daily through patient records, wherein nursing data mirrors the benchmarks of nursing care. The health team, including other members, relies on these records to make informed care decisions. Patient records have been regarded as a supplementary account of care in the absence of the patients themselves (2).

According to (3) and (26), nurses allocate 15-25% of their time to document nursing care during their daily routines. However, a significant portion of nurses' time is directed toward direct patient care, as they may perceive Integrated patient development records and Documentation as less important or redundant. In the evolution of nursing, particularly in the professionalization process aimed at maintaining nursing as a noble and respected profession in society, Integrated patient development records and Documentation becomes essential. This is because Integrated patient development records and Documentation serves as a reflection of the quality of nursing care provided. The challenge arises as nursing practitioners find it difficult to balance their time between direct patient care and thorough Integrated patient development records and Documentation.

Nurses may sometimes underestimate the significance of Integrated patient development records and Documentation in every nursing action. Several factors contribute to this oversight, including the extensive workload beyond the nurse's responsibilities, which must be shared with the nursing team. Additionally, the perceived complexity and time-consuming nature of the taught recording system, coupled with variations in the knowledge and abilities of nursing staff regarding the standardized Integrated patient development records and Documentation system, serve as reasons for non-compliance. Nurses in inpatient settings often come from diverse educational backgrounds, with varying levels of expertise and graduation timelines. Despite shared tasks, coordination efforts, and delegated responsibilities, there is a lack of uniformity in adherence to Integrated patient development records and Documentation standards. This inconsistency persists even when a standardized Integrated patient development records and Documentation format is provided in many health centers or hospitals (27).

The results of the research that has been done show that the distribution of nursing care Integrated patient development records and Documentation is based on the Nursing Care Integrated patient development records and Documentation variable from 36 medical records of Respondents with The highest total was Not Good, namely 24 medical records of respondents (66.7%) and Total Good, namely 12 medical records of respondents (33.3%).

## 4. CONCLUSION

After analyzing and discussing the results, it can be inferred that the Integrated patient development records and Documentation of nursing care for patients with diabetes mellitus in the inpatient room of Siti Khadijah Islamic Hospital, Palembang, based on 36 medical records of respondents, predominantly falls into the "not good" category, constituting 24 medical records (66.7%), while the "good" category comprises 12 medical records of respondents (33.3%).

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