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Assessment of Nurses' autonomy level in Basra Teaching Hospitals

A Research Project submitted

A Research

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Degree of the Bachelor in Nursing

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بسم الله الرحمن الرحيم

﴿يَا أَيُّهَا الَّذِينَ آمَنُوا كُونُوا قَوَّامِينَ بِالْقِسْطِ شُهَدَاءَ لِلَّهِ وَلَوْ عَلَى أَنْفُسِكُمْ أَوِ الْوَالِدَيْنِ وَالْأَقْرَبِينَ إِنْ يَكُنْ غَنِيًّا أَوْ فَقِيرًا فَاللَّهُ أَوْلَى بِهِمَا فَلَا تَتَّبِعُوا الْهَوَى أَنْ تَعْدِلُوا وَإِنْ تَلْوُوا أَوْ تُعْرِضُوا فَإِنَّ اللَّهَ كَانَ بِمَا تَعْمَلُونَ خَبِيرًا﴿١٣٥﴾﴾ [النساء: ١٣٥]

صدق الله العلي العظيم

We dedicate this humble work to our parents, brothers and sisters…

To the soul of martyrs who award their souls as redemption to our lovely country, Iraq…

To our colleagues in the nursing profession

To our colleagues and professors…

To our supervisor Zahra Abbas…

To all who helps us…

The researchers

We would like to express our thanks and gratitude at first to.

Allah then we would like n to express thank to our supervisor

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Supports.

Also, we would like to thanks all nurses whom precipitated in

the study

Abstract

Background: Professional autonomy entails the ability to make judgments and act in line with one's professional knowledge base. A knowledge of autonomy is required to define and enhance the nursing profession in quickly changing health care contexts.

Objectives: To measure nurses' independence in clinical decision-making and the link between nurses' independence in clinical decision-making and their professional and socio-demographic characteristics. The perceived limitations to a nurse's independence level in clinical decision-making were also tackled.

Methods: Methods: Descriptive-cross-sectional design was conducted in the present study. A purposive sample of (106) who had met the study's inclusion criteria were targeted. Granting Nursing Activity Scale (NAS's) author permission to use the instrument, data collected from the period February 25th, 2022, to March 25th, 2022. Data were analyzed through the use of IBM-Statistical Package for Social Sciences (SPSS) version 17 in which descriptive and inferential statistical measures were employed.

Results: Most common barriers of professional autonomy were absence of legislations protecting professional duties (80%), hospital administration style (73.7%), unit manager (46.7) and the domination or authority of physicians (53%). There were not significant statistical associations between professional autonomy and some professional & demographic characteristics There was strong significant statistical association between work shift (p= 0.009) and professional autonomy.

Conclusions: Professional autonomy in clinical decision-making is a concept with multiple faces, and its path cannot be determined by a single factor.

Recommendations: The field of nursing work is fully described and clarified based on authenticated job description provided that it is activated with the guarantee of appropriate legal legislation

Supporting and encouraging nurses to exercises autonomy in clinical practice by providing laws and professional policies that protects them.

List of Contents

Subjects	Page
Acknowledgments	I
Abstract	II
List of Contents	IV
List of Tables	VII
List of Figures	VIII
List of Appendices	VIII
List of Abbreviations	
Chapter One Introduction	
1-1 Overview	2
1.2. Importance of study	2
1.3. Objectives	3
1.4. Research Question	3
1.5. Problem Statement	3
1.6. Definition of Terms	4
1.6. A. Theoretical Definition	4
1.6. B. Operational definition	4
Chapter Two Review of Literature	
2.1. Historical Overview of Nursing Autonomy	6
2.2. Theoretical Framework	7

2.2.1. Empowerment Theory	**7**
2.3.1 Nursing Autonomy	**9**
2. 3.2. Factors Affecting Nursing Autonomy	**10**
2.4. Previous Literature	**11**
Chapter Three: Methods and Procedures	
3.1 Description of the Research Design	**15**
3.2 Administrative Arrangement and Ethical Consideration	**16**
3.2. 2. Ethical Consideration	**16**
3.3. Setting of the Study	**16**
3.4. Sample and Sampling Method	**16**
3.5. Inclusion Criteria	**17**
3. 6. Exclusion Criteria	**17**
3. 7. Steps of the study	**17**
3. 7.1. Translation and content validity of instrument	**17**
3. 7.2. Reliability of instrument and pilot study	**20**
3. 8. Data Collection	**20**
3. 9. Statistical Procedure	**21**
3. 10. Limitations of the Study	**21**
Chapter Four: Results of the Study	**23-32**
Chapter Five: Discussion of the Study Findings	**33-39**
Chapter Six: Conclusions & Recommendations	**40-42**

6.1. Conclusions	41
6.1. Recommendations	42
Reference	**43-53**
Appendix	**54-69**

List of Tables

Table No.	Titles	Page
3-1	**The number of Experts and its Implication on the Acceptable Cut-off Score of CVI**	**18**
3-2	**The Relevance Ratings on the Item Scale by Nine Experts**	**19**
3-3	**Reliability of Research Instrument**	**20**
4.1	The Demographics and professional characteristics	**24-26**
4.2	Barriers of Applying Professional Autonomy	**27**
4.3	Overall Level of Autonomy	**28**
4.4	Relationship between Autonomy Demographic Characteristics of Sample	**29-31**

List of Figures

Figure No.	Title	Page
2.3.1	Figure (1) Show Empowerment Theory	9
4.2	Figure (2) Barriers of Applying Professional Autonomy	27
4.3	Figure (3) Overall Level of Autonomy	28

List of Appendices

ITEM	APPENDICES
1	Panel Of Experts
2	Questionnaire in Arabic Language
3	Questionnaire in English Language
4	Administrative Agreements

List of Abbreviations

ITEM	Meaning
NAS	Nursing Activity Scale
INS	Iraqi Nursing Syndicate
FHS	Family Health Strategy
PHC	Primary Health Care
CVI	Content Validity Index
I-CVI	Item-level Content Validity Index
S-CVI	Scale-level Content Validity Index
S-CVI/UUA	Scale-level Content Validity Index based on Universal Agreement
S-CVI/AV	Scale-level Content Validity Index based on average method
%	Percent
>	More than
S	Significant
N.S	Non-Significant
F	Frequency
SPSS	Statistical Package for Social Science Program

Chapter ONE

Introduction

Chapter One Introduction

1-1 Overview:

The notion of autonomy as a broad phrase is defined in several ways, and because its structure is complicated, there are differing viewpoints and no consensus on its definition(Amini *et al.*, 2015a) (Varjus, Leino-Kilpi and Suominen, 2011) . Some define it as the ability to direct one's personal life and make decisions about one's own affairs (Adebayo *et al.*, 2005) . Others viewed it as freedom or independence from external restraints(Skår, 2010a) (Varjus, Leino-Kilpi and Suominen, 2011) . As a result, autonomy has become an increasingly significant attribute of the nursing profession in order to attract students to nursing programs and retain experienced and qualified nurses in the field. Furthermore, nurses with a limited amount of autonomy may have a range of negative psychological and professional sentiments such as deprivation, dissatisfaction, sense of lack of commitment and lack of motivation(Farsi *et al.*, 2010) . Autonomy can also have an impact on service quality. Patient's outcome, care safety professional identity levels of burnout such study is especially important at this difficult point in the history of the health-care system, when the entire globe is confronting an unknown epidemic of Covid-19(Adriaenssens, De Gucht and Maes, 2015). This necessitates that the health-care system rise to the occasion by providing the necessary space for nurses to carry out their tasks under the cover of professional autonomy in clinical decision-making(Smolowitz *et al.*, 2015).

1.2. Importance of study

Researchers have discovered why nurses quit the nursing profession and the elements that lead to nurses' work satisfaction, which is especially important given the

world's rising nursing shortage. The nurse's work acceptability, contentment, and excellent quality of patient care were all influenced by her considerable autonomy and low organizational constraints.

1.3. Objectives

1 -Assess nurses' autonomy level in Basra teaching hospitals.

2 -Assess relationship between nurses' autonomy level in Basra teaching hospitals with their socio-demographic characteristics and professional characteristics.

3-To detect the perceived barriers of nurse's autonomy level Basra teaching hospitals.

1.4. Research Question

1 -Are there any barriers in the hospital environment that hinder the nurse from exercising the limits of independent professional authority provided by law ?

2 -Is there a difference in nurse independence in clinical decision-making across critical care units, emergency departments, and medical-surgical nurses?

3 -Is there relationship between nurse independence in clinical decision-making in critical care units and emergency departments, Medical-Surgical nurse's department, and their professional and socio-demographic features?

1.5. Problem Statement

Clinical autonomy is identical with decision-making independence. Clinical autonomy is described as the right of nurses to make clinical judgments and exercise professional judgment based on their own clinical competence in order to support a wide range of nursing practices, as established by law enforcement authorities,

guidelines, and moral ideals(De Brouwer *et al.*, 2014) (Traynor, Boland and Buus, 2010) .

1.6. Definition of Terms

Autonomy

1.6. A. Theoretical Definition

Autonomy is frequently used to refer to decision-making independence. The meaning of autonomy is widely understood in nursing literature; however, there is no agreement on a global concept. It is defined as the ability to carry out situational accountability and considered autonomous judgment based on knowledge and skills without close supervision. (Maharmeh *et al.*, 2016)

1.6. B. Operational definition

The ability of nurses working in critical care units, emergency rooms, and medical-surgical departments to be accountable for their actions and make independent decisions without direct supervision.(Cone and Murray, 2002)

Chapter TWO

Review of Literature

Chapter Two: Review of Literature

2.1. Historical Overview of Nursing Autonomy

During the late 19th century, nursing roles were defined and affected by women's socialization characteristics, such as dependence and submission due to the dominance of women in the profession (Jondrow *et al.*, 1982). Women socialization also affected nursing through the socialization experienced by the majority of its members in their roles as both women as well as nurses.

The social, religious, traditions, and laws of countries have historically profoundly influenced the experiences of socialization and tended to limit women's autonomy. Women used to be often prohibited from working certain jobs or at certain hours, owning property, controlling their income, voting, obtaining credit on their accounts, and even keeping their parental rights (Padavic and Reskin, 2002)

After a divorce or widowhood. Laws have changed slowly, but behaviors and beliefs that support those laws are evolving much slower. Slowly shifting perceptions may explain non-nursing groups' attempts to regulate nursing practice (Spengler, 1976). An attempt by hospital administration and medicine to impose supervision on nursing and make it completely dependent on the medicine. As a result of physicians' control over nurses during Victorian times, they assumed women were more dependent, less inspired, and less productive than men, so they expected them to need supervision (Ashley, 1976).

The literature reveals the source of numerous limitations that imposed autonomy in nursing. Examples include nurses performing duties outside their standard role when other health care members, such as pharmacists, doorkeepers, professional therapists, and physical therapists, are unavailable, wasting their time and stealing their time to effectively communicate with their clients to recognize their needs and make effective nursing care plans ((Schutzenhofer, 1988);Muff, 1982; Singleton and Nail, 1984; (Welch, 1980)).

Nursing autonomy is also limited by the dominated organizational culture in which nurses are

practicing. In the late 1970s and the early 1980s studies conducted to examine the cause of the nursing shortage, found a lack of well-defined nurses' roles, poor staffing, no policies and standard that guide nursing practice as the main reasons of nurses to decide to leave the nursing profession (Wandelt, Pierce and Widdowson, 1981); (Lysaught, 1981).

2.2. Theoretical Framework

2.2.1. Empowerment Theory

Autonomy and empowerment seemed to be closely related, and yet the two concepts are different, but often used synonymously. Autonomy is the ability of individuals to do their job according to their knowledge and experience without direct instructions. Empowerment is the granting of power to individuals through authority and resources ((Ibrahim, El-Magd and Sayed, 2014); (Singh, Pilkington and Patrick, 2014)). (Kanter, 1993) believed and confirmed that employees are motivated when they have the opportunity to improve their work results, increase their productivity, promote their expertise, and thus achieve greater job satisfaction. Kanter's theory consists of two concepts: structural and psychological empowerment. One of the two elements of Kanter's theory is structural empowerment. (Kanter, 1993) clarified that organizations aim to improve performance and efficiency in this area by providing resources and support to employees needed to achieve organizational goals. Organizational efforts are critical to promoting autonomy in care through the provision of appropriate support, training, and policymaking (Labrague, McEnroe-Petitte and Tsaras, 2019)

Support was defined as a leader delegating responsibility and autonomy in decision-making to employees and directing them when necessary to enhance their practice (Horwitz and Horwitz, 2017)(Kanter, 1993); (Kim and Fernandez, 2017). Nurse managers play a significant role in increasing the autonomy of staff nurses. This may be accomplished by employing participatory management practices, trusting nurses' decision-making

abilities, and delegating power and decision-making duty to staff nurses (Masih *et al.*, 2019); (Banan, 2020).

(Kanter, 1993), focusing on psychological empowerment, claimed that autonomy in the workplace may be verified if individuals think that they have authority and power in practice. Role ambiguity may arise when nurses believe there is no specific job description or succinct standard of practice, which leads to misunderstandings of accountability and perceptions and is viewed as a hindrance to practice autonomy in health care settings (AllahBakhshian *et al.*, 2017). Although the idea of empowerment is not defined, (Kanter, 1993) provided the framework for what psychological empowerment is by defining control, which is then passed to workers. (Kanter, 1993)defined power as the ability to act to attain predetermined goals. Individuals utilize their imagination and ingenuity to find the proper tools and resources to execute their work.

Kanter also defines the informal and formal power levels, which are both recognized globally. Informal power is defined as the ability of non-leaders to manage and achieve goals, whereas formal power is defined as strong influence obtained from a role or title of authority (Kanter, 1993); (Laschinger *et al.*, 2001). When individuals are given authority and empowerment, they are better able to fulfill their roles and have a stronger sense of accomplishment. The amount of liberty to carry out their duties allows for empowerment in the workplace (Kanter, 1993)

Kanter's idea was a good fit for the existing research. When organizations give nurses who work in critical care units, emergency rooms, and medical-surgical departments more authority and autonomy, they realize their role more effectively and have more autonomy in making decisions about patients and organizations based on their knowledge and experience rather than being directed by other health care providers (s). As a result, job performance will improve, efficiency will grow, skills will be promoted, and job happiness will arise. Nurses require more autonomy and authority in clinical decision-making in critical care and emergency departments than in other health care settings,

simply because critical care nurses deal with unstable and critical conditions and work in a time-limited environment that necessitates rapid and urgent decisions to save patients' lives and prevent life-long disabilities.

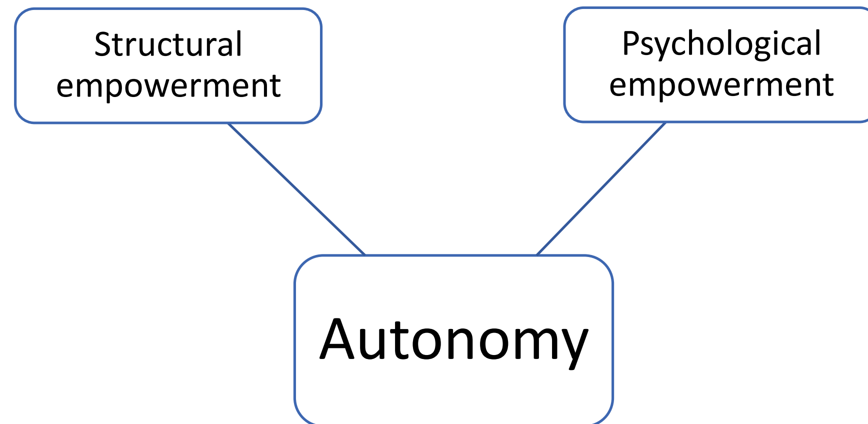


Figure (1) Show Empowerment Theory

2.3.1 Nursing Autonomy

Autonomy is a Greek term made up of two parts: autos (self) and nomos (rule), and it refers to the ability to act independently (Rose *et al.*, 2007). The right to make autonomous and official decisions in accordance with the area of practice, as well as the right to act on those judgments (Lewis and Batey, 1982) . The ability to think, determine and act based on such understandings, acting freely, autonomously, and without hindrances (Hope, 1987) . Recent research proposes five key definitions of autonomy, including freedom, decision-making competence, judgment, knowledge, and self-determination (Keenan, 1999). Each definition has the same thing in common: free decision-making and operating within the cover of professional health care duties.

Nursing autonomy is founded on the primary nursing (Petersen and Way, 2017). role in the knowledge society. The ability to act independently is derived from positional authority. It indicates that nursing practice autonomy is

acquired through organizational and professional experience (MacDonald, 2002). According to the research, there are two types of autonomy in nursing: clinical autonomy, independence, and the ability of nurses to make decisions about patient care. Organizational structures, governance, laws, rules, and procedures may all have an impact on a healthcare professional's ability to make judgments in a specific clinical practice setting. This second level of autonomy necessitates that a nurse operates in the administrative sector, executing and monitoring the climate of their work environment (Harrington, 2015; Petersen *et al.*, 2015; Petersen and Way, 2017) .

2. 3.2. Factors Affecting Nursing Autonomy

Findings from the literature revealed a link between gender serotype personality characteristics and nursing autonomy. Male and female personality qualities differ; feminine characteristics include being dependant, emotionally focused, kind, risk-taking, and sensitive. Male qualities, on the other hand, include freedom, leadership capacity, and aggressiveness. In nursing, historically, female dominance in the profession has resulted in a lack of internal aptitude to practice autonomy due to the prevalent view that nursing is a dependent practice; poor self-confidence and low self-esteem are important internal barriers that affect nurses' capacity to exercise autonomy(Schutzenhofer, Musser and Chi, no date; John and Harris, 1985; Skår, 2010b) .

Nurses needed training and education that focused on the notion of autonomy to gain confidence in making autonomous patient decisions and establish a more mature professional identity. Nurses must be knowledgeable and have the competence and abilities to recognize and handle patient situations to make autonomous judgments. (AllahBakhshian *et al.*, 2017). Age and experience have been found to have favorable benefits on nursing autonomy in certain published research, however, age and years of experience have been found to have non-significant effects on autonomy in other studies. In the nursing literature, the link between nursing autonomy, age, and experience is not yet established (Amini *et al.*, 2015b; Melo *et al.*, 2016).

Authoritarian impediments to halfway or complete independence include, but are not limited to, a mandate rather than a strong and less roused clinical climate, dictatorial initiative, doctor strength, and a lack of trust, regard, and joint effort among medical services colleagues, particularly among doctors and attendants, a lack of relational help and inspiration given by associates and chiefs, and a lack of power and strengthening for doctors (Salhani and Coulter, 2009; Hartog and Benbenishty, 2015; Chênevert, Jourdain and Vandenberghe, 2016).

2.4. Previous Literature

The published literature was synthesized for five articles and characterized. These were examined to determine the determinants of critical care and emergency unit nurses' clinical decision-making independence. These are found by searching for recent English language articles in the field of nursing with the keywords "determinants, independence level of clinical decision-making" and focusing on autonomy, critical care units, emergency, and Medical-Surgical departments. To a large extent, the selected publications reported in this review were published within the last 7 years. However, the widely cited and highly regarded older publications have not been removed. Because of their richness in providing the best quality literature and open access policy, the key search engines used were Bio-Med-Central, Google Scholar, and Research Gate.

(Dorgham and Al-Mahmoud, 2013) assessed dominant leadership styles and level of decision-making autonomy among 101 critical care nurses in the Kingdom of Saudi Arabia (KSA) and Egypt. The study was carried out in Intensive care units at two hospitals namely; King Fahd Hospital of the University and Tanta Main University Hospital. A convenient sample of 16 head nurses, 35 critical care nurses from Egypt and 11 head nurses and 39 critical care nurses from KSA was used. The findings of this study showed that critical care nurses had autonomy decision-making in the area of value base in both countries. Critical care nurses valued their autonomy and wanted to provide the best possible care for their patients. Interestingly, the findings show that nurses in KSA had

higher decision-making autonomy than nurses in Egypt. This may be attributed to the fact that the ratio number of nurse-patients and workload in KSA is less than that in Egypt.

(Amini *et al.*, 2015a), The goal of this study was to find out how much autonomy nurses have in hospitals affiliated with Iran's Zanjan University of Medical Sciences. A systematic random sampling method was used to recruit 252 subjects for this descriptive cross-sectional study. The A questionnaire, including the Dempster Practice Behavior Scale, was used to collect data. Descriptive statistics are used to analyze data. as well as to compare the overall score and its subscales to demographic variables, analysis of variance and t-test. There were tests carried out. In this study, the nurses had a moderate level of professional autonomy. Age, gender, work experience, working position, and place of work all showed significant differences in the research sample, according to statistical tests. The findings of this study revealed that, in comparison to western societies, most of the nurses who participated in the study have less professional autonomy. More research is needed to determine the factors that contribute to this disparity and how we can promote the autonomy of Iranian nurses

(Maharmeh, 2017), The aim of this study was to describe Jordanian critical care nurses' experiences of autonomy in their clinical practice A descriptive correlational design was applied using a self-reported cross-sectional survey. A total of 110 registered nurses who met the eligibility criteria participated in this study. The data were collected by a structured questionnaire, A majority of critical care nurses were autonomous in their decision-making and participation in decisions to take action in their clinical settings, Also, they were independent to develop their own knowledge. The study identified that their autonomy in action and acquired knowledge were influenced by a number of factors such as gender and area of practice.

(Balsanelli, David and Ferrari, 2018) the aim of this study was to assess how Primary Health Care (PHC) nurses identify their professional autonomy in daily work

and how this autonomy is perceived by other professionals of the multi-professional team. Exploratory, descriptive study in which the theoretical-methodological reference was dialectical hermeneutics anchored in the premises of the Sociology of Professions. The Data were collected through semi structured interviews with 27 nurses from the Family Health Strategy (FHS) and ten professionals from the Family Health Support Center in the city of São Paulo. The resulting empirical material underwent discourse analysis. The findings revealed the professional autonomy of PHC nurses is perceived in the following categories: the possible autonomy, the autonomy dictated by protocols and the subordination to medical work.

(Hara, Asakura and Asakura, 2020)this study aimed to investigate changes in nurses' attitudes toward professional autonomy and occupational commitment over time, and their effect on nurses' intentions to leave, using a two-wave longitudinal design. Anonymous, self-report questionnaires were distributed to all nurses working at 28 hospitals in western Japan on two separate occasions (n = 1778). Multivariate analysis using a generalized estimation equation was conducted, with the intention to leave at Time 2 as the dependent variable, and the changing secular trends in all subscales of attitudes toward professional autonomy and occupational commitment as the independent variables. Age, sex, education, and intention to leave at Time 1 were control variables. Results showed that increasing changing secular trends in control over work conditions, which is a subscale of attitudes toward professional autonomy, increased intention to leave at Time 2, while increasing changing secular trends in all subscales of occupational commitment decreased intention to leave at Time 2. Nurses with a progressive attitude toward discretion of control over work conditions may have higher intentions to leave. Therefore, increasing control over their work conditions may reduce this intention. Additionally, it is necessary to continually enhance nurses' occupational commitment by offering professional development programs.

Chapter THREE

Methods & Procedures

Chapter Three: Methods and Procedures

The chapter summarizes the research methods that were used to assess the nurse's autonomy level in Basra teaching hospitals, assess relationship between the nurse's autonomy level and their professional and socio-demographic characteristics, and to detect the perceived barriers of nurses' independence level in the clinical decision-making process. This chapter addresses the following topics: research design, sample, setting, data collection procedures, sample inclusion and exclusion criteria, the validity of the questionnaire, pilot study, reliability of the study instrument, ethical considerations and human subject protection, Administrative Arrangement, data analysis plan, and limitations of the study.

3.1 Description of the Research Design

Across-Sectional descriptive design was employed to conduct this study. Research is defined as a systematic investigation of phenomena through the collection of quantifiable data and the implementation of statistical, mathematical, or computational techniques. Quantitative research collects information from existing and potential customers using sampling methods and sending online surveys, online surveys, questionnaires, etc., the results of which can be depicted in the form of a number. After carefully understanding these numbers to predict the future of a product or service and make changes accordingly.

An example of quantitative research is a survey conducted to understand the level of nurse independence in critical care units and medical emergency and surgical departments and their occupational, social, and demographic characteristics. A nurse independence level questionnaire form can be run to ask questions such as how many patients you often provide nursing care to in your current workplace or you can apply your own independent professional competency limits. Does the law guarantee in a hospital environment? And other such questions

3.2 Administrative Arrangement and Ethical Consideration

3.2.1. Administrative Arrangement

After getting the approval of the Council of Nursing College, University of Basra for the study protocol, and prior to data collection, the researcher submitted a detailed description about the study, including problem statement, objectives, Importance of study and Research Question to the Basra Health Directorate (Human Development and Training Center) in order to obtain an official permission to carry out the study.

3.2. 2. Ethical Consideration

Ethical approval was granted by the participating hospitals' ethical committees. Participants were informed that their participation was entirely voluntary and that their identities would not be revealed (no personal information was recorded). In order to gain access to the actual research data, which was only available to the research team, participants were given identification numbers rather than names. In the cover letter to the questionnaire, participants were also given detailed information about the study's goals and their rights. Those who agreed to participate were given a sealed envelope containing a questionnaire package, and returning the completed questionnaire was considered implied consent.

3.3. Setting of the Study

The study was conducted virtually, nurses working in critical care units, emergency rooms, and medical surgical departments as participants in Al-Sadr Teaching Hospital, Al-Faiha Teaching Hospital, and Basra Teaching Hospital

3.4. Sample and Sampling Method

A purposive sample of (106) who had met the study's inclusion criteria were targeted. Granting Nursing Activity Scale (NAS's) author permission to use the instrument, data collected from the period February 25th, 2022, to March 25th, 2022. Data The Thompson equation was not used to calculate sample size since the precise number of participants (RNs working in critical care

units, emergency departments, and medical-surgical departments in Basra, Iraq) could not be acquired.

3.5. Inclusion Criteria

Participation criteria for this study. These nurses worked in critical care units, emergency rooms, and medical-surgical departments. Participants in the study must have a minimum of one year of experience in the clinical care setting in Basra, as well as a nursing institute degree.

3. 6. Exclusion Criteria

Excluded from the study were health care professionals who graduated from other colleges and worked in the nursing field to cover the nursing shortage.

3. 7. Steps of the study

3. 7.1. Translation and content validity of instrument

The instrument was translated from English to Arabic by two experts after receiving permission from Dr.Schutzenhofer. The first expert was a faculty member at Basra University College of Education, Department of English, with a doctorate degree in English language, and the second expert was a faculty member at Baghdad University, College of Nursing, with a doctorate degree in Nursing. To reach a consensus, the researcher conducted a combined analysis of the translated material. To revise the grammatical structure and ensure that it is appropriate for Arabic. To summarize, the first expert translated the English version of the tool into Arabic. After that, the Arabic version was converted to English.

The instrument was presented to a panel of experts made up of nine faculty members (six from the adult nursing department, two from mental health and emergency/trauma services, and one from nursing management). The Content Validity Index (CVI) developed

by Kline was used by the expert panel to assess the content validity of this edition (2011). This index is a four-point Likert-type ordinal scale with four alternative responses for each item. 1 indicates that the response is not relevant, 2 indicates that it is somewhat relevant, 3 indicates that it is rather relevant, and 4 indicates that it is very relevant.

Table (3-1)

The number of Experts and its Implication on the Acceptable Cut-off Score of CVI

Number of experts	Acceptable CVI values	Source of recommendation
Two experts	At least 0.80	Davis (1992)
Three to five experts	Should be 1	Polit & Beck (2006), Polit et al., (2007)
At least six experts	At least 0.83	Polit & Beck (2006), Polit et al., (2007)
Six to eight experts	At least 0.83	Lynn (1986)
At least nine experts	At least 0.78	Lynn (1986)

There are two forms of CVI, in which CVI for item (I-CVI) (Item- level Content Validity Index) and CVI for scale (S-CVI) (Scale-Level Content Validity Index). The two methods for calculating S-CVI, in which the average of the I-CVI scores for all items on the scale (S-CVI/Ave) and the proportion of items on the scale that achieve a relevance scale of 3 or 4 by all experts (S-CVI/UA) (Scale-Level Content Validity Index) based on the universal agreement method.

Prior to the calculation of CVI, the relevance rating must be recoded as 1 (relevance scale of 3 or 4) or 0 (relevance scale of 1 or 2) as shown in (Table 3-2). To calculate CVI it must be calculated based on expert in agreement (sum up relevant rating provided by all experts for each item), I-CVI (Item-Level Content Validity Index) $I - CVI = agreed\ item \div number\ of\ expert$ and S-CVI/Ave Scale-Level Content Validity Index based on the average)

$S - CVI = Sum\ of\ I - Ave\ \ CVI\ scores \div number\ of\ items.$

Table (3-2)

The Relevance Ratings on the Item Scale by Nine Experts

Items	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Expert 8	Expert 9	Expert in Agreement	I-CVI
Q1	1	1	1	1	1	1	1	1	1	9	1
Q2	1	1	1	1	1	1	1	1	1	9	1
Q3	1	1	1	1	1	1	1	1	1	9	1
Q4	1	1	1	1	1	1	1	1	1	9	1
Q5	1	1	1	1	1	1	1	1	1	9	1
Q6	1	1	1	1	1	1	1	1	1	9	1
Q7	1	1	1	1	1	1	1	1	1	9	1
Q8	1	1	1	1	1	1	1	1	1	9	1
Q9	1	1	1	1	1	1	1	1	1	9	1
Q10	1	1	1	1	1	1	1	1	1	9	1
Q11	1	1	1	1	1	1	1	1	1	9	1
Q12	1	1	1	1	1	1	1	1	1	9	1
Q13	1	1	1	1	1	1	1	1	1	9	1
Q14	1	1	1	1	1	1	1	1	1	9	1
Q15	1	1	1	1	1	1	1	1	1	9	1
Q16	1	1	1	1	1	1	1	1	1	9	1
Q17	1	1	1	1	1	1	1	1	1	9	1
Q18	1	1	1	1	1	1	1	1	1	9	1
Q19	1	1	1	1	1	1	1	1	1	9	1
Q20	1	1	1	1	1	1	1	1	1	9	1
Q21	1	1	1	1	1	1	1	1	1	9	1
Q22	1	1	1	1	1	1	1	1	1	9	1
Q23	1	1	1	1	1	1	1	1	1	9	1
Q24	1	1	1	1	1	1	1	1	1	9	1
Q25	1	1	1	1	1	1	1	1	1	9	1
Q26	1	1	1	1	1	1	1	1	1	9	1
Q27	1	1	1	1	1	1	1	1	1	9	1
Q28	1	1	1	1	1	1	1	1	1	9	1
Q29	1	1	1	1	1	1	1	1	1	9	1
Q30	1	1	1	1	1	1	1	1	1	9	1
S- CVI\Ave 1											

CVI for this study was (1) indicating excellent content validity level of the NAS (Nursing Activity Scale) according to nine expert opinion. See reference results which are displayed in table (3-1) (as cited in Lynn, 1986).At least nine expert CVI ratio must be 0.78.

3. 7.2. Reliability of instrument and pilot study

To evaluate the instrument's dependability, a pilot study must be conducted (NAS). It was conducted using a form in hospital poll on thirty nurses who worked in critical care units, emergency rooms, and medical-surgical departments (February 1st 2022 to March 25th, 2022). Nurses in the pilot study met the same study sample's requirements. The goal of the pilot study was to see if the questionnaire contents were clear and understandable to the study participants, as well as to identify any hurdles that might arise throughout the study process and to determine the questionnaire's reliability. Cronbach's Alpha was used to assess the research instrument's reliability using the IBM-Statistical Package for the Social Sciences SPSS program for (30) NAS items.

Table (3-3)

Reliability of Research Instrument

Methods of Reliability	Criteria of the Study	No. of Items	Actual value	Accepted Value	Assessment
Cronbach's Alpha	Nursing Activity Scale	30	0.79	0.70	Acceptable

The results of Table (3-3) show that the research instrument is acceptable and sufficient to evaluate the sample according to Cronbach 's Alpha value (0.79). Therefore, the instrument is reliable to test research phenomenon.

3. 8. Data Collection

Data were collected through the administration of the NAS (Schutzenhofer, 1987) to nurses who were working in critical care units, emergency and Medical-Surgical department in Basra by self-administer questionnaire from period February 25th, 2022 to March 25th, 2022.

The questionnaire response is a true reflection of the participant's agreement to participate in the study. Part one of the research instrument included professional and socio-demographic characteristics such as age, gender, educational level, work place, years of experience, work shift, and number of patients, working sector nature, working setting, and number of nurses in work shift. Part two consists of 30 NAS items, which are detailed in Appendix (3).

3. 9. Statistical Procedure

1. Descriptive analyses: to describe the socio-demographic information, professional characteristics, and professional autonomy of study subjects.
2. Pearson Chi-Square was used to measure the association between professional autonomy and the socio-demographic information and professional characteristics of study subjects.

3. 10. Limitations of the Study

There were some barriers that existed during the course of the study including however not limited to, the severe shortage of nurses and their preoccupation with providing health services to patients, hospitals have a small number of nurses.

The Some 30 to 50 percent of nurses refuse to participate in this study because they are unsure that anything will change, and they are unsure that their profession will be respected by health care professionals from other disciplines as well as by nurses themselves.

Nursing profession is despised by society, which is frustrating for nurses. The examination time for students of the fourth stage falls during the data collection phase.

In Iraq, particularly in Basra, it does not receive much attention in nursing research.

The assistant director of a hospital refused to conduct a search in his facility because he believes that nurses lack independence in making critical and emergency decisions,

that the decision should be returned exclusively to the doctor, and that the nurse follows the doctor's orders without question.

Chapter FOUR

RESULTS

Chapter Four: Results of the Study

Chapter four presents the results from a cross-sectional inquiry, which was basically designed to assess the nurse's independence level in clinical decision making, to examine the statistical association and difference between nurse's independence level in clinical decision-making and their professional & socio-demographic characteristics and to detect the perceived barriers of nurse's independence level in clinical decision-making was targeted.

Table (4.1) The Demographics and professional characteristics

Variables	*Characteristics*	*F*	*P*
Age	*18-28*	*36*	*34.0*
	28-38	*45*	***42.5***
	>39	*25*	*23.6*
Sex	*Male*	*56*	***52.8***
	Female	*50*	*47.2*
Education Level	*Diploma in Nursing*	*67*	***63.2***
	Bachelor's in nursing	*39*	*36.8*
Working Sector	*Emergency Department*	*36*	***34.0***
	Critical Care Units	*15*	*14.2*
	Coronary Care Units	*11*	*10.4*
	Respiratory care unit	*6*	*5.7*

	Medical Department	*13*	*12.3*
	Surgical Department	*7*	*6.6*
Experience	*1-4 years*	*40*	***37.7***
	5- 9 years	*32*	*30.2*
	10- 15 years	*16*	*15.1*
	>15 years	*18*	*17.0*
Professional Role	*Nurse Executing an Administrative Role*	*38*	*35.8*
	Bedside Nurse	*68*	***64.2***
Working Shift	*Morning (8 am-2 pm)*	*67*	***63.2***
	Evening(2 pm-8 pm)	*20*	*18.9*
	Night (8 pm – 8 am)	*11*	*10.4*
	>12-hour Sentinel Nurse	*8*	*7.5*
Having Nursing Association	*No*	*11*	*10.4*
	Yes	*95*	***89.6***
Association Membership	*No*	*72*	***67.9***
	Yes	*29*	*27.4*
	Not Apply to me	*5*	*4.7*

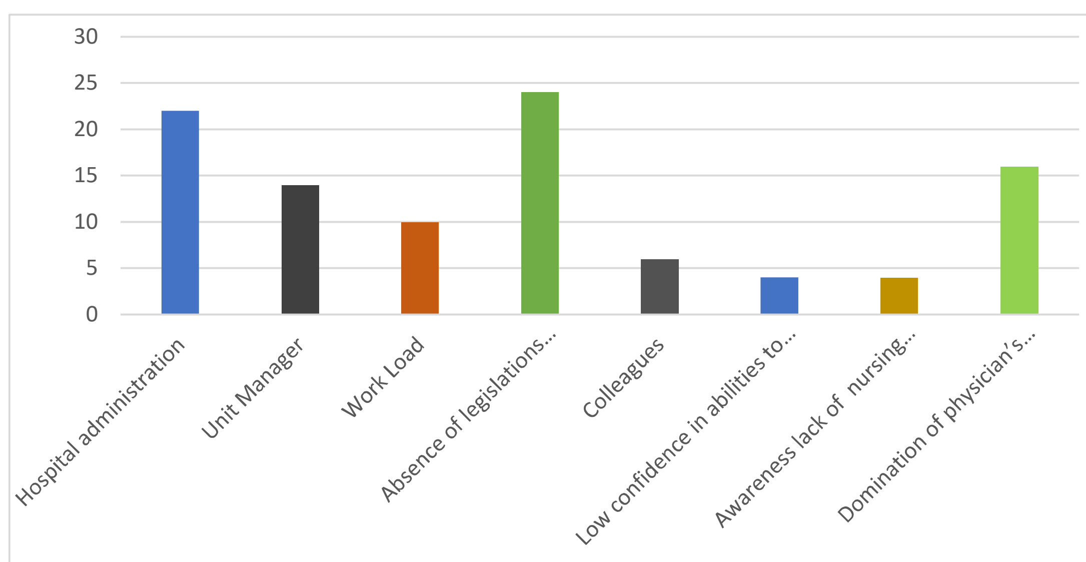
Number of Nurses	*1- 5*	*84*	***<u>79.2</u>***
	5- 10	*18*	*17.0*
	>10	*4*	*3.8*
Applying Job Description	*No*	*67*	***<u>63.2</u>***
	Yes	*39*	*36.8*
Having Job Description	*No*	*46*	*43.4*
	Yes	*60*	***<u>56.6</u>***
Professional Autonomy in Curriculum	*No*	*51*	*48.1*
	Yes	*55*	***<u>51.9</u>***

The underlined numbers in Table (1) represent the highest percentages of the selected variables. In which, more than half (52.8 %) of the study sample were males. Less than half (42.5%) of the study sample were classified as adult individuals within age range of 28 – 38 years. Furthermore, most of them (63.2%) were holding diploma degree. About (34.0%) were practicing nursing in emergency department. Furthermore, most of them were working in morning shift (63.2%).1-4 years' experience in recent unit was the dominant choice of the study subjects, representing (37.7%). Most nurses were employed as bedside nurses (64.2%). Of equal importance (79.2%), representing 1-5 nurses, was the highest percentage of nurse's number during work shift. The majority of respondents indicated having nursing association (89.6%) but having not an active association membership, and (56.6%) indicated having a job description. But (63.2.9%) of them were not able to apply job description. Surprisingly, only (51.9%) of respondents reported that

professional autonomy was covered during their academic preparation curriculum.

Table (4.2) Barriers of Applying Professional Autonomy

Perceived barriers	f	%
Hospital administration	23	**73.7**
Unit Manager	15	**46.7**
Work Load	11	33.3
Absence of legislations protecting professional duties	26	**80**
Colleagues	6	20
Low confidence in abilities to execute professional duty independently	4	13
Awareness lack of nursing authority & professional responsibilities limit	4	13
Domination of physician's authority	17	**53**
Total	106	100



Figure(2) Barriers of Applying Professional Autonomy

The underlined numbers in Table (2) represent the highest percentages of the perceived barriers according to nurses' choices. In which, Absence of legislations protecting professional duties (80%), hospital administration style (73.7%), unit manager (46.7) and the domination or authority of physicians

(53%), were the prevailing barriers that may have prevent nurses from authenticating professional autonomy.

Table (4.3) Overall Level of Autonomy

Statistics	N	%	Mean	Result
Very Low	2	1.9%	**2.9245**	**High**
Low	18	17%		
High	68	64.2%		
Very High	18	17%		
Total	106			

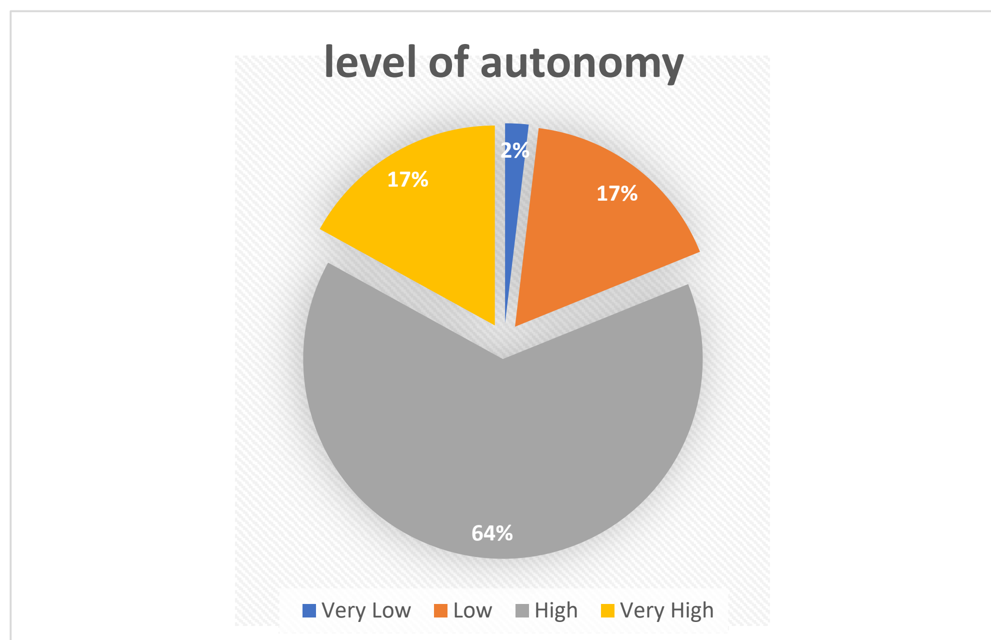


Figure (3) Overall Level of Autonomy

The underlined numbers in Table (3) represent the highest percentages of the selected variables. In terms of professional autonomy level, the highest percentage (64.2%) of study sample were classified as having a higher level of

Professional autonomy, while lowest percentage (1.9%) of study participants were classified as having lower level of professional autonomy.

Table (4.4) Relationship between Autonomy Demographic Characteristics of Sample

Variables	**Statistics**	**Mean**	**P-Value**	**Result**
Age	28- 38	2.9000	0.805	Insignificant
	18-28	2.9028		
	>39	3.0000		
Sex	Male	2.8214	0.079	Insignificant
	Female	3.0400		
Education Level	Diploma in Nursing	3.0075	0.085	Insignificant
	Bachelor's in nursing	2.7821		
Work Sector	Emergency Department	2.9722	0.089	Insignificant
	Critical Care Units	2.8571		

	Coronary Care Units	2.5333		
	Respiratory care unit	2.9091		
	Burns unit	3.0833		
	Medical Department	3.1364		
	Surgical Department	2.7692		
	Emergency Department	3.4286		
Experience	1-4 years	2.9250	0.208	Insignificant
	5- 9 years	3.0000		
	10- 15 years	2.6250		
	>15 years	3.0556		
Professional Role	Nurse Executing an Administrative Role	2.9079	0.845	Insignificant
	Bedside Nurse	2.9338		
Working Shift	Morning (8 am-2 pm)	2.9925	**0.009**	**Significant**

	Evening(2 pm-8 pm)	2.5500		
	Night (8 pm – 8 am)	2.8636		
	>12 hour Sentinel Nurse	3.3750		
Having Nursing Association	No	2.8182	0.569	Insignificant
	Yes	2.9368		
NursingAssociation Membership	No	2.9514	0.735	Insignificant
	Yes	2.8448		
	Not Apply to me	3.0000		
Number of Nurses	1- 5	2.9643	0.446	Insignificant
	5- 10	2.7500		
	>10	2.8750		
Applying Job Description	No	2.9030	0.657	Insignificant
	Yes	2.9615		
Having Job Description	No	2.9457	0.762	Insignificant
	Yes	2.9083		
Professional Autonomy in Curriculum	No	2.8235	0.124	Insignificant
	Yes	3.0182		

Table (4) shows that there is no statistical significant association between subject's gender (p= 0.079), age (p=0.805), educational level (p=0.085), work sector (p=0.089), experience (p=0.208), professional role (p = 0.845), having nursing association(p =0.569),nursing association membership (p=0.735), number of nurses (p=0.446), applying job description (p=0,657),having job description(p=0.762),professional autonomy in curriculum (p= 0.124) and their professional autonomy level. There are strong significant statistical association between work shift (p= 0.009) and professional autonomy.

Chapter
Five
discussion

Chapter Five: Discussion of the Study Findings

This chapter provides summary of interpretation and discussion of the study findings in a way that reflects its objectives supported by available literatures.

The findings in table (1) showed that the majority of study participants age group was 28-38 years representing (%42.5) of the study sample. This result is supported with study was done by (Keshk, Qalawa and Aly, 2018), found in their study that the highest percent of study participant (50%) within age group (26-34).

Regarding the level of education, findings of the study indicated that more than half of study sample were holding diploma degree (63.2%). Another study conducted among nurses in Egypt, found that most of nurses were holding diploma (71.7%) (Hendam, Fakhy and Mohamed, 2018).

In the present study, (52.8%) of study sample were male. Another study indicated that the highest percentage of study respondents were male (54.2%) (Gizaw et al., 2018). Furthermore, the challenging nature of nursing profession has hindered females from joining nursing, which created a critical imbalance as shown in Iraqi Nursing Syndicate (INS)'s statistics as male: female nurse ratio is 75:25 (Iraqi Nursing Syndicate [INS], 2014). This ratio was reflected by the descriptive statistics of sample demographics, which were, more male nurses (55.4%) participated in this study than females (44.6%).

About working place, most of the study sample were working in emergency department (34.4%). The study result supported with (Amini et al., 2015b) nurses' autonomy level in teaching hospitals and its relationship with the underlying factors showed that more than quarter of their study samples (49.2%) were working in non-critical care units.

Concerning working shift, most of study subjects were work during morning shift (63.2%). Another was study conducted to assess nurse's work autonomy on patient care and unit operation which stated that (59.8%) of sample were working in day shift (Mrayyan and Awamreh, 2010)(Mrayyan, 2006). This result is not surprising due to

the fact that the number of the nurses who work in morning shift is more than night shift. This can be explained by the fact that most nurses preferred working in morning more than night shift, due to administrative and duties nature factors. Morning shift provide opportunities for sleeping, learning and developing teamwork skill from other health care providers that are available.

The study found that the more than half percentage in terms of years of experience in hospital and recent unit of study participants between 1-4 years (37.7%). These findings agreed with (Mohamed, 2018), which indicated that the highest percentage of experience years was less than ten years (51.0%). These results were not surprising due to the fact that the majority of study participants were within age group 28-38 years.

Professional role is another variable that this study has highlighted, whereas less than two third of the study participants were bedside nurses (64.2%). This finding is congruent with(Labrague et al., 2019), in which the highest percent of study sample were practicing nursing as a staff nurse position (84.7%). This result was not surprising due to the fact that staff nurses forms the majority of heath care system when compared with nurses who hold managerial positions.

Surprisingly, only (51.9%) of respondents reported that professional autonomy was covered during their academic preparation as a topic in the nursing curriculum. In contrast, (Maharmeh et al., 2016) indicated that nursing autonomy and professionalism in the nursing were not emphasized in the nursing core curriculum.

About (79.2%), representing 1-5 nurses is the most percentage of nurse's number during work shift. Having high numbers of admitted clients, nursing staff shortage, is not surprising because of data collected phase was conducted during Covid-19 pandemic. That led to increase work load and decreasing number of health care providers in the world due to the fact that nurses being the front line of fighting the pandemic has led to high morbidity and mortality rate among them.

More than two third of respondents indicated having not a nursing association membership (67, 9%), have nursing association (89.6%) and (56.6%) indicated having a job description. However, only (43.4%) of them were able to apply job description. This result supported with (Zahra Abbas Abdulnabi and Sadeq Abdul-Hussein Hassan Al-Fayyadh, no date). Study conducted in Arab speaking countries found more than half of respondents have nursing association (52.5%) and (50.8%) indicated having a job description. However, only (41.9%) of them were able to apply job description.

As presented in Table 2, the highest percentages of the perceived barriers of nursing professional autonomy according to the subjects of the current study were the absence of law(s), describing and protecting professional duties (80%), followed by hospital administration style (73.7%), followed by domination of physician's authority (53%), followed by unit manager (46.7).These were the dominant barriers that may have prevented nurses from authenticating professional autonomy. These findings are supported by a study which found that physician-dominated of the health care system and autocratic hospital management were the most common obstacles of nursing autonomy (Maharmeh et al., 2016). Other studies indicated that inra-professional conflict such as absence of respect, trust and collaboration between physicians and nurses were barriers that must be addressed to upgrade nurse's professional autonomy. Nurses will be empowered when having the confidence to step forward embracing their professional and ethical authority through creating collaborative relationships with physicians (Avila et al., 2013; Hartog and Benbenishty, 2015; Georgiou, Papathanassoglou and Pavlakis, 2017). Theses study findings also supported by structural element of empowerment theory that suggested organization must be provide authority, support and resources to employees that required for achieving the organizational objectives (Kanter, 1993).

In terms of professional autonomy levels, table 3 showed less than two third of percentage (64.2%) of study sample were classified as having a higher level of professional autonomy, while lowest percentage (1.9%) of study

participants were classified as having lower level of professional autonomy. These findings were consistent with (Keshk, Qalawa and Aly, 2018)who concluded that nearly half of their study participants had high level of professional autonomy. Another study conducted to identify facets of a situation and investigate associations between leadership styles and job satisfaction, indicated that most study respondents had high level of professional autonomy (Lapeña et al., 2017). Result of current study inconsistent with (Labrague, McEnroe-Petitte and Tsaras, 2019)which aimed to determine the degree of professional autonomy, as well as its predictors and outcomes among Filipino practitioners, which suggested that the highest percentage of study sample had low level of professional autonomy. Such result's variance can be explained by: style of hospital administration, organizations that provide authority, power, and job description, clarify roles and standard to nurses and the existence of a nursing union that legislates laws that protect nurses from legal prosecution while they exercise autonomous decision making between countries.

Table 4 showed associations between subject's socio-demographic and professional characteristics and professional autonomy. The results of the present study indicated no statistically significant association between subject's educational level, gender, age, years of experiences and level of professional autonomy. These findings confirm previous studies demonstrating no statistical association between age, gender and level of education and professional autonomy (Kleinpell-Nowell, 1999; Chumbler, Geller and Weier, 2000; Theses and Taylor, 2008; Banan, 2020) .In contrast, other studies have showed that the level of nursing autonomy was significantly associated with education, age and gender(Mrayyan, 2005; Cajulis, Fitzpatrick and Kleinpell, 2007; Ericsson, Whyte IV and Ward, 2007; Supametaporn, 2013; Motamed-Jahromi et al., 2015).

Results of percent study showed no statistically significant association between having an active membership of a nursing association and nurses' professional autonomy. These findings are incongruent with (Baykara and Şahinoğlu, 2014) who suggested, organizational

membership was comparatively necessary for professional autonomy development, despite the fact that most nurses feel that belonging to a professional association would improve their autonomy. These results are not surprising due to the fact that study sample were from Iraq, which recently approved the nursing syndicate legislation. To be exact, during the last few years. Which had not yet evolved to boost nurse's professional autonomy.

Presenting the professional role of nurses, the results of study sample show no statistical significant association between professional roles nature and nurse's professional autonomy level. This result is incongruent with (Mrayyan, 2005; Amini et al., 2015b; Lapeña et al., 2017)who showed that nurse-manger had higher level of professional autonomy than staff nurses due to the fact that nurse-manger had authority, experience and skills more than staff nurses. Current results are not surprising considering that most (76.6%) of study participant were staff nurses. Furthermore, absence of job description that clarify limits of professional autonomy in clinical decision making make nurses staff and nurse-manger fear from legal prosecution.

Presenting working place, Findings of study showed no statistical significant association between working setting and nurse's professional autonomy level .This result is supported by (Cotter, 2013), which indicated no statistical significant association between work setting and professional autonomy. These findings were inconsistent with other study (Shohani, Rasouli and Sahebi, 2018) which showed a significant relationship between professional autonomy and work place. These results are a direct reflection to nature and structure of the health care setting, dominant administrative policy, and nurses: patient ratio in health care setting among the covered countries.

Furthermore, findings of the current study indicated significant association between working shift time, no significant association between number of nurses in the work shift and nurse's autonomy level. These results were supported with (Bucknall, 2003; Mohsen, Mahvash and Fazlolah, 2004)which indicated that nurses during night shift make more autonomous decision than day time due to decrease the necessary contact with other health care

profession . About association between number of nurses and professional autonomy, current findings are inconsistent with Georgiou et.al (2017) suggested nurses-patient ratio and work load may decrease ability of the nurses to make autonomous decision.

The present study showed no statistical significant association between organizational variables such as having job description, and ability to apply job description, having nursing organization and nurse's professional autonomy level. These results incongruent with other study (Maharmeh et al., 2016)which indicated a strong association between organizational role to provide clear definition of nurse's role and authority to gain competency and make autonomous decision making. These results are not surprising of study sample were from Iraq, who have no authenticated job description and most of Iraqi nurses have role ambiguity. These results agreed with the psychological element of empowerment theory which considered that autonomy could be achieved when employee had a full understanding of their role and organization provide clear job description, standard and policy making (Kanter,1993).

Chapter Six

Conclusions and recommendations

Chapter Six: Conclusions & Recommandations

6.1. Conclusions

1. There was a statistical significance association between professional autonomy level and working shift. There was not a statistical significance association between professional autonomy levels and age, sex, level of education, professional role, number of the nurse, having nursing association, having job description, having association member ship, ability to apply job description, working place and years of experience.
2. Most common barriers of professional autonomy are absence of law protecting professional duties, unit manager, domination of physician's authority and hospital administration style. This result reflects the importance of removing all obstacles to upgrade nurse's professional autonomy.
3. Although the higher percentages of nurses possess a high level of independence; a significant percentage falls within a medium-low level of independence. This finding should not be overlooked, since the nursing profession is the official advocate of the human life.
4. Almost two fifth of the study sample has reported that no job description was available to them in their practice setting. This highlights a serious gap in health care systems that must be addressed. Surprisingly, even for those who reported that they have a job description, the highest percentage of them have reported that they were not able to practice according to their job description.

6.1. Recommendations

1. Supporting and encouraging nurses to exercises professional autonomy in clinical practice by providing law, standards, and policies, which protect them when executing their role in work fields.

2. Working to improve collaborative relationship between nurses and physicians to enhance patient outcomes. This approach will lead to decreasing physician's domination and increase nurses' autonomy.

3. To enhance nursing self-government, strong unified nursing organizations and professional associations are also needed. However, as a prerequisite for professional authority, the role of nurses in clinical practice must be fully defined and clear job descriptions is to be created.

4. finally, further research must be performed in nursing autonomy area, due to lack of such studies in Iraq.

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Appendix

Appendix (1)

Panel Of Experts

List of experts

ت	اسم الخبير	اللقب العلمي	الشهادة	الاختصاص	مكان العمل
1	محفوظ فالح	أستاذ	دكتوراه	فسيولوجيا	كلية التمريض
2	سجاد سالم	أستاذ دكتور	بورد	طب اَسرة	كلية التمريض
3	وصفي ضاهر	استاذ مساعد	دكتوراه	فسلجه مرضية	كلية التمريض
4	سندس باقر	استاذ مساعد	دكتوراه	تمريض الام والوليد	كلية التمريض
5	عبد الكريم سلمان	استاذ مساعد	ماجستير	تمريض بالغين	كلية التمريض
6	هاجر سالم	استاذ مساعد	ماجستير	تمريض اطفال	كلية التمريض
7	هشام حسين	مدرس	دكتوراه	أشعة تشخيصية	كلية التمريض
8	افكار فاضل	مدرس	ماجستير	تمريض نفسية وعقلية	كلية التمريض
9	كاظم جواد	مدرس	ماجستير	تمريض اطفال	**كلية التمريض**

Appendix (2)

Questionnaire in Arabic Language

زملائي وزميلاتي من الملاك التمريضي المحترمون.نرجومنكم المشاركة في الاجابة على فقرات الاستبيان التالي الذي تم عمله لاغراض بحثية صرفة. نثمن استجابتكم الكريمة! سوف لن نأخذ من وقتك سوى 5-9 دقائق للاجابة التامة. علما بان المعلومات التي ستزودنا بها ستستخدم لاغراض البحث العلمي فقط. **ان اجابتك تعد موافقة من حضرتك للاشتراك بالدراسة.شكرا جزيلا!**

الجزء الاول : المعلومات الاجتماعية الديموغرافية

ضمن أي فئة عمرية من الاتي، يقع عمرك؟

- 18-28
- 28- 38
- 39- واكبر

ماهو جنسك؟

□ذكر

□انثى

ماهو تحصيلك الدراسي؟

□معهد تمريض

□بكالوريوس تمريض

الجزء الثاني: الخصائص المهنية

أين تعمل حاليا؟

□ردهة الطوارىء

□وحدات الرعاية الحرجة

□وحدة العناية المركزة

□وحدة ا نعاش القلب

□ وحدة الانعاش الرؤي

□ وحدة الحروق

□ردهة الباطنية

□ردهة الباطنية

ضمن أي فئة من الاتي تقع عدد سنوات خبرتك العملية في المستشفى منذ بدءعملك

1- 1-4 سنوات .

2- 5- 9 سنوات .

3- 10- 15 سنوات .

4- اكثر من 15 سنة

أي من الخيارات الاتية يصف دورك المهني؟

□مسؤول ردهة (ممرض يمارس مهام ادارية اضافة الى مهام العمل)

□ممرض (ممرض يمارس مهام سريرية فقط)

ضمن أي من الاتي تقع وجبة / وردية عملك؟

□صباحي(8 صباحا– 2 مساءا)

□مسائي (2 مساءا – 8 مساءا)

□ ليلي (8 مساءا – 8 صباحا)

□ ممرض خافر (12 ساعة واكثر)

- هل توجد نقابة تمريض في بلدك

□نعم □ لا

في حال اجابتك بنعم هل انت عضو في نقابة التمريض ؟

□نعم □ لا □ لاينطبق علي

ما هو عدد الممرضين اثناء مناوبة عملك ؟

□ 1- 5

□ 5- 10

□ اكثر من 10

هل هنالك توصيف وظيفي(حدود صلاحياتك وواجباتك المهنية) معتمد رسميا لمهنة التمريض في بلدك ؟

□ نعم □ لا

هل تعرف ما هو توصيفك التمريضي الوظيفي(حدود صلاحياتك وواجباتك المهنية) ؟

□ نعم □ لا

هل احتوت المناهج التمريضية خلال دراستك على مفردات تتركز على توضيح حدود استقلاليتك في الممارسة المهنية في التمريض ؟

□ نعم □ لا

هل تستطيع ان تطبق حدود صلاحياتك المهنية المستقلة التي كفلها لك القانون في بيئة المستشفى ؟

□ نعم □ لا

في حال اجابتك بلا عن السؤال السابق فما هي العوائق التي تمنعك من تطبيق حدود صلاحياتك المهنية المستقلة التي كفلها لك القانون في بيئة المستشفى؟

1-ادارة المستشفى

2- مسوؤل الردهة

3-ضغط العمل .

4- زملاء العمل .

5- سلطة الاطباء .

6- لا امتلك ثقة من قدرتي على اداء دوري المهني بشكل مستقل

7- عدم وجود قانون يحميني عند تطبيقي لصلاحياتي المهنية المستقلة

8- عدم معرفتي بحدود صلاحيتي وواجباتي المهنية المستقلة

9- كل ما ذكر اعلاه

10- لاينطبق علي

-الجزء الثاني :

التسلسل	الفقرة	من غير المرجح أن أتصرف بهذه الطريقة	من غير جدا المرجح أن أتصرف بهذه الطريقة	من المرجح أن أتصرف بهذه الطريقة	من المرجح جدا أن أتصرف بهذه الطريقة
-1	اضع خطة وظيفية لنفسي وار اجعها بانتظام لإنجاز خطواتها.				
-2	اتطلع لممارسة الرعاية التمريضة المستقلة(التي لااحتاج فيها لوصاية طبية) بعد حصولي على التعليم والخبرة المناسبة.				
-3	اعارض اي امر من الطبيب بخصوص خروج المريض من المستشفى بدون اعطاء فرصة المتابعة التمريضة سيما اذا لم تكتمل الخطه التعليميه للمريض .				
-4	ابدأ البحث العلمي للتحقيق في مشكلة تمريضية سريرية متكررة ضمن حيز عملي.				
-5	ارفض إعطاء دواء ممنوع على المريض استخدامه على الرغم من إصرار الطبيب على إعطاء الدواء				
-6	استشير الطبيب المسؤول عن معالجة المريض إذا كان المريض لا يستجيب لخطة العلاج				
-7	يعتمد تحديد ما أقوم به من عمل كممرضة/ممرض على مهنة التمريض كاساس وليس على مهنة الطب أو الطبيب.				
-8	أقوم بتقييم حاجة المريض الراقد في المستشفى للرعاية التمريضية المنزلية واحدد الحاجة لمثل هذه الاحالة دون انتظار امر الطبيب				
-9	اقترح تغييرات في توصيفي الوظيفي كممرض على المسؤولين من أجل تطوير مهني ذا جودة				
-10	اجيب على أسئلة المريض حول علاج جديد او تغير بالعلاج قبل ان اقوم باعطاء العلاج				

				له، سواء تم ذكر ذلك مسبقًا من قبل الطبيب ام لا.	
				اقوم بجولات تفقدية مهنية داخل الردهة للاطلاع على حالة المريض في حالة كنت مسوؤلا عن وردية \ وجبة العمل	-11
				ارفض اعطاء اي علاج غير مناسب للمريض على الرغم من ضغط زملائي في الملاك التمريضي لاتباع امر الطبيب	-12
				استشير زملائي في الملاك التمريضي عندما لا يستجيب المريض لخطة الرعاية التمريضية .	13
				اعتمدعلى المستجدات العلمية المطروحة في الابحاث التمريضية الحديثة لتنفيذ الرعاية للمريض كصفة اساسية مستمرة في عملي	-14
				اشرع في استشارة نفسية مع طبيب المريض إذا أوضح تقييمي المهني حاجة المريض إلى مثل ذلك الاجراء.	15
				اعزز أنشطة التمريض المبتكرة، كمتابعة حالة للمرضى المغادرين المستشفى مؤخرًا، لتقييم فعالية خطة التعليم التمريضي للمرضى وذلك من خلال وسائل التواصل الالكتروني المتنوعة	-16
				أقوم بتقييم مستوى فهم المريض فيما يتعلق بإجراء الفحوصات التشخيصية ومخاطرها قبل استشارة طبيب المريض إذا كان لدى المرضى أسئلة حول مخاطر هذه الإجراءات التشخيصية.	-17
				أتحمل المسؤولية الكاملة عن أفعالي المهنية دون توقع حماية الطبيب أو المستشفى لي في حال ارتكابي لسوء الممارسة او الاخطاء المهنية.	-18
				اقوم بتطوير قنوات اتصال فعالة في مؤسستي فيما يخص مهنة التمريض والتي من خلالها اقوم بايصال صوتي في صنع السياسات التي تؤثر على رعاية المرضى	-19
				اقوم بتطوير وتحسين أدوات التقييم المناسبة لمجال تخصص عملي التمريضي السريري.	-20
				ادون البيانات الخاصة بتقييمي البدني لحالة المريض في السجل الصحي(ملف	-21

	المريض)لاستخدمها في تخطيط وتنفيذ الرعاية التمريضية				
-22	ابدا بوضع وتهيئة خطة رعاية تمريضية مناسبة لحالة المريض لحين خروجة من المستشفى حتى في حالة عدم التخطيط لمثل تلك الخطة من قبل الطبيب.				
23	ابلغ مدير المستشفى أو مسؤول الوحدة المناسب في حال تمت مضايقتي أو التجاوز على حدود صلاحياتي المهنية من قبل الطبيب.				
-24	اعرض نصيحتي ومشاركتي على المسؤولين بشان تصميم وحدة تمريض جديدة او شراء ادوات جديدة ليستخدمها الممرضين في ممارسة مهام عملهم.				
-25	أقوم باكمال التقييم النفسي الاجتماعي لكل مريض ارعاه واستخدام هذه البيانات في صياغة خطة الرعاية التمريضة .				
-26	اقوم باخذ وسائل واداوات التقييم من التخصصات الساندة الاخرى لكي أستخدمها في تعزيز جودة ممارساتي التمريضية السريرية				
-27	انفذ إجراءات رعاية المرضى باستخدام حكمي المهني لتلبية احتياجات المريض حتى وان كان هذا يعني الانحراف عن التعليمات الموصى بها في دليل اجراءات المستشفى.				
-28	ارفض ان اعين او اعمل بشكل موقت في وحدة تمريض تخصصية في حال افتقاري للخبرة والمعلومات الكافية لاداء الدور المهني المطلوب				
-29	ابدء باحالة المريض إلى الخدمة الاجتماعية والنظام الغذائي بناءً على طلب المريض وحالته الصحية حتى في حالة عدم وجود طلب من الطبيب.				
-30	اكتب أوامر تمريضية لمراقبة العلامات الحيوية بشكل اكثر تكررا من المعتاد سيما للحالات المتدهورة للمرضى حتى في حالة عدم وجود أمر طبي لعمل هذه المراقبة بشكل متكرر.				

Appendix(3)

Questionnaire in English Language

My colleagues from the nursing staff, we ask you to participate in the performance of the following questionnaire that was conducted for purely research purposes. You will be asked to respond to each paragraph according to the likelihood of implementing the procedure in each paragraph. Please respond to each paragraph even if you have never encountered such a situation before. It takes not more than ten minutes to answer the questionnaire. Thank you very much for your understanding, response and cooperation.

Part one: Sociodemographic information

Personal information:

Age:

- 18-28
- 28 - 38
- 39- and older

Gender:

-Male

- Female

Level of education:

- Nursing institute

-Bachelor of nursing

Part Two: Professional Characteristics:

Workplace:

Emergency department

Critical care units:

- Intensive care unit (ICU).

- Coronary care unit (CCU).

- Respiratory care unit (RCU).

- Burn unit.

-Medical department

-Surgical department

Years of experience

- In the hospital

1-4 years

5-9 years

10-15 years

More than 15 years

Your responsibility in the unit:

- Nurse manger (a nurse who practices administrative tasks in addition to work tasks)

-Nurse (a nurse practicing clinical tasks only)

Work shift:

- Morning (8 AM -2 PM)

- Evening (2 PM - 8 PM)

-night (8 PM—8AM)

-More than 12 h (Sentinel Nurse)

Is there a nursing Syndicate in your country?

-Yes -No

-If your answer is yes, are you a member of the Nursing Syndicate?

-Yes -No – Not apply to me

-How many numbers of nurses during work shift?

-1-5.

-5-10.

-More than 10.

-Is there a job description (limits to your professional powers and duties) officially approved for the profession of nursing in your country?

-Yes -No

-If you answered yes to the previous question, can you apply the limits of your independent professional powers that the law guarantees to you in the hospital environment?

-Yes -No -Not apply to me

-If you answered no to the previous question, what are the barriers that prevent you from implementing the limits of your independent professional powers that the law guarantees for you in the hospital environment?

-Hospital administration

-Unit Manager

-Work Load

-Absence of legislations protecting professional duties

-Colleagues

-Low confidence in abilities to execute professional duty independently

-Awareness lack of nursing authority & professional responsibilities limit

-Health care institution dominant policy

-Domination of physician's authority

-All of the aforementioned barriers

-Not apply to me.

-Did the nursing curricula contain vocabulary during your studies that focus on clarifying the limits of your independence in the professional practice of nursing?

- Yes - No

Part Three: Nursing Activity Scale

Note: Use the following scale in responding to paragraphs. Please do not add any explanatory phrases to the paragraphs to justify your answer.

N	Items	Very unlikely of me to act in this manner	Unlikely of me to act in this manner	Likely of me to act in this manner	Very likely of me to act in this manner
1	Develop a career plan for myself and regularly review it for achievement of steps in the plan.				
2	Consider entry into independent nursing practice with the appropriate education and experience.				
3	Voice opposition to any medical order to discharge a patient without an opportunity for nursing follow-up if the teaching plan for the patient is not completed.				
4	Initiate nursing research to investigate a recurrent clinical nursing problem.				
5	Refuse to administer a contraindicated drug despite the physician's insistence that the drug be given.				
6	Consult with the patient's physician if the patient is not responding to the treatment plan.				
7	Depend upon the profession of nursing and not on physicians for the ultimate determination of what I do as a nurse.				

8	Evaluate the hospitalized patient's need for home nursing care and determine the need for such a referral without waiting for a physician's order.				
9	Propose changes in my job description to my supervisor in order to develop the position further.				
10	Answer the patient's questions about a new medication or change in medication before administering drug, whether or not this has been done previously by the physician.				
11	Institute nursing rounds on the patient unit.				
12	Withhold a medicine that is contraindicated for a patient despite pressure from nursing peers to carry out the medical order.				
13	Consult with other nurses when a patient is not responding to the plan of nursing care.				
14	Routinely implement innovations in patient care identified in the current nursing literature.				
15	Initiate a request for a psychiatric consult with the patient's physician if my assessment of the patient indicated such a need.				
16	Promote innovative nursing activities, like follow-up phone calls to recently discharged patients, to evaluate the effectiveness of patient teaching.				
17	Assess the patient's level of understanding concerning a diagnostic procedure and its risks before consulting with the patient's physician if a patient has questions about the risks of the procedure.				
18	Assume complete responsibility for my own professional actions without expecting to be protected by the physician or hospital in the case of a malpractice suit.				
19	Develop effective communication channels in my employing institution for nurses' input				

	regarding the policies that affect patient care.				
20	Develop and refine assessment tools appropriate to my area of clinical practice.				
21	Record in the chart the data from my physical assessment of the patient to use in planning and implementing nursing care.				
22	Initiate discharge planning concerning the nursing care of the patient, even in the absence of discharge planning by the physician.				
23	Report a physician who harasses me to the appropriate manager or administrator.				
24	Offer input to administrators concerning the design of a new nursing unit or the purchase of new equipment to be used by nurses.				
25	Complete a psychosocial assessment on each patient and use this data in formulating nursing care.				
26	Adapt assessment tools from other disciplines to use in my clinical practice.				
27	Carry out patient care procedures utilizing my professional judgment to meet the individual patient's needs even when this means deviating from the "cookbook" description in the hospital procedure manual.				
28	Decline a temporary reassignment to a specialty unit when I lack the education and experience to carry out the demands of the assignment.				
29	Initiate referrals to social service and dietary at the patient's request even in the absence of a physician's order.				
30	Write nursing orders to increase the frequency of vital signs of a patient whose condition is deteriorating even in the absence of a medical order to increase the frequency of such monitoring.				

Appendix (4)

Administrative Agreements

جمهورية العراق
وزارة الصحة
دائرة صحة البصرة
مكتب المدير العام
مركز التدريب والتنمية البشرية
شعبة ادارة المعرفة/البحوث

العدد : ١٥٤
التاريخ : ٢٠٢٢/٢/١٧

الى/ م. الفيحاء التعليمي
م. الصدر التعليمي
م. البصرة التعليمي

م/ تسهيل مهمة

درست لجنة البحوث في دائرة صحة البصرة مشروع البحث ذي الرقم(٥٥٧) المعنون:
(تقييم مستوى استقلالية الممرضين في المستشفيات التعليمية وعلاقتها بالرضى الوضيفي) والمقدم من قبل الباحثين المدرجة اسمائهم ادناه (محمد عبد الواحد محمد / حنين عقيل علي / علي فاضل يوسف)كلية التمريض- جامعة البصرة . في دائرة صحة البصرة
بتاريخ ٢٠٢٢/٢/١٧ وقررت:

"الموافقة على تنفيذ مشروع البحث بصيغته المقدمة ولامانع من تنفيذه في مؤسسات الدائرة."

لتفضلكم بالاطلاع وتسهيل مهمة الباحث لا جراء بحثة مع التقدير....

المرفقات:
قرار لجنة البحوث المرقم ١٨٧/ ٢٠٢٢

د. علي كاظم الربيعي

الطبيبة الاختصاص
ع/ د. رجاء احمد محمود
مديرة مركز التدريب والتنمية البشرية
١٧/ ٢ /٢٠٢٢

وزارة الصحة
دائرة صحة البصرة
مركز التدريب والتنمية البشرية
لجنة البحوث

رقم القرار١٨٧/٢٠٢٢
تاريخ القرار ١٧ /٢/٢٠٢٢

قرار لجنة البحوث

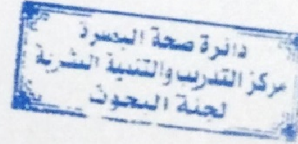
درست لجنة البحوث في دائرة صحة البصرة مشروع البحث ذي الرقم(٥٥٧) المعنون:

(تقييم مستوى استقلالية الممرضين في المستشفيات التعليمية وعلاقتها بالرضى الوظيفي) والمقدم من الباحثين المدرجة اسمائهم ادناه (محمد عبد الواحد محمد / حنين عقيل علي / علي فاضل يوسف)كلية التمريض- جامعة البصرة . في دائرة صحة البصرة

بتاريخ ١٧/٢/٢٠٢٢ وقررت:

"الموافقة على تنفيذ مشروع البحث بصيغته المقدمة ولأمانع من تنفيذه في مؤسسات الدائرة."

الطبيب الاختصاص
د. علي كاظم قاسم
مقرر لجنة البحوث / دائرة صحة البصرة
١٧/ ٢/ ٢٠٢٢



المرفقات :

لا يوجد

الملاحظات:

- تم تخويل رئيس لجنة البحوث او مقرر اللجنة للتوقيع على هذا القرار استنادا الى النظام الداخلي للجنة البحوث .
- الموافقة تعني أن مشروع البحث قد استوفى المعايير الأخلاقية والعلمية لإجراء بحث والمعتمدة في وزارة الصحة، اما التنفيذ فيعتمد على التزام الباحث بتعليمات المؤسسة الصحية التي سينفذ فيها البحث. وعلى الباحث التواصل مع مسئول البحوث في المؤسسة الصحية التي يجرى بها البحث واطلاعه على مجريات البحث بشكل دوري ولحين انتهاء البحث.

الخلاصة

الخلفية: الاستقلالية المهنية هي القدرة على إصدار الأحكام والتصرف بما يتماشى مع قاعدة المعرفة المهنية للفرد. يجب معرفة الاستقلالية لتحديد وتعزيز مهنة التمريض في سياقات الرعاية الصحية المتغيرة بسرعة.

الاهداف:لقياس الاستقلالية المهنية للممرضين في اتخاذ القرارات السريرية والعلاقة بين استقلالية الممرضين في صنع القرار السريري وخصائصهم المهنية والاجتماعية والديموغرافية. .فضلا عن اكتشاف المعوقات التي تمنع الممرضين من ممارسة استقلاليتهم المهنية .

المنهجية: اجريت دراسة وصفية مقطعية استخدم فيها استبيان تقييم النشاط التمريضي بعد اخذ اذن المؤلفة . استهدفت الدراسة (106) فردا ممن حققوا معايير شمول الدراسة. تم جمع عينة الدراسة من الفترة 25 فبراير 2022 إلى 25 مارس 2022. تم تحليل نتائج الدراسة بواسطة استخدام برنامج التحليل الاحصائي اصدار 17حيث تم استخدام اختبارات وصفية واستدلالية.

النتائج:اشارت نتائج الدراسة الى وجود عوائق للاستقلالية المهنية اهمها: هي غياب التشريعات التي تحمي الواجبات المهنية (80٪) ، أسلوب إدارة المستشفى (73.7٪) ، مسوؤل الردهة (46.7) وسيطرة أو سلطة الأطباء (53٪). لا توجد ارتباطات ذات دلالة إحصائية بين الاستقلالية المهنية وبعض الخصائص المهنية والديموغرافية كان هناك ارتباط إحصائي قوي بين وردية العمل (0.009) والاستقلالية المهنية.

الاستنتاجات: متغير الاستقلالية المهنية في صنع القرار السريري مفهوم ذو اوجه متعددة ولايمكن تحديد مساره من خلال عامل واحد بل هو نتاج لتفاعل عوامل متعددة منها الذاتية والمهنية والمؤسساتية. نصف المشاركين في الدراسة لديهم مستوى منخفض الى متوسط من الاستقلالية في اتخاذ القرارات السريرية لذلك يجب تسليط الضوء على ازالة جميع العوائق التي تمنع الممرضين من ممارسة استقلاليتهم المهنية .

التوصيات: يتم وصف وتوضيح مجال العمل التمريضي بشكل كامل بناء على الوصف الوظيفي الموثق شريطة أن يتم تفعيله مع ضمان التشريعات القانونية المناسبة دعم وتشجيع الممرضين على ممارسة الاستقلالية في الممارسة السريرية من خلال توفير القوانين والسياسات المهنية التي تحميهم.

جامعة البصرة

كلية التمريض

وزارة التعليم العالي

والبحث العلمي

تقييم مستوى الاستقلالية للممرضين في مستشفيات البصرة التعليمية

بحث تخرج تقدم به

محمد عبد الواحد محمد

علي فاضل يوسف

حنين عقيل علي

الى

كلية التمريض

جامعة البصرة

اشراف

مدرس مساعد

زهراء عباس عبد النبي