An evaluation of nursing documentation as it relates to pro re nata (prn) medication administration.

A research report presented in partial fulfillment of
the requirements for the degree of

Master of Nursing
in
Mental Health

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New Zealand.

Frances Heather Jenkinson

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Abstract

Aims of the project:

1. To investigate if documentation related to pro re nata (Latin, prn) medication administration by mental health nurses, in a particular Forensic Psychiatry Clinic, in a metropolitan city in New Zealand, complies with the requirements of the National Mental Health Sector Standards (Ministry of Health, 1997), the specific District Health Board's policies, the local policies of the Forensic Psychiatry Clinic, the Code of Conduct for Nurses and Midwives (Nursing Council of New Zealand, 1999) and follows the nursing process.
2. To investigate whether there are any variations in the documentation practices between nursing shifts.

Methods: A retrospective file audit was conducted at a forensic psychiatry clinic in a city in New Zealand. Non-random sampling was used. Data was collected from all admissions in 2002 that had prn medication administered during the first four weeks. A document questionnaire was designed to capture the required data to answer the research questions

Results: From the sample of 27 files data was collected from up to 170 nursing entries. This was primarily a descriptive and exploratory study. None of the nursing entries met all the requirements of the National Mental Health Sector Standards (Ministry of Health, 1997), company policies, local area policies and/or the Code of Conduct for Nurses and Midwives (Nursing Council of New Zealand, 1999) in relation to nursing documentation. Nearly 47% of the prn medication administered had no documentation, apart from that in the medication-recording chart, to indicate it had been given. Approximately 85% of prn administrations had no evidence of an assessment prior to administration. Where it was documented that a client had requested medication, nearly 82% had no evidence of assessment. A large number of prn medications were administered from prescriptions that did not meet legal or policy requirements. Evidence of planning was lacking in the documentation with nearly 98% of the notes not indicating the rationale for a choice of route of administration where this was permitted on the prescription. No nursing entry offered a rationale for the choice of dose where this was allowed. The name of the medication, dose, route and/or time administered was frequently missing. Of the prn administrations considered for an outcome, nearly 60% had no documented outcome. Little difference was found in the nursing documentation between the shifts. However it was noted that for day and afternoon shift, the earlier in the shift the medication was administered the less likely there was to be any mention of the medication being administered.

Conclusion: The findings established extremely poor documentation practices. The lack of evidence of patient assessment, prior to administration of the medication in the documentation, raises the issue of whether this is being done prior to prn medication administration or simply not being documented. The documentation left questions about decision making in the planning of administration. The large number of medication administrations lacking a documented outcome raises uncertainty about nurses' knowledge of evaluating care, or even whether they are actually evaluating the care given. As a result of these findings, it is recommended that further research in this area be undertaken in New Zealand.

This work is dedicated to my mother
who passed away in March 2003
and gave me
so much encouragement.

Acknowledgements

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Table of Contents

List of Tables

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