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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

at Massey University, Albany Campus, New Zealand.

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2003
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.
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# Table of Contents

**AIMS OF THE PROJECT** .................................................................................................................. 1
**INTRODUCTION** ................................................................................................................................. 2
**LITERATURE REVIEW** .......................................................................................................................... 4
  THE IMPORTANCE OF NURSES' DOCUMENTATION ........................................................................... 4
  QUALITY OF DOCUMENTATION .......................................................................................................... 4
  WHY NURSES DO NOT DOCUMENT .................................................................................................... 5
  PRN MEDICATION ADMINISTRATION ................................................................................................. 6
  PRN MEDICATION DOCUMENTATION .................................................................................................. 7
**METHODOLOGY** ..................................................................................................................................... 10
  THEORETICAL FRAMEWORK ................................................................................................................ 10
  METHOD ................................................................................................................................................... 10
  ETHICS .................................................................................................................................................... 10
  DEVELOPMENT OF THE RESEARCH TOOL ........................................................................................... 11
  VALIDITY AND RELIABILITY ................................................................................................................ 12
  SAMPLING ............................................................................................................................................. 12
  DATA COLLECTION .................................................................................................................................. 13
  DATA ANALYSIS ..................................................................................................................................... 13
  DEFINITION OF TERM ........................................................................................................................... 13
**RESULTS** ............................................................................................................................................... 14
  SAMPLE CHARACTERISTICS .................................................................................................................. 14
  BASIC DOCUMENTATION REQUIREMENTS ........................................................................................ 14
  ASSESSMENT DOCUMENTATION REQUIREMENTS .............................................................................. 15
  PLANNING DOCUMENTATION REQUIREMENTS ................................................................................... 18
  INTERVENTION DOCUMENTATION REQUIREMENTS ........................................................................... 19
  OUTCOME OR EVALUATION DOCUMENTATION REQUIREMENTS ...................................................... 19
  NURSING SHIFT DOCUMENTATION DIFFERENCE .............................................................................. 22
    Assessment documentation per nursing shift ....................................................................................... 23
    Planning documentation per nursing shift ........................................................................................... 26
    Intervention documentation per nursing shift ...................................................................................... 27
    Outcome documentation per nursing shift ........................................................................................... 29
**DISCUSSION** ....................................................................................................................................... 31
**LIMITATIONS** ....................................................................................................................................... 36
**RECOMMENDATIONS** .......................................................................................................................... 38
**CONCLUSION** ....................................................................................................................................... 39
**REFERENCES** ......................................................................................................................................... 40
**APPENDIX A: Documentation requirements** ..................................................................................... 44
**APPENDIX B: Data collection questionnaire** ....................................................................................... 46
**APPENDIX C: Occurrence of variables** ................................................................................................. 53
**APPENDIX D: Number of prn doses administered per drug per week** ................................................ 54
**APPENDIX E: Number of prn administrations per time of day** ........................................................... 55
**APPENDIX F: Documented evidence of assessment per drug** ............................................................... 56
**APPENDIX G: Documented evidence of assessment per nursing rank** .............................................. 62
**APPENDIX H: Documented evidence of assessment per prescription and non-prescription drug** ........... 64
**APPENDIX I: Prescription non-compliance** ......................................................................................... 65
**APPENDIX J: Documented evidence of outcome per drug** ................................................................... 67
**APPENDIX K: Documented evidence of outcome per nursing rank** .................................................... 72
**APPENDIX L: Prn medication administered per nursing shift** ............................................................... 74
**APPENDIX M: Assessment per nursing shift** ......................................................................................... 75
**APPENDIX N: Prescription/non-prescription assessment per nursing shift** .......................................... 77
**APPENDIX O: Documented evidence of assessment per nursing shift and drug** ................................... 81
**APPENDIX P: Outcome documentation per nursing shift** .................................................................... 94
List of Tables

TABLE 1: Summary of documentation errors by nurses ........................................ 8
TABLE 2: Basic requirements present in nursing entries .................................. 15
TABLE 3: Categories of assessment ................................................................. 16
TABLE 4: Frequency of documented evidence of assessment ........................... 17
TABLE 5: No documented evidence of assessment per medication .................. 17
TABLE 6: Categories of outcome ................................................................. 21
TABLE 7: Frequency of documented evidence of outcome ............................ 21
TABLE 8: Basic requirements per nursing shift .............................................. 23
TABLE 9: No documented assessment per prescription/non-prescription medications per nursing shift .......................................................... 24
TABLE 10: Source of information as documented by nursing staff .................. 25
TABLE 11: Nursing shift comparisons of prn medication being administered for what it was prescribed .............................................................. 27
TABLE 12: Medications administered per nursing shift with no documented evidence of administration in nursing notes........................................ 29
TABLE F1: Benztropine - frequency of documented evidence of assessment .... 56
TABLE F2: Chlorpromazine - frequency of documented evidence of assessment 56
TABLE F3: Clonazepam - frequency of documented evidence of assessment .... 57
TABLE F4: Haloperidol - frequency of documented evidence of assessment ........ 57
TABLE F5: Zopiclone - frequency of documented evidence of assessment .......... 58
TABLE F6: Lactulose - frequency of documented evidence of assessment ........ 58
TABLE F7: Lorazepam - frequency of documented evidence of assessment ....... 59
TABLE F8: Mylanta - frequency of documented evidence of assessment ........... 59
TABLE F9: Panadeine - frequency of documented evidence of assessment ....... 60
TABLE F10: Paracetamol - frequency of documented evidence of assessment .... 60
TABLE F11: Salbutamol - frequency of documented evidence of assessment .... 61
TABLE F12: Voltaren - frequency of documented evidence of assessment ......... 61
TABLE G1: Frequency of RN’s documented evidence of assessment ................ 62
TABLE G2: Frequency of ENs’ documented evidence of assessment ............... 62
TABLE G3: Frequency of HA’s documented evidence of assessment ............... 63
TABLE G4: Frequency of Unknown nursing rank’s documented evidence of assessment .......................................................... 63
TABLE H1: Frequency of assessment per prescription drugs ......................... 64
TABLE H1: Frequency of assessment per non-prescription drugs .................... 64
TABLE H1: Prescriptions without a frequency and number of administrations ... 65
TABLE H2: Prescriptions without a maximum dose in 24 hours and number of administrations .............................................................. 66
TABLE J1: Benztrapine - frequency of documented outcome ......................... 66
TABLE J2: Chlorpromazine - frequency of documented outcome .................. 67
TABLE J3: Clonazepam - frequency of documented outcome ....................... 68
TABLE J4: Haloperidol - frequency of documented outcome ......................... 68
TABLE J5: Zopiclone - frequency of documented outcome ......................... 69
TABLE J6: Lactulose - frequency of documented outcome ........................... 69
TABLE J7: Lorazepam - frequency of documented outcome ......................... 70
TABLE J8: Mylanta - frequency of documented outcome ............................. 70
TABLE J9: Panadeine - frequency of documented outcome ......................... 71
TABLE J10: Paracetamol - frequency of documented outcome ....................... 71
TABLE K1: Frequency of documented outcome by RNs .............................. 72
TABLE K2: Frequency of documented outcome by ENs .............................. 72
TABLE K3: Frequency of documented outcome by Has ............................... 73
TABLE K4: Frequency of documented outcome by unknown rank ................ 73
TABLE M1: Day shift frequency of documented evidence of assessment .......... 75
TABLE M2: Afternoon shift frequency of documented evidence of assessment ... 75
TABLE M3: Night shift frequency of documented evidence of assessment ....... 76
TABLE N1: Frequency of assessment by day shift ....................................... 77
TABLE N2: Frequency of assessment by afternoon shift ............................. 77
TABLE N3: Frequency of assessment by night shift ..................................... 78
TABLE N4: Frequency of assessment by day shift ....................................... 78
TABLE N5: Frequency of assessment by afternoon shift ........................................... 79
TABLE N6: Frequency of assessment by night shift .................................................. 79
TABLE N7: Combined prescription medication assessment per shift ................................. 80
TABLE N8: Combined non-prescription medication assessment per shift .......................... 80
TABLE O1: Benztropine – day shift - frequency of documented assessment ...................... 81
TABLE O2: Benztropine – afternoon shift - frequency of documented assessment ............... 81
TABLE O3: Chlorpromazine - day shift - frequency of documented assessment .................. 82
TABLE O4: Chlorpromazine - afternoon shift - frequency of documented assessment ........... 82
TABLE O5: Chlorpromazine - night shift - frequency of documented assessment ............... 83
TABLE O6: Clonazepam - day shift - frequency of documented assessment ........................ 83
TABLE O7: Clonazepam - afternoon shift - frequency of documented assessment ............... 84
TABLE O8: Clonazepam - night shift - frequency of documented assessment ..................... 84
TABLE O9: Haloperidol - afternoon shift - frequency of documented assessment ............... 85
TABLE O10: Zopiclone - afternoon shift - frequency of documented assessment ................. 85
TABLE O11: Zopiclone - night shift - frequency of documented assessment ....................... 86
TABLE O12: Lactulose - day shift - frequency of documented assessment .......................... 86
TABLE O13: Lactulose - afternoon shift - frequency of documented assessment .................. 87
TABLE O14: Lorazepam - day shift - frequency of documented assessment ........................ 87
TABLE O15: Lorazepam - afternoon shift - frequency of documented assessment ................. 88
TABLE O16: Lorazepam - night shift - frequency of documented assessment ...................... 88
TABLE O17: Mylanta – day shift - frequency of documented assessment ............................ 89
TABLE O18: Mylanta – afternoon shift - frequency of documented assessment ..................... 89
TABLE O19: Mylanta - night shift - frequency of documented assessment .......................... 90
TABLE O20: Panadeine - day shift - frequency of documented assessment .......................... 90
TABLE O21: Panadeine - afternoon shift - frequency of documented assessment ................... 91
TABLE O22: Paracetamol – day shift - frequency of documented assessment ....................... 91
TABLE O23: Paracetamol - afternoon shift - frequency of documented assessment ................. 92
TABLE O24: Paracetamol - night shift - frequency of documented assessment ..................... 92
TABLE O25: Salbutamol inhaler - day shift - frequency of documented assessment ................. 93
TABLE O26: Voltaren - afternoon shift - frequency of documented assessment ..................... 93
TABLE P1: Quality of outcome documentation by day shift nursing staff ......................... 94
TABLE P2: Quality of outcome documentation by afternoon shift nursing staff ..................... 94
TABLE P3: Quality of outcome documentation by night shift nursing staff .......................... 94
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