

Medication documentation and delivery geared to RPN's

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Vision and mission of RPNAO

- Nursing...one profession...collaboration in action.
- “Dedicated to quality driven decisions that enhance professional practical nursing.”

<http://www.rpno.org>

Documentation

□ Documentation:

- is an integral part of safe and effective nursing practice
- is a record of the critical thinking used in professional practice

<http://www.cno.org/documentation>

Documentation continued

- Documentation is:
 - the foremost source of reference and communication between nurses and other health care providers
 - written evidence of nursing practice
 - done primarily to ensure continuity of care for residents

Martin, Hinds & Felix, 1999

Core standards for documentation

- ❑ These are the minimum standards of documentation.
 - ❑ A nurse maintains documentation that is:
 - clear, concise and comprehensive
 - accurate, true and honest
 - RELEVANT
 - reflective of observations, not of unfounded conclusions
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Core standards continued

- timely and completed only during or after giving care/medications
 - chronological (in the order that the event happened)
 - a complete record of nursing care or medications provided, including assessments, a plan of care, implementation and evaluation
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Core standards continued

- legible and NON-ERASABLE (most homes require a black ink ballpoint pen that is permanent—NO PENCIL)
- permanent, retrievable
- confidential
- client-focused
- completed using specific Home forms

Five “rights” of medication delivery

- Right Drug
 - Right Patient
 - Right Dose
 - Right Route
 - Right Time
 - Other rights to consider:
 - right reason, technique, drug formula
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What to chart in terms of medication documentation

- The “rule of thumb” in charting in LTC is charting by exception
 - PRN medication delivery is an exception and must be documented:
 - on the medication record (MAR)
 - on the resident’s chart in the multidisciplinary notes
 - at the end of shift report
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Methods of charting

PAR	DAR	SOAPE
Problem	Data	Subjective
Action	Action	Objective
Response	Response	Assessment
		Planning and Evaluation

Delivering medication in LTC

- Some common issues that arise in long-term care:
 - the client refuses medication
 - administering emergency medication
 - mixing medications in a client's food
 - a client may not be capable of making treatment decisions
 - administering meds to large numbers
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Strategies for dealing with medication delivery concerns

- Work with physician to stagger times
- Review meds regularly to ensure use
- Administer meds to clients as they enter or exit the dining room to provide required pleasurable dining
- *Important* --document all discussions with client and family

A nurse's responsibility:

- ❑ to notify the client or substitute decision maker (SDM) of a medication change—for example an antibiotic
 - ❑ to notify SDM of change in orders and chart in the multi-disciplinary notes if he/she is unable to reach the family and to follow-up
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Highlights from CNO standard on medication documentation

- A nurse meets the standard by:
 - documenting verbal/telephone orders in the client's record
 - including the physician's name
 - verifying orders documented by a non-authorized person

<http://www.cno.org/medication>

Following medication administration

- A nurse meets the standard by:
 - evaluating client outcomes including benefits, side effects and signs of drug interactions
 - documenting the outcomes
 - advocating for systems that facilitate safe and effective administration

<http://www.cno.org/medication>

Over the counter medications

- The nurse must:
 - assess the client's condition before recommending OTC drugs
 - document the client assessment and any action or advice given
 - document on the client's plans of care if he/she is capable of self-administering

<http://www.cno.org/medication>

Medication errors

- The nurse meets the standards by:
 - clarifying unclear or incomplete orders
 - avoiding unusual abbreviations or symbols
 - reviewing current drug information as necessary
 - advocating and participating in necessary error-reporting/documentation

<http://www.cno.org/medication>

Conclusion

- Medication delivery and documentation is a challenge for sure in long-term care
 - Excellent documentation:
 - is a permanent client record
 - avoids misconceptions/errors
 - protects the nurse and the client
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