Template (to be adapted by care home)
Medication to be administered on a PRN (when required) basis in a care home environment

The PRN Purpose & Outcome Protocol (PRN POP)

Background

The term PRN (from the Latin *pro re nata*: for an occasion that has born/arisen) is given to a medication which is to be taken "when required" and is usually prescribed to treat short term or intermittent medical conditions and not to be taken regularly i.e. not given as a regular daily dose or offered only at specific times e.g. medication rounds. Analgesics, occasional night time sedatives and laxatives are amongst common examples of medicines prescribed in this way.

PRN prescribing is a highly advantageous and effective way for a person to be treated if they are suffering with an acute or irregular condition. However the person is also open to abuse if the medication is used inappropriately or excessively.

The PRN Purpose & Outcome Protocol may be used as a tool to support good practice. It is designed to both assure sufficient information is provided and highlight any overlooked areas in order to minimise risk and encourage the appropriate use of PRN medication administered to residents in a care home setting.

To ensure the medication is given as intended a specific plan for administration of PRN medication must be made. Information on why the medication has been prescribed and how to give it should be sought from the prescriber, the supplying pharmacist or other healthcare professionals involved in the treatment of the resident.

As it is for occasional use PRN medication should not be offered or given only at the times listed on the Medication Administration Record (MAR) or at specific medication rounds. The person should be offered the medication at the times they are experiencing the symptoms or at the times specified by the prescriber (see example scenarios below).

Records

There must be clear records made in the home for PRN medication, including the outcome for the resident once the medication is taken. Each organisation will have different paperwork on which to make medication administration and care records, for example some will have a facility for making records on the reverse of the MAR chart, others will not. The way records are to be used should be stated in the medication policy.

The MAR Chart

PRN medication must be recorded on the Resident's MAR chart stating:

- the name of medication
- the route (if other than oral)
- the dose
- the frequency
- the minimum time interval between doses
- the maximum number of doses in 24 hours

The PRN Care Plan

A specific person-centred plan must be drawn up for each PRN medication for each resident. Ideally this will be kept in close proximity to the resident's medication records. The plan should include:

- The date when medication was started by the prescriber
- What the medication is for and the expected outcome
- Who will be responsible for observing the need for the medication - for example will the person ask for it or will the care staff make the decision to offer the medication (see example scenarios below).
- Who will be responsible for initiating the administration.
- What alternatives / other course of action may be followed before the medication is offered (if any) and at what point, and by whom the decision be made by to offer the medication.
- The date for review - ensuring there is a mechanism for this to be followed up.

So that clinical decisions are not made by non-clinical staff, clear dosage instructions must be obtained for each PRN medication. In order for the dosage instructions to appear on the medication label and MAR chart, the prescriber must first state specific instruction on the prescription. Note: if a variable dose is prescribed there should be clarity at the outset on how the decision to administer one or two tablets for example, by non-clinical staff will to be made.

The response to medication should be clearly stated in the resident's clinical notes and a record of whether or not the medication is achieving the expected outcomes should be made.

Other medications that the resident may be taking must also be taken into account. For example if paracetamol is to be taken as a regular daily dose and co-codamol (which also contains paracetamol) is to be taken as a PRN for breakthrough pain, the prescriber/pharmacist should indicate specific instructions and raise awareness of the paracetamol content in both preparations. Suitable directions should be provided for example:

Paracetamol 500mg tablets
two to be taken three times a day (regular medication)

Co-codamol 8/500 two to be taken at night when required for pain relief (PRN medication)

It is essential that administering staff are educated to understand the requirement to give only one of the medicines within the required time frame. Remember also to take into account any homely remedies.

The way that the administration of PRN medication is recorded may be determined by the resident's requirements. Outlined below are three scenarios which highlight this however these examples are not exhaustive and it must be ensured that for every PRN medication a care plan is in place to substantiate the records.

Scenario 1

Mrs Jones has been prescribed paracetamol to be given up to four times a day for intermittent pain in her knee.

Following an in-depth discussion about the medication with Mrs Jones it has been agreed that she is able and willing to ask you for her medication when she is experiencing pain.

It is important that the medication is given at the time she is experiencing symptoms and not at specific medication round times instead.

This information should be clearly stated in her care plan along with any other useful information (as described above – PRN Care Plan). As the medication will be administered "as required" in its true sense, on this occasion it would not be appropriate to have times ready printed on the MAR chart but when the medication is administered the time of administration must be clearly stated on the MAR by the person administering.

Scenario 2
Mr Smith has been prescribed paracetamol to be given up to four times a day for intermittent pain in his wrist.

Following an in-depth discussion about the medication with Mr Smith and his family it has been agreed by all that he may not be able to ask you for his medication when he is experiencing pain however he is likely to show other signs such as remaining seated when he is usually active. It is important that the medication is given at the time he is experiencing symptoms and not at specific medication round times instead.

In this case it is it will be necessary to clearly state the signs he will show and any other useful information (as described above – PRN Care Plan) which will indicate his need for medication. As the medication will be administered "as required" in its true sense, on this occasion it would not be appropriate to have times ready printed on the MAR chart but when the medication is administered the time of administration must be clearly stated on the MAR by the person administering.

Scenario 3
Cynthia has been prescribed paracetamol to be given up to four times a day for intermittent back pain. Following an in-depth discussion about the medication with Cynthia she has decided that, although she may decline the medication, she would like to be offered it four times throughout the day. She has asked that it is offered to her by the care staff when the "medication round" is being carried out at the times she takes her other medicines (08:00, 1:00, 6:00 & 10:30).

In this case it is a clear request from the resident that she has asked you to do something as a matter of course to support her with her pain and you will need to evidence your actions. On this occasion it would be appropriate to have times stated on the MAR chart and annotate the MAR chart with the appropriate code that indicates the action taken – either your initials against the time she takes the medication or the code which denotes "offered but declined" should she decline the medication once you have offered it.

There will be other scenarios individual to each resident. In any case ensure the following:

- A care plan is written up.
- The required time lapse between doses is maintained.
- A record of the outcome is made and this is monitored.
- The quantity administered is recorded if the dose is variable.
- Up to date records and audit trails are maintained to evidence actions.

Reviewing PRN medication

To determine the ongoing need and the efficacy of the medication it must be regularly reviewed. A date for a formal review of the medication should be stated in the resident's clinical records however feedback from the care home team is essential as part of the review process and, should

staff recognise a need for a review before the stated review date, then the prescriber should be contacted. The outcome of the review must be documented in the care plan.
Some examples for care home staff to consider are as follows:

- Is the expected outcome being achieved?
- Is the resident taking the PRN frequently?
  - Should this become a regular medication?
  - Should an alternative be considered?
- Is the resident taking the PRN very infrequently?
  - Could a homely remedy be used?
  - Is there still a need for a medication

Discontinuing PRN medication

Should the prescriber authorise the medication to be stopped then the following must take place:

- Cross out the medication on the MAR chart, writing the date it was stopped and by whom. This should be signed and countersigned by a second member of staff.
- Update the resident's notes to reflect the change.
- Contact the GP practice team to confirm that the records at the practice reflect the change.
- Notify the supplying pharmacy that the medication has stopped in order that it does not appear on the next MAR chart.
- Monitor the resident in case symptoms re-occur in which case a further review will be required.
- Dispose of remaining medication following the care home's procedure for disposal.

Ordering PRN medication

PRN medication should be provided in its original pack rather than in a Monitored Dosage System (MDS) – blister pack. This will maintain the manufacturer's expiry and reduce waste.

Any in-date medication that remains at the end of the month must be carried forward to the next month. A record of the quantity carried forward must be made (ideally on the MAR chart) for audit trail purposes.

All stocks must be checked and taken into account before ordering.

Only order the quantity that will be required to take the resident to the next cycle.

When MAR charts are provided by the supplying pharmacy and no PRN medication is requested for that particular cycle, the MAR chart should still include the item until informed by the care home or prescriber that the medication is no longer required; at this point the medication should be removed by the pharmacy from the MAR chart.

The appendices may be used to support the use of PRN medication:

- Appendix 1 PRN Initial Checklist
- Appendix 2 PRN Medication Support Plan

PRN Initial Checklist

Resident……..date of birth……

Medication……..date prescribed……

Dose……

Care worker completing the protocol……..date……..

	Question	**Mark as appropriate**	**Provide details where necessary**
1	Who initiated the medication? E.g. GP, consultant psychiatrist.		
2	Who was involved in the initiation process i.e. resident, care worker, family?		
3	Has the prescriber given complete details for the reason the medication was prescribed?	Yes☐ No☐	
4	Is there a record on the MAR chart of what the medication has been prescribed for and is this detailed further in the care plan?	Yes☐ No☐	
5	Has the prescriber given complete details for the times the medication is to be offered / administered if applicable?	Yes☐ No☐ N/A☐	
6	Have the details for the times the medication is to be offered/administered been recorded in the care plan/MAR if applicable?	Yes☐ No☐ N/A☐	
7	Is there a specific time of day/night the patient needs to take the medication?	Yes☐ No☐	
8	Is the medication time-limited?	Yes☐ No☐	
9	If the medication is time-limited is the duration recorded on the MAR/in the care plan?	Yes☐ No☐	
10	Who is to make the decision as to whether the resident requires the medication once it has been prescribed i.e. care worker, resident?		
11	Is the way in which this will be communicated between the care worker and the resident recorded in the care plan?	Yes☐ No☐	
12	Is the way in which the symptoms manifest themselves recorded in the care plan?	Yes☐ No☐	
13	Is the maximum dose to be given in twenty four hours recorded on the MAR chart?	Yes☐ No☐	
14	Is the length of time to leave between doses recorded on the MAR chart?	Yes☐ No☐	
15	Is the medication to be taken at times other than the usual medication rounds?	Yes☐ No☐	
16	Have steps been taken to ensure this happens?	Yes☐ No☐	
17	Are there any other interventions that could/should be made before the medication is administered?	Yes☐ No☐	

18	Once administered, is there provision for the desired outcome to be recorded in the care plan?	Yes☐ No☐	
19	Should the outcome experienced by the resident be communicated to anybody?	Yes☐ No☐	
20	Is a record kept when the outcome is communicated to anybody?	Yes☐ No☐	
21	Is the medication to be administered immediately the symptoms occur?	Yes☐ No☐	
22	Is there a protocol is in place to ensure that a dose of medication is not duplicated or given at the wrong time?	Yes☐ No☐	
23	Is there a mechanism in place to check whether the medication is being taken regularly?	Yes☐ No☐	
24	If the medication is being taken regularly is there provision for the reason to be recorded?	Yes☐ No☐	
25	If the medication is being taken regularly is there a protocol in place to ensure that a referral is made to the prescriber for a review?	Yes☐ No☐	
26	Is there a date for reviewing the medication?	Yes☐ No☐	
27	If the resident should experience symptoms but is not offered the medication will this recorded?	Yes☐ No☐	
28	Is a record kept of how the outcome is communicated to the care worker by the resident?	Yes☐ No☐	
29	Is a record of how to assess the outcome kept?	Yes☐ No☐	

Action Points (if any of the above are not addressed, state the actions required below).

When Required (PRN) Medication Support Plan

Name:	DOB: NHS No:
Name of medication: Strength: Form: Route of Administration:	Dose: Minimum time interval between doses: Maximum dose in 24 hours: Any Special instructions e.g. before or after food on empty stomach:
Prescribed by:	Reason medication prescribed:
Describe as much detail below as possible using the following as prompts: • the condition being treated • symptoms to look out for • indicators • type and site of pain • possible alternatives to attempt before giving medication • how you will know when to offer the medication	• behaviours • triggers • expected outcome • where to record the outcome • methods of communication • when to refer to prescriber • who will decide the medication is to be offered
Any additional comments/information	
Completed by:	Date:
Date of next review:	

Please complete this form for each PRN medication and use the PRN Purpose & Outcome Protocol as an aide memoire.