NHS
Suffolk and
North East Essex

Good Practice Guidance for Care Homes: 'When Required' Medicines

Purpose of this guidance

This guidance aims to support staff who administer 'when required' (PRN) medicines to ensure they have a complete and robust process in place. Every resident should have a person-centred care plan for each PRN medicine prescribed which contains enough information to support staff to administer the medicine appropriately. As these care plans are more commonly referred to as 'PRN protocols', this description is used throughout this guidance document. More information on what should be included in these plans can be found on the Care Quality Commission (CQC) website under 'When required medicines in adult social care'.

A prescription for a PRN medicine should only be considered if homely remedies and self-care options have been exhausted or are not appropriate - see Suffolk and North East Essex Homely Remedy and Self-Care toolkit.

What is a PRN medicine?

A PRN medicine is a treatment that is not required by the resident on a regular basis. It is usually prescribed or purchased to treat a short term or intermittent medical condition such as pain, indigestion or insomnia, and the dosage may be variable; it is not intended to be given as a regular dose.

PRN protocols and documentation

The care home should have a policy in place to ensure that PRN medicines are administered as intended by the prescriber.

The prescriber should provide:

- the reason the medicine has been prescribed
- the intended outcome
- clear dosage instructions: this includes the maximum amount to be taken in a 24-hour period, and the minimum interval between doses. Where a variable dose is prescribed there should be clear direction as to what dose should be given. 'Use as directed' is not appropriate
- where more than one PRN medicine is available and has been prescribed to treat the same condition, the prescriber should advise how and in what order they should be administered.
- When to review the medicine and an expected duration of treatment.

The care home should complete a person-centred PRN protocol for each PRN medicine prescribed. These protocols are best kept with the resident's Medicines Administration Record (MAR).

Each PRN protocol should include:

- the reason the medicine has been prescribed
- details of alternative support or interventions to use before giving the medicine
- when to offer the medicine, including if the resident can ask for the medicine or if they need prompting
- the signs or symptoms to look out for including non-verbal cues and signs of need
- how to administer the medicine
- how much to give, including if a variable dose has been prescribed, the maximum amount to be taken in a 24-hour period, and the minimum interval between doses
- Where more than one when required medicine is available for the same condition, it should state how and in what order they will be administered.
- the desired outcome and what to do if the medicine is not effective
- when to refer to a healthcare professional (HCP)

Use decision-making tools such as a pain chart to assist residents in describing symptoms and severity or the Bristol Stool Chart to support decision making.

PRN medicines should be offered to the resident when they are experiencing symptoms; this should not be limited to medicines rounds or times printed on MARs.

Record keeping

When a PRN medicine is administered, the following information should be recorded on the resident's MAR:

- reason(s) for administration
- date and exact time of administration
- dose given
- outcome and whether the medicine was effective
- signature of the administering staff member

The administration of all medicines should be recorded on the MAR immediately to prevent a medicine administration error or an accidental overdose occurring. It is also good practice to record in the resident's daily notes when each PRN medicine is offered.

After a dose of medicine is administered, the resident should be monitored to see if their symptoms have been relieved or have resolved, and the outcome recorded. Care home staff may need to contact a healthcare professional if the medicine does not have the expected effect or if the resident experiences any adverse effects.

Reviewing and discontinuing PRN medicine

Regular reviews of PRN medicines should be completed collaboratively and include care home staff, healthcare professionals and the resident if appropriate. PRN medicines to manage a person's behaviour should be prescribed for as short a time as possible. Their use should be recorded and reviewed; any concerns about overuse should be discussed with the prescriber.

Care home staff should contact the prescriber for advice or a medicine review if the resident:

- appears to be experiencing side effects
- appears not to be responding to the medicine
- shows signs of their medical condition deteriorating
- requests the medicine more frequently than usual or more than prescribed
- consistently uses more or less than prescribed during each medicine cycle - the quantity may need increasing or decreasing to avoid waste or interim requests
- rarely requests or regularly declines the PRN medicine. In this case a homely remedy may be more appropriate. See SNEE ICB Homely Remedies and Self-Care Toolkit

The GP practice should remove any discontinued PRN medicines from the repeat template for accuracy.

Storage, ordering and disposal

- PRN medicines should be available to the resident on request. The resident may wish to keep some PRN medicines to hand. Risk assessments must be completed for this
- If PRN medicines are left over at the end of the monthly cycle and they are still current and in date, the medicines should be carried forward to the next cycle to avoid unnecessary waste. Refer to SNEE guidance Reducing Medicines Waste in Care Homes
- Care home staff should record the quantity of medicine carried forward on the new MAR. This will ensure an accurate record of the stock level, which will help when undertaking audits
- If a PRN medicine is discontinued, it must be disposed of as per the care home's medicines waste policy and removed from the MAR.

Some PRN medicines are used infrequently, so do not need to be ordered regularly – examples include salbutamol inhalers and GTN sprays. Unnecessary ordering of these medicines may inappropriately suggest poor symptom control or a worsening condition.

References

1. NICE guideline SC1. Checklist for health and social care staff developing and updating a care home medicines policy. May 2014
2. CQC – Adult Social Care: Information for Providers. When required medicines in adult social care - Care Quality Commission 21st January 2025
3. Adapted from guidance produced by Herts Valley CCG and North Hertfordshire CCG and Bedfordshire, Luton and Milton Keynes ICB
4. NHS England, Constipation resources for carers, Bristol Stool chart accessed online 25/03/2025 Bristol Stool Chart

Appendix 1: Example of requirements of a patient centred PRN protocol

- The following information must be referred to when offering and administering PRN medicine.
- A new document must be completed for each individual PRN medicine and be kept with the resident's MAR for reference.
- Response to treatment should be recorded on the reverse of the resident's MAR, or in the additional notes section.
- Details to include: the date, time and quantity given, the reason for administration and the result of the outcome.

<table>
<tr><td>Care Home Name:</td><td>Resident's name:
Full legal name as it appears on MAR chart/NHS records.</td></tr>
<tr><td>Room Number:</td><td>Date of Birth:
As it appears on records</td></tr>
<tr><td>Name of prescriber:
As it appears on Prescription information</td><td>Treatment start date:</td></tr>
<tr><td>Name of medicine:</td><td>Form:
Tablet/Syrup/Capsule/Spray/Drops/Patch/Cream</td></tr>
<tr><td>Strength:</td><td>Route of administration:
Oral/ topical/ sublingual/ transdermal/ buccal/ subcutaneous/ inhaled</td></tr>
<tr><td>Dose and frequency:
Quantity that can be given at one time and how often in 24 hours as per the label instructions/directions given by registered healthcare professional.</td><td>Minimum time interval between doses:
As per label or patient information leaflet.</td></tr>
<tr><td>Maximum dose in 24 hours:
As per label or patient information leaflet.</td><td>Prescribed/Self-Care item</td></tr>
<tr><td colspan="2">Reason(s) for administration:
When should the medicine be offered?
What condition is the medicine for?
How do you know that the medicine needs to be offered?
Can the resident tell you verbally that they need the medicine?
What signs/symptoms does the residents show?
Are communication tools required?</td></tr>
<tr><td colspan="2">Expected/desired outcome:
What is the desired response to the medicine?
How will you know if the medicine has had the desired response?
Do you need to take any observations?
What do you need to do if it hasn't had the desired response?
How long should the medicine take to show an effect?</td></tr>
<tr><td>Special instructions: for example,
Before or after food?
On an empty stomach?
May colour urine?
Any point at which the medicine will need to be reviewed?</td><td>Predicted side effects:
Use current patient information leaflet to list.</td></tr>
<tr><td colspan="2">Any additional comments/ information: for example,
Food and drink to avoid
Specialist administration instructions e.g. how and when to prime administration device
Any administration preferences e.g. from spoon or hand
Rinse mouth after use</td></tr>
<tr><td>Completed by: Care home staff member 1
Signed:</td><td>Checked by: Care home staff member 2
Signed:</td></tr>
<tr><td colspan="2">Review Date: according to your care setting's policies and procedures or if directions change.</td></tr>
</table>

Appendix 2: Example of a completed patient centred PRN protocol for Paracetamol

- The following information must be referred to when offering and administering PRN medicine.
- A new document must be completed for each individual PRN medicine and be kept with the resident's MAR for reference.
- Response to treatment should be recorded on the reverse of the resident's MAR, or in the additional notes section.
- Details to include: the date, time and quantity given, the reason for administration and the result of the outcome.

Care Home Name: Caring Residential Home	**Resident's name:** Jane Doe
Room Number: 12	**Date of Birth:** 01.01.1945
Name of prescriber: Dr E Smith	**Treatment start date:** 17th June 2023
Name of medicine: Paracetamol	**Form:** Tablet
Strength: 500mg	**Route of administration:** Oral
Dose and frequency: Take 2 tablets every four to six hours when required.	**Minimum time interval between doses:** 4 hours.
Maximum dose in 24 hours: 8 tablets as 4 doses	**Prescribed/Self-Care item** Prescribed
Reason(s) for administration: Jane has a diagnosis of osteoarthritis and can get pain in her lower back, hips and knees. Jane is able to communicate verbally and will tell us if she is in pain. Jane prefers to use a heat pad on her lower back before requesting pain relief. Jane may hold her lower back or struggle to walk if she is in pain.	
Expected/desired outcome: Jane will usually tell us if the pain relief has worked. She will be able to move more easily. Jane normally feels relief from her pain within 30 minutes of taking her paracetamol. If paracetamol does not work initially offer Jane a follow up heat pad treatment. A further dose of paracetamol can be given 4-6 hours later if needed.	
Special instructions: Jane is 63kg if her weight drops below 50kg seek medical advice as this requires a dose reduction.	**Predicted side effects:** Side effects are rare with paracetamol. Stop taking the tablets and seek medical advice if any of the following occur skin rashes, unexpected bruising or bleeding, persistent tiredness, nausea, sudden weight loss, loss of appetite, yellowing of skin and eyes.
Any additional comments/ information: (*e.g. food/drink to avoid)* Do not take more than 8 tablets in 24 hours. In case of accidental overdose seek immediate medical attention. Do not take any other paracetamol containing products at the same time as this medication. If Jane's weight drops below 50kg seek medical advice.	
Completed by: **Signed:**	**Checked by:** **Signed:**
Review Date: *according to your care setting's policies and procedures or if directions change.*	