NHS
Kent and Medway
Clinical Commissioning Group

Kent and Medway CCG

When Required Medications

Best Practice Guidance

Approved by: KMMOC, Clinical Cabinet
Approval Date: Ratified By Clinical Cabinet March 2022
Review Date: March 2024

Definition

'When required' or PRN medications are medicines that should only be taken when the need arises, and/or for intermittent periods of time. These medications are not intended for regular, defined interval use. In addition medicines may be prescribed as a variable dose or a range of doses that may be suitable such as 'Inhale one to two puffs 'when required' to accommodate symptom flexibility.

Documentation in care plans

The following information should be included in a patient's care plan to ensure 'when required' medicines are clearly described and ensure carers assess the need for 'when required' medications on an individualised patient basis (Please see Appendix 1 for a sample 'when required' protocol, Appendix 2 shows guidance on what information to document).

- The indication of a medicine
- Dose instructions
- Symptoms to look out for and when to offer medication
- Appropriate alternative interventions to use before medicines are administered
- If and when it is appropriate to give a varied dose
- If the resident is able to express the need for a medicine or if they need prompting or observing for signs of need
- When the medicines should be reviewed or monitored
- How long the resident is expected to need the medicine e.g. short term/ long term
- When to check with the prescriber

Ordering

It is recommended that 'when required' medication should be dispensed in its original packaging with the pharmacy label on it. This provides flexibility and reduces waste.

- Any 'when required' medication that is still in use and in date should be 'carried forward' from one month to the next.
- It is not necessary to destroy unused, in date 'when required' medication each month. Stock levels of a 'when required' medication must be appropriate for the resident's changing needs so as to avoid excess stock levels.

Care homes should ensure the 'Homely Remedy' scheme is utilised as it is not always necessary to request a prescription for some treatments required for less than 48 hours.

Storage

Care homes should ensure PRN medications are stored securely and that they are accessible throughout the day and night as requests often occur outside of regular medication rounds.

Administration

- The 'when required' protocol should clearly state what symptoms to look out for and when such a medication can be offered.

- Carers should be fully aware of the availability of the 'when required' medicine, the quantity to be given, the interval between doses and the maximum daily quantity allowed.
- When a medication is prescribed at a variable dose, the care plan should include information on how a decision is made on the dose to administer (e.g 1 or 2 tablets).
- Carers should give consideration to patients who may not have the capacity to refuse medication offered. It is good practice to provide decision making aids such as the Wong-Baker face scale to assist patients in describing their current symptoms.

Monitoring & when to refer

- On a regular basis, residents' requirements for the 'when required' medicines ought to be reviewed.
- The review should also consider if the medicine is still required, having the desired outcome, over-used or refused despite apparent need. If a patient's needs have changed over time, a medication review may be required. (this can be done by PCN pharmacists or GPs in collaboration with the patient and the relatives.
- The dose should be clearly outline on the PRN medication paper work. If there is any confusion over when to give the medication or what dose to give the prescriber or appropriate health care professional should be contacted to clarify.

Record Keeping

- It is recommended that only administration is recorded on the MAR sheet although some care home policies state that staff must record evidence that the medicine has been offered and not needed (and may be recorded using a defined code).
- If a patient is assessed as needing the 'when required' medicine but refuses to take it, this should be marked as a refusal on the MAR sheet.
- The care plan should state clearly when PRN medication should be administration. This is usually at the request of a patient, if an assessment is done (by care home staff) or by prompting the patient. If the patient is to be prompted, the care home should decide where and how the prompting is recorded.

Any such administration or refusal record should be recorded immediately on the MAR sheet. It is good practice to record the following on the reverse of the MAR sheet for a corresponding administered/refused 'when required' dose:

- The quantity of medicine given if variable dose e.g. 1 or 2;
- The time given. (It is essential that the time is documented to allow the correct interval between doses to be calculated),
- The reason for administration e.g. headache, back pain, bowels not opened for xx days, rash on arm
- The signature of staff involved in the administration
- The outcome of the medication – the resident should be monitored after the dose is given to ensure desired outcome of the medication is achieved or if further action is to be taken
- Any other relevant supporting information regarding the administration

Discontinuing 'when required' medication

Only the prescriber can authorise changes to 'when required' medication.

- If the 'when required' medicine was issued as a **one-off acute** (for short term use) medication and has not been used for TWO or more months, this could be removed from the MAR and the stock destroyed.
- If the 'when required' medicine is on the repeat medication list and has not been used for THREE or more months, contact the patient's GP to review - an exception to this would be medicines such as Glyceryl Trinitrate spray to prevent an angina attack or Salbutamol inhaler to prevent an asthma attack which should be prescribed as PRN on the patients MAR chart.
- If the patient continues to use 'when required' medication at regular intervals, it may be more appropriate to cease the 'when required' medication and refer to the prescriber to request the medicine as a regular medication.

Sources:

NICE (2014). Managing medicines in care homes. NICE: London
CQC (2010). Summary of regulations, outcomes and judgement framework. CQC: London.
CQC When required medicines in adult social care: https://www.cqc.org.uk/guidance-providers/adult-social-care/when-required-medicines-adult-social-care

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Appendix 1

Name:	
DOB:	**Room number:**
Medication:	**Form:**
Strength:	**Route of administration:**
Dose and frequency:	**Minimum time between doses:**
Maximum dose in 24 hours:	
Reason for administration:	
How decision is reached to give dose:	
When to administered varied dose:	
Actions to take prior to administration:	**Actions to take after administration:**
Expected outcome:	**Potential side effects:**
Additional information:	**When to refer to GP:**
Completed by:	
Date completed:	
Review date:	

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Appendix 2

Name:	
DOB: *xx/xx/xxxx*	**Room number:** *x*
Name of Medication: Brand and/or generic	**Form:** *Tablet, capsule, liquid, etc.*
Strength: *xxMG xxMG/xxML*	**Route of administration:** *Oral, topical*
Dose and frequency: *Number of tablets* *How many times a day*	**Minimum time between doses:** *Minimum number of hours between each dose*
Maximum dose in 24 hours: Total maximum dose in 24 hours	
Reason for administration: *When the medicine should be given – describe in as much detail as possible the condition being treated. (e.g. signs and symptoms, behaviours, type of pain – where and when, expected outcome). Topical items should indicate where they should be applied.*	
How decision is reached to give dose: *Can the resident express the need for them medication.* *If unable to express need how do you know to administer? (e.g. non-verbal signs, behaviours, use of decision making aids, not opened bowels for xxx days)*	
When to administered varied dose: *Detail on how to decide what dose to give*	
Actions to take prior to administration: *Non medication interventions* *Other medications available*	**Actions to take after administration:** *What to monitor*
Expected outcome: *What is the intended outcome of the medication (e.g. relief of pain, pass bowel)*	**Potential side effects:** *Use patient information leaflet or BNF to document common side effects.*
Additional information: *To be given with/without food* *Avoid alcohol* *Do not take with any other paracetamol containing products.*	**When to refer to GP:** *Not effective at upper dose regularly* *Never requested* *Requesting regularly* *Side effects experienced*
Completed by:	
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