# (Insert House Operator Logo)

# (Insert House Operator Name)

Protocol for the Administration of PRN Medication

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| **Resident Name:** | **Date of Birth:** |
| **Address:** |  |
| **Name of Medication Prescriber:** | **Contact Details of Prescriber:** |

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| **PRN medication:**  **Dosage of PRN:**   * Per dosage: * Maximum dosage per calendar day: * If PRN is required on more than one occasion per calendar day:   *\*Any changes made by the prescribing practitioner in relation to any aspect of the administration of PRN medication must result in a full review and update of this protocol by a qualified Behaviour Support Practitioner (including updated consent).* |
| **Purpose of prescribed medication:**  **Possible side effects and adverse effects of medication:**  In the event that adverse effects of medication are suspected, staff should contact the resident representative:  Staff should also contact one of the following for further information:   * Prescribing doctor or pharmacist (During consultation hours) * Poisons hotline (131126) * And/or emergency medical services (To be phones directly in the event of an emergency) |

**When to consider PRN**

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| **PRN should be considered when:** |
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**Administration of PRN by House Staff**

It is desirable to minimize the delay in administering PRN when it is required.

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| 1. Ensure paperwork pertaining to the administration of PRN is up-to-date and check dosage. 2. Ensure that the resident has **not** exceeded the maximum PRN dosage for the “calendar day” (a “calendar day” is from 12.00am until 11.59pm on any given day). Check that there is a MINIMUM of [insert time frame] since the resident last had PRN. 3. Staff should contact parents [insert before/after] administering PRN medication on [insert contact details]. 4. Sign the medication chart to say PRN was administered. 5. Record that PRN was administered on:  * Medication chart * Communication/shift report  1. **When PRN is given in conjunction with an incident of self-injurious behaviour, damage to property or harm to another person, ensure that an incident report is completed as soon as (safely) possible after the administration of PRN.** |

**Expected effects of PRN medication**

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**Overview of review and monitoring processes**

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| **Review schedule by Behaviour Support Practitioner:** To be reviewed by Behaviour Support Practitioner as requested by the resident’s medical practitioner. This protocol should be reviewed at least every 12 months.  **Review schedule by Prescriber:** To be reviewed by medication prescriber as per review of patient. | **Monitoring:** Staff should complete resident’s medication chart every time PRN is administered. Staff should also complete the communication and shift report. |

**PNR Consent, Endorsement and Authorisation**

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| **Name, signature and contact details of resident representative endorsing this plan:** | **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** |
| **Name, signature and contact details of Behaviour Support Practitioner endorsing this plan:** | **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** |
| **Name, signature and contact details of prescriber to indicate that this PRN Plan is accurate for the administration of PRN:** | **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date:** |

*Disclaimer: Once completed, the information in this “Protocol for the Administration of PRN Medication” must* ***not*** *be changed or altered in any way, and must be reviewed on a regular basis. Any changes made by the prescribing practitioner in relation to the administration of PRN will render this document out-of-date, and a full review and update of this protocol by a qualified Behaviour Support Practitioner (including updated consent) will need to be completed.*