# (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)
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**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.**
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**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.*