

PRO RE NATA (PRN) PRESCRIPTION IN AN INPATIENT LOW SECURE LEARNING DISABILITY UNIT

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SUMMARY

Introduction: Pro Re Nata (PRN) prescribing in psychiatry is a common and valuable facility to be used in acutely distressed patients. It is open to misuse and PRN prescribing may be unnecessary/inappropriate.

Aim: The aim of the audit is to ensure safe and effective prescription of PRN medication.

Audit Standards: The standards were set in congruence with the guidance from the local trust policy.

Methodology: All of the inpatient records at Wood Lea clinic were studied over a 2 month period.

Conclusions: Most of the standards against which the clinical notes were assessed gave evidence of good medical practice. Patient demographics demonstrated a 100% record of the NHS number but the patient's name and ward fell short.

Recommendations: This was presented locally and measures put in place to address gaps. Re-audit should be performed within a year in order to complete the audit cycle and to ensure that recommendations/action plan have been followed through.

Key words: PRN medication – audit - standards

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INTRODUCTION

The Wood Lea Clinic is ten-bedded Low Secure Forensic Unit for people with Learning Disability. In addition to the diagnosis of learning disability, the patients have a wide range of other psychiatric co morbidities including: personality disorders, disorders of sexual preference, autism, mood disorders and epilepsy.

Pro Re Nata (PRN) prescribing in psychiatry is a common and valuable facility to be used in acutely distressed patients. As an indication of its usefulness, all in-patient medication charts are provided with the facility to prescribe PRN medications to be used in situations where de-escalation techniques have not been successful in calming down an acutely distressed patient.

Nonetheless, it is open to misuse and PRN prescribing may be unnecessary or inappropriate.

This audit reviews PRN medication prescription in Wood Lea Clinic against the backdrop of the local trust policy on safe prescription of PRN medication. The PRN medication charts will be reviewed against the standards set and evaluated for the percentage of compliance to the standards.

AIMS

The aim of the audit is to ensure safe and effective prescription of PRN medication in Wood Lea Clinic. This is particularly important because most of the psychotropic medications used for PRN purposes can have serious side effects and hence the need to monitor their prescription and use.

This audit is a local audit and falls under the Services for People who have a Learning disability (SPLD) Inpatient, Beds and Luton.

We sought approval from the local audit committee.

AUDIT STANDARDS

The standards were set in congruence with the guidance from the local trust policy.

The following standards were selected upon which the data was assessed:

- In addition to standard prescription writing requirement, the prescriber shall specify:
 - the intended indication (e.g. 'for pain', 'for nausea');
 - the minimum interval between doses (e.g. '6-hourly');
 - the maximum number of doses that may be given within 24 hours (e.g. 'max. 3 doses in 24 hours' or 'max. 4mg in 24 hours').
- Alternative routes of administration for the same drug shall be written as separate prescriptions – the practice of writing the route as 'PO/IM' or 'PO/PR' is not acceptable.
- The maximum number of doses to be administered and/or maximum duration of treatment should be stated where relevant.
- Review of 'PRN' medications: The administration records for 'PRN' medications, and the patient's ongoing need for these items to remain on the chart, must be reviewed at least every 7 days, or more

frequently if clinically appropriate. The dates of such reviews must be documented in the patient's healthcare record. "PRN" antipsychotics should be reviewed after 7 days or 6 doses whichever is the shorter and recorded as above.

- Every 'PRN' dose of medication administered must be recorded on the chart with the date and time of administration. A corresponding entry must be made in the patient's healthcare record detailing the reason why the 'PRN' dose was given, and the date and time of administration.

METHODOLOGY

All of the inpatient records at Wood Lea clinic were studied over a 2 month period (1 October 2014 to 30 November 2014).

All the medication charts of the patients were examined for prescription of PRN medication for:

- Patient Details – Name, NHS Number, Ward Name;
- Medications mentioned in Black Ink and Capital Letters ;
- Indication for prescription, minimum interval between doses, maximum number of doses mentioned;
- Alternative routes of administrations must be written as separate prescriptions;
- Printed Name, Signature, Designation and date of prescription should be mentioned;
- Recorded date, time, dose and signature at the time of administration

The clinical records were examined for:

- Recorded reason for administration of PRN medication;
- Review of psychotropic PRN medication after 7 days or 6 doses, to change to regular medication or to cancel the medication if not required.

The audit tool was developed by the clinical audit team who also analysed the data following the collection. See appendix 1 for Audit tool.

FINDINGS

Full results can be found in table 1, the following figures illustrate the key finding.

Figure 1 outlines the compliance with mentioning Patient's Name, Ward and NHS number mentioned in the PRN section of the medication chart. Patients name was mentioned only in 90.90% and NHS number was mentioned in 100% of the charts. The Ward was mentioned only in 45.45% of the charts.

Figure 2 outlines that the compliance for recording indication for prescription, maximum interval between doses and the maximum number of doses was 100% in all.

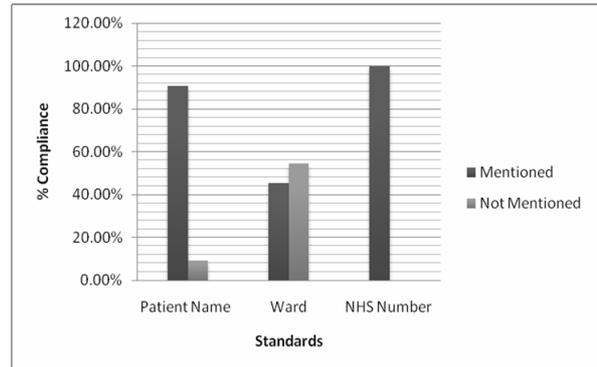


Figure 1. Patient's Names

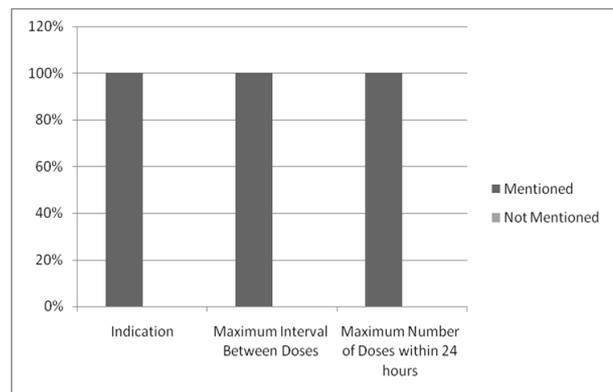


Figure 2. Maximum Interval Between Doses

Figure 3 indicates the compliance with recording the date, time, and signature at the time of administration of the drug. It was found to be 100% in congruence with the standards.

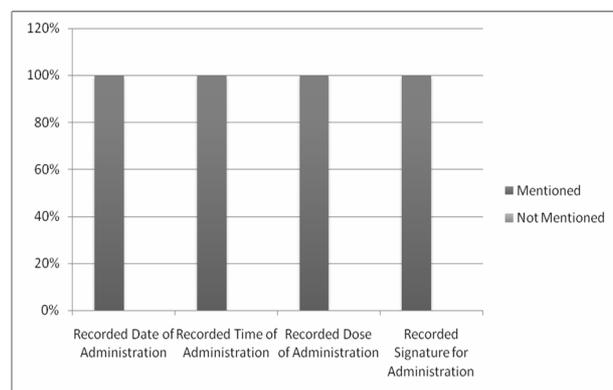


Figure 3. Date and Time of Administration, Dose and Signature

Figure 4 shows that there is 100% compliance towards writing medications in the medications charts in capitals and black ink.

Figure 5 shows the compliance with mentioning the printed name of the doctor, date and signature of the doctor in the PRN section of the medication chart. Whilst Printed Name and Signature was mentioned in 100% of the charts, date was only mentioned in 97.56% of the charts.

Table 1. Full Results (Audit tool assessed utilised per patient).

1. Patient Demographics which includes the patient name, ward and NHS number were checked on each PRN prescription sheet. It was found that there was 90.90% (10 out of 11) compliance towards mentioning of the patient's name, 45.45% (5 out of 11) towards mentioning the ward name while NHS number was mentioned in all the charts with 100% compliance.
2. Medications were always written with black ink and in capital letters with 100% compliance to the standards.
3. Indication was not mentioned in 2.43% (1 out of 41) of the medications prescribed for the patients.
4. Minimum interval between the doses and maximum number of doses within 24 hours was mentioned beside all the PRN medication with 100% compliance.
5. None of the drugs were mentioned to be administered by multiple routes. Only one route of administration was mentioned for each of the medications.
6. It must be noted that the route of administration was not mentioned in 2.43% (1 out of 41) of the medications prescribed.
7. The record of date, time, dose of administration and the signature of the nurse administering the drug showed 100% compliance with the standards.
8. The prescriber's name and signature was mentioned in all the charts with 100% while the date of prescription was mentioned only in 97.56% (40 out of 41) of the charts.
9. The nursing notes were examined for the documentation of the reason for administration of the PRN medication. It was found that only 8 out of 42 entries (19.40% compliance) had reason for administration mentioned in the nursing notes.
10. It must be noted that one entry in the nurses chart showed different PRN medication record to the record made in the PRN medication chart and also, records of one date were not available in the electronic system.
11. In view of review of antipsychotic PRN medication, only one antipsychotic drug was mentioned as a PRN medication and it was not found to be administered. Review after 7 days or for cancellation due to lack of use was checked in the subsequent medical notes. There was no mention for review of the PRN antipsychotic medication found in the medical notes.

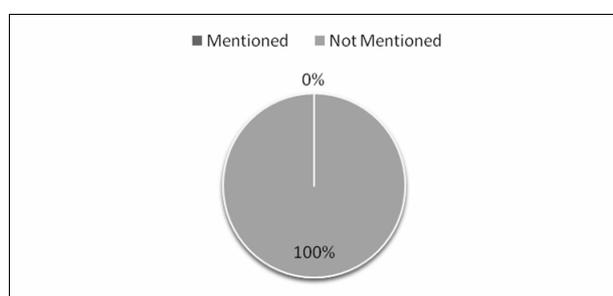


Figure 4. Medication in Capitals

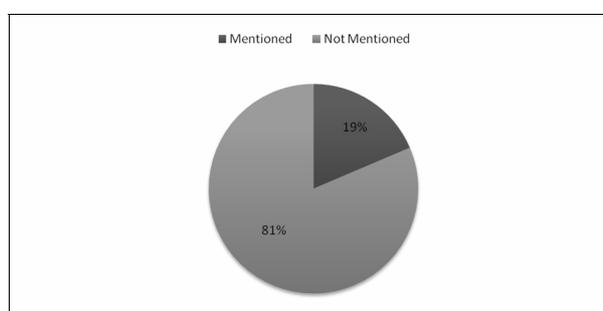


Figure 6. Reason for administration

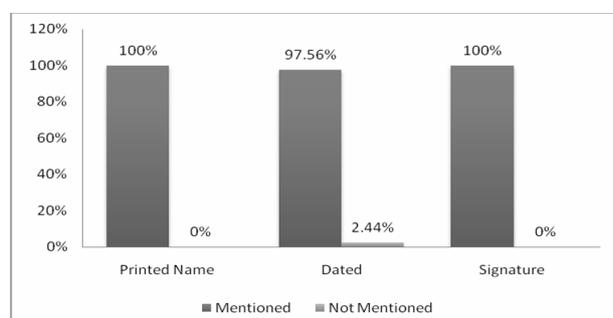


Figure 5. Name and signature

Figure 6 indicates the compliance with mentioning the reason for administration in the nursing notes and it should be noted that 81% were not compliant whilst only 19% were.

In view of review of antipsychotic PRN medication, only one antipsychotic drug was mentioned as a PRN medication and it was not found to be administered. Review after 7 days or for cancellation due to lack of use was checked in the subsequent medical notes. There was no mention for review of the PRN antipsychotic medication found in the medical notes.

CONCLUSIONS

In conclusion, it may be noted that most of the standards against which the clinical notes was assessed gave evidence of good medical practice.

Medication written in capitals and black ink, indication for prescription, maximum interval between doses

and the maximum number of dose with the recorded time, date, signature and dose during administration was 100%.

Patient demographics demonstrated a 100% record of the NHS number but the patient's name and ward fell short.

Printed Name of the doctor and signature were mentioned in all the charts but the date for was absent in 2.44% of the charts.

The record of the reasons for administration of the PRN medication in the nursing notes was lacking in majority of the notes examined. Review of antipsychotic medications in the clinical notes were not mentioned for cancellation or to change to regular medication.

All drugs were prescribed only with one route of administration and no alternative routes were mentioned.

RECOMMENDATIONS

Patient's Name and Ward Name should be mentioned in all the PRN section of the medication charts and

strict adherence should be encouraged. The nursing notes must adequately mention the administration of PRN medication and the reason for administration to the patient.

Documentation of regular review of all PRN medication should be encouraged including anti-psychotic medications.

A re-audit should be conducted within one year to complete the audit loop and ensure that suggested recommendations and action plan have been followed.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. *Maudsley Prescribing Guidelines Wiley*, 2015.

Appendix 1. Data Collection tool

Criteria	PRN Medication									
	Drug 1	Drug 2	Drug 3	Drug 4	Drug 5	Drug 6	Drug 7	Drug 8	Drug 9	Drug 10
Patient Name										
Ward										
NHS Number										
Medication written in capitals and black ink										
Indication										
Maximum Interval Between Doses										
Maximum Number of Doses within 24 hours										
Alternative Routes of Administration										
Review ever 7 days/6 doses										
Recorded Date of Administration										
Recorded Time of Administration										
Recorded Dose of Administration										
Recorded Signature for Administration										
Reason for Administration entry										
Printed Name										
Dated										
Signature										
Mentioned	<input type="checkbox"/>									
Not Mentioned	<input type="checkbox"/>									
Not Applicable	NA									

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