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Abstract

Pro re nata (PRN) medication is medication administered by nurses as required commonly in response to a patient's symptoms or behaviour including insomnia, agitation or anxiety. There is a paucity of research around the process of PRN administration in mental health settings in Ireland and international evidence suggests inconsistencies in practices. This study aimed to explore the process of PRN medication administration by mental health nurses. Using a qualitative descriptive design, semi-structured interviews were undertaken with 19 mental health nurses in three acute inpatient units in one mental health service in Ireland. Most participants reported undertaking an assessment of the patient before administering PRN medication however many also reported having observed incidents of poor practice. There was evidence of some interdisciplinary sensitivities around instructions regarding the use of PRN medications between doctors who prescribed them and nurses who dispensed them. A need for service improvements were also identified including the use of alternative strategies to PRN use such as de-escalation techniques and education around psychopharmacology. PRN medication is commonly used in mental health settings however this study suggests that there is potential for improvement in relation to how it is prescribed and administered. Overuse of PRN medication has been associated with increased morbidity. Mental health nurses are required to carefully consider whether PRN medication is warranted in the first instance and how its use might impact on patients.

Introduction

Pro re nata (PRN) medication is medication given 'as the occasion arises', and is usually given in specific circumstances in response to an identified patient need (Martin, Arora, Fischler, & Tremblay, 2017). The decision to administer PRN medication is most frequently made by nurses, sometimes initiated by patient request and other times initiated by assessment of a particular person's needs at a given time (Usher, Baker, Holmes, & Stocks, 2009). The administration of PRN medication in mental health settings is a common occurrence (Stewart, Robson, Chaplin, Quirk, & Bowers, 2012), with reviews suggesting that between 70-90% of in-patient service-users receive PRN psychotropic medication (Baker, Lovell, & Harris, 2008a). The administration of PRN medication varies significantly between mental health settings making it difficult to establish whether its use has increased or decreased although Mullen and Drinkwater (2011) report in their study how PRN

administration reduced from an average of 314 administrations per month in 2005 to 181 per month in 2009. Commonly used PRN medications include benzodiazepines, antipsychotics and sedative medications which are given in response to anxiety, agitation and insomnia (Stewart et al., 2012; Martin et al., 2017; Geffen et al., 2002a).

For many patients who take PRN medications there is a beneficial effect however a recent study by Martin et al. (2017) reported that PRN medications are not uniformly effective for all who take them with PRN antipsychotics reported being effective 74% of the time while PRN benzodiazepines were only reported to be effective 55% of the time. Furthermore, there is evidence to suggest that PRN medication is often misused by nurses, doctors and patients themselves (Baker, Lovell, & Harris, 2007; Usher et al., 2009; Winship, 2010). This misuse includes administering the medication to keep patients quiet and sedated rather than establishing the cause of the problem (Baker, Lovell, Easton, & Harris, 2006; Usher et al., 2009), administering it for different reasons than prescribed (Martin et al., 2017) and patients requesting it for non-indicated reasons including feeling bored or altering their consciousness (Cleary, Horsfall, Jackson, O'Hara-Aarons, & Hunt, 2012). A lack of appropriate assessment prior to administration of PRN medication has also been reported by Olajide, Mansfeld, Olubankole, & Udoka (2016) who noted how PRN medication was prescribed to new admissions regardless of it being required or not. Overuse of PRN medication in combination with regularly prescribed psychotropic drugs can contribute to a host of adverse effects including metabolic syndrome and extra-pyramidal side-effects (Olajide et al., 2016). In addition, most medications prescribed as an anxiolytic or as a hypnotic have the potential for psychological and physiological dependence thereby heightening the complications associated with them (Martin et al., 2017). There is therefore a need to be cautious around the administration of PRN medication and to explore whether other interventions might be best suited as first line interventions. Martin, Arora, Fischler, & Tremblay (2018) identified that non-pharmacological interventions prior to the administration of PRN medications are not well documented and appear to be infrequently used. Previous studies have identified a pattern of nurses resorting to PRN medication as a first rather than a last line of treatment (Baker et al., 2007; Usher et al., 2009). A systematic review of evidence around the use of PRN psychotropic medication concluded that its use was often based on clinical experience and habit rather than high quality evidence (Whicher, Morrison, & Douglas-Hall, 2003). This is supported by a later review which was unable to identify any trial-based evidence to support the use of PRN medication over regularly prescribed psychotropic medication (Douglas-Hall & Whicher, 2015). This is concerning not only

because of the adverse effects associated with these medications but also because mental health nurses are well positioned to offer much-needed non-pharmacological interventions to help prevent and relieve some of the distress experienced by patients (Jones & Coffey, 2012).

Mental health nursing in Ireland is moving from the traditionally dominant medical model towards a more recovery-focused model with greater emphasis on service user involvement and psycho-social care (Cusack, Killoury, & Nugent, 2017). This was formalised in 2012 when the Health Service Executive (HSE) published a report detailing its ‘Vision for Psychiatric/Mental Health Nursing’ in Ireland (HSE, 2012). This report put collaboration with service users at the heart of mental health nursing practice and advocated a holistic approach to care. The administration of psychotropic medication, including PRN medication, is still an important component of the role of the mental health nurse in Ireland and is not incongruent with employing a recovery-orientated care programme. Recognising the move towards partnership and recovery approaches to care, Hemingway and Snowden (2012) identify the responsibility of the nurse to have the appropriate knowledge, skills and caring attributes to attend to medication management sufficiently while being inclusive of patient needs and preferences. Nurses remain the key decision makers in the administration of PRN medication so there is increasing responsibility on them to be transparent about their decision to administer the drug (Barr, Wynaden, & Heslop, 2018). However, the role of clinical decision-making underlying nurses’ administration of PRN medications is under-researched (Winship, 2010) and there is no published research on how mental health nurses in Ireland make a decision about administering PRN medication and how this process might be improved to provide a better experience for the service user.

Aim of the study

The aim of this study was to explore the process of PRN medication administration by mental health nurses in acute inpatient settings. The specific objectives were to:

1. Identify factors that influence nurses’ decision-making around the administration of PRN medication;
2. Identify what, if any, therapeutic interventions are used prior to the administration of PRN medication;
3. Identify nurses’ views on how practice around PRN medication can be improved.

Study design

A qualitative descriptive design was utilised in this study. This design is commonly used in healthcare research as it facilitates the provision of broad insights into particular phenomena

and has great potential to clearly describe the experiences of both service users and healthcare providers. In this study, the descriptive design facilitated the candid description of nurses' experiences around the administration of PRN medication thereby gaining insights from informants regarding a poorly understood phenomenon (Kim, Sefcik, & Bradway, 2017). Individual semi-structured interviews are the most common method of data collection in qualitative descriptive research (Kim et al., 2017) and are the data collection method used in this study. An interview guide based on existing literature and on the aim and objectives of this study guided the conduct of the interviews.

Methods

Sample and Procedure

The study site was an acute inpatient service in Dublin, Ireland. The service comprised 3 adult mental health units from where the sample was drawn; two were acute inpatient mental units and one was a High-Dependency Unit (HDU) which in total comprised approximately 50 in-patient beds. The majority of patients were admitted on a voluntary basis. Each acute inpatient unit had one Clinical Nurse Manager and four staff nurses on day duty, and three staff nurses on night duty. The HDU had a Clinical Nurse Manager and two staff nurses on day duty and two staff nurses on night duty. A purposeful sampling strategy was employed which sought Registered Psychiatric Nurses who had experience of administering PRN medication. Posters advertising the study were placed in the staff rooms of the units by a gatekeeper, an administrative staff member who was a medium for recruitment by helping advertise the study. Twenty nurses contacted the researcher stating their interest in participating in the study, with 19 agreeing to be interviewed. One person withdrew citing a lack of time to undertake the interview. An information sheet and consent form was sent to each participant and for those who agreed to participate an interview time and location was set. In all cases, participants opted to be interviewed in an office made available to the researcher in an administration wing of the mental health service. At participants' request, all interviews took place on the days they were on duty either on their scheduled break or after their shift ended. Written consent was obtained prior to each interview and interviews were audio recorded and ranged in length from 25 minutes to 85 minutes. Ethical approval to undertake the study was granted from the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin. Participants were provided with the opportunity to request transcripts of their interviews however no participant requested this.

Data Analysis

A thematic data analysis approach was taken informed by the 6-step framework of Braun and Clarke (2006). All interviews were transcribed by the lead researcher (MJ) which provided the opportunity to become immersed in the data. The analysis process began by reading the transcripts several times to increase familiarisation with the data. The process continued through the generation of initial codes which were then collapsed to contribute to the initial formation of themes. At this stage, there were eight themes identified however in a further level of analysis these themes were refined to the final 3 themes presented here as there was insufficient data to support all 8 themes. In line with the recommendations in Braun and Clarke's (2006) final stage, the findings are presented in themes with reference to participant quotes, which are presented *verbatim* and which capture the essence of the findings and provides evidence for the themes. The three themes that emerged are:

1. Factors affecting decision-making around the use of PRN medication.
2. Challenges associated with the use of PRN medication.
3. Improving nursing practices around the administration of PRN medication.

The development of these three themes captures the main findings in this study and also directly address the aim and objectives of the study.

Findings

A total of 19 mental health nurses participated in this study, of which 3 were male and 16 were female. The years since qualified of the sample ranged from just under 1 year to 10 years, with most participants (n=12) qualified less than 5 years. Each participant was interviewed once.

Factors affecting decision-making around the use of PRN medication

Participants spoke at length about the factors that impacted on their decision to administer PRN medication and it was clear that for most the decision to administer these medications was not taken lightly and was influenced by a number of variables. Most participants discussed the importance of assessing the patient and cited this as an influencing factor on the decision to administer PRN medication:

I think it differs depending on who you are giving it to, so how well you know the patient or not, or what kind of mental state they are in at that time, your assessment of them really. (Participant 2- F).

Many participants identified the importance of undertaking a formal risk assessment and cited this as a significant influence on whether PRN medication was administered. Risk was conceptualised here as risk to the patient themselves but also risk to other patients and to staff. It was highlighted that some patients present with a significant degree of agitation which had the potential to develop in to aggression and violence. It was also recognised that there was an element of unpredictability about some patients' behaviours when they were agitated:

Eh based on your observation on how you see the patient whether or not they are escalating, agitated or aggressive and if you feel that they are going to be a threat or an immediate threat or not safe for others then I would administer PRN orally or intramuscularly. (Participant 6- F).

The importance of assessing for psychotic symptoms and their impact was also identified and some participants were also aware of the potential impact of their interventions with the patient:

I would be observing what their behaviour would be like, are they overwhelmed with the hallucination and when you speaking with them are you calming them or triggering or something like that (Participant 5- M).

While most participants identified that PRN medication was administered based on need following assessment of the patient, it was also some participants' perception that in some instances PRN medication appeared to be administered as a means to keep the patient quiet and to make for an easier on-duty shift:

The administration of PRN medication overall I feel can be to keep the patient quiet for the benefit of other psychiatric nurses (Participant 17- F).

Sometimes nurses can give it to keep the patient quiet, rather than find out why the patient is distressed (Participant 1- F).

Participants noted that some nurses appeared to be too quick to administer PRN medication and in the case of hypnotics, did not allow the patient to try to get to sleep without the medication in the first instance:

I have been in a lot of arguments with my colleagues as I don't understand why we give the PRN sleeping tablet when it's only 22:00hrs and the patient hasn't even tried to sleep and probably have no intentions to go to bed for another 2hrs or so (Participant 8- F).

Participants also spoke of the importance of 'being prepared' and having a patient written up for PRN medication should the person become agitated. One participant noted how this might be likely to occur with an 'assisted admission' which is when a patient is involuntarily admitted and brought to the place of admission by an assisted admissions team. In these circumstances, it was reported that nurses specifically requested that PRN medication be prescribed so that they could deflect a potentially violent incident:

If somebody is referred to us and they are going to come as involuntary with the assisted admissions team we always request PRN to be charted so that we have our first line of defence that will actually help us to minimise the harm to themselves or others. (Participant 16- M).

Challenges associated with the use of PRN medication

While participants clearly identified that PRN medication had a role to play particularly in helping calm patients who were experiencing agitation, it was also apparent that there were a number of challenges with the use of PRN medication, and these primarily related to issues which developed between nurses whose job it was to administer PRN medication, and doctors whose job it was to prescribe them. One issue that was raised repeatedly was the tendency for some doctors to be overly prescriptive when charting PRN medication which participants believed suggested that nurses could not be trusted to administer them appropriately. Examples were given where doctors would write instructions such as 'administer when agitated' or 'only for insomnia' on the Kardex. Participants believed this impacted on their autonomy as a mental health professional and suggested that they did not have the ability to discern in what instances PRN was actually required:

I have seen Kardexes written with 'only when agitated' as an instruction on when to give PRN, to be honest, I think it is very patronising to see (Participant 8- F).

It was clear that participants felt undermined by this explicit instruction around the administration of PRN medication and believed their professional judgement should be trusted and respected:

You are only going to give it if the patient is distressed and you have tried other things, you know you are not going to give it if they are complaining of a headache (Participant 19- F).

A further interdisciplinary issue which arose focused on how PRN medications were prescribed and reviewed. In some instances, participants recounted how doctors made changes to PRN prescriptions without discussing it with the nurses administering them or with the patients receiving them. Again, some participants believed that their professional opinion was not sought and this was frustrating as participants highlighted that they were the ones who spent most time with patients and were best placed to report on the necessity for PRN medication. When changes to PRN medication, and particularly changes to longstanding PRN prescriptions were made without consultation with the patient, this made for a difficult scenario where nurses had to inform patients that they could no longer have their PRN medication:

The next thing you see is the PRN is gone when that was not even discussed or mentioned during the MDT meeting and the patient is looking for that PRN (Participant 14- F).

While previously participants reported being frustrated at overly prescriptive instructions issued by doctors around the administration of PRN medication, it was also reported that in some cases, too little information was provided by the doctor about how the PRN medication should be administered and this led to confusion:

I had to ask the doctor 'how much do you want to give, and how often?' because when you write PRN and go away do you mean PRN once or infinity? (Participant 14- F).

Improving nursing practices around the administration of PRN medication.

Participants were energised when it came to discussing how nursing practices around the administration of PRN medication could be improved. In the first instance, participants highlighted the need to consider alternative therapeutic strategies prior to the administration of PRN medication:

There are other things that I think could be tried first before you give them PRN, things to help with sleep, so they feel sleepy at night-time. (Participant 9-F)

Similarly, other participants identified the need to respond therapeutically and ‘de-escalate’ situations rather than using PRN medication as a first line intervention, or as previously described by a participant as a ‘first line of defence’:

You can offer them time and the setting to ventilate their concerns and feelings, just to see if you can de-escalate the situation before you jump in straight away to administer PRN medication. (Participant 7-F).

The requirement for on-going education on psychopharmacology and the administration of PRN medication was reported by a number of participants. As previously identified, most participants in this sample were qualified less than 5 years. Accordingly, many reported not feeling confident in the administration of PRN medication and suggested the need for more supervisory guidance in this practice:

Tomorrow there will be four junior nurses in the unit. I wish there was something in place for us to be aware of when to give it because not all of us are experienced enough to give PRN. I know I am not experienced so it would be helpful if there was some guidance of when to give it. (Participant 17-F)

The importance of having a more senior nurse to discuss the administration of PRN medication with was also identified:

I definitely don't feel experienced enough to give PRN, I prefer to discuss with another senior nurse. I actually don't feel comfortable administering it without having discussed it. (Participant 18-F)

Education around medication generally but specifically around the use of PRN was also advocated. It was believed that this might make participants more mindful about the need to administer PRN only when required rather than as custom and practice:

Well if people are reminded more often about how they practice they might stop and question why they are giving the PRN medication. You get into bad habits and you have to learn these skills again to keep the standard up. (Participant 11-F)

Participants also identified good practices that they had seen in other mental health settings that could be transferred to their place of work and which might improve the process of PRN medication administration:

Where I used to work before coming here there was a section on the Kardex where you could write the reason for administering so that was a good practice, here that section is not there (Participant 12-M).

Discussion

The majority of participants in this study reported administering PRN medication following appropriate assessment of the patient however a number of participants also perceived there to be an inappropriate use of PRN medication at times. Overreliance on, and poor practices around the use of PRN medication have been reported in many studies (Baker et al., 2007; Barr et al., 2018) with the suggestion that in some instances, its use may benefit staff more than patients (Curtis, Baker, & Reid, 2007). Participants in this study perceived that PRN medication was sometimes used as a means to keep patients quiet and to maintain calm on the unit and were given in the absence of any needs assessment. Issues of power and control over patients in the administration of medication have been identified previously (Baker et al., 2006; Duxbury, Wright, Bradley, & Barnes, 2010; Hipp et al., 2018). Service users have reported receiving PRN medication without knowing why which resulted in anger and a perceived lack of control around their care (Cleary et al., 2012). This inappropriate use of psychotropic medication is reminiscent of controlling and coercive practices in mental health

nursing (Curtis et al., 2007) which should, by now, be consigned to history. It is far removed from the recovery-orientated care which is the preferred model of mental health nursing practice in Ireland (Cusack et al., 2017) and in many countries internationally (Lim, Wynaden, & Heslop, 2018). Hipp et al. (2018) identify how service users report feeling disempowered and frustrated when given medication which they do not feel they need. Patient empowerment, control and autonomy are key tenets of recovery-orientated services; and as the use of PRN medication can reduce patients' ability to self-regulate and can leave them feeling disempowered there is a requirement to carefully consider its use in the context of recovery-orientated service provision.

Another poor practice around the administration of PRN medication identified in this study was how PRN medication was often the first line of intervention without consideration of any other alternative. Participants reported that PRN medications were often the first port of call when a patient couldn't sleep or was becoming agitated. This is a finding that has been reported in previous studies of PRN medication administration (Barr et al., 2018; Hallett & Dickens, 2015). It is clear that in some, usually emergency situations where a person is highly distressed or agitated, the use of PRN medication as a first-line intervention may be warranted. However, there are many situations where PRN medication could instead be considered as a second or even third level intervention after other more recovery-focused nursing interventions (Lim et al., 2018). The use of de-escalation techniques in the case of a person who is agitated (Hallett & Dickens, 2015) or the use of psychosocial interventions for a service user who is experiencing anxiety (Martin, Ham, & Hilton, 2018) are recovery-focused alternatives that may be tried in the first instance before the administration of PRN medication as these non-pharmacological interventions increase self-regulation and coping strategies thereby providing better longer term outcomes. Patients themselves have also identified alternatives to PRN medication including going for a walk, talking to staff and going to a quiet place (Cleary et al., 2012). A safety plan which is a recovery-orientated co-produced plan of care can also be developed to identify antecedents to risk behaviour, personal strengths and possible interventions including self-regulating strategies which can help reduce risk (Higgins et al., 2015; Lim, Wynaden, & Heslop, 2017). Identifying reasons and triggers to escalating behaviour has been identified by mental health nurses as central to recovery-focused care particularly when patients have experienced previous trauma (Lim et al., 2018). As the risk of morbidity associated with the administration of PRN medication in combination with regularly prescribed antipsychotics are potentially increased, it is imperative that alternatives are considered first, that PRN medications are used for the correct

reasons and that their use is monitored (Martin et al., 2017). Furthermore, the use of non-pharmacological alternatives to PRN medication which can have more sustainable outcomes can help empower patients towards self-management and recovery (Martin et al., 2018).

The majority of participants in this study were less than 5 years qualified and they identified their clinical inexperience as a factor in the administration of PRN medication. Clinical inexperience has previously been linked with overuse of PRN medication in situations where junior practitioners did not have the skills to employ alternative therapeutic practices to PRN medication (Geffen et al., 2002b; Baker et al., 2007). Nurses who are less confident in managing challenging behaviour may be inclined to use more restrictive and less recovery-orientated interventions including the use of PRN medications (Lim et al., 2018). This suggests that junior mental health nurses may still require some mentoring from more senior staff when making a decision about whether to use PRN medication in a given instance or to employ alternative solutions. Participants did not identify seeking guidance about the use of PRN medication from local policies and protocols however it has been reported that there is variation in the mental health policies and protocols that exist within mental health services in Ireland (Higgins et al., 2016). In addition, participants in this study reported lacking sufficient educational preparation to know when to appropriately administer PRN medications. A lack of knowledge around PRN medication on the part of some nurses has been identified in previous studies (Geffen et al., 2002b; Martin et al., 2017) and there has been a call for improved education of nurses around psychotropic medications (Haw, Stubbs, & Dickens, 2015) and particularly around the use of PRN medication (Stewart et al., 2012). Previous studies have identified that pre-registration nursing education did not go far enough to adequately prepare mental health nurses to make decisions around the correct administration of PRN medication (Usher et al., 2009). The literature also suggests that the shortfall in educational preparation about PRN medication is sometimes met by pharmaceutical companies (Usher et al., 2009) which is problematic as their objectivity is questionable (Healy, 2016).

Interdisciplinary issues between doctors who prescribed PRN medication and nurses who administered them were widely reported in this study. When changes were made to PRN medication there appeared in some instances to be a lack of consultation between doctors and patients which frequently meant that nurses were left to inform patients of this change, a finding identified in other studies (Duxbury et al., 2010). Previous studies have reported an uncoordinated approach of prescribing within the team (Barr et al., 2018) and have called for

greater collaboration between doctors, nurses and patients when it comes to the prescription and administration of PRN medication (Stewart et al., 2012; Duxbury et al., 2010). In particular, patient education about the purposes and potential benefits of PRN medication is important so that they can be involved in making an informed decision about taking them (Cleary et al., 2012; Hipp et al, 2018).

A review of studies exploring psychotropic PRN medication use in inpatient mental health care found that in many cases there was an absence of indications for use in PRN prescriptions (Wright, Stewart, & Bowers, 2012). Nonetheless, there are signs that this situation is improving, and in many clinical settings it is now standard practice to write the indication for the PRN on the medication order (Martin et al., 2017). However, Baker et al. (2007) found that when indications for use of PRN medication were unclear, nursing staff were left to interpret when and in what circumstances PRN was necessary. This has been flagged as problematic as knowledge about psychotropic medication and views on what are appropriate indicators of PRN can differ significantly between doctors and nurses (Geffen et al., 2002b) leading to a lack of consistency around the use of these medications (Barr et al, 2018). Participants in the Baker et al. (2007) study reported this as a problem however in the present study participants reported being unhappy when doctors were overly prescriptive about the circumstances in which PRN medication could be administered. This was interpreted by participants as a reduction in their autonomy which they believed indicated a lack of trust between doctors as the prescribers and nurses as the administrators of PRN medications. The administration of PRN medication is traditionally an area where mental health nurses have exercised a high degree of autonomy (Usher et al., 2009; Mullen & Drinkwater, 2011). However, it could be argued that more precise prescribing of PRN medication by doctors is good practice and does not necessarily impact on nurses' professional autonomy as they are still required to make an independent assessment of patient need prior to the administration of PRN medication (Cleary et al., 2012).

The findings from this study extend what has previously been identified internationally about the administration of PRN medications by mental health nurses. While the issue regarding poor practices around the use of PRN medication has been reported in a number of studies, the finding around interdisciplinary conflict and in particular the perceived threat to nurses' autonomy is not one which has been frequently reported. This study is also the first to report on the PRN administration practices of mental health nurses in Ireland which is an important process to examine in light of the re-orientation of mental health services to have a greater service-user focus with a holistic approach to care.

This study has identified some poor practices around the use of PRN medication that require discussion from an ethical perspective. When undertaking research within the healthcare setting, there is the potential for researchers to observe poor or unsafe practices or to hear about them (Krause, Palmer, Bowers, & Buckwalter, 2011). It is generally accepted that should participants disclose dangerous practices which suggest the potential for harm to others researchers should consider divulging this information to an appropriate authority or professional (Johnson & Long, 2015). However, responding to care that is of poor quality, where care practices are problematic, but do not meet the definition of reportable abuse, is not so straightforward (Krause et al., 2011). In this study, anecdotes of poor nursing practice around the use of PRN medication were recounted by participants however they were recounted about other individuals and were not an account of their own practice. Furthermore, although the administration of PRN medication without adequate assessment, or to 'keep patients quiet' may be considered poor practice, there was no suggestion by participants that the medications administered were not prescribed or subsequently recorded or in some instances were not perhaps necessitated. Some practices identified in this study are therefore classified as 'poor' rather than 'unsafe' or 'dangerous' practice and were not reported to authorities.

The results of this study are limited by the fact that it was carried out in one mental health inpatient service. It is likely that practices around PRN administration differ between mental health settings (Stewart et al., 2012). Accordingly, it would be beneficial to extend this study to other mental health settings. A further limitation of this study was the fact that the majority of participants were qualified less than 5 years. It is possible that more experienced nurses would have different views on the administration of PRN medication.

Conclusion

PRN medication continues to be a commonly used treatment modality in mental health practice and mental health nurses have a central role to play in its administration. As the use of PRN medications is associated with increased morbidity particularly in cases of polypharmacy, there is a requirement for careful consideration of its use. Dealing with the inappropriate use of PRN medications in addition to increasing transparency and consistency in their prescription and administration can result in better outcomes for those who take them. Improved communication between doctors who prescribe them, nurses who administer them and patients who take them can also contribute to an improvement in patient outcomes.

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