CHAPTER 16

TYPES OF MEDICATION ORDERS
Policies for Medication Orders

1. Verbal Orders in the Nursing Home
2. Standing Orders
3. Ancillary Orders
4. Stop Orders
5. Hidden Orders
NURSING HOME

VERBAL ORDERS
IN THE NURSING HOME

REQUIREMENTS OF NURSING HOME

1. No specific time period designated
   a. Must have policy and procedure
   b. Must be accomplished in a timely manner
   c. Must be signed no later than next regular visit by practitioner

2. Order may be taken by nurse or other licensed health care specialist and verified.

3. Recorded. Dated. Signed by person taking the order

4. Telephone order form

REQUIREMENTS OF VENDOR PHARMACY

1. Receives from nursing home or practitioner

2. Verifies Rx

3. Signed written prescription or fax on hand when Schedule II delivered to the home unless an emergency then signed written prescription or fax within 7 days.

4. Timely delivery of medications
Verbal Medication and Treatment Orders

POLICY:

All verbal orders for medications and treatments shall be received only by a licensed nurse or other licensed or registered health care specialist in their own area of specialty. When verbal orders are received they shall be immediately reduced to writing, dated, and signed by the person receiving the order.

METHODS:

All verbal orders are to be written in triplicate on the three-part telephone order form. The original copy (yellow) will promptly mailed or hand carried to the physician for signature. The green copy is affixed to the patient’s chart until it is replaced with signed original. The pink copy is sent to the vendor pharmacist.

All verbal orders are to be written on the physician’s order sheet by the licensed person receiving the order and on the medication administration record.

All verbal orders by consulting physicians must be countersigned by the attending physician.
# SAMPLE OF PATIENT SPECIFIC STANDING ORDERS

## ADMINISTRATION OF MEDICATION

I request that the Nursing Staff or designated personnel of the __________ Facility administer the following medicine or treatment to:

| Telephone Order: |  
|------------------|--
| Child’s Name:    | Date/Time:   |
| MD:              |  
| Received By:     |  

### PRN ORDERS * FILL IN DOSAGE

#### MEDICATION OR TREATMENTS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage and Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACETAMINOPHEN SOLN 160MG/5CC</strong></td>
<td>* BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN OR RECTAL TEMP OVER 101F – MAXIMUM 2 DAYS</td>
</tr>
<tr>
<td><strong>GLYCERIN SUPPOSITORIES -INFANT</strong></td>
<td>1 SUPP RECTALLY ON 3RD DAY IF NO BOWEL MOVEMENT</td>
</tr>
<tr>
<td><strong>SUDAFED SYRUP</strong></td>
<td>ONE TEASPOONFUL BY MOUTH FOUR TIMES A DAY AS NEEDED FOR NASAL CONGESTION – MAXIMUM 2 DAYS</td>
</tr>
<tr>
<td><strong>VINEGAR &amp; PEROXIDE 50/50 MIXTURE</strong></td>
<td>2-4 DROPS IN EACH EAR FOR MONTHLY EAR CLEANING</td>
</tr>
<tr>
<td><strong>DELSYM SUSPENSION</strong></td>
<td>* TEASPOONFULS BY MOUTH TWICE A DAY AS NEEDED FOR COUGH MAXIMUM 2 DAYS</td>
</tr>
<tr>
<td><strong>FLEET PEDIATRIC ENEMA</strong></td>
<td>RECTALLY ON 5TH DAY IF NO BOWEL MOVEMENT</td>
</tr>
<tr>
<td><strong>HYDROGEN PEROXIDE 3%</strong></td>
<td>TO MINOR SKIN WOUNDS AFTER SOAP &amp; WATER AS NEEDED FOR CLEANSING</td>
</tr>
<tr>
<td><strong>WHITE’S A&amp;D OINTMENT</strong></td>
<td>TO DIAPER RASH WITH EACH DIAPER CHANGE. MAXIMUM 6 TIMES DAILY</td>
</tr>
<tr>
<td><strong>NEOSPORIN OINTMENT</strong></td>
<td>TO MINOR SKIN WOUNDS AFTER CLEANSING DAILY</td>
</tr>
<tr>
<td><strong>CALAMINE LOTION</strong></td>
<td>TO INSECT BITES UP TO FOUR TIMES A DAY</td>
</tr>
<tr>
<td><strong>KAOPECTATE SUSP</strong></td>
<td>TWO TABLESPOONFULS BY MOUTH AFTER EACH LOOSE (WATERY) BOWEL MOVEMENT UP TO 24 HOURS</td>
</tr>
<tr>
<td><strong>BETADINE SOLUTION</strong></td>
<td>TO MINOR SKIN WOUNDS AFTER SOAP AND WATER AS NEEDED FOR CLEANSING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>PHYSICIAN’S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL SPECIALIZATION:</td>
<td></td>
</tr>
</tbody>
</table>

16.5
Ancillary Orders in the Nursing Home

1. Ancillary orders usually appear on the right hand side of the Physician Order Sheet.

2. The Physician’s signature on the Physician Order Sheet monthly keeps these Ancillary Orders updated.

3. Ancillary orders usually refer to information other than medication that allow the nurse to do certain things to a resident.

4. Examples of Ancillary Orders
   a. Patient Care Plan approved as written
   b. Patient is free of communicable diseases and TB
   c. May go out on pass with Meds
   d. May participate in in-house Activities as planned
   e. May participate in outings into the community as tolerated Yes No
   f. Resident is capable of understanding rights Yes No
   g. May go on leave of absence with meds and responsible party

5. Examples of a poor ancillary order
   a. Nurse may crush meds PRN
   b. Nurse may alter dosage form PRN
   c. Patient may be restrained PRN for patient safety

6. Other examples of Ancillary Orders (usually defined in nursing Policies & Procedures)

   **Urinary Retention:** Catheterize with a 16 French, 5 ml, indwelling catheter. If residual is greater than 75 ml, leave the catheter in place and notify the physician; if less than 75 ml, remove and notify the physician.

   **Indwelling Catheter:** Encourage fluids to 2000 ml daily unless restricted by order; keep accurate I and O; perineal care with soap and water twice daily; replace catheter every 30 days or if no drainage in 4 hours, irrigate with 50 ml saline once.

   **Leaking Catheter:** Attempt irrigation with 60 ml saline; if leaking continues, remove the catheter and replace with one size larger except Supra Pubics.
<table>
<thead>
<tr>
<th>MEDICATION ORDERS</th>
<th>OTHER ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/04/99 ROUTINE</td>
<td>NONE:</td>
</tr>
<tr>
<td>05/06/99 ROUTINE</td>
<td>PHYSICIAN:</td>
</tr>
<tr>
<td></td>
<td>ALERGENS:</td>
</tr>
<tr>
<td>RECORD VITAL SIGNS EVERY SHIFT</td>
<td>DIAGNOSIS:</td>
</tr>
</tbody>
</table>
Automatic Stop Orders in the Nursing Home

Definition

1. The definition of a “Stop order” differs in a nursing home when compared to a Hospital.

2. In a nursing home a “Stop Order” alerts the nurse to contact the physician to determine if therapy should be continued or not. **The drug cannot be stopped without first getting the MD’s approval**

3. The “stop order” policy is activated when an order is written without a specific length of therapy defined.

4. Since all drugs must be updated every 30 days the maximum stop order in any policy should not exceed 30 days - Standard of Practice

5. Stop order policies should be simple so that nursing does not violate the policy

6. Vendor pharmacist should be monitoring this policy but Consultant should also be looking at orders for appropriate stop dates

7. Drug categories expected to be found in a “Stop Order” policy:
   - Antibiotics
   - Barbiturates
   - Narcotics
   - Anticoagulants

8. Quirks:
   - Topical antibiotics
   - Antibiotics used for acne – should be written “indefinitely” to bypass the stop order policy
   - Schedule II prn’s
Automatic Stop Orders in the Nursing Home

STOP ORDER PROCEDURES

MEDICATIONS NOT SPECIFICALLY PRESCRIBED AS TO TIME AND NUMBER OF DOSES WILL AUTOMATICALLY BE DISCONTINUED ACCORDING TO THE FOLLOWING PROCEDURES:

1. EACH RESIDENT'S MEDICATION MUST BE CHECKED DAILY.
2. MEDICATIONS ARE NOT TO BE DISCONTINUED BEFORE THE PHYSICIAN IS CONTACTED.
3. THE NURSE SUPERVISOR IS RESPONSIBLE FOR CONTACTING THE PHYSICIAN TO OBTAIN RENEWAL ORDERS AND WILL FOLLOW THROUGH UNTIL OBTAINED
4. AUTOMATIC STOP ORDERS MUST BE POSTED AT EACH NURSES STATION

MEDICATIONS WILL BE AUTOMATICALLY STOPPED AS FOLLOWS

1. ANALGESICS 30 DAYS
2. ANTIANEMICS 30 DAYS
3. ANTIBIOTICS (ORAL & PARENTERAL) 10 DAYS
4. ANTIEMETICS 30 DAYS
5. ANTIHISTAMINES 30 DAYS
6. BARBITURATES 30 DAYS
7. CARDIOVASCULAR 30 DAYS
8. CATHARTICS 30 DAYS
9. CENTRAL NERVOUS SYSTEM STIMULANTS 30 DAYS
10. COUGH & COLD PREPARATIONS 30 DAYS
11. DIURETICS 30 DAYS
12. HYPNOTICS 30 DAYS
13. NARCOTICS 30 DAYS
14. PSYCHOTHERAPEUTIC AGENTS 30 DAYS
15. SEDATIVES (NON-BARBITURATES) 30 DAYS
16. SULFONAMIDES 30 DAYS
17. VITAMINS 30 DAYS
18. DRUGS WHOSE DOSAGE DEPENDS ON LABORATORY RESULTS SUCH AS ANTICOAGULANTS, ANTIDIABETICS, ETC., ARE RECORDED AND MEDICATIONS ADJUSTED AS ORDERED.
19. ALL OTHER DRUGS WILL BE AUTOMATICALLY STOPPED AFTER 30 DAYS
HIDDEN ORDERS

1. Drugs that have been administered outside of the facility  
   (Emergency Room visit, Dental visits, Specialist appointments)

2. Drugs that may be administered during a procedure in the facility but not  
   documented in the patient’s chart (example: Lidocaine w Epi)

3. Drugs that may be part of a bundled procedure such as a Prep kit for a colonoscopy

4. Drugs that may be used as part of a protocol but not individually documented  
   on the chart.

When the clinical picture does not match the side effect profiles of medications on the patient’s  
chart, the consultant should:

1. Review the drugs in the cart to make sure that they were filled correctly  
2. Review the MAR and Treatment sheet to see if all medications are documented  
3. Look at PRN medication use  
4. Rule out the possibility that a wrong medication was administered  
5. Look for Hidden orders
HOSPITAL

Medication orders in the hospital

1. Medication orders (§482.23)

   a. All medication orders, (except influenza and pneumococcal polysaccharide vaccines), must be
documented and signed by a practitioner who is authorized by hospital policy, and in
accordance with State law, to write orders and who is responsible for the care of the patient.

   b. Influenza and pneumococcal polysaccharide vaccines may be administered per physician-
approved hospital policy after an assessment of contraindications.

   c. Standing orders

Hospitals may adopt policies and procedures that permit the use of standing orders to address
well-defined clinical scenarios involving medication administration.
   • The policies and procedures must address the process by which a standing order is
developed; approved; monitored; initiated by authorized staff; and subsequently
authenticated by physicians or practitioners responsible for the care of the patient.
   • The specific criteria for a nurse or other authorized personnel to initiate the execution
of a particular standing order must be clearly identified in the protocol for the order,
i.e., the specific clinical situations, patient conditions or diagnoses in which initiating the
order would be appropriate.
   • Policies and procedures must address the education of the medical, nursing, and other
applicable professional staff on the conditions and criteria for using standing orders and
the individual staff responsibilities associated with their initiation and execution.
   • An order that has been initiated for a specific patient must be added to the patient’s
medical record at the time of initiation, or as soon as possible thereafter.
   • Policies and procedures must specify the process whereby the physician or other
practitioner responsible for the care of the patient acknowledges and authenticates the
initiation of all standing orders after the fact, with the exception of influenza and
pneumococcal polysaccharide vaccines, which do not require such authentication in
accordance with §482.23(c)(2).
   • Establish a process for monitoring and evaluating the use of standing orders, including
proper adherence to the order’s protocol. There must also be a process for the
identification and timely completion of any requisite updates, corrections,
modifications, or revisions.
   • Medical staff, nursing, and pharmacy must approve written and electronic standing
orders, order sets, and protocols. Orders and protocols are to be based on nationally
recognized and evidence-based guidelines and recommendations. Nurses can initiate
approved standing orders/protocols in certain circumstances prior to getting the patient
specific order.
d. Physician Approved Protocol (PAP)

A set of pre-approved patient care instructions that require a specific medical order in the patient’s medical record prior to implementation. Example: Pharmacy Pharmacokinetic Physician Approved Protocol.

- Provider must order PAP prior to initiation of components
- Orders executed as a component of the PAP must be written in the medical record
- No requirement for provider co-signature of orders

2. Each order page must be signed and dated.

3. **Hospital policy defines WHO can write orders**

- Medical Staff Categories
  - Physicians (including Hospitalists)
  - Dentists
  - Podiatrists
  - Medical Staff Extenders
    - PA
    - ARNP
    - CRNA
    Unless required by hospital policy, does not need a countersignature prior to implementing orders
- Must have a mechanism to verify DEA and any restrictions

4. Verbal and Telephone Orders

a. Define in hospital policies who can give and receive medication orders
b. Who can give – whomever is authorized to prescribe
c. Who can receive a verbal or telephone order. Examples include:
   i. Pharmacists, Nurses – any order
   ii. Dieticians – food orders
   iii. Respiratory Therapists – related to respiratory care
d. Are minimized whenever possible
e. Immediately write down and “read back” to verify (NOT REPEAT)
f. The CMS requirement for authentication of verbal orders within 48-hours has been deleted. The authentication timeframe should be based on state law and surveyors will survey to the organization’s policy (related standard RC.02.03.07 EP 4).
5. Preprinted orders – develop mechanism for pharmacist approval
   a. CHALLENGE to keep current and eliminate use of old versions
   b. Use ISMP safe order writing guidelines
   c. Do not abbreviate drug names
   d. Assure appropriate drug use (including Formulary medications)
   e. Must be regularly reviewed and updated by the organization

6. Any restrictions on who can write defined in policy (e.g., use of new antibiotic restricted to an infectious disease physician, chemotherapy must be written on chemotherapy order form)

7. Circumstances medication order automatically discontinues and process to reinstate must be approved by the medical staff.
   a. Post-operatively new orders must be written.
   b. CANNOT write “resume medication” orders.
   c. Automatic Drug Stop Orders.
      i. Can be a HARD stop as defined in policy.
      ii. CMS (Medicare Condition of Participation): §482.25 (b) (5) drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is predetermined by the medical staff.
      iii. Must be approved by the medical staff.
      iv. Evaluate need – may cause more harm than good
    v. Examples include:
       1. Parenteral nutrition – 24 hour (daily order)
       2. Antibiotics – 7 days unless otherwise indicated
       3. Transfer levels of care – only if required by hospital policy

8. Range orders – must have consistency in interpretation between care givers. Example: Tylenol 325 mg 1-2 PO or PR q 4-6 h PRN temperature >101F.

9. **PRN orders must clearly indicate reason.** Cannot have multiple medications with same reason such as both Tylenol and morphine “PRN pain”.

10. Medical Residents may be unlicensed (TRN or UO) using institution’s DEA and unique suffix

11. Prescription pads – tamper resistant paper, control to prevent diversion

14. Order Authentication – (May 16, 2012): **Authentication of orders**: CMS made permanent its temporary requirement that all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner responsible for the patient’s care who is authorized to write orders (related standards RC.02.03.07 EP 4 and RC.01.02.01 EP 4).
POLICY NUMBER: CP02.058
CATEGORY: Patient Care

TITLE: Medication Orders

POLICY: Hospital departments shall honor only those patient orders for medications that are supported by a signed electronic order or a signed written order when appropriate.

For inpatients, all orders, including verbal/telephone orders, pre-printed orders and Physician Approved Protocols must be authenticated by a credentialed medical staff member, fellow, resident, or by a nurse practitioner (ARNP/CRNA/CNM), physician assistant (PA) or dentist acting within the scope of his/her approved clinical privileges. Verbal/telephone orders may be given and authenticated in the inpatient setting under specific guidelines outlined in this procedure.

Orders written by medical students cannot be executed without the co-signature of a physician.

PURPOSE: To establish guidelines for clearly and completely communicating and recording medication orders necessary for treatment to be delivered in a safe and efficient.

PROCEDURE:

I. Medication orders:

   A. Medication orders must be legible and contain the following information to be considered complete:

      1. Patient name
      2. Patient’s designated medical record number or account number, if one has been assigned.
      3. Signature of prescriber, including date and time.
      4. If the order is not clear or is incomplete, the ordering physician or other authorized individual needs to be contacted for clarification prior to carrying out the order.

   B. Abbreviations

      1. Abbreviated drug names should be avoided.
      2. Abbreviations on the “Unsafe Abbreviations” list should not be carried out until clarified by the healthcare professional responsible for implementing the order.

   C. Order Clarification

      1. The healthcare professional responsible for implementing the order shall not carry out orders that are not complete, potentially contain an error, or are illegible.
II. Written Orders

Written orders should be utilized only in the following situations during EMR downtime, preventing electronic ordering.

III. Verbal / Telephone Orders

A. Orders may be given via telephone when the ordering practitioner is not able to place the order and a delay in executing the order would compromise patient care.

B. Verbal orders may be given in person by the ordering practitioner only in an emergent situation or during sterile procedures where ungloving may be impractical.

C. Verbal/telephone orders may be taken only by a licensed or registered healthcare professional within their scope of practice and related to the area of professional responsibility.

D. When a verbal/telephone order is taken, the healthcare professional receiving the order shall record the following:

   1. Date and time;
   2. Patient name;
   3. Patient identification number; only if the number is not already indicated;
   4. Complete order (as outlined above in II.B.1-7); and
   5. Name and identifying information of the ordering practitioner, by first and last name, or last name and provider number.

H. The prescribing practitioner should spell out the drug name when pronunciation of the drug is difficult or likely to be misinterpreted (e.g. xanax versus zantac; ceftazadine versus cefazolin).

I. The dosage should be stated in metric units and numerically (e.g. say “one five – fifteen mg” because “fifteen” is frequently heard as “fifty”).

J. The verbal/telephone order shall then be read-back to the ordering practitioner by the healthcare professional receiving the order to verify the accuracy of the transcription. No verbal/telephone order may be executed until the order is read-back to the ordering practitioner and is confirmed.

K. The verbal/telephone order shall be authenticated, timed and dated by the practitioner giving the order within 72 hours, except in the following circumstances:

L. Verbal/telephone orders will not be accepted for cancer chemotherapy, or total parenteral nutrition orders, but may be accepted for order clarification.
VII. Order Sets

A. Definition – An Order Set is a pre-defined group of specific orders for a particular diagnosis, procedure or medication use from which the provider may select diagnosis or treatment options. Order sets are found in the EMR and may include hard copy orders for areas not using the EMR.

B. Order sets should be reviewed by the medical staff and approved by the facility’s Evidence Based Order Set Committee and Forms Committee as appropriate prior to use. All order sets should follow the approved format.

C. Only medications listed in the Formulary may be listed in order sets.

D. Orders sets may not include any unsafe abbreviations.

E. PRN orders with time ranges are not allowed on order sets.

VIII. “Stat” or Now Medication Orders

A. The medical staff should notify the RN of all STAT or NOW orders.

B. STAT and NOW medication orders are implemented as soon as possible, based on patient need, within 60 minutes of receipt of the written or electronic order.

IX. Change/Cancellation/Resume/Renew

A. The attending physician or his/her designee is responsible for determining when the existing orders no longer meet the patient’s needs and shall modify the orders as indicated.

B. Orders for blanket reinstatement such as “resume”, “renew”, or “continue previous orders” will not be accepted.

C. Medical orders must be reconciled or modified following surgery, when a patient is transferred to another level of care, when a patient is transferred to another service or upon delivery of maternity patient.

X. Additional Instructions

A. Medication Orders shall include:

1. Name of medication, dose, route, and frequency; as applicable

2. Generic name of the medication (preferred), or brand name of medication.

3. Dosage of medication, expressed in metric units. Pediatric doses should be written as a weight based dose to be administered and include the method of determining that dose, e.g. metric units per meter squared (m² when applicable). Pediatric doses must be written
as weight-based for cancer chemotherapy and neonatal TPN base components and electrolytes.

B. Other considerations:

1. Standard medication concentrations should be used when possible.

2. Medications should be ordered by dosage for single ingredient products if appropriate (acetaminophen 500mg versus acetaminophen 2 tablets).

3. For each medication, there shall be a diagnosis, condition, or reason documented in the patient's medical record.

C. Patient Specific Information

1. The minimum amount of information about the patient that is to be available to those involved in medication management includes the following:
   a. The patient’s age
   b. The patient’s gender
   c. The patient’s current medications
   d. The patient’s diagnoses, co-morbidities, and concurrently occurring conditions
   e. The patient’s relevant laboratory values
   f. The patient’s allergies and past sensitivities
   g. The patient’s weight and height in metric units
   h. Pregnancy and lactation status
   i. Prior to admission medications or for areas not on the EMR, the Home Medication Profile

2. All healthcare professionals placing medication orders, dispensing medications, and/or administering medications shall have ready access to patient specific information in order to minimize medication errors.

D. Hold Orders

1. Physician orders to "hold" a medication will be honored for one dose only. Medications orders with specific hold parameters (e.g. hold Digoxin if pulse is below 60) are honored.

2. Any other “hold” order for medication will be treated as a discontinuation of the medication(s) and will require a complete reorder of the medication.
E. Range Orders

1. Orders for dosage ranges are acceptable and will be interpreted as follows:

   a. Individual patient dose to be administered will be within the order range and appropriate to the severity of symptoms.

   b. The patient's input related to medication, dose and route of administration will be considered.

   c. Patient factors will be considered in selecting dose and time interval, including patient age, potential medication reaction (e.g. if patient has received sedatives, sleep agents), current physical condition impacting choice (i.e. stage of labor, liver, renal disease, or a change in mental status). These factors may include:

      i. Pain intensity (as determined by self-report, behavioral assessment and/or physiologic parameters)

      ii. Hypertension/hypotension

      iii. Body temperature

      iv. Other patient complaints or clinical assessment as appropriate

   d. Patient reassessment for symptom relief and potential side effects will be done and documented within a reasonable time frame based on onset of action for the medication and route of administration.

   e. If symptom relief is not obtained and the maximum dose of the order has not been administered; the dose may be titrated up to achieve relief as long as the maximum dose within the order time frame is not exceeded.

   f. The next dosing of the PRN medication will take into account severity of symptoms and the patient’s response to the previously administered doses. The dosage will be adjusted accordingly, for administration at the next time interval. For example: Oxycodone 5-15 mg every 4 hours PRN Pain. If the patient received 10 mg of oxycodone for a pain score of 7 in the final hours of a prescribed dose interval, consider this when starting a new dose time interval. For example, if 10mg of oxycodone was administered at 11am and the new interval begins at noon and the patient still has pain requiring analgesia, consider that previous dose when giving the next dose. If however, the dose was administered 1/2 hour prior to the new interval, wait another 30 minutes before re-dosing to give the previous dose time to take effect.

2. PRN orders with time ranges are strongly discouraged and are not allowed on order sets. Orders for a time range will be indicated at the shortest time interval, e.g. every 4-6 hours PRN will be interpreted as every 4 hours PRN.
F. Automatic Stop Orders

1. The Pharmacy & Therapeutics/or appropriate facility Committee will determine those drugs that require an automatic stop order.

2. All medication orders greater than 60 days must be reviewed and if appropriate, discontinued by a practitioner.

G. “As Needed” (PRN) Orders

1. The indication for all “as needed” medications should be included as part of the medication order.

2. Multiple “as needed” medications ordered for the same indication, must include specific prioritization instructions to nursing staff by the ordering practitioner.

H. Titrating/Tapering Orders

Medication orders, in which the dose is either progressively increased or decreased by a particular amount, must include all elements listed in section I of this policy. In addition, the order should include, as appropriate:

1. Specific instructions as to the amount of drug to increase or decrease.

2. The specific parameter being monitored (e.g. – blood pressure; heart rate), if applicable.

3. The specific interval for the increase or decrease (e.g. – after each dose; times X doses).

4. The specific dosage increase or decrease (e.g. – 2 mg BID for 3 days, then 1 mg BID for 1 day, etc.).

5. Any patient parameter that may change the titration or taper schedule.

I. Contingency Orders

1. Must have an objective parameter on which the contingency is based, and must have clear objective instructions based on the outcome of the specified parameter (e.g. Give oral potassium 20mEq if potassium level is less than 3mEq).
**Adult Patient Controlled Analgesia Orders**

(All orders with a ☐ must be checked to activate. All orders with a ☑ are activated.)

1. **PCA Orders:**

- Select agent and complete information below.
- These orders will supersede any previous standing orders for agents selected below.
- No IM, IV, or PO analgesics or sedatives unless otherwise indicated by prescriber / service ordering PCA.
- Notify prescriber / service if the maximum dose is reached prior to the 4-hour time limit and pain persists.
- If "Continuous / Basal Rate" is initiated with PCA, must indicate "around-the-clock" or "nightly" as outlined below.
- All orders with a ☐ must be checked to be activated.

<table>
<thead>
<tr>
<th>Parameters</th>
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<th>Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Morphine</td>
<td>Hydromorphone (DLAUDID)</td>
<td>Fentanyl</td>
</tr>
<tr>
<td></td>
<td>(concentration = 1 mg/(mL)</td>
<td>(concentration = 0.2 mg/(mL)</td>
<td>(concentration = 10 mcg/(mL)</td>
</tr>
<tr>
<td>Initial Loading Dose / Bolus</td>
<td>0.1 - 10 mg</td>
<td>0.2 - 0.8 mg</td>
<td>20 - 40 mcg</td>
</tr>
<tr>
<td>PCA Dose</td>
<td>0.1 - 2 mg</td>
<td>0.1 - 0.3 mg</td>
<td>5 - 20 mcg</td>
</tr>
<tr>
<td>Lookout Interval</td>
<td>5 - 10 min</td>
<td>5 - 10 min</td>
<td>4 - 8 min</td>
</tr>
<tr>
<td>One-Hour Limit</td>
<td>5 - 15 mg</td>
<td>0.5 - 3 mg</td>
<td>50 - 150 mcg</td>
</tr>
<tr>
<td>Continuous / Basal Rate*</td>
<td>0.1 - 5 mg/hr</td>
<td>0.1 - 1 mcg/hr</td>
<td>10 - 50 mcg/hr</td>
</tr>
<tr>
<td>Breakthrough Pain</td>
<td>2 - 5 mg IV q6hr PRN</td>
<td>1 - 2 mg IV q6hr PRN</td>
<td>10 - 25 mg IV q6hr PRN</td>
</tr>
</tbody>
</table>

* Higher PCA concentrations may be used in patients with very high opioid requirements. Contact pharmacy for more information.

* If basal rate is ordered, start at the following "initial" settings: morphine = 0.5 mg/hr; hydromorphone = 0.2 mg/hr; fentanyl = 10 mcg/hr, unless otherwise specified.

**NOTE:** Metabolites of morphine and hydromorphone may accumulate in patients with renal dysfunction. Dosing adjustments are often necessary in these patients. Contact pharmacy for dosing assistance if needed.

3. **Patient Monitoring:**

- check these parameters (vital signs, pain scale, sedation scale, and oxygen saturation) at the following schedule:
  - upon initiation of PCA, q2hr x 2 after PCA initiation, then q4hr for the duration of therapy.
- Pulse oximetry monitoring is required for PCA with basal infusion of any opioids.

4. **Supplemental Medications:**

- If respiratory rate less than 8, stop PCA; mix naloxone (NARCAN) 0.4 mg in 10 mL of NS in a syringe. Give 0.02 mg

(0.5 mL) IV slowly over 2 minutes. If no response within 1 - 2 minutes, repeat dose (to a total of 0.8 mg or 20 mL).


- If nausea and/or vomiting occur:
  - Give promethazine (PHENERGAN) 6.25 - 12.5 mg PO or IV q6hr PRN.
  - Other:
  - If pruritus occurs, give diphenhydramine (BENADRYL) 25 mg PO or IV q6hr PRN.

5. **Supplemental Analgesia:**

- keterolac (TORADOL) 15 mg IM/IV q6hr for 48 hours PRN pain (for patient 66 years and over), or for patients with renal insufficiency, maximum = 60 mg in 24 hours.
- Other:

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<tr>
<th>Pharmacy Use Only: 067795-B-1</th>
<th>Patient Name: Patient Identification #:</th>
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Physician's Orders (page 1 of 1)

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