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
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
NURSING HOME

SAMPLE POLICY & METHODS

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:

<table>
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<tr>
<th>Telephone Order:</th>
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<tr>
<td>Child’s Name:</td>
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PRN ORDERS  * FILL IN DOSAGE

MEDICATION OR TREATMENTS

ACETAMINOPHEN SOLN 160MG/5CC
* BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN OR RECTAL TEMP OVER 101F – MAXIMUM 2 DAYS

GLYCERIN SUPPOSITORIES -INFANT
1 SUPP RECTALLY ON 3RD DAY IF NO BOWEL MOVEMENT

SUDAFED SYRUP
ONE TEASPOONFUL BY MOUTH FOUR TIMES A DAY AS NEEDED FOR NASAL CONGESTION – MAXIMUM 2 DAYS

VINEGAR & PEROXIDE 50/50 MIXTURE
2-4 DROPS IN EACH EAR FOR MONTHLY EAR CLEANING

DELSYM SUSPENSION
*_____ TEASPOONFULS BY MOUTH TWICE A DAY AS NEEDED FOR COUGH MAXIMUM 2 DAYS

FLEET PEDIATRIC ENEMA
RECTALLY ON 5TH DAY IF NO BOWEL MOVEMENT

HYDROGEN PEROXIDE 3%
TO MINOR SKIN WOUNDS AFTER SOAP & WATER AS NEEDED FOR CLEANSING

WHITE’S A&D OINTMENT
TO DIAPER RASH WITH EACH DIAPER CHANGE. MAXIMUM 6 TIMES DAILY

NEOSPORIN OINTMENT
TO MINOR SKIN WOUNDS AFTER CLEANSING DAILY

CALAMINE LOTION
TO INSECT BITES UP TO FOUR TIMES A DAY

KAOPECTATE SUSP
TWO TABLESPOONFULS BY MOUTH AFTER EACH LOOSE (WATERY) BOWEL MOVEMENT UP TO 24 HOURS

BETADINE SOLUTION
TO MINOR SKIN WOUNDS AFTER SOAP AND WATER AS NEEDED FOR CLEANSING

DATE      PHYSICIAN’S SIGNATURE

MEDICAL SPECIALIZATION: _________________________________
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.
### MEDICATION ORDERS

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### OTHER ORDERS

- **ANCILLARY**
  - NONE:
  - PHYSICIAN:
  - ALLERGIES:
  - DIAGNOSIS:

- **DIET**
  - YES NO INDECENT LIBERTY FOR SPECIAL OCCASIONS
  - YES NO ALCOHOLIC BEVERAGE AT SPECIAL OCCASIONS

- **SUPPLEMENTS**
  - YES NO ORAL NUTRITION FOR SPECIAL OCCASIONS

- **ENTERAL FEEDINGS**
  - YES NO INTRAVENOUS ORAL FEEDING
  - YES NO GASTRIC FEEDING
  - YES NO VENOUS FEEDING
  - YES NO ORAL DILATION FEEDING

- **PUMP OR BOLUS**
  - YES NO INTRAVENOUS ORAL FEEDING
  - YES NO GASTRIC FEEDING
  - YES NO VENOUS FEEDING
  - YES NO ORAL DILATION FEEDING

- **CHECK PLACEMENT OF FEEDING TUBE BEFORE DURING DURING AND AFTER MEDICATION ADMINISTRATION**
  - YES NO INTRAVENOUS ORAL FEEDING
  - YES NO GASTRIC FEEDING
  - YES NO VENOUS FEEDING
  - YES NO ORAL DILATION FEEDING

- **PLAN OF TREATMENT**
  - CONTINUED NEXT PAGE

- **PHYSICIAN SIGNATURE**: 
- **DATE**: 

- **CODE**: UNKNOWN
  - DIAGNOSIS NOT SPECIFIED

- **AMEND**: VERIFY ALLERGIES

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16.7
NURSING HOME

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
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 Postsed 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
MEDICATION ORDERS IN THE HOSPITAL

1. Medication orders(§482.23(c)(2))
   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 *(Updated and effective December 22, 2011)*

      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. Likewise, standing order 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).

      The policies and procedures must also 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.

      **May 16, 2012 - Standing orders**: CMS has added a requirement for medical staff, nursing, and pharmacy to 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 (related standard MM.04.01.01). Nurses can initiate approved standing orders/protocols in certain circumstances prior to getting the patient specific order. The Joint Commission is developing an FAQ related to this issue.

2. Each order page must be signed and dated.

3. Who can write orders (defined by hospital – MUST have privileges)
♦ Medical Staff Categories
  ▪ Physicians (including Hospitalists)
  ▪ Dentists
  ▪ Podiatrists
  ▪ Medical Staff Extenders (non-licensed independent practitioners)
    ➢ PA (refer to 1970 Attorney General Opinion Letter)
    ➢ ARNP
    ➢ CRNA
  Unless required by hospital policy, does not need a countersignature prior to implementing orders

♦ Mechanism to verify DEA and any restrictions
♦ Prevent imposters

64B8-30.008 Formulary.
(1) PHYSICIAN ASSISTANTS APPROVED TO PRESCRIBE MEDICINAL DRUGS UNDER THE PROVISIONS OF SECTION 458.347(4)(e) OR 459.022(4)(e), F.S., ARE NOT AUTHORIZED TO PRESCRIBE THE FOLLOWING MEDICINAL DRUGS, IN PURE FORM OR COMBINATION:
  (a) Controlled substances, as defined in Chapter 893, F.S.
  (b) General, spinal or epidural anesthetics.
  (c) Radiographic contrast materials.
(2) A supervising physician may delegate to a prescribing physician assistant only such authorized medicinal drugs as are used in the supervising physician’s practice, not listed in subsection (1).
(3) Subject to the requirements of this subsection, Sections 458.347 and 459.022, F.S., and the rules enacted thereunder, drugs not appearing on this formulary may be delegated by a supervising physician to a prescribing physician assistant to prescribe.
(4) Nothing herein prohibits a supervising physician from delegating to a physician assistant the authority to order medicinal drugs for a hospitalized patient of the supervising physician, nor does anything herein prohibit a supervising physician from delegating to a physician assistant the administration of a medicinal drug under the direction and supervision of the physician.


4. Pharmacist must review original order (NCR copy, FAX, scanned, physician order entry)
  o MM 05.01.01 Pharmacists review each prescription or order for medication and contact the prescriber or orderer when questions arise (except when a licensed independent practitioner [LIP] with appropriate clinical privileges controls prescription or ordering, preparation, and administration, as in endoscopy or cardiac catheterization laboratories, surgery, or during cardiorespiratory arrest, and for some emergency orders when time does not permit)
Medicare COP §482.25 (b) Standard: Delivery of Services: All medication orders (except in emergency situations) should be reviewed for appropriateness by a pharmacist before the first dose is dispensed.

5. Verbal and Telephone Orders – defined in medical staff policies
   ♦ define in hospital policies who can give and receive medication orders
   ♦ who can give – whomever is authorized to prescribe
   ♦ who can receive (examples)
     Pharmacists, nurses – any order
     Dieticians – food orders (including TPN?)
     Respiratory Therapists – related to respiratory care
   ♦ Are minimized whenever possible
   ♦ Immediately write down and “read back” to verify (NOT REPEAT)
   ♦ **Verbal orders**: 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). Organizations in the process of changing the timeframe due to the CoP revision will not be scored on this standard.

6. Preprinted orders – develop mechanism for pharmacist approval
   CHALLENGE to keep current & eliminate use of old versions
   ♦ Use ISMP safe order writing guidelines - Patient Safety
   ♦ Do not abbreviate drug names
   ♦ Assure appropriate drug use (including Formulary medications)
   ♦ Use is recommended by CMS
   ♦ Must be regularly reviewed and updated by the organization
   ♦ AVOID Standing Orders – use preprinted ORDER instead
     EXAMPLES: ICU admission orders, PCA order form, chemotherapy order form, TPN order form, treatment of community acquired pneumonia order form, Xigris order form, etc.

7. Hidden orders – need a policy
   ♦ Protocol for radiology exam [BE, IVP] when ordered also includes a bowel prep unless otherwise requested by the prescriber

8. 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)
9. Circumstances medication order automatically discontinues and process to reinstate must be approved by the medical staff
   ♦ Post-operatively new orders must be written
   ♦ CANNOT write “resume medication” orders
   ♦ Automatic Drug Stop Orders
     ▪ Can be a HARD stop as defined in policy
     ▪ 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.
     ▪ Must be approved by the medical staff
     ▪ Evaluate need – may cause more harm than good
     ▪ Examples
       o Parenteral nutrition – 24 hour (daily order)
       o Antibiotics – 7 days unless otherwise indicated
       o Transfer from ICU to any other unit – only if required by hospital policy

10. 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 (dose range, route range, frequency range)

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

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

13. 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).
SAMPLE ORDER WRITING POLICY:

POLICY
Standards for writing medication orders are used by practitioners at sample hospital. Pharmacists and nursing staff contact the prescriber to clarify orders that are unclear.

PROCEDURE

A. Writing Medication Orders

1. Prior to writing any medication order, prescribers should verify that the medication is available on the formulary, if applicable.

2. The patient's medication profile and medical record (e.g., relevant laboratory values such renal and hepatic function, height and weight, age, pregnancy/lactation status, etc.) should be reviewed prior to writing any medication orders. This will decrease the likelihood of any drug-drug or drug-disease interactions. Practitioners should also verify patient allergy information and past sensitivities.

3. Only medications needed to treat the patient's condition are ordered.

4. Medication orders are written clearly.
   a) Prescribers should review all drug orders for accuracy and legibility immediately after they have been written and prior to sending them to the pharmacy.
   b) Care must be exercised when using decimal points.
      (1) Never use a zero after a decimal point. Use 1 mg, not 1.0 mg, since the later may be misinterpreted as 10 mg.
      (2) Always use a zero in front of a decimal point. Use 0.5 ml, not .5 ml, since the later may be misinterpreted as 5 ml.
      (3) Avoid the use of decimal points whenever possible. For example, use 125 mcg instead of 0.125 mg.
   c) Abbreviations should be avoided in all possible circumstances in order to improve patient safety and avoid medication errors.
   d) Medication orders should be written in legible handwriting preferably printed.
   e) Felt-tip pens and pencils should not be used to write medication orders.
   f) Chemical drug names (6-MP, AZT) and investigational names should not be used when writing medication orders.
   g) Do not use any coined names for drug preparations or cocktails not commercially available (e.g., yellow bag, SMOG enema, GI cocktail, etc.) unless otherwise described in approved procedures. These types of orders should state exactly what the prescriber wishes the preparations to contain in order to avoid medication errors. (Note: "Magic Mouthwash" is an approved compound at NFRMC with procedures defining its ingredients).
Drug names should not be abbreviated as they may not be recognized or they may be misinterpreted or confused with another similar abbreviation. For example MgSO4 (magnesium sulfate) and MSO4 (morphine sulfate) should never be used. (Reference policy 900-2.210 Abbreviations, Unacceptable).

i) Avoid vague directions such as “use as directed”.

j) To minimize the opportunity for errors with look-alike and sound-alike medications, prescribers are encouraged to supply the indication for medications that look-alike and/or sound-alike. The use of preprinted orders when available is also encouraged.

k) Use proper spacing when writing orders. For example, propranolol20mg can appear to read as propranolol 120 mg.

l) Include all necessary suffixes (such as XL, EC, XR, etc.) in order to ensure that the intended dosage form is dispensed.

m) The use of slashes (/) should be avoided in medication orders as they can be misread as ones.

n) All weights and volumes should be expressed in the metric system. The apothecary system (grains, drams, minims) should not be used.

o) Avoid prescribing the dose of liquids in terms of milliliters, if possible. Instead indicate the dose in milligrams (or as appropriate). As an example, acetaminophen (Tylenol) 5ml is an incomplete order, as the dose is not clearly indicated; the Tylenol is available in several concentrations.

p) Write out the dose in numerals, if applicable. For example write “2 tablets” instead of “ii tablets”.

q) Avoid ordering medications by their dosage form (1 amp, 1 vial, 1 tablet, etc.). The order is unclear if several strengths are available.

r) Indicate the total dosage to be administered rather than mg/kg unless an approved procedure exists to further define these orders (for example, an approved procedure exists for enoxaparin [Lovenox] rounding doses). For pediatric patients, the order should include both the mg/kg and the total dosage.

s) Use standardized administration times whenever possible

t) Include the desired stop dates when applicable.

u) Use hospital-approved preprinted order forms whenever applicable (e.g., heparin protocol, chemotherapy order form, parenteral nutrition order form, PCA order form etc.)

5. All medication orders should include the following:
   a) Patient's name and medical record or account number
b) Patient's allergies or sensitivities

c) **Generic or brand name** and **dose** of the drug.

d) Dosage form of the drug

e) Directions on **route** and **frequency** of administration

f) Duration of therapy (specify if it is a one time order)


g) These requirements also apply to orders for medication-related devices (e.g., nebulizers and catheters).

h) Signature of the prescriber with printed name if unclear

i) Date and time that the order was written

j) (Bolded items [also marked with an “**”] indicate the minimum required for a medication order. Orders that do not contain these elements cannot be carried out until completed by the physician

6. PRN orders must include (1) Frequency and (2) Reason. For example: Acetaminophen (Tylenol) orders must indicate the PRN reason such as “for pain” or “for a fever or temperature > XXX”. A list of presumed indications, approved by the P&T Committee, will be used in cases where the prescriber has not given an indication. See Appendix A.

7. Range Orders: Nurses, pharmacists and other care providers will apply the following guidelines for consistent interpretation of range orders.

   a.) Orders indicating a **dosage** range will begin with the smallest dose being administered. The medication is reassessed at a time frame appropriate for the route of administration, and if needed, the remainder of the next higher dose may be administered. For subsequent doses, the total amount administered to obtain relief may be given. For PACU patients the pain algorithm is followed.

   For example, it may be appropriate to reassess an IV administered medication in 15-30 minutes and a rectal, IM or orally administered medication in 30-60 minutes.

   For example, “XX 1-2 tablets every 4-6 hours as needed for pain” – the nurse may administer one tablet and if the patient's pain is not relieved after a suitable assessment period an additional tablet may be administered. For subsequent doses, 2 tablets may be administered at the appropriate time interval.

   b.) Orders indicating a **frequency** range will automatically be interpreted as the shortest frequency being allowable for “as needed” orders unless it conflicts with the maximum daily dosage of that medication.

   **Examples:**

   “Percocet-5 1 tablet every 4-6 hours as needed for pain” – doses may be administered as frequently as every four hours. The order is interpreted as “every 4 hours PRN”.

   “Hydrocodone/APAP 5/500 1-2 tabs po q4-6h PRN” – giving 2 tabs (1000 mg) 6 times per day (q4h) would exceed the recommended maximum acetaminophen dose of 4000 mg/day. In this case the order is interpreted as “every 4 hours PRN” and a message would be placed on the MAR, which indicates the maximum dose to administer.
8. Orders for continuous infusions include the following:
   a) Initial dose if any
   b) Dose in units/time: for example ml/hr or mg/kg/hr
   c) Objective or measurable parameters by which to change or titrate the dose within a
      specified range (refer to number 11, below). Orders such as titrate morphine to
      comfort are not acceptable.

9. Cancellation of Previous Orders - All previous orders are canceled when patients go to
   surgery or are transferred to or from a special care unit. New orders must be written
   once a patient is accepted to a new unit. Orders for blanket reinstatement of previous
   orders (such as “resume pre-op meds” or “resume home meds”) are not acceptable and
   must be clarified with the prescriber and new orders written.

10. Taper orders – Orders for tapering of medications must include the dosing limits for
     tapering the medication and the time factors required to achieve the desired clinical state
     for the patient. Tapering requirements for commercially available taper medications
     (e.g., Medrol DosePak® and Z-Pak®) will be detailed on the medication administration
     record with the medication dispensed in unit-dose packaging from the pharmacy
     department.

11. Titration orders - Orders for medications that require titration must include the desired
     state the prescribing physician wants for the patient (for example titrate medication to
     achieve blood pressure of __/__). Dosage adjustment increments must be known
     before titrating medication to allow clinical staff to determine how much to increase or
     decrease the medication as attempts are made to achieve “ordered state” for the patient.
     Titration increments may vary depending on the patient’s clinical status, co morbid
     conditions and other factors. The frequency of dose adjustments will vary with upward
     and downward adjustments generally being unequal.

12. Hold orders: Hold orders must specify a specific time period or number of doses in which
     to hold the medication otherwise the medication order will be discontinued.

13. Do not order Herbal medications.

14. Investigational medications: An attempt will be made to continue a patient's participation
     in an investigational drug study when the patient is admitted to the hospital unless
     otherwise contraindicated. The Principle Investigator will be contacted to obtain
     information about the medication and to answer any staff questions. The patient’s
     attending physician will order the continuation of the investigational medication once an
     assessment has been made that the patient should continue on the investigational drug.

15. The prescriber is expected to write his/her own medication orders. Verbal and telephone
     orders should be minimized whenever possible. Verbal orders should be reserved for
     emergency situations or when ungloving is unpractical.

16. Medications to be continued after discharge must be written as a prescription by an
     authorized practitioner following applicable state and federal regulations. Document
     discharge prescriptions written for the patient in the patient’s medical record.
     Medications previously dispensed to the patient for hospital use are not given to the
     patient.
B. **Contacting the Prescriber for Clarification**

If the medication order is written in such a way as to create a potential for medication error (such as incomplete, illegible, or unclear), or there are questions about the appropriateness or other circumstances that could have an adverse outcome on the patient, the nurse or pharmacist receiving the order is responsible for contacting the prescriber for clarification prior to administering / dispensing any doses of the medication. Reference policies: Medical Staff Rules and Regulations, Dispensing and Labeling of Medications 900-1.432.03, 900-1.440.000 Medication Administration and Documentation.

C. **Modification of Written Medication Orders**

1. Orders should never be altered once completed.
2. To revise an order that has already been sent to the nurse / pharmacy, a new clarification order should be written.
3. If the order has not been sent to pharmacy, simply draw a single line though the error, write "void" or similar above the line and initial the order.
4. Do not erase or use “White Out” in the medical record.

D. **Standing Orders**

a. The Medical Executive Committee must approve all protocols and standing orders. When implemented, a notation must be documented in the medical record. For example, when the nurse implements the “Hypoglycemic Protocol” he/she writes a physician order to initiate the Hypoglycemic Protocol.

b. Standing orders are instructions for patient care under specific circumstances (e.g. ED orders for patients presenting with an acute MI, patients presenting in late labor). Non-LIP’s may be specifically trained and deemed competent by the Medical Staff to recognize the specific clinical circumstances in which the standing orders are to be activated prior to LIP approval.

c. Preprinted order sets designed to list all of the possible orders usually favored by a physician or group of physicians are approved by the Forms Committee and become patient specific orders only when completed and signed by the prescriber.

E. **Special Populations**

a. When writing chemotherapy or pediatric orders, dose/m² or dose/kg should always be used. In addition, the patient’s weight and/or height and the total calculated dose should be included.

b. Any chemotherapy or pediatric medication order should always be double-checked for calculation or dosing errors.
### APPENDIX

**PRESUMED INDICATIONS FOR PRN ORDERS**

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>INDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambien</td>
<td>Zolpidem</td>
<td>Sleep/Insomnia</td>
</tr>
<tr>
<td>Atrovent</td>
<td>Ipratropium</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>Cepacol Loz</td>
<td></td>
<td>Sore Throat</td>
</tr>
<tr>
<td>Chloraseptic Loz</td>
<td></td>
<td>Sore Throat</td>
</tr>
<tr>
<td>Colace/Surfak</td>
<td>Docusate</td>
<td>Constipation</td>
</tr>
<tr>
<td>Combivent</td>
<td>Albuterol/ Ipratropium</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>Compazine</td>
<td>Prochlorperazine</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>Davocet</td>
<td></td>
<td>Mild Pain</td>
</tr>
<tr>
<td>Demerol</td>
<td>Meperidine</td>
<td>Severe Pain</td>
</tr>
<tr>
<td>Dilaudid</td>
<td>Hydromorphone</td>
<td>Severe Pain</td>
</tr>
<tr>
<td>Dulcolax</td>
<td>Bisacodyl</td>
<td>Constipation</td>
</tr>
<tr>
<td>Fleet Enema</td>
<td></td>
<td>Constipation</td>
</tr>
<tr>
<td>Flexeril</td>
<td>Cyclobenzaprine</td>
<td>Muscle Spasm</td>
</tr>
<tr>
<td>Haldol</td>
<td>Haloperidol</td>
<td>Agitation</td>
</tr>
<tr>
<td>Imitrex</td>
<td>Sumatriptan</td>
<td>Migraine</td>
</tr>
<tr>
<td>Immodium</td>
<td>Loperamide</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Lomotil</td>
<td></td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Lortab</td>
<td></td>
<td>Moderate Pain</td>
</tr>
<tr>
<td>Maalox</td>
<td></td>
<td>Indigestion</td>
</tr>
<tr>
<td>Metamucil</td>
<td>Psyllium</td>
<td>Constipation</td>
</tr>
<tr>
<td>Milk of Magnesia</td>
<td>Magnesium Hydroxide</td>
<td>Constipation</td>
</tr>
<tr>
<td>Motrin</td>
<td>Ibuprofen</td>
<td>Mild Pain</td>
</tr>
<tr>
<td>Mylicon</td>
<td>Simethicone</td>
<td>Gas Pain/Bloating</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td></td>
<td>Chest pain</td>
</tr>
<tr>
<td>Phenergan</td>
<td>Promethazine</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>Percocet</td>
<td></td>
<td>Moderate Pain</td>
</tr>
<tr>
<td>Proventil</td>
<td>Albuterol</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>Relpax</td>
<td>Eleetroptan</td>
<td>Migraine</td>
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<tr>
<td>Restoril</td>
<td>Temazepam</td>
<td>Sleep/Insomnia</td>
</tr>
<tr>
<td>Robaxin</td>
<td>Methocarbamol</td>
<td>Muscle Spasm</td>
</tr>
<tr>
<td>Senakot S</td>
<td></td>
<td>Constipation</td>
</tr>
<tr>
<td>Pseudoephedrine</td>
<td>Sudafed</td>
<td>Congestion</td>
</tr>
<tr>
<td>Skelaxin</td>
<td>Metaxalame</td>
<td>Muscle Spasm</td>
</tr>
<tr>
<td>Soma</td>
<td>Carisoprodol</td>
<td>Muscle Spasm</td>
</tr>
<tr>
<td>Tylenol</td>
<td>Acetaminophen</td>
<td>Mild Pain or Temp above 101</td>
</tr>
<tr>
<td>Zanaflex</td>
<td>Tizanidine</td>
<td>Muscle Spasm</td>
</tr>
<tr>
<td>Zofran</td>
<td>Ondansetron</td>
<td>Nausea/Vomiting</td>
</tr>
</tbody>
</table>
August 25, 2010

Patricia A. Draper, Esq.
Meyer, Brooks, Demma and Blohm, P.A.
131 North Gadsden Street (32301)
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Tallahassee, Florida

Re: Physician Assistants Ordering Controlled Substances in Hospital Settings

Dear Ms. Draper:

Here we go again! I find it hard to believe that this issue is still out there and the misconception that physician Assistants (PAs) may not order controlled substances in hospital settings persists. As far as the Board of Medicine and the Council on Physician Assistants are concerned this has been a settled matter for quite some time.

I have read the July 8, 2010 scope of practice analysis authored by Ms. Jackie Gonzalez which cites to Ms. Maria Currier’s legal analysis on the question of whether PAs may order controlled substances in hospital settings and I respectfully disagree with its conclusion. The analysis inexplicably ignores Section 458.347(4)(e), Florida Statutes, the very statutory provision that addresses this issue.

Section 458.347(4)(e) reads in part as follows:

A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician’s practice unless such medication is listed on the formulary created pursuant to paragraph (f).

The provision goes on to set forth the circumstances under which a PA may prescribe legend drugs other than controlled substances. Section 458.347(4)(e), however, goes further and explicitly excludes the ordering of drugs in hospital settings from the restrictions set forth in paragraph (4). It reads as follows:

This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.
The Board of Medicine and the Council on Physician Assistants, the state agencies charged with interpreting, implementing, and enforcing Section 458.347, have consistently held that the above quoted language authorizes supervisory physicians to delegate to PAs the authority to order controlled substances for patients in hospital settings.

Ms. Currier seems to take the position that "prescribing" and "ordering" drugs are synonymous but the again the Board and the Council disagree with that conclusion. Under Section 458.347(4) the legislature does not use the terms "prescribe" and "order" interchangeably. The legislature specifically differentiates between the two by explicitly excluding the "ordering" of drugs in hospital settings from the prescribing restrictions set forth in paragraph (4). If the legislature had intended for "ordering" drugs to mean the same thing as "prescribing" drugs it would have used the term "prescribing" consistently throughout the statute and would not have differentiated ordering drugs in hospitals from prescribing drugs in general.

Florida Courts have consistently held that, "[a]n administrative agency’s interpretation of a statute which it is legislatively charged with administering is entitled to great weight and should not be overturned unless clearly erroneous." United Grand Condo. Owners, Inc. v. Grand Condo. Ass’n, 929 So.2d 24, 25 (Fla. 3rd DCA 2006). The Board and the Council, based on the statutory language set forth above, have consistently held that supervisory physicians may delegate to PAs the authority to order controlled substances for patients in hospital settings. This is their current position on the matter. I will notify you if their position should change in the future.

Respectfully,

Edward A. Tellechea
Senior Assistant Attorney General