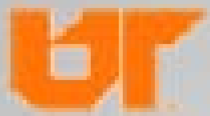
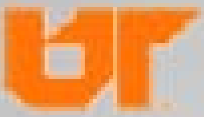


Writing Orders

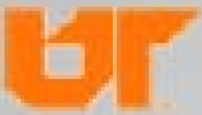
Intern School

Capstone 2017-2018



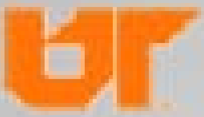
Objectives

- By the end of this workshop, students will be able to…
  - Write admission orders in a consistent, organized manner
  - Write prescriptions in the appropriate format
  - Apply general order and prescription writing principles to the EMR



Writing Orders

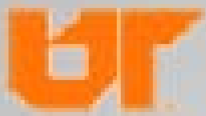
- Most Important Communication piece
- Culmination of all skills (Assessment, Analysis, Plan)
- Initiates all care
- Historical record; Sequence of events
- Communication to all caregivers
- Communication to lawyers



Basics

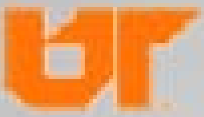
- Medical Records Committee approved forms
- Date, Time, legible author label
- Every page with name and MR number

- ERROR?
  - Single line through
  - Initial, date, time



Verbal Orders

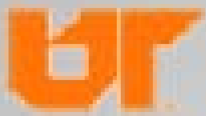
- MD not immediately available and order is urgent
- Must be signed, dated, and timed within 24 hr
- Can’t be used for DNR, chemotx, post-op, TPN, heparin, initial parenteral narcotic



Admission Orders - ADC VAAN DISML

- **A**DC VAAN DISML
- Admit to (location/bed type, service, MD, pager)

"Admit to PCU Surgery A, Dr Cox, Collins, Han 555-1212"



Admission Orders

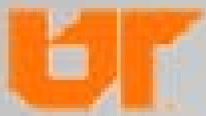
- ADC VAAN DISML
  - Diagnosis: working diagnosis or chief complaint

“Diagnosis: Pancreatitis”

Admission Orders
ADC VAAN DISML

• Good	No anticipated complications HD stable
• Fair	Pt. Is ill, may have complications
• Poor	Very ill pt., chronically or terminally ill, not HD stable
• Guarded	Very ill pt., clinical outcome not predictable
• Critical	Desperately ill, unstable patient“

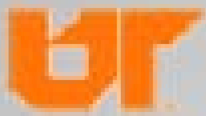
“Condition: Fair



Admission Orders
ADC VAAN DISML

- Vital Signs (T, P, R, BP)
- Patient’s condition dictates frequency
- Special variables need orders: orthostatics, neurostatus, pulse oximetry
- Review daily
- “Call MD” parameters

“Vital signs q 4 hours x two then q 8 hours. Call MD for P>120 or < 60, SBP <100 or > 160”

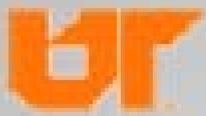


Admission Orders
ADC VAAN DISML

Activity

- Restricted/Encouraged
- Bed rest
- Bed rest with bathroom privileges/bedside commode
- Up in chair/hall
- Walk with assistance -how often
- Up ad lib

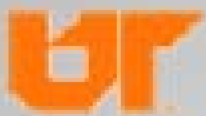
“Activity: Bed rest with bathroom privileges”



Admission Orders
ADC VAAN DISML

- Allergies
  - Include the medication and reaction

"Allergies: Penicillin – Hives and Wheezing"

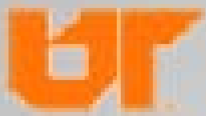


Admission Orders
ADC VAAN DISML

- Nursing Instructions
  - Intake and Output
  - Daily weights
  - Patient positioning/turning
  - Wound care
  - Foley catheter, nasogastric tube
  - "Call" orders -e. g. pain, urine output

"1. Strict I/O's, 2. Foley catheter to bs drainage, 3. NG tube to low intermittent suction"

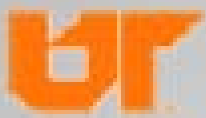
"Call MD for …"



Admission Orders
ADC VAAN **D**ISML

- Diet
  - Oral Nutrition -restricted or normal diet
    (diabetes, renal or liver disease)
- NPO for altered mental status, pre-surgical patients, some abdominal problems
- If NPO, need order for alternative hydration and nutrition

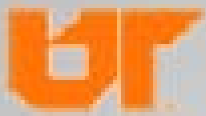
"NPO except for medications"



Admission Orders
ADC VAAN DISML

- Intravenous Fluids
  - Be specific about composition, rate and quantity
  - D_5W -5 % Dextrose in Water
  - D_5½NS -5% Dextrose in half normal saline
  - NS -Normal Saline
  - LR -Lactated Ringers solution

"Infuse one Liter of NS at 500 cc/hr, then 150cc/hr"



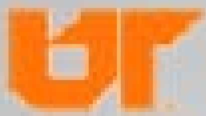
Admission Orders
ADC VAAN DISML

- Special Studies and consults
  - Imaging
  - CV studies – ECG, ECHO
  - Neuro studies- EEG
  - Provide clinical indication
  - Communicate directly with consulting physician

    "1. Portable CXR for chest pain and dyspnea

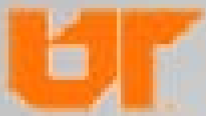
    2. ECG-Stat for chest pain

    3. Consult cardiology "58 yo AAM with unstable angina" (MD has called consultant)"



Admission Orders
ADC VAAN DISML

- Medications
  - Drug name (not symbols)
  - Dosage
  - Route of administration
  - Instructions for frequency and/or dosing interval
  - Be specific
  - Cancel previous order if changing dose
  - STAT-talk to nurse
  - Review daily

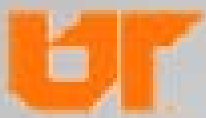


Admission Orders
ADC VAAN DIS**M**L

1. Morphine sulfate 4 mg iv, q6 hrs, first dose now

2. Percocet, 5mg/325mg cap p.o. q 4 hr prn for pain

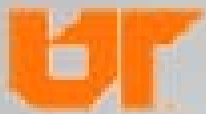
3. Phenergan 25 mg iv, q 4-6 hrs prn for nausea/vomiting



Admission Orders
ADC VAAN DISML

- Blood Products
  - Be specific (packed RBC;s, platelets, fresh frozen plasma)
  - How many units
  - What you want done
  - Type and crossmatch should precede transfuse order

"Type and cross 4 units of PRBC's. Transfuse two units now; hold 2 units in blood bank"

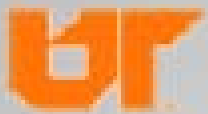


Admission Orders
ADC VAAN DISML

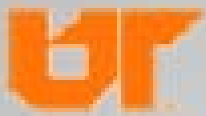
- Laboratory
  - Order what you need
  - Specify timing when necessary (fasting, timed drug levels)

1. " CBC with diff, CMP, LDH, Hepatitis profile, PT, PTT, and INR in early AM, 5-19-15"
2. "Vancomycin 1 gram iv q 12 hrs.

Please draw trough level 30 min before third dose."

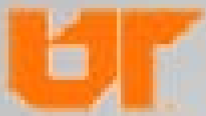


Writing Prescriptions



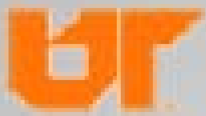
Rational approach

1. Make a diagnosis
2. Understand the pathophysiology
3. Select a therapeutic objective
4. Select drug of choice
5. Determine dosing
6. Plan to monitor results of therapy
7. Educate your patient



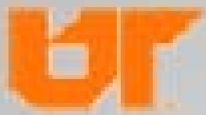
Component Elements of the Prescription

- Heading→ Physician's name, practice address and telephone number, DEA number
- Date prescription is written
- Patient Information→ Name, address, age (esp., if for a pediatric or geriatric patient)



Component Elements of the Prescription

- Body of the Prescription (Note: Exhibit)
  - *$R_{X:}$* Name of the prescribed drug or drug product. Also included is the strength of the medication, the number or quantity of the prescribed drug in addition to the dosage form
    - Eg: Hydrochlorothiazide 25 mg tablet
    - DO NOT use abbreviations for drugs prescribed unless the abbreviation is official, e.g., SSKI (Saturated Solution of Potassium Iodide), NSS (Normal Saline Solution), HCTZ (Hydrochlorothiazide), NTG (Nitroglycerin), MTX (Methotrexate)
    - Avoid “unofficial” abbreviations



Component Elements of the Prescription - Body of the Prescription

- **Sig→ *Signatura***

  Directions for use, e.g., one cap PO every 8 hrs.
  - Avoid “*ut dictum*” or “as directed.” Units should be spelled out rather than writing “U.”
  - Latin abbreviations (Appendix B) are acceptable as well as plain English
  - Commonly confused Latin abbreviations include: *qd, qod*
- **Refills→** “N” times or NR. Leaving this section blank implies that the prescription is non- refillable.

MEDICAL CENTER HOSPITAL

500 - 600 W 4TH STREET ODESSA, TEXAS Ph. 333 7111

FOR Vazquez Ramon AGE ______

ADDRESS [illegible] DATE 6/23/95

Isordil 20mg # 120 -
20 mg P.O. Q6 hours

NO REFILLS ☐

Ferrous Sulfate 300mg # 100
300mg P.O. TID c̄ meals

REFILLS

LABEL ☐

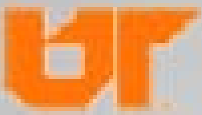
Humulin N
30 units SQ Q am.

[illegible signature]

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

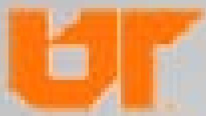
D.E.A. #

730 C37 7/88 IH 88-270



Schedules of Controlled Substances

- **Schedule I** → No medical use with a high abuse and dependence potential
  - A physician cannot write for this schedule of drugs
  - e.g., LSD, Marijuana*, Heroin, Mescaline, PCP
- **Schedule II** → A written prescription is required for this schedule. However, there are no refills allowable.
  - Morphine, oxycodone, ritalin
- **Schedule III**→ Drugs in this schedule have a moderate abuse and dependence potential; refills allowed
  - Tylenol with codeine, butalbital, anabolic steroids
- **Schedule IV**→ Drugs in this schedule are considered to have low abuse and low dependency potential
  - benzodiazepams, phenobarbital
- **Schedule V**→ Drugs in this schedule have the least amount of abuse potential and an unlikely dependency
  - Robitussin AC, kopectolin, anti-diarrheals



APPENDIX A

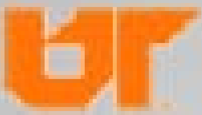
PARTIAL LIST OF CONTROLLED SUBSTANCES BY SCHEDULE

SCHEDULE I

Heroin
LSD
Marijuana
Mescaline
Methaqualone
Peyote

SCHEDULE II

Amobarbital (Amytal)
Amphetamine
Cocaine
Codeine Sulfate or Phosphate
Fentanyl (Sublimaze, Duragesic)
Hydromorphone (Dilaudid)
Mepridine (Demerol)
Methamphetamine (Desoyn)
Methylphenidate (Ritalin)
Morphine (Pantopon, MS Contin)
Methadone (Dolophine, ORLAAM)
Oxycodone (Roxicodone)
Oxymorphone (Numorphan)
Pentobarbital (Nembutal)
Percocet
Percodan
Secobarbital (Seconal)
Sufentanil (Sufenta)
Tincture of opium



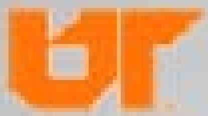
SCHEDULE III

Acetaminophen with codeine (Tylenol with Codeine)
Anabolic steroids (Androderm, Halotestin, Testoderm, Winstrol)
Pentobarbital rectal suppository (Nembutal suppositories)
Benzphetamine (Didrex)
Butalbital (Butisol, Fioricet, Fiorinal)
Dihydrocodeine (Synalgos-DC)
Hydrocodone (Codimal, Hycomine, Vicodin, Vicoprofen)
Paregoric
Aprobarbital (Alurate)

Ketamine (Ketlar)
Phendimetrazine (Plegine)
Thiopental (Pentothal)

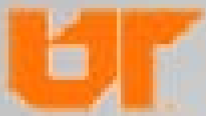
SCHEDULE IV

Alprazolam (Xanax)
Butorphanol (Stadol)
Chloral Hydrate (Noctec)
Chlordizepoxide (Librium)
Clonazepam (Clonopin)
Clorazepate (Tranxene)
Diazepam (Valium)
Diethypropion (Tenuate, Tepanil)
Ethchlorvynol (Placidyl)
Flurazepam (Dalmane)
Halazepam (Paxipam)
Lorazepam (Ativan)
Mazidol (Mazanor, Sanorex)
Meprobamate (Equanil, Miltown)
Modafinil (Provigil)
Oxazepam (Serax)
Pentazocin (Talwin NX)
Phenobarbital
Phentermin hydrochloride (Fastin)
Phentermin resin (Ionamin)
Propoxyphene (Darvon, Darvocet)
Temazepam (Restoril)
Triazolam (Halcion)
Zaleplon (Sonata)
Zolpidem (Ambien)



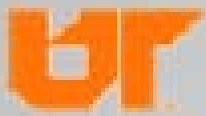
EMR Advice

- Take the time to learn it well
- Use the templates
  - Hyperkalemia example

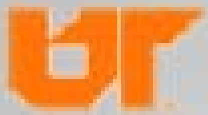


Admission orders examples

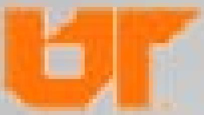
- Case:
  - 58 yo AAF presented to the ED with intermittent nausea and dyspnea on exertion occurring 2-3 times in the last 2 hours. When the last episode was not relieved by rest, she presented to the ED.
  - PMH: HTN, glaucoma, COPD
  - FMH: F-COPD; M-SLE, ESRD, CAD; Sr-breast cancer
  - Soc: smokes ½ ppd, no alcohol, no drugs
  - T 98.6, BP 174/98, P 98, RR 22. CV: no JVD, Regular rhythm, no S3 or S4; Lungs bibasilar crackles; abd normal; ext no edema
  - ECG: LVH and ST segment depression in V4-V6; Troponin <0.5
  - CBC and BMP normal



- October 1, 2017 1:07PM
-
-
- Admit to Medicine –Telemetry bed; Dr Smith 777-9876
- Dx-Unstable Angina, possible MI
- Condition-gaurded
- Vitals- q 2 hr X 2 then q 4 hr
- Allergies- NKDA
- Activity-Bed rest
- Nursing-Daily wts, strict I's/O's, Call MD and get stat ECG for chest pain
- Diet-1500 cal AHA diet
- INT (or insert PIV)
- (studies) ECG q AM, CXR Pa & Lat "Dyspnea on exertion"
- Medications:
  - O_2 – 2L BNC
  - Enoxaparin 1 mg/kg SC q 12 hr
  - ASA 325 mg po now (chew) then I po daily
  - Atorvastatin 40 mg po qHS
  - Lisinopril 20 mg po daily
  - NTG 0.4 mg SL q 5 min x 3 prn chest pain
  - Metoprolol 50 mg po BID
  - Morphine 4 mg IV q 4-6 hr prn chest pain
- Laboratory- CBC w/diff, CMP, Troponin q 6 hr X2, PT/PTT
-
-
- If ECG's and troponins don't indicate MI in progress, would order an ECHO to evaluate LV function
- She should go out on all the meds above except heparin and oxygen. ASA can be 81 mg daily.

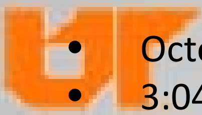


- Lisinopril 20 mg tablet
  - Take one PO daily
  - Dispense 30 tablets
  - 3 refills



Case #2

- Case
  - 28 yo white female G2, P1, Ab1, 27 weeks twin IUP presents to weekly OB appointment with complaints of contractions and neck pain.
  - PE: T 97.9, BP 148/94, P 88, RR 12. On pelvic exam she is 20% effaced and 3 cm dilated
  - PMH Spontaneous abortion at 29 wks gestation 1 year earlier
  - Meds: PNV

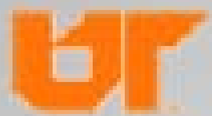


- October 1, 2017
- 3:04 AM
- Admit to L and D
- DX-Preterm labor, twin gestation, 27 weeks, elevated BPs
- Condition- fair
- VS q shift except serial BPs, q 30 minutes
- External monitor
- Bed rest with bathroom privileges
- No drug allergies
- Compression stockings while in bed, I and O q shift.
- Diet- NPO
- IVF: D5LR at 125cc/hour
- Neonatology consult
- Medications:
- Beta-methasone 12 mg IM q 24 hours X 2 doses
-
- Magnesium sulfate- 6 gm bolus over 30 minutes,. Then infuse 2 gm /hr.*(this is premixed now and would be for neuroprotection; if pre-eclampsia diagnosed based on persistently elevated BPs, abnormal labs or symptoms like headache, Mag would be continued)*
-
- Penicillin 5 million units IV now. If rapid GBS positive then continue penicillin 3 million units q 4 hrs until delivery
-
-
- Lab- CBC, Blood type, toxemia labs: plts, CMP, Uric acid, liver function tests, UDS
- Urine culture
- GBS culture- rapid

Case #3

- Case
  - 42 yo male presents with c/o RUQ pain worsening over the last 2 days. Pain began after a meal of fast food fried chicken the day before. Also has nausea, vomiting, loss of appetite and dark urine. Fever and chills for the past 6 hours.
  - Exam: T 101.9, BP 88/54, HR 120, RR 28. Appears toxic, abdominal exam is protruberant, +BS, tender in RUQ with guarding but no rebound

- October 1, 2017
- 11:34 AM
- Admit to Surgery ICU
- Dx-Cholangitis, Septic Shock
- Condition-critical
- Vitals q 15 minutes
- Allergies-NKDA
- Activity: Bedrest
- Nursing- place 2 large bore iv's, place foley catheter, strict I's/O's. Call MD for worsening mental status; Call MD for MAP < 65; place compression stockings and pneumatic boots
- Diet-NPO
- IVF- 1 liter bolus NS, repeat for MAP < 65, then 150 cc/hr (*this will vary based on fluid status and electrolytes)*
- Studies-
  - Bedside abdominal USG "suspect Cholangitis with septic shock"
  - Portable CXR "RUQ pain and septic shock"
  - Portable KUB flat and upright "RUQ pain and sepsis"
  - ECG, stat
-
- Medications
  - Vancomycin 1 gm IV q 12 hr, first dose stat
  - Meropenem 1 gm IV q 8 hr, first dose stat
  - Acetaminophen 650 mg suppository q 8 hr prn temp > 102 (*arbitrary based on*
  - Nexium 40 mg IV q day
-
- Laboratory: Blood cultures, 2 sets, drawn 10 minutes apart, UA, CBC w/diff, CMP, GGTP, lactate, PT/PTT
-
- His d/c meds will likely include analgesics and stool softeners
-
-



Thank you!