Presentation must be viewed in “Slide Show” format in order for the link to the examination at the end of the presentation to work.
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
Entries into the Medical Record

- Entries may be made into the medical record by: Physicians, Nurses, PT/OT/ST, Pharmacists, MSW, RT, Dietician, Care Coordinator, Students, Pastoral Care, Ethicists, MA, PA, MHT, CAN, PCA, Special Ed Teachers, Dentists, Midwives, EMT, RT, Paramedic, Recreation Specialist, Psych Intern, Extern and Fellow
Your entries communicate to all of these professionals
Entry Basics

- Only forms approved by the Medical Records Committee shall be used in the record
- All entries must be legible with author clearly labeled, with date and time
- Every page shall contain patient’s name and medical record number
- Who is responsible for this? YOU, and anyone writing on the page
What if I make an error?

- When an error occurs, a line should be drawn through it and the word error written on the line. This is followed by name, title, date and time.
- Then, re-write proper information.
- Late entry - Mark “late entry”
Co-Signature Requirements

- Med Student entries (all entries) must be signed by supervising physician, immediately.
- Med Student – Orders cannot be implemented until co-signed
- Residents - H&P signed by attending physician.
Identification Stamp

- Use of identification stamp is encouraged.
- When stamp is used, a signature must still be present above the stamp.
Diagnostic and therapeutic orders

**Who can write orders?**

- Advance Practice Nurse
- Physician Assistant (cannot give verbals)
- Resident
- Physician
Verbal Orders

- Have specific utility
  - Emergency Medicine
  - If practitioner is not immediately available and order has urgency
  - Must be signed, dated and timed within 48 hours (except Med orders and restraint orders which are 24)
Verbal Orders

- Cannot be used for Chemo, DNR/Code Status; Post OP, PCA; Hyper-alimentation; Withdrawal of life support; Heparin; Initial parenteral orders of narcotics
Five Documentation Basics for Orders

- 1. Timely
- 2. Clear
- 3. Concise
- 4. Organized
- 5. Legible

Re-evaluate as frequently as required for patient condition changes
Flag the Chart

- Orders can’t be initiated until the chart is released.
- Flag regular orders with the color Red on the dial
- Flag STAT orders with the color Yellow on the dial, then alert the RN or Clerical Specialist that STAT orders exist.
Admission and Continued Care

- **Admit to _______ Unit.** (Specify if monitored bed is needed)
- **Condition of patient**

  Good – Excellent or good prognosis. Conscious. Vitals stable and WNL. Patient comfortable.

  Fair – Favorable prognosis. Conscious. VSS and SNL. Minor complications and patient is uncomfortable.

  Serious – Patient is acutely ill with questionable prognosis. VS may not be stable or WNL. There is a chance for improved prognosis.

  Critical – Questionable prognosis. VS unstable and not WNL. Major complications. Death may be imminent.
● Primary Diagnosis
● Other Diagnoses
● Allergies
- Category of Care (DNR, Full)
- Nutrition (NPO, Liquids, Type of diet)
- Activity Level (precautions, bed rest, elevation of bed, weight bearing restrictions, rotation bed)
- Therapies (PT, OT, ST)
Nursing

- Vital Signs
- Neuro Checks
- Invasive Monitoring requirement
- I/O
- Accu Checks
- Vascular Checks
- Catheter Status
- Wound Care
Consults

- Medical/Surgical
- Dietary
- Wound Specialist
- ET
Studies and Tests

- Radiology – specific part; symptoms
- Nuclear Medicine
- Lab Tests
- ABGs
Wash your hands
Respiratory Therapy

- Oxygen - cannula or mask, what rate, include saturation parameters
- Vent Management orders need mode of ventilation, vent rate, tidal volume, FIO2, PEEP and pressure support requirements
- Aerosol Treatments - Careful with unit dose and inhalation therapy (Meds)
- Suction – if PRN, list indication
- Incentive Spirometry
Respiratory Therapy

- Percussion and Postural Drainage needs an indication and what lobes to concentrate on as well as frequency.
- Bi PAP/CPAP orders need pressures written; Oxygen titration parameters
● Discharge Planning (ask on admission)
  – Assessment
  – Patient Education
Things to Remember

- DVT prophylaxis
- Fall Precautions
- Seizure Precautions
- Devices
- Restraints
Do not use anywhere in the medical record

- U - write unit
- IU - write International unit
- QD, QOD - write daily and every other day
- Trailing zero - **write X (not X.0)**
- Lack of leading zero - **write 0.5 not .5**
Do not use anywhere in the record

- MS - means many things….write out
- MSO4 - write morphine sulfate
- MgSO4 write magnesium sulfate
- Ug - write mcg or microgram
- cc - write ml for milliliters
- AS, AD, AU, OS, OD, OU
- Instead, write left ear, right ear or both ears, left eye, right eye or both eyes
Transfer orders

- Required for continuity of patient at different levels of care.
- Transfers between units if acute to ICU or ICU to Acute
- Transfers to other facilities
Post Surgical Orders

- All new orders will allow for changes that have occurred in the OR
Discharge Orders

- Complete hospital form. Focus on continuity and reconciliation
Medication Orders

- Must be on Doctors order form or other approved form (Heparin, Lovenox and Protonix)
- Include all - **Drug; Strength; Route; Frequency**
- All strengths and volume in metric system
- Parameters required for PRN (fever, pain)
For Medication dose ranges, only one range per statement

- Ranges
  - Morphine xx - xx every 4-6 hours for pain
  - Incorrect
  
  - Correct way
    - Morphine xx - xx every 4 hours for pain or
    - Morphine xx every 4 - 6 hours for pain
All medication orders must be individually reordered following surgery. “Resume” orders are not acceptable.

“Resume Home Meds” cannot be used.

Any ambiguous or illegible order will be required to be re-written prior to filling the medication.
• Stat orders may be called to the pharmacy by nursing. The written form must be faxed to pharmacy asap
Home Medications

- All medications brought into the hospital to be utilized by inpatients will be verified first by pharmacy as the proper medication prior to administration.
General Medication Process

● Order is written
● Order form faxed to pharmacy
● Order transcribed into the system to create a patient profile
● At the same time, RN or designee transcribes onto MAR until new MAR arrives
● Pyxis filled, MAR printed
Antibiotics

- Unless otherwise specified, orders are in effect for 8 days only.
- Pharmacy will send a note on day 7 saying drug will stop unless acted upon
High Alert Medications

- Opiates
- Concentrated Electrolytes
- Insulin
- Chemotherapy
- Heparin
- TPN
- Look Alike, Sound Alike
Look Alike Sound Alike drugs should have generic and brand name both used when possible.
Compliance seems so easy, but it’s not

- Watch unapproved abbreviations
- 5 Basics (Pt, drug, dose, route, time)
- PRN need a rationale
- Don’t use two ranges in same order (20-40 mg q 4-6 hours)
- Legibility
- Sustained Release Narcotics not PRN
Let's see some examples. Can you identify the issue?
- Percocet 5/375 i-ii po q 4-6 h
- Clonidine 0.2 mg patch @ 2300
- Percocet i-ii q 4 h
- Clonidine 0.2 mg patch @ 2300 and desired frequency, (or x 1)
- Nasacort 2 puffs INH bid
- Estrogen patch patient may apply own at home dose
- Nasacort isn’t an inhaler (spray)
- Need strength for medication
- Estrogen needs dose. We don’t know what home dose is.
● NaHCO3 648 ml po daily
Dangerous abbreviations
Resume Albuterol and Advair as pre-op
Post op requires new orders, no resume orders
• Give pt percocet dose x 1 now
Percocet needs strength
Check Mg+ on the already present sample if possible please
Dangerous abbreviation
• Start 0.9 Na Cl 100 ml/hr
• Add the above dose of K+ as already ordered to the fluid
• IV needs frequency, K+ needs specified dose, “above order” dangerous
• Cancel above orders
- Dangerous!
- You all knew that one. 😊
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<th>Date</th>
<th>Time</th>
<th>DOCTOR'S ORDERS</th>
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<tbody>
<tr>
<td>11/17/05 7:45 am</td>
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<td>Plavix 75 mg PO daily</td>
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<td>Glipizide 10 mg PO twice a day</td>
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<td>Metformin 500 mg PO twice a day</td>
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<td></td>
<td>30 mg Pravachol 500 mg PO twice a day</td>
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<td>Lopid 600 mg PO twice a day</td>
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<td>AA well but run ECG daily XU SCA</td>
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<td></td>
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<td>Altace 10 mg PO daily</td>
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<tr>
<td></td>
<td></td>
<td>Accupril 45 mg PO daily</td>
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<td>Fish Oil 1200 mg PO twice a day</td>
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**Insulin Sliding Scale**

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**RISK MANAGEMENT**

@ 2 L/h through NC to keep O2 Sat > 92%
**Doctor's Orders**

**Date:** 11/17/2005 07:20

**Admit under Observation status.**

- Diagnoses: CHF exacerbation
- Condition: Stable
- Vital signs per routine
- Allergy: NKDA
- Nursing: per routine
- Diet: cardiac/renal diet
- Activity: ad lib
- Labs: CBC with diff, Chem 7, Mg, K
- Ce x 3 q 8 hrs apart.
- Daily vit.
- I/O 1 charting
- Heslock IV
- Send D-dimer
- Send sputum for C/S
- IV fluid: Heslock

**Medications:**
- Augmentin 500 mg PO twice a day
- Lasix 10 mg IV twice a day
- Cozaar 25 mg PO twice a day
- Lipitor 40 mg PO daily
- Hydralazine 25 mg PO three times a day
- Losartan 50 mg PO daily
- Indur 25 mg PO daily
- Coumadin 3 mg PO 3 days/week
- Coumadin 2 mg PO 2 days/week
- Protonix 40 mg PO daily
- Captopril 31.25 mg PO daily

- 3-4'1m through N/NC to keep B/P > 90/70.

**Diagnosis:** (Any monitored 3/1)

**Erroneous Order:** Wrong drug

**Signature:**

- Dr. Gayal
- Pharmacist
<table>
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<tr>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/14/2005 3:00 AM</td>
<td>Calcium carbonate, 3 grams orally</td>
</tr>
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</table>

*Rev. 3/02*
- It's not so easy.
- Slow down. Re-read what you wrote.
- Ask for help.
Please use the link below to access the Order Writing examination.

If you have any questions, please contact the GME Office at 419-383-4244.