



FAQS: PHYSICIAN'S ORDERS

Question: Why do we need a script/order?

Answer: Legally a nurse can ONLY administer medication pursuant to an order from a legally authorized practitioner. It is legal proof of the order and it verifies the order on both the pharmacy label and the MAR. Copies of all prescriptions, orders, or approvals for medications currently being taken by persons while at the facility must be retained at the facility.

Prescriptions, orders, or approvals for medication shall be written at least once a year or more frequently if required by law or by a prescriber.

Question: We have a consult report that the consulting doctor writes recommendations and sometimes medication orders on. Is there any reason this cannot be used as an order?

Answer: This process is generally governed by agency policy and the individual primary and consulting physicians. Many agencies will not accept consulting MD's recommendations until the primary physicians approves it. Other agencies accept and implement consultants' recommendations on consult sheets as orders. Each agency needs to establish a policy on this issue.

Question: The primary doctor writes a progress note the day of a visit. On the bottom he writes for some lab tests to be done in 2 weeks. He signs it. Would this be considered his orders? Do we have to go back to the unit, copy what he wrote in the order section of the chart and have him/her sign it again at the next visit?

Answer: A signed progress note would suffice as an MD's order for survey purposes. However, it is an agency decision. . An actual "order section" of a medical record is pretty rare these days. Consults, progress notes, and annual physical exams have really become the source of documentation of most MD's orders which are usually formalized into monthly, quarterly, or semi-annual orders, (depending on the order and the type of home) and renewed at the frequency determined by the type of facility.

Question: Do telephone orders have to be co-signed by a physician?

Answer: No. However, it is considered best practice to have the MD either fax a copy of the order or send a prescription in the mail.

Question: Is a duplicate pharmacy label acceptable as a doctor's order for a medication?

Answer: No. A pharmacy label is just that; a label created by a pharmacy. It is an INDICATION that a doctor's order was conveyed to the pharmacy. A residence must have a copy of the actual order against which to check the pharmacy label.

Question: The doctor discharges a client from the hospital. He writes his own discharge orders and signs them. We are faxed a copy. These are his orders. Do we need to recopy them and have him sign them again?

Answer: From a survey perspective, OMRDD would look to see that the recommendations/orders made by the discharging MD were reviewed and acted upon at the residence. OMRDD would be looking for consistency of care - not what form it was placed on, especially if the discharging MD is the consumer's primary MD. Agencies should have a specific policy to address this issue.

Question: We want to be able to use oxygen in an emergency situation. What kind of orders would be needed? Could we have an MD issue non-specific orders & write a policy with guidelines as to the administration for our clients (e.g. those with known Chronic Obstructive Pulmonary Disease (COPD) or unknown respiratory conditions)? Are nurses allowed to initiate the emergency use of oxygen in the absence of either a specific or non-specific order?

Answer: If there is a consumer who has COPD or other respiratory condition, the registered nurse should discuss the use of oxygen with the primary care physician. Any order should be specific to the consumer, with specific directions for use. The more objective the order the better. (e.g.: when the pulse ox is below 90 give 4 l/m O₂ by nasal cannula. Check pulse ox in one hour. D/C O₂ when pulse ox is 94 or greater.) Vague orders such as : "give 4 l/m O₂ if having difficulty breathing" are too subjective.

Nurses are not allowed to administer O₂ without an order.

Question: We have no infection control or employee health nurse. We are relying on nurses to volunteer to immunize staff. The physician writes a "standing" order indicating that the nurses are authorized to give staff vaccinations. There is also a protocol for the handling of emergency treatment of anaphylaxis. One nurse asked me if nurses are

"covered" (liability/malpractice) when they give vaccinations to staff.

Answer: In this scenario it is assumed that the "nurse" is an RN as LPNs cannot implement non-patient specific standing orders. Each agency should check with their own malpractice insurance carrier for a definitive answer. Generally, as long as the nurses are acting within their scope of practice (which giving immunizations is), are performing the task at the request/direction of their employer (which they would be), are acting in good faith and with reasonable care in the performance of the task (which I assume they would be) the task is usually covered. State employed nurses would be covered under the Public Officer's Law provided that the above conditions were met.

The nurse would be personally liable if an injury or damage results from intentional wrongdoing or recklessness on the part of the nurse.

Question: Our agency is having a hard time getting prescriptions from physicians because most of physician now send electronic scripts directly to pharmacies.

Answer: With the advent of e-scripts it has become a challenge to get copies of scripts. There are several systems that you could use to obtain on order:

- Have a place on your consult sheet for the MD to fill in that says: New/reordered medications:
- Ask the pharmacy to print out the e-script
- Ask the office nurse to print out the e-script
- Take a verbal order from the MD that you would transcribe onto an order sheet
- List the medication, strength, dose, frequency, route and fax to the MD office. request that the MD sign to verify the order.

Question: Does the script have to match the pharmacy label?

Answer: Not necessarily. When a medication dose has been changed by the prescriber, a sticker that refers to the new order or with the new directions may be placed over the directions section of the original label. The person's name and the name and strength of the medication shall remain clearly visible. The change must be properly documented in the persons' clinical record. Documentation is required as to why it doesn't match.

Question: Do I have to dispose of PRN medications when a new script/order is written?

Answer: The medication is "good" until the manufacturer's expiration date. The date may be for more than one year.

Question: Does the script for a medication expire in 30 days when the prescription for a PRN medications has 0 refills?

Answer: No. The PRN order is good for up to one year (unless for controlled substances).

Question: What do we need OTC orders for?

Answer: Any medication that by state and/or federal laws, rules and/or regulations do not require a prescription. This would include medications such as Tylenol, ibuprofen, TUMS, Robitussin, bacitracin, etc.

Question: Do we need orders for items such as chapstick, moisturizing lotions, bug repellent, sun screen etc.?

Answer: These items can be used with nursing orders

QUESTION: In an ICF, is it allowable to utilize a standardized form for OTC -PRN meds that the MD signs annually and has very specific guidelines for use? For example, Acetaminophen 325 mg 2 tabs po q4h PRN headache, not to exceed 6 doses (12 tabs) in a 24 hr period. The form also clearly states that the med cannot be administered longer than 48 hours without notifying the prescribing practitioner. Also, on the form it indicates that agency policy states that the RN must be notified before administering any PRN med. I have seen and used this form many times in the CRs but this is an ICF. Is this acceptable?

ANSWER: A standardized form is acceptable PROVIDED the standardized form is individualized for each consumer (has a line for the consumer's name, any drug allergies, etc.) and provided it is signed by the primary care provider on at least an annual basis.

Question:

I need clarification re: renewal of medication orders. It has always been my understanding that medication orders were renewed monthly unless the doctor indicates there were to be renewals. I now have a situation where I have an order for Klonopin that was written on 3/9/07. The doctor marked no refill but we still have some medication on hand. We have asked for a new order and have received a message from the pharmacy that states that the order is good for as long as we have pills on hand and that we don't need a new order at this time. However, it is past the 30 days. I am also concerned because this is a controlled substance. It is understood that the person will probably be on medication long term, but unknown as to what dosage, etc. I am specifically trying to clarify OMRDD regulations not Medicare or Medicaid regulations.

Answer:

There are no "OMRDD regulations" as we do not govern the practice of medicine or pharmacy. There are no OMRDD regulations that require monthly orders. That is a very

old ICF practice but it is not, and never was, a regulation.

The length of time a prescription for a controlled substance is valid is determined by the schedule of the substance. Please refer to 10 NYCRR 80 for prescribing information for the various schedules of controlled substances.

Question: There was a change in Medicaid law that allows an MD's office to call in a prescription that does not need to be refilled, like an antibiotic, and not have to follow it with a hard copy script. This leaves the agency without an order or script for the medication.

Answer: Nurse (and in our case, DAs) may only administer medication upon the order of an authorized prescriber. A written order is preferred. A pharmacist may not write out the order that makes it a third party order and it is not valid.

There are several ways of handling this situation. The simplest is to have the residence copy the information from the pharmacy label and fax it to the authorized prescriber. Ask the prescriber to verify the information, sign the order, and fax it back. While best practice is to have a nurse do this, in OMRDD certified facilities, properly trained AMAP staff may take a verbal order.

**Question:
Can a chiropractor write orders/scripts/instructions for OTCs and other medications in our facilities.**

Answer: By New York State Education Law section 6551 paragraph 3:
"A license to practice chiropractic shall not permit the holder thereof to prescribe, administer, dispense, or use in his practice drugs or medicines. . . ."

14 NYCRR 633.17 requires that all medications, including OTCs, be approved/ordered /prescribed by the individual's practitioner, defined in 14 NYCRR 633.99(c) as a person, who by State law is authorized to designate for use any medication needed by a person (whether designated on a required prescription order form, or, for over-the-counter medications, in another acceptable manner.)

Therefore, chiropractors may not order OTCs in OMRDD certified facilities.

**Question: Orders must be transcribed as written by the physician. If the physician writes an order: "Dilantin 130 mg po BID" Dilantin does not come in 130 mg tablets or capsules. Our nurse transcribed the order as:
Dilantin 100 mg po bid 8 am 8 pm
Dilantin 30 mg po bid 8 am 8 pm
Is this an allowable way to transcribe the order?**

Answer: This is acceptable. The example given above appears to be more clear than the alternative way to transcribe the order which would be: Dilantin 130 mg. po bid, GIVE 1, 100 mg capsule and 1, 30 mg capsule at 8 AM and 8PM Survey wise, however, there would not be a problem either way.

Question: Does the RN working at an OMRDD residence have to have a single overseeing physician for medical orders and/or RN practice?

ANSWER: There is no regulation or requirement that an RN working at an OMRDD IRA have a single physician writing medical orders.