

LESSON PLAN: 6

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: II GENERAL PRINCIPLES

SCOPE OF UNIT:

This unit includes medication terminology, dosage, measurements, drug forms, transcribing physician's orders, packaging, storage, infection control, and accountability.

INFORMATION TOPIC: II-6 OR DEMONSTRATION:

TRANSCRIBING PHYSICIAN'S ORDERS

(Lesson Title)

OBJECTIVES – THE STUDENT WILL BE ABLE TO:

1. Identify the two types of physician's orders.
2. Match the terms which determine what kind of a verbal or written order the physician has given with their definitions.
3. Identify the general principles used when transcribing orders.
4. List the items to be transcribed on the Medication Administration Record (MAR).
5. List the items to be transcribed on the medication card.
6. List the items found on the prescription label.
7. Record essential information on records.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Sample physician's order sheets, medication records, medication cards, and prescription labels.
2. Abbreviation list for the facility.
3. HO 11: Sample Completed Physician's Order Sheet.
4. HO 12: Sample Completed Physician's Telephone Order Sheet.
5. HO 13: Sample Completed PRN Medication Form.
6. HO 14: Sample Completed Medication Administration Record (MAR).

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 6 prior to class and be prepared to discuss the information presented.

INTRODUCTION:

No medication can be given to a resident without a physician's order, so the administration of medications actually begins with that physician's order. Once the order has been obtained, the task of transcribing the order onto the facility's Medication Administration Record (MAR) may be completed. This lesson will identify the terms and general principles related to transcribing all medication orders and describes the records used in the transcription process.

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OUTLINE:

I. Types of Physician's Orders

A. Written.

1. Directly on the order sheet by the physician or prescriber (HO 11).
2. Indirectly by a prescription (permitted in an RCF when a direct written order is not required by the facility).

B. Verbal.

1. Physician gives the order verbally, either directly or by telephone to another person who is responsible for writing it on the order sheet (HO 12).
2. State regulations determine whether a medication technician may accept verbal orders in a RCF, ICF, or SNF. The verbal order must be reviewed by a nurse or pharmacist prior to administration of the medication.

II. Terms Describing Physician's Orders

A. Automatic stop orders – policy that puts a limit on the length of time a medication can be given before the physician must be consulted for a continuation of the order.

B. Discontinue orders – medications are stopped and no longer administered to the resident.

C. One-time orders – single dose is administered only one time.

D. PRN orders – meds are administered only as needed according to a designated time frame identified in the order. All prn orders must contain a specific reason for giving the medication such as pain, fever, etc. The licensed nurse assesses the resident and makes the decision when to administer a prn medication.

E. Renewal orders – continues the medications which were previously prescribed for the resident; usually done once a month.

F. Routine orders – orders for medications the resident takes on an on-going basis.

G. Short-Term Orders/Limited Orders – physician determines the number of doses or days the medication is to be administered. The medication is given only for

this prescribed time. For example: Antibiotics that are ordered to be given twice a day for 7 days.

- H. STAT orders – these meds are administered immediately, one-time only such as Nitroglycerine STAT.
- I. Change in order.
 - 1. Original order discontinued.
 - 2. New order written.
 - 3. If a label is to be changed on the medication container to reflect new directions, this must be done by the pharmacist. It is unacceptable for a CMT or nurse to write on the medication label.
 - 4. If no new label is to be used, the medication container should be flagged with a "change in order" sticker to indicate new directions.

III. General Principles in Transcription

- A. All transcription must be error-free. To reduce the chance of errors:
 - 1. Writing should be clear, neat, and legible. Print if necessary.
 - 2. Blue or black ink is preferred by most facilities. Do not use a felt tip pen as the ink can run or bleed through the MAR.
 - 3. Use only abbreviations on the the list of accepted abbreviations established by the facility.
 - 4. Keep distractions to a minimum.
 - 5. Orders should be completely transcribed all at one time. Leaving and coming back to orders may mean something is overlooked or forgotten.
 - 6. Recopy from the original order. The more an order is recopied, the greater the chance an error can occur. The medication technician should take responsibility to find the original order and copy only from it.
 - 7. Review unclear orders with the charge nurse or physician before attempting to transcribe them whenever necessary. The physician's handwriting may not be very legible. Review directly with the physician if he/she is in the facility, or review by phone if the physician is not on the premises.
 - 8. Verify verbal orders by writing them down and reading them back to the physician exactly as given. Say in words the meaning of any abbreviations used.

9. Spell drug names back to physician when pronunciation is unclear. If the physician uses an unapproved abbreviation or term, repeat the order back to the physician using the correct abbreviation or term for clarification.
10. Transcribe all orders onto each document exactly as they appear on the original written order. If an unapproved abbreviation or symbol was used in the original order, clarify the order with the physician.
11. Verify all completed transcriptions with licensed nurse.
12. If an error is made, cross it out and write “mistaken entry” and your name and date above it.
13. When transcribing medication orders onto the MAR, following your facility’s guidelines regarding the timing of medications ordered daily, BID, TID, QID, etc. Pay special attention to medications that must be given before or after meals and assign them the correct time for administration.

CAUTION: Accuracy is essential in transcribing all physicians' orders.

IV. Medication Administration Record (MAR) (HO 13, HO 14)

- A. A Permanent record that is part of a resident's chart. Maybe a paper or an electronic document.
- B. Items found on medication record include:
 1. Name of resident – first name, middle initial and last name.
 2. Allergies to foods and/or medications.
 3. Date medication administered.
 4. Time medication administered.
 5. Name of the drug.
 - a. Written just as given by physician.
 - b. May be provided in generic form.
 - c. Verify that medications sent in generic form are indeed the same medication as the physician ordered.
 6. Strength of the drug.
 - a. Not all medications will have a strength designated. If strength is not specified, confirm there is ONLY one strength available.

- b. Most medication comes in more than one strength.
 - 7. Dosage – amount of medication given.
 - 8. Route of administrations (e.g., oral, rectal, topical, etc.).
 - 9. Signature of person administering drug.
 - a. Small square for initials.
 - b. Official signature (first initial, last name, and title) recorded beside the initials the person is using must appear on the MAR.
- C. Access to an electronic MAR (sometimes referred to as an e-MAR) may require the CMT to use a password to access the computer software program. It is important to be trained on the use of the software prior to administering and documenting medications using this system.

V. Medication Card

- A. Medication cards are used in some facilities to identify medications when it is necessary to remove them from their original container prior to administration. If a medication leaves the original packaging and is not administered at once, it must have a medication card(s) with it at all times.
- B. Items found on the medication card.
 - 1. Full name of the resident.
 - 2. Room number of the resident.
 - 3. Name of the medication.
 - 4. Dosage and strength of the medication.
 - 5. Times of administering the medication.
 - 6. Route of administration.
 - 7. Date the medication was ordered.
 - 8. Physician's name.

VI. Prescription Label

- A. Found on the medication container (bottle, unit dose card or pack).
- B. Check for accuracy.

VIII. Summary and Conclusion

- A. Types of physician's orders.
- B. Terms describing physician's orders.
- C. General principles in transcription.
- D. Medication administration record (MAR).
- E. Medication card.
- F. Prescription label.
- G. Facility records.

Care must be taken when transcribing physician's orders. An error could be deadly for your resident. The next lesson is on packaging, storage, infection control, and accountability.