

Physicians Orders and Transcribing Packet

DSP should complete the worksheet at the end of the packet after reviewing:

- **“Transcribing Medication Sheets”**
- **“Monthly medication Sheet for Dave Doe”**
- **“How to determine what time to administer medication”**

There must be a written physicians order for all prescription **and** non-prescription medications. To have a complete order the following information must be included:

1. The individual’s full name
2. The date of the order
3. Name of the medication
4. Dosage and administration information
5. Route of administration
6. Physician’s signature

Remember to check the physician’s order over carefully and to ask questions!

Make sure that you and the individual understand why the medication is being prescribed, what side effects to watch for, and any special instructions.

Transcribing Medication Sheets

Transcribing means copying information from the pharmacy label to the Medication sheet (record) and the progress notes. The purpose of transcription is to set up the Medication Sheet so that the DSP can **perform the three checks before administering** a medication and can accurately document the medications that have been given.

- On the top of the med. sheet the person's allergies or NKA (No Known Allergies) should be written in bold RED letters.
- Fill in the person's name, case number, the primary physician or doctor who ordered the medication(s), and the month and year.
- Check the medication order against the pharmacy label to make sure they match and are clear and understandable. This should be done with every medication prescribed for the individual.
- If there is an error on the pharmacy label it must be returned to the pharmacy for a new label. We are not pharmacists and by law may not change a pharmacy label.
- This is a legal document. You must use permanent ink. You may not use correction fluid or other means of covering up errors. If you make an error while transcribing the order write error, highlight it out, and start over.
- Transcribe what is written on the medication label to the medication sheet. The physicians order must be transcribed exactly as written on the pharmacy label.
All of the following information should be included:
 1. Name of Medication
 2. Dosage- mgs, tabs, mls, etc
 3. Frequency- BID, TID, once daily, etc.
 4. Route to be administered- per g-tube, by mouth, etc.
 5. Time to be administered
 6. Special instructions- Take with food, milk, after meals, chewable, etc.
 7. Generic name of Medication
- All liquid medications, when transcribed on a medication sheet, should be recorded in mg/ml/cc as well as the amount to be given.
- When a medication is ordered for a specific number of days, you must calculate the date and time of the last dose. To do this, multiply the number of times the medication is given each day by the number of days for which it is prescribed. That gives you the total number of doses that the person will receive. Count the doses, starting from the first time the medication is given to determine the date and time of the last dose.

- If a medication is time limited, draw a line when the medication should be finished. AFTER IT IS ALL GIVEN, highlight out the remaining documentation area, write d/c, date it, and slash through where the order is written with highlighter.
- Draw an arrow, in the appropriate color, to the start date. Write “start” above the line for the shift when the medication will first be administered.
- Two squares should be left for documenting. The medication passer will fill in the time in the top square, and initial the square below it on the correct date AFTER giving the med.
- Leave at least two lines between each different medication.
- Each staff that passes medications in the home must initial and sign the bottom of the medication sheet.
- At the very bottom of the medication sheet, there should be a code for abbreviations, i.e. H=home, W=work, S=school, d/c=discontinued, etc.
- When documenting a PRN medication, be sure to indicate if it was administered in the a.m. or p.m. Always check for the last time a PRN medication was given **BEFORE** giving.
- 12:00 PM = noon, 12:00 AM = midnight, Midnight is the last dose of the day.
- If an error is made when documenting meds, circle it in red. Also, document the error in the progress notes.
- Neatness counts. If your handwriting is not easily read, you need to print the information that you are transcribing.

Transcribing Worksheet

Name: _____

Score: _____ Pass / Fail

Date: _____

Directions: Read the information and answer the questions.

An individual you support, Homer Simpson (case number 896745), has a Doctor's appointment. The appointment is on October 15, 2008 at 10:15, with Dr. Feelgood. Homer has been complaining about not feeling well, he has had some problems with feeling too hot or cold, and he says that his throat hurts.

1. What do you need to take to the appointment?

2. What do you need to tell Homer about the appointment? Do you need to tell him anything?

After Dr. Feelgood examines and talks to Homer he writes the following order:

Homer Simpson	10/15/08
Penicillin 500mgs- Take one tablet every 8 hours by mouth, for 10 days. Dispense 30.	
Motrin 600mgs – Take one tablet every 4-6 hours for pain/ discomfort, PRN, by mouth. Dispense 50.	

3. What does the DSP do now? Check all that apply.
 - a. Take the order to the pharmacy
 - b. Document
 - c. Transcribe the medication
 - d. Have a soda and take a break; it has been a long day.
 - e. Pick up the medication from the pharmacy and assure the information on the label matches the order.
 - f. Have a snack; this is a lot of work.
4. Where will you document the new medication?
5. Transcribe the medication.

How to Determine What Time to Administer the Medication

If the physician would like the medication given at a certain time this will be included in the prescription/medication order. Ex: Tegretol 250 mgs, one tablet three times at day, give at 8, 4, & 8.

OR

If the physician would like a certain amount of time between doses the medication order would state every 6 hours, or every 8 hours. Ex: Tegretol 250 mgs, one tablet every 8 hours (this medication would have to have eight hours between each dose)

If the physician's order doesn't indicate a time to be administered or a certain amount of time between doses then DSP staff may schedule the medication doses at the times that will work best for the individual and fit with the individual's daily schedule. It is usually recommended that there be at least four hours between doses of the same medication.

Here are some time schedule examples!

Your Home's time schedule must be posted.

HOW OFTEN	TIME
Once a day or daily – q.d.	8 a.m. or 7 a.m.
Twice a day – b.i.d.	8 a.m. and 8 p.m. or 7 a.m. and 7 p.m.
Three times a day – t.i.d.	8 a.m., 12 noon, and 4 p.m. or 7 a.m., 1 p.m., and 7 p.m.
Four times a day – q.i.d.	8 a.m., 12 noon, 4 p.m., and 8 p.m. or 7 a.m., 11 a.m., 3 p.m., and 7 p.m.
Q 6 hours*	7 a.m., 1 p.m., 7 p.m., and 1 a.m.
Q 8 hours*	7 a.m., 3 p.m., and 11 p.m.

* Can give late if prior approval from physician or RN has been obtained.