Position Statement – North Carolina Board of Physical Therapy Examiners

7. Managing and Recording Medications

Adopted – June 28, 1999
Revised – Sept. 23, 2010, June 17, 2015, June 5,2024
Reviewed – June 6, 2018, Sept. 2, 2020, June 8, 2022

Gathering information on the medication a patient is taking and the patient's ability to take the proper dosage would be considered within the scope of practice for a physical therapist. It would also be appropriate for a physical therapist to provide basic information on medications that may have an impact on the PT plan of care; however, to provide an educational intervention, especially on medications unrelated to the PT plan of care, would **not** be considered within the scope of practice for a physical therapist.

It is also appropriate for a PTA to document medication changes if all the PTA is doing is simply recording changes in medication orders from the physician, PA, or nurse practitioner, but it is not appropriate for the PTA to make any interpretations or recommendations regarding medications. However, if a PTA believes that a medication change could result in harm or injury to the patient, the PTA should immediately notify the PT who will then contact the referring practitioner.

If a PT identifies a discrepancy between the discharge medication order and the prescription on the bottle or the amount that the patient claims to be taking, it is the responsibility of the physical therapist to contact the appropriate health care practitioner about the discrepancy. As always, the PT should document the conversation or correspondence.

Any change in medication should be forwarded to the home health nurse. The health care practitioner can ask the PT to confirm with the patient the medications that the patient is taking and there are no changes in the dosages, etc.

It would **not** be a violation of the **North Carolina Physical Therapy Practice Act** or Board rules for a PT to advise a patient as to what PRN standing orders involving the medications exist.

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