Origination:	*10/1/1998*
Last Approved:	*1/22/2018*
Last Revised:	*1/22/2018*
Next Review:	*1/21/2021*
Owner:	*Ann Ottman: Assistant Quality Officer*
Policy Area:	*SMH Hospital Policy*
References:	
Applicability:	*University of Rochester - Strong Memorial Hospital*

8.01 General Patient Care Orders Policy

Inpatient Orders

For all inpatient care orders a Patient Care Order sheet or electronic order must be documented in the patient's medical record. The right column of the Patient Care Order sheet is for drug orders and the left column is for non-drug orders and IVs. SMH approved protocol driven order sheets are also acceptable**.** Outpatient orders are written in the patient's medical record (See "Outpatient Orders," below). All patient care orders must be in writing or electronically entered, dated, timed, and signed.

For Nursing Practice:

- All orders must be acknowledged by a registered nurse in eRecord.

Overview

1. Orders for patient care (e.g., admission request, medications, tests) may be documented in the medical record by members of the medical staff privileged in order writing, as supported by hospital policy (See Section 14 of SMH Policies and Information Manual). Orders documented in the medical record /entered by a resident not privileged in order writing or a medical student, must be reviewed and authenticated by a supervising physician (a more senior privileged resident or attending physician) prior to implementation, except in an emergency where delay would jeopardize patient care.
2. Where appropriate, orders for patient care pursuant to clinical care protocols or guidelines approved by Clinical Council may be documented in the medical record /entered by a pharmacist. These orders do not require authentication. Providers will be notified according to the requirements of the relevant policy. (See Department of Pharmacy policies 8.C- Medication Orders, 11.B - Intravenous to Oral Conversion and 16.F - Pharmacist Ordering Laboratory Values).
3. When a practitioner requests a test or procedure (diagnostic or therapeutic) the practitioner must also document an order in the medical record.
4. Orders for "Do Not Resuscitate" or physical restraint must be handled according to specific additional policies. See SMH Policies 9.03.3 Withholding or Withdrawing Unwanted Life-Sustaining Medical Care 10.02 Restraints, or Psychiatry Policy & Procedure Manual.
5. All medication orders for patients 18 years or less and adults weighing less than 40 kilograms require the patient's current weight documented in the medical record. For patients less than 40 kg., a weight-based (e.g., mg/kg) or body surface area-based (e.g., mg/m2) dosage calculation is required for each medication. eRecord automatically back calculates the dose as weight based for all patients less than 40

kg. Orders for medications that are not usually ordered by weight or dosage unit do not require the calculation (e.g., eye drops, topical preparations, multivitamins). The Department of Pharmacy will not accept inpatient medication orders that do not contain the required information.

6. An order for a medication for which the patient has a previously recorded history of allergy or adverse reaction must not be a verbal order and include an explanation or a reference to an explanation (progress note) of the decision to prescribe the medication.
7. Any patient care order judged by the person receiving the order to be in error is not to be implemented. The order in question must be clarified, and completely re-ordered (if indicated) prior to implementation.
8. All medication orders for controlled substances, including anabolic steroids, expire after 7 days and must be re-written for continuation.
9. All medication orders other than controlled substances must be re-ordered after 60 days.
10. Abbreviations used in medication orders must be approved by the Documentation Committee (See policy 6.04). Orders that contain unapproved abbreviations will be returned to be rewritten.

Protocol Orders

Protocol orders are provider initiated after seeing the patient and may include a link to an approved protocol or directions in the order. All necessary orders (e.g., labs, medications, tests) are indicated in the protocol or order set.

1. Provider initiated after seeing the patient: Except in emergency situations where the provider may give a verbal order to initiate the protocol. Protocols may be found in eRecord as either an orderable smart group or SmartSet.
2. The first order of each order set for each protocol will include a “nursing communication order” in which the display name clearly identifies the protocol. The provider will sign the group of orders all contained in the order set.
    a. This communication order will include the specifics of the protocol or the approved protocol available electronically will be printed and placed in the patient’s medical record.
    b. This communication order will appear on the nurses’ current orders report, clearly delineating that the patient is on the ordered protocol.
3. All medications related to the protocol will be included in the orderable smart group or order set and clearly marked in the electronic medical record as being part of the protocol.
4. Appropriate procedure orders will also be included within the orderable smart group or order set.
5. Procedure orders, such as lab draws, in which frequency is variable based on conditions identified in the protocol, will be ordered utilizing the order entry functionality by the nurse based on the strict terms/ conditions of the protocol.
    a. A provider co-signature is not required as ordering of the protocol implies that the accompanying lab needs to be executed.
    b. The nurse places the order and identifies the attending, by name, as the ordering/authorizing provider.
    c. Within the order composer the nurse chooses the “Per Protocol” order mode. This will allow that specific lab order to be enacted.
    d. Utilizing order entry, nurse searches the preference list for the appropriate procedure (e.g., lab)

order.

Hold Orders

There are multiple reasons that a medication may need to be held (i.e., not given) or delayed (i.e., given at a later time) without the order being discontinued. A medication may be held based upon patient specific parameters, or held or delayed for a specific period of time because of a scheduled procedure or test. This policy will describe the process for adequately documenting the hold or delay of a medication. Proper documentation of this process is important to avoid the medication from defaulting to an overdue status.

1. All medication orders written at SMH to hold or delay medication must contain instructions defining under what conditions the medication should be held.
2. Types of hold orders:
    a. Individual Medication Hold Based on patient specific parameters:
        i. Patient specific parameters are entered into the administration instructions when the medication is ordered.
        ii. When the patient's condition meets the hold parameters, the nurse selects the "hold" action and indicates a reason to hold that specific medication for that specific administration time.
        iii. This type of hold is potentially applicable to each individual administration time for medications with hold parameters specified.
    b. Hold a medication under a specific condition
        i. Unless otherwise specified a hold order means the medication will not be given to the patient.
        ii. The provider enters a nursing hold medication order which will specify the medication to be held and the specific duration of the hold order (not to exceed 24 hours).
        iii. In the eMAR, the nurse selects the "hold" action and enters a reason for the hold for each dose of the medication held.
    c. Hold MAR when a patient goes to a procedure area or to the OR
        i. An order to hold scheduled medications on the MAR will be placed. This could happen when the patient changes level of care such as phases of care for a procedure or going to the OR.
        ii. In the eMAR the nurse opens the administration screen and places the medication on MAR Hold and gives a reason. The medication will be on MAR hold until the nurse completes the MAR unhold function.
        iii. Hold orders **must** specify the period of time the hold order is in effect or the number of doses to be held. This should be no more than 24 hours or one dose.
        iv. Hold orders should not be used to postpone an order to discontinue a medication.
        v. Hold orders written without any qualification will be considered an order to discontinue the medication.

Ambulatory Orders

1. Orders for patient care (e.g., medications, tests) may be documented in the medical record by members of the medical staff privileged in order writing, as supported by hospital policy (See Section 14 of SMH Policies and Information Manual). Orders documented in the medical record /entered by a resident not

privileged in order writing or a medical student, must be reviewed and authenticated by a supervising physician (a more senior privileged resident or attending physician) prior to implementation, except in an emergency where delay would jeopardize patient care. All medications administered to the patient must be documented on the MAR.

2. Non medication ***patient specific*** orders (such as diagnostic testing) could be, at the discretion of the attending provider:
    a. Written directly using CPOE
    b. Written in the **progress note** section of their documentation with the prefix: "Orders:"
        i. For example: "Orders: Ms. Smith will get a CBC, Lipid Profile, and Comprehensive Metabolic At her next visit"
        ii. For example: "Orders: Mr. Jones will get a right shoulder x-ray before being seen in the office at her next visit"
        iii. For example: "Orders: Ms. Cystic will get a urinalysis today"
    c. Sent, by the responsible providers, as a patient specific in-basket message to the office staff
    d. Orders may be decided upon in a "pre-clinic huddle" in the morning. All orders would be at the direction of the attending physician and would be patient specific. Any orders resulting from this huddle would:
        i. Be entered directly into the system by a licensed provider directly using CPOE
        ii. Written, by a licensed authorized provider, on a paper clinic schedule in the patient specific section of that schedule, and individually hand signed. The paper document would need to be filed and saved by the office manager in a secure location for a minimum of six years.
    e. All orders conveyed to office staff by other than direct provider CPOE must be patient specific and be fully qualified.
    f. Standing orders are not permitted, except where specifically spelled out by NYSDOH and SMH policies.
    g. The provider will be responsible for cosigning all orders entered by others (as their agent) within 24 hours
    h. Verbal orders may only be entered by a licensed registered nurse or pharmacist.
    i. Areas that have a primary system that drives clinical care (Aria for Rad Onc) do use transcription for orders to entered into one system that needs to be present in another system.
3. Medical Scribes are unlicensed staff hired to enter patient information into the medical record at the direction of the attending physician.
    a. Medical Scribes **Can**:
        - Assist the provider in navigating the medical record;
        - Locate prior notes, labs, imaging for provider review;
        - Enter documentation into the medical record on direction of the provider;
        - When directed by their supervising provider scribes may enter low risk orders such as:
            - laboratory tests
            - electrocardiograms

- medication refills or reorders
- basic imaging orders
- ambulatory referrals
- physical or occupational therapy
- activity orders
- diet orders
- measurement requests (e.g. pulse oximetry, CIWA score)
- **All such orders must be signed by the supervising provider prior to the order being active.**

b. Medical Scribes **Cannot**:

- Take verbal orders;
- Translate for patients;
- Handle bodily fluids;
- Touch patients;
- Act independently without direct clinical oversight;
- Conduct other duties while acting as the medical scribe;
- Be the final author/gignature on notes;
- Scribes may not enter:
  - medication orders that are new, involve complex dose or frequency changes, or are complex (e.g., chemotherapy, biologicals)
  - advanced imaging orders (e.g., CT, MRI, PET)
  - interventional procedures
  - nuclear medicine studies
  - imaging stress tests

Imaging Sciences Orders

Any time an imaging sciences order is canceled, there must be a phone call made to Imaging Sciences (275-1111).

Nursing Communication Orders

1. Nursing communication orders are free text orders that should only be used when a defined order does not exist. Nursing communication orders may not be used to order/modify any medication, medication changes require modification to the original order, discontinuation of the previous order or a time one order to be used.
2. There are three basic categories of communication orders to consider: one-time orders, constant ongoing orders, and periodic ongoing orders. eRecord categorizes the orders so the nurse can see them grouped based on which type they are and how often they occur. Then the nurse takes appropriate action depending on the types of orders. eRecord helps nurses manage these orders so outdated orders do not

remain active on the patient's chart. Leaving many of these one-time tasks active means they appear on the patient's orders summary, which can cause clutter and end-user confusion.

NURSING ACTIONS ("NURSING ACTION ORDERS")

A discrete list of actions (recognized as orders within eRecord) that nurses can place within their scope of practice. These orders do not require a provider co-signature.

A. Nursing actions that are considered orders in eRecord were approved by the Nursing Task Force and Clinical Architects e.g.:
   1. Specific diet orders / diet modifiers outlined by policy: (e.g., bereavement tray)
   2. Isolation Precautions (see Infection Prevention Policy 3.2 General Policies for Isolation Precautions)
   3. Chaplain Visit Request
   4. Nutritional Consult
   5. Oncology Nursing Consult (HH only)
   6. Wound Consult
   7. Respiratory Consult
   8. Ostomy/Skin Consult
   9. Social Work Consult
   10. Lactation Consult
   11. Ethics Consult
   12. Child Life Consult (SMH only)
   13. Aspiration/Fall/Seizure Precautions
   14. Vaccines – flu & pneumococcal only (standing order)
   15. Flight Risk (SMH only)
   16. Diabetes nurse Consult (HH only)
   17. Consults for Home Care Nursing
       - Home Care Liaison (SMH only)
       - VNS
       - Livingston Co.
       - Lifetime
       - Home Care of Rochester
   18. Lab hold blood order (SMH only)
   19. Update PCP(Primary Care Provider)/Attending

B. The nursing action is placed by the nurse who identifies the attending as the ordering/authorizing provider.
   1. Although the attending provider is included in the nursing action order, they are not required to co-

sign the order and may not be aware of the order at the time it is entered.

2. It is the responsibility of the nurse entering the order to communicate this to the providers caring for the patient using unit/service patient care planning channels e.g., rounds.

References:

SMH Policy 8.01.1 eRecord Patient Care Orders
Stage2_EPCore_1_CPOE_MedicationOrders.pdf (CMS)

Attachments:

I: Requirements *- & Recommendations for Medication Order Writing
II: Do Not Use Abbreviations

Approval Signatures

Approver	Date
Ann Ottman: Assistant Quality Officer	1/22/2018
Ann Ottman: Assistant Quality Officer	1/16/2018
Ann Ottman: Assistant Quality Officer	12/19/2017
Ann Ottman: Assistant Quality Officer	12/19/2017