QUINTE HEALTHCARE CORPORATION

Medical – Orders

Title: Medical – Orders		**Policy No:**	**3.11.8**
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Approved By:	**Medical Advisory Committee (MAC)**		

1. POLICY

Orders for treatment/medication must be written/authorized by healthcare professionals with prescribing privileges at Quinte Healthcare Corporation (QHC). A fully completed Prescriber's Order Form is mandatory before initiation of treatment and/or medication administration. These orders are kept as part of the patient's medical record.

Due to the risk associated with verbal orders their use is restricted to emergencies or urgent patient care situations, or where the prescriber cannot document his/her orders, i.e. in a code situation. In all other situations the health care professional will request written orders when the prescriber is present.

Orders sent/received by email or text message are not acceptable.

2. DEFINITIONS

Telephone order: An order communicated via telephone by an authorizer who is not physically present to write the order.

Verbal order: An order that is communicated by an authorizer who is present in the practice environment.

Medical Student: A person who is currently in medical school and has not completed a medical degree.

Medical Resident: A person, who has completed their medical degree, passed a national licencing exam and is completing the post-graduate residency portion of their education.

3. PROCEDURE

The procedure below will be followed to ensure complete and accurate orders are received prior to initiating procedures or administering medications. This is essential to the provision of safe care.

a. Orders shall be completed either by hand or electronically on an approved order set or prescriber's order sheet.
b. Hand written orders shall be written legibly in blue or black ink.
c. The list of "Do Not Use "abbreviations will be followed. Refer to Administrative Policy 2.1 Abbreviations for the list of approved abbreviations. Medication names must never be abbreviated.
d. If the prescriber's signature is not recognizable the signatory shall print their name below the signature.
e. Orders written by a medical student must be countersigned by a licensed physician before the order is processed. It is the responsibility of the medical student to ensure that orders are countersigned. Orders written by medical residents do not require a counter signature.
f. Orders written by a consulting physician or nurse practitioner are suggest orders – these orders should be written as "XX Suggests Orders". Suggest orders must be co-signed in person or telephone verification obtained from the MRP prior to the orders being implemented. Orders written by Acute Pain Service (APS) are an exception and do not require verification from the MRP prior to being implemented.
g. The prescriber must include the date (day, month, year) and time of the order on the order sheet.
h. Allergy status including drug and latex allergies must be listed on every order sheet. An unknown allergy status must be indicated.
i. The prescriber is responsible for "flagging" the chart that orders exist. Urgent or stat orders must be brought to the attention of nursing staff immediately.
j. All orders must be sent to pharmacy as soon as possible after the prescriber's authorization.
k. All medication orders must contain the patient's full name, the date the order is written, medication name, dose, frequency, route of administration, times to administer, purpose for a PRN medication, and the prescribers name, signature, and designation.
    - Each medication order must be administered as the prescriber intended. If the order is not clear, cannot be given as ordered or an error is suspected the prescriber must be contacted for verification.
l. The duration of drug therapy or number of doses to be administered will be specified in the order whenever appropriate.
m. Pharmacy must be notified when medications are initiated, discontinued or restarted.

n. A nurse or authorized unit communications clerk (UCC) must transcribe all written orders to the patients' record and record the date and time of transcription and the transcriber's initials.
o. All orders must be checked by a second nurse (or nurse if the original transcription is completed by a UCC). The nurse will document the date, time and their initials when the orders have been checked.
p. A nurse shall review the chart to ensure that all orders have been transcribed and checked at the beginning and at the end of the shift.
q. Any errors, omissions or discrepancies found on the cMAR will be communicated to pharmacy using the Pharmacy Communication sheet at the time of discovery.

Telephone and Verbal Orders

a. Verbal orders must only be taken in emergency situations or when the prescriber is unable to write the order (i.e., during a sterile procedure etc.).
b. Telephone orders may be taken when the prescriber is not present to write the order.
c. Health care providers authorized to take telephone and verbal orders include:
    - Registered Nurse (RN)
    - Registered Practical Nurse (RPN)
    - Nurse Practitioner (NP)
    - Registered Pharmacist (RPh)
    - Registered Pharmacy Technician (RPhT)
    - Registered Respiratory Therapist (RT)
    - Registered Dietician (RD)
    - Registered Midwife (RMW)
    - Physician Assistant (PA)
d. The health care provider receiving the order will:
    - Clearly identify the patient's name, room number and diagnosis
    - **Read back** each order in its entirety to the prescriber
    - Use clarification questions when required
    - Write the complete order on the prescribers order sheet indicating verbal order or telephone order. Include the date, time, prescribers name and your signature.
e. The prescriber will counter sign the order at the first available opportunity.
f. A pharmacist can receive a telephone order from a physician when they are not present on the unit and enter it into Meditech as a "New Telephone Order". This electronic order is then printed to the floor and co-signed by the physician in the usual fashion. The pharmacist will notify the unit the order is being sent.

Care Transitions

All previous orders are automatically discontinued when:
a. A patient undergoes an anaesthetic in the operating room.
b. A patient has delivered an infant.
c. A patient is moved to or from Rehabilitation, Mental Health, BSTU or Complex Continuing Care to another unit within QHC. This is considered a discharge and subsequent admission.

In these circumstances:

- Print the medication reorder sheet prior to the patient leaving the department.
- New orders must be written by the Most Responsible Provider (MRP).
- The receiving unit is responsible for obtaining new orders.
- Pharmacy must be notified.

d. Admission to and from the Intensive Care Unit.
   - The attending intensivist or on-call delegate will complete transfer orders and complete physician to physician hand over as per Policy 3.3 Critical Care – Adult ICU Admission and Discharge Policy

24 Hour Chart Checks:

- The nurse will check each chart nightly for order completion.
- cMARs are checked nightly against previous day's cMAR.
- Orders written within the immediate past 24 hours must be checked directly with the cMAR (original order to cMAR), and with the admin data screen.
- Orders greater than 24 hours old may be checked with the previous cMAR or the original order.
- If an order has not been signed off, it is the nurse's responsibility to follow through on verifying and actioning, as appropriate, the missed order.
- A QHC Cares event report is to be completed on any omissions or errors identified.
- After verifying the completeness of the transcribed orders the nurse will draw a line immediately below the last order verified in the patient chart and write "24 hour check" plus his/her signature, designation, date, and time.

If the order sheet has been labelled with the incorrect patient information and the back copy has been sent to pharmacy, the nurse shall:

- Take a pen and stroke out the orders on the original order sheet and write "Discontinue – Incorrect Patient" on this order sheet with the date, time and their initials.
- Send a copy of this order sheet to the pharmacy department.
- Re-copy the orders on a new order sheet that has been labelled with the correct patient's label, date, time and signature. The copied orders must be reviewed by a second nurse.
- Confirm with the prescriber that the correct patient matches the orders.
- Send a copy of the order sheet from the incorrect patient and the back copy of the new order sheet to pharmacy department.
- Place the original order sheet, with the orders that have been crossed out on the chart of the patient of which it was initially stamped (incorrect patient).

APPENDICES AND REFERENCES

References:

College of Nurses of Ontario. (2014). *Medication, Revised 2014*. Toronto, Ontario: College of Nurses of Ontario

College of Physicians and Surgeons of Ontario. (2002). [Electronic reference] *Preventing Medication Errors.* Retrieved December 10, 2008, from: http://www.cpso.on.ca/policies/policeis/default.aspx?ID=1838

College of Respiratory Therapists of Ontario (2013). Orders for Medical Care. Toronto, Ontario: College of Respiratory Therapists of Ontario. http://www.crto.on.ca/pdf/PPG/OrdersMC.pdf

Potter, P. & Perry, A. (2018). *Fundamentals of Nursing* (9th ed.). St, Louis, Missouri: Mosby

Cross References:

Policy 2.1 Abbreviations Do Not Use List of Symbols Acronyms and Dose Designations
Policy 3.3 Critical Care – Adult ICU Admission and Discharge Policy