- The development of guidelines for requesting and receiving test results on an emergency or stat basis, the identification and definitions of critical tests and critical values, to whom and by whom critical test results are reported, and monitoring compliance
- Writing down, or entering into a computer, the complete order or test result by the receiver of the information; using closed-loop communication with the receiver reading back the order or test result; and the sender confirming that what has been written down and read back is accurate. Permissible alternatives for when the read-back process may not always be possible may be identified, such as in the operating theatre and in emergent situations in the emergency department or intensive care unit.

Measurable Elements of COP.01.00

1. Ⓓ The hospital implements a written uniform process for prescribing patient orders that includes the following:
   - Information required in the order
   - Identifying orders that may be received verbally, via telephone, and via text (*See also* MMU.04.01, ME 6)
   - Who is qualified and permitted to prescribe patient orders (*See also* MMU.04.00, ME 1)
   - How and where orders are documented uniformly in patient medical records
   - Which staff are authorized to receive and record verbal, telephone, and text orders, in accordance with laws and regulations
   - Time frame in which verbal, telephone, and text orders must be signed by the prescriber
2. Diagnostic imaging and clinical laboratory test orders include a clinical indication/rationale when required for interpretation.
3. Complete verbal orders, including telephone orders, are documented and read back by the receiver and confirmed by the individual giving the order.
4. Procedures and treatments are carried out as ordered and are documented in the patient's medical record.
5. The results of procedures and treatments performed are documented in the patient's medical record. (*See also* ASC.03.02, ME 3)
6. Verbally reported test results are documented and read back by the receiver and confirmed by the individual giving the test result.

Standard COP.01.01

An individualized plan of care is developed and documented for each patient.

Intent of COP.01.01

The plan of care outlines care, treatment, and services to be provided to an individual patient. The overall goal of a plan of care is to achieve optimal clinical outcomes. The planning process is collaborative and uses the data from the initial assessment and reassessments performed by members of the health care team to identify and to prioritize the care, treatments, and services required to meet the patient's needs. The patient and family are involved in the planning process with the health care team.

The care plan is developed within 24 hours of admission as an inpatient and is updated as appropriate to reflect the patient's evolving condition. The plan of care is documented in the patient's medical record.

The plan of care for a patient must be related to their identified needs. Patient needs may change as the result of clinical improvement or new information from a routine reassessment (for example, abnormal laboratory or radiography results), or they may be evident from a change in the patient's condition (for example, loss of consciousness). The plan of care is revised based on these changes and is documented in the medical record as notes to the initial plan or as a new plan of care.

One method of developing care plans is to identify and establish measurable goals. Measurable goals can be chosen by the responsible practitioner with the nurse and other health care team members. Measurable goals are observable, achievable targets related to patient care and expected clinical outcomes.

Goals must be realistic, specific to the patient, and time-based to provide a means for measuring progress and outcomes related to the plan of care. Examples of measurable, realistic goals include the following:

- The patient will resume and maintain an adequate cardiac output as indicated by a heart rate, rhythm, and blood pressure that are within normal limits.
- The patient will demonstrate proper self-administration of insulin injections prior to hospital discharge.
- The patient will be able to walk from his bed to the visitor lounge with a standard walker, bearing weight as tolerated on the affected leg.

Note: A single, integrated plan of care that identifies measurable goals expected by each health care practitioner is preferable. It is good practice for the plan of care to reflect individualized, objective, and measurable goals to facilitate reassessment and revision of the plan of care.

Some departments may conduct multidisciplinary patient care conferences for patients receiving complex care from multiple services. Examples of such patients include the following:

- Patients receiving rehabilitative services
- Patients with multiple diagnoses in intensive care units
- Patients with complex discharge planning needs

Any results or conclusions from collaborative patient care team meetings or similar patient discussions are written in the patient's medical record.

Measurable Elements of COP.01.01

1. The care for each patient is planned by the responsible practitioner, nurse, and other members of the health care team within 24 hours of admission as an inpatient.
2. The plan of care is individualized based on the patient's initial assessment data and identified needs and is documented in the patient's medical record.
3. The plan of care is updated or revised based on any changes in the patient's condition and is documented in the patient's medical record. (*See also* AOP.01.05, ME 1; ASC.04.03, ME 4)
4. The results or conclusions of any patient care team meetings or other collaborative discussions are documented in the patient's medical record.

Standard COP.01.02

The provision of high-risk services is guided by professional practice guidelines, laws, and regulations.

Intent of COP.01.02

Providing high-risk services involves unique risks to patients and staff; the hospital establishes and implements guidelines and procedures to identify and decrease risks associated with these services. Some services are considered high risk because of the complex medical equipment, the nature of the treatment, the potential for harm to the patient, or toxic effects of certain high-risk medications.

High-risk care is supported by the use of such tools as the following:

- Clinical practice guidelines
- Hospital policy and procedures
- Clinical pathways

These tools are important for staff to understand and implement in a uniform manner. Hospital leaders are responsible for the following: