Standards, Intents, and Measurable Elements

Care Delivery for All Patients

Standard COP.01.00

There is a uniform process for prescribing and completing treatment orders.

Intent of COP.01.00

A uniform process for the prescription, completion, and documentation of patient orders contributes to the integration and coordination of patient care activities, more effective use of human and other resources, and the increased likelihood of better patient outcomes.

Each member of the health care team records observations and treatments in the patient's medical record. Many patient care activities require a qualified individual to prescribe an order for that activity. Examples of such activities include the following:

- Orders for laboratory testing
- Administration of medications
- Specific nursing care
- Nutrition therapy
- Rehabilitative therapy

These orders are documented in the patient's medical record and must be easily accessible.

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. Patient care circumstances that can be critically affected by poor communication include verbal and telephone patient care orders, verbal and telephone communication of critical test results, and handover communications.

Patient care orders given verbally in person and over the telephone, if permitted under local laws and regulations, are some of the most error-prone communications. Different accents, dialects, and pronunciations can make it difficult for the receiver to understand the order being given. For example, drug names and numbers that sound alike, such as erythromycin and azithromycin or fifteen and fifty, can affect the accuracy of the order. Background noise, interruptions, and unfamiliar drug names and terminology often compound the problem. When received, a verbal order must be transcribed as a written order, which adds complexity and risk to the ordering process.

Clinical and diagnostic procedures and treatments performed are documented in the patient's medical record. The outcomes or results of any treatment or procedure are documented in the patient's medical record. Information about who requested the procedure or treatment and the indication for the procedure or treatment are included in the documentation.

Orders should be in a designated section of the medical record (for example, an orders requisition form in a hard copy medical record or order entry section of an electronic health record). They should not be interspersed throughout various sections of the medical record (for example, the order requisition form and progress notes), as this increases the likelihood of a missed order. Safe practices for communicating orders and test results include the following:

- Limiting verbal communication of prescription or medication orders to urgent situations in which immediate written or electronic communication is not feasible. For example, verbal orders can be disallowed when the prescriber is present, and the patient's chart is available. Verbal orders can be restricted to situations in which it is difficult or impossible for hard-copy or electronic order transmission, such as during a sterile procedure.

- 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.