ORDERS MANAGEMENT POLICY

Summary of Changes

	New	Previous
All Sites	Widespread CPOE with exceptions such as Residential Care	Pockets of CPOE
	Alerts Management principles	
	Refused order – new functionality in CST Cerner electronic health record (EHR)	Function not available
	Proposed order – new functionality in EHR	Function not available
	Co-sign orders as soon as possible in alignment with Medical Staff Rules.	As soon as possible
	Orders for chemotherapy agents (including those used for non-oncological indications) must be written or electronically entered directly by the prescriber. Exception: Telephone orders are permitted to hold or discontinue current chemotherapy for safety reasons. Reasons must be documented in patient's health record.	
	Approved list of medication with dose banding rules (Appendix D)	
	Standardized categories of medication for Dose Range Order Dose range orders (as single order format dose range orders) applicable to the medication listed in Appendix E	
	Stop medication list (Appendix F) including hard and soft stop medications	
VCH		To facilitate chemotherapy preparation, changes to previously-written or previously-entered orders may be made by a pharmacist upon verbal or telephone order from a prescriber.
PHC		
PHSA		Numerous policies

Table of Contents

1. Introduction

1.1 Purpose

The purpose of this policy is to provide a foundation for safe, consistent and efficient communication of orders reducing the potential for preventable errors or adverse events and resulting in improved patient care.

1.2 Scope

This policy applies to Health Care Professionals across the Health Organizations (HO, i.e. Vancouver Coastal Health (VCH), Providence Health Care (PHC) and Provincial Health Services Authority (PHSA) and all types of orders:

1.2.1 Health Care Professionals

This includes:

a. All Designated Health Care Professionals (DHCP) authorized to prescribe, transcribe or receive orders for patient specific care under terms consistent with their scope of practice, and/or Medical Staff Rules and Regulations, and according to HO policy.

1.2.2 Types of Orders

a. All **orders** including, but not limited to, medication orders, nutrition/diet orders, diagnostic orders, patient care activities and consult/referral requests.

2. Policy

2.1 Order Writing

2.1.1 General Principles

All orders

a. will be written by a DHCP who assumes responsibility for the accuracy and validity of the order within their scope of practice, including in situations where proxy documentation is allowed (See Documentation Policy Section 2.2.8)

b. will be entered and managed electronically using Computerized Provider Order Entry (CPOE) when available.

c. will be written on approved forms during downtime (Refer to Downtime Procedure) or in areas where CPOE is not implemented.

d. will be written in a manner that provides clear legible direction containing all the details necessary for action by a DHCP within their scope of practice. Medication orders must also be written in accordance with Accreditation Canada Standards (See Appendices A, B and C).

e. can only be changed, corrected, or clarified by writing a discontinue order, followed by a complete new order.

   Exception: Continuous infusions where the rate may be modified without writing a preceding discontinue order.

f. can be voided by a pharmacist.

2.1.2 Alerts Management

a. Providers are responsible for reviewing all alerts encountered during CPOE.

b. Providers use clinical knowledge and judgment to decide whether to proceed with an order by overriding an alert.

c. When required within the EHR, providers using clinical judgement to override an alert, must indicate the reason for alert override within before proceeding.

d. Clinicians who obtain and enter telephone or verbal orders, or initiate orders, must manage any EHR alerts generated in consultation with the provider. The provider is responsible for making the clinical decision to override the alert, or modify the order.

e. Clinicians entering an order within their scope of practice must address all alerts encountered during order entry.

2.2 Maintenance of Orders

a. All Providers

i. Have a responsibility for **maintaining orders**.

ii. Must ensure that the CPOE orders profile is maintained at least once per day (24 hours).

Exceptions:

- Residential Care/Alternate Level of Care orders are written as required based on any change with patient status; in general, providers are required to visit/assess a patient a minimum of once every three months.
- Ambulatory/Outpatient medication orders must be reviewed at the next scheduled visit or at a minimum annually.

b. All Nursing and Allied Health Professionals

i. Have a responsibility for the maintenance of orders.

ii. Must ensure that the CPOE orders profile is maintained at least once each shift.

Exceptions:

- Residential Care Nursing and Allied Health maintain orders at each shift if the chart is flagged with a new order, and regularly weekly.
- Ambulatory/Outpatient medication orders must be reviewed at every visit.

2.3 Orders Reconciliation

a. All orders need to be reviewed to ensure that they are clinically relevant by the Most Responsible Provider (MRP) when a patient is transferred into their care.

b. In the CST Cerner electronic health record (EHR) environment, when medication reconciliation is required per policy all orders must be reconciled (see Medication Reconciliation Policy).

2.4 Verbal and Telephone Orders

2.4.1 Verbal Orders

a. **Verbal orders** will only be accepted by a DHCP when the ordering Provider is in an **emergent or procedural situation** and is therefore unable to write the order.

b. **Read back process** must be used for all verbal orders.

c. The accepting DHCP must transcribe the verbal order in the patient's health care record at the earliest possible time.

d. EHR Alerts (e.g. for allergy status) generated for the given verbal order shall be managed in consultation with the ordering DHCP.

e. All orders must be co-signed by the ordering Provider at the earliest possible time in alignment with HO Medical Staff Rules. In the community setting without an EHR, if the Provider is not available to sign the order, a new faxed order should be provided by the Provider to confirm the verbal order.

2.4.2 Telephone Orders

a. **Telephone orders** will be accepted by a DHCP in situations where the order is urgently needed and the ordering Provider is not able to write or electronically enter the order directly into the patient's health record.

b. The accepting DHCP must transcribe the telephone order in the patient's health care record at the earliest possible time.

c. Read back process must be used for all telephone orders.

d. Telephone orders must be received directly by a DHCP and cannot be relayed through a third party or left on voice mail or with answering services or sent by text message.

e. EHR Alerts (e.g. for allergy status) generated for the given telephone order shall be managed in consultation with the ordering Provider.

f. All orders must be co-signed at the earliest possible time in alignment with HO Medical Staff Rules. In the community setting without EHR, if the Provider is not available to sign the order, a new faxed order should be provided by the Provider to confirm the telephone order

2.5 Chemotherapy Orders

a. Orders for chemotherapy agents (including those used for non-oncological indications) must be written or electronically entered directly by the prescriber.

Exception:

Telephone orders are permitted to hold or discontinue current chemotherapy for safety reasons. Reasons must be documented in patient's health record.

2.6 Oral Contrast Orders

a. All medical imaging exam preparation orders must be entered in to the patient's EHR.

b. In Radiology, Radiologists and Radiation Oncologists can enter oral contrast orders.

c. In Radiology, Medical Radiation Technologists (MRTs) can enter oral contrast orders as per corresponding Delegated Medical Act.

2.7 Medication Dose Banding Orders

a. Medication **dose banding** occurs according to the approved rule for each medication listed in Appendix D.

2.8 Medication Dose Range Orders

a. The use of range dosing in a single order format should only be used when flexibility in dosing is considered to be critical and the benefit outweighs the risks.

b. The follow categories of medication have been approved for range dose ordering via CPOE

   i. Oral **PRN** pain control medications (e.g. acetaminophen)

   ii. Oral PRN agitation medications (e.g. QUEtiapine)

   iii. Oral PRN acute seizure control medications

   iv. Oral PRN acute blood pressure control medications (e.g. caPTOPRil)

   v. Oral PRN antiemetic medications (e.g. dimenhyDRINATE / ondansetron)

   vi. Parenteral PRN antiemetic medications (e.g. dimenhyDRINATE / ondansetron)

c. Dose range orders (as single order format dose range orders) will be applicable to the medications listed in Appendix E.

2.9 Stop Medication Orders.

a. If duration of therapy is not specified on selected medications (See Appendix F) a soft or hard stop date will apply to the order. When the AutoStop Medication Report is printed for a patient, the provider should review the report to ensure that the medication order is still clinically required.

2.10 Order Priorities

2.10.1 Pharmacy Orders

a. An ordering provider who writes a STAT order must immediately notify the most responsible receiving DHCP verbally or by telephone that a STAT order has been entered.

b. For STAT orders, Pharmacy and Nursing will work together to begin medication administration immediately, with a target of less than 15 minutes from order placement.

c. For NOW orders, Pharmacy and Nursing will work together to begin medication administration as soon as possible, with a target of less than 60 minutes from order placement.

d. For ROUTINE Orders, Pharmacy will verify, fill and deliver to floor before next scheduled dosing time (if filling/delivery is necessary)*. Target medication administration at next scheduled dosing time **

   *Assuming pharmacy is open and medication is available on site.
   **Once medication is received.

2.10.2 Laboratory Orders

a. For priority of Laboratory Orders see Appendix G.

2.11 Proposed Orders (EHR)

a. Critical Care Physicians, Nurses, Allied Health Professionals, Pharmacists and Medical Students (see 2.19. 1 and 2.19.2) can propose orders for co-signature.

b. Proposed orders must be signed by a Provider.

c. Proposed orders must not be used for urgent or emergent situations.

d. Medical Staff must not propose orders to be signed by another Medical Staff.

Exception: Residential Care will not use the proposed order function.

2.12 Suggest Orders (non EHR- paper)

Suggest orders should

a. Only be used for suggesting orders/recommendations from one Medical Staff to another Medical Staff.

b. Only be documented on the consult note or progress note section of the patient health record. Any "suggest" medication orders/recommendations documented on a prescriber's order form will NOT be treated as active orders.

2.13 Planned/Future Orders

a. Future orders require DHCP action to order and plan.

b. Future orders require DHCP action if clinical judgement is required.

c. Future orders may be activated for operational requirements according to predefined unit/department/site specific procedure.

d. For Medical Imaging and Cardiac Imaging planned orders in Residential Care a patient specific renewal order will be written for a specified amount of time (e.g. for every one month or every 3 months).

2.14 Conditional Orders

a. Conditional orders are acted upon by a DHCP when the condition in the order is met.

b. Additional orders can also be entered to an external department (e.g. Lab) if outlined in the originating conditional order (e.g. if the urinalysis is positive for white blood cells (WBC) then send for urine culture).

2.15 Refused Orders (EHR)

a. In situations where an ordering provider does not agree with an order for co-signature in the Message Centre, they will review the order and document the reason for refusal.

2.16 Hold Medication Orders

a. "Hold Medication" orders must state the clinical event or the duration that the medication is to be held. For hold medications that have an indefinite hold time or unstated clinical event, providers are to discontinue the medication and re-order when appropriate.

2.17 Safety Validation of Orders

a. If an order is unclear or uses an element that is specifically deemed unacceptable, or is unsafe in any other manner, the execution of that order must be delayed. The ordering provider will be notified immediately by the person deeming the order unsafe or unclear and the order will be clarified and a new order will be written.

2.18 Standing Orders

a. Standing Orders are not approved for use anywhere.

2.19 Student Orders

2.19.1 Medical, Midwifery, and Nurse Practitioner Students

a. Can only write Proposed Orders in CST Cerner EHR which must be co-signed by their supervising DHCP.

b. Are allowed to accept and enter verbal orders in the CST Cerner EHR for individual orders and propose PowerPlans.

c. Should follow local HO and educational institution policy for requirements for completing orders in paper health record (see Section 4 Related Policies: AD 1700 Clinical Clerks: Orders for Patients, BCCW Medical Students Years 3 &4) and UBC Faculty of Medicine MD Undergraduate Program Policy: Expectations of Medical Students in Supervised Clinical Settings (031A)).

2.19.2 All other non-medical students

a. Students are to follow this policy and any standards set by their educational institution, with the following stipulations:

   i. Students can enact/follow orders, provided it is appropriate within their professional body standards and supervision.

   ii. Students will seek the guidance of their Clinical Instructor, Preceptor, or Most Responsible DHCP when enacting/following any orders.

3. Responsibilities and Compliance

3.1 Responsibilities

Designated Health Care Professionals are responsible for:

a. Clear communication of information to ensure orders are legible, complete, accurate and safe in accordance with this policy and their scope of practice.

3.2 Compliance

a. Compliance with this policy is expected. Anyone noting a violation of the policy may support others to locate and understand the policy and/or advise leadership of the need for education and support regarding the policy. After education and support is offered, and the person remains non-compliant, the HO may remove the person from their workplace position (job) up to and including termination of employment or privileges within the organization

4. Definitions

Alert(s) appear as pop-up messages to warn of missing patient data such as height/weight or allergies that provide decision support for an order. This is especially important for medication orders.

Clear legible direction means any **prescription/order** is **written** or transmitted in a complete, clear and legible manner. Legibility may be subjective in nature, but if a healthcare professional requires interpretation/confirmation from a second individual, the order is considered illegible.

Computerized Provider Order Entry (CPOE): a process of electronic entry of orders by DHCPs for the treatment of patients/clients. The orders are communicated over a computer network to health care providers fulfilling the order.

Conditional Orders are patient-specific orders and are not considered to be standing orders. A conditional order consists of a condition and action usually written in the form of *'if-then*' statements. For example – if tolerating oral fluids, then discontinue peripheral IV.

Designated Health Care Professionals (DHCP): refers to both Regulated Health Care Professionals (RHCP) and Approved Non-regulated Health Care Professionals (ANHCP).

a. **Regulated Health Care Professionals:** Professionals regulated by regulatory colleges under the *Health Professions Act* (e.g. Physicians, Midwives, Pharmacists, Nurses, and Dietitians). For complete list see BC Ministry of Health Professional Regulation.

b. **Approved Non-regulated Health Care Professionals**: non-regulated professionals (including students) designated through the health organizations approval process (e.g. Medical Imaging Technologists, Cardiology Technologists, Respiratory Therapists).

c. **Students** in Designated Health Care Professions.

Dose Banding: a system whereby drug doses that are calculated and fall within defined ranges or "bands" are rounded up or down to predetermined standard doses.

Electronic Signature: A generic, technology-neutral term for the various ways that an electronic record can be signed. It is considered legally binding as a means of identifying the author of a medical record entry and confirms the contents are what the author intended.

Emergent or procedural situation means a life-threatening situation wherein the patient could suffer significant harm without rapid or immediate therapeutic and/or diagnostic intervention or during sterile procedures where ungloving is not practical.

Maintaining Orders refers to actions such as discontinuing any order that is no longer required, reconciling conflicting orders (e.g. multiple diet orders for example), resolving duplicate orders (e.g. unnecessary repetition of lab tests) and adding new orders as per the patient's condition or recommending any of these actions to a provider or to the MRP.

Order/Prescription: A direction provided by a DHCP for a specific task (e.g. diagnostic imaging order, medication order) to be available for and/or administered to a specific patient.

Patient refers to patient, client, resident, or person in receipt of healthcare services.

Planned/Future Orders refers to orders that will be actioned at a later time. Orders in the EHR designated as future will stay in a planned state in a PowerPlan or a future state for individual orders until they are initiated (e.g. Patient may be inpatient but orders may be placed for medications for after the patient is discharged i.e. 3 days of outpatient antibiotics). Planned orders are those that have been entered to be initiated at a later time.

PRN is an abbreviation for the Latin term "pro re nata" which translates to "as needed."

Proposed Orders are orders which are held in a planned state in the EHR until the Provider reviews and either accepts or rejects the order. Accepting a proposed a proposed order will make it an active order.

Provider refers to Physicians, Pharmacists, Registered Midwife, Registered Nurse Practitioner and Provider students, within their scope of practice.

Procedural situation refers to when a provider is in a sterile procedure where ungloving is not practical.

Read Back Process: the process of reading back verbatim a telephone or verbal order to verify accuracy. Unfamiliar drug names need to be spelled out using "T" as in "Tom", "C" as in "Charlie" etc. Each numerical digit needs to be pronounced separately saying, for example, "one-six" instead of "sixteen"

Soft Stop is defined as automatic default stop date reminders.

Standing Orders refers to an order or set of orders, including order sets or pre-printed orders, which is/are designated to be given as a complete set of orders without an individual patient assessment or individual patient-specific order review.

Suggest orders are only recommendations and are not considered active orders.

Telephone Order: An order given during a telephone conversation between the person authorized to give the order and person authorized to receive the order.

Verbal Order: An order given during a face to face conversation between the persons authorized to give the order and the person authorized to receive the order.

Write, written, or writing means the act of printing or hand-writing an order, and may include the entry into a technology such as a computer or similar documentation device (i.e. CPOE) but specifically excludes a ***verbal order*** or ***telephone order***.

5. Related Resources

5.1 Related Practice Guidelines/Protocols/Procedures

BCMHSUS FPH Standard Work - Discontinuing Medication Orders

5.2 Related Policies

BC Cancer Systemic Therapy Treatment Delivery Process III-10

BCCW Automatic Stop Orders

BCCW Discontinuation and Re-ordering of Pre-Operative Medication Orders

BCCW Duration of Medication Orders

BCCW Medical Students Years 3 and 4

BCMHSUS FPH CCR-602H Processing Telephone, Written and Verbal Orders

BCMHSUS FPH CCR-601 Safe Medication Order Writing

BCMHSUS FPH CCR-635H Automatic Stop Orders

Prescribing Policies - Lower Mainland Pharmacy Services

VCH - AD 1700 - CLINICAL CLERKS: ORDERS FOR PATIENTS

6. References

B.C. Children's and Women's Hospital. Medication Order Requirements Policy. 2016.

Island Health Authority. 2016. Orders Management Policy.

VCH-PHC. 2016. Medication Order Requirements Policy. 7. Appendices

7. Appendices

Appendix A: Order Requirement Standard

Appendix B: Standard International (SI) Units Chart

Appendix C:
Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations

Appendix D: Approved Medications with Dose Banding Rules

Appendix E: Dose-Range Order Medications (as single order format dose range orders)

Appendix F: Soft Stop Alert Medication List

Appendix G: Laboratory Order Priorities

Appendix A: Order Requirement Standard

All orders must be clear, complete and readable. In accordance with Accreditation Canada Standards, all prescriptions must contain the following elements.

Table 1: Elements of a Safe Prescription

Required Elements	Detailed Description
All prescriptions are legibly written	Print where possible, especially for unusual or complex details.
Two patient-specific identifiers, one of which is full patient name	Patient name and Personal Health Number; or Patient name and date of birth; or Patient name and Medical Record number
Patient-specific information relevant to medication orders	Gender Height/weight (in metric only) Allergy information Pregnancy/breastfeeding
Date and time	Letters are used for the month e.g. 26 AUG/12 or AUG 26/12 Time using the 24-hour clock
Drug name	Generic drug names are preferred Drug products containing multiple (i.e. more than two) ingredients are identified by brand name
Dose is described in Standard International (SI) units	**See** Appendix B For pediatric (weighing less than 40 kg) and chemotherapy orders, include the dose based on the weight or body surface area along with the patient-specific dose e.g. 100 mg (10 mg/kg) or 200 mg (100 mg/m^2)
Dosage form	Write in full (e.g. capsule, inhaler) and include formulation descriptions (e.g. sustained release products)
Route(s) of administration	
Frequency of administration	Do not use frequency ranges (e.g. q 4-6 hr)

Required Elements	Detailed Description
Duration – specify stop date if required	If the number of doses or the stop date are not specified, the site-specific automatic stop order policy applies (e.g. antibiotics)
PRN is always accompanied by specified frequency and/or maximum daily dose	Include clinical condition to which the PRN applies
Legible prescriber identification	Signature, college ID number and printed surname or **Electronic Signature**
Designations found on the VCH-PHC Do Not Use list of dangerous abbreviations are NEVER used when communicating medication information	**See** Appendix C

Appendix B: Standard International (SI) Units Chart

Description	SI Unit:	Abbreviation
Length	metre centimetre millimetre	m cm mm
Surface Area	square metre	m^2
Mass	kilogram gram milligram microgram	kg g mg mcg
Volume	litre millilitre millimole	L mL mmol
Time HH:MM (24-hour clock)	day hour minute second	d h min s
Temperature	degree Celsius	°C

Appendix C:
Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

Abbreviation	Intended Meaning	Problem	Use Instead
U	Unit	Mistaken for "0" (zero), "4" (four), or cc	unit
IU	International unit	Mistaken for "IV" (intravenous) or "10" (ten)	unit
Abbreviations for drug names		Misinterpreted because of similar abbreviations for multiple drugs; e.g. MS, MSO_4 (morphine sulphate), $MgSO_4$ (magnesium sulphate) may be confused for one another	full drug names
QD QOD	Every day Every other day	QD and QOD have been mistaken for each other, or as 'QID'; the Q has also been misinterpreted as "2" (two)	daily every other day
OD	Every Day	Mistaken for "right eye". (OD = *oculus dexter*)	daily
OS, OD, OU	Left eye, right eye, both eyes	May be confused with one another	left eye, right eye both eyes
D/C	Discharge	Interpreted as "discontinue whatever medications follow" (typically discharge medications)	discharge
cc	cubic centimetre	Mistaken for "u" (units)	mL
µg	microgram	Mistaken for "mg" (milligram) resulting in one thousand-fold overdose	Mcg

Symbol	Intended Meaning	Potential Problem	Use Instead
@	at	Mistaken for “2” (two) or “5” (five)	at
> <	Greater than Less than	Mistaken for “7” (seven) or the letter “L”; confused with each other	greater than/above less than/below
Trailing zero	x.0 mg	Decimal point is overlooked resulting in 10-fold dose error	Never use a zero by itself after a decimal point: **x mg**
Lack of leading zero	.x mg	Decimal point is overlooked resulting in 10-fold dose error	Always use a zero before a decimal point: **0. x mg**

Appendix D: Example list of Approved Medications with Dose Banding Rules

- dalteparin
- daptomycin
- enoxaparin
- fluorouracil
- gentamicin
- heparin
- tobramycin
- vancomycin

Appendix E: Dose-Range Order Medications (as single order format dose range orders)

acetaminophen	meperidine
acetaminophen-codeine 300-30 mg tab	methotrimeprazine
acetaminophen-codeine 300-60 mg tab	metoclopramide
acetaminophen-codeine 32-1.6 mg/mL oral liq	midazolam
ASA	morphine
captopril	naproxen
chlorpromazine	NIFEdipine
codeine	olanzapine oral dissolving
diazepam	olanzapine
diclofenac	ondansetron
diclofenac EC	ondansetron oral dissolving
dimenhyDRINATE	oxyCODONE
ephedrine	oxyCODONE-acetaminophen 2.5-325 mg tab
fentanyl	oxyCODONE-acetaminophen 5-325 mg tab
haloperidol	phenylephrine
hydrALAZINE	prochlorperazine
HYDROmorphone	QUEtiapine
ibuprofen	SUFentanil
ketorolac	traZODone
labetalol	TYLENOL #1 EQUIV tab
LORazepam	TYLENOL #2 EQUIV tab
LORazepam sublingual	TYLENOL #3 EQUIV tab
loxapine	

Appendix F: AutoStop Alert Medication List

- Anti-infectives - 7 days HARD stop
  (Note: antiretrovirals (ARVs) or tuberculosis (TB) medications are excluded)
- Oseltamivir - 5 days HARD stop
- Injectable controlled / narcotics - 7 days SOFT stop
- Oral controlled / narcotics - 7 days SOFT stop (excluding methadone, buprenorphine-naloxone, methylphenidate, fentanyl Patches)
- Inhalation solutions - 7 days SOFT stop (excluding salbutamol, ipratropium, budesonide, iprtropium-salbutamol)
- Topical eye/ear steroids - 7 days SOFT stop
- Topical steroids - 28 days SOFT stop

Appendix G: Laboratory Order Priorities

Priority	Emergency Department (ED) Collections	Inpatient Collections	TMS blood/product orders (site/inventory/product dependent)
STAT	Highest priority. Collected as soon as possible	Highest priority Collected with 15 minutes	Highest priority Product ready as soon as possible
Urgent	2nd highest priority Default for all ad-hoc ED Lab orders	2nd highest priority. Collected within 60 minutes	2nd highest priority. Product ready in 1 hour.
Routine	For ED inpatients only	To be collected in collection batch nearest requested collection time	Product ready in 4hrs
Timed	Collected within 15min of requested time	Collected within 15min of requested time	Product ready at requested time
AM Draw*	To be collected in the first collection batch of the following calendar day	To be collected in the first collection batch of the following calendar day	N/A
Add On**	To request additional testing on a sample already in the lab	To be used to request additional testing on a sample already in the lab	N/A

*AM Draw Priority is the default priority for those tests that are always done fasting.

**Add On Priority will be associated only with the Lab - Add On Test orderable and will trigger the printing of a label from Sunquest in the lab.

*Early Discharge: The unit orders Early Discharge Request and lab will generate log to review and prioritize work for morning collections. The process will be monitored with potential adjustments.

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