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Medication Order Requirements Policy

Policy: A formal, clear, concise, and non-negotiable statement directing staff decision-making

1. Introduction

1.1. Description

Every health care provider is responsible for the clear communication of medication information. Medication orders are frequently misinterpreted if incomplete, illegible or contain ambiguous abbreviations. These practices result in medication errors and can negatively impact patient outcomes.

This policy provides parameters to guide safe, consistent and efficient communication of medication and nutrition orders resulting in improved patient care and a reduction of preventable medication errors and adverse events.

1.2. Scope

This is a joint policy between Vancouver Coastal Health (VCH) and Providence Health Care (PHC).

This policy applies to:

- All Vancouver Coastal Health (VCH) and Providence Health Care (PHC) health care providers qualified to prescribe, transcribe, or receive medication or nutrition orders for VCH-PHC clients and other related medication processes;
- All written, faxed, or electronically printed prescriptions and the related computer output from any source (e.g. medication labels, profiles and medication administration records);
- Complementary and alternative medication orders (e.g. vitamins, herbal or nutraceuticals);
- Parenteral and oral nutrition supplements (excluding diet orders);
- All medication orders; and
- Pre-printed orders for medications.

2. Policy

2.1. Guiding Principles

- Every health care provider is responsible for the clear communication of medication information.
- Each prescription is complete and contains all details necessary for action by other health care providers and fulfills regulatory requirements.
- Illegible, ambiguous, incomplete, or otherwise unsafe prescriptions are clarified with the prescriber (or designate).
- Designations on the "VCH-PHC Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations (Appendix C) will never be used.
- Compliance with this policy is audited for quality improvement purposes.

2.2. Medication Order Requirement

Each medication order must be clear, readable, and complete, including all details necessary for action by other health care providers in accordance with the VCH-PHC Medication Order Requirement Standard (Appendix A).

2.3. Audits

Medication orders will be periodically audited for adherence to the "VCH-PHC Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations" (Appendix C). Pharmacy staff will periodically perform audits in accordance of the "Lower Mainland Pharmacy Services Targeted Prescribing Practices Policy and Procedures".

Results of the audits will be reported to the Regional Pharmacy and Therapeutics Committee. Prescriber and transcriber practice leaders will monitor audit results and take action to improve adherence with the Medication Order Standards.

2.4. Responsibilities

2.4.1. All VCH-PHC Health Care Providers

Every health care provider is responsible for the clear communication of medication information and must ensure medication orders are clear, legible and complete in accordance with this policy.

2.4.2. Pharmacy Staff

Pharmacy staff will conduct audits of medication orders in accordance with the "Lower Mainland Pharmacy Services Targeted Prescribing Practices Policy and Procedures".

2.4.3. Regional Pharmacy and Therapeutic Committee

The committee will review and monitor results of the audits to identify trends for the purpose of Quality Improvement.

2.4.4. Practice Leaders

Practice leaders will review specific incidents of unacceptable prescribing and transcribing practices, provide feedback to individual prescribers or transcribers and follow up on performance issues.

2.5. Compliance

Specific incidents of unacceptable prescribing or transcribing practices will be provided to the Practice leaders of the prescriber or transcriber.

The Practice leaders involved will provide feedback to individual prescribers and transcribers and follow up on performance issues (see VCH Medical Staff Rules 5.8.2 and PHC Medical Staff Rules 5.8.3.4).

3. Supporting Documents and References

3.1. Appendices

- Appendix A: Medication Order Requirement Standard
- Appendix B: Standard International (SI) Units Chart
- Appendix C: VCH-PHC Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations

3.2. Standards/Guidelines/Forms

- Accreditation Canada: Medication Management Standards v.10 (January 2016)
- British Columbia Safe Medication Order Writing: Best Practice Guideline (December 2011)

3.3. Related Policies

- Lower Mainland Pharmacy Services Targeted Prescribing Practices Policy
- VCH Medical Staff Rules
- PHC Medical Staff Rules

3.4. Definitions

"Medication Order" means a prescription for any medication, parenteral or oral nutrition supplement requiring authorization from a prescriber in an acute or outpatient setting.

"Prescriber" means a qualified health care provider with prescribing privileges for applicable client care areas within VCH or PHC.

"Prescription" has the same meaning as Medication Order.

"Telephone Order" means verbal communication of a prescription by a prescriber by telephone (to a licensed health care provider authorized to receive a medication order) when the prescriber cannot reasonably attend to write or electronically enter the order in the health record.

"Transcriber" means a health care provider with a qualifying scope of professional practice to receive and document a verbal or telephone medication order on the health record.

"Verbal Order" means verbal communication of a prescription to an authorized licensed health care provider by a prescriber who is present or in close proximity.

3.5. Keywords

do not use abbreviations, illegible prescribing, medication order, medication order writing, nutrition orders, pre-printed orders

3.6. Questions

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Appendix A: Medication Order Requirement Standard

Elements of a Safe Medication Order

Medication 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 Medication Order

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)
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
Designations found on the VCH-PHC Do Not Use list of dangerous abbreviations are NEVER used when communicating medication information	**See Appendix C**

Verbal and Telephone Orders

Patient care may be compromised when prescribers do not write or electronically enter orders directly in the health record. These orders are more prone to error. Therefore, in addition to the Elements of a Safe Medication Order the following conditions for communication of prescriptions must be met for verbal and telephone orders. Verification of all verbal and telephone orders is the shared responsibility of both the prescriber and transcriber. The practitioner receiving the order confirms the indication for the medication with the prescriber. It is the responsibility of the transcriber receiving the order to ensure that the order is reasonable within the context of the client's condition, prior to initiating the order.

- Verbal communication of an order is only acceptable in emergent or life-threatening situations or during sterile procedures where ungloving is not practical.
- Telephone communication of an order is only acceptable when the medication is urgently needed and the prescriber is unable to write or electronically enter the order directly into the patient's health record.
- The transcriber receiving the order verbally repeats the entire order to the prescriber for verification.
- The order is immediately transcribed into the client's health record along with the name, designation and college ID of the transcriber.
- The prescriber (or designate) reads and signs the order in accordance with the VCH Medical Staff Rules or PHC Medical Staff Rules. In the community setting, if the prescriber is not available to sign the order, a new faxed order should be provided by the prescriber to confirm the verbal or telephone order.

Orders for Chemotherapy Agents

Orders for chemotherapy agents (including those used for non-oncological indications) must be written or electronically entered directly by the prescriber (exception: orders to hold or discontinue).

To facilitate chemotherapy preparation, changes to a previously-written or previously-entered orders may be made by a pharmacist upon verbal or telephone order from a prescriber. However, the dose must not be administered until the new order has been signed and dated by a prescriber. If the prescriber is not available to sign, a new faxed order should be provided by the prescriber reflecting the dose changes.

Medication Order Interpretation

The following principles will guide interpretation of a medication order. Orders that are unclear or incomplete must be clarified with the prescriber or his/her delegate.

1. **Once an order is written, it cannot be altered in any way**

   To change, correct or clarify a medication order, a "discontinue" order is written, followed by the new complete order.

2. **Medication orders at changes in level of care**

   Medication orders are discontinued and new orders must be written when there is a change in the level of care.

   All pre-operative medication orders are discontinued and new medication orders must be written or electronically entered post-operatively, except for the following patients or procedures:

   - Adult ICU/Critical Care patients when going to or returning from the operating room;
   - Central venous catheter insertion;
   - Pacemaker insertion;
   - Hemodialysis and peritoneal access
   - Scope procedure through a natural orifice.

   Each order must be written or electronically entered in full and meet all of the required Elements of a Safe Medication Order.

   Orders to "resume pre-op meds", "resume home meds", "may take usual meds" etc. are not acceptable as they do not fulfill all of the required Elements of a Safe Medication Order and as such, would require clarification with the prescriber.

3. **"Hold" orders**

   "Hold" orders must state the duration that the medication is to be held. Medications in "Hold" orders without a specified duration will be discontinued.

4. **"Suggest" orders**

   Qualified recommendations such as "suggest" or "if OK with attending team" orders should be written in consultants' or progress notes. Any "suggest" medication orders documented on a prescriber's order form will NOT be treated as active orders.

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

Do Not Use

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**
Dose Designation	**Intended Meaning**	**Potential Problem**	**Use Instead**
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**

Adapted from ISMP Canada's "Do Not Use" List (2006) at: http://www.ismp-canada.org/dangerousabbreviations.htm