Ordering Norms

Ordering

Ordering is an activity of health care prescribers whereby direction is given relating to investigations, medications and other interventions requested in the service of patient care. Computerized Prescriber (or Physician or Provider) Order Entry (CPOE) refers to the process of a medical prescriber entering and sending investigation and intervention orders or instructions electronically via a digital health record instead of paper charts.

Connect Care commits to tools and workflows that make CPOE as easy as possible for prescribers. Indeed, with the convenience of ordering on any computer or mobile device, anywhere, anytime; ordering is easier to do, and do well, than when constrained by paper.

Goals

Connect Care ordering workflows should be:

Anchored	The ordering provider should remain associated with an ordering process from initiation through fulfillment and ascertainment of effect.
Accurate	Orders should clearly and precisely direct a course of action with as much supplemental comment as needed to ensure that the order intent is realized for a patient's unique circumstances; with any conditional elements clear enough to allow the health care team to know exactly how they might change the order action.
Appropriate	Providers order within bounds set by their scope of practice, training, experience and capabilities; avoiding unnecessary requests for investigations or interventions normally performed without orders by other healthcare professionals.
Assisted	Order-associated clinical decision supports should be clinically pertinent, have significant impact, demonstrably prevent errors and not unnecessarily impede workflow with duplicative, ineffective or non-essential hard stops.
Accountable	Ordering activities should be transparent about who is the ordering provider, the authorizing provider and the most responsible provider.
Approved	Consultant orders are saved, not signed, if not approved for direct implementation by the responsible provider or service and trainee orders are marked for co-signature, not signed, unless approval to sign has been explicitly authorized.
Attested	Ordering providers should not sign a request unless confident that all elements of the order are understood and intended, including any decision supports triggered by the order.

Importance

CPOE offers the means by which health process and outcome improvements can be facilitated by a CIS. It provides a focal point for clinical decision supports which, in turn, can help providers avoid unsafe medications, promote best practices and learn how to improve system performance. Studies show that the move from paper to CPOE decreases common medication errors by 50% or more.

It is important that the prescriber issuing an order interact with the CIS when doing so. That is the only way that orders can be grouped to avoid oversight, checked for completeness, and harmonized with other orders to avoid misadventure.

Commitment

The Connect Care initiative seeks near 100% CPOE where its clinical information system (CIS) is the record of care. Physicians, residents, nurse practitioners and other prescribers must work closely with their nursing and allied health colleagues to ensure optimal care, which includes optimized order entry.

Norms

The Connect Care clinical information system (CIS) serves all who provide care where Connect Care is the. Ordering Norms are about how Connect Care users collaborate to ensure error-free clarity of directions for investigations, monitoring, interventions, referrals and care transitions.

Some ordering activities are low risk while others have major impact on patients, providers and the health care system. Order Entry norms help prescribers acknowledge a shared understanding about who is responsible for ordering workflows, what activities can be delegated and under what circumstances.

Minimum Use

Order Entry Norms complement Minimum Use Norms, which outline expectations clinicians have of one another for using the CIS in a way that assures safe and collaborative care. Minimum Use Norms are provincially endorsed, backed by professional regulatory bodies and consistent with Alberta Health Services (AHS) Medical Staff Rules.

One minimum use norm holds that where Connect Care is used as the record of care: “All tests, interventions and medications that can be ordered in the CIS must be ordered in the CIS.”

Policy

AHS has organizational accountability for standards-compliant clinical ordering. Relevant policies and procedures must be followed by all health care providers. For example, Medical Staff Rule 4.21.2.5 (a) states: “…Where electronic order entry is available, utilization of the system is mandatory.” Ordering Norms complement but do not replace AHS policy, directives and procedures relating to order entry.

Applicability

Connect Care Order Entry Norms apply to all Clinicians who see patients where Connect Care is the record of care. The guidance applies whether orders are recorded through direct entry, voice recognition, clinical scribe or verbal transcription; anywhere and anytime across the care continuum.

Order Entry

What is it?

Clinicians indicate intended health care investigations, interventions and care services through "Orders" placed in the digital health care record. Order entry relates to complete capture of all orderable health services provided to a patient together with order properties (e.g., duration, repeats, stopping rules, alert and review parameters, etc.) that assure safe and effective fulfillment of the request.

Why does it matter?

All members of the care team rely on complete, accurate, clear and specific orders to coordinate care activities, assign accountability, and enable surveillance of the health outcomes associated with orders. Orders are one of the most common triggers for clinical decision supports. These help avoid inappropriate health care services while flagging potentially harmful interventions. Any second-hand (e.g., "verbal" or "scribe" or other delegated order-entry) orders isolate the prescriber from decision-supports and other aids to patient safety.

Who is responsible?

All clinicians are responsible for good order management – those entering orders, those validating orders and those carrying out activities based on the orders. Connect Care is committed to 100% prescriber order entry in the clinical information system. Hybrid (CIS and paper or CIS and alternate information system) order management is not permitted.

How is it done?

Orders are managed in orders activity parts of the chart in all care contexts. A "mark as reviewed' should additionally be used by team members to attest to awareness of currently active orders. Indeed, "Orders" are not directives, but rather information objects that also serve team task management, care coordination, and therapy optimization. They are part of the record of care and support practice audits, reporting and safety assurance.

Do	Order Entry	Don't
• Order all investigations, interventions, medications, consultations and care services in the CIS where it is the record of care. • Include stop dates on all orders unless the order is intended to persist continuously. • Use stop dates to force review of the effects of ongoing interventions. • Record all medication refills and repeats in the chart. • Reconcile (review appropriateness and possible reversion to prior state) orders at transitions of care.		• Ignore alerts about upcoming expiring orders. • Order repeating investigations (e.g. daily labs) not subject to repeating re-evaluation. • Order investigations, interventions or services for which there is not a justifying health problem.

Order Management

What is it?

Prescriber perspective

Order Management relates to complete capture of all orderable health services provided to a patient together with order properties (e.g., duration, repeats, stopping rules, alert and review parameters, etc.) that assure safe and effective fulfillment of the service request. It also involves reviewing all the orders available for a patient, removing those no longer appropriate and placing new orders when clinically appropriate. Providers should be managing orders and avoiding placement of duplicate orders.

Non-prescriber perspective

Acknowledging orders involves the receiving and reviewing of orders for appropriateness by an authorized health care provider. Appropriateness review includes consideration of the:

- Completeness of the order (e.g. does it include all the elements required for that order?)
- Accuracy of the order (e.g. right patient)
- Suitability/appropriateness of the order based on the patient's status (e.g. does it fit the patient's needs?)

Why does this matter?

When a clinician places an order, the order lets other clinicians know about tasks that have been or should be carried out for a patient. Order entry activities work in combination with the Order Composer to allow clinicians to place, modify, and discontinue orders.

Who is responsible?

All clinicians are responsible for good order management – those entering orders, those validating orders and those carrying out activities based on the orders.

It remains a professional responsibility to review and discuss treatment plans with patients and families to ensure that they are patient-centered. If a clinician has concern(s) or requires further clarity about an order, even after it has been acknowledged, they are responsible to discuss the order with the most responsible health practitioner.

How is it done?

When a clinician signs an order, it triggers actions for other clinicians and systems. The effects of orders may appear in many locations, including order reconciliation, order review and medication administration records.

Clinicians can view detailed information about orders from a variety of locations, as well as modify orders, reorder orders, or prepare for a procedure by releasing an instance of a standing or future order.

Do	Order Management	Don't
• Reconcile orders at transitions of care. • Be alert to and act upon co-sign requirements.		• Ignore expiring orders flags. • Forget to co-sign orders to make them active.

Order Delegation

What is it?

The Connect Care initiative seeks near 100% CPOE where its clinical information system (CIS) is the record of care. This means that orders should be entered directly to the CIS by the ordering provider. There may be extraordinary circumstances when or where this is not possible.

Why does this matter?

It is important that the prescriber issuing an order interact with the CIS when doing so. That is the only way that orders can be grouped to avoid oversight, checked for completeness, and harmonized with other orders to avoid misadventure.

Who is responsible?

Protocolized Orders

Sometimes orders are part of a set or protocol where the important decisions are made in advance and conditionals are built into the plan. The orders are pre-directed and signed by the responsible prescriber. Subsequently, medical support staff may act on instructions in the plan, including requesting test or therapy adjustments explicitly called for by the plan. In this way, CPOE function is preserved while non-physicians can assist with things like triggering tests that are part of a referral triage protocol or ensuring standardized preoperative preparations. These situations are not an exception because the prescriber simply issues the “orders” as part of a protocol.

Urgent Verbal Orders

While there are local and regional variations in practice, it is important to recognize that AHS policies, professional guidelines, and legislation allow for verbal orders (whether the alternative is paper or digital) in specific situations. AHS directives are clear:

- Verbal (in-person) medication orders shall only be accepted by a health care professional in an **emergency situation** or an urgent situation where delay in treatment would place a **patient** at risk of serious **harm**, and it is not feasible for the prescriber to document the medication order (e.g., during a sterile procedure, during a resuscitation).
- Verbal medication orders shall not be accepted for **chemotherapy** unless the order is to hold or discontinue the medication.

Authorized health care professionals (e.g. nurses) can take a verbal order from a physician and transcribe (enter) it onto the system. The expectation is that the nurse can immediately inform the prescriber of any alerts or other decision supports (e.g. dosage checks) that arise during the order-transcription process.

Telephone Orders

Connect Care prescribers have easy access to the patient’s chart and quick-order tools from any computer, mobile device or smart phone. The need for verbal orders given via telecommunications should be rare. However, policy allows for situations where there is urgent need and no alternative to a telephone-delivered (“telephonic”) order:

- Telephonic (conveyed by telephone and/or radio) medication orders shall only be accepted by a health care professional where the authorized prescriber is not physically present to document the medication order and a delay in ordering, administering, or discontinuing the medication would compromise patient care and/or **patient safety**.
- A telephonic medication order shall not be accepted via voicemail.
- Telephonic medication orders shall not be accepted for chemotherapy unless the order is to hold or discontinue the medication.

Again, the expectation is that the telephonic order is delivered to an authorized provider (nurse) who can immediately inform the prescriber of decision supports arising during the order-transcription process. Under no circumstances are text message, email or other asynchronous communications acceptable.

Other Exceptions

The intent of Connect Care is to improve care. Unforeseen situations may arise where an alternative to CPOE is compellingly justified by safety considerations. Such exception-cases must be described in standardized way and submitted for approval at the level of the Connect Care Executive Committee.

How is it done?

The clear expectation is that all Connect Care prescribers will enter the vast majority of orders directly to the CIS. Orders may be entered indirectly in the following situations, with the proviso that the person entering orders on behalf of the prescriber is able to receive, relay and act on decision supports:

- **Accommodated Orders**
  In rare situations, an authorized provider may not have physical capacity to interact with the CIS. Under duty-to-accommodate, authorized and certified medical scribes may be able to enter orders on their behalf.
- **In-Person Verbal Orders**
  These will be accepted in an emergency or if the situation otherwise precludes CPOE and time is of the essence (e.g. a patient needs analgesia for a broken leg and the physician is in the middle of performing a procedure) and the indirect order entry is facilitated by a provider able to recognize, relay and act on prescriber responses to decision-supports.
- **Telephonic Verbal Orders**
  Synchronous indirect orders relayed via telephone or radio will be accepted when the prescriber cannot be reasonably expected to access Connect Care for CPOE in the time-frame appropriate for the clinical circumstance (e.g. driving in the car, scrubbed in the operation room) and an authorized provider is available to help relay and act on decision-supports.

Facilitating acceptable indirect prescriber orders (accommodated, verbal or telephonic) requires health care providers with order-entry capacity and training to enter order(s) to the CIS. They can do this only if within their scope of practice and training. There may be circumstances where extended role non-nurses (e.g. medical scribes) have been trained and authorized.

Do	Order Delegation	Don't
• Limit indirect order-entry to rare circumstances justified by urgency and/or compelling patient safety needs.		• Avoid computerized (desktop, mobile, voice-activated) order entry because of inconvenience or lack of training.