Physician’s Orders for the New Graduate Registered Nurse
Education Module

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Title: Physician’s Orders

Learning Objectives:

Upon completion of this education module, the new graduate registered nurse will:

 ✓ Discuss the formal and informal processes of communication with primary care providers.
 ✓ Describe the process used to obtain orders for admission and discharge of a client and to complete medication reconciliation upon admission and discharge.
 ✓ Anticipate orders that may be needed as a result of communicating a change in client status to a health care provider: emergent and non-emergent.
 ✓ Recognize and use communication tools specific to the clinical facility.
 ✓ Describe the types of orders used in health facilities.
 ✓ Review facility-specific and unit-specific policies related to when provider’s orders are needed i.e. use of restraints, etc.
 ✓ Review agency- and/or unit-specific pre-printed physician’s orders and when these are used i.e. pre-procedure, pre-operative, induction of labor, etc.
 ✓ Review appropriate abbreviations, symbols, acronyms and dose designations for use in health care facilities.

Interactive Exercises:

 ✓ Use of an SBAR communication tool. See Appendix A.
 ✓ Review SBAR Communication, Guidelines for Communicating with Physicians Using SBAR and the SBAR tools.
 ✓ Determine what communication tool(s) is used by the employer. With the preceptor, discuss how it is used. Compare and contrast this tool with the SBAR communication tools.
 ✓ All newly licensed nurses are to complete scenario # 1 and 2 and one additional scenario of choice, using an appropriate SBAR tool from the facility, or in Appendix A.
 ✓ Review written SBAR communication tools with the preceptor. Discuss scenario responses with the preceptor and compare and contrast how the preceptor would have responded. If in a group of newly hired nurses, discuss responses with other group members. Compare and contrast individual responses with those of the other group members.
 ✓ Discuss situations when SBAR is not effective. Preceptor, in the role of the provider does a role play with the nurse in the following situations: provider is not cooperative in using the SBAR format and terminates the call abruptly before responding to the nurse’s concern; provider will not agree to any of the nurse’s recommendations and gets upset.
   1) Discuss how the nurse felt in this role play, how she handled the discussion, what could have been done differently. If in a group of newly hired nurses, discuss observations of other group members.
2) Preceptor and other nurses from the unit/facility discuss their personal experiences in the use of SBAR and difficulties with the communication process with providers.

✓ Locate phone numbers of providers affiliated with facility or unit.
  a) Are there differences in how communication occurs among individual providers, groups of providers, and on weekdays versus the night shift and weekends?
  b) Identify the telephone chain of communication used by the facility i.e. a secretary/paging system receives calls and forwards them to the unit, providers call nurses directly, a charge nurse calls all providers, etc.
  c) Discuss the pros and cons of this communication system with the preceptor.

✓ Locate and review a list of accepted common abbreviations or terms used in the facility or unit i.e. ER (emergency room), BMP (basic metabolic panel), O₂ sat (pulse oximetry), etc.
  a) Are these within the accepted guidelines of the ISMP and Joint Commission? (See Appendix D)
  b) Discuss this list with the preceptor: its location, how often it is revised/updated, what is acceptable and unacceptable according to hospital protocol, differences between units, variations within the facility.
  c) Complete an audit of a chart or electronic health record reviewing all abbreviations used and clarify which are official and unofficial.

✓ This section (# 4) is to be completed by the newly licensed nurse working in long-term care or assisted living using the protocol for change of condition for communication in a long-term care or assisted living community. See Appendix.
  a) Review this communication tool.
  b) Complete the 3 scenarios.
  c) Review responses to scenarios with the preceptor. Discuss individual responses and compare and contrast how preceptor would have responded. If in a group of newly hired graduate nurses, discuss individual responses with other group members. Compare and contrast individual responses with those of the other group members.

✓ Review the physician’s order sheets used in the facility. If standard order sets are used, obtain a copy to review.
  a) Review the facility policy/procedure on obtaining and completing provider’s orders; how the orders are taken off and initiated; how to check on the status of an order in process; when orders are to be called to provider (i.e. renewal, discontinuation, etc.).
  b) Discuss this policy and these procedures with the preceptor.
  c) Review pre-printed orders (pre-op, pre-procedure, Code Blue, etc.), what information the nurse is expected to obtain, complete and/or insert.
  d) Preceptor and nurse participate in taking orders off a chart or electronic health record and initiating these orders, check on the status of an order, discuss how an order is handled if needed, and any follow-up needed with provider, ancillary departments or other members of the health care team.

✓ Role play obtaining physician’s orders for the admission of one client and the discharge of another client with the preceptor in the role of the provider; complete the medication reconciliation process; complete prescriptions to be given to the client being discharged.
a) Select a newly admitted client and another who is being discharged. Review these clients’ health records.

b) Using client information and SBAR communication tools, contact the provider (preceptor) to obtain admission and discharge orders, complete medication reconciliation and prescriptions for home use.

c) Use a blank physician’s order sheet to write these orders. If the facility uses standard order sets for admission and discharge, obtain a copy of order sets and use them in this role play activity; use other related forms.

✔ Review the Check-Back or Read-Back Communication Strategy. See Appendix C.
   a) With the preceptor, review how this strategy is implemented in the facility.
   b) Using provider’s orders on select client health records, identify where and how this is documented.

✔ Appendix D – reading and writing provider’s orders. For these scenarios, the following documents are to be reviewed:
   a) Joint Commission’s Official “Do Not Use List”
   b) ISMP’s List of Error-Prone Abbreviations, Symbols and Dose Designations

✔ Appendix E – Types of Orders in Facilities.
   a) Select health care records of 2-3 clients on the unit and review the provider’s orders.
      Identify the types of written orders, order sets or pre-printed orders.
   b) With the preceptor, review the facility policy on:
      1) when a verbal or telephone order can be taken and not taken; exceptions to this policy
      2) who can write orders within the agency (i.e. resident physicians, consulting physicians, non-affiliated physicians, nurse practitioners, etc.)
      3) renewal of specific standing orders (i.e. use of restraints, narcotics, specific medications).
      4) location of prescription pads and identifying information to be added to a prescription given to a client (sticker with identifying information related to admission, etc.), use of a computerized form
      5) what and when prescriptions may be called to a community pharmacy; who can call

Other recommended activities:

✔ Review transfer process of a client to another health care facility.

✔ Review standing orders for use in a Code Blue and facility policy on documentation and implementation of verbal orders during a Code.

✔ Discuss the rules and regulations of the State Nurse Practice Act regarding a nurse writing/calling prescriptions; review agency policy on writing/calling prescriptions; review facility prescription pad or electronic prescriptions.

✔ Review heparin protocol and standing orders related to heparin administration; protocol for initiating TPN; or other similar standing orders.
References


Supplemental Resources

Facility communication tool (SBAR) for communication with providers

Facility/electronic forms: for medication reconciliation, client transfer, Code Blue

Facility Policy and Procedure Manual

Facility pre-printed order sets (i.e. preoperative, postoperative, labor and delivery, radiologic interventions, heparin protocol, etc.)

Facility prescription/electronic prescriptions

On Demand Presentation: Effective Teamwork as a Care Strategy – SBAR and Other Tools for Improving Communication
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/Effective+Teamwork+as+a+Care+Strategy+SBAR+and+Other+Tools+for+Improving+Communication+Between+Careg.htm?TabId=0&player=wmp
Accessed 10/1/10

Protocol and/or guidelines for Code Blue within the facility

Rules and Regulations of the Nebraska State Nurse Practice Act

SBAR: A Communication Handbook for All Staff
SBAR: Staff Training for Improved Communication
http://www.hcmarketplace.com/ Accessed 10/1/10

SBAR Training Video for Acute Care Settings
http://www.saferhealthcare.com/educational-resources/educational-resources/sbar-training-video-for-acute-care-settings Accessed 10/1/10
Appendix A

SBAR Communication

✓ Describe the meaning of SBAR
✓ Discuss why SBAR is needed
✓ Describe the SBAR process

Principles of error-free interactions:

✓ REMEMBER TO introduce yourself and state your title.
✓ Communicate interactively, slowly and promote questions.
✓ Communicate up-to-date information regarding care, treatment, services and condition.
✓ Limit interruptions to avoid losing or skewing information.
✓ Allow adequate time.
✓ Require a verification process such as check-back or read-back.
✓ Ensure the receiver of information has the opportunity to review relevant data, including prior care, treatment and services.

The challenges:

✓ Poor communication leads to errors in provider’s orders.
✓ Communication styles vary. Health care workers have been trained to use varying communication styles.
✓ Lack of assertiveness is a problem.
✓ Language barriers such as non-English speaking patients/staff pose particular challenges.
  • Distractions such as emergencies can take your attention away from the current task at hand.
  • Physical proximity may be an issue.
  • Personalities can make it difficult to communicate with particular individuals.
  • During heavy workload periods, all of the necessary details may not be communicated, or they may be communicated but not verified.
  • Disagreements may disrupt the flow of information between communicating individuals.
Verifying and acknowledging the exchange of information may not occur. Transitions in care are the most significant time when communication breakdowns occur.

Focus is on answers to 3 main questions of providers:

✓ What is the problem?
✓ What do you need me to do?
✓ When do I have to respond?

Advantages:

✓ Provides for a standardized approach from clinician to clinician
✓ Provides direction.
✓ Improves care planning.

Guidelines for Communicating with Providers Using the SBAR Process

Use the following modalities according to provider preference, if known. Wait no longer than five minutes between attempts.

1. Direct page (if known)
2. Provider’s Call Service
3. During weekdays, the provider’s office directly
4. On weekends and after hours during the week, provider’s home phone
5. Cell phone

Before assuming that the provider you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

Prior to calling the provider, follow these steps:

• Have I seen and assessed the patient myself before calling?
• Has the situation been discussed with resource nurse or preceptor?
• Review the chart for appropriate provider to call.
• Know the admitting diagnosis and date of admission.
• Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
• Have available the following when speaking with the provider:
  • Patient’s chart
  • List of current medications, allergies, IV fluids, and labs
  • Most recent vital signs
  • Reporting lab results: provide the date and time test was done and results of previous tests for comparison
  • Code status

When calling the provider, follow the SBAR process:

(S) Situation: What is the situation you are calling about?

• Identify self, unit, patient, room number.
• Briefly state the problem, what is it, when it happened or started, and how severe.

(B) Background: Pertinent background information related to the situation could include the following:

• The admitting diagnosis and date of admission
• List of current medications, allergies, IV fluids, and labs
• Most recent vital signs
• Lab results: provide the date and time test was done and results of previous tests for comparison
• Other clinical information
• Code status

(A) Assessment: What is the nurse’s assessment of the situation?

(R) Recommendation: What is the nurse’s recommendation or what does he/she want?

Examples:
• Notification that patient has been admitted
• Patient needs to be seen now
• Order change

Document the change in the patient’s condition and provider notification.
SBAR

Communication with a Provider – Critical Situation

S

I am calling about <patient name and location>.
The patient's code status is <code status>
The problem I am calling about is ____________________.
I am afraid the patient is going to arrest.
I have just assessed the patient personally:
Vital signs are: Blood pressure ___/___, Pulse ____, Respiration___ and temperature ______
I am concerned about the:
Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual
Pulse because it is over 140 or less than 50
Respiration because it is less than 5 or over 40.
Temperature because it is less than 96 or over 104.

B

The patient's mental status is:
Alert and oriented to person place and time.
Confused and cooperative or non-cooperative
Agitated or combative
Lethargic but conversant and able to swallow
Stuporous and not talking clearly and possibly not able to swallow
Comatose. Eyes closed. Not responding to stimulation.
The skin is:
Warm and dry
Pale
Mottled
Diaphoretic
Extremities are cold
Extremities are warm
The patient is not or is on oxygen.
The patient has been on ________ (l/min) or (%) oxygen for ______ minutes (hours)
The oximeter is reading ____%  
The oximeter does not detect a good pulse and is giving erratic readings.

A

This is what I think the problem is: <say what you think is the problem>
The problem seems to be cardiac infection neurologic respiratory _____
I am not sure what the problem is but the patient is deteriorating.
The patient seems to be unstable and may get worse, we need to do something.
I suggest or request that you <say what you would like to see done>.
- transfer the patient to critical care
- come to see the patient at this time.
- Talk to the patient or family about code status.
- Ask the on-call family practice resident to see the patient now.
- Ask for a consultant to see the patient now.

Are any tests needed?
- Do you need any tests like Chest X-ray, ABG, EKG, CBC, or BMP? Others?

If a change in treatment is ordered then ask:
- How often do you want vital signs?
- How long to you expect this problem will last?
- If the patient does not get better when would you want us to call again?

### SBAR Scenarios

#### Scenario # 1 (Adult Med-Surg)
Mr. O is 63 years old. He was dizzy and light-headed at home and almost fell. His wife brought him to the ER. He was admitted with syncope. He has been previously treated at this hospital for congestive heart failure and acute myocardial infarction. He feels like he is “pretty healthy” as he only takes NSAIDs for chronic back pain.
He arrived on the unit at 1600. His nurse is Jenny, RN. She assessed: BP 138/84, T 98.6, P 76 and regular, RR 16. Lab test results were normal. The IV infiltrated during transport. She started a new IV and put a warm compress on the old site. She reported off to Ben, RN at 1900. At 2130, the UAP found Ben and told him that he had just helped get Mr. O. off the bedpan. Mr. O had a large, black tarry stool and was complaining of not feeling well. Ben went to assess Mr. O.: BP 94/66, P 114, RR 24, 0₂ sat 97%. He was pale and his skin was clammy. Mr. O said he just didn’t feel well and could not get comfortable. He asked if he could have something for his belly. “It is really hurting!” Ben assessed his abdomen and found that it was distended and Mr. O had diffuse abdominal pain. He rated his pain a 6 on a scale of 1-10.

#### Scenario # 2 (Cardiology)
Mrs. S is a 72 year old who lives alone and is very independent. She was shoveling snow on Monday morning after the big storm. While shoveling she developed a crushing sensation in her chest. This is not the first time she has had chest pain. She has a history of angina, though she has never had a heart attack. She takes an aspirin every day and keeps nitroglycerin tabs in her pocket “just in case”. She took a nitroglycerin tab and an aspirin and drove herself to the hospital. Mrs. S was admitted to the hospital on Monday afternoon with chest pain, rule out myocardial infarction.
She has been a patient on cardiology for 4 days. She has had no chest pain since Monday and has been ruled out for a heart attack. She has an IV of 0.9% NS at TKO and expects to go home in the morning. At 2200, Mrs. S put her call light on. Her nurse Sue, RN, answered the call light. Mrs. S stated that she was having chest pain and rated it a 9/10 on the pain scale. Sue had the UAP check her vitals and call the EKG technician to run a monitor strip. Sue, RN, went to get her a nitroglycerin tab. BP: 90/52, P 120, RR 36 with labored breathing, 0₂ sat 85% on room air. Her EKG shows ST changes. Sue gave Mrs. S a nitroglycerin tab sublingually. There was no relief to her chest pain and her BP decreased to 80/52. Sue placed Mrs. S on oxygen at 2L and her 0₂ sat improved to 91%. Mrs. S is very anxious and states she feels terrible. Sue increased her IV fluids to 100 mL/h and called the physician.

#### Scenario # 3 (Obstetrics)
Margie, a 25-year-old primipara, is in the recovery room after a low forceps delivery of a nine pound, two ounce, term male. Margie plans to breast feed the baby.
Forty-five minutes after delivery, Margie’s vital signs are BP 100/60, P 88 and RR 16. Her fundus is firm and is at the level of the umbilicus, no clots observed. She has a continuous trickle of bright red lochia. No change in perineal edema, ice pack applied and peripads changed. Peripads and chux weight indicate 300 mL blood loss.

Fifteen minutes later the fundus is massaged and remains firm at umbilical level and midline. A constant trickle of bright red lochia persists with no clots expressed. Peripads and Chux weighed showing and additional 200 mL blood loss. Vital signs: BP 90/52, P 110 and RR 20.

Scenario # 4 (Respiratory)
Mr. Jones is a 35 year old and had a bowel resection 3 days ago. Yesterday morning it was noted that Mr. Jones required 4 L of oxygen to maintain SaO2 of 92%. His lung sounds were decreased in the bases, cough was weak and ineffective. He required much coaching to use his incentive spirometer, and was only able to generate inspiratory volumes of 400 mL. Mr. Jones was started on intermittent positive pressure breathing treatments to increase lung expansion.

Today Mr. Jones states his pain is greatly reduced. He is able to use his incentive spirometer, and generate inspiratory volumes of greater than 1500 mL. His SaO2 is 94% on room air. He is able to produce a strong cough on command, and his lung sounds are clear in all lung fields.

Scenario # 5 (NICU)
Baby Z. is 3 weeks old infant in NICU. He was at 27 weeks gestation when delivered. He has been progressing well after a short period of CPAP and remains in 24% O2 support. He is receiving continuous tube feedings. He has demonstrated a steady weight increase.

For the first time today, he has had episodes of apnea. When Sue, the evening nurse, came on and did her assessment she noted he was tachypneic with RR of 75. As she was documenting her assessment, Baby Z. had a bradycardia episode and his O2 sat decreased to 75%. His heart rate returned to 130 with stimulation and Sue increased the oxygen to 28%. He also had some regurgitation of formula. His muscle tone is diminished and his coloring is mottled. She listened to his breath sounds and noted that they were equal and clear. His abdomen is soft and not distended. The day nurse reported that he had slept a lot today and his mother felt he wasn’t as alert as usual.

Scenario # 6 (Rehab)
Mr. D is a 55-year-old who was picking up a bag of cat food when he experienced pain to the low back and within an hour, the pain was radiating down the posterior aspect of the left leg and to the foot. He came in for an evaluation 2 days ago and was unable to complete the full evaluation because of pain. He had no weakness on evaluation but his left ankle DTR was slightly diminished. Both flexion and extension movements produced pain however flexion produced greater pain. No clear centralization was achieved.

He returns today with a 9/10 pain. When he is placed on a bike to try a warm up, he noticed that he didn’t feel the seat very well. He is a hesitant to ride and distressed because last night he had an episode of bowel incontinence. He feels this happened because he has been “pushing so hard trying to urinate the last couple days, he just pushed too hard when he coughed.” He feels that if the bike makes him cough it may happen again. The bike does not change his pain and he has no demonstrated weakness today.

On further treatment, repeated movements did not improve his pain or symptoms. He does not centralize and continues to report numbness to his inner legs bilaterally and groin area. His left leg pain continues to radiate down the posterior thigh and to the foot.
Appendix B

Using Protocols for Change of Condition When Caring for Residents in an Assisted Living Community (ALC)

This communication guide is for use by a nurse, caregiver or UAP when reporting to the primary care provider or designated nurse:

- Resident’s name
- Age
- Current medications and recent (new changes)
- Allergies
- Sex of the resident
- Vital signs, if possible and according to ALC policy; physical assessment findings, behavioral changes, activity level and other pertinent findings
- Responsible party for the resident or nearest relative
- Advanced directives, if any
- Past medical history and current diagnoses (e.g. diabetes, hypertension, had a stroke last year, etc.)
- Information obtained when answering the protocol questions or following agency policy and procedure related to the change in the resident’s condition

The following is a list of the conditions that should be addressed in the ALC policies/procedures:

- Activity change
- Agitation or behavior changes
- Bleeding
- Blood pressure
  1. Low blood pressure
  2. Orthostatic blood pressure
  3. High blood pressure
- Breathing problems
- Chest pain
- Chest discomfort
- Confusion
✓ Cough or cold symptoms
✓ Diarrhea
✓ Dizziness
✓ Eating/appetite changes
✓ Eye problems
✓ Falls
✓ Fever
✓ Headache
✓ Hearing (worsening)
✓ Itching
✓ Medication problems/errors
✓ Memory Problem (see confusion)
✓ Mouth Pain
✓ Nausea and vomiting
✓ Pain – new or worse
✓ Seizures
✓ Skin Changes
✓ Sleep problems (more than 3 days in a row)
✓ Stomach pain
✓ Swallowing problem
✓ Swelling
✓ Urine problems
✓ Vaginal problems
✓ Vision changes (see eye problems)
✓ Walking (change in) Weakness
✓ Weight change (loss or gain) (see eating/appetite changes)

✓ *The American Medical Directors Association has put together this information based on the views of experts and evidenced based literature as a guide to gathering information about what is
going on with the adult resident and to communicate that information directly to someone designated by the ALC’s policy.

The following are examples of staff roles and responsibilities in monitoring residents with acute changes of conditions (ACOC):

Caregiver (or UAP) --

✓ Recognize and report condition changes
✓ Make frequent observations of the resident’s condition and symptoms
✓ Communicate findings according to protocol to appropriate staff
✓ Tell the ALC manager or person in charge if follow-up has not occurred
✓ Review the resident’s status with caregivers on the next shift before leaving for the day

Nurse --

✓ Respond to caregiver’s concerns about a resident
✓ Recognize condition changes early
✓ Assess/evaluate the resident’s symptoms and physical function. Communicate detailed description of observations and symptoms to nurse manager or provider (depending on policy).
✓ Document in the resident’s medical record
✓ Update the nurse manager or provider if resident’s condition deteriorates or resident fails to improve within expected time frame
✓ Report resident’s status to the nurse manager or provider (depending on policy) as appropriate

Nurse Manager or Person in Charge --

✓ Ensure consistent, timely evaluation, documentation and reporting of relevant information about the resident
✓ Communicate the detailed descriptions of observations, symptoms and physical function of the resident to the provider (if that is policy) and document in the resident’s medical records
✓ Provide provider with a copy of advanced directives, if available
✓ Ensure effective communication of necessary information to other members of the interdisciplinary team, including relevant clinicians, caregivers or care technicians, resident, health care surrogates/responsible family member, ancillary staff and others responsible for the resident’s care.

ALC Scenario # 1

Helen, a care technician in an assisted living community, is helping Mrs. Elmer with her bath. Helen notices that the resident has become increasingly short of breath. When Helen asks Mrs. Elmer about the change in her breathing, she responds by saying that it started last night. This morning when she weighed herself she noticed that she was 2 lbs heavier. Helen finishes assisting Mrs. Elmer and then calls Tammy, the primary nurse.

- H = I’m caring for Mrs. Elmer and she is experiencing more shortness of breath (SOB) when walking today. When I walked her to the bathroom for her bath she had SOB which she didn’t have on Monday (today is Wednesday). Mrs. Elmer also said that she weighs 2 lbs more than yesterday. I also noticed that her ankles are swollen. If I press on the swollen area and remove my finger you can see the indentation.

- T = It’s probably her Congestive Heart Failure (CHF) again.

- H = I think you need to see Mrs. Elmer.

Tammy goes to check on Mrs. Elmer.

List the assessments to be completed on Mrs. Elmer. Include specific questions to be asked this resident.

Using the communication guide for ALCs, what additional information is needed before calling the provider?

Complete an SBAR based on the above information.

ALC Scenario # 2

Mr. Smith is a 78-year-old with CHF and hypertension residing in an assisted living community. Today’s vital signs are: T - 98.6, P – 104, R – 24, and BP - 188/90. His respiratory status is worse today as evidenced by increased respiratory rate and having SOB when ambulating 8 feet (baseline ability - ambulate 20 feet). Lung sounds were previously clear, but today he has crackles in the posterior lower lobes bilaterally. He usually has +1 edema in both ankles, but today it is +2 and slightly pitting. He has gained 6 lbs over 4 days. His current daily medications include: Digoxin 0.125 mg, Lasix 20 mg, Potassium 20 meq and Prinivil 5 mg. He has no standing/PRN orders. Mr. Smith’s dietary intake was not much different than his normal 2 gm Na diet, except for eating ham for dinner 2 days ago. The nurse calls the provider, Dr. Gannon with an update.

- Dr. Gannon, I am Nancy Stevens, the nurse in charge, at ABC Assisted Living Community. I’m calling about Mr. James Smith, whose blood pressure, respirations and weight are elevated.

- Mr. Smith is a 78-year-old patient, with a diagnosis of CHF and hypertension. BP has increased to 188/90, respirations to 24. He is SOB when ambulating 8 feet, previously SOB at 20 feet. Weight has increased 6 lbs in 4 days. Cracks are present in the posterior lower lobes of both lungs. He is compliant with medications. For the most part he is compliant with his 2 gm Na diet, with the exception of eating ham for dinner 2 days ago.

- Mr. Smith is experiencing fluid retention which may or may not have been exacerbated by the ham dinner.

✓ I would like to give Mr. Smith a dose of IV Lasix now, and then continue with his daily oral Lasix dose in the A.M. We will measure his urine output for the next 24 hours to assess his diuresis. I will assess his respiratory status and urine output. May I draw a stat potassium level? I
will call you with the results tomorrow morning. The on-coming nurse will assess Mr. Smith’s SOB and urine output in 2 hours.

Are there any additional assessments that should have been completed on Mr. Smith? Any additional questions that should have asked of this resident?

What information was not included in the nurse’s communication with the provider, based on the ALC communication guide?

Identify any alterations in communication that should have made, based on the SBAR communication tool.

**ALC Scenario #3**

Mrs. Jones is a 81-year-old female in an assisted living community whose past medical history includes a series of TIA's over a 2 year span, followed by a mild stroke. She was in a rehabilitation facility and recovered, then returned to the ALC. Mrs. Jones also has severe carotid artery stenosis. She has become increasingly unsteady on her feet within the last several weeks. A referral was made to PT to evaluate lower extremity strengthening and gait. PT personnel saw Mrs. Jones and their findings include: ambulates 15–20 feet using furniture and walls. Both ambulation and standing balance are fair. Strength: BUE 3+/5, BLE 3+/5. No other gait abnormalities noted. Patient showers alone and uses grab bars. A fall risk assessment indicates the patient scored as high risk. The nurse in charge is asked to call the provider.

- Dr. Silverman, I am Diane Thomas, the nurse at Golden Meadows Assisted Living. I am calling about Mrs. Jones who was seen by PT due to increasing weakness. She scored as high risk on our fall risk assessment related to ambulation, using only walls and furniture for support for short distances; her balance is fair.
- This resident has developed increasing weakness in her legs and she has a balance issue that is putting her at risk for a fall.
- I believe she needs an order for a standard walker and shower chair.

Are there any additional assessments that should have been completed on Mrs. Jones? Any additional questions that should have been asked of PT personnel or care technicians? Any additional orders that should have been requested of the provider?

What information was not included in the nurse’s communication with the provider, based on the ALC communication guide?

Identify any alterations in communication that should have been made, based on the SBAR communication tool.
Appendix C

Check-Back or Read-Back Communication Strategy

Closed-loop communication method:

✓ The sender initiates the message.
✓ The receiver verbally acknowledges receipt of the message
✓ The initial sender verifies the message as received

When obtaining physician’s orders, this communication strategy has been expanded to include the “check-back” or “read-back” loop.

✓ The sender initiates the message
✓ The receiver accepts the message and restates it
✓ The sender verifies that the re-statement of the original message is correct or amends it, if it is incorrect. The sender “checks-back” or “reads-back” the message.
✓
Example:
The nurse calls the provider to request an order for increasing the client’s diet from clear liquids to medical liquids on the following day. The provider acknowledges that this is an appropriate change. The nurse then verbally restates the provider’s order: “the order is to change the client’s diet from clear liquids to medical liquids beginning tomorrow 10/7/10”. The nurse then writes this order as follows:

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/06/10</td>
<td>Change clear liquid diet to medical liquids beginning 10/07/10. Telephone 2045 order from Dr. Phillips. TORB-----------------------------D. Petersen RN</td>
</tr>
</tbody>
</table>

An accepted abbreviation is “TORB” which means the telephone order was read back. If this were a verbal order written by the nurse, “VORB” could be used, indicating the verbal order was repeated. These abbreviations fulfill the third step in this communication strategy. This strategy was recommended by the Joint Commission on Accreditation of Healthcare Organizations (2007) in their 2008 National Patient Safety Goals.

It is important to understand how this check-back communication strategy is used in a health care facility. Consult the policy manual about the correct procedure for check-back when taking a physician’s order and the accepted abbreviations which can be used.
Appendix D

Physician’s Orders – Scenario # 1

✓ Review the Physician’s Order sheet below.

✓ Using the ISMP’s List of Error-Prone Abbreviations, Symbols and Dose Designations and the Joint Commission’s Official “Do Not Use” List, identify errors that must be clarified. Make a list of these errors and the corrections that are needed. Discuss this list with the preceptor.

✓ Role play how these orders would be clarified with the physician. The preceptor will play the part of the physician.

<table>
<thead>
<tr>
<th>Date</th>
<th>Progress Notes</th>
<th>Date</th>
<th>Physician’s Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/10</td>
<td></td>
<td>1. Admit to unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Clear liquids tonight only, then NPO in AM on 10/2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. A &amp; P chest x-ray Stat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Start IV of D5W.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Timoptic 1 gtt OU q8AM &amp; qHS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Lanoxin .25 mg QD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Up ad lib</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. D/C PO iron</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Accu-check QID</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Sliding scale insulin: 150-200 – 2 units; 200-250 – 4 units; 250-300 – 6 units; 300-350 – 8 units; 350-400 – 10 units; over 400 – call for orders.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Lantus Insulin 14 units SQ at 2100.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Consult with Wound Care regarding ulcer on left foot.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. PT to review use of walker.</td>
<td></td>
</tr>
</tbody>
</table>

---------------------------------------------Dr. P. Lawrence-----------------------------

Scenario # 2

✓ Preceptor (in the role of a physician) selects 2 clients’ health record from the unit and calls the newly licensed nurse to give:
a. admission orders

✓ discharge orders
✓ Newly licensed nurse should be in a conference room or nurses’ station to receive the phone call.

✓ Preceptor and newly licensed nurse will then convene and review the orders given and those received.
  a. Are there any discrepancies in these orders? Missing information?
  b. Is the terminology correct?
  c. Are the abbreviations correct?
  d. Was the check-back strategy used? Is the check-back recorded on the orders received?

Appendix E

Types of Orders in Facilities

Common types of orders are based on the frequency and/or urgency of use.

✓ Standing orders or routine orders -- Are carried out until the provider cancels the order by another order or until a prescribed number of days elapse. It typically includes a final date, number of treatments or doses. Facilities may have policies for automatically discontinuing standing orders.

✓ PRN orders – Are used only when a client requires it. Specific situations are identified when this order is to be implemented.

✓ Single (one-time) orders – Are carried out only once at a specific time.

✓ STAT orders – Indicate that a single activity is to be done immediately and only once. These are often written for emergencies when a client’s condition changes suddenly.

✓ Now orders – This is more specific than a one-time order and is used when the situation requires a designated action right away, as in a STAT order. If it is a medication, the nurse has up to 90 minutes to administer the medication, unless otherwise designated by facility policy.

✓ Prescriptions – the provider writes prescriptions for clients who are to take medication or follow up on an activity outside the facility. It includes more information than a regular order because the client needs to understand how to take the medication or complete the designated action.*

Examples of common orders:

Standing or routine orders:

✓ Ambulate with assistance twice daily until discharge.

✓ Enalapril PO daily.

✓ PTT to be drawn every 6 hours for 24 hours.

✓ 2000 mg Na diet.

PRN orders:

✓ Motrin 200 mg PO every 4 hours PRN for joint pain.

✓ May have ice pack to shoulder PRN for muscle ache.
✓ May ambulate off the unit if desires.
✓ One glass of beer with evening meal if resident requests.

Single (one-time) orders:
✓ Colace: take 2 tabs tonight at bedtime with 8 ounces of water.
✓ Metabolic panel to be drawn tomorrow.
✓ Send to radiology to have feeding tube placement checked prior to initiating enteral feeding.
✓ IV bolus of 500 mL normal saline at 100 mL/hr.

STAT orders:
✓ Give Morphine Sulfate 4 mg IVP STAT.
✓ ECG to be done STAT.
✓ Patient to be seen by Cardiology STAT.
✓ Transfer to ICU STAT.

Now orders:
✓ Make patient NPO.
✓ Change IV fluid to Lactated Ringer’s at 125 mL/hr.
✓ Weigh patient and call weight to provider’s office.
✓ Call results to provider’s office after x-ray completed.

Prescriptions:
✓ Date/time: 10/2/10 0945; Patient: Margaret Claussen; DOB: 5/11/35; Flexeril 10 mg PO, one tablet three times a day, 30 tablets, no refills, L. Shepherd MD
✓ Cardiac Rehabilitation daily, beginning 5 days following discharge, at Hamilton Cardiac Center per protocol. R. Olson MD
✓ Apply zinc oxide ointment to wound twice daily until healed. Wash wound with soap and water prior to application. Do not cover. L. Rice RN, Wound Care
✓ Coumadin level to be checked every 3 days at outpatient laboratory. Have results called to provider's office. M. Norton OD

* Refer to facility policy and the State Nurse Practice Act governing a nurse writing prescriptions for a provider.
### Official “Do Not Use” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”.</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Period after the Q mistaken for “l” and the “O” mistaken for “I”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg*)</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (X mg)</td>
<td></td>
<td>Write 0 X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

* Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

### Additional Abbreviations, Acronyms and Symbols

(For possible future inclusion in the Official “Do Not Use” List)

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; (greater than)</td>
<td>Misinterpreted as the number “7” (seven) or the letter “L”</td>
<td>Write “greater than”</td>
</tr>
<tr>
<td>&lt; (less than)</td>
<td>Confused for one another</td>
<td>Write “less than”</td>
</tr>
<tr>
<td>Abbreviations for drug names</td>
<td>Misinterpreted due to similar abbreviations for multiple drugs</td>
<td>Write drug names in full</td>
</tr>
<tr>
<td>Apothecary units</td>
<td>Unfamiliar to many practitioners</td>
<td>Use metric units</td>
</tr>
<tr>
<td>@</td>
<td>Confused with metric units</td>
<td>Write “at”</td>
</tr>
<tr>
<td>cc</td>
<td>Mistaken for U (units) when poorly written</td>
<td>Write “mL” or “ml” or “milliliters” (”mL” is preferred)</td>
</tr>
<tr>
<td>μg</td>
<td>Mistaken for mg (milligrams) resulting in one thousand-fold overdose</td>
<td>Write “mcg” or “micrograms”</td>
</tr>
</tbody>
</table>
ISMP’s List of Error-Prone Abbreviations, Symbols, and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP Medication Error Reporting Program (MERP) as being frequently misspelled and involved in harmful medication errors. They should NEVER be used when communicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

The Joint Commission has established a National Patient Safety Goal that specifies that certain abbreviations must appear on an accredited organization’s “do-not-use” list; we have highlighted these items with a double asterisk (**). However, we hope that you will consider others beyond the minimum Joint Commission requirements. By using and promoting safe practices and by educating another about hazards, we can better protect our patients.

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>pg</td>
<td>Microgram</td>
<td>Misset as “mg”</td>
<td>Use “mg”</td>
</tr>
<tr>
<td>AD, AS, AU</td>
<td>Right ear, left ear, each ear</td>
<td>Misset as AD, AS, AU (right ear, left ear)</td>
<td>Use “right ear; left ear, or each ear”</td>
</tr>
<tr>
<td>DD, DS, DU</td>
<td>Right eye, left eye, each eye</td>
<td>Misset as DD, DS, DU (right eye, left eye)</td>
<td>Use “right eye; left eye, or each eye”</td>
</tr>
<tr>
<td>BT</td>
<td>Bedtime</td>
<td>Misset as “BD” (hence daily)</td>
<td>Use “bedtime”</td>
</tr>
<tr>
<td>cc</td>
<td>Cubic centimeters</td>
<td>Misset as “c” (units)</td>
<td>Use “cc”</td>
</tr>
<tr>
<td>D/C</td>
<td>Discontinue or discontinue</td>
<td>Misinterpretation of discontinuation if D/C (intended to mean “discontinue”) has been misinterpreted as “discontinued” when followed by a list of discharge medications</td>
<td>Use “discontinue”</td>
</tr>
<tr>
<td>inj</td>
<td>Injection</td>
<td>Misset as “IV” or “Intramuscular”</td>
<td>Use “Injection”</td>
</tr>
<tr>
<td>IN</td>
<td>Intramuscular</td>
<td>Misset as “IM” or “IV”</td>
<td>Use “Intramuscular” or “IM”</td>
</tr>
<tr>
<td>hs</td>
<td>Half-strength</td>
<td>Misset as bedtime</td>
<td>Use “half-strength” or “bedtime”</td>
</tr>
<tr>
<td>hs</td>
<td>At bedtime, hours of sleep</td>
<td>Misset as half-strength</td>
<td>Use “half-strength”</td>
</tr>
<tr>
<td>IV**</td>
<td>International unit</td>
<td>Misset as IV (intravenous) or IV (intravascular)</td>
<td>Use “units”</td>
</tr>
<tr>
<td>q.d. or qD</td>
<td>Once daily</td>
<td>Misset as “right eye” (0.001-seconds duration), leading to oral liquid medications administered in the eye</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>GJ</td>
<td>Orange juice</td>
<td>Misset as 60 or 62 (right or left eye); drugs meant to be dissolved in orange juice may be given in the eye</td>
<td>Use “orange juice”</td>
</tr>
<tr>
<td>Per os</td>
<td>By mouth, orally</td>
<td>The “po” can be mistaken as “left eye” (0.001-seconds duration)</td>
<td>Use “PO; by mouth” or “orally”</td>
</tr>
<tr>
<td>q.d. or qD**</td>
<td>Every day</td>
<td>Misset as q.d. especially if the period after the “q” or the tail of the “q” is misunderstood as an “i”</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>qhs</td>
<td>Nightly at bedtime</td>
<td>Misset as “qhs” or every hour</td>
<td>Use “Nightly”</td>
</tr>
<tr>
<td>qhs</td>
<td>Nightly or at bedtime</td>
<td>Misset as “qhs” (every hour)</td>
<td>Use “Nightly” or “at bedtime”</td>
</tr>
<tr>
<td>q.d. or qD**</td>
<td>Every other day</td>
<td>Misset as “q.d.” (daily) or “q.d.” (four times daily) if the “s” is poorly written</td>
<td>Use “every other day”</td>
</tr>
<tr>
<td>qid</td>
<td>Daily</td>
<td>Misset as q.d. (four times daily)</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>qpm, etc.</td>
<td>Every evening at 6 PM</td>
<td>Misset as every 6 hours</td>
<td>Use “daily at 6 PM” or “6 PM daily”</td>
</tr>
<tr>
<td>SC, SD, sub q</td>
<td>Subcutaneous</td>
<td>SC mistaken asST (intravenous); SD mistaken as “serum” every “s” if “serum” has been misinterpreted as “serum” (i.e., a nephew is ordered “sub q 2 hours before surgery” misunderstood as every 2 hours before surgery)</td>
<td>Use “SC” or “subcutaneously”</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective serotonin reuptake inhibitor</td>
<td>Misset as “SSRI”</td>
<td>Spell out “selective serotonin reuptake inhibitor”</td>
</tr>
<tr>
<td>SSI</td>
<td>Sliding scale insulin</td>
<td>Misset as “strong solution of insulin (Liqui/insul)’</td>
<td>Spell out “sliding scale insulin”</td>
</tr>
<tr>
<td>TIW or Bw</td>
<td>Twice a week</td>
<td>Misset as 2 or 3 times a week</td>
<td>Use “2 times weekly”</td>
</tr>
<tr>
<td>Bw</td>
<td>Twice a week</td>
<td>Misset as “2 times a day” or “twice a week”</td>
<td>Use “2 times weekly”</td>
</tr>
<tr>
<td>U or u**</td>
<td>Unit</td>
<td>Misset as the number 0 or 4, causing a 0.001-seconds error or greater (e.g., 40 as 400 or 4 as 44); mistake as “c” as dose given in volume instead of units (e.g., 40 as 4000)</td>
<td>Use “U” or “u”</td>
</tr>
<tr>
<td>OD</td>
<td>As directed (“ut dicter”)</td>
<td>Misset as unit dose (e.g., different 15 mg of insulin “10” mistaken as a unit (5000) dose)</td>
<td>Use “as directed”</td>
</tr>
</tbody>
</table>

Dose Designations and Other Information

<table>
<thead>
<tr>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>mg</td>
<td>Misset as 10 mg if the decimal point is not seen</td>
<td>Do not use trailing zeros for doses expressed in whole numbers</td>
</tr>
<tr>
<td>mg</td>
<td>Misset as 5 mg if the decimal point is not seen</td>
<td>Use zero before a decimal point when the dose is less than a whole unit</td>
</tr>
<tr>
<td>Drug Name Abbreviations</td>
<td>Intended Meaning</td>
<td>Misinterpretation</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>ARA A</td>
<td>vitamin A</td>
<td>Mistaken as vitamin A (ARA C)</td>
</tr>
<tr>
<td>ALT</td>
<td>vitamin E</td>
<td>Mistaken as acetaminophen or acetaminophen-OH (E)</td>
</tr>
<tr>
<td>CPZ</td>
<td>contraceptive</td>
<td>Mistaken as chlordiazepoxide</td>
</tr>
<tr>
<td>DPT</td>
<td>dinatrium-phosphoglycerate</td>
<td>Mistaken as diphenylhydantoin (DPT)</td>
</tr>
<tr>
<td>D-to</td>
<td>diluted淘npoum or diluted phospliate of guum (DOP)</td>
<td>Mistaken as dilute phospliate of guum</td>
</tr>
<tr>
<td>HCl</td>
<td>hydrochloride or hydrochloride</td>
<td>Mistaken as potassium chloride (The &quot;K&quot; is misinterpreted as &quot;K&quot;)</td>
</tr>
<tr>
<td>HCT</td>
<td>hydrocortisone</td>
<td>Mistaken as hydrocortisone</td>
</tr>
<tr>
<td>HCZ</td>
<td>hydrochlorothiazide</td>
<td>Mistaken as hydrochlorothiazide (seen as HC250 mg)</td>
</tr>
<tr>
<td>M&amp;G**</td>
<td>magnesium sulfate</td>
<td>Mistaken as magnesium sulfate</td>
</tr>
<tr>
<td>MEX</td>
<td>methotrexate</td>
<td>Mistaken as methotrexate</td>
</tr>
<tr>
<td>PCA</td>
<td>procainamide</td>
<td>Mistaken as procainamide</td>
</tr>
<tr>
<td>PTH</td>
<td>propylthiouracil</td>
<td>Mistaken as propylthiouracil</td>
</tr>
<tr>
<td>T3</td>
<td>tyroid with iection No. 3</td>
<td>Mistaken as levothyroxine</td>
</tr>
<tr>
<td>TAC</td>
<td>tramadol</td>
<td>Mistaken as tramadol, tramadol, or tramadol citrate</td>
</tr>
<tr>
<td>TNK</td>
<td>TNP</td>
<td>Mistaken as &quot;TPN&quot;</td>
</tr>
<tr>
<td>ZnO3**</td>
<td>zinc sulfate</td>
<td>Mistaken as zinc sulfate</td>
</tr>
</tbody>
</table>