Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the NCQAC is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the NCQAC. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and//or decrease risk.

Title:	Standing Orders and Verbal Orders	*Number:* NCAO 6.0
References:	RCW 18.79 Nursing Care WAC 246-840 Practical and Registered Nursing Nursing Scope of Practice Decision Tree RCW 28A.210.383 Epinephrine Auto injectors (EPI Pens)-School Supply-Use	
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Approved By:	Nursing Care Quality Assurance Commission	

Conclusion Statement

The NCQAC concludes that nurses may follow standing orders to carry out medical regimens under the direction of an authorized provider (physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, advanced registered nurse practitioner, or licensed midwife). This would also include the ability to delegate to credential or non-credentialed unlicensed assistive personnel (UAP) to implement standing orders. Standing orders should be developed and approved by medical, pharmacy, and nursing leadership based on nationally recognized evidence-based guidelines and recommendations. Standing orders act as written care directives from an authorized provider. Nurses must implement standing orders as written and stay within the confines of the direction outlined. Nurses may also carry out verbal or telephone orders. Medical record documentation must reflect that the nurse is following a standing order, verbal order, or telephone order. The nurse must document any deviation or decision not to follow the standing order, consultation activities, and outcomes. The standards of practice using standing orders and verbal orders are the same regardless whether order entry is done using paper on in an electronic health record.

Nurses are accountable and responsible for the care they provide regardless of whether they are carrying out a medical regimen using standing orders, verbal orders, or written orders. The use of electronic health records does not take away the requirement for critical thinking and clinical judgment. Nurses must have the training, skills, knowledge, and ability to carry out medical regimens regardless of the way the orders are communicated. Nurses should follow their institutional policies and procedures. Any questions about permitted actions must be addressed and clarified with an authorized provider before implementation. The nurse must use professional judgment and contact the medical provider for consultation when unexpected patient symptoms, complications, or other situations occur. NCQAC advises nurses to use the **Scope of Practice Decision Tree** to determine whether an activity directed through a standing order or verbal order is within the nurse's individual scope of practice.

Background and Analysis

Historically, standing orders have been used and continue to be used, in almost every health care institution. An article in the American Journal of Public Health from 1947 (Tabershaw and Hargreaves) identified many of the same issues and controversies seen today. Defining the nurse's roles and responsibilities in carrying out standing orders is necessary to avoid the perception the nurse is practicing medicine.

In 2008, the Centers for Medicare and Medicaid Services (CMS) issued interpretive guidance of the Joint Commission's regulations and terminated the longstanding practice of giving care under standing orders. This ruling created major barriers to care delivery. In response to the ruling, the CMS issued new rules in 2012 authorizing the use of standing orders to reduce the burden on providers, decrease delay of timely medical care, and improve access. Washington State nursing law and rules do not define or reference standing orders. Therefore, the NCQAC refers to the CMS definitions of standing orders that include order sets, pre-printed orders, and protocols for patient orders, whether they are in printed or electronic form. The American Nurses Association supports CMS changes to once again permit the use of standing orders for nurses to administer treatments and give medications.

In the New England Journal of Medicine (2014), Ghorob and Bodenhimer address the national demand-capacity imbalance while enhancing quality and reducing clinician stress and burnout. They provide examples of standing orders for prescription refills. They conclude that care needs to be shared with an empowered health care team requiring a paradigm shift reallocating care to nurses and other non-clinician team members. They identify three areas where this could be beneficial: prescription refills, chronic care management, and panel management (chronic care and population based preventive management).

Standing orders act as written care directives from an authorized provider delineating the circumstances and describing the parameters of specific situations under which a nurse may act to carry out specific medical orders. Standing orders may be patient-specific or condition-specific health care needs. Condition-specific standing orders waive the usual requirement of the existence of a treatment relationship between the patient and the authorized medical provider prior to the execution of a medical order. Standing orders allow for facilitation of timely interventions and the removal for barriers to care for various patient populations and in situations where a medical practitioner is not readily available. Standing orders describe the specific type of medical practice, delineate the process the nurse must follow, identify the patient population that may be serviced, specify the level of supervision required and govern the locations where the services may occur. Standing orders are often designed for the use of certain patient populations with specific diseases, disorders, health problems, symptoms, emergency situations, and routine processes (e.g. admission orders, surgical pre-operative orders). Examples of situations in which standing orders may be beneficial include immunization administration, treatment of common health problems, emergency care, urgent care, health screening activities, occupational health services, public health clinical services, school health, correctional settings, telephone triage and advice services, nurse-on-call services, and ordering of lab tests or treatments for certain categories of patients. Several studies show that standing orders increase service delivery for preventive services (Agency for Health Care Research and Quality). The Institute for Safe Medication Practices (ISMP) provides guidance on using pre-printed order sets to ensure safety in using this method of standing orders. Electronic standing orders can be successfully adapted without significant time burdens and implemented into the daily workflow of primary care practices such as screening, immunizations and diabetes measures (Nemeth, Ornstein, Jenkins, Wessel and Nietert). Recently adopted electronic medical records software may not accurately capture orders implemented by standing order. Caution must be exercised to accurately document when following a standing order.

State and Federal Law and Rule

The CMS requires standing orders be based upon nationally recognized evidence-based guidelines and recommendations. Medical, pharmacy, and nursing leadership must develop, review, and approve standing orders. Neither state nor federal law requires institutions to use standing orders. Insurance companies may not reimburse for services provided using standing orders. Other factors such as accreditation standards and risk

management concerns may influence whether an institution uses standing orders. The CMS requires standing orders to be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for care of the patient, who is authorized to write orders by hospital policy, and according to state law. They also require authentication of verbal orders based on state law requirements and/or facility policy.

The Washington State nursing law and rules do not address the use of standing orders or verbal orders. RNs and LPNs may carry out medical regimens under the direction of an authorized provider (physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, advanced registered nurse practitioner, or licensed midwife). RNs and LPNs may delegate care to UAP. The method of communicating the direction is not addressed or defined. Other state laws and rules define and describe requirements for using standing orders, protocols, and guidelines:

- In hospitals, verbal orders for drugs may be issued to RNs and LPNs only in emergency or unusual circumstances and must be immediately recorded and signed by the person receiving the order. The order must be authenticated by the prescribing practitioner within 48 hours (WAC 246-873-090). Hospitals must also have an authentication process to verify that an entry is complete, accurate, and final. Hospitals and ambulatory surgical facilities define protocols and standing orders to mean written or electronically recorded descriptions of actions and interventions for implementation by designated hospital or ambulatory surgical facility staff under defined circumstances recorded in policy and procedure [(WAC 246-320-010(53) and 246-330-010(38)]. When pre-established patient care guidelines or protocols are used, they must be documented in the medical record and be pre-approved or authenticated by an authorized practitioner [(WAC 246-320-226(g) and 246-330-205(g)].
- Schools allow RNs to follow standing orders, using stock inventory, to give epinephrine for potentially life threatening allergic reactions (RCW 28A.210.383). The law does not allow delegation to UAP to give epinephrine without a student-specific prescription.
- Schedule II controlled substances cannot be dispensed by standing order. A written or electronic prescription from an authorized prescriber is required unless the drug is dispensed directly by an authorized practitioner (RCW 69.50.308). Schedule II controlled substances may not be refilled.

Recommendations

RNs and LPNs may implement medical care based on patient-specific, condition-specific standing orders, or verbal orders. This includes the act of delegation to credentialed or non-credentialed UAP following state laws, rules, and scope of practice. The NCQAC provides the following recommendations:

- Nursing leadership should be involved in developing and approving standing orders.
- Standing orders should be developed based on nationally recognized and evidence-based guidelines and recommendations.
- Institutions should have policies and procedures to implement standing orders and verbal orders.
- Standing orders should be reviewed and revised as needed, or annually.
- Changes to standing orders should be communicated as soon as possible to nursing staff and these should be reviewed by nursing staff as changes occur.
- Verbal orders should be repeated to the prescriber for clarity and (if possible) confirmed with another nurse.
- Verbal orders should be dated, timed, and authenticated by an authorized medical provider as required by state or federal law, or following institution policy.
- Nurses may receive, transcribe, and transmit verbal orders relayed from health care professionals or support staff.

Recommendations for developing standing orders include the following:

- Identify the patient population to be treated according to the standing orders.
- Specify which acts require any particular level of experience, training, education, or certification.
    - Conditions, symptoms or situations in which the standing order will be used;
    - Assessment criteria;
    - Objective or subjective findings;
    - Plan of care including medical and pharmaceutical treatment based on assessment criteria;
    - Nursing actions;
    - Follow-up or monitoring requirements;
- Specify those who may perform the actions required using the standing orders.
- Delineate under what circumstances the actions may be performed.
- Specify the scope of supervision required.
- Identify special circumstances under which the person implementing the standing order is to immediately communicate with the medical provider.
- Identify limitations on the practice setting (if any).
- Provide a method of maintaining a written record of those authorized to use standing orders.
- Establish a method for initial and continuing evaluation of the competence of those authorized to use standing orders.
- Specify documentation requirements.
- Specify authentication requirements.
- Provide a method of periodic review of standing orders.
- Delineate inclusion and exclusion requirements for which the nurse must consult with a medical practitioner for routine, urgent, or emergent situations including the communication process between the nurse and medical practitioner as appropriate.
- Date written and last reviewed.
- Identify diagnostic and procedural coding in the standing order.

Conclusion

The NCQAC concludes that nurses may follow written and approved standing orders or verbal orders to carry out medical regimens. The NCQAC advises nurses to use the *Scope of Practice Decision Tree* to determine whether an activity is within the nurse's individual scope of practice. Nurses should always consider whether their actions are prudent and reasonable.

References

Department of Health and Human Services Centers for Medicare and Medicaid Services: Reform of Hospital and Critical Access Hospital Conditions of Participation. 42CFR Parts 482 and 485; CMS 3244-F, RIN 0938-AQ89, Federal Registry-Rules and Regulations (2012)

Guidelines for Standard Order Sets - Institute for Safe Medication Practices

Implementing and Evaluating Electronic Standing Orders in Primary Care Practice: A PPRNet Study: Journal of the American Board of Family Medicine. Nemeth, Ornstein, Jenkins, Wessell, and Nietert (2012)

Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation (2012)

Sharing the Care to Improve Access to Primary care: New England Journal of Medicine. Ghorob, A. and Bodenheimer, T. (2014)