Improving nursing ordering practices for efficient, timely & safe care

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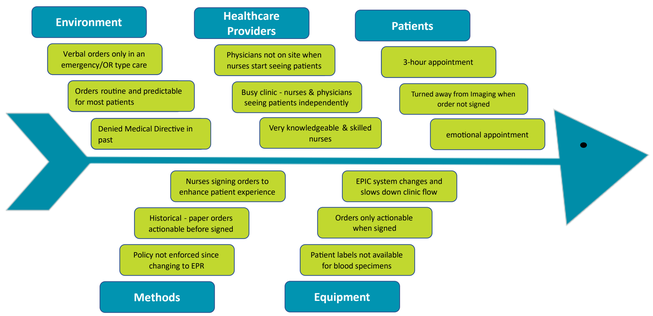
Background

The College of Nurses practice standard[1] and hospital policy both limit the use of verbal orders to emergencies and other exceptional circumstances. As an ambulatory hospital, WCH should have low volumes of verbal orders outside of operating procedures and emergency care. Nevertheless, high usage of verbal orders in various clinical settings was discovered in an audit. Anticipating, understanding, or monitoring for changes in ordering practices had not been considered since EPIC was implemented in 2015. Thus, finding large volumes of verbal orders came as a surprise.

Professional Practice set out to utilize a quality lens to understand systemic issues compelling clinicians to disregard policy and regulatory standards and improve nursing ordering practices.

Diagnostics



Aim Statement

Eliminate the use of inappropriate verbal orders in Bay Centre for Birth Control Clinic (BCBC) by April 30, 2023

Patient-centred care & clinic efficiency are primary drivers of nursing practice.
Sustaining standards of practice must address these drivers.

Results

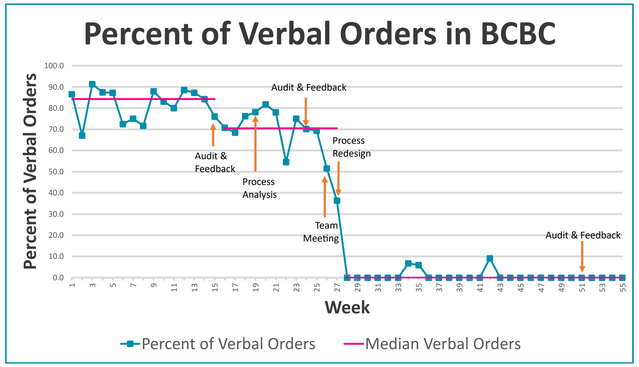


Figure 1. Outcome Measure

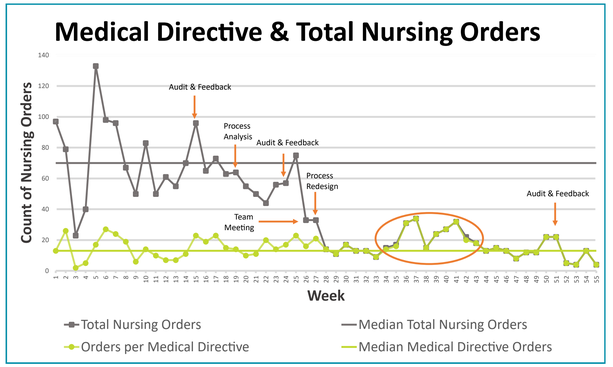


Figure 2. Balancing Measures

- Baseline data show random variation in the percent of verbal orders used in the clinic. Most are verbal orders!!
- Once the Manager receives the data there is a shift in practice with reduced verbal order use.
- A trend toward reduced verbal orders begins once new audited results are shared with clinic leadership.
- Attending a nursing team meeting and notifying all clinicians that policy will be enforced continues the trend and results in the elimination of verbal orders.
- Although the aim is achieved, root causes must be addressed to prevent return to inappropriate practices.

- The total number of nursing orders shifted shortly after the manager was notified of the issue and eventually consisted of only medical directive orders.
- The use of medical directive orders remained stable with random variation evident. However, there was a shift in the late summer resulting in more medical directive orders being placed. An audit of the raw data revealed appropriate use of medical directive orders.

Family of Measures

- Outcome: Percent of verbal orders
- Process: CBC laboratory verbal order count; count of interventions
- Balancing: Count of medical directive orders in relationship to total nursing orders; qualitative review of change impact

Theory of Change

- Nurses want to work to full scope, and work collaboratively to maintain efficient, timely, patient-centred and safe care.
- The Knowledge-to-Action Framework[2] and The Model for Improvement[3] guided the improvement process.
- A safe space was created for process analysis and team meeting by building trust, active listening, empowering nurses to contribute to redesign and permanent solutions.
- Audit and feedback, education, and alignment of workflow to roles also targeted a shift in culture.
- A medical directive is awaiting approval. This will address root causes and relieve nurses of practices that risk their license.

Lessons Learned

- The improvement team must connect with all stakeholders including physicians early in the process to understand the implications of verbal orders, address concerns, and participate in change.
- Lessons are being applied as the project continues in clinics throughout the hospital.

Acknowledgements

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References:

1. College of Nurses of Ontario. (2022). Practice Guideline: Authorizing Mechanisms. 2. Graham, I., et al. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions*, 26(1); 13-24.

3. Ogrinc, G, et al. (2018). *Fundamentals of health care improvement: A guide to improving your patients' care*. The Joint Commission and the Institute for Healthcare Improvement. ISBN: 978-1-63585-038-3