



Standing Orders: Lessons Learned

CP3 Toolkit: Planned Care

The following was adapted from a [July 21, 2016 presentation](#) by Carolyn Shepherd, formerly of Clinica Family Health in Colorado. It describes the lessons learned as Clinica implemented standing orders.

- Start by picking **non-controversial protocols** such as a nurse treating head lice, the front desk ordering mammograms for women over 50, MAs giving vaccines due or a clinical pharmacist adjusting insulin.
- Test several **PDSA cycles of a standing order template** that works for your team. Assure all the protocols then follow the same template. This makes it easier for staff to find what they need quickly.
- It is very important to assure **provider buy-in** by reviewing these protocols carefully with provider staff. **Get agreement** that the evidence supports the protocol and teams will follow the protocol.
- **Pay attention to providers who show resistance.** Address their issues openly with the team.
- Include **whether co-sign is required or if optional**, when it's recommended. This is often a strategy to get acceptance from reluctant providers. A similar strategy is to include PEER audits of complex protocol visits.
- The provider team needs to agree that if a problem develops, **providers need to contact clinical leadership directly**, not the staff person assigned in the protocol to do the work. It is a performance issue if a provider sabotages the established process.
- Attend to the **Nursing Board requirements**. For example, in Oregon where "diagnosing" is an issue, make the protocols "symptom specific"-dysuria rather than UTI, sore throat rather than Strep pharyngitis, etc.
- Include **when to ask for more help in the protocol**. This explicitly empowers staff to seek help. Suggest symptoms that might indicate another diagnosis or warning signs.



- **Demonstrate documentation and billing in your EHR in the protocol.** This helps to decrease variation and assure that the data is entered so it can be collected for clinical measures.
- Plan for **ad hoc updates**, such as when the antibiotics change for treatment of lower GU GC, need to remove the quinolones and leave only the cephalosporin regimens. This could be done by a nurse, or a clinical pharmacist, or a provider.
- Assure an **annual review and update of the protocol**. It was too big a task to do them all at once. We put them on a calendar throughout the year. This could be great work for providers or nurses on FMLA who want some hours.
- **Re-train staff after the review**, including all staff on the team. This can be a brief 5-minute conversation during a team huddle. It is good for the front office, the CMAs, nurses and providers to all receive the review training. This will decrease confusion, sabotage, and variation in care and informs staff about the nursing role. This is an opportunity for “team talk” (what the team can provide to the patient).
- Handing off work is hard for providers. **The clinical leader needs to encourage and support providers** to let the process work and to stay out of the way.