

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

1.4.19 Nursing Standardized Procedures, Protocols, Order Sets, Clinical Pathways, and Standing Orders

(a) Policy

- (1) California Correctional Health Care Services (CCHCS) shall maintain standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders to legally allow nursing staff within CCHCS to perform direct and indirect patient care utilizing evidence-based nursing practices consistent within the scope of practice of each nursing classification.
- (2) Standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders are developed and approved collaboratively at the headquarters level by a multidisciplinary practice group whose membership consists of nurses and physicians and conform to the requirements of the California Code of Regulations (CCR), Title 16, Sections 1366-1366.4, Sections 1379, and Sections 1470-1474.

(b) Purpose

To provide direction, promote consistency, and support the practice of nursing utilizing standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders within CCHCS in accordance with all applicable statutes, rules, and regulations.

(c) Applicability

- (1) This policy is applicable to all Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), Psychiatric Technicians (PTs), Certified Nursing Assistants (CNAs) and Medical Assistants (Mas) employed by, contracted with, or volunteering for the State of California while providing services to patients within the care of the California Department of Corrections and Rehabilitation (CDCR).
- (2) This policy is not applicable to inpatient facilities licensed by the California Department of Public Health under the CCR, Title 22, unless the standardized procedure, protocol, order set, clinical pathway, and standing order are also adopted in writing by the appropriate governing body as required by CCR, Title 22.

(d) Responsibility

- (1) CDCR and CCHCS departmental leadership, at all levels of the organization, within the scope of their authority, shall ensure administrative and clinical systems are in place and appropriate tools, training, and levels of resources are available so that nursing staff can successfully implement the provision of evidence-based nursing services to patients under the care of CCHCS/CDCR.
- (2) The Deputy Director, Nursing Services, is responsible for statewide planning, implementation, and evaluation of the nursing services provided within CCHCS/CDCR. For the purposes of this policy, the Deputy Director, Nursing Services, shall collaborate with the Deputy Director, Medical Services, for implementation.
- (3) Regional Health Care Executives (RHCEs) are responsible for implementation of this policy at the subset of institutions within an assigned region.
- (4) The Chief Executive Officer (CEO) is responsible for implementation of this policy at the institution level. The CEO may delegate this responsibility to the institutional Chief Nurse Executive (CNE) and Chief Medical Executive (CME) but retains overall responsibility.

(e) Procedure Overview

This procedure provides direction to promote consistency and support professional practice by nurses providing services within the CDCR and CCHCS to the fullest extent of their licensure using standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders in accordance with all applicable statutes, rules, and regulations.

(f) Responsibility

(1) Statewide

CDCR and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance and levels of resources are available so that CCHCS health care staff can successfully implement this procedure.

(2) Regional

RHCEs Regional CNEs are responsible for implementation of this procedure at the subset of institutions within an assigned region.

(3) Institutional

(A) The CEO has overall responsibility for implementation and ongoing oversight of a system to provide management of the patient care services to include the implementation of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders at an assigned institution. The CEO delegates

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decision-making authority to designated institutional health care executives for daily operations and ensures adequate resources are deployed to support the system.

- (B) All members of the institutional leadership team are responsible for ensuring all necessary resources are in place to support the successful implementation of this procedure at all levels of the institution.
- (C) All members of the institutional leadership team shall ensure access to and utilization of equipment, supplies, health information systems, patient registries and summaries, and evidence-based guidelines necessary to implement this procedure.
- (D) All members of the institutional leadership team as a part of the quality management process on an ongoing basis shall:
 - 1. Review health care staff performance including the overall quality of services, health outcomes, assignment of consistent and adequate resources, utilization of dashboards, patient registries, patient summaries, decision support tools, and address issues pertaining to the use of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders.
 - 2. Provide health care staff with adequate resources including training, staffing, physical plant, information technology, and equipment/supplies necessary to accomplish tasks required during the use of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders.
- (E) The CNE and the CME shall develop an interdisciplinary process to ensure that each health care staff member utilizing standardized procedures, protocols, and order sets shall have at a minimum:
 - 1. Training on policies and procedures during orientation; whenever new standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders are issued; and as needed.
 - 2. Demonstrated competency in the use of each standardized procedure, protocol, order set, clinical pathway, and standing order prior to their performance of the tasks outlined in the standardized procedure, protocol, order set, clinical pathway, and standing order.
 - 3. An established training file (proof of practice file) containing documentation of the health care staff member's training and initial and ongoing competency evaluations for each standardized procedure, protocol, order set, clinical pathway, and standing order used by the health care staff member.

(g) Procedure

(1) General Requirements

Each standardized procedure, protocol, order set, clinical pathway, and standing order shall be developed and implemented using an interdisciplinary process that meets the following minimum requirements:

- (A) Uses an interdisciplinary team appropriate to the item being developed (i.e., nursing, medicine, pharmacy, mental health, dental, etc.).
- (B) Ensures that each standardized procedure, protocol, order set, clinical pathway, and standing order developed is evidence-based, conforms to any applicable departmentally approved Care Guide, and supports the Complete Care Model Policy as outlined in the Health Care Department Operations Manual (HCDOM), Section 1.4.18, Nursing Competency Program.
- (C) Identifies the parties responsible for the training and implementation of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders.
- (D) Determines the method and frequency of competency testing and the documentation of the results. Competency testing shall, at a minimum, meet the requirements of HCDOM, Section 1.4.18, Nursing Competency Program.
- (E) Ensures the requirements of Section (f)(3)(E) are met.
- (F) Identifies a method of ensuring the distribution of approved standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders to all staff within the organization. The placement of a signed copy of the documents on a departmentally-approved intranet webpage accessible to all health care staff meets the requirements of availability for the purposes of this paragraph.

(2) Standardized Procedures/Nurse Protocols

- (A) Standardized procedures/nurse protocols shall be developed at the statewide level under the direction of the Deputy Directors of Nursing Services, Medical Services, Mental Health Program, Dental Services (as applicable), and the Chief of Pharmacy Services (as applicable).
- (B) The Deputy Directors of Nursing Services, Medical Services, Mental Health Program, Dental Services, (as applicable), and the Chief of Pharmacy Services (as applicable) shall ensure that an interdisciplinary process,

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which includes input from all appropriate disciplines and regional and institutional subject matter experts, is used during the development of standardized procedures and nurse protocols.

- (C) Standardized procedures/nurse protocols shall be approved and signed at the statewide level and issued to the field for implementation to ensure standardization of patient care, full implementation within the Electronic Health Record System (EHRS), improvement of patient outcomes, and management of risk throughout the organization.
- (D) Standardized procedures shall be in writing, dated, and signed by the departmental designated staff (i.e., Deputy Directors of Nursing Services, Medical Services, Dental Services, and other Deputy Directors as applicable) and shall, at a minimum:
 - 1. Specify which standardized procedure functions RNs may perform and under what circumstances.
 - 2. State any specific requirements that are to be followed by RNs in performing particular standardized procedure functions.
 - 3. Specify any experience, training, and/or education requirements for performance of standardized procedure functions.
 - 4. Establish a method for initial and continuing evaluation of the competence of those RNs authorized to perform standardized procedure functions.
 - 5. Provide a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
 - 6. Specify the scope of supervision required for performance of standardized procedure functions (e.g., immediate supervision by a provider).
 - 7. Set forth any specialized circumstances under which the RN is to communicate immediately with a patient's provider concerning the patient's condition.
 - 8. State the limitations on settings, if any, in which standardized procedure functions may be performed.
 - 9. Specify patient record-keeping requirements.
 - 10. Provide a method of periodic review of the standardized procedures.

(3) Clinical Pathways

- (A) Clinical pathways shall be developed at the statewide level under the direction of the Deputy Directors of Nursing Services, Medical Services, Mental Health Program, Dental Services, and the Chief of Pharmacy Services (as applicable).
- (B) The Deputy Directors of Nursing Services, Medical Services, Mental Health Program, Dental Services (as applicable), and the Chief of Pharmacy Services (as applicable) shall ensure that an interdisciplinary process, which includes input from all appropriate disciplines and regional and institutional subject matter experts, is used during the development of clinical pathways.
- (C) Clinical pathways shall be approved and signed by the departmental designated staff (i.e., Deputy Directors of Nursing Services, Medical Services, and other Deputy Directors, as applicable) at the statewide level and issued to the field for implementation to ensure standardization of patient care, full implementation within the EHRS, improvement of patient outcomes, and management of risk throughout the organization.
- (D) Clinical pathways shall contain the following elements at a minimum:
 - 1. A statement of the goals and key elements of care based on evidence, best practice, and patients' expectations and characteristics.
 - 2. Means of communication among the care team members and with patients.
 - 3. The coordination of the care process by coordinating the roles and sequencing the activities of the interdisciplinary care team and patients.
 - 4. An explanation of who may perform individual elements of the clinical pathway if there are limitations based on the individual scopes of practice for the members of the care team (i.e., a task may be performed by the RN but not the LVN/PT).
 - 5. Requirements for documentation, monitoring, and evaluation of variances and outcomes.
 - 6. Identification of the appropriate resources necessary to implement the clinical pathway.
 - 7. Specification of any experience, training, and/or education requirements for performance of functions listed in the clinical pathway.
 - 8. A method for initial and continuing evaluation of the competence of health care staff authorized to perform clinical pathway functions.

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9. A method of maintaining a written record of those persons authorized to perform clinical pathway functions.
10. Specification of the scope of supervision required for the performance of clinical pathway functions (e.g., immediate supervision by a provider).
11. Directives for any specialized circumstances under which the health care staff is to communicate immediately with a patient's provider concerning the patient's condition.
12. Limitations on settings, if any, in which clinical pathway functions may be performed.
13. Patient record-keeping requirements.
14. A method of periodic review of the clinical pathway.

(4) Order Sets

- (A) Order sets may be proposed at the statewide, regional, or local level.
- (B) Order sets shall be approved at the statewide level and issued to the field for implementation to ensure standardization of patient care, full implementation within the EHRS, improvement of patient outcomes, and management of risk throughout the organization.
- (C) Order sets shall be developed using an interdisciplinary process as outlined in Section (g)(1) above. No order set shall be used without first being approved through the appropriate Quality Management Committee approval process and signed by the departmental designated staff (i.e., Deputy Director of Nursing Services, Medical Services, and other Deputy Directors as applicable).
- (D) When developing and approving order sets, consideration shall be given to the following at a minimum:
 1. Order sets are reflective of current "best practices."
 2. Order sets are comprehensive and consider other disciplines as required by the actions being performed (e.g., screen patient for smoking history. The RN shall provide smoking cessation counseling if the patient has smoked within 12 months).
 3. Automatic orders are pre-selected to reduce the possibility of their being overlooked. Pre-selected automatic orders on a paper document shall include the following line, "Strike through entire line to cancel a pre-selected order." Pre-selected orders in the EHRS (i.e., on the PowerPlan) can be deselected to individualize the order.
 4. Order sets are reflective of national performance measures as appropriate (e.g., Joint Commission Standards and National Hospital Inpatient Quality Measures).
 5. Order sets are reflective of national patient safety goals, if appropriate (e.g., provides vital sign parameters and parameters for notifying the provider).
 6. Infection control measures are considered, as appropriate.
 7. Equipment and medications listed are readily available at the institution and on the formulary.
 8. Instructions are complete, unambiguous, and clear (i.e., designate no range orders without objective measures to determine the correct dose; avoid overlapping parameters to guide medication administration that make it difficult to interpret the correct directions).
 9. The use of symbols is kept to a minimum; avoid letters, numbers, and abbreviations that may be easily confused or misinterpreted.
 10. Attempts are made to remove or reduce look-alike or sound-alike items, and "tall-man lettering" is used for all look-alike names and words.
 11. Upper case letters are used appropriately (e.g., when lower case letters are used, "PRN" can be easily misread as "pm").
 12. Paper orders are written on one side of the sheet only. Orders written on the reverse side of sheets are often overlooked. The reverse side of orders are best used only for references, additional information, etc.

(5) Standing Orders

- (A) Standing orders may be proposed at the statewide, regional, or local level.
- (B) Standing orders shall be approved at the statewide level and issued to the field for implementation to ensure standardization of patient care, full implementation within the EHRS, improvement of patient outcomes, and management of risk throughout the organization.
- (C) Standing orders shall be developed using an interdisciplinary process as outlined in Section (g)(1) above. No standing order shall be used without first being approved through the appropriate headquarters Quality Management Committee approval process and signed by the departmental designated staff (i.e., Deputy Director of Nursing Services, Medical Services, and other Deputy Directors as applicable).

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- (D) Standing orders shall:
 - 1. Be conditioned upon the occurrence of certain clinical events.
 - 2. Be initiated by the treating health care provider.
 - 3. Demonstrate a patient/provider relationship.
 - 4. Be patient specific.
- (E) Once the triggering event is identified, an allied health professional or licensed independent provider may initiate treatment pursuant to a standing order.
- (F) No standing order shall authorize a health care staff member to exceed their scope of practice or level of training.
- (G) When developing and approving standing orders, consideration shall be given to the best practices noted in Section (g)(4) above regarding order sets including the following at a minimum:
 - 1. Standing orders are reflective of current “best practices.”
 - 2. Standing orders are comprehensive and consider other disciplines as required by the actions being performed.
 - 3. Standing orders specify the circumstances under which the drug or treatment is to be administered and/or provided.
 - 4. Standing orders specify the types of medical conditions of patients for whom the standing orders are intended.
 - 5. If the standing order addresses the administration of medications, it must be initially approved by the Pharmacy and Therapeutics Committee and be periodically reviewed by that committee.
 - 6. Standing orders are specific as to the drug, dosage, route, and frequency of administration of any medication.

(6) Statewide Nursing Standardized Procedures Committee

Statewide leadership shall designate a standing committee that will be responsible for the development and review of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders at an organizational level. Permanent members of the committee shall be the Deputy Directors of Nursing Services and Medical Services. Other Deputy Directors shall be invited as the subject matter of the standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders (i.e., Pharmacy, Ancillary Services, etc.).

- (A) The committee shall coordinate actions with the Clinical Guidelines Committee, the Pharmacy and Therapeutics Committee, and/or other statewide stakeholders as indicated to ensure that the developed decision-support tools conform to evidence-based practice and are supported by other statewide policies and procedures.
- (B) The committee shall ensure that all material(s) necessary to support the full implementation of decision-support tools are provided in conjunction with their release. Examples of these materials include, but are not limited to, lesson plans, competencies, webinars, and Learning Management System training sessions.
- (C) The committee shall ensure that all approved decision-support tools are signed by the appropriate Deputy Directors and/or Directors. Decision-Support Tools approved at the statewide level do not require additional approval at the regional or institutional level.
- (D) Decision-Support Tools shall not be modified at the regional or institutional level. Recommendations for change shall be submitted using the process described below in Section (g)(7)(D).

(7) Institutional Nursing Standardized Procedures Committee

Institutional leadership shall designate a standing committee reporting to the local Quality Management Committee for oversight of the training, implementation, maintenance, record-keeping, and review of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders at the institutional level. The committee shall:

- (A) Take corrective action as needed to identify issues related to the implementation and use of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders within the institution.
- (B) Take the appropriate corrective action to resolve and/or elevate concerns identified in the review.
- (C) Document all reviews and actions taken and forward to the local Quality Management Committee.
- (D) Make recommendations to the statewide committee for the development of new standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders and/or the review of existing decision support.

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(8) Institutional Nursing Standardized Procedures Monitoring Program

The CEO and institutional leadership team shall establish an ongoing monitoring program to periodically assess the quality of the training, implementation, maintenance, record-keeping, and review of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders. The monitoring process shall include, but is not limited to:

- (A) A review of the competency program results for health care staff including trends identified during didactic and hands on training (i.e., common deficiencies).
- (B) Rates of utilization for each standardized procedure, protocol, order set, clinical pathway, and standing order.
- (C) A review of order sets to ensure that they are being utilized appropriately and that the orders continue to meet the patient care needs of the institution's population, current policy, and health care "best practices."
- (D) A review of trended outcome data (i.e., registry "improvements") for each standardized procedure, protocol, order set, clinical pathway, and standing order in use. Variances from the expected standardized usage shall be reviewed, trended, and considered during the periodic review conducted as described in item five below.
- (E) Status of the periodic review for each standardized procedure, protocol, order set, clinical pathway, and standing order utilized within the institution.
- (F) A periodic review of local population management session reports to identify local trends in patient care needs and outcomes that might benefit from the development (or modification) of a standardized procedure, protocol, order set, clinical pathway, and standing order. The committee shall make a recommendation with supporting data to the regional executive leadership team when a potential need is identified.
- (G) Adherence to policy guidelines, protocols, and decision-support tools as they relate to the development, training, and usage of standardized procedures, protocols, order sets, clinical pathways, guidelines, and standing orders.

References

- Business and Professions Code, Division 2, Chapter 5, Article 3, Section 2069
- Business and Professions Code, Division 2, Chapter 6, Article 2, Section 2725
- California Code of Regulations, Title 16, Division 13, Chapter 3, Article 2, Sections 1366 – 1366.4
- California Code of Regulations, Title 16, Division 13, Chapter 3, Article 4, Section 1379, Standardized Procedures for Registered Nurses
- California Code of Regulations, Title 16, Division 14, Article 7, Sections 1470 – 1474
- California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 3, 51241, Physician Relationship to Nonphysician Medical Practitioners
- California Board of Registered Nursing, Standardized Procedure Guidelines.
<http://www.rn.ca.gov/pdfs/regulations/npr-i-19.pdf>
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 9, Article 4, Sections 91040.8 – 91040.9.1
- Health Care Department Operations Manual, Chapter 1, Article 4, Section 1.4.18, Nursing Competency Program
- Joint Commission Standards MM.04.01.01
- American Nurses Association, Correctional Nursing: Scope and Standards of Practice, 2nd Ed; Silver Spring, MD., 2013
- AHRQ: Promoting Best Practice and Safety through Preprinted Physician Orders
https://www.ahrq.gov/downloads/pub/advances2/vol2/advances-ehringer_17.pdf

Revision History

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