

Nursing Triage and the Use of Standing Orders in Student Health Care Settings

As nurses working in student health, we are often (if not always) the “front line” of assessment of patient needs for immediate or deferred care, or for referral to other health care settings. As such, there are three things it behooves us to bear in mind:

- 1) Be confident of what you know. You are an experienced professional; don’t be afraid to accept that.
- 2) Be aware of what you don’t know. Our specific discipline gives us a unique perspective on patient care; that perspective, as well as the legal parameters of our practice, sets limits upon our area of expertise.
- 3) So, be confident of what you know, be aware of what you don’t know, and lastly, don’t confuse those two things. ☺

It might be useful here to recall the origin of the term triage, which grew out of the practice of French physicians in WWI when those responsible for the removal of the wounded from the battlefield or their care afterwards divided victims into three categories:

- Those who are likely to live, regardless of what care they receive;
- Those who are likely to die, regardless of what care they receive;
- Those for whom immediate care might make a positive difference in outcome.

(Ref: Wikipedia, <http://en.wikipedia.org/wiki/Triage>

We can be grateful to practice in settings where life and death are rarely on the line. As nurses in college health, we might more aptly use three slightly different categories for our triage of patients:

- 1) Those we most likely cannot kill (even when we would like to...)
- 2) Those for whom we are going to call EMS. (The one who are not GOMERs but GEISERNs: Get ‘Em Into Some ER Now!)
- 3) Those we may be able to help.

Given that most of us will readily recognize those in the second category (and may prefer to forget those in the first), we will now turn our attention to those in this last group; the ones we might help today. There are several tools we possess that can help this category of patients:

- 1) Our knowledge: what we know, what we don’t, and what to do about specific situations that fall within our scope of practice;
- 2) Our skills as educators. College health is a great place for nurses. We are, after all, the primary patient educators in a wide variety of clinical settings, and every nurse

- who has practiced for any length of time has experience in communicating effectively with patients to improve care outcomes.
- 3) Protocols: a written plan or reference specifying the procedures to be followed in assessing or providing care for a particular condition. E.G. *Telephone Triage Protocols for Nurses* by Julie K. Biggs, RN, BSN, MHA (Lippincott), now in its fourth addition. This is a book that is useful even when not on the telephone (as in face to face encounter, though reading from the book while doing the assessment can give patients some small doubt as to your experience and knowledge...) in assessing those more out of the ordinary complaints we all encounter at times.
 - 4) Standing orders.

It is about standing orders that we would like to share a bit more today. As a review, we may want to think afresh about what it meant by the term “standing order”. A standing order is a written document containing rules, policies, procedures, regulations, and orders for the conduct of patient care in various stipulated clinical situations. Standing orders are usually formulated collectively by the professional members of a department in a health care facility. Standing orders usually name the condition and prescribe the action to be taken in caring for the patient, including the dosage and route of administration for a drug or the schedule for the administration of a therapeutic procedure. (**Ref: Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.**)

Standing orders have several advantages for nurses in the college health setting:

- 1) They allow the initiation of necessary care in a more timely fashion when prescribing providers are not readily available or are overbooked;
- 2) They allow the nurse to operate to some extent beyond her or his scope of practice by implementing procedures or treatments under the auspices of a prescribing provider and the facility's administration;
- 3) They improve, if you will, customer service by making care for simple conditions more accessible to patients, sometimes at lower cost.

That said, standing orders, to convey these benefits, must adhere to some fairly rigid guidelines. These can be found in their entirety in various places with some variation, but most will have these points in common:

- 1) The order should address only one specific situation or condition;
- 2) The protocol outlined should be developed jointly by the groups of professionals involved in its implementation (i.e. MDs, ARNPs, PAs, RNs);
- 3) The order should clearly state its purpose, the policy of the institution that allows its use, the procedure to be followed, any contraindications to screen for or precautions to be observed, the documentation required, and the specific action that is authorized. The order should also indicate on what date it was issued, and for what period of time it is to

- remain in effect (thus encouraging periodic review). It should be signed by the Medical Director or other person who is the designated head of the facility or department.
- 4) For implementation of procedures, the order should stipulate what symptoms the patient reports (subjective findings), the pertinent history to be explored and documented, the specific clinical findings, including lab tests to be documented, the presumed assessment, and the specific treatment authorized.
 - 5) The implemented and documented order should be cosigned by a provider whose licensure is appropriate to the action taken (e.g. a prescribing provider for issue of an Rx).

The two standing orders I most frequently implement in my practice at SFC, outside of the ones that cover immunizations, are those for treatment of UTI and streptococcal pharyngitis (strep throat). Since these include specific objective data gained from point of care lab tests (urine dip stick in the first case and rapid strep screen in the second), I am comfortable in utilizing these orders to provide needed treatment in the absence or unavailability of a prescribing provider.

Back to the issue of knowing what you do and don't know, and not confusing the two, is the issue of knowing what you can and cannot do under a standing order and not exceeding the parameters of that order. Thus, in situations that are not an exact fit to the order's protocol, I will consult a provider by telephone to obtain a verbal order instead, or to establish that the patient needs to be seen by the provider. This could range from something as simple as an allergy to the approved medication or a variance or oddity in the patient's history (e.g. frequent UTIs or history of pyelonephritis in the case of a UTI). And this becomes a matter of personal clinical judgment as well as one's relationships with the available providers. A simple rule is to know yourself, know your colleagues, and allow them to know you. No nurse should ever feel compelled to implement a standing order simply because it exists. Operate within your comfort zone. For example, our institution has a standing order that allows RNs to initiate contraceptive prescriptions for non-medically complicated patients without seeing a medical provider. I don't use it simply because it's out of my comfort zone in terms of clinical experiences.

Last but never, ever, least, document your use of the order carefully and make certain you submit it for cosignature by your designated provider. I find the best documentation is a template that follows the exact outline of the standing order as written (i.e. symptoms, pertinent history, VS, point of care lab results, etc.) Your note should state that the plan implemented was per standing order, thus enshrining the order's authority in the patient's medical record.

A brief word about diagnostic and procedural coding for the implementation of a standing order: follow the guidelines of your specific facility. These are too varied to be addressed in a

session with this limited amount of time. They are also affected by whether or not your facility accepts third party reimbursement for services.

To review, we have looked a bit at what issues are considered in Nursing Triage in the college health setting, how standing orders can extend our ability to provide care and assist our providers with their workload, what standing order need to encompass to be valid, and what things, personal and institutional, to consider when implementing them and documenting that action. At this point, we would be pleased to hear your questions or comments, or your own experience with standing orders in your facility.