Guidance for Countersigning/Auditing Standing Orders including Audit tool

It is recommended that the registered nurse (RN) informs the Issuer within a defined period (i.e., 96 hours of the standing order being utilised) either:

1. Via an electronic message e.g., adding an electronic task to the Issuer's task list in Medtech or other relevant Practice Management System asking for them to countersign the SO, **or**
2. The RN enters the patient name in an "Appointment Book" template set up specifically for Standing Orders. The appointment template is accessed by the Issuer and a note is added to patient file verifying approval for the use of the SO.

STANDARD FOR Countersigning/Audit

When countersigning or auditing the RN's use of the SO, the Issuer should confirm that:

1. The patient has met the specific criteria that are outlined in the Standing Order prior to administration/supply of the medication;
2. A full assessment of the patient was undertaken by the RN prior to the administration of the Standing Order medication;
3. The medication was administered/dispensed in accordance with the Standing Order;
4. There is evidence that any specific diagnostic measurements have been completed to support the decision to administer/supply the medication;
5. Clinical record information includes all of the following:
   - Medication Name
   - Dose
   - Route
   - Amount administered/supplied
   - Time given
   - Allergies
   - Follow-up plan
6. The management of an adverse reaction and follow up is documented (if applicable);
7. Information if the medication was either "supplied" or "administered" under the Standing Order including reference to the Standing Order (if applicable).
8. Nurse should add new medication issued into the PMS, tagging it as "administered in clinic" or similar e.g. if using Medtech, enable this feature by activating the "administered in clinic" function.

Addressing Countersigning/Audit Concerns related to use of Standing Orders

- An objective and measurable assessment is required to ensure consistency in the implementation and documentation of each Standing Order. Refer to the Audit tool on the following page. It may be used in conjunction with either the counter-signing or randomised audit process.
- Where the issuing Issuer/auditor, when countersigning/auditing the use of a Standing Order, has any concerns about the content of the consultation, they should discuss these in person with the RN concerned, using a non-judgmental educational approach. A plan of action should be documented focused on reflective educational teaching to address the identified learning need and knowledge gaps within the practice setting.
- Where the issuing Issuer/auditor has repeated concerns about the use of Standing Orders by a particular RN, this should be discussed with the RN by the clinical leader of the practice / service and a mitigation strategy agreed. Until competency has been assured her/his authorisation will be cancelled.
- Where the Issuer/ has/ repeated concerns about the use of a specific Standing Order by a RN, a problem definition of the concern will be clarified, in conjunction with the wider Practice Clinical Leadership, and a solution offered to the Standing Orders Development Group who will either review and change, or remove from use, that Standing Order.
- If an adverse incident occurs in the use of a Standing Order, then that is managed as per the Significant Event Auditing practice policy. In addition, the Standing Orders Development Group will be asked to revise the Standing Order if considered necessary.

RN:			METRO AUCKLAND STANDING ORDER AUDIT TOOL										
Date of Audit		Name of AUDITOR			Medication					Number of Clinical Files Audited			
			Key for Scoring:		**MET = 3**			**PARTIALLY MET = 2**			**NOT MET = 0**		**Not applicable (N/A) = 3**
PATIENT SAMPLE			1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	Comments
The patient has met the specific criteria that are outlined in the Standing order prior to administration/supply of the Medication													
A full assessment of the patient was undertaken by the RN prior to the administration of the Standing Order medication													
The medication was administered/dispensed in accordance with the Standing Order													
There is evidence that any specific diagnostic measurements have been completed to support the decision to administer/supply the medication													
DOCUMENTATION													
Clinical record information includes all of the following: • Medication Name • Dose • Route • Amount administered/supplied • Time given • Allergies • Follow-up plan													
The management of an adverse reaction and follow up (if applicable)													
Whether the medication was either “supplied” or “administered” under the Standing Order													
Reference to the Standing Order													
Audit meets required standard Yes ☐ No ☐ If no, Remedial Action Plan documented here:													