Verbal Orders

Nurses implement diagnostic and therapeutic regimens in response to orders or prescriptions by licensed practitioners (172 NAC 99-003.04). Licensed practitioners are health care professionals with statutory authority to prescribe medications and treatments (172 NAC 99-002). Nurses receive orders in written/electronic or verbal formats. Nurses are responsible and accountable for the care they provide regardless of the way orders are communicated.

Verbal orders involve communication between a prescriber (sender) and licensed nurse (receiver) with the authority to receive and record the orders. Verbal orders are inherently subject to risk of error. The potential for verbal orders to be misunderstood, misheard, or transcribed incorrectly is augmented in the presence of different accents, dialects, and pronunciations used by both prescribers and recipients of the order. Factors such as unfamiliar or sound-alike drug names, background noise, fatigue, workload and interruptions are all associated with the potential for error when using verbal orders (Institute for Safe Medication Practices [ISMP], 2017; Wakefield & Wakefield, 2009). Telephonic and electronic audio connections may not only obscure clarity of the spoken word, but also eliminate visualization of nonverbal cues and behaviors that support effective communication.

Facilities are responsible for policies and procedures that identify conditions for the acceptance
and implementation of verbal orders. The patient medical record must necessarily allow for
documentation that provides a retrievable record of the communication between the prescriber
and the nurse, as well as the action or nursing interventions that occurred consequent to the
receipt and implementation of verbal orders.

DESCRIPTION

1. **Verbal orders are orders provided face-to-face or by telephone** by a prescriber to a
   licensed nurse.

2. **Verbal orders occur as a single transaction between one prescriber and one**
   licensed nurse. This assures the receiving nurse of an opportunity to seek
   clarification directly from the prescriber.

3. **Verbal orders predicate written or electronic order entry formats.** Verbal orders
   must always be transcribed to the patient medical record by the nurse.

4. **Verbal orders are subsequently reviewed and authenticated by the prescriber.**
   The prescriber must cosign or authenticate the orders to validate the order.

RECOMMENDATIONS

The following strategies are recommended to decrease the risk of error associated with verbal
orders (ISMP, 2017; National Coordinating Council for Medication Error Reporting and
Prevention [NCCMERP], 2015; National Quality Forum [NQF], 2010).

Prescribers (Senders)

1. **Respond to requests from the nurse for clarification or compliance with facility**
   policies for the acceptance of verbal orders.

2. **Confirm patient and allergies.** Identify the patient using full name and birth date,
   and confirm allergies with the order receiver before issuing orders.
3. Are vigilant regarding the risks associated with medication orders

   Avoid drug name abbreviations;

   Spell out drug names and use a phonetic alphabet for sound-alike letters, e.g., “T” as in Tango, “E” as in Edgar; “M” as in Mary, “N” as in Nancy);

   Provide the indication for medications which are likely to be unfamiliar and/or to help distinguish sound-alike drug names;

   Avoid abbreviations for dose, route, or frequency, e.g., U, IU, SC, QD;

   Communicate doses individually and not as a total daily dose, e.g., 2 tabs, 500mg each, twice daily with meals, NOT 4 tabs daily; and

   Provide weight-based doses. Include the mg per kg dosage along with the patient specific dose for all weight-based neonatal and pediatric medication orders.

4. Allow time for direct order entry. Prescribers can be expected to wait until the receiver is in front of a computer and the patient record is accessed for direct order entry. Direct entry of verbal orders into an electronic health record is difficult and will require additional time for both the prescriber and nurse.

5. Participate in read-back. Expect (or ask) the nurse to read back the order as s/he transcribes it in the patient medical record.

6. Request patient verification. Ask the nurse to read back the patient’s name and birth date on the screen or order form that was used to transcribe the verbal order.

Nurses (Receivers)

1. Do not accept verbal orders from office staff, another nurse or anyone who is not an authorized, licensed prescriber.

2. Transcribe directly into the medical record. Transcribe verbal orders into the
patient medical record as they are being communicated. Transcription from scrap paper to the medical record has been shown to increase the opportunity for error. Verbal orders should be dated, timed and signed in some way by the nurse receiving the order.

3. **Read-back.** Read the order back to the prescriber for verification even if the receiver is confident that he or she has heard the order correctly. Read-back should be a habit and compliance periodically reviewed. The read-back process is widely recognized as the single most important strategy to reduce errors with verbal orders.

4. **Understand the indication.** The verbal order should make sense to the nurse in the context of the patient’s condition and problem list. If unfamiliar with a particular medication, ask the prescriber for the indication and list this information in the record.

5. **Discourage misuse.** Do not accept verbal orders when the prescriber is present and physically able to write or enter an order. Verbal orders should be used infrequently, if at all, when the prescriber has access to electronic patient records for order entry.

6. **Do not transcribe abbreviations or clinical jargon.** If an abbreviation is given as part of a verbal order, transcribe and read back the meaning of the abbreviation, e.g., QID would be written or transcribed, and read back as *four times daily.* Use the same process for clinical jargon.

7. **Avoid verbal orders for new or changes in existing medication orders.** When telephone communication with a prescriber results in the need to prescribe or change an existing medication order, ask the prescriber to transmit the order electronically or by fax.

**Policies and Procedures**

1. **Identify licensees authorized to prescribe and accept verbal orders.**
2. **Explicitly limit verbal orders to a single transaction** between the prescriber and nurse. Subsequent clarification or changes are transcribed as separate entries into the medical record.

3. **Limit verbal orders.** There are situations in which verbal orders are unavoidable. Limit verbal orders to true emergencies or circumstances in which the prescriber is physically unable to electronically transmit, write, or fax orders (e.g., working in a sterile field or an emergency). Policies and procedures should identify how orders are documented in the medical record when implementation necessarily takes precedence (e.g., during a resuscitation).

4. **Prohibit verbal orders for convenience, or as a means to circumvent an electronic prescribing system.** Verbal orders should be used infrequently if at all when electronic patient records are available. Electronic health record systems provide the safest means of communicating medication prescription orders to pharmacies.

5. **Limit verbal orders for standing order sets.** Verbal orders for standing order sets should be avoided in non-emergent situations such as when admitting or discharging patients, or during medication reconciliation when prescribing medications. Order sets with required decision points for the prescriber (e.g., blank lines or drop-down boxes) should be completed by the prescriber.

6. **Prohibit verbal orders for chemotherapy.** Verbal orders for chemotherapy should be limited to holding or discontinuation. Chemotherapeutic agents are not administered in emergent situations and the dosing regimens are often complex.

7. **Require read-back.** Read-back means that the licensed nurse (receiver) of a verbal
order records the order and reads (not repeats) it back to the prescriber (sender).

8. **Standardize** “Do Not Use” abbreviations, acronyms, symbols, and dose designations that cannot be used throughout the organization.

9. **Define the elements of a complete verbal order.** Complete verbal orders eliminate the need for interpretation, (e.g., unit of measure, dose, start time, frequency and duration).

10. **Authentication.** Identify the required time frame for review and co-signature or authentication of verbal orders by the prescriber.

References:


Wakefield, D.S. & Wakefield, B.J. (2009). Are verbal orders a threat to patient safety?