

ADVISORY OPINION

OPINION: Verbal Orders
ADOPTED: 7/2018
REVISED: 8/2020/ 7/2022
REAFFIRMED: 7/2022

This Nebraska Board of Nursing advisory opinion is issued in accordance with the Nebraska Nurse Practice Act, Neb. Rev. Stat. 38-2216 (2). As such, this advisory opinion is for informational purposes only and is non-binding. The advisory opinions define acts, which in the opinion of the board, are or are not permitted in the practice of nursing.

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 treatments (172 NAC 99-002) and services. Nurses are responsible and accountable for the care they provide regardless of the way orders are communicated.

Computerized provider order entry (CPOE) is the preferred method for submitting orders. (Centers for Medicare and Medicaid Services [CMS], 2017). Computerized provider order entry is any process which requires licensed practitioners to place orders directly into the electronic medical record (EMR). The Joint Commission and CMS prohibit the use of secure text messaging platforms to send patient care orders (The Joint Commission, 2022; CMS, 2017).

A verbal order is acceptable only when a CPOE or written order cannot be submitted by the licensed practitioner. For the purpose of this Advisory Opinion, ***verbal orders*** are real-time oral communication between a licensed practitioner as a ***prescriber (sender)*** and a ***licensed nurse (receiver)*** with the authority to receive and record transcribe the orders in the patient medical record. The implication is that a licensed receiver has the knowledge and judgement to seek clarification also in real time if needed from the sender. Verbal orders require immediate action by individuals who are practicing within the scope of their licensure, certification or practice in accordance with law and regulation, as well as organizational policy (The Joint Commission, 2020).

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 electronic or written 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.** Identify circumstances where verbal orders are unavoidable such as during procedures or emergencies where the prescriber is physically unable to provide a CPOE or written order. Policies and procedures should identify when and how orders are entered in the medical record when verbal order implementation necessarily takes precedence.
- 4. Prohibit verbal orders for convenience, or as a means to circumvent an electronic order entry system.** Verbal orders should be used infrequently if at all when an EMR is available. Electronic medical 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:

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