Physician-Nurse Verbal Orders: A Review of the Literature

Topic Summary
August 2013

Clinical Question: “For registered nurses within the acute care hospital environment and emergency department, what is the quantity, quality, and consistency of the evidence for the process of physician-nurse verbal orders via an electronic healthcare records system?”

Conclusions: Verbal order (VO) literature is limited and focused on recommendations to (a) limit their use, and to (b) standardize policies/practices in order to optimize communications, decision-making, understanding, transcription, and execution. It is widely believed that VO can threaten patient safety, as they can be misunderstood, misinterpreted, or miswritten (See Appendix A, Page 22). VO should be limited to emergency situations or where there is no other method to communicate or clarify an order. VO should not be permitted in situations where the prescribing provider is present, except during a code, emergency, or bedside procedures.

Verbal Order Definition: Orders that are spoken aloud in person or by telephone and requires transcription into a medical record, followed by the prescriber reviewing, authenticating, and signing the transcribed order.

Key Summary of the Literature:
- There is a legal presumption that physicians will communicate appropriate verbal orders and nurses will regularly and routinely execute such orders carefully and correctly.
- VO in the Emergency Department have long been a “way of life” and are used routinely as a method of communication, especially for every day, non-urgent needs.
- VO are one type of workaround used by healthcare providers to bypass new technology and adapt the work process to cope with difficulties in workflow.
- VO policies, including telephone orders, have been formatted according to federal and state law, rules, and regulations, as well as accreditation guidelines and institutional agency policy.
- An organization may develop a policy that allows (a) a Licensed Independent Provider (LIP) to give a VO to be transcribed by an authorized individual and (b) another LIP to implement and authenticate the VO when the original LIP is unavailable.
- The Joint Commission does not support scribes entering VO and deems texting orders as unacceptable.
- Personnel subject themselves and their institutions to unnecessary liability when they do not follow safety-related policies and procedures such as verbal/telephone order policies.

Recommendations: Based on the evidence, the following recommendations are offered for consideration:
- VO policies must adhere to federal/state law, rules, and regulations, as well as accreditation guidelines.
- Hospitals need to develop and support policies that eliminate the use of VO when prescribers are present in the hospital, and limit the use of telephone orders.
- Never use VO as a routine method of order communication (See Verbal Order Process Model, Wakefield & Wakefield, 2009).
- VO are to be written and transcribed only by authorized staff as designated by the organization.
- Verbal and telephone orders should be limited to emergency situations or where there is no other way to communicate or clarify an order.
- VO should not be permitted in situations where the prescriber is present on the unit where the patient being prescribed is located, except during a code, emergency, or bedside procedures.
- VO should not be used for complex chemotherapy or do-not-resuscitate orders.
- Make computer systems more accessible for physicians and nurses at the time of decision making.
- Establish periodic monitoring and evaluation of VO practices to ensure organizational compliance.
- Incorporate VO policies into medical staff bylaws.
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Verbal Order Policies: Based on the above evidence and subsequent recommendations, verbal and telephone order policies should contain the following elements and precautions:2,4,7,14

- Definition of verbal order13
- Recipient must be able to identify the prescriber2
- Conversation should be able to be heard, second person listening whenever possible, 2,4,7 particularly if the person taking the message is inexperienced2
- Patient must be properly identified2,7
- VO must be consistent with patient’s diagnosis/condition, 2,4,7 be clear and concise, 2,4,7 each numerical digit pronounced separately, 4 and drugs spelled when necessary7
- VO must be repeated to prescriber, 2,7 and transcribed onto the chart immediately2
- VO must be reviewed and countersigned by prescriber within a predetermined time frame; 2,4,7 if timeframe is not established by state law, hospitals are to establish their own3
- VO must be dated, timed, and authenticated by the ordering practitioner or another authorized practitioner responsible for care of the patient per hospital policy and state law2,4,13
- Do not accept VO for chemotherapy because of their complexity and potential for errors4
- Physicians or LIP will not text orders10
- Limit verbal orders to formulary drugs4
- VO documentation must reflect whether the order is a verbal or a telephone order14

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Literature Search Strategies: An evidence review on the selected clinical topic was conducted in June 2013 to determine the quantity, quality, and consistency of the evidence. This review examined the evidence for the process of physician-nurse verbal orders via an electronic healthcare records system. An open year review of the evidence was conducted via PubMed, Cochrane Library, BMJ, and Ovid electronic databases and Google using the search terms of “verbal orders,” “nurse,” “registered nurse,” “policies,” “CPOE,” “protocol,” “guidelines,” Joint Commission standards,” “CMS standards,” JCAHO standards,” “texting verbal orders,” and “California state regulations,” either alone, mixed, or in combination. This review yielded 64 relevant hits (excluding Google) with 10 duplicates. 14 articles or regulations were selected for inclusion. One additional article was located via reference links. A final reference was correspondence with the California Board of Registered Nursing. A total of 16 references were reviewed in detail. After careful examination, 2 references were eliminated as they reflected outdated regulations or could not be traced to the original source. The remaining 14 articles pertained to the clinical topic of inquiry and were included in the final review. The articles were ranked using the CCIRES Evidence Leveling System (See Page 20) and included six state, federal, and accreditation regulatory documents, two opinion pieces, one white paper, one literature review, one systematic policy review, and three research studies. Result limitations include a lack of research studies and few detailed definitions or descriptions of what constitutes a verbal order.5,13,14 However, the information presented in this review provides the best available evidence to date to aid clinicians in the design of policies, procedures, and protocols related to the process of physician-nurse verbal orders.

   - Department of Consumers Affairs/BRN regulations for registered nurses’ scope of practice
   - Broad outline of dispensation of drugs or devices by registered nurses upon an order from a licensed physician, surgeon, certified nurse-midwife, nurse practitioner, or physician assistant. Verbal orders not specifically mentioned.
   - BRN nursing education consultant stated in an email that “agency policy will specify the time limit for physician signature or other relevant responsibilities.”

   - Survey results of directors of nursing and directors of pharmacy on types and extensiveness of verbal order/telephone order policies in their institutions
     i. 100 hospitals randomly selected, 250 beds or greater, general medical/surgical, short stay, non-governmental
   - Significant number of hospitals were attempting to regulate use of verbal orders and telephone orders
     i. 35.5% of hospitals had policies that prohibit the use of verbal orders when the physician was physically present on the unit where the order was given in non-emergency non-bedside procedure situations
        1. Policy followed 41.1 % of the time – Directors of nursing
        2. Policy followed 11.1% of the time – Directors of pharmacy
     ii. Deficiency in these policies was that physicians were not required to countersign verbal and telephone orders in all cases
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- Nursing and pharmacy personnel subject themselves and their institutions to unnecessary liability when they do not follow safety-related policies and procedures such as verbal/telephone order policies
- Hospitals need to develop policies that eliminate the use of verbal orders when physicians are present in the hospital
- Hospitals need to develop policies that limit the use of telephone orders
  1. Hospital nursing directors and pharmacy directors must work together to develop effective policies that control verbal and telephone orders
     1. Have these policies incorporated into the medical staff by-laws
     2. Final step is enforcement of these policies
- Background: Verbal and telephone orders for medications have the potential to become a significant source of medication errors in hospitals
  1. Errors may stem from the following situations:
     1. Order not heard correctly
     2. Physician misspoke
     3. Excessive background noise or distractions
     4. Misspelled medication names
     5. Order transcribed in wrong chart
     6. Order not placed on the chart immediately
  2. Verbal and telephone orders should be limited to emergency situations or where there is no other way to communicate or clarify an order
     1. All communication cannot be in writing; there are circumstances where verbal and telephone orders are permissible
     2. Should not be permitted in situations where the prescribing physician is present on the unit where the patient being prescribed is located, except during a code, emergency, or bedside procedures
  3. When verbal and telephone orders are necessary, take the following precautions:
     1. Recipient must be able to identify the prescriber
     2. Conversation should be able to be heard
     3. Patient must be properly identified
     4. Prescribed medication should be consistent with patient’s diagnosis and condition
     5. Order must be clear and concise
     6. Order must be repeated to prescriber
     7. Order should be written on a 8 ½ x 11 sheet of paper (article is pre-CPOE)
     8. Order must be transcribed onto patient’s chart immediately
     9. Order must be reviewed and countersigned within 24 hours by the prescriber
     10. Receiving verbal and telephone orders should be limited to the nurse manager, charge nurse, or supervisor
   - May 16, 2012 document outlining the Centers for Medicare & Medicaid Services (CMS) final revisions for Hospital and critical access hospital Conditions of Participation (CoP) changes, effective July 16, 2012.
   - Verbal Orders: Eliminated requirement for authentication of verbal orders within 48 hours; deferred to applicable federal and state law to establish authentication time frames.
     i. Hospitals should make efforts to minimize the use of verbal orders.
     ii. If verbal orders are used, they should be used infrequently.
   - Authentication of Orders: Made permanent the requirement that all orders, including verbal orders, must be dated, timed, and authenticated by either ordering practitioner or another practitioner who is responsible for care of the patient and is authorized to write order per hospital policy and in accordance with state law.
     i. If there is no state law establishing a timeframe, a hospital would be allowed to establish their own timeframe for authentication of orders, including verbal orders.
     ii. A hospital is free to adopt a more stringent policy than required under the regulations, should it believe it is prudent to do so.
     iii. Authenticate orders promptly by either an ordering practitioner or another practitioner who is responsible for care of the patient “only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.”

   - Bi-monthly acute care medication safety alert newsletter; January 24th 2001 edition highlighted verbal orders
   - Verbal Orders definition: orders that are spoken aloud in person or by telephone.
     i. Offer more room for error
        1. Interpretation of what someone else says, which is problematic re: accents, dialects, pronunciations, back ground noise, interruptions, unfamiliar terminology
        2. Transcribed as a written order: adds complexity and risk
           a. More room for error if nurse receiving verbal order, then calls it to pharmacy
     ii. No one except prescriber can verify recipient heard the message correctly
        1. Only real record of order is in the memories of those involved
        2. Prescribers must enunciate clearly, pronounce each numerical digit separately, and spell unfamiliar drug names
     iii. Recommendations:
        1. Ensure verbal order makes sense in context of patient's condition
        2. Second person listen to the verbal order whenever possible.
           a. Required if person taking the message is inexperienced
        3. Record verbal order directly onto an order sheet in the patient's chart whenever possible
           a. Obtain phone number for follow-up questions
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4. Receiver to sign, date, time, and note the order according to procedure
5. Prescriber to verify and sign/date orders within a predetermined time frame
6. Never use verbal orders as a routine method of order communication
   a. Do not allow verbal orders when the prescriber is present and the patient's chart is available
   b. Reserved for situations where it is difficult or impossible for hard copy or electronic order transmission (e.g., orders communicated during a sterile procedure, etc.).
7. Do not accept verbal orders for chemotherapy because of their complexity and potential for errors.
   a. Ensure laboratory studies completed and available when prescribers are on site to avoid dose adjustments after the prescriber leaves
8. Telephone communication: Ask the prescriber to hand write the orders and fax them to the facility when feasible instead of communicating the orders verbally
9. Do not allow medication requests from nursing units to the pharmacy unless the order has been transcribed onto an order form and simultaneously faxed or otherwise seen by a pharmacist before the medication is dispensed
10. Limit verbal orders to formulary drugs. The names of drugs unfamiliar to staff are more likely to be misheard and their uses and dosages may be less familiar.
11. Limit the number of personnel who may receive telephone orders to ensure familiarity with hospital guidelines and the ability to recognize the caller, which reduces the potential for fraudulent telephone orders (ISMP Medication Safety Alert! January 10, 2001).
12. Whenever possible, have a pharmacist receive all verbal orders for medications
   a. Ensure a mechanism for pharmacists to transcribe the orders directly into the medical record

   • Descriptive study examining the characteristics of verbal orders at a tertiary children’s hospital, as inputted into the chart via the institution’s computerized provider order entry system (CPOE) (study period August 2003 to January 2004)
     i. Rate of total verbal orders and rate of unsigned verbal orders were examined before, during, and after CPOE administration
     ii. By determining the characteristics of verbal orders, healthcare institutions can better understand issues surrounding this issue
   • CPOE implementation significantly effected verbal orders and unsigned verbal orders
     i. After CPOE implementation, 10% of orders generated weekly were verbal orders
     ii. Medication orders from physicians to nurses were the primary source of verbal orders
     iii. Greatest rates of verbal orders were from
         1. Psychiatry (74%) and involved medications (38%)
         2. Physician to nurse (25%)
         3. Laboratory orders (22%)
         4. [Continue]
iv. Greatest rates of medications verbal orders
   1. Psychotherapeutics (24%)
   2. Antihistamines (14%)
   3. Analgesics and antipyretics (9%)
   4. Fluids and electrolytes (9%)

v. Medical physicians had a larger rate of verbal orders than surgical physicians

vi. Verbal orders rates were reduced from 23% before CPOE to 10% after CPOE implementation

vii. Unsigned verbal orders rates were reduced from 43% before CPOE to 19% after CPOE implementation

• Background: There is limited data regarding the epidemiology of verbal orders and their impact on patient safety
   i. Verbal orders can be misunderstood, misinterpreted, or miswritten
   ii. Few clinical studies, most case reports, demonstrating harm to patients from verbal orders
   iii. AHRQ: “the best approach for ensuring patient safety will be one in which the general insistence on evidence does not prevent implementation of practical, low risk, but under-studied interventions that seem likely to work
      1. Reduction of verbal orders is similar to other patient safety practices that make common sense but generally lack supporting evidence

   • Qualitative study examining the medication-use process after implementation of a CPOE system in an academic hospital in the Netherlands
      i. 2006-2007 Data included 21 interviews with clinician end-users, paper-based and system generated documents used daily, and educational materials
         1. Focused on 5 phases of medication-use cycle: prescribing, communication, dispensing, administration, and monitoring
   • Problems in Medication Use Process
      i. Problems: Cognitive overload on physicians and nurses; unmet information needs; miscommunication of orders and ideas; coordination of interrelated task between co-working professionals; potentially faulty administration phase, suboptimal monitoring of medication plans
         1. Majority of reported problems were in the communication and prescription phases
            a. Miscommunication of orders and ideas between physicians and nurses
      ii. Use of workarounds and variation in their types were more evident in communication, administration, and dispensing phases
         1. Workarounds are often unavailable, unstable, or unreliable
            a. Unnecessarily increase the workload and cognitive efforts of providers
         2. Verbal orders identified as a clinical workflow problem
         3. Verbal orders cited as a workaround to address and deal with problems associated with medication-use process
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- CPOE and Verbal Orders
  i. Providers are actively involved in bypassing the technology or in adapting the work process to cope with difficulties in their workflow
     1. Context of CPOE use compelled providers to bypass it
        a. Verbal orders still used frequently
        b. Orders entered later by physicians simply for documentation purposes questions CPOE’s beneficial impact on patient safety
           i. CPOE documentation does not reflect what happened in real practice
     2. In certain instances workarounds burden providers with extra time and effort or endanger patient safety
     3. If physician forgets to enter an order, the nurse may follow up the order based on his/her notes or physicians’ verbal order
  ii. Problem: Delay in Order Entry for Newly Admitted Patients
      1. Root Cause: Time-consuming process of order entry
      2. Resulting Workarounds:
         a. Verbal or paper-based orders for most important and urgent of medication
         b. Call from nurses to remind physicians to enter medication orders
  iii. Problem: Communication of Orders
       1. Root Cause: Lack of bedside systems; busy physician schedules (especially residents)
       2. Resulting Workarounds:
          a. Physicians emphasize the order verbally, then write it down, sign it for nurses
          b. Nurses directly inquire for confirmation by direct communication or phone call
  iv. Problem: Verbal Communication of Orders
       1. Root Cause: Busy evening or night shifts for residents; emergency situations
       2. Resulting Workarounds:
          a. Nurses write in administration records or other nurses notes that physician prescribed medication
          b. Nurses call physician to follow up issuing electronic version of verbal orders
  v. Problem: Drug Administration without Electronic Orders
     1. Root Cause: Verbal orders during medical rounds, due to lack of bedside systems and busy physicians (especially evening/night shifts)
     2. Resulting Workarounds:
        a. Nurses start to administer drugs based on physicians’ verbal order, even if they do not have electronic orders
        b. Nurses call back physicians to remind them to enter orders
        c. Next shift nurse may ask other doctors to issue electronic order

- Workarounds: Two patterns of workarounds that are intertwined in practice
  i. Workflow barriers introduced by technology and its components
     1. Lack of mobile computer devices was a major barrier
  ii. Organizational processes not reengineered to effectively integrate with the technology
     1. Making administration records more accessible for physicians and nurses at the time of decision making
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- Recommendations:
  i. Incorporate system redesign and work processes to ensure that:
     1. Systems are more compatible with hectic work environment
     2. Usability improved for quick and genuine order entry and data registry
     3. Patient data and interrelated task of co-working providers are adequately integrated to support clinical workflow

   - Article outlining the hazards of verbal orders in the emergency department, with recommendations for organizations, as well as for prescribers, and receivers of verbal orders.
   - Verbal Orders in the Emergency Department
     i. Long been a “way of life”
     ii. Used routinely as a method of communication, especially for every day, non-urgent needs
     iii. Verbal orders often cause miscommunications resulting in medication errors
         1. Should be used as little as possible
   - Telephone orders are a necessary evil in today’s mobile society
   - JCAHO identified verbal orders as potentially error prone
     i. Urged practitioners to “improve the effectiveness of communication”
     ii. Organizations need to “implement a process for taking verbal or telephone orders or critical test results that requires a verification or read-back of the entire order or test result by person receiving the order or result.”
   - Organizational Policies for Verbal Orders
     i. When practitioners are standing face-to-face, verbal orders should only be used when absolutely necessary (emergencies or when physician is working under sterile conditions and cannot write)
     ii. Administrators/managers need to support verbal order policies that limit use of verbal orders for benefit of patient safety
         1. Simultaneously must provide resources necessary for alternative methods of communication
   - Prescriber Recommendations
     i. Enunciate the drug name clearly; spelling drug name is ideal
     ii. Use both brand and generic name to clarify which drug is being ordered (particularly useful with sound alike drugs)
     iii. Avoid use of volume amounts to direct the drug dose (Avoid “1 amp;” say, 1 mg)
     iv. Use single-digit read-back/repeat-back to verify dose (“teen” numbers are often confused, such as “15” and “50”)
     v. Expect a “read back” for any order given by telephone
     vi. During an emergency, expect a “repeat-back” confirmation from the listener: “that was atropine 1 mg”
     vii. During a code, nurse giving the medication acknowledges that the drug has been administered, so prescribers should hear “atropine 1 mg given”
     viii. Sign the code sheet/trauma sheet that was used for recording verbal orders as soon as possible, before leaving the area

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Listener/Receiver Recommendations
1. Validate patient’s name, allergies, diagnosis, or other pertinent information
2. Read back/repeat back the order clearly and ensure validation of accuracy occurs from the prescriber
3. Ensure that the order makes sense in the context of the patient’s condition
4. Have a second person verify that they heard the same order, directly recording it onto the code sheet as documentation of the verbal order
5. If the order is a telephone order, obtain a telephone number or beeper number for follow-up questions
6. Attempt to have prescribers fax a written order, if possible, to validate the verbal order already taken
7. Never use verbal orders as a routine method of communication (when the physician and the chart are present, when it is not an emergency, and when it is not during a sterile procedure)

   - Question and Answer OR Nursing Law section of AORN journal, with answers given by a JD.
     1. Question: What are nurses’ responsibility for verbal orders given during surgery?
   - Verbal orders in the OR are legally and clinically appropriate
     1. Legal presumption that:
       1. The physician will communicate appropriate verbal orders
       2. The nurses will regularly and routinely execute such orders carefully and correctly
   - Issues regarding Computerized Physician Order Entry (CPOE), verbal order processes such as physician signature time limit, and inappropriate verbal orders were not discussed

   - TJC Standards FAQ Details answering the question, “Is it acceptable for one Licensed Independent Practitioner (LIP) to authenticate on behalf of another LIP?”
   - Answer: Organizations need to develop policies and procedures, consistent with law and regulation, which define the circumstances and mechanisms under which one LIP could authenticate for another LIP
     1. Consistent with TJC standards and CMS Conditions of Participation (CoP) it would be acceptable for an organization to:
       1. Develop and implement a policy that allows an LIP to give a verbal order that has been transcribed by a nurse or other authorized individual
       2. Allows another LIP to implement and authenticate the verbal order when the original LIP is unavailable

   - TJC Standards FAQ Details answering the question, “Is it acceptable for physicians and licensed independent practitioners (and other practitioners allowed to write orders) to text orders for patients to the hospital or other healthcare setting?”
   - Answer: It is not acceptable for physicians or licensed independent practitioners to text orders for patients to the hospital or other healthcare setting.
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i. This method provides no ability to verify the identity of the person sending the text

ii. There is no way to keep the original message as validation of what is entered into the medical record


- TJC Standards FAQ Details answering the following questions

  i. “What is a scribe and how are they used?”
     1. Scribe does not and may not act independently but can document previously determined physician’s or practitioner’s diction and/or activities
     2. Used in ED where they accompany the physician/practitioner and record information into medical record to allow physician/practitioner to spend more time with patient and have accurate documentation

  ii. “Do TJC standards allow organizations to utilize scribes?”
     1. TJC does not endorse nor prohibit the use of scribes
        a. No orders are being entered into the medical record by scribes (RC.01.04.01)
        b. If organization chooses to use scribes, surveyors expect to see compliance with all of the Human Resources, Information Management, Leadership (contracted service standard) Right and Responsibilities, Compliance with the Record of Care and Provision of Care standards
           a. Organization implements PI process to ensure the scribe is not acting outside of job description, authentication is taking place, and no orders are being entered into the medical record by scribes (RC.01.04.01)
           b. “Scribed for Dr. X by name of scribe and title” date, time of entry
           c. Physician/practitioner must authenticate before physician/practitioner and scribe leave the area, as other practitioners may be using the documentation to inform their patient-related decisions
              i. Authentication cannot be delegated by another physician/practitioner
     iii. “Can scribes enter orders for physicians and practitioners?”
         1. TJC does not support scribes being utilized to enter orders for physicians or practitioners due to additional risk added to the process.

12. The Joint Commission (2012). Chapter: Record of care, treatment, and services – verbal orders (RC.02.03.07).

- The Joint Commission Hospital Standards from 2012.

  i. Verbal and telephone orders are written appropriately and transcribed only by qualified staff as designated by the organization.


- Paper describing the (1) very limited existing research on verbal orders, (2) a model of verbal order use identifying potential error trigger points and (3) a verbal order research agenda

- Very little systematic study of the actual threat posed by their use.; VO may represent 20% or more of all inpatient orders
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i. Commonly used when prescribers (i.e., physician, nurse practitioner (NP), physician’s assistant (PA)) are unable or unwilling to write in the medical record or electronically enter orders using a computerized provider order entry (CPOE) system

- Appropriate and inappropriate uses of VO:
  i. Necessary when prescriber is in the middle of a procedure or medical emergency, and it is impractical to stop patient care to write a patient care order
  ii. Necessary if the prescriber is not physically present when a new patient care order is needed (e.g., at night)
  iii. VO should not be used for complex chemotherapy or do-not-resuscitate orders
  iv. Great variation in their appropriate use during other types of patient care activities (e.g., patient rounds, interdisciplinary team meetings, other non-emergent patient care situations or teaching healthcare learners)
  v. Of particular concern is when face-to-face VO may become routine and used as a convenience rather than a necessity, thus replacing prescribers’ writing or electronically entering patient care orders

- Verbal Order Literature
  i. Research Literature:
     1. Indications for using VO, VO policies and procedures, and the extent of VO use have not been studied in depth
        a. Primarily of non-systematic and anecdotal evidence of the relationship between VO utilization and actual or potential patient harm
     2. Only large-scale study of hospital VO polices is a 1990 report of a survey of nursing and pharmacy leaders’ self-report of selected features of their hospitals’ VO policies (See Reference #2, Dahl & Davis, 1990).
     3. Only study specifically looking at errors associated with VO was conducted in an inpatient pediatric setting in the mid-1990s, and had the counterintuitive finding of a fourfold decreased risk of error associated with verbal as compared with handwritten orders
     4. A recent systematic review assessing evidence of the error risk associated with VO also found only the one aforementioned study
        a. Based on the lack of research, concluded that despite the “common-sense” of limiting VO, there is no empirical support for adopting changes in VO policies.
  ii. Practice Literature:
     1. Vast majority of VO-related literature has focused on practical recommendations to (1) limit VO use, and to (2) standardize VO policies and practices to optimize VO communications, decision- making, understanding, transcription and execution
        a. Widely believed that VO represent a threat to patient safety; Use of VO in situations where they are not immediately necessary for patient care (ie, provider convenience) may contribute to avoidable errors and adverse events as well increasing workload for those receiving the orders
        b. Most clearly evidenced by specific recommendations from the Joint Commission, the National Quality Forum (NQF) and others requiring “read-
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backs’” and other strategies aimed at reducing or standardizing how VO are communicated

2. Specific recommendations and suggestions categorized into 7 general areas:
   a. (1) when VO should and should not be used
   b. (2) who is allowed to give and receive the VO;
   c. (3) what constitutes a VO, and the related verbal content that must be documented
   d. (4) limitations and prohibitions in the use of VO
   e. (5) authorization and validation of the VO
   f. (6) strategies, techniques and specific actions to increase the clarity and effectiveness of the VO
   g. (7) requirements for periodic monitoring and evaluation of VO practices and compliance with organizational policies and procedures

iii. VO Research Agenda: Broad range of questions needing further research fall under three categories:
   1. Nature, Extent and Appropriateness of Current VO Use
   2. Nature, Extent and Causal Role of VO in Medical Error
   3. Strategies for Minimizing VO-Related Errors and Harm

   • Systematic review of hospital and telephone order policies in acute care setting
     i. Stratified random sample documents abstracted from access, rural, urban hospitals in Iowa and Missouri and academic medical centers in the U.S; 40 total hospitals
     ii. Limitations
        1. Did not reach sample size of 10 hospitals for each category
        2. Influenced by limited focus on policies from medical staff, nursing, pharmacy departments
        3. General medication ordering and administration policies might have details not repeated in verbal order policies
        4. Policy review and not primary data collection through observation
        5. Results do not reflect the reliability of which policies are followed
   • Little systematic study of strategies and policies used by hospital to ensure appropriate use, accurate communication by sender, understanding by receiver, initial documentation, subsequent transcription into medical record
   • Verbal Order literature to date is relatively limited
     i. Primarily based on anecdotal data
     ii. Not examined hospital verbal order policies at depth
     iii. Exception is 1990 study by Dahl and Davis (Reference #2)
   • Verbal Order Definition: Includes all telephone and face-to-face patient care orders that
     i. Ordering prescriber communicates verbally
     ii. Require subsequent transcription into patient’s medical record
     iii. Require prescriber to subsequently review and sign transcribed order
• Key Elements of a Verbal Order Policy
  i. Authorization to give verbal order
     1. Physicians, Physician Assistants, Nurse Practitioners most common
     2. Licensed Independent Practitioners
     3. No policy clarified who qualifies as an “authorized agent” or “office designee”
     4. No process discussed related to communication of order between prescriber and “authorized agent” or “office designee”
  ii. Authorization to receive (take) verbal order
     1. 27 different job titles listed
     2. Registered nurse, licensed practical nurse, pharmacists
        a. Generic term “nurse” used in several policies
     3. Smaller hospitals had greater range of individuals authorized to receive verbal orders
     4. Statements limiting verbal order receiver to take specific types of orders on the basis of the recipient’s scope of practice under state licensure laws
  iii. Definition of verbal order
     1. Very few policies included a definition of verbal orders
        a. “A prescribed order communicated orally, spoken face-to-face, by telephone or other auditory device to a licensed or registered healthcare professional authorized to accept verbal/phone orders from a physician.”
        b. “Verbal orders are orders for medications, treatments, interventions, or other patient care that are communicated as oral, spoken communication between senders and receivers either face-to-face or by telephone.”
        c. “Verbal med order: any order from the physician to the nurse that is given by mouth—in person or over the phone.”
        d. “A verbal order has been verbally relayed by a licensed independent practitioner, either in person, over the phone, or e-mail to qualified individual.”
  iv. Required documentation of verbal order
     1. Verbal Order Documentation Requirements
        a. Contains definition of verbal order
        b. Requires documenting who received order
        c. Requires documenting who gave order
        d. Requires documenting date/time order received
        e. Specifies time period for cosigning by prescriber
        f. Requires documentation to reflect verbal vs. telephone order
     2. Consistent in who gave/received orders, date/time, needed to be cosigned by the person giving the order
     3. Less consistent in documenting orders given verbally in a face-to-face situation versus telephone orders
  v. Time frame in which verbal orders must be cosigned
     1. Marked inconsistencies in time frame for cosigning orders
     2. Conflicting time frames within the same hospital found for all hospital categories
  vi. Prohibitions in using verbal orders
Physician-Nurse Verbal Orders: A Review of the Literature

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1. Only common explicit prohibition was for starting chemotherapy or changing doses of chemotherapy
   a. Many hospital allowed a verbal order to stop chemotherapy treatment
2. Prohibition on:
   a. Sound alike medications
   b. High risk medications
   c. CPOE systems prohibit the use of face-to-face verbal orders while provider is in the hospital, except for emergencies and during procedures
      i. Requirement that providers must log on to a computer while at home to give a verbal order
vii. Authentication and validation of verbal orders
   1. Only a few non-academic hospitals required any form of procedure to authenticate identity of person giving order
   2. Majority of academic hospitals required authentication, such as call back to office and physician identification number
      a. Telephone orders from a physician’s office must be immediately followed up with fax of order as verification mechanism
viii. Mechanisms to ensure accuracy of verbal order content
   1. All hospitals required verbal read-back by person receiving order
   2. Fewer hospitals required
      a. Avoid abbreviations
      b. Spell out prescribed drug name by either prescriber or receiver
      c. Use of leading zeros but not trailing zeros
   3. None of the policies explicitly prohibited use of verbal orders for “Same meds as at home” or “same meds”

• Verbal Order Policies Discussion
i. Intent of verbal order policies is to clearly spell out the process by which verbal orders are given and received within an institution
   1. Issues of transmission clarity and potential inaccuracy
   2. Issues regarding oversight of the communication process and quality
ii. Existence of a verbal order policy does not guarantee similar interpretation by those who use it
   1. Gap analysis between processes in policy versus clinical practice can identify areas for additional consensus building, education, and ongoing monitoring
iii. Implementation of EHR and CPOE will not eliminate verbal orders
   1. Should decrease the number of nonemergency verbal orders when the physicians are inside the hospital
   2. Specific policies pertaining to verbal orders in conjunction with EHR and CPOE information and communication technologies will be needed
      a. One policy explicitly stated face-to-face verbal orders were not allowed and prescribers will have to use a computer to enter the orders
      b. Mobile technology raises the question of whether or to what extent telephone orders will also not be allowed
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iv. Avoid inconsistencies within multiple verbal order policies in one hospital
   1. Could reflect fragmented approaches to policy updates
   2. Should different types of verbal orders such as medications orders have a shorter authentication period?
Physician-Nurse Verbal Orders: A Review of the Literature

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Reference List


Physician-Nurse Verbal Orders: A Review of the Literature

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   Programid=47

    &StandardsFAQChapterId=123

    - Human Resources. Available at
    Id=426&StandardsFAQChapterId=19

12. The Joint Commission (2012). *Chapter: Record of care, treatment, and services – verbal orders*
    *(RC.02.03.07).* Joint Commission E-dition. Available at

    Safety in Health Care, 18*(3), 165-168.

    review of verbal order policies in acute care hospitals. *The Joint Commission Journal on Quality
    and Patient Safety, 38*(1), 24-33.
### Electronic Database Search Methodology

Literature search topic: For registered nurses within the acute care hospital environment and the emergency department, what is the quantity, quality, and consistency of the evidence for the process of physician-nurse verbal orders via an electronic medical records system?

Date(s): June-July 2013

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# Physician-Nurse Verbal Orders: A Review of the Literature

## Topic Summary

*August 2013*

## Google Search

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<th>Google Search</th>
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**TOTALS** 13,097,000 | 17 | 7 | 10 | 4 | 6 |

## Reference/Contextual Links #1

Citation: California Board of Registered Nursing (2013). *Regulations: Nursing Practice Act, Business Professions code 2725.1.* Department of Consumer Affairs. Available at [http://www.rn.ca.gov/regulations/bpc.shtml#2725.1](http://www.rn.ca.gov/regulations/bpc.shtml#2725.1)

## Reference/Contextual Links #2


**Total Articles Included in Literature Review: Database (6) + Google (6) Contextual Links (2) = 14**

*Additional articles/information found in references lists and/or article review*

### Inclusion Criteria:

Verbal orders, registered nurses, physicians, inpatient acute care, emergency department, electronic medical record, scope of practice, computerized physician order entry (CPOE), policies/procedures

### Exclusion Criteria:

Orders other than verbal orders, healthcare professionals other than registered nurses and physicians, settings other than acute care/inpatient and emergency department, issues outside of scope of practice
### Collaborative Center for Integrative Reviews and Evidence Summaries

**CCIRES© Evidence Leveling System (ELS)**

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<th>DESCRIPTION</th>
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<th>ARTICLE NUMBER</th>
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<td>B</td>
<td>Well-designed controlled studies, both randomized and nonrandomized, prospective or retrospective studies, and integrative reviews with results that consistently support a specific action, intervention, or treatment</td>
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<td>Qualitative studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
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<td>D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
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<td>E</td>
<td>Theory-based evidence from expert opinion or multiple case reports, case studies, consensus of experts, and literature reviews</td>
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*A large sample has adequate power to detect the observed effect with confidence (as seen in significant Confidence Intervals). A small sample may lack confidence in the power of the desired effect (Polit & Beck, 2008)*

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Designed by Emma M. Cuenca and Cecelia L. Crawford, Collaborative Center for Integrative Reviews and Evidence Summaries (CCIRES); ©Kaiser Permanente SCAL Regional Nursing Research Program, May 2011

*Adapted from AACN Evidence Leveling System (2009) and Canadian Medical Association & Centre for Evidence-Based Medicine, Levels of the Evidence (2001)*

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*Created by Cecelia L. Crawford, DNP, RN and Anjai Shields, BS; © Kaiser Permanente, SCAL Regional Nursing Research Program, August 7, 2013*
Purpose/intended Audience

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