Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840. An advisory opinion adopted by the NCQAC is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the NCQAC. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and//or decrease risk.

Title:	Verbal Orders	*Number:* NCAO 29.00
References:	RCW 18.79 Nursing Care WAC 246-840 Practical and Registered Nursing	
Contact:	Deborah Carlson, MSN, BSEd, RN, CPM Director of Nursing Practice	
Phone:	360 236-4703	
Email:	NursingPractice@doh.wa.gov or ARNPPractice@doh.wa.gov	
Effective Date:	November 12, 2021	
Supersedes:	NA	
Approved By:	Nursing Care Quality Assurance Commission (NCQAC)	

Conclusion Statement

The registered nurse (RN) and licensed practical nurse (LPN) may, based on their individual judgment of each situation, accept verbal orders from an authorized health care practitioner or a direct intermediary or agent. The nurse is responsible to ensure there is a valid, complete medication/treatment order prior to the administration of prescriptive medications or the implementation of a medical intervention/treatment. The nurse has the right and responsibility to confirm orders when there is a question of authenticity or accuracy of the orders. The nurse is responsible to recognize the appropriateness of the order with respect to the plan of care, and for implementing the order, or obtaining clarification from the prescriber. Orders must be complete enough so that no further medical judgment is needed when the order is implemented.

Background and Analysis

Washington state nursing law and rule does not address the use of verbal orders. The method of communicating orders under the direction of an authorized practitioner is not addressed or defined. Other state laws and rules define requirements for verbal orders for specific settings. Examples include (but not limited to):

- Nursing Homes (RCW 74.42.230)
- Residential Treatment Facilities (WAC 246-337-105)

- Private Psychiatric and Alcoholism Hospitals (WAC 246-322-210)

The nurse implements diagnostic and therapeutic regimens in response to orders or prescriptions by an authorized health care practitioner. The nurse is responsible and accountable for the care they give 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, 2017). A verbal order is acceptable only when a CPOE or written order cannot be submitted. Verbal orders are real-time oral communication between the prescriber (sender) and a licensed nurse (receiver) with the authority to receive and record transcribe the orders in the medical record. The implication is that the licensed receiver has the knowledge and judgment to seek clarification also in real time if needed from the sender. Verbal orders require immediate action by individuals who are practicing with the scope of their licensure, certification, or practice following law and regulation, and organizational policy (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 prescribers and recipients of the order. Factors such as sound-alike drug names, background noise, fatigue, workload, and interruptions are associated with the potential for error (Institute for Safe Medication Practices (2017). Telephonic and electronic audio connections may obscure clarity and eliminate visualizing nonverbal cues and behaviors that support effective communication.

Facilities are responsible for policies and procedures that identify conditions of the acceptance and implementation of verbal orders. The patient medical record must necessarily allow for documentation that provide as 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.

Recommendations

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

Prescribers (Senders)

1. Respond to request form 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, birth date, and confirm allergies with the order receiver before issuing orders.
3. Be vigilant about the risks associated with medication orders:
    a. Avoid drug name abbreviations.
    b. Spell out drug names and use a phonetic alphabet for sound-alike letters.
    c. Give the indication for medications which are likely to be unfamiliar and/or help distinguish sound-alike drug names.
    d. Avoid abbreviations for dose, route, or frequency.

e. Communicate doses individually and not as a total daily dose;
f. Use weight-based doses.
g. Allow time for direct order entry.
h. Participate in read-back.
i. Request patient verification.

Nurses (Receivers)

1. Identify the prescriber and confirm that there is a known provider relationship the patient even if the order is delivered by another provider.
2. Confirm orders when there is a question of authenticity or accuracy of the orders.
3. Transcribe directly into the medical record including the date, time, and signature and if order was given directly by the prescriber or by an intermediary or agent.
4. Read-back the order to the prescriber for verification even if the receive is confident they heard the order correctly.
5. Understand the indication for the order. Ask the prescriber for the indication is not clear in the context of the patient's condition and problem list and document this in the record.
6. Discourage misuse of accepting verbal orders when the prescriber present and physically able to write or enter an order. Verbal orders should be used infrequently when the prescriber has access to CPOE.
7. Do not transcribe abbreviations or clinical jargon.
8. Avoid verbal orders for new or changes in existing medical orders. Ask the prescriber to send the order electronically or by facsimile.

Policies and Procedures

1. Identify health care practitioners authorized to prescribe and accept verbal orders.
2. Explicitly limit verbal orders to a single transaction between the prescriber and the nurse. Transcribe separate entries into the medical record for subsequent clarification or changes.
3. Limit verbal orders by identifying 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.
4. Prohibit verbal orders for convenience, or as a means to circumvent an electronic order system.
5. Limit verbal orders for standing order sets.
6. Prohibit verbal orders for chemotherapy.
7. Require read-back.
8. Standards "Do Not Use" abbreviations, acronyms, symbols, and dose designations that cannot be used.
9. Define the elements of a complete verbal order.
10. Identify the required time frame for review and co-signature or authentication of verbal orders by the prescriber.

Conclusion

The nurse must exercise professional responsibility and prudent judgment when accepting and transcribing verbal orders.

References

172 NAC 99. (2004). Regulations Governing the Provision of Nursing Care. (2004). https://www.nebraska.gov/rules-andregs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-099.pdf

CMS. (2018). Texting of Patient Information among Healthcare Providers in Hospitals and Critical Access Hospitals (CAHs). Center for Clinical Standards and Quality/Quality, Safety and Oversight Group. https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/SurveyCertificationGenInfo/Downloads/QSO-18-10-ALL.pdf

ISMP. (2017). Despite technology, verbal orders persist, read back is not widespread, and errors continue. https://www.ismp.org/resources/despite-technology-verbalorders-persist-read-back-not-widespread-and-errors-continue

NCCMERP. (2015). Recommendations to reduce medication errors associated with verbal medication orders and prescriptions. http://www.nccmerp.org/recommendations-reducemedication-errors-associated-verbal-medication-orders-and-prescriptions

NQF (2010). Safe practice 13: Order read-back and abbreviations. Safe Practices for Better Healthcare—2010 Update: A Consensus Report.

The Joint Commission. (2016). Update: Texting orders. Joint Commission Perspectives, 36(5). www.jointcommission.org/assets/1/6/Update_Texting_Orders.pdf

The Joint Commission. (2018). Documentation assistance provided by scribes. Joint Commission Perspectives, 38(8). Updated April 16, 2020. https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/record-of-care-treatment-and-servicesrc/000002210/

Wakefield, D.S. & Wakefield, B.J. (2009). Are verbal orders a threat to patient safety? Qual Saf Healthcare 18(3): 165-168.