Verbal Order Errors Continue

Verbal orders, while highly discouraged in most health care settings, are still used widely today. Verbal orders may be necessary in certain situations such as emergencies and during sterile procedures. However, verbal orders are often misunderstood, misheard, or transcribed incorrectly and therefore highly prone to error. Add various accents, dialects and pronunciations by the prescribers as well as sound-alike drug names and dosing numbers, background noise and distractions and you have a recipe for confusion and mistakes.

Verbal orders are typically received via telephone, face-to-face, or by voicemail. The Joint Commission (TJC) includes a requirement under the Provision of Care, Treatment, and Services (PC 02.01.03, EP 20) for the receiver of a verbal order to record it and read (not repeat) it back to the prescriber. Unfortunately, this best practice occurs less than half of the time for some practitioners to almost never for others. Errors associated with verbal orders includes:

- Transcription errors
- Misheard sound-alike drug names
- Prescriber confusion
- Misheard dose
- Misunderstood dose
- Misheard frequency
- Route confusion

The following recommendations may reduce errors associated with verbal orders:

Prescribers and Receivers of Verbal Orders

- Prohibit verbal orders for chemotherapy, except to hold or discontinue.
- Limit verbal orders to true emergencies or in situations which the prescribers is physically unable to electronically send, write or fax orders such as working in a sterile field.
- Limit verbal orders to formulary drugs which will prevent unfamiliar drugs from being misheard.
- Define the process including limitations on verbal orders, elements of a complete verbal order, requirements for communication of verbal orders, direct transcription into the medical record and the readback process for verification.
- Clarify all communications: avoid drug name abbreviations and error-prone dose, route or frequency abbreviations. Spell out drug names and individual dose, not a total daily dose, and pronounce each digit of a number separately.

Prescribers

- Wait until the receiver of the order is in front of a computer with the patient's record pulled up to directly enter the order.
- Identify patient using the full name and birth date, and confirm allergies with the order receiver.
- Speak clearly and ask the receiver to read back the order as transcribed in the patient's medical record.
- Provide the indication for the medication to help prevent confusion with sound-alike medications.

References

1. Institute for Safe Medication Practices. (2017). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201706.pdf

- Provide complete orders including the unit of measure for each dose and frequency of administration.
- Avoid voicemail orders in the inpatient setting; in the outpatient setting, repeat orders on voicemail a second time.
- Provide weight-based doses, including mg per kg dosage, with the patient-specific dose for all weight-based neonatal and pediatric orders.
- Request patient verification by asking the recipient to read back the patient's name and birth date on the screen or order form.

Receivers:

- Verify the order by reading it back to the prescriber. This is the most important strategy to reduce errors with verbal orders.
- Immediately transcribe verbal orders directly into the medical record.
- Make sure the verbal order makes sense and is related to the patient's condition. Record the medication's indication, per the prescriber, directly on the order or with the order.
- Discourage verbal orders by not accepting them if the prescriber is present and able to document the order.
- Do not accept verbal orders from a "middle-man" such as office staff who is not the original prescriber.
- Do not accept verbal orders for chemotherapy.
- Do not accept abbreviations, instead transcribe and read back the meaning of the abbreviation instead of the abbreviation itself.

References

1. Institute for Safe Medication Practices. (2017). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201706.pdf