pennsylvania
DEPARTMENT OF HEALTH

28 Pa. Code §107.62 (a-b) Oral Orders (Verbal Orders)

Structured Exception

§107.62 (a)
The Department waives the current requirement that oral orders be countersigned by a practitioner within 24 hours and allows up to 7 days from initial issue of the order for verification and authentication of the countersignature of an oral order. This exception waives ONLY the current requirement for countersignature by a practitioner within 24 hours. (107.62 (a)). It does not apply to any other regulations pertaining to any aspect of issuing, accepting, or carrying out oral orders.

§107.62 (b)
In addition, the Department expands the list of personnel who may accept a physician's oral orders to include certified physician assistants, speech therapists, licensed dietician nutritionists, and occupational therapists, each within their individual therapy regimens, their legally authorized scopes of practice, hospital privileges and other relevant hospital policies and procedures and, if applicable, agreements with supervising/collaborating physicians. In addition, radiologic technicians may accept oral orders related to medical imaging studies, provided these studies are for diagnostic purposes. This applies to physician's oral orders only.

Oral orders are to be used infrequently. The Department expects that oral orders shall be accepted only under urgent circumstances when it is impractical for the orders to be given in a written manner by the responsible practitioner. Oral orders may not be issued or accepted for initiation of antineoplastic agents.

Clinical evidence/support for this exception
Since 2001, verbal orders have been a safety priority.[1] Most of the current studies look at various factors that increase the safety of verbal orders, but few of these have considered the effect of the timing of verbal orders. The two issues of concern with this exception are the timing of co-signing the verbal orders and who should be allowed to take a verbal order.

There is a paucity of data on impact of the timing of co-signing of verbal orders as it relates to verbal order safety.[2] Recommended times in the literature vary from 24 hours[3] to a default 30 days In practice, the timing is even more varied among hospitals, described in both numerical and word descriptions as follows: 12 hours, 24 hours, 2 working days, 48 hours, 48 hours after discharge, 72 hours, 96 hours, 30 days, as soon as possible, at next visit, before leaving unit, earliest convenience, next day, next time patient is cared for, and prior[5] to emergency room discharge or procedure completion. In fact, time frames are sometimes not consistent even within the same hospital.

Given the wide variations in the literature, other considerations become important in terms of timely documentation and verification of who actually issued the order.

Methods to authenticate and validate verbal orders include a call back to the office of the doctor giving the order to verify or a fax of the order to the office.

Of course, in the event of medical error, it is important to correct the problem as soon as possible. These issues are balanced by what CMS calls the burden on hospitals. One practice that is used is a seven-day window as a time frame to determine when a verbal order should be signed. Balancing practical matters, such as the issuing practitioner's ability to come into the hospital, against the need to verify and authenticate orders, a week seems a reasonable time frame in which to catch a systemic error in a verbal order and authenticate who actually gave the order.

Multiple methods are identified in the literature to help improve safety of verbal orders. One of the most important of these is to limit the use of verbal orders only to receivers who have the ability to understand the implications of what has been ordered. Clarity between oral prescribers and receivers is the crux of safety concerns about oral orders. Wakefield states in a 2012 study that having someone else beside the health care professional who is to carry out the order (that is, the true receiver) take the order "can raise issues of transmission clarity and potential inaccuracy. The message that is passed on may end up being unclear to the true receiver who may be unclear or lack sufficient clarification to carry out the order. In worst case scenario such a murky transition can result in a true medical error."[7] Wakefield goes on to note that this type of error can be compounded when non-health providers, such as unit secretaries, are allowed to receive verbal orders. The corollary to this is that those with best knowledge of particular area and who are, in fact, the true receiver of the order may be in the best position from a patient safety perspective to take verbal orders.

A 1994 study by West[8] attributed his inability to substantiate the common belief that verbal orders have more errors than written orders, based on the fact that verbal orders that may have originally contained an error are corrected by the receiving nurse . There are number of other methods for ensuring the accuracy of verbal orders.

It should be noted that most studies[9,10] agree that starting antineoplastic agents should not be permitted under any circumstances, since these medications carry great risk to the patients and are not administered in an emergency or urgent situation.

Because of the lack of clinical data, it seems reasonable to allow a limited exception to cosigning within seven days and to limit this exception to those providers who are giving verbal orders to true receivers operating in the clinical area and within the scope of their practice. The Department requires that with this exception there be multiple methods for authentication and verification of oral orders content and the authorizing provider. Oral orders may never be used for initiation of antineoplastic agents.

Minimum requirements for this exception

A. Written policy specific to oral orders that includes and reflects all regulatory requirements and all the hospital's procedures pertaining to oral orders, including time requirement for counter signature of the issuing physician.

B. Written policy specific to sound-alike drugs and the use of oral orders
C. Process for monitoring and tracking the incidence of oral orders
D. Medical staff bylaws must specify the personnel qualified to accept oral orders

Documentation to be provided to the Dept by the facility
All policies (A-D) outlined above.
Copy of appropriate section of medical staff bylaws.

Footnotes:

1. Kohn, Linda T; Corrigan, Janet M; Donaldson, Molla S. editors. *To Err is Human, Building a Safer Health System*. Washington DC: National Academy of Sciences; 2000.
2. Wakefield, Douglas S.; Wakefield, Bonnie J.; Despins, Laurel; Brandt, Julie; Davis, Wade; Clements, Koby; Steinmann, William. "A Review of Verbal Orders: Policies in Acute Care Hospitals." *The Joint Commission Journal on Quality and Patient Safety*. 38 (1), 2012. Pp 24-33.
3. Institute for Safe Medication Practices (ISMP). "Instilling a Measure of Safety into Those 'Whispering Down the Lane:' Verbal Orders." *Medication Safety Alert***.** January 24, 2001**.** www.ismp.org/newsletters/acutecare/articles/20010124.asp.
4. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). "The Standard FAQ: Record of Care, Treatment, and Services (CAMAC / Ambulatory Health Care)." www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=8&StandardsFAQChapterId=1 3
5. Wakefield, op.cit.
6. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services. Medicare and Medicaid Programs Conditions of Participation: Requirements for History and Physical Examination: Authentication of Verbal Order; Securing Medication; and Postanesthesia Evaluation. CMS, DHHS action proposed rule. 42 CFR part 482 CMS-3122-P RIN0938-AM88. *Federal Registry* 70(57), March 25 2005. Pp. 15265-15264. www.gpo.gov/fdsys/pkg/FR-2005-03-25/pdf/05-5916.pdf
7. Wakefield, op.cit
8. West, D.W.; Levine, S.; Magram,G.; MacCorkle,A.H.; Thomas, P.; Upp, K. "Pediatric Medication Order Error Rates Related to the Mode of Order Transmission." *Archives of Pediatric & Adolescence Medicine*. 148(12), December 1995. Pp. 1322-6.
9. ISMP, op. cit.
10. National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). "Recommendations to Reduce Medication Errors Associated with Verbal Medication Orders and Prescriptions". www.nccmerp.org/council/council2001-02-20.html