

PHYSICIAN ORDER SHEET & VERBAL ORDERS WHITE PAPER

An *ad hoc* workgroup of the American Health Care Association's (AHCA's) Clinical Practice Committee (CPC), the Physicians Order Workgroup reviewed certain order writing practices in nursing homes, including the use of verbal orders. Working alongside the American Medical Directors Association (AMDA), the workgroup obtained input from diverse sources based on a series of questions about such practices. After reviewing and discussing that input, the workgroup presented a summary of the issues related to physician orders and solicited additional comments from the CPC and a diverse group of providers and practitioners. Recommendations from the Physicians Order Workgroup follow the overview of relevant issues offered below.

OVERVIEW OF RELEVANT ISSUES

Care must be authorized.

In nursing homes, treatments and interventions other than routine care must be based on orders from a licensed health care practitioner (*e.g.*, a physician or advanced practice nurse). The physician's order sheet (POS) is used nationwide as the means to document all orders.

Use of verbal orders is common.

Nursing homes use several different terms for orders that are not written directly by practitioners, *e.g.*, "verbal orders" (v.o.) and "telephone orders" (t.o.). This document refers to all such orders as "verbal orders." Regardless of terminology, any such designation implies that the orders were based on direct communication with the practitioner via telephone, fax, email, or other method.

Nursing homes often rely on verbal orders. Verbal orders are sometimes necessary because—among other reasons—physicians generally are only present in the facility intermittently and may not be readily available to receive and discuss information or give orders directly in a timely fashion.

Control over writing verbal orders is variable.

There is considerable variability in the control and oversight of verbal orders. State laws and regulations, including state practice acts, vary as to who can write orders independently.

Facility protocols governing order writing on the POS vary in specifying when and to what extent such orders are acceptable. Facility policies range from strict limits on who can write orders to restrictions against writing any verbal orders not based on an approved protocol or obtained from direct communication with a practitioner to having few, if any, restrictions.

Physician attitudes vary regarding the use of verbal orders. Many physicians generally support the use of verbal orders; however, the extent to which a physician will authorize or approve of protocol-based orders or other orders not based on direct communication with the physician varies.

Orders have important implications and consequences.

Medical orders have significant consequences and implications. These consequences range from highly beneficial to life-threatening, or anywhere in between. Nationally, there is growing concern about patient safety and about medication overuse and errors, including the dangers of unclear, inadequate, and inappropriate orders. There is growing emphasis on proper medication utilization and safe order writing.

Medical orders should result from a review of relevant information that is part of a critical thinking process. This process includes, among other things, considering the significance of symptoms and test results (including why those symptoms or results constitute a problem needing a treatment); whether current treatments are appropriate or could be causing or contributing to a problem; the patient's goals and wishes; and the relevance, risks, and benefits of proposed treatments. Orders can be problematic when based upon an inadequate assessment, misinterpretation of symptoms and their causes (*e.g.*, causes of problematic behavior or anorexia and weight loss), or misunderstanding of relevant treatments and test results (*e.g.*, the significance of asymptomatic bacteriuria).

RECOMMENDATIONS

AHCA's Physicians Order Workgroup offers the following recommendations regarding the use of the Physician Order Sheet (POS) and verbal orders.

RECOMMENDATION:

Each facility should educate its staff and practitioners about the implications of writing orders on the POS, and related documentation guidelines.

Every facility should remind its staff and practitioners that writing orders is a major responsibility with potentially significant consequences. The medical director, administrator, and director of nursing should lead the effort to educate the staff and practitioners about the implications of writing orders (including verbal orders), relevant legal and regulatory standards, and the elements of safe order writing. Nursing and other staff should be informed about who is authorized to write and give orders, and when to question orders before they transcribe and follow them.

For example, some suggest that inappropriate or unauthorized verbal orders may constitute the unlicensed practice of medicine. Inappropriate use of verbal orders may be inconsistent with Medicare rules about certifying medical necessity of various services such as rehabilitation therapies and podiatry.

RECOMMENDATION:

Each facility should have a policy and/or protocol governing writing orders on the POS, including circumstances for writing verbal orders.

A facility's medical director, administrator, and director of nursing should collaborate to clarify the prerogatives and restrictions on writing orders, including verbal orders. The facility should communicate a written policy or protocol to all health care practitioners (*e.g.*, physicians, podiatrists,

nurse practitioners, and others) and to other professionals (such as dietitians and therapists) who provide direct care and/or consultation.

A written protocol or policy should cover who is allowed to write on the POS, and under what circumstances. It should also clarify when it is permissible to write a verbal order that is not based on direct communication with the physician (*i.e.*, verbal, email, or fax), and who can do so. Examples of allowable situations might include orders written according to protocols for screening and instituting physical therapy (including clarification of therapy details) and to obtain consent for influenza immunization during flu season.

RECOMMENDATION:

Each facility should be aware of how its physician order sheet (POS) is used.

This review would include collecting information regarding who is writing orders (verbal or otherwise), when they are doing so, and whether they are respecting the limits of their authority to write such orders. A review should also cover whether orders meet recommended criteria for safe order writing (*i.e.*, orders are clear, legible, accurate, and complete). The medical director, director of nursing, and consultant pharmacist should coordinate this review.

In addition, when the director of nursing and medical director—with the input of the consultant pharmacist as indicated—review the charts of patients who decline or die unexpectedly or have a complication requiring hospitalization, they should consider whether incorrect or inappropriate orders (including medications) may have played a role.

Possible venues to disseminate this information might include monthly quality improvement and/or staff meetings. Key individuals to inform about the findings from such reviews include the administrator, director of nursing, medical director, practitioners, and the managers and staff of disciplines involved in direct care. The facility should encourage the staff and practitioners to report any inappropriate uses of verbal orders, and it should be prepared to act regarding individuals who fail to follow protocols related to verbal orders (*i.e.*, those who write unauthorized orders that are not covered by pertinent protocols).

RECOMMENDATION:

Each facility should institute measures that seek to reduce errors related to verbal orders.

Each facility should take measures to try to reduce errors related to verbal orders. Anyone writing a verbal order should clearly and correctly identify the ordering practitioner (*i.e.*, first and last name spelled correctly and correct credentials such as MD or NP). Verbal orders should be read back to the practitioner to ensure that they were understood and transcribed correctly. All orders (written and verbal) should include both the date and the time that the order is written or transcribed.

RECOMMENDATION:

Each facility should have a clear and thoughtful approach to developing and using preauthorized orders.

“Preauthorized” or “protocol-based” orders (treatment or testing protocols that are implemented and/or continued in the facility based on preauthorization) are often pertinent and helpful. These orders may be for a limited duration (*e.g.*, on admission) or ongoing. Such orders can reduce phone calls to physicians and allow for timely implementation of appropriate interventions. The term “standing” orders can be ambiguous and confusing; it is probably best to replace the term “standing” with “preauthorized” or a similar designation.

Protocols for preauthorized orders should be clear and unambiguous. Protocols should clarify any specific actions that may be needed such as documenting detailed assessment of the patient before giving a medication or calling a physician if no improvement is noted within 24 hours of starting an intervention. Such orders may not be applicable to every clinical situation, and should not substitute for a careful assessment of each situation to ensure that the patient’s condition fits the parameters for applying the protocol. Protocols should explain adequately how to determine whether an intervention should be made (*i.e.*, criteria for deciding when and how to intervene for problematic behavior. Further, these protocols should clarify what is inappropriate or unacceptable. For example, a protocol authorizing application of a topical treatment for dermatitis would direct staff to discontinue application of the topical treatment should the problem worsens or blistering occur as a skin rash may be due to a medical condition such as a drug reaction, rather than the dermatitis that the protocol covers. The medical director and director of nursing should review and revise preauthorized order protocols as needed.

RECOMMENDATION:

Medical directors should review issues related to verbal orders with their attending physicians.

The medical director should strive to educate and inform physicians and other practitioners regarding verbal orders and related issues. While supporting the appropriate use of verbal orders, the medical director should discourage the excessive use of verbal orders that take the place of adequate physician participation in reviewing and managing medical issues. For example, a physician’s input is often critical in evaluating and treating individuals with anorexia and weight loss; therefore, physicians should not just routinely authorize dietitians to write verbal orders to test and treat such individuals.

Facilities that cannot get adequate or timely physician participation and/or medical director support should address those issues vigorously. Having to “work around” physicians is often a symptom of bigger issues, which may represent considerable liability for a facility as would be the case if a facility allowed inadequately trained and skilled individuals to order tests and treatments.

Facilities should encourage staff from all disciplines (*e.g.*, dietitians, nurses, therapists, and others) to discuss their observations and concerns about patients with the attending physician. Such staff should work with the medical director to obtain timely responses from any physicians helping to assess and determine a plan of treatment for issues (*e.g.*, weight loss or behavioral changes), to include obtaining any related lab tests and other medical evaluations.