HOT SHEET

Verbal and Telephone Orders

Date:   February 29, 2012
To:      Nursing and Clinical Staff
From:  Baptist Health Nurse Executives:  Tammy Daniel, Barbara Gingher, Carolyn
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There has been much discussion over the past several days regarding verbal and telephone orders with the SHIELD implementation. In an attempt to clarify, we have developed this communication to review our intent, our policy and external regulatory standards. We hope this communication will lead to better understanding and help support the excellent patient care we deliver everyday.

INTENT: It is the intent of the Baptist Health leadership to support an environment that minimizes the use of verbal and telephone orders in an effort to decrease the opportunity for error. We understand in the delivery of care there are times that both verbal and telephone orders are needed to provide quality and timely patient care. The medical staff leadership, in partnership with our clinical leaders, proactively developed care sets, power plans, protocols and standing orders to minimize the need for verbal and telephone orders.

Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into SHIELD without delaying treatment. **For example, if the physician is providing care to another patient and issues a verbal order for the patient you are caring for, please enter the verbal order. The physician should not be asked to interrupt the care of one patient to enter the order himself/herself for another patient. It is in the best interest of both patients that orders and care are delivered as quickly as possible.**

Telephone orders should be used only when the practitioner is no longer in the department or the hospital and is not in a reasonable position to enter orders. **For example, a physician called at home should not be expected to enter orders on his/her computer. Telephone orders are to be accepted.**

With the transition to SHIELD we do not want to see verbal or telephone orders used as a way to defer using the new electronic order entry. During this transition we all will be much slower than normal in the documentation of the delivery of care. We may see an increase initially of some telephone or verbal orders due to the need for timely care. However, we now have the ability to track and trend the number of telephone and verbal orders by practitioner. In keeping with regulatory standards, Baptist Health leadership will review the data and ensure that we are minimizing the use of both verbal and telephone orders. We take full responsibility of this oversight and do not want our patient care givers in the position to monitor this.
POLICY: BAPTIST HEALTH--POLICY AND PROCEDURE--No. 7.01.03
Section: Patient Care Subject: Medication, Administration Of

Telephone orders are accepted by a licensed practitioner from the physician or physician designee. Also refer to policy 7.11.24
Communication Types for CPOE and Downtime

a. Nursing staff will enter order into EMR or on written physician order sheet. The medication order shall contain the following information: date, time, medication, dose, route, frequency of administration, physician issuing the order, and individual receiving the order.
b. The entered or written order must be read back to the physician or physician designee for verification.

The order will be signed by the individual receiving the order as a “T.O.” with the name (first initial, last name) and title of the individual receiving the order during downtime. In the EMR, the nurse will select the appropriate Communication Type.

Verbal orders are not accepted unless it is during an emergency Situation. (“impossible or impractical”)

Telephone orders are unavoidable however, use only when necessary; limit use when possible.

EXTERNAL REGULATORY STANDARDS

CMS 482.3 (c) If verbal orders are used they are to be used infrequently.

Interpretive Guideline: Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into a computer (in the case of a hospital with an electronic prescribing system) without delaying treatment. Verbal orders are not to be used for the convenience of the ordering practitioner.

CMS expects nationally accepted read-back verification practice to be implemented for every verbal order. Verbal orders should be recorded directly onto an order sheet in the patient’s medical record or entered into the computerized order entry system, if the hospital employs one. As required by 482.24 (b) all verbal orders must be promptly documented in the patient’s medical record and signed by the individual receiving the order.
Joint Commission  MM04.01.01 Medication orders are clear and accurate

In this standard the Joint Commission indicates that the hospital minimizes the use of telephone medication orders.

Program: Hospital
Chapter: Record of Care, Treatment, and Services
Rationale: N/A
Elements of Performance:

1. The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.
2. Only authorized staff receives and record verbal orders.
3. Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.
4. Verbal orders are authenticated within the time frame specified by law and regulation.