Data Shows Verbal Drug Orders Are Often Misunderstood

Although sometimes necessary, verbal orders can lead to errors unless safe practice protocols are in place

HARRISBURG: Patients are at greater risk of medication errors when drugs are ordered verbally or over the telephone, according to an article published in the June 2006 issue of the Patient Safety Advisory. The Advisory advocates a read-back procedure in which the person receiving the order writes it down, reads it back, and gets confirmation that they understood the order correctly.

Reports submitted to the Pennsylvania Patient Safety Reporting System (PA-PSRS) include errors that could have been prevented if the read-back technique was used. The read-back technique was also recently added as one of the 2007 National Patient Safety Goals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to address error-prone procedure orders.

While most medication errors (99%) submitted to PA-PSRS do not result in patient harm, the risk of harm remains a concern since medication errors comprise the largest number of reports submitted (26%) to PA-PSRS overall. According to national statistics, medication errors are also a major patient safety problem throughout the country.

“Medical errors are more likely to occur with verbal orders because interpreting speech can be problematic due to accents, dialect and pronunciation,” said Alan B.K. Rabinowitz, administrator of the Patient Safety Authority. “Background noise, interruptions and unfamiliar drug names also make the problem worse. Many times the person taking the order is relying on memory to get the order right, and we’ve seen through our data this dramatically increases the risk of error.”

The article points out a study conducted by physicians at Cincinnati Children’s Hospital Medical Center in which researchers examined 75 orders done verbally and -more-
found the error rate dropped from 9.1 percent to zero after the practice of entering the information into the computer, reading the order back and confirming it with the doctor was made a standard practice when issuing verbal orders.

“Limiting verbal orders as much as possible is the number one piece of advice we’re giving to facilities to avoid medical error,” Rabinowitz said. “We’ve also supplied facilities with a tool kit to help them implement the National Patient Safety Goal established to address the error-prone procedure of verbal orders.”

The tool kit includes: 1) a stand-alone reprint of the article for easy distribution to physicians, nurses, pharmacists and other clinicians; 2) a poster to remind caregivers of the importance of the read-back procedure; 3) a slideshow about verbal orders that can be used for education and training; 4) a sample policy on verbal orders based on the guidance provided in the article; and 5) a brief survey that can be used to measure staff awareness and compliance with a facility’s verbal order policy.

The article, entitled “Improving the Safety of Telephone or Verbal Orders,” also includes several other safe practices that facilities can follow to minimize the risk from verbal orders.

Other articles in the June Advisory provide analysis of the following events based on actual reports submitted to PA-PSRS by healthcare facilities in Pennsylvania:

- **Risks associated with hydrofluoric acid exposure and the importance of early diagnosis and treatment:** The article highlights the dangers if treatment is delayed for someone who has been exposed to hydrofluoric acid or other potentially hazardous chemicals.

- **Procedures to help reduce the risk of transplant tissue contamination:** Potentially contaminated tissue prompted one hospital to identify and adopt new procedures for safer tissue handling.

- **Problems associated with Demerol:** The article cites cases that highlight the need to reconsider the appropriateness of this widely prescribed painkiller.

- **Trends in adverse event reporting among behavioral health hospitals:** Reports from behavioral health hospitals highlight interesting differences, but also many similarities, in the types of patient safety problems confronting clinicians in these facilities compared with their counterparts in acute care settings. This article is also accessible as a stand-alone reprint.

For a copy of the June 2006 Patient Safety Advisory, go to [http://www.psa.state.pa.us/psa/lib/psa/advisories/jun_2006_advisory_v3_n2.pdf](http://www.psa.state.pa.us/psa/lib/psa/advisories/jun_2006_advisory_v3_n2.pdf)
BACKGROUND

The Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error (Mcare) Act as amended, to help reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety. Under the Act, all Pennsylvania-licensed hospitals, birthing centers, ambulatory surgical facilities and certain abortion facilities are required to report what the Act defines as “serious events” and “incidents” to the Authority. More than 445 healthcare facilities are subject to Act 13 reporting requirements.

Facilities submit reports of serious events and incidents through the Pennsylvania Patient Safety Reporting System (PA-PSRS), a confidential web-based system that was developed for the Authority under a contract with ECRI, a Pennsylvania-based independent, non-profit health services research agency, in partnership with EDS, a leading international, information technology firm, and the Institute for Safe Medication Practices (ISMP), also a Pennsylvania-based, non-profit health research organization.

More than 330,000 reports have been submitted through PA-PSRS since the program was initiated in June 2004. Ninety-six percent of these reports are Incidents or “near-misses.” Based on those reports, the Authority issues quarterly and supplementary Patient Safety Advisories to advise hospitals and other healthcare facilities about steps they can take to reduce and prevent patient harm.

For more information on the Patient Safety Authority, PA-PSRS or previous Patient Safety Advisories, visit the Authority’s website at www.psa.state.pa.us.

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