To Sign or Not to Sign Verbal Orders

by Susan Clark, RRA

The value of obtaining physician signatures on verbal orders after the patient's discharge from care is a concept that has been debated for several years. Typically, state regulations require that verbal orders be signed or authenticated. In some states a specific time frame—such as 24 hours—is defined for obtaining the signature. Similarly, most healthcare organizations have comparable wording within medical staff regulations or policies. Lack of compliance has resulted in state, federal, and Joint Commission on Accreditation of Healthcare Organizations citations. Debate has centered on compliance of this requirement, the intent of the requirement, and the highly labor-intensive process involved in achieving compliance.

The requirement for a physician to sign the verbal order within a defined period was developed in order to protect the patient. In the event that the order was transcribed inaccurately, the error would be detected and addressed quickly. However, obtaining the signature has traditionally been a post-discharge process for most healthcare organizations, making the job of the health information manager labor-intensive and defeating the original intent of the requirement. Further, questions have been raised regarding the value authentication adds to either the quality of the care provided or to the medical record itself.

Breaking from Tradition

Recognizing this nearly 10 years ago, hospitals within Centura Health (a large integrated healthcare delivery system in Colorado) and several other healthcare organizations throughout Colorado discontinued flagging unsigned verbal orders post discharge. This action was taken after lobbying efforts of two Denver HIM department directors won the support of a major physician malpractice insurer in the state. From the insurer's point of view, flagging and signing orders post discharge constituted falsifying the record and did not contribute to the quality of care provided to the patient.

To ensure compliance with Joint Commission standards, many hospitals instituted random reviews to monitor concurrent signing of orders and did succeed in achieving some level of compliance. Over the years, the Joint Commission cited very few hospitals for unsigned verbal orders.

However, in November 1997, a Centura Hospital was issued a citation by the Colorado Department of Public Health and Environment. The citation was for failure of physicians ordering medications and treatment to countersign their verbal orders within 24 hours—as required by state law, Chapter IV 19.23 of the Colorado Code of Regulations (6 C.C R. 1011.1). During the survey, the reviewers acknowledged that the requirement was outdated but that they were legally compelled to issue the citation when unsigned verbal orders were identified in charts.

This development placed the issue on center stage once more. With a facility licensure at stake, serious discussions ensued regarding alternatives. These discussions in-volved the organization's legal counsel and representatives from the health information management and quality departments. Various me-thods of obtaining the signatures were considered and rejected. Physician satisfaction was a concern; reinstituting the flagging of unsigned verbal order post discharge would not only increase the number of records to complete but the number of delinquent records as well.

History in the Making

In December 1997, the decision was made to seek a waiver from the Colorado Department of Public Health and Environment, citing that obtaining signatures for verbal orders was unacceptably burdensome. To support this contention, an analysis of the cost involved in obtaining signatures for verbal orders was calculated for the hospital cited. It was determined that the number of affected physicians would be about 1211 and the number of verbal orders per record per day would be about 1.3. To ensure that orders were signed concurrently, nurses would identify that a verbal order that had been received was not signed, tag the deficiency, and notify the physician to come to the unit and sign the order. Follow up would continue until the order was signed. The actual time invested would depend upon physician responsiveness; however, this could easily consume 15 minutes per

chart per day. At a hospital averaging a daily census of 180, 45 hours per day (5.62 FTEs) would be needed to pursue this process. Within HIM, an additional 1.5 FTEs would be needed to analyze charts, send additional physician deficiency letters, and handle the increased record handling. The total cost would be as follows:

5.62 x 2030 x $22/hr = $257,171
1.5 x 2030 x $10/hr = $ 31,200
Approximate total = $288,371

As discussions with the Colorado Department of Public Health and Environment were pursued to obtain a waiver, assistance was enlisted from the president of the Colorado Hospital Association (CHA) to lobby for change in the state's regulations. Well versed in this issue, the CHA president agreed to arrange a meeting with representatives from the department.

The meeting took place in January 1998. As a result, the Colorado Department of Public Health and Environment committed to issuing an interpretive guideline to its regulation that will result in the elimination of enforcement. The interpretive guideline is not yet finalized. However, it is expected to state that verbal orders will be deemed authenticated unless countermanded by the physician within 24 hours.

When the guideline is finalized, medical staff rules and regulations will be revised within Centura facilities (and likely at other facilities throughout the state) in accordance with this wording. Further, in the event of a HCFA survey where the issue of verbal order authentication is raised, the Centura position will be to cite adherence with state regulations.

Our experience demonstrates that it is possible to initiate the change of a state regulation. Consequently, rather than implement a process to comply with a regulation or requirement that does not add value, HIM professionals can and should take the lead to initiate change.

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