Verbal Orders Compliance and How We Achieved It

by Mary Pat Curry, RHIA; Lisa Trask, MPA, RN; Eric Liederman, MD, MPH; David Hutchinson, BSN, RN; and Alice Zeboski, BSN, RN

Thoughtful software design and good communication are fundamental ingetting physicians to sign verbal orders within the 48-hour mandate. Fines help a lot, too.

What hospital in the United States hasn't struggled to comply with mandates from their state and the Joint Commission on Accreditation of Healthcare Organizations to get verbal orders signed in a timely manner? Until recently, the University of California, Davis, Health System (UCDHS) was no different. Having tried many different approaches over the years, a multidisciplinary work group consisting of the patient care services, HIM, and information systems departments devised a combination of policies, procedures, and technical tools that allowed UCDHS to finally reach verbal order compliance. Here is our story.

The Struggle for Compliance

Timely authentication of verbal orders has been problematic for both clinicians and HIM staff responsible for monitoring compliance for many years. In California, state law requires that the prescriber countersign verbal orders for drugs within 48 hours.1 State surveyors have interpreted this regulation to extend to all verbal orders, not just drug orders. Federal law defers to applicable state law.2 The Joint Commission looks at the processes for receiving and transcribing verbal orders as well as evidence that they are authenticated within the specified timeframe.3

At UCDHS, a review of meeting minutes reveals that verbal order compliance has been a regular agenda item for the medical records committee since the early 1990s. It was obvious that the system of ongoing education, manual monitoring of orders, and the labor-intensive process of flagging unsigned orders was not effective. The HIM labor cost for flagging unsigned orders, post-discharge data collection, and supervisory monitoring and reporting totaled approximately $250,000 in 1998. Yet even this type of investment did not result in the level of compliance necessary to avoid Type I recommendations from the Joint Commission.

UCDHS received Type I recommendations in both 1995 and 1998 for noncompliance in signing verbal orders within 48 hours. In an effort to curtail the number of verbal orders being issued, the quality of care committee deemed that verbal orders could only be issued in emergencies. At the same time, nursing and HIM staff began more diligent flagging and monitoring of verbal orders.

The verbal order policy was further revised to include fines for orders not signed within 48 hours. Compliance briefly rose to an all-time high of 87 percent. However, fines were not imposed because of cumbersome logistics and the perceived difficulty clinicians faced in locating the in-house charts necessary to sign orders within the timeframe. Therefore, compliance quickly dropped below 20 percent.

As an interim method to better organize orders for signature, all verbal orders were to be written on a separate verbal order sheet and filed in a centralized binder prominently located at each nursing station. Compliance increased to 30 percent. Meanwhile, with the 2001 Joint Commission survey on the horizon, efforts were directed toward developing an electronic verbal order system.

Designing a New Tool

Over a period of six months in the fall of 2000, the patient care services department took the lead and worked with the information systems and HIM departments to create a stand-alone system that would allow nurses to enter verbal orders and physicians to sign them. The system was piloted in March 2001 on the UCDHS trauma unit, chosen because of its physical characteristics, access to computers, patient population, and physician group. Nurses logged into the system, which was installed on all of the trauma unit computers, and simply typed the verbal orders into the system. Physicians logged in to review and electronically sign the orders. Over a period of several months, based on feedback from the pilot, the system was modified, and we eventually achieved 100 percent compliance in the pilot area and averted a third Type I Joint Commission citation.

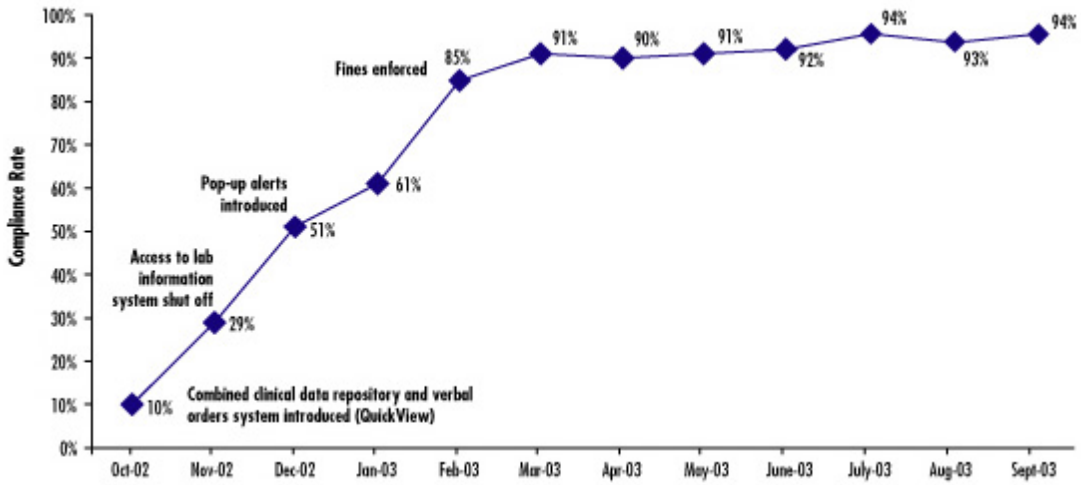
Even though the verbal order system was working well, we realized that something more was needed to make it attractive to our diverse and widespread staff. Running a pilot was one thing, but asking 6,000 medical and other staff to use a system just for verbal orders would be difficult. We decided that giving the staff an integrated results viewer, or clinical data repository (CDR), would provide the added incentive. In the spring of 2001 we began designing the integrated system and implemented it along with the verbal order feature in the summer of 2002. We named the program "QuickView."

To avoid managing the program on thousands of individual workstations, we deployed it using thin-client technology, which in a practical sense allowed the program to be maintained and updated on a few servers. Although our clinicians liked being able to access all relevant patient data in one place, many were dissatisfied with the system's responsiveness and, unfortunately, nicknamed the program "SlowView." Working with IS, the verbal orders work group determined that the thin-client technology operated far more sluggishly on older computers. Replacing the old workstations resolved the problem of speed.

Initially clinicians did not have to use QuickView to look up patient data because they also had direct access to the laboratory information system (LIS). Since physicians did not have to use QuickView, they also could avoid the verbal orders system. As a result, verbal orders compliance slumped to a dismal 10 percent (see "Carrot and Stick," below). After several months, the pathology department requested that access to the LIS be turned off outside of the laboratory, effectively pushing physicians onto QuickView to access laboratory values. Verbal order compliance almost tripled to 29 percent when physicians were forced to use QuickView.

Carrot and Stick

Percentage of Verbal Orders Signed by Ordering MD within 48 Hours



Although the need to look up patient results brought physicians to within a click from the verbal orders component of QuickView, most of them didn't take the extra step. Some doctors hated spending time checking for verbal orders only to find that they had none to sign. Many explained that they intended to check every day but would get so busy they would forget. They wanted to be notified when they had verbal orders to sign.

Thus, shortly after access to the LIS was disconnected, an alert feature was added to the look-up system. If a doctor had verbal orders to sign, a pop-up box listing the number of orders awaiting signature appeared upon log-in. We considered automatically directing the physicians to the verbal orders system from the pop-up box; however, we decided to not interfere with results look-up, since doing so could impair patient care. The pop-up notification nearly doubled the verbal order compliance rate to 51 percent.

$10 Motivation

Despite a well-designed application, training, and good communication, old habits thrived. Nurses were entering verbal orders on the system, but physicians were not signing them within 48 hours. By the end of January 2003, our bottom-up implementation strategy gained us a meager 61 percent compliance. A complementary top-down approach was needed, so we returned to the idea of using fines as a motivator. The fine was set at $10 for each verbal order not signed within 48 hours, charged against the department of the noncompliant physician.

With the full support of the dean and the health system CEO, the fining policy became effective February 2003. Some objections were voiced, but the majority of physician leaders understood the power of fines; the same mechanism has been used effectively to correct medical records deficiencies. All fines were distributed to the school of medicine's scholarship program.

Behavior change resulting in compliance was impressive. The first month was painful for a few departments, but overall compliance reached 85 percent. With concentrated effort on the part of many, overall compliance rates from March through September 2003 ranged from 90 percent to 94 percent.

The Components of Success

Strict monitoring of verbal order compliance by HIM staff continues, but in an automated fashion. HIM staff generate daily reports, which are used by individual departments to notify physicians of pending verbal orders in an effort to avoid fines. Monthly reports are sent to department chairs indicating the amount of fines incurred for noncompliant verbal orders.

Procedures were developed with the patient care services department to handle the small percentage of verbal order entry errors (e.g., wrong physician, wrong patient, wrong medication). The quality of care committee uses this data as part of its patient safety goals to assist clinicians in reducing preventable errors. The ability to sign orders electronically also saves physicians time, as they no longer have to walk from nursing unit to unit to sign verbal orders by hand.

We learned that success did not depend on one factor, but instead required attention to culture (the procedures involved in a verbal order), technology (the ease in creating and signing an order), and policies (administrative support). Along the way we learned that changing something as simple as how verbal orders are done can have ripple effects on multiple departments and that the entire health system (staff, systems, policies, administration, culture, and infrastructure) is in fact an integrated whole. But the best lesson is that seemingly intractable problems that have existed for many years can indeed be solved—with persistence, teamwork, and imagination.

Notes

1. California Code of Regulations, Title 22, Div. 5, Ch. 1, Section 70263 (g).
2. Code of Federal Regulations, Title 42, 482.23 (c)(2).
3. Comprehensive Accreditation Manual for Hospitals, 2004, Joint Commission on Accreditation of Healthcare Organizations, Standard Intent of IM.6.50.

Mary Pat Curry *(marypat.curry@ucdmc.ucdavis.edu) is manager, health information management department;* ***Lisa Trask*** *is assistant director, hospital and clinics;* ***Eric Liederman*** *is medical director, clinical information systems;* ***David Hutchinson*** *is nurse specialist; and* ***Alice Zeboski*** *is administrative nurse manager, health information management department, at the University of California, Davis, Health System.*

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