Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
Phone: (512) 305-7400 Fax: (512) 305-7401 www.bon.texas.gov

Katherine A. Thomas, MN, RN
Executive Director

May 6, 2013

James (Larry) Holly, M.D.
C.E.O. SETMA
Southeast Texas Medical Association
375 13TH Street
Beaumont, Texas 77702

Re: Response to April 20, 2013 Correspondence

Dr. Holly,

I was forwarded your correspondence dated April 20, 2013, for a response. Please be advised that the Texas Board of Nursing is not authorized under the Nursing Practice Act (NPA) or the Board's Rules and Regulations to provide a definitive opinion on SETMA's activities.

First, you have asked for an official statement regarding the ability of hospital staff nurses to receive an order from a hospital-credentialed RN who is employed by a physician when that order originates with a physician who is on the staff of the hospital. Essentially, your question is focused on the verbal transition of orders. The NPA's description of an RN's scope of practice, and the Six-Step Decision-Making Model for Determining Nursing Scope of Practice should provide you with a good understanding of the Board of Nursing's position on an RN's scope of practice. However, we cannot provide you with an advisory opinion, or legal advice, as to whether or not your current practice falls within an RN's scope of practice.

The NPA and the Board of Nursing Rules and Regulations are written broadly so that every nurse may be able to apply them to his or her own practice setting. The Board of Nursing does not have a list of tasks that a nurse can or cannot perform, because each nurse has a different practice setting, background, knowledge base, and level of competence.

Nurses must use his or her best judgment when deciding how to verify physician orders; whether they should administer a medication or perform other tasks.

As such, the Board of Nursing can only provide general guidance and recommendations. Beyond the resources you have already reviewed, you may wish to review and consider the following:

- Archived Bulletin article titled, *Patient Safety with Verbal Order*, July 2007 issue, page 14 (attached);
- Recommendations regarding this and similar issues can be found from a variety of third-party sources:
  - The Institute for Safe Medication Practices (ISMP): http://www.ismp.org
  - The Agency for Healthcare Research and Quality: http://www.ahrq.gov
  - The Institute of Medicine: http://www.iom.edu
  - The Joint Commission: http://www.jointcommission.org

Second, you have asked for an official Board of Nursing assessment that SETMA is working within the RN's Scope of Practice and to communicate that assessment to CMS and to the administration of Christus St. Elizabeth in Beaumont and to Baptist Hospital of Southeast Texas.

In short, the Board of Nursing has no statutory authority to issue advisory opinions or make official assessments of a particular practice setting outside of the limited scope of Section 301.607 of the Nursing Practice Act, which concerns Certified Registered Nurse anesthetists. Additionally, the Board of Nursing cannot endorse your current practice, either privately or publicly.

I hope the above referenced, and included, materials clarify the Board of Nursing's position on this issue.

Sincerely,

James W. Johnston, General Counsel
Board Certified – Administrative Law
Texas Board of Legal Specialization

Patient Safety with Verbal Orders

Verbal and telephone orders are one of the major problem prone areas of nursing and healthcare, with reported errors that have lead to patient harm and even death. Concern for patient safety is such that one of the National Patient Safety Goals - 2007 for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) includes the following goal relating to verbal orders:

"For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]"

The National Coordinating Council for Medication Error Reporting and Prevention [http://www.nccmerp.org] developed the following recommendations to help prevent errors when taking verbal or telephone orders cannot be avoided:

Recommendations to Reduce Medication Errors Associated with Verbal Medication Orders and Prescriptions

Confusion over the similarity of drug names accounts for approximately 25% of all reports to the USP Medication Errors Reporting (MER) Program. To reduce confusion pertaining to verbal orders and to further support the Council's mission to minimize medication errors, the following recommendations have been developed. In these recommendations, verbal orders are prescriptions or medication orders that are communicated as oral, spoken communications between senders and receivers face to face, by telephone, or by other auditory device.

Recommendations

Verbal communication of prescription or medication orders should be limited to urgent situations where immediate written or electronic communication is not feasible.

Health care organizations[4] should establish policies and procedures that:

- Describe limitations or prohibitions on use of verbal orders
- Provide a mechanism to ensure validity/authenticity of the prescriber
- List the elements required for inclusion in a complete verbal order
- Describe situations in which verbal orders may be used
- List and define the individuals who may send and receive verbal orders
- Provide guidelines for clear and effective communication of verbal orders.

Leaders of health care organizations should promote a culture in which it is acceptable, and strongly encouraged, for staff to question prescribers when there are any questions or disagreements about verbal orders. Questions about verbal orders should be resolved prior to the preparation, or dispensing, or administration of the medication. Verbal orders for antineoplastic agents should **NOT** be permitted under any circumstances. These medications are not administered in emergency or urgent situations, and they have a narrow margin of safety. Elements that should be included in a verbal order include:

- Name of patient
- Age and weight of patient, when appropriate
- Drug name
- Dosage form (e.g., tablets, capsules, inhalants)
- Exact strength or concentration
- Dose, frequency, and route
- Quantity and/or duration
- Purpose or indication (unless disclosure is considered inappropriate by the prescriber)
- Specific instructions for use
- Name of prescriber, and telephone number when appropriate
- Name of individual transmitting the order, if different from the prescriber.

The content of verbal orders should be clearly communicated.

The name of the drug should be confirmed by any of the following:

- Spelling
- Providing both the brand and generic names of the medication
- Providing the indication for use
- In order to avoid confusion with spoken numbers, a dose such as 50 mg should be dictated as "fifty milligrams...five zero milligrams" to distinguish from "fifteen milligrams...one five milligrams."
- In order to avoid confusion with drug name modifiers, such as prefixes and suffixes, additional spelling-assistance methods should be used (i.e., S as in Sam, X as in x-ray).
- Instructions for use should be provided without abbreviations. For example, "1tab tid" should be communicated as "Take/give one tablet three times daily."
- Whenever possible, the receiver of the order should **write** down the complete order to enter it into a computer, then **read** it back, and receive confirmation from the individual who gave the order or test result.
  All verbal orders should be reduced immediately to writing and signed by the individual receiving the order.
  Verbal orders should be documented in the patient's medical record, reviewed, and countersigned by the prescriber as soon as possible.
- Health care organizations include community pharmacies, physicians' offices, hospitals, nursing homes, home care agencies, etc.

The above information is accessible in its entirety at the NCCMERP Web page at http://www.nccmerp.org/council/council2001-02-20.html. Nurses are also encouraged to check with the nursing organizations that represent their specific area of practice, as professional organizations may also have additional guidance statements that are more restrictive and/or prescriptive than the general recommendations listed above.