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National Coordinating Council for Medication Error Reporting and Prevention

Council Recommendations

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

Upcoming Meetings:

June 9, 2009:

[Agenda](#)

Meetings are held at USP headquarters in Rockville, MD.

[NCC MERP 10 Year Anniversary Report](#) and
[Executive Summary](#)

Preamble

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

1. Verbal communication of prescription or medication orders should be limited to urgent situations where immediate written or electronic communication is not feasible.
2. Health care organizations* 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.
3. 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.
4. 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.
5. 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.

6. 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.

7. All verbal orders should be reduced immediately to writing and signed by the individual receiving the order.

8. 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.](#)

Adopted: February 20, 2001

Revised: February 24, 2006

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