

## PRACTICE STANDARD

# Registered Nurses: Acting by Giving Client-specific Orders

## Introduction

The *Registered Nurses: Acting by Giving Client-specific Orders* standards set the expectations that registered nurses<sup>1</sup> must meet when they are giving **client-specific orders**.

Registered nurses may provide care to **clients** by giving client-specific orders for an **activity** that they are competent and allowed to perform within their autonomous scope of practice. Registered nurses need to know when they are allowed to act within their autonomous scope of practice to give a client-specific order before giving that order. A consultation, referral or professional recommendation is not an order.

Registered nurses giving client-specific orders also follow the *Registered Nurse: Acting within Autonomous Scope of Practice* standards.

Certified registered nurses giving client-specific orders also follow the practice standards for their area(s) of certification.

## Standards

1. Registered nurses accept sole accountability and responsibility for the client-specific orders they give.
2. Registered nurses give client-specific orders for activities that are:
  - a. Within the registered nurse's autonomous scope of practice as outlined in the *Nurses and Midwives Regulation*<sup>2</sup>,
  - b. In alignment with BCCNM ethics standards and practice standards,
  - c. Allowed by organizational/employer policies, processes, and restrictions, and

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<sup>1</sup>References to registered nurses in this standard include registered nurses, licensed graduate nurses and certified registered nurses.

<sup>2</sup>Under the *Regulated Health Practitioners Regulation* and the *Nurses and Midwives Regulation*:

- a registered nurse may give an order to perform a restricted activity listed in section 36(1) of the *Nurses and Midwives Regulation* that is within the registered nurse's autonomous scope of practice, and a licensed practical nurse may act under that order, and
- a certified registered nurse may give an order to perform a restricted activity listed in section 21(1), 36(1) or 51(1) of the *Nurses and Midwives Regulation* that is within the certified registered nurse's autonomous scope of practice, and
  - a licensed practical nurse may act under that order if the activity is listed in section 36(1),
  - a registered nurse may act under that order if the activity is listed in section 21(1), and
  - a registered psychiatric nurse may act under that order if the activity is listed in section 51(1).

- d. Within their individual **competence**.
3. Registered nurses only give client-specific orders when organizational supports, processes, and resources, including policies and procedures, exist that:
  - a. Outline the accountability and responsibility of the nurse, and
  - b. Ensure continuity of care for the client including the requirements and procedures for responding to questions about client-specific orders, amending client-specific orders and evaluating client outcomes.
4. Registered nurses carry out assessments and make an appropriate **nursing diagnosis**<sup>3</sup> to ensure that the client's condition can be improved or resolved by the ordered activity before giving a client-specific order.
5. Registered nurses give client-specific orders that consider the unique characteristics, needs and wishes of the client, contain enough information for the order to be carried out safely and are:
  - a. Based on evidence,
  - b. Clear and complete, and
  - c. Documented, legible, dated and signed with a unique identifier such as a written signature or an electronically generated identifier.
6. Registered nurses give verbal or telephone client-specific orders only when there are no reasonable<sup>4</sup> alternatives and it is in the best interest of the client. In these situations, registered nurses:
  - a. Ensure that they have the necessary information to conduct the assessment required to give the client-specific order, which may include gathering information from another health care provider when the nurse is not able to directly observe the client,
  - b. Ask for the client-specific order to be read back to confirm it is accurate,
  - c. Follow up to ensure that the client-specific order is documented in the client record.
7. Registered nurses using documents that set out the usual care for a particular client group or client (e.g., pre-printed orders or order sets) make the information client-specific by adding the name of the individual client, making any necessary changes, dating their client-specific orders and signing with their unique identifier.
8. Registered nurses identify the specific document (e.g., a decision support tool) in the client's record, including the name and the date of publication, when they reference that document in a client-specific order.
9. Registered nurses follow the standards for *Registered Nurses: Acting within Autonomous Scope of Practice* and/or *Registered Nurses: Giving Client-specific Orders* when they change or cancel a client-specific order and are responsible and solely accountable for any changes that they make.

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<sup>3</sup> Certified registered nurses may also make a diagnosis of a disease, disorder or condition that is within the autonomous scope of the nurse's certification and the nurse's individual competence.

<sup>4</sup> Reasonable refers to the common understanding that licensees of the nursing profession would have as to what is appropriate in the situation.

10. Registered nurses communicate and collaborate with the professional who gave the client-specific order, the client, and other members of the health care team when changing or cancelling a client specific order.
11. Registered nurses follow legal and ethical obligations regarding consent for the care referred to in their client-specific orders.

## Glossary

**Activities:** Refers to restricted activities or any other activity that is related to the care of clients that requires the professional knowledge, skills, ability and judgment of a nurse.

**Client:** Person receiving health services.

**Client-specific order:** An instruction or authorization given by a regulated health professional to provide care for a specific client, whether or not the care or service includes a restricted activity or a non-restricted activity.

**Decision support tools (DSTs):** Evidence-based documents used by nurses to support clinical judgment and decision-making by guiding the assessment, diagnosis and treatment of client-specific clinical problems.

**Nursing diagnosis:** A clinical judgment made by a nurse of a client's mental or physical condition to determine whether the condition can be prevented, improved, ameliorated or resolved by the performance of activities or provision of other care or services that is within the nurse's scope of practice to provide without an assessment or diagnosis of the client by another regulated health professional.

**Restricted Activity:** An activity that is performed in the course of providing a health service and is prescribed by the regulations under the *Health Professions and Occupations Act* as a restricted activity.

## Revision history

Version #	Approved by board	Bylaw in-force	Description
1.0	March 1, 2026	April 1, 2026	Initial publication

Effective April 1, 2026, this practice standard, and any amendments to it, is made a bylaw under the authority of the *Health Professions and Occupations Act, B.C.*

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