Welcome to this module on client-specific orders. In this module, we will look at the legal requirements, organizational policies, and individual competencies necessary for navigating client-specific orders. We recommend that you complete the *Know Your Scope: Navigating the Controls on Practice* module first. Let's get started!

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Click on the first lesson below—or the "*Start Module*" button above—when you're ready to begin.

Estimated time: 30-40 minutes

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Territorial acknowledgement

We acknowledge the rights and title of the First Nations, whose collective unceded territories encompass the land base colonially known as British Columbia. We give specific thanks to the hən[]q[]əmin[]əm[] speaking peoples—the x[]məθkʷəy̓əm (Musqueam) and sel'íl'witulh (Tsleil-Waututh) Nations—and the Sḵwx̱wú7mesh-ulh Sníchim speaking peoples—the Sḵwx̱wú7mesh Úxwumixw (Squamish Nation)—on whose unceded territories BCCNM's office is located. We also give thanks for the medicines of these territories and recognize that laws, governance, and health systems tied to these lands and waters have existed here for over 9,000 years.

We also acknowledge the unique and distinct rights, including rights to health and wellness, of First Nations, Inuit, and Métis Peoples from elsewhere in Canada who now live in British Columbia. As leaders in the settler health system, we acknowledge our responsibilities to these rights under international, national, and provincial law.

Lesson 2 of 9

Introduction

Nurses regularly work with client-specific orders. Knowing how to recognize, validate, and act on them is key to safe, competent, and ethical care. This module applies the BCCNM Acting with Client-Specific Orders practice standard to everyday practice.

What you will learn

By the end of this module, you'll be able to:

1. Explain what a client-specific order is and when it is required.
2. Identify who can give orders and for which activities.
3. Apply the four controls on practice to decisions about carrying out orders.
4. Assess your own competence and consider client-centred factors before acting.
5. Communicate clearly and collaborate with prescribers and the care team.
6. Reflect on your practice and plan for continued learning.

Lesson 3 of 9

Client-specific orders

It's important to understand why client-specific orders matter. They are the mechanism that connects nursing practice to the decisions of other authorized health professionals, ensuring activities are performed safely and within regulation. Nurses must recognize what makes an order valid and know their responsibilities before carrying it out.

What is a client-specific order?

A client-specific order is an instruction or authorization from a regulated health professional that directs a nurse to carry out specific activities for an individual client.

- Orders often include restricted activities that require an order under regulation, such as administering medications or diagnostic tests.
- Less commonly, orders may involve non-restricted or restricted activities that do not require an order, even though nurses may perform these within their autonomous scope of practice.
- Consultations, referrals, and recommendations are not orders.

📌 In practice, this looks like: Accepting a verbal or telephone order only if no other option is available, repeating it back to confirm accuracy, and documenting it right away. Check your employer's policy for guidance about verbal orders.

What makes an order valid?

A valid order must be (flip each card to learn more):

Documented	The order must be recorded in the client's health record to ensure accurate documentation and reference.

Detailed	The order must include all necessary details for safe execution, such as timing, frequency, and dosage instructions.
Signed	The order must be validated with the issuing health professional's written or electronic signature.
Client-specific	The order must clearly state the client it applies to.

Practice snapshot: Rhonda addresses a vague order

In this practice snapshot, Rhonda is faced with a vague order and demonstrates how to clarify it to ensure safe, accountable nursing care.

Rhonda receives a medication order that reads: “Give pain meds PRN.” She notices right away that the order is incomplete. Instead of guessing, she calls the prescriber to clarify which medication is intended, at what dose, and how often it can be given.

Once she receives a clear order—“Morphine 5 mg PO every 4 hours PRN for moderate pain”—she documents the clarification and proceeds safely. By taking this extra step, Rhonda ensures her client receives the right medication at the right time.

📌 In practice, this looks like: Acting only on orders that are complete, clear, and appropriate—and reaching out to the health professional who gave the order if anything is missing, unclear, or concerning. Work together to clarify and confirm that the order is safe and appropriate before proceeding.

Check your understanding

Which of the following criteria must be met for a client-specific order to be considered valid? Select all that apply.

a) The order must include all necessary details, such as timing and dosage.

b) The order must be documented in the client’s health record.

c) The order must be verbal and given during an urgent situation.

d) The order must be signed by the issuing health professional.
e) The order must comply with legal and regulatory standards.

Key takeaways

Understanding client-specific orders is essential for nurses to ensure safe, competent, and ethical care. Here are some key takeaways:

- Recognize the role of client-specific orders. They connect nursing actions to health professionals' decisions.
- Ensure validity of orders. Check for proper documentation, details, signatures, and that they are client-specific.
- Clarify unclear orders. This maintains safety and accountability in nursing care.

Now that you know what a client-specific order is and what makes it valid, we'll look at nursing activities and who is authorized to give orders nurses can act with.

Lesson 4 of 9

Orders and nursing activities

In nursing practice, not every activity can be carried out the same way. Some actions fall within your autonomous scope, while others are legally restricted and may require an order from another health professional.

Recognizing when you can act without an order (autonomously), and when you require an order, helps you make sound clinical decisions, protects client safety, and ensures you are practising within BCCNM standards, limits, and conditions.

Here's a clear breakdown of how nursing activities are categorized in regulation, and who can give the orders that nurses may follow:

Non-restricted activities

Definition: Activities that fall within the general scope of nursing and do not appear on the regulation's list of "restricted activities." Nurses are allowed to perform them autonomously (without an order) if standards and employer policies are met and the nurse is competent.

Examples:

a) Health teaching and health promotion
b) Assisting clients with activities of daily living
c) Documenting
d) Planning client care
e) Using isolation techniques
f) Using some types of equipment (e.g., lifts, slings)
g) Providing psychosocial support

Orders*:*

a) No order required (generally). Nurses act autonomously, guided by BCCNM's Acting Within Autonomous Scope of Practice standard, employer policies, and their own competence.

b) Employer policy may still require an order for some non-restricted activities (e.g., pronouncing death, applying restraints).

Restricted activities that do not require an order

Definition: These are activities legally classified as "restricted" because they carry a higher risk. Nurses are authorized to perform them autonomously (without an order) if standards and employer policies are met and the nurse is competent.

Examples*:*

a) Initiating oxygen therapy
b) Immunizing clients (when trained, competent, and using decision support tools)
c) Diagnosing a physical or mental condition (e.g., hypoglycemia, anxiety exacerbation in a client with an anxiety disorder)
d) Performing TB screening
e) Using ultrasound to measure bladder volume

Orders:
No order required from another professional if:

- The activity is permitted by regulation
- The nurse meets the practice standard *Acting Within Autonomous Scope of Practice limits, conditions*.
- The nurse is competent and supported by employer policy.

Restricted activities that require an order

Definition: To legally perform certain restricted activities, a nurse must be acting under a client-specific order. In this case, the order is an authorizing mechanism and allows the nurse to act within their scope when:

a) the activity is part of nursing scope of practice,
b) the person giving the order (such as a physician, nurse practitioner, or other authorized professional) is allowed to perform that activity on their own, and
c) the regulation says nurses of that designation (RN, LPN, or RPN) may act with that type of order.

LPNs, RNs, and RPNs may not perform these activities autonomously.

Examples:

- Administering prescription medications (e.g., anti-hypertensives, chemotherapy)
- Casting a fracture of a bone
- Applying laser to destroy tissue

Orders:
For RNs and RPNs: Orders can be given by a physician, nurse practitioner, dentist, midwife, naturopathic doctor, podiatrist, pharmacist, certified RN, or certified RPN.

For LPNs: Orders can be given by a physician, nurse practitioner, dentist, midwife, naturopathic doctor, podiatrist, pharmacist, RN, RPN, or dietitian.

If you're unsure whether an activity requires an order, always check the legislation, BCCNM standards, limits, and conditions, and your employer's policies before proceeding.

📌 In practice, this looks like: Acting with an order from a non-listed health professional only if the activity is within your autonomous scope, you are competent to do it, and your employer's policies support it.

Check your understanding

Which of the following health professionals are authorized to issue client-specific orders for **restricted activities** that require an order that nurses can act with? Select all that apply.

a) Physicians
b) Certified RNs and Certified RPNs
c) Nurse practitioners
d) Midwives
e) Speech language pathologists

When an order may still be needed

Even if regulation allows nurses to act autonomously, a client-specific order may still be required in certain situations:

- When you do not have the competence to determine if the client would benefit from the activity. For example, you can apply a cast but you cannot decide if a client needs one.
- To meet a BCCNM requirement to only perform the activity with a client-specific order.
- When employer policy requires it. For example, your organization requires a physician's order

for IV hydration, even if it is within your scope.

- Resources or supports are lacking. For example, you cannot perform a procedure without the required decision-support tools, supervision, or equipment.

Key takeaways

Understanding the distinction between autonomous and ordered actions is crucial for safe nursing practice. This knowledge ensures compliance with standards and enhances client safety. Here are some key takeaways:

- Recognize your scope. Understand which activities you can perform autonomously and which require an order.
- Know the regulations. Familiarize yourself with BCCNM standards, limits, and conditions, and employer policies regarding nursing activities.
- Identify who can issue orders for restricted activities that require an order to ensure compliance.
- Always verify before acting. If in doubt about an order's validity, seek guidance.

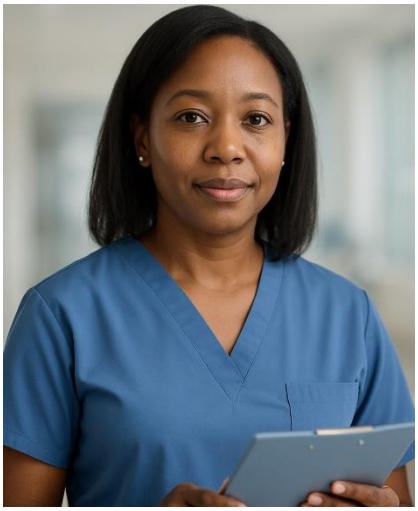
Knowing who can give orders is one step. Next, we'll explore the legal and professional requirements that shape how you act with them.

Lesson 5 of 9

Legal & professional requirements

Nurses are responsible and accountable to multiple layers of control when acting with a client-specific order. Before acting, you need to be certain that what you're about to do is legally authorized. This means understanding:

- The *Acting with Client-specific Orders practice standard*, and
- The four controls on practice.



Practice point

BCCNM's *Acting with Client-specific Orders practice standard* outlines your **responsibilities and accountabilities** when acting with orders to provide care.

Controls on practice

The four controls on practice form a decision-making framework that guides nurses in determining their legal and professional authorization to perform activities. This structured process ensures that your actions align with legislation, professional standards, employer policies, and your own competence.

Take a look at the framework below. As you review it, think about how each control interacts with the others to guide your decision-making.

Before acting autonomously, complete this quick check.

If you answer no or feel uncertain, pause and seek support, supervision, or further education before proceeding

Level 1 – Legislation and regulation

Ask yourself:

- Am I authorized to perform it under my nursing regulation?
- Can I perform the activity within my autonomous scope of practice (without an order) or do I need a client-specific order from an authorized health professional?
- Have I considered other relevant legislation?

If yes to above: Move to Level 2.
If no: Stop and seek guidance.

Your responsibilities: Comply with your nursing regulation, understand legal requirements, and determine if you're legally authorized to perform an activity.

Level 2 - BCCNM bylaws, standards, limits & conditions

Ask yourself:

- Do I have a practising nursing licence from BCCNM to practice in B.C.?
- Does this activity align with BCCNM practice standards including those related to scope of practice?
- Do I meet limits and conditions to perform this activity, if there are any?

If yes to above: Move to Level 2.
If no: Stop and seek guidance.

Your responsibilities: BCCNM standards are not used in isolation. Make sure you are following all relevant standards, limits, and conditions (limits are restrictions set by BCCNM on activities; conditions are requirements set by BCCNM that must be met to perform an activity).

Level 3 – Organizational policies

Ask yourself:

- Is the activity within my job or role description?
- Does my employer allow me to perform this activity?
- Does my employer have policies and procedures that authorize and support me in performing this activity?
- Are there sufficient resources to support me before, during and after the activity?

If yes to above: Move to Level 2.
If no: Stop and seek guidance.

Your responsibilities: Know your role within your employment setting and any limits specific to that role. Determine if employers support nurses to perform an activity in your practice setting. Review relevant policies, check resource availability, and consult with your employer and health-care team.

Employers are responsible for defining staff roles and whether nurses can perform specific activities in the practice setting. If your practice setting does not support the performance of an activity, you can advocate for and assist in the development of policies and procedures in the interest of client safety.

Level 4 – Individual nurse competence

Ask yourself:

- Do I have the competence (knowledge, skill, attitude, and judgment) to:
  - Assess whether it is appropriate to perform the activity?
  - Perform the activity?
  - Manage the client before, during and after the activity?

- Do I have a plan and strategies to obtain and maintain my competence?

If yes to above: Move to Level 2.
If no: Stop and seek guidance.

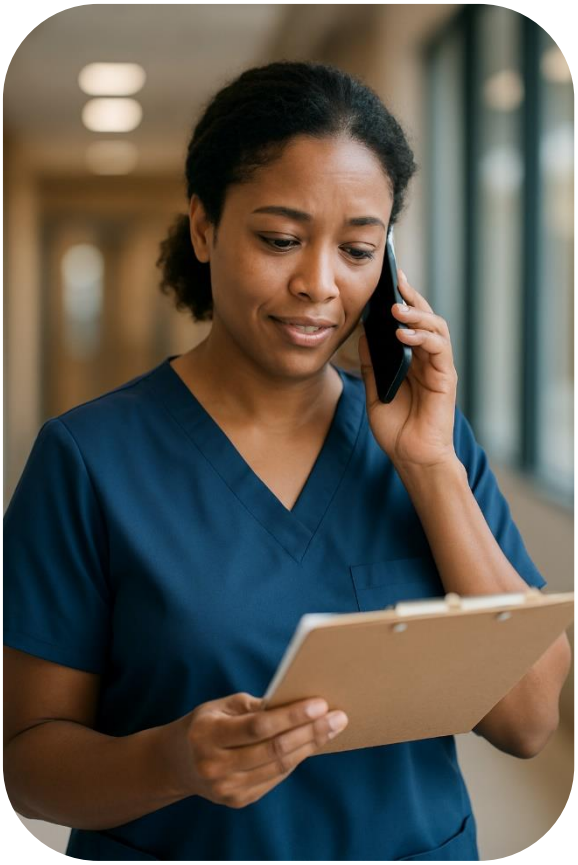
Your responsibilities: Reflect on your practice and competence. Each nurse is unique and may need different amounts of training, support, and resources to be competent to safely perform a particular activity.

📌 In practice, this looks like: Before carrying out an order, confirming the activity is within nursing scope, aligns with BCCNM standards and employer policies, and is something you are personally competent to do.

Nursing competence is the ability to deliver safe, competent, and ethical care. It is grounded in current knowledge, practical skills, sound judgment, and professional attitudes, applied within the context of each client's clinical situation. Nurses are accountable for honestly assessing their competence and must ensure they are prepared before carrying out any order.

Practice snapshot: Applying the controls on practice

This practice snapshot shows how a nurse applies the four controls on practice to ensure their actions are safe, competent, and legally authorized.



Nia is asked to administer a new IV medication. Regulation and standards authorize this activity, but the employer requires additional training. Nia acknowledges she is not yet permitted, explains this to the prescriber, and arranges for a trained colleague to administer while she completes the training.

Takeaway: All four controls must align before you carry out an order. Regulation alone is not enough—standards, policies, and competence complete the framework for safe practice.

Reflection

Think about a time when you carried out a client-specific order.

How did you ensure that your actions were within your scope of practice, consistent with regulatory requirements, and employer policies?

Check your understanding

Match each of the four controls on practice with its corresponding description by putting a, b, c, or d next to its match.

Legislation and regulation ____

BCCNM bylaws, standards, limits & conditions ____

Organizational policies ____

Individual nurse competence ____

a) Determines if an activity is legally authorized under nursing regulation and other relevant laws.

b) Defines scope of practice, limits, and conditions set by BCCNM that must be followed.

c) Specifies whether an activity is supported by employer policies and resources in the practice setting.

d) Focuses on the nurse's knowledge, skills, and judgment to perform an activity safely.

a)

Key takeaways

This lesson focused on the legal and professional requirements nurses must follow when acting on client-specific orders. The four controls on practice provide a structured framework for informed decision-making. Here are some key takeaways:

- Understand the four controls on practice. They guide your decision-making process regarding legal and professional authorization.
- Verify your legal authority. Always check regulations and BCCNM standards, limits, and conditions before performing any nursing activity.
- Know your employer policies. Ensure your actions align with your job description and employer's support.

Legal and professional requirements set the boundaries. Next, we'll focus on client-centred decision-making and communication.

Client-centred decision-making & communication

As a nurse, you are responsible for ensuring that every client-specific order you carry out promotes safety, dignity, and well-being. This means using critical thinking, clear communication, and collaboration with clients, families, and the health-care team to confirm that the order is safe, ethical, and aligned with the client's needs, treatment goals, and preferences. Also, nurses have a responsibility to obtain or verify consent for care they provide.

Assessing orders with a client-centred lens

When you receive a client-specific order, your responsibility is to act thoughtfully and safely. Consider:

Order appropriateness

- Is the order still right for the client's current condition?
- Are there any risks, contraindications, or changes?
- Example: An order to increase a P medication was written yesterday, but today the client's BP is much lower. Reassess and consult before administering.

Client engagement

- Explain the order to the client and answer questions
- Consider their values, preferences, and consent
- Obtain client consent
- Example: A client with a nasogastric (NG) tube order expresses fear and asks about alternatives. The nurse pauses, consults the provider, and updates the client and family.

Cultural safety

- Respect the client's identity, traditions, and worldview
- Be open to feedback and adjust your approach as needed
- Example: If a client's culture requires same-gender care providers for certain procedures, identify and respect this before proceeding.

Safety

- Confirm resources, equipment, and supports are in place
- Consider if timing or setting affects safety
- Example: A client is ordered anticoagulants, but the latest blood clotting reading is dangerously high. You hold the dose and consult the provider before continuing.

📌 In practice, this looks like: Before carrying out an order, confirming the activity is within nursing scope, aligns with BCCNM standards and employer policies, and is something you are personally competent to do.

If an order raises concerns

You must take proactive, accountable steps to ensure client safety if you determine:

- The client's condition has changed significantly since the order was written and it may no longer be appropriate.
- The order is inconsistent with the client's existing condition(s).
- The client's needs, preferences, or values have not been considered, it's not in line with their wishes or cultural requirements, or they have withdrawn consent.
- The nurse lacks the competence, skill, or experience to proceed.
- There's any concern that the ordered intervention could cause more harm than benefit.
- An error is evident in the order (e.g., 40 mg acetaminophen instead of 400 mg).

📌 In practice, this looks like: If you have concerns about an order, contact the health professional who gave it, discuss the issue, and collaborate to make sure the client receives safe and appropriate care.

Strategies to address potentially unsafe orders

When faced with potentially unsafe orders, nurses need practical strategies to safeguard clients while ensuring care remains competent, ethical, and legally sound. Consider the following:

- **Reassess the client.** Gather current and relevant data by reassessing the client to ensure an accurate assessment and understanding of their condition and needs.
- **Hold or delay the order**. If proceeding with the order poses a risk, hold or delay it to prevent potential harm to the client and consult with the ordering health professional.
- **Consult or notify the prescriber.** Share updates with the prescriber and discuss alternative options to ensure the best course of action for the client.
- **Document clearly.** Maintain clear documentation of your rationale, communication, and the resulting care plan to ensure transparency and accountability.
- **Engage the health-care team.** Collaborate with the health-care team, especially when inter-professional insights or decisions are necessary, to provide comprehensive care.

Practice snapshot

Listen to hear how a nurse handles an order for treatment that goes against a client's expressed preferences.

Respecting client wishes

In some situations, an order may conflict with a client's wishes, values, or cultural beliefs. Nurses have a professional responsibility to pause, clarify, and ensure care remains safe and respectful.

Listen to Melinda describe a situation like this in her own practice.

"I received an order for a blood transfusion for my client. Medically, it was appropriate—but I knew this client had previously told me, based on their cultural and religious beliefs, that they did not want blood products. Instead of just going ahead, I stopped and checked with the client to confirm their wishes. They were very clear: they did NOT want the transfusion. I contacted the doctor right away, explained the client's decision, and documented both our discussion and the refusal of treatment. By pausing, consulting, and respecting the client's values, I was able to provide care that was safe, ethical, and client-centred."

Changing or cancelling orders

Sometimes nurses may need to adjust or hold an order—for example, if the client's condition changes or if following the order exactly as written could cause harm. However, this can only be done under very specific circumstances. The guidelines below outline when you may change or cancel an order yourself, and when you must hold the order and contact the prescriber.

You may change or cancel an order if **all** the following

You are **not** authorized to change or cancel an order:

📌 **In practice, this looks like:** Following orders as written unless you are authorized and competent to make changes—never altering or cancelling an order that is outside your scope.

Check your understanding

You receive an order to insert a feeding tube for a client. The client expresses hesitation, saying they want more time to talk with their family before proceeding.

a) Carry out the order immediately, since it is valid and authorized.
b) Pause, confirm the client's wishes, and notify the prescriber of the client's concerns.
c) Cancel the order on your own authority.
d) Encourage the client to proceed immediately to avoid delaying treatment.

Reflection

Have you ever received an order that didn't feel right? How did you respond?

What strategies do you use (or can you learn) to effectively communicate concerns with prescribers

Key takeaways

This lesson highlighted the significance of client-centred decision-making and communication in nursing practice. Nurses use critical thinking and collaboration to ensure client safety and well-being. Here are some key takeaways:

- Prioritize client safety. Assess the client's condition before carrying out any orders.
- Communicate concerns effectively. Address questionable orders with the prescriber to ensure safety.
- Document thoroughly. Keep detailed records of assessments and communications about client care.
- Collaborate with the health-care team. Work with other professionals to deliver ethical and comprehensive care.

Communication ensures orders are carried out safely and keep the client at the centre of care. To complete the module, let’s look at reflection and growth.

Lesson 7 of 9

Reflection & growth

Nursing practice extends far beyond simply carrying out client-specific orders. To provide safe, competent, and ethical care, nurses have a **professional obligation** to reflect thoughtfully on their practice.

Reflection is a deliberate process of reviewing your experiences:

- What went well
- Identify areas for improvement
- Consider how your actions impacted outcomes

📌 **In practice, this looks like:** Carrying out advanced activities with an order only if you have the necessary education, training, and experience to stay competent and provide safe care.

Reflection is about growth

Reflection is not about blame—it's about growth.
By pausing to reflect, you can:

- Recognize when to seek help.
- Identify learning needs.
- Plan how to build your competence for future practice.
- Strengthen your accountability and resilience.

Small steps lead to real change.

Voices from practice

Listen to these nurses explain how reflecting on experiences improve their practice. As you listen, think about how their experiences connect to your own and what lessons you can apply in your practice.

"Reflection is really important in my practice because it helps me pause and think about what went well, what I could improve, and how my decisions affect clients. Taking that time to reflect makes me more mindful, builds my confidence, and ultimately helps me provide safer, more compassionate care." Eli, LPN

"I see reflection as a key part of my professional growth. By looking back on my experiences, I can identify learning needs, build on my strengths, and set goals for improvement. Reflection keeps me accountable and helps me grow as a nurse so I can keep providing the best care possible." ~ Arabelle, RPN

"Not every shift goes the way I hoped. Recently, a situation didn't go as well as it should have, and I kept replaying it in my mind. Taking time to reflect helped me understand what I could have done differently, and what I can do better next time. Reflection turns difficult moments into learning opportunities—and that's how I grow as a nurse."

Planning for continuing learning

Reflection doesn't just help you understand what happened—it **helps you grow**. Based on your reflection:

- Identify areas where you can build confidence or update your knowledge
- Seek out continuing education opportunities or mentorship to enhance your skills.
- Share your insights with your team to foster collective learning and improvement.

Practice snapshot: Reflection in action

Listen to Dakota describe how reflecting on an experience helped her realize that asking for help was an act of safe, accountable practice, not a failure.

Dakota: Turning uncertainty into learning
Dakota receives a client-specific order for a medication she doesn't recognize: *"Administer 20 mg oral minoxidil once daily for refractory hypertension."*
She pauses. Unsure about minoxidil, she doesn't proceed immediately. Instead, she checks her unit's clinical drug reference and learns it is a potent vasodilator used in difficult-to-control hypertension.

Afterward, Dakota reflects on her knowledge gap. To strengthen her practice, she sets a goal to review both common and uncommon medications, compare their actions, and learn key monitoring requirements—turning uncertainty into an opportunity for growth. Listen as Dakota describes her experience.

"At first, I froze a little when I saw the order for minoxidil. I knew it as a hair-loss treatment, but I didn't realize it was sometimes used as a blood pressure medication. I couldn't give something I didn't fully understand, so I paused. I looked it up in our drug reference, reviewed the indications, side effects, and nursing considerations, and then confirmed with the pharmacist that the dose and route were appropriate. Once I had the information, I felt much more confident. I gave the medication, documented carefully, and monitored my client's blood pressure afterward.

When I reflected later, I realized I need to be more familiar with less common antihypertensives. So I set myself a learning goal: to review not only the common medications but also the less frequently used ones—like minoxidil—so I can be prepared and provide safe care in the future."

Overcoming barriers

Planning for continued learning can be challenging. Instead of ignoring these challenges, focus on practical strategies to overcome them. Use the tips below to transform common barriers into opportunities for growth.

Barrier	***Strategy***
"I don't have time."	Break learning into small pieces. Try microlearning—set aside just 10–15 minutes regularly for a podcast, short article, or module. Small steps add up over time.
"I can't access courses or training."	Look for free or low-cost options like BCCNM learning modules, professional association

	webinars, or unit journal clubs. Peer-to-peer teaching can also expand your knowledge without formal courses.
"I don't know where to start."	Ask a mentor, clinical educator, or experienced colleague for guidance. They can help you identify priorities and suggest resources that match your learning goals.
"I forget to track my learning."	Keep a simple learning journal or digital folder. Note reflections after client situations, jot down goals, and record progress. This also provides evidence for performance reviews or renewal.

Key takeaways

Reflection is a vital component of nursing practice, ensuring safe and ethical care through continuous learning and self-assessment. Here are some key takeaways:

- Reflect regularly. Thoughtful reflection enhances nursing practice and patient care.
- Learn from experiences. Identifying both successes and areas for improvement is crucial.
- Seek help when needed. Asking for assistance is a sign of accountability, not weakness.
- Overcome challenges. Use practical strategies to turn barriers into opportunities for growth.

By embracing accountability, reflection, and lifelong learning, nurses can continue to act autonomously with confidence while ensuring safe, competent, ethical, and culturally safe care.

Great work—you've reached the end of the module! Let's see how much you've learned with the final quiz.

Lesson 8 of 9

Quiz

Welcome to the final quiz! This is an opportunity to test your understanding of the material covered. Remember, this is a chance to reinforce your learning and identify any areas that may need further review. A score of 80% is required to pass the quiz.

Question

01/07

Which of the following is a requirement for a valid client-specific order?

a) It does not require verification of the nurse's competence before acting.
b) It must be clear and specific to the client.
c) It must be written by any member of the health-care team.
d) It can be based on general guidelines for all clients.

Question

02/07

Under what conditions can a nurse act on client-specific orders from non-listed health professionals?

a) The activity is within the nurse’s autonomous scope of practice, but employer policies are not required.
b) The activity is within the nurse’s autonomous scope of practice and supported by employer policies, but BCCNM standards do not apply.
c) The activity is within the nurse’s autonomous scope of practice, and BCCNM standards are met, but the order can be verbal recommendations.
d) The activity is within the nurse’s autonomous scope of practice, meets all BCCNM standards, and is supported by employer policies.

Question

03/07

What does competence mean in the context of acting with client-specific orders?

a) Being able to perform any activity as long as it is ordered by an authorized health professional.
b) Having the ability to perform activities without considering the clinical context or client-specific risks.

c) Relying on team members to ensure the activity is performed safely and effectively.

d) Having the knowledge, skill, attitudes, judgment, and support to perform the activity safely and effectively in your current context.

Question

04/07

What is the primary purpose of the *Acting with Client-specific Orders practice standards* for nurses?

a) To prioritize organizational policies over client safety.

b) To set clear requirements to ensure informed, ethical, and safe decision-making when acting on client-specific orders.

c) To provide detailed instructions for every possible client scenario.

d) To ensure nurses always follow physician orders without question.

Question

05/07

What should a nurse do if they are unable to carry out a client-specific order due to lack of competence or resources?

a) Ignore the order and wait for the prescriber to follow up.

b) Proceed with the order despite the limitations.

c) Carry out the order without verifying the client's current condition or needs.

d) Communicate with the prescriber to explain the situation and seek guidance.

Question

06/07

When is a client-specific order required? Select all that apply.

a) Anytime you interact with a client.
b) To perform a restricted activity that requires an order under regulation.
c) When it is a condition under BCCNM standards.
d) When an organizational policy requires it.
e) When a client requests it.
f) When performing non-restricted activities.

Question

07/07

Match the key concepts of client-centred care and safety with their importance in ensuring safe, competent practice. Consider how each concept contributes to maintaining client well-being and professional accountability.

Valid client-specific orders ___
Four controls on practice ___
Confirming competence ___
Effective communication and collaboration ___
Reflection and continuous learning ___

a) Ensures clarity, specificity, and authorization by a regulated health professional.
b) Helps maintain safety by adhering to legal and professional standards, employer policy and are competent.
c) Verifies that you have the required skills and knowledge to act safely.
d) Facilitates teamwork and minimizes risks through clear communication and collaboration.
e) Encourages growth and adaptation to enhance care quality and safety.

Answer key

Page 7

Which of the following criteria must be met for a client-specific order to be considered valid? Select all that apply.

a) The order must include all necessary details, such as timing and dosage.

b) The order must be documented in the client's health record.
c) The order must be verbal and given during an urgent situation.
d) The order must be signed by the issuing health professional.
e) The order must comply with legal and regulatory standards.

Page 11

Which of the following health professionals are authorized to issue client-specific orders for **restricted activities** that require an order that nurses can act with? Select all that apply.

a) Physicians
b) Certified RNs and Certified RPNs
c) Nurse practitioners
d) Midwives
e) Speech language pathologists

Page 18

Legislation and regulation - Determines if an activity is legally authorized under nursing regulation and other relevant laws.

BCCNM standards, limits, and conditions - Defines scope of practice, limits, and conditions set by BCCNM that must be followed.

Organizational policies - Specifies whether an activity is supported by employer policies and resources in the practice setting.

Individual nurse competence - Focuses on the nurse's knowledge, skills, and judgment to perform an activity safely.

Page 23

You receive an order to insert a feeding tube for a client. The client expresses hesitation, saying they want more time to talk with their family before proceeding.

a) Carry out the order immediately, since it is valid and authorized.
b) Pause, confirm the client's wishes, and notify the prescriber of the client's concerns.
c) Cancel the order on your own authority.
d) Encourage the client to proceed immediately to avoid delaying treatment.

Page 30 - Quiz

01/07

Which of the following is a requirement for a valid client-specific order?

a) It does not require verification of the nurse's competence before acting.

b) It must be clear and specific to the client.

c) It must be written by any member of the health-care team.

d) It can be based on general guidelines for all clients.

02/07

Under what conditions can a nurse act on client-specific orders from non-listed health professionals?

a) The activity is within the nurse's autonomous scope of practice, but employer policies are not required.

b) The activity is within the nurse's autonomous scope of practice and supported by employer policies, but BCCNM standards do not apply.

c) The activity is within the nurse's autonomous scope of practice, and BCCNM standards are met, but the order can be verbal recommendations.

d) The activity is within the nurse's autonomous scope of practice, meets all BCCNM standards, and is supported by employer policies.

03/07

What does competence mean in the context of acting with client-specific orders?

a. Being able to perform any activity as long as it is ordered by an authorized health professional.

b. Having the ability to perform activities without considering the clinical context or client-specific risks.

c. Relying on team members to ensure the activity is performed safely and effectively.

d. Having the knowledge, skill, attitudes, judgment, and support to perform the activity safely and effectively in your current context.

04/07

What is the primary purpose of the *Acting with Client-specific Orders practice standards* for nurses?

a) To prioritize organizational policies over client safety.

b) To set clear requirements to ensure informed, ethical, and safe decision-making when acting on client-specific orders.

c) To provide detailed instructions for every possible client scenario.

d) To ensure nurses always follow physician orders without question.

05/07

What should a nurse do if they are unable to carry out a client-specific order due to lack of competence or resources?

a) Ignore the order and wait for the prescriber to follow up.

b) Proceed with the order despite the limitations.

c) Carry out the order without verifying the client's current condition or needs.

d) Communicate with the prescriber to explain the situation and seek guidance.

06/07

When is a client-specific order required? Select all that apply.

a) Anytime you interact with a client.

b) To perform a restricted activity that requires an order under regulation.

c) When it is a condition under BCCNM standards.

d) When an organizational policy requires it.

e) When a client requests it.

f) When performing non-restricted activities.

07/07

Match the key concepts of client-centred care and safety with their importance in ensuring safe, competent practice. Consider how each concept contributes to maintaining client well-being and professional accountability.

Valid client-specific orders - Ensures clarity, specificity, and authorization by a regulated health professional.

Four controls on practice - Helps maintain safety by adhering to legal and professional standards, employer policy and are competent.

Lesson 9 of 9

Module wrap-up & next steps

You've now explored the essentials of acting within your autonomous scope of practice: understanding what it means, checking legal and policy requirements, confirming competence, keeping client safety at the centre, communicating and collaborating, and reflecting for growth. Here are some key takeaways:

Key takeaways

- Always check the four controls on practice before acting autonomously.
- Be honest about your competence and seek help when needed.
- Keep client safety and cultural respect central to decisions.
- Communicate clearly with clients, families, and colleagues.
- Reflect and keep learning.

Next steps

- Apply these lessons to your daily decision-making.
- Share what you've learned with your team to strengthen collective practice.

Congratulations! By completing this module, you've reinforced your ability to act autonomously with confidence, accountability, and client-centred care.

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