KENTUCKY BOARD OF NURSING
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ADVISORY OPINION STATEMENT

IMPLEMENTATION OF PATIENT CARE ORDERS

The Kentucky Board of Nursing is authorized by Kentucky Revised Statutes (KRS) Chapter 314 to regulate nurses, nursing education and practice, promulgate regulations and to issue advisory opinions on nursing practice, in order to assure that safe and effective nursing care is provided by nurses to the citizens of the Commonwealth.

The Kentucky Board of Nursing issues advisory opinions as to what constitutes safe nursing practice. As such, an opinion is not a regulation of the Board and does not have the force and effect of law. It is issued as a guideline to licensees who wish to engage in safe nursing practice, and to facilitate the delivery of safe, effective nursing care to the public.

Opinion: Implementation of Patient Care Orders

Approved Date: 2/1987
Revised: 1/1993; 6/1993; 10/1996; 6/1998; 6/2004; 2/2005; 10/2010; 10/2019; 12/2020
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Accountability and Responsibility of Nurses

In accordance with KRS 314.021(2), nurses are responsible and accountable for making decisions that are based upon the individuals' educational preparation and current clinical competence in nursing, and requires licensees to practice nursing with reasonable skill and safety. Nursing practice should be consistent with the *Kentucky Nursing Laws*, established standards of practice, and be evidence based.

Rationale for Advisory Opinion

The Board receives inquiries related to the roles of nurses in the implementation of patient care orders. The Board issued the following advisory opinion.

Advisory Opinion

Nurses are held responsible and accountable for their decisions regarding the receipt and implementation of patient care orders based upon the individuals' educational preparation and clinical competence in nursing. Technological advancements have provided additional forms of communication for patient care orders. The nurse's practice should be consistent with the *Kentucky Nursing Laws*, established standards of practice, and be evidence based.

Health care guidelines are evidence-based statements of best practice in the prevention, diagnosis, or management of a given symptom, disease, or condition for individual patients under normal circumstances. CMS requires that standards of practice and standards of care be entered into policy and procedure and guidelines.

The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) utilize the term licensed independent practitioner (LIP) when referring to providers and prescribers. LIPs include physicians, physician assistants (PAs), advanced practice registered nurses (APRNs), or dentists.

Communication

"Verbal and written communication among staff and with patients was listed as one of the 10 most frequently identified root causes of medical errors…." (The Joint Commission, 2012).

Nurses are responsible to clearly and effectively communicate with everyone involved in health care.

Each facility should encourage effective open communication between members of the health care staff and provide written policies regarding the appropriate methods of communication, and the information that may or may not be communicated therein, as well as when and how to address any issues that arise.

Methods of Patient Care Order Submission

It is within the scope of practice of licensed practical nurses (LPNs) and registered nurses (RNs) to accept orders from qualified licensed independent practitioners (LIPs), in accordance with their employing agencies/facilities written policies and state and federal laws.

Facilities/agencies should maintain specific written policies on the acceptance of patient care orders. These policies should address the:

- Responsibilities of LPNs, RNs, and LIPs; and
- Use of various methods of communication, transcription, acknowledgement, and verification of orders.

The LIPs issuing the order must be identified and a patient-practitioner relationship must exist.

The nurse must review and verify the order in a timely manner according to written facility/agency policies.

The Joint Commission (2016) issued the following recommendations related to patient care orders:

- All health care organizations should have policies prohibiting the use of unsecured text messaging also known as short message service, from a personal mobile device for communicating protected health information.
- The Joint Commission and CMS agree that computerized provider order entry (CPOE), which refers to any system in which clinicians directly place orders electronically, should be the preferred method of submitting orders, as it allows providers to directly enter orders into the electronic health record (EHR).
- In the event that a CPOE or written order cannot be submitted, a verbal order is acceptable on an infrequent basis.
- The use of secure text orders is not permitted at this time. (The Joint Commission, 2016).

Implementation of Patient Care Orders

1. Roles of Nurses in the Receipt of Direct Verbal Orders or Conveyed via the Telephone

Although, the preferred method of order submission is CPOE or in written format, it is not feasible in all situations. It is within the scope of nursing practice for registered nurses or licensed practical nurses to accept direct and telephone orders of a qualified LIP and/or verbal intermediary.

- Verbal orders "occur when a health care provider gives therapeutic orders to an RN while they are standing in proximity to one another."
- Telephone orders "occur when a health care provider gives therapeutic orders over the phone to an RN." (Potter et al., 2017.)

Telephone and verbal orders are discouraged and should only be used "when absolutely necessary and not for the sake of convenience." (Potter et al., 2017)

State and federal regulations governing the operation of various health care facilities have established rules regarding the receipt of verbal orders by nurses. (902 KAR 20:016; 048; 051) Therefore, nurses should accept verbal orders according to established policy of the health care facility that complies with the applicable state and federal regulations. (For additional information contact: The Cabinet for Health and Family Services, Office of Inspector General, Frankfort, Kentucky 40621).

A. Verbal/Telephone Orders – "Repeat and Verify" – "Read-Back" Process

When accepting any verbal order, whether received directly or via the telephone, the nurse should record the order in writing, either directly into the CPOE or on the order sheet to be entered later. *Essentials for Nursing Practice* states the following regarding the process for accepting verbal orders:

> "After the nurse transcribes an order, the nurse uses the read-back process and documents the process to provide evidence that the information was received … (and) was verified with the provider….It is wise to have a second person listen to [telephone orders]."" (Potter et al., 2017))

During this process the nurse repeats the order back to the qualified LIP/intermediary, and receives verification from the qualified LIP/intermediary that the order is correct, and document that the repeat and verify process was completed. Where possible, the nurse should first put the order in writing and then immediately read it back to the qualified LIP/intermediary for verification, and subsequently document that the "repeat and verify" step was completed.

Agency/facility policies should provide a set time frame for the LIP to co-sign, verifying the order legally.

2. Roles of Nurses in the Receipt of Orders Conveyed by an Intermediary or Agent of the Qualified Provider

An order of a qualified LIP for patient care which is conveyed by someone other than the LIP (e.g., pharmacist, clerical staff, etc.) may be accepted by nurses, providing the individual conveying the order is acting as a direct intermediary or agent of the LIP.

The Office of the Attorney General, in OAG 79-506, addressed the issuance of orders through an intermediary of the physician. The Opinion speaks to the need for a nurse to exercise judgment to authenticate that the order is indeed an order of the physician and that: "If a nurse has doubt about the validity or the authenticity of an order, she should be careful to check it directly with the physician." (A copy of the opinion may be obtained from the Office of the Attorney General, Frankfort, Kentucky 40601.)

Safeguards should be taken to implement a process that will provide for safe and effective care when an intermediary of the qualified LIP conveys written or verbal orders. As stated above, when accepting verbal orders, the nurse should repeat and verify the order. When possible, any order, which is conveyed through an intermediary of the qualified LIP should be put in writing and contain the name of the qualified LIP, intermediary, and the person receiving/documenting the order.

A nurse may serve as an intermediary for a qualified LIP in accordance with the employing agency's policies.

A. Roles of Nurses in the Implementation of Orders Issued by an APRN

As authorized by KRS Chapter 314, nurses may implement orders issued by an advanced practice registered nurse.

B. Roles of Nurses in the Implementation of Orders Written by a Physician Assistant[1]

KRS 311.858 permits physician assistants to practice medicine or osteopathy with physician supervision. A physician assistant may perform those duties and responsibilities that are delegated by the supervising physician. A physician assistant is considered an agent of the supervising physician. The statute further authorizes physician assistants to prescribe and administer nonscheduled legend drugs and medical devices to the extent delegated by the supervising physician. Pursuant to KRS 314.011(6)(c) and KRS 314.011(10)(c) registered nursing practice and licensed practical nursing practice includes administration of medication or treatment as ordered by the physician, physician assistant, dentist or advanced practice registered nurse.
The nurse should be familiar with the supervising physician's practice relationship with the physician assistant. An order issued independently by a physician assistant is not considered a legal patient care order. If a nurse has reason to believe that a physician assistant is practicing independently of the supervising physician or has otherwise violated the applicable law, the nurse should report this to the supervising physician and to the Kentucky Board of Medical Licensure and should not implement the order.

Also, if a nurse has reason to question the appropriateness of a physician assistant's order, the nurse should contact the supervising physician and follow Section 5.

C. Roles of Nurses in the Implementation of Orders Written by a Pharmacist

Nurses may implement orders written by a pharmacist when the pharmacist is functioning under a collaborative care agreement pursuant to KRS 315.010.

3. Receipt of Orders by Clerical Staff

Policies and procedures of a health care facility should clarify whether clerical staff may receive and transcribe orders of a qualified LIP. A nurse who implements an order is responsible for assuring the order is appropriate, accurate, and complete.

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[1] For information regarding the regulation, supervision and certification of the physician assistant, contact the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. (502-429-8046).

4. Roles of Nurses in Questioning the Appropriateness of an Order and Refusal to Implement an Order

Pursuant to KRS 314.011(10) and 314.021(2), a licensed practical nurse provides care and exercises judgment under the direction of a registered nurse, physician, physician assistant, advanced practice registered nurse, or dentist.

Pursuant to KRS 314.011(6) and 314.021(2), a registered nurse is licensed to exercise independent judgment regarding the well-being of patients.

The duty to exercise critical thinking skills and sound nursing judgment, based upon an individual's educational preparation and experience, is personal to each licensee and may not be relinquished to others. This duty takes precedence over qualified LIP instructions or facility policies where following such instructions or policies would risk harm to a patient.

It is the responsibility and the obligation of a nurse to question a patient care order that is deemed inappropriate by a nurse according to his/her educational preparation and clinical experience. In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse should not implement the order until it is verified for accuracy with the qualified LIP

A nurse is obligated to not change an order of a qualified LIP without the qualified LIP's order to do so. The nurse who has deemed that an order is inappropriate for a patient should:

A. Follow the appropriate channels of communication to inform both the qualified LIP giving the order and the nursing supervisor that the order has not been executed pending clarification/verification; and

B. Work collaboratively with the qualified LIP and appropriate nursing personnel to reach a resolution in the matter.

"If you knowingly carry out the questionable order without obtaining any supporting consultation from your supervisor or administrative staff you are legally responsible for the harm suffered by your patient." (Potter, 9th)

5. Use of Protocols, Standing Orders, and Routine Orders

The terms "protocol," and "standing or routine orders," are not defined in the *Kentucky Nursing Laws* (KRS Chapter 314) and are often used differently in various health care settings. Such orders may apply to all patients in a given situation or be specific pre-printed orders of a given qualified LIP. The determination as to when and how "protocols and standing/routine orders" may be implemented by nurses is a matter for internal deliberation by the health care facility.
The Joint Commission (2019) and CMS (2014) have identified definitions for medication orders to provide clarification on these terms including the following:

Standing order are orders that are prewritten orders which include specific instructions from the licensed independent practitioner (LIP) to administer a medication to a person in a clearly defined circumstance. Standing orders contain orders for the patient based on various stipulated clinical situations and require prior approval in policy by the medical staff. They usually name the condition and prescribe the action to be taken in caring for the patient. They must be well-defined clinical situations with evidence to support standardized treatments. ***Standing orders may be initiated without an initial order by the nurse if the patient meets certain, specific criteria. Standing orders must be signed off or authenticated by the practitioner***. Standing orders are commonly used in the ICU, surgery, and ED. Examples might include:

- Administer influenza vaccine to patients who have not had one in the specified period
- The surgery center has pre-op standing orders to initiate IV access on all patients and initiate the administration of lactate ringers at 125 ml/ hour
- Initiate the Rapid Response Team

Order sets are tools designed to help LIPs as they write orders. They include a list of individually selectable interventions that the ordering practitioner may choose from. An order is an evidence based statement of best practice in the prevention, diagnosis, or management of a given symptom, disease, or condition for individual patients under normal circumstances. Pre-printed order sets may be used with organizational approval and review and can be specific to a physician identifying individualized orders. Examples might include:

- Acute MI, CHF, or Pneumonia;
- CABG, stroke, asthma, ventilation weaning,
- Total knee replacement, total hip replacement, hip fracture

Signed and held orders are orders from a LIP to administer medications or complete interventions for a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s). Examples might include:

- A patient scheduled for surgery and the LIP enters orders that are signed and held for pre-operative, operative, and PACU care for pain management to be released during various phases of care.
- A patient admitted to the medical-surgical unit from the ED with signed and held orders to be implemented when the patient is transferred.
- A patient was seen in the LIP's office and signed and held orders were entered for when the patient returns for labs and ultrasound later that day.

Protocols are a "step by step statement of a procedure routinely used in the care of individual patients to assure that the intended effect is reliably achieved." They require the patient to meet clinical criteria. ***Protocols differ from standing orders, as there must be an initial order from the LIP to initiate the protocol. The initial order may be a verbal, telephone, or written order.*** Examples might include:

- Heparin protocol
- Obstetric hypertensive crisis protocol
- Hypoglycemia/hyperglycemia protocols

Standing orders and protocols must be dated and timed and signed off or authenticated by the ordering LIP responsible for the patient's care. They must be in accordance with professional standards of practice law and regulation. They must be consistent with hospital policies and procedures. They must be consistent with CMS bylaws, rules, and regulations. Medication orders and protocols must be consistent with nationally recognized and evidenced-based guidelines. In addition, protocols and standing orders should be officially approved by the facility medical, pharmacy, and nursing staff, or approved by the LIP for the individual patient (The Joint Commission Standards FAQ Medication Administration (2019) and The Joint Commission Complete Medication Order EP Revision, 2019).

It is the advisory opinion of the Board that:

Nurses may implement qualified LIP issued protocols and standing/routine orders, including administration of medications, following nursing assessment. Protocols/orders are a set of predetermined criteria that define nursing actions in a given situation and should be written so that there is no doubt as to the requirements to implement the order(s). Protocols/orders should reflect interventions in response to side effects and adverse events related to implementation of the orders, and should include parameters for the nurse to consult the physician/LIP.

6. Completion of Written Prescriptions Containing Incomplete Information and Use of Pre-signed Blank Prescriptions

Hospitals follow a written policy that defines the required elements of a complete medication order, including when indication for use is required on a medication order, the precautions for ordering

medications with look-alike or sound-alike names, and actions to take when medication orders are incomplete, illegible, or unclear.

- Minimum required elements of a complete medication order which must include: medication name, medication dose, medication route, and medication frequency
- For medication titration orders, required elements include the medication name, medication route, initial or starting rate of infusion (dose/minute), frequency or incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes (The Joint Commission Complete Medication Order EP Revision, 2019).

It is not within the scope of nursing practice for a nurse to independently insert or write in a dosage/time (frequency)/ route on a prescription or in a medical order blank space. These are components of prescribing and should be determined by the LIP. In addition, it is illegal for a nurse to independently fill in a blank prescription that has been pre-signed by a LIP.

Determining Scope of Practice

KRS 314.021(2) holds all nurses individually responsible and accountable for the individual's acts based upon the nurse's education and experience. Each nurse must exercise professional and prudent judgment in determining whether the performance of a given act is within the scope of practice for which the nurse is both licensed and clinically competent to perform. In addition to this advisory opinion statement, the Kentucky Board of Nursing issued Advisory Opinion Statement #41 RN/LPN Scope of Practice Determination Guidelines which contains the KBN Decision-Making Model for Determining Scope of Practice for RNs/LPNs, and published the APRN Scope of Practice Decision Making Model providing guidance to nurses in determining whether a selected act is within an individual nurse's scope of practice now or in the future. A copy of the KBN Decision-Making Model for Determining Scope of Practice for RNs/LPNs may be downloaded from the Board's website and a copy of the APRN guidelines may be downloaded from the Board's website at www.kbn.ky.gov.

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Applicable Statutes From the *Kentucky Nursing Laws*[2]

KRS 314.011(6) defines "registered nursing practice" as:

> …The performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:
>
> a) The care, counsel, and health teaching of the ill, injured, or infirm;
>
> b) The maintenance of health or prevention of illness of others;
>
> c) The administration of medication and treatment as prescribed by physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board, and which are consistent either with American Nurses' Association Scope and

[2] A copy of the *Kentucky Nursing Laws* may be downloaded from the Kentucky Board of Nursing website at http://kbn.ky.gov.

Standards of Practice or with standards of practice established by nationally accepted organizations of registered nurses. Components of medication administration include, but are not limited to:

1. Preparing and giving medication in the prescribed dosage, route, and frequency, including dispensing medications only as defined in subsection (17)(b) of this section;
2. Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
3. Intervening when emergency care is required as a result of drug therapy;
4. Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
5. Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
6. Instructing an individual regarding medications;

d) The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and

e) The performance of other nursing acts which are authorized or limited by the board, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

KRS 314.011(10) defines "licensed practical nursing practice" as:

…The performance of acts requiring knowledge and skill such as are taught or acquired in approved schools for practical nursing in:

a) The observing and caring for the ill, injured, or infirm under the direction of a registered nurse, advanced practice registered nurse, physician assistant, a licensed physician, or dentist;

b) The giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the board;

c) The administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board which is consistent with the National Federation of Licensed Practical Nurses or with Standards of Practice established by nationally accepted organizations of licensed practical nurses;

d) Teaching, supervising, and delegating except as limited by the board; and

e) The performance of other nursing acts, which are authorized or limited by the board and which are consistent with the National Federation of [Licensed] Practical Nurses' Standards of Practice or with Standards of Practice established by nationally accepted organizations of licensed practical nurses.

Resource List

Calloway, S. D. (2014). CMS requirements on order sets, protocols, preprinted and standing orders [PowerPoint slide] Retrieved from http://wwwfiles.ahcmedia.com/webinar/2014/T141205/T141205-PPT.pdf

Potter, P.A., Perry, A.G., Stockert, P.A., & Hall, A.M. (2017). *Fundamentals of Nursing* (9th ed.). St. Louis: Elsevier/Mosby.

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The Joint Commission. (2012). Hand-off communication. Retrieved from https://www.jointcommission.org/assets/1/6/tst_hoc_persp_08_12.pdf