



**KENTUCKY BOARD OF NURSING**  
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<http://kbn.ky.gov>

**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

**Editorial Revision:** 1/2011; 5/2012;  
10/2015; 5/2018

**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.

## **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 Center for Transforming Healthcare: *Hand-off communication*, 2012.

[https://www.jointcommission.org/assets/1/6/tst\\_hoc\\_persp\\_08\\_12.pdf](https://www.jointcommission.org/assets/1/6/tst_hoc_persp_08_12.pdf).)

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 providers/prescribers, 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 providers/prescribers; and
- Use of various methods of communication, transcription, acknowledgement, and verification of orders.

The provider/prescriber 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.

In December of 2016, The Joint Commission 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. [December of 2016, The Joint Commission Perspectives (Retrieved from [https://www.jointcommission.org/assets/1/6/Clarification\\_Use\\_of\\_Secure\\_Text\\_Messaging.pdf](https://www.jointcommission.org/assets/1/6/Clarification_Use_of_Secure_Text_Messaging.pdf))]

## **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 prescriber/provider 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, Perry, Stockert, Hall, *Essentials for Nursing Practice*, 9<sup>th</sup> edition.)

Telephone and verbal orders are discouraged and should only be used “when absolutely necessary and not for the sake of convenience.” (Potter, 9<sup>th</sup>)

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, 9<sup>th</sup>)

During this process the nurse repeats the order back to the qualified provider/intermediary, and receives verification from the qualified provider/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 provider/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 provider 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 provider for patient care which is conveyed by someone other than the provider (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 physician/provider.

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 provider 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 provider, should be put in writing and contain the name of the qualified provider, intermediary, and the person receiving/documenting the order.

A nurse may serve as an intermediary for a qualified provider 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<sup>1</sup>**

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 provider. A nurse who implements an order is responsible for assuring the order is appropriate, accurate, and complete.

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<sup>1</sup> 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 provider 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 provider.

A nurse is obligated to not change an order of a qualified provider without the qualified provider'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 provider giving the order and the nursing supervisor that the order has not been executed pending clarification/verification; and
- B. Work collaboratively with the qualified provider 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, 9<sup>th</sup>)

#### **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 provider. 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.

It is the advisory opinion of the Board that:

Nurses may implement qualified provider 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/provider. In addition, protocols and standing/routine orders should be officially approved by the facility medical and nursing staff, or approved by the prescriber for the individual patient.

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

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 prescriber. In addition, it is illegal for a nurse to independently fill in a blank prescription that has been pre-signed by a prescriber.

**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](http://www.kbn.ky.gov).

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**Applicable Statutes From the *Kentucky Nursing Laws*<sup>2</sup>**

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 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;

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

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.