



Client-specific Orders: Safe & Accountable Practice

Welcome to this module on client-specific orders. In this module, we review the legal requirements, organizational policies, and individual competencies that support safe, competent, and ethical practice when acting under client-specific order.

We recommend that you first complete the [Know Your Scope: Navigating the Controls on Practice](#) module.

Disclaimer: This learning resource is for educational purposes only. It is not intended to guide, direct, or determine clinical practice and must not be relied on as a substitute for professional judgment, regulatory requirements, or organizational policies. Scenarios and examples are fictional and are used solely to illustrate learning concepts. Practice decisions must be based on the specific clinical context, applicable legislation, standards, and individual competence.

Estimated time: 30 minutes

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Territorial acknowledgement

Acknowledging traditional territory is for many First Nations a long-standing practice and a regular aspect of governance relationships and ceremony. Territory acknowledgements are an act of respect and reconciliation at formal meetings, conferences or public events (Territory Acknowledgements, FNHA).



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[]məθk^wəy'əm (Musqueam) and sel'íl'witulh (Tseil-Waututh) Nations—and the Sk̓wx̓wú7mesh-ulh Sníchim speaking peoples—the Sk̓wx̓wú7mesh 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 laws.

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.

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

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

Nursing scope of practice is set out in the Regulated Health Practitioners Regulation (RHPR) and the Nurses and Midwives Regulation (NMR), together referred to as "Regulation".

Client-specific orders

Client-specific orders guide nursing actions based on decisions made by other health professionals. Nurses are required to know what makes an order complete and what responsibilities they have before carrying it out.

What is a client-specific order?

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

- Orders **authorize restricted activities** that require an order under Regulation, such as administering medications or performing diagnostic tests.
- Less commonly, an order may be given for an activity a nurse can already perform autonomously—such as a restricted activity that does not require an order under the Regulation, or a non-restricted activity.
- **Consultations, referrals, and recommendations are not orders.**

What makes an order complete?

A complete order must be:

Legally authorized: Comes from a regulated health professional and meets legal and regulatory requirements.

Client-specific: Clearly states the client it applies to.

Detailed: Includes all necessary details for safe execution, such as timing, frequency, and dosage instructions.

Documented: Is recorded in the client's health record to ensure accurate documentation and reference.

Signed: Includes the health professional’s signature or other approved identifier (e.g., electronic identifier).

In practice: Before acting under an order, a nurse confirms the activity is authorized in Regulation, aligns with BCCNM standards/limits/conditions, is supported by employer policy, and is within their competence.

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 NP 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 breakthrough pain”—she documents the clarification in the client’s health record and proceeds safely. By taking this extra step, Rhonda ensures her client receives the right medication at the right time.

In practice: Act only under orders that are complete, clear, and appropriate. Contact the ordering health professional if anything is missing, unclear, or concerning to confirm the order is safe before proceeding.

Check your understanding

Which of the following criteria must be met for a client-specific order to be considered complete? 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:

- Client-specific orders connect nursing actions to health professionals' decisions
- Verify orders are complete by confirming they are authorized, client-specific and include complete documentation, required details, and appropriate signature/identifier.
- Clarify unclear orders.

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

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 an appropriate health professional.

Recognizing when you can act without an order (autonomously), and when you require an order, supports 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

Non-restricted activities are activities within the broad scope of nursing practice that are not identified as restricted activities in Regulation. While the Regulation does not specifically limit these activities, nurses must still use professional judgment and ensure they meet all applicable regulatory, ethical, and employer requirements before performing them.

Examples:

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

Nurses may act independently, guided by BCCNM's *Acting Within Autonomous Scope of Practice standard*, employer policies, and their own competence. Generally, no order is required. However, some non-restricted activities are higher risk (e.g., applying restraints, initiating enteral feeding). In these situations, BCCNM or your employer may require an order

before the activity is performed.

Restricted activities that do not require an order

Restricted activities that do not require an order are restricted activities that nurses may perform independently when they meet the limits, purposes, and conditions set out in Regulation. These activities must be carried out in accordance with BCCNM standards, any applicable limits and conditions, employer policies, and the nurse's competence.

Examples:

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

No order is required from another health professional if:

- The activity is authorized in Regulation, and
- The nurse meets BCCNM requirements (including *Acting Within Autonomous Scope of Practice standard* and any applicable limits/conditions), and
- The nurse is supported by employer policy (including using any required processes/tools) and competent.

Restricted activities that require an order

Some restricted activities require a client-specific order. LPNs, RNs, and RPNs cannot perform these activities autonomously and require authorization from an appropriate regulated health professional. Orders authorize the nurse to perform the activity when all of the following are met:

- The activity is part of nursing scope of practice,
 - Regulation states that the class of licensee (LPN, RN, or RPN) is authorized to perform the activity when acting under an order.
 - The order is given by a health professional authorized in Regulation to provide that type of order.
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- The ordering health professional is allowed to perform the activity autonomously within their own scope of practice.

Examples:

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

The following regulated health professionals can issue orders nurses may act under:

- For RNs and RPNs: Orders may be provided by a physician, nurse practitioner, dentist, midwife, naturopathic doctor, podiatrist, pharmacist, certified RN, or certified RPN.
 - For LPNs: Orders may be provided by a physician, nurse practitioner, dentist, midwife, naturopathic doctor, podiatrist, pharmacist, RN, RPN, or dietitian.
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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.

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.
- 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 legal 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. Here are some key takeaways:

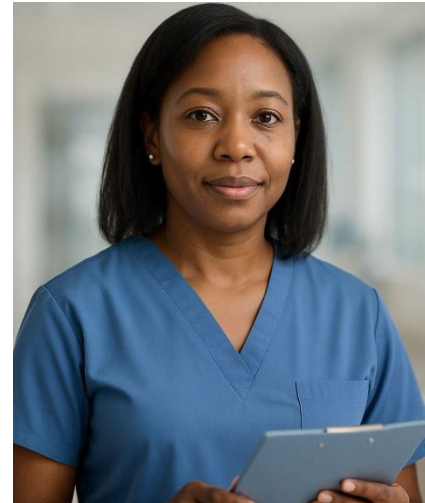
- Recognize your scope. Understand which activities you can perform autonomously and which require an order.
- Know the Regulations. Familiarize yourself with BCCNM standards, limits, and conditions, and employer policies regarding nursing activities.
- Identify who can issue orders for restricted activities 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.

Legal & professional requirements

When acting under a client-specific order, nurses are responsible and accountable within multiple layers of oversight. This requires understanding:

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



Practice point

BCCNM's Acting Under Client-specific Orders practice standard outlines your responsibilities and accountabilities when acting under orders. Take a moment to review the practice standard before

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 and regulation, BCCNM 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.

LEVEL 1 - LEGISLATION AND NURSING REGULATIONS

Your first responsibility is to determine if you're legally authorized to perform an activity.

Ask yourself:

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

If yes to all the 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, AND CONDITIONS

Next, you must ensure you are following all relevant BCCNM 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).

Ask yourself:

- Do I have a practising nursing licence from BCCNM?
- Does this activity align with BCCNM bylaws and standards?
- Do I meet BCCNM limits and conditions to perform this activity, if there are any?

If yes to all the above: Move to Level 3.

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 - EMPLOYER POLICIES

It is your responsibility to review relevant employer policies and resources and consult with your employer and health-care team to understand any limits specific to your role in your employment setting.

Ask yourself:

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

If yes to all the above: Move to Level 4.

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.

LEVEL 4 - INDIVIDUAL NURSE COMPETENCE

Finally, you should always reflect on your individual practice and competence. Each nurse is unique and may need different amounts of training, support, and resources to safely perform a particular activity.


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 all the above: Proceed with the activity.

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.

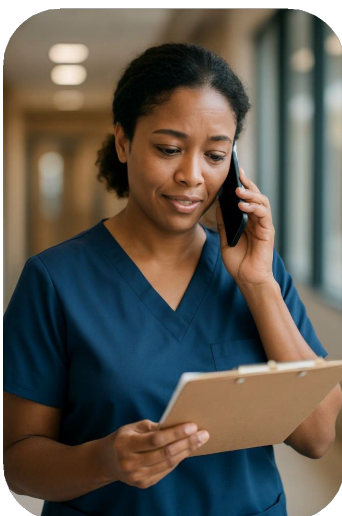
 **In practice:** Before carrying out an order, confirm the activity is within nursing scope, aligns with BCCNM standards and employer policies, and is something you are personally competent to do.



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 BCCNM standards authorize this activity, but the employer requires additional training. Nia acknowledges she is not yet trained, explains this to the ordering health professional, 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—BCCNM standards, employer policies, and the nurse’s 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 and consistent with regulatory requirements and employer policies?

Check your understanding

Match each of the four controls on practice with its corresponding description.

Determines if an activity is legally authorized under Regulation and other relevant laws.	a) Legislation and regulation b) BCCNM standards, limits, conditions c) Employer policies d) Individual nurse competence
Defines scope of practice, limits, and conditions set by BCCNM that must be followed.	a) Legislation and regulation b) BCCNM standards, limits, conditions c) Employer policies d) Individual nurse competence
Specifies whether an activity is supported by employer policies and resources in the practice setting.	a) Legislation and regulation b) BCCNM standards, limits, conditions c) Employer policies d) Individual nurse competence
Focuses on the nurse's knowledge, skills, attitudes, and judgment to perform an activity safely.	a) Legislation and regulation b) BCCNM standards, limits, conditions c) Employer policies d) Individual nurse competence

Key takeaways

This lesson focused on the legal and professional requirements nurses must follow when acting under 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 Regulation 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.

Next, we'll explore client-centred decision-making and communication when acting under an order.

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. Nurses also have a responsibility to obtain or confirm the client’s informed consent, as required, before proceeding.

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 blood pressure (BP) medication was written yesterday, but today the client's BP is much lower. The nurse reassesses and consults the ordering health professional before administering.

CLIENT ENGAGEMENT

- Explain the order to the client and answer their questions.
- Respect their treatment choices, values, and preferences.
- Obtain client consent.

Example: A client with a nasogastric (NG) tube order expresses fear and asks about alternatives. The nurse pauses, clarifies the client's concerns, and consults the ordering health professional.

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 coagulation result (INR/aPTT) is critically high. The nurse holds the dose and consults the ordering health professional before continuing.

 **In practice:** Assess the client before carrying out an order to make sure their condition still warrants the activity and that it remains safe and appropriate.

If an order raises concerns

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:** If you have concerns about an order, contact the ordering health professional, 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 ordering health professional.** Share updates with the ordering health professional 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: 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. Read how Melinda describes 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 stop an order, for example, if the client's condition changes or if following the order exactly as written could cause harm. The guidelines below outline when you may change or cancel an order yourself, and when you must hold the order and contact the ordering health professional.

You may change or cancel an order if **all** the following conditions are met:


- The activity is within your autonomous scope under Regulation.
- The change aligns with BCCNM standards, limits, and conditions.
- You follow employer policies and processes.
- You can safely manage any outcomes, both intended and unintended.

When you cannot change or cancel an order

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

- If the activity requires an order, do not change or cancel it independently—hold the order and contact the ordering health professional.
- The change is not supported by your employer’s policy.
- You are unsure about the client’s status or your ability to manage outcomes.

In these cases, do not proceed autonomously. Hold the order and contact the ordering professional.

 **In practice:** Follow orders as given unless you are authorized and competent to make changes. Never alter or cancel 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 complete and authorized.
- b) Pause, confirm the client’s wishes, and notify the ordering professional 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 seem right? How did you respond?

What strategies do you use (or can you learn) to effectively communicate concerns with the ordering health professional or team members?

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.

Our final lesson will look at reflection and growth in practice.

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. This cycle of reflection is crucial for continuous improvement and upholding accountability.

Reflection is a deliberate process of reviewing your experiences to:

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

By applying lessons learned, you can enhance your competence and confidence, fostering professional growth and self-awareness.



 In practice: Carry out restricted activities that require an order only when you have the education, training, and experience to 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

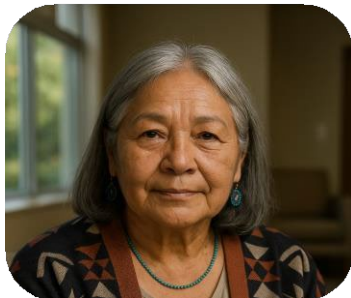
Listen to these nurses explain how reflecting on experiences improve their practice. As you listen, think about how their experiences connect to your own and what lessons you can apply in your practice.



Eli, an LPN, shares how mentoring others has shaped his approach to safe and accountable 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



Arabelle, an RPN, reflect on how self-reflection has helped her grow in practice: *“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



Nora, an RN, reflects on how she builds confidence by checking her competence and seeking support when needed. *“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.”* Nora, RN

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



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>“I don’t have time.”</i>	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>“I can’t access courses or training.”</i>	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>“I don’t know where to start.”</i>	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>“I forget to track my learning.”</i>	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.

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

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.

01/06

Which of the following is a requirement for a complete 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.

02/06

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

- a) Being able to perform any activity as long as it is ordered by a regulated 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.

03/06

What is the primary purpose of the *Acting Under Client-specific Orders* practice standard?

- 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.

04/06

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 all non-restricted activities.

05/06

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 ordering health professional 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 ordering health professional to explain the situation and seek guidance.

06/06

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.

<p>Ensures clarity, specificity, and authorization by a regulated health professional.</p>	<ul style="list-style-type: none"> a) Complete client-specific orders b) Four controls on practice c) Confirming competence d) Reflection and continuous learning e) Effective communication and collaboration
<p>Helps maintain safety by adhering to legal and professional standards, employer policy and are competent.</p>	<ul style="list-style-type: none"> a) Complete client-specific orders b) Four controls on practice c) Confirming competence d) Reflection and continuous learning e) Effective communication and collaboration
<p>Verifies that you have the required skills and knowledge to act safely.</p>	<ul style="list-style-type: none"> a) Complete client-specific orders b) Four controls on practice c) Confirming competence d) Reflection and continuous learning e) Effective communication and collaboration
<p>Encourages growth and adaptation to enhance care quality and safety.</p>	<ul style="list-style-type: none"> a) Complete client-specific orders b) Four controls on practice c) Confirming competence d) Reflection and continuous learning e) Effective communication and collaboration
<p>Facilitates teamwork and minimizes risks through clear communication and collaboration.</p>	<ul style="list-style-type: none"> a) Complete client-specific orders b) Four controls on practice c) Confirming competence d) Reflection and continuous learning e) Effective communication and collaboration

Module wrap-up and next steps

You've now explored the essentials of acting with client-specific orders: understanding what a complete order is, knowing who can provide it, applying the four controls on practice, confirming your competence, keeping client-centred care at the core, communicating and collaborating with prescribers and the team, and using reflection to guide your ongoing growth.

Key takeaways

- A complete order must be client-specific, clear and come from a regulated/authorized health professional.
- Always apply the four controls on practice before acting with an order.
- Confirm your competence and provide client-centred care.
- Communicate, clarify, and collaborate to ensure safety.
- Reflect and keep learning to grow your practice.

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 confidence, accountability and responsibility when acting with client-specific orders.

Your thoughts, please

To help us create resources that meet your needs, please complete the 2-minute survey below to let us know what you think. Your feedback will help us improve this and future resources we create for our learners. Thanks in advance!

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Answer key

Page 7

Which of the following criteria must be met for a client-specific order to be considered complete? 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 10

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 16

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 22

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 complete and authorized.
- b) Pause, confirm the client's wishes, and notify the ordering professional 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 29 – Quiz

01/06

Which of the following is a requirement for a complete 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.

02/06

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

- a) Being able to perform any activity as long as it is ordered by a regulated 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.

03/06

What is the primary purpose of the *Acting Under Client-specific Orders* practice standard?

- 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.

04/06

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 all non-restricted activities.

05/06

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06/06

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.

Complete 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.

Confirming competence - Verifies that you have the required skills and knowledge to act safely.

Reflection and continuous learning - Encourages growth and adaptation to enhance care quality and safety.

Effective communication and collaboration- Facilitates teamwork and minimizes risks through clear communication and collaboration.



Thank you for completing the module! Want to learn more?

Check out one of the other modules in the [Scope of Practice Learning Series](#).

Certificate of completion

To receive a certificate of completion, print this page and fill in your name and the date.



CERTIFICATE OF COMPLETION

**Client-specific Orders:
Safe & Accountable Practice**
Scope of Practice Learning Series

presented to

Date completed

*Thank you for completing this learning module.
Please continue to apply this knowledge
to your nursing practice.*