



Nebraska Board of Nursing

ADVISORY OPINION

OPINION: Standing Orders &
Protocols
ADOPTED: December, 2012
REVISED:
REAFFIRMED:

This Nebraska Board of Nursing advisory opinion is issued in accordance with the Nebraska Nurse Practice Act, [Neb. Rev. Stat. 38-2216 \(2\)](#). As such, this advisory opinion is for informational purposes only and is non-binding. The advisory opinions define acts, which in the opinion of the board, are or are not permitted in the practice of nursing.

Standing Orders & Protocols

The practice of nursing is defined in the Nebraska Nurse Practice Act: “Practice of nursing means the performance for compensation or gratuitously of any act expressing judgment or skill based upon a systematized body of nursing knowledge. Such acts include the identification of and intervention in actual or potential health problems of individuals, families, or groups, which acts are directed toward maintaining health status, preventing illness, injury, or infirmity, improving health status, and providing care supportive to or restorative of life and well-being through nursing assessment and through the execution of nursing care and of diagnostic or therapeutic regimens prescribed by any person lawfully authorized to prescribe. Each nurse is directly accountable and responsible to the consumer for the quality of nursing care rendered. Licensed nurses may use the services of unlicensed individuals to provide assistance with personal care and activities of daily living”. Neb. Rev. Stat. 38-2210

The scope of practice for both the RN and LPN does not include making a medical diagnosis or prescribing medical treatments or medications. The RN and LPN practice does include the execution of diagnostic or therapeutic regimens ordered by a licensed practitioner, defined in the act as “a person lawfully authorized to prescribe medications or treatments.” Neb. Rev. Stat. 38-2209 An RN may only make a nursing assessment, nursing diagnosis and implement nursing interventions. The LPN may contribute to the nursing assessment, nursing diagnosis, and may implement nursing interventions. A nurse may not practice under standing orders or protocols that require the nurse to make medical judgments outside the nurse’s scope of practice. The Nurse Practice Act confers no authority to practice medicine or surgery. Neb. Rev. Stat. 38-2218

Standing orders: means medical treatment orders generated by a licensed practitioner who identifies an action or medication that must be implemented or administered. The use of standing orders must be

documented as an order in the patient's medical record and signed by the licensed practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.

While there is significant merit to the use of standing orders, there is also the potential for harm to patients if agencies use such orders so nurses are routinely expected to make clinical decisions outside their scope of practice. This is a complex issue that requires careful consideration by agencies, physicians, nurses and other licensed health care professionals, experts in patient safety and quality improvement, and patients.

Standing orders should be clearly written to include the signs and symptoms, rather than a medical diagnosis and should include parameters for the nurse to refer and consult with the licensed practitioner. They should include the parameters under which the nurse may act in specified situations and outline the assessment, testing, and treatment a nurse may perform on behalf of the licensed practitioner. The standing orders must be in writing, dated and signed by the medical director or licensed practitioner, and reviewed and updated periodically.

Protocol: means a series of actions (which may include a number of medications) that may be implemented to manage a patient's clinical status. A protocol allows the application of specific interventions to be decided by the nurse based on the patient meeting certain criteria outlined in the protocol as long as the intervention is within the scope of practice of the nurse. A protocol includes alternative actions or "exceptions" to the prescriptive orders which allow for individual patient circumstance as assessed by the nurse. These "exceptions" are addressed by application of an algorithm that is a step-by-step procedure for solving a problem or accomplishing the intervention. An agency may, if it chooses, have protocols which are developed by licensed practitioners and are designed to standardize and optimize patient care in accordance with current clinical guidelines or standards of practice.

Registered nurses may implement a protocol issued by a licensed practitioner for a specific group of patients when a patient meets the criteria for initiating the protocol. Protocols may include both independent nursing activities and nursing activities requiring a health care provider order and collaboration. Nursing protocols should include the following content:

1. Title
2. Definition or Purpose
3. Specific population to whom the protocol applies

4. Assessment data to be obtained
5. Collaboration parameters when appropriate
6. Interventions to be implemented
7. Anticipated outcome
8. Signature of the licensed authorized prescriber who authorized implementation of the guideline

The nurse is responsible for documenting the implementation of the protocol and the nursing care provided under the protocol.

Preprinted order set: refers to a tool generally designed to assist licensed practitioners as they write orders. Order sets may include computerized programs that are the functional equivalent of hard copy preprinted order sets. Such tools may include a menu of medications or actions from which the authorized prescriber makes selections to be applied to a particular patient. They sometimes include a standard combination of medications and actions to be followed without amendment whenever the practitioner selects that order. All orders, preprinted or otherwise, in the medical record must be dated, timed, and authenticated by the person responsible for providing or evaluating the service provided.

A licensed nurse is accountable to be competent for all nursing care that he/she provides. Competence means the ability of the nurse to apply interpersonal, technical and decision-making skills at the level of knowledge consistent with the prevailing standard for the nursing activity being applied. Accountability also includes acknowledgment of personal limitations in knowledge and skills, and communicating the need for specialized instruction prior to providing any nursing activity.

References

Centers for Medicare & Medicaid Services Memorandum, October 24, 2008

Nevada BON Advisory Opinion

Update: In June 2004, the Board approved revisions to Advisory Opinion Statement #14

Alabama Board of Nursing

Kentucky BON Roles of Nurses in the Implementation of Patient Care Orders [PDF Format - 35k] to include information on the use of protocols and standing/routine orders. KY

New Hampshire BON Clinical Care Guidelines

Alabama 610-X-6-.09 Patient Care Orders History: Filed March 20, 2003. Effective April 24, 2003.

North Carolina BON Advisory Opinion

Agency for health Care Policy and Research

Ohio Joint Regulatory Statement, 2003

North Dakota Board of Nursing practice statements