COLLEGE OF
REGISTERED NURSES
OF BRITISH COLUMBIA

Scope of Practice

For Nurse Practitioners

Protecting the public by effectively regulating registered nurses and nurse practitioners

Standards, Limits and conditions

College of Registered Nurses of British Columbia

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CRNBC Standards of Practice

CRNBC is responsible under the Health Professions Act for setting standards of practice for its registrants. The CRNBC Standards of Practice are:

- Professional Standards
- Practice Standards
- Scope of Practice Standards.

Professional Standards

Professional Standards are statements about levels of performance that nurses are required to achieve in their practice. They provide an overall framework for the practice of nursing in British Columbia.

Practice Standards

Practice Standards set out requirements related to specific aspects of nurses' practice.

Scope of Practice Standards

Scope of Practice Standards set out standards, limits and conditions related to the scope of practice for registered nurses and nurse practitioners.

All CRNBC Standards are available at www.crnbc.ca

From time to time, this document may be revised to reflect changes to the standards, limits and conditions. Please check the CRNBC website www.crnbc.ca regularly for updates.

Where to Get Assistance

For further information on Scope of Practice or any nursing practice issue, contact CRNBC Practice Support at 604.736.7331 (ext. 332) or 1.800.565.6505. Email practice@crnbc.ca

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INTRODUCTION

Nurse practitioners are health professionals who have achieved the advanced nursing practice competencies at the graduate level of nursing education that are required for registration as a nurse practitioner with CRNBC. Nurse practitioners provide health care services from a holistic nursing perspective, integrated with the autonomous diagnosis and treatment of acute and chronic illnesses, including prescribing medications. The entry-level expectations for each stream of nurse practitioner practice (family, adult, pediatric) are set out in CRNBC's *Competencies Required for Nurse Practitioners in British Columbia*.

The **scope of practice**[1] for nurse practitioners in British Columbia is set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act. The Regulation specifies that nurse practitioners provide activities in accordance with **Standards, Limits and Conditions** established by CRNBC on the recommendation of the Nurse Practitioner Standards Committee.

As with all CRNBC registrants, nurse practitioners are expected to meet all CRNBC Standards of Practice: Professional Standards, Practice Standards and Scope of Practice Standards. In addition nurse practitioners must meet standards for:

- Regulatory Supervision of Nurse Practitioner Restricted Activities
- Ordering Diagnostic Services and Managing Results
- Financial Incapability Assessments
- Advanced Procedures and Activities
- Prescribing Drugs
- Opioid Agonist Therapy | Continuation Prescribing of Buprenorphine-Naloxone
- Medical Assistance in Dying
- Physician Consultation and Referral

This document:

- explains the Nurses (Registered) and Nurse Practitioners Regulation and the Health Professions Act as they pertain to nurse practitioner scope of practice
- sets out additional Standards, Limits and Conditions related to nurse practitioner scope of practice.

Nurse practitioners in B.C. practise in one of three streams of nurse practitioner practice: family, adult or pediatric. The Standards, Limits and Conditions in this document apply to all three streams of nurse practitioner practice. However, some limits and conditions apply specifically to certain streams, for example, nurse practitioners in the adult and family streams may be able to prescribe a drug that nurse practitioners in the pediatric stream cannot prescribe. Nurse practitioner streams of practice are described in Appendix B.

1 Terms defined in the Glossary (Appendix 1) are highlighted in bold type the first time they appear in this document.

PART 1: SCOPE OF PRACTICE EXPLAINED

Part 1 explains the scope of practice for nurse practitioners:

A. What the Regulation covers

B. How nursing practice is described in the Regulation

C. CRNBC Standards, Limits and Conditions

D. Controls on nursing practice.

A. What the Regulation Covers

The Nurses (Registered) and Nurse Practitioners Regulation sets out, among other things:

- Reserved titles for nurses
- A scope of practice statement
- Restricted activities for registered nurses and nurse practitioners

Reserved Titles

The Regulation states that the following titles are reserved for exclusive use by CRNBC registrants:

- Registered nurse
- Licensed graduate nurse
- Nurse
- Nurse practitioner
- Registered nurse practitioner

Only registrants who are registered with CRNBC in the nurse practitioner class can use the title "nurse practitioner" or "registered nurse practitioner." Nurse practitioners are also authorized under the Regulation to use the title "registered nurse." When nurse practitioners practise in a registered nurse role, they use the title registered nurse.[2]

2 Refer to the CRNBC Practice Standard *Appropriate Use of Titles* to understand your obligations and the potential concerns related to nurse practitioners working in registered nurse roles. A nurse practitioner who wishes to practise as a registered nurse is advised to contact a CRNBC nursing practice consultant before doing so.

For more information on titles, refer to the CRNBC Bylaws and the Practice Standard *Appropriate Use of Titles*.* Requirements related to abbreviated titles and to indicating your stream of practice (i.e., family, adult, pediatric) are included in this practice standard.

Scope Of Practice

Scope of practice refers to the activities that nurse practitioners are educated and authorized to perform. These activities are established through the legislated definition of nursing practice and are complemented by Standards, Limits and Conditions set by CRNBC.

The Regulation states that registrants of CRNBC may practise nursing. Nursing is defined as the health profession in which a person provides the following services:

- Health care for promoting, maintaining and restoring health
- Prevention, treatment and palliation of illness and injury, primarily by assessing health status, planning and implementing interventions, and coordinating health services

This definition is broad and applies to both registered nurses and nurse practitioners.

Exceptions

Nurse practitioners provide care only within their authorized scope of practice and in the practice stream in which they are registered (family, adult, pediatric), except in two situations. Nurse practitioners may provide care outside the scope of practice:

- In situations involving imminent risk of death or serious harm that arise unexpectedly and require urgent action, nurse practitioners are ethically obliged to provide the best care they can, given the circumstances and their individual **competence**.[3]
- Where a formal **delegation** process is in place. To date, no activities for nurse practitioners have been approved for delegation. Therefore, nurse practitioners are not authorized to carry out any activity outside the scope of practice of nurse practitioners. Delegation under the Health Professions Act requires an agreement between the College of Physicians and Surgeons of British Columbia (CPSBC) and CRNBC. Nurse practitioners with questions should contact the CRNBC Practice Support Department at practice@crnbc.ca.

3 Employers and nurse practitioners should not rely on the emergency exemption when an activity is considered an expectation of practice in a particular setting.

Restricted Activities

Restricted activities are clinical activities that present a significant risk of harm to the public and are therefore reserved for specified health professions only.[4] The Regulation assigns specific restricted activities to registered nurses and nurse practitioners. The scope of nurse practitioner practice builds on the scope of registered nurse practice, and therefore nurse practitioners must be familiar with the scopes of practice for registered nurses and for nurse practitioners.

The following three points will help you in understanding the Regulation in relation to scope of practice:

- Section 9 of the Regulation describes the restricted activities that can be carried out by nurse practitioners. Examples of these activities are diagnosing a disease or disorder, prescribing drugs, and ordering forms of energy such as diagnostic imaging services, ultrasound and laser.
- Nurse practitioners are also authorized to independently carry out other restricted activities for which registered nurses require an order. An example includes inserting a pessary.
- Nurse practitioners are authorized to issue an order to a registered nurse.

For more on registered nurse scope of practice, refer to CRNBC's *Scope of Practice for Registered Nurses: Standards, Limits and Conditions*.

B. How Practice is Described in the Regulation

Two Key Principles

The Health Professions Act and Nurses (Registered) and Nurse Practitioners Regulation support and clarify two key principles that CRNBC believes uphold safe nursing practice:

- The scope of practice for nurse practitioners reflects the reality of practice.
- Clear responsibility and accountability among health professionals is fundamental to the provision of safe and ethical **client** care by competent nurses.

The Regulation supports the first principle by reflecting common practice of both registered nurses and nurse practitioners (see below). It supports the second principle by clarifying responsibility and accountability of registered nurses and nurse practitioners in their practice. For example, the Regulation makes clear that certain activities may be carried out by registered nurses without an **order**, while other activities require a client-specific order. The Regulation also defines what an order is and who may give an order to a registered nurse.

4 The B.C. government is developing a master list of restricted activities. A list of proposed restricted activities is available on the provincial government website www.health.gov.bc.ca/professional-regulation. The Nurses (Registered) and Nurse Practitioners Regulation sets out the restricted activities from this list that are within the scope of practice of registered nurses and nurse practitioners.

Three Kinds of Nursing Practice

The Regulation sets out three kinds of nursing practice:

- General registered nurse practice
- Certified registered nurse practice
- Nurse practitioner practice

General Registered Nurse Practice

In carrying out general practice activities, registered nurses move from novice to expert without having to obtain any additional regulatory approval from CRNBC. General practice includes:

- Activities that are restricted and activities that are not restricted
- Activities that do not require an order and activities that require a client-specific order

Many activities that registered nurses and nurse practitioners carry out are not restricted. The Regulation includes these activities in the broad definition of nursing. They are fundamental to registered nurse and nurse practitioner practice, and many are complex. They include activities related to counselling, health promotion and prevention of some illnesses and injuries.

Sections 6 and 7 of the Regulation list the restricted activities that registered nurses may carry out as part of general practice. Nurse practitioners are authorized to carry out all the activities in Section 6 and do not require an order to carry out activities in Section 7.

Although no additional regulatory approval is needed to carry out general registered nurse practice activities, CRNBC has the authority to determine:

- Which activities are considered the practice of nursing within the scope of practice set out in the Regulation
- Any standards, limits and conditions that may apply

Registrants who are in doubt about whether some aspect of their practice falls within the scope of registered nurse practice should contact the CRNBC Practice Support Department at practice@crnbc.ca.

Certified Registered Nurse Practice

Section 8 of the Regulation describes some activities as **certified practices**. Registered nurses cannot carry out these activities until they have been certified through an education program approved by CRNBC and placed on the CRNBC certified practice register. Nurse practitioners who wish to work as a CRNBC-certified registered nurse must contact CRNBC at register@crnbc.ca to establish their eligibility and be entered on the certified practice register.

Nurse Practitioner Practice

Nurse practitioner scope of practice includes all activities within the scope of practice of registered nurses. As with registered nurses, an activity that is within the scope of practice of nurse practitioners may not be within an individual nurse practitioner's competence.

A nurse practitioner whose practice is at the level of a general registered nurse or a certified practice registered nurse would not be considered to be practising at the level of a nurse practitioner. CRNBC continuing competence requirements state that the nurse practitioner must practise at the level of a nurse practitioner.

Table 1 indicates the practice activities for each kind of nursing practice and the CRNBC regulatory requirements for each.

Table 1: Nursing Practice Activities and CRNBC Regulatory Requirements

	Practice activities	Regulatory requirements
General RN Practice	Activities that are not restricted Sections 6 and 7 restricted activities as set out in the Regulation	CRNBC Standards of Practice (RN Scope of Practice Standards, Professional Standards, Practice Standards) Registration with CRNBC in the general registered nurse class
Certified RN Practice	Section 8 restricted activities for certified practice as set out in the Regulation	CRNBC Standards of Practice (RN Scope of Practice Standards, Professional Standards, Practice Standards) Completion of certification program approved by CRNBC Registration with CRNBC and on the certified practice register
Nurse Practitioner Practice	All activities within scope of practice for general RN practice Section 9 restricted activities for nurse practitioners as set out in the Regulation	CRNBC Standards of Practice (Nurse Practitioner Scope of Practice Standards, Professional Standards, Practice Standards) Registration with CRNBC in the nurse practitioner class

C. Standards, Limits and Conditions

The Health Professions Act gives CRNBC the authority to establish, monitor and enforce standards, limits and conditions for registered nurse and nurse practitioner practice. The standards, limits and conditions for nurse practitioners are recommended to the CRNBC Board by the Nurse Practitioner Standards Committee in accordance with the Nurses (Registered) and Nurse Practitioner Regulation and CRNBC Bylaws.

- **Standard** – a desired and achievable level of performance against which actual performance can be compared. It provides a benchmark below which performance is unacceptable.

- **Limit** – specifies what nurse practitioners are not permitted to do. For example, the authority to initiate an order for blood products is limited to nurse practitioners who are working in acute and/or associated specialty care practice settings and who meet other conditions.

- **Condition** – sets out the circumstances under which nurse practitioners may carry out an activity. For example, nurse practitioners are required to complete a specific course and meet other requirements before they are authorized to order blood.

Whenever appropriate, CRNBC uses standards rather than limits and conditions to provide direction for practice.

D. Controls on Nursing Practice

There are four levels of controls on nurse practitioner's practice:

1. The first level of control is the Regulation, which sets out the scope of practice in fairly broad strokes.

2. The second level is CRNBC standards, limits and conditions, which complement and further define and limit the scope of practice set out in the Regulation.[5]

3. The third level of control is any organizational or employer policies that may restrict the practice of nurse practitioners in a particular agency or unit. Nurse practitioners providing services in or employed by an organization need to be familiar with any organizational/employer policies relevant to their practice.

4. The fourth level of control is an individual nurse practitioner's competence to carry out a particular activity.

Figure 1 on the next page illustrates the levels of controls on practice.

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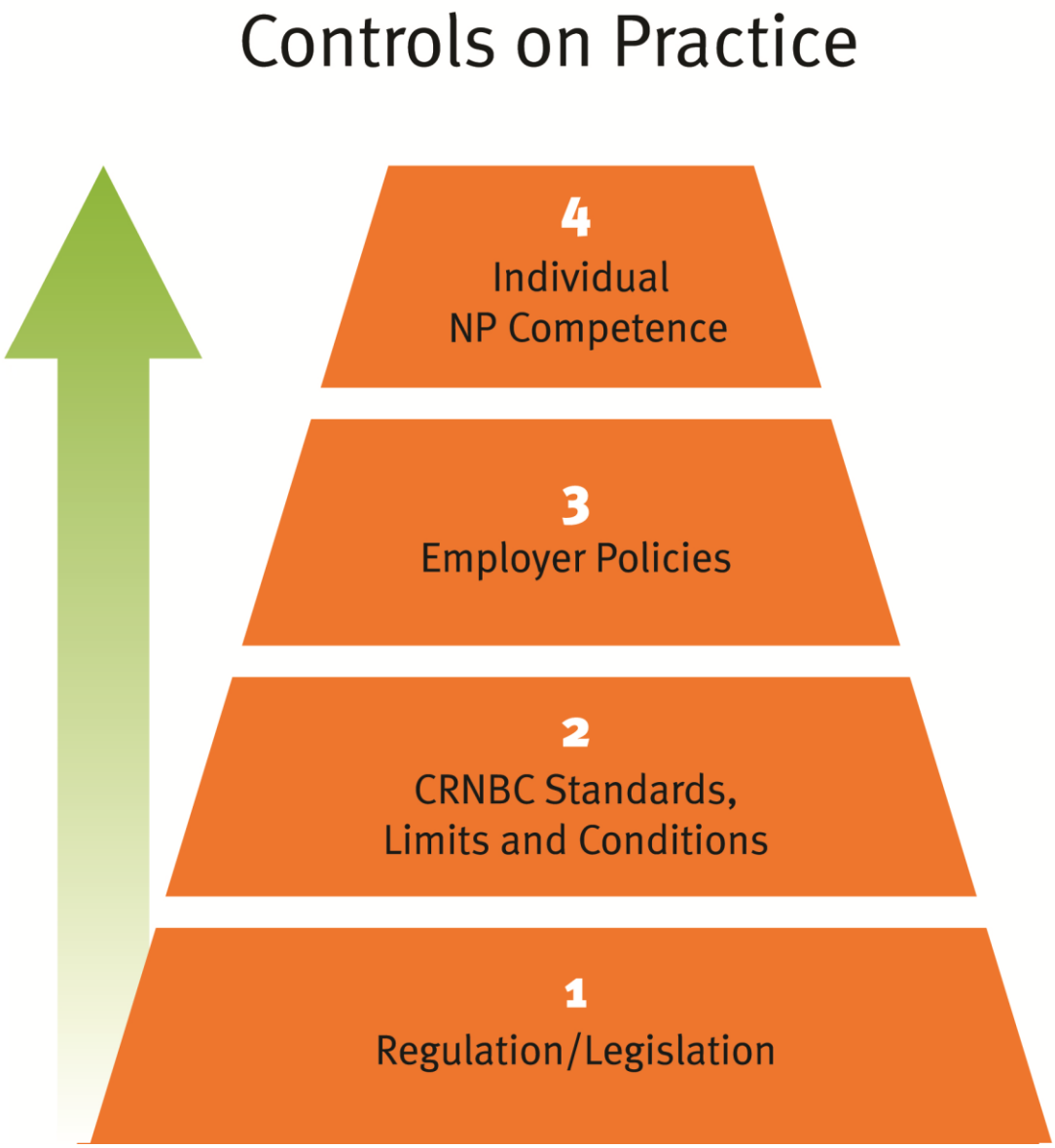
5 Nurse practitioners in certain contexts of practice may require broader authority than what is permitted in the current limits and conditions. Such nurse practitioners may apply to the CRNBC Nurse Practitioner Standards Committee. The committee will determine if the authority can be expanded and what limits and conditions may be necessary.

Figure 1: Controls on Practice



PART 2: STANDARDS, LIMITS AND CONDITIONS

Part 2 sets out the standards, limits and conditions established by the CRNBC Board for nurse practitioner practice, as recommended to the CRNBC Board by the Nurse Practitioner Standards Committee (NPSC) in accordance with the Nurses (Registered) and Nurse Practitioners Regulation and CRNBC Bylaws.

A. Regulatory Supervision of Nurse Practitioner Restricted Activities

Introduction

Regulatory supervision is the process that NPs follow to authorize students to perform restricted activities. Restricted activities NPs are authorized to carry out are listed in Section 9(1) of the *Nurses (Registered) and Nurse Practitioners Regulation* and include activities such as diagnosing diseases and disorders, ordering diagnostic tests and prescribing.

The regulatory supervision process consists of four components:

- knowing the NP student's competence
- authorizing the activities the NP student may perform
- setting the conditions for the student to perform the activities
- managing risks to the client

Standards

Standard 1

Nurse practitioners providing regulatory supervision for a nurse practitioner student performing a restricted activity listed in Section 9(1) of the Nurses (Registered) and Nurse Practitioners Regulation follow this process:

1. Determine that the student has the competence to perform the restricted activity.
2. Make a decision to authorize the restricted activity, considering at a minimum:
    - the student's stream of practice and level of experience
    - the client's health condition, needs and consent
    - the restricted activity to be performed (task factors)
    - the practice setting (changing circumstances, institutional/employer policy)
3. Establish with the student, the conditions under which the restricted activity may be performed, including:

- reviewing the student's assessments of clients' health, differential diagnoses and/or diagnosis
- reviewing/discussing recommendations and treatments/interventions made or to be made
- signing all prescriptions and diagnostic tests
- being on site or readily available to consult and/or collaborate to protect the interests of the client

4. Act to manage risks to the client. Anticipate and manage potential and actual risks which originate from the activities of the nurse practitioner student being supervised. This includes, but is not limited to, reviewing and revising supervision decisions to ensure client interests are protected.

Standard 2

Nurse practitioners only agree to supervise the performance of those restricted activities that are within their own individual competence.

B. Diagnosing and Health Care Management

I. Ordering Diagnostic Services and Managing Results

Introduction

Diagnostic services that NPs order include:

- laboratory,
- miscellaneous services (such as cardiac stress tests, echocardiograms, Holter monitoring, amniocentesis, etc.), and
- imaging (including x-ray, ultrasound, nuclear medicine, computerized tomography scans and magnetic resonance imaging)

Standards

Standard 1

Nurse practitioners order diagnostic services, provide appropriate follow-up, diagnose and manage diseases, disorders and conditions within the scope of practice for nurse practitioners and their individual competence.

Standard 2

Nurse practitioners engage in evidence informed diagnosing and management considering best practice guidelines and other relevant guidelines and resources.

Standard 3

Nurse practitioners:

- provide the appropriate clinical information when ordering diagnostic tests
- establish mechanisms within their practice setting(s) to track and follow-up on diagnostic test results
- ensure clients are informed, in a timely manner, of diagnostic test results, implications and needed follow-up
- communicate, as needed, diagnostic test results with key providers involved in the client's care

Standard 4

Nurse practitioners document follow-up (and follow-up attempts) with the client and key providers on significant diagnostic test results, next steps and the care and treatment needed.

Limits and Conditions

Nurse practitioners do not take responsibility for final interpretation of medical imaging studies. Appropriate treatment may be initiated while awaiting final interpretation by the diagnostic radiologist.

II. Advanced Assessments

Nurse practitioner educational programs commonly prepare graduates with the competencies to independently conduct advanced assessments such as cognitive assessments. Nurse practitioners conducting financial incapability assessments do so consistent with the following limits and conditions. Nurse practitioners wishing to conduct advanced assessments for which they have not had formal theoretical and clinical learning should contact CRNBC Practice Support at practice@crnbc.ca

Financial Incapability Assessments

Nurse practitioners may act as qualified health care providers under Part 2.1 of the Adult Guardianship Act for the purpose of conducting the functional component of a financial incapability assessment in accordance with Part 3 of the Statutory Property Guardianship Regulation under that Act, if they successfully complete the Ministry of Health course "A Guide to the Certificate of Incapability Process under the Adult Guardianship Act."

Nurse practitioners acting as qualified health care providers under Part 2.1 of the Adult Guardianship Act must also follow the Ministry of Health and Public Guardian and Trustee's procedural guide, "A Guide to the Certificate of Incapability Process under the Adult Guardianship Act."

III. Advanced Procedures and Activities

Introduction

Advanced procedures and activities encompass:

- the restricted activities set out in Section 9 of the *Nurses (Registered) and Nurse Practitioner Regulation*,
- activities that are not restricted, and/or
- non-core procedures and activities[6] for nurse practitioners as defined by the British Columbia Medical Quality Initiative for Nurse Practitioner Clinical Privileges

Standards

Standard 1

Before incorporating an advanced procedure or activity into their practice, nurse practitioners consider:

- their foundational education in relation to the procedure or activity
- employer support that ensures the required organizational infrastructure is in place to support the nurse practitioner and the practice setting to incorporate the activity into practice
- inclusion and exclusion criteria for the client population
- risks to clients that are associated with performing the activity
- measures that would be taken to mitigate risks and make the activity as safe as possible
- how nurse practitioners will manage outcomes both intended and unintended
- how outcomes would be tracked and evaluated
- availability of best practice guidelines or other evidence-based tools

6 The British Columbia Medical Quality Initiative defines *non-core procedures and activities* as those which are outside of the core activities and that require further training or demonstration of skill. Core activities are defined as those procedures or activities that the majority of practitioners in the specialty perform and inherent activities/procedures requiring similar skill sets.

Standard 2

Nurse practitioners perform advanced procedures and activities within their level of competence having acquired the knowledge and skill through additional education[7].

Standard 3

Nurse practitioners perform advanced procedures and activities only when performance occurs with *sufficient frequency* to maintain competence.

Limits and Conditions

Nurse practitioners carrying out advanced procedures and activities including non-core procedures and activities, do so consistent with the following limits and conditions. Nurse practitioners who are uncertain about whether a procedures or activity is within the scope of practice should contact CRNBC Practice Support at practice@crnbc.ca

Blood and Blood Products

Nurse practitioners order Immune Globulin in accordance with BC Centre for Disease Control guidelines.

All other blood and blood products:

Nurse practitioners order blood and blood products after:

- successfully completing additional education such as certification in transfusion medicine in the nationally recognized course Bloody Easy Lite and
- reviewing the following resources of the Ontario Regional Blood Coordinating Network and being knowledgeable with respect to their content:
    - Bloody Easy 3: Blood Transfusions, Blood Alternatives and Transfusion reactions. A Guide to Transfusion Medicine
    - Blood Easy Coagulation Simplified

Nurse practitioners order blood and blood products in accordance with the B.C. Provincial Blood Coordinating Office guidelines.

Setting Fractures and Reducing Dislocations

Nurse practitioners are limited to setting a closed, simple fracture of a bone.

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7 Additional education is structured education (e.g. workshop, course, program of study) designed so that nurse practitioners can attain the competencies required to carry out a specific activity as part of nurse practitioner practice. Additional education builds on the entry-level competencies of nurse practitioners, identifies the competencies expected of learners on completion of the education, includes both theory and application to practice, and includes an objective, external evaluation of learners' competencies on completion of the education. The terms does not refer to a course or program approved by CRNBC for CRNBC certified practice.

Nurse practitioners are limited to reducing dislocations of the fingers and toes (digits of the upper and lower extremities).

Nurse practitioners have authority to reduce anterior shoulder dislocations on the condition that the NP has the competence to interpret the x-ray if clinically indicated.

Ordering or Applying Hazardous Forms of Energy

Nurse practitioners do not apply x-rays.

Nurse practitioners do not give an order or apply laser for the purpose of destroying tissue.

Cosmetic Treatments

Nurse practitioners do not order or apply anti-aging treatments such as Botox Cosmetic® and facial fillers.

C. Prescribing Drugs

Standards

Standard 1

Nurse practitioners prescribe drugs within nurse practitioners' scope of practice[8] and individual competence within that scope of practice and the stream in which the nurse practitioner is registered to practice (family, adult, pediatric).

Standard 2

Nurse practitioners are solely accountable for their prescribing decisions including when responding to requests for continuation of prescriptions ordered by another prescriber.

Standard 3

Nurse practitioners prescribe from provincial Drug Schedules I, IA (Controlled Prescriptions) and II (B.C. Pharmacy Operations and Drug Scheduling Act www.bclaws.ca) and in accordance with:

- CRNBC Standards of Practice, and
- the Controlled Prescription Program of the College of Pharmacists of British Columbia

8 As per CRNBC's *Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions*

Standard 4

Nurse practitioners undertake medication reconciliation to ensure accurate and comprehensive medication information is communicated consistently across health care transitions.

Standard 5

Nurse practitioners engage in evidence-informed prescribing and consider best practice guidelines and other relevant resources when prescribing for clients, including complementary or alternative health therapies.

Standard 6

Nurse practitioners participate in the Canadian Adverse Drug Reaction Reporting Program and also report adverse reactions to vaccines.

Standard 7

Nurse practitioners meet the following expectations when prescribing drugs:

i. Consider the client's health history (including mental health history, substance use, addiction history, and family history) lifestyle, circumstances, age/gender, current health status and perspective and other relevant factors.

ii. Undertake and document a clinical evaluation including an appropriate history, physical examination and review of relevant tests, imaging and specialist reports.

iii. Review the client's PharmaNet medication profile when access is available[9], and where applicable other data sources (e.g. electronic health record medication profile).

iv. Note drug allergies ensuring that they are prominently highlighted at the front of the record or as appropriate.

v. Complete prescriptions accurately and completely, including:

- Date of issue
- Client name, address (if available) and date of birth.
- Client weight if appropriate.
- Name, strength and dosage form of the substance and the quantity prescribed and quantity to be dispensed. Note: If the prescriber intends to prohibit generic substitution, it must be done in accordance with the Health Professions Act Chapter 183, Part 2.2.

9 Nurse practitioners must register as soon as possible with the Ministry of Health for Access to PharmaNet program appropriate to the practice sites where they will be prescribing.

- Directions for use – refers to the frequency or interval or maximum daily dose, route of administration and the duration of drug therapy.

- Directions for number of allowable refills and interval between refills as appropriate. If a prescription includes more than one drug, any drug that may be refilled must be clearly identified. If all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug.

- Prescriber's name, address, telephone number and written (not stamped) signature, including unique nurse practitioner identifier/number (i.e., prescribing number).

- For prescriptions sent by facsimile (fax)[10] to a pharmacy, in accordance with the College of Pharmacy Bylaws, Community Pharmacy Standards of Practice Section 6(1) (a-c):

  a. the prescription must be sent only to the pharmacy of the client's choice with no intervening person having access to the prescription authorization;

  b. the prescription must be sent directly from the prescriber's office or directly from a health institution for a client of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy; and

  c. the prescription must include all information listed above and in addition must include: time and date of transmission; name and fax number of the pharmacy intended to receive the transmission; and the practitioner's phone number, fax number and unique identifier.

  Document the prescription on the client record, including the informed consent process, treatment goal and/or diagnosis and/or clinical indication.

vi. Inform client, as appropriate, of pharmacist's authority to adapt (change, renew, substitute) a prescription and:

- ensures that the client understands when it is necessary to see the nurse practitioner for assessment, in particular, if the client is receiving drugs for chronic conditions/indications;

- collaborates and communicates, as appropriate, with a pharmacist in advance of providing a client with a prescription;

- indicates the appropriate number of refills for drugs for chronic conditions/indications;

- writes "do not renew" or "do not alter" if, in the nurse practitioner's professional opinion, the pharmacist-initiated adaption would be clinically inappropriate (cannot stamp or pre- print such an order); and

- ensures that upon receipt of a notification form (College of Pharmacists of British Columbia Policy #58 Appendix D) indicating a pharmacist initiated prescription adaption

10 Prescriptions for drugs that are part of the Controlled Prescription Program cannot be faxed. Prescriptions for long term care and extended care licenced facility patients do not require the use of CPP forms and may be faxed to the authorized community pharmacy.

for the nurse practitioner's client, that the form is appropriately noted and placed in the client record in a timely fashion

vii. Provide educational information to clients about prescription and non-prescription drugs that include information regarding:

- the expected action of the drug;
- the importance of adherence to prescribed frequency and duration of the drug therapy;
- potential side-effects;
- signs and symptoms of potential adverse effects (e.g., allergic reactions) and action to take if they occur;
- potential interactions between the drug and certain foods, other drugs or substances;
- specific precautions to take or instructions to follow; and
- recommended follow-up.

Monitor and document the client's response to drug therapy and make appropriate follow- up recommendations.

Standard 8

Before initiating or continuing the prescribing of controlled drugs and substances, nurse practitioners:

- register with the Ministry of Health for the Access to PharmaNet program appropriate to the practice sites where they will be prescribing controlled drugs and substances
- review the client's PharmaNet medication profile and where applicable other data sources (e.g. electronic health record medication profile)
- consider best practice prescribing guidelines associated with the context or contexts[11] for which they are prescribing controlled drugs and substances. (For example; the Canadian Guideline for Safe and Effective Uses of Opioids for Chronic Non Cancer Pain.)*
- consider contraindications and potential drug interactions in particular with the ongoing use of psychotropic, sedating, or narcotic medication. Avoid co-prescribing whenever possible.
- document the indication and duration for which the controlled drug is being prescribed, the goals of treatment and the rationale for their use over alternatives (if applicable). At follow-up visits treatment goals should be reviewed and revised as needed

11 For the contexts of pain, these include:
- Acute pain is defined as pain with a duration lasting less than three months.
- Palliative pain is defined as pain experienced as a result of an advanced illness and includes cancer pain.
- Chronic non-cancer pain is defined as pain with a duration lasting greater than three months.

- advise and ensure clients are aware of medical complications and side effects as well as risks including physical tolerance, psychological dependence, addiction, and diversion and provide clients with education and strategies for minimizing risk (e.g., safe storage and disposal, pill counts)
- recognize that the risk is strongly associated with dose
- incorporate specific evidence-informed strategies for assessing, managing and monitoring the risks of abuse, addiction and diversion including a treatment agreement
- prescribe the minimum amount of medication necessary balancing the quantity of medication prescribed with the need to reassess the client and the risk of harm that may result if the client runs out of medication
- adopt, as appropriate, pharmacovigilance strategies such as pill counts and urine drug screens

Standard 9

When prescribing controlled drugs and substances nurse practitioners assess the client in person. Exceptions may be made only in circumstances when the client is:

- known to the nurse practitioner and/or
- is being assessed in person by another health care provider

Standard 10

Nurse practitioners meet the following requirements:

- Store all prescription pads including those provided by the Controlled Prescription Program in a secure and locked area that is not accessible to the public nor to health care staff
- Report controlled prescription pad loss, theft or misuse to CRNBC, the College of Pharmacists of BC and the BC Privacy Commissioner. In the case of theft, a report must also be made to the police
- Return controlled prescription pads to CRNBC when changing status to non-practicing or inactive, if on extended leave for longer than 12 months, or if moving out of BC
- Do not provide any person with a blank, signed prescription
- Ensure accurate client documentation, client confidentiality, controlled prescription pad security, and control drug diversion by storing the duplicate copy of the prescription form with the client health record, not within the controlled prescription pad

Standard 11

Nurse practitioners do not prescribe controlled drugs and substances for themselves or a family member.

For other medications (non-controlled drugs and substances), nurse practitioners do not self- prescribe or prescribe for a family member except for a minor/episodic condition and only when there is no other prescriber available. See CRNBC Practice Standard *Boundaries in the Nurse-Client Relationship*.

Limits and Conditions on Compounding, Administering, Dispensing and Medication Inventory Management

Nurse practitioners are authorized to compound[12], administer and dispense all drugs that they are authorized to prescribe.

For drugs that nurse practitioners do not have the authority to prescribe nurse practitioners are authorized to compound, administer and dispense them (with the exception of the dried leaf cannabis product and anti-aging products) as long as they have a physician order.

For the dried leaf cannabis product see Limits and Conditions No. 6 (AHFS 28:00) Central Nervous Agent of this prescribing standard.

For anti-ageing products see Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions, Section II, Advanced Interventions, Cosmetic Treatments.

In most circumstances drugs will be dispensed by a pharmacist. Nurse practitioners who dispense medications are required to meet the CRNBC Practice Standard Dispensing Medications.*

Nurse practitioners who manage a drug inventory follow the CRNBC Practice Standard Medication Inventory Management.* Additionally, CRNBC has prepared a resource Nurse-Managed Medication Inventory: Information for Employers* that provide advice to employers on medication inventory management. The Nurse-Managed Medication Inventory: Information for Employers may be useful to nurse practitioners working in certain settings such as remote settings. Nurse practitioners managing a medication inventory need to be particularly mindful of legal requirements related to controlled drugs and substances.

12 Compounding has a narrow definition in nursing practice: “to mix a drug with one or more other ingredients” *Nurses (Registered) and Nurse Practitioner Regulation* Definitions Section 1.

Limits and Conditions

Limits and Conditions by Drug Category

Commonly prescribed drugs are listed in the limits and conditions by therapeutic category. Drugs categorized using the American Hospital Formulary Service (AHFS) Drug Information * classification system.

Drug categories where there are no exceptions, and nurse practitioners may prescribe all drugs in these categories, include:

- **(AHFS 4:00) Antihistamine Drugs;**
- **(AHFS 32:00) Contraceptives (foams, devices);**
- **(AHFS 40:00) Electrolytic, Caloric and Water Balance;**
- **(AHFS 48:00) Respiratory Tract Agents;**
- **(AHFS 56:00) Gastrointestinal Drugs;**
- **(AHFS 86:00) Smooth Muscle Relaxants; and**
- **(AHFS 88:00) Vitamins.**

A drug category with the letters C (continuation prescribing only) and/or O (cannot prescribe) mean there are restrictions on nurse practitioner prescribing. From some of these, there may be an "exemption" to the overall level of authority.

Continuation prescribing means that a physician in British Columbia initiates the drug therapy and the nurse practitioner assumes responsibility and authority for the continuation of the drug therapy, including ongoing assessment and monitoring, re-ordering and/or making adjustments to the drug therapy, and consultation and/or referral as needed.

Code:

O cannot be prescribed
C continuation prescribing only

Any drugs that are **not** specifically identified with an "O" or a "C" **can** be prescribed by nurse practitioners as long as the nurse practitioner adheres to CRNBC's standards of practice and nurse practitioners' scope of practice[13] and individual competence within that scope of practice and the stream in which the nurse practitioner is registered to practice (family, adult, pediatric).

13 As per CRNBC's *Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions*

1. (AHFS 8:00) Anti-infective Agents

C Anti-tuberculosis agents

O Chronic hepatitis drugs (e.g., Interferon)

C HIV drugs – limited to nurse practitioners who undertake both:

i. additional education offered/approved by the B.C. Centre for Excellence in HIV/AIDS (BC-CfE) or its equivalent; and
ii. a clinical practicum offered by the BC-CfE.

The following conditions also apply:

i. the nurse practitioner must use current BC-CfE guidelines;
ii. ii) the nurse practitioner must have a minimum of five patients in his or her practice requiring HIV/AIDS care;
iii. the nurse practitioner must keep evidence on file of yearly related professional development activities; and
iv. clients' under the care of nurse practitioners will be reviewed by a consulting HIV-treating physician at least once a year.

2. (AHFS 10:00) Anti-Neoplastic Agents

C For all anti-neoplastic agents and limited to nurse practitioners working in multidisciplinary oncology settings at the B.C. Cancer Agency (BCCA) or affiliated clinics under the following conditions:

i. completion of both the BCCA/General Practitioners in Oncology (GPO) education program or the equivalent and relevant clinical learning;
ii. write a minimum of 100/year of chemotherapy prescriptions and
iii. keep evidence on file of ongoing/yearly professional development activities in oncology therapeutics.

Exemption: Nurse practitioners (family, adult) may prescribe the following anti-neoplastic agents without meeting the above limit and conditions:

C Methotrexate – Prescribing is limited to adult clients only (for inflammatory disease)

C Tamoxifen and Aromatase Inhibitors – Prescribing is limited to adult clients who are on BCCA Protocol for Adjuvant Breast Cancer.[14] Note: Prescription must include the BCCA protocol code.

3. (AHFS 12:00) Autonomic Drugs

14 Resources available at www.bccancer.bc.ca
- Cancer Management Guidelines: Use of Adjuvant Hormonal Therapy (Breast Cancer). Search *Adjuvant Hormonal Therapy*.
- Cancer drug information. Search *Cancer Drug Manual*.
- Cancer education. Search Breast Cancer Nursing Education Resource.

- C Antiparkinsonism agents

- O Depolarizing and non-depolarizing skeletal muscle relaxants - **Exemption:** NPs who meet CRNBC's requirements to provide medical assistance in dying (MAiD) will be able to prescribe neuromuscular blocking agents that are part of the BC MAiD protocol for the sole purpose of providing medical assistance in dying.

- O Ergot alkaloids

4. (AHFS 20:00) Blood Formers and Coagulators

- C Hematopoietic growth factor

- O Thromboembolytic enzymes – **Exemption**: Nurse practitioners in acute care settings have authority to initiate prescribing to clear plugged venous lines and pleural tubes.[15]

5. (AHFS 24:00) Cardiovascular Drugs

- C Anti-arrhythmics – **Exemption**: Nurse practitioners (family, adult) have full authority to initiate prescribing under the following conditions:

  i. client is an adult;
  ii. nurse practitioner is working in an acute or specialty care setting;
  iii. nurse practitioner uses the same **decision support tool** (clinical guideline/protocol) used by other providers in the practice setting to manage the care.

6. (AHFS 28:00) Central Nervous Agents

Nurse practitioners do not prescribe controlled drugs and substances for self-injection by the client.

Nurse practitioners who incorporate controlled drugs and substances prescribing into their practice will have:

i. successfully completed one of the following foundational courses accepted by CRNBC in controlled drugs and substances prescribing:,

   University of Ottawa Continuing Educational Development of NPs Prescribing Narcotics and Controlled Substances
   http://cpd.np-education.ca/?post_type=products&p=36

   Athabasca University: Prescription and Management of Controlled Drugs and Substances
   http://fhd.athabascau.ca/programs/pd/

   Saskatchewan Polytechnic Controlled Drugs and Substances Act (CDSA) online module
   http://saskpolytech.ca/programs-and-courses/continuing-

15 Nurse practitioners are expected to use the same protocol for this procedure as used by other providers in the same setting.

education/programs.aspx?p=mult&c=2421

ii. completed CRNBC's Nurse Practitioner Registrant Learning Resource for nurse practitioner prescribing of controlled drugs and substances

iii. met the required CRNBC Competencies for the Prescribing of Controlled Drugs and Substances for the context or contexts for which they are prescribing

iv. completed additional education[16] in prescribing for the management of non-cancer pain.

Note: See Section D. Opioid Agonist Therapy | Continuation Prescribing of Buprenorphine-Naloxone for additional education requirements for opioid substitution therapy prescribing.

- O General anaesthetics - **Exemption:** NPs who meet CRNBC's requirements to provide medical assistance in dying (MAiD) will be able to prescribe the anaesthetics that are part of the BC MAiD protocol for the sole purpose of providing medical assistance in dying.
- O Amphetamine and its salts – **Exemption:** Continuation prescribing for Dextroamphetamine to be prescribed only for the treatment of Attention Deficit Hyperactivity Disorder in children.
- O Benzphetamine and its salts
- O Methamphetamine and its salts
- O Phenmetrazine and its salts
- O Phendimetrazine and its salts
- O Barbiturates - **Exemption**: NPs who meet CRNBC's requirements to provide medical assistance in dying (MAiD) will be able to prescribe the barbiturates that are part of the BC MAiD protocol for the sole purpose of providing medical assistance in dying.
- C Buprenorphine-Naloxone (See Standard D. Opioid Agonist Therapy | Continuation Prescribing of Buprenorphine-Naloxone)
- O Cannabis, its preparations, derivatives and similar synthetic preparations
  Nurse practitioners are not authorized to prescribe, issue a medical document for, dispense, compound, or administer the dried cannabis leaf product.
- O Coca
- O Heroin

16 Additional education is structured education (e.g. workshop, course, program of study) designed so that nurse practitioners can attain the competencies required to carry out a specific activity as part of nurse practitioner practice. Additional education builds on the entry-level competencies of nurse practitioners, identifies the competencies expected of learners on completion of the education, includes both theory and application to practice, and includes an objective, external evaluation of learners' competencies on completion of the education. The terms does not refer to a course or program approved by CRNBC for CRNBC certified practice.

- O Ketamine
- O Opium
- O Methadone
- O Meperidine
- O Sodium Oxybate (Xyrem)
- O Methylphenidate (Ritalin) – **Exemption:** Continuation prescribing for the treatment of Attention Deficit Hyperactivity Disorder in children.
- O Dextroamphetamine – **Exemption:** Continuation prescribing for the treatment of Attention Deficit Hyperactivity Disorder in children.

7. (AHFS 52:00) Eye, Ear, Nose and Throat Preparations

- C Antiglaucoma agents
- O Ophthalmologic steroids

8. (AHFS 60:00) Gold Compounds

- O Gold Compounds

9. (AHFS 68:00) Hormones and Synthetic Substitutes

- O Androgen/anabolic steroids (**Exemption:** Testosterone[17]-see below condition)

  Nurse practitioners who incorporate the prescribing of testosterone into their practice will have met the CRNBC Competencies for the Prescribing of Controlled Drugs and Substances for the context or contexts for which they are prescribing.

- O Infertility drugs (e.g., gonadotropin-releasing hormones)
- O Pituitary (anti-diuretic) (e.g., vasopressin) – **Exemption:** May be prescribed by nurse practitioners (family, pediatric) for children with bedwetting
- O Human growth hormone

10. (AHFS 76:00) Oxytocics

- O Oxytocics

11. (AHFS 80:00) Serums, Toxoids and Vaccines

17 Note that Testosterone is a targeted substance under the Food and Drug Regulations.

Blood products – See Section B: Limits and Conditions on Advanced Interventions

12. (AHFS 84:00) Skin and Mucous Membrane Agents

C Topical fluorouracil in adults

C Psoralens (Methoxsalen) in adults

O Oral retinoids (e.g. Acitretin)

13. (AHFS 92:00) Miscellaneous

O Immunomodulators (biologic response modifiers)

O Botox Cosmetic® – See Section B: Limits and Conditions on Advanced Interventions.

D. Opioid Agonist Therapy | Continuation Prescribing of Buprenorphine-Naloxone

Scope of Practice Standards for Nurse Practitioners

Scope of Practice Standards establish the standards, limits and conditions for nurse practitioner practice. They link with other standards, policies and bylaws of CRNBC and of all legislation relevant to nurse practitioner practice.

Introduction

Buprenorphine is a controlled drug under the *Controlled Drugs and Substances Act*. Prescribing the drug occurs in the context of addiction treatment, which is a complex emerging area of practice for nurse practitioners.

Standards

Nurse practitioners prescribing buprenorphine-naloxone must meet the regulatory requirements for NP prescribing of controlled drugs and substances in British Columbia. See the NP Prescribing Standards, Limits and Conditions in the *NP Scope of practice document*.

Nurse practitioners must have the requisite knowledge about the intended impacts and side effects of buprenorphine-naloxone and its role in addiction treatment.

Nurse practitioners treating substance use disorders must be familiar with the diagnosis and management of common mental illness and be aware of the treatment resources in their community. Nurse practitioners will document the discussion with the patient regarding the availability and benefits of biopsychosocial support.

Before continuation prescribing buprenorphine-naloxone nurse practitioners must:

- undertake a comprehensive psychosocial and physical assessment of the client using the DSM-5 diagnosis of opioid disorders or DSM-IV-TR diagnosis of opioid dependence and document accordingly, and/or confirm the assessment with the prescriber who initiated the drug
- review the client's current medication profile through PharmaNet
- undertake a best possible medication history with the client
- document review of PharmaNet on the client's chart, and
- develop treatment plans with treatment goals, in collaboration with the client, to direct client care.

Nurse practitioners must prescribe buprenorphine dispensed daily under the supervision of a healthcare professional (daily witnessed ingestion) until the client has sufficient clinical stability and is able to safely store buprenorphine-naloxone take-home doses.

Nurse practitioners must write the continuation buprenorphine-naloxone prescription on a duplicate Controlled Prescription Program pad, specifying start and stop dates and indicating dispense with ingestion or carry doses.

When prescribing buprenorphine-naloxone, nurse practitioners implement urine drug testing protocol including supervised random testing.

Limits and Conditions

Nurse practitioners are limited to **continuation only** prescribing of buprenorphine-naloxone.

Nurse practitioners continuation prescribing buprenorphine-naloxone must have completed:

- additional education[18] such as the following on-line educational module on the prescribing of buprenorphine-naloxone www.suboxonecme.ca or the equivalent, and including a preceptorship, of a minimum of two half-days length, under the guidance of a practitioner with expertise in the prescribing of buprenorphine-naloxone, the treatment of clients with substance use disorders and a license to prescribe methadone

The preceptorship needs to cover the competencies associated with initiation, dosing, writing prescriptions, urine drug testing, carry policy, counselling and documentation.

Resources for the prescribing of buprenorphine-naloxone

Guidelines of the College of Physicians and Surgeons of BC including:

- the Methadone and Buprenorphine Clinical Practice Guidelines
- the professional standard on Safe Prescribing of Drugs with Potential for Misuse/Diversion

The **Centre for Addiction and Mental Health** in Ontario offers both an introductory course in buprenorphine prescribing:

- Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians

And a range of introductory and advanced courses in the treatment of clients with substance use disorders:

- CAMH Educational Courses

18 Additional education is structured education (e.g. workshop, course, program of study) designed so that nurse practitioners can attain the competencies required to carry out a specific activity as part of nurse practitioner practice. Additional education builds on the entry-level competencies of nurse practitioners, identifies the competencies expected of learners on completion of the education, includes both theory and application to practice, and includes an objective, external evaluation of learners' competencies on completion of the education. The terms does not refer to a course or program approved by CRNBC for CRNBC certified practice.

The **BC Centre for Substance Use** is in progress with development of a guideline for the clinical management of opioid disorders as well as an on-line course on substance use disorders and working effectively in treatment with clients.

The RACE Line

RACE is a program that provides family physician and nurse practitioner access to specialist consultation by telephone. The program's goal is to improve communication and knowledge transfer between primary care providers and specialists.

Consultation is available province-wide in a wide variety of specialties including addiction treatment, with some variability by health region. Additional information including downloadable apps can be found at www.raceconnect.ca or tel: (604) 696-2131 or 1-877-696-2131.

E. Medical Assistance in Dying

Scope of Practice Standards establish the standards, limits and conditions for nurse practitioner practice. They link with other standards, policies and bylaws of CRNBC and all legislation relevant to nurse practitioner practice.

Introduction

In accordance with the Criminal Code of Canada and provincial legislation, under certain limited circumstances, nurse practitioners may provide a person with medical assistance in dying (MAiD).

In addition to meeting these Scope of Practice Standards, nurse practitioners contemplating participation in medical assistance in dying need to confer with their employer about their employer's requirements.

Nurse practitioners are encouraged to seek the guidance of legal counsel or legal advice from the Canadian Nurses Protective Society. Nurse practitioners may also contact practice support at CRNBC to discuss professional and ethical obligations.

The nurse practitioner role in medical assistance in dying under the Criminal Code can encompass:

- determining the eligibility of the person requesting medical assistance in dying based on the eligibility criteria established in the Criminal Code
- providing MAiD by administering the medical assistance in dying substances to a person, at their request, that causes their death
- providing MAiD by prescribing[19] and/or providing the medical assistance in dying substances to a person, at their request, so that they may self-administer the substance and in doing so cause their own death
- aiding in the provision of medical assistance in dying by a medical practitioner or another nurse practitioner[20]

Conscientious Objection

Nothing in the Criminal Code compels nurse practitioners to aid in the provision of medical assistance in dying, determine eligibility for, or provide medical assistance in dying. A nurse practitioner may have moral or religious beliefs and values that differ from those of a client. Nurse practitioners who have a conscientious objection to medical assistance in dying may arrange with their employer to refrain from aiding in the provision of, assessing eligibility for, or providing MAiD.

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19 Nurse practitioners are authorized to compound, administer and dispense all the drugs that they are authorized to prescribe. Compounding has a narrow definition in nursing practice: "to mix a drug with one or more other ingredients" *Nurses (Registered) and Nurse Practitioner Regulation* Definitions Section 1.

20 Nurse practitioners aiding in the provision of medical assistance in dying by a medical practitioner or nurse practitioner will adhere to the Medical Assistance in Dying Registered Nurse Scope of Practice Standards.

Under CRNBC's *Duty to Provide Care* practice standard, nurse practitioners who have a conscientious objection to medical assistance in dying are required to follow the standards which include the requirement for nurse practitioners with a conscientious objection to take all reasonable steps to ensure that the quality and continuity of care for clients are not compromised.

To refrain from aiding in the provision of, determining eligibility for, or providing medical assistance in dying, nurse practitioners with a conscientious objection must notify their organization as soon as the client requests medical assistance in dying. Nurse practitioners are required to ensure a safe transfer of care to an alternate provider that is continuous, respectful and addresses the unique needs of a client.

Determining Eligibility for Medical Assistance in Dying

Under the Criminal Code, the process for providing medical assistance in dying requires the assessment of two independent medical assessors one of whom must be the person prescribing and administering the medical assistance in dying substances. Only a nurse practitioner registered in British Columbia or a physician may be a medical assessor.

Both of the medical assessors must agree in writing that the person requesting medical assistance in dying meets the criteria for MAiD as set out by the Criminal Code, which includes that the person has a grievous and irremediable medical condition causing suffering that is intolerable to the person. A request for medical assistance in dying is contextual to the person's medical condition, its natural history and prognosis, treatment options and the risks and benefits associated with each option. Nurse practitioners are responsible to ensure that the person requesting medical assistance in dying understands such factors and is able to communicate a reasoned decision based on that understanding.

Under the Criminal Code, both medical assessors must be independent of each other. To be considered independent, each of the medical assessors must:

- not be a mentor to the other practitioner or responsible for supervising their work
- not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request
- not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

Proxy for Signing Consent if the Person Requesting Medical Assistance in Dying is Unable to Sign

The Criminal Code requires that if the person requesting medical assistance in dying has the mental capacity to make a free and informed decision with respect to their health, but is physically unable to sign and date the request for medical assistance in dying, another person – who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a

recipient, in any other way, of a financial or material benefit resulting from that person's death – may do so in the person's presence, on the person's behalf and under the person's express direction.

Witnessing Medical Assistance in Dying Requests

The Criminal Code requires that a person's request for medical assistance in dying must be made in writing, in the presence of two independent witnesses who must then also sign the request.

To be considered independent, a witness:

- must be at least 18 years of age
- must understand the nature of the request for medical assistance in dying
- must not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death
- must not be an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides
- must not be directly involved in providing health care services to the person making the request
- must not directly provide personal care to the person making the request

Standards

1. Nurse practitioners will have a complete and full discussion with the person about medical assistance in dying that provides the person with the information required to make informed decisions about medical assistance in dying, including information about the means that are available to relieve the person's suffering, including palliative care, and communicate this information in a way that it is easily understood by the person.

2. Nurse practitioners must inform the client requesting medical assistance in dying of the following and the information must be included in the client's medical record with a copy provided to the client:

    - the client's diagnosis and prognosis
    - feasible alternatives (including comfort care, palliative care and pain control)
    - option to withdraw the request for medical assistance in dying at any time
    - risks of taking the prescribed substances intended to cause death

3. Nurse practitioners assess the cultural and spiritual needs and wishes of the person seeking medical assistance in dying and explore ways the person's needs could be met within the context of the care delivery.

4. Nurse practitioners work with their organizations and other members of the health care team to ensure that the person requesting medical assistance receives high quality, coordinated and uninterrupted continuity of care and, if needed, safe transfer of the client's care to another health care provider.

5. Nurse practitioners acting as a medical assessor and determining a person's eligibility to receive medical assistance in dying as permitted under the Criminal Code must ensure that the person requesting medical assistance in dying meets the following requirements:

    - is eligible for publicly funded health-care services in Canada
    - is at least 18 years of age and capable of making decisions with respect to their health
    - has a grievous and irremediable medical condition, which means meeting all of the following criteria:
        - they have a serious and incurable illness, disease or disability
        - they are in an advanced state of irreversible decline in capability
        - the illness, disease, disability or state of decline causes them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable
        - their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining
    - has made a voluntary request in writing for medical assistance in dying that, in particular, was not made as a result of external pressure
    - has given informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering including palliative care

6. Nurse practitioners acting as a medical assessor and determining a person's eligibility to receive medical assistance in dying as permitted under the Criminal Code must ensure that:

    - both medical assessors are satisfied that the client is mentally capable of making a free and informed decision with respect to their health care at the time of the request and throughout the process.
    - if either medical assessor is unsure that the client has capacity to consent to medical assistance in dying the client must be referred to another practitioner, with expertise in capacity assessment, such as a psychologist, psychiatrist, neurologist, geriatrician, or family physician/general practitioner with additional training and expertise for a further in-person capacity assessment
    - the client maintains mental capacity for medical assistance in dying to proceed. If at any time during the progression of the client's condition, the client loses the mental capacity to rescind his or her decision, MAiD ceases to be an option

7. Nurse practitioners cannot provide medical assistance in dying to a person who is not mentally capable to give consent including when consent is given through an alternate or substitute decision-maker or a personal advance directive.

8. One of the medical assessors, but not both, may provide their assessment by telemedicine. Nurse practitioners must ensure that during the telemedicine assessment, another regulated health professional is in physical attendance with the client to act as a witness to the assessment.

9. Nurse practitioners must, before prescribing, providing or administering medical assistance in dying to a person as permitted under the Criminal Code:

    - be of the opinion that the person meets all of the eligibility criteria established for medical assistance in dying
    - ensure that person's request for medical assistance for dying was made in writing and signed and dated by the person or their proxy
    - ensure that the request for medical assistance in dying was a voluntary request and was not made as a result of external pressure
    - ensure that the request was signed and dated after the person was advised by a physician or nurse practitioner that they have a grievous and irremediable condition
    - be satisfied that the request for medical assistance in dying was signed and dated by the person or by their proxy before two independent witnesses who then also signed and dated the request
    - ensure that the client has been informed that they may, at any time, and in any manner, withdraw their request
    - ensure that another medical assessor (physician or nurse practitioner) has provided a written opinion that the person meets all of the eligibility criteria established for medical assistance in dying
    - be satisfied that they and the other medical assessor are independent
    - ensure that there are at least 10 days between the day on which the request was signed by or on behalf of the client and the day on which medical assistance in dying is provided, or if both medical assessors are of the opinion that the client's death or loss of capacity to provide informed consent is imminent, any shorter period that the medical assessors consider appropriate to the circumstances
    - immediately before providing the medical assistance in dying give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying
    - ensure that all necessary measures are taken to provide a reliable means by which the person will understand the information that is provided to them and communicate their decision, including when the person has difficulty communicating.

10. Nurse practitioners who prescribe or administer the substances to be used in medical assistance in dying must do so in the client's name, on the pre-printed provincial prescription, and document on the prescription that the indication is medical assistance in dying. The prescribing nurse practitioner must receive the substances for medical assistance in dying directly from the dispensing pharmacist.

11. Nurse practitioners who prescribe or administer the substances for medical assistance in dying must personally attend the client during the self-administration or personally administer the substances for medical assistance in dying, and in either case must remain in attendance until death is confirmed. This responsibility must not be delegated or assigned to any other person.

12. Nurse practitioners who prescribe or administer the substances for medical assistance in dying are responsible for completing the medical certificate of death, and for complying with any request for information or provision of medical records required by an agency tasked with completing a review of medical assistance in dying. The medical certificate of death must

indicate that the manner of death involved medical assistance in dying and that the cause of death is the underlying illness/disease causing the grievous and irremediable medical condition.

13. Nurse practitioners administering the medical assistance in dying substances are required to complete the medication administration record provided by the pharmacist and retain that record as part of the medical record. Additionally, nurse practitioners are responsible for returning to the pharmacy any unused substances as soon as reasonably practicable and ideally within 48 hours of confirmation of the client's death. This responsibility must not be delegated or assigned to any other person.

14. Nurse practitioners must document the following information in the client's medical record:

    - copies of all relevant medical records from other physicians/practitioners involved in the client's care supporting the diagnosis and prognosis of the client's grievous and irremediable condition, disease or disability; this includes ensuring that a specialist has provided a diagnosis and prognosis, including treatment recommendations, and that this has been discussed with the client by the specialist
    - all requests for medical assistance in dying with a summary of the discussion
    - confirmation that the two medical assessors discussed and determined which practitioner will prescribe and/or administer the substance used for medical assistance in dying
    - confirmation by the prescribing practitioner that all the requirements have been met including the steps taken and the substance prescribed
    - confirmation that after the completion of all documentation, and just prior to administration, the patient was offered the opportunity to withdraw the request

15. Nurse practitioners must use and follow provincial pre-printed forms, guidelines and order sets specific to medical assistance in dying including the:

    - Medical Assistance in Dying Record of Patient Request
    - Medical Assistance in Dying Assessor's Assessment Record
    - Medical Assistance in Dying Assessor-Prescriber Assessment Record
    - Medical Assistance in Dying Consultant Assessment of Patient's Informed Consent Decision Capability (if required)
    - British Columbia Medical Assistance in Dying Prescription
    - Medical Assistance in Dying Document Submission Checklist
    - BC Coroners Service Report of MAiD Death form

Limits and Conditions

Nurse practitioners providing medical assistance in dying must:

- possess demonstrated knowledge of and function within the parameters and criteria of the Criminal Code of Canada and other legislation, regulations, regulatory college standards, court decisions and provincial and organizational policy and procedures related to medical assistance in dying
- have the competence to:
    - confirm the diagnosis of a grievous and irremediable medical condition and the prognosis of reasonably foreseeable death based on medical consultation and diagnostic reports, and by synthesizing and integrating this evidence for the purpose of completing the eligibility assessment
    - assess the person against criteria in the Criminal Code of Canada related to medical assistance in dying
    - assess the capacity of the person to consent to medical assistance in dying and when it is necessary to refer for further capacity assessment, and
    - implement the provincial medical assistance in dying substances protocols and manage the intended and unintended outcomes
- have completed additional education[21] and a preceptorship under the guidance of a qualified practitioner with expertise in medical assistance in dying in order to acquire the needed competencies for both eligibility assessment and the provision of medical assistance in dying, and
- NOT participate in medical assistance in dying for themselves or a family member

21 Additional education is structured education (e.g. workshop, course, program of study) designed so that nurse practitioners can attain the competencies required to carry out a specific activity as part of nurse practitioner practice. Additional education builds on the entry-level competencies of nurse practitioners, identifies the competencies expected of learners on completion of the education, includes both theory and application to practice, and includes an objective, external evaluation of learners' competencies on completion of the education. The terms does not refer to a course or program approved by CRNBC for CRNBC certified practice.

F. Physician Consultation and Referral

Consultation and **collaboration** with other health care providers is an essential component of safe, appropriate and integrated health care. Nurse practitioners initiate discussion, collaboration consultation with and/or referral to other members of the health care team in a timely and appropriate manner.

Consultation/Referral Defined

Consultation/referral, as used in the following standards, refers to a specific request by a nurse practitioner for a physician (including specialists) to become involved in the care of a client.[22] The responsibility to consult with or refer to a physician lies with the nurse practitioner and is made in collaboration with the client. A nurse practitioner may also seek consultation with or transfer care to a physician at the request of the client.

Levels of physician involvement following nurse practitioner consultation/referral:

- The physician provides an opinion and recommendation to the nurse practitioner who continues to have primary responsibility for the health care of the client, or
- The physician assumes concurrent responsibility for some aspects of the care, and the physician and nurse practitioner together clarify who is assuming responsibility for the various aspects of the client's care, including coordination of the overall care, or
- The care of the client is transferred to the physician who then assumes primary responsibility for the care.

22 Nurse Practitioners consult or refer to physicians in accordance with the CRNBC Nurse Practitioner Standards for Diagnosing and Health Care Management and consider best practice guidelines (including the B.C. Medical Services Commission Guidelines and Protocols) regarding consultation and referral.

Standards for Physician Consultation and Referral

Standard 1

The nurse practitioner consults with or refers to physicians when the client's health condition or needs are such that:

- the diagnosis and plan of treatment is beyond the knowledge, skill and judgment of the nurse practitioner to determine;
- the care that is required is beyond the nurse practitioner's competencies, scope of practice and stream of practice;
- sign(s), symptoms(s) or report(s) of diagnostic or laboratory tests suggest that a client's condition is destabilizing or deteriorating and is beyond the ability of the nurse practitioner to manage, or
- the anticipated outcomes of therapy are not realized and further treatment is beyond the ability of the nurse practitioner to manage, or the target symptoms are not responding to treatment.

Standard 2

The nurse practitioner communicates and consults with or refers to physicians by:

- clearly presenting the reason for and the level of urgency of the consultation or referral;
- describing the level of physician involvement requested at the time a referral is made;
- determining the availability of the physician to provide the consultation in a timely and appropriate manner;
- ensuring that the physician has appropriate access to the client's relevant health information
- confirming with the physician, following the consultation, the level of physician involvement; and
- documenting the request for and outcome of the consultation or referral.

Standard 3

The nurse practitioner and the consulting physician conjointly establish methods for communicating about their mutual client's health condition and treatment decisions in situations in which client care is shared

Appendix A

Glossary

Advanced interventions: Activities, including restricted activities described in the Nurses (Registered) and Nurse Practitioners Regulation, Section 9 (1) (a),(c),(d), (e) and (g), that are carried out independently by nurse practitioners and are included within the scope of practice of nurse practitioners in British Columbia. The nurse practitioner achieves competence for these activities both during and after graduation from a nurse practitioner program through formal theoretical and clinical learning. Examples of advanced interventions include wound closure, incision and drainage, insertion of IUDs, endometrial biopsy, and cognitive behaviour therapy.

Alternative provider: A physician or a nurse practitioner who assumes overall primary care of the client in the absence of the nurse practitioner.

Anti-aging: Refers to treatments that target some of the changes that happen to faces and bodies with human aging, such as fine lines, wrinkles, age spots, uneven skin tone, spider veins and sagging skin. Treatments often include Botox, facial fillers and laser.

Certified practices: Restricted activities that are subject to regulatory provisions under Section 8 of the Nurses (Registered) and Nurse Practitioners Regulation. These provisions require registered nurses to successfully complete a certification program approved by CRNBC before carrying out the restricted activities designated as certified practices. Certified practices are also referred to as CRNBC-certified practices to distinguish them from activities that employers or other organizations certify.

Client: An individual, family, group, population or entire community who require nursing expertise. In some clinical settings, a client may be referred to as a patient or resident.

Clinical learning: The application of knowledge and skills achieved in both theoretical and laboratory education while learning to provide direct care with clients. A physician or nurse practitioner with the competence and authority to provide the required care assumes responsibility for overseeing the clinical learning to confirm competence of the registrant. If the activity is not within the scope of practice of the registrant, then CRNBC standards for regulatory supervision of employed nursing students or CRNBC standards for delegation must be followed.

Collaboration: Joint communication and decision-making with the expressed goal of working together toward identified health outcomes while respecting the unique qualities and abilities of each member of the group or team.

Consultation/referral: Consultation, including referral, refers to a specific request by a nurse practitioner for a physician to become involved in the care of a client.

Continuation ordering: The physician makes the initial order for treatment and the nurse practitioner has the responsibility and accountability to continue ordering the treatment, including adjusting as necessary and referring when appropriate.

Continuation prescribing: The physician initiates the drug therapy and the nurse practitioner assumes responsibility and authority for the continuation of the drug therapy, including ongoing assessment and monitoring, re-ordering and/or making adjustments to the drug therapy, and referral as needed.

Competence: The integration and application of knowledge, skills, attitudes and judgments required to perform safely and ethically within an individual's nursing practice or in a designated role and setting and includes both entry-level and continuing competence.

Condition: The type of nursing diagnosis that a registered nurse is authorized to make through the Nurses (Registered) and Nurse Practitioners Regulation. A condition is different from a disease or disorder. A condition can be improved or resolved by the registered nurse's interventions and achieves outcomes for which the registered nurse is accountable (e.g., post-operative urinary retention).

Decision support tool: Evidence-based document used to guide the assessment, diagnosis and treatment of client-specific clinical problems; also called clinical practice guidelines, protocols.

Delegation: Sharing authority with other health care providers to provide a particular aspect of care. Delegation among regulated care providers occurs when a restricted activity is within the scope of the delegating profession and outside the scope of the other profession.

Dispense: The selection, preparation and transfer of a medication to a client, and taking steps to ensure its pharmaceutical and therapeutic suitability and its proper use. Dispensing may also include collecting money for the medication on behalf of the employer.

Established patients: Patients in a nurse practitioners primary care practice for whom the nurse practitioner is the primary care provider.

Evidence informed practice: Practice which is based on successful strategies that improve client outcomes and are derived from a combination of various sources of evidence, including research, national guidelines, policies, consensus statements, expert opinion, quality improvement data and client perspectives.

Levels of physician involvement: The physician provides an opinion and recommendation to the nurse practitioner who continues to have primary responsibility for the health care of the client; or the physician assumes concurrent responsibility for some aspects of the care and the physician and the nurse practitioner together clarify who is assuming responsibility for the various aspects of the client's care, including coordination of the overall care; or the care of the client is transferred to the physician who then assumes primary responsibility for the care.

Limits and Conditions: As related to scope of practice, what nurse practitioners are not permitted to do (limits) and the circumstances under which nurse practitioners may carry out an activity (conditions).

Order: An instruction or authorization for a specific client given by a health professional (i.e., a physician, midwife, podiatrist, nurse practitioner, dentist or naturopath) to a registered nurse to carry out an activity that includes a restricted activity listed in Section 7 of the Regulation. This includes pre-printed orders that set out the usual care for a particular client group or client problem and are made client-specific by the health professional adding the name of the individual client, making any necessary changes to the pre-printed order to reflect the needs of the individual client, and signing the order. The Regulation also permits orders that refer to other documents. However, to support safe practice, these documents should be placed on the client's chart.

Primary care provider: Health professionals who take primary responsibility for an established group of patients for whom they provide: longitudinal person focused care; comprehensive care for most health needs; first contact assessment for new health care needs; and referral and coordination of care when it must be sought elsewhere. Primary health care providers, together with non-government organizations, work as a team with patients and their extended families. A primary care provider is ideally chosen by an individual to serve as his or her health care professional to address a wide variety of health issues including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury.

Primary care (primary health care): The element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury. It is the element within primary health care, an approach to health and a spectrum of services beyond the traditional health care system. Primary health care includes all services that play a part in health, such as income, housing, education, and environment.

Restricted activities: Higher risk clinical activities that must not be performed by any person in the course of providing health services, except members of a regulated profession that have been granted specific legislative authority to do so, based on their education and competencies.

Scope of practice: The activities that nurses are educated and authorized to perform set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act and complemented by standards, limits and conditions set by CRNBC.

Standards: A desired and achievable level of performance against which actual performance can be compared. It provides a benchmark below which performance is unacceptable.

Appendix B

Nurse Practitioner Streams of Practice Described

Three streams of practice are used by CRNBC to register nurse practitioners: family, adult and pediatric. The following description for each stream of nurse practitioner practice includes a profile of a newly graduated nurse practitioner for that stream. The purpose of the descriptions is to provide more clarity on each stream for employers, nurse practitioners and other regulatory bodies. This information is excerpted from the CRNBC *Competencies Required for Nurse Practitioners in British Columbia*.

Nurse Practitioner (Family)

The nurse practitioner (family) is educated to provide health care services to persons of all ages, including, newborns, infants, toddlers, children, adolescents, adults, pregnant and postpartum women, and older adults. The nurse practitioner (family) brings advanced knowledge and experience with persons and families of all ages to the context of practice that is usually in, but not limited to, community clinics, health care centres or other community settings. The nurse practitioner (family) develops and sustains partnerships with clients of all ages and may serve as the primary care provider to individuals and their families.

Profile of the Newly Graduated Nurse Practitioner (Family)

Entry-level nurse practitioners (family) are prepared with the competencies to work independently with clients of all ages in general primary care settings. Entry-level nurse practitioners (family) effectively diagnose and treat acute/episodic health conditions, diseases and disorders, and chronic illnesses prevalent to the client population served. Mental health at the primary care level is included in the entry-level competencies of the nurse practitioner (family).

At the time of beginning practice, the nurse practitioner (family) is not prepared to independently provide care for clients with complex health problems or chronic diseases with multiple co-morbidities, such as one would find in specialty practice areas, acute care settings and complex residential care. The entry-level nurse practitioner (family) may go on to develop the competencies to provide care for clients with higher acuity and complexity or specialized needs through practice experience, mentorship and formal and informal education.

Nurse Practitioner (Adult)

The nurse practitioner (adult) is educated to provide health care services to young, middle-aged and older adults. Care of older adolescents may also be provided by a nurse practitioner (adult) in some instances when the adolescent's developmental age and/or lifestyle may more closely approximate that of an adult. Nurse practitioners (adult) can be found in acute and residential care as well as community settings. The nurse practitioner (adult) develops and sustains partnerships with adults and their families and may serve as the primary care provider for adults.

Profile of the Newly Graduated Nurse Practitioner (Adult)

Entry-level nurse practitioners (adult) are prepared with the competencies to enter practice in environments such as acute and residential care settings where clients with acute and complex care needs and multi-system problems are found. They are prepared with the same primary care competencies for the care of adults as the nurse practitioner (family) and then focus on the care of adults with higher acuity, complexity and co-morbidities. The competencies to care for the frail older person with complex care needs and co-morbidities are included in the preparation of the nurse practitioners (adult).

Their broad preparation allows them to practise across the continuum of care and to serve as the primary care provider to adults. At the time of beginning practice, the nurse practitioner (adult) is not prepared with specialized competencies unique to a particular practice area. The entry-level nurse practitioner (adult) may go on to provide care for adults with specialized needs through practice experience, mentorship and formal and informal education.

Nurse Practitioner (Pediatric)

The nurse practitioner (pediatric) is educated to provide health care services to children, including newborns, infants, toddlers, children and adolescents. The term “children” in the following description refers to this age range. In some instances, nurse practitioners (pediatric) may provide care to young adults whose developmental age may closely approximate that of a child or adolescent rather than that of an adult, or a young adult who has been receiving care from the nurse practitioner (pediatric) for a chronic disease since childhood (e.g., cystic fibrosis). Nurse practitioners (pediatric) can be found in acute and residential care as well as community settings. The nurse practitioner (pediatric) develops and sustains partnerships with children and their families and may serve as the primary care provider to children. They attend to transition issues to ensure ongoing care from other providers as the adolescent becomes an adult.

Profile of the Newly Graduated Nurse Practitioner (Pediatric)

Entry-level nurse practitioners (pediatric) are prepared with the competencies to enter practice in environments, such as acute and residential care settings where clients with acute and complex care needs and multi-system problems are found. They are prepared with the same primary care competencies for the care of children as the nurse practitioner (family) and then focus on the care of children with higher acuity, complexity and co-morbidities.

Their broad preparation allows them to practise across the continuum of care and to serve as the primary care provider to children. At the time of beginning practice, the nurse practitioner (pediatric) is not prepared with specialized competencies unique to a particular practice area. The entry-level nurse practitioner (pediatric) may go on to provide care for children with specialized needs through practice experience, mentorship and formal and informal education.

Appendix C

Resources

CRNBC Resources

- Quality Assurance and Continuing Competence for Nurse Practitioners (available in the Quality Assurance section of the CRNBC website www.crnbc.ca)
- Competencies Required for Nurse Practitioners in British Columbia (available in the Registration & Renewal/Nurse Practitioner How to Register section of the CRNBC website www.crnbc.ca)

Standards of Practice

See complete list on the CRNBC website www.crnbc.ca. Nurse practitioners are expected to review all CRNBC Practice Standards to determine relevance to their practice. Some standards selected for relevance to NP practice are:

- *Scope of Practice for Registered Nurses: Standards, Limits and Conditions*
- *Professional Standards for Registered Nurses and Nurse Practitioners*
- *Appropriate Use of Titles* Practice Standard
- *Conflict of Interest* Practice Standard (includes information related to communicating with pharmaceutical companies)
- *Consent* Practice Standard
- *Dispensing Medications* Practice Standard
- *Duty to Provide Care* Practice Standard
- *Medication Inventory Management* Practice Standard
- *Boundaries in the Nurse-Client Relationship* Practice Standard (includes information related to treating members of a nurse practitioner's family or friends)

Practice Support

Information, education and consultation about scope of practice are available from CRNBC's Practice Support Department. Email practice@crnbc.ca or telephone 604.736.7331 (ext. 332) or 1.800.565.6505 (ext. 332).

Other Resources

American Hospital Formulary Service (AHFS) Drug Information classification system
www.ahfsdruginformation.com/products_services/di_ahfs.aspx

British Columbia Ministry of Health Services Guidelines and Protocols. Search guidelines and protocols at www.gov.bc.ca/health

British Columbia Cancer Agency www.bccancer.bc.ca:

- Cancer Management Guidelines: Use of Adjuvant Hormonal Therapy (Breast Cancer). Search *Adjuvant Hormonal Therapy*.
- Cancer drug information. Search *Cancer Drug Manual*.
- Cancer education. Search *Breast Cancer Nursing Education Resource*

British Columbia Centre for Excellence HIV/AIDS Care Therapeutic Guidelines and education courses.
www.cfenet.ubc.ca

British Columbia Provincial Blood Coordinating Office guidelines
www.pbco.ca/index.php?option=com_content&task=category&id=29&Itemid=69

Maternal Serum Screening (MSS) programs genetic counsellors are available as a resource related to genetic counselling and will provide on request education sessions and advice.
www.bcprenatalscreening.ca

Perinatal Services BC: Guidelines and Standards
www.perinatalservicesbc.ca/health-professionals/guidelines-standards/standards/core-competencies-for-management-of-labour

PharmaNet Compliance Standards for access to PharmaNet data. Search *PharmaNet Compliance Standards* at www.health.gov.bc.ca Nurse practitioners are encouraged to access PharmaNet to review clients' medication history and to validate patient's medication profile with patient or most appropriate caregiver whenever possible.

Provincial and federal (controlled) drug schedules can be found on the College of Pharmacists website www.bcpharmacists.org

Resources for Nurse Practitioner Prescribing

Rapid Access for Consultative Expertise (RACE) Program and Line

RACE is a program that provides family physician and nurse practitioner access to specialist consultation by telephone. The program's goal is to improve communication and knowledge transfer between primary care providers and specialists.

Consultation is available province-wide in a wide variety of specialties, with some variability by health region. Additional information including downloadable apps can be found at www.raceconnect.ca

Tel: (604) 696-2131 or 1-877-696-2131

Relevant Legislation

- B.C. Pharmacy Operations and Drug Scheduling Act;
- federal Food and Drug Act and Regulations;
- federal Controlled Drugs and Substances Act and Regulations; and,

Regulations under the federal Controlled Drugs and Substances Act relevant to nurse practitioner prescribing and managing of controlled drugs and substances include the New Classes of Practitioners Regulations, the Narcotic Control Regulations, and the Benzodiazepines and Other Targeted Substances Regulations.

Nurse practitioners are not authorized to prescribe, nor issue a medical document for, nor dispense, nor compound, nor administer the dried cannabis leaf product. However, they may encounter clients who are accessing these products and so may be interested in the parameters of the federal ***Marijuana for Medical Purposes Regulations***.

Provincial legislation can be found at www.bclaws.ca

Federal controlled drug and substances legislation and schedules can be found at www.laws-lois.justice.gc.ca

American Hospital Formulary Service (AHFS) Drug Information Classification System

The American Hospital Formulary Service (AHFS) publishes the AHFS Pharmacologic-Therapeutic Classification codes used throughout the health care industry as means for drug classification. www.ahfsdruginformation.com

Best Practice Guidelines

The Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non Cancer Pain. http://nationalpaincentre.mcmaster.ca

CDC Guideline for prescribing opioids for chronic pain – United States, 2016.

www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

For palliative pain, see the B.C. Guidelines www.bcguidelines.ca/submenu_palliative.html in particular Part 2: Pain and Symptom Management.

CRNBC Medication-Related Practice Standards

CRNBC Practice Standard *Dispensing Medications*:

www.crnbc.ca/Standards/PracticeStandards/Pages/dispensing.aspx

CRNBC Practice Standard *Medication Inventory Management*:

www.crnbc.ca/Standards/PracticeStandards/Pages/medicationinventory.aspx

CRNBC Practice Standard *Medication Administration*

www.crnbc.ca/Standards/PracticeStandards/Pages/medicationadmin.aspx

Nurse-Managed Medication Inventory: Information for Employers:

crnbc.ca/Standards/Lists/StandardResources/498NseMgedMedInventoryEmployers.pdf

CRNBC Competencies for Nurse Practitioner Prescribing of Controlled Drugs and Substances

www.crnbc.ca/Standards/NPScopePractice/prescribing/Pages/NP_Competencies_for_prescribing.aspx