

Scope of Practice

For Nurse Practitioners

*Protecting the public by
effectively regulating registered
nurses and nurse practitioners*

STANDARDS
LIMITS
CONDITIONS

This document contains information about the scope of practice for nurse practitioners in British Columbia.

- Part 1 explains how the *Nurses (Registered) and Nurse Practitioners Regulation* and BC College of Nursing Professionals (BCCNP) establish nurse practitioner scope of practice.
- Part 2 sets out the standards, limits and conditions related to nurse practitioner scope of practice.

Information in this document is subject to change as BCCNP policy is revised or legislation is amended. BCCNP registrants will be notified of changes.

If you have questions about your scope of practice or other standards, you can contact a Regulatory Practice Consultant. Email practice@bccnp.ca or telephone 604.742-6200 or 1.866.880.7101

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TABLE OF CONTENTS

TABLE OF CONTENTS	3
PART 1: INTRODUCTION	5
A. The Nurses (Registered) and Nurse Practitioners Regulation	5
Scope of Practice	5
Duty to Provide Care	6
Restricted Activities	6
B. The Role of BCCNP: Standards, Limits and Conditions	7
C. Controls on Nursing Practice	7
PART 2: STANDARDS, LIMITS AND CONDITIONS	9
A. Regulatory Supervision of Nurse Practitioner Student Restricted Activities	9
Introduction	9
Standards	9
B. Consultation and Referral	10
Standards	10
C. Ordering Diagnostic Services and Managing Results	11
Introduction	11
Standards	11
Limits and Conditions	11
D. Advanced Assessments	12
Introduction	12
Limits and Conditions	12
E. Advanced Procedures and Activities	12
Introduction	12
Standards	13
Limits and Conditions	13
F. Prescribing Drugs	14
Introduction	14
Standards	15
Limits and Conditions	18

G. Opioid Agonist Treatment Prescribing for Opioid Use Disorder	21
Introduction	21
Standards	21
Limits and Conditions	22
H. Medical Assistance in Dying.....	23
Introduction	23
Standards	26
Limits and Conditions	30
Appendix A. Glossary	31
Appendix B. Resources	32

PART 1: INTRODUCTION

Nurse practitioners are registered nurses with experience and advanced nursing education at the master's level. Nurse practitioners autonomously diagnose, treat and manage acute and chronic physical and mental illnesses.

As advanced practice nurses, nurse practitioners:

- analyze, synthesize and apply evidence to make decisions about their clients' health care
- provide a comprehensive range of essential health services grounded in professional, ethical and legal standards within a holistic model of care
- work collaboratively with their clients to establish measurable goals, and identify and advocate to close gaps in health outcomes

The scope of practice 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 BCCNP on the recommendation of the Nurse Practitioner Standards Committee.

Nurse practitioners in B.C. practise in one of [three streams of practice](#): family, adult or pediatric. The standards, limits and conditions in this document apply to all three streams of nurse practitioner practice. The entry-level expectations for nurse practitioner practice are set out in the [Entry Level Competencies for Nurse Practitioners in Canada](#).

A. The Nurses (Registered) and Nurse Practitioners Regulation

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

- Reserved titles for nurses¹
- A scope of practice statement
- Restricted activities for registered nurses and nurse practitioners

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 the standards, limits and conditions set by BCCNP.

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

- a) Health care for the promotion, maintenance, and restoration of health;
- b) Prevention, treatment and palliation of illness and injury, primarily by
 - i. assessing health status,
 - ii. planning, implementing and evaluating interventions, and
 - iii. coordinating health services;
- c) Medical assistance in dying.”

¹ See the [Appropriate Use of Titles Practice Standard](#) and the [BCCNP Bylaws](#) for more information.

Nurse practitioner scope of practice includes all activities within the scope of practice of registered nurses.

DUTY TO PROVIDE CARE

As set out in the [Duty to Provide Care Practice Standard](#), nurse practitioners provide care only within their authorized scope of practice, except:

- In situations involving imminent risk of death or serious harm that arise unexpectedly and require urgent action. In emergencies, nurse practitioners are ethically obliged to provide the best care they can, given the circumstances and their level of competence.²
- In situations where a restricted activity has been formally delegated. To date, no activities for nurse practitioners have been approved for delegation. Delegation under the Health Professions Act requires an agreement between the College of Physicians and Surgeons of British Columbia (CPSBC) and BCCNP.

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.³ The Regulation assigns specific restricted activities to registered nurses and nurse practitioners.

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.

Sections 6 and 7 of the Regulation list the restricted activities that registered nurses may carry out as part of general practice.⁴ Section 7 of the Regulation describes the restricted activities for which registered nurses require an order. As the scope of nurse practitioner practice builds on the scope of registered nurse practice, nurse practitioners are authorized to independently carry out Section 6 and 7 activities. They are also one of the listed health professionals who can issue orders to registered nurses for Section 7 activities.

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 such as counselling, health promotion and the prevention of some illnesses and injuries.

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

3 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.

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

B. The Role of BCCNP: Standards, Limits and Conditions

The Health Professions Act gives BCCNP 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 BCCNP Board by the Nurse Practitioner Standards Committee in accordance with the Regulation and BCCNP Bylaws.

- Standard – an expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance.
- Limit – specifies what nurse practitioners are not permitted to do.
- Condition – sets out the circumstances under which nurse practitioners may carry out an activity.

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

As with all BCCNP registrants, nurse practitioners are expected to meet all BCCNP Standards of Practice for RNs and NPs. The [BCCNP Standards of Practice](#) include:

- Professional Standards
- Practice Standards
- Scope of Practice Standards, Limits and Conditions

C. Controls on Nursing Practice

There are four levels of controls on nurse practitioners' practice:

The Regulation, which sets out the scope of practice in fairly broad strokes.

BCCNP standards, limits and conditions, which complement and further define and limit the scope of practice set out in the Regulation.

Organizational or employer policies that may restrict the practice of nurse practitioners in a particular agency or unit.

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.

Controls on Practice

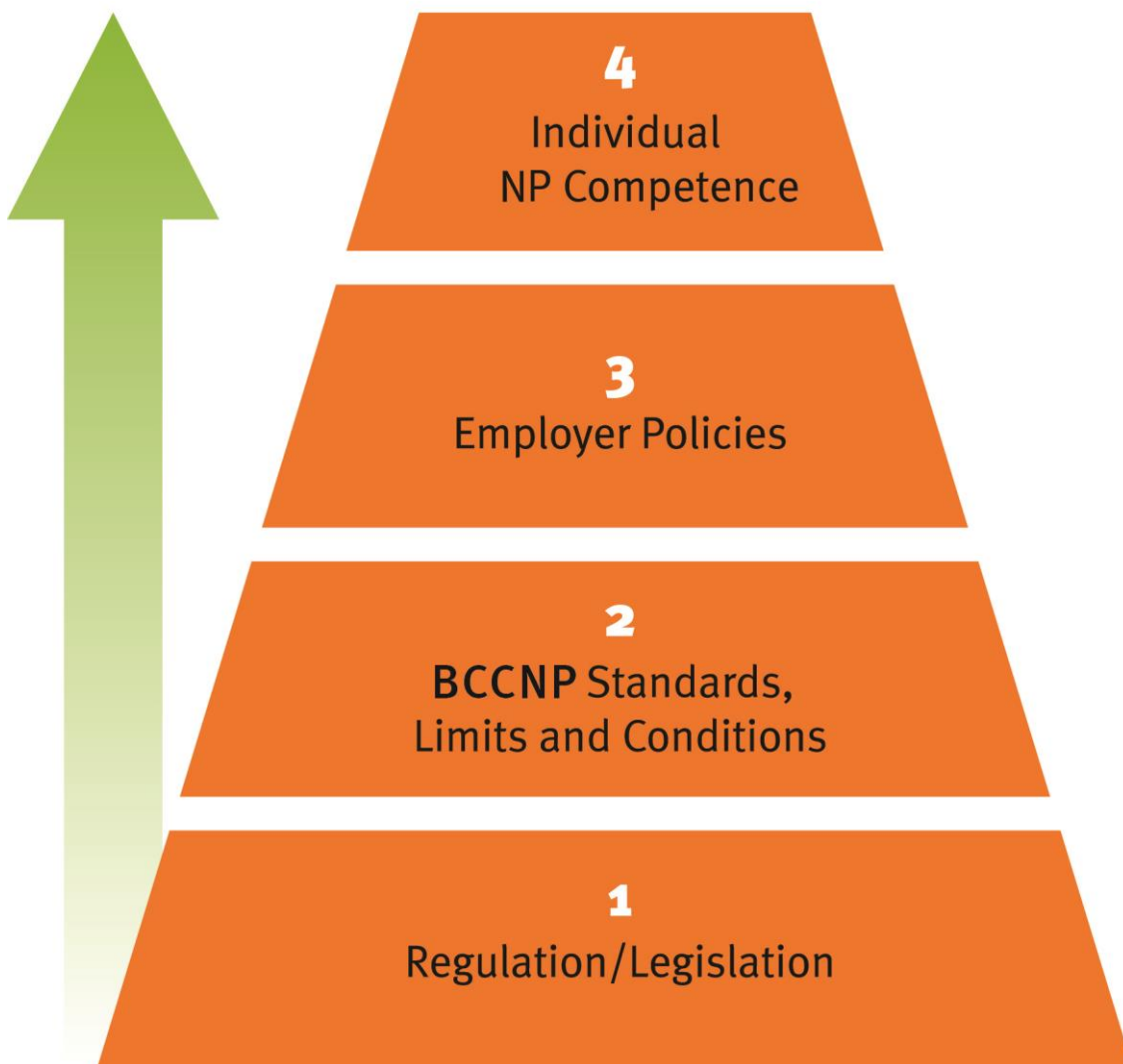


Figure 1: Controls on Practice

PART 2: STANDARDS, LIMITS AND CONDITIONS

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

A. Regulatory Supervision of Nurse Practitioner Student Restricted Activities

INTRODUCTION

Regulatory supervision is the process that NPs follow to authorize nurse practitioner 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

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:
 - a. Determine that the student has the competence to perform the restricted activity.
 - b. Make a decision to authorize the restricted activity, considering at a minimum:
 - i. the student's stream of practice and level of experience
 - ii. the client's health condition, needs and consent
 - iii. the restricted activity to be performed (task factors)
 - iv. the practice setting (changing circumstances, institutional/employer policy)
 - c. Establish with the student, the conditions under which the restricted activity may be performed, including:
 - i. reviewing the student's assessments of clients' health, differential diagnoses and/or diagnosis
 - ii. reviewing/discussing recommendations and treatments/interventions made or to be made
 - iii. signing all prescriptions and diagnostic tests
 - iv. being on site or readily available to consult and/or collaborate to protect the interests of the client
 - d. 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.

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

B. Consultation and Referral

STANDARDS

1. Nurse practitioners are accountable for the care they provide and the decisions that they make when sharing client care with other health care professionals.
2. Nurse practitioners consult with or make a referral to other health care professionals when:
 - a. they encounter client care needs beyond the scope of practice for nurse practitioners or their individual competence, and/or
 - b. client care would benefit from the expertise of other health care professionals.
3. Nurse practitioners make referral decisions in collaboration with the client.
4. When consulting with or making a referral to another health care professional, nurse practitioners:
 - a. present the reason for and the level of urgency of the consultation or referral
 - b. describe the level of involvement requested
 - c. provide relevant client health information
 - d. confirm the health care professional's ongoing level of involvement with the client
 - e. document the request for and outcome of the consultation or referral in the client's health record
5. When providing consultations to or receiving referrals from other health care professionals, nurse practitioners:
 - a. confirm the reason for and level of urgency of the request
 - b. confirm the level of involvement requested
 - c. ensure that they have access to relevant client health information
 - d. notify the health care professional if they are unable to provide a consultation or receive a referral
 - e. confirm their ongoing level of involvement with the client
 - f. document the request for and outcome of the consultation or referral

C. Ordering Diagnostic Services and Managing Results

INTRODUCTION

Diagnostic services that nurse practitioners 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

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.
2. Nurse practitioners engage in evidence informed diagnosing and management considering best practice guidelines and other relevant guidelines and resources.
3. Nurse practitioners:
 - a. provide the appropriate clinical information when ordering diagnostic tests
 - b. establish mechanisms within their practice setting(s) to track and follow-up on diagnostic test results
 - c. ensure clients are informed, in a timely manner, of diagnostic test results, implications and needed follow-up
 - d. communicate, as needed, diagnostic test results with key providers involved in the client's care
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

1. 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.

D. Advanced Assessments

INTRODUCTION

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 BCCNP Practice Support at practice@BCCNP.ca

LIMITS AND CONDITIONS

Financial Incapability Assessments

1. 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.”](#)
2. 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.”](#)

Incapability Assessments for Care Facility Admission

Nurse Practitioners acting as prescribed health care providers under Part 3 of the Health Care (Consent) and Care Facility (Admission) Act for the purpose of conducting an assessment to determine whether an adult is incapable of giving or refusing consent to admission to, or continued residence, in a care facility, must:

1. Have successfully completed the Ministry of Health [course](#), “Consent to Care Facility Admission in British Columbia: A Course for Managers and Assessors”; and
2. Follow the Ministry of Health guidelines, “Practice Guidelines for Seeking Consent to Care Facility Admission”.

E. 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 activities⁵ for nurse practitioners as defined by the [British Columbia Medical Quality Initiative for Nurse Practitioner Clinical Privileges](#)

STANDARDS

1. Before incorporating an advanced procedure or activity into their practice, nurse practitioners consider:
 - a. their foundational education in relation to the procedure or activity
 - b. 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
 - c. inclusion and exclusion criteria for the client population
 - d. risks to clients that are associated with performing the activity
 - e. measures that would be taken to mitigate risks and make the activity as safe as possible
 - f. how nurse practitioners will manage outcomes both intended and unintended
 - g. how outcomes would be tracked and evaluated
 - h. availability of best practice guidelines or other evidence-based tools
2. Nurse practitioners perform advanced procedures and activities within their level of competence having acquired the knowledge and skill through additional education.⁶
3. Nurse practitioners perform advanced procedures and activities only when performance occurs with sufficient frequency to maintain competence.

LIMITS AND CONDITIONS

Blood and Blood Products

1. Nurse practitioners order immune globulin in accordance with BC Centre for Disease Control guidelines.
2. Nurse practitioners order blood and blood products (with the exception of immune globulin) in accordance with the [B.C. Provincial Blood Coordinating Office guidelines](#).
3. Nurse practitioners who order blood and blood products (with the exception of immune globulin) must:

5 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.

6 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 term does not refer to a course or program approved by BCCNP for BCCNP certified practice.

- a. successfully complete additional education⁶ (e.g. [Bloody Easy Lite](#) offered by the [Ontario Regional Blood Coordinating Network](#)); and
- b. review the following resources of the [Ontario Regional Blood Coordinating Network](#) and be knowledgeable with respect to their content:
 - i. [Bloody Easy 4: Blood Transfusions, Blood Alternatives and Transfusion Reactions. A Guide to Transfusion Medicine Fourth Edition](#)
 - ii. [Blood Easy Coagulation Simplified](#)

Setting Fractures and Reducing Dislocations

4. Nurse practitioners:
 - a. are limited to setting a closed, simple fracture of a bone
 - b. are limited to reducing dislocations of the fingers and toes (digits of the upper and lower extremities)
 - c. 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

5. Nurse practitioners:
 - a. do not apply x-rays
 - b. do not give an order or apply laser for the purpose of destroying tissue

Cosmetic Treatments

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

F. Prescribing Drugs

INTRODUCTION

Nurse practitioners prescribe drugs in accordance with relevant federal and provincial legislation and the BCCNP Standards of Practice. In particular, the [Nurses \(Registered\) and Nurse Practitioners Regulation](#) gives nurse practitioners the authority to prescribe [Schedule I, IA, and II drugs](#), subject to the standards, limits and conditions set by BCCNP.

The Prescribing Drugs standards, limits and conditions apply when nurse practitioners are initiating, continuing or discontinuing the prescribing of a drug. Continuation prescribing includes re-ordering and/or making adjustments to the drug therapy, ongoing assessment and monitoring, and consulting with and/or referring clients to other health care professionals as needed.

Nurse practitioners are authorized to compound, administer, and dispense all drugs that they have the authority to prescribe. For drugs that nurse practitioners do not have the authority to prescribe, they are authorized to compound, dispense or administer them with a client-specific order from a listed health professional who is authorized to prescribe the drug in British Columbia

Authorizing Medical Cannabis ⁷

Under section 272 of the Cannabis Regulations, a nurse practitioner may authorize medical cannabis for a client if it is required for the condition for which the client is receiving treatment. Nurse practitioners may provide a medical document or, if practising in a hospital, issue a written order for medical cannabis, in accordance with the requirements of Part 14 of the Cannabis Regulations. The Prescribing Drugs standards apply to the authorization of medical cannabis. Nurse practitioners who plan to authorize medical cannabis first familiarize themselves with the Cannabis Act and Cannabis Regulations (in particular, Part 14), review the information about cannabis that is available from the Canadian Nurses' Protective Society (CNPS), and review and comply with their organization's policies about medical cannabis.

STANDARDS

1. Nurse practitioners prescribe drugs within nurse practitioners' scope of practice, relevant legislation and their individual competence.
2. Nurse practitioners are accountable for their prescribing decisions.
3. Before prescribing, nurse practitioners ensure their competence to:
 - a. establish or confirm a diagnosis for the client
 - b. manage the treatment and care of the client
 - c. monitor and manage the client's response to the drug
4. Nurse practitioners use current evidence to support decision-making when prescribing.
5. Nurse practitioners apply relevant guidelines⁸ when prescribing.
6. When prescribing, nurse practitioners:
 - a. consider the client's health history and other relevant factors (e.g. age, gender, lifestyle, the client's perspective on their health)
 - b. undertake and document an appropriate clinical evaluation (e.g. physical examination, review of relevant tests, imaging and specialist reports)
 - c. obtain the best possible medication history for the client using PharmaNet (when access is available⁹) and other sources
 - d. review the medication history and take action to address any discrepancies
 - e. ask about the client's drug allergies and ensure drug allergy information is accurately and appropriately documented
 - f. document the drugs prescribed to the client and the indication(s) for the drugs

⁷ Medical cannabis refers to cannabis that is authorized by a medical document or written order issued under Part 14 of the Cannabis Regulations. It does not include prescription drugs containing cannabis, which are listed in in Schedule I of the Drug Schedules Regulation and are regulated under Part 8 of the Cannabis Regulations. Nurse practitioners who prescribe Schedule I drugs containing cannabis comply with the same standards, limits and conditions that apply to the prescribing of any other Schedule I drugs.

⁸ Guidelines include those from BC Cancer, BC Centre for Excellence in HIV/AIDS, BC Centre on Substance Use, Perinatal Services BC, and BC Centre for Disease Control.

⁹ Nurse practitioners register for Pharmanet access appropriate to the practice sites where they will be prescribing (e.g. Community Health Practice Access to PharmaNet).

- g. establish a plan for reassessment/follow-up
 - h. monitor and document the client's response to the drugs prescribed (as appropriate)
7. Nurse practitioners undertake medication reconciliation to ensure accurate and comprehensive medication information is communicated consistently across health care transitions.
8. When prescribing, nurse practitioners provide information to clients about:
- a. the expected action of the drug
 - b. the duration of the drug therapy
 - c. specific precautions or instructions for the drug
 - d. potential side-effects and adverse effects (e.g. allergic reactions) and action to take if they occur
 - e. potential interactions between the drug and certain foods, other drugs, or substances
 - f. recommended follow-up
9. Nurse practitioners complete prescriptions accurately and completely, including:
- a. the date the prescription was written
 - b. client name, address (if available) and date of birth
 - c. client weight (if required)
 - d. name, strength and dose of the drug
 - e. the quantity prescribed and quantity to be dispensed
 - f. dosage instructions (e.g. the frequency or interval, maximum daily dose, route of administration, duration of drug therapy)
 - g. refill authorization if applicable, including number of refills and interval between refills
 - h. prescriber's name, address, telephone number, written (not stamped) signature, and prescriber number
 - i. date of transmission, the name and fax number of the pharmacy intended to receive the transmission, and the practitioner's fax number if the prescription is being faxed¹⁰
 - j. directions to the pharmacist not to renew or alter if a pharmacist-initiated adaption would be clinically inappropriate
10. When notified of a pharmacist-initiated prescription adaption, nurse practitioners document the adaption in the client record.
11. Nurse practitioners report adverse drug reactions to the [Canada Vigilance Program](#).
12. Nurse practitioners prescribe controlled drugs and substances in accordance with the [Controlled Prescription Program](#).
13. When prescribing controlled drugs and substances, nurse practitioners meet the Prescribing Drugs standards and also:
-
- 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 controlled prescription program forms and may be faxed to the authorized community pharmacy.

NOTE: Effective March 19, 2020, and for the duration of the COVID-19 pandemic, it is acceptable for prescribers to fax prescriptions, or give verbal prescriptions for controlled drugs to pharmacists, and then deliver (by mail courier or other means) a hard copy of the original duplicate form. [More information](#).

- a. assess the client in person, or by telehealth with visual assessment if clinically appropriate, except in cases where the client is:
 - i. known to the nurse practitioner, and/or
 - ii. being assessed in person by another health care provider
 - b. document their review of the client’s PharmaNet medication profile
 - c. document the indication and duration for which the drug is being prescribed, the goals of treatment, and the rationale for the drug’s use over alternatives (if applicable)
 - d. prescribe the lowest possible dose and the minimum quantity to be dispensed
 - e. know the risks of co-prescribing opioid and sedative-hypnotic drugs (e.g. benzodiazepines) and limit co-prescribing whenever possible; document the rationale and the follow-up plan if co-prescribing is necessary
 - f. advise clients about the side effects and risks of controlled drugs and substances as applicable (e.g. physical tolerance, psychological dependence, addiction, diversion)
 - g. implement evidence-informed strategies for minimizing risk (e.g. treatment agreements, pill counts, urine drug screens, client education about safe storage and disposal)
14. When authorizing medical cannabis, nurse practitioners meet the Prescribing Drugs standards and also:
- a. review the client’s medication profile and history through PharmaNet and other sources
 - b. document their review of the client’s PharmaNet medication profile
 - c. document the indication and duration for which medical cannabis is being authorized, the goals of treatment, and the rationale for its use over alternatives
 - d. advise clients about the side effects and risks of medical cannabis
 - e. complete medical documents or written orders for cannabis in accordance with the requirements set out in the [Cannabis Regulations](#) ¹¹
 - f. retain any copy of the medical document for cannabis in the client health record
15. Nurse practitioners:
- a. store all controlled prescription pads and personalized prescription pads in a secure and locked area
 - b. report all loss, theft or misuse of personalized prescription pads or controlled prescription pads to BCCNP, PharmaNet Support Services, the police, and, if any client information is contained on the missing pad, the BC Privacy Commissioner¹²
 - c. return controlled prescription pads to BCCNP if no longer practising in BC¹³
 - d. store the duplicate copy of a controlled prescription with the client health record, not within the controlled prescription pad
16. Before changing to non-practising or inactive registration with BCCNP (and therefore relinquishing prescribing authority), nurse practitioners take steps to ensure prescription refills and part-fills are managed for clients.

¹¹ Requirements for completing a medical document or written order for cannabis are set out in sections 273 and 274 of the [Cannabis Regulations](#).

¹² See the BCCNP Controlled Prescription Pads webpage for more information about lost or stolen pads.

¹³ See the BCCNP Controlled Prescription Pads webpage for more information about returning pads to BCCNP.

LIMITS AND CONDITIONS

The table below sets out the limits and conditions for nurse practitioner prescribing. These limits and conditions supplement the prescribing standards listed above. Nurse practitioners who are uncertain about their authority to prescribe a certain drug should contact BCCNP regulatory practice support at practice@BCCNP.ca.

Prescribing	
1. Nurse practitioners do not prescribe controlled drugs and substances or authorize medical cannabis ¹⁴ for themselves, a family member, or anyone else who is not a client the nurse practitioner is treating in their professional capacity.	
2. Nurse practitioners do not prescribe non-controlled drugs and substances for themselves or a family member except for a minor/episodic condition and only when there is no other prescriber available.	
3. Nurse practitioners do not provide any person with a blank, signed prescription.	
4. Nurse practitioners do not provide any person with a blank, signed medical document for cannabis.	
5. Antiretroviral therapy for the prophylaxis or treatment of HIV infection	a. Nurse practitioners who prescribe antiretroviral therapy for the prophylaxis or treatment of HIV infection must meet the education requirements of the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE). b. Nurse practitioners apply the clinical practice guidelines of the BC-CfE when prescribing antiretroviral therapy for the prophylaxis or treatment of HIV infection.
6. Blood and blood products	a. Nurse practitioners who prescribe blood and blood products must meet the standards, limits and conditions set out in <i>E. Advanced Procedures and Activities</i> .
7. Cosmetic treatments	a. See the limits for cosmetic treatments (e.g. Botox Cosmetic®) set out in <i>E. Advanced Procedures and Activities</i> .
8. Cancer drug treatment ¹⁵	a. Nurse practitioners who prescribe cancer drug treatment must meet the education requirements of BC Cancer. b. Nurse practitioners apply the clinical practice guidelines of BC Cancer when prescribing cancer drug treatment.

¹⁴ As noted in footnote 7 above, “medical cannabis” does not include Schedule 1 drugs containing cannabis.

¹⁵ Cancer drug treatment: treatment using drugs which inhibit or prevent the proliferation of cancers, including chemotherapy, hormonal therapy, immunotherapy, targeted therapy and others (BC Cancer).

Prescribing	
9. General anesthetics	<ul style="list-style-type: none"> a. Nurse practitioners do not prescribe general anesthetics for the purpose of inducing general anesthesia. b. Nurse practitioners who prescribe general anesthetics for the purpose of medical assistance in dying must meet the standards, limits and conditions set out in <i>H. Medical Assistance in Dying</i>.
10. Controlled drugs and substances	<ul style="list-style-type: none"> a. Before prescribing controlled drugs and substances, nurse practitioners must register for PharmaNet access appropriate to the practice sites where they will be prescribing controlled drugs and substances (e.g. Community Health Practice Access to PharmaNet). b. Nurse practitioners who prescribe controlled drugs and substances must successfully complete one of the following courses: <ul style="list-style-type: none"> i. University of Ottawa: Prescribing Narcotics and Controlled Substances ii. Athabasca University: Prescription and Management of Controlled Drugs and Substances iii. Saskatchewan Polytechnic: Controlled Drugs and Substances Act (CDSA) Module for Nurse Practitioners iv. University of Toronto: Controlled Drugs and Substances Essential Management and Prescribing Practices c. Nurse practitioners who prescribe controlled drugs and substances must complete BCCNP's Controlled Drugs and Substances (CDS) Prescribing Module. d. Nurse practitioners who prescribe controlled drugs and substances must meet the BCCNP Competencies for NP Prescribing of Controlled Drugs and Substances for the context or contexts in which they are prescribing. <p>Note: See prescribing limits 1, 2, 3 and 4 above.</p>
10.1 Chronic Non-Cancer Pain ¹⁶	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe controlled drugs and substances for chronic non-cancer pain must complete additional education. ¹⁷

¹⁶ Chronic non-cancer pain is pain with a duration of three months or longer that is not associated with a diagnosis of cancer (National Pain Centre, 2017).

¹⁷ 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 term does not refer to a course or program approved by BCCNP for BCCNP certified practice.

Prescribing	
10.2 Methadone for analgesia	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe methadone for analgesia must complete: <ol style="list-style-type: none"> i. the Methadone for Pain in Palliative Care course offered by the Canadian Virtual Hospice ii. a preceptorship with an experienced methadone for analgesia prescriber
10.3 Opioid agonist treatment for opioid use disorder	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe opioid agonist treatment for opioid use disorder must meet the standards, limits and conditions set out in <i>G. Opioid Agonist Treatment Prescribing for Opioid Use Disorder</i> .
10.4 Medical Assistance in Dying	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe drugs for the purpose of medical assistance in dying must meet the standards, limits and conditions set out in <i>H. Medical Assistance in Dying</i> .
10.5 Amphetamine, Benzphetamine, Methamphetamine, Phendimetrazine, Phenmetrazine, and their salts	<p>Nurse practitioners prescribe these controlled drugs and substances only for the treatment of narcolepsy, hyperkinetic disorders in children, epilepsy, parkinsonism, or hypotensive states associated with anesthesia as per the federal <i>Food and Drug Regulations</i> Section G.04.001.</p> <p>Nurse practitioners prescribing these controlled drugs and substances meet requirements in 10a-d.</p> <p>Note: Nurse practitioners have full prescribing authority for dextroamphetamine as it is not considered a designated drug under the Food and Drug Regulations Section G.04.001.</p> <p>Please refer to the CDS Prescribing FAQs for additional clarification:</p>
10.6 Anabolic steroids and their derivatives	<p>Nurse practitioners do not prescribe anabolic steroids or their derivatives, except testosterone, as per the federal <i>New Classes of Practitioner Regulations</i> Section 4(2)(a).</p> <p>Nurse practitioners prescribing testosterone meet requirements in 10a-d.</p>
10.7 Coca leaves	Nurse practitioners do not prescribe coca leaves as per the federal <i>New Classes of Practitioner Regulations</i> Section 4(2)(b).
10.8 Opium	Nurse practitioners do not prescribe opium as per the federal <i>New Classes of Practitioner Regulations</i> Section 4(2)(b).

G. Opioid Agonist Treatment Prescribing for Opioid Use Disorder

INTRODUCTION

The standards, limits and conditions in this document set out the requirements for prescribing¹⁸ opioid agonist treatment for opioid use disorder. These standards, limits and conditions do not apply to prescribing opioid agonists for pain and other symptoms.

STANDARDS

1. Nurse practitioners prescribing opioid agonist treatment meet the standards, limits and conditions set out in *F. Prescribing Drugs*.
2. Nurse practitioners prescribing opioid agonist treatment apply the clinical practice guidelines for the treatment of opioid use disorder established by the [British Columbia Centre on Substance Use](#).
3. Nurse practitioners prescribing opioid agonist treatment apply knowledge about:
 - a. substance use disorders including opioid use disorder
 - b. treatment strategies for opioid use disorder (e.g. opioid agonist treatment, psychosocial treatment interventions)
 - c. harm reduction strategies for opioid use disorder
4. When prescribing opioid agonist treatment, nurse practitioners:
 - a. make or confirm a diagnosis of opioid use disorder using the DSM-5™ diagnostic criteria
 - b. review the client's medication profile and history through PharmaNet and other sources
 - c. assess for other substance use disorders and/or concurrent use of substances (e.g. alcohol, benzodiazepines, other sedative-hypnotics)
 - d. develop a treatment plan that takes into account any risks identified during the client's assessment
5. Nurse practitioners prescribe opioid agonist treatment in a manner that promotes client and public safety (e.g. prescribe as daily witnessed ingestion until the client has sufficient clinical stability and is able to safely store take-home (carry) doses).

¹⁸ Includes initiating, continuing, or discontinuing the prescribing of a drug.

LIMITS AND CONDITIONS

1. Nurse practitioners who only prescribe buprenorphine-naloxone on a continuation basis for the treatment of opioid use disorder must complete:
 - a. additional education¹⁹
 - b. a preceptorship, of a minimum of two half-days length, under the guidance of a practitioner who has expertise prescribing opioid agonist treatment and treating clients with opioid use disorder

2. Nurse practitioners who prescribe opioid agonist treatment for opioid use disorder (other than continuation prescribing of buprenorphine-naloxone) must:
 - a. meet the education requirements of the [British Columbia Centre on Substance Use](#)
 - b. complete a preceptorship that meets the requirements of the British Columbia Centre on Substance Use

¹⁹ 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 BCCNP for BCCNP certified practice.

H. Medical Assistance in Dying

INTRODUCTION

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

Only two forms of medical assistance in dying are permitted under the Criminal Code:

- the administering by a medical practitioner or nurse practitioner of a substance to a person at their request that causes their death
- the prescribing or providing by a medical practitioner or a nurse practitioner of a substance to a person at their request, for their self-administration and in doing so cause their own death.

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.

Legal advice is available for nurse practitioners from the [Canadian Nurses Protective Society](#). Nurse practitioners may also contact [practice support](#) at BCCNP to discuss professional and ethical obligations.

End of Life Care

There is an important distinction between the intended outcomes of medical assistance in dying and palliative care. The purposeful and intended outcome of medical assistance in dying is to assist an eligible client explicitly requesting assistance in dying to end their life in a respectful, culturally appropriate, safe, ethical, and competent manner. Medical assistance in dying is not an appropriate alternative for a client who is seeking palliative care.

The Criminal Code requires that a client requesting medical assistance in dying is informed of the means that are available to relieve their suffering, including palliative care. This supports the client requesting medical assistance in dying to gather information needed to make an informed decision about their health care options.

Health professionals are permitted to provide information about medical assistance in dying as an end of life option to clients. However, directing, counselling or recommending a client to end their life remains an offence under the Criminal Code.

Definitions

The following terms are used in this standard:

- *Assessor*: A nurse practitioner or medical practitioner who is responsible for completing an eligibility assessment of the client.
- *Assessor-Prescriber*: A nurse practitioner or medical practitioner who is responsible for completing both an eligibility assessment and providing medical assistance in dying by prescribing and (when applicable) administering the substance to be used in MAiD. This role may be referred to by other regulatory colleges as the “prescribing nurse practitioner”.

Nurse Practitioner Role in Medical Assistance in Dying

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

- determining the eligibility of the client 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 client, at their request, that causes their death
- providing MAiD by prescribing and/or providing the medical assistance in dying substances to a client, 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 practitioner²⁰

Transfer of Request for Care

Any nurse practitioner receiving a written request for MAiD who transfers the care of the client to another provider or care coordinator for any reason must complete the provincial form to report details about this transfer of care. See the [BC Ministry of Health Medical Assistance in Dying website](#) for more details.

Conscientious Objection

A nurse practitioner may have beliefs and values that differ from those of a client. 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. The [Duty to Provide Care](#) practice standard provides guidance on how a nurse practitioner can address conscientious objection.

Nurse practitioners with a conscientious objection take all reasonable steps to ensure that the quality and continuity of care for clients seeking or receiving medical assistance in dying are not compromised. This includes ensuring a safe transfer of care to an alternate provider that is timely, continuous, respectful and addresses the unique needs of a client

Nurse practitioners with a conscientious objection must notify their organization well before the client is to receive medical assistance in dying. If medical assistance in dying is unexpectedly proposed or requested and no arrangement is in place for alternative providers, nurse practitioners must inform those most directly involved in the care of the client of their conscientious objection.

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 assessors. One of the assessors must be the person prescribing and administering the medical assistance in dying substances (or prescribing the substances for self-administration [i.e., the assessor-prescriber]). Only a nurse practitioner registered in British Columbia or a medical practitioner may be an assessor or assessor-prescriber.

Both the assessor-prescriber and the second assessor must agree in writing that the client requesting medical assistance in dying meets the criteria for MAiD as set out by the Criminal Code, which includes that the client has a grievous and irremediable medical condition causing suffering that is intolerable to the client. A request for medical assistance in dying is contextual to the client'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 client requesting medical

²⁰ Nurse practitioners aiding in the provision of medical assistance in dying by a medical practitioner or nurse practitioner will adhere to the standards for medical assistance in dying identified in the Scope of Practice for Registered Nurses: Standards, Limits and Conditions.

assistance in dying understands such factors and is able to communicate a reasoned decision based on that understanding.

Under the Criminal Code, both the assessor-prescriber and the second assessor must be independent of each other. To be considered independent, each of the 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 client making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that client's death, other than standard compensation for their services relating to the request
- not know or believe that they are connected to the other assessor or to the client making the request in any other way that would affect their objectivity.

Witnessing Requests for Medical Assistance in Dying

The Criminal Code requires that a client'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 client making the request, or that they will receive, in any other way, any financial or other material benefit resulting from the client's death
- must not be an owner or operator of any health care facility at which the client 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 client making the request
- must not directly provide personal care to the client making the request

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

The Criminal Code requires that if the client 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 may sign in the client's presence, on the client's behalf, and under the client's express direction. The person acting as a proxy must:

- be at least 18 years of age
- understand the nature of the request for medical assistance in dying, and
- not know or believe that they are a beneficiary under the will of the client making the request, or that they will receive, in any other way, any financial or other material benefit resulting from the client's death.

Reporting Requirements

For the purpose of oversight or monitoring of MAiD, there are specific requirements and timeframes for reporting MAiD information. Reporting requirements may apply to nurse practitioners in the following situations:

- Transfer of care in response to a written request
- Withdrawal of request by the client
- Determination of ineligibility
- Death of client from another cause
- Provision of MAiD by administering a substance

- Provision of MAiD by prescribing or providing a substance for self-administration

For more information on reporting requirements and timeframes, please visit the [BC Ministry of Health Medical Assistance in Dying website](#).

STANDARDS

1. Nurse practitioners participating in any aspect of medical assistance in dying understand and comply with the Criminal Code and other legislation, the BCCNP standards of practice, and provincial and organizational policies and procedures related to medical assistance in dying.
2. Nurse practitioners will have a complete and full discussion with the client about medical assistance in dying that provides the client with the information required to make informed decisions about medical assistance in dying, including information about the means that are available to relieve the client's suffering, including palliative care.
3. Nurse practitioners ensure that all necessary measures are taken to provide a reliable means by which the client will understand the information that is provided to them and communicate their decision, including when the client has difficulty communicating.
4. 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:
 - a. the client's diagnosis and prognosis
 - b. feasible alternatives (including comfort care, palliative care and pain control)
 - c. option to withdraw the request for medical assistance in dying at any time
 - d. risks of taking the prescribed substances intended to cause death
5. Nurse practitioners assess the cultural and spiritual needs and wishes of the client seeking medical assistance in dying and explore ways the client's needs could be met within the context of the care delivery.
6. Nurse practitioners work with their organizations and other members of the health care team to ensure that the client 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.
7. Nurse practitioners acting as an assessor or assessor-prescriber must ensure clients requesting medical assistance in dying meet the following eligibility criteria, as set out in the Criminal Code, including that the client:
 - a. is eligible for publicly funded health-care services in Canada
 - b. is at least 18 years of age and capable of making decisions with respect to their health
 - c. has a grievous and irremediable medical condition, which means meeting all of the following criteria:
 - i. they have a serious and incurable illness, disease or disability
 - ii. they are in an advanced state of irreversible decline in capability
 - iii. 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
 - iv. 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

- d. has made a voluntary request in writing for medical assistance in dying that, in particular, was not made as a result of external pressure
 - e. 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
8. Nurse practitioners acting as an assessor or assessor-prescriber must ensure that:
 - a. the client requesting MAiD is competent and able to give free and informed consent to MAiD. Consent cannot be given for MAiD through an alternate or substitute decision-maker, or a personal advance directive.
 - b. both assessors are satisfied that the client is mentally capable of making a free and informed decision with respect to medical assistance in dying at the time of the request and throughout the process.
 - c. if either 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 (e.g., a psychologist, psychiatrist, neurologist, geriatrician, or family physician/general practitioner with additional training and expertise) for a further capacity assessment.
 9. Nurse practitioners acting as an assessor-prescriber must ensure that the client maintains mental capacity for medical assistance in dying in order to proceed. If at any time during the progression of the client’s condition, the client loses the mental capacity to rescind their decision, MAiD ceases to be an option.
 10. One of the 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.

Notice: March 27, 2020 (updated April 22, 2020, for clarity). Effective immediately and for the duration of the COVID-19 public health emergency in British Columbia, the standard allowing only one assessor to conduct a telemedicine assessment for a client requesting MAiD is temporarily rescinded. Both assessors may conduct the assessment by telemedicine. Telemedicine assessments must meet the requirements set out in federal legislation as well as the standards and expectations that apply to in-person assessments. For MAiD assessments, telemedicine includes video of sufficient quality to ensure expected safeguards are in place. A telephone interview is not sufficient in most circumstances.

Notice: March 27, 2020. Effective immediately and for the duration of the COVID-19 public health emergency in British Columbia, the requirement for a regulated health professional to be in physical attendance with the client to act as a witness to a telemedicine assessment is temporarily subject to the following exception: No witness is required for a telemedicine assessment if a regulated health professional is not reasonably available for that purpose.

11. Nurse practitioners acting as an assessor-prescriber must, before prescribing, providing or administering medical assistance in dying to a client as permitted under the Criminal Code:
 - a. be of the opinion that the client meets all of the eligibility criteria established for medical assistance in dying
 - b. ensure that the request for medical assistance in dying was a voluntary request and was not made as a result of external pressure

- c. ensure that the request was signed and dated after the client was advised by a physician or nurse practitioner that they have a grievous and irremediable condition
 - d. be satisfied that the request for medical assistance in dying was made in writing and signed and dated by the client or by their proxy before two independent witnesses, who then also signed and dated the request
 - e. ensure that the client has been informed that they may, at any time, and in any manner, withdraw their request
 - f. ensure that another assessor (physician or nurse practitioner) provided a written opinion that the client meets all of the eligibility criteria established for medical assistance in dying
 - g. be satisfied that they and the other assessor are independent
 - h. ensure that there are at least 10 days between the day on which the request was signed²¹ by or on behalf of the client and the day on which medical assistance in dying is provided, or if both 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
12. Immediately before providing medical assistance in dying, the nurse practitioner acting as an assessor-prescriber must give the client an opportunity to withdraw their request and ensures that the client gives express consent to receive medical assistance in dying.
 13. Nurse practitioners acting as an assessor-prescriber, who prescribe²² 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.
 14. The nurse practitioner acting as an assessor-prescriber must receive the substances for medical assistance in dying directly from the dispensing pharmacist.
 15. Nurse practitioners acting as an assessor-prescriber must personally attend the client during the self-administration or personally administer the substances for medical assistance in dying, and must remain in attendance until death is confirmed. This responsibility must not be delegated or assigned to any other person.
 16. Nurse practitioners acting as an assessor-prescriber are responsible for completing the medical certificate of death. 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.
 17. Nurse practitioners comply with information or medical record requests made by a provincial agency tasked with a review of medical assistance in dying.
 18. Nurse practitioners comply with reporting requirements established for the oversight or monitoring of MAiD. The required information must be submitted to the BC Ministry of Health using the applicable provincial forms and within the established timeframes for reporting²³.

²¹ The Criminal Code requires 10 "clear days" from the valid request to the procedure. The day the request is signed in a valid manner is Day 0 and the day of the procedure is Day 11; the 10 days are the days between those points. "Signed in a valid manner" means that the request is: made in writing and signed by the person or a proxy; signed and dated after the person was informed they had a grievous and irremediable condition; and signed and dated in the presence of two independent witnesses, who meet the conditions in the Criminal Code.

²² When prescribing substances for MAiD, nurse practitioners also follow the Prescribing Drugs standards, limits, and conditions found in Part F, including the limits and conditions on controlled drugs and substances.

²³ Timeframes for reporting are dependent on the information being submitted. Refer to the BC Ministry of Health Medical Assistance in Dying website for more information.

19. Nurse practitioners administering the medical assistance in dying substances complete the Provincial Medication Administration Record and retain it as part of the medical record. Additionally, nurse practitioners are responsible for returning to the pharmacy any unused substances as soon as reasonably practicable, within 72 hours of confirmation of the client's death. This responsibility must not be delegated or assigned to any other person.

Notice: March 27, 2020. Effective immediately and for the duration of the COVID-19 public health emergency in British Columbia, the requirement that nurse practitioners must not delegate or assign the return of MAiD substances to any other person is temporarily subject to the following exception: A nurse practitioner may ask another physician, nurse practitioner, licensed practical nurse, registered nurse, registered psychiatric nurse or pharmacist to return the substances to the pharmacy. The nurse practitioner must document the name of the person assigned to return the substances in the client record.

20. Nurse practitioners must ensure the following information is present in the client's medical record:
 - a. copies of all relevant medical records from other medical practitioners/ health care professionals 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
 - b. documentation of all requests for medical assistance in dying with a summary of the discussion
 - c. confirmation that the assessor-prescriber and the second assessor discussed and determined which practitioner would prescribe and/or administer the substance used for medical assistance in dying
 - d. confirmation by the assessor-prescriber that all the requirements have been met including the steps taken and the substance prescribed
 - e. confirmation that after the completion of all documentation, and just prior to administration, the client was offered the opportunity to withdraw the request
21. Nurse practitioners must use and follow the applicable provincial forms, guidelines, and pre-printed provincial prescription specific to medical assistance in dying.

LIMITS AND CONDITIONS

1. Nurse practitioners acting as assessors or assessor-prescribers for medical assistance in dying must:
 - a. possess demonstrated knowledge of and function within the parameters and criteria of the Criminal Code and other legislation, regulations, regulatory college standards, and provincial and organizational policy and procedures related to medical assistance in dying
 - b. have the competence appropriate to their role, including competence to:
 - i. 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
 - ii. assess the client against criteria in the Criminal Code related to medical assistance in dying
 - iii. assess the capacity of the client to consent to medical assistance in dying and when it is necessary to refer for further capacity assessment, and
 - iv. implement the provincial medical assistance in dying substances protocols and manage the intended and unintended outcomes
 - c. not participate in medical assistance in dying for themselves or a family member.
2. To be eligible to act as an assessor, nurse practitioners must have completed additional education²⁴ 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 eligibility assessment in medical assistance in dying.
3. To be eligible to act as an assessor-prescriber, nurse practitioners must have completed additional education²⁴ and a preceptorship under the guidance of a qualified medical practitioner or nurse 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.

²⁴ 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 term does not refer to a course or program approved by BCCNP for BCCNP certified practice.

Appendix A. Glossary

Additional education: 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 term does not refer to a course or program approved by BCCNP for BCCNP certified practice.

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

Competence: The integration and application of knowledge, skills and judgment required for safe and appropriate performance in an individual's practice.

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).

Nursing: the health profession in which a person provides the following services: a) health care for the promotion, maintenance, and restoration of health; b) prevention, treatment and palliation of illness and injury, primarily by i) assessing health status, ii) planning, implementing and evaluating interventions, and iii) coordinating health services; c) medical assistance in dying.

Order: An "order" is any instruction or authorization given by a regulated health professional to provide care for a specific client, whether or not the care or service includes any restricted activity. Orders can include instructions that set out the usual care for a particular client group or client problem and are made client-specific by the ordering regulated health professional. The order must be documented in the client's permanent record by the regulated health professional; include all the information needed for the ordered activity to be carried out safely (e.g. time, frequency, dosage, etc.); and include a unique identifier such as a written signature or an electronically generated identifier. Once given, orders may be transcribed in other documents such as a client care plan.

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 nurses are educated and authorized to perform as set out in the *Nurses (Registered) and Nurse Practitioners Regulation* under the Health Professions Act and complemented by standards, limits and conditions established by BCCNP.

Standard: An expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance.

Appendix B. Resources

NURSE PRACTITIONER COMPETENCIES & STREAMS OF PRACTICE

- [*Entry-Level Competencies for Nurse Practitioners in Canada*](#)
- [*Applying the Competencies Required for Nurse Practitioners in British Columbia*](#)
- [*Nurse Practitioner Streams of Practice*](#)
- [*Competencies for Nurse Practitioner Prescribing of Controlled Drugs and Substances*](#)

PRACTICE STANDARDS

See complete list on the BCCNP website www.bccnp.ca.

- [*Appropriate Use of Titles*](#)
- [*Boundaries in the Nurse-Client Relationship*](#)
- [*Communicable Diseases: Preventing Nurse-to-Client Transmission*](#)
- [*Conflict of Interest*](#)
- [*Consent*](#)
- [*Delegating Tasks to Unregulated Care Providers*](#)
- [*Dispensing Medications*](#)
- [*Documentation*](#)
- [*Duty to Provide Care*](#)
- [*Duty to Report*](#)
- [*Employed Student Registrants*](#)
- [*Medication Administration*](#)
- [*Medication Inventory Management*](#)
- [*Privacy and Confidentiality*](#)
- [*Regulatory Supervision of Nursing Student Activities*](#)
- [*Telehealth*](#)

PROFESSIONAL STANDARDS

- [*Professional Standards for Registered Nurses and Nurse Practitioners*](#)

PRACTICE SUPPORT

If you have questions about your scope of practice or other standards, you can talk with a Regulatory Practice Consultant. Email practice@BCCNP.ca or telephone 604.736.7331 (ext. 332) or 1.800.565.6505 (ext. 332).

RELEVANT LEGISLATION

- [*BC Laws*](#)
- [*Justice Laws Website*](#)
- [*Legislation Relevant to Nurses' Practice*](#)

PRESCRIBING RESOURCES

- [Rapid Access to Consultative Expertise \(RACE\)](#) (604) 696-2131 or 1-877-696-2131
- [Electronic Consultative Access to Specialist Expertise \(eCASE\)](#)

OPIOID AGONIST TREATMENT PRESCRIBING RESOURCES

Guidelines

BC CENTRE ON SUBSTANCE USE

- [A Guideline for the Clinical Management of Opioid Use Disorder](#)
- [Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder](#)

COLLEGE OF PHYSICIANS AND SURGEONS OF BC

- [Safe Prescribing of Drugs with Potential for Misuse/Diversion](#)

Education

Courses available from the [BC Centre on Substance Use](#):

- [Provincial Opioid Addiction Treatment Support Program](#) — for prescribers who plan to prescribe opioid agonist treatment for opioid use disorder
- [Online Addiction Medicine Diploma](#) — for health care professionals interested in learning about providing care for all substance use disorders, including opioid addiction