

PRACTICE STANDARD

Nurses: Medication

Introduction

This practice standard sets expectations that **nurses** must meet when they perform **medication-related activities** within their authorized scope of practice, including medication-related **restricted activities**. This practice standard is applied in conjunction with all other standards, limits and conditions associated with medication-related activities, including the standards, limits and conditions for acting within autonomous scope of practice, acting under **client-specific orders**, prescribing, giving client-specific orders, and medical assistance in dying. For certified registered nurses and certified registered psychiatric nurses, their certification-specific standard(s) apply as well.

Standards

1. Nurses perform only those medication-related activities as allowed by:
 - a. Relevant provincial or federal legislation or regulations,
 - b. BCCNM's ethics standards and practice standards including any applicable limits, and conditions on performing the activity,
 - c. Organizational/employer policies, processes, and restrictions, and
 - d. The nurse's individual **competence**.
2. Nurses follow relevant provincial or federal legislation or regulations, BCCNM's ethics standards and practice standards including any applicable limits, and conditions on performing the activity, and organizational/employer policies, processes, and restrictions when performing any medication-related activity.
3. Nurses use current evidence to support their decision-making about **medications** and their medication practices.
4. Nurses follow infection prevention and control principles when performing medication-related activities.
5. Before performing any medication-related activity, nurses know the medication's:
 - a. Therapeutic use/indications,
 - b. Expected effects,
 - c. Dosage(s),
 - d. Precautions,
 - e. Contraindications,
 - f. Form (e.g. tablet, liquid), and route for administration,

- g. Interactions,
 - h. Side effects, and
 - i. Adverse effects.
6. Nurses assess the appropriateness of the medication for the **client** before administering, dispensing, or prescribing a medication.
7. Nurses assess and respect the client's values, beliefs, personal preferences, language, learning needs, abilities, mental state, and level of understanding, to support the client (or the **client's representative**) to be an active participant in making informed decisions about the medication.
8. Nurses educate the client (or the client's representative) about the medication they are receiving, including, as applicable:
 - a. The reason the client is receiving the medication,
 - b. The expected action of the medication,
 - c. The duration of the medication therapy,
 - d. Specific precautions or instructions for the medication,
 - e. Potential side-effects and adverse effects (e.g. allergic reactions) and action to take if they occur,
 - f. Potential interactions between the medication and certain foods, other medications, or substances,
 - g. Handling and storage requirements,
 - h. Recommended follow-up.
9. Nurses identify the effect of their own values, beliefs, and experiences on their clinical decision-making about medication related activities, recognize potential conflicts and take action for the client's needs to be met.
10. Nurses take action when a medication does not seem:
 - a. Appropriate, because the client's condition has changed,
 - b. Evidence-informed, or
 - c. Reflective of the client's individual needs, characteristics, values/beliefs, or personal preferences.
11. Nurses collaborate, communicate, and/or consult with the health-care team in making decisions about medication-related activities, including:
 - a. Consideration of the broader plan of care for the client developed by the health-care team,
 - b. The follow-up needed with respect to medication when the client's care is transferred to another health professional, or when the client transfers to another clinical or care setting or to their home,
 - c. When the client's care would benefit from the expertise of other health care professionals,
 - d. When the needs of the client exceed the nurse's individual **competence** or scope of practice, and
 - e. Documenting the plan of care.
12. When a pharmacist has not reviewed and verified a medication's pharmaceutical and therapeutic suitability, or if it is unclear whether this has occurred, nurses take steps to ensure pharmaceutical and therapeutic suitability before administering or dispensing a medication by:

- a. Reviewing the client's best available medication history and other personal health information,
 - b. Assessing the client's known allergies and ensuring medication allergy information is documented,
 - c. Considering potential medication interactions, contraindications, therapeutic duplications, side effects, adverse effects, and any other potential problems,
 - d. Using current, evidence-informed resources to support their clinical decision-making, and
 - e. Considering the client's ability to follow the medication regimen.
13. Nurses administer, dispense, or prescribe medications only for clients under their care, except in an emergency.

MEDICATION ADMINISTRATION

14. Before administering a medication to a client, nurses verify, at minimum, the:
- a. Client name and second client identifier,
 - b. Medication,
 - c. Dose,
 - d. Time and frequency,
 - e. Route, and
 - f. Reason for administration to the client.
15. Before administering a medication, nurses ensure they have the competence to:
- a. Monitor the client's response to the medication, and
 - b. Recognize and manage intended and adverse outcomes of the medication.
16. Nurses only administer medications they themselves, a pharmacist, or a pharmacy technician have prepared, except in an emergency or during large-scale immunization efforts where organizational policies, processes, and restrictions are in place to ensure safe practices.
17. Nurses record the administration of medication on an individual medication profile and/or client record each time a medication is administered.

DISPENSING MEDICATIONS

18. When dispensing a medication, nurses:
- a. Ensure the product has not expired,
 - b. Label the medication legibly with:
 - i. Client name and second client identifier,
 - ii. Medication name, dosage, route, and strength,
 - iii. Directions for use,
 - iv. Quantity dispensed,
 - v. Date dispensed,
 - vi. Initials of the nurse dispensing the medication,
 - vii. Name, address, and telephone number of the agency from which the medication is dispensed,
 - viii. Name and designation of the prescribing health professional, and

- ix. Any other information that is appropriate and/or specific to the medication,
 - c. Hand the medication directly to the client, or, if appropriate, to the client's representative or another authorized delegate.
19. When dispensing a medication, nurses record dispensing information on an individual medication profile and/or client record that includes:
- a. Client name, address, phone number, date of birth,
 - b. Allergies and adverse medication reactions, if available,
 - c. Date dispensed,
 - d. Name, strength, dosage of medication,
 - e. Quantity of medication dispensed,
 - f. Intended duration of therapy, specified in days (if applicable),
 - g. Directions to client,
 - h. Name of prescribing health professional, and
 - i. Signature and title of the person dispensing the medication.
20. In response to the opioid crisis, nurses are authorized to dispense naloxone to a person who is neither their client nor their client's representative, but who may encounter an individual experiencing a suspected opioid overdose.
- a. In this instance, which is an exception, nurses would not be expected to follow all of the principles outlined above with respect to a potential individual recipient of the naloxone, to the extent it is not possible to do so when that individual's identity is unknown.
 - b. Nurses take steps to ensure public safety by teaching the person to whom they dispense the naloxone how to respond to individuals experiencing a suspected opioid overdose.
 - c. Nurses follow all applicable organizational/employer policies, processes, and restrictions, regarding naloxone.

ACTING WITHIN AUTONOMOUS SCOPE OF PRACTICE (WITHOUT AN ORDER)

21. Nurses are accountable and responsible when they make a decision that a client's physical or mental condition would benefit from the administration or dispensing of a medication within their autonomous scope of practice.
22. When administering or dispensing a medication within their autonomous scope of practice, nurses:
- a. Follow organizational policies, processes, and restrictions, as applicable.
 - b. Assess the client's health status including allergies.
 - c. Make or confirm a **nursing diagnosis** of a condition¹² that can be improved or resolved by administering or dispensing a medication.
 - d. Decide whether the client would benefit from the medication, having considered:

¹ Registered nurses and registered psychiatric nurses certified in a BCCNM certification program may also make a diagnosis of a disease, disorder or condition that is within the autonomous scope of the nurse's BCCNM certification program and the nurse's individual competence.

² Nurse practitioners may also make a diagnosis of a disease, disorder or condition that is within their autonomous scope of practice and the nurse practitioner's individual competence.

- i. Known risks and benefits
 - ii. Other relevant factors specific to the client or situation
 - iii. Assessment of medication alternatives
- e. Manage, monitor, and evaluate the client's response to the medication (as applicable) including intended and unintended outcomes.
- f. Communicate and collaborate with the client (or the client's representative) and the health-care team and document the **nursing diagnosis**, decision, actions, and outcomes related to the medication administered or dispensed to the client.

PREVENTING MEDICATION ERRORS

23. Nurses identify the human and system factors that may contribute to medication errors and/or near misses, and they act to prevent or minimize them.
24. Nurses take action, including following organizational/employer policies, processes, and restrictions, and when an error or near miss occurs at any point of a medication-related activity.

MEDICATION INVENTORY MANAGEMENT

25. Nurses who have responsibility for the management of medication inventory follow organizational/employer policies and processes and, as needed, consult with, and seek guidance from expert resources and pharmacists regarding:
- d. Handling,
 - e. Storage,
 - f. Organization of medication,
 - g. Security,
 - h. Transport,
 - i. Disposal, and
 - j. Recording of medications.

Glossary

Client: person receiving health services.

Client's Representative: a person with legal authority to give, refuse or withdraw consent to health care on a client's behalf, including, as appropriate:

- (a) a "committee of the patient" under the Patients Property Act,
- (b) the parent or guardian of a client under 19 years of age with parental responsibility to give, refuse or withdraw consent to health care for the child under section 41(f) of the Family Law Act,
- (c) a representative authorized by a representation agreement under the Representation Agreement Act to make or help in making decisions on behalf of a client,

- (d) a temporary substitute decision maker chosen under section 16 of the Health Care (Consent) and Care Facility (Admission) Act, or
- (e) *a substitute decision maker chosen under section 22 of the Health Care (Consent) and Care Facility (Admission) Act.*

Client-specific order: an instruction or authorization given by a regulated health professional to provide care for a specific client, whether or not the care or service includes a restricted activity or a non-restricted activity.

Competence: the integration and application of current knowledge, skills, ability, and judgment required to perform ethically, safely and in accordance with all applicable ethics standards and practice standards.

Medication: refers to Schedule I, IA, II, III, and unscheduled drugs as defined in the provincial [Drug Schedules Regulation](#) under the [Pharmacy Operations and Drug Scheduling Act](#) (PODSA).

Medication-related activities: activities that include, but are not limited to, administering, dispensing, compounding, prescribing, preparing, handling, storing, securing, disposing of, and transporting medication.

Nurses: refers to licensed practical nurses, nurse practitioners, registered nurses, and registered psychiatric nurses licensed with BCCNM.

Nursing diagnosis: A clinical judgment made by a nurse of a client's mental or physical condition to determine whether the condition can be prevented, improved, ameliorated or resolved by the performance of activities or provision of other care or services that it is within the nurse's scope of practice to provide without an assessment or diagnosis of the client by another regulated health professional.

Restricted Activity: An activity that is performed in the course of providing a health service and is prescribed by the regulations under the *Health Professions and Occupations Act* as a restricted activity.

Revision history

Version #	Approved by board	Bylaw in-force	Description
1.0	March 1, 2026	April 1, 2026	Initial publication

Effective April 1, 2026, this practice standard, and any amendments to it, is made a bylaw under the authority of the *Health Professions and Occupations Act, B.C.*

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