



NURSE PRACTITIONERS

# Scope of Practice

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 Nurses and Midwives (BCCNM) 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 BCCNM policy is revised or legislation is amended. BCCNM registrants will be notified of changes.

If you have questions about your scope of practice or other standards, you can submit a query via the [standards support form](#).

## Revision Log

Revision Date	Revisions Made
Sept. 1, 2020	Published by BCCNM (new college)
Sept. 24, 2020	Minor revision to MAiD standard 8c, as per BCCNM board Sep. 24, 2020 decision
March 1, 2020	References to Telehealth practice standard removed (standard rescinded)
April 6, 2021	Revisions to bring MAiD standards, limits and conditions in line with changes to the Criminal Code
November 25, 2021	Added standards and limits and conditions for prescribing pharmaceutical alternatives for safer supply; updated standards and limits and conditions for prescribing opioid agonist treatment
June 30, 2022	Updated MAiD standards, limits, and conditions related to returning unused substances to pharmacy; removed COVID-19 temporary exemption
August 2, 2022	Added new limits and conditions for the ordering and provision of medical aesthetics
February 1, 2023	Updated Section D to reflect changes to the <i>Mental Health Act</i>
April 28, 2023	Updated limits and conditions for nurse practitioners applying X-rays
July 18, 2023	Update to requirements for verbal and faxed CPP prescriptions
September 21, 2023	Amendments to the standards related to prescribing medications to address gaps identified by engagement with key informants and audiences.
December 20, 2023	Amendments to the prescribing standard to rescind the limit related to amphetamines and other designated drugs.
January 25, 2024	Amendments to the Mental Health and Capacity Assessment standards, limits, and conditions; removed limit related to prescribing anabolic steroids and their derivatives.

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## 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 BCCNM 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 nurses<sup>1</sup>
- 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 BCCNM.

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

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<sup>1</sup> See the [Use of Title practice standard](#) and the [BCCNM Bylaws](#) for more information.

- 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.”

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.<sup>2</sup>
- 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 BCCNM.

### 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.<sup>3</sup> 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.

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

<sup>3</sup> 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](http://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.

Sections 6 and 7 of the Regulation list the restricted activities that registered nurses may carry out as part of general practice.<sup>4</sup> 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.

## B. The Role of BCCNM: Standards, Limits and Conditions

The *Health Professions Act* gives BCCNM 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 BCCNM Board by the Nurse Practitioner Standards Committee in accordance with the Regulation and BCCNM 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, BCCNM uses standards rather than limits and conditions to provide direction for practice.

As with all BCCNM registrants, nurse practitioners are expected to meet all BCCNM Standards of Practice for RNs and NPs. The BCCNM Standards of Practice include:

- [Professional standards](#)
- [Practice standards](#)
- *Scope of Practice for NPs: Standards, Limits and Conditions* (this document)

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<sup>4</sup> For more on registered nurse scope of practice, refer to BCCNM's [Scope of Practice for Registered Nurses: Standards, Limits and Conditions](#).



## C. Controls on Nursing Practice

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

1. The Regulation, which sets out the scope of practice in fairly broad strokes.
2. BCCNM standards, limits and conditions, which complement and further define and limit the scope of practice set out in the Regulation.
3. Organizational or employer policies that may restrict the practice of nurse practitioners in a particular agency or unit.
4. An individual nurse practitioner's competence to carry out a particular activity.

### 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 BCCNM Board by the Nurse Practitioner Standards Committee (NPSC) in accordance with the Regulation and BCCNM 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 apply X-rays<sup>5</sup> only after completing additional education,<sup>6</sup> and when organizational supports, including policies and procedures, are in place to support the safe application of X-rays.
2. Nurse practitioners applying X-rays also follow the standards for [Advanced Procedures and Activities](#).
3. Nurse practitioners apply X-rays in an appropriate clinical setting that is suitable to safely perform the procedure and includes the equipment and supplies needed to manage any emergency situations.
4. Nurse practitioners only use Health Canada-approved devices when applying X-rays.
5. Nurse practitioners do not take responsibility for the final interpretation of medical imaging studies. Nurse practitioners may initiate appropriate treatment while waiting for the final interpretation from a diagnostic radiologist.

## D. Mental Health & Capacity Assessments

### STANDARDS FOR MENTAL HEALTH AND CAPACITY ASSESSMENTS

1. When completing a medical certificate for involuntary admission under the *Mental Health Act* or a capacity assessment,<sup>7</sup> nurse practitioners act in compliance with the nurse practitioner standards of practice, relevant legislation, employer policies, and their individual competence.
2. Nurse practitioners completing a medical certificate for involuntary admission under the *Mental Health Act* or a capacity assessment discuss with the client the reasons for completing the medical certificate or the findings of the capacity assessment.

### MENTAL HEALTH ACT – INVOLUNTARY ADMISSIONS

The *Mental Health Act* sets out the criteria for the involuntary admission of a person to a provincial mental health facility, psychiatric unit, or observation unit (a “designated facility”) for up to 48 hours for examination and psychiatric treatment.

Under the *Mental Health Act*, nurse practitioners are authorized to complete:

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- 5 Per the Nurses (Registered) and Nurse Practitioners Regulation, nurse practitioners do not apply X-rays for the purpose of computerized axial tomography.
  - 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 BCCNM for BCCNM certified practice.
  - 7 Capacity assessments include the statutory incapability assessments described in these standards, as well as any other capacity assessments that a nurse practitioner is authorized to provide.

- The first medical certificate to support a person's involuntary admission under section 22(1) (Involuntary Admission);
- An examination of a person requested by a police officer or constable under section 28 (Emergency Procedures) and, if required, the first medical certificate to support that person's involuntary admission under section 22(1) (Involuntary Admission).

Nurse practitioners complete Form 4.1 (First Medical Certificate [Involuntary Admission]) after examining the person in accordance with section 22(3) of the *Mental Health Act*.

Under the *Mental Health Act*, nurse practitioners are not permitted:

- To complete a second medical certificate (Form 4.2) under section 22(2) to support a person's continued involuntary admission and treatment,
- To complete Form 6 (Medical Report on Examination of Involuntary Patient [Renewal Certificate]),
- To provide a second medical opinion, or
- To authorize or take responsibility for an Extended Leave (Form 20).

A person examined by a nurse practitioner under sections 22 or 28 is considered to be their client for the purposes of BCCNM standards, limits, and conditions.

Before requesting involuntary admission of a client under the *Mental Health Act*, nurse practitioners must meet the following limits and conditions.

### Limits and Conditions

1. Nurse practitioners successfully complete the following course before completing a Form 4.1 (First Medical Certificate [Involuntary Admission]) under the *Mental Health Act*:
  - a. Protecting People's Rights: Mandatory Mental Health Act Forms (Physicians and Nurse Practitioners)<sup>8</sup>
2. Nurse practitioners who complete a medical certificate for involuntary admission of a client under the *Mental Health Act* do so only after assessing the client in person.
3. Nurse practitioners act in accordance with the B.C. Ministry of Health document *Guide to the Mental Health Act*.

### ADULT GUARDIANSHIP ACT – FINANCIAL INCAPABILITY ASSESSMENTS

Under the *Statutory Property Guardianship Regulation*, nurse practitioners are authorized to conduct the functional component of an assessment for financial capability (the adult's ability to manage their

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<sup>8</sup> Available through the PHSA Learning Hub.

own financial affairs – section 32(3) of the *Adult Guardianship Act*). A medical component must also be completed and only a medical practitioner may do that assessment.

### Limits and Conditions

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."](#)

## HEALTH CARE (CONSENT) AND CARE FACILITY (ADMISSION) ACT – INCAPABILITY ASSESSMENTS FOR CARE FACILITY ADMISSION

Under section 16 of the *Health Care Consent Regulation*, nurse practitioners are prescribed as assessors for the purposes of Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act*. This authority allows a nurse practitioner to assess an adult for capability to give consent to admission to, or continuing residence in, a care facility (section 26 of the *Health Care [Consent] and Care Facility [Admission] Act*).

### Limits and Conditions

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".

## MORE INFORMATION

Nurse practitioners with questions regarding the standards, limits, and conditions for mental health and capacity assessments can submit them via the [standards support form](#).

For more information on the legislation listed above, see the BCCNM document [Legislation Relevant to Nurses Practice](#).

## 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 activities<sup>9</sup> 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.<sup>10</sup>
3. Nurse practitioners perform advanced procedures and activities only when performance occurs with sufficient frequency to maintain competence.

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9 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.

10 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 BCCNM for BCCNM certified practice.



## 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:
  - a. Successfully complete additional education<sup>6</sup> (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

1. 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

1. Nurse practitioners:
  - a. Do not give an order or apply laser for the purpose of destroying tissue

### Medical Aesthetics<sup>11</sup>

1. Nurse practitioners order medical aesthetic procedures only when:

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<sup>11</sup> "Medical aesthetics" refers to elective non-surgical clinical procedures that include the performance of a restricted activity (activities listed in sections 6, 7 and 9 of the *Nurses (Registered) and Nurse Practitioners Regulation*) and are primarily intended to alter or restore a person's appearance.

- a. The individual acting on the order is a nurse holding practising registration with BCCNM; and,
  - b. The ordering nurse practitioner, or another nurse practitioner or medical practitioner who has assumed responsibility for the care of the client, is or will be present within the facility when the procedure is being performed and immediately available for consultation.
2. Nurse practitioners complete additional education<sup>12</sup> before providing or ordering medical aesthetic procedures.
  3. Nurse practitioners only provide medical aesthetic procedures or order them to be performed in an appropriate clinical setting that is suitable to safely perform the procedure and includes the equipment and supplies necessary to manage emergency situations.
  4. Nurse practitioners only use Health Canada-approved drugs, substances and medical devices when providing or ordering medical aesthetic procedures.
  5. Nurse practitioners only provide or order medical aesthetic procedures for clients under the age of 19 for the treatment of acne or scarring.
  6. Nurse practitioners do not provide or order any medical aesthetic procedures that require conscious/procedural sedation or general anesthesia.

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<sup>12</sup> 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 BCCNM for BCCNM certified practice.

## F. Prescribing Drugs

### INTRODUCTION

Nurse practitioners prescribe drugs in accordance with relevant federal and provincial legislation and the BCCNM 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 BCCNM.

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 <sup>13</sup>

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

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<sup>13</sup> 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.

- 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 guidelines<sup>14</sup> when prescribing.
6. When prescribing, nurse practitioners:
  - a. Consider the client's health history and other relevant factors (e.g. age, sex, gender, past medical and mental health history, lifestyle, risks factors and the client's perspective on their health)
  - b. Undertake and document an appropriate clinical evaluation (e.g. physical examination, mental health examination, review of relevant tests, imaging and specialist reports)
  - c. Obtain and review the best possible medication history for the client using PharmaNet and/or other sources (including any traditional medicines, natural health products, non-prescription medications, and substance use, in addition to prescribed medications), and take action to address any discrepancies
  - d. Ask about the client's drug allergies and ensure drug allergy information is accurately and appropriately documented
  - e. Document the drugs prescribed to the client and the indication(s) for the drugs
  - f. Establish a plan for reassessment/follow-up
  - g. 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

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<sup>14</sup> 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 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. The name of the drug or ingredients, strength if applicable, and dose
  - 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 faxed<sup>15</sup>
  - 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:
  - 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

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<sup>15</sup> Effective April 17, 2023, when a verbal or faxed CPP prescription is issued to a pharmacy, a faxed copy of the CPP form is now acceptable. A hard copy of the original CPP prescription form no longer needs to be sent to the pharmacy. Prescriptions for long-term care and extended care licenced facility patients do not require the use of controlled prescription forms and may be faxed to the authorized community pharmacy.

- 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)
  - h. Follow the requirements of the [British Columbia Controlled Prescription Program](#)<sup>16</sup> including requirements related to securing and disposing of prescription pads; reporting any loss, theft or misuse of the prescription pads; and record retention.
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](#)<sup>17</sup>
  - f. Retain any copy of the medical document for cannabis in the client health record
15. Before changing to non-practising or inactive registration with BCCNM (and therefore relinquishing prescribing authority), nurse practitioners take steps to ensure prescription refills and part-fills are managed for clients.

## 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

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<sup>16</sup> [Controlled Prescription Program | College of Pharmacists of British Columbia \(bcpharmacists.org\)](#)

<sup>17</sup> Requirements for completing a medical document or written order for cannabis are set out in sections 273 and 274 of the [Cannabis Regulations](#).

about their authority to prescribe a certain drug should contact BCCNM regulatory practice support via the [standards support form](#).

Prescribing	
1. Nurse practitioners do not prescribe controlled drugs and substances or authorize medical cannabis <sup>18</sup> 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	<p>a) Nurse practitioners who prescribe antiretroviral therapy for the prophylaxis or treatment of HIV infection must meet the <a href="#">education requirements</a> of the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE).</p> <p>b) Nurse practitioners apply the <a href="#">clinical practice guidelines</a> of the BC-CfE when prescribing antiretroviral therapy for the prophylaxis or treatment of HIV infection.</p>
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. Medical aesthetics	a) See the limits and conditions for medical aesthetics, set out in <i>E. Advanced Procedures and Activities</i> .
8. Cancer drug treatment <sup>19</sup>	<p>a) Nurse practitioners who prescribe cancer drug treatment must meet the education requirements of BC Cancer.</p> <p>b) Nurse practitioners apply the <a href="#">clinical practice guidelines</a> of BC Cancer when prescribing cancer drug treatment.</p>
9. General anesthetics	a) Nurse practitioners do not prescribe general anesthetics for the purpose of inducing general anesthesia.

<sup>18</sup> As noted in footnote 7 above, "medical cannabis" does not include Schedule 1 drugs containing cannabis.

<sup>19</sup> 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	
	<p>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>.</p>
10. Controlled drugs and substances	<p>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. <a href="#">Community Health Practice Access to PharmaNet</a>).</p> <p>b) Nurse practitioners who prescribe controlled drugs and substances must successfully complete one of the following courses:</p> <ol style="list-style-type: none"> <li>i. <a href="#">University of Ottawa: Prescribing Narcotics and Controlled Substances</a></li> <li>ii. <a href="#">Athabasca University: Prescribing Controlled Drugs</a></li> <li>iii. <a href="#">Saskatchewan Polytechnic: Controlled Drugs and Substances Act (CDSA) Module for Nurse Practitioners</a></li> <li>iv. <a href="#">University of Toronto: Controlled Drugs and Substances Essential Management and Prescribing Practices</a></li> </ol> <p>c) Nurse practitioners who prescribe controlled drugs and substances must complete BCCNM's <a href="#">Controlled Drugs and Substances (CDS) Prescribing Module</a>.</p> <p>d) Nurse practitioners who prescribe controlled drugs and substances must meet the BCCNM <a href="#">Competencies for NP Prescribing of Controlled Drugs and Substances</a> for the context or contexts in which they are prescribing.</p> <p><b>Note:</b> See prescribing limits 1, 2, 3 and 4 above.</p>
10.1 Chronic Non-Cancer Pain <sup>20</sup>	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. <sup>21</sup>

<sup>20</sup> 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).

<sup>21</sup> 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



Prescribing	
10.2 Methadone for analgesia	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe methadone for analgesia must complete: <ul style="list-style-type: none"> <li>a) The <a href="#">Methadone for Pain in Palliative Care</a> course offered by the Canadian Virtual Hospice</li> <li>b) A preceptorship with an experienced methadone for analgesia prescriber</li> </ul>
10.3 Opioid Agonist Treatment for Opioid Use Disorder/ Pharmaceutical Alternatives for Safer Supply	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe opioid agonist treatment for opioid use disorder and/or pharmaceutical alternatives for safer supply must meet the standards, limits and conditions set out in <i>G. Prescribing for Opioid Use Disorder and/or Pharmaceutical Alternatives for Safer Supply</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 Coca leaves	Nurse practitioners <b>do not</b> prescribe coca leaves as per the federal <i>New Classes of Practitioner Regulations</i> Section 4(2)(b).
10.6 Opium	Nurse practitioners <b>do not</b> prescribe opium as per the federal <i>New Classes of Practitioner Regulations</i> Section 4(2)(b).

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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 BCCNM for BCCNM certified practice.

## G. Prescribing for Opioid Use Disorder and/or Pharmaceutical Alternatives for Safer Supply

### INTRODUCTION

The standards, limits and conditions in this document set out the requirements for prescribing<sup>22</sup>:

- Opioid agonist treatment for opioid use disorder; and/or
- Pharmaceutical grade alternatives to illicit drugs for clients who are at risk of drug toxicity events and death (pharmaceutical alternatives for safer supply)

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 and/or pharmaceutical alternatives for safer supply meet the standards, limits and conditions set out in *F. Prescribing Drugs*;
2. Nurse practitioners prescribing opioid agonist treatment and/or pharmaceutical alternatives for safer supply 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 substance use and opioid use disorder
3. Nurse practitioners prescribe opioid agonist treatment and/or pharmaceutical alternatives for safer supply in a manner that promotes client and public safety.

### LIMITS AND CONDITIONS

1. Nurse practitioners who prescribe opioid agonist treatment for opioid use disorder and/or pharmaceutical alternatives for safer supply must:
  - a. Meet the education requirements of the [British Columbia Centre on Substance Use](#); and
  - b. Complete a preceptorship that meets the requirements of the British Columbia Centre on Substance Use
2. Nurse practitioners who prescribe opioid agonist treatment for opioid use disorder must apply the clinical practice guidelines for the treatment of opioid use disorder established by the British Columbia Centre on Substance Use.

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<sup>22</sup> Includes initiating, continuing, or discontinuing the prescribing of a drug.

3. Nurse practitioners who prescribe pharmaceutical alternatives for safer supply must:
  - a. Follow clinical protocols as per the Ministry of Mental Health and Addiction/Ministry of Health [Access to Prescribed Safer Supply in British Columbia: Policy Direction](#) or the guidance of the British Columbia Centre on Substance Use; and
  - b. Participate in evaluation and monitoring of prescribing of pharmaceutical alternatives for safer supply as per the Ministry of Mental Health and Addiction/Ministry of Health [Access to Prescribed Safer Supply in British Columbia: Policy Direction](#).

## H. Medical Assistance in Dying

### INTRODUCTION

In accordance with the Criminal Code and other legislation, the BCCNM standards of practice, and provincial and organizational policies and procedures, nurse practitioners may provide a client with medical assistance in dying (MAiD).

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, legal and competent manner.

Nurse practitioners contemplating participation in medical assistance in dying need to confer with their employer about their employer's requirements.

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

### Overview of Medical Assistance in Dying

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 client at their request that causes their death
- The prescribing or providing by a medical practitioner or a nurse practitioner of a substance to a client at their request, for their self-administration that in doing so causes their own death.

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. However, directing, counselling or recommending a client to end their life remains an offence under the Criminal Code.

As of March 17, 2021 the MAiD eligibility criteria and safeguards in the Criminal Code were updated. Updates include that clients with a grievous and irremediable medical condition no longer require their death to be reasonably foreseeable to be eligible receive MAiD; however, additional safeguards have been added to the Criminal Code which must be satisfied before a MAiD can be provided to such a client. In certain circumstances, clients whose death is reasonably foreseeable can also now waive the requirement for final consent to receive MAiD if they lose the capacity to consent before MAiD is provided to them.

## 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 practitioner<sup>23</sup>

## Transfer of Request for Care

Any nurse practitioner receiving a written request for MAiD who transfers the care of the client 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.

The standard requires nurse practitioners with a conscientious objection to take all reasonable steps to ensure that the quality and continuity of care for clients seeking or receiving medical assistance in

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<sup>23</sup> 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.

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.

The *Duty to Provide Care practice standard* also requires nurse practitioners with a conscientious objection to 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, that practice standard further requires nurse practitioners to inform those most directly involved in the care of the client of their conscientious objection.

### Eligibility Requirements for Medical Assistance in Dying (Criminal Code Section 241.2(1) and (2))<sup>24</sup>

As of March 17, 2021, clients who wish to receive MAiD must satisfy all of the following eligibility criteria:

- Be 18 years of age or older and have decision-making capacity
- Be eligible for publicly funded health care services
- Make a voluntary request that is not the result of external pressure
- Give informed consent to receive MAiD, meaning that the client has consented to receiving MAiD after they have received all information needed to make this decision, including information about the means available to relieve their suffering (including palliative care)
- Have a serious and incurable illness, disease or disability (excluding a mental illness)
- Be in an advanced state of irreversible decline in capability
- Have enduring and intolerable physical or psychological suffering that is intolerable to them and cannot be alleviated under conditions the client considers acceptable

### Procedural Safeguards (Criminal Code s. 241.2(3))<sup>25</sup>

The following procedural safeguards must be satisfied before MAiD is provided to any client:

- The request for MAiD must be made in writing; a written request must be signed by an independent witness, and it must be made after the client is informed that they have a "grievous and irremediable medical condition"
- Two independent nurse practitioners or medical practitioners, including the assessor-prescriber and a second independent assessor, must assess the client and confirm their opinion that the client meets all of the eligibility criteria listed above
- The client must be informed that they can withdraw their request at any time, in any manner

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24 See also: Justice Canada. (2021, March 19). Canada's new medical assistance in dying (MAiD) law. <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>

25 See also: Justice Canada. (2021, March 19). Canada's new medical assistance in dying (MAiD) law. <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>

- If the client has difficulty communicating, all necessary measures must be taken to provide a reliable means for the client to understand the information provided to them and communicate their decision
- The client must be given an opportunity to withdraw consent and must expressly confirm their consent immediately before receiving MAiD; however, this “final consent” requirement can be waived in certain circumstances for a client whose natural death is reasonably foreseeable

### Additional Procedural Safeguards for Clients Whose Natural Death is not Reasonably Foreseeable (Criminal Code s. 241.2(3.1))<sup>26</sup>

In addition to all of the above safeguards, the following further procedural safeguards must also be satisfied before MAiD is provided to any client whose natural death is not reasonably foreseeable:

- If neither the assessor-prescriber nor the second independent assessor who has assessed the client has expertise in the medical condition that is causing the client’s suffering, they must consult with another nurse practitioner or medical practitioner who has such expertise
- The client must be informed of available and appropriate means to relieve their suffering, including counselling services, mental health and disability support services, community services and palliative care, and must be offered consultations with professionals who provide those services
- The client, the assessor-prescriber, and the second independent assessor who has assessed the client must all have discussed reasonable and available means to relieve the client’s suffering, and they must all agree that the client has seriously considered those means
- There must be at least 90 days between the time that the client is first assessed as meeting the eligibility criteria listed above and the time that MAiD is provided to the client; however, this period can be shortened (as the assessor-prescriber considers appropriate in the circumstances) if both the assessor-prescriber and the second independent assessor have completed their assessments of the client, and if they both agree that the client is about to lose the capacity to make health care decisions.

### Independence of Assessor-Prescriber and Second Assessor (Criminal Code s. 241.2(6))

To act as the client’s assessor-prescriber or as the second independent assessor who assesses the client, a nurse practitioner or medical practitioner must meet all of the following requirements:

- Neither the assessor-prescriber nor the second assessor may be a mentor to the other or responsible for supervising their work

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<sup>26</sup> See also: Justice Canada. (2021, March 19). Canada’s new medical assistance in dying (MAiD) law. <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>

- They must not know or believe that they are a beneficiary under the client's will, or that they will benefit in any other way from the client's death
- They must not know or believe that they are connected to the client or the other practitioner in another other way that would affect their objectivity

### Witnessing Requests for Medical Assistance in Dying (Criminal Code s. 241.2(5) and (5.1))<sup>27</sup>

The role of the independent witness is to provide confirmation of the client's signing and dating of their request for MAiD, and that the client understands what they are signing.

An independent witness must be at least 18 years of age and must understand what it means to request MAiD.

An independent witness can be a paid professional personal or health care worker who does not act as the client's assessor-prescriber or the second independent assessor.

To be considered independent means that the witness **cannot**:

- Know or believe that they are a beneficiary under the client's will, or that they will benefit in any other way from the client's death
- Be an owner or operator of a health care facility where the client lives or is receiving care
- Be a caregiver for the client, unless that is their primary occupation for which they are paid

### Proxy for Signing Consent if the Client Requesting Medical Assistance in Dying is Unable to Sign (Criminal Code s. 241.2(4))

If the client requesting MAiD 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 MAiD, 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 what it means to request MAiD, and
- Not know or believe that they are a beneficiary under the client's will, or that they will benefit in any other way from the client's death.

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<sup>27</sup> See also: Health Canada. (2021, March 18). Medical assistance in dying. <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>



### Waiver of Final Consent (Criminal Code s. 241.2(3.2))<sup>28</sup>

As of March 17, 2021, the requirement for the client to confirm their final consent immediately before receiving MAiD may be waived for a client whose natural death is reasonably foreseeable, in the event that the client loses the capacity to consent before MAiD is provided, provided that:

- The client has been assessed and approved to receive MAiD
- The client is at risk of losing decision-making capacity before their preferred date to receive MAiD, and the assessor-prescriber has informed them of that risk
- The client makes an arrangement in writing with the assessor-prescriber to waive final consent, under which the assessor-prescriber will administer MAiD on their preferred date if they have lost the capacity to provide final consent at that time

The agreement to waive final consent will be invalid if the client, after having lost decision-making capacity, demonstrates refusal or resistance to the administration of MAiD by words, sounds or gestures. Reflexes and other types of involuntary movements, such as a response to a touch or to the insertion of a needle, do not constitute refusal or resistance.

### Advance Consent for MAiD by Self-Administration (Criminal Code s. 241.2(3.5))<sup>29</sup>

As of March 17, 2021, clients approved to receive MAiD who choose to self-administer the substance for MAiD may also make an arrangement in writing with the assessor-prescriber if complications arise after the ingestion of the substance, causing loss of decision-making capacity but not death.

Such arrangements allow the client to provide their consent in advance to practitioner-administered MAiD, in the event of complications with self-administration, and if the practitioner is present at the time of self-administration. All clients who choose to self-administer a substance for the purpose of MAiD can make such an arrangement with the assessor-prescriber, regardless of their prognosis.

### Reporting Requirements

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

- Transfer of care in response to a written request
- Withdrawal of request by the client
- Completion of a MAiD eligibility assessment

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<sup>28</sup> See also: Justice Canada. (2021, March 19). Canada's new medical assistance in dying (MAiD) law. <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>

<sup>29</sup> See also: Justice Canada. (2021, March 19). Canada's new medical assistance in dying (MAiD) law. <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>

- 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, 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 BCCNM standards of practice, and provincial and organizational policies and procedures related to medical assistance in dying.
2. Nurse practitioners 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. This must include information about the means that are available to relieve the client's suffering, including palliative care (Criminal Code, section 241.2(1)(e)). More specifically, when the client's natural death is not reasonably foreseeable, the nurse practitioner acting as an assessor-prescriber must ensure that the client has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care, and that the client has been offered the opportunity for consultations with professionals who provide those services or that care (Criminal Code, section 241.2(3.1)(g)).
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:
  - a. The client's diagnosis and prognosis
  - b. Feasible alternatives (including 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 ensure the information provided in standard 4 is included in the client's medical record and that a copy is provided to the client.
6. 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.

7. 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.
8. Nurse practitioners acting as an assessor or assessor-prescriber must ensure clients requesting medical assistance in dying meet the eligibility criteria set out in the Criminal Code (section 241.2(1) and (2)).<sup>30</sup>
9. Nurse practitioners acting as an assessor or assessor-prescriber must ensure that:
  - a. They meet the independence requirements set out in the Criminal Code (section 241.2(6)).<sup>31</sup>
  - b. 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.
  - c. 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.
  - d. 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.
10. Nurse practitioners acting as an assessor or assessor-prescriber may provide their assessment virtually if they comply with the following conditions:
  - a. Nurse practitioners ensure that during the virtual assessment, another regulated health professional is in physical attendance with the client to act as a witness to the assessment, unless no other regulated health professional is reasonably available to attend in person.
  - b. Virtual assessments must meet the requirements set out in federal legislation and all other standards and expectations that apply to in-person assessments.
  - c. Virtual assessment must include video of sufficient quality to ensure expected safeguards are in place.

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<sup>30</sup> Section 241.2(1) sets out the general eligibility criteria to receive MAiD. Section 241.2(2) set out the criteria for a "grievous or irremediable condition".

<sup>31</sup> Section 241.2(6) establishes independence requirements for both the assessor-prescriber and the second assessor who assesses the client to confirm their eligibility for MAiD.

11. Nurse practitioners acting as an assessor-prescriber, before prescribing, providing or administering medical assistance in dying to a client, must comply with all applicable procedural safeguards set out in the Criminal Code (section 241.2(3) or (3.1)).<sup>32</sup>
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 ensure that the client gives express consent to receive medical assistance in dying, unless they meet the criteria in the Criminal Code for waiver of final consent (section 241.2(3.2) or (3.5)).<sup>33</sup>
13. Nurse practitioners acting as an assessor-prescriber, who prescribe<sup>34</sup> or administer the substances to be used in medical assistance in dying, must do so in the client's name, using the provincial medical assistance in dying prescription form.
14. The nurse practitioner acting as an assessor-prescriber must receive the substances for medical assistance in dying directly from the dispensing pharmacist, and must inform the dispensing pharmacist that the substances are intended for the purpose of medical assistance in dying.
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 complete 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 reporting.<sup>35</sup>

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32 Section 241.2(3) establishes the procedural safeguards when death is reasonably foreseeable. Section 241.2(3.1) establishes the procedural safeguards when death is not reasonably foreseeable.

33 Section 241.2(3.2) sets out criteria for a waiver of final consent for clients whose death is reasonably foreseeable. Section 241.2(3.5) sets out criteria for advance consent for clients who choose to self-administer a MAiD substance.

34 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.

35 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 acting as an assessor-prescriber are responsible for ensuring that any unused substances are returned to the pharmacy as soon as reasonably practicable, within 72 hours of confirmation of the client's death.
  - a. If a nurse practitioner acting as an assessor-prescriber is not reasonably available to return unused substances to the pharmacy themselves, they may ask another nurse practitioner, or a licensed practical nurse, registered nurse, registered psychiatric nurse, physician 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 use and follow the applicable provincial forms, prescriptions and guidelines, specific to medical assistance in dying.
21. Nurse practitioners must ensure the following information is present in the client's medical record:
  - a. All applicable [provincial forms](#) for medical assistance in dying, including the BC Medical Assistance in Dying Prescription form and Medication Administration Record
  - b. 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
  - c. Documentation of all requests for medical assistance in dying with a summary of the discussion
  - d. 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
  - e. Confirmation by the assessor-prescriber that all the requirements have been met including the steps taken and the substance prescribed
  - f. Confirmation that after the completion of all documentation, and just prior to administration, the client was offered the opportunity to withdraw their request, or that the client waived final consent and did not demonstrate refusal or resistance to the administration of MAiD by words, sounds or gestures.

## 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, BCCNM standards,

- and provincial and organizational policy and procedures related to medical assistance in dying.
- b. Have the competence appropriate to their role, including to:
    - i. Diagnose or confirm the diagnosis of a grievous and irremediable medical condition and, if applicable, the prognosis of reasonably foreseeable death
    - 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 determine 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 education<sup>36</sup> 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 education<sup>33</sup> 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.

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<sup>36</sup> 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 BCCNM for BCCNM 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 BCCNM for BCCNM 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 BCCNM.

**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 BCCNM website [www.bccnm.ca](http://www.bccnm.ca).

- [Boundaries in the Nurse-Client Relationship](#)
- [Communicable Diseases: Preventing Nurse-to-Client Transmission](#)
- [Conflict of Interest](#)
- [Consent](#)
- [Delegating Tasks to Unregulated Care Providers](#)
- [Documentation](#)
- [Duty to Provide Care](#)
- [Duty to Report](#)
- [Employed Student Registrants](#)
- [Medication](#)
- [Privacy and Confidentiality](#)
- [Regulatory Supervision of Students](#)
- [Use of Title](#)

### PROFESSIONAL STANDARDS

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

### STANDARDS AND GUIDANCE SUPPORT

If you have questions about your scope of practice or other standards, you can submit it using the [standards support form](#).



## 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

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900 – 200 Granville St  
Vancouver, BC V6C 1S4  
Canada

[www.bccnm.ca](http://www.bccnm.ca)

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