APPENDIX A –

CANADA: LEGISLATION AND POLICY

(Appendices O - 1 to N.W.T. & Nun. - 34)
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Registered Nurses in the Extended Class

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OUR MISSION is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.
Introduction

A Registered Nurse (RN) who earns Extended Class designation [RN(EC)] has successfully demonstrated her/his competence to the College of Nurses of Ontario (CNO) as a Primary Health Care Nurse Practitioner (PHCNP). In addition to upholding the standards of practice for RNs in the General Class, RN(EC)s are expected to meet the following Extended Class standards of practice.

RN(EC)s have advanced knowledge and decision-making skills in health assessment, diagnosis, therapeutics (including pharmacological, complementary and counselling interventions), health care management, and community development and planning. Their scope of practice includes:

- assessing and providing services to clients in all developmental stages, and to families and communities; and
- providing comprehensive health services encompassing:
  - health promotion and education,
  - prevention of diseases and injuries,
  - treatment,
  - rehabilitation,
  - continuity of care, and
  - support services.

RN(EC)s have the legislated authority to perform controlled acts beyond those authorized to RNs and Registered Practical Nurses (RPNs).

Standards of Practice

The College's standards of practice outline the knowledge, skills, judgment and attitudes necessary for safe practice, including accountabilities and responsibilities. All nurses, including RN(EC)s, must know and practise in accordance with the standards relevant to their practice area. This document contains the standards of practice, the quality assurance expectations and references to the legislation and regulations specific to RN(EC) practice.

The standards of practice provide an overall framework for nursing practice, and link with other standards, guidelines and competencies developed by the College. They describe practice expectations and apply to all nurses in all practice areas. Other standards of practice include the Therapeutic Nurse-Client Relationship, Medication and professional misconduct regulations. For a comprehensive understanding of College standards, refer to CNO’s Compendium of Standards of Practice for Nurses in Ontario.

Scope of Authority

Using a scope of practice model, the Regulated Health Professions Act, 1991 (RHPA) and the Nursing Act, 1991 set and guide the practice of nursing. The practice framework consists of two elements: a scope of practice statement and a series of authorized or controlled acts.

When ordered by a physician, dentist, midwife, or chiropodist, or when permitted by the Nursing Act regulations, all nurses can perform the following controlled acts:

1. performing a prescribed procedure below the dermis;
2. administering a substance by injection or inhalation; and
3. putting an instrument, hand or finger beyond a body orifice or artificial opening to the body.

In addition, RN(EC)s can perform the following controlled acts:

4. communicating to a client or his/her representative:
   - a diagnosis made by the RN(EC),
   - identifying, as the cause of a client's symptoms, a disease or disorder identified from the client's health history,
   - the findings of a comprehensive examination, or
• the results of any laboratory tests or other tests and investigations that the RN(EC) can order or perform.
5. prescribing a drug as designated in the regulations;
6. administering a drug by inhalation or injection that RN(EC)s may prescribe; and
7. ordering the application of a form of energy prescribed in the regulations (i.e. diagnostic ultrasound).

RN(EC)s can also order laboratory and diagnostic tests, such as x-rays and ECGs, and can complete a Medical Certificate of Death in specific circumstances.

The legislation authorizing RN(EC)s to perform these additional controlled acts is described in the College’s Regulated Health Professions Act: Scope of Practice and Controlled Acts Model.

Standards Specific to the RN(EC) Scope of Practice
RN(EC)s must adhere to the following nine standards for their practice areas.

1. Competencies for practice
Extended Class registration is based on the demonstration of competence in each of the six competency areas:
• health assessment and diagnosis;
• therapeutics (pharmacological, complementary and counselling interventions);
• role and responsibility;
• health promotion and disease prevention;
• family health; and
• community development and planning.

Once registered, RN(EC)s are accountable to practise in accordance with these competencies and practice standards.

Health assessment and diagnosis
To diagnose a disease or disorder within the RN(EC) scope of practice, the RN(EC) must:
• complete a health assessment, including a health history and physical examination;
• use sound clinical judgment and diagnostic reasoning when synthesizing health information;
• modify assessment techniques according to the client’s condition, culture and stage of development;
• apply pathophysiology principles, including etiology, developmental considerations, pathogenesis and clinical manifestations of commonly encountered acute and chronic illnesses and injuries;
• determine the need for, and order from, an approved list of screening and diagnostic laboratory tests and interpret the results for diagnosis or to monitor clients who have a previously diagnosed disease or disorder;
• determine the need for, and order and interpret reports of x-rays, ECGs and diagnostic ultrasounds for diagnosis or to monitor clients who have a previously diagnosed disease or disorder; and
• communicate health findings and/or the diagnosis, the prognosis and treatment options for those conditions.

Therapeutics
Within their scope, RN(EC)s initiate and manage the care of clients with diseases or disorders, and/or monitor the ongoing therapy of clients with chronic stable illness by providing effective pharmacological, complementary or counselling interventions. To meet the standard, the RN(EC) must:
• appraise critically and apply current, relevant research into clinical practice;
• apply pharmacology knowledge, including pharmacokinetics and pharmacodynamics, when selecting and prescribing drugs included in the schedules of the regulations;
• incorporate/recommend complementary therapies;
• provide effective counselling to individuals, families or groups;
• manage the treatment of clients with diseases or disorders, or clients with previously diagnosed chronic stable diseases or disorders by doing the following:
  ◦ assisting/supporting/facilitating clients to design, follow and evaluate recommended therapeutic regimens,
  ◦ monitoring the effect of the chosen therapy and making necessary adjustments, and
  ◦ evaluating the effect of selected treatments and interventions using sound diagnostic reasoning skills; and
• determine the need for, and competently suture tissue in and above the fascia.

Role and responsibility

RN(EC)s practise autonomously, offering the full scope of primary health care practice, including consultation with physicians or other health care professionals when the client requires care beyond the RN(EC)'s scope of practice. To meet the standard, the RN(EC) must:
• articulate the RN(EC) role within nursing, and the responsibilities/accountabilities inherent in autonomous practice and in relation to other health care professionals; and
• consult with a physician in accordance with the standards for consultation with physicians (p. 5) and/or refer the client to another health care professional.

Consultation or referral can occur at any point in the assessment, when planning, implementing or evaluating the client's care, or whenever the client's condition requires care beyond the RN(EC)'s scope of practice.

Health promotion and disease prevention

RN(EC)s implement strategies to promote health and prevent illness with individuals, families and groups. To meet the standard, the RN(EC) must:
• determine the need for, and implementation of, health promotion, and primary and secondary prevention strategies for individuals, families, and communities, or for specific age and cultural groups; and
• apply theories of teaching and learning when providing health education to individuals and groups.

Family health

RN(EC)s are proficient in interventions relating to the assessment and care of families. To meet the standard, the RN(EC) must:
• synthesize information from clients to identify broader implications for health within the family;
• use family assessment tools to evaluate family strengths and needs; and
• apply theories of family dynamics, interactions and role expectations when managing family health.

Community development and planning

RN(EC)s are proficient in interventions relating to community assessment, development and program planning. To meet the standard, the RN(EC) must:
• synthesize information from clients to identify broader implications for health within the community;
• use community assessment data and determinants of health to identify community needs and resources when developing and implementing age and culturally sensitive community development programs; and
• apply epidemiology and demography principles to clinical practice.

2. Consultation with physicians

Standards for consultation with physicians focus on situations that extend beyond the RN(EC)'s scope of practice. It is expected that consultation will occur according to these standards at any time during the nurse-client relationship, including during the management and treatment of clients' health conditions. RN(EC)s are
authorized to communicate to an individual a diagnosis of a disease or disorder made by the nurse when certain conditions are met, one of which is compliance with the prescribed standards of practice respecting consultation with members of other professions. Reference to these expectations is included in the Nursing Act which states that an Extended Class member is not authorized to communicate a diagnosis unless she/he “has complied with the prescribed standards of practice respecting consultation with members of other health professions.”

Collaboration
Collaboration, the cornerstone of multidisciplinary care, involves working with one or more members of the health care team who each make a unique contribution from within the limits of her/his scope of practice. RN(EC)s are expected to consult and collaborate with other health professionals as appropriate, to ensure that their clients' overall health care needs are met.

Consultation
Consultation is an explicit request by an RN(EC) for a specific physician to become involved in the care of the client for which the RN(EC) has primary responsibility at the time of the request. Consultation happens when the nurse reaches the limit of the RN(EC) scope of practice, beyond which she/he cannot provide care independently and additional information and/or assistance is required from a professional with a more extensive knowledge base related to the specific client situation.

Assumptions
Consultation expectations are based on the following assumptions:
- RN(EC)s are accountable for establishing a consultative relationship with a physician;
- consultation occurs with a family physician, however, RN(EC)s may consult with a specialist physician if appropriate to the situation and practice setting;
- RN(EC)s are accountable for knowing and complying with consultation expectations in a timely manner;
- CNO expectations are a requirement for consultation and not necessarily for transfer of care. The decision to transfer care is made jointly with a physician;
- consultation follows an explicit request and can occur in a variety of ways (e.g., face-to-face, by telephone, in writing, etc.);
- the degree to which the physician becomes involved varies from providing an opinion and recommendation to providing an opinion, recommendation and concurrent intervention; to assuming primary responsibility for the care of the client (transfer of care);
- consultation may be required at any stage from the initial assessment to the evaluation of treatment effectiveness. Consultation expectations also apply when managing a client with a chronic condition;
- RN(EC)s and the physician develop agreeable structures and processes for consultation; and
- the need for additional consultation guidelines depends on the type of practice, the available resources, changing health care needs and the RN(EC)'s experience. If required, guidelines are developed within individual agencies.

Procedural expectations
When requesting a consultation by a physician, to meet the standard the RN(EC) must:
- explain the reason for, and the level of urgency of, the consultation;
- describe the level of consultation requested: an opinion, recommendation and concurrent intervention; or immediate transfer of care;
- ensure the physician has access to the client's known health information;
- confirm that the RN(EC) and the physician have an agreement and understanding of each

1 The Nursing Act, 1991, Section 5.1.2.
other's responsibilities specific to the situation; and
- document the request for, and outcome of, the consultation.

**Clinical expectations**

To meet the standard, the RN(EC) will seek consultation with a physician:
- when the diagnosis and/or treatment plan is unclear or beyond the scope of RN(EC) practice to determine (but not limited to) if any of the following are present:
  - persistent or recurring sign(s)/symptom(s) that cannot be attributed to an identifiable cause;
  - sign(s), symptom(s), report(s) of imaging or laboratory tests suggesting a previously undiagnosed chronic systemic illness;
  - symptomatic or laboratory evidence of decreased/ing function of any vital organ or system;
  - sign(s) of recurrent or persistent infection;
  - any atypical presentation of a common illness or unusual response to treatment;
  - any sign(s)/symptom(s) of a sexually transmitted disease in a child;
  - any sign(s)/symptom(s) of behavioural changes that cannot be attributed to a specific cause; and/or
  - deviation from normal growth and development in an infant or child.
- in potentially life-threatening situations, including, but not limited to, the presence of any of the following:
  - sign(s)/symptom(s) of an acute event that is potentially threatening to life, limb or senses;
  - sign(s)/symptom(s) of obstruction of any system;
  - signs of severe or widespread infection;
  - a fever of 39°C or higher in a child aged three to 36 months with no identifiable focus of infection;
  - any sign(s)/symptom(s) of illness in a child less than three months old;
  - any blunt, penetrating or other wound that may involve damage below the fascia or functional impairment; and/or
  - sign(s)/symptom(s) of any fetal or maternal pregnancy risk factor.
- when a client's chronic condition destabilizes, including, but not limited to, the presence of any of the following:
  - symptomatic or laboratory evidence of destabilization; and/or
  - unexpected deterioration in the condition of a client who is being managed for a previously diagnosed illness.

3. **Communicating a diagnosis**

An RN(EC) is authorized to communicate to a client or her/his representative a diagnosis made by the member identifying, as the cause of a client's symptoms, a disease or disorder that can be identified from:
- the client's health history;
- the findings of a comprehensive health examination; or
- the results of any laboratory tests or other tests and investigations that the RN(EC) is authorized to order or perform.

The *Nursing Act* states that an Extended Class member is not authorized to communicate a diagnosis unless she/he "has complied with the prescribed standards of practice respecting consultation with members of other health professions."

When an RN(EC) identifies a disease or disorder which is beyond her/his scope of practice, she/he must comply with the standards for consultation with physicians (p. 5).

4. **Prescribing drugs**

RN(EC)s are authorized to prescribe drugs from an approved list. The following outlines their scope of responsibility and process expectations for prescribing drugs:

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2 The *Nursing Act, 1991*, Section 5.1.2.
A. Scope of responsibility
The Nursing Act authorizes RN(EC)s to prescribe drugs from two schedules:
• Schedule 2 — immunizing agents; and
• Schedule 3 — scope of prescription drugs.

Conditions and limitations
The route and/or purpose for some drugs are included in the schedules. Although these drugs may have additional routes or uses, RN(EC)s can only prescribe them for the routes or purposes identified in the schedules. These limitations, called conditions, restrict when or how agents and drugs can be prescribed. The conditions may describe a context (e.g., in an emergency), a condition (e.g., for the purpose of treating sexually transmitted diseases) or a route (e.g., oral preparation). These limitations reflect the RN(EC)’s scope, and she/he is required to know and adhere to these conditions.

Over-the-counter (OTC) drugs
OTC drugs are not on Schedule 3 because they do not require a prescription. Any nurse who recommends OTC drugs is accountable for her/his decision, and the outcome of that decision. RN(EC)s must know which OTC drugs are beyond their scope to recommend or prescribe (e.g., insulin, heparin).

When OTC drugs are identified in the Ontario Drug Benefit Plan, or in other insurance plans that provide reimbursements for the drugs, RN(EC)s may prescribe those OTC drugs within their scope of practice.

Monitoring and documenting drug responses
Monitoring and documenting a client’s response to drug therapy is integral to the authority to prescribe drugs. The RN(EC) may decide to continue, adjust or withdraw the drug which they have prescribed, or consult with a physician in accordance with the standards for consultation with physicians (p. 5).

When an RN(EC) recommends a change to a medication regimen originally prescribed by another health care provider, the RN(EC) must follow up with the original prescriber to discuss the changes, when reasonable, to enhance communication, collaboration and respect among health professionals.

Monitoring adverse drug reactions
A serious adverse drug reaction (ADR) is defined as a "noxious and unintended response to a drug that occurs at any dose and requires inpatient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening or results in death." An RN(EC) who assesses a serious ADR, or is notified of a serious ADR in a client to whom she/he prescribed medications, is required to report it to the Adverse Drug Reaction Reporting Centre of Health Canada within 48 hours:

- Ontario Regional ADR Centre
- LINDIS Drug Information Centre
- London Health Sciences Centre
- 339 Windermere Rd.
- London, ON N6A 5A5
- Telephone: 519 663-8801
- Toll-Free: 1 866 234-2345
- Facsimile: 519 663-2968
- Toll-Free: 1 866 678-6789
- E-mail: adr@lhsc.on.ca

Dispensing drugs
Dispensing drugs includes the selection, preparation and transfer of one or more drugs for administration. It is a controlled act not authorized to nursing. However, nurses can dispense drugs when delegated by a pharmacist or physician. Delegation is required for dispensing drugs that

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3 Canadian Adverse Drug Reaction Monitoring Program Guidelines for the Voluntary Reporting of Adverse Drug Reactions by Health Professionals, Health Canada. www.hc-sc.gc.ca
must be prescribed, including pharmaceutical drug samples of prescription drugs.

Delegation is required for dispensing, regardless of whether the RN(EC) prescribes the medication, implements a medical directive to order the medication, or whether the medication is ordered by another health professional.

For more information on the delegation of dispensing, refer to the Medication practice standard.

Implementing RN(EC) drug prescriptions by RNs and RPNs
RN(EC)s are authorized to order prescriptions for immunization agents and drugs for administration by RNs and RPNs. RN(EC)s must be reasonably available for consultation, as required.

B. Process expectations
Recognizing an authorized prescriber
Before dispensing drugs, pharmacists must confirm that the prescription has come from an authorized prescriber. All pharmacies have access to the Ministry of Health’s online communications system, which includes the names and registration numbers of all authorized prescribers, including all RN(EC)s.

Pharmacists must verify that the RN is a member of the Extended Class, and that the drug is within the RN(EC)’s scope of practice.

Completing a legal prescription
To expedite the dispensing process, the RN(EC) must accurately complete a legal prescription with the following information:
• date;
• client name and address (if available; clients may have no fixed address);
• name, strength, dose and quantity of prescribed drug (refers to the drug’s generic name, the strength, dose and the amount to be dispensed);
• directions for use (refers to the administration route, frequency and the duration. It may also include special instructions, such as “take with food” or “apply sparingly to the skin.”);
• number of allowable refills (any drug that may be refilled must be identified. If all drugs on a multiple prescription require refills, nurses should clearly identify the number of refills for each one.); and
• prescriber’s name, address, signature and Extended Class designation [RN(EC)] and her/his CNO registration number.

Pre-printed and blank prescription pads
RN(EC)s may use blank or pre-printed prescription pads that include the nurse’s name and business address.

Prescription pads should be stored in a secure area away from the public or non-medical staff. To prevent theft or forgery, never provide anyone with blank (signed or unsigned) prescription forms.

Client education
To educate clients about prescription and non-prescription drugs, RN(EC)s must provide information on the following:
• expected action of the drug;
• importance of compliance with prescribed frequency and duration of the drug therapy;
• potential side effects;
• signs/symptoms of potential adverse reactions and actions to take if they occur;
• potential interactions between the drug and certain foods, other drugs, or substances;
• specific precautions to take or instructions to follow;
• recommended follow-up plan; and
• reporting any adverse drug reaction to the RN(EC).

Faxed prescriptions
An RN(EC) may send a fax of a prescription directly to a pharmacist. The pharmacist will take steps to ensure the faxed prescription is authentic. However, neither a client, nor any other intermediary, may fax prescriptions to the pharmacy.
Telephone prescriptions
An RN(EC) should be ready to verify her/his prescriptive authority when calling in a prescription. The information provided over the phone must be consistent with a written prescription.

To meet the standard, RN(EC)s must:
- communicate physicians' orders to pharmacists;
- accept physicians' orders from pharmacists; and/or
- communicate orders established through implementing medical directives.

Medical directives
Although institutions may have medical directives allowing RN(EC)s to order drugs beyond the Extended Class drug schedules, the community pharmacist can only prepare and dispense drugs under the prescriber's name. Community pharmacists will not accept a copy of a medical directive authorizing the RN(EC) to renew certain medications beyond their drug schedules, as a substitute for a prescription. A drug renewal is considered to be a new prescription made under the prescriber's name, regardless of any existing medical directives (College of Pharmacists of Ontario). For more information on medical directives, refer to CNO's Medical Directives practice guideline.

Prescription renewals
RN(EC)s can renew drugs contained within the RN(EC) drug schedules regardless of whether they were the original prescribers. However, they cannot independently write a renewal prescription for drugs not contained in their drug schedules. In other words, an RN(EC) can authorize a prescription renewal originally prescribed by a physician, only if it is listed in the RN(EC)'s drug schedules. RN(EC)s must establish methods for updating physicians on their mutual clients' health conditions and on treatment decisions, including drug renewals.

Ontario drug benefit (ODB)
ODB funds certain drugs that RN(EC)s may prescribe, if they are dispensed in Ontario. RN(EC)s should inform clients who are considering moving out of the province or vacationing.

ODB drug lists are updated and published throughout the year. When a discrepancy between ODB-listed drugs and the RN(EC) drug list occurs, RN(EC) list takes precedence.

Limited use drugs
Limited use prescriptions must include a Limited Use/Nutrition Product Form that indicates the reason for use. Only those drugs that meet limited use criteria are considered for reimbursement.

Prescribing for self or family members
Prescribing for, or providing any other aspect of health care for self or family members is not recommended. The College's Therapeutic Nurse-Client Relationship standard is focused on establishing and maintaining relationship within professional therapeutic boundaries. RN(EC)s should not prescribe for themselves or family, except in emergencies or when there is no health care provider available.

Proposing additions to the drug list
Submissions can be made annually using the RN(EC)s Drug Change Request Forms available at www.cno.org or by FastFax (document #41057) at 416 963-7502. The submission requires evidence-based medical or nursing literature with references and a rationale outlining the following:
- its applicability to RN(EC) scope of practice (i.e., efficacy, safety and cost-effectiveness); and
- its usages in the management of an acute, episodic health condition, including illness prevention or a stable chronic condition.

5. Ordering laboratory tests
RN(EC)s can order laboratory tests according to the Laboratory and Specimen Collection Centre Licensing Act. The following outlines the RN(EC)'s scope of responsibility and practice expectations when ordering laboratory tests.
A. Scope of responsibility
RN(EC)s can request the taking, collecting and processing of specimens for a range of tests, as well as order and perform venipuncture for blood samples for laboratory tests. However, RN(EC)s cannot order another nurse (RN or RPN) to perform this activity. The RN(EC) may order specific laboratory tests to do the following:
• monitor the ongoing condition of a client;
• confirm symptoms of decreasing/increasing function of a vital organ or system;
• confirm a diagnosis of a short-term, episodic illness or injury;
• rule out a potential diagnosis that would require physician consultation; and/or
• perform screening activities.

RN(EC)s interpret laboratory test results in the context of the individual client’s presentation, make decisions about treatment or consult a physician in accordance with the standards.

Laboratory tests not included on the RN(EC) list must be ordered directly by a physician, by means of a medical directive or by a client-specific order. The RN(EC) may request a laboratory report for physician-ordered tests for clients who the RN(EC) is managing.

B. Process expectations
To meet the standard, the RN(EC) must consider the following questions before ordering a laboratory test:
• is the test required to determine an appropriate treatment plan? and
• are the screening activities age-appropriate, evidence-based and cost-effective?

Laboratory test requisition forms must include all required information and the RN(EC)’s signature, designation and OHIP identification number. This identification number authorizes OHIP payment for lab and diagnostic tests, and does not permit the RN(EC) to make direct claim submissions to OHIP. To obtain an identification number, RN(EC)s must complete and submit the application form included in their registration package to the Ministry of Health and Long-Term Care.

RN(EC)s must document the laboratory tests ordered on the client’s permanent record as part of the treatment plan.

RN(EC)s are expected to take or handle specimens, in accordance with CNO’s Infection Control practice guideline. RN(EC)s can contact any licensed laboratory for information about the shipping and transportation of infectious substances.

Proposing additions to the laboratory test list
Submissions can be made annually using the RN(EC)’s Lab and Diagnostic Change Request Forms available at www.cno.org or by FastFax (document #41057) at 416 963-7502. The submission requires evidence-based medical or nursing literature with references and a rationale outlining the following:
• its applicability to RN(EC) scope of practice, (e.g., efficacy, safety and cost-efficiency); and
• its usages in the management of an acute, episodic health condition, including illness prevention, or a stable chronic condition.

6. Ordering x-rays, ultrasounds and other diagnostic tests
The following outlines the scope of responsibility and practice expectations of RN(EC)s when ordering x-rays, diagnostic ultrasounds and other tests. The RN(EC) may order these tests to:
• confirm the diagnosis of an episodic illness or injury as suggested by the client’s history and/or physical findings;
• rule out a potential diagnosis that would require physician consultation if present;
• assess and monitor ongoing conditions of stable chronic illnesses; and/or
• screen for diseases.

The performance of a test includes the following steps:
1. Determining the need for a specific
diagnostic test. The RN(EC) must know the contraindications to ionizing radiation exposure, and the associated risks and benefits of ordering specific tests.

2. Performing the diagnostic test. An RN(EC) may perform an ECG if she/he has the competence, but may not operate an x-ray machine or perform a diagnostic ultrasound.

3. Analyzing and interpreting the diagnostic test. The authorized analysis and interpretation of an x-ray film, ultrasound or ECG is the responsibility of a radiologist or qualified professional and falls outside of the RN(EC) scope of practice. RN(EC)s are expected to consult with the radiologist or another qualified professional if the interpretation of such tests require clarification.

4. Making a decision based on the diagnostic test results. If the RN(EC) understands the interpretation of abnormal test results, she/he can make treatment decisions and/or consult with a physician in accordance with the standards for consultation with physicians (p. 5).

A. Scope of Responsibility

Ordering Ultrasounds
Under the Nursing Act RN(EC)s can order diagnostic ultrasounds of the abdomen, the pelvis and the breast, including obstetrical ultrasounds. RN(EC)s must base their treatment decisions on the radiologist's interpretation of the ultrasound. (See "Explanation for ordering x-rays and ultrasounds.")

Ordering x-rays
Under the Expanded Nursing Services for Patients Act, 1997 (ENSPA), Section 6 of the Healing Arts Radiation Protection Act (HARP) authorizes RN(EC)s to order x-rays of the chest, ribs, arm, wrist, hand, leg, ankle or foot, as well as mammography. This also allows x-ray machine operators to perform x-ray procedures ordered by RN(EC)s. (See "Explanation for Ordering x-rays and Ultrasounds.")

Explanation for ordering x-rays and ultrasounds
RN(EC)s cannot order shoulder and hip x-rays. However, an x-ray of the humerus or femur may include part of the shoulder or the hip in order to visualize the proximal portions. The need for any other x-ray or ultrasound must be ordered by a physician through a medical directive or a client-specific order. The RN(EC) may request a copy of the radiologist's x-ray or ultrasound report for clients who she/he is managing.

Ordering electrocardiograms (ECGs)
For clients in non-urgent or non-acute circumstances, RN(EC)s can order and have ECGs interpreted by a qualified professional. Once the ECG data are interpreted, RN(EC)s should base their interventions on the results and/or consult with a physician in accordance with the standards for consultation with physicians (p. 5).

B. Process expectations
The RN(EC) must include the type of x-ray or ultrasound required, the necessary views, the clinical reason for the tests, her/his signature the designation RN(EC), and her/his Ministry identification number on the requisition. The RN(EC) must document the ordered tests in the client's permanent record.

Proposing additions to the diagnostics list
Submissions can be made annually using the RN(EC)s Lab and Diagnostic Change Request Forms. The submission requires evidence-based medical and/or nursing literature with references and a rationale outlining:
- its applicability to scope of practice including efficacy, safety and cost-efficiency; and
- its usages in the management of an acute, episodic health condition, including illness prevention, or a stable chronic condition.

RN(EC)s and the Public Hospital Act
Changes to the Public Hospital Act enable RN(EC)s, hired as staff by hospitals, to order diagnostic testing and treatment (e.g., prescribe...
drugs) for outpatients of the hospital. This legislation does not apply to hospital inpatients.

**Applying for hospital privileges for out-patient diagnostic testing**

The *Public Hospital Act* permits RN(EC)s to order diagnostic procedures and laboratory tests in a hospital, for their outpatients. This applies to non-hospital staff RN(EC)s who practise in a community where the only available diagnostic testing is at the local hospital.

RN(EC)s must apply to the hospital’s Medical Advisory Committee for hospital privileges for outpatient diagnostic testing. RN(EC)s who are granted such privileges must adhere to the committee’s policies and procedures as legislated in Regulation 965 of the *Public Hospital Act*.

**Role of medical advisory committee**

According to the *Public Hospital Act* (Sec. 7.2 P. R43) a hospital’s Medical Advisory Committee can make recommendations to the board regarding RN(EC), dental and midwifery staff in the following areas:

- every application for appointment or re-appointment to such staff;
- the hospital privileges to be granted to each member of such staff;
- bylaws respecting them and bylaws respecting the medical staff;
- the quality of care provided in the hospital by the medical staff, dental staff, midwifery staff and by the Extended Class nursing staff; and
- the clinical and general rules respecting the medical, dental, midwifery and Extended Class nursing staff as may be necessary in the circumstances.

**7. Completing a medical certificate of death**

The *Vital Statistics Act* gives RN(EC)s the authority to complete Medical Certificates of Death — Form 16 — in specific circumstances.

The Medical Certificate of Death is part of the death registration form and an important legal document detailing the fact and circumstance of death, and statistics on causes of death.

RN(EC)s can complete a Medical Certificate of Death during the last illness of the deceased when:

- the RN(EC) had primary responsibility for the deceased’s care;
- the death was expected;
- a documented medical diagnosis of a terminal disease had been made by a medical practitioner;
- there was a predictable pattern of decline; and
- no unexpected events or complications arose.

“Primary responsibility” for the deceased’s care means the RN(EC) had an established professional nurse-client relationship with the client and was involved in providing care to the client either independently or as a member of a team of health care providers. It is inappropriate for RN(EC)s to sign the Medical Certificate of Death for clients they did not care for, did not have contact with or did not know.

Unexpected events or complications that arose during the last illness of the deceased include such things as death caused by an accident, such as a fall, or an unanticipated adverse drug reaction.

When the RN(EC) is uncertain whether the circumstances surrounding the death of the client were unexpected, she/he is required to consult with a physician.

Prior to performing this activity, RN(EC)s are required to read and carefully follow the instructions described in the *Handbook on Medical Certification of Death from the Office of the Registrar General*.

**8. The quality assurance program**

The *Regulated Health Professions Act* requires that each regulatory college develop, establish and maintain standards of practice to assure the quality of the practice of the profession, and programs to promote continuing competence among the
members of the profession. The College’s Quality Assurance (QA) Program has three components: Reflective Practice, Practice Review and the Practice Setting Consultation Program”.

As part of CNO’s Quality Assurance regulations, RN(EC)s must undergo an assessment of their knowledge, skills and judgment to ensure that they are competent to practise and have established a consultative network with other health professionals. RN(EC)s must also participate in Reflective Practice annually.

**RN(EC) Practice Review**
The College’s QA Program is designed to facilitate and support the ongoing competence of nurses. Collaboration with physicians and other health professionals is essential for successful RN(EC) practice and integral to maintaining and enhancing RN(EC) competence. The QA Committee has established a process for RN(EC)s Practice Review after the completion of 1,800 hours or the first three years of registration, whichever comes first.

Practice Review ensures that RN(EC)s have established networks for consultation with members of other health professions and are practising in accordance with the College’s standards for consultation with physicians (p. 5). This is evaluated through case examples supplied by RN(EC)s that illustrate situations (e.g., the destabilization of a chronic condition, a potentially life-threatening situation, and when a treatment plan is unclear or beyond the scope of practice) requiring physician consultation.

**9. Initiation and performance of controlled act procedures**
The Nursing Act gives RNs and RN(EC)s who meet certain conditions the authority to initiate specific controlled acts, meaning they may independently decide that a specific procedure is required and initiate it in the absence of a physician’s order or medical directive. The knowledge, skill and judgment required to initiate a procedure is greater and different from that required to perform the same procedure. An RN(EC) may perform the procedure or write an order for an RN or RPN to perform it.

**A. Scope of responsibility**
To initiate and perform any of the controlled act procedures authorized to RN(EC)s, the RN(EC) must:

- have the knowledge, skill and judgment to perform the procedure safely, effectively and ethically;
- have the knowledge, skill and judgment to determine whether the individual’s condition warrants performance of the procedure; and
- determine that the individual’s condition warrants performance of the procedure, having considered:
  - the known risks and benefits to the individual,
  - the predictability of the outcome,
  - the safeguards and resources available to safely manage the outcomes, and
  - other relevant factors specific to the situation.

**Performing controlled act procedures**
The controlled acts procedures authorizes RN(EC)s to perform:

**(i) Wound care and suturing**
Initiating care of a wound below the dermis or below the surface of a mucous membrane includes any of the following procedures:

- cleansing, soothing, irrigating, probing, debriding, packing and dressing;
- suturing, except below the fascia and in cases where there may be underlying damage. This allows RN(EC)s to make the independent decision that suturing is required, and to choose the suturing material and local anesthetic from the RN(EC) drug list; and
- applying freezing agents and excising lesions above the dermis or on the mucous membrane.

This excludes the authority to aspirate, excise or biopsy a lesion below the dermis or mucous membrane.
(ii) Venipuncture to establish peripheral intravenous access
The RN(EC) may initiate and establish peripheral intravenous (IV) access, as well as IV therapy, and choose the type of solution, the rate and infusion duration. IV solutions do not require a prescription and are not included in the drug schedules.

(iii) Venipuncture to obtain a blood sample
RN(EC)s can perform venipuncture, or order laboratory technicians to perform the procedure, for the purpose of obtaining a blood sample for a test set out in the laboratory test list. They can also order specific laboratory tests and order lab technologists to process those tests. RN(EC)s cannot order RNs or RPNs to perform venipuncture.

(iv) Injection and inhalation of immunization agents and drugs
In addition to prescribing an immunization agent or a drug from the list, RN(EC)s can administer an agent or drug that the member may prescribe by means of injection or inhalation.

Performing activities for the purpose of assessing, treating and assisting an individual, or making a diagnosis
For the purpose of assessing, treating or assisting an individual with health management activities, or making a diagnosis, RN(EC)s can initiate and perform a procedure that requires:
- putting an instrument beyond the point where nasal passages normally narrow, beyond the larynx or beyond the opening of the urethra;
- putting an instrument or finger beyond the individual's anal verge or into an artificial opening into the individual's body; and
- putting an instrument, hand or finger beyond the individual's labia majora.

Comparatively, RNs can only assess or assist an individual with health management activities.

It is important to note that under the Nursing Act, RN(EC)s cannot order RNs or RPNs to perform these procedures.

Ordering Procedures
RN(EC)s can order procedures for their clients that RNs and RPNs may perform. When ordering nurses to perform a procedure, RN(EC)s must be reasonably available for consultation as required.

Exceptions to this are in the Nursing Act; RN(EC)s cannot order another nurse to perform the following procedures:
- suturing;
- venipuncture to establish venous access;
- venipuncture to obtain blood samples;
- a procedure that requires putting an instrument:
  - beyond the point of the nasal passages where they normally narrow,
  - beyond the individual's larynx, or
  - beyond the opening of the urethra;
- a procedure that requires putting an instrument or finger beyond the anal verge and/or into an artificial opening into the individual's body; and
- a procedure that requires putting an instrument, hand or finger beyond the labia majora.

Appendix

RN(EC) Drug and Lab Lists
To obtain the complete and current list of laboratory tests that may be ordered by RN(EC)s and the list of drugs that may be prescribed, see CNO's Web site at www.cno.org or use the FastFax at 416 963-7502, toll-free (Ontario) 1 877 963-7502 and order document #41059.
Appendix O-2

SCHEDULE 2

Diphtheria vaccines – single entity or combination drugs
Haemophilus b vaccine
Hepatitis A vaccine
Hepatitis B immune globulin
Hepatitis B vaccine
Influenza vaccine
Measles vaccines – single entity or combination drugs
Meningococcal vaccine
Mumps vaccine
Pertussis vaccine
Pneumococcal vaccine
Poliomyelitis vaccine
Rh (D) immune globulin
Rubella vaccine
Tetanus vaccines – single entity or combination drugs
Tetanus Immune Globulin
Varicella vaccine

O. Reg. 131/07, s. 1.

SCHEDULE 3

Acarbose — for renewal only
Acebutolol — for renewal only
Acetic acid/benzethonium chloride/hydrocortisone compound
Acyclovir (oral)
Acyclovir (topical preparation)
Alendronate sodium — for renewal only
Allopurinol — for renewal only
Amantadine hydrochloride
Amitriptyline — for renewal only
Amlodipine besylate — for renewal only
Amoxicillin
Amoxicillin and clavulanate
Aqueous procaine penicillin G — for the purpose of treating sexually transmitted diseases
Atenolol — for renewal only
Atorvastatin — for renewal only
Azithromycin
Beclomethasone dipropionate (inhalation) — for renewal only
Benazepril — for renewal only
Benzathine penicillin G — for the purpose of treating sexually transmitted diseases
Benzoyl peroxide
Betamethasone sodium phosphate and gentamicin sulfate otic solution
Betamethasone valerate
Bisoprolol — for renewal only
Budesonide — for renewal only
Bupropion — for smoking cessation only
Bupropion — for renewal only for antidepressant therapy
Butoconazole nitrate
Candesartan cilexetil — for renewal only
Captopril — for renewal only
Carbamazepine — for renewal only
Cefixime — for the purpose of treating sexually transmitted diseases
Celecoxib — for renewal only
Cephalexin
Cilazapril — for renewal only
Ciprofloxacin extended release
Ciprofloxacin HCl
Ciprofloxacin HC (otic)
Citalopram — for renewal only
Clarithromycin (oral)
Clindamycin (oral)
Clindamycin (topical preparation)
Clindamycin phosphate (vaginal cream)
Clopidogrel bisulfate — for renewal only
Cloxacillin (oral preparation)
Collagenase
Condylline
Conjugated Estrogens
Conjugated Estrogens and medroxyprogesterone acetate
Cyanocobalamin (Vitamin B12)
Desogestrel and ethinyl estradiol
Dextrose 50 per cent (injectable preparation) — in an emergency
Diazepam (injectable preparation) — in an emergency
Diclofenac sodium and misoprostol
Dienestrol
Diltiazem — for renewal only
Diphenhydramine hydrochloride (injectable preparation) — in an emergency
Doxycycline hyclate
Doxylamine succinate and pyridoxine hydrochloride
Econazole
Enalapril maleate — for renewal only
Epinephrine
Epinephrine hydrochloride (injectable preparation) — in an emergency
Eprosartan mesylate — for renewal only
Erythromycin and benzoyl peroxide
Erythromycin and tretinoin
Erythromycin base
Erythromycin estolate
Erythromycin ethylsuccinate
Erythromycin ethylsuccinate/sulfisoxazole acetyl
Erythromycin stearate
Erythromycin with ethyl alcohol lotion
Escitalopram — for renewal only
Esomeprazole — for renewal only
Estradiol-17 beta (micronized)
Estradiol-17 beta (transdermal)
Estradiol-17 beta (Silastic ring)
Estropipate (piperazine estrone sulfate)
Estradiol-17 beta hemihydrate
Estradiol-17 beta norethindrone acetate
Estrone (cone or cream)
Ethinyl estradiol and cyproterone acetate
Ethinyl estradiol/drospirenone
Ethinyl estradiol and ethynodiol diacetate
Ethinyl/etonogestrel (vaginal ring)
Ethinyl estradiol and levonorgestrel
Ethinyl estradiol and norethindrone
Ethinyl estradiol and norethindrone acetate
Ethinyl estradiol and norgestimate
Ethinyl estradiol and norgestrel
Etidronate disodium/calcium carbonate — for renewal only
Famciclovir
Fluconazole (oral) — for vulvovaginal candidiasis only
Flunisolide
Fluocinolone acetonide
Flumethasone pivalate/clioquinol compound
Fluoxetine — for renewal only
Fluticasone propionate (inhalation) — for renewal only
Fluticasone propionate (nasal)
Fluvastatin — for renewal only
Fluvoxamine — for renewal only
Folic acid
Formoterol fumarate dihydrate — for renewal only
Fosinopril sodium — for renewal only
Framycetin sulphate
Framycetin sulphate/gramicidin/dexamethasone compound otic solution
Furosemide — for renewal only
Fusidic acid (topical preparation)
Fusidic acid 1% viscous eye drops
Gabapentin — for renewal only
Gentamicin sulphate (otic, ophthalmic and topical)
Gliclazide — for renewal only
Glyburide — for renewal only
Haloperidol — for chronic nausea in palliation
Hydrochlorothiazide — for renewal only
Hydrochlorothiazide/amiloride — for renewal only
Hydrochlorothiazide/candesartan — for renewal only
Hydrochlorothiazide/cilazapril — for renewal only
Hydrochlorothiazide/enalapril — for renewal only
Hydrochlorothiazide/eprosartan — for renewal only
Hydrochlorothiazide/irbesartan — for renewal only
Hydrochlorothiazide/lisinopril — for renewal only
Hydrochlorothiazide/losartan — for renewal only
Hydrochlorothiazide/pindolol — for renewal only
Hydrochlorothiazide/quinapril — for renewal only
Hydrochlorothiazide/spironolactone — for renewal only
Hydrochlorothiazide/telmisartan — for renewal only
Hydrochlorothiazide/triamterene — for renewal only
Hydrochlorothiazide/valsartan — for renewal only
Hydrocortisone (topical preparation)
Hydrocortisone-17-valerate
Hydroxyzine hydrochloride (oral preparation)
Ibuprofen
Irbesartan — for renewal only
Imiquimod
Ipratropium bromide — for renewal only
Ipratropium bromide (inhaler or nebulizer solution) — in an emergency
Ipratropium bromide/salbutamol sulfate — for renewal only
Ketoconazole (topical)
Ketoprofen
Labetalol — for renewal only
Lansoprazole — for renewal only
Levocabastine HCl
Levofloxacin
Levonorgestrel
Levonorgestrel releasing intrauterine system
Levothyroxine sodium — for renewal only
Lidocaine hydrochloride 1 per cent and 2 per cent, with or without epinephrine (local anaesthetic)
Lisinopril — for renewal only
Lorazepam (injectable preparation, oral and sublingual) — in an emergency
Losartan potassium — for renewal only
Lovastatin — for renewal only
Mebendazole
Medroxyprogesterone acetate (injectable preparation and oral)
Mefenamic acid
Meloxicam — for renewal only
Mestranol and norethindrone
Metformin hydrochloride — for renewal only
Metoprolol — for renewal only
Metronidazole (oral and topical preparations)
Minocycline hydrochloride
Mirtazapine — for renewal only
Misoprostol
Mometasone furoate
Mometasone furoate monohydrate
Montelukast sodium — for renewal only
Moxifloxacin
Mupirocin
Nadolol — for renewal only
Naproxen
Naproxen sodium
Naratriptan — for renewal only
Nicotine patch
Nifedipine — for renewal only
Nitrofurantoin
Nitroglycerin SL or spray — in an emergency
Norelgestromin and ethinyl estradiol (transdermal patch)
Norethindrone
Norethindrone acetate/ethinyl estradiol
Nortriptyline — for renewal only
Nystatin (oral)
Ofloxacin
Olopatadine HCl
Omeprazole — for renewal only
Oseltamivir phosphate
Pantoprazole (oral) — for renewal only
Paroxetine — for renewal only
Penicillin V
Perindopril erbumine — for renewal only
Phenazopyridine HCl
Phenytoin — for renewal only
Pindolol — for renewal only
Pioglitazone — for renewal only
Pivampicillin
Podophyllum resin
PPD-B (Mantoux)
Pravastatin — for renewal only
PregVit
Progesterone
Propranolol — for renewal only
Quinapril — for renewal only
Rabeprazole — for renewal only
Raloxifene HCl — for renewal only
Ramipril — for renewal only
Ranitidine HCl (oral)
Risedronate sodium hemi-pentahydrate — for renewal only
Rizatriptan — for renewal only
Rosiglitazone — for renewal only
Rosuvastatin — for renewal only
Salbutamol (inhaler or nebulizer solution) — in an emergency, for renewal or for use in spirometry
Salmeterol xinafoate — for renewal only
Salmeterol xinafoate/fluticasone propionate — for renewal only
Sertraline — for renewal only
Silver sulfadiazine
Simvastatin — for renewal only
Sodium cromoglycate (ophthalmic and nasal preparations)
Spironolactone — for renewal only
Sulfacetamide sodium
Sumatriptan — for renewal only
Telmisartan — for renewal only
Terbutaline sulfate — for renewal only
Terconazole
Terbinafine (topical use; or oral use for the treatment of onychomycosis only)
Tetracycline hydrochloride (oral preparation)
Timolol — for renewal only
Tiotropium bromide monohydrate — for renewal only
Tobramycin 0.3% ophthalmic solution
Topiramate — for renewal only
Trandolapril — for renewal only
Tretinoin (topical)
Triamcinolone acetonide
Trichloroacetic acid 50-80%, Bichloroacetic acid 50-80%
Trimethoprim
Trimethoprim and sulfamethoxazole (oral preparation)
Valacyclovir hydrochloride
Valproic acid — for renewal only
Valsartan — for renewal only
Venlafaxine — for renewal only
Verapamil extended release — for renewal only
Zafirlukast — for renewal only
Zanamivir
Zolmitriptan — for renewal only
O. Reg. 433/07, s. 1.
Extract from Registered Nurses Act (Nfld & Lab.), s.11.1

11.1 (1) A nurse practitioner licensed under this Act may

(a) communicate to a patient or that person's substitute decision maker a diagnosis made by that nurse practitioner identifying a disease or disorder which may be identified from

(i) the patient's health history,

(ii) the findings of a health examination performed by the nurse practitioner, and

(iii) the results of any laboratory or other tests the nurse practitioner is
authorized to perform;

(b) order the application of a form of energy

(i) prescribed by the regulations, or

(ii) which he or she is authorized to order by a practice protocol issued to him or her by the council under the regulations;

(c) order laboratory or other tests

(i) prescribed by the regulations, or

(ii) which he or she is authorized to order by a practice protocol issued to him or her by the council under the regulations; and

(d) prescribe a drug

(i) designated to in the regulations, or

(ii) which he or she is authorized to prescribe by a practice protocol issued to him or her by the council under the regulations.

(2) A nurse practitioner shall not communicate a diagnosis made under paragraph (1)(a) unless he or she has complied with the standards and scope of practice respecting collaboration with members of other health professions

(a) prescribed in the regulations; or

(b) set by a practice protocol issued to him or her by the council under the regulations.

2001 c29 s1
Appendix N.L. - 4

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Important Information  
(Includes disclaimer and copyright information and details about the availability of printed and electronic versions of the Statutes.)

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NEWFOUNDLAND AND LABRADOR  
REGULATION 65/98

Nurse Practitioner Regulations  
under the  
Registered Nurses Act

Amended by:  
89/00  
41/02  
6/04  
68/05

NEWFOUNDLAND AND LABRADOR  
REGULATION 65/98

Nurse Practitioner Regulations  
under the  
Registered Nurses Act

(Filed June 29, 1998)

Under the authority of section 22.1 of the Registered Nurses Act, the council with the approval of the minister makes the following regulations.

Filed at St. John’s, June 29, 1998.

Pamela Baker  
President of the Council of the  
Association of Registered Nurses of Newfoundland
REGULATIONS

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Schedule A

Schedule B

Schedule C

Short title

1. These regulations may be cited as the Nurse Practitioner Regulations.

Definitions

2. In these regulations
   (a) "Act" means the Registered Nurses Act;
   (a.1) "acute illness or injury" means illness or injury with gradual or sudden onset that requires intervention;
   (b) "chronic illness or injury" means long term illness or injury previously diagnosed and with a management plan determined by a physician and requiring consultation and collaboration for ongoing care;
   (c) "collaboration" means a nurse practitioner working together with a patient and one or more health professionals within a primary health care team to achieve a common goal;
   (c.1) "committee" means the consultative and approvals committee appointed under section 22.1 of the Act;
   (d) "consultation" means the consultative interaction between a nurse practitioner and a primary care physician, initiated by specific request of the nurse practitioner for an opinion, recommendation or concurrence in the treatment of a patient;
   (e) "intervention categories" include
      (i) emergent – illness or injury that is potentially threatening to life, limb or function and requires immediate intervention,
      (ii) urgent – serious illness or injury requiring emergency intervention, and
      (iii) non-urgent – minor illness or injury requiring intervention;
   (e.1) "nurse practitioner - primary health care" means a registered nurse who meets the requirements for licensure by the association for practice as a nurse practitioner in accordance with Parts I to V;
(e.2) "nurse practitioner - specialist" means a registered nurse who meets the requirements for licensure by the association for practice as a nurse practitioner - specialist;

(f) "primary care physician" means a general practitioner, family practitioner or other non-specialist practitioner;

(g) "primary health care" means essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and the country can afford, and includes health promotion, injury and illness prevention, cure, rehabilitation and support.

(h) [Repealed by 89/00 s2]

Application of Parts

2.1 (1) Parts I to V of these regulations apply only to a nurse practitioner - primary health care.

(2) Part VI of these regulations apply only to a nurse practitioner - specialist.

PART I
EXPECTATIONS FOR CONSULTATION

Collaborative relationship

3. A nurse practitioner

(a) shall establish and document a collaborative working relationship with a primary care physician; and

(b) may establish working relationships with other health professionals, for the purposes of consultation.

Specialist consultation

4. Consultation will normally occur with a primary care physician with whom a collaborative working relationship has been established, but a nurse practitioner may consult with a specialist physician when the primary care physician is not available and if appropriate to the patient needs and practice setting.

Transfer of care

5. A decision to transfer care shall be made by the nurse practitioner and physician following consultation.
Forms of consultation

6. A request for consultation may be made in person, by telephone or other electronic communication or in writing.

Consultation required

7. Consultation may be required at any stage of the nurse practitioner - patient relationship.

Consultation documentation

8. A nurse practitioner shall document all requests for consultation and outcomes of those consultations.

Clinical expectations for consultation

9. A nurse practitioner shall consult with a physician

(a) when a diagnosis or treatment plan is unclear or beyond the scope of the nurse practitioner to determine, including situations in which the following conditions are present:

   (i) persistent or recurring signs or symptoms that cannot be attributed to a readily identifiable cause,

   (ii) signs, symptoms or reports of imaging or laboratory tests suggestive of a previously undiagnosed chronic or systemic illness,

   (iii) symptomatic or laboratory evidence of decreased or decreasing function of an organ or system,

   (iv) signs of recurrent or persistent infection,

   (v) atypical presentation of a common illness or unusual response to treatment,

   (vi) signs or symptoms of sexually transmitted disease in a child,

   (vii) signs or symptoms of behavioural changes that cannot be attributed to a specific cause, or

   (viii) deviation from normal growth or development expectations in an infant or child;

(b) in urgent and emergent situations including, when any of the following conditions are present:
(i) signs or symptoms of an acute event that is potentially threatening to life, limb or senses,
(ii) signs or symptoms of obstruction of any system,
(iii) signs of severe or widespread infection,
(iv) fever greater than 39°C Celsius in a child aged 3 to 36 months with no identifiable focus of infection,
(v) all signs or symptoms of illness in an infant under 3 months of age,
(vi) blunt, penetrating or other type of wound that may involve damage below the fascia or involve functional impairment, or
(vii) signs or symptoms of a fetal or maternal distress;

(c) when a patient’s chronic illness or injury destabilizes, including situations where there is

(i) symptomatic or laboratory evidence of destabilization or unexpected deterioration in the condition of a patient who is being managed for a previously diagnosed illness, or

(ii) imposition of an acute illness or injury on a chronic condition; and

(d) regarding reassessment, on an annual basis, of a patient with a chronic condition.

PART III
DIAGNOSIS

Sch A description

10. Schedule A, Diagnosis, of these regulations includes those illnesses and injuries that expectedly will be encountered in a nurse practitioner’s common practice.

Conveying a diagnosis

11. The ability of a nurse practitioner to convey to a patient a diagnosis made of an illness or injury contained in Schedule A is qualified by the expectations for consultation with a physician as defined by the graphing key of the Schedule and by other requirements contained in these regulations.

PART IV
DIAGNOSTIC TESTS

Sch B description

12. Schedule B, Diagnostic Tests, of these regulations includes those tests which will be ordered most commonly, independently by a nurse practitioner in providing care to patients.
Special assistance

13. Diagnostic tests not included in Schedule B but required for monitoring a patient’s chronic illness or injury may be ordered by the nurse practitioner following consultation with the patient’s physician and the test requisition shall reference the physician’s name.

PART V
PRESCRIPTIVE AUTHORITY

Sch C description

14. Schedule C, Prescriptive Authority, of the regulations includes those drugs that may be prescribed independently or administered in the course of practice by a nurse practitioner.

Over the counter medication

15. A nurse practitioner may prescribe an over the counter medication for the purpose of accessing a drug plan which has plan coverage for the over the counter medication.

Prescription renewal

16. A nurse practitioner may write a prescription for the renewal of a drug prescription, originally written by a physician, only for a patient on that nurse practitioner’s case load who is being managed consultatively with a physician.

Prescription renewal requirements

17. A prescription renewal written by a nurse practitioner shall contain the full name of the physician who initially prescribed the drug.

Prescription inquiries

18. Questions regarding prescriptions written at first instance by a nurse practitioner shall be directed to that nurse practitioner.
Annual review of Schedules

19. The Schedules to these regulations will be reviewed annually by the committee appointed by the minister under section 22.1 of the Act, but may be reviewed more frequently if necessary by a sub-committee that may bring forward recommendations to the committee.

PART VI
NURSE PRACTITIONER - SPECIALIST

Practice protocol

20. (1) A person licensed as a nurse practitioner - specialist by the council shall practice only as provided for in a practice protocol issued to him or her.

(2) A practice protocol referred to in subsection (1) is not transferrable.

Nurse practitioner speciality

21. (1) A nurse practitioner who wishes to practise as a nurse practitioner-specialist shall apply to the committee for approval of a practice protocol that will apply to him or her.

(2) A practice protocol submitted to the committee under subsection (1) shall be developed in the manner required by the committee and shall include

(a) a description of the location and work environment where the nurse practitioner-speciality service will be practised;

(b) a description of responsibilities and reporting requirements of the nurse practitioner-specialist including the

(i) laboratory and other tests that may be ordered,

(ii) forms of energy that may be ordered or prescribed,

(iii) classes of drugs that may be ordered or prescribed,

(iv) collaborative process for communicating diagnosis information to the patient,

(v) non pharmaceutical intervention that may be ordered and applied,

(vi) consultations that may be made when clinically indicated to manage patient care outside the scope of practice of the nurse practitioner-specialist, and

(vii) policies, procedures and protocols, if any, related to the activities referred to in subparagraphs (i) to (vi); and

(c) other information that the committee may require.

(3) The committee shall, within 2 months of receiving an application under subsection (1)
(a) approve the submitted practice protocol;
(b) approve the submitted practice protocol with conditions;
(c) request further information from the nurse practitioner--specialist applicant and reconsider the application; or
(d) reject the application for the approval of the practice protocol.

(4) A person nominated by the Association of Registered Nurses of Newfoundland and Labrador for the purpose shall, in writing, notify the nurse practitioner--specialist applicant of a decision made under subsection (3) and shall provide reasons where conditions are placed upon the practice protocol, further information is required or where an application is rejected.

(5) A decision of the committee is final.

(6) The committee may, with the written consent of the committee and of the
(a) employer of the nurse practitioner--specialist; and
(b) nurse practitioner--specialist,

to whom a practice protocol applies amend or modify a practice protocol approved under this section in order to incorporate new practice procedures into that protocol.

Schedule A
Diagnosis

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Key: U/E - Urgent/Emergent  
     U - Urgent
NU(nc) – Non-Urgent (non-chronic)
NU(c) – Non-Urgent (chronic)
C – Consultation: Discretionary (d); Yes (y)

EMERGENT CATEGORY

The Emergent Category or Emergencies listed below are serious illnesses or injuries that occur suddenly and threaten life. The illnesses and injuries listed are those for which the nurse practitioner can independently administer drugs prior to a consultation. The specific drugs are identified in Schedule C concerning prescriptive authority of nurse practitioners.

Acute Asthma Attack
Acute Poisoning (patient stable)
Anaphylaxis
Cardiac Arrest
Coma
Fluid Resuscitation (massive hemorrhage or other shock syndrome)
Myocardial Infarction
Pulmonary Edema
Severe Pain Control (acute)
Status Epilepticus

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Schedule B

Diagnostic Tests

MICROBIOLOGY

Cultures - cervical, vaginal, and urethral
Cultures - GC culture and smear
Cultures - sputum
Cultures - stool
Cultures - urine
Cultures - throat swab for streptococcus screen
Fungal scrapings
Parasites and ova (feces concentration)
Parasites and ova, smear only, special stain
Pertussis scrapings
Pinworm (Scotch tape prep)

CYTOLOGY

Cervicovaginal smear (Pap)

BIOCHEMISTRY

AC sugar
PC sugar
Creatinine
Glycosylated hemoglobin - Hgb AIC
Lipid Profile
Potassium
Prostate specific antigen
Sodium
Thyroid Stimulating Hormone
Urea
Urinalysis, routine
Urinalysis microscopic

IMMUNOLOGY
Monospot screen
Pregnancy tests

HEMATOLOGY
CBC and differential

FORMS OF ENERGY
Chest X-Ray
EKG
Mammogram (as per screening guidelines)
Obstetrical/pelvic ultrasound (as per screening guidelines 18 to 20 weeks)
X-ray limb

MISCELLANEOUS
Prenatal blood screening (as per provincial guidelines)

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Schedule C
Prescriptive Authority

Drugs by Therapeutic Classification

Anti-infective Drugs
Amebicides
metronidazole

Anthelmintics
piperazine
pyrvinium pamoate
mebendazole

Antibiotics
Amino glycosides
gentamicin (not intramuscular or intravenous)

Antifungal Antibiotics
Fluconazole
nystatin (all forms)
terazol

Cephalosporins
cephalexin monohydrate

Macrolides
erthromycin and its salts

Penicillins
amoxicillin
amoxicillin clavulanic acid
ampicillin
cloxacillin sodium
penicillin G
penicillin V

Tetracycline
tetracycline

Sulfonamides
sultrin vaginal cream
trimethoprim-sulfamethoxazole

Urinary Anti-infectives
nitrofurantoin
trimethoprim

Autonomic Drugs
Antimuscarinics/Antispasmodics
hyoscine butylbromide (up to a maximum of 7 days)

Skeletal Muscle Relaxants
cyclobenzaprine (up to a maximum of 7 days)

Miscellaneous
meclizine nicotine acid and niacin
nicotine transdermal

Central Nervous System Drugs
Analgesics and Antipyretics
Nonsteroidal Anti-Inflammatory Drugs
ibuprofen
indomethacin
mefenamic acid
naproxen

Opiate Agonists
acetaminophen with codeine
codeine phosphate (up to a maximum of 7 days)

Miscellaneous
phenazopyridine

Antihistamines
diphenhydramine (oral and injectible)

Anxiolytics, Sedatives and Hypnotics
Benzodiazepines
chlordiazepoxide (up to a maximum of 10 days)
lorazepam (sublingual or oral up to a maximum of 7 days)
temazepam (up to a maximum of 7 days)

Miscellaneous
amitriptyline (up to a maximum of 50 mg daily)
hydroxyzine (up to a maximum of 7 days)

Gastrointestinal Drugs
Antiemetic
dimenhydrinate (any route)
metoclopramide

H₂ Antagonists
cimetidine
ranitidine

Antitussive, Expectorants, and Mucolytics Drugs
codeine preparations (up to a maximum of 7 days)
Eye, Ear, Nose and Throat Preparations

Anti-infectives

Antibiotics
- betamethasone and gentamicin
- chloromycin ophthalmic ointment
- gentamicin drops and ointment
- sulfonamides
  - sulfacetamide sodium 10% drops and ointment

Anti-inflammatory agents
- beclomethasone nasal spray
- flumethasone pivalate-clioquinol ear drops
- hydrocortisone neomycin polymyxin B compound

Miscellaneous
- fluorescien eye drops and strips

Hormones and Synthetic Substitutes

Contraceptives
- Depo-Provera injectable
- oral birth control tablets

Estrogens
- conjugated estrogens vaginal cream

Local Anaesthetics
- lidocaine viscous and spray
- lidocaine 1% and 2% with and without epinephrine
- tetracaine ophthalmic solution 0.5%

Serums, Toxoids and Vaccines
- immunizations according to current provincial guidelines
- influenza vaccine

Skin and Mucous Membrane Drugs

Anti-infectives

Antibiotics
- erythromycin topical acne pads
- clindamycin acne preparations
- framycetin dressings

Antivirals
- acyclovir oral for shingles
- acyclovir topical

Anti-inflammatory Agents
- coal tar preparations (including LCD)
- flumethasone pivalate-clioquinol
- hydrocortisone
- hydrocortisone-framycetin sulfate-cinchocaine
- HCL-Esculin
- pramoxine HCL-hydrocortisone acetate-zinc sulfate
- triamcinolone dental paste

Vitamins
- folic acid
Prescriptive Authority During Emergent Situations

The listing which follows identifies the independent prescriptive authority of the nurse practitioner during specific emergent situations.

Acute asthma attack
salbutamol (Metered Dose Inhaler, nebulizer)

Acute poisoning (patient stable)
activated charcoal

Anaphylaxis
epinephrine 1:1000
epinephrine 1:10,000 for infants less than 12 months
normal saline intravenous
diphenhydramine hydrochloride intramuscular

Cardiac Arrest
normal saline intravenous

Coma
naloxone hydrochloride
dextrose 50% with water intravenous

Fluid resuscitation (massive haemorrhage or other shock syndrome)
normal saline intravenous
ringer’s lactate intravenous

Myocardial Infarct
nitroglycerine sublingual
normal saline intravenous
dextrose 5% with water intravenous
morphine 2.5 mg intravenous (single dose)

Pulmonary Edema (adult)
furosemide 40 mg intravenous (single dose)
morphine 2.5 mg intravenous (single dose)
dextrose 5% with water intravenous

Severe pain control (acute)
dimenhydramine (as antinauseant) intramuscular/intravenous
nitrous oxide 50% and oxygen 50% by inhalation
morphine intramuscular 15 mg maximum dose (single dose)

Status Epileptics
diazepam intravenous or per rectum
lorazepam intravenous or per rectum

Miscellaneous
oxygen
intravenous infusions

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GUIDING PRINCIPLES

(Preamble to Schedules A, B, & C Nurse Practitioner Primary Health Care Regulations)

DIAGNOSIS

1. The list of diagnoses is not all inclusive and exhaustive. The NP-PHC will initiate
treatment for those diagnoses within the NP-PHC scope of practice. When outside the
NP-PHC’s scope of practice to treat, she/he will consult with the primary care physician.

2. The practice of the NP-PHC requires the application of knowledge and the simultaneous
exercise of professional judgement and skill.

3. The diagnosing authority of the NP-PHC is only one component of the full scope of
practice for the nurse practitioner.

4. The NP-PHC collaborates/consults with primary care physicians and other health
professionals in the ongoing care and management of client’s with chronic illnesses (refer
to the Regulations).

5. The NP-PHC may or may not consult with the primary care physician when a client with
a stable chronic illness, previously diagnosed, presents with an acute illness unrelated to
the chronic condition.

6. Regional Boards/Agencies have a responsibility to establish policies and procedures to
govern client care during an emergency situation when a physician is not available.
These policies and procedures will be developed collaboratively by all appropriate health
professionals and in keeping with accepted standards of practice.

DIAGNOSTIC TESTS

1. Specific tests will be ordered and interpreted by the NP-PHC for a variety of reasons,
including but not limited to:

   • the collection of assessment data required to reach a diagnosis which is within the
     NP-PHC’s scope of practice;
   • the clinical management of health conditions which are within the NP-PHC’s scope
     of practice;
   • the monitoring of a client’s chronic illness. Diagnostic tests required for
     monitoring of a chronic condition and which are not included in the attached list
     will be ordered by the NP-PHC following consultation with the client’s physician.
2. Regional Boards/Agencies have a responsibility to establish policies and procedures which provide more specific direction regarding the ordering of diagnostic tests by the NP-PHC and the process to be used to ensure timely interpretation of tests which are outside the scope of the NP-PHC to interpret. These policies and procedures will be developed collaboratively by all appropriate health professionals and in keeping with accepted standards of practice.

**PRESCRIPTIVE AUTHORITY**

1. Specific drugs will be prescribed by the NP-PHC for a variety of reasons, including:
   - care required during a normal health event;\(^1\)
   - the clinical management of acute illnesses or injuries which are within the NP-PHC scope of practice will be required as part of the ongoing collaborative management of a chronic illness;
   - the initial management of emergency conditions in anticipation of an imminent or immediate consult to a physician.

2. In the best interest of client care, and to allow flexibility in clinical practice, the list of drugs in Schedule C is not considered to be all inclusive and exhaustive. This list will not limit the NP-PHC’s ability to prescribe new medications, according to treatment standards for a particular condition, as they become available. The list should be subject to at least an annual review.

3. Regional Health Boards/Agencies have a responsibility to establish policies and procedures to govern medical care during an emergency situation when a physician is not available. These will include medical treatment in life threatening situations where the nature of the treatment exceeds the scope of practice of the NP-PHC. Policies and procedures will be developed collaboratively by all relevant health care professionals and would include, for example, the initiation of intravenous therapy and the administration of emergency drugs.

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\(^1\)normal health event — includes conditions that require interventions to assist individuals to promote, maintain, and manage their health throughout the various stages of the life cycle.
Association of Registered Nurses of Newfoundland

Standards of Practice and Competencies
For Nurse Practitioners

Approved by:
Council of the Association of Registered Nurses
of Newfoundland, August 1998

Acknowledgement: ARNN gratefully acknowledges the work of the College of Nurses of Ontario in preparing the various drafts of the Standards and Competencies for Nurse Practitioners.
ASSOCIATION OF REGISTERED NURSES OF NEWFOUNDLAND

STANDARDS OF PRACTICE
FOR
NURSE PRACTITIONERS

August 1998

Introduction

Nurse Practitioners, registered to practice in Newfoundland and Labrador, are expected to meet and exceed all of the requirements for registered nurses as identified in the Standards for Nursing Practice in Newfoundland and Labrador, 1995. It is not the intent of these Standards to duplicate expectations found in other publications. The Standards for Nursing Practice in Newfoundland and Labrador, 1995 should be used as reference when reading these Standards in order to fully understand the expectations and scope of practice of nurse practitioners.

These Standards of Practice for Nurse Practitioners identify the additional minimum expectations for nurse practitioners. These Standards apply to the practice of nurse practitioners - primary health care and nurse practitioners - specialist (acute care, long term care, and community health).

Standard 1: Specialized Body of Knowledge

The nurse practitioner bases practice on knowledge of nursing science and content from other sciences.

Indicators:

1.1 Presents an informed view of the role of the nurse practitioner within the nursing profession, the health care system, and society.

1.2 Demonstrates understanding and synthesis of pathophysiology of common acute illness and injury, stable chronic disorders, normal health events and emergency health needs commonly encountered in practice.

1.3 Demonstrates understanding and synthesis of pharmacology, including pharmacokinetics and pharmacodynamics of drugs that are prescribed to manage health situations commonly encountered in practice.
1.4 Demonstrates understanding and synthesis of the principles and interventions related to health promotion, injury and illness prevention, cure, rehabilitation, and support\(^1\) in the initial and ongoing management of commonly encountered health situations.

1.5 Demonstrates an understanding of the principles of primary health care and/or specialty in working with the client\(^2\).

1.6 Justifies decisions with reference to current, relevant research findings.

Standard 2: *Competent Application of Knowledge in Partnership with Client*

The nurse practitioner systematically collects and synthesizes data about the health of the client, applies knowledge and makes clinical judgements in defining health needs, as well as developing, implementing, and evaluating the plan of care.

**Indicators:**

2.1 Demonstrates advanced assessment techniques, critical thinking and clinical decision-making skills.

2.2 Uses a systemic approach to collect and interpret health data through the completion of a comprehensive and holistic health assessment\(^3\).

2.3 Orders and interprets the results of diagnostic tests in the clinical management of health situations commonly encountered in practice.

2.4 Prescribes and/or monitors the administration of medications related to health situations encountered in practice.

2.5 Synthesizes data and identifies specific diagnoses.

\(^1\) support - includes palliation.

\(^2\) client - includes individuals, families, groups, populations or entire communities.

\(^3\) health assessment - includes health history and physical examination.
2.6 Collaboratively interacts in a therapeutic manner with clients in the development, implementation, and evaluation of an appropriate plan of care.

2.7 Uses an evidence-based approach in practice.

Standard 3:  *Provision of a Service to the Public*

The nurse practitioner collaborates and consults with others in providing health care services.

3.1 Promotes and facilitates collaborative partnerships with the client.

3.2 Acts as a catalyst to mobilize clients to assume responsibility for their health needs.

3.3 Practices autonomously and collaboratively as a member of a health team.

3.4 Initiates consultation with members of the health team for an opinion, recommendation or concurrence in the care of clients.

3.5 Refers clients to services from other members of the health team when the requirements for care are outside the nurse practitioner’s scope of practice.

3.6 Demonstrates a cost effective and efficient approach to the provision of care.

3.7 Assumes a leadership role in influencing healthy public policy.

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*health team - includes intra disciplinary, inter disciplinary, and inter sectoral members.*
Nurse practitioners (NPs) are registered nurses whose practice is focused on providing services to manage the health needs of individuals, families, and communities. NPs are accountable to diagnose, treat, manage, monitor and evaluate clients' health conditions within the limits of their educational preparation, competence and legislated scope of practice. NPs will order screening and diagnostic tests that are consistent with the policies and procedures of the DHA.

Based on their client population, and as part of their practice, NPs have the authority to order and interpret screening and diagnostic tests, with the exception of diagnostic imaging tests. Diagnostic imaging tests can be ordered by NPs, but they cannot perform or interpret these tests. NPs will base decisions for treatment plans on a radiologist's interpretation.

Nurse practitioners may, in accordance with the competencies and standards established by the College’s Council and subject to any conditions and/or restrictions imposed on their licence, order screening and diagnostic tests in the following areas:

**Diagnostic Imaging Tests**
- X-rays
- Scans
- Ultrasounds

**Laboratory Tests**
- Microbiology
- Cytology/Pathology
- Biochemistry
- Immunology
- Hematology
- Virology

**Other**
- Additional tests required by the client population (e.g., pulmonary function tests, ECG).

*The names of all licensed nurse practitioners are published on the College’s website.*
Authorized Practices Schedule

Schedule of Drugs and Drug Interventions for Primary Health Care Nurse Practitioners
Authorized Practices Schedule
Schedule of Drugs and Drug Interventions for Primary Health Care Nurse Practitioners

Nurse Practitioners prescribe drugs in accordance with the competencies and standards approved by Council. Non-prescription drugs, including Schedule II drugs, will not be listed in the following Schedule of Drugs and Drug Interventions for Primary Health Care Nurse Practitioners in Nova Scotia because they can be obtained without a prescription. A nurse practitioner who recommends that a client purchase and use a non-prescription drug is accountable for her/his actions in making the decision. The nurse practitioner can write a prescription for a non-prescription drug.

Note: * - Indicates that the drug is not reimbursed by the Nova Scotia Pharmacare Program.
E - Indicates that the drug has an exception status for reimbursement through the Nova Scotia Pharmacare Program.

Antidepressant Agents
  Citalopram
  Fluoxetine
  Paroxetine
  Venlafaxine
  Nabumetone
  Naproxen
  Naproxen sodium
  Sulindac
  Tenoxicam
  Tiaprofenic acid
  Tolmetin sodium

Antidiabetic Agents
  Acarbose
  Gliclazide
  Glimepiride *
  Glyburide
  Insulin
    Regular (Toronto)
    NPH
  Aspart - E
  Lispro - E
  Metformin
  Nateglinide *
  Pioglitazone - E
  Repaglinide *
  Rosiglitazone *
  Tolbutamide
  Glibenclamide
  Glimepiride
  Glipizide
  Nateglinide *
  Pioglitazone
  Repaglinide *
  Rosiglitazone *

Antimicrobial Agents
  Acyclovir
  Amantadine
  Amoxicillin
  Amoxicillin and clavulanate
  Azithromycin - E
  Benzathine penicillin G
  Cefixime
  Ceftriaxone sodium - for the purpose of treating sexually transmitted diseases
  Cephalaxin
  Cefprozil
  Cefturoxime
  Ciprofloxacin - E
  Clarithromycin
  Cloxacillin (oral preparation)
  Doxycycline hyclate
  Erythromycin and its salts
  Famiclovir
  Fluconazole
  Nitrofurantoin
  Nystatin
  Penicillin V
  Pivampicillin
  Metronidazole
  Tetracycline hydrochloride
  Trimethoprim and sulfamethoxazole

College of Registered Nurses of Nova Scotia
Schedule of Drugs and Drug Interventions for Primary Health Care Nurse Practitioners, July 2006
Valacyclovir hydrochloride

**Asthma/COPD**
- Beclomethasone (inhalation)
- Budesonide (inhalation)
- Fluticasone (inhalation)
- Formoterol (inhalation) - E
- Ipratropium (inhalation)
- Salbutamol (inhalation)
- Salmeterol (inhalation) - E
- Tiopropium - E

**Cardiac/Antihypertensive Agents**
- Amlodipine *
- Atenolol
- Benazepril *
- Candesartan
- Captopril *
- Dilatizem
- Enalapril
- Hydrochlorothiazide
- Furosemide
- Lisinopril
- Losartan
- Metoprolol
- Nitroglycerine *
- Perindopril
- Perindopril Plus
- Propranolol
- Ramipril
- Timolol *
- Triazide (hydrochlorothiazide/triamterene)
- Valsartan
- Verapamil

**Gastrointestinal**
- Cimetidine
- Esomeprazole
- Famotidine
- Lansoprazole - E
- Metoclopramide
- Nizatidine
- Omeprazole - E
- Orlistat *
- Pantoprazole - E
- Rabeprazole - E
- Ranitidine
- Sibutramine *

**Hormonal Agents**
- Estradiol (intravaginal for menopausal systems)
- Ethinyl estradiol in strengths of 35mcg or less in combination with norethindrone (for oral contraception)
- Ethinyl estradiol in strengths of 35mcg or less in combination with norethindrone acetate (for oral contraception)

**Immunizing Agents**
- Gardasil *
- Hepatitis A vaccine
- Hepatitis B vaccine
- Hepatitis A & B vaccine
- Meningococcal vaccine
- Pneumococcal vaccine
- Rabies vaccine
- Varicella vaccine

**Nasal Agents**
- Beclomethasone dipropionate
- Budesonide
- Flunisolide
- Fluticasone propionate
- Levocabastine hydrochloride
- Mometasone furoate monohydrate
- Sodium cromoglycate
- Sumatriptan
- Triamcinolone acetonide

**Ophtalmic Agents**
- Bethamethasone sodium phosphate/gentamicin sulfate in combination
- Erythromycin
Framycetin sulfate/gramicidin/dexamethasone in combination
Gentamicin sulfate
Hydrocortisone/neomycin sulfate/polymyxin B sulfate in combination
Levocabastine hydrochloride
Proparacaine hydrochloride
Sodium cromoglycate
Sulfacetamide sodium
Tetracaine

**Osteoporosis Management**
- Alendronate
- Etidronate
- Raloxifene *
- Risedronate

**Otic Agents**
- Benzethonium chloride/acetic acid/hydrocortisone in combination
- Betamethasone sodium phosphate/gentamicin sulfate in combination
- Flumethasone pivalate/clioquinol in combination
- Framycetin sulphate/gramicidin/dexamethasone in combination
- Gentamicin sulfate
- Hydrocortisone/neomycin sulfate/polymyxin B sulfate in combination

**Serum Lipid Reducing Agents**
- Atorvastatin *
- Cholestryamine
- Colestipol
- Fenofibrate
- Gemfibrozil
- Niacinamide *
- Pravastatin
- Rosuvastatin
- Simvastatin

**Topical Agents**
- Acyclovir
- Benzoil peroxide
- Betamethasone valerate
- Clindamycin
- Econazole
- 3% Erythromycin/ 5% Benzoil peroxide in combination
- Erythromycin
- Flumethasone pivalate/clioquinol in combination
- Framycetin sulphate
- Fusidic acid
- Gentamicin sulfate
- Hydrocortisone
- Imiquimod
- Metronidazole
- Mupirocin

Podophyllin
Podophyllum resin
Silver sulfadiazine
Terconazole
Terbinafine
Tretinoin 0.025% or less

**Other**
- Benzydamine hydrochloride (oral rinse) – E
- Betahistine
- Bupropion HCL (oral) – For smoking cessation
- Doxylamine/pyridoxine hydrochloride in combination (oral)
- Ergometrine (injectable)- For prevention and control of post-partum hemorrhage only.
- Folic acid (oral) - Considered a prescription drug in preparations containing more than 1 mg of folic acid/dosage form or where the daily dose exceeds 1 mg.
- Hydroxyzine hydrochloride (oral) - E
- Lidocaine hydrochloride 1% and 2%, with or without epinephrine (injectable)
- Mebendazole (oral)
- Naratriptan (oral) - E
- Oxytocin (injectable) - For prevention and control of post-partum hemorrhage only.
- Phenazopyridine hydrochloride (oral)
- Prochlorperazine (oral and injectable)
- Rho(D) Immune Globulin
- Rizatriptan (oral) - E
- Sumatriptan (oral and injectable) - E
- Tuberculin PPD-B (Mantoux) (intradermal)
- Zolmitriptan (oral) - E

**Emergency Use**
- Dextrose 50% (injectable)
- Diphenhydramine hydrochloride (injectable)
- Epinephrine hydrochloride 1: 10,000 (injectable)
- Naloxone (injectable)
GUIDELINES FOR THE DEVELOPMENT AND APPROVAL OF COLLABORATIVE PRACTICE AGREEMENTS:
NURSE PRACTITIONERS

2005
INTRODUCTION

In accordance with the RN Act (2001), the College of Registered Nurses of Nova Scotia regulates the practice of nurse practitioners and authorizes them to independently perform a full range of health services that extend beyond those of registered nurses in the active-practising class. Nurse practitioners are accountable for the assessment, diagnosis, treatment and evaluation of clients’ health conditions, within the limits of the nurse practitioner’s educational preparation, competence and legislated scope of practice.

The Guidelines for the Development and Approval of Collaborative Practice Agreements: Nurse Practitioners provide nurse practitioners, collaborative practice teams, and organizations with a framework for the development and approval of collaborative practice agreements. The guidelines can be adapted according to the processes set out by the employing agency.

Principles of collaborative practice
The principles of collaborative practice guide decisions pertaining to the authorized acts for the practice of nurse practitioners, as well as the context of a collaborative practice as documented in a collaborative practice agreement.

Collaborative practices should:

- facilitate a coordinated, integrated and comprehensive team approach to client/patient care.
- be guided by evidence, best-practice and clinical guidelines
- be driven by a concern for the health and well-being of a client population.
- be focused on patient health outcomes
- ensure accountability to the community or population group being served.
- respect open communication, autonomous professional judgement and shared decision making.
- support continuing competence
- incorporate the standards of practice and code of ethics for nurse practitioners and physicians.

THE COLLABORATIVE PRACTICE AGREEMENT

A collaborative practice agreement is a written agreement between the members of a collaborative practice team and may include, depending on the processes set out by the employing agency, the context of practice and the regulatory and professional documentation.

Context of practice

The context of practice defines specific areas of responsibility and accountability of the collaborative practice team for a client population, each other, and the team as a whole. In relation to context of practice, a collaborative practice agreement may include the following:

1. Documentation of how the collaborative practice team will address the health needs of its designated client population and facilitate a coordinated and integrated approach to care. Examples include:
   
a) the population served by the collaborative practice team.
b) the services provided (e.g., acute and chronic care, primary and secondary prevention, health promotion, advocacy, education) and how services are communicated to the client population.
c) how the need for services is identified (e.g., client population requirements, location, availability of other services and resources).

d) how the practice is linked with laboratory, diagnostic imaging and pharmacy services (e.g., policies and protocols, formal agreements with departments, other services, other facilities).

e) agreements with other organizations and health care providers who offer different levels of care to ensure access to a continuum of coordinated care for the designated client population.

f) mechanisms for consultation and referrals from the NP to the physician, and vice versa.

g) authorization by the respective district health authority, as appropriate, for nurse practitioners to visit and follow-up with hospitalized clients.

h) the hours of operation and mechanism for accessibility outside of these hours.

i) continuous quality improvement (CQI) initiatives and evaluation that address safety, adherence to the authorized practice schedules of the collaborative practice agreement, access, appropriateness, efficiency, cost of services, client satisfaction and care outcomes (e.g., the percent of clients that meet the targets for improved health care outcomes; chart audits).

2. Description of the responsibilities and accountabilities between and among members of the team. Examples include:

   a) how the nurse practitioner and the physician work together, and share practice trends and responsibilities.

   b) coverage for planned or unplanned absences.

   c) the process for reviewing, maintaining and developing the continued competence of the collaborative practice team.

   d) the team policy for review of services and revision of the collaborative practice agreement.

   e) any additional formal structures, mechanisms, clinical practice guidelines, and policies not already identified (e.g., team/committee meetings, agency policies).

Regulatory and Professional Documentation

Regulatory and professional documentation includes:

   a) a statement of professional liability coverage (e.g., liability protection numbers from respective protective societies and respective employer liability coverage, as applicable).

   b) an effective (start) date for the agreement.

   c) names and licence numbers of members of the collaborative practice team.

   d) signatures of each member of the team and employer as applicable.
Standards of Practice for Nurse Practitioners

2005
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INTRODUCTION

The Registered Nurses Act (S.N.S., 2001, c.10) defines the practice of nurse practitioners as:

the practice in which a nurse practitioner (NP) may, subject to a collaborative practice agreement and in accordance with the standards of practice of nurse practitioners,

i) make a diagnosis identifying a disease, disorder, or condition;

ii) communicate the diagnosis to the client;

iii) order and interpret screening and diagnostic tests approved through a process set out in the Regulations;

iv) select, recommend, prescribe, and monitor the effectiveness of drugs and interventions, through the process set out in the Regulations;

v) perform procedures approved through a process set out in the Regulations.

The RN Act (2001) identifies two classes of nurse practitioners: primary health care nurse practitioners and specialty nurse practitioners.

Primary health care nurse practitioners, as members of a collaborative practice team, provide primary health services to clients across the lifespan. Primary health services include health promotion, illness and injury prevention, acute episodic care, continuing care of chronic conditions, and education and advocacy. Primary health care nurse practitioners may be employed in community-based health settings, primary healthcare organizations or in health agencies that provide primary health services.

Specialty nurse practitioners, as members of a collaborative practice team, provide specialized health services to designated client population groups requiring focused health and illness care. Specialized health services include health promotion; illness and injury prevention; coordination and management of acute, emergent health problems and chronic health conditions; and education and advocacy relevant to the client population in a designated specialty. Specialty nurse practitioners may be employed by acute care facilities, specialty clinics or health agencies that provide specialized health services.

Registered nurses who meet the criteria for licensing in the Nurse Practitioner Class, as set out in the Registered Nurses Act (2001) and the Registered Nurses Regulations (2001) can use the designation Nurse Practitioner, NP, N.P., Primary Health Nurse Practitioner or Specialty Nurse Practitioner.

This document is a companion document to the Nurse Practitioner Competencies (CRNNS, September 2005), to be used by nurses, nurse educators, regulatory bodies, other health professionals, employers, and others who are interested in the nurse practitioner role and expectations of nurse practitioners.
STANDARDS FOR NURSING PRACTICE

The Standards for Nursing Practice (CRNNS, 2003) establish the minimum professional practice performance that the public can expect from any registered nurse in any setting or role. The RN Act (2001) authorizes nurse practitioners to independently perform a range of health services that extend beyond those of registered nurses in the active-practising class; health services that require a high level of autonomy in the decision-making and accountability related to client health outcomes. Therefore, in addition to the minimum performance expectations to meet standards on accountability, continuing competence, application of knowledge, skills and judgment, professional relationships and advocacy, professional leadership and self-regulation, nurse practitioners are required to meet the following standards and conditions for practice, to reflect their legislated scope of practice.

STANDARDS OF PRACTICE FOR NURSE PRACTITIONERS

STANDARD 1: ACCOUNTABILITY

The nurse practitioner is accountable to the public for competent, safe and ethical care.

The nurse practitioner:

1.1 is accountable to diagnose, treat, manage, monitor and evaluate clients’ health conditions within the limits of the nurse practitioner’s educational preparation, competence and legislated scope of practice.

1.2 will perform comprehensive and focused health assessments and histories, and physical examinations, by using multiple tools and sources of data.

1.3 may determine, order and interpret screening and laboratory tests approved by the Diagnostic & Therapeutics Committee and subject to the health organization’s policies, to:
   • screen clients’ health activities and risks
   • diagnose or confirm an acute illness or injury
   • monitor the health status of clients with a previously diagnosed disease or disorder
   • confirm increasing or decreasing organ function as indicated by a health history or signs and symptoms
   • determine a potential diagnosis that, if present, would require consultation with an appropriate physician for treatment.

1.4 may order mammography, X-rays of the chest and extremities, and diagnostic ultrasounds of the abdomen, pelvis or breast, and other tests as per the authorized practice schedule approved by the Diagnostic & Therapeutics Committee. This authority does not include performing or interpreting these tests. The nurse practitioner will base decisions for treatment plans on a radiologist’s interpretation.

1.5 will, when ordering and interpreting laboratory tests:
   • be guided by best-practice evidence on the appropriateness, safety and cost-effectiveness of each test
   • adhere to provincial or health organization policies or standards for ordering diagnostic tests, as well as for documenting and reporting test results
   • discuss with clients the reason for the test, benefits and associated risks.
1.6 will establish a system to receive and track results of tests and to communicate in a timely manner with clients and other health providers involved in a client's care.

1.7 will understand the significance of reports of test results and interpretations by specialists and act appropriately (e.g., develop or change a plan of care, consult or follow up with a physician or specialist as appropriate).

1.8 will initiate, manage, and monitor the care of clients by providing safe, effective and appropriate pharmacological and non-pharmacological therapy to clients with acute, emergent and chronic health conditions for a client population within the NP's focus of practice.

1.9 will, when prescribing drugs:
- prescribe within parameters described in the Schedule of Drugs approved by the Diagnostic & Therapeutics Committee;
- prescribe drugs according to federal and provincial legislation (e.g., Food and Drugs Act and its regulations);
- adhere to ethical, legal, and professional standards of drug therapy;
- consider the evidence on outcomes and cost-effectiveness;
- recognize the influence of marketing strategies of pharmaceutical industries on prescriptive practice, and verify information independently;
- provide clients with relevant information and counseling on drug therapies, including cost-effective alternative choices, as applicable;
- repeat or continue a drug originally prescribed by a physician only following an assessment and decision regarding ongoing treatment for conditions within the nurse practitioner's focus of practice and level of competence;
- monitor and document a client's response to drug therapy, and decide to continue, adjust, or withdraw a drug, or to consult with a physician in accordance with the standards on consultation;
- consult with the primary physician or prescribing physician prior to repeating, discontinuing and/or changing prescribed drug or drugs for clients whose conditions fall outside of the nurse practitioner's focus of practice and level of competence;
- consult or collaborate with pharmacists, as appropriate;
- complete prescriptions accurately and completely, according to the Pharmacy Act and regulations, and other relevant legislation, standards and policies;
- document prescriptions on clients' health records.

1.10 when considering an alternative or complementary therapy with a client, ensures that it does not interfere with the therapeutic care or pose a risk to the client's health and safety and the client has information on the research evidence on such therapy.

1.11 performs non-invasive and invasive procedures for which competence has been developed and maintained, to assess, restore, regain or maintain physiological stability of clients.

1.12 documents and reports adverse events associated with drugs and other therapies.

1.13 obtains informed consent from clients prior to performing procedures.

1.14 maintains and stores client health records according to provincial, federal legislation, professional standards, and relevant policies.

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1 **Definition:** "Focus of practice" throughout this document also refers to the nurse practitioners' area of specialty.
STANDARD 2: CONTINUING COMPETENCE

The nurse practitioner attains and maintains competencies relevant to own scope of practice.

The nurse practitioner will:

2.1 maintain and document the required hours of practice within the NP scope of practice (e.g., 600 hours in preceding two years).

2.2 engage in formal and informal continuing education appropriate to NP scope of practice and relevant to own area of practice.

2.3 provide evidence of additional education and competencies to employer when changing focus of practice.

2.4 demonstrate current knowledge and ability to critically appraise information on therapies, best practices, guidelines and resources relevant to client population within one’s area of practice.

2.5 engage in reflective practice, seek feedback from peers and collaborating partners and/or participate in practice reviews to determine learning needs, areas of improvements and develop a learning plan or action plan.

2.6 document and keep a record of continuing competence activities to provide to the College upon request.

STANDARD 3: APPLICATION OF KNOWLEDGE, SKILLS AND JUDGMENT

The nurse practitioner will demonstrate core competencies expected of NPs specific to focus of practice, legislated scope of practice and conditions for collaborative practice and consultation.

The nurse practitioner will:

3.1 define the specific area of practice and client population for whom the NP is competent to practise.

3.2 establish a collaborative practice agreement with a physician or group of physicians in her/his area of practice, based on the guidelines established by the College (Appendix A) and in accordance with policies of the employing health organization.

2 Definition: Consultation, including referrals, is defined as an explicit request from a nurse practitioner for a collaborating practice physician to become involved in the care of a client for which the nurse practitioner, at the time of the request, has primary responsibility. Consultation can occur through face-to-face discussions, by telephone or in writing. The manner in which consultation takes place will be dictated by the urgency of the request for consultation, and the availability or accessibility of the physician.

3 Definition: The RN Act (2001) defines a “collaborative practice agreement” (CPA) as a written agreement by members of a collaborative practice team which, subject to decisions of the Diagnostic & Therapeutics Committee, may include the following authorized acts:

1) Screening and diagnostic tests that may be ordered and interpreted by the NP.

2) Drugs and interventions that may be chosen, recommended, prescribed and monitored by the NP.

3) Procedures that are authorized to be performed by the NP.

4) Consultation process with physicians required for all or any of the above.
3.3 establish a consultation relationship with physicians, pharmacists and other healthcare providers as appropriate to area of practice.

3.4 recognize the need for and initiate timely, relevant and appropriate referrals and/or consultations with other healthcare professionals or community agencies.

3.5 initiate consultations with most appropriate healthcare professionals when an outcome of a drug therapy, intervention and/or treatment plan is beyond the NP’s scope of practice or competence.

3.6 document the request for and outcome of a consultation in a client’s health record.

3.7 involve clients in the consultation process, starting with the identification of the need for consultation and the outcomes.

**Conditions for Consultation**
Consultation is required at any point during a client’s care when the expertise of a physician is necessary before the nurse practitioner can independently proceed with the diagnosis, treatment and management of the client’s health condition. Consultation may occur by face-to-face meetings, in writing or electronically, as appropriate to the situation. The nurse practitioner will consult and/or refer to a collaborating practice partner or other physician at any point in the management of client care (i.e., assessing, planning, implementing or evaluating) when a client’s condition is such that:

1) a diagnosis and/or treatment plan is unclear or beyond the scope of the nurse practitioner to determine.

2) the care that is required approaches the limits of the nurse practitioner’s competencies and/or scope of practice, beyond which the NP cannot provide care independently.

3) a client’s health condition destabilizes or deteriorates.

4) signs, symptoms, or reports of imaging or laboratory tests suggest:
   • a previously undiagnosed systemic illness
   • obstruction of a vital organ
   • systemic infection
   • potential threat to life, limb or senses.

**Outcomes of Consultations**
Consultations may result in one of the following:

1) The physician provides an opinion and recommendation on treatment or intervention to the NP, who maintains primary responsibility for client care.

2) The physician assumes concurrent responsibility with the NP for the care of a client, in which case the NP and physician discuss and document who is responsible for the coordination and specific aspects of the client’s care.

3) The physician assumes primary responsibility for client care.

**Standard 4: Professional Relationships and Advocacy**
The nurse practitioner establishes professional therapeutic relationships with clients and advocates for clients in their relationships with the health system.
**Standard 5: Professional Leadership**
The nurse practitioner demonstrates professional leadership in the delivery of quality nursing healthcare services to the public.

The nurse practitioner will:

5.1 practise according to the ethical, legislative, and professional standards consistent with the increased responsibility and accountability of the NP role.

5.2 understand and demonstrate the change in scope of practice from that of a registered nurse and accept accountability for client care.

5.3 recognize and respect the differences in the scope of practice, expertise and contributions of other members of the health team.

5.4 establish collaborative relationships and networks with other healthcare providers and organizations, including other nurse practitioners, registered nurses, physicians, pharmacists, social workers, nutritionists, community agencies, and others as appropriate to the needs of the client population in area of practice.

5.5 provide consultation and accept referrals from other health providers for health conditions within scope of practice and expertise.

5.6 contribute to the development of standards, practice guidelines, education and research initiatives in NP’s clinical focus of practice.

5.7 act as a role model and mentor to registered nurses, other nurse practitioners and other health professionals within the health team.

**Standard 6: Self-regulation**
The nurse practitioner assumes personal accountability to practise nursing competently and ethically.

The nurse practitioner will:

6.1 assume accountability for client care decisions and actions within the limits of legislated scope of practices and level of competence.

6.2 accept responsibilities for and only provide health services for which competence has been achieved and maintained and authority has been granted by legislation, standards or policies.

6.3 recognize and address breaches of practice, legal and ethical standards by self or others in a timely and appropriate manner.
REFERENCES


APPENDIX A

GUIDELINES FOR COLLABORATIVE PRACTICE AGREEMENTS
A collaborative practice agreement, jointly developed and signed by collaborative practice team members, should include:

- effective dates of the agreement;
- licence/registration numbers of the collaborative practice team members;
- description of the responsibilities and accountabilities of the collaborating practice team to the client population;
- description of the responsibilities and accountabilities of each member of the collaborative practice team to each other and to the team and, if applicable, to the employing health organization;
- description of mechanisms for ongoing communication between and among members of the team that demonstrate support for autonomous professional judgment and shared decision-making;
- description of mechanisms for consultation and referrals from the NP to the physician, and vice versa;
- continuous quality improvement initiatives and evaluation processes that address safety; and
- a statement of professional liability coverage (e.g., Canadian Nurses Protective Society or Canadian Medical Protective Association) and employer liability coverage as applicable.
Appendix N.B. – 11

NURSE PRACTITIONER SCHEDULES FOR ORDERING:

X-rays
Ultrasounds
Other Forms of Energy

Laboratory & Other Tests

Drugs

NURSES ASSOCIATION OF NEW BRUNSWICK

Revised November 2006
NURSE PRACTITIONER SCHEDULES

Schedule "A" - X-rays, Ultrasounds, and Other Forms of Energy ........................................ 3
Schedule "B" - Laboratory and Other Tests ......................................................................... 4
Schedule "C" - Drugs Excluded or Limited ........................................................................ 8
Schedule "D" - Drugs Not listed in the New Brunswick Prescription Drug Program Formulary .......................................................... 13
Schedule “A”
X-rays, Ultrasounds and Other Forms of Energy

A Nurse Practitioner is authorized to order the x-rays, ultrasounds and other forms of energy designated in Schedule “A”.

**Ultrasounds**
- Abdomen
- Pelvis
- Breast
- Obstetrical
- Carotid doppler

**X-rays**
- Skeletal
- Chest
- Abdomen
- Mammography
- Bone density

**Other**
- Electrocardiogram (E.C.G.)
- Holter Monitor
- Spirometry (Pulmonary Function Test)
- 24-hour blood pressure monitoring;

such further x-rays, ultrasounds and forms of energy required for monitoring a patient’s chronic illness or injury following consultation with the patient’s physician and the order for such tests shall include reference to the physician’s name.
Schedule “B”
Laboratory and Other Tests

A Nurse Practitioner is authorized to order the laboratory and other tests designated in Schedule “B”.

Chemistry

- Albumin, Protein
- ALT
- Amylase
- Arterial Blood Gases
- AST
- Bilirubin, total
- Bilirubin, conjugated
- Breath Urea
- BUN (Urea)
- Calcium
- Chloride
- Cholesterol, total
- CPK
- Creatinine
- Gamma glutamyl transpeptidase (GGT)
- Glucose, quantitative
- Glucose challenge
- High Density, Low density, Very Low Density Lipoprotein Cholesterol
- Iron, Total - with iron binding capacity
- Lipid - total
- Magnesium
- Phosphatase, Alkaline
- Phosphorus (inorganic phosphate)
- Potassium
- Protein, total
- Sodium
- Triglycerides
- Uric Acid
Chemistry (Hormones)
Beta HCG
Cortisol
Estradiol
Estriol
Free Testosterone
FSH (Pituitary Gonadotrophins)
HCG (Human Chorionic Gonadotrophins)/Maternal Screen - written consent required
LH
Parathyroid Hormone (PTH)
Progesterone
Prolactin
Thyroid Stimulating Hormone (TSH)
T4
Vitamin D

Chemistry (Serum Protein electrophoresis)
Alpha fetoprotein screen
Folate
Ferritin
Glycosylated hemoglobin - Hgb A1C
Iron
PSA
TIBC and % Transferrin saturation
Transferrin
Vitamin B12

Chemistry (Urine)
Drug Screen
HCG
24-hour urine and microalbuminurea screening
Urinalysis
Urine lytes

Hematology
C-Reactive Protein
Complete blood count (CBC)
Differential
ESR
Platelet Count
Reticulocyte Count
Coagulation
Bleeding time (BT)
D-dimer
INR
Prothrombin Time (PT)
PT-INR
Partial Thromboplastin Time (PTT)

Therapeutic Drug Monitoring
Acetaminophen
Alcohol
Aminophylline (Theophylline)
Arsenic
ASA
Carbamazepine (Tegretol)
Digoxin
Drug Screen
Lead
Lithium
Phenobarb
Phenytoin (Dilantin)
Primadone
Quinidine
Salicylate
Valproic Acid

Microbiology
Antibiotic sensitivity
Blood culture
Cervical swabs
Herpes Simplex swab
Pap smear
Pin worm- scotch tape test
Sputum - gram stain, culture, AFB, tuberculosis
Stool culture
Surface culture
Throat swab
Urine culture
Vaginal swabs
Wet mount for trichomonas

Nuclear Medicine
Schillings test
Serology (Blood Bank)

ANA
Antibody Screening
Antibody titre
Blood Grouping
Cold Agglutinins
Hep screen
HIV - written consent required
H-pylori
Mono spot
Rubella titre
Rubeola titre
Varicella titre
VDRL

Other Tests

Electrocardiogram (E.C.G.)
Holter Monitor
Mantoux test
Spirometry (Pulmonary Function Test)
24-hour blood pressure monitoring
24-hour pulse oximetry;

such further laboratory and other tests required for monitoring a client’s chronic illness
or injury following consultation with the patient’s physician and the order for such tests
shall include reference to the physician’s name.
Schedule "C"
Drugs Excluded or Limited

A Nurse Practitioner is authorized to prescribe the drugs found in the New Brunswick Prescription Drug Program Formulary, including Appendix IV - Special Authorization, as amended from time to time, except as excluded or limited in Schedule "C".

The drugs listed in this Schedule "C" may not be prescribed by Nurse Practitioners except as noted below. References in this Schedule to:

(i) "Exceptions" mean that the drugs identified may be prescribed by a Nurse Practitioner,
(ii) "for maintenance" means that a Nurse Practitioner may prescribe the drugs in the same dosage as originally ordered for the continuation of therapy provided the said drugs had been previously prescribed for the patient by a physician,
(iii) "in palliative care" means that a Nurse Practitioner may prescribe the drugs indicated to a patient who has been categorized as a recipient of palliative care by a physician, and
(iv) "for planned adjustment" means that a Nurse Practitioner may prescribe and adjust the dosage of the drugs within minimum and maximum dosages that have been established in a written plan with the collaborating physician.

### Identification Code | Therapeutic Classification
---|---
08:22:00 | Quinolones
Exceptions: (a) Ciprofloxacin
(b) Levofloxacin
(c) Moxifloxacin
(d) Norfloxacin

10:00:00 | Antineoplastic agents
Exceptions: (a) Methotrexate sodium for maintenance; and
(b) Tamoxifen citrate for maintenance.
(c) Epoetin alfa for maintenance

12:08:04 | Antiparkinsonian agents
Exception: (a) Benztropine Mesylate for maintenance

24:04:04 | Amiodarone Hydrochloride for maintenance

28:08:08 | Opiate Agonists (Narcotic Analgesics)

28:08:12 | Opiate partial agonists

Nurses Association of New Brunswick
Nurse Practitioner Schedules - Revised November 2006
<table>
<thead>
<tr>
<th>Identification Code</th>
<th>Therapeutic Classification</th>
</tr>
</thead>
</table>
| 28:08:92            | Miscellaneous Analgesics and Antipyretics  
Exception: (a) Acetaminophen |
| 28:12:04            | Anticonvulsants (Barbiturates) |
| 28:12:08            | Anticonvulsants (Benzodiazepines) |
| 28:16:04            | Psychotherapeutic Agents (Antidepressants)  
Exceptions: (a) Amitriptyline Hydrochloride  
(b) Bupropion HCL  
(c) Citalopram Hydrobromide  
(d) Fluoxetine Hydrochloride  
(e) Fluvoxamine Maleate  
(f) Mirtazapine  
(g) Paroxetine  
(h) Sertraline Hydrochloride  
(i) Venlafaxine HCL  
(j) All other psychotherapeutic agents (antidepressants) for maintenance |
| 28:16:08            | Psychotherapeutic Agents (Tranquilizers)  
Exceptions: (a) Olanzapine for maintenance  
(b) Prochlorperazine in palliative care;  
(c) Stemetil  
(d) Thioridazine Hydrochloride in palliative care;  
(e) All other Psychotherapeutic Agents (tranquilizers) for maintenance |
| 28:20:00            | Respiratory and Cerebral Stimulants |
| 28:24:08            | Anxiolytics, Sedatives, Hypnotics (Benzodiazepines) |
| 28:28:00            | Antimanic agents  
Exception: (a) Lithium carbonate for maintenance |
| 52:00               | All Ophthalmic preparations contained in class 52:00  
Exceptions: (a) Erythromycin  
(b) Fusidic acid  
(c) Gentamicin sulphate  
(d) Levocabastine  
(e) Polymyxin B Sulfate/Bacitrazin Zinc |
<table>
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<tr>
<th>Identification Code</th>
<th>Therapeutic Classification</th>
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<tbody>
<tr>
<td>52:10:00</td>
<td>Carbonic anhydrase inhibitors</td>
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<tr>
<td>60:00:00</td>
<td>Gold Compounds</td>
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<tr>
<td>64:00:00</td>
<td>Heavy Metal Antagonists</td>
</tr>
<tr>
<td>68:08:00</td>
<td>Androgens</td>
</tr>
<tr>
<td>68:28:00</td>
<td>Pituitary hormones</td>
</tr>
<tr>
<td>84:06:00</td>
<td>Acinonide</td>
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<tr>
<td></td>
<td>Clobetasol Propionate</td>
</tr>
<tr>
<td></td>
<td>Clobetasone Butyrate</td>
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<tr>
<td></td>
<td>Desonide</td>
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<tr>
<td></td>
<td>Dexamethasone</td>
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<tr>
<td></td>
<td>Diflorasone Diacetate</td>
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<tr>
<td></td>
<td>Diflucortolone Valerate</td>
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<tr>
<td></td>
<td>Fluocinolone Acetonide</td>
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<td>Fluocionide</td>
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<tr>
<td></td>
<td>Halcinonide</td>
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<tr>
<td></td>
<td>Salicylic Acid/Betamethasone</td>
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<td></td>
<td>Salicylic Acid/Betamethasone Diproprionate</td>
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<td></td>
<td>Salicylic Acid/Flumethasone Pivalate</td>
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<td></td>
<td>Triamcinolone Acetonide</td>
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<tr>
<td>84:16:00</td>
<td>Acitretin</td>
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<tr>
<td>84:36:00</td>
<td>Isotretionin</td>
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<tr>
<td></td>
<td>Fluorouracil</td>
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<tr>
<td>86:12:00</td>
<td>Genitourinary Smooth Muscle Relaxants</td>
</tr>
<tr>
<td></td>
<td>Exception:</td>
</tr>
<tr>
<td></td>
<td>(a) Oxybutyn HCL</td>
</tr>
<tr>
<td></td>
<td>(b) All other Genitourinary Smooth Muscle Relaxants for maintenance</td>
</tr>
<tr>
<td>92:00:00</td>
<td>Bromocriptine Mesylate</td>
</tr>
<tr>
<td></td>
<td>Azathioprine</td>
</tr>
<tr>
<td></td>
<td>Exceptions:</td>
</tr>
<tr>
<td></td>
<td>(a) Allopurinol for maintenance</td>
</tr>
<tr>
<td></td>
<td>(b) Azathioprine for maintenance</td>
</tr>
<tr>
<td></td>
<td>(c) Etidronate disodium for maintenance</td>
</tr>
</tbody>
</table>

Nurses Association of New Brunswick
Nurse Practitioner Schedules - Revised November 2006
New Brunswick Prescription Drug Program
Formulary: Appendix IV - Special Authorization

Drugs Excluded

Bimatoprost (Lumigan)
Botulinum Toxin Type A (Botox)
Buserelin Acetate (Suprefact)
Capecitabine (Xeloda)
Celecoxib (Celebrex)
Clozapine (Clozaril and generic brands)
Cyproterone Acetate (Androcur and generic brands)
Delta-9-Tetrahydrocannabinol (Marinol)
Etanercept (Enbrel)
Fentanyl (Duragesic)
Filgrastim (Neupogen-Amgen)
Fludarabine (Fludara)
Flutamide (Euflex and generic brands)
Gabapentin (Neurontin and generic brands)
Ganciclovir (Cytovene)
Goserelin Acetate (Zoladex)
Imatinib (Gleevec)
Infliximab (Remicade)
Interferon Alfa-2B Ribavirin (Rebetron)
Lamivudine (Heptovir)
Lamotrigine (Lamictal and generic brands)
Latanoprost (Xalatan)
Latanoprost/Timolol (Xalacomb)
Leflunomide (Arava)
Leuprolide (Lupron and Lupron Depot)
Levetiracetam (Keppra)
Linezolid (Zyvoxam)
Nafarelin Acetate (Synarel)
Naltrexone (Revia)
Nilutamide (Anadron)
Octreotide Acetate (Sandostatin and Sandostatin Lar)
Ondansetron (Zofran)
Oxcarbazepine (Trileptal)
Oxycodone (Oxy IR and Oxycontin CR)
Peginterferon Alfa-2A (Pegasys)
Peginterferon Alfa-2B+Ribavirin (Pegetron)
Quetiapine (Seroquel)
Rifabutin (Mycobutin)
Riluzole (Rilutek)
Rivastigmine (Exelon)
Sevelamer (Renagel)
Drugs Excluded con’t

Sirolimus (Rapamune)
Somatropine (Humatrope) (Saizen)
Tacrolimus (Protopic)
Thyrotropin Alpha (Thyrogen)
Tizanidine (Zanaflex)
Tobramycin (Tobi)
Travoprost (Travatan)
Tretinoin (Vesanoid)
Tryptophan (Tryptan and generic brands)
Ursodiol (Urso) (Urso DS)
Valganciclovir (Valcyte)
Vigabatrin (Sabril)

Drugs Limited / For Maintenance

Anastrozole (Arimidex)
Atovaquone (Mepron)
Bosentan (Tracleer)
Calcitonin Salmon (Miacalcin, Apo-Calcitonin)
Desmopressin (DDAVP)
Dipyridamole Extended Release/ASA Immediate Release (Aggrenox)
Donepezil (Aricept)
Entacapone (Comtan)
Epoetin Alfa (Eprex)
Exemestane (Aromasin)
Finasteride (Proscar)
Galantamine (Reminyl)
Insulin Aspart (Novorapid)
Insulin Lispro (Humalog)
Letrozole (Femara)
Raloxifene (Evista)
Risperidone (Risperdal) (Risperdal M)

• Controlled Drugs except as permitted by the Controlled Drugs and Substances Act (CDSA).
• Drugs for off-label use.
Schedule “D”
Drugs Not Listed in the New Brunswick Prescription Drug Program Formulary

The drugs listed in this schedule “D” may be prescribed by Nurse Practitioners.

A Nurse Practitioner is authorized to prescribe vaccines in accordance with the immunization standards for New Brunswick Public Health Services as outlined in the New Brunswick Immunization Handbook and the Canadian Immunization Guide as revised from time to time, and “vaccine” means any biological product used in the New Brunswick immunization program.
COMPETENCIES AND STANDARDS OF PRACTICE FOR NURSE PRACTITIONERS IN PRIMARY HEALTH CARE

NURSES ASSOCIATION OF NEW BRUNSWICK
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OUR MISSION

The Nurses Association of New Brunswick is a professional organization that exists to support nurses and to protect the public by promoting and maintaining standards for nursing education and practice, and by advocating for healthy public policy.

The Nurses Association of New Brunswick endorses the principles of self-regulation, that is, promoting good practice, preventing poor practice and intervening when practice is unacceptable.

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Effective October 2002
The Nurses Act was amended in July 2002 to enable the practice of nurse practitioners in New Brunswick. The nurse practitioner role is regulated in addition to that of a registered nurse because the nurse practitioner performs activities that are not considered part of the scope of practice of registered nurses. This role is a nursing role, and nurse practitioners must practise in accordance with all standards relevant to the nursing profession including the NANB Standards for Nursing Practice and the CNA Code of Ethics for Registered Nurses.

Nurse practitioners have the potential to make a significant contribution to new models of health care delivery based on primary health care principles. NANB has promoted the utilization of nurse practitioners in emergency rooms, community health centres, family practice, and nursing homes.

The present document lists the competencies and standards which focus on the responsibilities in nurse practitioner practice which require additional regulation by NANB.
2. SCOPE OF PRACTICE OF THE NURSE PRACTITIONER IN PRIMARY HEALTH CARE

A nurse practitioner is a registered nurse who meets the requirements for registration with the Nurses Association of New Brunswick for practice as a nurse practitioner. The nurse practitioner has completed a nurse practitioner program in primary health care and has advanced knowledge and clinical expertise in assessment, diagnosis, and health care management. The nurse practitioner in primary health care is a generalist who offers comprehensive and continuous care to clients across the health continuum and throughout the client's lifespan. The client is defined as individual, family, groups and community. The nurse practitioner provides comprehensive primary health care services including health promotion, disease and injury prevention, curative, rehabilitative and supportive services to clients in all health settings. As a member of the interdisciplinary health team, the nurse practitioner role is both autonomous and collaborative in nature.

The "practice of a nurse practitioner" is defined in the Nurses Act (amended July 2002) as the practice in which a nurse practitioner may:

- diagnose or assess a disease, disorder or condition, and communicate the diagnosis or assessment to the client;
- order and interpret screening and diagnostic tests;
- select, prescribe and monitor the effectiveness of drugs; and
- order the application of forms of energy.

This authority is what makes the practice of nurse practitioners different from that of all other registered nurses.

The screening and diagnostic tests that may be ordered and interpreted, the drugs that may be selected or prescribed, and the forms of energy that may be ordered by the nurse practitioner are established by the Nurse Practitioner Therapeutics Committee and are set out in Schedules "A," "B" and "C" in the NANB Rules. The Nurse Practitioner Therapeutics Committee, which is made up of two physicians, two pharmacists and two nurse practitioners, meets at least once annually and makes recommendations to the NANB Board regarding the schedules. The Minister of Health and Wellness must approve the schedules or any changes made to the schedules prior to implementation.
3. NURSE PRACTITIONER COMPETENCIES

Competencies are defined as knowledge, skills, attitudes, and judgements required to perform safely in own area of nursing practice.

The following competencies are required by nurse practitioners upon entry into practice. They reflect the advanced knowledge and skills which require additional regulation on the part of the Nurses Association of New Brunswick. Nurse practitioner competencies build on the competencies required of all nurses.

The nurse practitioner competencies are grouped under the following headings:
(i) Health Assessment and Diagnosis.
(ii) Health Management of Acute and Chronic Health Conditions,
(iii) Health Promotion and Disease Prevention, and
(iv) Professional Role and Responsibilities

(i) Health Assessment and Diagnosis

The nurse practitioner:
• completes a comprehensive health assessment, including an appropriate health history and physical examination;
• demonstrates sound clinical judgement and diagnostic reasoning abilities in synthesizing health information in order to identify a health condition and make a diagnosis;
• modifies assessment techniques according to the client’s condition, culture, and stage of development;
• synthesizes information from individual clients to identify broader implications for health within the family or community;
• applies the principles of physiology, pathophysiology and pathogenesis, including clinical manifestations of commonly encountered health conditions in order to make a diagnosis;
• determines the need for, orders and interprets the results of relevant screening and diagnostic laboratory tests; and/or interprets reports of x-rays and diagnostic ultrasounds, as per Schedules “A” and “B” in the NANB Rules Respecting Nurse Practitioners (APPENDIX “A”) to:
  • diagnose a health condition,
  • monitor clients who have a previously diagnosed health condition, or
  • alter/adjust therapy previously established;
• effectively communicates health findings and/or the diagnosis of a health condition to the client and discusses the prognosis and options for treatment for those conditions;
• establishes a mutually acceptable plan of care based upon established priorities of care that maximizes health potential.

(ii) Health Management of Acute and Chronic Health Conditions

The nurse practitioner manages the treatment of clients’ health conditions by:
• providing effective pharmacological, counselling, or other interventions;
• assisting/supporting clients to design and follow the plan of treatment and care;
• selecting/prescribing the appropriate treatment/intervention according to current best-practice guidelines;
• applying knowledge of pharmacology, including pharmacokinetics and pharmacodynamics when selecting/prescribing drugs as per Schedule “C” of the NANB Rules Respecting Nurse Practitioners (APPENDIX “A”) to treat health conditions;
• monitoring the effect of the chosen therapy, including pharmacological and non-pharmacological treatment modalities;
• evaluating the effect of selected treatments and interventions using sound diagnostic reasoning skills;
3. NURSE PRACTITIONER COMPETENCIES

- altering therapy and making necessary adjustments when indicated;
- ensuring reasonable access to a physician for the purposes of consultation and referral or transfer of any client to a physician for care; and
- initiating timely and appropriate consultation, referral or collaboration with physicians and/or with other members of the health care team.

(iii) Health Promotion and Disease Prevention

The nurse practitioner:
- determines the need for and provides health promotion services to clients who are healthy or who have acute or chronic conditions;
- implements primary, secondary and tertiary prevention strategies for individuals, families and communities, or for specific age and cultural groups, in accordance with population health principles;
- provides anticipatory guidance and counselling to reduce risk factors and prevent disease and disabilities; and
- applies theories of teaching and learning when providing health education to individuals, families and groups.

(iv) Professional Role and Responsibilities

The nurse practitioner:
- practices both autonomously and collaboratively, offering the full scope of nurse practitioner practice;
- demonstrates knowledge of relevant professional, ethical and legal standards for nurse practitioner practice and incorporates such standards in practice;
- participates as a member of the health care team in the provision of health care by interacting with professional colleagues to provide comprehensive care;
- recognizes the importance of maintaining nurse practitioner competencies by actively seeking learning opportunities and continuing education programs;
- participates in quality assurance review including systematic review of records and treatment plans; and
- maintains active registration as a nurse practitioner with NANB.
PART II 1. STANDARDS FOR ESTABLISHING AND COMMUNICATING A DIAGNOSIS

The nurse practitioner performs a comprehensive health assessment and synthesizes data from multiple sources to formulate a differential diagnosis of a health condition. The nurse practitioner communicates health assessment findings and/or diagnosis, and discusses prognosis and treatment options with the client.

The nurse practitioner:
• utilizes critical thinking and applies current relevant clinical research findings in assessing health conditions of clients;
• orders preventative and diagnostic procedures based on client's age, history and presenting signs and symptoms; and
• communicates effectively with client, intentionally including principles of health promotion, illness/disease prevention, and capacity development in client teaching, and other interventions based on the established diagnosis.
2. STANDARDS FOR ORDERING X-RAYS AND ULTRASOUNDS

Nurse practitioners are authorized to order specific x-rays and diagnostic ultrasounds as listed in Schedule “A” in the NANB Rules Respecting Nurse Practitioners (2002) (APPENDIX “A”):

- to confirm the diagnosis of a short term, episodic illness or injury as suggested by the client’s history and/or physical findings;
- to rule out a potential diagnosis that, if present, would require consultation with a physician for treatment;
- to assess/monitor ongoing conditions of clients with chronic illnesses;
- for screening activities;
- to monitor the ongoing condition of a client with a previously diagnosed illness or disorder; or
- to confirm symptoms of decreasing/increasing function of a vital organ or system.

Any x-ray or ultrasound not found on the list must be ordered by a physician.

The nurse practitioner:

- knows the contraindications to ionizing radiation exposure, and the associated risks and benefits of ordering an x-ray or an ultrasound;
- obtains informed consent prior to ordering an x-ray or ultrasound, and
  - explains the reason(s) for the x-ray or ultrasound;
  - explains the general risks and benefits of performing the x-ray or ultrasound, and
  - answers any questions that the client has;
- understands the radiologist’s diagnostic interpretation of a specific x-ray or ultrasound and consults with the radiologist if the interpretation of an x-ray or ultrasound requires clarification;
- makes decisions about treatment based on results of x-rays and/or consults with a physician in accordance with the expectations for consultation with physicians by nurse practitioners;
- may request a copy of the radiologist’s x-ray or ultrasound report for x-rays or ultrasounds ordered by a physician for clients with whom the nurse practitioner has been involved in providing care; and
- documents the x-ray or ultrasound order on the permanent client record as part of the treatment plan.

The authority to order x-rays does not include operating the x-ray machine, nor does the authority to order ultrasounds include performing or interpreting the ultrasound.

The interpretation of an x-ray film and/or of an ultrasound is the responsibility of a radiologist and falls outside the scope of practice of the nurse practitioner.
3. STANDARDS FOR ORDERING LABORATORY TESTS

Nurse practitioners are authorized to order laboratory tests as listed in Schedule “B” of the NANB Rules Respecting Nurse Practitioners (2002) (APPENDIX “B”):

- to confirm the diagnosis of a short term, episodic illness or injury as suggested by the client’s history and/or physical findings;
- to rule out a potential diagnosis that, if present, would require consultation with an appropriate physician for treatment;
- to assess/monitor ongoing conditions of clients with chronic illnesses;
- for screening activities;
- to monitor the ongoing condition of a client with a previously diagnosed illness or disorder; or
- to confirm symptoms of decreasing/increasing function of a vital organ or system.

Laboratory tests not included in Schedule “B” must be ordered by a physician.

The nurse practitioner:

- interprets the laboratory tests in the context of the individual client’s presentation, makes decisions about treatment, and/or consults in accordance with the expectations for consultation with physicians by nurse practitioners;
- may request a copy of a laboratory report for laboratory tests ordered by a physician for clients with whom the nurse practitioner has been involved in providing care;
- documents the order for laboratory tests on the permanent client record as part of the treatment plan;
- takes or handles specimens in accordance with the infection control guidelines in place; and
- complies with the transportation of infectious substances guidelines (Transport Canada guidelines are available from all laboratories) in preparing specimens for transport.
4. STANDARDS FOR PRESCRIBING DRUGS

Nurse practitioners are authorized to prescribe a range of drugs while respecting the restrictions/limitations outlined in Schedule "C" established in the NANB Rules Respecting Nurse Practitioners (2002) (APPENDIX "C"):

The authority does not include dispensing drugs. Nurse practitioners may administer a limited quantity of a specific drug to the client so that the client may start therapy immediately while waiting for the pharmacy to open to fill a prescription.

The nurse practitioner:
• completes prescriptions accurately and completely including the following information (Pharmacy Act):
  • date of issue;
  • name and address (if available) of client;
  • name, strength and quantity of prescribed drug - refer to the generic name of the drug;
  • quantity of the drug which may be dispensed;
  • directions for use - refers to the frequency, route of administration, and the duration of drug therapy, and special instructions, such as "take with food";
  • directions for number of allowable refills and interval between refills, where applicable - if a prescription includes more than one drug, any drug that may be refilled must be clearly identified;
  • if all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug; and
  • prescriber's name, address, telephone number, fax number and signature or unique nurse practitioner identifier;
• provides educational information to clients about prescription and non-prescription drugs which includes information regarding:
  • the expected action of the drug;
  • the importance of compliance with prescribed frequency and duration of the drug therapy;
  • the potential side effects;
  • the signs and symptoms of potential adverse effects (e.g. allergic reactions) and action to take if they occur;
  • potential interactions between the drug and certain foods, other drugs, or substances;
  • specific precautions to take or instructions to follow; and
  • recommended follow-up;
• establishes a working relationship with the pharmacist(s) for purposes of consultation;
• monitors and documents the client's response to drug therapy. Based on the client's response, the nurse practitioner may decide to continue, adjust, or withdraw the drug, or to consult with a physician in accordance with the expectations for consultation;
• establishes appropriate methods for keeping physicians informed of their mutual clients' health conditions and of their treatment decisions (including decisions to repeat particular drugs);
• stores blank prescriptions in a secure area that is not accessible to the public; It is improper practice to provide any person with a blank, signed prescription as this may lead to potential theft or forgery.;
• does not prescribe for family members or for oneself; and
• does not become involved in self-care and encourages friends and family members to seek care from other health care providers.
A prescription may be transmitted by facsimile to a pharmacy, provided that the following requirements are met (Pharmacy Act):

- the prescription must be sent only to the pharmacy of the client’s choice with no intervening person having access to the prescription;
- the prescription must be sent directly from the prescriber’s office or directly from a health institution for a patient of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy;
- the prescription must include all information listed above, and in addition must include:
  - time and date of transmission;
  - name and fax number of the pharmacy intended to receive the transmission; and
  - a signed certification that the prescription represents the original of the prescription drug order, the addressee is the only recipient and there are no others, and the words “This certifies that the above prescription has been transmitted only to the pharmacy indicated.”
The term consultation means an explicit request by a nurse practitioner for a physician to become involved in the care of a client for which the nurse practitioner, at the time of the consultation request, has primary responsibility. Consultation is required when the nurse practitioner approaches or reaches the limits of nurse practitioner practice, beyond which she or he cannot provide care independently and additional information and/or assistance is required. The nurse practitioner also recognizes the need for and initiates consultation with other members of the health care team in a timely manner.

The Nurses Act stipulates that the nurse practitioner must have reasonable access to a physician for the purpose of consultation with respect to any client and be able to refer or transfer any client to the care of a physician.

The nurse practitioner must provide to the NANB Registrar, annually, the employee’s name and a statement from the employer verifying that the nurse practitioner, in the course of employment, has reasonable access to a physician for the purpose of consultation and referral or transfer of any client to a physician for care. The nurse practitioner must notify the NANB Registrar immediately if employment circumstances change.

**Clinical expectations**

The nurse practitioner seeks consultation with a physician:

- when the signs, symptoms, diagnosis and plan of treatment are unclear or beyond the knowledge, skill and judgement of the nurse practitioner to determine, including but not limited to the following:
  - persistent or recurring sign(s) or symptom(s) that cannot be attributed to an identifiable cause;
  - sign(s), symptom(s), report(s) of imaging or laboratory tests suggestive of a previously undiagnosed chronic systemic illness;
  - symptomatic or laboratory evidence of decreased or decreasing function of any vital organ or system;
  - sign(s) of recurrent or persistent infection;
  - any atypical presentation of a common illness or unusual response to treatment;
  - any sign(s) or symptom(s) of a sexually transmitted disease in a child;
  - any sign(s) or symptom(s) of behavioral changes that cannot be attributed to a specific cause; and
  - deviation from normal growth and development in an infant or child;

- in potentially life-threatening situations, (emergent situations) including but not limited to the following:
  - any sign(s) or symptom(s) of an acute event that is potentially threatening to life, limb, or senses;
  - sign(s) or symptom(s) of obstruction of any system;
  - signs of severe or widespread infection;
  - a fever greater than 39° in a child 3-36 months with no identifiable focus of infection;
  - any sign(s) or symptom(s) of illness in a child less than 3 months;
  - any blunt, penetrating, or other wound that may involve damage below the fascia or functional impairment; and
  - sign(s) or symptom(s) of any fetal or maternal pregnancy risk factor;

- when a client’s chronic condition destabilizes, including but not limited to the following:
  - symptomatic or laboratory evidence of destabilization and/or unexpected deterioration in the condition of a client who is being managed for a previously diagnosed illness.

Consultation may be required at any stage of the nurse practitioner-client relationship, from the time of the initial assessment through to the evaluation of effectiveness of treatment. Expectations for consultation also apply when managing the care of a client with a chronic condition. Consultation
5. STANDARDS FOR CONSULTATIONS AND REFERRAL

takes place following a formal request and can occur in a variety of ways, for example, face to face, by telephone, in writing. The degree to which the physician becomes involved may vary. Consultation may result in the physician providing an opinion and recommendation; an opinion, recommendation, and concurrent intervention; or assuming primary responsibility for the care of the client (transfer of care). Consultation occurs with a family physician; however, a nurse practitioner may consult with a specialist physician if appropriate to the situation and the practice setting.

When requesting a consultation by a physician, the nurse practitioner:
• clearly presents the reason for and the level of urgency of the consultation;
• describes the level of consultation requested: an opinion and recommendation; an opinion, recommendation, and concurrent intervention; or immediate transfer of care;
• ensures that the physician has appropriate access to the client’s known health information;
• confirms the understanding of the nurse practitioner and physician responsibilities in the specific situation; and
• documents the request for and outcome of the consultation.
NURSES ASSOCIATION OF NEW BRUNSWICK
165 Regent Street
Fredericton, NB E3B 7B4
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e-mail: nanb@nanb.nb.ca
Extract from Prince Edward Island Regulations
s. 6(2)-(4)

(2) Where a nurse practitioner is diagnosing or assessing a disease, disorder or condition of a client, the nurse practitioner shall, subject to subsection (3), consult with the primary medical practitioner of the client, as soon as is reasonable in the circumstances, if

(a) the client’s diagnosis or assessment is unclear to the nurse practitioner or beyond the scope of the nurse practitioner to determine;

(b) the client has or demonstrates

(i) a persistent or recurring sign or symptom that cannot be attributed to an identifiable cause,

(ii) a sign or symptom that suggests that the client has a previously undiagnosed chronic systemic illness,

(iii) a symptom that suggests that the client has decreased or decreasing function in any vital organ or body system,

(iv) a sign of a recurrent or persistent infection,

(v) any atypical presentation of a common illness or unusual response to treatment,

(vi) any sign or symptom of sexually transmitted disease in the client if the client is a child,

(vii) any sign or symptom of a behavioural change that cannot be attributed to a specific cause, or

(viii) any deviation from normal growth and development in the client if the client is an infant child;
(c) a diagnostic or screening test conducted on the client suggests that the client has
   (i) a previously undiagnosed chronic systemic illness, or
   (ii) a decreased or decreasing function in any vital organ or body system;
   (d) the client has a potentially life-threatening disease, disorder or condition; or
   (e) the client has a chronic condition, and the client has or demonstrates signs or symptoms, or a diagnostic or screening test indicates, that the chronic condition has destabilized.

(3) Where a nurse practitioner
   (a) is required by subsection (2) to consult with the primary medical practitioner of a client; and
   (b) is satisfied, after making one or more reasonable attempts to consult with the primary medical practitioner of the client, that the primary medical practitioner is unavailable for consultation,
the nurse practitioner shall, notwithstanding anything to the contrary in subsection (2), consult with another medical practitioner about the health of the client, if it is not reasonable in the circumstances to make further attempts to consult with the primary medical practitioner.

(4) Where a nurse practitioner is of the opinion that a client’s health or safety is at immediate risk, the nurse practitioner may, without consulting with the primary medical practitioner of the client, transfer the care of the client to another medical practitioner or to a hospital. (EC91/06)
Appendix Q-14

Regulation respecting Ordre des infirmières et infirmiers du Québec classes of specialities related to the performance of acts contemplated in section 36.1 of the Nurses Act

Professional Code
(R.S.Q., c. C-26, s. 93, par. c. 94, par. e, h and i and 94.1)

Nurses Act
(R.S.Q., c. I-8, s. 14, par. f)

DIVISION I
GENERAL PROVISIONS AND DEFINITIONS

1. The purpose of this regulation is to regulate the classes of specialties for which members of the Ordre des infirmières et infirmiers du Québec must qualify in order to perform acts contemplated in section 36.1 of the Nurses Act (R.S.Q., c. I-8). It sets out other terms and conditions for the issue, by the Bureau of the Ordre des infirmières et infirmiers, of specialist's certificates, and determines the standards regarding diploma and training equivalence for the purpose of issuing such certificates, and the procedure for equivalence recognition.

Its purpose is also to regulate the issue of training cards to specialized nurse practitioner candidates and determine the professional acts she may perform under certain terms and conditions.

O.C. 997-2005, s. 1.

2. In this regulation:

(1) "specialized nurse practitioner candidate" means a nurse:

(a) who is registered in a graduate-level training program leading to a degree granting access to a specialist's certificate issued by the Order, and who serves a clinical training period as part of this program;

(b) who is eligible to sit the specialty examination corresponding to the specialty concerned, as set out in Division III;

(2) "training site" means the centres operated by institutions, within the meaning of the Act respecting health services and social services (R.S.Q., c. S-4.2), affiliated with a university that offers the clinical training specified for the purposes of obtaining a diploma qualifying candidates for an Order specialist's certificate as well as physicians' offices, medical clinics, dispensaries or other facilities providing first-line care; a list of such sites has been drawn up by the program review subcommittee.
The fees payable under this regulation are those prescribed by the Bureau of the Order, pursuant to subparagraph 8 of section 86.0.1 of the Professional Code (R.S.Q., c. C-26).


3. The classes of nursing specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act (R.S.Q., c. I-8) are as follows:

   (1) nurse practitioner specializing in neonatology;
   (2) nurse practitioner specializing in nephrology;
   (3) nurse practitioner specializing in cardiology;
   (4) nurse practitioner specializing in first-line care.

O.C. 997-2005, s. 3; O.C. 669-2007, s. 2.

4. A specialist's certificate related to one of the classes of specialties set out in section 3 shall be issued to a nurse who meets the following conditions:

   (1) she holds a diploma recognized by government regulation, pursuant to the first paragraph of section 184 of the Professional Code (R.S.Q., c. C-26), granting access to a specialist's certificate issued by the Order, or has been recognized as possessing equivalence, as set out in Division IV;

   (2) she holds the following:

      (a) if specializing in cardiology, an attestation of training in advanced cardiac life support (ACLS) issued by a master instructor recognized by the Heart and Stroke Foundation of Quebec, in compliance with standards detailed in the current edition of the Handbook of Emergency Cardiovascular Care for Health Care Providers, published by the Heart and Stroke Foundation of Canada;

      (b) if specializing in neonatology, an instructor's level attestation of training in neonatal resuscitation issued by a master instructor recognized by the Heart and Stroke Foundation of Quebec, in accordance with the standards detailed in the current edition of the Handbook of Emergency Cardiovascular Care for Health Care Providers published by the Heart and Stroke Foundation of Canada;

   (3) she passes the specialty examination corresponding to the specialty concerned, as set out in Division III;

   (4) if she has been granted equivalence as set out in Division IV, she has successfully completed an integration program including a 3-month clinical training period in a graduate training program leading to a diploma granting access to a specialist's certificate issued by the Order;

   (5) she pays the required fees for the purpose of obtaining a specialist's certificate.

O.C. 997-2005, s. 4.

DIVISION II
TRAINING CARDS

5. Specialized nurse practitioner candidates who hold a training card issued by the secretary of the Order may perform professional acts contemplated in

Division II of the Regulation respecting the activities contemplated in section 31 of the Medical Act which may be performed by classes of persons other than physicians (O.C. 996-2005), provided that she complies with the terms and conditions set out therein.

O.C. 997-2005, s. 5; O.C. 669-2007, s. 3.

6. A training card shall be issued by the secretary of the Order to a specialized nurse practitioner candidate who meets the following conditions:

(1) she is registered in a graduate-level training program leading to a diploma granting access to a specialist's certificate issued by the Order or has been granted equivalence as set out in Division IV;

(2) she pays the required fee for the purpose of obtaining a training card;

(3) if specializing in cardiology or neonatology, she holds an attestation of training as set out in subparagraph 2 of section 4.

Note: The Secretary of the Order shall issue a training card to a nurse who requests one during the 6 months following 13 September 2007 and who meets the following conditions:

(1) she is registered in the “extended class” category on the Roll of the College of Nurses of Ontario or as a “nurse practitioner” on the Register of the Nurses Association of New Brunswick;

(2) she has practiced:

(a) a minimum of 3,360 hours, over the 3 years preceding her request, as a nurse registered in the “extended class” category on the Roll of the College of Nurses of Ontario or in the “nurse practitioner” category on the Register of the Nurses Association of New Brunswick; or

(b) a minimum of 3,360 hours, over the 3 years preceding her request, as a nurse in Canada, and holds a graduate diploma in Nursing Science issued in Canada;

(3) she pays the required fee for the purpose of obtaining a training card. A nurse holding a training card issued pursuant to the first paragraph above is, for purposes of the Regulation respecting Ordre des infirmières et infirmiers du Québec classes of specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act (O.C. 997-2005, 05-10-26), a “specialized nurse practitioner candidate” and she holds training equivalence for purposes of obtaining a “nurse practitioner specializing in first-line care” specialist’s certificate. Her training card is valid for the period during which she is eligible to sit the examination related to the specialty concerned. She is eligible to sit the examination prescribed for “nurse practitioners specializing in first-line care”, in accordance with Division III of the Regulation respecting Ordre des infirmières et infirmiers du Québec classes of specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act, and must sit the exam within the year following the date of issue of her training card. After the year has expired, she may not sit the examination unless she proves to the Bureau of the Order that she has kept her knowledge up to date and maintained her professional skills. A “nurse practitioner specializing in first-line care” specialist’s certificate will be issued to her, provided she meets the following conditions:

(1) she passes the specialty examination related to the “nurse practitioner specializing in first-line care” specialty, in accordance with Division III of the...
Regulation respecting Ordre des infirmières et infirmiers du Québec classes of specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act;

(2) she pays the required fee for the purpose of obtaining a specialist's certificate. (O.C. 669-2007, s. 17)

A nurse requesting a training card as set out in section 17 of Order in council 669-2007 must produce the following supporting documentation, as the case may be:

(1) a certified true copy of her graduate diploma in nursing, obtained in Canada;

(2) an attestation regarding the number of hours of practice, as set out in subparagraph 2 of the first paragraph of section 17 of Order in council 669-2007;

(3) proof of registration on the roll or register of the professional order specified in subparagraph 1 of the first paragraph of section 17 of Order in council 669-2007. (O.C. 669-2007, s. 18)

O.C. 997-2005, s. 6; O.C. 669-2007, ss. 4, 17 and 18.

7. The training card shall indicate the name of the specialized nurse practitioner candidate and the site at which she is serving her clinical training period. The card is valid for the entire period during which the specialized nurse practitioner candidate is registered in the graduate training program leading to a diploma granting access to a specialist's certificate issued by the Order and, as the case may be, for the period of her eligibility to sit the specialty examination, in the specialty concerned, as set out in Division III.

O.C. 997-2005, s. 7.

DIVISION III
SPECIALTY EXAMINATION

§ 1. Eligibility

8. Nurses who meet the conditions set out in subparagraphs 1 and 2 of section 4 shall be eligible to sit the specialty examination.

O.C. 997-2005, s. 8.

9. Nurses eligible to sit the specialty examination must sit the professional examination in the year following the date on which they obtain their diploma or the date on which they are granted diploma or training equivalence, as set out in Division IV.

After this year, nurses can only sit the specialty examination if they prove to the Bureau of the Order that they have kept their knowledge up to date and maintained their professional skills.

O.C. 997-2005, s. 9; O.C. 669-2007, s. 5.

§ 2. Specialty Examination

10. The specialty examination shall cover the theoretical and clinical aspects of the specialty concerned. In particular, it shall assess, in various clinical situations, the assimilation and application of knowledge and skills acquired by the nurse, for
the purpose of determining if she is able to practice independently as a specialized nurse practitioner in the specialty concerned.

O.C. 997-2005, s. 10.

11. For each specialty, an examination committee shall be formed, consisting of a specialized nurse practitioner in the specialty concerned, appointed by the Bureau of the Order, and 2 physicians in the specialty concerned, one of whom shall be appointed by the Bureau of the Collège des médecins du Québec and the other of whom shall be appointed jointly, as chair of the examination committee, by the Bureaus of both orders. The chair shall not hold the right to vote.

Should no specialized nurse practitioner in the specialty concerned be available, the Bureau of the Order shall appoint a nurse with at least 3 years of relevant clinical experience.

The persons appointed shall serve a term of 2 years. They shall remain on duty until they are reappointed or replaced.

Substitutes for each of the members sitting on the committee shall be appointed in accordance with the provisions of the first paragraph.

The Bureau of the Order may, after consulting the Bureau of the Collège des médecins, designate one or more experts to assist the examination committee.

O.C. 997-2005, s. 11.

12. The examination committee shall determine the orientations related to the development of the content of the specialty examination, approve the content of the specialty examination before each examination session, administer the examination and determine whether or not a nurse has passed the specialty examination.

O.C. 997-2005, s. 12.

13. Examination sessions shall be held at least one per year, on the date and at the time and location determined by the Bureau of the Order.


14. To sit the specialty examination, a nurse must register at least 2 months prior to the date set for the examination session and pay the required fees.


15. A nurse may sit the specialty examination in French or English.

O.C. 997-2005, s. 15.

16. The Bureau of the Order shall send the nurse her examination results in writing.

O.C. 997-2005, s. 16.

17. Registration under false pretenses, fraud, plagiarism, participation in fraud or plagiarism or attempted fraud or plagiarism with respect to a specialty examination shall result in failure of the specialty examination, by decision of the
Bureau of the Order. Within 15 days of its decision, the Bureau must notify the nurse of this decision in writing.

A nurse who fails the specialty examination for one of the reasons set out in the first paragraph may request a review of the decision rendered by the Order Bureau, provided that she files a written request with the Order secretary within 30 days of receipt of such decision.

At its first regular meeting following the date on which the request for review was received, the Bureau of the Order must examine this request. It must, before rendering a decision, allow the nurse to submit her comments at this meeting.

A nurse who wishes to attend the meeting in order to be heard must notify the secretary of the Order at least 5 days before the scheduled meeting date. The nurse may, however, submit her comments in writing to the secretary at any time before the scheduled meeting date.

The decision of the Bureau of the Order shall be final and must be sent to the nurse by registered mail within 30 days following the date of the meeting.

O.C. 997-2005, s. 17.

18. A nurse who fails the specialty examination may resit the examination 2 more times.

However, she may not sit a supplemental examination more than 3 years after the date set out in section 9 unless she proves to the Bureau of the Order that she has kept her knowledge up to date and maintained her professional skills.

The provisions of sections 10 to 17 regarding the specialty examination shall apply to the supplemental examination.

O.C. 997-2005, s. 18.

§ 3. Request for review

19. A nurse who fails the specialty examination may request a review of the examination committee's decision by the review committee if she believes that the cause of her failure involved a factor related to the examination procedure.

She must submit this request within 30 days following the date on which the examination results were received, and pay the required fees.

O.C. 997-2005, s. 19.

20. The review committee shall be composed of 2 members appointed by the Bureau of the Order and one member appointed by the Bureau of the Collège des médecins.

O.C. 997-2005, s. 20.

21. Review committee decisions shall be rendered by a majority of members.

O.C. 997-2005, s. 21.

22. Within 30 days of receipt of the request for review, the review committee may render one or several of the following decisions:
(1) refuse the request for review;

(2) cancel the nurse's specialty examination and authorize her to sit a new specialty examination, at no additional cost, on a date set by the secretary of the Order, which will not be considered a supplemental examination within the meaning of section 18, and, as required, recommend that the composition of the examination committee for that examination be changed.

The Bureau of the Order shall notify the nurse, in writing, of the review committee's decision, and this decision shall be final.

O.C. 997-2005, s. 22.

DIVISION IV
DIPLOMA EQUIVALENCE GRANTING ACCESS TO A SPECIALIST'S CERTIFICATE

§ 1. Diploma equivalence standards

23. A nurse holding a diploma in a specialty set out in section 3, issued by an educational institution outside Quebec, shall be granted diploma equivalence for purposes of issuing a specialist's certificate provided that she meets the following conditions:

(1) she has completed, over the 5 years preceding her registration in a graduate program in the specialty concerned, the prerequisite, related to the training program, stipulated in Schedule I;

(2) the diploma she obtained after completing university studies meets the graduate-level training requirements set out in Schedule I, in the specialty concerned.

"Diploma equivalence" means recognition, in application of Division IV, that a diploma issued by an educational institution located outside Quebec attests that the level of knowledge and skill of the nurse or holder of such diploma is equivalent to that acquired by the holder of a diploma recognized by government regulation, pursuant to section 184 of the Professional Code (R.S.Q., c. C-28), and granting access to a specialist's certificate issued by the Order.


23.1. A graduate diploma, issued by a Canadian university and preparing a nurse to work as a nurse practitioner in primary healthcare is equivalent to a diploma giving access to a specialist's certificate issued to nurse practitioners specializing in first-line care.

O.C. 669-2007, s. 7.

24. Notwithstanding sections 23 and 23.1, if the diploma that is the subject of an application for equivalence was obtained more than 3 years before such application and the knowledge to which it attests no longer corresponds, given the developments within the profession, to the knowledge currently taught in a graduate training program leading to a diploma granting access to a specialist's certificate issued by the Order, the nurse shall be granted training equivalence in accordance with sections 25 and 26, provided she has acquired, since she earned her diploma, the required level of knowledge and skill.


§ 2. Training equivalence standards
25. A nurse shall obtain training equivalence for purposes of issuing a specialist's certificate if she possesses a level of knowledge and skill equivalent to that acquired by the holder of a diploma granting access to a specialist's certificate issued by the Order, acquired via a minimum of 3,360 hours of work experience, performed over the 5 years preceding her application for equivalence, in one of the care units stipulated in subparagraph 1 of sections 1 to 3 of Schedule I, in first-line care or in a hospital centre in one or several fields specified in paragraph 1 of section 4 of Schedule I.

The term “training equivalence” means the recognition, in application of Division IV, that a nurse's training proves she has acquired a level of knowledge and skill equivalent to that acquired by the holder of a diploma recognized by government regulation, pursuant to section 184 of the Professional Code (R.S.Q., c. C-26), as granting access to a specialist's certificate issued by the Order.


26. As part of the evaluation of the training submitted in support of a training equivalence application, the committee as set out in section 28 and, as the case may be, the Bureau of the Order shall take the following factors into consideration:

(1) the nature and duration of the nurse's experience;
(2) the nature and content of the courses taken;
(3) clinical training;
(4) total number of years of schooling;
(5) the fact that the nurse holds one or several diplomas.

O.C. 997-2005, s. 26; O.C. 669-2007, s. 10.

§ 3. Diploma or training equivalence recognition procedure

27. Nurses who must have a diploma or training recognized as equivalent for purposes of obtaining a specialist's certificate issued by the Order must submit an application, pay the required fees and enclose the following documents, as the case may be:

(1) a certified, true copy of their specialized nurse practitioner diploma or certificate issued outside Quebec, legally authorizing them to practice in the specialty concerned;
(2) an attestation, supported by letters of reference from medical authorities and nurses concerned, indicating that they are practicing or have practiced the equivalent specialty competently;
(3) proof that they are in good standing with the competent authority in the location where they practice the equivalent specialty;
(4) an attestation indicating that they have completed their graduate nurse practitioner training in an equivalent specialty outside Quebec, including a description of the training completed, theory courses taken, clinical training periods served, duration of clinical training periods, and proof that they were completed successfully;

(5) reports on clinical training periods served as part of the graduate program, which must be signed by the competent authorities of the universities with which the training sites are affiliated; 

(6) an attestation describing their clinical nursing experience, acquired in the specialty concerned; 

(7) attestations of ongoing training in the specialty concerned, received during the 3 years preceding their request for equivalence recognition; 

(8) all diplomas they hold, as well as any documents related to other factors that the Bureau may take into consideration pursuant to section 26.

Documents submitted in support of an application for diploma or training equivalence that are written in a language other than French or English must be accompanied by a French or English translation. Such translation must be certified by the certified translator who translated the document.

O.C. 997-2005, s. 27.

28. The record of the nurse who applies for equivalence recognition shall be forwarded to the equivalence eligibility committee, formed by the Bureau in application of paragraph 2 of section 86.0.1 of the Professional Code (R.S.Q., c. C-26) to examine the request and decide whether to grant or refuse to grant the diploma or training equivalence requested.

O.C. 997-2005, s. 28; O.C. 669-2007, s. 11.

29. The equivalence eligibility committee shall be composed of 3 representatives appointed by the Bureau of the Order but who are not members of the Bureau and 2 representatives appointed by the Bureau of the Collège des médecins. The committee members shall sit on this committee until they are replaced.

The decisions of the committee shall be rendered by the majority of members, including one representative appointed by the Collège des médecins.

O.C. 997-2005, s. 29; O.C. 669-2007, s. 12.

30. Within 15 days following the date on which the equivalence eligibility committee renders its decision to grant or refuse to grant equivalence, the committee must notify the nurse in writing.

If the committee refuses to grant the equivalence requested, it must, at that time, inform the nurse, in writing, of the conditions she must meet in order to obtain such equivalence.


31. A nurse who is notified that the equivalence eligibility committee has decided not to grant equivalence may request a review of the decision, provided that she submits a request in writing to the secretary of the Order within 30 days of receipt of the decision.

The Bureau of the Order must, at its first regular meeting following the date on which such request was received, examine the request for review. It must, before rendering a decision, allow the nurse to submit her comments at this meeting.

A nurse who wishes to attend the meeting in order to be heard must notify the
secretary of the Order at least 5 days prior to the scheduled meeting date. The nurse may, however, submit comments in writing to the secretary at any time before the scheduled meeting date.

The decision of the Bureau of the Order shall be final and must be sent to the nurse by registered mail within 30 days of the date on which the meeting took place.


31.1. The Bureau of the Order may solicit experts for the purpose of examining a request for review submitted pursuant to the first paragraph of section 31.

O.C. 669-2007, s. 15.

32. (Omitted).

O.C. 997-2005, s. 32.

SCHEDULE I

(s. 23 and 25)

1. Nurse practitioner specializing in neonatology:

   (1) Training program prerequisites:

   3,360 hours in a neonatal intensive care unit;

   (2) Graduate program including 15 shifts of clinical duty, of at least 8 hours each, supervised by a neonatologist, and 1,490 hours as follows:

   (a) 510 hours of theory courses, including:

   Branch: Nursing Science

   (i) 45 hours in research and statistics;

   (ii) 45 hours in ethics and legal aspects;

   (iii) 45 hours in theoretical bases of nursing science;

   (iv) 45 hours in the role of the specialized nurse practitioner;

   (v) 45 hours in intervention with families;

   Branch: Medical Science

   (i) 45 hours in advanced general physiopathology and 90 hours in the physiopathology of neonatology;

   (ii) 30 hours in advanced general pharmacology and 45 hours in pharmacology related to neonatology;

   (iii) 75 hours in advanced clinical assessment in neonatology and therapeutic intervention, including full physical examination, diagnostic tests and interpretation of results;

   (b) 980 hours of clinical training, including:
(i) 600 hours in intensive care, including the delivery room, prenatal consultation, and transportation;
(ii) 300 hours in intermediate neonatal care;
(iii) 80 hours in an ambulatory care clinic.

2. Nurse practitioner specializing in nephrology:
   (1) Training program prerequisites:
   3,360 hours in a nephrology or adult critical care unit;
   (2) Graduate program of 1,465 hours as follows:
   (a) 555 hours of theory courses, including:
       Branch: Nursing Science
       (i) 45 hours in research and statistics;
       (ii) 45 hours in ethics and legal aspects;
       (iii) 45 hours in theoretical bases of nursing science;
       (iv) 45 hours in the role of the specialized nurse practitioner;
       (v) 45 hours in intervention with families;
       Branch: Medical Science
       (i) 75 hours in advanced general physiopathology and 90 hours in the physiopathology of nephrology;
       (ii) 45 hours in advanced general pharmacology and 45 hours in pharmacology related to nephrology;
       (iii) 75 hours in advanced clinical assessment in nephrology and therapeutic intervention, including full physical examination, diagnostic tests and interpretation of results;
   (b) 910 hours of clinical training, including:
       (i) 105 hours in predialysis;
       (ii) 105 hours in peritoneal dialysis;
       (iii) 175 hours in hemodialysis;
       (iv) 175 hours in kidney transplantation;
       (v) 350 hours in a clinical field or fields in which the nurse practitioner specializing in nephrology practices.

3. Nurse practitioner specializing in cardiology:
   (1) Training program prerequisites:
   3,360 hours in a cardiology or cardiac surgery unit, intensive care or emergency;
(2) Graduate program of 1,535 hours as follows:

(a) 555 hours of theory courses, including:

Branch: Nursing Science

(i) 45 hours in research and statistics;
(ii) 45 hours in ethics and legal aspects;
(iii) 45 hours in theoretical bases of nursing science;
(iv) 45 hours in the role of the specialized nurse practitioner;
(v) 45 hours in intervention with families;

Branch: Medical Science

(i) 75 hours in advanced general physiopathology and 90 hours in the physiopathology of cardiology;
(ii) 45 hours in advanced general pharmacology and 45 hours in pharmacology related to cardiology;
(iii) 75 hours in advanced clinical assessment in cardiology and therapeutic intervention, including full physical examination, diagnostic tests and interpretation of results;

(b) 980 hours of clinical training:

(i) 210 hours in ambulatory care;
(ii) 70 hours in coronary or cardiac surgery intensive care;
(iii) 245 hours in a medical cardiology unit;
(iv) 105 hours in rhythmology;
(v) 140 hours performing consultations;
(vi) 140 hours in a cardiac surgical unit;
(vii) 70 hours in hemodynamics.

4. Nurse practitioner specializing in first-line care:

(1) Training program prerequisites:

3,360 hours in first-line care or in a hospital centre in one or several of the following fields: emergency/critical care, medicine, surgery, obstetrics or pediatrics;

(2) Graduate program of 1,580 hours, divided as follows:

(a) 630 hours of theory courses including:

Branch: Nursing Science

(i) 45 hours in the use of scientific evidence;
(ii) 45 hours in theoretical bases of nursing science;

(iii) 135 hours in the following fields: health education, interprofessional collaboration, ethics and legal aspects;

Branch: Medical Science

(i) 135 hours in pharmacology;

(ii) 270 hours in the following fields: physiopathology, clinical assessment.

(b) 950 hours of clinical training in the field of the speciality concerned.

Appendix Q - 15

Regulation respecting the activities contemplated in section 31 of the Medical Act which may engaged in by classes of persons other than physicians

Medical Act
(R.S.Q., c. M-9, s. 19, 1st par., subpar. b)

Professional Code
(R.S.Q., c. C-26, s. 94.1)

1. The purpose of this Regulation is to determine, among the professional activities that may be performed by physicians, those that pursuant to the terms and conditions set out in the Regulation, may be engaged in by a nurse first surgical assistant, a specialized nurse practitioner contemplated in the Regulation respecting Ordre des infirmières et infirmiers du Québec classes of specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act (O.C. 997-2005) or another person.

O.C. 996-2005, s. 1.

DIVISION I
NURSE FIRST SURGICAL ASSISTANT

2. In order to be authorized to perform the professional activities described in section 3, a nurse first surgical assistant must have a minimum of 3 years of experience in an operating room, including at least 1 year in the concerned surgical discipline.

He or she must also hold:

(1) a baccalaureate in nursing sciences issued by a Quebec university, or have completed at least 60 credits in nursing as part of a university program other than the program leading to the certificate mentioned in subparagraph 2;

(2) a certificate in perioperative nursing care issued by the Université du Québec à Trois-Rivières;

(3) an attestation dating back less than two years, confirming the successful completion of training in cardiopulmonary resuscitation issued by a master instructor recognized by the Heart and Stroke Foundation of Quebec, according to the standards detailed in the current edition of the Handbook of Emergency Cardiovascular Care for Healthcare Providers.

O.C. 996-2005, s. 2.

3. A nurse first surgical assistant may, within the context of clinical and technical assistance to the surgeon and according to a medical prescription, perform complementary clinical and technical activities during the surgical procedure under the following conditions:

(1) he or she performs these activities in the presence of the surgeon responsible for the surgical procedure;

(2) he or she performs these activities in a hospital centre contemplated in the Act respecting health services and social services (R.S.Q., c. S-4.2) or the Act respecting health services and social services for Cree Native persons (R.S.Q., c. S-5).

For the performance of these activities, a nurse first surgical assistant must maintain his or her skills in cardiopulmonary resuscitation by obtaining a biennial attestation issued pursuant to section 2, subparagraph 3.

At no time may he or she act simultaneously as a nurse in internal service.

O.C. 996-2005, s. 3.

4. A nurse may perform the activities described in section 3 if he or she abides by the conditions provided therein, and if on December 28, 2000:

(1) he or she either held a certificate in perioperative nursing care issued by the Université du Québec à Trois-Rivières or was enrolled in a program of studies leading to this certificate and was issued the certificate;

(2) he or she had been issued an attestation less than two years prior, confirming the successful completion of training in cardiopulmonary resuscitation issued pursuant to section 2, subparagraph 3.

DIVISION II
SPECIALIZED NURSE PRACTITIONER

§ 1. Authorized activities

5. A nurse who holds a specialist's certificate in any of the classes of specialties stipulated in the Regulation respecting Ordre des infirmières et infirmiers du Québec classes of specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act (O.C. 997-2005) may perform the following medical activities, under the terms and conditions stipulated in subsection 2:

(1) prescribing diagnostic examinations;
(2) using diagnostic techniques that are invasive or entail risks of injury;
(3) prescribing medications and other substances;
(4) prescribing medical treatment; and
(5) using techniques or applying medical treatments that are invasive or entail risks of injury.

O.C. 996-2005, s. 5.

§ 2. Terms and conditions for authorization

6. A nurse practitioner specialized in neonatology is authorized to perform an activity stipulated in section 5, in neonatology, under the following terms and conditions:

(1) he or she engages in that activity with a newborn infant, whether premature or full-term, who presents a pathology requiring admission to intensive care or intermediate neonatal care during the infant's stay in a hospital centre within the meaning of the Act respecting health services and social services (R.S.Q., c. S-4.2) where tertiary care in neonatology is provided;
(2) this activity must be the subject of a rule governing medical care or a rule governing the use of medicines that is in force in this hospital centre, unless this involves prescribing a medication contemplated in Schedule II or III of the Regulation respecting the terms and conditions for the sale of medications (O.C. 712-98) and is performed in accordance with the provisions of Division II of the Règlement sur les normes relatives aux ordonnances faites par un médecin (Decision 05-02-23);
(3) this nurse must maintain his or her skills in neonatal resuscitation by obtaining a biennial instructor's level attestation of training in neonatal resuscitation issued by a master instructor recognized by the Heart and Stroke Foundation of Quebec according to the standards detailed in the current edition of Handbook of Emergency Cardiovascular Care for Healthcare Providers, published by the Heart and Stroke Foundation of Canada.

O.C. 996-2005, s. 6; O.C. 668-2007, s. 2.

7. A nurse practitioner specialized in nephrology is authorized to perform an activity stipulated in section 5, subparagraphs 1, 3 or 4, in nephrology, under the following terms and conditions:

(1) he or she engages in that activity with a patient suffering from renal failure who requires care and services in pre-dialysis, hemodialysis, peritoneal dialysis or kidney transplantation in a hospital centre within the meaning of the Act respecting health services and social services (R.S.Q., c. S-4.2) where dialysis care is offered with the aid of a nephrology department;
(2) this activity must be the subject of a rule governing medical care or a rule governing the use of medicines that is in force in this hospital centre, unless this involves prescribing a medication contemplated in Schedule II or III of the Regulation respecting the terms and conditions for the sale of medications (O.C. 712-98), and is performed in accordance with the provisions of Division II of the Règlement sur les normes relatives aux ordonnances faites par un médecin (Decision 05-02-23), adapted as required.

O.C. 996-2005, s. 7; O.C. 668-2007, s. 3.

8. A nurse practitioner specialized in cardiology is authorized to perform an activity stipulated in section 5, in cardiology, under the following terms and conditions:

(1) he or she engages in that activity with a hospitalized or ambulatory adult clientele requiring care and services for heart failure, in secondary prevention, in post-surgery including heart transplants, in a congenital heart disease clinic, in hemodynamics, or in electrophysiology, in a hospital centre within the meaning of the Act respecting health services and social services (R.S.Q., c. S-4.2), where cardiology care and services are dispensed by at least 3 cardiologists, excluding locum cardiologists;
(2) this activity must be the subject of a rule governing medical care or a rule governing the use of medicines that is in force in this hospital centre, unless this involves prescribing a medication contemplated in Schedule II or III of the Regulation respecting the terms and conditions for the sale of medications (O.C. 712-98), and is performed in accordance with the provisions of Division II of the Règlement sur les normes relatives aux ordonnances faites par un médecin (Decision 05-02-23).
(3) this nurse must maintain his or her skills in cardiovascular resuscitation by obtaining a biennial instructor's level attestation of training in cardiovascular resuscitation issued by a master instructor recognized by the Heart and Stroke Foundation of Quebec according to the standards detailed in the current edition of the Handbook of Emergency Cardiovascular Care for Healthcare Providers published by Heart and Stroke Foundation.

O.C. 996-2005, s. 8; O.C. 668-2007, s. 4.

§ 2.1. Terms and conditions for authorization of primary care

8.1. A specialized nurse practitioner in primary care is authorized to engage in an activity stipulated in section 5, in primary care, under the following terms and conditions:

(1) he or she engages in that activity with an ambulatory clientele:
   (a) requiring the evaluation of the person’s health or detection of a health problem;
   (b) presenting a common health problem;
   (c) presenting a stable chronic disease;
   (d) requiring the follow-up of a pregnancy.

(2) he or she engages in that activity in partnership with a family physician;

When the nurse practises elsewhere than in a centre operated by an establishment in the meaning of the Act respecting health services and social services (R.S.Q., c. S-42) or the Act respecting health services and social services for Cree and Inuit Native persons (R.S.Q., c. S-5), the partnership must be recognized in a written agreement.

O.C. 668-2007, s. 5.

8.2. For the purposes of this Division, the term “common health problem” means a health problem that presents the following characteristics:

(1) a relatively high incidence in the community;
(2) clinical symptoms and signs usually affecting a single system;
(3) an absence of deterioration in the general condition of the person;
(4) usually a quick and favorable course.

O.C. 668-2007, s. 5.

8.3. For the purposes of this Division, “stable chronic disease” means a disease that has been the subject of a diagnosis by a physician and of a medical treatment plan giving the expected results.

O.C. 668-2007, s. 5

8.4. The specialized nurse practitioner in primary care engages in his or her activities under the following terms and conditions:

(1) he or she prescribes diagnostic examinations stipulated with Schedule I of this Regulation;

(2) he or she uses the following diagnostic techniques:
   (a) pelvic examination;
   (b) rectal touch;
   (c) cervico-vaginal smear;
   (d) radial arterial puncture;

(3) he or she prescribes medications and other substances in accordance with Schedule II of this Regulation and the provisions of Division II of the Règlement sur les normes relatives aux ordonnances faites par un médecin (Décision, 05-02-23), adapted as required;

(4) he or she prescribes the following medical treatments:
   (a) cryotherapy, except on the face and internal genital organs;
   (b) eye irrigation;
   (c) fluorescein staining;
(d) irrigating ears;
(e) oxygenotherapy;
(f) peripheral venous access;
(g) cleansing enema;
(h) bladder catheterization;
(i) nasogastric tube;

(5) he or she uses the following medical techniques or applies the following medical treatments:
(a) suture a wound, except below the fascia or in the presence of underlying lesions;
(b) incise and drain an abscess above the fascia;
(c) install a esophageal tracheal double cannula airway device.

O.C. 668-2007, s. 5.

8.5. The specialized nurse practitioner in primary care must request the intervention of the partner physician in the following cases:

(1) his or her evaluation does not allow the clear identification of the common health problem, the criteria to initiate the medical treatment are not clear or the situation exceeds the skills of the specialized nurse practitioner in primary care, specifically in the presence of one of the following factors:
(a) a persistent or recurrent sign or symptom to which no cause can be assigned;
(b) a sign, a symptom or a result of medical imaging or laboratory analysis suggesting the presence of an undiagnosed chronic or systemic disease;
(c) a symptom or an analysis result demonstrating the decline or alteration of the function of an organ or a system;
(d) a symptom, a sign or a laboratory analysis result suggesting a recurrent or persistent infection;
(e) an atypical manifestation of a common disease or an unusual reaction to treatment;
(f) a sign or a symptom of change of behavior which cannot be attributed to a specific cause.

(2) he or she notes that the growth or development of a newborn, an infant or a child is abnormal or observes the presence of a sign or a symptom of disease in the newborn or the infant of 3 months old or less other than thrush, seborrheic dermatitis, diaper rash or tear duct obstruction;

(3) there is a suspicion of abuse or the presence of a sign of abuse or a symptom of a sexually transmitted infection in a child;

(4) a chronic condition becomes worse, especially in the presence of one of the following factors:
(a) a symptom or a result of laboratory analysis indicating deterioration of a patient;
(b) the unexpected deterioration of the condition of a patient already treated for a diagnosed disease.

(5) a woman more than 32 weeks pregnant;

(6) his or her evaluation allows the identification of a symptom, a sign or a result of medical imaging or laboratory analysis suggesting a risk for the pregnant woman or the unborn child;

(7) the situation imperils the life or the physical or mental integrity of a person.

Further to the intervention of the partner physician, he or she may continue the practice of the activities stipulated in section 8.4 within the limits of the medical treatment plan determined by this physician.

O.C. 668-2007, s. 5.

§ 3. Other authorized persons


Besides the terms and conditions stipulated in subdivisions 2 and 2.1, a specialized nurse practitioner candidate performs this activity under the following terms and conditions:

(1) the activity is performed in a training site indicated on a training card issued pursuant to the Regulation

Regulation respecting the activities contemplated in section 31 of the Medical Act which... Page 5 of 17

respecting Ordre des infirmières et infirmiers du Québec classes of specialties related to the performance of acts contemplated in section 36.1 of the Nurses Act under the supervision of a medical specialist of the specialty contemplated or of a family physician as appropriate, with the collaboration of a specialized nurse practitioner or, failing that, a nurse who has at least 3 years of relevant clinical experience;

(2) the activity is performed insofar as it is required to complete the program in which he or she is enrolled and, when the latter is completed, during the period in which he or she is eligible for the examination prescribed for that specialty as contemplated in Division III of this Regulation.

O.C. 996-2005, s. 9; O.C. 668-2007, s. 6.

10. A nurse or a person authorized by special authorization under Section 33 of the Professional Code (R.S.Q., c. C-26) to practise the profession of nursing in Quebec may perform an activity stipulated in section 5 if he or she is enrolled in a university training program outside Quebec that leads to a specialized nurse practitioner diploma.

Besides the terms and conditions stipulated in subdivisions 2 and 2.1, a person contemplated in the first paragraph performs this activity under the following terms and conditions:

(1) the activity is performed in a training site indicated on the list drawn up by the program review subcommittee, pursuant to the Regulation respecting the committees on training of the Ordre des infirmières et infirmiers du Québec (O.C. 1000-2005), indicated in the special authorization stipulated in the first paragraph, where applicable, under the supervision of a medical specialist of the specialty contemplated or of a family physician as appropriate, with the collaboration of a specialized nurse practitioner or, failing that, a nurse who has at least 3 years of relevant clinical experience;

(2) the activity is performed insofar as it is required to complete the program in which he or she is enrolled.

O.C. 996-2005, s. 10; O.C. 668-2007, s. 7.

DIVISION III

11. This Regulation replaces the Regulation respecting the activities contemplated in section 31 of the Medical Act which may be performed by classes of persons other than physicians (O.C. 769-2004).

O.C. 996-2005, s. 11.

12. (Omitted).

O.C. 996-2005, s. 12.

SCHEDULE I

(s. 8.4, par. 1)

(1) RADIOLOGICAL EXAMINATIONS

(1) head and neck
  - mandibula
  - nasal bone
(2) chest
  - lungs
  - thorax (rib cage)
(3) spine
  - cervical spine
  - dorsal spine
  - lumbosacral spine
(4) upper limbs
  - scapula
  - shoulder
  - clavicle
  - humerus

- elbow
- forearm
- wrist
- hand
- fingers
  (5) lower limbs
  - hip
  - femur
  - knee and patella
  - leg
  - ankle
  - foot
  - toes
(6) abdomen
- abdomen
(7) miscellaneous
- mammography
- osteodensitometry
(2) ULTRASOUND EXAMINATIONS
(1) breast (thorax)
- breast ultrasonography as part of an abnormal screening mammogram
(2) abdomen
- abdominal ultrasound
- pelvic ultrasound
(3) obstetrics
- obstetrical ultrasound
(4) genital organs
- ultrasound of scrotum
(5) surface ultrasound
- peripheral venous system
(3) OTHER DIAGNOSTIC TESTS
- Resting electrocardiogram
- Pulmonary function tests (spirometry, peak expiratory flow, FEV1)
- Ambulatory monitoring of blood pressure (ABPM)
(4) LABORATORY ANALYSES
(1) microbiology
  (a) fresh vaginal state
  (b) cultures
- expectorations

- throat
- urine
- cervical
- urethral
- stools
- purulent discharge
- fungus
  (c) specimens for viral testing
  - flu
  - herpes simplex
  - rotavirus
  - respiratory syncytial virus
  (d) testing
  - for C. Difficile
  - for BK in expectoration (tuberculosis)
  - for pinworms
  - for parasites in stools
  (e) serologie
  - hepatitis A, B, C antigens or antibodies
  - Elisa syphilis test
  - non-syphilis test: VDRL
  - HIV antibody
  - herpes and chlamydia by immunofluorescence method
  - C-reactive protein excluding ultrasensitive
  - mono test

(2) biochemistry/blood
- amylase
- bilirubin, direct and total
- chlorides
- creatine phosphor-kinase (CPK)
- creatinine
- assays of phenobarbital, lithium, carbamazepine, theophylline, digoxin, dilantin, valproic acid
- hormonal assays:
  - follicle-stimulating hormone (FSH)
  - luteinizing hormone (LH)
  - thyreotropic hormone (TSH)
- vitamin assays:
  - vitamin B12
  - folic acid
- gamma glutamyl transferase (GGT)
- glycaemia
- orally provoked hyperglycemia
- glycated aemoglobin HbA1c
- iron binding capacity
- iron, ferritin
- lactose tolerance test
- presence of lead in the blood
- lipase
- lipid check-up
- arterial and capillary gas
- alkaline phosphatase
- phosphorous
- electrolytes
- total protein
- prealbumin and albumine
- transaminase
- uric acid
- sweat test
- street and date-rape drugs and blood alcohol level testing
- occult blood in stools
- βhCG (qualitative)

(3) biochemistry/urine
- urinanalysis
- microalbuminuria on urination or 24-hour urine collection
- pregnancy test
- 24-hour creatinine clearance
- street and date-rape drugs
- enzyme technique testing:
  - chlamydia
  - gonorrhoea

(4) cytology
- cervico-vaginal smear
- spermogram
- test for sperm, post-vasectomy or in vaginal fluid

(5) hematology
- haemogram
- coagulogram
- prothrombin time (PT - RNI)
• activated partial thrombin time (PPT or APPT)
• reticulocytes countocytes
• sedimentation rate
• blood group determination (crossmatch test)

(6) antenatal screening
• anticytomegalovirus antibody
• toxoplasmosis antibody
• B-19 parvovirus
• rubeola antibody
• anti-varicella antibody
• alpha-fetoprotein, estradiol

SCHEDULE II
(s. 8.4, subpar. 3)

LIST OF CLASSES OF MEDICATION THAT THE NURSE PRACTITIONER SPECIALIZED IN PRIMARY CARE CAN PRESCRIBE WITH OR WITHOUT RESTRICTION

This list is based on the classification used by the Régie de l'assurance maladie du Québec to establish the list of medications.

Specifications

P Can be prescribed, renewed or stopped unless there is a limit indicated.

R Can be prescribed according to the original dose to maintain treatment, provided that the medication in question has already been prescribed for the patient by the partner physician (renewal). Maximum duration of 6 months.

A Can be prescribed as dose adjustment provided that the drug in question had been prescribed for the patient by the partner physician and the physician has established a medical treatment plan (as part of joint follow-up).

Specifications

4:00 Antihistamine Drugs P
8:00 Anti-infective Agents

8:08 Mebendazole P (orally only)
8:12.04 Nystatin P (orally only)
8:12.06 Cephalosporins P (orally only)
8:12.12 Macrolides P (orally only)
8:12.16 Penicillins P (orally only)

<p>| 8: 12.18 | Ciprofloxacin | P | (5 days or less) |
| 8: 12.18 | Norfloxacin | P | (5 days or less) |
| 8: 12.20 | Sulfonamides | P | (orally only) |
| 8: 12.20 | Trimethoprim / Sulfamethoxazole | P | (orally only) |
| 8: 12.24 | Tetracyclines | P | (orally only) |
| 8: 12.28 | Antibacterials, Miscellaneous | P | (orally only) |
| 8: 12.28 | Clindamycin | P | (pediatrics only) |
| 8: 12.28 | Erythromycin / Acetylsulfisoxazol | P | |
| 8: 14.08 | Fluconazol (single dose) | P | (orally only) |
| 8: 16.04 | Antituberculosis Agents | R | (orally only) |
| 8: 18.04 | Adamantanes | P | (7 days or less) |
| 8: 18.32 | Nucleosides and Nucleotides | P | (7 days or less) |
| 8: 30.08 | Antimalarials | P | (for prevention) |
| 8: 30.92 | Metronidazol | P | (orally only) |
| 8: 36 | Urinary anti-infectives | P | (orally only) |
| 10: 00 | Antineoplastic Agents | | |
| 10: 00 | Methotrexate as Antirhumatismal | R |
| 10: 00 | Tamoxifen | |
| 12: 00 | Autonomic Drugs | |
| 12: 08.04 | Antiparkinsonian Agents | R |
| 12: 08.08 | Ipratropium (Bromide) | R | (aerosol) |
| 12: 12.08 | Beta-Adrenergic Agonists | | |
| 12: 12.08 | Formoterol | R | (14 days or less for 1 treatment) |
| 12: 12.08 | Salbutamol (sulfate) | P | |
| 12: 12.08 | Salmeterol | R | |</p>
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<td>12: 16</td>
<td>Sympatholytic Agents</td>
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<td>12: 92</td>
<td>Nicotine</td>
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<td>Blood Formation, Coagulation and Thrombosis</td>
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<td>20: 04.04</td>
<td>Iron Preparations</td>
<td>(for 1 month) orally only</td>
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<td>20: 12.04</td>
<td>Anticoagulants</td>
<td>R and A orally only</td>
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<td>24: 00</td>
<td>Cardiovascular Drugs</td>
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<td>Cardiotonic Agents</td>
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<td>Bile Acid Sequestrants</td>
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<td>Fibric Acid Derivatives</td>
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<td>HMG CoA Reductase Inhibitors</td>
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<td>Direct Vasodilators</td>
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<td>Alpha-adrenergic Blocking Agents</td>
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<td>Angiotensin II Receptor Antagonists</td>
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<td>P (14 days or less)</td>
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<td>28: 08.08</td>
<td>Codeine</td>
<td>P (12 tablets only)</td>
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http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file...

11/2/2007
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<td>Adrenals</td>
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<td>P</td>
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<td>Theophyllin</td>
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<td>Etidronate disodium/Calcium carbonate</td>
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<td>Terazosin</td>
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Local/Topical Anesthetic Agents

- **Topical Lidocaine-prilocain**
  
  - **Lidocaine Hydrochloride with or without epinephrine. injectable**
  
  - **Tetracaine Hydrochloride**

Intravenous Solutions

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<tr>
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<td>1. Aluminum Hydroxide</td>
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<td>2. Bisacodyl</td>
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<tr>
<td>3. Capsaicine</td>
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<td>4. Donepezil</td>
</tr>
<tr>
<td>5. Estradiol</td>
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<td>6. Galantamine</td>
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<tr>
<td>7. Gliclazide</td>
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<tr>
<td>8. Glimepiride</td>
</tr>
<tr>
<td>9. Mineral oil</td>
</tr>
<tr>
<td>10. Magnesium</td>
</tr>
<tr>
<td>11. Memantine</td>
</tr>
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<td>12. Metronidazole</td>
</tr>
<tr>
<td>13. Island dressings</td>
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<tr>
<td>14. Alginate dressings</td>
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<tr>
<td>15. Activated charcoal dressing</td>
</tr>
<tr>
<td>16. Sodium chloride dressing</td>
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<td>17. Hydrocolloid dressing</td>
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O.C. 668-2007, s. 8.

O.C. 996-2005, 2005 G.O. 2, 4813
A registered nurse on the Extended Practice Register RN(EP) has successfully demonstrated the competencies identified in the Competencies for the Registered Nurse (Extended Practice), RN(EP) Register and has provided evidence of meeting the application requirements in accordance with the Extended Practice Regulation of the Registered Nurses Act. In addition to upholding the Standards of Practice for Registered Nurses in Manitoba and the Code of Ethics for Registered Nurses (2002), RN(EP)s are expected to meet the following Standards of Practice for Registered Nurses on the Extended Practice Register.
Standard I: Consultation and Collaboration

RN(EP)s consult and collaborate with other health professionals as appropriate and in accordance with the Competencies for the Registered Nurse (Extended Practice) RN(EP) Register, to ensure that the overall health care needs of their clients are met.

Indicators:
1. Establishes a consultative relationship with a physician, pharmacist and other health professionals appropriate to the client population for whom the RN(EP) provides care.
2. Consults with family physicians and specialist physicians if appropriate to the situation and the practice setting.
3. Knows the consultation expectations and complies with these in a timely manner.
4. RN(EP)s who consult with another health professional are not necessarily required to transfer the care of the client to that individual. The decision to transfer care is made jointly between the RN(EP) and the health professional.
5. Seeks consultation at any stage of the acute/chronic illness continuum in the care of a client from the initial assessment to the evaluation of treatment effectiveness as deemed necessary by the RN(EP).
6. Develops appropriate structures and effective processes for consultation.
7. Establishes appropriate methods for keeping health professionals informed of their mutual clients' health conditions and of their treatment decisions, including decisions to repeat particular drugs.

Standard II: Prescribing Drugs

RN(EP)s prescribe drugs relevant to the nurse's area of practice and client population served in accordance with the Extended Practice Regulation, all other relevant provincial and federal legislation, the Competencies for the Registered Nurse (Extended Practice) RN(EP) Register, and recognized best practices.

Indicators:
8. Completes prescriptions accurately, completely and legibly including the following information:
   a) date of issue;
   b) name and address of the person for whom the drug is prescribed;
   c) the weight of the client if a child or the age of the client if it has a bearing on the dosage of the prescribed drug;
   d) name, strength and quantity of the prescribed drug;
   e) directions for use, including the frequency, route of administration, duration of drug therapy, and special instructions;
   f) directions for number of allowable refills and interval between refills, where applicable. If a prescription includes more than one drug, any drug that may be refilled must be clearly identified with the number of allowable refills for each drug;
   g) prescriber's name, address, telephone number, fax number and signature. Signature stamps are not acceptable;
   h) the treatment goal and/or diagnosis and/or clinical indication.
9. Provides educational information to clients about prescription and non-prescription drugs which includes information regarding:
   a) expected action of the drug;
   b) importance of compliance with prescribed frequency and duration of the drug therapy;
   c) potential side effects;
   d) signs and symptoms of potential 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 such as herbal and homeopathic remedies;
   f) specific precautions to take or instructions to follow; and
   g) recommended follow-up;
10. Prescribes for clients based on assessment obtained through direct client contact.
11. Establishes a working relationship with the pharmacist(s) for purposes of consultation and education of clients.
12. Monitors and documents the client's response to drug therapy. Based on the client's response, the RN(EP) may decide to continue, adjust, or withdraw the drug, or to consult with a physician and/or pharmacist in accordance with the expectations for consultation.
13. Stores blank prescriptions in a secure area that is not accessible to the public. Does not provide any person with a blank, signed prescription.
14. Does not prescribe for their family members or for themselves.
15. Transmits a prescription by facsimile to a
Pharmacy provided that the following requirements are met:

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

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

c) the prescription must include all information listed in Indicator 8, and in addition must include:

i. time and date of transmission;

ii. name and fax number of the pharmacy intended to receive the transmission; and

iii. a signed certification that the prescription represents the original of the prescription drug order, the addresser is the only recipient and there are no others, and the words "This certifies that the above prescription has been transmitted only to the pharmacy indicated."

iv. the original prescription must be validated, securely filed, retained for 2 years, be available for inspection, and not transmitted elsewhere at another time.

16. Transmits all verbal prescriptions (new and refills) directly to the pharmacist.

17. Monitors adverse drug reactions and reports these in accordance with reporting requirements of Health Canada. (see appendix A)

18. Maintains a record of all prescriptions written including refills.

Standard III: Ordering Screening and Diagnostic Tests

RN(EP)s order specific screening and diagnostic tests relevant to the nurse's area of practice and client population served in accordance with the Extended Practice Regulation, the Laboratory Requisition Regulation of the Health Services Insurance Act, the Competencies for the Registered Nurse (Extended Practice) RN(EP) Register, and recognized best practices.

Indicators:

19. Orders screening and diagnostic tests:

   a) to confirm the diagnosis of a short term, episodic illness or injury as suggested by the client's history and/or physical findings;

   b) to rule out a potential diagnosis that, if present, would require consultation with an appropriate physician for treatment;

   c) to assess/monitor ongoing conditions of clients with chronic illnesses;

   d) for screening activities;

20. Develops efficient processes for receiving and tracking the results of screening and diagnostic tests and for ensuring that other health professionals involved in the mutual care of clients are informed of test results in a timely way.


22. Explains to clients the reasons for ordering specific screening and diagnostic tests and the associated risk and benefits.

23. Adheres to provincial or agency standards for ordering, documenting and reporting results of screening and diagnostic tests.

24. Understands the significance of test results and the diagnostic interpretation made by a specialist. Consults with the specialist for clarification of the diagnostic interpretation when necessary.

Standard IV: Performing Minor Surgical and Invasive Procedures

RN(EP)s perform minor surgical and invasive procedures competently and in accordance with the Extended Practice Regulation, Competencies for the Registered Nurse (Extended Practice) RN(EP) Register and recognized best practices.

Indicators:

25. Assumes responsibility for maintaining competence in the minor surgical and invasive procedures required for the purpose of assessment, treatment, or management of an individual's health.

26. Performs only those minor surgical and invasive procedures for which competence has been developed and maintained.

27. Performs only those minor surgical and invasive procedures which are required for the assessment, treatment or management of an individual's health.

28. Obtains informed written consent prior to performing the procedure.
Glossary

Collaboration
Collaboration, the cornerstone of multidisciplinary care, involves working with one or more members of the health care team who each make a unique contribution from within the limits of her or his scope of practice.

Consultation
Consultation is an explicit request by an RN(EP) for another health professional to become involved in the care of a client for which the RN(EP) has primary responsibility at the time of the request. Consultation takes place when the registered nurse reaches the limit of the RN(EP) scope of practice, beyond which she/he cannot provide care independently and additional information and/or assistance is required from a professional with a more extensive knowledge base related to the specific client situation. Consultation can occur in a variety of ways including face to face discussion, by telephone and in writing.

References


Appendix A

Monitoring Adverse Drug Reactions
A serious adverse drug reaction (ADR) is defined as a "noxious and unintended response to a drug that occurs at any dose and that requires inpatient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening or results in death." An RN(EP) who assesses a serious ADR, or is notified of a serious ADR in a client to whom she/he prescribed medications, is required to report it to the Adverse Drug Reaction Reporting Centre of Health Canada within 48 hours:

National ADR Reporting Unit
Adverse Reaction and Medication Error Assessment Division
Bureau of Licensed Product Assessment
Therapeutic Products Programme
AL 0201C2
Ottawa ON K1A 1B9
Tel: (613) 957-0337
Fax: (613) 957-0335
E-mail: cadrmp@hc-sc.gc.ca

For more information, please contact a Nursing Practice Consultant at (204) 774-3477 or (800) 665-2027 (Manitoba toll-free).

Nursing Practice Expectations represent achievable levels of performance approved by the College of Registered Nurses of Manitoba Board of Directors. All practicing members of the College are expected to comply with the Nursing Practice Expectations. For additional information, please see the Registered Nurses Act and Regulations. Publications are available on our website at www.crnm.mb.ca

Board Approved: 11/2004
Published: 04/2005
SCHEDULE A

PART 1: DIAGNOSTIC TESTS

1. Diagnostic radiological procedures

   Head and Neck
   - Facial bones
   - Mandible

   Chest
- Chest, single P.A.
- P.A. and lateral
- Ribs

Spine and Pelvis
- Pelvis, A.P. view
- Skeletal survey (thorax, skull, thoracic and lumbar spine, pelvis, two (2) long bones)
- Spine, complete
- Skeletal survey - suspect child abuse

Upper Extremity
- Clavicle
- Elbow
- Fingers
- Forearm
- Hand
- Humerus
- Shoulder, A.P. and lateral routine
- Wrist

Lower Extremity
- Ankle
- Femur
- Foot
- Hip
- Knee or patella
- Tibia and fibula
- Toes

Abdomen
- Abdomen, single view

Gastrointestinal Tract
- Stomach and duodenum, fluoroscopy and radiography (including esophagus)
- Cholecystogram, oral

Urinary Tract
- K.U.B.
- Pyelogram, intravenous, routine including preliminary film

Miscellaneous
- Voiding Cysto-urethrogram (VCUG)
- Mammography
- Bone Mineral Densitometry

2. Diagnostic ultrasound services
Head and Neck
- Sonography, soft tissues (e.g. thyroid, parathyroid, salivary glands, orbits) real time

Breast (chest)
- Sonography, breast unilateral real time study
- Sonography, breast bilateral real time study
- Sonography, breast unilateral real time study where performed by sonologist
- Sonography, breast bilateral real time study where performed by sonologist

Abdomen
- Sonography, abdominal complete real time
- Sonography, abdominal limited (e.g. single organ, quadrant, follow up time) real time
- Sonography, renal (bilateral), or aorta or retroperitoneum real time

Obstetrics & Female Pelvis

Genitalia
- Sonography, scrotum

Miscellaneous - Doppler Studies

Vascular Studies
3. Computerized axial tomography
4. Other diagnostic tests

- Electrocardiogram (ECG)
- Electromyelogram (EMG)
- Holter monitor
- Spirometry
- 24-hour blood pressure monitoring
- Sleep Studies

PART 2: LABORATORY PROCEDURES

BACTERIOLOGY

- Antibiotic level, serum
- Antibiotic Sensitivity
Cultures
- blood, aerobic and anaerobic
- throat swab
- urine
- cervical
- vaginal
- urethral
- bowel contents for enteric organisms
- pus for other sites
- body fluids (e.g. ascitic, pleural, spinal fluids, etc.)
- other than above
- tuberculosis
- Dark Field Examination
- Microscopic Examination of Smears and Wet Preparations, trichomonads
- fungi
- pinworms (Scotch Tape Method)
- parasites (stool)
- Screening test for bacteruria, spoon or agar slide technique
- Microscopic examination of synovial fluid under polarized light for uric acid crystals

BIOCHEMISTRY
- Alcohol
- Ammonia
- Amylase
- Phenobarbital
- Bilirubin, direct and total
- total
- Calcium
- Carbon monoxide, quantitative
- Chlorides
- Creatine phosphokinase (CPK)
- Creatinine
- Gamma Glutamyl Transferase
- Glucose, quantitative
- tolerance test up to and including five (5) bloods and five (5) urines
- Hemoglobin, chromatography or electrophoresis
- Glycosated hemoglobin - Hbg A1
- Iron, binding capacity
- Iron, serum
- Ketones (quantitative)
- Ketones (qualitative)
- Lactic acid
- Lactose tolerance
- Lead-serum-diagnostic excluding environmental and occupational screening
- Lipase
- Lipids, cholesterol, total
- cholesterol, high density lipoprotein (HDL)
- triglycerides
- Magnesium
- Osmolality - blood or urine
- pCO
- pH of blood
- pO
- All three (3) above combined
- Phosphatase, acid
- alkaline
- Phosphorus
- Potassium, serum or urine, any method
- Potassium and sodium, serum or urine when done together, any method
- Protein, total
- serum albumen, quantitation
- electrophoresis (to include total protein)
- Salicylates
- Serum Quinidine Blood Level
- Serum Lithium Determination
- Sodium, serum or urine, any method
- Transaminase (S.G.O.T.)
- Transaminase (S.G.P.T.)
- Urea quantitative
- Uric Acid

CYTOLOGY AND TISSUES

Cytology
- Cervico-vaginal smear
- Other submitted smears prepared by the clinician from body fluids
- preparation and examination of smears from fluids submitted when direct smears are made in the laboratory
- preparation and examination of smears from submitted specimens requiring centrifugation and/or filtration
- preparation and examination of smears from submitted specimens requiring centrifugation and/or filtration and preparation of cell blocks
- Seminal fluid, complete analysis
- Sperm, search, post vasectomy or in vaginal fluid

Tissues
- Surgical specimens - with paraffin sections

FECES
- Blood, occult

HEMATOLOGY
Automated Hematology
- platelet count
- red cell count (Electric Counter)
- reticulocyte count
- White cell count
- White cell differential count and cell morphology
- count
- prothrombin, consumption
- thrombin time
- time, partial
- Examination with report, of blood smear by a Pathologist, or by a Hematologist who has not seen the Patient in formal consultation, when specifically requested by a registered nurse (extended practice)
- Hematocrit
- Hemoglobin (photoelectric)
- Malaria, or other parasites
- Sedimentation rate
- Sickle cell identification

SEROLOGY
- Antibody determination, precipitin test
- Antinuclear antibodies (to include positive and negative controls)
- Antistreptolysin titre
- Cold agglutinins
- Coombs tests, direct and indirect
direct only
- C-reactive protein
- Heterophile antibodies, screen (single tube or single slide test)

URINE
- Albumen, biuret
- Amylase
- Bence-Jones protein
- Bilirubin
- Coproporphyrin or urocoproporphyrin, quantitative
- Creatine, quantitative
- Creatinine, quantitative
clearance
- Glucose, quantitative (not stick, tablet or tape)

HORMONES
- chorionic gonadotropins (pregnancy test) immunological
- quantitative titration
- 17-ketogenic steroids
- 17-ketosteroids
- Lead (quantitative)
- Porphobiligen (Watson-Schwartz test)
- Porphorins, fractional
- Growth hormone
- Stone analysis
- Urinalysis, stick, tape or tablet for sugar, protein, ketones, urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere
- Urinalysis, complete, including microscopic examination of centrifuged specimen

RADIOASSAY AND LIGAND ASSAY
- Chorionic Gonadotropin
- Cortisol
- Digoxin
- Dilantin (phenytoin)
- Folic Acid
- F.S.H. (Pituitary Gonadtropins)
- Immunoglobulin
- Insulin
- L.H. (Luteinizing hormone)
- Progesterone
- Testosterone
- Vitamin B
- Estradiol
- Ferritin
- Carcino-embryonic antigen
- 17-Hydroxyprogesterone
- Prolactin

Thyroid Function Tests
- Thyroxine T-4 (Free or Total)
- T-3 Uptake
- Thyroid Stimulating Hormone (TSH)

OTHER TESTS
- Albumin creatinine ratio
- Breath Urea Test
- CK-MB
- Creatine Kinase (CK)
- DHEAS dehydroepiandrosterone sulfate
- Parathyroid hormone (PTH)
- Vitamin D
- Vitamin E, A, K
- Alphafetoprotein screen
- HCG, AFP, Estradiol
- PSA
- Fat Studies (feces)
- Troponin
- Drug Monitoring
- Drug Screening
- INR
- Lactate dehydrogenase
- Myoglobin
- Blood Grouping/Cross Match
Appendix M – 18

Extract from Manitoba Regulations, Schedule B

SCHEDULE B

1. Any drug or device listed in Part 1 or 2 of the Specified Drugs Regulation under The Prescription Drugs Cost Assistance Act.

2. The following drugs:

- Apo-Naproxen EC
- Celebrex
- Mobicox
- pms-Meloxicam
- ratio-Meloxicam
COMPETENCIES FOR THE REGISTERED NURSE (EXTENDED PRACTICE), RN(EP) REGISTER

Registration on the RN(EP) register is based on the demonstration of competence at an advanced level in each of four competency areas:

1. Assessment and Diagnosis of Client Health/Illness Status
2. Pharmacotherapeutics and other Therapeutic Interventions in Client Care Management
3. Population Health and Illness/Injury Prevention
4. Professional Responsibilities and Accountabilities
Assessment and Diagnosis of Client Health/Illness Status

1. Performs comprehensive health assessment. This includes a health history, assessment of clients' and families' perceptions of their health status, assessment of the physical, psychosocial, cultural and spiritual dimensions of health.

2. Employs critical thinking and diagnostic reasoning skills in clinical decision-making by synthesizing health information to identify health risks and concerns and to make appropriate diagnoses.

3. In the process of making a diagnosis, applies scientific knowledge that considers: etiology, development stages, physiology, pathophysiology and pathogenesis, and the clinical manifestations of commonly encountered acute illnesses, injuries, chronic disorders, normal health events and emergency health needs. Applies this broad scientific knowledge to understand the human response to health conditions, diseases or disorders.

4. Selects appropriate screening and diagnostic tests and interprets reported findings based on sound clinical reasoning and critical thinking. Applies knowledge to interpret, comprehend and apply to clinical situations.

5. Effectively communicates health findings and/or diagnoses to clients and families, discusses health outcomes/prognosis, reviews treatment options, assists/supports clients with personal responses to their health conditions and creates an environment in which effective learning can take place.

6. Initiates timely, efficient consultation, collaboration, and/or referral to physicians, other health care providers and social support/resources as appropriate to assess and diagnose client health/illness status.

7. Documents timely, accurate and relevant clinical data, findings and conclusions.

Pharmacotherapeutics and Other Therapeutic Interventions in Client Care Management

1. Collaborates with the client and, where applicable with their family, in prioritizing health conditions and intervening appropriately including initiation of effective emergency care and crisis intervention.

2. Applies knowledge of pharmacology including pharmokinetics, pharmacotherapeutics and pharmacodynamics when selecting and prescribing drugs as provided for in the regulation. Additional competencies for prescriptive authority required by the RN(EP) are as follows:
   - selects the drug therapy based on an understanding of pharmacology and clients' health condition, disease, or disorder;
   - applies knowledge of pharmacology and best practice standards in selecting and monitoring drug therapy (including, but not limited to, complications of other drugs, contraindications and adverse reactions, treating conditions, diseases, disorders and injuries) within the RN(EP)'s scope of practice and clinical practice setting;
   - demonstrates knowledge of professional responsibilities relevant to the selection and management of controlled substances;
   - prescribes in accordance with both provincial and federal standards and legislative requirements; and
   - consults and/or collaborates with and/or refers to physicians and pharmacists as appropriate.

3. Collaborates with the client and, where applicable with the family, in management and monitoring of a health condition, disease or disorder by:
   - developing a mutually acceptable action plan that considers client wishes and is based on evidence-based standards of care and practice guidelines;
   - utilizing best standards of care/practice for the specific client population;
   - monitoring the effect of the chosen treatment with the client and making necessary adjustments;
• evaluating and documenting the effect of the plan of care including selected treatment and interventions using sound diagnostic reasoning skills and accepted outcome criteria;
• revising and modifying the plan accordingly and referring, consulting and collaborating as needed with physicians, pharmacists and other health care providers;
• scheduling follow-up visits with clients to monitor and evaluate their health/illness status.

4. Performs clinical assessment and procedures/interventions/activities/counseling integral to the clinical management of clients with emergent, urgent and non-urgent conditions.

5. Performs those minor surgical and invasive procedures as provided for in the regulation and within the RN (EP)'s scope of practice and clinical practice setting.

6. Facilitates and fosters active communication, learning, partnerships, collaboration and linkages between the client and appropriate community resources.

7. Initiates timely, efficient consultation, referral and/or collaboration with physicians, pharmacists, other health care providers and social support/resources as appropriate for the client situation.

8. Educates other nurses, health care professionals and clients about the link between nursing interventions and outcomes.

Population Health and Illness/Injury Prevention

1. Collaborates with populations/communities to assess needs through the generation of and application of qualitative and quantitative information (e.g. epidemiological information, interviews, surveys, research findings, evidence-based protocols, community assessments) to address the identified needs.

2. Initiates, with other health care providers and sectors, to plan and develop health promotion/prevention programs based on assessed needs, culture, evidence-based strategies and available resources.

3. Participates in the implementation, monitoring and evaluation of health promotion and illness/injury prevention programs in partnership with other health care providers, communities, social and public service sectors.

4. Develops and uses follow-up systems within the practice setting to ensure the delivery of appropriate services and to demonstrate effective service utilization and efficacy.

5. Promotes and advocates for an environment that facilitates learning and maximizes participation and ability to attain control of their health.

6. Advocates for health promotion and culturally sensitive health care at the policy level and promotes healthy public policy by participating in legislative and policy-making activities that influence health services and practices.

7. Collaborates with other health care providers and sectors to use knowledge of determinants of health and principles of community development to help groups and communities obtain the services they need to meet their health goals.

Professional Responsibilities and Accountabilities

1. Understands the changes in scope of practice from that of a registered nurse on the register of practicing registered nurses and how this affects responsibilities and accountabilities when functioning as registered nurses on the register of extended practice.

2. Understands and incorporates the additional professional and legal standards and ethical decision-making involved in the diagnosis and treatment of acute and chronic illnesses, including prescribing and administering medications.
3. Defines the specific area(s) of practice and the client population for whom she/he is competent to provide health care services. Provides only those services she/he is authorized and competent to provide and refers clients who require health services beyond the individual nurse’s competence.

4. Assumes responsibility and accountability for formally requesting consultation and referring clients to physicians or other members of the health care team at any point in the assessment and management of client health/illness status. This is essential whenever the client’s condition requires care beyond the included practices scope of practice and/or the individual nurse’s competence.

5. Practises in accordance with legislative acts, regulations, CRNM bylaws and Board of Directors policies relevant to the nurse’s area of practice and client population served.

For more information, please contact a Nursing Practice Consultant at (204) 774-3477 or (800) 665-2027 (Manitoba toll-free).

Nursing Practice Expectations represent achievable levels of performance approved by the College of Registered Nurses of Manitoba Board of Directors. All practicing members of the College are expected to comply with the Nursing Practice Expectations. For additional information, please see the Registered Nurses Act and Regulations. Publications are available on our website at www.crnm.mb.ca

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4 STANDARDS OF PRACTICE FOR REGISTERED NURSES ON THE EXTENDED PRACTICE REGISTER
BYLAW VI - CATEGORIES OF PRACTICE

SECTION 1. CATEGORIES OF PRACTICE.

(1) The practice of registered nursing shall consist of the following practice categories:

(a) general practice category; and
(b) nurse practitioner category.

SECTION 2. GENERAL PRACTICE CATEGORY.

(1) Membership in the general practice category is limited to:

(a) a registered nurse who has practising membership status; and
(b) a graduate nurse who has graduate nurse membership status.

SECTION 3. NURSE PRACTITIONER CATEGORY.

(1) Membership in the nurse practitioner category is limited to a registered nurse who has practising membership status in the general practice category and who has been granted a licence to practise within the nurse practitioner category.

(2) In the course of engaging in the practice of registered nursing in the nurse practitioner category, a registered nurse may, subject to conditions or restrictions imposed on his or her licence, perform the following:

(a) diagnose and treat common medical disorders in accordance with the competencies and standards established by council;

(b) in accordance with the competencies and standards established by council, order, perform, receive and/or interpret reports of screening and diagnostic tests in the following areas:

(i) microbiology;
(ii) cytology;
(iii) biochemistry;
(iv) immunology;
(v) haematology;
(vi) forms of non contrast radiographic energy except MRI; and
(vii) virology.

(c) prescribe and/or dispense:

(i) drugs listed in schedules I, II and III of *The Drug Schedules Regulations, 1997*, as amended from time to time;

(ii) drugs in the Health Canada Non-Insured Health Benefits list, as amended from time to time;

(iii) products with a Drug Identification Number that may be sold without a prescription in accordance with the competencies and standards established by council and in accordance with federal legislation.

(d) in accordance with the competencies and standards established by council, perform minor surgical and invasive procedures in the following areas:

(i) suturing;

(ii) irrigation;

(iii) incision and drainage;

(iv) excisions;

(v) intubation; and

(vi) insertion.

(3) Council may recognize and approve a specialty in the nurse practitioner category and authorize an entry on a member's licence to practise in that specialty in accordance with the competencies and standards it establishes.

(4) In the course of engaging in the practice of registered nursing in the nurse practitioner category, the member shall meet the nurse practitioner standards and competencies established by council, taking into account the specific role of the member.

(5) To obtain initial licensing in the nurse practitioner category, a registered nurse must:

(a) be a member in good standing;

(b) be currently licensed as a registered nurse;

(c) have practised 4500 hours as a registered nurse;
(d) have satisfactorily completed:

(i) a nurse practitioner category registered nursing program approved or recognized by council; or

(ii) within three years from the date this bylaw takes effect, a prior learning assessment recognized by council;

(e) have satisfactorily completed a demonstration of nurse practitioner competencies approved or recognized by council; and

(f) complete the prescribed application forms and pay the fees set by the association in the manner prescribed by council.

(6) In addition to subsections (5) and (7), a person who last practised registered nursing outside Saskatchewan in an advanced practice role that is recognized by council to be equivalent to the nurse practitioner category in Saskatchewan must, to obtain initial licensing in the nurse practitioner category, produce evidence establishing to the satisfaction of council that the person was in good standing in a nurse practitioner role in the jurisdiction where the nurse last practised registered nursing.

(7) To maintain eligibility for registration in the nurse practitioner category, a registered nurse must:

(a) work in nursing practitioner activities approved by the association for at least eighteen hundred hours in the three years immediately preceding the application; and

(b) hold a membership in the nurse practitioner category with the association or a regulatory body recognized by the association while working in approved nurse practitioner activities for these hours to contribute to eligibility for registration.

(8)(a) At the expiration of three years from the date this bylaw takes effect, a registered nurse will only be authorized to practise in the nurse practitioner category as described in subsection (2) of section 3, if he/she has a licence in the nurse practitioner category.

(b) On application and where council considers it appropriate, the council may extend the time required to comply with subsection 8(a).

(9) A registered nurse with a licence in the nurse practitioner category who practises less than 1800 hours in the nurse practitioner category in the preceding three years must:

(a) satisfactorily complete a nurse practitioner category re-entry program approved or recognized by council.
(b) arrange to have forwarded by the director of the program to the registrar:

(i) a certified copy of records outlining the theory and the clinical content of the re-entry program;

(ii) a statement indicating successful completion of the re-entry program; and

(c) provide references as required by the council.

(10) To register for the subsequent year in the nurse practitioner category a person must:

(a) maintain eligibility for registration as set out in section 3(7) or section 3(9); and

(b) complete the prescribed inventory and renewal form and submit it with the annual registration fee, or the initial installment in the manner prescribed by council, to the registrar by November 1st.

(11) On application and where council considers it appropriate, the council may waive the requirements of section 3(7)(a).

(12) A licence to practise registered nursing as a nurse practitioner may be issued to a person who meets the requirements of section 3(10).

(13) Council may place conditions or restrictions on a licence in the nurse practitioner category taking into account the need to protect the public, the particular circumstances of the registered nurse and the context of practice including client population, type of care, service delivery model and/or staffing.
Registered Nurse (Nurse Practitioner)  
RN(NP)  
Standards  
&  
Core Competencies  
2003
Because of the rapidly changing environment in which Registered Nurse(Nurse Practitioners) practice, competency statements in this document are broad. More detailed companion documents will be developed as the need arises.

The Saskatchewan Registered Nurses’ Association gratefully acknowledges the work of the Committee on Registered Nurse(Nurse Practitioner) Competencies:

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The SRNA also wishes to thank key stakeholders and the many RNs that have provided the valued feedback to develop this document.
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I. Introduction

The Saskatchewan Registered Nurses’ Association (SRNA) is the professional regulatory body for the registered nursing profession with the mandate to promote and ensure competent, caring nursing for the people of Saskatchewan. The SRNA fulfills its mandate in a variety of ways. The SRNA establishes a minimum or safe level of competence for graduate nurses, registered nurses, and registered nurse (nurse practitioners) [RN(NP)s] by:

- identifying foundation competencies which all graduate and registered nurses, and RN(NP)s must be capable of demonstrating;
- setting educational standards for entry to the profession;
- collaborating on the competencies to be assessed for the registered nurse and RN(NP) licence;
- ensuring other registration and licensure requirements are met;
- describing standards for nursing practice to which all graduates, registered nurses, and RN(NP)s are held accountable; and
- establishing mechanisms to ensure the continuing competence of its members.

SRNA has the legislated mandate through The Registered Nurses Act, 1988 to ensure that all of its members provide an acceptable level of nursing practice as identified in the SRNA Standards and Foundation Competencies for the Practice of Registered Nurses (2000). These standards represent the criteria against which all registered nurses practicing in the four major domains of direct care, education, administration, and research will be measured by clients, employers, colleagues, and themselves.

The Registered Nurses Act, 1988 has defined the practice of nursing as the performance or coordination of health care services including but not limited to:

- observing and assessing the health status of clients and planning, implementing and evaluating nursing care; and
- the counselling, teaching, supervision, administration and research that are required to implement or complement health care services; for the purpose of promoting, maintaining, or restoring health, preventing illness and alleviating suffering...” (p. 1.2)

Amendments to The Registered Nurses Act, 1988 have enabled the regulation of the registered nurse (nurse practitioner) [RN (NP)] role within Saskatchewan. This document identifies the core competencies that are expected of each RN(NP) within Saskatchewan. These competencies are in addition to the entry level competencies of all Registered Nurses in Saskatchewan as identified in the SRNA Standards and Foundation Competencies for the Practice of Registered Nurses (2000).

Re-registration for the RN(NP)

RN(NP)s will need to meet the following criteria for re-registration:

1. 1800 hours in three years of practice in the RN(NP) category.
2. Completion of continuing competency documents.
II. Standards and Competencies for the Registered Nurse (Nurse Practitioner) [RN(NP)]

A standard is a desired and achievable level of performance against which actual performance can be compared. Standards and foundational competencies for RN(NP) nursing practice reflect the philosophical values of the profession and clarify what the nursing profession expects of its RN(NP) members. These standards apply to every setting and provide a standard to measure the basic level of safe RN(NP) nursing practice across the province. The standards state minimum levels below which performance is unacceptable. Individual members may exceed these standards. These standards and competencies expand upon the SRNA’s Standards and Foundation Competencies for the Practice of Registered Nurses (2000).

Besides the individual RN(NP) the SRNA and Employers have responsibilities related to the Registered Nurse (Nurse Practitioner) RN(NP) Standards and Core Competencies, 2003.

Responsibilities:

1. Individual RN(NP): Is responsible to act professionally and be accountable for her/his own practice. This accountability is not relieved by agency policies of employers or other organizations. Each individual RN(NP) is responsible to maintain her/his own level of competence (knowledge, skills and judgement) in their practice as a RN(NP).

2. SRNA: Is responsible for ensuring that the registered nursing profession as a whole carries out its commitment to the public. In carrying out this commitment, the SRNA provides confidential consultation to assist RNs and RN(NP)s with practice issues, promote standards, guidelines and policies for safe nursing practice in accordance with the defined scope of nursing practice.

3. Employers have an obligation to provide essential support systems, including human and material resources, so that RN(NP)s are able to meet the minimum standards of practice as defined in the Standards and Foundation Competencies for the Practice of Registered Nurses in Saskatchewan (2000) and the Registered Nurse (Nurse Practitioner) RN(NP) Standards and Core Competencies, 2003. Employers are also responsible for developing and maintaining care standards and accreditation standards. RN(NP)s participate in meeting accreditation and care standards of their employing agency.
III. Registered Nurse (Nurse Practitioner) [RN(NP)]

RN(NP)s are integral members of the health care team who provide and coordinate initial, continuing and comprehensive advanced nursing services in rural, remote and urban areas of the province. RN(NP)s serve the ethnoculturally diverse populations of Saskatchewan across the continuum of health-care throughout the life span. The spectrum of health services that RN(NP)s provide encompasses: health promotion and maintenance of wellness; illness and injury prevention; health condition, and health care management of common acute and chronic illnesses, including ordering diagnostic investigations and prescribing treatment including medications.

Amendments to The Registered Nurses Act, 1988 have enabled the regulation of the RN(NP) role in Saskatchewan. According to the Amendments to Section 24, a registered nurse who meets the requirements set up by the bylaws will be licenced to practice as a RN(NP), may and have the regulatory authority to:

a) order, perform, receive and interpret reports of screening and diagnostic tests that are designated in the bylaws;

b) prescribe and dispense drugs in accordance with the bylaws;

c) perform minor surgical and invasive procedures that are designated in the bylaws;

d) diagnose and treat common medical disorders.

The above-cited legislated practices provide the legal basis by which RN(NP)s can practice those competencies that had traditionally been reserved for the practice of medicine, dentistry and/or pharmacy. These skills are only a part of the core competencies required for RN(NP)s. The core RN(NP) competencies are grouped into four categories, which encompasses the four legislated functions. The categories of the framework and the standards and core competencies should be viewed in a holistic manner. The four categories of core standards and competencies are:

I. health assessment and diagnosis of client/illness status;

II. health care management, pharmacotherapeutics and therapeutic interventions;

III. health promotion and illness/injury prevention; community development; and

IV. registered nurse (nurse practitioner) [RN(NP)] professional responsibilities and accountabilities.

The competencies related to health promotion, illness/injury prevention and community development are foundational to the practice of all registered nurses including RN(NP). Integration of this category into the core set of RN(NP) competencies establishes that the provision of RN(NP) health care services occurs within a delivery model that emphasizes the health promotion and illness/injury prevention. RN(NP)s offer health promotion and illness/injury prevention services to clients who are healthy or have acute and/or chronic conditions, diseases or disorders. RN(NP)s are expected to be knowledgeable about the principles of Community Development. If the RN(NP)s role requires active participation in community development such as in community or rural/remote
practice settings, then the RN(NP) is expected to develop additional community development competencies that are more comprehensive to this role.

The standards and core competency statements are entry level which one would expect the beginning RN(NP) to exhibit after graduation from a RN(NP) education program or one deemed equivalent. Each RN(NP) is expected to demonstrate the core RN(NP) standards and competencies for registration as a RN(NP). These are the minimum requirements and as RN(NP)s move along the continuum from novice to expert level RN(NP)s, they will increase in depth of knowledge in how they meet the competencies required for practice. Furthermore, the Registered Nurse (Nurse Practitioner) RN(NP) Standards and Core Competencies, 2003 statements are not meant to stand alone but rather be considered along with the SRNA Standards and Foundation Competencies for the Practice of Registered Nurses (2000) and the attached Clinical Expectations.
IV. Guiding Principles for the Registered Nurse (Nurse Practitioner) [RN(NP)]

The guiding principles include key values and assumptions regarding competencies for the RN(NP).

1. The RN(NP) must meet the SRNA Standards and Foundation Competencies for the Practice of Registered Nurses (2000) and the CNA Code of Ethics for Registered Nurses.

2. The competencies for the RN(NP) are built on the entry level competencies identified for new graduates beginning to practice as registered nurses in Saskatchewan in the SRNA Standards and Foundation Competencies for the Practice of Registered Nurses (2000).

3. The competencies for the RN(NP) are entry-level competencies expected of the novice RN(NP). Individual members may exceed these minimum entry-level competencies.

4. The competencies for the RN(NP) will be progressive, always evolving, encompassing a wide range of nursing knowledge, skills, experience and judgement.

5. The competencies will reflect the unique needs of the people, and the cultures of the people of Saskatchewan.

6. Preparation to practice as a RN(NP) is based upon nursing knowledge, skills, and judgement acquired through nursing education and previous practice experience as a registered nurse.

7. RN(NP)s are accountable for the knowledge, skills, and judgement necessary to independently provide a full range of comprehensive health care services to clients, families, communities and the public.

8. The scope of practice of the RN(NP) encompasses the activities for which the RN(NP) is competent to perform, and is influenced by the setting in which they practice, and the needs of the clients.

9. The RN(NP) maintains accountability for competencies inherent of the RN(NP) role.

10. RN(NP)s are accountable for and will have access to education (formal and informal) to ensure acquisition and maintenance of competencies for practice.

11. The RN(NP) works in collaboration with other members of the health care team.

12. The RN(NP) competencies will be used by the SRNA to establish eligibility of RNs for assessment prior to registration as a RN(NP) in Saskatchewan, and for the approval of RN(NP) educational programs.

13. The development of RN(NP) competencies in Saskatchewan builds on the work of other Canadian jurisdictions and will contribute to the goal of national regulatory consistency.
V. Standards and Core Competencies for the Registered Nurse (Nurse Practitioner) [RN(NP)] Practice

Category I Health Assessment and Diagnosis

STANDARD:
The RN(NP) performs a comprehensive and holistic health assessment, and synthesizes data from multiple sources to make a diagnosis within the scope of practice of the RN(NP).

CORE COMPETENCIES:
1. Performs an advanced, comprehensive and holistic health assessment, including a relevant health history and physical assessment.
2. Adapts assessment tools and techniques according to individual client needs, stage of development and cultural aspects.
3. Determines the need for, orders, performs, receives and interprets the appropriate diagnostic tests (See Clinical Expectation 2).
4. Communicates verbally and in writing, history, physical assessment findings, diagnosis, and treatment plan when indicated.
5. Communicates progress and treatment options with the client and other members of the team, when indicated.
6. Consults with other health care providers in an appropriate and timely manner (See Clinical Expectation 5).
7. Analyzes and synthesizes data from multiple sources to establish a differential and working diagnosis (See Clinical Expectation 1).
8. Analyzes and synthesizes data from multiple sources to identify and monitor a health situation.
Category II Health Care Management, Pharmacotherapeutics and Therapeutic Interventions

STANDARD:
The RN(NP) initiates, manages, directs and monitors the care of clients, based on the assessment findings, within the scope of practice of the RN(NP).

CORE COMPETENCIES:
1. Critically appraises and applies current, relevant research into clinical practice from an evidence-based framework.
2. Applies knowledge of pharmacology including pharmacokinetics, pharmacodynamics and best practice standards in selecting, prescribing and monitoring drugs to treat conditions, diseases, disorders and injuries within the RN(NP)’s scope of practice and clinical practice setting (See Clinical Expectation 3).
3. Competently dispenses medications in communities where there is no pharmacy available (See Clinical Expectation 4).
4. Competently performs minor surgical and invasive procedures appropriate or integral to the clinical management of clients with common/urgent/emergent problems/conditions (See Clinical Expectation 6).
5. Consults and refers appropriately in the provision of coordinated care to clients (See Clinical Expectation 5).
6. Collaborates with the client and health care team in management and monitoring of a health situation by:
   a) prioritizing health conditions and interventions appropriately and in collaboration with the client and client’s family;
   b) assisting/supporting/facilitating clients to plan, follow and evaluate therapeutic regimens;
   c) monitoring the effect of the chosen therapy, making necessary adjustments within the RN(NP) scope of practice; and
   d) evaluating the effect of the plan of care including selected treatments and interventions.
7. Recognizes the need and provides for crisis intervention and counselling for common, emergent or urgent psychosocial conditions/situations.
8. Applies principles of transcultural nursing, family nursing, role expectations, and change when managing the care of families.
9. Communicates verbally and in writing, the client’s progress and treatment options and plans with the client and other members of the team, when indicated.
Category III  Health Promotion, Illness/Injury Prevention & Community Development

STANDARD:
The RN(NP) implements strategies to promote health with clients and within communities and to prevent injury/illness with clients.

CORE COMPETENCIES:

1. Assesses client needs by compiling qualitative and quantitative information about clients (e.g. epidemiological information, interviews, surveys, research findings, and community assessments).

2. Participates in the development of health promotion/prevention programs based on assessed needs, culture and evidence-based strategies and available resources for clients who are healthy or have acute or chronic conditions.

3. Participates in health promotion/prevention programs in partnership with others including the community, colleagues and other sectors.

4. Applies principles of teaching and learning when providing health education to individuals, families and groups.

5. Monitors, evaluates and modifies health promotion/prevention programs in partnership with the client and other members of the health care team.

6. Encourages client to take responsibility for maintaining and/or improving health by increasing knowledge of, control over, and influence on, health determinants.

7. Advocates for health promotion at the policy level and promotes healthy public policy by participating in legislative and policy-making activities that influence health services and practices.

8. Is knowledgeable, utilizes the principles and participates in community development within each RN(NP)'s practice setting.

9. Implements primary, secondary and tertiary prevention strategies for individuals, families, and communities or for specific age and cultural groups, in accordance with population health principles.
Category IV  Registered Nurse (Nurse Practitioner) [RN(NP)] Professional Responsibilities and Accountabilities

STANDARD:
The RN(NP) functions both autonomously and collaboratively within the scope of RN and RN(NP) practice. The RN(NP) responsibilities and accountabilities further build on Standard XIV of the Standards and Foundation Competencies for the Practice of Registered Nurses (2000).

CORE COMPETENCIES:
1. Articulates the role and responsibilities of the RN(NP) to clients, the general public and other health professionals.
2. Accepts sole responsibility and accountability for all actions taken within the scope of RN(NP) practice.
3. Incorporates professional, legal, and ethical decision-making guidelines into the RN(NP) practice.
4. Acts as a resource person, preceptor and/or mentor for students, nurses, and other health care professionals, and the community.
5. Demonstrates leadership in clinical practice to meet multiple health care needs.
6. Advocates for clients.
7. Participates in nursing, interdisciplinary, and/or inter-sectoral research that relates to her/his practice.
8. Promotes healthy public policy through community involvement.
9. Participates in emergency preparedness and environmental health planning as part of a team.
10. Promotes the ongoing development of the professional role of the RN(NP).
11. Develops and implements an ongoing evaluation of own RN(NP) practice.
12. Accepts personal responsibility for ongoing professional development related to RN(NP) competence, including, but not limited to, continuing education related to prescriptive authority and health management.
13. Maintains active registration as a RN(NP) with the SRNA.
Clinical Expectations for RN(NP)s

Note: Clinical Expectations have been developed to add further clarity to the RN(NP) role. These must be used in conjunction with the RN(NP) Standards and Core Competencies document and are not intended to stand alone.
Clinical Expectation 1: Establishing and Communicating a Diagnosis

The RN(NP) performs a comprehensive health assessment and synthesis data from multiple sources to formulate one or more differential diagnosis/diagnoses of a health condition.

In diagnosing within the scope of practice for the entry level RN(NP), using a holistic approach, applies the knowledge of:

a) nursing practice;

b) pathophysiology, including etiology;

c) developmental, mental health (psychological), sociological and environmental health considerations;

d) pathology and clinical manifestations of commonly encountered acute/chronic health problems, injuries, stable chronic disorders, normal health events, and emergency health needs;

e) epidemiology; and

f) current relevant research.
Clinical Expectation 2: Diagnostic Tests

RN(NP) performs a comprehensive health assessment and synthesizes data from multiple sources to formulate a differential diagnosis of a health condition through the ordering, performing, receiving and interpreting of diagnostic tests. RN(NP)s are authorized to order diagnostic tests as determined by scope and type of RN(NP) practice.

The RN(NP) will:
- be guided by best practice evidence on the appropriateness, safety and cost-effectiveness of each diagnostic test
- adhere to provincial or agency standards for ordering diagnostic test.

Ordering

Ordering has been interpreted to mean that the RN(NP) may make a request for laboratory test. The RN(NP) is authorized to request diagnostic tests for the following purposes:
- to confirm the diagnosis of a short-term, episodic illness or injury as suggested by the client’s history and/or physical findings;
- to rule out a potential diagnosis that, if present, would require consultation with an appropriate physician for treatment;
- to assess/monitor ongoing conditions of clients with chronic illnesses;
- for screening activities;
- to monitor the ongoing condition of a client with a previously diagnosed illness or disorder; or
- to confirm symptoms of decreasing/increasing function of a vital organ or system.

The RN(NP) will:
- obtain informed consent prior to requesting a diagnostic test;
- explain the reason(s) for the diagnostic test;
- explain any risk(s) and/or benefit(s) of the diagnostic test;
- answer any questions the client has;
- document the request of any diagnostic tests.

The following tests may be requested by the RN(NP) after consulting with an appropriate physician(s). The physician’s name must accompany the RN(NP)’s on the requisition.
- Computed Tomography Scans (CT Scans);
- Out of Province Test.

In accordance with SRNA Bylaw VI, Section 3(2)(b)(vi), RN(NP)s can not order/request Magnetic Resonance Imaging (MRI) tests.
Performing
Performing has been interpreted to mean the collection of the sample specimens and handling of these specimens. The collection of specimens may be done through venipuncture, through a direct examination route (i.e. pelvic exam), or as expelled by the client (i.e. voided urine, sputum collection).

The authority to perform the diagnostic tests does not include operating the instrumentation. Point of care testing devices (i.e. pregnancy test kits, hemoglobinometer) must be agency approved and in accordance with the Laboratory Quality Assurance Program. Point of care testing devices are to be used as a screening tool. Definitive testing should be referred to the laboratory.

In clinical practice settings where there is inadequate laboratory, radiology or electrocardiology personnel staff to perform the tests, it is the responsibility of the RN(NP) to contact SRNA for further development of standards and agreements with the appropriate professional/regulatory body.

Receiving and Interpreting
The RN(NP) will receive the results of the diagnostic tests and interpret the results in relation to common medical disorders. The RN(NP) will refer to the primary team physician if the result of a diagnostic test is beyond a common medical disorder. The interpretation of these results will be used to make decisions regarding treatment for clients. Within the health care team, each team needs to identify the process for consulting appropriate medical specialists outside the team, as needed, for further consultation / management decisions.

Laboratory and Non–Contrast Forms of Energy (Except MRI)
1. Laboratory Tests
The RN(NP):

- documents the order and results of laboratory tests on the permanent client record as part of the treatment plan;
- collects the appropriate specimens for testing when there is no other appropriate health care provider to do so;
- takes or handles specimens in accordance with the infection control guidelines in place;
- complies with the transportation of infectious substances guidelines (Dangerous Goods Regulations, IATA Air Transport Canada) in preparing specimens for transport;
- interprets the laboratory tests in the context of the individual client’s presentation, makes decisions about treatment, and/or consults in accordance with the expectations for consultation with physicians by RN(NP)s; and
• may request a copy of a laboratory report for laboratory tests ordered by a physician for clients with whom the RN(NP) has been involved in providing care.

2. Radiographs and Ultrasounds

In the ordering and interpretation of x-rays and ultrasounds, the RN(NP) will:

• maintain the safety of the client through consideration of contraindications to ionizing radiation exposure, and the associated risks and benefits of ordering a x-ray or an ultrasound;
• consult with the radiologist if the interpretation of a x-ray or ultrasound requires clarification;
• make decisions about treatment based on results of x-rays and/or consults with a physician;
• request a copy of the radiologist’s x-ray or ultrasound report for x-rays or ultrasounds ordered by a physician for clients with whom the RN(NP) has been involved in providing care:
• document the x-ray or ultrasound order and report findings on the permanent client record as part of the treatment plan; and
• recognize that the final interpretation of a x-ray and an ultrasound is the responsibility of a radiologist and falls outside the scope of practice of the RN(NP).
Clinical Expectation 3: Prescribing Medications

RN(NP)s can prescribe medications in accordance with applicable Saskatchewan legislation from: Saskatchewan Health, the Saskatchewan Formulary, and the Health Canada, FNIHB, Non-Insured Health Benefits Program, as amended from time to time. RN(NP)s can also prescribe over the counter medications, as appropriate.

With the privilege of prescribing, RN(NP)s:
1. Do not prescribe for family members or for oneself when other RN(NP)s or MDs are available.
2. Do not become involved in self-diagnosis and management and encourage friends and family members to seek care from other health care providers.

A medication prescription order may be identified in a client’s chart or on a prescription pad. The client’s chart is appropriate for some isolated centres where there is no stand-alone/separate pharmacy. RN(NP)s need to establish a working relationship with a pharmacist(s) for purposes of consultation.

RN(NP)s need to:
1. Provide educational information to clients about prescription and non-prescription drugs which includes information regarding:
   - the expected action of the drug;
   - the importance of compliance with prescribed frequency and duration of the drug therapy;
   - the potential side effects;
   - the signs and symptoms of potential adverse effects (e.g., allergic reactions) and action to take if they occur;
   - potential interactions between the drug and certain foods, other drugs, or substances;
   - specific precautions to take or instructions to follow; and
   - recommended follow-up.

2. Monitor and document the client’s response to drug therapy, as needed. Based on the client’s response, the RN(NP) may decide to continue, adjust, or withdraw the drug, or to consult with a physician in accordance with the expectations for consultation.

3. Establish appropriate methods for keeping physicians informed of their mutual clients’ health conditions and of their treatment decisions (including decisions to repeat particular drugs).
Prescription Pad Medication Orders

1. Complete prescriptions accurately and completely including the following information:
   • date of issue;
   • name and address (if available) of client;
   • name, strength and quantity of prescribed drug – refer to the generic name of the drug;
   • quantity of the drug which is to be dispensed;
   • directions for use – refers to the frequency, route of administration, and the duration of drug therapy, and special instructions, such as “take with food”;
   • directions for number of allowable refills and interval between refills, where applicable – if a prescription includes more than one drug, any drug that may be refilled must be clearly identified;
   • if all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug; and
   • prescriber’s name, address, telephone number, fax number and signature or unique RN(NP) identifier.

2. Store blank prescriptions in a secure area that is not accessible to the public. It is improper practice to provide any person with a blank, signed prescription as this may lead to potential theft or forgery.

Prescription Transmission Via Facsimile

A prescription may be transmitted by facsimile to a pharmacy, in accordance with the following criteria:

• The prescription must be sent only to the pharmacy of the client’s choice with no intervening person having access to the prescription.

• The prescription must be sent directly from the prescriber’s office or directly from a health institution for a client of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy.

• The prescription must include all information listed above, and in addition must include:
  • time and date of transmission;
  • name and fax number of the pharmacy intended to receive the transmission; and
  • a signed certification that the prescription represents the original of the prescription drug order, the addressee is the only recipient and there are no others, and the words “This certifies that the above prescription has been transmitted only to the pharmacy indicated”.

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Clinical Expectation 4: Dispensing Medications

The RN(NP) may dispense medications where there is no pharmacy or pharmacist available.

In the dispensing of medications, the RN(NP) will:

1. Ensure that the transaction(s) is accessible and recorded on an individual prescription profile and/or client record each time a drug is distributed. The profile will include:
   a) client’s name;
   b) drug name and drug dosage;
   c) directions for use;
   d) quantity distributed;
   e) expiry date, when applicable;
   f) date distributed; and
   g) initials of the RN(NP) distributing the drug.

2. Ensure that the prescription label indicates the:
   a) client’s name;
   b) drug name and drug dosage;
   c) direction for use;
   d) quantity distributed;
   e) expiry date, when applicable;
   f) date distributed;
   g) initials of the RN(NP) distributing the drug; and
   h) the location from which the drug is distributed, including name, address and telephone number.

3. Ensure that the label can be easily read by the client or client’s guardian.

4. Ensure that appropriate special circumstances / auxiliary labels (e.g., shake well) are affixed.

5. Initiate client education regarding the drug, including but not necessarily limited to:
   a) identify the purpose of the drug(s) being distributed;
   b) dosage regime and instructions required to achieve the intended therapeutic response, expected benefits and side effects, and storage requirements; and
   c) written medication information.

6. Assess the level of the client’s understanding.
Clinical Expectation 5: Referrals and Consultations

Referrals:

The SRNA believes that RN(NP)s are members of the health care team and thus may need to initiate referrals amongst other members of the team within a timely manner to ensure that the needs of the clients are met. RN(NP)s are authorized and accountable to formally request a referral of a client to physicians, physiotherapists, occupational therapists, dieticians, counselor, etc at any point:

1. in the assessment and management of the client’s health / illness status;
2. when the client’s condition requires the care beyond the RN(NP)s scope of practice and / or competence or
3. when the specialized knowledge, skills and judgment of a specific care provider is required.

Consultation:

The term consultation has traditionally been used as a referral between physicians. The SRNA believes that the RN(NP) must have reasonable access to the primary physician within the team for the purpose of consultation with respect to any client. A process must be put into place for consultation of physicians outside the health care team. This consultation with a medical specialist outside the health care team should be done in collaboration with the primary team physician. Consultation with the primary team physician is required when:

- the RN(NP) approaches or reaches the limit of her/his scope of practice;
- signs, symptoms, diagnosis or plan or treatments are unclear or beyond the RN(NP)s scope of practice; or
- the client’s health care condition destabilizes or a potentially life-threatening (emergent) situation arises.

The consultation of a medical specialist outside the RN(NP)s health care team maybe required through the discussion of a client’s health condition with the primary team physician. The consultation may be required or occur at any stage of the RN(NP) client relationship, from the time of initial assessment through to the evaluation of effectiveness of treatment, including the ongoing management of clients with chronic health conditions.

Consultation may take place through a formal request. The degree to which a medical specialist becomes involved in the care will vary according to the practice setting and/ or client situation. Consultation may result in the:

1. provision of an opinion and recommendation for management;
(2) provision of an opinion, recommendations for management and concurrent interventions; or
(3) direct management of the care of the client by the medical specialist.

When requesting a consultation, the RN(NP):

- clearly presents the reason for and the level of urgency of the consultation;
- describes the level of consultation requested:
  (1) an opinion;
  (2) a recommendation for management;
  (3) concurrent intervention; or
  (4) immediate transfer of care to the consulted physician.
- ensures that the consultant has appropriate access to the client’s known health information;
- confirms the understanding of the RN(NP) and consultant responsibilities in the specific situation; and
- documents the request for and outcome of the consultation.
Clinical Expectation 6: Minor Surgical and Invasive Procedures

The RN(NP) competently performs minor surgical and invasive procedures appropriate or integral to the clinical management of clients with common/urgent/emergent problems/conditions.

As per the Saskatchewan Registered Nurses’ Association Bylaws (2003), RN(NP)s perform the following:
- suturing
- irrigations
- incision and drainage
- excisions
- intubations
- insertions

In performing the above listed procedures within the scope of practice for entry level RN(NP), using a holistic approach, applies the knowledge of:
- pathophysiology related to the procedure;
- pathology, clinical manifestation and etiology of common/urgent/emergent problems/conditions requiring the above listed minor surgical and invasive procedures;
- epidemiology;
- current relevant research, and
- nursing practice.

It is the responsibility of the RN(NP) perform the listed procedures if
- it is a procedure that the RN(NP) is competent to perform;
- it is within their role as defined by the employer.
REFERENCES


GLOSSARY OF TERMS

Client: the individual, family, group, community and/or population to whom nursing activities are directed.

Collaboration: to work together with others.

Common: conditions, diseases or disorders that RN(NP)s see regularly within the particular context of their own practices.

Community: the population residing in the immediate area and in the country where the program is based.

Community Development: an incremental process through which individuals, families and communities gain the power, insight and resources to make decisions and take action regarding their well being.

Competence: the overall display by a nurse, in the professional care of client(s), the knowledge, skill, and judgment required in the practice situation. The nurse functions with care and regard for the welfare of the client and in the best interests of the public, nurses and nursing profession.

Competency: the demonstration, by a nurse, of knowledge, skill and judgement derived from the nursing roles and functions, within a specified context.

Consultation: a deliberation of two or more health care professions about the diagnosis or treatment. (O’Toole, 1997).

Environment: a mosaic composed of cultural, social, technological, psychological, political, economic, occupational, and physical influences. These interlocking but distinct environments each have their own impact or potential for impact on health.

Evidence-Based Practice: caring for patients/clients by explicitly integrating clinical research evidence with pathophysiologic reasoning, caregiver experiences, applicable theory and client preferences (adapted from Cook & Levy, 1998).

Family: a social unit which includes friends and/or relatives who have an ongoing, close, structured relationship and who are related by bloodline, adoption of close association.

Graduate: one who has successfully completed the requirements of an approved nursing education program.

Group: set of individuals who have come together for a shared reason.

Guiding Principles: a fundamental truth or method of operation (principle) that leads, directs or shows the way (guides).
Health Determinants: the range of personal, social, economic and environmental factors which determines the health status of individuals or populations. (Saskatchewan Health, 2002).

Individual: single human being throughout the lifespan, including neonate, infant, child, adolescent, adult or elderly adult.

Intervention: actions taken to meet client needs.

Minor: any procedure that a RN(NP) performs regularly to manage conditions/diseases that are common to their practice.

Nurse: for the purpose of this paper, the term “nurse” means registered nurse.

Nurse Practitioner: a Registered Nurse who provides comprehensive nursing services in a specialized area of practice based on further knowledge and decision-making skills in assessment, diagnosis and health care management including but not limited to prescription of drugs. A RN(NP)’s practice is based on in-depth knowledge of nursing and other related fields gained through additional education and practice.

Outcome: the end result of goal directed activities.

Population: all persons sharing a common health issue, problem or characteristic. These people may or may not come together as a group.

Population Health: is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health. (Health Canada, 2002).

Qualitative Information: information collected in narrative (nonnumerical) form. (i.e. social support networks). (Loiselle & Profetto-McGrath, 2004, p. 481).

Quantitative Information: information collected in a numerical form. (i.e. infant mortality rate). (Loiselle & Profetto-McGrath, 2004, p. 481).

Referral: an arrangement for services by another care provider or agency. (O’Toole, 1997).

Regulatory Authority: the authority vested in the nurse professional through legislation to permit registered nurses to autonomously provide health services.

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

Unstable situation: situation, in which the client has atypical responses, poorly defined problems, and/or unpredictable outcomes.
BYLAW V.1 – CONTINUING COMPETENCE

SECTION 1: CONTINUING COMPETENCE PROGRAM.

(1) For the purposes of clause 38.1(1)(a) of the Act, the continuing competence program administered by the SRNA for both the general practice and nurse practitioner membership categories is established as the program for reviewing and improving the quality of nursing care provided by members.

(2) A registered nurse licensed in the general practice category must participate in the continuing competence program for that membership category.

(3) A registered nurse licensed in the nurse practitioner category must participate in the continuing competence program for the general practice category as well as the continuing competence program for the nurse practitioner category.

(4) As part of the continuing competence program, a registered nurse must complete, in each membership year, a reflective practice review in the form provided by the association, which includes:

   (a) a personal assessment of her or his own nursing practice according to the nursing practice standards approved by the council;

   (b) feedback on the personal assessment obtained by the registered nurse;

   (c) a written learning plan developed from the personal assessment and feedback and implemented; and

   (d) a written evaluation of the result of the learning plan on the practice of the registered nurse.

(5) Each registered nurse shall retain his or her reflective practice review for five membership years following the end of the membership year in which the review is completed and shall produce it to the registrar at any time on request.

(6) A registered nurse who does not complete a reflective practice review in a membership year is not eligible to be licensed to practice in the membership year next ensuing.

(7) The registrar may suspend a registered nurse’s licence to practice where the registrar determines that the registered nurse has not completed a reflective practice review in accordance with these bylaws.

(8) Subject to the approval of the Minister and publication in the Gazette, subsection (1) of this bylaw comes into force as provided for in subsection 14(7) of the Act, and subsections (2) to (7) of this bylaw come into force on December 1, 2006.
Appendix A – 23

Extract from Alberta Regulation, s. 15(1)

15(1) Regulated members on any register may, within the practice of registered nursing and in accordance with the standards of practice governing the performance of restricted activities approved by the Council, perform the following restricted activities:

(a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue below the dermis or the mucous membrane;

(b) to insert or remove instruments, devices, fingers or hands

(i) beyond the cartilaginous portion of the ear canal,

(ii) beyond the point in the nasal passages where they normally narrow,

(iii) beyond the pharynx,

(iv) beyond the opening of the urethra,

(v) beyond the labia majora,

(vi) beyond the anal verge, or

(vii) into an artificial opening into the body;

(c) to insert into the ear canal under pressure, liquid, air or gas;

(d) to reduce a dislocation of a joint except for a partial dislocation of the joints of the fingers and toes;

(e) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmaceutical Profession Act;

(f) to administer a vaccine or parenteral nutrition;

(g) to compound or administer blood or blood products;

(h) to administer diagnostic imaging contrast agents;

(i) to administer radiopharmaceuticals, radiolabelled substances, radioactive gases or radioaerosols;

(j) to prescribe or administer nitrous oxide, for the purposes of anaesthesia or sedation;

(k) to perform a psychosocial intervention with an expectation of treating a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
(i) judgment,

(ii) behaviour,

(iii) capacity to recognize reality, or

(iv) ability to meet the ordinary demands of life;

(l) to manage labour or deliver a baby.
(5) A regulated member on the nurse practitioner register may, within the practice of registered nursing, perform the restricted activities listed in subsection (1) and the following additional restricted activities when practising as a nurse practitioner:

(a) to prescribe a Schedule 1 drug within the meaning of the Pharmaceutical Profession Act;

(b) to prescribe parenteral nutrition;

(c) to prescribe blood products;

(d) to order and apply any form of ionizing radiation in medical radiography;

(e) to order any form of ionizing radiation in nuclear medicine;

(f) to order non-ionizing radiation in magnetic resonance imaging;

(g) to order or apply non-ionizing radiation in ultrasound imaging, including any application of ultrasound to a fetus;

(h) to prescribe diagnostic imaging contrast agents;

(i) to prescribe radiopharmaceuticals, radiolabelled substances, radioactive
gases and radioaerosols.
APPENDIX A - 25

INTENTIONALLY OMITTED
Health Professions Act: Standards for Registered Nurses in the Performance of Restricted Activities

October 2005
Approved by the Alberta Association of Registered Nurses (AARN) in October 2005 for use when regulations for registered nurses were proclaimed under the *Health Professions Act* (HPA). Proclamation occurred on November 30, 2005 and the AARN became the College and Association of Registered Nurses of Alberta (CARNA).

Permission to reproduce this document is granted; please recognize CARNA.

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HEALTH PROFESSIONS ACT: STANDARDS FOR THE PERFORMANCE OF RESTRICTED ACTIVITIES

INTRODUCTION

The Health Professions Act (HPA) (2000) provides a regulatory structure for all self-governing health professions in Alberta. It is intended to make professional legislation transparent to the public and recognizes that professions have overlapping scopes of practice. Under HPA there is a common framework across all health professions for:

- registration
- discipline
- continuing competence and
- restricted activities

Each profession develops regulations specific to the profession before HPA comes into force for that profession. Sections 133 and 134 of HPA outline those matters about which a profession can make regulations and bylaws. In addition, each profession has a practice statement that outlines the practice of that profession. The practice statement for registered nurses (RNs) is in Schedule 24 of HPA (see Appendix A). In addition, the College and Association of Registered Nurses of Alberta (CARNA) document Scope of Practice for Registered Nurses (2005) has been developed to articulate and describe registered nursing practice for members, the public and other stakeholders.

RESTRICTED ACTIVITIES

HPA introduces the concept of restricted activities. “Restricted activities are regulated health services which have been identified as involving a significant degree of risk to the public. They are also activities that demand specific competencies on the part of the person performing them” (Alberta Health & Wellness, 2000, p. 12.).

The complete list of restricted activities is in Schedule 7.1 of the Government Organization Act (GOA) (1999) (see Appendix B). “Members of several different professions may be authorized to perform the same restricted activities” (Ibid, p. 12.).

RESTRICTED ACTIVITIES AUTHORIZED BY CARNA REGULATIONS

HPA provides authority for a profession to make a regulation that identifies those restricted activities its regulated members may perform and any conditions or supervisory requirements that may be applicable to the performance of the restricted activity. Although CARNA authorizes, through regulations, its regulated nurse members to perform a number of restricted activities, this does not mean that a regulated member is authorized to perform any restricted activity in any situation in any practice setting. Regulated members who may perform restricted activities authorized by CARNA include those on the following registers:

- registered nurse
- certified graduate nurse
- temporary

- courtesy
- nurse practitioner
It should be noted that those on the temporary register are allowed to perform all restricted activities. This register includes new graduates and internationally educated nurses who are in the process of meeting registration requirements including an employer reference where applicable and the writing of the registration exam. Employers are encouraged to provide comprehensive orientation and mentoring for those on the temporary register and may place limits on the independent performance of restricted activities until all registration requirements have been met. Those on the temporary register should not be placed in charge or left alone on a unit unless they have the necessary experience and competencies.

The restricted activities that CARNA regulated members are authorized to perform under the Registered Nurses Profession Regulation are identified in Section 15 of that regulation. They are as follows:

15(1)(a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue below the dermis or the mucous membrane;

(b) to insert or remove instruments, devices, fingers or hands
   (i) beyond the cartilaginous portion of the ear canal,
   (ii) beyond the point in the nasal passages where they normally narrow,
   (iii) beyond the pharynx,
   (iv) beyond the opening of the urethra,
   (v) beyond the labia majora,
   (vi) beyond the anal verge, or
   (vii) into an artificial opening into the body;

(c) to insert into the ear canal under pressure, liquid, air or gas;

(d) to reduce a dislocation of a joint except for a partial dislocation of the joints of the fingers and toes;

(e) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmaceutical Profession Act;

(f) to administer a vaccine or parenteral nutrition;

(g) to compound or administer blood or blood products;

(h) to administer diagnostic imaging contrast agents;

(i) to administer radiopharmaceuticals, radiolabelled substances, radioactive gases or radioaerosols;

(j) to prescribe or administer nitrous oxide, for the purposes of anaesthesia or sedation;

(k) to perform a psychosocial intervention with an expectation of treating a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
   (i) judgment,
   (ii) behaviour,
   (iii) capacity to recognize reality, or
   (iv) ability to meet the ordinary demands of life;

(l) to manage labour or deliver a baby.
15(2) Despite subsection (1)(e), a regulated member on any register performing the restricted activity described in that subsection shall not distribute, trade or barter for money or valuable consideration, or keep for sale or offer for sale a Schedule 1 drug or a Schedule 2 drug within the meaning of the *Pharmaceutical Profession Act* but may distribute or give away a Schedule 1 drug or a Schedule 2 drug without expectation or hope of compensation or reward.

15(3) A regulated member registered on the registered nurse register or on the certified graduate nurse register may, within the practice of registered nursing, perform the restricted activity of ordering or applying non-ionizing radiation in the application of ultrasound imaging.

15(4) Despite subsection (3), regulated members on the registered nurse register or on the certified graduate nurse register are authorized to apply ultrasound to a fetus only under the supervision of a person who provides health services and is authorized by a regulation under this Act or by another enactment to apply ultrasound to a fetus.

Nurse practitioners may perform all the restricted activities that registered nurses may perform. In addition they may perform the following restricted activities:

15(5)(a) to prescribe a Schedule 1 drug within the meaning of the *Pharmaceutical Profession Act*;

(b) to prescribe parenteral nutrition;

(c) to prescribe blood products;

(d) to order and apply any form of ionizing radiation in medical radiography;

(e) to order any form of ionizing radiation in nuclear medicine;

(f) to order non-ionizing radiation in magnetic resonance imaging;

(g) to order or apply non-ionizing radiation in ultrasound imaging, including any application of ultrasound to a fetus;

(h) to prescribe diagnostic imaging contrast agents;

(i) to prescribe radiopharmaceuticals, radiolabelled substances, radioactive gases and radioaerosols.

**STANDARDS FOR THE PERFORMANCE OF RESTRICTED ACTIVITIES**

Registered nurses in Alberta practise under a legislated definition of nursing which is consistent with the practice of nursing as outlined in Schedule 24 of HPA and CARNA documents, such as *Scope of Practice for Registered Nurses, Entry-to-Practice Competencies (2005)*, and *Nursing Practice Standards (2003)*. The *Scope of Practice* statement identifies that:

- The practice of nursing focuses on human beings and their needs for nursing care.
- The goal of nursing is to assist clients\(^1\) to attain and maintain optimal health, wellness and independence.
- The major objective of nursing is to maximize the ability of clients to meet their health needs.

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\(^1\) The term 'client' can refer to patients, residents, families, groups, communities and populations.
The restricted activities identified in Schedule 7.1 of GOA provide a legal framework for restricted activities but they do not provide a list of specific interventions or tasks that might fall within the definition of the restricted activity.

For example,

15(1)(a) to cut a body tissue, to administer anything by invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue below the dermis or the mucous membrane

can include a range of interventions/tasks from injections to deep wound debridement.

There are many restricted activity interventions such as catheterizations, suctioning or medication administration by injection that are core to practice in certain areas. Other restricted activity interventions such as initiating a PICC line or deep wound debridement may only be done by registered nurses with specialized knowledge and skill in certain practice settings. In other situations the performance of a particular restricted activity may be new to the practice area due to a shift in client needs. For example, in many long-term care units, residents are now being treated in the nursing home for medical conditions rather than being sent to the hospital.

The Nursing Practice Standards apply to overall care and to all regulated members of CARNA in clinical practice, research, education and administration. This document builds on those standards and identifies standards for the performance of restricted activity interventions in clinical practice.

This document also includes guidelines that are to be used to determine if a particular restricted activity intervention not currently performed by RNs in a particular setting should become part of their nursing practice. In order for the regulated member to perform the intervention, it would have to fall within the parameters of a restricted activity authorized by CARNA regulations.

1. STANDARDS FOR THE PERFORMANCE OF RESTRICTED ACTIVITY INTERVENTIONS

Standard One: Responsibility and Accountability

All regulated members of CARNA are responsible and accountable for the performance of restricted activity interventions within their nursing practice in accordance with the definitions outlined in the CARNA Nursing Practice Standards:

- Responsibility: Obligation to fulfill the terms of implied or explicit contractual agreement in accordance with professional and legal nursing standards.
- Accountability: Nurses are answerable for their practice, and they act in a manner consistent with their professional responsibilities and standards of practice.

Standard Two: Knowledge and Skill in the Performance of Restricted Activities

HPA emphasizes the importance of competence in the performance of restricted activities. Knowledge and skill in the performance of restricted activity interventions is more than the safe and competent performance of the intervention. It also includes
assessment, decision-making, and critical judgment in the clinical situation, as well as monitoring of the client response to the intervention.

Section 16 of the regulations for registered nurses under HPA state: “Despite section 15, regulated members must restrict themselves in performing restricted activities to those activities that they are competent to perform and to those that are appropriate to the member’s area of practice and the procedure being performed”.

Standard Three: Practice Setting Policy Support

In an employment situation, a regulated member must perform a restricted activity intervention in accordance with employer policy. Whether or not a registered nurse performs a specific restricted activity will be dependent upon:

- employer policy
- whether or not the restricted activity is appropriate for the practice setting
- registered nurse competence to perform the restricted activity, including completion of any education required to perform the restricted activity in a safe, competent and ethical manner

Job descriptions should address the performance of restricted activities. As an example, a generic job description may indicate that registered nurses can perform any of the restricted activities that are authorized through the registered nurse regulations. On a particular unit or within a program area, there may be specific statements within a job description or in unit/program policy identifying specific nursing interventions/tasks that fall within a restricted activity that are performed in the practice setting.

Those nurses in self-employed practice will be authorized to perform a restricted activity provided:

- the restricted activity is appropriate for the practice setting
- the registered nurse is competent to perform the restricted activity and has the necessary education to perform the restricted activity in a safe, competent manner
- the Registration Committee has approved the self-employed practice or non-traditional practice of the regulated registered nurse member, including the restricted activities to be performed. Self-employed practice is to be reviewed every two years by CARNA.

2. Guidelines for Determining if a Specific Intervention Should Become a Part of Registered Nursing Practice

A number of health professionals may be authorized to perform a specific restricted activity. Factors influencing which health professional will perform the restricted activity intervention in a given situation include:

- authorization by the professional’s regulatory college to perform the restricted activity
- needs of the client
- context of care including the acuity/stability/complexity of the client
- service delivery model
- knowledge and competency of the health-care professional
- availability of health professionals in the practice setting
continuity of care within the setting

The practice of registered nurses, like that of other health-care professionals, is constantly evolving. In the assessment of client care and nursing practice, employers and registered nurses may identify interventions/tasks within a restricted activity authorized for registered nurses that they are not currently performing. Assessment of the clinical situation may indicate that it would be reasonable for a registered nurse to perform that restricted activity intervention. The following guidelines have been identified to provide assistance to administrators, managers and registered nurses in determining if interventions within a restricted activity category should be incorporated as a part of registered nurses’ practice in that particular practice setting.

1: Assessment of Client Need, Intent and Purpose of the Restricted Activity Intervention

The determination of whether or not a registered nurse performs a specific intervention/task within a restricted activity category must be mutually agreed upon between registered nurses and other health-care professionals in the practice setting. The determination should be supported by institutional policy, be the same on any shift and driven by the needs of the client, not by the desire for convenience of health-care professionals. For example, the registered nurse may be the only available provider in a practice setting during the night shift who has a competency in a particular restricted activity intervention. If the RN is not allowed to perform this intervention on a day shift, they should not be allowed to perform it on nights. Additionally, if the person was not competent to provide the intervention, it does not matter if they are the only available provider – they must not perform the activity.

2: Knowledge and Skill to Perform the Restricted Activity Intervention Safely

The responsibility for attaining and maintaining competence in the restricted activity intervention is held jointly by registered nurses and their employers. One of the important factors to consider when decisions are made as to whether or not a particular restricted activity intervention should become a part of nursing practice is the opportunity to maintain competence.

The RN is expected to:
- identify his/her own learning needs with respect to the restricted activity intervention
- practise only within his/her areas of competence, and
- utilize available educational resources to attain and maintain competency in the activity

Employers have the responsibility to:
- provide orientation and staff development programs based on identified learning needs related to the goals of the organization, and
- ensure the provision of the necessary resources for RNs to attain and maintain competency in the restricted activity interventions required by the needs of clients in the practice setting
Registered nurses and employers share responsibility for collaborating on the ongoing evaluation of the need for and the performance of all interventions, including the competence of the practitioners involved. Employers will need to strive for consistent methods to evaluate RN competence.

3: Identification and Establishment of Policies and Procedures to Facilitate Safe and Competent Performance of the Activity

The development and implementation of evidence-based policies and procedures is critical to support safe and competent performance of restricted activity interventions. As part of this process there must be mutual agreement by the professionals involved in the practice setting that this intervention will become a part of nursing practice.

In any practice setting, registered nurses have both the right and the professional obligation to question policies and procedures inconsistent with therapeutic client outcomes, current practices and safety standards. Accordingly, where the performance of a particular restricted activity intervention in a specific practice setting is not consistent with therapeutic client outcomes, current practices and/or safety standards, registered nurses have the professional responsibility to refuse the acceptance of such a restricted activity intervention, and to communicate their concern to the employer. Employers have the responsibility to address the concerns outlined with respect to the proposed restricted activity intervention. In such instances, the particular restricted activity intervention should only be incorporated as a part of registered nursing practice when all concerns of the parties affected have been satisfactorily addressed.

RESTRICTED ACTIVITIES: SPECIFIC CLINICAL EXAMPLES

Under HPA it is recognized that health professionals have overlapping scopes of practice. Several professional groups will have authority to perform the same restricted activity. The context of the practice situation will determine the extent to which a health professional will practice within the full scope of a restricted activity. The following clinical situations are discussed in order to provide guidance for registered nurses and their employers. All examples provided are subject to the standards and guidelines on the previous pages.

Dispense, Sell, Compound

The CARNA regulations state that CARNA regulated members will be given authority to:

15(1)(e) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmaceutical Profession Act.

Schedule 7.1 of GOA defines dispense as:

1(c) 'dispense' means
(i) with respect to drugs, to provide a drug pursuant to a prescription for a person, but does not include the administration of a drug to a person;
and sell as:

1 (h) ‘sell’ includes
   (i) distribute, trade or barter for money or other valuable consideration,
   (ii) distributing and giving away without expectation or hope of compensation or reward,
   (iii) keeping for sale, and
   (iv) offering for sale.

Section 15(2) of the CARNA regulations places limits on the interpretation of ‘sell’ based on the above definition.

15(2) Despite subsection (1)(e), a regulated member on any register performing the restricted activity described in that subsection shall not distribute, trade or barter for money or valuable consideration, or keep for sale or offer for sale a Schedule 1 drug or a Schedule 2 drug within the meaning of the *Pharmaceutical Profession Act* but may distribute or give away a Schedule 1 drug or a Schedule 2 drug without expectation or hope of compensation or reward.

The authority to perform the restricted activity of dispensing and selling does not mean that registered nurses will now be able to dispense or sell medications in the same manner as would pharmacists. It will, however, provide flexibility to meet client needs where a pharmacist is unavailable. Situations where this authority might be needed include, but are not limited to:

- provision of partial doses of a medication or a full prescription in a small rural emergency or where a pharmacy is not available
- providing birth control pills or the “morning after” pill in a family planning clinic
- providing medication for a client who is leaving a health-care facility on a pass for a limited time period when a pharmacist is not available to do so
- providing medications or a full prescription to treat sexually transmitted infections according to protocols in a STD clinic

In applying the standards outlined in this document the following must be considered:

- Is there a pharmacist available?
- If there is no pharmacist, is this medication or practice necessary to meet the needs of clients or vulnerable populations?
- Do the regulated members have the knowledge and skill to appropriately dispense the medication?

In dispensing a medication there are 6 major issues to consider.

1. appropriateness of the prescription
2. dispensing procedures to ensure the integrity of the drug distribution system
3. labeling the drug correctly
4. documentation of the dispensing
5. client education
6. storage of the drugs

The Alberta College of Pharmacists has developed Standards of Practice for dispensing. They are available from the college and are on their website under the “Practice
Reference Library” tab (www.pharmacists.ab.ca). In any setting where RNs will be dispensing medications, the Standards of Practice developed by the Alberta College of Pharmacists are to be followed. The Alberta College of Pharmacists or a pharmacist must be involved in establishing the infrastructure, policies and procedures in those specific situations where it is appropriate for RNs to dispense medications. This will assist in ensuring the integrity of the drug distribution system, client safety and quality control.

The definition of compound in the GOA is as follows:

1(b) “compound” means to mix together 2 or more ingredients of which at least one is a drug for the purposes of dispensing a drug or drugs.

There are instances in nursing practice where regulated members of CARNA might engage in compounding where two ingredients are mixed, one of which is a drug for the purposes of dispensing. Examples include:

- mixing lidocaine and Maalox for a client to take home for relief of pain
- crushing tablets for pediatric clients and mixing them with strawberry syrup for administration at home
- mixing two types of insulin and leaving the syringes with the client for self-administration

In each of these examples, the regulated member of CARNA is mixing two drugs and giving it to the client for the purposes of self-administration by the client at a later time. The regulated member is mixing commercially available products. A commercially available product is defined by pharmacists as:

A pharmaceutical product authorized for use in Canada by the Health Protection Branch of Health and Welfare Canada, and having received a Notice of compliance, has been assigned a Drug Identification Number (DIN) and marketed in Canada. (Canadian Society of Hospital Pharmacists, 2001)

The mixing of pharmaceutical products of all dosage forms, oral liquid or solid, parenteral and topical often affects the storage requirements, stability and, thus, the efficacy of the product. Consultation with a pharmacist and/or published references is encouraged if the nurse has not prepared the compound in the past and is required for any compounds that will be stored beyond 24 hours.

Reducing Dislocation of Joints

CARNA regulations provide authority for regulated members to:

15(1)(d) to reduce a dislocation of a joint except for a partial dislocation of the joints of the fingers and toes.

When policies were being formulated to guide HPA regulation development, focus groups were held to discuss which restricted activities were being performed by registered nurses. Focus group discussions indicated that in many rural facilities RNs were reducing dislocated shoulders in certain situations before a physician was involved. The intent of this authorization is to allow that practice to continue. It should be noted that partial reduction of dislocation of the joints of the fingers and toes is not a restricted activity.
Application of the standards requires:
1. policy development to support the practice and identify parameters and limitations
2. education of RNs in performing this restricted activity intervention
3. quality assurance mechanisms to evaluate and support safe, competent practice

**Cutting Body Tissue, Performing Surgical or Other Invasive Procedures**

Carna regulations authorize regulated members to:

15(1)(a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue below the dermis or the mucous membrane.

This is a very broad restricted activity that could include a wide range of interventions. It is not intended to allow registered nurses to perform surgery, but is intended to allow for a variety of restricted activity interventions, such as injections, deep wound debridement, medicated tube feedings and establishing a PICC line, provided the standards for the performance outlined in this document are followed and applied appropriately.

**Nitrous Oxide**

In the Carna regulations regulated members are authorized to:

15(1)(j) to prescribe or administer nitrous oxide, for the purposes of anaesthesia or sedation.

Nitrous oxide is often used by clients in an obstetrical unit. The intent of this authorization is to support RNs in that practice. Any other use of nitrous oxide would have to follow and apply the standards and guidelines outlined in this document very carefully.

Application of the standards requires:
1. policy development to support the practice and identify parameters and limitations
2. education of RNs in performing this restricted activity intervention
3. quality assurance mechanisms to evaluate and support safe, competent practice

**Exceptions to Restricted Activities**

Section 2 of Schedule 7.1 of GOA identifies the following as **not being** restricted activities:

(a) activities of daily living, whether performed by the individual or by a surrogate on the individual’s behalf
(b) giving information and providing advice with the intent of enhancing personal development, providing emotional support or promoting spiritual growth of individuals, couples, families and groups, and
(c) drawing venous blood

In addition, Schedule 7.1 identifies those situations in which a health-care aide might perform a restricted activity or an activity of daily living. Carna, in partnership with the College of Licensed Practical Nurses of Alberta (CLPNA) and the College of Registered Psychiatric Nurses of Alberta (CRPNA), has developed the document 10
Decision-Making Standards for Nurses in the Supervision of Health-Care Aides: Restricted Activities and Activities of Daily Living (2003) to provide guidance for regulated members who work with health-care aides.

Students in a nursing education program leading to initial entry-to-practice as a registered nurse, are not regulated members of CARNA. The performance of restricted activities by these students in a clinical practicum or employment situation is discussed in the CARNA document Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care (2005).

CONCLUSION

The introduction of a regulatory framework for restricted activities will have many implications for staff, managers, educators and researchers. Policies and procedures will be required to address the performance of restricted activities by a number of health-care providers. Practice settings will need to determine who will provide which restricted activity interventions within the context of the situation and in the best interest of the client.

Interdisciplinary coordination and collaboration will be a critical element in organizing the delivery of care. The CARNA document Guidelines for Assignment of Client Care and Staffing Decisions (2005) provides further guidance in matching the right provider to the right care and ensuring safe staffing decisions. CARNA policy and practice consultants are available to assist regulated members and their managers and employers in the implementation of the restricted activities framework.
REFERENCES


Canadian Society of Hospital Pharmacists.


APPENDIX A

Health Professions Act
Schedule 24
Profession of Registered Nurses

Practice

3 In their practice, registered nurses do one or more of the following:
   (a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to
      (i) assist individuals, families, groups and communities to achieve their optimal physical, emotional, mental and spiritual health and well-being,
      (ii) assess, diagnose and provide treatment and interventions and make referrals,
      (iii) prevent or treat injury and illness,
      (iv) teach, counsel and advocate to enhance health and well-being,
      (v) co-ordinate, supervise, monitor and evaluate the provision of health services,
      (vi) teach nursing theory and practice,
      (vii) manage, administer and allocate resources related to health services, and
      (viii) engage in research related to health and the practice of nursing,
   and
   (b) provide restricted activities authorized by the regulations.
APPENDIX B

Government Organization Act
Schedule 7.1
Health Services Restricted Activities

Definitions

1 In this Schedule,

(a) “activity of daily living” means an activity that individuals normally perform on their own behalf to maintain their health and well-being, and includes

(i) routine and invasive self-care activities, including but not restricted to the removal of slivers and the cleaning of wounds, and

(ii) specifically taught procedures, which generally result in predictable and stable responses, including but not restricted to catheterization, maintenance of drainage tubes and administration of drugs by injection;

(a.1) “administration of a drug” means the supplying of a dose of a drug to a person for the purpose of immediate ingestion, application, inhalation, insertion, instillation or injection;

(b) “compound” means to mix together 2 or more ingredients of which at least one is a drug for the purposes of dispensing a drug or drugs, but does not include reconstituting a drug or drugs with only water;

(c) “dispense” means

(i) with respect to drugs, to provide a drug pursuant to a prescription for a person, but does not include the administration of a drug to a person;

(ii) with respect to corrective lenses, to verify corrective lenses objectively to the prescription;

(d) “drug” means drug as defined in the Pharmaceutical Profession Act;

(e) “health service” means a service provided to people

(i) to protect, promote or maintain their health,

(ii) to prevent illness,

(iii) to diagnose, treat or rehabilitate them, or

(iv) to take care of the health needs of the ill, disabled, injured or dying;

(f) “Minister” means the Minister responsible for the Health Professions Act;

(g) “restricted activity” means an activity named as a restricted activity in section 2;

(h) “sell” includes

(i) distribute, trade or barter for money or other valuable consideration,
(ii) distributing and giving away without expectation or hope of compensation or reward,

(iii) keeping for sale, and

(iv) offering for sale;

(i) "surrogate" means a person authorized by an individual or by the individual's guardian, if the guardian is authorized to give such authorization, to assist the individual in carrying on an activity of daily living.

Restricted activities

2(1) The following, carried out in relation to or as part of providing a health service, are restricted activities:

(a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue
   (i) below the dermis or the mucous membrane or in or below the surface of the cornea;
   (ii) in or below the surface of teeth, including scaling of teeth;
(b) to insert or remove instruments, devices, fingers or hands
   (i) beyond the cartilaginous portion of the ear canal,
   (ii) beyond the point in the nasal passages where they normally narrow,
   (iii) beyond the pharynx,
   (iv) beyond the opening of the urethra,
   (v) beyond the labia majora,
   (vi) beyond the anal verge, or
   (vii) into an artificial opening into the body;
(b.1) to insert into the ear canal
   (i) under pressure, liquid, air or gas;
   (ii) a substance that subsequently solidifies;
(c) to set or reset a fracture of a bone;
(d) to reduce a dislocation of a joint except for a partial dislocation of the joints of the fingers and toes;
(e) to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;
(f) to prescribe a Schedule 1 drug within the meaning of the Pharmaceutical Profession Act;
(g) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmaceutical Profession Act;
(h) to administer a vaccine or parenteral nutrition;
(i) to prescribe, compound or administer blood or blood products;
(j) to prescribe or administer diagnostic imaging contrast agents;
(k) to prescribe or administer anesthetic gases, including nitrous oxide, for the purposes of anesthesia or sedation;
(l) to prescribe or administer radiopharmaceuticals, radiolabelled substances, radioactive gases or radioaerosols;
(m) to order or apply any form of ionizing radiation in
   (i) medical radiography,
   (ii) nuclear medicine, or
   (iii) radiation therapy;
(n) to order or apply non-ionizing radiation in
   (i) lithotripsy,
   (ii) magnetic resonance imaging, or
   (iii) ultrasound imaging, including any application of ultrasound to a fetus;
(o) to prescribe or fit
   (i) an orthodontic or periodontal appliance,
   (ii) a fixed or removable partial or complete denture, or
   (iii) an implant supported prosthesis;
(p) to perform a psychosocial intervention with an expectation of treating a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
   (i) judgment,
   (ii) behaviour,
   (iii) capacity to recognize reality, or
   (iv) ability to meet the ordinary demands of life;
(q) to manage labour or deliver a baby;
(r) to prescribe or dispense corrective lenses.

(2) Despite subsection (1), the following are not restricted activities:

(a) activities of daily living, whether performed by the individual or by a surrogate on the individual’s behalf;
(b) giving information and providing advice with the intent of enhancing personal development, providing emotional support or promoting spiritual growth of individuals, couples, families and groups, and
(c) drawing venous blood.
Regulations

3 On consulting with the Health Professions Advisory Board under the Health Professions Act, the Minister may make regulations authorizing a person or a category of persons other than a regulated member or category of regulated members under the Health Professions Act, to perform one or more restricted activities subject to any conditions included in the regulations.

Offence

4(1) No person shall perform a restricted activity or a portion of it on or for another person unless

(a) the person performing it

(i) is a regulated member as defined in the Health Professions Act, and is authorized to perform it by the regulations under the Health Professions Act,

(ii) is authorized to perform it by a regulation under section 3, or

(iii) is authorized to perform it by another enactment,

or

(b) the person performing it

(i) has the consent of, and is being supervised by, a regulated member described in clause (a)(i), and

(ii) is permitted to perform the restricted activity under a regulation made under section 131(1)(d)(i) of the Health Professions Act by the council of the college of the regulated member referred to in subclause (i), and there are regulations made under section 131(1)(d)(ii) of the Health Professions Act by the council of the college of that regulated member respecting how regulated members must supervise persons who provide restricted activities under this clause.

(2) Despite subsection (1), if no person who is authorized under subsection (1) is available to perform the restricted activity or a portion of it, a person may without expectation or hope of compensation or reward provide a restricted activity or a portion of it to provide physical comfort to or to stabilize another person who is ill, injured or unconscious as a result of an accident or other emergency.

(3) No person, other than a person authorized to perform a restricted activity under subsection (1)(a), shall or shall purport to consent to, provide supervision of and control of, another person performing the restricted activity or a portion of a restricted activity.

(4) No person shall require another person to perform a restricted activity or a portion of a restricted activity if that other person is not authorized in accordance with subsection (1) to perform it.

Penalty

5 A person who contravenes section 4 is guilty of an offence and liable

(a) for a first offence, to a fine of not more than $5000,

(b) for a 2nd offence, to a fine of not more than $10 000, and
(c) for a 3rd and every subsequent offence, to a fine of not more than $25,000 or to imprisonment for a term of not more than 6 months or to both fine and imprisonment.

Burden of proof
6 In a prosecution under this Schedule, the burden of proving that a person was authorized to perform a restricted activity by section 4(1) is on the accused.

Injunction
7 The Court of Queen's Bench, on application by a person authorized by the Minister by way of originating notice, may grant an injunction enjoining any person from doing any act that contravenes section 4 despite any penalty that may be provided by section 5 in respect of that contravention.

RSA 2000 cH-7 s137; 2001 c21 s25; 2005 c13 s2
8 (1) A registrant in the course of practising nursing may

(a) make a nursing diagnosis identifying a condition as the cause of the signs or symptoms of the individual,

(b) for the purpose of wound care, perform a procedure on tissue below the dermis or below the surface of a mucous membrane,

(c) for the purposes of collecting a blood sample or donation, perform venipuncture,

(d) for the purposes of establishing intravenous access, maintaining patency or managing hypovolemia,

   (i) perform venipuncture, or

   (ii) administer a solution by instillation through a parenteral method,

(e) administer

   (i) oxygen or humidified air by inhalation, or

   (ii) nutrition by instillation through an enteral method,

(f) for the purposes of assessing an individual or ameliorating or resolving a condition identified through the making of a nursing diagnosis, administer a solution

   (i) by irrigation, or

   (ii) by instillation through an enteral method,

(g) for the purposes of assessing an individual or ameliorating or resolving a condition identified through the making of a nursing diagnosis, put an instrument or a device, hand or finger

   (i) into the external ear canal, up to the eardrum,

   (ii) beyond the point in the nasal passages where they normally narrow,

   (iii) beyond the pharynx,

   (iv) beyond the opening of the urethra,

   (v) beyond the labia majora,

   (vi) beyond the anal verge, or

   (vii) into an artificial opening into the body,

(h) for the purposes of assessing an individual or ameliorating or resolving a condition identified through the making of a nursing diagnosis, put into the external ear canal, up to the eardrum,
(i) air that is under pressure created by the use of an otoscope, or
(ii) water that is under pressure created by the use of an ear bulb syringe,

(i) apply ultrasound for the purposes of bladder volume measurement, blood flow monitoring or fetal heart monitoring,

(j) apply electricity using an automatic external defibrillator,

(k) compound, dispense or administer by any method a drug specified in Schedule II of the Drug Schedules Regulation, B.C. Reg. 9/98, or

(l) dispense or administer the following drugs specified in Schedule I of the Drug Schedules Regulation, B.C. Reg. 9/98:

(i) epinephrine, for the purpose of treating anaphylaxis;

(ii) dextrose in concentrated solutions for parenteral nutrition, for the purpose of treating hypoglycemia.
Reserved actions for services under an order

9 (1) A registrant in the course of practising nursing may

(a) perform a procedure on tissue below the dermis, below the surface of a mucous membrane or in or below the surface of the cornea,

(b) administer a substance, other than a drug that is specified in a Schedule of the Drug Schedules Regulation, B.C. Reg. 9/98,

(i) by injection,

(ii) by inhalation,

(iii) by mechanical ventilation,

(iv) by irrigation, or

(v) by instillation through an enteral or parenteral method,

(c) put an instrument or a device, hand or finger

(i) into the external ear canal, up to the eardrum,

(ii) beyond the point in the nasal passages where they normally narrow,

(iii) beyond the pharynx,
(iv) beyond the opening of the urethra,
(v) beyond the labia majora,
(vi) beyond the anal verge, or
(vii) into an artificial opening into the body,

(d) put into the external ear canal, up to the ear drum, a substance that is under pressure,
(e) apply electricity for the purposes of
   (i) cardioversion, including defibrillation,
   (ii) adjusting a pacemaker,
   (iii) adjusting or setting implanted cardiac devices, or
   (iv) electro-cauterization,
(f) compound, dispense or administer by any method a drug specified in Schedule I or IA of the Drug Schedules Regulation, B.C. Reg. 9/98,
(g) design or compound a therapeutic diet if nutrition is administered through an enteral method,
(h) conduct allergy challenge testing or allergy desensitizing treatment that involves injection, scratch tests or inhalation,
(i) conduct allergy challenge testing by any method if the individual being tested has had a previous anaphylactic reaction, or
(j) conduct a cardiac stress test for the purposes of diagnosis and treatment planning.

(2) The following limits or conditions apply to the provision or performance by a registrant of a service that includes the provision or performance of an activity described in subsection (1):

(a) the registrant must not provide or perform the service except for the purpose of complying with an order;
(b) before the provision or performance of the service,
   (i) the health professional who gives the order must be authorized under an enactment to provide or perform the service, and
   (ii) the registrant must be authorized under the Act, the regulations and the bylaws to provide or perform the service.
Reserved actions for certified practices

10 (1) A registrant in the course of practising nursing may
(a) provide or perform an activity described in section 9 (1), except compound, dispense or administer a drug specified in Schedule 1A of the Drug Schedules Regulation, B.C. Reg. 9/98,

(b) make a diagnosis identifying a disease, disorder or condition as the cause of the signs or symptoms of the individual,

(c) manage normal labour in an institutional setting if the primary maternal care provider is absent or unavailable, or

(d) give an order to apply X-ray for diagnostic or imaging purposes, except X-ray for computerized axial tomography.

(3) It is a limit or condition on the provision or performance by a registrant of a service that includes the provision or performance of an activity described in subsection (1) that, before providing or performing the service, the registrant has successfully completed a certification program established or approved by or under the bylaws to ensure registrants are qualified and competent to provide or perform that service in the practice setting in which it is to be provided or performed by the registrant.
Scope of Practice for Nurse Practitioners (Family)

Standards, Limits and Conditions
CRNBC Standards of Practice

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

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

**Professional Standards**

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

**Practice Standards**

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

**Scope of Practice Standards**

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

All CRNBC Standards are available online at www.crnbc.ca

**WHERE TO GET ASSISTANCE**

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

Nurse practitioners are registered nurses who have achieved additional competencies required for registration as a nurse practitioner with the College of Registered Nurses of British Columbia (CRNBC). Their scope of practice includes providing health care services from a holistic nursing perspective combined with a focus on diagnosing and treating acute and chronic illnesses, including prescribing medications.

Nurse practitioners are required to practise in accordance with CRNBC’s Standards of Practice (Professional Standards, Practice Standards, and Scope of Practice Standards). Nurse practitioners must meet requirements for ongoing registration, including continuing competence requirements and a quality assurance practice review. The principles for nurse practitioner continuing competence requirements and quality assurance program and the Continuing Competence Requirements for Nurse Practitioners in British Columbia can be found online at www.crnbc.ca under Registration (applying for nurse practitioner).

The legal authority for the nurse practitioner scope of practice is set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act (see the B.C. Ministry of Health website www.healthservices.gov.bc.ca). Nurse practitioners must be familiar with both the registered nurse and nurse practitioner scope to understand their scope of practice. Reserved title as it applies to nurse practitioner is also addressed in the Regulation. See Appendix A for further information on the Regulation as it pertains to nurse practitioners.

The Regulation assigns reserved actions to nurse practitioners for activities such as: making a diagnosis to identify a disease, disorder or condition; ordering diagnostic services; and prescribing and dispensing drugs. As specified in the Regulation, these activities are provided in accordance with standards, limits and conditions established by CRNBC.

This document includes the standards with limits and conditions specific to the scope of nurse practitioner (family) practice for: diagnosing (including ordering diagnostic services and providing or performing treatments and interventions); prescribing and dispensing medications; and physician consultation and referral.

From time to time, this document may be revised to reflect changes to the limits and conditions, in particular to ordering diagnostic services and prescribing drugs. Please check the CRNBC website (www.crnbc.ca) regularly for updates.

Section A: Diagnosing and Health Care Management

PART I - STANDARDS

Nurse practitioners (family) are expected to be competent to meet standards and practice expectations for diagnosing and health care management of clients as a requirement for practice in British Columbia (B.C.).

Nurse practitioner practice is not focused solely on diagnosing and managing diseases, disorders and conditions. As primary health care providers, nurse practitioners emphasize health promotion and disease and injury prevention. This comprises activities in all three levels of primary, secondary and tertiary prevention. Activities might include:

- promoting healthy living through assessing for developmental milestones or implementing interventions, such as health education, nutrition and exercise counselling, marriage and family counselling, and sex education;
- preventing disease through interventions, such as immunizations, promoting protection from occupational and environmental hazards, accidents and carcinogens or educating high risk groups about substance abuse; and
- facilitating early diagnosis and treatment through screening for diseases and disorders, such as various cancers (e.g., breast, cervical, colorectal, prostate), diabetes, hypertension, HIV, osteoporosis, and elevated cholesterol or by prompt identification and treatment of infectious disease.

Nurse practitioners (family) undertake developmental screening and surveillance of children for early identification of developmental delays and referral as indicated. As primary health care providers, they work collaboratively with their local communities, other members of the health care team and health authorities to ensure essential health care for their clients.

Nurse practitioners diagnose and manage the care and treatment of clients who present with common acute and chronic physical and mental diseases, disorders and conditions. They are prepared to recognize and/or screen for a number of diseases, disorders and conditions, such as iritis or pericarditis that may be included in their differential diagnosis, but which are beyond their competence and scope of practice. When suspected as the primary diagnosis, such diseases, disorders and conditions are immediately referred to a physician or transferred to emergency medicine as appropriate.

When a nurse practitioner (family) has patients in her or his primary care practice who have a disease or disorder that is being managed by a physician (e.g., patients with cancer, AIDS), the nurse practitioner is expected to be competent to monitor the condition of these patients and refer them to their physicians should a need arise.

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2 Primary Health Care: Essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost the community and country can afford. Essential health care includes health promotion, disease and injury prevention, curative care, rehabilitation and supportive care, including palliative care.
Scope of Practice

FOR NURSE PRACTITIONERS (FAMILY) STANDARDS, LIMITS AND CONDITIONS

Standards

STANDARD 1
Nurse practitioners diagnose and manage diseases, disorders and conditions within the limits of the nurse practitioner’s legislated scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult or pediatric).

STANDARD 2
Nurse practitioners have an ethical obligation to be available to provide care for their established patients on a 24-hour basis either personally or through ongoing call schedules. Nurse practitioner call schedules are made at the level of the practice setting. When a nurse practitioner signs off to an alternative provider, there must be mutual agreement and willingness on the part of the alternative provider as to when and how the provider will assume the responsibility for the patient’s care.

STANDARD 3
Nurse practitioners refer patients to a physician at any point in time as deemed necessary in accordance with CRNBC’s standards for nurse practitioner - physician consultation.

STANDARD 3
Entry-level nurse practitioners have the competence to diagnose and manage common acute and chronic physical and mental diseases, disorders and conditions and meet expectations as outlined on pages 7-12:

<table>
<thead>
<tr>
<th>Code:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>The nurse practitioner diagnoses and manages independently or refers as appropriate. Will refer to physician at any point as deemed necessary or at some stage as per accepted guidelines. Referrals are in accordance with CRNBC’s standards for nurse practitioner - physician consultation (see Section C).</td>
</tr>
<tr>
<td>C</td>
<td>The nurse practitioner establishes or strongly suspects the diagnosis and consults with a physician for the management plan or consults with a physician to confirm the diagnosis, and as a result of the consultation: i) the nurse practitioner receives an opinion and recommendation, and assumes ongoing primary responsibility and authority for the plan of care; ii) the physician assumes concurrent responsibility for some aspects of the plan of care; or iii) the care is transferred to the physician or emergency medicine as appropriate.</td>
</tr>
</tbody>
</table>
Common Diseases and Disorders Diagnosed and Managed by the Entry-Level Family Nurse Practitioner

1. **Common Neurological Diseases/Disorders**
   - D Headaches – primary headaches without structural or systemic pathology
   - D Simple febrile seizure disorder in children
   - D Bell’s palsy (with any eye symptoms refer immediately to ophthalmologist)
   - D Tremors – benign (essential tremors)
   - D Herpes zoster (with ophthalmic herpetic lesion refer immediately to ophthalmologist)
   - D Peripheral neuropathies
   - D Restless leg syndrome in adults
   - C Alzheimer’s disease and related dementias
   - C Chronic seizure disorders in adults
   - C Parkinson’s disease
   - C Multiple sclerosis
   - C Cerebral vascular disorder
   - C Trigeminal neuralgia
   - C Meningitis
   - C Delirium

2. **Common Dermatologic Diseases/Disorders**
   - D Parasitic – scabies and pediculosis
   - D Fungal – candidiasis, dermatophytooses (tinea and onychomycosis)
   - D Bacterial – impetigo, folliculitis, furuncles and carbuncles
   - D Viral – warts and herpes simplex
   - D Acne vulgaris
   - D Dermatitis – atopic (eczema), contact and seborrheic
   - D Lyme disease
   - D Psoriasis in adults
   - D Pityriasis rosea
   - D Sunburn
   - D Pigmented nevi
   - D Bacterial – cellulitis
   - D Non-malignant skin lesions
   - C Malignant skin lesions
3. Common Disorders and Diseases of the Eyes, Ears, Nose and Throat

**Eyes**
- D Blepharitis
- D Chalazion
- D Hordeolum
- D Simple foreign body
- D Simple corneal abrasion
- D Nasal lacrimal duct obstruction
- D Conjunctivitis
- C Cataracts
- C Glaucoma

**Ears**
- D Cerumen impaction
- D Otitis externa
- D Labyrinthitis
- D Otitis media
- D Foreign body
- D Ménière's disease in adults
- D Benign positional paroxysmal vertigo

**Nose and Throat**
- D Rhinitis
- D Cervical adenitis
- D Anterior epistaxis
- D Sinusitis
- D Pharyngitis
- D Stomatitis and glossitis
- D Temporomandibular joint disease
- D Gingivitis
- D Tonsillitis

4. Common Diseases and Disorders of the Respiratory Tract

- D Asthma
- D Bronchiolitis over 6 months
- D Bronchitis acute/chronic
- D Croup
- D Influenza
- D Community acquired pneumonia
- D Pertussis
- D Smoking addiction/cessation
- D Upper respiratory infection
- C Epiglotitis
- C Tuberculosis
- C Chronic obstructive pulmonary disease
- C Interstitial lung disease
5. **Common Diseases/Disorders of the Cardiovascular System**
   - D Hyperlipidemia in adults
   - D Stasis ulcers in adults
   - D Varicose veins in adults
   - D Chronic heart failure in adults
   - D Hypertension in adults
   - D Superficial thrombophlebitis in adults
   - D Peripheral vascular disease in adults
   - D Chronic stable angina pectoris in adults
   - C Mitral valve prolapse in adults
   - C Arrhythmias in adults
   - C Coronary artery disease in adults
   - C Hyperlipidemia in children

6. **Common Diseases/Disorders of the Gastrointestinal System**
   - D Anal fissures
   - D Colic
   - D Constipation
   - D Diarrhea or vomiting
   - D Gastroenteritis
   - D Hemorrhoids in adults
   - D Irritable bowel syndrome
   - D Parasitic/bacterial infections
   - D Hepatitis A (viral) in adults
   - D Diverticular disease in adults
   - D Dysphagia in adults
   - D Encopresis
   - D Gastro-reflux disease (GERD) in adults
   - D Hyperbilirubinemia
   - D Peptic ulcer in adults
   - C Cholecystitis in adults
   - C Hernia
   - C Chronic inflammatory bowel disease in adults (ulcerative colitis and Crohn's)
   - C Pancreatitis (chronic) in adults
7. Common Diseases / Disorders of the Renal and Genitourinary Systems
   - Lower urinary tract infections
   - Primary nocturnal enuresis
   - Interstitial cystitis
   - Nephrolithiasis (renal calculi)
   - Pyelonephritis in adults
   - Urinary incontinence in adults
   - Renal failure in adults

8. Common Diseases / Disorders of the Reproductive System
   **Male**
   - Balanitis
   - Epididymitis in adults
   - Sexually transmitted diseases
   - Benign prostatic hyperplasia in adults
   - Epididymitis in children after puberty
   - Impotence/erectile dysfunction in adults
   - Phimosis
   - Prostatitis in adults
   - Hydrocele in adults
   - Varicocele

   **Female**
   - Dysmenorrhea
   - Family planning and contraception
   - Mastitis
   - Menopause
   - Premenstrual syndrome
   - Vulvovaginal infections (including vaginitis in infants and toddlers as well as all other age groups and sexually transmitted diseases)
   - Pelvic inflammatory disease
   - Ovarian cyst
   - Primary amenorrhea
   - Polycystic ovary syndrome
   - Endometriosis

9. Common Pre and Post Natal Disorders / Conditions
   - Gestational hypertension
   - Post partum depression
   - Hyperemesis gravidarum
   - Gestational diabetes
10. Common Diseases and Disorders of the Musculoskeletal System

D Bursitis
D Cervical muscle strain and spasm
D Costochondritis
D Fibromyalgia in adults
D Joint pain/injury (sprains, strains, and pain)
D Osteoarthritis in adults
D Plantar fasciitis
D Tendinitis/tenosynovitis
D Carpal tunnel syndrome in adults
D Impingement syndromes
D Osteoporosis in adults
D Paget’s disease in adults
D Repetitive motion syndrome
D Subluxation of the radial head (nursemaid’s elbow)
C Herniated disc
C Meniscal and ligament tears

11. Common Diseases/Disorders of the Endocrine and Metabolic Systems

D Diabetes type II in adults
D Gout in adults
D Hypothyroidism in adults
D Obesity
C Hyperthyroidism in adults
C Cushing’s syndrome in adults
C Diabetes type I in adults

12. Common Hematological and Immune Diseases/Disorders

Hematologic
D Anemia (microcytic)
D Anemia (normocytic) in adults
D Anemia (macrocytic) in adults
C Anemia (sickle cell) in adults

Immune
D Allergic reactions
D Chronic fatigue syndrome in adults
D Infectious mononucleosis in adults
C Rheumatoid arthritis in adults
C Sjögren’s syndrome
C Systemic lupus erythematosus in adults
13. **Common Infectious Diseases in Children**
   - Coxsackie viral infection
   - Fifth disease
   - Roseola
   - Mumps
   - German measles (rubella)
   - Chickenpox
   - Infectious mononucleosis
   - Rubeola

14. **Common Psychiatric Diseases/Disorders and Mental Health/Psychosocial Problems**

   **Psychiatric Diseases**
   - Anxiety disorders (panic attacks, phobias, generalized anxiety disorder, adjustment disorder)
   - Obsessive compulsive disorder in adults
   - Attention deficit disorder in adults
   - Depression in adults
   - Substance abuse and dependence
   - Post traumatic stress disorder in adults

   **Mental Health/Psychosocial Problems**
   - Domestic violence – elder abuse, spousal abuse
   - Sexual assault
   - Child abuse and neglect (mandatory reporting)
   - Grief
   - Insomnia

15. **Common Emergency Problems** (*all within the nurse practitioner's scope and competence depending on the severity. Referral would be indicated when beyond scope and competence*)
   - Wounds and lacerations
   - Burns
   - Animal and human bites
   - Arthropod bites and stings
   - Poisoning
   - Foreign body obstructions
   - Mild/minimal head trauma
   - Fractures (not requiring reduction or casting)
PART II - LIMITS AND CONDITIONS

Limits and conditions apply to health care management of clients with respect to:
- ordering diagnostic services (imaging and laboratory services); and
- providing or performing advanced treatments and interventions.

Ordering Diagnostic Services

LABORATORY SERVICES

Nurse practitioners are authorized to order laboratory and other tests as designated below. Note: When ordering a CAT scan or Holter Monitoring for a client, the nurse practitioner has a professional obligation to first discuss the case with a physician. The test is independently ordered by the nurse practitioner and identification of the physician is not required. A formal consultation is not required unless requested by the physician.

Any laboratory test not found on the list must be ordered by a physician.

Hematology and Blood Bank

ANA
Anti-DNA
Cold agglutinins – qualitative
Hematology profile (to include automated Hgb, WBC, platelet count, Hct, RBC indices and differential white cell count when indicated) (NB: singles may be ordered)
Haemoglobin electrophoresis
Direct and indirect coombs
Latex test (rheumatoid factor)
Infectious mononucleosis

Microbiology

Acid fast organisms – (microbacterial)
C. difficile toxin
Fungal culture

Malaria and other parasites
Partial thromboplastin test
Prothrombin time/INR
RBC morphology
Red cell folate
Reticulocyte count and/or Heinz bodies
Rh(D) typing
Thalassaemia/haemoglobinopathy investigation
Sickle cell identification

Chlamydia (NAT) – urine, (NAT) SWAB, and /or culture
Fungus – direct examination KOH preparation (office)

College of Registered Nurses of British Columbia
Scope of Practice
FOR NURSE PRACTITIONERS (FAMILY)

Blood culture – aerobic and/or anaerobic
Hepatitis A – IgM (Anti-HAV-IgM)
Hepatitis B – core antibody (Anti-HBC), surface antibody (Anti-HBS)
Hepatitis Be Antigen
Hepatitis C (serology)
Polymerase Chain Reaction (PCR)
Routine cultures – routine culture, cervical, vaginal, urethral, sputum, wound, urine and/or nose and/or throat

Smear for inclusion bodies
Genital culture – combined vagino-anorectal or vaginal culture for group B streptococcus only, vaginal smear and culture for bacteria (BV and Trichomonas) and/or other sites

Chemistry
Acid phosphatase – total or fractions
Albumin – serum/plasma
Alcohol
Alanine aminotransferase (ALT)
Alkaline phosphatase
Alpha 1 – antitrypsin
Amylase – serum/plasma
Arsenic
Aspartate aminotransferase (AST)
Bicarbonate – serum/plasma
Bilirubin – direct and/or total
C – reactive protein
Calcium – total, serum/plasma and/or urine random
Carbamazepine

Stool culture
Streptococci – rapid test (office)
Anti-streptolysin “O” titre
Trichomonas and/or candida – direct examination
Examination for pinworm ova
Stool examination – concentration methods; for amoebae
Macroscopic examination of parasite and/or direct microscopic examination
Serological tests – for antigens; for identification of bacterial micro-organisms
Viral culture
CD4/CD8 Counts
Viral Load

Chloride – quantitative - serum/plasma
Sweat test for cystic fibrosis
Cholesterol, total
Cortisol
Creatine kinase (CPK)
Creatinine – random urine and timed urine collection and/or serum/plasma
Digoxin
Drug assay – single and multiple
Drugs of abuse screen – urine
Screening assays
Electrophoresis – protein (quantitative)
Estradiol
Fat, microscopic examination – feces
Ferritin – serum

These HIV monitoring tests are ordered by nurse practitioners working in a model of shared care delivery for HIV patients. Nurse practitioners monitoring patients with HIV do so in accordance with the BC Centre for Excellence HIV/AIDS Care Therapeutic Guidelines. Education courses are available through the BC Centre for Excellence www.cfenet.ubc.ca Note: Nurse practitioners do not prescribe antiretrovirals.
<table>
<thead>
<tr>
<th>Test</th>
<th>Serum/Plasma</th>
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<tbody>
<tr>
<td>Folic acid</td>
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<tr>
<td>Follicle stimulating hormone (FSH)</td>
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<tr>
<td>Glucose - gestational assessment (Random) and 2 hr post 75 g screening for gestation diabetes</td>
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<tr>
<td>Glucose quantitative - serum/plasma (fasting and random)</td>
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<tr>
<td>Glucose tolerance test - 2 hours (oral)</td>
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<tr>
<td>Gamma Glutamyl transpeptidase (GGTP)</td>
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<tr>
<td>Haemoglobin, A1C</td>
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<td>Helicobacter pylori - carbon 13 urea breath test</td>
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<td>HDL</td>
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<td>High density lipoproteins cholesterol (HDL cholesterol)</td>
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<tr>
<td>IgG (Anti -TTG) (Celiac screening)</td>
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<td>Ig A antigliadin (Celiac screening)</td>
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<td>Iron - total and binding capacity</td>
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<td>Lead</td>
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<td>Lactate dehydrogenase (LHD)</td>
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<td>Lithium - serum/plasma</td>
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<td>Luteinizing hormone (LH)</td>
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<td>Lipase</td>
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<td>Lipoprotein A and/or B</td>
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<tr>
<td>Magnesium - serum/plasma</td>
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<td>Mercury</td>
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<td>Micro albumin</td>
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<td>Albumin - urine, serum</td>
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<td>Osmolality - serum</td>
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<tr>
<td>Oxygen - capacity or content (direct gas analysis)</td>
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<tr>
<td>Parathyroid hormone (intact)</td>
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<tr>
<td>pH, pCO2, and pO2</td>
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<tr>
<td>Phenytoin - quantitative</td>
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<tr>
<td>Phosphates - serum/plasma</td>
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<tr>
<td>Plasma homocyst(e)ine</td>
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<td>Potassium - serum/plasma</td>
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<td>Pre albumin</td>
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<td>Pregnancy test - serum</td>
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<td>Primidone (mysolene)</td>
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<td>Progesterone - serum/plasma</td>
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<tr>
<td>Prolactin</td>
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<tr>
<td>Prostatic specific antigen (PSA - testing - as per guidelines)</td>
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<tr>
<td>Proteins - total, quantitative - timed urine collection, or serum or plasma</td>
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<tr>
<td>Quantitative beta hCG</td>
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<tr>
<td>Salicylates, quantitative - serum</td>
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<tr>
<td>Sodium - serum plasma, random urine, whole blood</td>
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<tr>
<td>Testosterone - total</td>
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<td>Theophylline</td>
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<tr>
<td>Thyroxine - free T4 as per guidelines and T3 free</td>
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<tr>
<td>Thyroid microsomal antibodies</td>
<td></td>
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<tr>
<td>Thyroid stimulating hormone (TSH) - any method (as per guidelines)</td>
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<tr>
<td>Transferrin</td>
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<tr>
<td>Triglycerides - serum/plasma</td>
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<td>Troponin</td>
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<tr>
<td>Urea - nitrogen quantitative - urine and/or serum/plasma</td>
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<tr>
<td>Urine - micro albumin</td>
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<tr>
<td>Uric acid - serum and timed urine collection</td>
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<tr>
<td>Urinalysis - complete, macroscopic and microscopic</td>
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<tr>
<td>Vitamins - B12 (as per guidelines) and Vitamin D (25 dihydroxy)</td>
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<tr>
<td>Zinc and DHEA-S</td>
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<tr>
<td>(Dehydroepiandrosterone-serum)</td>
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</tbody>
</table>
Scope of Practice

FOR NURSE PRACTITIONERS (FAMILY) STANDARDS, LIMITS AND CONDITIONS

Miscellaneous
E.C.G. tracing, without interpretation and/or with interpretation

ELISA (HIV antibody screening test) 4

Holter monitoring

Maternal Serum Screening (MSS) tests, including alpha fetoprotein test (Ria) 5

Semen – complete examination including total count, motility count, pH and morphology

Sperm – seminal examination for presence or absence

Peak expiratory flow rate

Screening spirometry – with FVC, FEV (i) and FEV (i)/FVC ratio without broncho dilators and/or before and after broncho dilators

Laboratory procedures shortlist (tests referred or performed in practitioner’s offices)

4 Ordering of this test includes the follow-up Western Blot and the PCR as determined by practice and laboratory standards.

5 MSS program’s genetic counselors are available as a resource and will provide (on request) relevant education sessions and advice. See the website www.bcwomens.ca/Services/PregnancyBirthNewborns/PrenatalDiagnosis/MaternalSerumScreening/default.htm
IMAGING SERVICES

- A nurse practitioner is authorized to order x-rays, ultrasounds and other forms of imaging as designated below.
- The final interpretation of x-ray and an ultrasound is the responsibility of the radiologist.
- Any x-ray or ultrasound not found on the list must be ordered by a physician.

Radiology

Head and Neck
- Skull – routine
- Paranasal sinuses
- Facial bones – orbit
- Nasal bones

Upper Extremity
- Shoulder girdle
- Humerus
- Elbow

Lower Extremity
- Hip*
- Femur
- Knee
- Tibia and fibula

Spine and Pelvis
- Cervical spine
- Thoracic spine
- Lumbar spine
- Sacrum and coccyx

Chest
- Thoracic viscera
- Ribs – one side
- Ribs – both sides

Abdomen
- Abdomen

Gastrointestinal Tracts – Barium
- Oesophagus only
- Oesophagus, stomach and duodenum (upper GI series)

Genito-Urinary System
- K.U.B.

* These may be ordered in combination.
Scope of Practice
FOR NURSE PRACTITIONERS (FAMILY) STANDARDS, LIMITS AND CONDITIONS

**Miscellaneous**
Bone survey – first anatomical area (for history of abuse – age of # and/or follow-up metastatic ca)
Bone survey – each subsequent anatomical area

Mammography – unilateral (rural may need to refer out)
Mammography – bilateral

**Bone Mineral Densitometry Using DEXA Technology**
Bone density – single area (as per guidelines)
Bone density – second area (as per guidelines)

**Diagnostic Ultrasound**

**Neck**
Soft tissues of neck

**Heart**
Echocardiography (real time) (as per guidelines)

**Thorax**
Breast sonogram – unilateral (as per billing criteria) with immediate needle biopsy and aspiration by attending radiologist as warranted
Breast sonogram – additional side

**Abdomen**
Abdominal
Renal B Scan

**Obstetrics and Gynecology**
Obstetrical (14 weeks gestation or over)
Obstetrical (under 14 weeks gestation)

B scan I.U.D. localization
Pelvic (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler

**Extremities**
Extremities

**Doppler Studies**
Peripheral arterial – resting arterial assessment
Carotid imaging – duplex scanning of neck vessels

Peripheral venous – laboratory assessment for deep venous system

**Other**
CAT Scan
Limits and Conditions on Treatments and Advanced Interventions

Nurse practitioners (family) commonly provide or perform treatments and interventions under reserved actions such as: simple wound closure (suturing); incision and drainage; punch biopsy; and insertion of IUDs and endometrial biopsy.\(^6\) To provide such treatments and interventions, a nurse practitioner must be able to give evidence of having acquired the skill through formal theoretical and clinical education and supervision.\(^7\)

**LIMITS AND CONDITIONS**

Nurse practitioners are currently prohibited from providing or performing the following treatments and interventions:

- applying X-rays for diagnostic or imaging purposes except for CAT as designated in the Limits and Conditions for Ordering X-rays; and
- setting or casting a closed simple fracture of a bone or reducing a dislocation.

Nurse practitioners wishing to undertake these activities must submit a formal request for consideration by the CRNBC Nurse Practitioner Standards Committee.

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\(^6\) Nurse practitioners undertaking this activity must ensure that they have been appropriately prepared with the competencies to perform the activity, including didactic preparation and clinical supervision; and do so only when the nature of their practice is such that performance of the activity occurs with sufficient frequency to maintain competence (e.g., nurse practitioners who have a focussed practice in women's health or who provided primary care services on a regular basis to women).

\(^7\) NOTE: Nurse practitioners wishing to provide treatments and interventions for which they have not had formal theoretical and clinical education and supervision should contact CRNBC before doing so. Contact the CRNBC Nursing Policy Department at 604.736.7331 (ext. 335) or 1.800.565.6505. E-mail: nurse.practitioner@crnbc.ca
Section B: Prescribing and Dispensing Drugs

PART I - STANDARDS

Prescribing Standards

STANDARD 1
Nurse practitioners prescribe drugs within the limits of the nurse practitioner's scope of practice and individual competence within that scope of practice.

STANDARD 2
Nurse practitioners prescribe from provincial Drug Schedules I, II and III in accordance with the B.C. Pharmacists, Pharmacy Operations and Drug Scheduling Act and the federal Controlled and Drug Substances Act and Regulation and the College of Registered Nurses British Columbia (CRNBC) Prescribing Standards, Limits and Conditions.

STANDARD 3
Nurse practitioners prescribe medications in accordance with ethical, legal and professional standards of drug therapy.

STANDARD 4
Nurse practitioners engage in evidence-based prescribing and consider best practice guidelines and other relevant guidelines when prescribing for clients, including when recommending complementary or alternative health therapies. A nurse practitioner ensures that the recommended complementary or alternative health therapy does not pose a greater risk to patient health or safety than prevailing health care practices, and does not interfere with concomitant health care practices.

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8 Competence: The integration and application of knowledge, skills, attitude and judgment required for safe performance in an individual's practice.
9 The provincial drug schedules can be found on the College of Pharmacists website at www.bcpharmacists.org/legislation/pdf/Drug_Schedules_Regulation.pdf
10 Under current federal regulations, nurse practitioners are not allowed to prescribe narcotics or controlled drugs. These regulations are currently under review.
11 CRNBC's Quality Assurance Program requires nurse practitioners to undergo mandatory review by CRNBC of their prescribing practices within the first two years of practice in B.C. and then at least every five years.
12 CRNBC publications that have particular relevance in guiding nurse practitioner practice ethics related to nurse-client relationships and situations of conflict of interest are Nurse-Client Relationships: Establishing Professional Relationships and Maintaining Appropriate Boundaries (Position Statement – pub. 389) and Use of Title (pub. 343). Both are available on the CRNBC website www.crnbc.ca
13 Including the B.C. Medical Services Plan (MSP) Guidelines and Protocols
14 See the CRNBC Practice Standard Complementary and Alternative Health Care (pub. 437).
STANDARD 5
Nurse practitioners may write prescriptions for clients (when required for reimbursement by insurance plans or to meet provincial regulations) for nutritional supplementation, appliances and devices and for drugs found in Schedules II and III. (Drugs listed in Schedules II and III do not legally require a prescription).

STANDARD 6
Nurse practitioners are solely accountable for their prescribing decisions.

STANDARD 7
Nurse practitioners participate in the Canadian Adverse Drug Reaction Reporting Program.

STANDARD 8
Nurse practitioners meet the following expectations when prescribing drugs:

1. Completes prescriptions accurately and completely including the following information (Bylaws to the Pharmacists, Pharmacy Operations and Drug Scheduling Act and Regulations):
   - date of issue;
   - name and address (if available) of client;
   - name, strength and dosage form of the substance and the quantity prescribed and quantity to be dispensed (Note: If the prescriber intends to prohibit generic substitution, it must be done in accordance with section 30 (1) and (3) of the Pharmacy Act);
   - directions for use – refers to the frequency or interval or maximum daily dose, route of administration and the duration of drug therapy;
   - directions for number of allowable refills and interval between refills (Note: While it is not legally required, if a prescription includes more than one drug, any drug that may be refilled must be clearly identified. If all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug); and
   - prescriber’s name, address, telephone number and signature including unique nurse practitioner identifier/number.
Note: Other elements, not legally required but that might be considered when prescribing include: indicating if a child resistant container is not indicated; indicating the use of the drug; noting client age, date of birth and weight if the client is on either end of the extreme of their weight range; and/or including special instructions, such as “take with food.”

Note: A prescription may be telephoned to the pharmacist (unless prohibited by legislation) and must include the prescription information outlined above.

Note: A prescription may be transmitted by facsimile (fax) to a pharmacy, provided that the following requirements are met (Pharmacy Act):

- the prescription must be sent only to the pharmacy of the client’s choice with no intervening person having access to the prescription authorization;
- the prescription must be sent directly from the prescriber’s office or directly from a health institution for a patient of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy;
- the prescription must include all information listed above and in addition must include:
  - time and date of transmission;
  - name and fax number of the pharmacy intended to receive the transmission; and
  - a signed certification that the prescription represents the original of the prescription drug order, the addressee is the only recipient and there are no others, and the original prescription is invalidated or retained such that it cannot be re-issued.

2. Documents the prescription on the client record.

3. Provides educational information to clients about prescription and non-prescription drugs that includes information regarding:
   - the expected action of the drug;
   - the importance of compliance with prescribed frequency and duration of the drug therapy;
   - potential side-effects;
   - signs and symptoms of potential adverse effects (e.g., allergic reactions) and action to take if they occur;
   - potential interactions between the drug and certain foods, other drugs or substances;
   - specific precautions to take or instructions to follow; and
   - recommended follow up.
4. Monitors and documents the client's response to drug therapy. Based on the client's response, the nurse practitioner may decide to continue, adjust or withdraw the drug, or to consult with a pharmacist, another nurse practitioner or with a physician in accordance with the CRNBC standards for nurse practitioner-physician consultation.

5. When client care is shared with a physician(s), conjointly determines with the physician, processes for access to the client's health record for purposes of treatment decisions and communication.

6. Stores blank prescriptions in a secure area that is not accessible to the public and does not provide any person with a blank, signed prescription.

7. Does not prescribe for oneself or become involved in self-care.

8. If other options are not available, may prescribe for family, friends or peers, provided the client/provider relationship is established and documented.

9. When receiving information from a pharmaceutical representative, independently verifies the information obtained.
Dispensing Standards

**STANDARD 1**
Nurse practitioners dispense medications in situations in which a pharmacist is not available or accessible, and/or it is in the best interest of the client to do so.

**STANDARD 2**
Nurse practitioners acquire, store, dispense and dispose of drugs in accordance with provincial and federal legislation and regulations, and standards and guidelines for best practice. Nurse practitioners who dispense other than drug samples or small quantities of medications must receive approval from CRNBC to be designated as a dispensing practitioner and comply with procedures for Approval Process for Dispensing Practitioners PharmaNet/Pharmacare as set out by the College of Pharmacists of British Columbia.

**STANDARD 3**
Nurse practitioners meet the following expectations when dispensing drug samples\(^\text{15}\) or small quantities of medication to their clients:

1. The prescription label (or envelope) indicates (Pharmacists, Pharmacy Operations and Drug Scheduling Act and Regulations):
   - client's name;
   - drug name, strength where appropriate, and dosage;
   - direction for use;
   - quantity dispensed;
   - date dispensed;
   - prescribing number of prescriber; and
   - initials of nurse practitioner distributing the drug and the location from which the drug is dispensed, including name, address and telephone number.

   **Note:** Any other information required by good pharmacy practice (not in the Act) is affixed, such as: expiry date; when applicable; or appropriate special circumstances/auxiliary labels (e.g., shake well).

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\(^{15}\) The CRNBC document *Use of Title* (pub. 343) has particular relevance in guiding nursing practitioner practice ethics related to situations of conflict of interest that may arise when communicating with pharmaceutical companies.
2. When indicated, the drug is dispensed in a child resistant container.

3. The label can be easily read by the client or client’s guardian or representative.

4. The drug is handed directly to the client or the client’s guardian or representative.

5. Client education is provided and includes assessment of the client’s level of understanding regarding the drug, including but not limited to the:
   - purpose of the drug;
   - dosage regime and instructions required to achieve the intended therapeutic response, expected benefits and side-effects, storage requirements; and
   - written medication information.

6. The transaction(s) is accessible and recorded on an individual prescription profile and/or client record each time a drug is dispensed. The profile will include:
   - client name, address, phone number, date of birth, gender and, when available, allergies and idiosyncratic responses and personal health number assigned by the B.C. Ministry of Health;
   - date dispensed;
   - name, strength, dosage of drug and quantity dispensed;
   - duration of therapy;
   - directions to patient; and
   - signature and unique identifier of the nurse practitioner dispensing the drug.
PART II - LIMITS AND CONDITIONS

Nurse practitioners prescribe drugs approved for sale as outlined in the B.C. Pharmacists, Pharmacy Operations and Drug Scheduling Act and the federal Food and Drug Act and Regulations, and in accordance with CRNBC’s Standards for Prescribing and Dispensing Drugs.

Nurse practitioners in certain contexts of practice may require broader prescriptive authority than what is permitted in the limits and conditions (e.g., to initiate anticoagulants). Such groups of nurse practitioners will apply to the CRNBC multidisciplinary Nurse Practitioner Standards Committee to expand their prescribing authority. The committee will set standards and other requirements, such as educational preparation, that specific groups of prescribers must meet to be approved for expanded authority.

Nurse practitioners will have authority to request “Special Authority” medications with the exception of two situations:

- they will not have “Special Authority” privileges for prescribing those drugs that have been designated for physician specialists only; and
- they will not have “Special Authority” privileges for prescribing medications for which they have continuation prescribing authority.

Under the federal Controlled Drug Substances Act and Regulations, nurse practitioners do not have authority to prescribe narcotics and controlled drugs, including benzodiazepines and other targeted substances. The federal regulations are currently under review. CRNBC recommends that nurse practitioners be given authority to prescribe narcotics and benzodiazepines for short-term use only (to a maximum of six weeks). CRNBC would review narcotic and benzodiazepine prescribing practices using the PharmaNet database. Nurse practitioners who require broader prescriptive authority to meet their clients’ needs would have to complete additional education as set out in the standards, limits and conditions set by the Nurse Practitioner Standards Committee. 17

For some medications needed in a client’s care, nurse practitioner prescribing may be limited to “continuation” prescribing. Continuation prescribing means that a physician initiates the drug therapy and the nurse practitioner assumes responsibility and authority for the continuation of the drug therapy, including ongoing assessment and monitoring, re-ordering and/or making dosage adjustments to the drug therapy, and referral as needed.

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16 Special Authority is a process used by PharmaCare in cases in which a prescriber wishes to prescribe a drug for a patient that is not covered by PharmaCare or, in some cases, not fully covered. Under the Limited Drug Coverage Program, drugs may be fully covered when on application to PharmaCare-established criteria are met. Approval is granted when the prescriber provides documentation to PharmaCare that meets the established criteria.

17 Under the Bylaws the Nurse Practitioner Standards Committee must develop and recommend to the Board standards, limits and conditions for the practice of nurse practitioners in accordance with section 11(3) of the HPA Regulation for Nurses (Registered) and Nurse Practitioners.
L I M I T S  A N D  C O N D I T I O N S

Nurse practitioners are authorized by the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act to prescribe Schedule I drugs as specified in the Drug Schedules Regulation 9/98 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act in accordance with the CRNBC limits and conditions as listed below. Commonly prescribed drugs are listed here by therapeutic category. Where nurse practitioners may prescribe all drugs in that category, it is noted by the term “no exceptions”. Where there are restrictions on nurse practitioner prescribing, they are noted by the type of restriction [i.e. “continuation” prescribing only (C) or cannot prescribe (O)].

<table>
<thead>
<tr>
<th>Code:</th>
<th>Description</th>
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<tbody>
<tr>
<td>O</td>
<td>cannot be prescribed</td>
</tr>
<tr>
<td>C</td>
<td>continuation prescribing only</td>
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</tbody>
</table>

1. **Antihistamine Drugs** – No exceptions.

2. **Anti-infective Agents** –
   
   C  Anti-tuberculosis agents (only for LTBI)
   
   O  Chronic hepatitis drugs (e.g., Interferon)
   
   O  HIV drugs

3. **Anti-Neoplastic Agents** (Anti-neoplastic drugs are not prescribed by nurse practitioners. To date, these agents are available only through the BC Cancer Agency) – Exception is:
   
   C  Methotrexate in adults (for inflammatory disease)

4. **Autonomic Drugs** –
   
   C  Antiparkinsonism agents
   
   O  Depolarizing and non-depolarizing skeletal muscle relaxants
   
   O  Ergot alkaloids

5. **Blood formers and Coagulators** –
   
   C  Hematopoietic growth factor
   
   C  Anticoagulants
   
   O  Thromboembolyc enzymes
   
   O  Hemostatic agents
   
   O  IV Iron preparations

College of Registered Nurses of British Columbia
6. Cardiovascular Drugs –
   C Antiarrhythmics

7. Central Nervous Agents –
   O General anesthetics
   O Benzodiazepines
   O Barbiturates
   O Narcotics
   O Methadone
   O Methylphenidate (Ritalin)
   O Dextroamphetamine sulphate

8. Contraceptives (foams, devices) – No exceptions and in accordance with the CRNBC nurse practitioner limits and conditions for treatments and interventions.

9. Electrolytic, Caloric and Water Balance –
   O Phosphate binders

10. Antitussives, Expectorants and Mucolytic Agents –
    O Narcotics

11. Eye, Ear, Nose and Throat Preparations –
    C Antiglaucoma agents
    O Ophthalmologic steroids
    O Carbonic anhydrase inhibitors


14. Hormones and Synthetic Substitutes –
    O Infertility drugs (e.g., gonadotropin-releasing hormones)
    O Prostaglandin
    O Pituitary (anti-diuretic) (e.g., vasopressin)
    O Androgen/anabolic steroids
    O Human growth hormone
15. **Oxytocics** – Not prescribed by nurse practitioners.

16. **Serums, Toxoids and Vaccines** –
   - Yellow fever immunization

17. **Skin and Mucous Membrane Agents** –
   - Topical fluorouracil in adults
   - Psoralens (Methoxsalen) in adults
   - Oral retinoids (Acitretin)

18. **Smooth Muscle Relaxants** – No exceptions.

19. **Vitamins** – No exceptions.

20. **Miscellaneous** –
   - Immunosuppressants
   - Immunomodulators (biologic response modifiers)
Section C: Physician Consultation and Referral

PART I - STANDARDS

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

Consultation, including referral, as used in these Standards, refers to a specific request by a nurse practitioner for a physician to become involved in the care of a client. The responsibility to consult with or refer to a physician lies with the nurse practitioner and is made in collaboration with the client. A nurse practitioner may also seek consultation with or transfer care to a physician at the request of the client.

Consultation may result in one of the following levels of physician involvement:

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

The nurse practitioner documents the request for and outcome of the consultation or referral.

Transfer or sharing of care occurs only after discussion and agreement among the client, the referring nurse practitioner and the physician.

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

19 Physicians requesting consultation payment under the B.C. Medical Services Plan payment schedule must render a written report, including their findings, opinions, and recommendations to the referring nurse practitioner.
Standards

**STANDARD 1**
The nurse practitioner consults with or refers to physicians when the client's health condition or needs are such that:

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

**STANDARD 2**
The nurse practitioner communicates and consults with or refers to physicians by:

- clearly presenting the reason for and the level of urgency of the consultation or referral;
- describing the level of physician involvement\(^{20}\) requested at the time a referral is made;
- determining the availability of the physician to provide the consultation in a timely and appropriate manner;
- ensuring that the physician has appropriate access to the client's relevant health information;
- confirming with the physician, following the consultation, the level of physician involvement; and
- documenting the request for and outcome of the consultation or referral.

**STANDARD 3**
The nurse practitioner and the consulting physician conjointly establish methods for communicating about their mutual client's health condition and treatment decisions in situations in which client care is shared.

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\(^{20}\) Levels of physician involvement: the physician provides an opinion and recommendation to the nurse practitioner who continues to have primary responsibility for the health care of the client; or the physician assumes concurrent responsibility for some aspects of the care and the physician and the nurse practitioner together clarify who is assuming responsibility for the various aspects of the client's care, including coordination of the overall care; or the care of the client is transferred to the physician who then assumes primary responsibility for the care.
PART II - LIMITS AND CONDITIONS

Nurse practitioners have the authority to refer to family practice physicians and family practice physicians who have specialized, for example, in palliative care, sports medicine, anesthesia or geriatrics. Nurse practitioners also have the authority to make direct request for consultation/referral to the following medical specialists:

- Clinical immunology and allergy – allergy testing
- Dermatology
- Ophthalmology
- Otolaryngology
- Internal medicine (and all subspecialties)
- Rheumatology – for autoimmune disorders (RA, lupus, Sjogren’s syndrome, polymyalgia arthritis)
- Neurology
- OB/GYN
- Orthopedics
- Pediatrics
- Psychiatry
- Physical medicine and rehabilitation
- General surgery (and all subspecialties)
- Urology
- Emergency medicine
- Anesthesia – for pain management
- Plastic surgery – for nevi, wounds, carpel tunnel
- Vascular surgery – for varicose veins, intermittent claudication and cold foot
- Neurosurgery – for back
Appendix A

The Nurses (Registered) and Nurse Practitioners Regulation

The Nurses (Registered) and Nurse Practitioners Regulation (available online at www.qp.gov.bc.ca/statreg/reg/H/HealthProf/233_2005.htm) sets out, among other things:

- reserved titles for nurses;
- a scope of practice statement;
- reserved actions for registered nurses and nurse practitioners.

RESERVED TITLES

The Regulation states that only registrants of the College of Registered Nurses of British Columbia (CRNBC) may use the titles “registered nurse” or “licensed graduate nurse.” CRNBC registrants may also use the title “nurse.” As well, the title “nurse practitioner” has become a reserved title under the new Regulation. Only those nurses who are registered with CRNBC in the nurse practitioner category can use the title “nurse practitioner” or “registered nurse practitioner.” Registered nurses with temporary registration as a nurse practitioner can use the title of nurse practitioner, but must call themselves nurse practitioner (temporary).

Nurse practitioners can also use the title “registered nurse” and can practise in a registered nurse role (i.e., not a nurse practitioner role). When practising in a registered nurse role, the nurse practitioner must practise within the registered nurse (RN) job description and scope of practice. However, he or she is held accountable to the CRNBC Competencies Required for Nurse Practitioners in British Columbia and the Nurse Practitioner Scope of Practice Standards. In other words, the nurse practitioner would be expected to act as a reasonable, prudent nurse practitioner would act.21

CRNBC Bylaws explain the allowable abbreviated titles for nurse practitioners:

- NP or RN-NP22
- NP (Temporary)

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21 NOTE: Nurse practitioners wishing to practise as an RN are advised to contact a CRNBC nursing practice consultant before doing so. Call CRNBC Practice Support at 604.736.7333 (ext. 332) or 1.800.565.6505. E-mail: practice@crnbc.ca

22 Nurse practitioners are advised to follow NP, in brackets, by the stream in which they are registered to practice [e.g., NP (Family) or NP (F); NP (Adult) or NP(A); NP (Paediatric) or NP(P)].
Scope of Practice
FOR NURSE PRACTITIONERS (FAMILY)

SCOPE OF PRACTICE
Scope of practice refers to the activities that nurses are educated and authorized to perform. These activities are:

- established through the legislated definition of nursing practice;
- complemented by standards, limits and conditions set by CRNBC.

Under the Regulation, a registrant of CRNBC may practise nursing, which is defined as the health profession in which a person provides or performs the following services:

- health care for the promotion, maintenance and restoration of health; and
- prevention, treatment and palliation of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and coordination of health services.

This definition does not refer to evaluation, but neither does it exclude it. Evaluation is, of course, an important part of nursing practice. The definition is broad and intended to apply to the practice of nursing of both groups of CRNBC registrants – registered nurses and registered nurse practitioners.

EXCEPTIONS
Nurses sometimes ask if it is ever appropriate to provide care that is outside the scope of practice set out in the Regulation. Nurse practitioners only provide care within their scope of practice, except in situations of life-threatening emergency. In these situations, nurse practitioners are ethically obligated to provide the best care they can, given the circumstances and their individual competence.

STANDARDS, LIMITS AND CONDITIONS
The Health Professions Act and the Nurses (Registered) and Nurse Practitioners Regulation give CRNBC the authority to establish, monitor and enforce standards, limits and conditions for nurses’ practice.

Standard: A desired and achievable level of performance against which actual performance can be compared. It provides a benchmark below which performance is unacceptable. Registered nurses are familiar with standards of practice, which are set out in CRNBC’s Professional Standards for Registered Nurses and Nurse Practitioners in British Columbia as well as in a series of CRNBC Practice Standards and the Nurse Practitioner Scope of Practice Standards.

Limits and Conditions: A limit is the point at which something must end. For example, while nurse practitioners are authorized to order a wide range of diagnostic services, they do not have authority to order MRIs. A condition is anything on which something else depends. For example, nurse practitioners can refer clients to an anaesthetist, but only for purposes of pain management. Nurses are accustomed to having restrictions placed on their practice by their employer, but having limits and conditions set by the regulatory body (CRNBC) is new. The CRNBC Nurse Practitioner Standards Committee develops and recommends nurse practitioner standards, limits and conditions for approval by the CRNBC Board.
RESERVED ACTIONS

The Regulation assigns reserved actions to nurse practitioners for activities such as: making a diagnosis to identify a disease, disorder or condition; ordering diagnostic services; and prescribing and dispensing drugs. As specified in the Regulation, these activities are provided in accordance with standards, limits and conditions established by CRNBC. CRNBC’s scope of practice documents include:

- Scope of Practice for Nurse Practitioners (Family): Standards, Limits and Conditions;
- Scope of Practice for Nurse Practitioners (Adult): Standards, Limits and Conditions; and

The scope of nurse practitioner practice builds on the scope of registered nurse practice. Nurse practitioners must be familiar with both registered nurse and nurse practitioner scope to understand the scope of nurse practitioner practice. For further details on the Nurses (Registered) and Nurse Practitioners Regulation as it pertains to registered nurse practice, please read the document on the CRNBC website entitled Scope of Practice for Registered Nurses: Standards, Limits and Conditions.23

23 Scope of practice documents can be found on the Nursing Practice section of the CRNBC website www.crnbc.ca
Scope of Practice

FOR NURSE PRACTITIONERS (FAMILY) STANDARDS, LIMITS AND CONDITIONS

Resources

Diagnosing and Health Care Management

TEXTS


GUIDELINES


WEB-BASED GUIDELINES
British Columbia Ministry of Health Services Guidelines and Protocols.
www.healthservices.gov.bc.ca/msp/protoguides/gps/index.html

Canadian Medical Association InfoBase. Clinical Practice Guidelines. mdm.ca/cpgsnew/cpgs/index.asp

USA National Guideline Clearinghouse. www.guidelines.gov/
Prescribing


Scope of Practice for Nurse Practitioners (Pediatric)

Standards, Limits and Conditions
CRNBC Standards of Practice

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

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

Professional Standards

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

Practice Standards

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

Scope of Practice Standards

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

All CRNBC Standards are available online at www.crnbc.ca

WHERE TO GET ASSISTANCE

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

Nurse practitioners are registered nurses who have achieved additional competencies required for registration as a nurse practitioner with the College of Registered Nurses of British Columbia (CRNBC). Their scope of practice includes providing health care services from a holistic nursing perspective combined with a focus on diagnosing and treating acute and chronic illnesses, including prescribing medications.

Nurse practitioners are required to practise in accordance with CRNBC’s Standards of Practice (Professional Standards, Practice Standards, and Scope of Practice Standards). Nurse practitioners must meet requirements for ongoing registration, including continuing competence requirements and a quality assurance practice review. The principles for nurse practitioner continuing competence requirements and quality assurance program and the Continuing Competence Requirements for Nurse Practitioners in British Columbia can be found online at www.crnbc.ca under Registration (applying for nurse practitioner).

The legal authority for the nurse practitioner scope of practice is set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act (see the B.C. Ministry of Health website www.healthservices.gov.bc.ca). Nurse practitioners must be familiar with both the registered nurse and nurse practitioner scope to understand their scope of practice. Reserved title as it applies to nurse practitioner is also addressed in the Regulation. See Appendix A for further information on the Regulation as it pertains to nurse practitioners.

The Regulation assigns reserved actions to nurse practitioners for activities such as: making a diagnosis to identify a disease, disorder or condition; ordering diagnostic services; and prescribing and dispensing drugs. As specified in the Regulation, these activities are provided in accordance with standards, limits and conditions established by CRNBC.

This document includes the standards with limits and conditions specific to the scope of nurse practitioner (family) practice for: diagnosing (including ordering diagnostic services and providing or performing treatments and interventions); prescribing and dispensing medications; and physician consultation and referral.

From time to time, this document may be revised to reflect changes to the limits and conditions, in particular to ordering diagnostic services and prescribing drugs. Please check the CRNBC website (www.crnbc.ca) regularly for updates.

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Section A: Diagnosing and Health Care Management

PART I - STANDARDS

Nurse practitioners (pediatric) are expected to be competent to meet standards and practice expectations for entry-level diagnosing and health care management of clients as a requirement for practice in British Columbia (B.C.). The nurse practitioner (pediatric) provides health care services to children from newborn infants to toddlers, school-aged children and adolescents. In some instances, nurse practitioners (pediatric) may provide care to young adults whose developmental age may closely approximate that of a child or adolescent rather than an adult, or to a young adult who has been receiving care from the nurse practitioner (pediatric) for a chronic disease (e.g., cystic fibrosis) since childhood. The setting in which nurse practitioners (pediatric) practise may vary according to the characteristics of the children and the focus of care activities, e.g., managing acute illness, acute exacerbations of chronic illness or significant co-morbidity in tertiary care, or managing chronic illness in residential or home care. The nurse practitioners (pediatric) can be found in acute care, community and residential settings and may serve as the primary care provider to children.

Nurse practitioner practice is not focused solely on diagnosing and managing diseases, disorders and conditions. As primary health care providers, nurse practitioners emphasize health promotion and disease and injury prevention. This comprises activities in all three levels of primary, secondary and tertiary prevention. Activities might include:

- promoting healthy living through assessing for developmental milestones or implementing interventions, such as health education, oral health education, child parenting practices and child behaviour advice, feeding and nutrition and exercise counselling, and sex education;
- preventing disease through interventions, such as immunizations, promoting protection from accidental ingestions/poisoning/burn/scalding, motor vehicle accidents and sun exposure or educating high risk groups about substance abuse;
- facilitating early diagnosis and treatment through screening for diseases and disorders, such as neonatal abnormalities, FASD, diabetes, and blood borne and sexually transmitted diseases; and
- screening high risk groups for conditions such as lead poisoning or by prompt identification and treatment of infectious disease.

Nurse practitioners (pediatric) undertake developmental screening and surveillance of children for early identification of developmental delays and learning disabilities, dental eruptions, and vision and hearing screening and referral as indicated. They work collaboratively with their local communities, other members of the health care team and health authorities to ensure essential health care for their clients.

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2 Primary health care: Essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost the community and country can afford. Essential health care includes health promotion, disease and injury prevention, curative care, rehabilitation and supportive care, including palliative care.
Nurse practitioners diagnose and manage the care and treatment of clients who present with common acute and chronic physical and mental diseases, disorders and conditions. Nurse practitioners are prepared to recognize and/or screen for a number of diseases, disorders and conditions, such as encephalitis, leukemia and nephritic syndrome which may be included in their differential diagnosis, but which are beyond their competence and scope of practice. When suspected as the primary diagnosis, such diseases, disorders and conditions are immediately referred to a physician or transferred to emergency medicine as appropriate.

When a nurse practitioner (pediatric) has patients in her or his practice who have a disease or disorder that is being managed by a physician (e.g., patients with cancer, juvenile rheumatoid arthritis), the nurse practitioner is expected to have the competence to monitor the condition of these patients and refer them to their physicians should a need arise.
Scope of Practice

STANDARDS, LIMITS AND CONDITIONS FOR NURSE PRACTITIONERS (PEDIATRIC)

Standards

**STANDARD 1**
Nurse practitioners diagnose and manage diseases, disorders and conditions within the limits of the nurse practitioner's legislated scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult or pediatric).

**STANDARD 2**
Nurse practitioners have an ethical obligation to be available to provide care for their established patients on a 24-hour basis either personally or through ongoing call schedules. Nurse practitioner call schedules are made at the level of the practice setting. When a nurse practitioner signs off to an alternative provider, there must be mutual agreement and willingness on the part of the alternative provider as to when and how the provider will assume the responsibility for the patient's care.

**STANDARD 3**
Nurse practitioners refer patients to a physician at any point in time as deemed necessary in accordance with CRNBC's standards for nurse practitioner-physician consultation.

**STANDARD 4**
Entry-level nurse practitioners have the competence to diagnose and manage common acute and chronic physical and mental diseases, disorders and conditions and meet expectations as outlined on pages 8-13.

**Code:**

D The nurse practitioner diagnoses and manages independently or refers as appropriate. Will refer to physician at any point as deemed necessary or at some stage as per accepted guidelines. Referrals are in accordance with CRNBC's standards for nurse practitioner-physician consultation (see Section C).

C The nurse practitioner establishes or strongly suspects the diagnosis and consults with a physician for the management plan or consults with a physician to confirm the diagnosis, and as a result of the consultation:

i) the nurse practitioner receives an opinion and recommendation, and assumes ongoing primary responsibility and authority for the plan of care;

ii) the physician assumes concurrent responsibility for some aspects of the plan of care; or

iii) the care is transferred to the physician or emergency medicine as appropriate.
Common Diseases and Disorders Diagnosed and Managed by the Entry-Level Pediatric Nurse Practitioner

1. Common Neurological Diseases/Disorders
   - Headaches – primary headaches without structural or systemic pathology
   - Simple febrile seizure disorder in children
   - Bell’s palsy (with any eye symptoms refer immediately to ophthalmologist)
   - Meningitis
   - Epilepsy

2. Common Dermatologic Diseases/Disorders
   - Parasitic – scabies and pediculosis
   - Fungal – candidiasis, dermatophytoses (tinea and onychomycosis)
   - Bacterial – impetigo, folliculitis, furuncles, carbuncles and paronychia, cellulitis
   - Viral – warts, molluscum contagiosum, herpes simplex and Herpes Zoster
   - Acne vulgaris
   - Dermatitis – atopic (eczema), contact, seborrheic and diaper
   - Drug eruptions, urticaria and erythema multiforme (minor)
   - Psoriasis
   - Pityriasis rosea
   - Sunburn
   - Pigmented nevi
   - Bacterial – cellulitis
   - Non-malignant skin lesions
   - Malignant skin lesions
3. Common Disorders and Diseases of the Eyes, Ears, Nose and Throat

**Eyes**
- Blepharitis
- Chalazion
- Conjunctivitis
- Hordeolum
- Nasal lacrimal duct obstruction
- Simple foreign body
- Simple corneal abrasion

**Ears**
- Cerumen impaction
- Otitis externa
- Otitis media
- Foreign body
- Perforated tympanic membrane

**Nose and Throat**
- Rhinitis
- Anterior epistaxis
- Sinusitis
- Gingivitis
- Pharyngitis
- Tonsillitis
- Stomatitis
- Cervical adenitis and lymphadenopathies
- Peritonsillar Abscess

4. Common Diseases and Disorders of the Respiratory Tract
- Asthma
- Bronchiolitis
- Bronchitis acute
- Croup
- Influenza
- Pneumonia
- Pertussis
- Smoking addiction/cessation
- Epiglottitis
- Tuberculosis
5. **Common Diseases/Disorders of the Cardiovascular System**
   - D Innocent heart murmur
   - D Primary/essential hypertension
   - D Rheumatic fever
   - D Presyncope/syncope
   - C Congenital heart disease
   - C Hyperlipidemia

6. **Common Diseases/Disorders of the Gastrointestinal system**
   - D Anal fissures
   - D Colic
   - D Constipation
   - D Diarrhea
   - D Encopresis
   - D Failure to thrive
   - D Feeding disorders
   - D Gastroenteritis
   - D Gastro-esophageal reflux disease/disorder (GERD)
   - D Hepatitis (viral) A
   - D Hyperbilirubinemia
   - D Irritable bowel syndrome
   - D Malabsorption Syndrome
   - D Obesity
   - D Parasitic infections (roundworm and pinworm)
   - D Peptic Ulcer
   - D Hernia (inguinal, hiatal, umbilical)
   - C Dysphagia

7. **Common Diseases/Disorders of the Renal and Genitourinary Systems**
   - D Primary nocturnal enuresis
   - D Lower urinary tract infections (female)
   - C Lower urinary tract infections (male)
   - D Vesicoureteral reflux
8. Common Diseases/Disorders of the Reproductive System

**Male**
- Balanitis
- Epididymitis in children after puberty
- Gynecomastia
- Pearly penile papules
- Phimosis and paraphimosis
- Sexually transmitted diseases
- Undescended testes
- Hypospadias

**Female**
- Primary and secondary amenorrhea
- Dysfunctional uterine bleeding
- Dysmenorrhea
- Contraception
- Labial adhesions
- Precocious puberty
- Premenstrual syndrome
- Premature thelarche
- Pelvic inflammatory disease
- Ovarian cyst
- Vulvovaginal infections (including vaginitis in infants and toddlers as well as other age groups) & sexually transmitted diseases (exception HIV and hepatitis C)

9. Common Diseases and Disorders of the Musculoskeletal System

- Bursitis
- Cervical muscle strain and spasm
- Costochondritis
- Fibromyalgia
- Joint pain/injury (sprains, strains, and pain)
- Lumbar lordosis
- Osgood-Schlatter disease
- Scoliosis
- Subluxation of the radial head
- Tendonitis/tendosynovitis
- Meniscus and ligament tears
- Herniated disc
- Brachial plexus injury

10. Common Diseases/Disorders of the Endocrine and Metabolic Systems

- Juvenile hypothyroidism
- Obesity
- Diabetes type I & II
- Phenylketonuria
11. **Common Hematological and Immune Diseases/Disorders**

**Hematologic**
- D Anemia
- C Sickle cell anemia
- C Idiopathic thrombocytopenia purpura
- C Hemophilia

**Immune**
- D Allergic reactions
- C Chronic fatigue syndrome
- C Juvenile rheumatoid arthritis

12. **Infectious Diseases**
- D Coxsackie viral infection
- D Fifth disease
- D Roseola
- D Mumps
- D German measles (rubella)
- D Chickenpox
- D Infectious mononucleosis
- D Lyme disease
- D Rubeola

13. **Common Psychiatric Diseases/Disorders and Mental Health/Psychosocial Problems**

**Psychiatric Diseases**
- D Anxiety Disorders (separation, generalized and obsessive compulsive disorder, panic disorders, school phobias)
- D Attention deficit disorder
- D Depression
- D Anorexia/bulimia
- C Autism

**Mental Health/Psychosocial Problems**
- D Aggression in children (social aggression, conduct disorder and oppositional disorder)
- D Child abuse and neglect (mandatory reporting)
- D Grief (bereavement)
- D Sleep problems such as sleeplessness and the parasomnias
- D Sexual assault
- D Substance abuse and dependence
14. **Common Emergency Problems** (*all within the nurse practitioner's scope and competence depending on the severity. Referral would be indicated when beyond scope and competence*)

- D Wounds and lacerations
- D Burns
- D Animal and human bites
- D Arthropod bites and stings
- D Foreign bodies
- D Poisoning
- D Mild/minimal head trauma
- D Chemical splashes in the eye
PART II - LIMITS AND CONDITIONS

Limits and conditions apply to health care management of clients with respect to:

- ordering diagnostic services (imaging and laboratory services); and
- providing or performing advanced treatments and interventions.

Ordering Diagnostic Services

LABORATORY SERVICES

Nurse practitioners are authorized to order laboratory and other tests as designated below. Note: When ordering a CAT scan or Holter Monitoring for a client, the nurse practitioner has a professional obligation to first discuss the case with a physician. The test is independently ordered by the nurse practitioner and identification of the physician is not required. A formal consultation is not required unless requested by the physician.

Any laboratory test not found on the list must be ordered by a physician.

Hematology and Blood Bank

ANA
Anti-DNA
Cold agglutinins – qualitative
Hematology profile (to include automated Hgb, WBC, platelet count, Hct, RBC indices and differential white cell count when indicated) (NB: singles may be ordered)

Haemoglobin electrophoresis
Direct and indirect coombs
Latex test (rheumatoid factor)

Infectious mononucleosis
Malaria and other parasites
Partial thromboplastin test
Prothrombin time/INR
RBC morphology
Red cell folate
Reticulocyte count and/or Heinz bodies
Rh(D) typing
Thalassaemia/haemoglobinopathy investigation
Sickle cell identification

Microbiology

Acid fast organisms – (microbacterial)
C. difficile toxin
Fungal culture

Chlamydia (NAT) – urine, (NAT) SWAB, and/or culture
Fungus – direct examination KOH preparation (office)
### Scope of Practice

**STANDARDS, LIMITS AND CONDITIONS FOR NURSE PRACTITIONERS (PEDIATRIC)**

<table>
<thead>
<tr>
<th>Blood culture – aerobic and/or anaerobic</th>
<th>Stool culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A – IgM (Anti-HAV-IgM)</td>
<td>Streplococci – rapid test (office)</td>
</tr>
<tr>
<td>Hepatitis B – core antibody (Anti-HBC), surface antibody (Anti-HBS)</td>
<td>Anti-streptolysin “O” titre</td>
</tr>
<tr>
<td>Hepatitis C Be Antigen</td>
<td>Trichomonas and/or candida – direct examination</td>
</tr>
<tr>
<td>Polymerase Chain Reaction (PCR)</td>
<td>Examination for pinworm ova</td>
</tr>
<tr>
<td>Routine cultures – routine culture, cervical, vaginal, urethral, sputum, wound, urine and/or nose and/or throat</td>
<td>Stool examination – concentration methods; for amoebae</td>
</tr>
<tr>
<td>Smear for inclusion bodies</td>
<td>Macroscopic examination of parasite and/or direct microscopic examination</td>
</tr>
<tr>
<td>Genital culture – combined vagino-anorectal or vaginal culture for group B streptococcus only, vaginal smear and culture for bacteria (BV and Trichomonas) and/or other sites</td>
<td>Serological tests – for antigens; for identification of bacterial micro-organisms</td>
</tr>
<tr>
<td>Genital culture – combined vagino-anorectal or vaginal culture for group B streptococcus only, vaginal smear and culture for bacteria (BV and Trichomonas) and/or other sites</td>
<td>Viral culture</td>
</tr>
<tr>
<td>CD4/CD8 Counts</td>
<td>Viral Load</td>
</tr>
</tbody>
</table>

### Chemistry

<table>
<thead>
<tr>
<th>Acid phosphatase – total or fractions</th>
<th>Chloride – quantitative - serum/plasma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin – serum/plasma</td>
<td>Sweat test for cystic fibrosis</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Cholesterol, total</td>
</tr>
<tr>
<td>Alanine aminotransferase (ALT)</td>
<td>Cortisol</td>
</tr>
<tr>
<td>Alkaline phosphatase</td>
<td>Creatine kinase (CPK)</td>
</tr>
<tr>
<td>Alpha 1 – antitrypsin</td>
<td>Creatinine – random urine and timed urine collection and/or serum/plasma</td>
</tr>
<tr>
<td>Amylase – serum/plasma</td>
<td>Digoxin</td>
</tr>
<tr>
<td>Arsenic</td>
<td>Drug assay – single and multiple</td>
</tr>
<tr>
<td>Aspartate aminotransferase (AST)</td>
<td>Drugs of abuse screen – urine</td>
</tr>
<tr>
<td>Bicarbonate – serum/plasma</td>
<td>Screening assays</td>
</tr>
<tr>
<td>Bilirubin – direct and/or total</td>
<td>Electrophoresis – protein (quantitative)</td>
</tr>
<tr>
<td>C – reactive protein</td>
<td>Estradiol</td>
</tr>
<tr>
<td>Calcium – total, serum/plasma and/or urine random</td>
<td>Fat, microscopic examination – feces</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Ferritin – serum</td>
</tr>
</tbody>
</table>

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3 These HIV monitoring tests are ordered by nurse practitioners working in a model of shared care delivery for HIV patients. Nurse practitioners monitoring patients with HIV do so in accordance with the BC Centre for Excellence HIV/AIDS Care Therapeutic Guidelines. Education courses are available through the BC Centre for Excellence www.cfenet.ubc.ca Note: Nurse practitioners do not prescribe anti-retrovirals.

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College of Registered Nurses of British Columbia
## Scope of Practice

### FOR NURSE PRACTITIONERS (PEDIATRIC)

<table>
<thead>
<tr>
<th>Test Requested</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Folic acid</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Follicle stimulating hormone (FSH)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Glucose – gestational assessment (Random) and 2 hr post 75 g screening for gestation diabetes</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Glucose quantitative – serum/plasma (fasting and random)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Glucose tolerance test – 2 hours (oral)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Gamma Glutamyl transpeptidase (GGTP)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Haemoglobin, A1C</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Helicobacter pylori – carbon 13 urea breath test</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>HDL</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>High density lipoproteins cholesterol (HDL cholesterol)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>IgG (Anti-TTG) (Celiac screening)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>IgA antgliadin (Celiac screening)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Iron – total and binding capacity</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Lead</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Lactate dehydrogenase (LHD)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Lithium – serum/plasma</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Luteinizing hormone (LH)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Lipase</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Lipoprotein A and/or B</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Magnesium – serum/plasma</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Mercury</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Micro albumin</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Albumin – urine, serum</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Osmolality – serum</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Oxygen – capacity or content (direct gas analysis)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Parathyroid hormone (intact)</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>pH, pCO2, and pO2</td>
<td>Serum/plasma</td>
</tr>
<tr>
<td>Phenytoin – quantitative</td>
<td>Serum/plasma</td>
</tr>
</tbody>
</table>

### Standards, Limits and Conditions

- Phosphates – serum/plasma
- Plasma homocyst(e)ine
- Potassium – serum/plasma
- Pre albumin
- Pregnancy test – serum
- Primidone (mysolene)
- Progesterone – serum/plasma
- Prolactin
- Prostatic specific antigen (PSA – testing – as per guidelines)
- Proteins – total, quantitative – timed urine collection, or serum or plasma
- Quantitative beta hCG
- Salicylates, quantitative – serum
- Sodium – serum plasma, random urine, whole blood
- Testosterone – total
- Theophylline
- Thyroxine – free T4 as per guidelines and T3 free
- Thyroid microsomal antibodies
- Thyroid stimulating hormone (TSH) – any method (as per guidelines)
- Transferrin
- Triglycerides – serum/plasma
- Troponin
- Urea – nitrogen quantitative – urine and/or serum/plasma
- Urine – micro albumin
- Uric acid – serum and timed urine collection
- Urinalysis – complete, macroscopic and microscopic
- Vitamins – B12 (as per guidelines) and Vitamin D (25 dihydroxy)
- Zinc and DHEA-S (Dehydroepiandrosterone-serum)
Miscellaneous

E.C.G. tracing, without interpretation and/or with interpretation

ELISA (HIV antibody screening test)\(^4\)

Holter monitoring

Semen – complete examination including total count, motility count, pH and morphology

Sperm – seminal examination for presence or absence

Peak expiratory flow rate

Screening spirometry – with FVC, FEV (i) and FEV (i)/FVC ratio without broncho dilators and/or before and after broncho dilators

Laboratory procedures shortlist (tests referred or performed in practitioner’s offices)

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\(^4\) Ordering of this test includes the follow-up Western Blot and the PCR as determined by practice and laboratory standards
IMAGING SERVICES

- A nurse practitioner is authorized to order x-rays, ultrasounds and other forms of imaging as designated below.

- The final interpretation of x-ray and an ultrasound is the responsibility of the radiologist.

- Any x-ray or ultrasound not found on the list must be ordered by a physician.

Radiology

Head and Neck
Skull – routine Mastoids
Paranasal sinuses Mandible
Facial bones – orbit Temporo-mandibular joints
Nasal bones Nasopharynx and/or neck, soft tissue

Upper Extremity
Shoulder girdle Forearm
Humerus Wrist
Elbow Hand (any part)

Lower Extremity
Hip* Ankle
Femur Foot (any part)
Knee Leg length films
Tibia and fibula

Spine and Pelvis
Cervical spine Pelvis*
Thoracic spine Sacroiliac joints
Lumbar spine Scoliosis film
Sacrum and coccyx

Chest
Thoracic viscera Sternum or sterno-clavicular joints
Ribs – one side Sternum and sterno-clavicular joints
Ribs – both sides

Abdomen
Abdomen Abdomen, multiple views

Gastrointestinal Tracts – Barium
Oesophagus only Small bowel follow through
Oesophagus, stomach and duodenum (upper GI Colon or double contrast air studies - barium series) enema

Genito-Urinary System
K.U.B.

* These may be ordered in combination.
**Miscellaneous**
Bone survey – first anatomical area (for history of abuse – age of # and/or follow-up metastatic ca)

Bone survey – each subsequent anatomical area

**Bone Mineral Densitometry Using DEXA Technology**
Bone density – single area (as per guidelines)

Bone density – second area (as per guidelines)

**Diagnostic Ultrasound**

**Neck**
Soft tissues of neck

**Heart**
Echocardiography (real time) (as per guidelines)

**Thorax**
Breast sonogram – unilateral (as per billing criteria) with immediate needle biopsy and aspiration by attending radiologist as warranted

**Abdomen**
Abdominal
Renal B Scan

**Obstetrics and Gynecology**
Obstetrical (14 weeks gestation or over)

Obstetrical (under 14 weeks gestation)

**Extremities**
Extremities

**Doppler Studies**
Peripheral arterial – resting arterial assessment
Carotid imaging – duplex scanning of neck vessels

**Other**
CAT Scan

Mammography – unilateral (rural may need to refer out)

Mammography – bilateral

Bone sonogram – additional side

B scan I.U.D. localization

Pelvic (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler

Peripheral venous – laboratory assessment for deep venous system
Limits and Conditions on Treatments and Advanced Interventions

Nurse practitioners (pediatric) commonly provide or perform treatments and interventions under reserved actions such as: simple wound closure (suturing); incision and drainage; and punch biopsy. To provide such treatments and interventions, a nurse practitioner must be able to give evidence of having acquired the skill through formal theoretical and clinical education and supervision.⁵

LIMITS AND CONDITIONS

Nurse practitioners are currently prohibited from providing or performing the following treatments and interventions:

- applying X-rays for diagnostic or imaging purposes except for CAT as designated in the Limits and Conditions for Ordering X-rays; and
- setting or casting a closed simple fracture of a bone or reducing a dislocation.

Nurse practitioners wishing to undertake these activities must submit a formal request for consideration by the CRNBC Nurse Practitioner Standards Committee.

⁵ NOTE: Nurse practitioners wishing to provide treatments and interventions for which they have not had formal theoretical and clinical education and supervision should contact CRNBC before doing so. Contact the CRNBC Nursing Policy Department at 604.736.7331 (ext. 335) or 1.800.565.6505. E-mail: nurse.practitioner@crnbc.ca
Section B: Prescribing and Dispensing Drugs

PART I - STANDARDS

Prescribing Standards

**STANDARD 1**
Nurse practitioners prescribe drugs within the limits of the nurse practitioner's scope of practice and individual competence within that scope of practice.

**STANDARD 2**
Nurse practitioners prescribe from provincial Drug Schedules I, II and III in accordance with the B.C. Pharmacists, Pharmacy Operations and Drug Scheduling Act and the federal Controlled and Drug Substances Act and Regulation and the College of Registered Nurses British Columbia (CRNBC) Prescribing Standards, Limits and Conditions.

**STANDARD 3**
Nurse practitioners prescribe medications in accordance with ethical, legal and professional standards of drug therapy.

**STANDARD 4**
Nurse practitioners engage in evidence-based prescribing and consider best practice guidelines and other relevant guidelines when prescribing for clients, including when recommending complementary or alternative health therapies. A nurse practitioner ensures that the recommended complementary or alternative health therapy does not pose a greater risk to patient health or safety than prevailing health care practices, and does not interfere with concomitant health care practices.

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6 Competence: The integration and application of knowledge, skills, attitude and judgment required for safe performance in an individual's practice.
7 The provincial drug schedules can be found on the College of Pharmacists website at www.bcpharmacists.org/legislation/pdf/Drug_Schedules_Regulation.pdf
8 Under current federal regulations, nurse practitioners are not allowed to prescribe narcotics or controlled drugs. These regulations are currently under review.
9 CRNBC's Quality Assurance Program requires nurse practitioners to undergo mandatory review by CRNBC of their prescribing practices within the first two years of practice in B.C. and then at least every five years.
10 CRNBC publications that have particular relevance in guiding nurse practitioner practice ethics related to nurse-client relationships and situations of conflict of interest are Nurse-Client Relationships: Establishing Professional Relationships and Maintaining Appropriate Boundaries (Position Statement – pub. 389) and Use of Title (pub. 343). Both are available on the CRNBC website www.crnbc.ca
11 Including the B.C. Medical Services Plan (MSP) Guidelines and Protocols
12 See the CRNBC Practice Standard Complementary and Alternative Health Care (pub. 437).


**Scope of Practice**

**FOR NURSE PRACTITIONERS (PEDIATRIC)**

**STANDARD 5**

Nurse practitioners may write prescriptions for clients (when required for reimbursement by insurance plans or to meet provincial regulations) for nutritional supplementation, appliances and devices and for drugs found in Schedules II and III. (Drugs listed in Schedules II and III do not legally require a prescription).

**STANDARD 6**

Nurse practitioners are solely accountable for their prescribing decisions.

**STANDARD 7**

Nurse practitioners participate in the Canadian Adverse Drug Reaction Reporting Program.

**STANDARD 8**

Nurse practitioners meet the following expectations when prescribing drugs:

1. Completes prescriptions accurately and completely including the following information (Bylaws to the Pharmacists, Pharmacy Operations and Drug Scheduling Act and Regulations):
   - date of issue;
   - name and address (if available) of client;
   - name, strength and dosage form of the substance and the quantity prescribed and quantity to be dispensed (**Note**: If the prescriber intends to prohibit generic substitution, it must be done in accordance with section 30 (1) and (3) of the Pharmacy Act);
   - directions for use – refers to the frequency or interval or maximum daily dose, route of administration and the duration of drug therapy;
   - directions for number of allowable refills and interval between refills (**Note**: While it is not legally required, if a prescription includes more than one drug, any drug that may be refilled must be clearly identified. If all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug); and
   - prescriber's name, address, telephone number and signature including unique nurse practitioner identifier/number.
### Note:
Other elements, not legally required but that might be considered when prescribing include: indicating if a child resistant container is not indicated; indicating the use of the drug; noting client age, date of birth and weight if the client is on either end of the extreme of their weight range; and/or including special instructions, such as "take with food."

### Note:
A prescription may be telephoned to the pharmacist (unless prohibited by legislation) and must include the prescription information outlined above.

### Note:
A prescription may be transmitted by facsimile (fax) to a pharmacy, provided that the following requirements are met (Pharmacy Act):

- the prescription must be sent only to the pharmacy of the client's choice with no intervening person having access to the prescription authorization;
- the prescription must be sent directly from the prescriber's office or directly from a health institution for a patient of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy;
- the prescription must include all information listed above and in addition must include:
  - time and date of transmission;
  - name and fax number of the pharmacy intended to receive the transmission; and
  - a signed certification that the prescription represents the original of the prescription drug order, the addressee is the only recipient and there are no others, and the original prescription is invalidated or retained such that it cannot be re-issued.

2. Documents the prescription on the client record.

3. Provides educational information to clients about prescription and non-prescription drugs that includes information regarding:
   - the expected action of the drug;
   - the importance of compliance with prescribed frequency and duration of the drug therapy;
   - potential side-effects;
   - signs and symptoms of potential adverse effects (e.g., allergic reactions) and action to take if they occur;
   - potential interactions between the drug and certain foods, other drugs or substances;
Scope of Practice
FOR NURSE PRACTITIONERS (PEDIATRIC)

STANDARDS, LIMITS AND CONDITIONS

- specific precautions to take or instructions to follow; and
- recommended follow up.

4. Monitors and documents the client's response to drug therapy. Based on the client's response, the nurse practitioner may decide to continue, adjust or withdraw the drug, or to consult with a pharmacist, another nurse practitioner or with a physician in accordance with the CRNBC standards for nurse practitioner - physician consultation.

5. When client care is shared with a physician(s), conjointly determines with the physician, processes for access to the client's health record for purposes of treatment decisions and communication.

6. Stores blank prescriptions in a secure area that is not accessible to the public and does not provide any person with a blank, signed prescription.

7. Does not prescribe for oneself or become involved in self-care.

8. If other options are not available, may prescribe for family, friends or peers, provided the client/provider relationship is established and documented.

9. When receiving information from a pharmaceutical representative, independently verifies the information obtained.
Dispensing Standards

**STANDARD 1**
Nurse practitioners dispense medications in situations in which a pharmacist is not available or accessible, and/or it is in the best interest of the client to do so.

**STANDARD 2**
Nurse practitioners acquire, store, dispense and dispose of drugs in accordance with provincial and federal legislation and regulations, and standards and guidelines for best practice. Nurse practitioners who dispense other than drug samples or small quantities of medications must receive approval from CRNBC to be designated as a dispensing practitioner and comply with procedures for Approval Process for Dispensing Practitioners PharmaNet/Pharmacare as set out by the College of Pharmacists of British Columbia.

**STANDARD 3**
Nurse practitioners meet the following expectations when dispensing drug samples or small quantities of medication to their clients:

1. The prescription label (or envelope) indicates (Pharmacists, Pharmacy Operations and Drug Scheduling Act and Regulations):
   - client’s name;
   - drug name, strength where appropriate, and dosage;
   - direction for use;
   - quantity dispensed;
   - date dispensed;
   - prescribing number of prescriber; and
   - initials of nurse practitioner distributing the drug and the location from which the drug is dispensed, including name, address and telephone number.

   **Note:** Any other information required by good pharmacy practice (not in the Act) is affixed, such as: expiry date; when applicable; or appropriate special circumstances/auxiliary labels (e.g., shake well).

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13 The CRNBC document *Use of Title* (pub. 343) has particular relevance in guiding nursing practitioner practice ethics related to situations of conflict of interest that may arise when communicating with pharmaceutical companies.
2. When indicated, the drug is dispensed in a child resistant container.

3. The label can be easily read by the client or client’s guardian or representative.

4. The drug is handed directly to the client or the client’s guardian or representative.

5. Client education is provided and includes assessment of the client’s level of understanding regarding the drug, including but not limited to the:
   - purpose of the drug;
   - dosage regime and instructions required to achieve the intended therapeutic response, expected benefits and side-effects, storage requirements; and
   - written medication information.

6. The transaction (s) is accessible and recorded on an individual prescription profile and/or client record each time a drug is dispensed. The profile will include:
   - client name, address, phone number, date of birth, gender and, when available, allergies and idiosyncratic responses and personal health number assigned by the B.C. Ministry of Health;
   - date dispensed;
   - name, strength, dosage of drug and quantity dispensed;
   - duration of therapy;
   - directions to patient; and
   - signature and unique identifier of the nurse practitioner dispensing the drug.
PART II - LIMITS AND CONDITIONS

Nurse practitioners prescribe drugs approved for sale as outlined in the B.C. Pharmacists, Pharmacy Operations and Drug Scheduling Act and the federal Food and Drug Act and Regulations, and in accordance with CRNBC’s Standards for Prescribing and Dispensing Drugs.

Nurse practitioners in certain contexts of practice may require broader prescriptive authority than what is permitted in the limits and conditions (e.g., to initiate anticoagulants). Such groups of nurse practitioners will apply to the CRNBC multidisciplinary Nurse Practitioner Standards Committee to expand their prescribing authority. The committee will set standards and other requirements, such as educational preparation, that specific groups of prescribers must meet to be approved for expanded authority.

Nurse practitioners will have authority to request “Special Authority”14 medications with the exception of two situations:

- they will not have “Special Authority” privileges for prescribing those drugs that have been designated for physician specialists only; and
- they will not have “Special Authority” privileges for prescribing medications for which they have continuation prescribing authority.

Under the federal Controlled Drug Substances Act and Regulations, nurse practitioners do not have authority to prescribe narcotics and controlled drugs, including benzodiazepines and other targeted substances. The federal regulations are currently under review. CRNBC recommends that nurse practitioners be given authority to prescribe narcotics and benzodiazepines for short-term use only (to a maximum of six weeks). CRNBC would review narcotic and benzodiazepine prescribing practices using the PharmaNet database. Nurse practitioners who require broader prescriptive authority to meet their clients' needs would have to complete additional education as set out in the standards, limits and conditions set by the Nurse Practitioner Standards Committee.15

For some medications needed in a client’s care, nurse practitioner prescribing may be limited to “continuation” prescribing. Continuation prescribing means that a physician initiates the drug therapy and the nurse practitioner assumes responsibility and authority for the continuation of the drug therapy, including ongoing assessment and monitoring, re-ordering and/or making dosage adjustments to the drug therapy, and referral as needed.

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14 Special Authority is a process used by PharmaCare in cases in which a prescriber wishes to prescribe a drug for a patient that is not covered by PharmaCare or, in some cases, not fully covered. Under the Limited Drug Coverage Program, drugs may be fully covered when on application to PharmaCare-established criteria are met. Approval is granted when the prescriber provides documentation to PharmaCare that meets the established criteria.

15 Under the Bylaws the Nurse Practitioner Standards Committee must develop and recommend to the Board standards, limits and conditions for the practice of nurse practitioners in accordance with section 11(3) of the HPA Regulation for Nurses (Registered) and Nurse Practitioners.
LIMITS AND CONDITIONS
Nurse practitioners are authorized by the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act to prescribe Schedule I drugs as specified in the Drug Schedules Regulation 9/98 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act in accordance with the CRNBC limits and conditions as listed below. Commonly prescribed drugs are listed here by therapeutic category. Where nurse practitioners may prescribe all drugs in that category, it is noted by the term “no exceptions”. Where there are restrictions on nurse practitioner prescribing, they are noted by the type of restriction [i.e. “continuation” prescribing only (C) or cannot prescribe (O)].

Code:
- O cannot be prescribed
- C continuation prescribing only

1. Antihistamine Drugs – No exceptions.

2. Anti-infective Agents –
   - C Anti-tuberculosis agents (only for LTBI)
   - O Chronic hepatitis drugs (e.g., Interferon)
   - O HIV drugs

3. Anti-Neoplastic Agents (Anti-neoplastic drugs are not prescribed by nurse practitioners. To date, these agents are available only through the BC Cancer Agency) – Exception is:
   - C Methotrexate in adults (for inflammatory disease)

4. Autonomic Drugs –
   - C Antiparkinsonism agents
   - O Depolarizing and non-depolarizing skeletal muscle relaxants
   - O Ergot alkaloids

5. Blood formers and Coagulators –
   - C Hematopoietic growth factor
   - C Anticoagulants
   - O Thromboembolytic enzymes
   - O Hemostatic agents
   - O IV Iron preparations
6. **Cardiovascular Drugs** –
   - Antiarrhythmics

7. **Central Nervous Agents** –
   - General anesthetics
   - Benzodiazepines
   - Barbiturates
   - Narcotics
   - Methadone
   - Methylphenidate (Ritalin)
   - Dextroamphetamine sulphate

8. **Contraceptives (foams, devices)** – No exceptions and in accordance with the CRNBC nurse practitioner limits and conditions for treatments and interventions.

9. **Electrolytic, Caloric and Water Balance** –
   - Phosphate binders

10. **Antitussives, Expectorants and Mucolytic Agents** –
    - Narcotics

11. **Eye, Ear, Nose and Throat Preparations** –
    - Antiglaucoma agents
    - Ophthalmologic steroids
    - Carbonic anhydrase inhibitors

12. **Gastrointestinal Drugs** – No exceptions.

13. **Gold Compounds** – Not prescribed by nurse practitioners.

14. **Hormones and Synthetic Substitutes** –
    - Infertility drugs (e.g., gonadotropin-releasing hormones)
    - Prostaglandin
    - Pituitary (anti-diuretic) (e.g., vasopressin)
    - Androgen/anabolic steroids
    - Human growth hormone
Scope of Practice
FOR NURSE PRACTITIONERS (PEDIATRIC)
STANDARDS, LIMITS AND CONDITIONS

15. Oxytocics – Not prescribed by nurse practitioners.

16. Serums, Toxoids and Vaccines –
   ○ Yellow fever immunization

17. Skin and Mucous Membrane Agents –
   ○ Topical fluorouracil in adults
   ○ Psoralens (Methoxsalen) in adults
   ○ Oral retinoids (Acitretin)


20. Miscellaneous –
   ○ Immunosuppressants
   ○ Immunomodulators (biologic response modifiers)
Section C: Physician Consultation and Referral

PART I - STANDARDS

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

Consultation, including referral, as used in these Standards, refers to a specific request by a nurse practitioner for a physician to become involved in the care of a client. The responsibility to consult with or refer to a physician lies with the nurse practitioner and is made in collaboration with the client. A nurse practitioner may also seek consultation with or transfer care to a physician at the request of the client.

Consultation may result in one of the following levels of physician involvement:

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

The nurse practitioner documents the request for and outcome of the consultation or referral.

Transfer or sharing of care occurs only after discussion and agreement among the client, the referring nurse practitioner and the physician.

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

17 Physicians requesting consultation payment under the B.C. Medical Services Plan payment schedule must render a written report, including their findings, opinions, and recommendations to the referring nurse practitioner.
Standards

**STANDARD 1**
The nurse practitioner consults with or refers to physicians when the client’s health condition or needs are such that:

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

**STANDARD 2**
The nurse practitioner communicates and consults with or refers to physicians by:

- clearly presenting the reason for and the level of urgency of the consultation or referral;
- describing the level of physician involvement\(^ {18} \) requested at the time a referral is made;
- determining the availability of the physician to provide the consultation in a timely and appropriate manner;
- ensuring that the physician has appropriate access to the client’s relevant health information;
- confirming with the physician, following the consultation, the level of physician involvement; and
- documenting the request for and outcome of the consultation or referral.

**STANDARD 3**
The nurse practitioner and the consulting physician conjointly establish methods for communicating about their mutual client’s health condition and treatment decisions in situations in which client care is shared.

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\(^ {18} \) Levels of physician involvement: the physician provides an opinion and recommendation to the nurse practitioner who continues to have primary responsibility for the health care of the client; or the physician assumes concurrent responsibility for some aspects of the care and the physician and the nurse practitioner together clarify who is assuming responsibility for the various aspects of the client’s care, including coordination of the overall care; or the care of the client is transferred to the physician who then assumes primary responsibility for the care.
PART II - LIMITS AND CONDITIONS

Nurse practitioners have the authority to refer to family practice physicians and family practice physicians who have specialized, for example, in palliative care, sports medicine, anesthesia or geriatrics. Nurse practitioners also have the authority to make direct request for consultation/referral to the following medical specialists:

Clinical immunology and allergy – allergy testing
Dermatology
Ophthalmology
Otolaryngology
Internal medicine (and all subspecialties)
Rheumatology – for autoimmune disorders (RA, Lupus, Sjogren's Syndrome, Polymyalgia Arthritis)
Neurology
OB/GYN
Orthopedics
Pediatrics

Psychiatry
Physical medicine and rehabilitation
General surgery (and all subspecialties)
Urology
Emergency medicine
Anesthesia – for pain management
Plastic surgery – for nevi, wounds, carpel tunnel
Vascular surgery – for varicose veins, intermittent claudication and cold foot
Neurosurgery – for back
Appendix A

The Nurses (Registered) and Nurse Practitioners Regulation

The Nurses (Registered) and Nurse Practitioners Regulation (available online at www.qp.gov.bc.ca/statreg/reg/H/HealthProf/233_2005.htm) sets out, among other things:

- reserved titles for nurses;
- a scope of practice statement;
- reserved actions for registered nurses and nurse practitioners.

RESERVED TITLES

The Regulation states that only registrants of the College of Registered Nurses of British Columbia (CRNBC) may use the titles “registered nurse” or “licensed graduate nurse.” CRNBC registrants may also use the title “nurse.” As well, the title “nurse practitioner” has become a reserved title under the new Regulation. Only those nurses who are registered with CRNBC in the nurse practitioner category can use the title “nurse practitioner” or “registered nurse practitioner.” Registered nurses with temporary registration as a nurse practitioner can use the title of nurse practitioner, but must call themselves nurse practitioner (temporary).

Nurse practitioners can also use the title “registered nurse” and can practise in a registered nurse role (i.e., not a nurse practitioner role). When practising in a registered nurse role, the nurse practitioner must practise within the registered nurse (RN) job description and scope of practice. However, he or she is held accountable to the CRNBC Competencies Required for Nurse Practitioners in British Columbia and the Nurse Practitioner Scope of Practice Standards. In other words, the nurse practitioner would be expected to act as a reasonable, prudent nurse practitioner would act.19

CRNBC Bylaws explain the allowable abbreviated titles for nurse practitioners:

- NP or RN-NP20
- NP (Temporary)

19 NOTE: Nurse practitioners wishing to practise as an RN are advised to contact a CRNBC nursing practice consultant before doing so. Call CRNBC Practice Support at 604.736.7331 (ext. 332) or 1.800.565.6505. E-mail: practice@crnbc.ca

20 Nurse practitioners are advised to follow NP, in brackets, by the stream in which they are registered to practice [e.g., NP (Family) or NP (P); NP (Adult) or NP(A); NP (Pediatric) or NP(P)].
SCOPE OF PRACTICE

Scope of practice refers to the activities that nurses are educated and authorized to perform. These activities are:

- established through the legislated definition of nursing practice;
- complemented by standards, limits and conditions set by CRNBC.

Under the Regulation, a registrant of CRNBC may practise nursing, which is defined as the health profession in which a person provides or performs the following services:

- health care for the promotion, maintenance and restoration of health; and
- prevention, treatment and palliation of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and coordination of health services.

This definition does not refer to evaluation, but neither does it exclude it. Evaluation is, of course, an important part of nursing practice. The definition is broad and intended to apply to the practice of nursing of both groups of CRNBC registrants – registered nurses and registered nurse practitioners.

EXCEPTIONS

Nurses sometimes ask if it is ever appropriate to provide care that is outside the scope of practice set out in the Regulation. Nurse practitioners only provide care within their scope of practice, except in situations of life-threatening emergency. In these situations, nurse practitioners are ethically obligated to provide the best care they can, given the circumstances and their individual competence.

STANDARDS, LIMITS AND CONDITIONS

The Health Professions Act and the Nurses (Registered) and Nurse Practitioners Regulation give CRNBC the authority to establish, monitor and enforce standards, limits and conditions for nurses' practice.

Standard: A desired and achievable level of performance against which actual performance can be compared. It provides a benchmark below which performance is unacceptable. Registered nurses are familiar with standards of practice, which are set out in CRNBC's Professional Standards for Registered Nurses and Nurse Practitioners in British Columbia as well as in a series of CRNBC Practice Standards and the Nurse Practitioner Scope of Practice Standards.

Limits and Conditions: A limit is the point at which something must end. For example, while nurse practitioners are authorized to order a wide range of diagnostic services, they do not have authority to order MRIs. A condition is anything on which something else depends. For example, nurse practitioners can refer clients to an anaesthetist but only for purposes of pain management. Nurses are accustomed to having restrictions placed on their practice by their employer, but having limits and conditions set by the regulatory body (CRNBC) is new. The CRNBC Nurse Practitioner Standards Committee develops and recommends nurse practitioner standards, limits and conditions for approval by the CRNBC Board.
Scope of Practice
FOR NURSE PRACTITIONERS (PEDIATRIC)  STANDARDS, LIMITS AND CONDITIONS

RESERVED ACTIONS
The Regulation assigns reserved actions to nurse practitioners for activities such as: making a diagnosis to identify a disease, disorder or condition; ordering diagnostic services; and prescribing and dispensing drugs. As specified in the Regulation, these activities are provided in accordance with standards, limits and conditions established by CRNBC. CRNBC's scope of practice documents include:

- Scope of Practice for Nurse Practitioners (Family): Standards, Limits and Conditions;
- Scope of Practice for Nurse Practitioners (Adult): Standards, Limits and Conditions; and

The scope of nurse practitioner practice builds on the scope of registered nurse practice. Nurse practitioners must be familiar with both registered nurse and nurse practitioner scope to understand the scope of nurse practitioner practice. For further details on the Nurses (Registered) and Nurse Practitioners Regulation as it pertains to registered nurse practice, please read the document on the CRNBC website entitled Scope of Practice for Registered Nurses: Standards, Limits and Conditions.\(^\text{21}\)

\(^{21}\) Scope of practice documents can be found on the Nursing Practice section of the CRNBC website www.crnbc.ca
Resources

Diagnosing and Health Care Management

TEXTS


GUIDELINES


WEB-BASED GUIDELINES

Canadian Medical Association InfoBase. Clinical Practice Guidelines. mdm.ca/cpgsnew/cpgs/index.asp

USA National Guideline Clearinghouse. www.guidelines.gov/
Prescribing


Scope of Practice for Nurse Practitioners (Adult)

Standards, Limits and Conditions
CRNBC Standards of Practice

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

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

Professional Standards

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

Practice Standards

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

Scope of Practice Standards

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

All CRNBC Standards are available online at www.crnbc.ca

WHERE TO GET ASSISTANCE

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

Nurse practitioners are registered nurses who have achieved additional competencies required for registration as a nurse practitioner with the College of Registered Nurses of British Columbia (CRNBC). Their scope of practice includes providing health care services from a holistic nursing perspective combined with a focus on diagnosing and treating acute and chronic illnesses, including prescribing medications.

Nurse practitioners are required to practise in accordance with CRNBC's Standards of Practice (Professional Standards, Practice Standards, and Scope of Practice Standards). Nurse practitioners must meet requirements for ongoing registration, including continuing competence requirements and a quality assurance practice review. The principles for nurse practitioner continuing competence requirements and quality assurance program and the Continuing Competence Requirements for Nurse Practitioners in British Columbia can be found online at www.crnbc.ca under Registration (applying for nurse practitioner).

The legal authority for the nurse practitioner scope of practice is set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act (see the B.C. Ministry of Health website www.healthservices.gov.bc.ca). Nurse practitioners must be familiar with both the registered nurse and nurse practitioner scope to understand their scope of practice. Reserved title as it applies to nurse practitioner is also addressed in the Regulation. See Appendix A for further information on the Regulation as it pertains to nurse practitioners.

The Regulation assigns reserved actions to nurse practitioners for activities such as: making a diagnosis to identify a disease, disorder or condition; ordering diagnostic services; and prescribing and dispensing drugs. As specified in the Regulation, these activities are provided in accordance with standards, limits and conditions established by CRNBC.

This document includes the standards with limits and conditions specific to the scope of nurse practitioner (adult) practice for: diagnosing (including ordering diagnostic services and providing or performing treatments and interventions); prescribing and dispensing medications; and physician consultation and referral.

From time to time, this document may be revised to reflect changes to the limits and conditions, in particular to ordering diagnostic services and prescribing drugs. Please check the CRNBC website (www.crnbc.ca) regularly for updates.

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Section A: Diagnosing and Health Care Management

PART I - STANDARDS

Nurse practitioners (adult) are expected to meet standards and practice requirements for entry-level diagnosing and health care management of clients as a requirement for practice in British Columbia (B.C.).

The nurse practitioner (adult) provides health care services to young, middle-aged and older adults. Care of older adolescents may also be provided by a nurse practitioner (adult) in some instances when the adolescent’s developmental age and/or lifestyle may more closely approximate that of an adult. The setting in which nurse practitioners (adult) practise will vary according to the characteristics of the adults and the focus of care activities (e.g., managing acute illness; acute exacerbations of chronic illness or significant co-morbidity in tertiary care; managing chronic illness in residential or home care). Nurse practitioners (adult) can be found in acute and long term care as well as community settings. Nurse practitioners (adult) may be the primary care providers for adults in some settings.

Nurse practitioner practice is not focused solely on diagnosing and managing diseases, disorders and conditions. As primary health care providers, nurse practitioners emphasize health promotion and disease and injury prevention. This comprises activities in all three levels of primary, secondary and tertiary prevention. Activities might include:

- promoting healthy living through assessing for developmental milestones of the adult and older adult or the impact of family transitions such as marriage, relocation, retirement, death and coping with palliative care and end-of-life issues or implementing interventions, such as health education, nutrition and exercise counselling, lifestyle and sex education;

- preventing disease through interventions promoting protection from occupational and environmental hazards, falls, and carcinogens or educating high risk adult groups about substance abuse or caregiver burden; and

- facilitating early diagnosis and treatment through screening for vision and hearing problems or screening for diseases and disorders, such as various cancers (e.g., breast, cervical, colorectal, prostate), diabetes, hypertension, HIV, osteoporosis, and elevated cholesterol or by prompt identification and treatment of infectious disease.

Nurse practitioners work with other health care providers and resources in other sectors in collaborative interdisciplinary relationships to provide health care for adults including the older adult. They may build on their nurse practitioner adult stream to specialize in the care of adults in such areas as mental health, geriatrics, palliative care, cardiology or neurology.

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2 Primary health care: Essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost the community and country can afford. Essential health care includes health promotion, disease and injury prevention, curative care, rehabilitation and supportive care, including palliative care.
Nurse practitioners (adult) diagnose and manage the care and treatment of clients who present with common acute and chronic multi-system physical and mental diseases, disorders and conditions. They are also prepared to recognize and/or screen for a number of diseases, disorders and conditions, such as iritis, pericarditis or temporal arteritis that may be included in their differential diagnosis, but which are beyond their competence and scope of practice. When suspected as the primary diagnosis, such diseases, disorders and conditions are immediately referred to a physician or transferred to emergency medicine as appropriate.

When a nurse practitioner (adult) has patients in her or his care or practice who have a disease or disorder that is being managed by a physician (e.g., patients with cancer), the nurse practitioner is expected to have the competence to monitor the condition of these patients and to consult their physician should a need arise.
Standards

**STANDARD 1**
Nurse practitioners diagnose and manage diseases, disorders and conditions within the limits of the nurse practitioner's legislated scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult or pediatric).

**STANDARD 2**
Nurse practitioners have an ethical obligation to be available to provide care for their established patients on a 24-hour basis either personally or through ongoing call schedules. Nurse practitioner call schedules are made at the level of the practice setting. When a nurse practitioner signs off to an alternative provider, there must be mutual agreement and willingness on the part of the alternative provider as to when and how the provider will assume the responsibility for the patient's care.

**STANDARD 3**
Nurse practitioners refer patients to a physician at any point in time as deemed necessary in accordance with CRNBC's standards for nurse practitioner-physician consultation.

**STANDARD 3**
Entry-level nurse practitioners have the competence to diagnose and manage common acute and chronic physical and mental diseases, disorders and conditions and meet expectations as outlined on pages 8-13:

**Code:**

**D** The nurse practitioner diagnoses and manages independently or refers as appropriate. Will refer to physician at any point as deemed necessary or at some stage as per accepted guidelines. Referrals are in accordance with CRNBC's standards for nurse practitioner-physician consultation (see Section C).

**C** The nurse practitioner establishes or strongly suspects the diagnosis and consults with a physician for the management plan or consults with a physician to confirm the diagnosis, and as a result of the consultation:

i) the nurse practitioner receives an opinion and recommendation, and assumes ongoing primary responsibility and authority for the plan of care;

ii) the physician assumes concurrent responsibility for some aspects of the plan of care; or

iii) the care is transferred to the physician or emergency medicine as appropriate.
Common Diseases and Disorders Diagnosed and Managed by the Entry-Level Adult Nurse Practitioner

The hallmark of nurse practitioner (adult) education is that the practitioner is prepared with the competencies to recognize, initiate diagnostic workup and then to either manage or co-manage, as appropriate, the complex care and treatment of clients who present with acute and chronic multi-system physical and mental diseases, disorders and conditions.

1. Common Neurological Diseases/Disorders
   - Headaches – primary headaches without structural or systemic pathology
   - Tremors – benign (essential tremors)
   - Delirium
   - Transient ischemic attacks (TIAs)
   - Peripheral neuropathies
   - Fibromyalgia
   - Herpes zoster
   - Trigeminal neuralgia
   - Bell’s palsy
   - Restless leg syndrome
   - Chronic seizure disorders
   - Parkinson’s disease
   - Multiple sclerosis
   - Cerebral vascular disorder
   - Meningitis/encephalitis
   - Alzheimer’s disease and related dementias

2. Common Dermatologic Diseases/Disorders
   - Parasitic – scabies and pediculosis
   - Fungal – candidiasis, dermatophytoses tinea and onychomycosis
   - Bacterial – impetigo, folliculitis, furuncles and carbuncles
   - Bacterial – cellulitis
   - Viral – warts and herpes simplex
   - Acne vulgaris and rosacea
   - Dermatitis – atopic (eczema), contact, seborrheic and stasis
   - Psoriasis
   - Pityriasis rosea
   - Lichen planus
   - Sunburn
   - Non-malignant skin lesions
   - Malignant skin lesions
3. **Common Disorders and Diseases of the Eyes, Ears, Nose and Throat**

**Eyes**
- D Blepharitis
- D Chalazion
- D Conjunctivitis
- D Simple corneal abrasion
- D Hordeolum
- D Nasolacrimal duct obstruction
- D Simple foreign body
- D Cataracts
- C Glaucoma
- C Orbital cellulitis
- C Uveitis

**Ears**
- D Benign positional paroxysmal vertigo
- D Cerumen impaction
- D Otitis media
- D Labyrinthitis
- D Mastoiditis
- D Meniere’s disease
- D Otitis externa
- D Perforated ear drum

**Nose and Throat**
- D Rhinitis
- D Cervical adenitis
- D Epistaxis
- D Gingivitis
- D Pharyngitis
- D Temporomandibular joint disease
- D Sinusitis
- D Tonsilitis
- D Stomatitis and glossitis

4. **Common Diseases and Disorders of the Respiratory Tract**
- D Asthma
- D Bronchitis and bronchiolitis
- D Chronic obstructive pulmonary disease
- D Influenza
- D Pneumonia
- D Pertussis
- D Smoking addiction/cessation
- C Tuberculosis
- C Sleep Apnea
- C Epiglottis
- C Interstitial lung disease
5. **Common Diseases/Disorders of the Cardiovascular System**
   - D Stable coronary artery disease
   - D Chronic heart failure
   - D Hypertension
   - D Hyperlipidemia
   - D Mitral valve prolapse
   - D Peripheral vascular disease
   - D Raynaud’s disease
   - D Stasis ulcers
   - D Superficial acute thrombophlebitis
   - D Varicose veins
   - C Arrhythmias
   - C Buerger’s disease
   - C Deep vein thrombosis

6. **Common Diseases/Disorders of the Gastrointestinal system**
   - D Anal fissures
   - D Cholecystitis
   - D Constipation
   - D Diarrhea
   - D Diverticular disease
   - D Gastroenteritis
   - D Gastro-reflux disease (GERD)
   - D Hemorrhoids
   - D Hepatitis A (viral)
   - D Hernia (hiatal, inguinal, umbilical)
   - D Irritable bowel syndrome
   - D Parasitic infections (roundworm and pinworm)
   - D Peptic ulcer
   - C Dysphagia
   - C Chronic inflammatory bowel disease (ulcerative colitis and Crohn’s disease)
   - C Chronic pancreatitis
   - C Hepatitis B & C
Scope of Practice

STANDARDS, LIMITS AND CONDITIONS FOR NURSE PRACTITIONERS (ADULT)

7. Common Diseases /Disorders of the Renal and Genitourinary Systems
   - Lower urinary tract infections
   - Interstitial cystitis
   - Pyelonephritis
   - Nephrolithiasis
   - Urinary incontinence
   - Renal failure
   - Other nephropathies

8. Common Diseases/Disorders of the Reproductive System
   **Male**
   - Balanitis
   - Benign prostatic hyperplasia
   - Epididymitis
   - Impotence/erectile dysfunction
   - Sexually transmitted diseases
   **Female**
   - Amenorrhea (primary)
   - Abnormal uterine bleeding
   - Atrophic vaginitis
   - Dysmenorrhea
   - Endometriosis
   - Family planning and contraception
   - Fertility problems
   - Mastitis
   - Prostatitis
   - Hydrocele
   - Varicocele
   - Menopause
   - Pelvic inflammatory disease
   - Premenstrual syndrome
   - Ovarian cyst
   - Vulvovaginal infections and sexually transmitted diseases (exception HIV and hepatitis C)
   - Polycystic ovary syndrome

9. Common Diseases and Disorders of the Musculoskeletal System
   - Bursitis
   - Carpel tunnel syndrome
   - Cervical/thoracic muscle strain and spasm
   - Costochondritis
   - Fibromyalgia
   - Impingement syndromes
   - Joint pain/injury (sprains, strains, and pain
   - Low back pain
   - Osteoarthritis
   - Osteoporosis
   - Plantar fasciitis
Scope of Practice
FOR NURSE PRACTITIONERS (ADULT) STANDARDS, LIMITS AND CONDITIONS

D Repetitive motion syndrome
D Tendonitis/tendosynovitis
D Paget's disease
C Meniscus and ligament tears
C Herniated disc

10. Common Diseases/Disorders of the Endocrine and Metabolic Systems
D Diabetes type II
D Gout
D Hypothyroidism
D Obesity
C Cushing's syndrome
C Diabetes insipidus
C Diabetes type I
C Hyperthyroidism (Graves disease)

11. Common Hematological and Immune Diseases/Disorders

Hematologic
D Anemia
C Chronic lymphocytic leukemia
C Anemia (sickle cell)
C Disseminated intravascular coagulation
C Non-Hodgkin's lymphoma
C Polycythemia vera

Immune
D Allergic reactions
C Chronic fatigue syndrome
C AIDS/HIV
C Rheumatoid arthritis
C Sjogren's syndrome
C Systemic lupus erythematosus

12. Infectious Diseases
D Chickenpox
D Coxsackie viral infection
D German measles (rubella)
D Giardiasis
D Infectious mononucleosis
D Influenza
D Lyme disease
D Measles (rubeola)
D Mumps
D Rocky mountain spotted fever
13. Common Psychiatric Diseases/Disorders and Mental Health/Psychosocial Problems

Psychiatric Diseases
- Anxiety disorders (panic attacks, phobias, generalized anxiety disorder, adjustment disorder)
- Post traumatic stress disorder
- Obsessive compulsive disorder
- Attention deficit disorder
- Depression

Mental Health/Psychosocial Problems
- Domestic violence – elder and spousal abuse
- Sexual assault

14. Common Emergency Problems (* all within the nurse practitioner’s scope and competence depending on the severity. Referral would be indicated when beyond scope and competence)
- Wounds and lacerations
- Burns
- Animal and human bites
- Arthropod bites and stings
- Foreign bodies
- Poisoning
- Head trauma
- Fractures (not requiring reduction or casting)
PART II - LIMITS AND CONDITIONS

Limits and conditions apply to health care management of clients with respect to:

- ordering diagnostic services (imaging and laboratory services); and
- providing or performing advanced treatments and interventions.

Ordering Diagnostic Services

LABORATORY SERVICES

Nurse practitioners are authorized to order laboratory and other tests as designated below. Note: When ordering a CAT scan or Holter Monitoring for a client, the nurse practitioner has a professional obligation to first discuss the case with a physician. The test is independently ordered by the nurse practitioner and identification of the physician is not required. A formal consultation is not required unless requested by the physician.

Any laboratory test not found on the list must be ordered by a physician.

Hematology and Blood Bank

ANA
Anti-DNA
Cold agglutinins – qualitative
Hematology profile (to include automated Hgb, WBC, platelet count, Hct, RBC indices and differential white cell count when indicated) (NB: singles may be ordered)
Haemoglobin electrophoresis
Direct and indirect coombs
Latex test (rheumatoid factor)

Microbiology

Acid fast organisms – (microbacterial)
C. difficile toxin
Fungal culture

Infectious mononucleosis
Malaria and other parasites
Partial thromboplastin test
Prothrombin time/INR
RBC morphology
Red cell folate
Reticulocyte count and/or Heinz bodies
Rh(D) typing
Thalassaemia/haemoglobinopathy investigation
Sickle cell identification
Chlamydia (NAT) – urine, (NAT) SWAB, and/or culture
Fungus – direct examination KOH preparation (office)
### Standards, Limits and Conditions for Nurse Practitioners (Adult)

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Procedure/Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood culture - aerobic and/or anaerobic</td>
<td>Stool culture</td>
</tr>
<tr>
<td>Hepatitis A - IgM (Anti-HAV-IgM)</td>
<td>Streptococci – rapid test (office)</td>
</tr>
<tr>
<td>Hepatitis B - core antibody (Anti-HBC), surface antibody (Anti-HBS)</td>
<td>Anti-streptolysin “O” titre</td>
</tr>
<tr>
<td>Hepatitis Be Antigen</td>
<td>Trichomonas and/or candida – direct examination</td>
</tr>
<tr>
<td>Hepatitis C (serology)</td>
<td>Examination for pinworm ova</td>
</tr>
<tr>
<td>Polymerase Chain Reaction (PCR)</td>
<td>Stool examination – concentration methods; for amoebae</td>
</tr>
<tr>
<td>Routine cultures – routine culture, cervical, vaginal, urethral, sputum, wound,</td>
<td>Macroscopic examination of parasite and/or direct</td>
</tr>
<tr>
<td>urine and/or nose and/or throat</td>
<td>microscopic examination</td>
</tr>
<tr>
<td>Smear for inclusion bodies</td>
<td>Serological tests – for antigens; for identification</td>
</tr>
<tr>
<td>Genital culture – combined vagino-anorectal or vaginal culture for group B</td>
<td>of bacterial micro-organisms</td>
</tr>
<tr>
<td>streptococcus only, vaginal smear and culture for bacteria (BV and Trichomonas)</td>
<td>Viral culture</td>
</tr>
<tr>
<td>and/or other sites</td>
<td>CD4/CD8 Counts ³</td>
</tr>
<tr>
<td>C - reactive protein</td>
<td>Viral Load ³</td>
</tr>
</tbody>
</table>

### Chemistry

- Acid phosphatase – total or fractions
- Albumin – serum/plasma
- Alcohol
- Alanine aminotransferase (ALT)
- Alkaline phosphatase
- Alpha 1 – antitrypsin
- Amylase – serum/plasma
- Arsenic
- Aspartate aminotransferase (AST)
- Bicarbonate – serum/plasma
- Bilirubin – direct and/or total
- Calcium – total, serum/plasma and/or urine random
- Carbamazepine

- Chloride – quantitative - serum/plasma
- Sweat test for cystic fibrosis
- Cholesterol, total
- Cortisol
- Creatine kinase (CPK)
- Creatinine – random urine and timed urine collection and/or serum/plasma
- Digoxin
- Drug assay – single and multiple
- Drugs of abuse screen – urine
- Screening assays
- Electrophoresis – protein (quantitative)
- Estradiol
- Fat, microscopic examination – feces
- Ferritin – serum

³ These HIV monitoring tests are ordered by nurse practitioners working in a model of shared care delivery for HIV patients. Nurse practitioners monitoring patients with HIV do so in accordance with the BC Centre for Excellence HIV/AIDS Care Therapeutic Guidelines. Education courses are available through the BC Centre for Excellence www.cfenet.ubc.ca. Note: Nurse practitioners do not prescribe anti-retrovirals.
Scope of Practice
FOR NURSE PRACTITIONERS (ADULT)

Folic acid
Follicle stimulating hormone (FSH)
Glucose – gestational assessment (Random) and 2 hr post 75 g screening for gestation diabetes
Glucose quantitative – serum/plasma (fasting and random)
Glucose tolerance test – 2 hours (oral)
Gamma Glutamyl transpeptidase (GGTP)
Haemoglobin, A1C
Helicobacter pylori – carbon 13 urea breath test
HDL
High density lipoproteins cholesterol (HDL cholesterol)
IgG (Anti –TTG) (Celiac screening)
Ig A antigliadin (Celiac screening)
Iron – total and binding capacity
Lead
Lactate dehydrogenase (LHD)
Lithium – serum/plasma
Luteinizing hormone (LH)
Lipase
Lipoprotein A and/or B
Magnesium – serum/plasma
Mercury
Micro albumin
Albumin – urine, serum
Osmolality – serum
Oxygen – capacity or content (direct gas analysis)
Parathyroid hormone (intact)
pH, pCO2, and pO2
Phenytoin – quantitative
Phosphates – serum/plasma
Plasma homocyst(e)ine
Potassium – serum/plasma
Pre albumin
Pregnancy test – serum
Primidone (mysoline)
Progesterone – serum/plasma
Prolactin
Prostatic specific antigen (PSA – testing – as per guidelines)
Proteins – total, quantitative – timed urine collection, or serum or plasma
Quantitative beta hCG
Salicylates, quantitative – serum
Sodium – serum plasma, random urine, whole blood
Testosterone – total
Theophylline
Thyroxine – free T4 as per guidelines and T3 free
Thyroid microsomal antibodies
Thyroid stimulating hormone (TSH) – any method (as per guidelines)
Transferrin
Triglycerides – serum/plasma
Troponin
Urea – nitrogen quantitative – urine and/or serum/plasma
Urine – micro albumin
Uric acid – serum and timed urine collection
Urinalysis – complete, macroscopic and microscopic
Vitamins – B12 (as per guidelines) and Vitamin D (25 dihydroxy)
Zinc and DHEA-S (Dehydroepiandrosterone-serum)
Miscellaneous

E.C.G. tracing, without interpretation and/or with interpretation

ELISA (HIV antibody screening test)  

Holter monitoring

Semen – complete examination including total count, motility count, pH and morphology

Sperm – seminal examination for presence or absence

Peak expiratory flow rate

Screening spirometry – with FVC, FEV (i) and FEV (i)/FVC ratio without broncho dilators and/or before and after broncho dilators

Laboratory procedures shortlist (tests referred or performed in practitioner’s offices)

4 Ordering of this test includes the follow-up Western Blot and the PCR as determined by practice and laboratory standards
IMAGING SERVICES

- A nurse practitioner is authorized to order x-rays, ultrasounds and other forms of imaging as designated below.

- The final interpretation of x-ray and an ultrasound is the responsibility of the radiologist.

- Any x-ray or ultrasound not found on the list must be ordered by a physician.

Radiology

**Head and Neck**

<table>
<thead>
<tr>
<th>Skull – routine</th>
<th>Mastoids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranasal sinuses</td>
<td>Mandible</td>
</tr>
<tr>
<td>Facial bones – orbit</td>
<td>Temporo-mandibular joints</td>
</tr>
<tr>
<td>Nasal bones</td>
<td>Nasopharynx and/or neck, soft tissue</td>
</tr>
</tbody>
</table>

**Upper Extremity**

<table>
<thead>
<tr>
<th>Shoulder girdle</th>
<th>Forearm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humerus</td>
<td>Wrist</td>
</tr>
<tr>
<td>Elbow</td>
<td>Hand (any part)</td>
</tr>
</tbody>
</table>

**Lower Extremity**

<table>
<thead>
<tr>
<th>Hip*</th>
<th>Ankle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femur</td>
<td>Foot (any part)</td>
</tr>
<tr>
<td>Knee</td>
<td>Leg length films</td>
</tr>
<tr>
<td>Tibia and fibula</td>
<td></td>
</tr>
</tbody>
</table>

**Spine and Pelvis**

<table>
<thead>
<tr>
<th>Cervical spine</th>
<th>Pelvis*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic spine</td>
<td>Sacroiliac joints</td>
</tr>
<tr>
<td>Lumbar spine</td>
<td>Scoliosis film</td>
</tr>
<tr>
<td>Sacrum and coccyx</td>
<td></td>
</tr>
</tbody>
</table>

**Chest**

<table>
<thead>
<tr>
<th>Thoracic viscera</th>
<th>Sternum or sterno-clavicular joints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ribs – one side</td>
<td>Sternum and sterno-clavicular joints</td>
</tr>
<tr>
<td>Ribs – both sides</td>
<td></td>
</tr>
</tbody>
</table>

**Abdomen**

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Abdomen, multiple views</th>
</tr>
</thead>
</table>

**Gastrointestinal Tracts – Barium**

<table>
<thead>
<tr>
<th>Oesophagus only</th>
<th>Small bowel follow through</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oesophagus, stomach and duodenum (upper GI series)</td>
<td>Colon or double contrast air studies - barium enema</td>
</tr>
</tbody>
</table>

**Genito-Urinary System**

| K.U.B.                    |                        |

* These may be ordered in combination.
Scope of Practice
STANDARDS, LIMITS AND CONDITIONS FOR NURSE PRACTITIONERS (ADULT)

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone survey – first anatomical area (for history of abuse – age of # and/or follow-up metastatic ca)</td>
<td>Mammography – unilateral (rural may need to refer out)</td>
</tr>
<tr>
<td>Bone survey – each subsequent anatomical area</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone Mineral Densitometry Using DEXA Technology</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone density – single area (as per guidelines)</td>
<td>Bone density – second area (as per guidelines)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Ultrasound</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Soft tissues of neck</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
</tr>
<tr>
<td>Echocardiography (real time) (as per guidelines)</td>
<td></td>
</tr>
<tr>
<td>Thorax</td>
<td></td>
</tr>
<tr>
<td>Breast sonogram – unilateral (as per billing criteria) with immediate needle biopsy and aspiration by attending radiologist as warranted.</td>
<td>Breast sonogram – additional side</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal</td>
<td></td>
</tr>
<tr>
<td>Renal B Scan</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obstetrics and Gynecology</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrical (14 weeks gestation or over)</td>
<td>B scan I.U.D. localization</td>
</tr>
<tr>
<td>Obstetrical (under 14 weeks gestation)</td>
<td>Pelvic (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extremities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doppler Studies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral arterial – resting arterial assessment</td>
<td>Peripheral venous – laboratory assessment for deep venous system</td>
</tr>
<tr>
<td>Carotid imaging – duplex scanning of neck vessels</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT Scan</td>
<td></td>
</tr>
</tbody>
</table>
Limits and Conditions on Treatments and Advanced Interventions

Nurse practitioners (adult) commonly provide or perform treatments and interventions under reserved actions such as: simple wound closure (suturing); incision and drainage; punch biopsy; and insertion of IUDs and endometrial biopsy. To provide such treatments and interventions, a nurse practitioner must be able to give evidence of having acquired the skill through formal theoretical and clinical education and supervision.

LIMITS AND CONDITIONS

Nurse practitioners are currently prohibited from providing or performing the following treatments and interventions:

- applying X-rays for diagnostic or imaging purposes except for CAT as designated in the Limits and Conditions for Ordering X-rays; and
- setting or casting a closed simple fracture of a bone or reducing a dislocation.

Nurse practitioners wishing to undertake these activities must submit a formal request for consideration by the CRNBC Nurse Practitioner Standards Committee.

5 Nurse practitioners undertaking this activity: must ensure that they have been appropriately prepared with the competencies to perform the activity, including didactic preparation and clinical supervision; and do so only when the nature of their practice is such that performance of the activity occurs with sufficient frequency to maintain competence (e.g., nurse practitioners who have a focussed practice in women's health or who provided primary care services on a regular basis to women).

6 NOTE: Nurse practitioners wishing to provide treatments and interventions for which they have not had formal theoretical and clinical education and supervision should contact CRNBC before doing so. Contact the CRNBC Nursing Policy Department at 604.736.7331 (ext. 335) or 1.800.565.6505. E-mail: nurse.practitioner@crnbc.ca
Section B: Prescribing and Dispensing Drugs

PART I - STANDARDS

Prescribing Standards

**STANDARD 1**
Nurse practitioners prescribe drugs within the limits of the nurse practitioner's scope of practice and individual competence within that scope of practice.

**STANDARD 2**
Nurse practitioners prescribe from provincial Drug Schedules I, II and III in accordance with the B.C. Pharmacists, Pharmacy Operations and Drug Scheduling Act and the federal Controlled and Drug Substances Act and Regulation and the College of Registered Nurses British Columbia (CRNBC) Prescribing Standards, Limits and Conditions.

**STANDARD 3**
Nurse practitioners prescribe medications in accordance with ethical, legal and professional standards of drug therapy.

**STANDARD 4**
Nurse practitioners engage in evidence-based prescribing and consider best practice guidelines and other relevant guidelines when prescribing for clients, including when recommending complementary or alternative health therapies. A nurse practitioner ensures that the recommended complementary or alternative health therapy does not pose a greater risk to patient health or safety than prevailing health care practices, and does not interfere with concomitant health care practices.

---

7 Competence: The integration and application of knowledge, skills, attitude and judgment required for safe performance in an individual’s practice.
8 The provincial drug schedules can be found on the College of Pharmacists website at www.bcpharmacists.org/legislation/pdf/Drug_Schedules_Regulation.pdf
9 Under current federal regulations, nurse practitioners are not allowed to prescribe narcotics or controlled drugs. These regulations are currently under review.
10 CRNBC’s Quality Assurance Program requires nurse practitioners to undergo mandatory review by CRNBC of their prescribing practices within the first two years of practice in B.C. and then at least every five years.
11 CRNBC publications that have particular relevance in guiding nurse practitioner practice ethics related to nurse-client relationships and situations of conflict of interest are Nurse-Client Relationships: Establishing Professional Relationships and Maintaining Appropriate Boundaries (Position Statement – pub. 389) and Use of Title (pub. 343). Both are available on the CRNBC website www.crnbc.ca
12 Including the B.C. Medical Services Plan (MSP) Guidelines and Protocols
13 See the CRNBC Practice Standard Complementary and Alternative Health Care (pub. 437).
Scope of Practice

FOR NURSE PRACTITIONERS (ADULT)

STANDARDS, LIMITS AND CONDITIONS

STANDARD 5
Nurse practitioners may write prescriptions for clients (when required for reimbursement by insurance plans or to meet provincial regulations) for nutritional supplementation, appliances and devices and for drugs found in Schedules II and III. (Drugs listed in Schedules II and III do not legally require a prescription).

STANDARD 6
Nurse practitioners are solely accountable for their prescribing decisions.

STANDARD 7
Nurse practitioners participate in the Canadian Adverse Drug Reaction Reporting Program.

STANDARD 8
Nurse practitioners meet the following expectations when prescribing drugs:

1. Completes prescriptions accurately and completely including the following information (Bylaws to the Pharmacists, Pharmacy Operations and Drug Scheduling Act and Regulations):
   - date of issue;
   - name and address (if available) of client;
   - name, strength and dosage form of the substance and the quantity prescribed and quantity to be dispensed (Note: If the prescriber intends to prohibit generic substitution, it must be done in accordance with section 30 (1) and (3) of the Pharmacy Act);
   - directions for use – refers to the frequency or interval or maximum daily dose, route of administration and the duration of drug therapy;
   - directions for number of allowable refills and interval between refills (Note: While it is not legally required, if a prescription includes more than one drug, any drug that may be refilled must be clearly identified. If all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug); and
   - prescriber’s name, address, telephone number and signature including unique nurse practitioner identifier/number.
Note: Other elements, not legally required but that might be considered when prescribing include: indicating if a child resistant container is not indicated; indicating the use of the drug; noting client age, date of birth and weight if the client is on either end of the extreme of their weight range; and/or including special instructions, such as “take with food.”

Note: A prescription may be telephoned to the pharmacist (unless prohibited by legislation) and must include the prescription information outlined above.

Note: A prescription may be transmitted by facsimile (fax) to a pharmacy, provided that the following requirements are met (Pharmacy Act):

- the prescription must be sent only to the pharmacy of the client’s choice with no intervening person having access to the prescription authorization;
- the prescription must be sent directly from the prescriber’s office or directly from a health institution for a patient of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy;
- the prescription must include all information listed above and in addition must include:
  - time and date of transmission;
  - name and fax number of the pharmacy intended to receive the transmission; and
  - a signed certification that the prescription represents the original of the prescription drug order, the addressee is the only recipient and there are no others, and the original prescription is invalidated or retained such that it cannot be re-issued.

2. Documents the prescription on the client record.

3. Provides educational information to clients about prescription and non-prescription drugs that includes information regarding:

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

4. Monitors and documents the client’s response to drug therapy. Based on the client’s response, the nurse practitioner may decide to continue, adjust or withdraw the drug, or to consult with a pharmacist, another nurse practitioner or with a physician in accordance with the CRNBC standards for nurse practitioner-physician consultation.

5. When client care is shared with a physician(s), conjointly determines with the physician, processes for access to the client’s health record for purposes of treatment decisions and communication.

6. Stores blank prescriptions in a secure area that is not accessible to the public and does not provide any person with a blank, signed prescription.

7. Does not prescribe for oneself or become involved in self-care.

8. If other options are not available, may prescribe for family, friends or peers, provided the client/provider relationship is established and documented.

9. When receiving information from a pharmaceutical representative, independently verifies the information obtained.
Dispensing Standards

**STANDARD 1**
Nurse practitioners dispense medications in situations in which a pharmacist is not available or accessible, and/or it is in the best interest of the client to do so.

**STANDARD 2**
Nurse practitioners acquire, store, dispense and dispose of drugs in accordance with provincial and federal legislation and regulations, and standards and guidelines for best practice. Nurse practitioners who dispense other than drug samples or small quantities of medications must receive approval from CRNBC to be designated as a dispensing practitioner and comply with procedures for Approval Process for Dispensing Practitioners PharmaNet/Pharmacare as set out by the College of Pharmacists of British Columbia.

**STANDARD 3**
Nurse practitioners meet the following expectations when dispensing drug samples or small quantities of medication to their clients:

1. The prescription label (or envelope) indicates (Pharmacists, Pharmacy Operations and Drug Scheduling Act and Regulations):
   - client’s name;
   - drug name, strength where appropriate, and dosage;
   - direction for use;
   - quantity dispensed;
   - date dispensed;
   - prescribing number of prescriber; and
   - initials of nurse practitioner distributing the drug and the location from which the drug is dispensed, including name, address and telephone number.

   **Note:** Any other information required by good pharmacy practice (not in the Act) is affixed, such as: expiry date; when applicable; or appropriate special circumstances/auxiliary labels (e.g., shake well).

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14 The CRNBC document *Use of Title* (pub. 343) has particular relevance in guiding nursing practitioner practice ethics related to situations of conflict of interest that may arise when communicating with pharmaceutical companies.
2. When indicated, the drug is dispensed in a child resistant container.

3. The label can be easily read by the client or client’s guardian or representative.

4. The drug is handed directly to the client or the client’s guardian or representative.

5. Client education is provided and includes assessment of the client’s level of understanding regarding the drug, including but not limited to the:
   - purpose of the drug;
   - dosage regime and instructions required to achieve the intended therapeutic response, expected benefits and side-effects, storage requirements; and
   - written medication information.

6. The transaction(s) is accessible and recorded on an individual prescription profile and/or client record each time a drug is dispensed. The profile will include:
   - client name, address, phone number, date of birth, gender and, when available, allergies and idiosyncratic responses and personal health number assigned by the B.C. Ministry of Health;
   - date dispensed;
   - name, strength, dosage of drug and quantity dispensed;
   - duration of therapy;
   - directions to patient; and
   - signature and unique identifier of the nurse practitioner dispensing the drug.
PART II - LIMITS AND CONDITIONS

Nurse practitioners prescribe drugs approved for sale as outlined in the B.C. Pharmacists, Pharmacy Operations and Drug Scheduling Act and the federal Food and Drug Act and Regulations, and in accordance with CRNBC's Standards for Prescribing and Dispensing Drugs.

Nurse practitioners in certain contexts of practice may require broader prescriptive authority than what is permitted in the limits and conditions (e.g., to initiate anticoagulants). Such groups of nurse practitioners will apply to the CRNBC multidisciplinary Nurse Practitioner Standards Committee to expand their prescribing authority. The committee will set standards and other requirements, such as educational preparation, that specific groups of prescribers must meet to be approved for expanded authority.

Nurse practitioners will have authority to request "Special Authority" medications with the exception of two situations:

- they will not have "Special Authority" privileges for prescribing those drugs that have been designated for physician specialists only; and
- they will not have "Special Authority" privileges for prescribing medications for which they have continuation prescribing authority.

Under the federal Controlled Drug Substances Act and Regulations, nurse practitioners do not have authority to prescribe narcotics and controlled drugs, including benzodiazepines and other targeted substances. The federal regulations are currently under review. CRNBC recommends that nurse practitioners be given authority to prescribe narcotics and benzodiazepines for short-term use only (to a maximum of six weeks). CRNBC would review narcotic and benzodiazepine prescribing practices using the PharmaNet database. Nurse practitioners who require broader prescriptive authority to meet their clients' needs would have to complete additional education as set out in the standards, limits and conditions set by the Nurse Practitioner Standards Committee.

For some medications needed in a client's care, nurse practitioner prescribing may be limited to "continuation" prescribing. Continuation prescribing means that a physician initiates the drug therapy and the nurse practitioner assumes responsibility and authority for the continuation of the drug therapy, including ongoing assessment and monitoring, re-ordering and/or making dosage adjustments to the drug therapy, and referral as needed.

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15 Special Authority is a process used by PharmaCare in cases in which a prescriber wishes to prescribe a drug for a patient that is not covered by PharmaCare or, in some cases, not fully covered. Under the Limited Drug Coverage Program, drugs may be fully covered when on application to PharmaCare-established criteria are met. Approval is granted when the prescriber provides documentation to PharmaCare that meets the established criteria.

16 Under the Bylaws the Nurse Practitioner Standards Committee must develop and recommend to the Board standards, limits and conditions for the practice of nurse practitioners in accordance with section 11(3) of the HPA Regulation for Nurses (Registered) and Nurse Practitioners.
Scope of Practice
FOR NURSE PRACTITIONERS (ADULT) STANDARDS, LIMITS AND CONDITIONS

LIMITS AND CONDITIONS
Nurse practitioners are authorized by the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act to prescribe Schedule I drugs as specified in the Drug Schedules Regulation 9/98 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act in accordance with the CRNBC limits and conditions as listed below. Commonly prescribed drugs are listed here by therapeutic category. Where nurse practitioners may prescribe all drugs in that category, it is noted by the term “no exceptions”. Where there are restrictions on nurse practitioner prescribing, they are noted by the type of restriction [i.e. “continuation” prescribing only (C) or cannot prescribe (O)].

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>O</td>
<td>cannot be prescribed</td>
</tr>
<tr>
<td>C</td>
<td>continuation prescribing only</td>
</tr>
</tbody>
</table>

1. **Antihistamine Drugs** – No exceptions.

2. **Anti-infective Agents** –
   - C Anti-tuberculosis agents (only for LTBI)
   - O Chronic hepatitis drugs (e.g., Interferon)
   - O HIV drugs

3. **Anti-Neoplastic Agents** (Anti-neoplastic drugs are not prescribed by nurse practitioners. To date, these agents are available only through the BC Cancer Agency) – Exception is:
   - C Methotrexate in adults (for inflammatory disease)

4. **Autonomic Drugs** –
   - C Antiparkinsonism agents (parasympatholytics and COMPT inhibitor)
   - O Depolarizing and non-depolarizing skeletal muscle relaxants
   - O Ergot alkaloids

5. **Blood formers and Coagulators** –
   - C Hematopoietic growth factor
   - C Anticoagulants
   - O Thromboembolytic enzymes
   - O Hemostatic agents
   - O IV Iron preparations
6. Cardiovascular Drugs –
   C Antiarrhythmics

7. Central Nervous Agents –
   O General anesthetics
   O Benzodiazepines
   O Barbiturates
   O Narcotics
   O Methadone
   O Methylphenidate (Ritalin)
   O Dextroamphetamine sulphate

8. Contraceptives (foams, devices) – No exceptions and in accordance with the CRNBC nurse practitioner limits and conditions for treatments and interventions.

9. Electrolytic, Caloric and Water Balance –
   O Phosphate binders

10. Antitussives, Expectorants and Mucolytic Agents –
    O Narcotics

11. Eye, Ear, Nose and Throat Preparations –
    C Antiglaucoma agents
    O Ophthalmologic steroids
    O Carbonic anhydrase inhibitors


14. Hormones and Synthetic Substitutes –
    O Infertility drugs (e.g., gonadotropin-releasing hormones)
    O Prostaglandin
    O Pituitary (anti-diuretic) (e.g., vasopressin)
    O Androgen/anabolic steroids
    O Human growth hormone
15. **Oxytocics** – Not prescribed by nurse practitioners.

16. **Serums, Toxoids and Vaccines** –
   - **Yellow fever immunization**

17. **Skin and Mucous Membrane Agents** –
   - **Topical fluorouracil in adults**
   - **Psoralens (Methoxsalen) in adults**
   - **Oral retinoids (Acitretin)**

18. **Smooth Muscle Relaxants** – No exceptions.

19. **Vitamins** – No exceptions.

20. **Miscellaneous** –
   - **Immunosuppressants**
   - **Immunomodulators (biologic response modifiers)**
Section C: Physician Consultation and Referral

PART I - STANDARDS

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

Consultation, including referral, as used in these Standards, refers to a specific request by a nurse practitioner for a physician to become involved in the care of a client. The responsibility to consult with or refer to a physician lies with the nurse practitioner and is made in collaboration with the client. A nurse practitioner may also seek consultation with or transfer care to a physician at the request of the client.

Consultation may result in one of the following levels of physician involvement:

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

The nurse practitioner documents the request for and outcome of the consultation or referral.

Transfer or sharing of care occurs only after discussion and agreement among the client, the referring nurse practitioner and the physician.

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

17 Physicians requesting consultation payment under the B.C. Medical Services Plan payment schedule must render a written report, including their findings, opinions, and recommendations to the referring nurse practitioner.
Scope of Practice
FOR NURSE PRACTITIONERS (ADULT)

Standards

**STANDARD 1**
The nurse practitioner consults with or refers to physicians when the client’s health condition or needs are such that:

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

**STANDARD 2**
The nurse practitioner communicates and consults with or refers to physicians by:

- clearly presenting the reason for and the level of urgency of the consultation or referral;
- describing the level of physician involvement<sup>18</sup> requested at the time a referral is made;
- determining the availability of the physician to provide the consultation in a timely and appropriate manner;
- ensuring that the physician has appropriate access to the client’s relevant health information;
- confirming with the physician, following the consultation, the level of physician involvement; and
- documenting the request for and outcome of the consultation or referral.

**STANDARD 3**
The nurse practitioner and the consulting physician conjointly establish methods for communicating about their mutual client’s health condition and treatment decisions in situations in which client care is shared.

<sup>18</sup> Levels of physician involvement: the physician provides an opinion and recommendation to the nurse practitioner who continues to have primary responsibility for the health care of the client; or the physician assumes concurrent responsibility for some aspects of the care and the physician and the nurse practitioner together clarify who is assuming responsibility for the various aspects of the client’s care, including coordination of the overall care; or the care of the client is transferred to the physician who then assumes primary responsibility for the care.
PART II - LIMITS AND CONDITIONS

Nurse practitioners have the authority to refer to family practice physicians and family practice physicians who have specialized, for example, in palliative care, sports medicine, anesthesia or geriatrics. Nurse practitioners also have the authority to make direct request for consultation/referral to the following medical specialists:

<table>
<thead>
<tr>
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<th>Specialty</th>
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<tbody>
<tr>
<td>Clinical immunology and allergy – allergy testing</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Physical medicine and rehabilitation</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>General surgery (and all subspecialties)</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>Urology</td>
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<tr>
<td>Internal medicine (and all subspecialties)</td>
<td>Emergency medicine</td>
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<tr>
<td>Rheumatology – for autoimmune disorders (RA, lupus, Sjogren's syndrome, polymyalgia arthritis)</td>
<td>Anesthesia – for pain management</td>
</tr>
<tr>
<td>Neurology</td>
<td>Plastic surgery – for nevi, wounds, carpel tunnel</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Vascular surgery – for varicose veins, intermittent claudication and cold foot</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>Neurosurgery – for back</td>
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Appendix A

The Nurses (Registered) and Nurse Practitioners Regulation

The Nurses (Registered) and Nurse Practitioners Regulation (available online at www.qp.gov.bc.ca/statreg/reg/H/HealthProf/233_2005.htm) sets out, among other things:

- reserved titles for nurses;
- a scope of practice statement;
- reserved actions for registered nurses and nurse practitioners.

RESERVED TITLES

The Regulation states that only registrants of the College of Registered Nurses of British Columbia (CRNBC) may use the titles “registered nurse” or “licensed graduate nurse.” CRNBC registrants may also use the title “nurse.” As well, the title “nurse practitioner” has become a reserved title under the new Regulation. Only those nurses who are registered with CRNBC in the nurse practitioner category can use the title “nurse practitioner” or “registered nurse practitioner.” Registered nurses with temporary registration as a nurse practitioner can use the title of nurse practitioner, but must call themselves nurse practitioner (temporary).

Nurse practitioners can also use the title “registered nurse” and can practise in a registered nurse role (i.e., not a nurse practitioner role). When practising in a registered nurse role, the nurse practitioner must practise within the registered nurse (RN) job description and scope of practice. However, he or she is held accountable to the CRNBC Competencies Required for Nurse Practitioners in British Columbia and the Nurse Practitioner Scope of Practice Standards. In other words, the nurse practitioner would be expected to act as a reasonable, prudent nurse practitioner would act.19

CRNBC Bylaws explain the allowable abbreviated titles for nurse practitioners:

- NP or RN-NP
- NP (Temporary)

19 NOTE: Nurse practitioners wishing to practise as an RN are advised to contact a CRNBC nursing practice consultant before doing so. Call CRNBC Practice Support at 604.736.7331 (ext. 332) or 1.800.565.6505. E-mail: practice@crnbc.ca

20 Nurse practitioners are advised to follow NP, in brackets, by the stream in which they are registered to practice [e.g., NP (Family) or NP (P); NP (Adult) or NP(A); NP (Pediatric) or NP(P)].
**SCOPE OF PRACTICE**

Scope of practice refers to the activities that nurses are educated and authorized to perform. These activities are:

- established through the legislated definition of nursing practice;
- complemented by standards, limits and conditions set by CRNBC.

Under the Regulation, a registrant of CRNBC may practise nursing, which is defined as the health profession in which a person provides or performs the following services:

- health care for the promotion, maintenance and restoration of health; and
- prevention, treatment and palliation of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and coordination of health services.

This definition does not refer to evaluation, but neither does it exclude it. Evaluation is, of course, an important part of nursing practice. The definition is broad and intended to apply to the practice of nursing of both groups of CRNBC registrants – registered nurses and registered nurse practitioners.

**EXCEPTIONS**

Nurses sometimes ask if it is ever appropriate to provide care that is outside the scope of practice set out in the Regulation. Nurse practitioners only provide care within their scope of practice, except in situations of life-threatening emergency. In these situations, nurse practitioners are ethically obligated to provide the best care they can, given the circumstances and their individual competence.

**STANDARDS, LIMITS AND CONDITIONS**

The Health Professions Act and the Nurses (Registered) and Nurse Practitioners Regulation give CRNBC the authority to establish, monitor and enforce standards, limits and conditions for nurses’ practice.

**Standard:** A desired and achievable level of performance against which actual performance can be compared. It provides a benchmark below which performance is unacceptable. Registered nurses are familiar with standards of practice, which are set out in CRNBC’s Professional Standards for Registered Nurses and Nurse Practitioners in British Columbia as well as in a series of CRNBC Practice Standards and the Nurse Practitioner Scope of Practice Standards.

**Limits and Conditions:** A limit is the point at which something must end. For example, while nurse practitioners are authorized to order a wide range of diagnostic services, they do not have authority to order MRIs. A condition is anything on which something else depends. For example, nurse practitioners can refer clients to an anaesthetist, but only for purposes of pain management. Nurses are accustomed to having restrictions placed on their practice by their employer, but having limits and conditions set by the regulatory body (CRNBC) is new. The CRNBC Nurse Practitioner Standards Committee develops and recommends nurse practitioner standards, limits and conditions for approval by the CRNBC Board.
RESERVED ACTIONS
The Regulation assigns reserved actions to nurse practitioners for activities such as: making a diagnosis to identify a disease, disorder or condition; ordering diagnostic services; and prescribing and dispensing drugs. As specified in the Regulation, these activities are provided in accordance with standards, limits and conditions established by CRNBC. CRNBC’s scope of practice documents include:

- Scope of Practice for Nurse Practitioners (Family): Standards, Limits and Conditions;
- Scope of Practice for Nurse Practitioners (Adult): Standards, Limits and Conditions; and

The scope of nurse practitioner practice builds on the scope of registered nurse practice. Nurse practitioners must be familiar with both registered nurse and nurse practitioner scope to understand the scope of nurse practitioner practice. For further details on the Nurses (Registered) and Nurse Practitioners Regulation as it pertains to registered nurse practice, please read the document on the CRNBC website entitled Scope of Practice for Registered Nurses: Standards, Limits and Conditions.21

21 Scope of practice documents can be found on the Nursing Practice section of the CRNBC website www.crnbc.ca
Resources

Diagnosing and Health Care Management

**TEXTS**


**GUIDELINES**


**WEB-BASED GUIDELINES**

Canadian Medical Association InfoBase. Clinical Practice Guidelines. mdm.ca/cpgsnew/cpgs/index.asp

USA National Guideline Clearinghouse. www.guidelines.gov/
Scope of Practice
FOR NURSE PRACTITIONERS (ADULT) STANDARDS, LIMITS AND CONDITIONS

Prescribing


Practice Guidelines for Primary Health Care Nurse Practitioners

Effective August 2005
PRACTICE GUIDELINES FOR
PRIMARY HEALTHCARE NURSE PRACTITIONERS

The Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU), under the authority of the Nursing Professions Acts of NWT and Nunavut has the responsibility to develop “guidelines respecting the practice of nurse practitioners”, which may be approved by the Minister of Health and Social Services.

This publication, dated August, 2005 is the first set of Guidelines to be approved. The Guidelines will be updated regularly as legislation, policies and practices change. The latest guidelines will be posted on the RNANT/NU website: www.rnantnu.ca

Acknowledgements

These Guidelines are based on Entry Level Competencies for Primary Health Care Nurse Practitioners, RNANT/NU (June 2000), as well as the following:


Canadian Medical Association, the Canadian Nurses Association, & the Canadian Pharmacists Association. (2003). Scopes of Practice. Ottawa: Author

NP Practice Guidelines Committee

A subcommittee of the RNANT/NU Nursing Practice Committee assumed the responsibility for drafting the NP Practice Guidelines.

Members of the Committee included:

Karen Graham, RN NP SCM OPN PHN BN MAEd., Chair
Kathleen Matthews, RN NP BScN
Jane Brebner, RN NP BScN
Elizabeth Cook, RN NP BScN MN-ANP
Donna Broemling, RN BN MN-ANP
Karen Benwell RN NP
Effective August 2005

Consultation

During the drafting process teleconference consultation was held with all of the NP’s registered with the Association, as well as:

- Dr. Bonifacio, MD, Radiologist, Stanton Territorial Hospital Authority
- Robin Greig, RT, Unit Manager, Stanton Territorial Hospital Authority Laboratory
- NWT Pharmacy Association (re: NP Prescription Regulations)
- Dr. John Morse, Internist, Chief of Staff, Stanton Regional Hospital
- NWT Medical Association
- Dr. Mark Lachmann, Family Physician, Baffin Regional Hospital
- Dr. Sandy MacDonald, Chief of Staff, Baffin Regional Hospital
Effective August 2005

RNANT/NU PRACTICE GUIDELINES
for PRIMARY HEALTH CARE NURSE PRACTITIONERS

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Effective August 2005
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RNANT/NU PRACTICE GUIDELINES
for PRIMARY HEALTH CARE NURSE PRACTITIONERS

Legislative Authority - Northwest Territories

Authority for the practice of Nurse Practitioners is derived from the
NWT NURSING PROFESSION ACT, S.N.W.T. 2003, c15.

Registered Nurses

2. (1) A registered nurse is entitled to apply nursing knowledge, skills and judgment
   (a) to promote, maintain and restore health;
   (b) to prevent and alleviate illness, injury and disability;
   (c) to assist in prenatal care, childbirth, and postnatal care;
   (d) to care for the terminally ill and the dying;
   (e) in the coordination of health care services; and
   (f) in administration, supervision, education, consultation, teaching, policy
development and research with respect to any of the matters referred to
in paragraphs (a) to (e).

Nurse Practitioners

4. (1) In addition to the functions set out in subsection 2(1), a nurse practitioner is
   entitled to apply advanced nursing knowledge, skills and judgment
   (a) to make a diagnosis identifying a disease, disorder or condition;
   (b) to communicate a diagnosis to a patient;
   (c) to order and interpret screening and diagnostic tests authorized in
guidelines approved by the Minister;
   (d) to select, recommend, supply, prescribe and monitor the effectiveness of
drugs authorized in guidelines approved by the Minister; and
   (e) to perform other procedures that are authorized in guidelines approved by
   the Minister.
   (2) The entitlement in subsection (1) is subject to the regulations, the bylaws and
any guidelines approved by the Minister.
   (3) A nurse practitioner may use the title "Nurse Practitioner" and may use after
his or her name the designation "N.P." or "R.N. (N.P.)".

Nurse Practitioner Practice Guidelines

5. (1) The Association may recommend to the Minister guidelines respecting the
practice of nurse practitioners.
(2) The Minister may approve the guidelines recommended by the Association.
NWT PHARMACY ACT, R.S.N.W.T. 1988,c.P-6
Including amendments made by:
S.N.W.T. 2002,c.11
S.N.W.T. 2002,c.17
S.N.W.T. 2003,c.15
In force January 1, 2004;
SI-004-2003
S.N.W.T. 2003,c.21,NIF

1. In this Act.
   "nurse practitioner" means a nurse practitioner under the Nursing Profession Act. (infirmière praticienne)

2. Nothing in this Act shall be deemed to prohibit or prevent
   (a.1) a nurse practitioner from exercising a privilege conferred by the Nursing Profession Act relating to the practice
   of a nurse practitioner in the Territories;

NWT Nurse Practitioner
PRESCRIPTION REGULATIONS R-056-2004

1. The substances that a pharmaceutical chemist may supply under subsection 21.1(1) of the Pharmacy Act to a person who
   has in his or her possession a prescription signed by a nurse practitioner are set out in the Schedule.

2. A pharmaceutical chemist may supply a substance set out in Column 1 of Part 1 of the Schedule subject to the
   conditions, limits and restrictions respecting the supply set out in Column 2.

3. A pharmaceutical chemist may supply a substance set out in Column 1 of Part 2 of the Schedule subject to the general
   conditions, limits and restrictions respecting the supply set out in Part 2 of the Schedule and the specific conditions,
   limits and restrictions respecting the supply set out in Column 2 of Part 2.
Effective August 2005

RNANT/NU PRACTICE GUIDELINES
for PRIMARY HEALTH CARE NURSE PRACTITIONERS

Legislative Authority - Nunavut

Authority for the practice of Nurse Practitioners is derived from the
NUNAVUT NURSING ACT, S.N.W.T. 1998, c.38, as duplicated for Nunavut by s.29 of the Nunavut Act, as amended by S.Nu. 2003, c.17.”

Definitions
1. In this Act,

"nurse practitioner" means a person who is registered under section 24 of the Nursing Profession Act (Northwest Territories);

"practice of nursing" means the practice of registered nurses, nurse practitioners, and temporary certificate holders;

6. Use of title - nurse practitioner
   (2) A nurse practitioner may use the title "Nurse Practitioner" and may use after his or her name the designation "N.P." or "R.N.(N.P.)": S.Nu. 2003,c.17,s.9.

Prohibitions
9. Prohibitions respecting nurse practitioners
   (2) Subject to subsections (3) and (4), no person shall
   (a) hold himself or herself out to the public by any title, designation or description as a nurse practitioner or under that title, designation or description render or offer to render services of any kind to a person for a fee or other remuneration, unless he or she is a nurse practitioner;
   (b) use the title "Nurse Practitioner" or the designation "N.P." or "R.N.(N.P.)", unless he or she is a nurse practitioner; or
   (c) knowingly employ or engage a person to practice as a nurse practitioner, unless the person so employed or engaged is a nurse practitioner.

NOTE: The Nunavut Nursing Act duplicates the NWT Nursing Profession Act, therefore all definitions, regulatory provisions and penalties regarding NP’s are identical. The Registered Nurses Association of the Northwest Territories and Nunavut is the regulatory body for both NWT and Nunavut nurses.

August 2005  Prescriptive Authority*

Pharmacy Regulations or Guidelines have not been enacted for Nunavut as of the date of this publication, August 2005, which means that Nurse Practitioners practicing in Nunavut, although they may be registered, have no provisions in place to define mechanisms or limitations of prescriptive authority. Nunavut NP’s therefore cannot prescribe independently at this time, and so must have all prescriptions co-signed by a Physician.
Effective August 2005
INTRODUCTION

The Nursing Profession Acts of the Northwest Territories and Nunavut (2004) enables the practice of nurse practitioners (NP’s) in the two territories. The nurse practitioner (NP) role is described in legislation as being in addition to that of a registered nurse, because the nurse practitioner performs activities that are considered beyond the scope of practice of registered nurses.

The nurse practitioner role is a nursing role, and NP’s must practise in accordance with all standards relevant to the nursing profession including:

- Standards for Nursing Practice for registered Nurses (RNANT/NU, 2003),
- Code of Ethics for Registered Nurses (CNA, 2002), and
- Entry Level Competencies for Primary Health Care Nurse Practitioners, (RNANT/NU, 2000).

Nurse practitioners have the potential to make a significant contribution to new models of health care delivery based on primary health care principles. RNANT/NU has promoted the utilization of nurse practitioners in emergency rooms, community health centres, family practice, and long term care facilities.

This document provides guidelines for Primary Health Care Nurse Practitioner practice.
In April 2003 a Joint Position Statement on Scopes of Practice was released by the Canadian Medical Association, the Canadian Nurses Association, and the Canadian Pharmacists Association. It includes the following:

**Principles**

*Focus:* Scopes of practice statements should promote safe, ethical, high-quality care that responds to the needs of patients and the public in a timely manner, is affordable and is provided by competent health care providers.

*Flexibility:* A flexible approach is required that enables providers to practise to the extent of their education, training, skills, knowledge, experience, competence and judgment while being responsive to the needs of the patients and the public.

*Collaboration and cooperation:* In order to support interdisciplinary approaches to patient care and good health outcomes, physicians, nurses and pharmacists engage in collaborative and cooperative practice with other health care providers who are qualified and appropriately trained and who use, wherever possible, an evidence-based approach. Good communication is essential to collaboration and cooperation.

*Coordination:* A qualified health care provider should coordinate individual patient care.

*Patient choice:* Scopes of practice should take into account patient’s choice of health care provider.

**Criteria**

*Accountability.* Scopes of practice should reflect the degree of accountability, responsibility and authority that the health care provider assumes for the outcome of his or her practice.

*Education:* Scopes of practice should reflect the breadth, depth and relevance of the training and education of the program(s), certification of the provider and maintenance of competency.”

(Joint Position Statement, CMA, CNA. CPhA. April 2003)
Effective August 2005

RNANT/NU NURSE PRACTITIONER SCOPE OF PRACTICE

The "practice of a nurse practitioner" is defined in the Nursing Profession Acts, NWT and NU (2003) as the practice in which a nurse practitioner may:

- diagnose or assess a disease, disorder or condition, and communicate the diagnosis or assessment to the client;
- order and interpret screening and diagnostic tests;
- select, prescribe and monitor the effectiveness of drugs; and
- order the application of forms of energy (x-ray, ultrasound).

These responsibilities are what makes the practice of nurse practitioners different from that of all other registered nurses. This is a nursing role and NPs practice in accordance with all standards relevant to the nursing profession.

In addition to the rights and privileges of all registered nurses, the NP has the authority to make and communicate a diagnosis of a common disease or disorder, order x-rays, ultrasounds and lab tests and prescribe a certain range of drugs as listed in the Nurse Practitioner Prescription Regulations (NWT)*. Nurse Practitioners have the authority to order supplies and equipment related to the care of their clients.

These Guidelines, established by the Nursing Practice Committee of the RNANT/NU, specify clinical and procedural expectations for screening and diagnostic tests and forms of energy that may be ordered and interpreted by the nurse practitioner, as well as defining expectations for Consultations and Prescriptions. The Guidelines are consistent with other legislation, policies and regulations governing the practice of nurse practitioners.
Effective August 2005

CONSULTATION AND REFERRAL

Scope of Responsibility

Consultation may be required at any stage of the nurse practitioner-client relationship, from the time of the initial assessment through to the evaluation of the effectiveness of treatment. Expectations for consultation also apply when managing the care of a client with a chronic condition. Consultation takes place following a specific request and can occur in a variety of ways, for example, face to face, by telephone, or in writing.

The NP consults with and refers to other health professionals as appropriate and as per regional policies), e.g. physicians, specialist physicians, physiotherapists, occupational therapists, dieticians, community health nurses (CHN’s)’s, Mental Health/Addictions Counselor etc. The degree to which the physician or other health professional becomes involved may vary.

Consultation may result in:
- provision of an opinion and recommendation;
- an opinion, recommendation, and concurrent intervention; or
- assumption of primary responsibility for the care of the client (transfer of care).

The need for additional consultation guidelines depends on the type of practice, the available resources, changing health care needs and the NP’s experience. If required, guidelines are developed within individual agencies.

Clinical Expectations

*The nurse practitioner seeks consultation* with a physician:

1. when the signs, symptoms, diagnosis and / or plan of treatment are unclear or beyond the knowledge, skill and judgment of the nurse practitioner to determine, including but not limited to the following:
   - persistent or recurring sign(s) or symptom(s) that cannot be attributed to an identifiable cause;
   - sign(s), symptom(s), report(s) of imaging or laboratory tests suggestive of a previously undiagnosed chronic systemic illness;
   - symptomatic or laboratory evidence of unexpectedly deteriorating function of any vital organ or system;
   - sign(s) of recurrent or persistent infection;
   - any atypical presentation of a common illness or unusual response to treatment;
   - any sign(s) or symptom(s) of a sexually transmitted infection in a child;
   - any sign(s) or symptom(s) of behavioral changes that cannot be attributed to a specific cause; and
   - significant deviation from normal growth and development in an infant or child;
Effective August 2005

2. in potentially life-threatening situations, (emergent situations) including but not limited to the following:

- any sign(s) or symptom(s) of an acute event that is potentially threatening to life, limb, or senses;
- sign(s) or symptom(s) of obstruction of any system:
- signs of severe or widespread infection:
- any blunt, penetrating, or other wound that may involve damage below the fascia or functional impairment; and
- sign(s) or symptom(s) of any significant fetal or maternal pregnancy risk factor;

3. when a client’s chronic condition unexpectedly destabilizes, including but not limited to the following:

- symptomatic or laboratory evidence of destabilization;
- unexpected deterioration in the condition of a client who is being managed for a previously diagnosed illness.

Procedural Expectations

When requesting a consultation by a physician, the nurse practitioner:

- clearly presents the reason for, and the level of, urgency of the consultation;
- describes the level of consultation requested: an opinion and recommendation; an opinion, recommendation, and concurrent intervention; or immediate transfer of care;
- ensures that the physician has appropriate access to the client’s known health information;
- confirms the understanding of the nurse practitioner and physician responsibilities in the specific situation; and
- documents the request for and outcome of the consultation.

NPs and the physician develop mutually agreeable structures and processes for consultation.

Other Consultations

The above principles would also apply when RNs and other team members consult with NPs, and when NP’s consult other health professionals.
Section A

Prescribing Drugs and Other Supplies and Equipment

Authority

As of August 2005, Nunavut (NU) prescriptive authority is not yet enacted through the NU Pharmacy Act. Therefore the following section refers only to NWT legislation at this time.

Nurse practitioners in the NWT and Nunavut are authorized to prescribe a range of drugs (for patients whom they have seen and assessed, according to the Nursing Profession Act (2003), Nurse Practitioner Prescription Regulations of the NWT Pharmacy Act (2004) and other relevant legislation.

The NWT Nurse Practitioner Pharmacy Act Regulations are available at:

Clinical Expectations for Prescribing

The nurse practitioner:

1. completes prescriptions accurately and completely including the following information (NWT NP Prescription Regulations, 2004):
   - date of issue;
   - name, DOB, and (HCP, address if available) of client;
   - name, strength and quantity of prescribed drug;
   - directions for use - refers to the frequency, route of administration, and the duration of drug therapy, and special instructions, such as “take with food”;
   - directions for number of allowable refills and interval between refills, where applicable - if a prescription includes more than one drug, any drug that may be refilled must be clearly identified;
   - if all drugs on a multiple prescription are to be refilled, identify the number of allowable refills for each drug; and
   - prescriber’s name, address, telephone number, fax number and signature and designation;
   - A medication prescription order may be identified in a client’s chart or on a prescription pad. The client’s chart is appropriate for some isolated centres where there is no stand-alone/separate pharmacy.
Effective August 2005

2. provides educational information to clients about prescription and non-prescription drugs;

3. Based on the client’s response, the nurse practitioner may decide to continue, adjust, or withdraw the drug, or to consult with a physician in accordance with the expectations for consultation;

4. Stores prescription pads in a secure area that is not accessible to the public.

Procedural Expectations

A prescription may be transmitted by facsimile or approved electronic method to a pharmacy, provided that the following requirements are met according to the NP Prescription Regulations of the NWT (2004).

- the prescription must be sent to the pharmacy of the client’s choice.
- the prescription must be sent directly from the prescriber’s office or directly from a health institution for a patient of that institution, or from another location providing that the pharmacist is confident of the prescription legitimacy;

Other Prescriptions

The nurse practitioner may also prescribe:

1. non-prescription drugs, in order to satisfy funding requirements, e.g. Non-Insured Health Benefits (NIHB) program of First Nations and Inuit Health Branch (FNHB). (Appendix A).

2. medically necessary supplies and equipment, prescription or non-prescription. (Appendix A). A binder is available from Non-Insured Health Benefits which lists these items.
Effective August 2005

SECTION B-1

DIAGNOSTIC TESTS

X-rays, Ultrasounds and other forms of energy

Scope of Responsibility

Nurse practitioners are authorized to order specific x-rays and diagnostic ultrasounds (see Appendix B-1).

- to confirm the diagnosis of a short term, episodic illness or injury as suggested by the client’s history and/or physical findings;
- to rule out a potential diagnosis that, if present, would require consultation with a physician for treatment;
- to assess/monitor ongoing conditions of clients with chronic illnesses;
- for screening activities;
- to monitor the ongoing condition of a client with a previously diagnosed illness or disorder; or
- to confirm symptoms of deteriorating function of a vital organ or system.

Consultation may be required at any stage of the process.

Clinical Expectations

The nurse practitioner:

- knows the contraindications to ionizing radiation exposure, and the associated risks and benefits of ordering an x-ray or an ultrasound;
- makes decisions about treatment based on results of x-rays and/or consults with a physician in accordance with the expectations for consultation with physicians by nurse practitioners;
- may request a copy of the radiologist’s x-ray or ultrasound report for x-rays or ultrasounds ordered by a physician for clients with whom the nurse practitioner has been involved in providing care;

It is the responsibility of the NP to realize the limitations of any equipment used in rural/remote settings and refer to the appropriate referral centre for any prescribed tests beyond the capacity of local equipment.
Scope of Responsibility

Nurse practitioners are authorized to order laboratory tests according to their Scope of Practice (see Appendix B-2)

• to confirm the diagnosis of a short term, episodic illness or injury as suggested by the client’s history and/or physical findings;

• to rule out a potential diagnosis that, if present, would require consultation with an appropriate physician for treatment;

• to assess/monitor ongoing conditions of clients with chronic illnesses;

• for screening activities;

• to monitor the ongoing condition of a client with a previously diagnosed illness or disorder; or

• to confirm symptoms of deteriorating function of a vital organ or system.

Clinical Expectations

The nurse practitioner:

• interprets the laboratory tests in the context of the individual client’s presentation, makes decisions about treatment, and/or consults in accordance with the expectations for consultation with physicians by nurse practitioners;

• may request a copy of a laboratory report for laboratory tests ordered by a physician for clients with whom the nurse practitioner has been involved in providing care:
The nurse practitioner is authorized to order other tests of health status in accordance with Appendix B-3.
Effective August 2005

SECTION C

PROCEDURES

Scope of Responsibility

NPs may independently decide that a specific procedure is required and initiate it in the absence of a physician’s order or medical (protocol/direction) according to Appendix C.) It is the responsibility of the NP to accurately assess his/her level of knowledge, skill and experience in the performance of a procedure.

To initiate and perform any of the procedures authorized to NPs, the NP must:

• have the knowledge, skill, and judgment to perform the procedure safely, effectively and ethically;
• have the knowledge, skill and judgment to determine whether the individual’s condition warrants performance of the procedure; and
• determine that the individual’s condition warrants performance of the procedure, having considered:
  o the known risks and benefits to the individual,
  o the predictability of the outcome,
  o the safeguards and resources available to safely manage the outcomes, and
  o other relevant factors specific to the situation.

Where the NP has attained independent certification in a skill or procedure in another discipline they may incorporate such skills / procedures in their practice provided they maintain current competence.

Additional NP Responsibilities

Driver's Medicals

Legislation related to Driver's Medicals performed by NPs is presently under review in the NWT and is not yet clarified in NU.
SECTION D

PROCESS FOR CHANGING THE NP PRACTICE GUIDELINES

Responsibility: The Nursing Practice Committee of the RNANT/NU
If other disciplines are involved in the change the committee would initiate a consultation process.

Frequency: The Nursing Practice Committee should review any requests yearly.

Process:
• obtain “Request for Amendment to NP Practice Guideline form” (see Appendix D) from the RNANT/NU
• complete and submit form to Nursing Practice Committee with rationale (eg. Impact on patient care, impact on NP practice, demonstration that it falls within the Scope of NP Practice).
Effective August 2005

GLOSSARY

Collaboration
"Joint communication and decision-making processes with one or more members of the health care team, each of whom makes a contribution from within the limits of her/his scope of practice. The expressed goal is one of working together with clients toward identified health outcomes, while respecting the unique qualities and abilities of each member of the group or team. " (CNA, June 2004, Core Competency Framework, Canadian Nurse Practitioner Examination. Ottawa: Draft as approved by the CNA Forum, p.11)

Consultation
An explicit request by a nurse practitioner to a physician or other member of the health care team, to become involved in the care of a client for which the nurse practitioner, at the time of the consultation request, has primary responsibility. Consultation is required when the nurse practitioner approaches or reaches the limits of nurse practitioner practice, beyond which she or he cannot provide care independently and additional information and/or assistance is required.

Nurse Practitioner
This Practice Guideline utilizes the Canadian Nurses Association definition:

“A nurse practitioner (NP) is an advanced practice nurse whose practice is focused on providing services to manage the health needs of individuals, families, groups and communities. The NP role is grounded in the nursing profession’s values, knowledge, theories and practice and is a role that complements, rather than replaces, other health care providers. NPs have the potential to contribute significantly to new models of health care based on the principles of primary health care (PHC).

NPs integrate into their practice elements such as diagnosing and treating health problems and prescribing drugs. NPs work autonomously, from initiating the care process to monitoring health outcomes, and they work in collaboration with other health care professionals. NPs practise in a variety of community, acute care and long-term care settings. These include, but are not limited to community health centres, nursing outposts, specialty units and clinics, emergency departments and long-term care facilities."

“The Nurse Practitioner”

Primary responsibility
The NP has an established professional nurse-client relationship with the client, and is involved in providing care to the client, either independently, or as a member of a team of health care providers.
Effective August 2005

**Procedure**
Any procedure that an NP performs regularly to manage conditions/diseases that are common to their practice.

**Referral**
The practice of sending a client to another health care provider for consultation or service (CNA, June 2004, Core Competency Framework, Canadian Nurse Practitioner Examination. Ottawa: Draft as approved by the CNA Forum, p.13.)
In addition to the medications nurse practitioners may prescribe under the Nursing Profession Act, (2003), Nurse Practitioner Prescription Regulations of the NWT Pharmacy Act (2004) and other relevant legislation, the nurse practitioner may also prescribe:

1. **non-prescription drugs**, in order to satisfy funding requirements, e.g. Non-Insured Health Benefits (NIHB) program of First Nations and Inuit Health Branch (FNIHB).

2. **medically necessary supplies and equipment**, prescription or non-prescription, including but not limited to:
   
   - bathing and toileting aids
   - cushions and protectors
   - environmental aids (dressing aids, feeding aids)
   - lifting and transfer aids
   - mobility aids
   - ostomy supplies and devices
   - urinary supplies and equipment
   - wound dressing supplies
   - miscellaneous supplies and equipment
   - birth control devices
A Nurse Practitioner is authorized to order x-rays, ultrasounds and other forms of Energy. This includes:

### Ultrasounds
- Abdomen
- Renal
- Pelvis
- Breast for diagnostic purposes
- Routine Obstetrical screening
  - For diagnostic purposes
    - Consult with MD or with the radiologist if no MD available
    - If follow-up is recommended by the radiologist, note this on the requisition

### X-rays
- Skeletal (axial, hip, limbs, sinus, maxillary-facial)
- Chest
- Abdomen
- Mammography for screening
  - For diagnostic purposes – consult with radiologist if no MD available
  - If follow-up recommended by the radiologist, note this on the requisition
- Bone density
- Upper GI Series
- Kidneys, Ureter, Bladder
- Intravenous Pylegram
- Kidneys, Ureter, Bladder

Such further x-rays, ultrasounds and forms of energy required for monitoring a patient’s chronic illness or injury following consultation with the patient’s physician and the order for such tests shall include reference to the physician’s name.
Appendix B-2
Laboratory and Other Tests

The laboratory and other tests that a Nurse Practitioner may order include but are not limited to:

Chemistry
Albumin, Protein
Alanine transaminase (ALT)
Alkaline Phosphatase (ALK)
Amylase
Arterial Blood Gases
AST
Bilirubin, total
Bilirubin, conjugated
Breath Urea
BUN (Urea)
Calcium
Chloride
Cholesterol, total
Complement Proteins
CPK
Creatinine
Gamma glutamyl transpeptidase (GGT)
Glucose, quantitative
Glucose challenge (GCT)
High Density, Low density, Very Low Density Lipoprotein Cholesterol
Iron, Total - with iron binding capacity
Lipid - total
Magnesium
Phosphorus (inorganic phosphate)
Potassium
Protein, total
Sodium
Triglycerides
Uric Acid

Chemistry (Hormones)
Cortisol
Estradiol
Estriol
Free Testosterone
Follicle Stimulating Hormone (FSH)
Human Chorionic Gonadotrophins (HCG)
Leutinizing Hormone (LH)
Parathyroid Hormone (PTH)
Progestrone
Prolactin
Thyroid Stimulating Hormone (TSH)
T4, T3 Thyroxine

Chemistry (Serum Protein electrophoresis)
Alphafetoprotein screen
Folate
Ferritin
Glycosylated hemoglobin - Hgb A1C
Iron
PSA
TIBC and % Transferrin saturation
Transferrin
Vitamin B12

Chemistry (Urine)
Drug Screen
HCG
Urinalysis R & M
Effective August 2005

**Hematology**
- Complete blood count (CBC)
- Differential
- ESR
- Platelet Count
- Reticulocyte Count
- Prothrombin Time (PT)
- PT-INR
- Partial Thromboplastin Time (PTT)

**Coagulation**
- Bleeding time (BT)
- D-dimer
- INR

**Therapeutic Drug Monitoring**
- Acetaminophen
- Alcohol
- Aminophylline (Theophylline)
- Arsenic
- ASA
- Carbamazepine (Tegretol)
- Digoxin
- Drug Screen
- Lead
- Lithium
- Phenobarb
- Phenytoin (Dilantin)
- Primadone
- Quinidine
- Salicylate
- Valproic Acid

**Microbiology**
- Culture & Sensitivity
  - Blood culture
  - Sputum - gram stain, culture, AFB
  - Stool culture
  - Surface culture
  - Throat swab
  - Urine culture
  - Vaginal & cervical swabs
- Wet mount for trichomonas
- Pin worm- scotch tape test

**Cytology / Histology**
- Cervical
- Urine
- Tissue

**Serology (Blood Bank)**
- ANA
- Antibody Screening
- Antibody titre
- Blood Grouping
- Cold Agglutinins
- Hepatitis screen
- HIV
- H-pylori
- Mono spot
- Rheumatoid Factor
- Rubella titre
- Rubeola titre
- RPR / VDRL

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**APPENDIX B-3**

**OTHER TESTS**

- Electrocardiogram (E.C.G.)
- Holter Monitor
- Spirometry (Pulmonary Function Test)
- 24-hour blood pressure monitoring;

Such further laboratory and other tests required for monitoring a client’s chronic illness or injury following consultation with the patient’s physician and the order for such tests shall include reference to the physician’s name.
APPENDIX C
PROCEDURES

The procedures performed by Nurse Practitioners include but are not limited to the following:

**General**
- Obtaining laboratory specimens
- Scratch or patch test
- Initiating Catheterization

**Obstetrics**
- Unexpected delivery
- Artificial Rupture of Membranes (ARM) if delivery is imminent
- Episiotomy PRN (cut and repair)

**Gynaecology**
- Endometrial biopsy
- Biopsy of vulva or vagina
- Removal of cervical polyp
- IUD Insertion & Removal
- Insertion of Pessary

**Minor Surgical Procedures**
- Infiltration of local anaesthetic (local, regional, or nerve block)
- Biopsy, skin or mucosa.
- Incision and drainage of superficial abscesses
- Removal by excision of superficial dermal lesions
- Removal of superficial foreign body (e.g. fishhook)
- Treatment of warts [Paring & Non-surgical treatment (cryotherapy, chemotherapy)]
Effective August 2005

Debridement of wound
Treatment of ingrown toenail (wedge / radical excision)
Radical incision of ingrown toenail
Suturing
Application of dermal bonding material or staples

Orthopedic Procedures
Closed Reduction of simple dislocations, such as:
Shoulder          Elbow
Finger             Metatarsal
Toes
Casting of non-displaced fractures

Otolaryngology
Simple removal of cerumen
Removal of foreign body, simple
Anterior packing or cautery of nose

Ophthalmology
Tonometry
Removal of foreign body from surface of eye, under local anaesthesia
Slit lamp examination
Effective August 2005
APPENDIX D
REQUEST FOR AMENDMENT TO THE NP PRACTICE GUIDELINES

Name of Applicant: __________________________________________

Practice Location: __________________________________________

Contact: Telephone (daytime) __________ Fax: ______________

Email: __________________________

Category:
☐ Referral / Consultation
☐ Prescribing Drugs and other Supplies
   Note: additions / deletions to the list of drugs that NPs may prescribe may
   require a change in legislation. This form is the first step in the process.
☐ Diagnostics
☐ NP Procedures

Requested Change:
☐ Add: __________________________________________
☐ Delete: __________________________________________
☐ Change: __________________________________________

Rationale:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

_________________________ ___________________________
Signature Date

Send completed form to: Nursing Practice Committee – NP Guidelines
c/o RNANT/NU. PO Box 2757, Yellowknife, NT X1A 2R1

OR Fax to: 867-873-2336

THIS FORM MAY BE PHOTOCOPIED
Effective August 2005
APPENDIX D
REQUEST FOR AMENDMENT TO THE NP PRACTICE GUIDELINES

Name of Applicant: _____________________________________________

Practice Location: ____________________________________________

Contact: Telephone (daytime) ______________ Fax: ________________

   Email: __________________________

Category:
□ Referral / Consultation
□ Prescribing Drugs and other Supplies
   Note: additions / deletions to the list of drugs that NPs may prescribe may
   require a change in legislation. This form is the first step in the process.
□ Diagnostics
□ NP Procedures

Requested Change:
□ Add: ________________________________________________

□ Delete: ________________________________________________

□ Change: ________________________________________________

   ________________________________________________

Rationale:

__________________________________________________________

Signature ___________________________ Date ________________

Send completed form to: Nursing Practice Committee – NP Guidelines
c/o RNANT/NU, PO Box 2757, Yellowknife, NT X1A 2R1

OR Fax to: 867-873-2336

CUT HERE
Effective August 2005
Effective August 2005

Ms. Elizabeth Cook  
President  
Registered Nurses Association of the NWT and Nunavut  
PO BOX 2757  
YELLOWKNIFE NT X1A 2R1  

Dear Ms. Cook:

**Practice Guidelines for Primary Health Care Nurse Practitioners**

Thank you for your June 7, 2005, letter in which you have presented the final draft of the Practice Guidelines for Primary Health Care Nurse Practitioners for my review and approval according to the *Northwest Territories (NWT) Nursing Profession Act*.  

As you have noted in the Practice Guidelines, “nurse practitioners have the potential to make a significant contribution to new models of health care delivered based on the primary health care principles” (p. 11); it is these principles that the Government of the Northwest Territories, Department of Health and Social Services has built upon in the development of an Integrated Service Delivery Model (ISDM). Within this model, there is a vision to have Nurse Practitioners (NPs) integrated into primary community care teams. To move toward this goal, I am pleased to approve the Practice Guidelines for Primary Health Care Nurse Practitioners as a valuable resource to NPs in the NWT.

Sincerely,

J. Michael Miltenberger

c Mr. D. J. (Dave) Murray  
Deputy Minister
Effective August 2005
August 5, 2005

Elizabeth Cook
President
RNANT/NU
PO Box 2757
Yellowknife, NT
X1A 2R1

RE: Nurse Practitioner Guidelines

Dear Barb,

I am writing to indicate my approval of the Practice Guidelines for Primary Health Care Nurse Practitioners as received, in accordance with the provisions of the Nursing Profession Act. I understand that these Guidelines were developed by the RNANT/NU in consultation with officials from the Northwest Territories and Nunavut.

We look forward to having Nurse Practitioners in our communities in the near future and I believe that these Guidelines will provide clarity and focus for these important health professionals.

I want to thank you and your staff for your hard work in developing the Nurse Practitioner Guidelines.

Sincerely,

Hon. Leona Aglukkaq
Minister of Health and Social Services
These Guidelines form an addendum to the August 2005 RNANT/NU Practice Guidelines for Primary Health Care Nurse Practitioners, approved by the Minister of Health and Social Services (the Minister), and are approved by the Minister under subsection 5(2) of the Nursing Profession Act, S.N.W.T. 2003, c.15 (NPA). For reference, section 5 of the NPA reads,

5. (1) The Association may recommend to the Minister guidelines respecting the practice of nurse practitioners.
   (2) The Minister may approve the guidelines recommended by the Association.

These Guidelines, as approved by the Minister, provide the necessary authority for nurse practitioners, as defined in section 1 (Definitions) of the NPA, to prescribe those drugs included in the following Schedules A, B and C, and replace the Nurse Practitioner Prescription Regulations, repealed with the coming into force of the new Pharmacy Act, S.N.W.T. 2006, c.24, on April 2, 2007.

For further clarification, according to subsection 20(1) of the new Pharmacy Act, which reads,

20. (1) Before dispensing a drug a pharmacist shall take reasonable steps to satisfy himself or herself that...
   (d) if the practitioner is a "nurse practitioner" as defined in section 1 of the Nursing Profession Act, he or she is entitled, under guidelines approved by the Minister under subsection 5(2) of that Act, to prescribe the drug.

a pharmacist should refer to Schedules A, B and C of these Guidelines in order to determine if a nurse practitioner is entitled to prescribe the drug in question before dispensing.

Approved By:
Minister of Health and Social Services

Date:
RNANT/NU
PRESCRIPTIVE AUTHORITY GUIDELINES for
NWT PRIMARY HEALTH CARE NURSE PRACTITIONERS
(PHCNP's)

Prescription Schedules A,B,C

*Please Note:
This is a COMPANION DOCUMENT to the
NIHB DRUG BENEFIT LIST.
*IT IS NOT TO BE USED ALONE

Schedule A is a list of inclusions by pharmacologic-therapeutic classification AND
exclusions and limitations itemized by sub-classification or drug name from the Jan 2007
NIHB Drug Formulary

Schedule B excludes all NAPRA Schedule 1 drugs NOT mentioned in Schedule A, but
contains a secondary list of inclusions that can be prescribed by NP's.

Schedule C is a list of inclusion of NAPRA Schedules 2, 3 and Unscheduled not previously
mentioned in Schedule A to the NP Guidelines

Definitions:

“Inclusion”: an NP MAY prescribe the drug or drugs listed in a particular sub-
classification.

“Exclusion”: an NP MAY NOT prescribe the drug or drugs listed in a particular sub-
classification.

“Limitation” restricts NP prescribing to a specified course length or clinical indication.

“Maintenance”: an NP may prescribe the drug in the same dosage as originally ordered for the
continuation of therapy provided the drug has been previously prescribed for the patient by a
physician. As outlined in the Practice Guidelines, it is the responsibility of the NP to continue
appropriate screening and monitoring when assuming care in collaborative practice. Note: The
NP must write “Maintenance” on Script.
General NP Prescription Guidelines:

1) A PHCNP can prescribe all drugs listed in the NIHB Formulary unless there is an exclusion or limitation noted in the schedule A.

2) A PHCNP must always prescribe within his/her scope of practice.

3) A Community NP (working in a Territorial Health Centre) may perform all duties of a Community Health Nurse (CHN) as well as the legally defined additional functions of the NP. Note: A Community NP may select, dispense, compound and repackage medication under medical directives, policy and guidelines, as the Community Health Nurses may do, in addition to prescribing.

4) Combination drugs: unless clearly stated otherwise,
   a) where both drugs are approved for initial, they are included.
   b) where one drug is excluded and the other is included, the combination is drug is excluded.
   c) where one drug is maintenance the other is an inclusion, the combination drug is maintenance.
**SCHEDULE A**

A PHCNP may prescribe all drugs in this schedule unless there is an exclusion or limitation.

<table>
<thead>
<tr>
<th>DRUG CATEGORY</th>
<th>TIME LIMIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIHISTAMINE DRUGS</strong></td>
<td>04:00.00</td>
</tr>
<tr>
<td>Inclusions: All</td>
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<tr>
<td><strong>ANTI-INFECTIVE DRUGS</strong></td>
<td>08:00.00</td>
</tr>
<tr>
<td>Anthelmintics</td>
<td>08:08.00</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Cephalosporins</td>
<td>08:12.06</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Macrolides</td>
<td>08:12.12</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Penicillins</td>
<td>08:12.16</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Quinolones</td>
<td>08:12.18</td>
</tr>
<tr>
<td>Inclusions: All</td>
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</tr>
<tr>
<td>Sulfonamides</td>
<td>08:12.20</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Tetracyclines</td>
<td>08:12.24</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Antibiotics</td>
<td>08:12:28</td>
</tr>
<tr>
<td>Inclusions: All except</td>
<td></td>
</tr>
<tr>
<td>Maintenance: Linezolid</td>
<td></td>
</tr>
<tr>
<td>Allylamines</td>
<td>08:14.04</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Azoles</td>
<td>08:14.08</td>
</tr>
<tr>
<td>Inclusions: All except</td>
<td></td>
</tr>
<tr>
<td>Exclusions: Oral Ketoconazole</td>
<td></td>
</tr>
<tr>
<td>Polyenes</td>
<td>08:14.28</td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
<tr>
<td>Antituberculosis Agents</td>
<td>08:16.04</td>
</tr>
<tr>
<td>Maintenance: All</td>
<td></td>
</tr>
<tr>
<td>NB: Rifampin can be prescribed for meningitis prophylaxis</td>
<td></td>
</tr>
<tr>
<td>NB: Isoniazid can be prescribed for chemoprophylaxis</td>
<td></td>
</tr>
<tr>
<td>Adamantanes</td>
<td>08:18.00</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Section</th>
<th>Time</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance: Amantadine</td>
<td></td>
<td>NB: May be prescribed for Influenza prophylaxis</td>
</tr>
<tr>
<td>Antiretrovirals</td>
<td>08:18:08</td>
<td>Maintenance: All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: prophylaxis after needle stick injury to be initiated per employer policy</td>
</tr>
<tr>
<td>Interferons</td>
<td>08:18:20</td>
<td>Exclusions: All</td>
</tr>
<tr>
<td>Nucleosides and Nucleotides</td>
<td>08:18:32</td>
<td>Inclusions: All except Ganciclovir &amp; Valganclovir</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusions: All</td>
</tr>
<tr>
<td>Amebicides</td>
<td>08:30:04</td>
<td>Maintenance: See 08:30.92 for Metronidazole which is an inclusion</td>
</tr>
<tr>
<td>Antimalarials</td>
<td>08:30:08</td>
<td>Inclusions: All except Hydroxychloroquine, Primaquine and Pyrimethaine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: See Schedule B re: Larium and Mallerone</td>
</tr>
<tr>
<td>Miscellaneous Antiprotozoals</td>
<td>08:30:92</td>
<td>Inclusions: All except Atovaquone, Pentamidine Trimetrexate</td>
</tr>
<tr>
<td>Urinary Anti-Infectives</td>
<td>08:36:00</td>
<td>Inclusions: All</td>
</tr>
<tr>
<td>Antineoplastic Drugs</td>
<td>10:00:00</td>
<td>Maintenance: All except Mitotane, Procarbazine, Temozolomide, Thioguanine, Tretinoin and Vincristine</td>
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<tr>
<td>AUTONOMIC DRUGS</td>
<td>12:00:00</td>
<td>Parasympathomimetics</td>
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<tr>
<td></td>
<td></td>
<td>Maintenance: All</td>
</tr>
<tr>
<td>Antiparkinsonian Drugs</td>
<td>12:08:04</td>
<td>Inclusions: All except Ethropropazine, Procyclidine, Ropirrole, Trihexyphenidyl</td>
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<tr>
<td>Antimuscarinics/Antispasmodics</td>
<td>12:08:08</td>
<td>Inclusions: All</td>
</tr>
<tr>
<td>Sympathomimetic Agents –</td>
<td>12:12:00</td>
<td>Inclusions: All except Salmeterol</td>
</tr>
<tr>
<td>Alpha-Adrenergic Agonists</td>
<td>12:12:04</td>
<td>Maintenance: Ethopropazine, Procyclidine, Ropirrole, Trihexyphenidyl</td>
</tr>
<tr>
<td>Category</td>
<td>Time</td>
<td>Notes</td>
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<tr>
<td>Maintenance: Midodrine</td>
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<tr>
<td><strong>Beta-Adrenergic Agonists</strong></td>
<td>12:12:08</td>
<td>Inclusions: All except Formoterol &amp; Terbutaline, Salmeterol</td>
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<tr>
<td><strong>Beta and Alpha-Adrenergic Agonists</strong></td>
<td>12:12:12</td>
<td>Inclusions: All</td>
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<tr>
<td><strong>Sympatholytic Agents</strong></td>
<td>12:16:00</td>
<td>Maintenance: All</td>
</tr>
<tr>
<td><strong>Skeletal Muscle Relaxants</strong></td>
<td>12:20:00</td>
<td>Inclusions: All except Dantrolene, Tizanidine</td>
</tr>
<tr>
<td><strong>Miscellaneous Autonomic Drugs</strong></td>
<td>12:92:00</td>
<td>Inclusions: All</td>
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<tr>
<td><strong>BLOOD FORMATION COAGULATION AND THROMBOSIS</strong></td>
<td>20:00:00</td>
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<tr>
<td><strong>Iron Preparations</strong></td>
<td>20:04:04</td>
<td>Inclusions: All injectable iron</td>
</tr>
<tr>
<td><strong>Anticoagulants</strong></td>
<td>20:12:04</td>
<td>Exclusions: All except Dalteparin sodium, Enoxaparin sodium</td>
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<tr>
<td><strong>Platelet Aggregation Inhibitors</strong></td>
<td>20:12:18</td>
<td>Maintenance: All</td>
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<td>Note: Clopidogrel – see 92:00.00</td>
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<td><strong>Hematopoietic Agents</strong></td>
<td>20:16:00</td>
<td>Exclusions: All</td>
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<tr>
<td><strong>Hemorrhheologic Agents</strong></td>
<td>20:24:00</td>
<td>Maintenance: Pentoxifylline</td>
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<td><strong>Hemostatics</strong></td>
<td>20:26:18</td>
<td>Maintenance: Tranexamic Acid</td>
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<td><strong>CARDIOVASCULAR DRUGS</strong></td>
<td>24:00:00</td>
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<td><strong>Antiarrhythmic Drugs</strong></td>
<td>24:04:04</td>
<td>Maintenance: All</td>
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<tr>
<td><strong>Cardiotonic Agents</strong></td>
<td>24:04:08</td>
<td>Maintenance: Digoxin</td>
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<tr>
<td>Drug Class</td>
<td>Time</td>
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<tr>
<td>Bile Acid Sequestrants</td>
<td>24:06:04</td>
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<td>Cholesterol Absorption Inhibitors</td>
<td>24:06:05</td>
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<td>Fibric Acid Derivatives</td>
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<tr>
<td>HMG-CoA Reductase Inhibitors (Statins)</td>
<td>24:06:08</td>
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<tr>
<td>Central Alpha-Agonists</td>
<td>24:08:16</td>
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<tr>
<td>Direct Vasodilators</td>
<td>24:08:20</td>
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<tr>
<td>Exclusion: Diazoxide</td>
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<tr>
<td>Maintenance: Hydralazine, Minoxidil oral</td>
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<tr>
<td>Nitrates and Nitrites</td>
<td>24:12:08</td>
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<tr>
<td>Maintenance: Isosorbide dinitrate, Nitroglycerine patch</td>
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<td>Miscellaneous Vasodilating Agents</td>
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<tr>
<td>Alpha-Adrenergic Blocking Agents</td>
<td>24:20:00</td>
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<tr>
<td>Maintenance: All</td>
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</tr>
<tr>
<td>Beta-Adrenergic Blocking Agents</td>
<td>24:24:00</td>
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<tr>
<td>Limitations: Atenolol and Metoprenol – included for hypertension only</td>
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<tr>
<td>Maintenance: Acebutolol, Bisoprolol, Carvedilol, Labetalol, Nadalol, Oxprenolol, Pindolol, Propranolol, Sotolol, Timolol</td>
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<tr>
<td>Dihydropyridines</td>
<td>24:28:08</td>
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<td>Maintenance: All</td>
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<tr>
<td>Miscellaneous Calcium Channel Blocking Agents</td>
<td>24:28:92</td>
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</tr>
<tr>
<td>Maintenance: All</td>
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<td>ACE Inhibitors</td>
<td>24:32:04</td>
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<tr>
<td>Inclusions: All</td>
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<tr>
<td>Angiotension II Receptor Antagonists</td>
<td>24:32:08</td>
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<tr>
<td>Aldosterone Receptor Antagonists</td>
<td>24:32:20</td>
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<tr>
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<tr>
<td>CENTRAL NERVOUS SYSTEM AGENTS</td>
<td>28:00:00</td>
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<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Inclusions/Exclusions</th>
<th>Date</th>
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<tbody>
<tr>
<td>Non-Steroidal Anti-Inflammatory Agents</td>
<td>Inclusions: All</td>
<td>28:08:04</td>
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<tr>
<td>Opiate Agonists</td>
<td>Exclusions: All</td>
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<tr>
<td>Opiate Partial Agonists</td>
<td>Exclusions: All</td>
<td>28:08:12</td>
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<tr>
<td>Miscellaneous Analgesics &amp; Antipyretics</td>
<td>Inclusions: All</td>
<td>28:08:92</td>
</tr>
<tr>
<td>Anticonvulsants-Barbiturates</td>
<td>Exclusions: All</td>
<td>28:12:04</td>
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<tr>
<td>Anticonvulsants-Benzodiazepines</td>
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<td>28:12:08</td>
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<tr>
<td>Anticonvulsants-Hydantoins</td>
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<td>28:12:12</td>
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<tr>
<td>Anticonvulsants-Succinimides</td>
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<td>28:12:20</td>
</tr>
<tr>
<td>Miscellaneous Anticonvulsants</td>
<td>Limitations - limited to post-herpetic neuralgia and herpetic pain, trigeminal neuralgia</td>
<td>28:12:92</td>
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<tr>
<td>Antidepressants</td>
<td>Inclusions: Amitriptyline, Bupropion</td>
<td>28:16:04</td>
</tr>
<tr>
<td></td>
<td>Exclusions: MAOIs - Phenelzine and Tranylcypromine</td>
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</tr>
<tr>
<td></td>
<td>Limitations: - Trazodone - may not be prescribed in a dosage more than 50mg.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- SSRI's and SNRI's - Citalopram, Fluoxetine, Fluvoxamine, Mirtazapine, Paroxetine,</td>
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</tr>
<tr>
<td></td>
<td>Sertraline and Venalafaxine are inclusions BUT limited to patients over 18 years of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>age. NP can initiate first course, Reassessment by physician within 3 months.</td>
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<tr>
<td></td>
<td>Maintenance: All other drugs in this sub-category</td>
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<tr>
<td>Antipsychotic Agents</td>
<td>Maintenance: All</td>
<td>28:16:08</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>Exclusions: All</td>
<td>28:20:04</td>
</tr>
<tr>
<td>Miscellaneous Anorexigenic Agents, Respiratory &amp; Cerebral Stimulants</td>
<td>Exclusions: All</td>
<td>28:20.92</td>
</tr>
<tr>
<td>Anxiolytics, Sedatives and Hypnotics – Benzodiazepines</td>
<td>Exclusions: All</td>
<td>28:24.08</td>
</tr>
<tr>
<td>Category</td>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>Miscellaneous Anxiolytics, Sedatives and Hypnotics</td>
<td>28:24:92</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
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<tr>
<td>Antimanic Agents</td>
<td>28:28:00</td>
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<tr>
<td>Selective Serotonin Agonists</td>
<td>28:32:28</td>
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<td>Maintenance: All</td>
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<td></td>
</tr>
<tr>
<td>Miscellaneous Central Nervous System Agents</td>
<td>28:92:00</td>
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<tr>
<td>Maintenance: All</td>
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<tr>
<td>CONTRACEPTIVES (NON-ORAL)</td>
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<tr>
<td>DIAGNOSTIC AGENTS</td>
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<tr>
<td>ELECTROLYTIC, CALORIC, AND WATER BALANCE</td>
<td>40:00.00</td>
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<tr>
<td>Alkalinizing Agents</td>
<td>40:08.00</td>
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</tr>
<tr>
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<td></td>
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<tr>
<td>Replacement Preparations</td>
<td>40:12.00</td>
<td></td>
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<tr>
<td>Inclusions: All</td>
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<tr>
<td>Calcium-Removing Resins</td>
<td>40:17.00</td>
<td></td>
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<td>Exclusions: All</td>
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<td></td>
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<tr>
<td>Ion-Removing Agents</td>
<td>40:18.00</td>
<td></td>
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<td></td>
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<tr>
<td>Caloric Agents</td>
<td>40:20.00</td>
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</tr>
<tr>
<td>Exclusions: All</td>
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<tr>
<td>DIURETICS</td>
<td>40:28.00</td>
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<tr>
<td>Loop Diuretics</td>
<td>40:28.08</td>
<td></td>
</tr>
<tr>
<td>Exclusion: Ethacrynic acid</td>
<td></td>
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<tr>
<td>Limitations: Furosemide approved for use for mild to moderate heart failure, up to 7 day course, to maximum of 2 Rx in 3 month period</td>
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<tr>
<td>Maintenance: Furosemide for long term use</td>
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<tr>
<td>Potassium-Sparing Diuretics</td>
<td>40:28.16</td>
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<td>Maintenance: All</td>
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<tr>
<td>Thiazide Diuretics</td>
<td>40:28.20</td>
<td></td>
</tr>
<tr>
<td>Limitations: Hydrochlorothiazide for management of hypertension</td>
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<table>
<thead>
<tr>
<th><strong>Maintenance: Spironolactone/HCT</strong></th>
</tr>
</thead>
</table>

**Thiazide Like Diuretics**
Exclusion: Chlorthalidone  
Maintenance: All others  

**Uricosuric Agents**
Inclusions: All except  
Limitations: Probenecid – restricted: for adjunctive therapy with antibiotics; maintenance only for gout  
Maintenance: Sulfinpyrazone  
Note: For Allopurinol see 92:00.00

**RESPIRATORY AGENTS**

**Antitussives**
Inclusions: All  

**Leukotriene Modifiers**
Inclusions: All  
NP can initiate first course, reassessment by physician within 3 months

**Mast Cell Stabilizers**
Inclusions: All  

**EYE, EAR NOSE AND THROAT (EENT) PREPARATIONS**

**EENT - Antiallergic Agents**
Inclusions: All  

**EENT – Antibacterials**
Inclusions: All  

**EENT – Antivirals**
Exclusions: All  

**EENT – Corticosteroids**
Inclusions: All for nasal, inhaled and otic use  
Maintenance: All for ophthalmic use  

**EENT – Nonsteroidal Anti-inflammatory agents**
Maintenance: All for ophthalmic use  

**EENT – Carbonic Anhydrase Inhibitors**
Inclusions: for high-altitude travel  
Maintenance: All others  

**EENT - Miotics**
Maintenance: All  

**EENT – Mydriatics**
Maintenance: All  

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<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
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<tr>
<td>EENT – Mouthwashes and Gargles</td>
<td>52:28.00</td>
<td>All</td>
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<tr>
<td>EENT – Vasoconstrictors</td>
<td>52:32.00</td>
<td>All</td>
</tr>
<tr>
<td>Miscellaneous EENT Drugs</td>
<td>52:92.00</td>
<td>Aluminum Acetate/Benzethonium Chloride Otic, all Methylcellulose-based ophthalmic preparations, all Petrolatum-based ophthalmic ointments, all Polyvinyl alcohol-based ophthalmic drops, all Sodium Chloride eye and nasal preparations, and all propylene glycol nasal preparations. Maintenance: All others</td>
</tr>
<tr>
<td>GASTROINTESTINAL DRUGS</td>
<td>56:00.00</td>
<td></td>
</tr>
<tr>
<td>Antacids and Adsorbents</td>
<td>56:04.00</td>
<td>All</td>
</tr>
<tr>
<td>Antidiarrhea Agents</td>
<td>56:08.00</td>
<td>All</td>
</tr>
<tr>
<td>Cathartics and Laxatives</td>
<td>56:12.00</td>
<td>All</td>
</tr>
<tr>
<td>Cholelitholytic Agents</td>
<td>56:14.00</td>
<td>Maintenance: All</td>
</tr>
<tr>
<td>Digestants</td>
<td>56:16.00</td>
<td>All</td>
</tr>
<tr>
<td>Emetics</td>
<td>56:20.00</td>
<td>Exclusions: All</td>
</tr>
<tr>
<td>Antihistamines (Anti-nauseants)</td>
<td>56:22.08</td>
<td>All</td>
</tr>
<tr>
<td>5-HT3 Receptor Antagonists</td>
<td>56:22.20</td>
<td>Maintenance: All</td>
</tr>
<tr>
<td>Miscellaneous Antiemetics</td>
<td>56:22.92</td>
<td>All except Nabilone Limitations: Domperidone – inclusion for breastfeeding; otherwise Maintenance</td>
</tr>
<tr>
<td>Histamine H2-Antagonists</td>
<td>56:28.12</td>
<td>All</td>
</tr>
<tr>
<td>Prostaglandins</td>
<td>56:28.28</td>
<td>Misoprostol - with Arthrotec;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- for pre-endometrial biopsy, IUD insertion or other GYN procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusions: All others</td>
</tr>
<tr>
<td>Category</td>
<td>Code</td>
<td></td>
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<tr>
<td>--------------------------------</td>
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<td></td>
</tr>
<tr>
<td><strong>Protectants</strong></td>
<td>56:28.32</td>
<td></td>
</tr>
<tr>
<td>Maintenance: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Proton-Pump Inhibitors</strong></td>
<td>56:28.36</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prokinetic Agents</strong></td>
<td>56:32.00</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-inflammatory Agents</strong></td>
<td>56:36.00</td>
<td></td>
</tr>
<tr>
<td>All maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GOLD COMPOUNDS</strong></td>
<td>60:00.00</td>
<td></td>
</tr>
<tr>
<td>Maintenance: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEAVY METAL ANTAGONISTS</strong></td>
<td>64:00.00</td>
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</tr>
<tr>
<td>Maintenance: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HORMONES AND SYNTHETIC SUBSTITUTES</strong></td>
<td>68:00.00</td>
<td></td>
</tr>
<tr>
<td><strong>Adrenals</strong></td>
<td>68:04.00</td>
<td></td>
</tr>
<tr>
<td>Inclusions: Beclomethasone, Budesonide, and Fluticasone for inhalation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limitations: Oral Prednisone-ADULT - acute therapy- up to 14 days to a maximum of 2 courses in 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Prednisone PEDIATRIC –</td>
<td></td>
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<tr>
<td>- for CROUP- one dose only- if more is needed, need to consult MD</td>
<td></td>
<td></td>
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<tr>
<td>- for other conditions- 5 day course, maximum once in three months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance: All others</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Androgens</strong></td>
<td>68:08.00</td>
<td></td>
</tr>
<tr>
<td>Exclusions: All except</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance: Danazol</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptives</strong></td>
<td>68:12.00</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
<td></td>
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<tr>
<td><strong>Estrogens</strong></td>
<td>68:16.04</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estrogen Agonists/Antagonists</strong></td>
<td>68:16.12</td>
<td></td>
</tr>
<tr>
<td>Maintenance: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alpha-Glucosidase Inhibitors</strong></td>
<td>68:20.02</td>
<td></td>
</tr>
<tr>
<td>Maintenance: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Biguanides</strong></td>
<td>68:20.04</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Insulins</strong></td>
<td>68:20.08</td>
<td></td>
</tr>
<tr>
<td>Inclusions: All</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Meglitinides
Maintenance: All 68:20.16

Antidiabetic Agents – Sulfonylureas
Maintenance: All 68:20.20

Thiazolidinediones
Maintenance: All 68:20.28

Parathyroid
Maintenance: All 68:24.00

Pituitary
Maintenance: All 68:28.00

Progestins
Inclusions: All 68:32.00

Thyroid Agents
Inclusions: All except
Maintenance: Thyroid 68:36.04

Antithyroid Agents
Maintenance: All 68:36.08

SERUMS, TOXOIDS AND VACCINES
Maintenance: All 80:00.00

SKIN AND MUCOUS MEMBRANE AGENTS (SMMA) 84:00.00

SMMA – Antibiotics
Inclusions: All 84:04.04

SMMA – Antivirals
Inclusions: All 84:04.06

SMMA – Antifungals
Inclusions: All 84:04.08

SMMA – Scabicides and Pediculicides
Inclusions: All 84:04.12

SMMA-Miscellaneous Local Anti-Infectives
Inclusions: All 84:04.92
<table>
<thead>
<tr>
<th><strong>SMMA - Anti-inflammatory Agents</strong></th>
<th>84:06.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All except</td>
<td></td>
</tr>
<tr>
<td>Maintenance: - Potent and very potent topical anti-inflammatory corticosteroid agents</td>
<td></td>
</tr>
<tr>
<td>- Corticosteroid enemas</td>
<td></td>
</tr>
<tr>
<td>Note: Very Potent topical corticosteroids: Beclomethasone dipropionate, Clobetasol, Halobetasol.</td>
<td></td>
</tr>
<tr>
<td>Potent topical corticosteroids: Amcinonide, Betamethasone valerate, Desoximetasone, Diflucortolone, Fluocinolone, Fluocinonide, Halcinonide and Mometasone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SMMA-Cell Stimulants and Proliferants</strong></th>
<th>84:16.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Basic Ointments and Protectants</strong></th>
<th>84:24.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Keratolytic Agents</strong></th>
<th>84:28.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Keratoplastic Agents</strong></th>
<th>84:32.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pigmenting Agents</strong></th>
<th>84:50.06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions: All</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Miscellaneous Skin and Mucous Membrane Agents</strong></th>
<th>84:92.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: Calcipotriol topical, Capsaicin, Collagenase, and Vitamin E topical</td>
<td></td>
</tr>
<tr>
<td>Exclusion: Accutane</td>
<td></td>
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<tr>
<td>Maintenance: All others</td>
<td></td>
</tr>
</tbody>
</table>

**SMOOTH MUSCLE RELAXANTS** 86:00.00

<table>
<thead>
<tr>
<th><strong>Genitourinary Smooth Muscle Relaxants</strong></th>
<th>86:12.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: Oxybutynin is a drug of inclusion, Maintenance: All others</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Respiratory Smooth Muscle Relaxants</strong></th>
<th>86:16.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance: All</td>
<td></td>
</tr>
</tbody>
</table>

**VITAMINS** 88:00.00

| Inclusions: All except                  |          |
| Maintenance: Alfalcaldiol, calcitriol and ergocalciferol maintenance | |

**UNCLASSIFIED THERAPEUTIC AGENTS** 92:00.00

| Inclusions: Alendronate, Allopurinol, Betahistine, Etidronate, Risendronate | |
| Limitations: Colchicine may be prescribed for acute therapy up to 10 days to a maximum of 2 courses in 3 months | |
| Exclusions: Adalimumab, Botulinum Toxin Type A, Infliximab, Leucovorin, Pamidronate. | |

RNANT/NU Prescriptive Authority Guidelines for NWT PHCNP's

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<table>
<thead>
<tr>
<th>NATURAL HEALTH PRODUCTS</th>
<th>92:01.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEVICES</th>
<th>94:00.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PHARMACEUTICAL AIDS</th>
<th>96:00.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusions: All except</td>
<td></td>
</tr>
<tr>
<td>Exclusion: Methadone</td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE B.

As Schedule A is based upon NIHB, and as NIHB does not list all drugs in NAPRA Schedule 1, this list will provide additional inclusion, maintenance and limitation drugs for NP Prescribing, in addition to Schedule A.

Inclusions- Drugs or Devices:
- All Health Canada approved hormonal contraceptive drugs and devices not mentioned in 32:00.00 and 68.12.00
- Cyclobenzaprine 10mg Tabs (Flexeril) – Muscle Relaxant
- Etodolac PO - NSAID used in RA
- Imiquimod (Aldara) - Genital Warts
- Moxifloxacin (Avelox) - Antibiotic
- Olopatadine (Patanol) - Anti-allergy eye drop
- Oseltamivir (Tamiflu) – Oral Antiviral
- Orphenadrine (Norflex) - Muscle relaxant

Limitations:
- Atovaquone/Proguanil combination (Malarone), and
- Mefloquine (Larium) - Antimalarials –
  Note: Must write name of referring agency or person on prescription eg CDC, Travel clinic, MD

- Ceftriaxone Injectable (Rocephen) -Injectable antibiotic- to treat STI’s only.

Maintenance:
- Buspirone (Buspar) – Anti-anxiety
- Griseofulvin PO – Systemic antifungal

SCHEDULE C.

Nurse Practitioners may prescribe any medications listed in NAPRA schedule 2, 3 and Unscheduled without exclusion and limitations.

This Schedule includes, but is not limited to:
- All Oral Iron Preparations.
- All Insulins including newest agents Lispro and Levemir
- All Vaccines given through the life span as per Immunization Schedule of the NWT
- Cholera vaccine in Oral form (Dukoral)
- Minoxidil 2% lotion for hair replacement
- Nitroglycerin sublingual immediate release dosage form eg SL tablets and sprays
- Tioconazole PV - Vulvovaginal Candidiasis