Resolution of the Board of the British Columbia College of Nurses and Midwives passed the 23rd day of January, 2026

Bylaw Amendment: Convert Practice and Ethics Standards into BCCNM Bylaws

WHEREAS the Board has considered the proposed bylaw amendments, which convert Practice and Ethics Standards into BCCNM Bylaws, as set out in the appendices circulated to the Board via email dated January 21, 2026 (recorded as a board email meeting dated January 23, 2026) in anticipation of the implementation of the Health Professions and Occupations Act;

AND WHEREAS the Board is satisfied that the proposed bylaw amendments are non-substantive in nature and necessary to ensure compliance with and the smooth transition to the Health Professions and Occupations Act as contemplated by section 538;

AND WHEREAS the Board is acting in accordance with the authority established in section 19(1) of the Health Professions Act and subject to the filing with the Minister of Health as required under section 19(3) of the Health Professions Act;

RESOLVED THAT the Board approves the conversion of Practice and Ethics Standards into BCCNM Bylaws, as set out in the appendices to the briefing note dated January 21, 2026, to take effect upon the expiry of the filing period specified by the Minister.

FURTHER RESOLVED THAT the BCCNM Board rescinds all of the standards tabulated in the 'Standard' column in the Tables 1, 2, and 3 in Appendix A, consequential to the Practice and Ethics Standards included in Appendix B, Appendix C, and Appendix D coming into effect as bylaws.

CERTIFIED A TRUE COPY

Natasha Prodan-Bhalla, DNP, MN/NP, BScN
Registrar and Chief Executive Officer

BCCN&M British Columbia College of Nurses & Midwives

Appendix A: Summary of Practice and Ethics Standards

TABLE 1. PRACTICE AND ETHICS STANDARDS – NURSING & MIDWIFERY (APPENDIX B)

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
Indigenous Cultural Safety, Cultural Humility, and Anti-racism	Nurses & Midwives: Indigenous Cultural Safety, Cultural Humility, and Anti-racism	All	Ethics	• Edited section headings • Made minor edits to improve readability • Edited language to align with HPOA and/or new HPOA Regulations • Removed information more suited to a learning resource • Reformatted/rearranged content

TABLE 2. PRACTICE AND ETHICS STANDARDS – NURSING (APPENDIX C)

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
Advanced Procedures and Activities	Nurse Practitioners: Advanced Procedures and Activities	NP	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability
Boundaries in the Nurse-Client Relationship	Nurses: Boundaries in the Nurse-Client Relationship	All Nursing	Ethics	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Removed information more suited to a learning resource • Reformatted/rearranged content • Removed clinical/ outdated content
Conflict of Interest	Nurses: Conflict of Interest	All Nursing	Ethics	• Moved definitions from footnotes into Glossary • Removed information more suited to a learning resource • Definition of 'client' added
Consent	Nurses: Consent	All Nursing	Practice	• Made minor edits to improve readability

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
Consultation and Referral	Nurse Practitioners: Consultation and Referral	NP	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability
Documentation	Nurses: Documentation	All Nursing	Practice	• Made minor edits to improve readability
Duty to Provide Care	Nurses: Duty to Provide Care	All Nursing	Ethics	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Removed information more suited to a learning resource
Duty to Report	Nurses: Duty to Report	All Nursing	Ethics	• Moved definitions from footnotes into Glossary • Edited section headings • Made minor edits to improve readability • Edited language to align with HPOA and/or new HPOA Regulations • Reformatted/rearranged content
Medical Assistance in Dying	Licensed Practical Nurses: Medical Assistance in Dying	LPN	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Edited language to align with HPOA and/or new HPOA Regulations • Removed information more suited to a learning resource
Medical Assistance in Dying	Nurse Practitioners: Medical Assistance in Dying	NP	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Removed information more suited to a learning resource • Reformatted/rearranged content
Medical Assistance in Dying	Registered Nurses: Medical Assistance in Dying	RN	Practice	• Moved definitions from footnotes into Glossary • Removed information more suited to a learning resource

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
Medical Assistance in Dying	Registered Psychiatric Nurses: Medical Assistance in Dying	RPN	Practice	• Moved definitions from footnotes into Glossary • Removed information more suited to a learning resource
Mental Health & Capacity Assessments	Nurse Practitioners: Mental Health & Capacity Assessments	NP	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Reformatted/rearranged content
Ordering Diagnostic Services and Managing Results	Nurse Practitioners: Screening & Diagnostic Tests and Imaging	NP	Practice	• Removed glossary terms that do not appear in the content, or explained in other standards
Prescribing Drugs	Nurse Practitioners: Prescribing Drugs	NP	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Edited language to align with HPOA and/or new HPOA Regulations • Removed information more suited to a learning resource
Prescribing for Opioid Use Disorder and/or Pharmaceutical Alternatives for Safer Supply	Nurse Practitioners: Prescribing for Opioid Use Disorder and/or Prescribed Alternatives	NP	Practice	• Moved definitions from footnotes into Glossary • Made minor edits to improve readability • Changed an outdated link to the most recent version • Added definition of “prescribed alternatives” to align with updated provincial policy • Transitioned language through the standard from “pharmaceutical alternatives for safer supply” to “prescribed alternatives”
Privacy & Confidentiality	Nurses: Privacy & Confidentiality	All Nursing	Practice	• No changes needed

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
Professional Standards for Licensed Practical Nurses	Licensed Practical Nurses: Professional Standards	LPN	Ethics	• Removed information more suited to a learning resource • Removed terms from Glossary that were not used in the standard • Aligned definition of "standard" with definition used in other Professional Standards
Professional Standards for Registered Nurses and Nurse Practitioners	Registered Nurses & Nurse Practitioners: Professional Standards	RN & NP	Ethics	• Edited section headings • Made minor edits to improve readability • Removed information more suited to a learning resource • Reformatted/rearranged content • Removed definitions that were outdated or more suitable for a learning resource
Professional Standards for Registered Psychiatric Nurses	Registered Psychiatric Nurses: Professional Standards	RPN	Ethics	• Made minor edits to improve readability • Removed information more suited to a learning resource • Removed clinical/ outdated content • Replaced outdated term of "cultural competence" with "cultural humility" • Removed outdated definition of "cultural safety" • Removed outdated reference to "continuing competence requirements"
Code of Ethics	Registered Psychiatric Nurses: Code of Ethics	RPN	Ethics	• Made minor edits to improve readability • Removed information more suited to a learning resource • Removed clinical/ outdated content

TABLE 3. PRACTICE AND ETHICS STANDARDS – MIDWIFERY (APPENDIX D)

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
Consultation, Referral and Transfer of Care	Midwives: Consultation, Referral and Transfer of Care	Midwifery	Practice	• No changes needed
Home & Community Birth	Midwives: Home & Community Birth	Midwifery	Practice	• Edited section headings • Reformatted/rearranged content
Policy for Required Procedures for Midwife or Client-initiated Termination of Care	Midwives: Termination of Care	Midwifery	Ethics	• Edited section headings • Made minor edits to improve readability • Removed clinical/ outdated content • Removed duplicative content
Policy on Appropriate Client-Midwife Relationships	Midwives: Boundaries in the Midwife-Client Relationship	Midwifery	Ethics	• Edited section headings • Made minor edits to improve readability • Edited language to align with HPOA and/or new HPOA Regulations • Removed information more suited to a learning resource • Removed clinical/ outdated content • Reformatted/rearranged content
Policy on Hospital Privileges	Midwives: Hospital Privileges	Midwifery	Practice	• Moved definitions from footnotes into glossary • Reformatted/rearranged content • Updated introduction
Policy on Informed Choice	Midwives: Informed Choice	Midwifery	Ethics	• Edited section headings • Made minor edits to improve readability • Reformatted/rearranged content • Removed clinical/ outdated content • Removed duplicative content
Policy on Medical Records	Midwives: Medical Records	Midwifery	Practice	• Edited section headings • Made minor edits to improve readability • Edited language to align with HPOA and/or new HPOA Regulations

Standard	Revised Title	Designation(s)	Standard Type (Practice or Ethics)	Summary of Changes
				• Removed information more suited to a learning resource • Reformatted/rearranged content
Policy on Requests for Care Outside Standards	Midwives: Requests for Care Outside Standards	Midwifery	Ethics	• Edited section headings • Removed information more suited to a learning resource • Removed clinical/ outdated content
Policy Statement on Complementary Therapies	Midwives: Complementary and Alternative Therapies	Midwifery	Practice	• Edited section headings • Made minor edits to improve readability
Preventing Transmission of Blood-borne Viruses	Midwives: Preventing Transmission of Blood-borne Viruses	Midwifery	Practice	• No changed needed
RM Code of Ethics	Midwives: Code of Ethics	Midwifery	Ethics	• Edited language to align with HPOA and/or new HPOA Regulations • Reformatted/rearranged content
Standards for Postpartum Care	Midwives: Postpartum Care	Midwifery	Practice	• Edited section headings • Made minor edits to improve readability • Removed information more suited to a learning resource • Reformatted/rearranged content • Revised Introduction and removed citation
RM Standards of Practice	Midwives: Professional Standards	Midwifery	Ethics	•
Policy on Practice Protocols	Midwives: Practice Protocols	Midwifery	Practice	• Made minor edits to improve readability • Removed information more suited to a learning resource • Removed clinical/ outdated content • Revised Introduction

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ETHICS STANDARD

Nurses & Midwives: Indigenous cultural safety, cultural humility, and anti-racism

Introduction

The purpose of this standard is to set expectations for how nurses and midwives are to provide culturally safe and anti-racist care for Indigenous clients.

This ethics standard is organized into six core concepts. Within each concept are the standards to which nurses and midwives are held.

Standards

1 SELF-REFLECTIVE PRACTICE (IT STARTS WITH ME)

Nurses and midwives examine the values, assumptions, beliefs, and privileges embedded in their own knowledge and practice, and consider how these may impact the therapeutic relationship with Indigenous clients.

Nurses and midwives:

1.1 Reflect on, identify, and do not act on any stereotypes or assumptions they may hold about Indigenous Peoples.

1.2 Reflect on how their privileges, biases, values, belief structures, behaviours, and positions of power may impact the therapeutic relationship with Indigenous clients.

1.3 Evaluate and seek feedback on their own behaviour towards Indigenous Peoples.

2 BUILDING KNOWLEDGE THROUGH EDUCATION

Nurses and midwives continually seek to improve their ability to provide culturally safe care for Indigenous clients.

Nurses and midwives:

2.1 Undertake ongoing education on Indigenous health care, determinants of health, cultural safety, cultural humility, and anti-racism.

2.2 Learn about the negative impact of Indigenous-specific racism on Indigenous clients accessing the health care system, and its disproportionate impact on Indigenous women and girls, and two-spirit, queer, and transgender Indigenous Peoples.[1]

2.3 Learn about the historical and current impacts of colonialism on Indigenous Peoples and how this may impact their health care experiences.

2.4 Learn about the Indigenous communities located in the areas where they work, recognizing that languages, histories, heritage, cultural practices, and systems of knowledge may differ between Indigenous communities.

3 ANTI-RACIST PRACTICE (TAKING ACTION)

Nurses and midwives take active steps to identify, address, prevent, and eliminate Indigenous-specific racism.

Nurses and midwives:

3.1 Take appropriate action when they observe others acting in a racist or discriminatory manner towards Indigenous Peoples by:

3.1.1 Helping colleagues to identify and eliminate racist attitudes, language, or behaviour.

3.1.2 Supporting clients, colleagues and others who experience and/or report acts of racism.

3.1.3 Reporting acts of racism or discrimination to leadership and/or the relevant health regulatory college.

4 CREATING SAFE HEALTH CARE EXPERIENCES

Nurses and midwives facilitate safe health care experiences where Indigenous clients' physical, mental/emotional, spiritual, and cultural needs can be met.

Nurses and midwives:

4.1 Treat clients with respect and empathy by:

4.1.1 Acknowledging the client's cultural identity.

4.1.2 Listening to and seeking to understand the client's lived experiences.

4.1.3 Treating clients and their families with compassion.

4.1.4 Being open to learning from the client and others.

4.2 Care for a client holistically, considering their physical, mental/emotional, spiritual, and cultural needs.

[1] Turpel-Lafond, M.E. (2021). pg. 72.

4.3 Acknowledge and incorporate into the plan of care Indigenous cultural rights, values, and practices, including ceremonies and protocols related to illness, birth, and death, where able.

4.4 Facilitate the involvement of the client's family and others (e.g., community and Elders, Indigenous cultural navigators, and interpreters) as needed and requested.

5 PERSON-LED CARE (RELATIONAL CARE)

Nurses and midwives work collaboratively with Indigenous clients to meet the client's health and wellness goals.

Nurses and midwives:

5.1 Respectfully learn about the client and the reasons the client has sought health care services.

5.2 Engage with clients and their identified supports to identify, understand, and address the client's health and wellness goals.

5.3 Actively support the client's right to decide on their course of care.

5.4 Communicate effectively with clients by:

5.4.1 Providing the client with the necessary time and space to share their needs and goals.

5.4.2 Providing clear information about the health care options available, including information about what the client may experience during the health care encounter.

5.4.3 Ensuring information is communicated in a way that the client can understand.

6 STRENGTHS-BASED AND TRAUMA-INFORMED PRACTICE (LOOKING BELOW THE SURFACE)

Nurses and midwives have knowledge about different types of trauma and their impact on Indigenous clients, including how intergenerational and historical trauma affects many Indigenous Peoples during health care experiences. Nurses and midwives focus on the resilience and strength the client brings to the health care encounter.

Nurses and midwives:

6.1 Work with the client to incorporate their personal strengths that will support the achievement of their health and wellness goals.

6.2 Recognize the potential for trauma (personal or intergenerational) in a client's life and adapt their approach to be thoughtful and respectful of this, including seeking permission before engaging in assessments or treatments.

6.3 Recognize that colonialism and trauma may affect how clients view, access, and interact with the health care system.

6.4 Recognize that Indigenous women, girls, two-spirit, queer, and trans Indigenous Peoples are disproportionately impacted by Indigenous-specific racism in the health care system and consider the impact gender-specific trauma may have on the client.

Glossary

Indigenous: First Nations, Inuit, and Métis Peoples in Canada.

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

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PRACTICE STANDARD

Nurse Practitioners: Advanced Procedures and Activities

Introduction

This practice standard sets the expectations that nurse practitioners meet when carrying out advanced procedures and activities that are within nurse practitioner scope of practice. Advanced procedures and activities encompass:

- The **restricted activities** for nurse practitioners,
- Activities that are not restricted, and/or
- Non-core procedures and activities[1] for nurse practitioners as defined by the British Columbia Medical Quality Initiative.

Standards

1. Before incorporating an advanced procedure or activity into their practice, nurse practitioners consider:
    a. Their foundational education in relation to the procedure or activity,
    b. Employer support that ensures the required organizational infrastructure is in place to support the nurse practitioner and the practice setting to incorporate the activity into practice,
    c. Inclusion and exclusion criteria for the **client** population,
    d. Risks to clients that are associated with performing the activity,
    e. Measures that would be taken to mitigate risks and make the activity as safe as possible,
    f. How nurse practitioners will manage outcomes both intended and unintended,

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

g. How outcomes would be tracked and evaluated, and

h. Availability of best practice guidelines or other evidence-based tools.

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

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

Limits & conditions

Blood and Blood Products

1. Nurse practitioners order blood and blood products in accordance with evidence based guidelines and recommendations (e.g., BC Communicable Disease Control Manual, Provincial Blood Coordinating Office Recommendations).

2. Nurse practitioners who order blood and blood products for transfusion must successfully complete additional education (e.g., Transfusion Camp for Nurse Practitioners or suitable equivalent).

Setting Fractures and Reducing Dislocations

1. Nurse practitioners:

   a. Are limited to setting a closed, simple fracture of a bone;

   b. Are limited to reducing dislocations of the fingers and toes (digits of the upper and lower extremities); and

   c. Have authority to reduce anterior shoulder dislocations on the condition that the NP has the competence to interpret the X-ray if clinically indicated.

Ordering or Applying Hazardous Forms of Energy

1. Nurse practitioners:

   a. Do not give an order or apply laser for the purpose of destroying tissue.

Medical Aesthetics

1. Nurse practitioners order medical aesthetic procedures only when:

   a. The individual acting on the order is a nurse holding practising registration with BCCNM; and

   b. The ordering nurse practitioner, or another nurse practitioner or medical practitioner who has assumed responsibility for the care of the client, is or will be present within

the facility when the procedure is being performed and immediately available for consultation.

2. Nurse practitioners complete additional education before providing or ordering medical aesthetic procedures.
3. Nurse practitioners only provide medical aesthetic procedures or order them to be performed in an appropriate clinical setting that is suitable to safely perform the procedure and includes the equipment and supplies necessary to manage emergency situations.
4. Nurse practitioners only use Health Canada-approved drugs, substances and medical devices when providing or ordering medical aesthetic procedures.
5. Nurse practitioners only provide or order medical aesthetic procedures for clients under the age of 19 for the treatment of acne or scarring.
6. Nurse practitioners do not provide or order any medical aesthetic procedures that require conscious/procedural sedation or general anesthesia.

Glossary

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

Client: individual receiving nursing care or services from a nurse.

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

Medical Aesthetics: elective non-surgical clinical procedures that include the performance of a restricted activity and are primarily intended to alter or restore a person's appearance.

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

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ETHICS STANDARD

Nurses: Boundaries in the Nurse-Client Relationship

Introduction

The nurse-client relationship is the foundation of nursing practice. It is therapeutic and focuses on the needs of the **client**. It is based on trust, respect and empathy. The nurse-client relationship is conducted within boundaries that separate professional and therapeutic behaviour from non-professional and non-therapeutic behaviour. A client's dignity, autonomy and privacy are kept safe within the nurse-client relationship.

Within the nurse-client relationship, the client is often vulnerable because the **nurse** has more power than the client. The nurse has influence, access to information, and specialized knowledge and skills. Nurses have the competencies to develop a therapeutic relationship and set appropriate boundaries with their clients. Nurses who put their personal needs ahead of their clients' needs misuse their power.

The nurse who violates a boundary can harm both the nurse-client relationship and the client. A nurse may violate a boundary in terms of behaviour related to favouritism, physical contact, friendship, socializing, gifts, dating, intimacy, disclosure, chastising and coercion.

This ethics standard sets the expectations nurses must meet when establishing, maintaining and ending the nurse-client relationship.

Standards

1. Nurses use professional judgment to determine the appropriate boundaries of a therapeutic relationship with each client. The nurse — not the client — is always responsible for establishing and maintaining boundaries.
2. Nurses are responsible for beginning, maintaining and ending a relationship with a client in a way that ensures the client's needs are first.
3. Nurses do not enter into a friendship or a romantic relationship with clients.
4. Nurses do not enter into sexual relations with clients, with or without consent.
5. Nurses are careful about socializing with clients and former clients, especially when the client or former client is vulnerable or may require ongoing care.

Last updated: September 2025

6. Nurses maintain the same boundaries with the client's family and friends as with the client.
7. Nurses help colleagues to maintain professional boundaries and report evidence of boundary violations to the appropriate person.
8. At times, a nurse *must* care for clients who are family or friends. When possible, overall responsibility for care is transferred to another health care provider. Nurses must also be aware where legislation specifically prohibits a nurse from providing care or services to friends or family members.
9. At times, a nurse may *want* to provide some care for family or friends. This situation requires caution, discussion of boundaries and the dual role[1] with everyone affected and careful consideration of alternatives.
10. Nurses who have a personal relationship with a client make it clear to clients when they are acting in a professional capacity and when they are acting in a personal capacity.
11. Nurses have access to privileged and confidential information, but never use this information to the disadvantage of clients or to their own personal advantage.
12. Nurses disclose a limited amount of information about themselves only after they determine it may help to meet the therapeutic needs of the client.
13. Nurses may touch or hug a client with a supportive and therapeutic intent and with the implicit or explicit consent of the client.
14. Nurses do not communicate with or about clients in ways that may be perceived as demeaning, seductive, insulting, disrespectful, or humiliating.
15. Nurses do not engage in any activity that results in inappropriate financial or personal benefit to themselves or loss to the client. Inappropriate behaviour includes neglect and/or verbal, physical, sexual, emotional and financial abuse.
16. Nurses do not act as representatives for clients under powers of attorney or representation agreements.
17. Nurses do not act as substitute decision maker under Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* when they:
    a. are also a "manager" (per the definition within the Act) responsible for the operation of the facility, or
    b. are responsible for admissions to a care facility.
18. Generally, nurses do not exchange gifts with clients. Where it has therapeutic intent, a group of nurses may give or receive a token gift. Nurses return or redirect any significant gift. Nurses do not accept a bequest from a client.

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1 A nurse in a dual role has both a personal and professional relationship with a client. While not desirable, a dual role is often unavoidable, particularly in small communities. Note that this may be prohibited in certain circumstances.

Glossary

Client: individual, family, group, population or entire community receiving nursing care or services from a nurse.

Nurse: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

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ETHICS STANDARD

Nurses: Conflict of Interest

Introduction

A conflict of interest occurs when a **nurse's** personal, business, commercial, political, academic or financial interests, or the interests of the nurse's family or friends, interfere with the nurse's professional responsibilities or a **client**'s best interests.

Standards

1. Nurses identify and seek to avoid actual, potential or perceived conflicts of interest.
2. Nurses avoid any behaviours including promoting private or business interests that place their personal gain ahead of their professional responsibilities.
3. Nurses handle all types of conflict of interest by identifying the problem, discussing it with the appropriate people and managing it ethically.
4. Nurses fully and accurately disclose, to the appropriate persons, any relationships, affiliations, financial interests or personal interests that may create a conflict of interest.
5. Nurses follow BCCNM's Bylaws when they advertise or promote professional services or products.
6. Nurses recognise the potential for gifts of any value to affect objectivity and use professional judgment when considering their acceptance.
7. Nurses only accept funds from **commercial sources** in the form of an **unrestricted grant** paid to the organization sponsoring the professional activity.

Glossary

Client: individual, family, group, population or entire community receiving nursing care or services from a nurse.

Commercial source: business or organization whose primary purpose is the for-profit sale of goods or services.

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

Unrestricted grant: funding given without constraints or conditions.

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ETHICS STANDARD

Nurses: Consent

Introduction

Consent is a voluntary, **informed** agreement to an act or purpose made by a capable individual. A client is capable if they can understand and appreciate the nature and consequences of the decision. A **client** (or the **client's representative**, if applicable) has the legal right to agree to, decline, or withdraw consent for proposed care, service, treatment, or research provided by a health professional at any time. Specific legislation may apply to consent in different settings.

Standards

1. **Nurses** recognize, respect, and promote the client's right (or client's representative, if applicable) to be informed and make decisions about their care. This includes their right to give, decline, or withdraw consent at any time.
    a. If applicable, nurses verify the person authorized to make health-care decisions on the client's behalf.
2. Nurses understand that a client's ability to give, decline, withdraw consent may vary at different times. Nurses continually assess the client's ability to **give** consent and facilitate the client's decision-making when the client is able.
3. Nurses acknowledge the power imbalances that can occur for clients seeking care and facilitate culturally safe environments and experiences where the client (or client's representative, if applicable) can make decisions about their care.
4. Nurses recognize factors such as trauma and Indigenous-specific racism as potential barriers to consent and are aware of non-verbal cues that may indicate the client (or the client's representative, as applicable) has questions or concerns about the proposed care, service, treatment or research.
5. Nurses obtain consent according to:
    a. Relevant legislation and regulations,
    b. The BCCNM bylaws and standards, and
    c. Organizational/employer policies and processes.
6. Nurses obtain or verify consent before providing care unless legislation allows an exception.

7. Nurses inform the client about any care they provide before it is given, even if the client has been deemed incapable of consenting and consent was given by the client's representative.
8. Nurses who participate in care proposed or provided by other health professionals:
    a. Assist the client (or client's representative, if applicable) to understand the information provided by others as required, and/or
    b. Notify the health professional who proposed the care if there are concerns about consent.
9. Nurses acting within their autonomous scope of practice (acting without a client-specific order) are responsible for obtaining consent from the client (or the client's representative, if applicable) before providing care or issuing an order.
10. When acting within their autonomous scope of practice and obtaining consent, nurses:
    a. Identify, and when possible, take action to address barriers affecting a client's (or the client's representative, if applicable) ability to consent to care;
    b. Assess the client's capacity to give, decline, or withdraw consent, and document and communicate to the health-care team any findings of incapacity;
    c. Provide factual and clear information to the client (or the client's representative, if applicable) about the proposed care, service, treatment, or research appropriate to their needs, skills, and abilities, including:
        i. The reason for the proposed care,
        ii. The nature of the proposed care,
        iii. The potential risks and benefits, including those specific for the client, and
        iv. Alternative options for care, and their risks and benefits;
    d. Give the client (or the client's representative, if applicable) the opportunity to ask questions and receive answers; and
    e. Allow the client (or the client's representative, if applicable) to make voluntary decisions about the proposed care, service, treatment, or research. This includes providing sufficient time within the context of the clinical situation for the client (or the client's representative, if applicable) to make an informed decision.
11. When obtaining written consent, nurses document the consent discussion and outcome, following organizational/employer policies and processes.
12. Nurses respect the rights of the client (or the client's representative, if applicable) to seek further information or other opinions and to involve others in the decision-making and consent process.

Glossary

Consent: voluntary, informed agreement to an act or purpose made by a capable individual.

Client: individual receiving nursing care or services from a nurse.

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

a. "committee of the patient" under the *Patients Property Act*,

b. parent or guardian of a child under 19 years of age with parental responsibility to give, refuse or withdraw consent to health care for the child under section 41(f) of the *Family Law Act*,

c. representative authorized by a representation agreement under the *Representation Agreement Act* to make or help in making decisions on behalf of a client,

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

e. substitute decision maker chosen under section 22 of the *Health Care (Consent) and Care Facility (Admission) Act.*

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

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PRACTICE STANDARD

Nurse Practitioners: Consultation and Referral

Introduction

This practice standard outlines the expectations for nurse practitioners when consulting with or making referrals to other health care professionals to support **client** care.

Standards

1. Nurse practitioners are accountable for the care they provide and the decisions that they make when sharing client care with other health care professionals.
2. Nurse practitioners consult with or make a referral to other health care professionals when:
    a. They encounter client care needs beyond the scope of practice for nurse practitioners or their individual **competence**, and/or
    b. Client care would benefit from the expertise of other health care professionals.
3. Nurse practitioners make referral decisions in collaboration with the client.
4. When consulting with or making a referral to another health care professional, nurse practitioners:
    a. Present the reason for and the level of urgency of the consultation or referral,
    b. Describe the level of involvement requested,
    c. Provide relevant client health information,
    d. Confirm the health care professional's ongoing level of involvement with the client, and
    e. Document the request for and outcome of the consultation or referral in the client's health record.
5. When providing consultations to or receiving referrals from other health care professionals, nurse practitioners:
    a. Confirm the reason for and level of urgency of the request,
    b. Confirm the level of involvement requested,

c. Ensure that they have access to relevant client health information,

d. Notify the health care professional if they are unable to provide a consultation or receive a referral,

e. Confirm their ongoing level of involvement with the client, and

f. Document the request for and outcome of the consultation or referral.

Glossary

Client: individual receiving nursing care or services from a nurse.

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

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PRACTICE STANDARD

Nurses: Documentation

Introduction

Documentation is any information entered in the client record that relates to the care or services provided to a **client** by a **nurse**. Through documentation, nurses communicate nursing assessments, the plan of care, interventions ordered or carried out, and outcomes to other health professionals, supporting safe and coordinated care.

Documentation forms a comprehensive record of care provided to a client. It reflects a nurse's application of knowledge, skill, and judgment, and can influence future care decisions. Documentation is widely accepted as evidence in legal proceedings and helps nurses recall specific situations. Clients may also request access to their records.

This practice standard sets the expectations nurses must meet when documenting in the client record.

Standards

1. Nurses document in alignment with:
    a. Relevant legislation and regulations,
    b. The BCCNM bylaws and standards, limits, and conditions, and
    c. Organizational/employer policies and processes.
2. Nurses are responsible and accountable for documenting in the client record the care they personally provide to the client. Care provided by others is documented by those individuals, unless there are exceptional circumstances such as an emergency.
3. Nurses document a decision-making process (such as assessment, planning, implementation, and evaluation), as applicable, to show the care they provided.
4. Nurses document all relevant information and communication related to the care of the client in a clear, concise, chronological, factual, timely, and legible manner.
5. Nurses document using respectful, non-discriminatory language that reflects cultural safety and anti-racism; respects the client's identity, context, and lived experience; and avoids stereotypes and assumptions.

6. Nurses document the date and time of each entry. Nurses clearly mark any late entries, recording the date and time of the late entry and the date and time of the actual event.
7. Nurses carry out more comprehensive, in-depth, and frequent documentation when clients are acutely ill, high-risk, or have complex health needs.
8. Nurses document client-specific concerns escalated to another health professional, the transfer of care (if applicable), and that professional's full name, title, and response.
9. Nurses document at the time they provide care or as soon as possible afterward.
10. Nurses do not document care before care is given.
11. Nurses ensure that unique client identifiers are on every page or part of the client record.
12. Nurses indicate their accountability and responsibility by signing each entry in the client record with a unique identifier (such as a written signature or an electronically generated identifier) and their regulated nursing title.
13. Nurses correct any documentation errors:
    a. In a timely manner,
    b. By taking the appropriate steps to mitigate any negative impacts of the documentation error, if applicable,
    c. In a manner that ensures the original information is visible/retrievable, and
    d. Following organizational/employer policies and processes.
14. Nurses respect clients' (or the **client's representative**, as applicable) right to access their own client records and request correction of the information if they believe there is an error or omission, following organizational/employer policies and processes.

USE OF ARTIFICIAL INTELLIGENCE

15. Nurses only use artificial intelligence (AI) to assist with documentation when:
    a. They have the approval to use AI by their organization/employer, and
    b. Their organization/employer has AI policies and processes.
16. Nurses who use AI to assist with their documentation:
    a. Remain solely accountable for the accuracy, objectivity, and completeness of their documentation entry, and
    b. Review and validate their AI-assisted documentation entries at the time they provide care or as soon as possible afterward.

Glossary

Client: individual receiving nursing care or services from a nurse.

Client's Representative: individual with legal authority to give, refuse, or withdraw consent to healthcare on a client's behalf, including:

a. "committee of the patient" under the *Patients Property Act*,

b. parent or guardian of a child under 19 years of age with parental responsibility to give, refuse or withdraw consent to health care for the child under section 41(f) of the *Family Law Act*,

c. representative authorized by a representation agreement under the *Representation Agreement Act* to make or help in making decisions on behalf of a client,

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

e. substitute decision maker chosen under section 22 of the *Health Care (Consent) and Care Facility (Admission) Act*.

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

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ETHICS STANDARD

Nurses: Duty to Provide Care

Introduction

Nurses have an obligation to provide safe, competent and ethical care to their clients, in accordance with BCCNM's Standards of Practice and relevant legislation. There are, however, some circumstances in which it is acceptable for a nurse to withdraw from or decline care provision.

This ethics standard sets the expectations nurses must meet when providing care to clients and ending the nurse-client relationship.

Standards

1. Nurses have a professional and legal obligation to provide their clients with safe, competent, and ethical care.
2. Nurses recognize that informed, capable clients have the right to be independent, make choices that put their health at risk, and direct their own care. Regardless of this right, nurses do not comply with client wishes when doing so would require a nurse to act against the law or BCCNM Standards of Practice.
3. Nurses do not provide care that is outside their scope of practice except in situations involving imminent risk of death or serious harm that arise unexpectedly and require urgent action. In emergencies, nurses are ethically obligated to provide the best care they can, given the circumstances and their level of competence. Employers and nurses should not rely on the emergency exemption when an activity is considered an expected practice in that setting.
4. Nurses do not allow their personal judgments about a client, or the client's lifestyle, to compromise the client's care by withdrawing or refusing to provide care.
5. Nurses may withdraw from care provision or refuse to provide care if they believe that providing care would place them or their clients at an unacceptable level of risk. Nurses consider relevant factors, including:
    a. the specific circumstances of the situation;
    b. their legal and professional obligations; and
    c. their contractual obligations.

6. Nurses who have a conscientious objection to a client's request for a particular treatment or procedure:
    a. listen and, when possible, explore the client's reason for the request or refusal and their understanding of options that could meet their needs;
    b. do not attempt to influence or change the client's decision based on the nurse's conscientious objection;
    c. do not allow their beliefs or values to alter or interfere with a client receiving safe, competent, and ethical care;
    d. ensure that the most appropriate person within the organization is informed of the conscientious objection well before a client is to receive the requested treatment or procedure;
    e. work with their organization/employer to ensure uninterrupted continuity of care including reporting the client's request and, if needed, safe transfer of the client's care to a replacement provider; and
    f. despite their conscientious objection, provide safe care to a client in situations involving imminent risk of death or serious harm that arise unexpectedly and require urgent action for their client's safety.
7. Nurses do not abandon their clients. Abandonment occurs when the nurse has engaged with the client or has accepted an assignment and then discontinues care without:
    a. negotiating a mutually acceptable withdrawal of service with the client; or
    b. arranging for suitable alternative or replacement services; or
    c. allowing the employer a reasonable opportunity to provide for alternative or replacement services.

Glossary

Client: individual, family, group, population or entire community receiving nursing care or services from a nurse.

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

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ETHICS STANDARD

Nurses: Duty to Report

Introduction

Nurses (in all positions and settings) have a legal and ethical obligation to report incompetent or impaired practice or unethical conduct of **regulated health professionals**. It is important for nurses to understand when to report, what to report and how to report, and to know what is legally and ethically required.

In B.C., the *Health Professions and Occupations Act* establishes a legal duty for nurses to report situations in which there is a good reason to believe that a regulated health professional's practice is impaired or incompetent and may pose a danger to the public. Nurses must also report any sexual misconduct by a regulated health professional. Nurses who make a report in good faith are protected from legal liability in circumstances where the nurse has a legal duty to report under the Act.

Under this practice standard, nurses also have an expanded duty to report situations in which they have reason to believe that a regulated health professional's practice poses a danger to the public because of unethical behaviour or for other reasons.

Nurses may have obligations to report regulated health professionals under other legislation and regulations. The specific legislation or regulation that applies to a nurse's practice depends on the work setting and the nature of the work.

Standards

1. When nurses identify that a colleague is unable to perform their duties, they take the necessary steps to protect **client** safety.
2. Nurses report, in writing, to the appropriate regulatory body when they have reason to believe that a regulated health professional is practising when they:
    a. are suffering from a mental or physical problem, an emotional disturbance, or an addiction to drugs or alcohol that impairs their ability to practise;
    b. have a pattern of incompetent practice that may pose a danger to the public;
    c. have behaved unethically in a way that may pose a danger to the public;
    d. otherwise present a danger to the public.
3. Nurses report, in writing, to the appropriate regulatory body if they believe that a regulated health professional has engaged in sexual misconduct.

4. If concerns about sexual misconduct are based on information from a client, nurses must first obtain the client's (or substitute decision-maker's) consent before making a report.
5. Nurses may have additional employment obligations to report any unprofessional conduct to their supervisor/employer and should also follow applicable employment policies. If no report has been made by the supervisor or employer, the nurse must make a direct report to the regulatory body.
6. Nurses working as employers, managers or business partners or associates of regulated health professionals report, in writing, to the appropriate regulatory body when they take any of the following actions against a regulated health professional based on a belief that their continued practice may pose a danger to the public because they are not competent to practise, or because their practise is impaired by a mental or physical problem, emotional disturbance, or an addiction to drugs or alcohol:[1]
    a. terminating the regulated health professional's employment;
    b. revoking, suspending or imposing restrictions on the regulated health professional's privileges; or
    c. dissolving a partnership or association with the regulated health professional.
7. Nurses have a legal duty to report to BCCNM when they have been charged with or convicted of a criminal offence identified by legislation as relevant to working with children or vulnerable adults. Nurses working as employers also have a legal duty to notify the appropriate regulatory body when they become aware that an employee who is a regulated health professional has been charged with or convicted of such an offence (*Criminal Records Review Act*, ss. 12 and 17).

Glossary

Client: individual, family, group, population or entire community receiving nursing care or services from a nurse.

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

Regulated Health Professional: a registrant of BCCNM or any health profession college under the *Health Professions and Occupations Act*.

1 This duty to report also applies if a nurse intends to take such action but the regulated health professional resigns, relinquishes their privileges, or dissolves their partnership or association before the nurse acts.

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PRACTICE STANDARD

Licensed Practical Nurses: Medical Assistance in Dying

Introduction

The *Licensed Practical Nurse: Medical Assistance in Dying (MAiD)* standards, limits, and conditions apply to licensed practical nurses when they are aiding a physician or a nurse practitioner (NP) to provide MAiD. Licensed practical nurses do not assess clients for the eligibility to receive MAiD. Licensed practical nurses do not administer or prescribe MAiD or provide substances to a person at their request for their self administration of MAiD.

The role of licensed practical nurses may include:

- Providing information
- Acting as an independent witness, as described in the *Criminal Code of Canada*
- Acting as a proxy, for a mentally capable client who is physically unable to sign a request for medical assistance in dying
- Acting as a witness in a virtual assessment
- Aiding a medical practitioner or nurse practitioner in the provision of medical assistance in dying

Licensed practical nurses cannot prescribe, compound, prepare, dispense or administer any substance intended for the purpose of medical assistance in dying. Licensed practical nurses can record information for reference use by the assessor-prescriber[1] as needed, but the assessor-prescriber is responsible for documenting the substance they administer or provide in the client's record and medication administration record.

Licensed practical nurses approached about aiding in the provision of medical assistance in dying should speak with their employer for further information about their role in MAiD. Employers may also further limit the role of nurses in MAiD.

1 A nurse practitioner or medical practitioner who is responsible for completing both an eligibility assessment and providing medical assistance in dying.

Standards

1. Licensed practical nurses ensure that a **client** has access to the information that the client requires to understand all of their options and to make informed decisions about medical assistance in dying and other end-of-life options such as palliative care.
2. Licensed practical nurses assess the cultural and spiritual needs and wishes of the person seeking medical assistance in dying and explore ways the person's needs could be met within the context of the care delivery.
3. Licensed practical nurses work with their organizations and other members of the health care team to ensure that the person requesting or receiving medical assistance receives high quality, coordinated and uninterrupted continuity of care and, if needed, safe transfer of the client's care to another health care provider.
4. Licensed practical nurses who participate in medical assistance in dying follow legal, legislative, regulatory and organizational requirements for aiding in the provision of medical assistance in dying.
5. Licensed practical nurses may return unused substances intended for the purpose of providing medical assistance in dying to the pharmacy, when asked by the assessor-prescriber. When asked to carry out such a request, licensed practical nurses ensure the drugs are stored securely until transported and are returned to the pharmacy within 72 hours of the MAiD procedure, and they sign any forms normally signed by the assessor-prescriber to note the return of the substances.

Limits & conditions

1. Licensed practical nurses only aid in the provision of medical assistance in dying and do not act as an **assessor** or **assessor-prescriber** or provide medical assistance in dying to a person (i.e., they do not prescribe, compound, prepare, dispense or administer any substances specifically intended for the purpose of providing medical assistance in dying, nor document the provision of medical assistance in dying).
2. Licensed practical nurses do not receive substances specifically intended for the purpose of providing medical assistance in dying from a pharmacist.
3. Licensed practical nurses do not direct or counsel clients to end their lives.
4. Licensed practical nurses participate in activities related to medical assistance in dying only as permitted under the *Criminal Code of Canada* and other legislation, regulations, regulatory college standards, and provincial and organizational policy and procedures.
5. Licensed practical nurses do not act as an independent witness if they:
    a. Provide health care services or personal care to the client, unless they are a paid personal or health care worker who provides those services as their primary occupation.
    b. Own or operate any facility where the client requesting medical assistance in dying resides or is receiving treatment

   c. Know or believe that they are a beneficiary under the client's will, or that they will otherwise receive any financial or other material benefit as a result of the client's death

6. Licensed practical nurses do not act as a proxy for signing any forms related to medical assistance in dying if they know or believe that they are a beneficiary under the will of the client making the request, or that they will receive, in any other way, any financial or other material benefit resulting from the client's death.
7. Licensed practical nurses who aid in the provision of medical assistance in dying successfully complete **additional education**.
8. Licensed practical nurses who aid in the provision of medical assistance in dying follow the BC provincial **decision support tool**, in accordance with employer policy.
9. Licensed practical nurses do not aid in the provision of medical assistance in dying for a family member.
10. Licensed practical nurses do not pronounce death related to medical assistance in dying.

Glossary

Additional education: structured education (e.g., workshop, course, program of study) designed for the nurse to attain the competencies required to carry out a specific activity. Additional education:

- builds on the entry-level competencies,
- identifies the competencies expected of learners on completion of the education,
- includes both theory and application to practice, and
- includes an objective evaluation of learners' competencies on completion of the education.

Assessor: nurse practitioner or medical practitioner who is responsible for completing an assessment of the client's eligibility for medical assistance in dying.

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

Client: individual receiving nursing care or services from a nurse.

Decision support tools (DSTs): evidence-based documents used by nurses to support clinical judgment and decision-making by guiding the assessment, diagnosis and treatment of client-specific clinical problems. DSTs come in various forms and are created by organizations or specialists in a specific area of health care.

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PRACTICE STANDARD

Nurse Practitioners: Medical Assistance in Dying

Introduction

In accordance with the *Criminal Code of Canada* and other legislation, the BCCNM standards of practice, and provincial and organizational policies and procedures, nurse practitioners may provide a client with medical assistance in dying (MAiD).[1]

The purposeful and intended outcome of MAiD is to assist an eligible client explicitly requesting assistance in dying to end their life in a respectful, culturally appropriate, safe, ethical, legal and competent manner.

For more information on MAiD, visit the BC Ministry of Health Medical Assistance in Dying website.

Standards

1. Nurse practitioners participating in any aspect of MAiD comply with the *Criminal Code of Canada* and other applicable legislation, BCCNM standards of practice, and provincial and organizational policies and procedures related to MAiD.
2. Nurse practitioners use and follow the applicable provincial forms, prescriptions, and guidelines specific to MAiD.
3. Nurse practitioners acting as an **assessor** or **assessor-prescriber** for MAiD must have the **competence** appropriate to their role, including the competence to:
    a. Diagnose or confirm the diagnosis of a grievous and irremediable medical condition and, if applicable, the prognosis of reasonably foreseeable death.
    b. Assess the **client** against criteria in the *Criminal Code of Canada* related to MAiD.
    c. Assess the capacity of the client to consent to MAiD and determine when it is necessary to refer for further capacity assessment.

[1] NPs who aid in the provision of MAiD follow the Registered Nurses: Medical Assistance in Dying practice standard.

d. Implement the provincial MAiD substances protocols and manage the intended and unintended outcomes.

4. Nurse practitioners acting as assessor or assessor-prescriber for MAiD apply the *Indigenous Cultural Safety, Cultural Humility, and Anti-Racism* standards in the context of MAiD, as applicable.

Determining Eligibility

5. When advising anyone about their potential eligibility for MAiD, nurse practitioners:

    a. Have a complete and full discussion with the person about MAiD that provides them with the information they need to make an informed decision, including the information required by the *Criminal Code of Canada* (sections 241.2(1)(e) and 241.2(3.1)(g)),[2] and

    b. Take reasonable steps to ensure the person does not perceive coercion, inducement, or pressure to pursue or not to pursue MAiD.

6. Nurse practitioners acting as an assessor-prescriber must ensure clients requesting MAiD meet the eligibility criteria set out in the *Criminal Code of Canada* (section 241.2(1) and (2)).[3]

7. Nurse practitioners acting as an assessor or assessor-prescriber determine eligibility only when all the health information required is obtained and complete, including **collateral information** necessary for the completion of a MAiD assessment.[4]

8. Nurse practitioners acting as an assessor or assessor-prescriber must ensure that:

    a. The client requesting MAiD has the capacity to give free and informed consent to MAiD. Consent cannot be given for MAiD through an alternate or substitute decision-maker or a personal advance directive.

    b. Both assessors are satisfied that the client has the capacity to make a free and informed decision with respect to MAiD at the time of the request.

    c. The client is referred to another practitioner with expertise in capacity assessment—such as a psychologist, psychiatrist, neurologist, geriatrician, or family physician/general practitioner with additional training and expertise—for a further capacity assessment if either assessor is unsure that the client has the capacity to consent to MAiD.

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[2] Section 241.2(1)(e) sets out the requirement to inform any MAiD client of the means available to relieve their suffering, including palliative care. Section 241.2(3.1)(g) sets out additional, more specific requirements to ensure that a MAiD client whose natural death is not reasonably foreseeable is informed about available and appropriate counselling services, mental health and disability support services and community services, in addition to palliative care, and to ensure the client is offered the opportunity to consult with relevant professionals who provide those services or that care.

[3] Section 241.2(1) sets out the general eligibility criteria to receive MAiD. Section 241.2(2) set out the criteria for a "grievous or irremediable condition."

[4] This standard is adapted from standard 10.3.4.1 and 10.3.4.2 of Model Practice Standard for Medical Assistance in Dying (Health Canada, 2023).

9. Nurse practitioners assess the cultural and spiritual needs and wishes of the client seeking MAiD and explore ways the client's needs could be met within the context of the care delivery.
10. Nurse practitioners ensure that the client requesting MAiD receives high quality, coordinated, and uninterrupted continuity of care and, if needed, safe transfer of the client's care to another health care provider.
11. Nurse practitioners ensure that the client's request for MAiD:
    a. Aligns with the client's values and beliefs,
    b. Is clear,
    c. Is enduring, and
    d. Is made during a period of stability rather than crisis.[5]
12. Nurse practitioners acting as an assessor or assessor-prescriber complete a suicide risk assessment for clients who are determined to be ineligible for MAiD and make appropriate referrals for suicide prevention supports and services based on the findings of the risk assessment.[6]
13. Nurse practitioners acting as an assessor or assessor-prescriber must be familiar with and adhere to any provincial or federal requirements relating to MAiD for clients who are being involuntarily treated under the *Mental Health Act* (Section 22) or who or are incarcerated at the time of requesting MAiD.

PROCEDURAL SAFEGUARDS

14. Nurse practitioners acting as an assessor-prescriber must comply with all applicable procedural safeguards set out in the *Criminal Code of Canada* (section 241.2(3) and (3.1))[7] before prescribing, providing, or administering MAiD to a client.
15. Immediately before providing MAiD, the nurse practitioner acting as an assessor-prescriber must give the client an opportunity to withdraw their request and ensure that the client gives express consent to receive MAiD, unless they meet the criteria in the *Criminal Code of Canada* for waiver of final consent (section 241.2(3.2) or (3.5)).[8]

VIRTUAL ASSESSMENT

16. Nurse practitioners acting as an assessor or assessor-prescriber may provide their assessment virtually if they comply with the following conditions:

[5] This standard is adapted from standard 11.1 of the Model Practice Standard for Medical Assistance in Dying (Health Canada, 2023). Serial assessments should be done as needed.
[6] This standard is adapted from standard 11.3 of the Model Practice Standard for Medical Assistance in Dying (Health Canada, 2023).
[7] Section 241.2(3) establishes the procedural safeguards when death is reasonably foreseeable. Section 241.2(3.1) establishes the procedural safeguards when death is not reasonably foreseeable.
[8] Section 241.2(3.2) sets out criteria for a waiver of final consent for clients whose death is reasonably foreseeable. Section 241.2(3.5) sets out criteria for advance consent for clients who choose to self-administer a MAiD substance.

a. Nurse practitioners ensure that during the virtual assessment, another regulated health professional is physically present with the client to act as a witness to the assessment, unless no other regulated health professional is reasonably available to attend in person.

b. Virtual assessments must meet the requirements set out in federal legislation and all other standards and expectations that apply to in-person assessments.

c. Virtual assessments must include video of sufficient quality to ensure expected safeguards are in place.

ADMINISTERING MAID

17. Nurse practitioners acting as an assessor-prescriber must receive the substances for MAiD directly from the dispensing pharmacist and must inform the dispensing pharmacist that the substances are intended for MAiD.

18. Nurse practitioners acting as an assessor-prescriber must personally attend the client during the self-administration or personally administer the substances for MAiD and must remain in attendance until death is confirmed. This responsibility must not be delegated or assigned to any other person.

19. Nurse practitioners acting as an assessor-prescriber are responsible for ensuring that any unused substances are returned to the pharmacy as soon as reasonably feasible, and within 72 hours of confirmation of the client's death.

    a. If a nurse practitioner acting as an assessor-prescriber is not reasonably available to return unused substances to the pharmacy themselves, they may ask another nurse practitioner, or a licensed practical nurse, registered nurse, registered psychiatric nurse, physician, or pharmacist to return the substances to the pharmacy. The nurse practitioner must document the name of the person assigned to return the substances in the client record.

DOCUMENTATION AND REPORTING

20. Nurse practitioners communicate with the client requesting medical assistance in dying, and document in the medical record with a copy provided to the client:

    a. The client's diagnosis and prognosis,

    b. Feasible alternatives to relieve suffering (including palliative care, pain control, and other services and supports),

    c. Option to withdraw the request for medical assistance in dying at any time, and

    d. Risks of taking the prescribed substances intended to cause death.

21. Nurse practitioners acting as an assessor-prescriber who prescribe[9] or administer the substances to be used in MAiD must do so in the client's name using the provincial MAiD prescription form.
22. Nurse practitioners acting as an assessor-prescriber complete the medical certificate of death. The medical certificate of death must indicate that the manner of death involved MAiD and that the cause of death is the underlying illness/disease causing the grievous and irremediable medical condition.
23. Nurse practitioners comply with information or medical record requests made by a provincial agency tasked with a review of MAiD.
24. Nurse practitioners comply with reporting requirements established for the oversight or monitoring of MAiD. The required information must be submitted to the B.C. Ministry of Health using the applicable provincial forms and within the established timeframes for reporting.[10]
25. Nurse practitioners must ensure the following information is present in the client's medical record:
    a. All applicable provincial forms for MAiD, including the B.C. Medical Assistance in Dying Prescription form and Medication Administration Record.
    b. Copies of all relevant medical records from other medical practitioners/health care professionals involved in the client's care supporting the diagnosis and prognosis of the client's grievous and irremediable condition, disease, or disability.
    c. Documentation of all requests for MAiD with a summary of the discussion.
    d. Confirmation that the assessor-prescriber and the second assessor discussed and determined which practitioner would prescribe and/or administer the substance used for MAiD.
    e. Confirmation by the assessor-prescriber that all the requirements have been met including the steps taken and the substance prescribed.
    f. Confirmation that after the completion of all documentation, and just prior to administration, the client was offered the opportunity to withdraw their request, or that the client waived final consent and did not demonstrate refusal or resistance to the administration of MAiD by words, sounds, or gestures.

Limits & conditions

1. To be eligible to act as an assessor, nurse practitioners must have completed the following in order to acquire the needed competencies for eligibility assessment for MAiD:

[9] When prescribing substances for MAiD, nurse practitioners also follow the Nurse Practitioners: Prescribing Drugs practice standard.
[10] Timeframes for reporting are dependent on the information being submitted. Refer to the BC Ministry of Health Medical Assistance in Dying website for more information.

   a. **Additional education** (e.g., Canadian Association of MAiD Assessors and Providers (CAMAP) Canadian MAiD Curriculum (CMC), health authority education, etc.); and

   b. A preceptorship under the guidance of a qualified practitioner with expertise in MAiD.

2. To be eligible to act as an assessor-prescriber, nurse practitioners must have completed the following in order to acquire the needed competencies for both eligibility assessment and the provision of MAiD:

   a. Additional education (e.g., CAMAP CMC, health authority education, etc.); and

   b. A preceptorship under the guidance of a qualified medical practitioner or nurse practitioner with expertise in MAiD.

3. Nurse practitioners do not participate as an assessor or assessor-prescriber in MAiD for themselves, their family members, or anyone else with whom they have a close personal relationship that may result in an actual, potential or perceived conflict of interest.[11]

Glossary

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

Assessor: nurse practitioner or medical practitioner who is responsible for completing an eligibility assessment of the client.

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

Client: individual receiving nursing care or services from a nurse.

Collateral Information: information provided about a person by the person's treating team, family members, or significant contacts (Federal Model Standards, 2022).

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

[11] See the Nurses: Conflict of Interest ethics standard for additional guidance.

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PRACTICE STANDARD

Registered Nurses: Medical Assistance in Dying

Introduction

The *Registered Nurse: Medical Assistance in Dying (MAiD)* practice standard applies to registered nurses when they are aiding a physician or a nurse practitioner to provide MAiD. Registered nurses do not assess clients for the eligibility to receive MAiD. Registered nurses do not administer or prescribe MAiD or provide substances to a person at their request for their self administration of MAiD.

The role of registered nurses[1] may include:

- providing information
- acting as an independent witness, as described in the Criminal Code
- acting as a proxy, for a mentally capable client who is physically unable to sign a request for medical assistance in dying
- acting as a witness in a virtual assessment
- aiding a medical practitioner or nurse practitioner in the provision of medical assistance in dying

Registered nurses cannot prescribe, compound, prepare, dispense or administer any substance intended for the purpose of medical assistance in dying. Registered nurses can record information for reference use by the assessor-prescriber[2] as needed, but the assessor-prescriber is responsible for documenting the substance they administer or provide in the client's record and medication administration record.

Registered nurses approached about aiding in the provision of medical assistance in dying should speak with their employer for further information about their role in MAiD. Employers may also further limit the role of nurses in MAiD.

Standards

1. Registered nurses ensure that a **client** has access to the information that the client requires to understand all of their options and to make informed decisions about medical assistance in dying and other end-of-life options such as palliative care.

1 Within this document, "registered nurse" includes a nurse practitioner who is aiding a medical practitioner or another nurse practitioner in the provision of medical assistance in dying.

2 A nurse practitioner or medical practitioner who is responsible for completing both an eligibility assessment and providing medical assistance in dying.

2. Registered nurses assess the cultural and spiritual needs and wishes of the person seeking medical assistance in dying and explore ways the person's needs could be met within the context of the care delivery.
3. Registered nurses work with their organizations and other members of the health care team to ensure that the person requesting or receiving medical assistance receives high quality, coordinated and uninterrupted continuity of care and, if needed, safe transfer of the client's care to another health care provider.
4. Registered nurses who participate in medical assistance in dying, follow legal, legislative, regulatory and organizational requirements for aiding in the provision of medical assistance in dying.
5. Registered nurses may return unused substances intended for the purpose of providing medical assistance in dying to the pharmacy, when asked by the assessor-prescriber. When asked to carry out such a request, registered nurses ensure the drugs are stored securely until transported and are returned to the pharmacy within 72 hours of the MAiD procedure, and they sign any forms normally signed by the assessor-prescriber to note the return of the substances.

Limits & conditions

1. Registered nurses only aid in the provision of medical assistance in dying and do not act as an **assessor** or **assessor-prescriber** or provide medical assistance in dying to a person (i.e., they do not prescribe, compound, prepare, dispense or administer any substances specifically intended for the purpose of providing medical assistance in dying, nor document the provision of medical assistance in dying).
2. Registered nurses do not receive substances specifically intended for the purpose of providing medical assistance in dying from a pharmacist.
3. Registered nurses do not direct or counsel clients to end their lives.
4. Registered nurses participate in activities related to medical assistance in dying only as permitted under the Criminal Code and other legislation, regulations, regulatory college standards, and provincial and organizational policy and procedures.
5. Registered nurses do not act as an independent witness if they:
    a. Provide health care services or personal care to the client, unless they are a paid personal or health care worker who provides those services as their primary occupation;
    b. Own or operate any facility where the client requesting medical assistance in dying resides or is receiving treatment;
    c. Know or believe that they are a beneficiary under the client's will, or that they will otherwise receive any financial or other material benefit as a result of the client's death.
6. Registered nurses do not act as a proxy for signing any forms related to medical assistance in dying if they know or believe that they are a beneficiary under the will of the client making the request, or that they will receive, in any other way, any financial or other material benefit resulting from the client's death.

7. Registered nurses who aid in the provision of medical assistance in dying successfully complete **additional education**.
8. Registered nurses who aid in the provision of medical assistance in dying follow the BC provincial **decision support tool**, in accordance with employer policy.
9. Registered nurses do not aid in the provision of medical assistance in dying for a family member.
10. Registered nurses do not pronounce death related to medical assistance in dying.

Glossary

Additional education: structured education (e.g., workshop, course, program of study) designed for the nurse to attain the competencies required to carry out a specific activity. Additional education:

- builds on the entry-level competencies,
- identifies the competencies expected of learners on completion of the education,
- includes both theory and application to practice, and
- includes an objective evaluation of learners' competencies on completion of the education.

Assessor: nurse practitioner or medical practitioner who is responsible for completing an assessment of the client's eligibility for medical assistance in dying.

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

Client: individual receiving nursing care or services from a nurse.

Decision support tools (DSTs): evidence-based documents used by nurses to support clinical judgment and decision-making by guiding the assessment, diagnosis and treatment of client-specific clinical problems. DSTs come in various forms and are created by organizations or specialists in a specific area of health care.

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PRACTICE STANDARD

Registered Psychiatric Nurses: Medical Assistance in Dying

Introduction

The *Registered Psychiatric Nurse: Medical Assistance in Dying (MAiD)* standards, limits, and conditions apply to registered psychiatric nurses when they are aiding a physician or a nurse practitioner to provide MAiD. Registered psychiatric nurses do not assess clients for the eligibility to receive MAiD. Registered psychiatric nurses do not administer or prescribe MAiD or provide substances to a person at their request for their self administration of MAiD.

The role of registered psychiatric nurses may include:

- providing information
- acting as an independent witness, as described in the *Criminal Code of Canada*
- acting as a proxy for a mentally capable client who is physically unable to sign a request for medical assistance in dying
- acting as a witness in a virtual assessment
- aiding a medical practitioner or nurse practitioner in the provision of medical assistance in dying

Registered psychiatric nurses cannot prescribe, compound, prepare, dispense, or administer any substance intended for the purpose of medical assistance in dying. Registered psychiatric nurses can record information for reference use by the assessor-prescriber[1] as needed, but the assessor-prescriber is responsible for documenting the substance they administer or provide in the client's record and medication administration record.

Registered psychiatric nurses approached about aiding in the provision of medical assistance in dying should speak with their employer for further information about their role in MAiD. Employers may also further limit the role of registered psychiatric nurses in MAiD.

Standards

1. Registered psychiatric nurses ensure that a **client** has access to the information that the client requires to understand all their options and to make informed decisions about medical assistance in dying and other end-of-life options such as palliative care.
2. Registered psychiatric nurses assess the cultural and spiritual needs and wishes of the person seeking medical assistance in dying and explore ways the person's needs could be met within the context of the care delivery.
3. Registered psychiatric nurses work with their organizations and other members of the health care team to ensure that the person requesting or receiving medical assistance receives high-quality, coordinated, and uninterrupted continuity of care and, if needed, safe transfer of the client's care to another health-care provider.
4. Registered psychiatric nurses who participate in medical assistance in dying, follow legal, legislative, regulatory, and organizational requirements for aiding in the provision of medical assistance in dying.
5. Registered psychiatric nurses may return unused substances intended for the purpose of providing medical assistance in dying to the pharmacy when asked by the assessor-prescriber. When asked to carry out such a request, registered psychiatric nurses ensure the drugs are stored securely until transported and are returned to the pharmacy within 72 hours of the MAiD procedure, and they sign any forms normally signed by the assessor-prescriber to note the return of the substances.

Limits & conditions

1. Registered psychiatric nurses only aid in the provision of medical assistance in dying and do not act as an **assessor** or **assessor-prescriber** or provide medical assistance in dying to a person (i.e., they do not prescribe, compound, prepare, dispense, or administer any substances specifically intended for the purpose of providing medical assistance in dying, nor document the provision of medical assistance in dying).
2. Registered psychiatric nurses do not receive substances specifically intended for the purpose of providing medical assistance in dying from a pharmacist.
3. Registered psychiatric nurses do not direct or counsel clients to end their lives.
4. Registered psychiatric nurses participate in activities related to medical assistance in dying only as permitted under the *Criminal Code of Canada* and other legislation, regulations, regulatory college standards, and provincial and organizational policy and procedures.
5. Registered psychiatric nurses do not act as an independent witness if they:
    a. Provide health care services or personal care to the client, unless they are a paid personal or health-care worker who provides those services as their primary occupation
    b. Own or operate any facility where the client requesting medical assistance in dying resides or is receiving treatment

   c. Know or believe that they are a beneficiary under the client's will, or that they will otherwise receive any financial or other material benefit as a result of the client's death

6. Registered psychiatric nurses do not act as a proxy for signing any forms related to medical assistance in dying if they know or believe that they are a beneficiary under the will of the client making the request, or that they will receive, in any other way, any financial or other material benefit resulting from the client's death.
7. Registered psychiatric nurses who aid in the provision of medical assistance in dying successfully complete **additional education**.
8. Registered psychiatric nurses who aid in the provision of medical assistance in dying follow the B.C. provincial decision support tool, in accordance with employer policy.
9. Registered psychiatric nurses do not aid in the provision of medical assistance in dying for a family member.
10. Registered psychiatric nurses do not pronounce death related to medical assistance in dying.

Glossary

Additional education: structured education (e.g., workshop, course, program of study) designed for the nurse to attain the competencies required to carry out a specific activity. Additional education:

- builds on the entry-level competencies,
- identifies the competencies expected of learners on completion of the education,
- includes both theory and application to practice, and
- includes an objective evaluation of learners' competencies on completion of the education.

Assessor: nurse practitioner or medical practitioner who is responsible for completing an assessment of the client's eligibility for medical assistance in dying.

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

Client: individual receiving nursing care or services from a nurse.

Decision support tools (DSTs): evidence-based documents used by nurses to support clinical judgment and decision-making by guiding the assessment, diagnosis, and treatment of client-specific clinical problems. DSTs come in various forms and are created by organizations or specialists in a specific area of health care.

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PRACTICE STANDARD

Nurse Practitioners: Mental Health & Capacity Assessments

Introduction

This practice standard outlines the expectations that must be met when nurse practitioners conduct assessments under provincial legislation, including the Mental Health Act (involuntary admissions), Adult Guardianship Act (financial incapability), and the Health Care (Consent) and Care Facility (Admission) Act (incapability assessments for care facility admission).

MENTAL HEALTH ACT – INVOLUNTARY ADMISSIONS

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

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

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

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

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

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

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

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

ADULT GUARDIANSHIP ACT – FINANCIAL INCAPABILITY ASSESSMENTS

Under the Statutory Property Guardianship Regulation, nurse practitioners are authorized to conduct the functional component of an assessment for financial capability (the adult's ability to manage their own financial affairs – section 32(3) of the Adult Guardianship Act). A medical component must also be completed and only a medical practitioner may do that assessment.

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

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

Standards

1. When completing a medical certificate for involuntary admission under the Mental Health Act or a capacity assessment, nurse practitioners act in compliance with the nurse practitioner standards of practice (including BCCNM's Indigenous Cultural Safety, Cultural Humility, & Anti-Racism practice standard), relevant legislation, employer policies, and their individual competence
2. Nurse practitioners completing a medical certificate for involuntary admission under the Mental Health Act or a capacity assessment discuss with the **client** the reasons for completing the medical certificate or the findings of the capacity assessment.
3. Nurse practitioners who perform assessments for involuntary admission under the Mental Health Act assess the client in person if possible, unless the nurse practitioner determines:
    a) that another assessment method (e.g., virtual assessment) together with any other available records and collateral information provide a sufficient basis for diagnosis and to establish the client's need for treatment and protection, and
    b) that an in-person assessment of the client would not provide additional useful information.

Limits & conditions

MENTAL HEALTH ACT – INVOLUNTARY ADMISSIONS

1. Nurse practitioners successfully complete the following course before completing a Form 4.1 (First Medical Certificate [Involuntary Admission]) under the Mental Health Act:
    a. *Protecting People's Rights: Mandatory Mental Health Act Forms (Physicians and Nurse Practitioners)*[1]
2. Nurse practitioners act in accordance with the B.C. Ministry of Health document, *Guide to the Mental Health Act*.

ADULT GUARDIANSHIP ACT – FINANCIAL INCAPABILITY ASSESSMENTS

1. Nurse practitioners may act as qualified health care providers under Part 2.1 of the Adult Guardianship Act for the purpose of conducting the functional component of a financial incapability assessment in accordance with Part 3 of the Statutory Property Guardianship Regulation under that Act, if they successfully complete the Ministry of Health course, *A Guide to the Certificate of Incapability Process under the Adult Guardianship Act*.
2. Nurse practitioners acting as qualified health care providers under Part 2.1 of the Adult Guardianship Act must also follow the Ministry of Health and Public Guardian and Trustee's procedural guide, *A Guide to the Certificate of Incapability Process under the Adult Guardianship Act.*

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

1. Nurse Practitioners acting as prescribed health care providers under Part 3 of the Health Care (Consent) and Care Facility (Admission) Act for the purpose of conducting an assessment to determine whether an adult is incapable of giving or refusing consent to admission to, or continued residence, in a care facility, must:
    a. Have successfully completed the Ministry of Health course, *Consent to Care Facility Admission in British Columbia: A Course for Managers and Assessors*; and
    b. Follow the Ministry of Health guidelines, *Practice Guidelines for Seeking Consent to Care Facility Admission*.

Glossary

Client: individual receiving nursing care or services from a nurse.

1 Available through the PHSA Learning Hub.

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PRACTICE STANDARD

Nurse Practitioners: Screening and Diagnostic Tests & Imaging

Introduction

This practice standard sets the expectations that nurse practitioners must meet when ordering, performing, and managing screening and diagnostic tests and imaging. Screening and diagnostic services that nurse practitioners order may include:

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

Standards

1. Nurse practitioners order screening and diagnostic services, provide appropriate follow-up, diagnose and manage diseases, disorders and conditions within the scope of practice for nurse practitioners and their individual **competence**.
2. Nurse practitioners engage in evidence-informed diagnosing and management considering best practice guidelines and other relevant guidelines and resources.
3. Nurse practitioners:
    a. Provide the appropriate clinical information when ordering screening and diagnostic tests and imaging.
    b. Establish mechanisms within their practice setting(s) to track and follow-up on screening and diagnostic tests and imaging results.
    c. Ensure **clients** are informed, in a timely manner, of screening and diagnostic test and imaging results, implications and needed follow-up.

   d. Communicate, as needed, screening and diagnostic test and imaging results with key providers involved in the client's care.

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

Limits & conditions

1. Nurse practitioners apply X-rays[1] only after completing **additional education**, and when organizational supports, including policies and procedures, are in place to support the safe application of X-rays.
2. Nurse practitioners applying X-rays also follow the standards for Error! Reference source not found..
3. Nurse practitioners apply X-rays in an appropriate clinical setting that is suitable to safely perform the procedure and includes the equipment and supplies needed to manage any emergency situations.
4. Nurse practitioners only use Health Canada-approved devices when applying X-rays.
5. Nurse practitioners do not take responsibility for the final interpretation of medical imaging studies. Nurse practitioners may initiate appropriate treatment while waiting for the final interpretation from a diagnostic radiologist.

Glossary

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

Client: individual receiving nursing care or services from a nurse.

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

[1] Per the Nurses and Midwives Regulation, nurse practitioners do not apply X-rays for the purpose of computerized axial tomography.

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PRACTICE STANDARD

Nurse Practitioners: Prescribing Drugs

Introduction

Nurse practitioners prescribe drugs in accordance with relevant federal and provincial legislation and the BCCNM Standards of Practice. In particular, nurse practitioners have the authority to prescribe Schedule I, IA, and II drugs, subject to the standards, limits and conditions set by BCCNM.

This practice standard applies when nurse practitioners are initiating, continuing or discontinuing the prescribing of a drug. Continuation prescribing includes re-ordering and/or making adjustments to the drug therapy, ongoing assessment and monitoring, and consulting with and/or referring clients to other health care professionals as needed.

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

AUTHORIZING MEDICAL CANNABIS

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

Standards

1. Nurse practitioners prescribe drugs within nurse practitioners' scope of practice, relevant legislation and their individual competence.
2. Nurse practitioners are accountable for their prescribing decisions.
3. Before prescribing, nurse practitioners ensure their competence to:

   a. Establish or confirm a diagnosis for the client,
   b. Manage the treatment and care of the client, and
   c. Monitor and manage the client's response to the drug.

4. Nurse practitioners use current evidence to support decision-making when prescribing.
5. Nurse practitioners apply relevant guidelines[1] when prescribing.
6. When prescribing, nurse practitioners:
   a. Consider the client's health history and other relevant factors (e.g. age, sex, gender, past medical and mental health history, lifestyle, risks factors and the client's perspective on their health),
   b. Undertake and document an appropriate clinical evaluation (e.g. physical examination, mental health examination, review of relevant tests, imaging and specialist reports),
   c. Obtain and review the best possible medication history for the client using PharmaNet and/or other sources (including any traditional medicines, natural health products, non-prescription medications, and substance use, in addition to prescribed medications), and take action to address any discrepancies,
   d. Ask about the client's drug allergies and ensure drug allergy information is accurately and appropriately documented,
   e. Document the drugs prescribed to the client and the indication(s) for the drugs,
   f. Establish a plan for reassessment/follow-up, and
   g. Monitor and document the client's response to the drugs prescribed (as appropriate).
7. Nurse practitioners undertake medication reconciliation to ensure accurate and comprehensive medication information is communicated consistently across health care transitions.
8. When prescribing, nurse practitioners provide information to clients about:
   a. The expected action of the drug,
   b. The duration of the drug therapy,
   c. Specific precautions or instructions for the drug,
   d. Potential side-effects and adverse effects (e.g. allergic reactions) and action to take if they occur,

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

e. Potential interactions between the drug and certain foods, other drugs, or substances, and

f. Recommended follow-up.

9. Nurse practitioners complete prescriptions accurately and completely, including:

    a. The date the prescription was written,

    b. Client name, address (if available) and date of birth,

    c. Client weight (if required),

    d. The name of the drug or ingredients, strength if applicable, and dose,

    e. The quantity prescribed and quantity to be dispensed,

    f. Dosage instructions (e.g. the frequency or interval, maximum daily dose, route of administration, duration of drug therapy),

    g. Refill authorization if applicable, including number of refills and interval between refills,

    h. Prescriber's name, address, telephone number, written (not stamped) signature, and prescriber number,

    i. Date of transmission, the name and fax number of the pharmacy intended to receive the transmission, and the practitioner's fax number if the prescription is being faxed[2], and

    j. Directions to the pharmacist not to renew or alter if a pharmacist-initiated adaption would be clinically inappropriate.

10. When notified of a pharmacist-initiated prescription adaption, nurse practitioners document the adaption in the client record.

11. Nurse practitioners report adverse drug reactions to the Canada Vigilance Program.

12. Nurse practitioners prescribe controlled drugs and substances in accordance with the Controlled Prescription Program.

13. When prescribing controlled drugs and substances, nurse practitioners meet the Prescribing Drugs standards and also:

    a. Assess the client in person, or by telehealth with visual assessment if clinically appropriate, except in cases where the client is:

        i. Known to the nurse practitioner, and/or

        ii. Being assessed in person by another health care provider

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

b. Document their review of the client's PharmaNet medication profile

c. Document the indication and duration for which the drug is being prescribed, the goals of treatment, and the rationale for the drug's use over alternatives (if applicable)

d. Prescribe the lowest possible dose and the minimum quantity to be dispensed

e. Know the risks of co-prescribing opioid and sedative-hypnotic drugs (e.g. benzodiazepines) and limit co-prescribing whenever possible; document the rationale and the follow-up plan if co-prescribing is necessary

f. Advise clients about the side effects and risks of controlled drugs and substances as applicable (e.g. physical tolerance, psychological dependence, addiction, diversion)

g. Implement evidence-informed strategies for minimizing risk (e.g. treatment agreements, pill counts, urine drug screens, client education about safe storage and disposal)

h. Follow the requirements of the British Columbia Controlled Prescription Program including requirements related to securing and disposing of prescription pads; reporting any loss, theft or misuse of the prescription pads; and record retention.

14. When authorizing medical cannabis, nurse practitioners meet the Prescribing Drugs standards and also:

    a. Review the client's medication profile and history through PharmaNet and other sources,

    b. Document their review of the client's PharmaNet medication profile,

    c. Document the indication and duration for which medical cannabis is being authorized, the goals of treatment, and the rationale for its use over alternatives,

    d. Advise clients about the side effects and risks of medical cannabis,

    e. Complete medical documents or written orders for cannabis in accordance with the requirements set out in the *Cannabis Regulations*[3], and

    f. Retain any copy of the medical document for cannabis in the client health record.

15. Before changing to non-practising or inactive registration with BCCNM (and therefore relinquishing prescribing authority), nurse practitioners take steps to ensure prescription refills and part-fills are managed for clients.

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

Limits & conditions

Prescribing		
1.	Nurse practitioners do not prescribe controlled drugs and substances or authorize medical cannabis[4] for themselves, a family member, or anyone else who is not a client the nurse practitioner is treating in their professional capacity.	
2.	Nurse practitioners do not prescribe non-controlled drugs and substances for themselves or a family member except for a minor/episodic condition and only when there is no other prescriber available.	
3.	Nurse practitioners do not provide any person with a blank, signed prescription.	
4.	Nurse practitioners do not provide any person with a blank, signed medical document for cannabis.	
5.	Antiretroviral therapy for the prophylaxis or treatment of HIV infection	a) Nurse practitioners who prescribe antiretroviral therapy for the prophylaxis or treatment of HIV infection must meet the education requirements of the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE). b) Nurse practitioners apply the clinical practice guidelines of the BC-CfE when prescribing antiretroviral therapy for the prophylaxis or treatment of HIV infection.
6.	Blood and blood products	a) Nurse practitioners who prescribe blood and blood products must meet the standards, limits and conditions set out in *NP: Advanced Procedures and Activities* practice standard.
7.	Medical aesthetics	a) See the limits and conditions for medical aesthetics set out in *NP: Advanced Procedures and Activities* practice standard.
8.	Cancer drug treatment[5]	a) Nurse practitioners who prescribe cancer drug treatment must meet the education requirements of BC Cancer. b) Nurse practitioners apply the clinical practice guidelines of BC Cancer when prescribing cancer drug treatment.
9.	General anesthetics	a) Nurse practitioners do not prescribe general anesthetics for the purpose of inducing general anesthesia. b) Nurse practitioners who prescribe general anesthetics for the purpose of medical assistance in dying must meet the standards, limits and conditions set out in *NP: Medical Assistance in Dying* practice standard.

[4] "Medical cannabis" does not include Schedule 1 drugs containing cannabis.

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

Prescribing	
10. Controlled drugs and substances	a) Before prescribing controlled drugs and substances, nurse practitioners must register for PharmaNet access appropriate to the practice sites where they will be prescribing controlled drugs and substances (e.g. Community Health Practice Access to PharmaNet). b) Nurse practitioners who prescribe controlled drugs and substances must successfully complete one of the following courses: i. University of Ottawa: Prescribing Narcotics and Controlled Substances ii. Athabasca University: Prescribing Controlled Drugs iii. Saskatchewan Polytechnic: Controlled Drugs and Substances Act (CDSA) Module for Nurse Practitioners iv. University of Toronto: Controlled Drugs and Substances Essential Management and Prescribing Practices c) Nurse practitioners who prescribe controlled drugs and substances must complete BCCNM's Controlled Drugs and Substances (CDS) Prescribing Module. d) Nurse practitioners who prescribe controlled drugs and substances must meet the BCCNM Competencies for NP Prescribing of Controlled Drugs and Substances for the context or contexts in which they are prescribing. **Note**: See prescribing limits 1, 2, 3 and 4 above.
10.1 Chronic Non-Cancer Pain[6]	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe controlled drugs and substances for chronic non-cancer pain must complete **additional education**.
10.2 Methadone for analgesia	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe methadone for analgesia must complete: a) The Methadone for Pain in Palliative Care course offered by the Canadian Virtual Hospice b) A preceptorship with an experienced methadone for analgesia prescriber

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

Prescribing		
10.3	Opioid Agonist Treatment for Opioid Use Disorder/ Prescribed Alternatives	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe opioid agonist treatment for opioid use disorder and/or pharmaceutical alternatives for safer supply must meet the standards, limits and conditions set out in *NP: Prescribing for Opioid Use Disorder and/or Prescribed Alternatives* practice standard.
10.4	Medical Assistance in Dying	In addition to meeting the requirements in 10a-d, nurse practitioners who prescribe drugs for the purpose of medical assistance in dying must meet the standards, limits and conditions set out in *NP: Medical Assistance in Dying* practice standard.
10.5	Coca leaves	Nurse practitioners **do not** prescribe coca leaves as per the federal *New Classes of Practitioner Regulations* Section 4(2)(b).
10.6	Opium	Nurse practitioners **do not** prescribe opium as per the federal *New Classes of Practitioner Regulations* Section 4(2)(b).

Glossary

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

Client: individual receiving nursing care or services from a nurse.

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

Medical cannabis: cannabis that is authorized by a medical document or written order issued under Part 14 of the Cannabis Regulations. It does not include prescription drugs containing cannabis, which are listed in in Schedule I of the Drug Schedules Regulation and are regulated under Part 8 of the Cannabis Regulations.

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

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PRACTICE STANDARD

Nurse Practitioners: Prescribing for Opioid Use Disorder and/or Prescribed Alternatives

Introduction

The standards, limits and conditions in this document set out the requirements for prescribing[1]:

- Opioid agonist treatment for opioid use disorder; and/or
- Regulated, pharmaceutical-grade medications of known quality and dosage to people at high risk of harm from the unregulated drug supply (**prescribed alternatives**).

These standards, limits and conditions do not apply to prescribing opioid agonists for pain and other symptoms.

Standards

1. Nurse practitioners prescribing opioid agonist treatment and/or prescribed alternatives meet the requirements in the *Nurse Practitioners: Prescribing Drugs* practice standard.
2. Nurse practitioners prescribing opioid agonist treatment and/or prescribed alternatives apply knowledge about:
    a. Substance use disorders including opioid use disorder,
    b. Treatment strategies for opioid use disorder (e.g. opioid agonist treatment, psychosocial treatment interventions), and
    c. Harm reduction strategies for substance use and opioid use disorder.
3. Nurse practitioners prescribe opioid agonist treatment and/or prescribed alternatives in a manner that promotes client and public safety.

[1] Includes initiating, continuing, or discontinuing the prescribing of a drug.

Limits and Conditions

1. Nurse practitioners who prescribe opioid agonist treatment for opioid use disorder and/or prescribed alternatives must:
    a. Meet the education requirements of the British Columbia Centre on Substance Use; and
    b. Complete a preceptorship that meets the requirements of the British Columbia Centre on Substance Use.
2. Nurse practitioners who prescribe opioid agonist treatment for opioid use disorder must apply the clinical practice guidelines for the treatment of opioid use disorder established by the British Columbia Centre on Substance Use.
3. Nurse practitioners who prescribe prescribed alternatives must:
    a. Follow clinical protocols as per the Ministry of Health Access to Prescribed Alternatives in British Columbia policy or the guidance of the British Columbia Centre on Substance Use; and
    b. Participate in evaluation and monitoring of prescribed alternatives for safer supply as per the Ministry of Health Access to Prescribed Alternatives in British Columbia policy.

Glossary

Client: individual receiving nursing care or services from a nurse.

Prescribed alternatives: regulated, pharmaceutical-grade medications of known quality and dosage prescribed to people at high risk of harm from the unregulated drug supply.

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ETHICS STANDARD

Nurses: Privacy and Confidentiality

Introduction

Nurses have ethical and legal responsibilities to protect the privacy and confidentiality of clients' **personal information**. Federal and provincial legislation protect a person's right to privacy and confidentiality of personal information. The specific legislation that applies to a nurse's practice depends on the work setting and the nurse's role. The BCCNM bylaws provide additional direction.

Standards

1. Nurses collect, use, access, and share clients' personal information:
    a. Only as needed to fulfill their professional responsibilities, and
    b. In alignment with:
        i. Relevant legislation and regulations,
        ii. The BCCNM bylaws and standards, and
        iii. Organizational/employer policies and processes.
2. Nurses share relevant personal information with the client's health-care team and inform the **client** how their personal information is shared (or **client's representative**, if applicable).
3. Nurses keep clients' personal information confidential and only share client's personal information outside the health-care team if the client (or client's representative, if applicable) gives consent, or if there is an ethical or legal requirement to do so.
4. Nurses respect the client's (or client's representative, if applicable) choices about who outside the health-care team can access their personal information, and only share it with those individuals if the client (or client's representative, if applicable) gives consent.
5. Nurses use strategies to prevent unauthorized access to client's personal information.
6. When possible in their practice setting, nurses use strategies that prevent others from overhearing the client's health information.
7. Nurses do not discuss clients' personal information in public areas (e.g., cafeteria, elevators) or on social media.

8. Nurses take action if they or others inappropriately access or share a client's personal information, in alignment with:
    a. BCCNM bylaws, and
    b. Organizational/employer policies and processes.

Glossary

Client: individual receiving nursing care or services from a nurse.

Client's Representative: individual with legal authority to give, refuse, or withdraw consent to healthcare on a client's behalf, including:

a. "committee of the patient" under the *Patients Property Act*,
b. parent or guardian of a child under 19 years of age with parental responsibility to give, refuse or withdraw consent to health care for the child under section 41(f) of the *Family Law Act*,
c. representative authorized by a representation agreement under the *Representation Agreement Act* to make or help in making decisions on behalf of a client,
d. temporary substitute decision maker chosen under section 16 of the *Health Care (Consent) and Care Facility (Admission) Act*, or
e. substitute decision maker chosen under section 22 of the *Health Care (Consent) and Care Facility (Admission) Act*.

Nurses: licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses, licensed graduate nurses, employed student nurses, and employed student psychiatric nurses.

Personal information: any identifiable information about the client, including their personal health information, but does not include their business contact information.

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ETHICS STANDARD

Licensed Practical Nurses: Professional Standards

Introduction

The professional standards for LPNs clarify the minimum requirements for LPN practice in any setting or nursing domain (clinical practice, administration, education or research) and provide **indicators** that BCCNM uses to measure LPN practice in British Columbia (BC).

A **standard** is an expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance.

Indicators are used to measure the actual performance of an individual nurse. The indicators found in this document are not written in order of importance, nor are they intended to be an exhaustive list.

Standards

STANDARD 1: RESPONSIBILITY AND ACCOUNTABILITY

The licensed practical nurse maintains **standards** of nursing practice and **professional conduct** established by BCCNM.

Indicators

1. Maintains current registration
2. Maintains own competence to practise
3. Maintains own physical, psychological and emotional **fitness to practise**
4. Practises within own level of competence, employer policies, the LPN **scope of practice** and all relevant legislation
5. Is accountable and responsible for own nursing decisions, actions and professional conduct
6. Seeks guidance and direction as required
7. Takes action to promote safe, competent and ethical care for clients
8. **Advocates** for and/or helps to develop policies and procedures consistent with BCCNM Standards of Practice

9. Understands the role of BCCNM and its relationship to one's own practice

STANDARD 2: COMPETENCY-BASED PRACTICE

The licensed practical nurse applies appropriate **knowledge**, skills, **judgment** and attitudes consistently in nursing practice.

Indicators

1. Bases nursing practice on current **evidence** from **nursing science**, other sciences and the humanities
2. Knows how and where to access information to support and provide safe, competent and ethical nursing practice and care for clients
3. Uses **critical thinking** when collecting and interpreting data, planning, implementing and evaluating nursing care
4. Collects information on **client status** and care needs from a variety of sources using assessment skills and a review of pertinent clinical data
5. Identifies, analyzes and uses relevant decision support tools and data when making decisions about client status and care requirements
6. Documents client assessments, care needs, planned interventions and outcomes in a timely manner
7. Communicates client status to other members of the **health care team** as appropriate
8. Evaluates client responses to care and revises the plan of care as necessary
9. Responds and adapts to changes in the practice environment
10. Shares nursing knowledge with clients, colleagues, students and others
11. Communicates professionally in interactions with clients, colleagues, students and others

STANDARD 3: CLIENT-FOCUSED PROVISION OF SERVICE

The licensed practical nurse provides nursing services and works with others in the best interest of clients.

Indicators

1. Makes the client the primary focus when providing nursing care
2. Involves clients in identifying and prioritizing their own health goals and learning needs
3. Supports clients to learn about the health care system and to access appropriate health care services
4. Understands and communicates the contribution of nursing to the **health** of clients

5. Communicates, **collaborates** and consults with clients and other members of the health care team about client care
6. Coordinates and facilitates continuity of care services for the client
7. Supervises, leads and assigns appropriately to other members of the health care team
8. Supports and guides other members of the health care team to meet client care needs
9. Participates in and advocates for changes that improve client care and nursing practice
10. Recognizes and reports the **incompetent** or impaired practice or unethical conduct of another health professional to the appropriate person or body

STANDARD 4: ETHICAL PRACTICE

The licensed practical nurse understands, upholds and promotes the ethical standards of the nursing profession.

Indicators

1. Demonstrates honesty and integrity at all times
2. Represents self clearly and accurately with respect to name, title and role
3. Respects and protects client worth, dignity, uniqueness and **diversity**
4. Protects client information and maintains privacy and confidentiality
5. Recognizes, respects and promotes the client's right to be informed and make informed choices
6. Begins, maintains and ends nurse-client relationships in a way that puts the client's needs first
7. Identifies the effect of own values, beliefs and experiences when providing nursing care
8. Identifies ethical issues, recognizes potential conflicts; takes action to prevent or resolve them by communicating with the health care team and consulting with the appropriate people; and evaluates effectiveness of actions
9. Makes decisions about the allocation of resources under one's control based on the needs of the client
10. Recognizes and respects the contribution of others on the health care team
11. Treats colleagues, students and other health care workers in a respectful manner

Glossary

Advocate: speak or act on behalf of self or others with the intent of influencing or adding voice and enhancing autonomy.

Assign: allocate clients or client care activities among care providers in order to meet client care needs.

Client: individuals (or their designated representative), families, groups and communities in receipt of nursing care. In some clinical settings, the client may be referred to as a patient or resident. In research, the client may be referred to as a participant.

Client status: clear, concise statement of a judgment made by a licensed practical nurse based on a holistic assessment, including the client's perspective of his or her health and/or illness responses. Other terms may be used for client status such as nursing diagnosis, clinical judgment, signs and symptoms, patient problems, patterns of health or goals.

Collaborate: joint communication and decision-making process with the expressed goal of working together toward identified outcomes while respecting the unique qualities and abilities of each member of the group or team. Each member of the health care team contributes within the limits of his or her legislated scope of practice and range of competencies.

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

Confidentiality: action taken to ensure, respect and preserve a person's privacy within ethical and legal protocols.

Critical thinking: purposeful, disciplined and systematic process of continual questioning, logical reasoning and reflecting using interpretation, inference, analysis, synthesis and evaluation to achieve a desired outcome.

Decision support tools: evidence-based documents used by licensed practical nurses to guide the assessment, diagnosis and treatment of client-specific problems.

Diversity: encompasses acceptance and respect based on the understanding that each individual is unique. These differences include culture, race, ethnicity, gender, sexual orientations, socio-economic status, age, physical abilities and political beliefs or ideologies.

Ethical: fundamental disposition of the licensed practical nurse toward what is good and right. Action toward what the licensed practical nurse recognizes or believes to be the best and most appropriate practice in a particular situation.

Evidence: data derived from various sources including research, national guidelines, policies, consensus statements, expert opinion and quality improvement.

Fitness to practise: all the qualities and capabilities of an individual relevant to their capacity to practise as a nurse, including, but not limited to, any cognitive, physical, psychological or emotional condition or a dependence on alcohol or drugs that impairs their ability to practise nursing.

Health: state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It includes physical, mental, spiritual, emotional, psychological and social health.

Health care team: clients, health care professionals, unregulated care providers, students and others who may be involved in providing care.

Incompetent practice: practice that does not demonstrate the integration and application of the knowledge, skills, attitudes and judgment required for safe, competent and ethical practice.

Indicator: illustration of how a standard is applied and met. Indicators provide specific criteria that are used, when applicable, to measure the actual performance of an individual nurse.

Judgment: intellectual process exercised in forming a conclusion, decision and plan-of-action based upon a critical analysis of relevant evidence.

Knowledge: broadly interpreted to extend beyond information, facts and "knowing about," to include cognitive, experiential and intuitive sources of knowledge applied in nursing practice.

Nursing science: knowledge (e.g., concepts, constructs, principles, theories) of nursing derived from systematic observation, study and research.

Professional conduct: behaviour that upholds the profession, including, but not limited to, practising in accordance with BCCNM standards, policies and bylaws and all legislation relevant to LPN practice.

Scope of practice: activities nurses are educated and authorized to perform as set out in the *Nurses and Midwives Regulation* under the *Health Professions and Occupations Act* and complemented by standards, limits and conditions established by BCCNM.

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

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ETHICS STANDARD

Registered Nurses & Nurse Practitioners: Professional Standards

Introduction

The Registered Nurses & Nurse Practitioners: Professional Standards establish the levels of performance that RNs and NPs are required to achieve in their practice.

Indicators provide specific criteria for meeting each standard in each of the four main areas of practice: clinical, education, administration and research. Indicators are used to measure the actual performance of an individual RN or NP. The indicators are not written in order of importance, nor are they intended to be an exhaustive list of criteria for each standard.

Standards

STANDARD 1: PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

Maintains standards of nursing practice and **professional conduct** determined by BCCNM.

Indicators: Clinical Practice

1. Is accountable and takes responsibility for own nursing actions and professional conduct.
2. Functions within own level of **competence**, within the legally recognized **scope of practice** and within all relevant legislation.[1]
3. Assesses own practice and undertakes activities to improve practice and meet identified learning goals on an ongoing basis.[2, 3]

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[1] Examples of relevant legislation include the Health Professions Act and the regulations under it, and other legislation governing nursing practice, such as the Health Care (Consent) and Care Facility (Admission) Act. Nurses are also required to comply with other federal and provincial legislation that may not be within BCCNM's regulatory mandate, but which may be enforceable by other regulatory bodies, tribunals or the courts.

[2] Requires investment of own time, effort and other resources.

[3] Requires investment of own time, effort and other resources.

4. Takes action[4] to promote the provision of safe, appropriate and ethical care to **clients**.
5. Advocates for and/or helps to develop policies and practices consistent with the standards of the profession.
6. Maintains own physical, psychological and emotional **fitness to practice**.
7. Maintains current registration.
8. Understands the role of the regulatory body and the relationship of the regulatory body to one's own practice.

Indicators: Education

1. Is accountable and takes responsibility for own nursing actions and professional conduct.
2. Functions within own level of **competence**, within the legally recognized **scope of practice** and within all relevant legislation.[2]
3. Assesses own practice and undertakes activities to improve practice and meet identified learning goals on an ongoing basis.[3, 4]
4. Takes action[5] to promote the provision of safe, appropriate and ethical care.
5. Advocates for and/or helps to develop policies, practices and education consistent with the standards of the profession.
6. Maintains own physical, psychological and emotional **fitness to practice**.
7. Maintains current registration.
8. Understands the role of the regulatory body and the relationship of the regulatory body to one's own practice.

Indicators: Administration

1. Is accountable and takes responsibility for own nursing actions and professional conduct.
2. Functions within own level of **competence**, within the legally recognized **scope of practice** and within all relevant legislation.[2]
3. Assesses own practice and undertakes activities to improve practice and meet identified learning goals on an ongoing basis.[3, 4]
4. Takes action[5] to promote the provision of safe, appropriate and ethical care.
5. Advocates for and develops policies and practices consistent with the standards of the profession.
6. Maintains own physical, psychological and emotional **fitness to practice**.

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[4] Taking action includes advocacy. Nurses advocate in ways that are consistent with their role and responsibilities. For example, nurses in clinical practice are expected to advocate for their client if the client's perspective is not being considered by another professional involved in their care, but not expected to lobby for legislative change.

7. Maintains current registration.
8. Understands the role of the regulatory body and the relationship of the regulatory body to one's own practice.

Indicators: Research

1. Is accountable and takes responsibility for own nursing actions and professional conduct.
2. Functions within own level of **competence**, within the legally recognized **scope of practice** and within all relevant legislation.[2]
3. Assesses own practice and undertakes activities to improve practice and meet identified learning goals on an ongoing basis.[3, 4]
4. Takes action[5] to promote the provision of safe, appropriate and ethical care.
5. Advocates for and/or helps to develop policies and practices that support research and the integration of research findings and other **evidence** into client care.
6. Maintains own physical, psychological and emotional **fitness to practice**.
7. Maintains current registration.
8. Understands the role of the regulatory body and the relationship of the regulatory body to one's own practice.

STANDARD 2: KNOWLEDGE-BASED PRACTICE

Consistently applies knowledge, skills and judgment in nursing practice.

Indicators: Clinical Practice

1. Bases practice on current **evidence** from **nursing science** and other sciences and humanities.
2. Knows how and where to access information to support the provision of safe, competent and ethical client care.
3. Uses **critical thinking** when collecting and interpreting data, planning, implementing and evaluating nursing care.
4. Collects information on client status from a variety of sources[5] using assessment skills, including observation, communication, physical assessment and a review of pertinent clinical data.
5. Identifies, analyzes and uses relevant and valid information when making decisions about client status.

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[5] Whenever possible, nurses involve clients in assessment, decision-making about client status, care planning, implementation and evaluation.

6. Communicates client status, using verifiable information, in terminology used in the practice setting.
7. Develops and communicates plans of care that include assessment data, decisions about client status, planned interventions and measurement of client outcomes.
8. Sets client-centred priorities when planning and providing care.
9. Uses **decision support tools** appropriately to assess and make decisions about client status and plan care.
10. Implements the plan of care, evaluates client's response and revises the plan as necessary.
11. Documents timely[6] and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes.
12. Shares nursing knowledge with clients, colleagues, students and others.
13. Communicates appropriately[7] in interactions with clients, colleagues, students and others.

Indicators: Education[8]

1. Bases education on current **evidence** from **nursing science** and other sciences and humanities.
2. Knows how and where to access information to support the delivery of safe, competent and ethical nursing and health education.
3. Uses **critical thinking** when collecting and interpreting data on learning needs and planning, implementing and evaluating nursing and health education programs.
4. Collects information on individual and group learning needs from a variety of sources.
5. Identifies, analyzes and uses relevant and valid information when planning education.
6. Communicates learning needs of individuals and groups using verifiable information.
7. Uses appropriate processes to plan education that address learning needs and strengths and include evaluation criteria.
8. Sets priorities when planning and providing education.
9. Engages learners using appropriate instructional methods, educational technologies and relevant learning theory.

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6 The timeliness of documentation will vary. When client acuity, complexity and variability is high, more frequent documentation is required than when clients are less acute, less complex and/or less variable.

7 Involves applying knowledge and skills related to such things as relationship-building, assertiveness, problem-solving and conflict resolution.

8 The indicators in the education, administration and research areas describe criteria for meeting the standard in an educator, administrator or research role. If clients are involved during the course of performing these roles, the Indicators in the clinical practice area would also apply.

10. Evaluates attainment of learning objectives using valid and reliable measures, and revises strategies as necessary.
11. Establishes and maintains appropriate education records.
12. Shares nursing knowledge with clients, colleagues, students and others.
13. Uses knowledge about learning and communications[8] to create a professional learning environment.

Indicators: Administration[9]

1. Bases administrative decisions on current **evidence** from **nursing science** and other sciences and humanities.
2. Knows how and where to access information to support the provision of safe, competent and ethical nursing practice and client care.
3. Uses **critical thinking** when collecting and interpreting data to make administrative decisions and planning, implementing and evaluating organizational strategies.
4. Collects information about organizational status from a variety of sources.
5. Identifies, analyzes and uses relevant and valid information when determining organizational problems or status.
6. Communicates organizational problems and status using verifiable information.
7. Plans administrative and other strategies to address organizational problems and strengths with accompanying evaluation criteria.
8. Sets priorities when planning and implementing administrative and other strategies.
9. Implements administrative and other identified strategies appropriately.
10. Evaluates process and/or outcomes of strategies and revises as necessary.
11. Establishes and maintains appropriate systems to manage clinical and administrative information.
12. Shares nursing knowledge with clients, colleagues, students and others.
13. Uses knowledge of organizational behaviour and communication[8] to create an environment in which cooperation, professional growth and mutual respect can flourish.

Indicators: Research[9]

1. Conducts or participates in research to create or refine evidence in the field of **nursing science** and/or other sciences and humanities.
2. Knows how and where to access information to support knowledge development for evidence-informed, safe, competent and ethical nursing practice.
3. Uses **critical thinking** when collecting and interpreting data to plan, conduct and evaluate research.

4. Develops and communicates research questions or hypotheses that are relevant and researchable.
5. Writes research proposals to address stated questions or hypotheses.
6. Collects research information from a variety of sources using valid and reliable data collection instruments and methods.
7. Identifies, analyzes and uses relevant information in conducting research.
8. Conducts research in accordance with accepted research methods and procedures.
9. Analyzes and interprets qualitative and quantitative data.
10. Writes appropriate reports and articles for publication.
11. Uses knowledge of communication[8] to share the practice implications and policy relevance of research in a meaningful way with nurses and others.
12. Shares nursing knowledge with clients, colleagues, students and others.

STANDARD 3: CLIENT-FOCUSED PROVISION OF SERVICE

Provides nursing services and works with others to provide health care services in the best interest of clients.

Indicators: Clinical Practice

1. Communicates, **collaborates** and consults with clients and other members of the **health care team**[9] about the client's care.
2. Coordinates client care in a way that facilitates continuity for the client.
3. **Assigns** clients and client care activities to other members of the health care team to meet client care needs.
4. **Delegates** appropriately to other members of the health care team.
5. Provides appropriate regulatory supervision of student activities.
6. Instructs and guides other members of the health care team to meet client care needs.
7. Participates in changes that improve client care and nursing practice.
8. Reports incompetent or impaired practice or unethical conduct to appropriate person or body.
9. Understands and communicates the role of nursing in the health of clients.
10. Assists clients to learn about the health care system and accessing appropriate health care services.

[9] Team members may be from more than one practice setting.

Indicators: Education[10]

1. Communicates, **collaborates** and consults with nurses, students and others about education.
2. Educates students and others about the nurse's role in the coordination of client care.
3. Educates nurses, students and others regarding **assignment** of clients and client care activities to meet client needs.
4. Educates nurses, students and others regarding appropriate **delegation** of nursing activities to other members of the **health care team**.
5. Educates others about appropriate **regulatory supervision**.
6. Instructs, guides and directs educational staff and students to meet client care needs.
7. Acts to implement changes that improve client care and educational practice.
8. Reports incompetent or impaired practice or unethical conduct to appropriate person or body; educates nurses and students to recognize and report such practices.
9. Understands and communicates the role of nursing in the health of clients.
10. Assists colleagues, students and others to learn about nursing practice and health care services.

Indicators: Administration[12]

1. Communicates, **collaborates** and consults with nurses and other members of the **health care team** about the provision of health care services.
2. Educates others about the nurse's role in the coordination of client care.
3. Develops policies that outline the responsibility and accountability for all involved in the appropriate assignment of clients and client care activities.
4. Develops policies that provide direction for nurses on appropriate **delegation** of nursing activities to other members of the health care team.
5. Develops supporting policies for appropriate regulatory supervision.
6. Guides, directs and seeks feedback from staff and others involved in the planning, delivery and evaluation of health care services as appropriate.
7. Directs and participates in changes to improve client care and administrative practice.
8. Takes appropriate action in situations of incompetent or impaired practice or unethical conduct up to and including reporting to the regulatory body; guides others in reporting such practices.

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[10] The indicators in the education, administration and research areas describe criteria for meeting the standard in an educator, administrator or research role. If clients are involved during the course of performing these roles, the Indicators in the clinical practice area would also apply.

9. Understands and communicates the role of nursing in the health of clients.
10. Assists clients, colleagues, students and others to learn about nursing practice and health care services.

Indicators: Research[12]

1. Communicates, **collaborates** and consults with nurses and others to plan, conduct and evaluate research.
2. Articulates and supports the translation of knowledge gained from research into policy and practice.
3. Guides and directs members of the research team as appropriate.
4. Participates in changes that promote evidence-based nursing practice.
5. Reports incompetent or impaired practice or unethical conduct to appropriate person or body.
6. Understands and communicates the role of nursing in the health of clients.
7. Assists colleagues, students and others to learn about the influence of research on nursing practice and health care services.

STANDARD 4: ETHICAL PRACTICE

Understands, upholds and promotes the ethical standards of the nursing profession.

Indicators: Clinical Practice

1. Makes the client the primary concern in providing nursing care.
2. Provides care in a manner that preserves and protects client dignity.
3. Demonstrates honesty and integrity.
4. Clearly and accurately represents self with respect to name, title and role.
5. Protects client privacy and confidentiality.
6. Recognizes, respects and promotes the client's right to be informed and make informed choices.

1. Promotes and maintains respectful communication in all professional interactions.[11]
2. Treats colleagues, students and other health care workers in a respectful manner.
3. Recognizes and respects the contribution of others on the health care team.
4. Makes equitable decisions about the allocation of resources[12] under one's control based on the needs of clients.

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[11] This includes interactions with clients, colleagues, students and others. It includes appropriate recognition of power differentials.

[12] The term "resources" is used broadly and includes the nurse's time and skills as well as equipment and supplies.

5. Identifies the effect of own values, beliefs and experiences in carrying out clinical activities; recognizes potential conflicts and takes action to prevent or resolve.
6. Identifies ethical issues; consults with the appropriate person or body; takes action to resolve and evaluates the effectiveness of actions.
7. Initiates, maintains and terminates nurse-client relationships in an appropriate manner.

Indicators: Education[13]

1. Educates others to learn about ethical practice.
2. Educates others to provide care in a manner that preserves and protects client dignity.
3. Demonstrates honesty and integrity.
4. Clearly and accurately represents self with respect to name, title and role.
5. Educates others to protect client privacy and confidentiality.
6. Educates others to recognize, respect and promote the client's right to be informed and make informed choices.
7. Promotes and maintains respectful communication in all professional interactions;[14] educates others to do the same.
8. Treats colleagues, students and other health care workers in a respectful manner; educates others about respectful communication and ways to effect positive behaviour change in the workplace.
9. Recognizes and respects the contribution of others on the health care team.
10. Makes equitable decisions about the allocation of resources[15] under one's control based on the needs of learners.
11. Identifies the effect of own values, beliefs and experiences in carrying out educational activities; recognizes potential conflicts and takes actions to prevent or resolve.
12. Assists others in identifying ethical issues; consults with the appropriate person or body; takes action to prevent or resolve and evaluates the effectiveness of actions.
13. Implements educational activities that support the initiation, maintenance and termination of nurse-client relationships in an appropriate manner.

Indicators: Administration[15]

1. Actively supports the creation of a practice environment that enables nurses to meet their ethical obligations.

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[13] The indicators in the education, administration and research areas describe criteria for meeting the standard in an educator, administrator or research role. If clients are involved during the course of performing these roles, the indicators in the clinical practice area would also apply.

2. Guides nurses and others in providing care in a manner that preserves and protects client dignity.
3. Demonstrates honesty and integrity.
4. Clearly and accurately represents self with respect to name, title and role.
5. Protects client privacy and confidentiality.
6. Creates a practice environment that supports the client's right to be informed and make informed choices.
7. Promotes and maintains respectful communication in all professional interactions;[14] guides others to do the same.
8. Treats colleagues, students and other health care workers in a respectful manner; addresses concerns related to disrespectful behaviour[14] in the workplace.
9. Recognizes and respects the contribution of others on the health care team.
10. Makes equitable decisions about the allocation of resources[15] under one's control based on the needs of clients.
11. Identifies the effect of own values, beliefs and experiences in carrying out administrative activities; recognizes potential conflicts and takes actions to prevent or resolve.
12. Supports the establishment of mechanisms that assist nurses in recognizing and resolving ethical issues.
13. Guides nurses to initiate, maintain and terminate nurse-client relationships in an appropriate manner.

Indicators: Research[15]

1. Advocates for and participates in processes that promote ethical and accountable research practices.
2. Ensures ethical guidelines are followed to protect research participants.
3. Demonstrates honesty and integrity.
4. Clearly and accurately represents self with respect to name, title and role.
5. Protects client privacy and confidentiality.
6. Ensures clients have the information necessary to make informed choices about their participation in research.
7. Promotes and maintains respectful communication in all professional interactions.[14]
8. Treats colleagues, students and other health care workers in a respectful manner.

[14] Includes bullying, harassment and inappropriate use of power.

9. Recognizes and respects the contribution of others on the research and health care teams.
10. Identifies the effect of own values, beliefs and experiences in carrying out research activities; recognizes potential conflicts and takes actions to prevent or resolve.
11. Identifies ethical issues; consults with the appropriate person or body; takes action to resolve and evaluates the effectiveness of actions.
12. Initiates, maintains and terminates nurse-client relationships in an appropriate manner.

Glossary

Assignment: allocation of clients or client care activities among care providers in order to meet client care needs. Assignment occurs when the required care falls within the employing agency's policies and role descriptions and within the regulated health care provider's scope of practice. Assignment to unregulated care providers occurs when the required care falls within the employing agency's policies and role description.

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

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

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

Critical thinking: purposeful, disciplined and systematic process of continual questioning, logical reasoning and reflecting through the use of interpretation, inference, analysis, synthesis and evaluation to achieve a desired outcome.

Decision support tools: evidence-based documents used by registered nurses to guide the assessment, diagnosis and treatment of client-specific problems.

Delegation: process by which a nurse may authorize an activity to be performed by an unregulated care provider who does not otherwise have authority to perform the activity.

Evidence: data derived from various sources including research, national guidelines, policies, consensus statements, expert opinion and quality improvement.

Fitness to practice: qualities and capabilities of an individual relevant to their capacity to practise as a nurse, including, but not limited to, any cognitive, physical, psychological or emotional condition, or a dependence on alcohol or drugs, that impairs their ability to practise nursing.

Health care team: clients, health care professionals, unregulated care providers, students and others who may be involved in providing care.

Indicator: illustration of how a standard is applied and met. Indicators provide specific criteria that are used, when applicable, to measure the actual performance of an individual RN or NP.

Nursing science: knowledge (e.g., concepts, constructs, principles, theories) of nursing derived from systematic observation, study and research.

Professional conduct: Behaviour consistent with actions that uphold the profession. This includes, but is not limited to, practising in accordance with BCCNM's Standards of Practice.

Scope of practice: activities RNs and NPs are educated and authorized to perform as set out in the Nurses and Midwives Regulation under the Health Professions and Occupations Act and complemented by standards, limits and conditions established by BCCNM.

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

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ETHICS STANDARD

Registered Psychiatric Nurses: Professional Standards

Introduction

The *Registered Psychiatric Nurses: Professional Standards* describe, in broad terms, the expected level of performance of all registered psychiatric nurses (RPNs). Professional Standards, along with the *Registered Psychiatric Nurses: Code of Ethics*, address the overarching professional requirements for all registered psychiatric nurses practicing in B.C. Under each standard there are a number of indicators that help determine how to meet the professional standard. The indicators are representative but not comprehensive for each standard.

Standards

STANDARD 1. THERAPEUTIC RELATIONSHIPS

The registered psychiatric nurse establishes collaborative professional, interpersonal, and therapeutic relationships with clients.

A registered psychiatric nurse:

1. Continually applies the therapeutic use of self within professional practice.
2. Recognizes and addresses power imbalances in therapeutic relationships.
3. Ensures client needs remain the focus of the therapeutic relationship.
4. Does not exploit the vulnerability of persons encountered through their practice.
5. Will not engage in any sexual behaviour while in a therapeutic relationship with a client, with or without consent.
6. Will not enter into a close personal or intimate relationship with a client or a former client who has received psychotherapeutic treatment from the registered psychiatric nurse.
7. Uses professional judgment, effective communication and interpersonal skills, and practices with integrity to establish, maintain and terminate the therapeutic relationship.

8. Recognizes and addresses transference and counter-transference and their impact on the therapeutic relationship.
9. Applies critical thinking and professional judgment in therapeutic relationships.
10. Establishes and negotiates boundaries in therapeutic relationships.
11. Practices according to the principles of informed consent and confidentiality.
12. Will make best efforts to find suitable alternatives to treating their own family or friends.
13. Develops partnerships using a client-centred, integrated and holistic approach.

STANDARD 2. COMPETENT, EVIDENCE-INFORMED PRACTICE

The registered psychiatric nurse continually acquires and integrates evidence-informed knowledge and builds on psychiatric nursing education and lifelong learning.

A registered psychiatric nurse:

1. Applies evidence-informed knowledge, skill, critical thinking and professional judgment to assess, plan, implement, and evaluate in the practice of psychiatric nursing.
2. Incorporates evidence-informed knowledge to promote safety and quality in psychiatric nursing practice.
3. Uses communication skills effectively.
4. Integrates cultural safety and cultural humility into their practice with diverse clients.
5. Recognizes potential risks and hazards, and implements interventions to promote a safe environment.
6. Integrates infection prevention and control principles in providing psychiatric nursing care.
7. Documents the application of the clinical decision-making process in a responsible, accountable and ethical manner.
8. Applies documentation principles to ensure effective written/electronic communication.
9. Remains current in knowledge relevant to their practice.
10. Incorporates knowledge of therapeutic modalities and conceptual models of psychiatric nursing.
11. Coordinates client care and/or health services throughout the continuum of care.
12. Establishes, maintains and coordinates a plan of care based on a comprehensive psychiatric nursing assessment.

STANDARD 3. PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

The registered psychiatric nurse is accountable and responsible for safe, competent and ethical psychiatric nursing practice that meets the standards of the profession and legislated requirements.

A registered psychiatric nurse:

1. Maintains current registration/licensure.
2. Practises in accordance with all relevant legislation and regulation including the Professional Standards for Registered Psychiatric Nurses.
3. Exercises professional judgment when agency policies and procedures are unclear or absent.
4. Assumes responsibility and accountability for continuing competence.
5. Seeks out the necessary resources using skill and professional judgment to address personal and professional limitations.
6. Recognizes the competencies and limitations of colleagues and/or students when assigning responsibilities.
7. Responds to and/or reports unsafe practice, professional incompetence, professional misconduct, and incapacity or fitness-to-practice issues to the appropriate authority.
8. Complies with any legal duty to warn and report, including abuse or potential harm to the public.
9. Self-reports to the regulatory body conditions that compromise their fitness to practice.
10. Uses technology, electronic communication and social media responsibly and professionally.

STANDARD 4. LEADERSHIP AND COLLABORATION IN QUALITY PSYCHIATRIC NURSING PRACTICE

The registered psychiatric nurse enhances the safety, quality and effectiveness of psychiatric nursing practice through leadership and collaboration.

A registered psychiatric nurse:

1. Engages in practices that promote physical, environmental and psychological safety.
2. Evaluates the effectiveness of interventions in psychiatric nursing practice.
3. Participates in quality improvement activities to initiate change in psychiatric nursing practice and in the health care system.
4. Collaborates with client, team members, families and other stakeholders to develop comprehensive psychiatric nursing care to achieve the client's health goals.
5. Mentors colleagues and stakeholders for the advancement of psychiatric nursing practice and quality health care.
6. Promotes collaborative practice among health care professionals through respectful working relationships and appropriate documentation practices.
7. Acts as a leader, teacher and role model to students, beginner practitioners and colleagues, supporting, Instructing and/or mentoring them in their professional development.

8. Takes action to resolve professional practice issues.
9. Collaborates with and advocates for clients.
10. Demonstrates professional leadership through:
    a. Building trusting relationships
    b. Creating empowering environments
    c. Supporting knowledge development and integration within the health care team
    d. Advancing psychiatric nursing practice and quality health care
    e. Leading and sustaining change and balancing competing values and priorities

STANDARD 5. PROFESSIONAL ETHICAL PRACTICE

The registered psychiatric nurse understands, upholds and incorporates the profession's Code of Ethics into their professional practice.

A registered psychiatric nurse:

1. Practises with honesty, integrity and respect, demonstrating the ethics, standards, principles, guidelines and values of the profession.
2. Applies the RPN: Code of Ethics in all areas of their practice.
3. Identifies the effect of their own values, beliefs and experiences in relationships with clients, recognizes potential conflicts, and takes action to prevent or resolve them.
4. Applies ethical and legal considerations in maintaining confidentiality in all forms of communication.
5. Supports the human, legal and moral rights of clients, including the right to make informed decisions and the right to live at risk.

Glossary

Client: individual, family, group, population or entire community that requires nursing expertise.

Competencies: integrated knowledge, skills, professional judgment and attitudes required by a registered psychiatric nurse to practice competently, ethically and safely (Verma, Paterson & Medves, 2006).

Continuing Competence: ongoing ability of a registered psychiatric nurse to integrate and apply the knowledge, skills, professional judgment, attitudes, values and interpersonal attributes required to practice safely and ethically in their current role and setting (CRPNA, September 2013).

Continuum of Care: comprehensive system of services and programs, ranging from mental health promotion and illness prevention to specialized services, and designed to match the needs of individuals and populations with appropriate care and treatment, and which vary according to levels of service, structure, and intensity of care. (Austin et al. 2019).

Counter-Transference: nurse's reactions to a client that are based on the nurse's unconscious needs, conflicts, problems, and views of the world. See also **Transference** (Austin & Boyd, 2010).

Evidence-Informed: care based on the collection, interpretation and integration of valid, important, and applicable patient-reported, clinician-observed, and research-derived evidence. (Halter, 2014).

Professional Judgment: evaluation of evidence to a make a clinical decision. It is the ability to make critical distinctions and achieve a balanced viewpoint, including the reaction of the registered psychiatric nurse to the client. (RPNRC Entry Level Competencies, November 2014).

Therapeutic Relationship: interpersonal process that is purposeful, goal directed and focused on achieving outcomes in the best interest of the client, in which the nurse maximizes their communication skills, understanding of human behaviour, and personal strengths to advance the client's interests and personal growth, and to promote health and well-being.

Therapeutic Use of Self: complex process of self-awareness through one's own growth and development, as well as one's interactions with others, that guides the process of developing, maintaining and terminating the therapeutic relationship.

Transference: client's experience of feelings toward the nurse, that were originally held toward significant others in their life. See also **Counter-Transference** (Halter, 2014).

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ETHICS STANDARD

Registered Psychiatric Nurses: Code of Ethics

Introduction

The BCCNM *RPN Code of Ethics* articulates the ethical principles and values that guide all members of the Psychiatric Nursing profession. It sets out the framework for professional responsibility and accountability while promoting high ethical standards in practice and providing a benchmark for Registered Psychiatric Nurses to use for self-evaluation.

Through the *Code of Ethics*, Registered Psychiatric Nurses uphold the values of:

- Safe, competent, and ethical practice to ensure the protection of the public;
- Respect for the inherent worth, right of choice, and dignity of persons;
- **Health**, **mental health**, and well-being; and,
- Quality practice.

Standards

1. SAFE, COMPETENT, AND ETHICAL PRACTICE TO ENSURE THE PROTECTION OF THE PUBLIC

The Registered Psychiatric Nurse:

a. Knows the difference between personal and professional relationships and assumes responsibility for those relationships.

b. Commits to building therapeutic relationships and behaves in a manner that protects the integrity of those relationships.

c. Ensures that the vulnerabilities of others are not exploited for one's own interests.

d. Practices within one's own level of competence and seeks out additional information or guidance when required.

e. Strives to ensure evidence-based practice while ensuring **continuing competence** throughout one's professional career.

f. Strives to maintain a level of personal health, mental health, and well-being in order to provide competent, safe, and ethical care.

g. Ensures that one neither initiates nor participates in any practice that is considered harmful to the welfare of others.

h. Protects the confidentiality of all information gathered in the context of the professional relationship.

i. Practices within relevant legislation that governs privacy, access, use, and disclosure of personal information.

j. Conducts one's self in a manner that reflects honesty, integrity, reliability, impartiality, and diligence.

k. Recognizes the expertise and limitations of co-workers/ colleagues or students when assigning or delegating responsibilities.

l. Recognizes one's own limitations and uses professional judgment when accepting responsibilities.

m. Reports, in good faith, any incompetent or unethical behaviour of health care providers to the appropriate authorities.

n. Accepts responsibility and accountability for one's own actions taking all necessary steps to prevent or minimize harm.

o. Refrains from permitting one's professional designation to be used for personal gain in connection with the endorsement of products or services.

p. Conducts one's self in a manner that promotes a positive image of the profession at the local, community, provincial, and national levels.

q. Practices according to provincial and federal statutes/acts/regulations/bylaws and the BCCNM standards of practice.

r. Understands, promotes, and upholds the ethical values of the profession.

2. RESPECT FOR THE INHERENT WORTH, RIGHT OF CHOICE, AND DIGNITY OF PERSONS

The Registered Psychiatric Nurse:

a. Respects people's autonomy and their right to choose by recognizing them as full partners in decision-making.

b. Strives to ensure that a person's choices are understood, expressed, and promoted.

c. Respects the unique, inherent worth and dignity of all persons and strives to ensure that the rights of individuals are upheld.

d. Recognizes and respects diversity and that a person's culture may influence health practices and decision making.

e. Upholds the person's legal and moral right to refuse treatment and to choose to live at risk as long as those decisions are in keeping with the law.

f. Knows, applies, and upholds the elements of informed consent.

g. Ensures psychiatric nursing decisions are consistent with the person's choices or the choices of a substitute decision maker, where applicable.

h. Provides opportunities for persons to make choices and decisions even when the capacity for self-determination is reduced.

3. HEALTH, MENTAL HEALTH, AND WELL-BEING

The Registered Psychiatric Nurse:

a. Respects the needs and values of each person within the physiological, psychological, developmental, socio-cultural, and spiritual dimensions.

b. Understands that physical health and mental health are interconnected and are a dynamic process that fluctuates across the lifespan.

c. Recognizes the complex relationships between emotional, developmental, physical, and mental health and the influence of social factors on physical and mental health and on illness.

d. Understands that perception, lifestyle, and expectations influence physical and mental health.

e. Recognizes the role of culture and spirituality in health promotion, illness prevention, and in **recovery**.

f. Strives to ensure equality in physical and mental health services.

4. QUALITY PRACTICE

The Registered Psychiatric Nurse:

a. Recognizes that community, socio-economic, and political systems influence all aspects of health.

b. Ensures that approaches to physical and mental health are collaborative, holistic, and dynamic and include promoting health, preventing illness, and ensuring interventions that promote rehabilitation and recovery.

c. Uses and contributes to research that promotes the ongoing development of Psychiatric Nursing knowledge, evidence-based practice, and improvements in mental health care.

d. Contributes to quality practice by promoting positive, healthy, and ethical working environments.

e. Contributes to promoting and maintaining safe practice environments.

f. Ensures that safe and competent practice is a priority by advocating for human and material resources.

g. Advocates for fair and equitable access to services and benefits and for equal treatment and protection of all persons.

h. Respects and values the knowledge and contributions of other health care providers and works in collaborative partnerships with others.

Glossary

Continuing competence: ongoing ability of an RPN to integrate and apply the knowledge, skills, judgment, and interpersonal attributes required to practice safely and ethically in a designated role and setting.

Health: state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization).

Mental Health: a state of well-being in which individuals realize their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community (World Health Organization).

Recovery: process in which people living with mental health problems and illnesses are empowered and supported to be actively engaged in their own journey of well-being.

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PRACTICE STANDARD

Midwives: Consultation, Referral, and Transfer of Care

Introduction

This practice standard sets the expectations midwives must meet when requesting or receiving a consultation, referral or transfer of care.

Standards

1. Midwives **consult, refer,** and/or **transfer care** to another health professional:
    a. In alignment with relevant legislation and regulations and BCCNM's standards, limits, and conditions,
    b. In alignment with organizational policies and processes,
    c. When the client's care needs are beyond the midwife's **scope of practice,** and/or
    d. When the expertise of other health professionals would be in the best interest of the client.
2. Midwives communicate with their clients when a consultation, referral, and/or transfer care is indicated.
3. Midwives ensure timely initiation of and follow-up on consultations, referrals, or transfers of care, taking into consideration clinical urgency, geography, and other factors.
4. Midwives collaborate with their clients and the health-care team to coordinate care.
5. When consulting, referring, and/or transferring care, midwives ensure the **most responsible provider (MRP)** is clearly identified to the client and the health-care team and is documented in the client's record.
6. Midwives may continue to provide midwifery care within their scope of practice when transfer of care is necessary.

7. When consulting with, referring, to or transferring care to another health-care professional, midwives:

    a. Present the reason for and urgency of the request,
    b. Describe the level of involvement requested,
    c. Provide relevant, complete, and accurate client health information, including details of any informed choice decisions made by the client,
    d. Confirm the health professional's ongoing level of involvement with the client, and
    e. Document the request for and outcome of the consultation, referral, or transfer.

8. When responding to a consultation, referral, or transfer of care request from another health professional, midwives:

    a. Confirm the reason for and urgency of the request,
    b. Confirm the level of involvement requested,
    c. Ensure access to relevant client health information and notify the health professional if they are unable to provide a consultation or accept the referral or transfer,
    d. Confirm their ongoing level of involvement with the client and MRP if the request is accepted, and
    e. Document and communicate the outcome to the MRP.

9. Midwives confirm with the client the completion of midwifery care and facilitate a transfer of care to another primary care provider if indicated.

Glossary

Consultation: request from one health professional (e.g., midwife, physician, nurse practitioner, physiotherapist) to another to provide input, advice, or guidance on the management of client care.

Most Responsible Provider (MRP): regulated health professional who is responsible for the overall management and coordination of client care.

Referral: request from one health professional (e.g., midwife, physician, nurse practitioner) to another to assume responsibility for management of one or more aspects of a client's care.

Scope of practice: activities that registered midwives are educated, competent, and authorized to perform.

Transfer of Care: transfer of overall responsibility, management, and coordination of client care to another regulated health professional who then becomes the client's MRP.

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PRACTICE STANDARD

Midwives: Home & Community Birth

Introduction

This practice standard sets the expectations that midwives must meet when providing intrapartum and postpartum care in home and community settings. Midwives offer care in a variety of settings such as hospitals and community settings such as homes, clinics, or birthing centres, where specialized medical, obstetrical, neonatal, surgical, and anaesthetic services are not available on site. In all settings, midwives must follow relevant regulations, BCCNM's standards, and applicable policies and processes.

Standards

When providing intrapartum and postpartum care to clients in home and community settings, midwives:

1. Carry and maintain the equipment, medications, and supplies as listed by Perinatal Service of British Columbia Equipment, Medications and Supplies for Home and Community Labour and Birth.
2. Follow evidence-informed procedures to prevent and control infection, including cleaning, disinfecting, and sterilizing equipment appropriately.
3. Ensure equipment and supplies are working correctly and that equipment, supplies, and medications are stored appropriately and not expired.
4. Ensure they maintain competency to provide care, including recognizing and managing complications and emergencies.
5. Maintain situational awareness and recommend transfer to a setting that offers higher level of care (e.g. a setting where medical, obstetrical, neonatal, surgical, and/or anaesthetic services are available), when necessary, based on the evolving situation including but not limited to emerging risk factors, poor or changing weather conditions, availability of an additional attendant, etc.
6. Initiate consultation and/or transfer of care when appropriate or required.
7. Ensure that at least one qualified additional attendant is present to assist for the birth and immediate postpartum period. The qualified additional attendant must:
    a. Be either:
        i. a licensed or regulated health professional holding practising/current registration or licensure, whose regulated scope of practice includes the services described in 7c. below,[1] OR

[1] This would ordinarily be a midwife, registered nurse, or nurse practitioner with current practicing registration with BCCNM, a physician with current practicing registration with the College of Physicians and Surgeons of British Columbia, or a paramedic currently licensed by the Emergency Medical Assistants Licensing Board.

ii. a fourth-year midwifery student in their final semester or a student in an internationally educated midwives bridging program in their supervised clinical practicum; and

b. Hold current cardiopulmonary resuscitation (CPR) certification, neonatal resuscitation (NRP) and obstetrical emergencies skills training; and

c. Be competent in the clinical skills necessary to support a primary midwife with intrapartum and postpartum care in home and community settings, including performing venipuncture, intravenous and intramuscular medication administration, resuscitation, oxygen therapy and documentation.

8. Supervise the provision of care provided by an additional attendant who is a student.

9. Communicate and collaborate with additional attendant(s) regarding the clinical situation, roles, and responsibilities, and provide orders or instructions as required.

10. Contact emergency health services if there is an emergency or a need for urgent transport.

11. Ensure there is an agreed upon emergency transport plan with the receiving hospital and emergency health services, which includes communication channels, processes, and the roles and responsibilities of all involved.

12. Contemporaneously document informed choice discussions, recommendations, plans, decisions, and actions to maintain complete records.

Limits and conditions

1. A midwife must hold hospital privileges in the community where they offer home and/or community birth OR they must work with at least one other perinatal care provider who has intrapartum hospital privileges and can be on call and available for clients in case of hospital transfer (as per BCCNM's Hospital Privileges practice standard).

2. Until a midwife meets the Policy on New Registrant Requirements, their additional attendant must be a practicing, provisional, or temporary emergency midwife registrant who has met the Policy on the New Registrant Requirements and is competent to provide home and/or community intrapartum care.

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ETHICS STANDARD

Midwives: Termination of care

Introduction

In rare occasions, a midwife or client may need to terminate care prior to the natural end of the midwifery-client relationship. Reasons for terminating care include but are not limited to a midwifery practice unexpectedly closing, an irreconcilable breakdown in the midwife-client relationship, or a client request for care outside of midwifery standards[1] that the midwife cannot accommodate. This practice standard outlines the requirements of midwives when terminating care or receiving notice of care termination from a client.

Standards

1. If the midwife decides to terminate care, either prenatally or during the postpartum period, the midwife must:
    a. inform the client of being unable to continue to provide midwifery care, provide a reasonable period of notice for the client to find alternate care (e.g. ten days to two weeks of notice, ideally in pregnancy prior to 37 weeks gestation, however, this may vary according to location and circumstances) and make a reasonable attempt to assist the client to find appropriate alternate care;
    b. follow-up immediately with a hand delivered or registered letter, or an alternative appropriate form of communication to the client, confirming termination of care by a date which provides the client with a sufficient amount of time to find another caregiver;
    c. continue to provide care within scope to the client for regularly scheduled visits during the notice period unless the client declines care;

[1] Refer to the Policy on *Requests for Care Outside Standards*

d. transfer care as soon as the client has identified a named caregiver who has agreed to assume responsibility for care, providing a copy of the client's health record to the new care provider upon transfer or directly to the client to bring to the first visit with the new care provider;

e. if the client has not identified a caregiver by the end of the notice period, the midwife may transfer care to an obstetrician, family physician or midwife who has agreed to take the client into care and who is appropriate to provide care suitable to the client's risk status, or a care facility or service if specific care providers cannot be identified. The midwife must notify the client that the care and records have been transferred, and provide contact information for the new provider(s) or service;

f. maintain in the client's health record a copy of the letter and/or the alternative form of communication notifying the client that care is being terminated, together with the proof of receipt, as well as a record of all care provided during the notice period;

g. provide an updated version of the PSBC Antenatal Records 1 and 2 to the referring local hospital if termination has taken place prenatally. This is in addition to the requirement of sending the 20 week and 36 week Antenatal Records 1 and 2 to the local hospital;

h. waive any fees that would typically be charged for transferring records to a new provider.

2. If the client decides to terminate care with the midwife, the midwife should:

a. record the termination of care and the reason given, if any, in the client's health record;

b. provide the client with a copy of their medical records to take to the new provider or release a copy of the client's medical record to the new caregiver if that provider sends a request for a copy of the client's health records signed by the client;

c. if no new caregiver information was provided, notify the hospital if it is a prenatal termination and/or notify public health if it is a postpartum termination and transfer the client's records to the client's family physician if possible.

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ETHICS STANDARD

Midwives: Boundaries in the midwife-client relationship

Introduction

The midwife-client relationship develops in a safe, comfortable environment of trust and mutual respect. It is that trust that gives midwives the power of their professional position and access to private knowledge. Establishing boundaries allows a safe connection for midwives to meet the needs of clients.

This ethics standard sets the expectations midwives must meet when establishing, maintaining and ending the midwife-client relationship.

Standards

1. Midwives treat all clients professionally.
2. Midwives act in clients' best interests.
3. Midwives respect clients' dignity and promote their autonomy.
4. Midwives must refrain from inappropriate involvement in clients' personal relationships.
5. Midwives avoid, as much as possible, any professional relationships with clients where the midwives' objectivity or competence could reasonably be expected to be impaired because of the professional's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship with the client or with another relevant person associated with or related to the client.
6. Midwives are restricted from providing midwifery care to family and/or household members. When it is unavoidable and a midwife must provide midwifery care to family or household members (e.g., emergencies or in small communities), midwives should:
    a. document the specific circumstances, an account of why the dualities or conflicts were unavoidable,
    b. document the informed consent of the clients for all services, and
    c. whenever possible, transfer overall responsibly for care to another health care provider.
7. Midwives decline to enter into a midwife-client relationship where a conflict of interest or potential conflict of interest exists.

8. Midwives do not enter into a sexual relationship with any client.
    a. If one year has passed since the last professional contact with the client, the former client will no longer be considered a client and a sexual relationship with the former client may be permitted.
    b. If there has been a previous sexual or romantic relationship, at least one year must have passed since the relationship ended before the midwife may accept the person into care.
    c. In the event that a former client requires midwifery care while engaged in a sexual relationship with a midwife, the midwife is not authorized to provide any midwifery services to the former client.
9. Midwives are expected to:
    a. Ensure that informed consent is an ongoing process, rather than a single discussion.
    b. Maintain appropriate and culturally sensitive eye contact.
    c. Respect clients' personal sense of space.
    d. Employ appropriate vocabulary for body parts and procedures while respecting clients' gender identity and preferred vocabulary.
    e. Be sensitive to words that could cause misunderstanding.
    f. Know when to recommend a translation service, and speak directly with clients when working with interpreters and members of the clients' support networks.
    g. Avoid inappropriate discussion of their personal life to clients, in a manner that seems to create an uncomfortable or inappropriate intimacy with clients.
    h. Acknowledge clients' fear and embarrassment which are natural emotions during pregnancy and childbirth.
    i. Avoid making comments that might be interpreted as inappropriate about clients' bodies or clothing.
    j. Provide clients with an opportunity to ask questions.
    k. Avoid inappropriately affectionate words and behaviour.
    l. Be sensitive to clients when discussing intimate issues or probing for personal or private information.
    m. Remain non-judgemental if clients discuss boundary violations.

10. Midwives avoid causing unnecessary distress or embarrassment to clients by inappropriate touching.

11. When doing vaginal examinations, midwives wear a glove on the opposite hand if that hand is touching the labia.

12. Midwives communicate appropriately with their clients when using physical touch by:

    a. obtaining their clients' consent;

    b. providing explanations throughout a procedure; and

    c. checking the level of understanding and consent of clients.

13. To ensure privacy, midwives:

    a. Discuss draping with clients and allow a choice of coverings for clinical procedures such as Pap tests and physical assessment;

    b. Allow clients enough time and privacy while disrobing; and

    c. Request clients' permission for students or others to observe procedures.

14. Midwives do not initiate or accept an invitation to become personal online friends with clients or clients' family members at any time during the period when a client is under their care.

15. Midwives refrain from exchanging gifts, hospitality or other benefits to avoid creating expectations for the type of care clients will receive and prevent the perception that the midwife's integrity may be compromised.

16. Midwives in clinical practice or in charitable or publicly funded settings do not accept or give commissions, rebates, fees, other benefits or anything of value for receiving or making a referral of a client to or from another person.

17. Midwives avoid selling or promoting products to clients, particularly if the products or similar substitutes are not medically required and readily available elsewhere for purchase.

18. Gifts are never solicited from clients. It may be acceptable on some occasions to accept a modest gift from clients.

19. If a gift must be refused, midwives explain why in a sensitive manner.

20. When deciding whether or not to accept a gift, midwives consider:

    a. whether the gift will change the nature of the relationship,

    b. the context in which the gift is offered, including the monetary value and appropriateness of the gift,

    c. the client's intent in offering the gift, and

    d. whether the client will expect a different level or nature of care.

Glossary

Conflict of Interest: arises where a reasonable person could form the view that a midwife's ability and obligation to act in the client's best interests may be affected or influenced by other competing interests. Such conflicts of interest can be real, potential or perceived. Conflicts of interest occur in a variety of circumstances including financial, non-financial, direct and indirect transactions with clients and others.

Family and/or household members: spouse, common-law partner, child (stepchild), parent (step-parent or parent-in-law), grandparent, grandchild, sibling or spouses of any of these, or any person who is a member of the midwife's household.

Professional Misconduct: includes **Sexual Abuse** or **Sexual Misconduct**, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession.

Sexual Abuse or Sexual Misconduct: sexual intercourse or other forms of physical sexual relations between a registrant and a client, touching, of a sexual nature, of a client by a registrant, or behaviour or remarks of a sexual nature by a registrant towards a client, but does not include touching, behaviour and remarks by a registrant towards a client that are of a clinical nature appropriate to the service being provided.

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PRACTICE STANDARD

Midwives: Hospital Privileges

Introduction

This practice standard sets expectations related to **hospital privileges** for midwives.

Standards

1. Midwives are required to have hospital privileges when **on call**.
2. Midwives who carry a **caseload** and do not have hospital privileges must share care with at least one other maternity health care provider who has hospital privileges and can provide continuous on call coverage to their shared clients.
3. All newly registered midwives, locum midwives, midwives relocating, and non-practising midwives returning to practice must apply for hospital privileges as soon as possible. Midwives must apply for and make every reasonable effort to obtain hospital privileges in the geographic area in which they intend to provide midwifery services.
4. Midwives must immediately notify BCCNM of any changes to their hospital privileges.

Limits & Conditions

1. During the period of time that it takes for a hospital privileges application to be processed, a midwife may carry a caseload and remain a practising registrant without hospital privileges. During this time, the midwife must work collaboratively with at least one other maternity health care provider who has hospital privileges and can be on call for clients. Once their hospital privileges application has been adjudicated, the midwife must immediately notify BCCNM of the outcome.

Glossary

Hospital privileges: formal approval from a facility with perinatal services in the geographic region where their clients plan to give birth and/or may require care that allows a midwife to provide specific clinical services within that facility. They are based on qualifications, training, and experience, and may include responsibilities like admitting and discharging patients, conducting births, prescribing medications, and managing emergencies.

On call: primary care provider available on an urgent basis to provide care.

Caseload: client or group of clients for whom the midwife (and/or their team) has agreed to provide primary care.

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ETHICS STANDARD

Midwives: Informed choice

Introduction

An informed choice discussion is a collaborative, non-authoritarian, culturally sensitive and on-going exchange of information between a midwife and client. This discussion supports understanding and decision making in clinical care.

Midwives have a duty to recommend care they determine is in the best interest of their client; the client may accept or decline their recommendation. The informed choice process ultimately results in either informed consent or informed refusal.

Standards

1. Midwives provide each client with information regarding relevant treatments, procedures, tests and medications throughout their care. Information should include:
    a. what is being proposed/offered and its risks/benefits;
    b. any alternatives to what is being proposed/offered and their risks/benefits;
    c. what would happen if no treatment/procedure/test/medication is chosen;
    d. relevant research evidence including any deficiency of clear evidence;
    e. relevant community standards of care and practices;
    f. their recommendation for the client, supported by evidence, BCCNM standards and community standards.
2. Midwives make reasonable efforts to ensure that the client has adequate opportunity and time to engage in the informed choice process.
3. If a midwife is concerned that the client may be incapacitated and cannot make informed choices, they consult an appropriate health professional.
4. Midwives document informed choice discussions in the medical record and communicate the client's choices with the health care team.

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PRACTICE STANDARD

Midwives: Medical records

Introduction

This practice standard sets expectations for midwives related to the creation, content, ownership, custody, confidentiality and ongoing accessibility of medical records for themselves and their clients.

Standards

RECORD CONTENT

1. Midwives are expected to maintain comprehensive medical records that document all aspects of care provided during the antepartum, intrapartum and postpartum periods for each individual client. This includes copies of the following:
    a. all laboratory results;
    b. operative procedures;
    c. prescriptions issued;
    d. consultation reports; and
    e. discharge summaries.
2. Medical records must be legible, in English and include documentation of the following:
    a. relevant medical history;
    b. all clinical assessments and observations;
    c. informed choice discussions;
    d. recommendations;
    e. plans of management;
    f. consultations requested; and
    g. transfers of care.
3. All verbal and written communication (including but not limited to in-person, telephone, video chat, text message, email message, letter and fax) related to clinical care must be clearly documented and maintained as part of the medical record.
4. Medical records may be maintained in paper or electronic format.

5. Completion of relevant standardized perinatal forms[1] issued by Perinatal Services BC (PSBC) is mandatory.
6. Additional narrative notes should be maintained in a consistent, timely and organized format. All entries should be legible, logical and include the date, the midwife's identification (initials, signature and/or BCCNM number) and where required, the time.
7. Midwives must co-sign entries made by learners in the medical record.
8. Midwives may amend or alter a medical record, but in doing so they must clearly identify themselves as well as the time, date and reason for the changes made. Medical records may not be altered after a complaint or legal action has been initiated, unless a clinical fact is missing and a clear late entry is made to the record.

CONFIDENTIALITY

9. Midwives must maintain and store their medical records in a confidential, secure and systematically organized manner (paper or electronic format[2]) and in accordance with relevant legislation.

DATA STEWARDSHIP

10. In all situations where a midwife is creating or contributing to medical records in a group or shared medical record environment, an associated ***practice protocol must be in place.*** The protocol must address physical security, data sharing with other health care providers, backup of electronic data, user-based levels of access, how ownership, custody, confidentiality and enduring access by individual midwives and clients are addressed, including following relocation, retirement or death of the midwives.

RECORDS RETENTION AND DESTRUCTION

11. As required by the *Limitation Act*, medical records must be retained for a minimum period of sixteen years from either the date of the last entry or from the age of majority (19 years of age in British Columbia), whichever is later (i.e. 35 years), except as otherwise required by law.
12. Midwives have a responsibility to ensure that records are properly disposed of ***after*** the legal retention period has expired. As per the *Bylaws for the British Columbia College of Nurses and Midwives (BCCNM)*, paper records may be destroyed by secure shredding or controlled incineration, and electronic records must be erased in a manner that ensures all traces of original data are destroyed.
13. Original records are considered the best evidence in the case of a complaint or a lawsuit; midwives should consider retaining original client records for any case where an incident

[1] Or equivalent in hospitals with electronic medical records that do not use PSBC forms.

[2] Records may be retained in electronic form as long as the electronic record is complete, permanent and unalterable.

report has been filed or a complaint has been made. Likewise, if the image quality compromises the legibility of the client record, then an original paper copy of the record should be kept.

CUSTODY AND ACCESS

Sharing of Records and Records Requests

14. Midwives must make copies of medical records available as follows:
    a. to an inspector or a quality assurance assessor for BCCNM under sections 26.1, 27, 28, 29, and 30 of the *Health Professions Act*;
    b. to another midwife or health care provider upon request by the client;
    c. to Perinatal Services BC (PSBC) (specifically, the standard perinatal forms) following a home birth for the purposes of perinatal data collection and analysis to the BC Perinatal Data Registry or alternate agency designated by BCCNM;
    d. to a client's legal representative when provided with a written, dated authorization from the client or client's legal representative specifying the records that are requested; and
    e. to the Coroner upon request. Coroners have the responsibility and authority under the *Coroners Act* to obtain copies of the complete medical record. Midwives are advised to consider seeking legal advice when involved in a coroner's investigation.
15. Midwives must also provide a copy of medical records to the client within thirty (30) days of the client's request. However, in accordance with section 29 of the *Personal Information Protection Act* (PIPA) the midwife may withhold parts of the client record which:
    a. are subject to solicitor-client privilege;
    b. contain confidential commercial information;
    c. contain investigative information on a matter still under investigation;
    d. contain information obtained in the conduct of a mediation or arbitration;
    e. through disclosure, could threaten the safety or physical or mental health of the patient or another individual; or
    f. contain personal information about another person.
16. Midwives may, for the purpose of providing or assisting in the provision of health care to a client, permit a health care provider within the client's circle of care to examine the client's medical record and may share with them information contained in the record. Client consent in this scenario is considered implicit.

Enduring Access

17. Midwives must have access to copies of or the original medical records for any clients who were previously or are currently under their professional care for the length of the legal retention period. When a copy of a medical record is retained by a midwife, that midwife has the same responsibility for ensuring that it continues to be maintained in a confidential and secure manner as if it were the original.
18. Clients must have access their medical records for the length of the legal retention period.

Changing Practices

19. When a midwife leaves a practice, the midwife may either retain copies of the medical records in which they documented care, or formally transfer custody of these records to another midwife. The original records may be kept at the midwifery practice or taken with the leaving midwife provided that all midwives involved in the client's care have access to a complete record that is properly stored and secure.

Ceasing Practice

20. When a midwife ceases to practice (no longer holds practising licensure), BCCNM's Bylaws stipulate that all medical records for any previous or current clients under their professional care that remain within the legal retention period, must be transferred to another midwife, health care provider, person or organization who has been retained to take custody of the records. The midwife transferring the records must ensure the transfer of records is secure and retain documentation of this transfer. The receiving midwife, health care provider, person or organization must confirm acceptance of custody of those records in writing. The receiving midwife, health care provider, person or organization assuming custody of the original records is also then responsible for the secure storage, retention and enduring access to both the BCCNM and clients to those records.
21. Midwives who transfer custody of original medical records must obtain and retain a written contract for service that assures for the duration of the legal retention period:
    a. the safety and confidentiality of the records;
    b. that the midwife, health care provider, person or organization assuming custody of the records notify the transferring midwife and the BCCNM if the location or access details of the records changes;
    c. the transferring midwife right of access;
    d. the client's right of access; and
    e. the duration of record storage required and appropriate means of disposing of records.
22. Midwives who cease to practice and transfer medical records to another location must also take reasonable steps to notify clients of the location of their medical records.

LOST AND STOLEN RECORDS

23. If medical records containing personal information are stolen or lost, the midwife must notify the Midwives Protection Program, the midwifery practice's privacy officer, the police and the Office of Information and Privacy Commissioner (OIPC) immediately. The midwife must also notify the individual(s) whose personal information has been stolen or lost, telling them the kind of information that has been compromised and steps that are being taken to recover it.

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ETHICS STANDARD

Midwives: Requests for care outside standards

Introduction

Midwives in British Columbia respect the rights of each client to make informed choices about their care that the client determines is in their own best interest. In some cases, a client will request care considered outside standards when making informed choices. This practice standard sets out the requirements of a midwife in the case that such a request for care outside standards is made.

Standards

1. Should a client request care outside standards, the midwife must:
    a. Engage the client in an informed choice discussion[1] as related to their request for care outside standards, with the understanding that this discussion may need to take place over a series of encounters,
    b. Initiate discussion, consultation or transfer of care if indicated,
    c. Consider their own ability to safely and reasonably offer the care that has been requested,
    d. Determine whether providing care as requested would place them or their client at an unacceptable level of risk, and
    e. Ensure contemporaneous documentation in the medical record.
2. If the midwife is unable to safely or reasonably provide the care requested, and/or has determined that providing the care requested creates an unacceptable level of risk, they must then take the following additional steps:
    a. Respectfully inform the client of their limited ability/inability to safely and/or reasonably provide the care requested and/or the risk(s) associated with their request,
    b. Offer a consultation with another midwife, physician or nurse practitioner for a second opinion,
    c. Provide the client with an opportunity to respond and ask any outstanding questions,

[1] Refer to the practice standard *Midwives: Informed Choice*.

d. Confirm the client's decision, and

e. Ensure contemporaneous documentation in the medical record.

3. If a client requests care outside of standards during an urgent or emergency situation, the midwife must:

   a. continue to provide the best care possible, and

   b. notify the hospital, request consultation if required, and if appropriate, call additional midwives and/or an ambulance.

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PRACTICE STANDARD

Midwives: Complementary and alternative therapies

Introduction

The British Columbia College of Nurses and Midwives (BCCNM) recognizes that clients have the right to choose complementary and alternative therapies while receiving midwifery care. As well, midwives may have knowledge of and may offer complementary and alternative therapies within their scope of practice.

Standards

1. Midwives who offer, refer to, discuss or have professional affiliation with providers of complementary or alternative therapies are expected to:
    a. provide sufficient information regarding the evidence, efficacy, risks and benefits of the conventional and proposed complementary or alternative therapy so that the client may make an informed choice decision, and document this discussion appropriately in the medical record;
    b. respect the autonomy of clients to choose or decline complementary or alternative therapies;
    c. recognize the potential effects of their position as a trusted, regulated medical professional on their client's choice to accept or decline the proposed therapy; and
    d. not withhold indicated medical examinations, investigations, therapies and/or physician consultation.
2. Midwives who practice complementary or alternative therapies must do so in an ethical manner that remains within their scope of care and level of competence.

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PRACTICE STANDARD

Midwives: Preventing Transmission of Blood-borne Viruses

Introduction

This standard sets the expectations for midwives to safeguard the health of their clients by minimizing the risk of transmitting **blood-borne viruses (BBVs)**.

Standards

1. Midwives follow relevant legislation and regulations, BCCNM's standards and bylaws, and organizational policies and processes.
2. Midwives take action to prevent the transmission of BBVs from themselves to their clients.
3. Midwives maintain their own wellness by:
    a. Knowing their serological and infectious status.
    b. Being appropriately immunized.
    c. Following up-to-date guidance on BBV self-testing frequencies according to level of risk.
    d. Testing for BBV whenever an exposure occurs.
4. Midwives comply with current organizational, provincial, and national authorities' guidance regarding:
    a. Preventing BBV transmission.
    b. Mitigating the risks of BBV transmission.
    c. BBV exposure management.
    d. Reporting obligations, including to the client, should an accidental BBV exposure occur.
5. Midwives who test positive for a BBV must:
    a. Consult with an expert in infectious diseases when appropriate.
    b. Seek advice on how to reduce the risk of transmission in their midwifery practice.

c. Take appropriate measures to prevent transmission to clients.

d. Only perform or assist to perform **exposure-prone procedures** when their health and viral loads make it safe.

Glossary

Blood-borne virus (BBV): virus carried in the blood that can be spread from one person to another, such as hepatitis B virus (HBV), hepatitis C virus (HCV), and/or human immunodeficiency virus (HIV). The pathogen can be transmitted through contact with blood or, in some situations, other body fluids.

Exposure-prone procedures (EPPs): invasive procedures that have a higher-than-average risk of injury to the midwife that may expose the client to the midwife's blood or vice versa. EPPs include when a midwife's fingers and a needle or other sharp instrument are in a difficult-to-visualize or highly confined anatomic site, such as vaginal laceration repair with hand-guided sharps.

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ETHICS STANDARD

Midwives: Code of Ethics

Introduction

The BC College of Nurses and Midwives' *Code of Ethics* is founded in and affirms the core values of midwifery. It articulates the ethical responsibilities of a midwife, in order to guide their professional practice and conduct in all situations.

Midwives are bound to this code as part of a regulatory process that serves in the interest of public safety.

Standards

PROFESSIONAL PRACTICE

1. The midwife's primary responsibility is to safeguard the well-being of the client and their newborn. To do so, the midwife:

    a) Accepts and provides care to each client without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not preclude instances where a midwife may reasonably refuse a client (such as where there are safety concerns, caseload, geographic or scope constraints).

    b) Uses their knowledge, judgment and expertise to provide a high standard of midwifery care which respects individuals' needs, values and dignity.

    c) Consults and/or transfers care in accordance with the standards and as necessary when a client's needs exceed the midwife's professional expertise or scope of practice.

    d) Promotes physiologic birth and birth close to home within the context of safe clinical practice and client choice.

    e) Ensures that no act or omission within their sphere of influence places a client at risk.

    f) Does not compromise care for reasons of personal or institutional expedience.

    g) Does not abandon a client in labour.

h) Does not practice midwifery while their ability to do so is impaired.

i) Acts in accordance with relevant legislation and the bylaws, standards and policies of their regulatory body.

RELATIONSHIPS AND ACCOUNTABILITY

2. The midwife develops a relationship of trust and partnership with the client. To do so, the midwife:

a) Informs the client of the scope and limitations of their midwifery practice.

b) Respects, upholds and practices informed choice and consent, leading to an evolving plan of care, in order to ensure the client's acceptance of responsibility for the outcomes of their choices.

c) Respects the autonomy and rights of each client to make decisions about their care that the client determines is in their best interest.

d) Advocates for the client.

e) May respectfully choose to not provide care to which they conscientiously object; however, the emphasis on individual conscience should not deprive anyone of essential health services.

f) Informs the client if for any reason the midwife is unable to provide care and assists the client in finding a suitable alternate care provider.

g) Does not abuse the privileged midwife-client relationship.

h) Recognizes the inherent power imbalance that exists within the midwife-client relationship and takes care to not take advantage of this imbalance for any reason.

i) Collects, uses and discloses only as much health information as necessary; shares information only to benefit the client and only with those within the client's circle of care.

j) Refrains from disclosing confidential information about a client without the consent of the client or the client's authorized representative, except where disclosure is required or authorized by the law.

k) Provides midwifery care to each client until time of discharge, care is no longer wanted, or care has been terminated with appropriate notice.

l) Commits to collaborative and respectful relationships with Indigenous clients through efforts to understand and implement the recommendations relevant to health care made in the report *Truth and Reconciliation Commission of Canada: Calls to Action*.

KNOWLEDGE, COMPETENCY AND LEARNING

3. The midwife maintains and facilitates safe and competent midwifery practice in all environment and cultures. To do so, the midwife:

a) Uses up-to-date, evidence-based professional knowledge and continuous professional development to maintain their own competence.

b) Facilitates ethical research in practice.

c) Assists learners, including students and colleagues, to develop and maintain professional competence.

d) Works with policy and funding agencies to define needs for health services and to ensure that resources are fairly allocated considering priorities and availability.

CONDUCT

4. **Midwives act as effective role models by maintaining both professional and ethical conduct. Midwives should not engage in any activity that would adversely affect the honour, dignity, or credibility of the profession. To do so, the midwife:**

    a) Interacts respectfully and honestly with the people with whom they work and practice.

    b) Builds a professional reputation based on their ability and integrity and advertises professional services only in a manner that upholds the dignity of the profession.

    c) Does not take advantage of publicly funded programs for personal financial gain.

    d) Does not use professional qualifications in the promotion of commercial products.

    e) Does not accept any gift, favour or hospitality which might be reasonably seen to create a conflict of interest.

    f) Is responsive in their communication and compliance with the requirements of their regulatory and professional bodies.

    g) Treats all colleagues, regardless of health care discipline or training, with respect.

    h) Recognizes the contribution and expertise of colleagues from other health care disciplines.

    i) Recognizes human interdependence within their field of practice and seeks to resolve inherent conflicts.

    j) Values their own personal health and wellness and takes steps to optimize meaningful co-existence of their professional and personal life.

    k) Supports and sustains other midwives in their professional roles, and actively nurtures their own and others' sense of self-worth.

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PRACTICE STANDARD

Midwives: Postpartum care

Introduction

The postpartum period is a critical time for the physical, emotional, and social well-being of the newborn and family. The intention of postpartum care is to promote optimal health for the newborn, mother, and family in both the short and long term, and to help prevent issues such as hospital readmissions or adverse outcomes. Typically, midwives offer postpartum care for up to six weeks following birth.

Standards

1. Midwives are expected to provide comprehensive care throughout the postpartum period, including a regular schedule of postpartum visits and 24-hour on call availability. Midwifery care in the postpartum period includes:
    a. Assessing maternal physical well-being, self-care and overall functioning during the postpartum period, and providing preventive care and advice;
    b. Assessing the physical well-being and development of the newborn;
    c. Conducting, collecting and/or referring for standard newborn screening tests in accordance with provincial guidelines, community standards and client choice
    d. Supporting the initiation and continuation of infant feeding, including interventions, complementary therapies or supplemental feeding as required, to ensure newborn well-being;
    e. Providing support, information and resources to the family regarding newborn care, growth, development, behaviour, nutrition, feeding and immunizations;
    f. Detecting complications and disease and arranging appropriate referral when required;
    g. Assessing mental and emotional well-being, in particular assessing for the occurrence and severity of postpartum depression; and arranging timely and appropriate referral when needed;
    h. Supporting the family in their sense of competence in parenting and in adopting healthy lifestyles;
    i. Counseling the family on issues such as nutrition, sexuality in the postpartum period and in the choice and use of contraceptive methods;
    j. Assessing need for and referral to various community resources.

2. In the immediate postpartum period, the midwife should remain in attendance until maternal and newborn well-being and stability are assured.
3. When coordinating ongoing postpartum visits, the midwife must take into account the clinical situation, antepartum history, intrapartum history, the socioeconomic, cultural, psychological and environmental circumstances, and as such should tailor visits to the needs of the individual family.
4. The midwife establishes a discharge plan with appropriate, community-based health care providers to ensure care is available when needed.
5. The midwife transfers care to another primary care provider if the midwife is unable to complete a full six-week course of postpartum care.
6. At discharge, the midwife provides copies of pertinent records to the client and appropriate primary health care provider.

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ETHICS STANDARD

Midwives: Professional Standards

Introduction

Midwives in British Columbia are autonomous health care professionals who provide perinatal and newborn care. The midwifery model is grounded in a holistic and evidence-informed approach that views pregnancy and childbirth as normal physiologic processes. Central to this model are the principles of continuity of care, informed choice, collaborative practice, and respect for clients as primary decision-makers. Midwives in BC practice across a range of settings and in partnership with clients, supporting families throughout the reproductive journey with dignity and respect.

The British Columbia College of Nurses and Midwives (BCCNM) holds registrants to the following standards to ensure safe and consistent practice and conduct within the midwifery scope in British Columbia.

Standards

1. **The midwife is an autonomous primary care provider within midwives' scope of practice.**

   The midwife:

   a. complies with all relevant legislation, BCCNM standards, limits and conditions, and BCCNM policies and bylaws;

   b. practises within scope;

   c. takes full responsibility for the care provided; and

   d. works cooperatively and collaboratively with other health care professionals and consults, refers, or transfers care when the client's care needs are beyond the midwife's scope of practice and/or it is in the client's best interest.

2. **The midwife is accountable to the client, the midwifery profession and the public for safe, competent and ethical care.**

   The midwife:

   a. conducts themselves professionally and with integrity at all times, and never in a way that puts the profession of midwifery in disrepute;

   b. ensures that the results from all tests, treatments, consultations and referrals are followed

up and acted upon in a timely manner;

c. never abandons a client in labour;

d. disclosures appropriate information to the client related to any harm or injury they experience while receiving midwifery care;

e. informs the client as to complaint and review procedures established under the *Act* and the bylaws;

f. participates in mortality and morbidity reporting and review processes as required; and

g. complies with the quality assurance program as established by BCCNM.

3. **The midwife works in partnership with the client recognising individual and shared responsibilities.**

   The midwife:

   a. develops a plan for care together with the client;

   b. discusses the scope of midwifery care with the client;

   c. involves the client's family accordingly;

   d. respects the client's value system; and

   e. practises in a culturally safe and competent manner.

4. **The midwife upholds the client's right to informed choice and consent.**

   The midwife:

   a. shares relevant information with clients in a non-authoritarian, cooperative manner;

   b. recognizes the client as the primary decision maker in their care;

   c. encourages clients to actively participate in care and to make informed choices;

   d. advocates for clients within their scope;

   e. respects the client's right to accept or decline treatments or procedures; and

   f. advises the client of their professional standards and recommendations with respect to safe care.

5. **The midwife provides continuity of care to the client.**

   The midwife:

   a. provides comprehensive care during pregnancy, labour, birth, and postpartum;

   b. either individually or within an established group, provides care with 24 hour on-call availability;

   c. either individually or within an established group, maintains a coordinated approach to clinical practice;

   d. ensures, within reason, that care is provided by a midwife or small group of health

professionals who are known to the client;

e. informs every client early in care of their on-call schedule and how care is organized and provided within their practice; and

f. endeavours to develop a relationship of therapeutic trust with each client.

6. **The midwife respects the client's right to make informed choices about the setting for birth and shall provide care in all appropriate settings.**

   The midwife:

   a. provides the client with the required information as the clinical situation evolves, including that related to safety, to make an informed choice about appropriate settings in which to give birth;

   b. provides care in a variety of settings including hospitals, homes and alternate community-based locations;

   c. ensures a safe environment in which to give birth; and

   d. notifies the appropriate agencies when any safety concerns arise.

7. **The midwife ensures that no act or omission places the client at unnecessary risk.**

   The midwife:

   a. follows current evidence and up to date clinical guidance;

   b. uses their knowledge, skills and judgement as well as local policies and protocols to plan and implement care;

   c. provides ongoing assessment and modifies planned care as required;

   d. responds promptly and appropriately to emergency situations;

   e. maintains access to appropriate equipment and supplies;

   f. recognizes when their ability to provide safe care is impaired due to factors such as fatigue, stress or illness, and refers the client to another health professional if available; and

   g. always complies with up-to-date guidance regarding infection prevention and control in all settings and takes additional precautions when routine practices are insufficient to prevent infection transmission.

8. **The midwife maintains complete and accurate health care records.**

   The midwife:

   a. uses records that facilitate accurate communication of information to and from consultants and institutions;

   b. reviews and updates records at each clinical contact with the client;

   c. ensures prompt review and entry of screening and diagnostic test results, treatments and

consultations into health care records;

d. ensures that records are legible, signed and dated;

e. documents decisions and professional actions;

f. documents informed choice discussions and recommendations;

g. documents errors, incidents and complaints, reports to the appropriate authorities and initiates restorative actions;

h. documents contemporaneously; and

i. refers to the BCCNM bylaws for additional requirements regarding client records.

9. **The midwife ensures confidentiality of information except with the client's consent, or as required to be disclosed by law, or in extraordinary circumstances where the failure to disclose will result in immediate and grave harm to the client.**

   The midwife:

   a. maintains, stores and disposes of records in accordance with the law; and

   b. maintains, stores and disposes of records in a manner that protects the confidentiality of information.

10. **The midwife participates in ongoing education and evaluation of self, colleagues, and the community.**

    The midwife:

    a. involves the client in evaluating midwifery practice and integrates the results of evaluation into practice;

    b. adjusts clinical practice after review of current literature and appropriate education or training;

    c. shares knowledge with colleagues and students and assists in developing mechanisms to promote this sharing; and

    d. maintains current knowledge of academic and professional research based on developments that are directly related to midwifery practice.

11. **The midwife critically assesses research findings for use in practice and supports research activities.**

    The midwife:

    a. complies with the BCCNM bylaws when engaged in any research activities;

    b. identifies areas for research, shares research findings and incorporates these appropriately into practice; and

    c. ensures that the research in which midwives participate meets acceptable standards of research methodology and design and is consistent with BCCNM's *Code of Ethics*.

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PRACTICE STANDARD

Midwives: Practice protocols

Introduction

A practice protocol is a written plan that explains how client care is coordinated. It describes how the practice manages specific areas of care during pregnancy, birth, and postpartum. Protocols can be community specific and adopt guidance from evidence-based sources. They promote transparency, informed choice for clients, and consistency among midwives sharing care. Protocols must align with the Midwives Regulation, BCCNM bylaws, and BCCNM Standards, and should be based on current evidence.

Standards

1. Each practice is required to have the following written protocols:
    a. A protocol describing how care of clients and their newborns is coordinated in the practice. This practice protocol must include:
        i. a way for current information on each client to be communicated to the on-call midwife;
        ii. regular review of each client's chart to ensure that an appropriate schedule of visits is maintained and clinical concerns are followed up in a timely manner; and
        iii. a process for evaluating the system's effectiveness.
    b. Clear protocols around the use of social media in midwifery practice, and the use of email, fax and text message with regard to communication with clients and the sharing of client information.
    c. A protocol for outlining responsibility for confidential and secure record storage and retention. Records must be accessible to all midwives who were involved with the provision of care. This practice protocol must include:
        i. where and how original client records or unalterable copies of those records are securely stored;
        ii. how the midwife or the client can access or obtain a copy of those records;
        iii. how original records and/or copies will be made available to all midwives who provided care to the clients in the event of a midwife leaving the practice or the practice closing;

iv. in the event a midwife ceases to practice or resigns from practice, how records will be stored, shared and retained for the duration of the legal retention period;

v. an outline of any fee charging process.

2. Protocols should be accessible to all practice members, including locums, and to clients upon request, reviewed regularly to ensure currency, and revised as necessary using available evidence, relevant community standards and client feedback.

3. Practices should maintain a written record of the protocols that are or have been followed by the practice for at least the previous five years. Any of the following systems is acceptable:

    a. A record of protocols that includes the date that each protocol came into effect within the practice, or

    b. A list of protocols, along with the dates that they were in effect within the practice, and an indication of where the protocol is located.

4. Practice protocols should be reviewed at least every three years to ensure compliance with best practices.