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Outline of ICN Guidelines on Prescriptive Authority for Nurses

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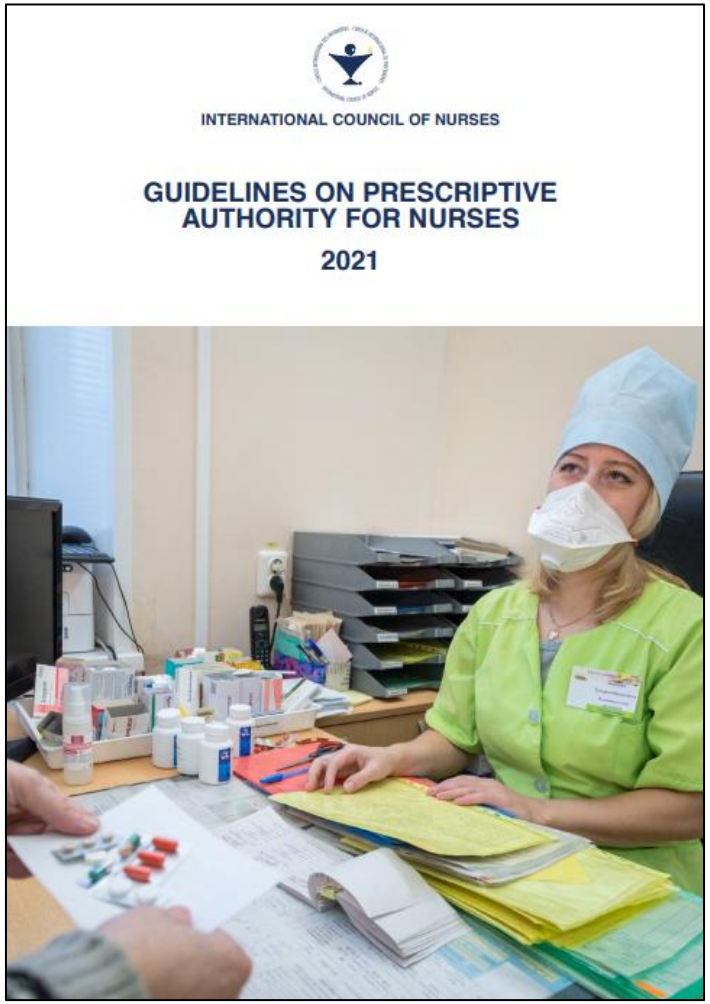
ICN published Guidelines on Prescriptive Authority for Nurses in 2021



<u>Purpose of these guidelines</u>

- to facilitate a common understanding of nurse prescribing
- to inform policymakers, educators, regulators, healthcare planners, nurses, and other healthcare professionals.

The emphasis is on common principles and best practice as prescriptive authority for nurses becomes an increasingly important component of their scope of practice and role contributions to support health.

The Guidelines recognise the diversity that currently defines nurse prescribing by describing current practice and nurse prescribing models globally.

https://www.icn.ch/sites/default/files/2023-04/ICN_Nurse_prescribing_guidelines_EN.pdf

Nurse prescribing models globally

- Dependent prescribing (Supplementary)
  - Partnership between an independent prescriber and a supplementary prescriber. The independent prescriber carries out the initial assessment and diagnosis; the supplementary prescriber prescribes from an open or limited formulary and consults with the independent prescriber before issuing the prescription.
- Prescribing by Protocol

Prescribing via a structured prescribing arrangement

- Designed for a specific group of patients who have a particular condition; medications are only provided within the terms of a pre-determined protocol. Prescribing via a structured prescribing arrangement is not considered independent prescribing but may be considered a form of supplementary prescribing (Abuzour, Lewis & Tully et al., 2018; Kroezen et al., 2011a; Gielen et al. 2014 cited by ICN 2021)

Independent Prescribing

- Legally permitted '*having the authority*' and qualified 'specifically *educated*' independent prescribers are responsible for the clinical assessment of a patient, the establishment of a diagnosis and decisions about the appropriateness of a medication, treatment or appliance, including the issuing of a prescription. Based on the country context, prescribing can take place from a limited or open formulary. Independent prescribing is also called initial, autonomous, substitutive and open prescribing (Abuzour, Lewis & Tully 2018; Kroezen et al. 2011a cited by ICN 2021).

Nurse prescribing

- Not a task but a level of authority that enables nurse clinical decision making and autonomy in patient care
  - Includes prescription of medicinal products
  - Non-medicinal products
  - Ionizing radiation
- The registered nurse prescriber initiates the treatment decision in discussion with and agreement with the person/service user (and/or carer, if applicable), providing a comprehensive description of the treatment prescribed including expectations of treatment and side-effects if any (Nurse and Midwifery Board of Ireland, 2020)

Authority

Nurses must have been given the Authority to prescribe ‘prescriptive authority’

Irish context:

Before registration in the Nurse Prescribers Division of the NMBI Register, the name must already be entered in the General, Psychiatric, Children’s, Intellectual Disability, Midwife or Public Health Nurse Divisions of the Register.

The Applicant must have three years recent post registration clinical experience (this must be within the past 5 years)

There should be demonstrable evidence of further education and the nurse/midwife should possess a competent level of information technology literacy.

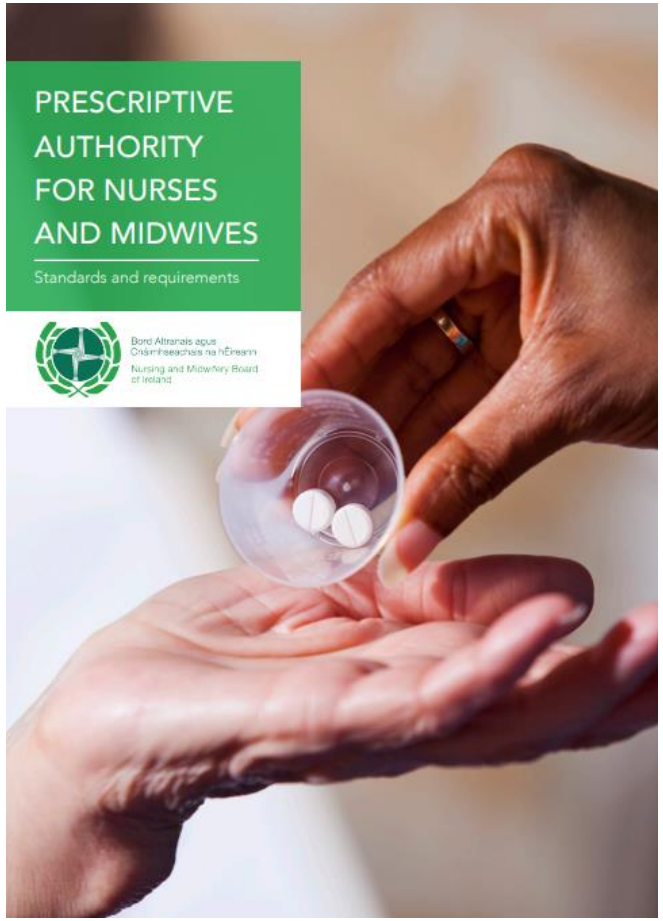
Education

Accredited programme of nurse prescribing

Content related to:

Professional Accountability and Responsibility

- Professional regulations and guidelines
- Accountability and responsibility for prescribing practice
- Critical review & self audit
- Reflective practice
- Risk management in medication management
- Public health issues for prescribing
- Evidence-based practice and clinical governance in relation to prescribing



https://www.nmbi.ie/NMBI/media/NMBI/Prescrptive-Authority-for-Nurses-and-Midwives.pdf?ext=.pdf

Legal and Ethical Aspects

- Legislation for Nursing/Midwifery Practice and Medication Management
- Legal liability and clinical indemnity for prescribing and expansion of nursing/midwifery practice
- Informed consent of patient/client for treatment
- Awareness and reporting of fraud
- Substance abuse/dependence
- Budgetary considerations (e.g. HSE National Shared Services Primary Care Reimbursement Service/ medical card)
- Licensing of medicinal products
- Ethics and prescribing
- Documentation requirements of prescribing

Pharmacology and Pharmacotherapeutics

- Pharmacotherapeutics, Pharmacodynamics, Pharmacokinetics
- Pharmacovigilance
- Process for identification and treatment of adverse reactions and interactions
- Medication error/near miss reporting – organisational policy
- Prescribing for special populations - the elderly, the young, pregnant or breast-feeding women, the intellectually disabled and those with mental illness
- Pharmacoeconomics (cost vs. benefit ratio)
- Influences on and psychology of prescribing
- Applied Biosciences to prescribing practice

Principles of the prescribing process

- Steps of prescribing process
- Assessment of patient/client – history and physical examination
- Requesting and interpretation of laboratory and diagnostic tests
- Consultation skills

1. Awareness of cultural and ethnic diversity of patient/client/family
2. Awareness of patient/client expectation for prescription medicinal products
3. Knowledge and skills for decision-making and treatment planning
4. Diagnostic reasoning – data synthesis
5. Risk vs. benefit ratio in treatment decisions
6. Use of non-pharmacological interventions in care plan

Conclusion

- ICN position paper on nurse prescribing
- Prescribing related sessions in Nashville – there will be presentations related to prescribing, regulation, accreditation, policy work that would be applicable and helpful to all those trying to advance nurse prescriptive authority in their country..
- There will be great opportunities for networking in this area also

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Advanced Practice Nursing & Prescriptive Authority across Europe

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- Presented by Caroline Bohlender

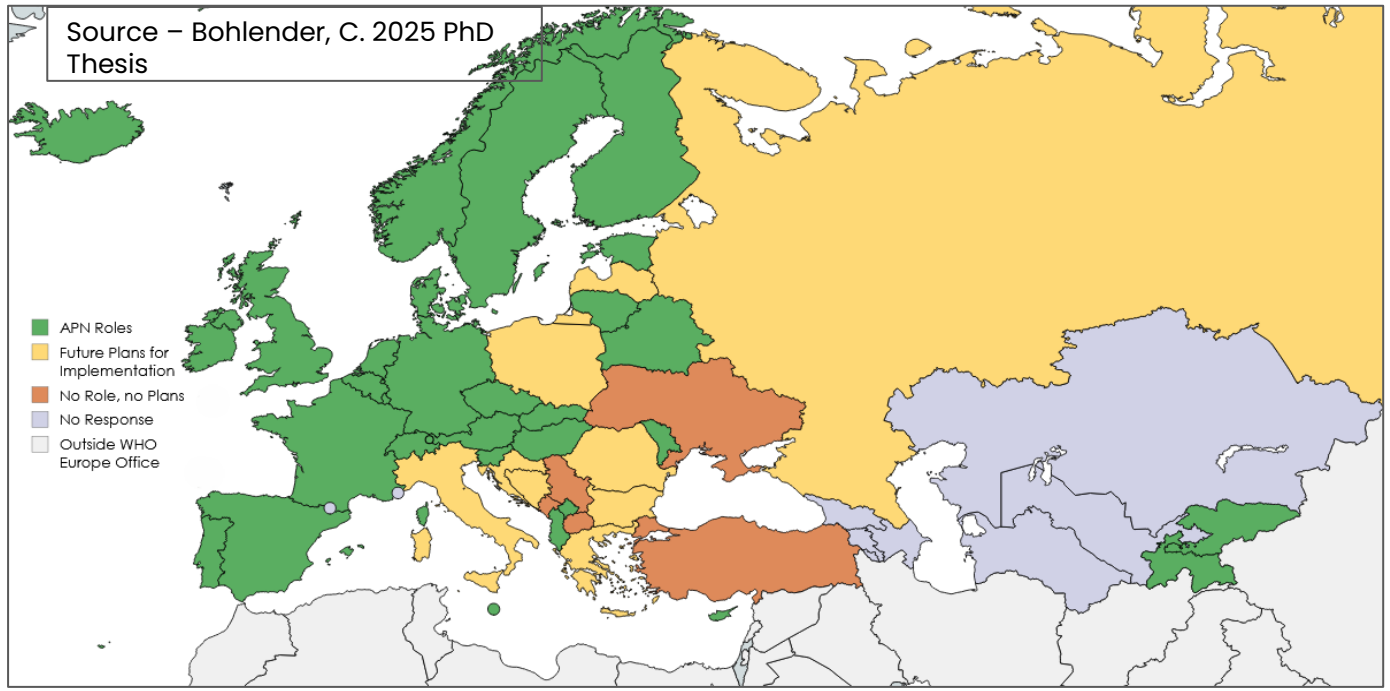
Without Regulation, There Can Be No Protection — And Without Protection, There Can Be No Trust

Professional Regulation, Prescribing Authority and the Case for Trust

Setting the Scene

Why This Matters Now

- Europe faces a deepening healthcare workforce crisis
- Advanced Practice Nurses (APNs) are an established solution — present in over half of European countries



- Nurse prescribing is central to full practice authority (FPA) — the most impactful level of APN development but often missing from APN scope of practice

The Safety-Critical Argument

Why prescribing demands a higher standard

- Nurse prescribing is not routine nursing — it operates in safety-critical territory
- Clinical diagnosis and medicine prescribing carry serious consequences if standards fall
- 49 of 53 European nursing regulators hold a mandate for public protection
- High-risk tasks require defined competency standards to manage risk
- Healthcare must be viewed through a safety-critical lens — not just a service delivery one

The Trust Problem

What happens without regulation

- Unregulated growth creates role variation
- Managers cannot determine what an APN was qualified to do
- Patients don't know who was treating them or to what standard
- Medical colleagues can’t verify competence
- Without a regulatory framework, trust has nothing to anchor against
- *"If you cannot define the role, you cannot regulate it — and if you cannot regulate it, you cannot trust it"*

Palmer, W. Julian, S. Vaughan, L. (2023). *Independent report on the regulation of advanced practice in nursing and midwifery.* N. Trust.

Regulation as a Bridge to Trust

How standards create confidence

- **Educational standards** — establish a verifiable, consistent baseline of competence
- **Registration** — makes the role visible, recognizable and legally accountable
- **Title protection** — signals to every patient and colleague what an APN is qualified to do
- **Revalidation** — provides ongoing assurance that standards are maintained throughout a career
- Together these mechanisms transform prescribing from a contested boundary into a trusted clinical tool

The Evidence: Regulation in Action

Ireland and the Netherlands

Ireland

- Successive policy from 2014–2017 established legal framework
- NMBI regulates APNs with defined educational standards
- Dual register — APNs and non-medical prescribers
- Prescribing integral to APN qualification
- Opposition now reported in past tense — trust established

The Netherlands

- 2012 decree + 2018 permanent legislation enabled independent prescribing
- BIG register — multidisciplinary, procedure-based, not profession-based
- APNs and physicians held to comparable regulatory standards
- Government department directly oversees regulation
- Waiting lists for training — demand exceeds funded places

The Barriers That Remain

Where regulation is still failing prescribing

- Legal barriers — many countries still ring-fence prescribing to the medical profession
- Financial barriers — training funding gaps limit APN workforce expansion
- Organisational barriers — systems still designed around physician-centric workflows
- Attitudinal barriers — traditional hierarchies persist, particularly where regulation is weak
- Regional fragmentation — devolved systems prevent national standardisation (UK, Switzerland, Germany)

The Core Logic

From Safety to Trust to Impact

Safety Standards
Regulation defines what is required to prescribe safely

Consistency
Every APN meets the same verified threshold

Familiarity
Stakeholders understand what APNs are qualified to do

Trust
Confidence is established in patients, colleagues and managers

Full Practice Authority
Autonomous prescribing is legally and professionally supported

Patient Impact
Better outcomes, improved access, cost-effective care

Dankers-de Mari, E. J. C. M., Thijssen, M. C. E., Van Hees, S. G. M., Albertus, J., Batenburg, R., Jeurissen, P. P. T., & Van Vught, A. J. A. H. (2023). How does government policy influence the employment and training of nurse practitioners and physician assistants? A realist analysis using qualitative interviews. Journal of Advanced Nursing, 79(7), 2553-2567.

What needs to happen

Recommendations for Policy and Practice

- Governments must remove legal barriers to prescribing — only legislation can achieve this
- Regulation must be mandatory, not voluntary — voluntary frameworks leave variation unresolved
- Previously outlined regulatory mechanisms established — Educational standards, Title protection, Revalidation
- **Nurses must be represented at policy-making level** — implementation without voice is unsustainable

Conclusion

Regulation is not the Obstacle but an Answer

- Nurse prescribing is clinically evidenced, economically justified and workforce-essential
- But prescribing without regulation is a liability — for patients, for practitioners, for the system
- Regulation essential part of conditions needed for trust and sustainability
- Trust enables the full practice authority that delivers real patient impact
- The countries that got this right did so through political will, early regulatory action and multi-stakeholder collaboration
- The countries still struggling share a commonality — the absence of that political commitment
- *"Prescribing rights without a regulatory framework is a liability. Prescribing rights within one is a solution."*

Final thought for future development

Regulation should follow risk.

But ***how*** much regulation — and of ***what*** — remains the open question.

OPTION A

Comprehensive, Profession-Based Regulation

Regulate the whole APN role — clinical skill, leadership, research and professional identity — not just individual tasks.

The argument: clinical competence, resilience and confidence could reduce risk more sustainably than task-controls alone.

Higher Investment

Broader Protection

OPTION B

Minimal, Targeted, Skill-Based Regulation

Regulate only the specific high-risk tasks — such as prescribing — and leave broader professional development outside the regulatory framework.

The argument: focused regulation avoids burden, reduces cost and is easier to implement consistently.

Lower barrier

Narrower scope

International practice shows no single consensus has emerged. The question is not whether to regulate — but whether minimal regulation is sufficient, or whether comprehensive regulation serves more effectively.

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Prescriptive Authority for Nurses Kenya's Perspectives in APN

[A tale of Contradictions and Catch-22]

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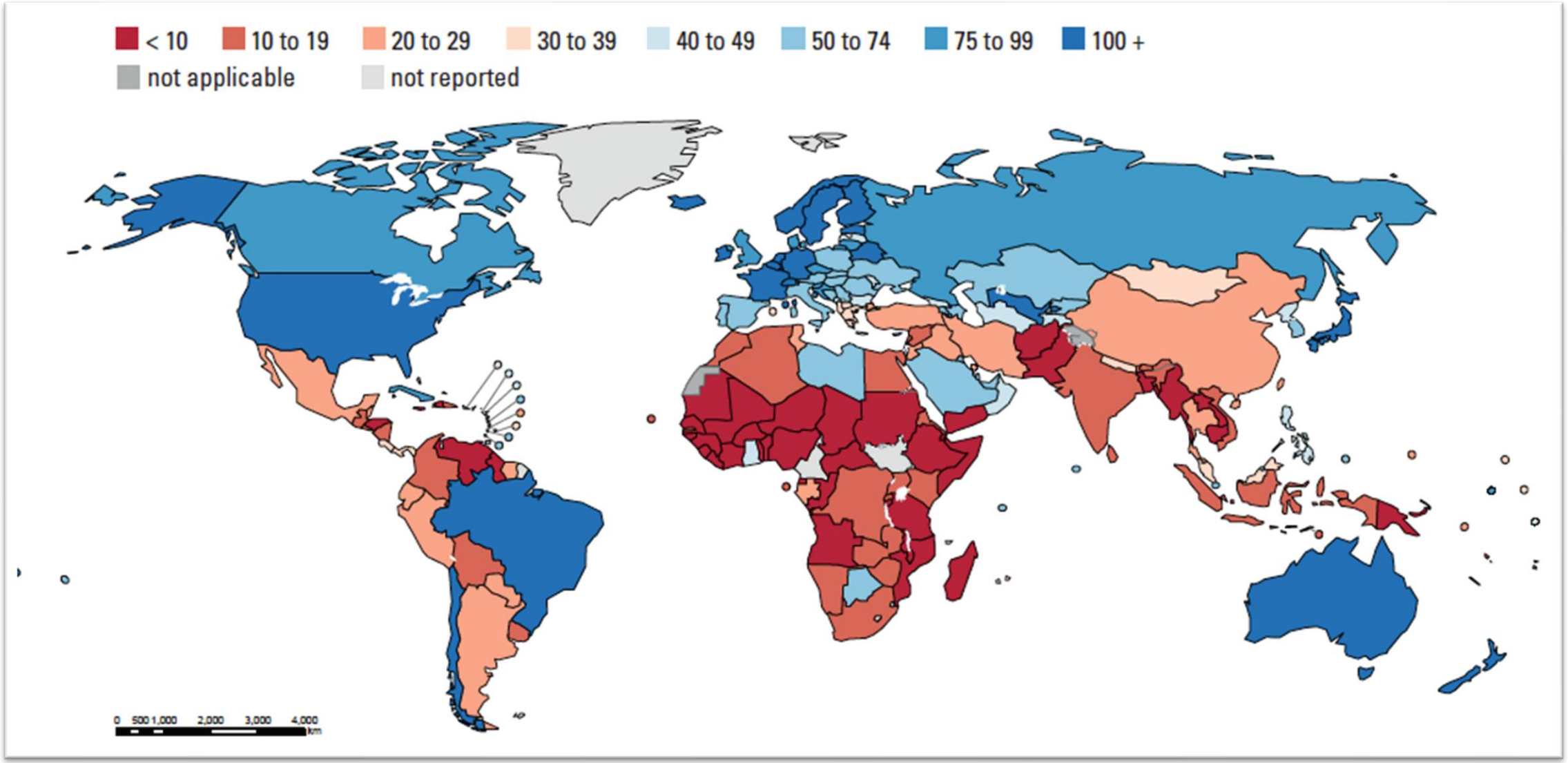
Global Context: Nurse Prescribing

- Nurse prescribing is a globally recognized practice
- ICN defines prescriptive authority as a core APN competency:
  - The legal right to prescribe medications, order diagnostics, and manage treatment plans
- Over 70 countries have some form of nurse prescribing, yet significant variation persists in scope, regulation, and legislative frameworks
- Global evidence confirms APNs deliver care comparable to physicians in primary and emergency settings (Htay & Whitehead, 2021)
- In Sub-Saharan Africa, nurses already perform advanced roles (diagnose, prescribe, treat) **but often without formal regulatory recognition or legal protection**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Kenya Health System Context

Kenya faces health workforce shortages and inequitable access to care.

Key realities:

- High demand for primary care services
- Rural health workforce shortages
- Increasing burden of chronic diseases

Strategic opportunity:

- Advanced Practice Nursing (APN)
- Task sharing and expanded scopes of practice

Prescriptive Authority: Where Do We Stand?

Legal and Regulatory Framework

Nursing practice in Kenya is governed by:

1. Nurses and Midwives Act (Cap 257)
    - Establishes regulation of nursing practice
2. Nursing Council of Kenya (NCK)
    - Licensing and regulation
3. National Scope of Practice for Nurses & Midwives

Prescriptive Authority: Where Do We Stand?

Current Reality

- Pharmacy and Poisons Act grants prescriptive authority only to medical practitioners, dentists, and veterinary surgeons
- Midwives may only "supply or dispense" — not independently prescribe
- APNs have no legal authority to prescribe despite advanced training
- Task-shifting without clear protocols in resource-constrained settings

The Consequence

- Nurses practice beyond legal frameworks, increasing medicolegal risk
- Brain drain: masters/PhD nurses move to academia/management due to lack of clinical career pathways
- Limited UHC gains
- Education and training gaps

Current Scope of Practice and Prescribing

Kenyan nursing scopes of practice allow:

- Administration of medicines
- Limited prescribing within defined roles
- Medication management in clinical settings

Practice governed by:

- NCK scope of practice
- Facility protocols
- National treatment guidelines

Formative Evidence on APN Prescriptive Authority

1. Gap Analysis

- Barriers: absence of regulation, opposition from medical profession, funding gaps, role confusion, and limited awareness

2. Stakeholder Perceptions

- APNs need autonomy, prescriptive authority, and enabling policies for diagnosis, prescription, and patient management

3. Delphi Consensus Study

- Experts achieved 96.6–100% consensus across 31 APN roles, including prescriptive authority, autonomous practice, and clinical leadership

Private Practice and Prescribing

Kenya allows licensed nurses to operate private clinics, regulated through the Nurses (Private Practice) Regulations.

Nurses engaged in private practice must:

- Obtain NCK practicing certificate
- Maintain essential drug supplies
- Record and monitor drug use
- Follow Pharmacy and Poisons Act

Opportunities for Prescriptive Authority

Opportunities

- Emergence of Advanced Practice Nursing
- Kenya Health Policy 2014–2030 and UHC agenda
- NCK Scope of Practice reform process already underway
- Growing ICN and global momentum for nurse prescriptive authority
- Robust research evidence & growing population needs

Expanding nurse prescribing could:

- Improve access to care
- Strengthen primary healthcare
- Support Universal Health Coverage
- Reduce physician workload

Challenges- Nurses Prescriptive Authority

Challenges

- Policy and legislative gaps
  - Pharmacy and Poisons Act excludes nurses from prescribing
- Physician resistance and interprofessional power dynamics
- County-level variation in implementation and deployment
- Limited mentorship and training programs
- Limited regulatory frameworks for APN prescribing
- Role ambiguity across professions
- **Nurses still prescribing**

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The Way Forward

Key priorities:

- Strengthen regulatory frameworks
- Define prescriptive authority for APNs
- Expand APN training programs
- Strengthen interprofessional collaboration
- Align with Universal Health Coverage goals

Kenya has the evidence, the expertise, and the policy window; what we need now is coordinated action.

1. **Amend the Pharmacy and Poisons Act** to formally grant prescriptive authority to qualified APNs/APMs
2. **Establish APN/APM licensing** within NCK with title protection and credentialing
3. **Gazette specialty-specific scopes** aligned with ICN guidelines with defined prescribing privileges
4. **Standardize education** at masters level with CUE-accredited programs and clinical practicum
5. **Deploy APNs/APMs across 47 counties** with standardized job descriptions and appropriate remuneration
6. **Build collaborative practice models** with mentorship, interprofessional teams, and monitoring frameworks

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Lessons from Singapore's Collaborative Prescribing Model

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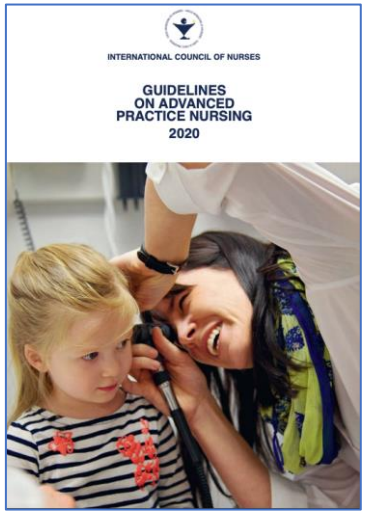
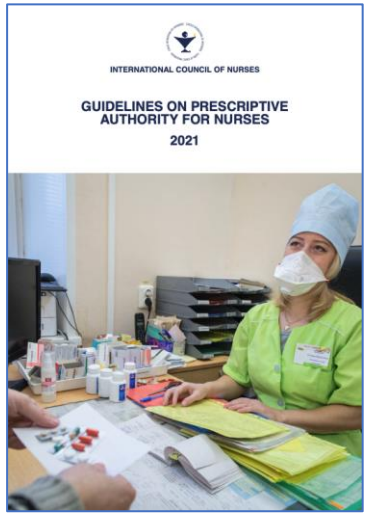
Why Nurse Prescribing Matters





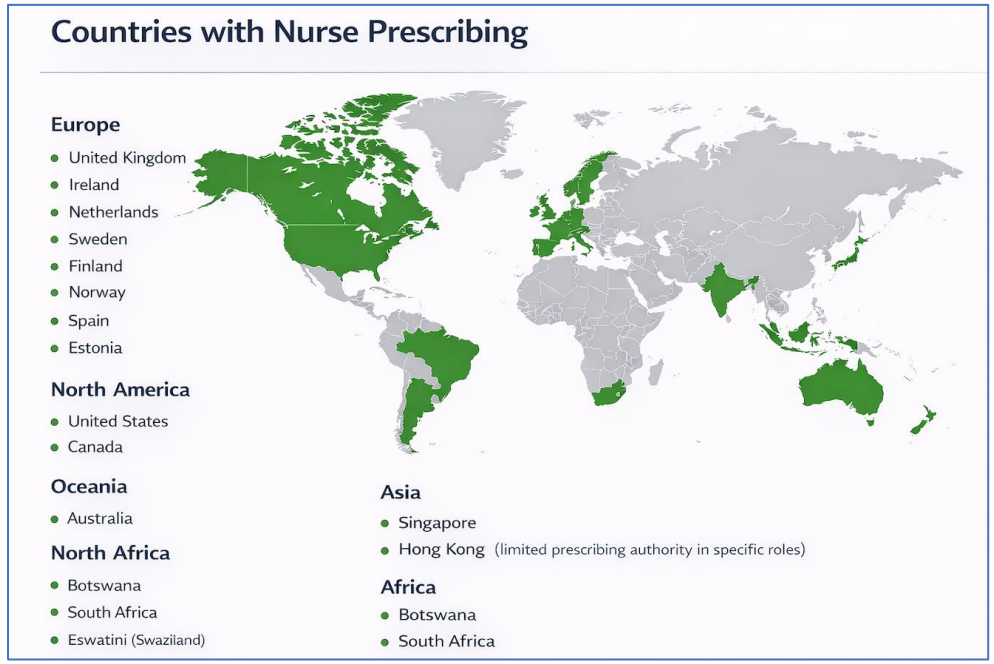
Global systems face increasing pressure:

- Aging populations and multimorbidity
- Shortage of physicians in many primary care systems
- Delays in treatment initiation
- Increasing complexity of medication management

ICN and WHO recognize advanced practice nurses (APNs) as critical to:

- Improving access to care
- Enhancing efficiency of health services
- Strengthening team-based healthcare
- Achieving better care outcomes

Global Development of Nurse Prescribing



Group of pharmacists, nurses certified to prescribe medicine

Participants also qualified to order tests but have to wait until their hospitals attain licence

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They are certified collaborative prescribing practitioners (clockwise from left, back row): Principal clinical pharmacist at National University Hospital Associate Professor Priscilla How; registered advanced practice nurse and senior lecturer at NUS Nursing Zhou Wentao; assistant director of nursing and APN at National Healthcare Group Polyclinics Carolyn Chan; APN at NUH Karen Koh and principal pharmacist (clinical) at Institute of Mental Health Ng Boon Tat.
PHOTO: LEE JIA WEN

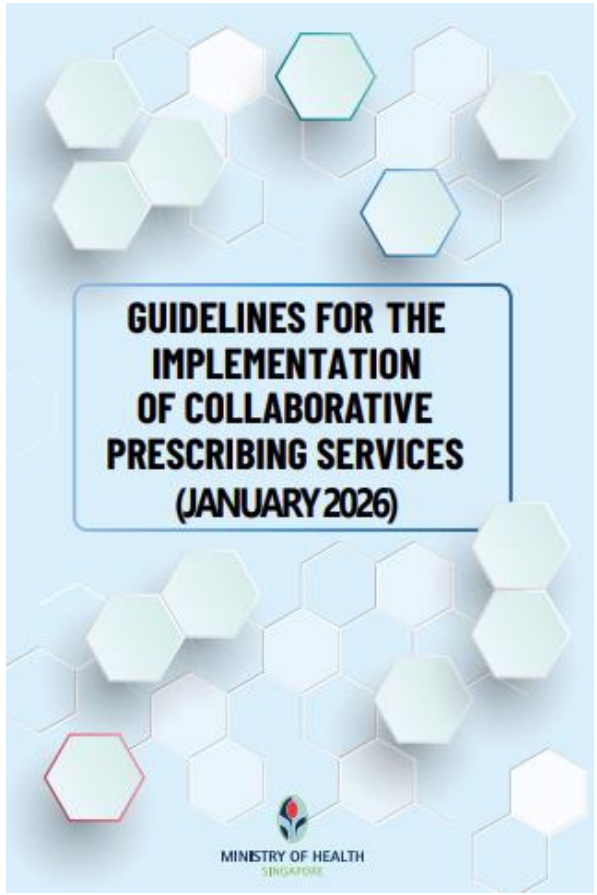
- In **Singapore**, Prescribing training established in 2018
- Only for **Advanced Practice Nurse (APN) and Pharmacist**

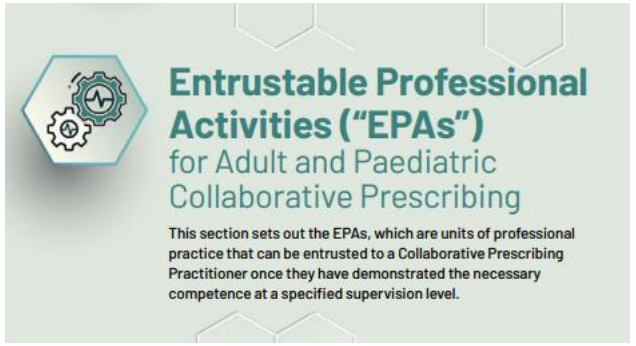
<u>Goals are to:</u>

- improve patient access
- optimise workforce utilisation
- strengthen advanced practice roles and practice on top of the licence

Singapore's Collaborative Prescribing Model

- Adopted a **structured collaborative prescribing model**
- Prescribing authority is supported by strong governance structures
- MOH Guidelines for implementation Collaborative Prescribing services detailed
  - Entrustable Professional Activities (EPAs)
  - Collaborative Prescribing Practice Guidelines
  - Collaborative Prescribing Clinical Governance Guideline





Prescribing Education and Credentialing in Singapore

Training Programme

The National Collaborative Prescribing Programme (NCPP)

Delivered by the NUS Yong Loo Lin School of Medicine, was integrated into the Master of Nursing programme in 2025.

Core Components

Core components include:

- Advanced pharmacology
- Clinical decision-making
- Legal and ethical prescribing
- Patient Safety & Medication Governance

Credentialing Requirements

- ✓ **Completion of** the training programme and passing the OSCE
- ✓ **80** hours of supervised clinical prescribing practice
- ✓ **Achievement of** the required clinical portfolio

✓ **Credentialed Collaborative** Prescriber

- Register with MOH
- Establish CPA
- CPA reviewed every 3 yearly

Collaborative Prescribing Practice Guidelines

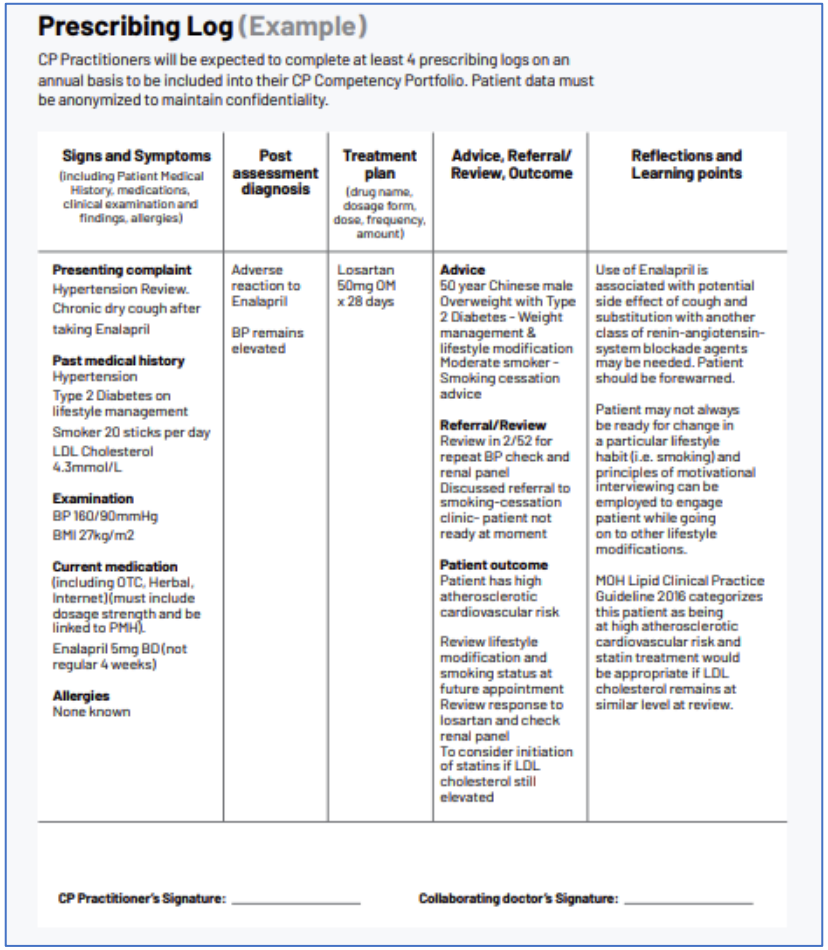
Prescribing is governed through a **Collaborative Practice Agreement (CPA)** with a supervising physician that defines:

- Patient groups and clinical conditions managed
- Approved drug formulary
- Scope of prescribing decisions
- Investigations and diagnostic tests permitted
- Referral and escalation criteria

Prescribing Governance and Safety

- Ensures prescribing is supported by **accountability and oversight**

- Key safeguards features are detailed:
  - Roles and responsibilities of the CP Practitioner
  - Roles and responsibilities of the Collaborating Medical Practitioner
  - Roles and responsibilities of the Employing institution
  - Institutional Collaborative Prescribing Governance
  - Credentialing Process
  - Disciplinary Management
  - Maintenance of Competency for CP Practitioners (Prescribing logs and CPE)



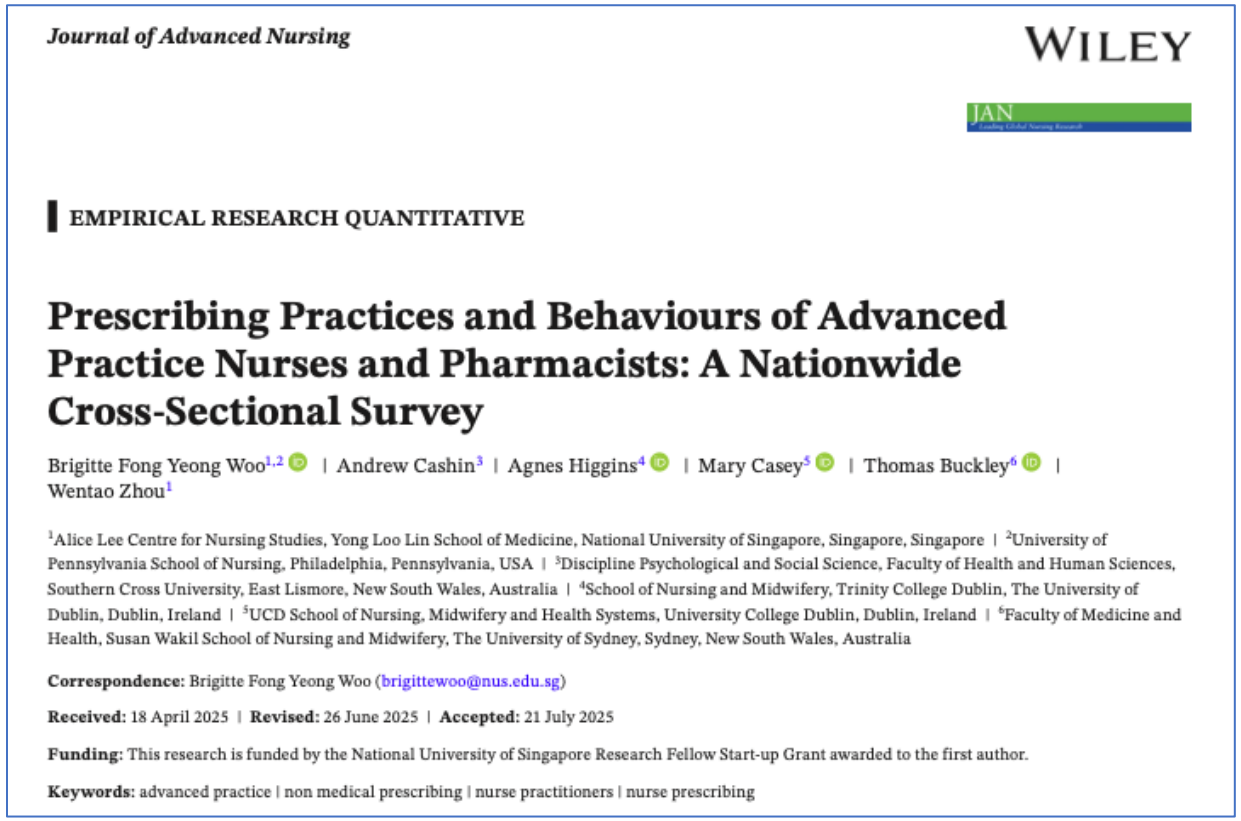
Prescribing Log (Example)

CP Practitioners will be expected to complete at least 4 prescribing logs on an annual basis to be included into their CP Competency Portfolio. Patient data must be anonymized to maintain confidentiality.

Signs and Symptoms (including Patient Medical History, medications, clinical examination and findings, allergies)	Post assessment diagnosis	Treatment plan (drug name, dosage form, dose, frequency, amount)	Advice, Referral/ Review, Outcome	Reflections and Learning points
Presenting complaint Hypertension Review. Chronic dry cough after taking Enalapril **Past medical history** Hypertension Type 2 Diabetes on lifestyle management Smoker 20 sticks per day LDL Cholesterol 4.3mmol/L **Examination** BP 160/90mmHg BMI 27kg/m2 **Current medication** (including OTC, Herbal, Internet)(must include dosage strength and be linked to PMH). Enalapril 5mg BD (not regular 4 weeks) **Allergies** None known	Adverse reaction to Enalapril BP remains elevated	Losartan 50mg OM x 28 days	**Advice** 50 year Chinese male Overweight with Type 2 Diabetes - Weight management & lifestyle modification Moderate smoker - Smoking cessation advice **Referral/Review** Review in 2/52 for repeat BP check and renal panel Discussed referral to smoking-cessation clinic- patient not ready at moment **Patient outcome** Patient has high atherosclerotic cardiovascular risk Review lifestyle modification and smoking status at future appointment Review response to losartan and check renal panel To consider initiation of statins if LDL cholesterol still elevated	Use of Enalapril is associated with potential side effect of cough and substitution with another class of renin-angiotensin-system blockade agents may be needed. Patient should be forewarned. Patient may not always be ready for change in a particular lifestyle habit (i.e. smoking) and principles of motivational interviewing can be employed to engage patient while going on to other lifestyle modifications. MOH Lipid Clinical Practice Guideline 2016 categorizes this patient as being at high atherosclerotic cardiovascular risk and statin treatment would be appropriate if LDL cholesterol remains at similar level at review.

CP Practitioner's Signature: _____ Collaborating doctor's Signature: _____

Evidence from National Research in Singapore



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EMPIRICAL RESEARCH QUANTITATIVE

Prescribing Practices and Behaviours of Advanced Practice Nurses and Pharmacists: A Nationwide Cross-Sectional Survey

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Keywords: advanced practice | non medical prescribing | nurse practitioners | nurse prescribing

Key findings:

- Prescribing constituted ~75% of clinical practice
- Most prescribing involved continuation of existing medications, with less time initiating new therapies
- Greatest confidence was seen in educating patients, legal prescribing, and monitoring treatment response
- Lower confidence was noted in complementary medicine- related tasks

Implications:

- consider a tiered, experience-based pathway toward greater prescriber autonomy
- Strengthen education and mentorship to improve confidence in deprescribing and medication adjustments.
- Ensure prescribers have access to high-quality clinical decision-support tools for evidence-based prescribing

Lessons for Successful Nurse Prescribing

Countries introducing nurse prescribing should consider:

- Clear regulatory frameworks
- Standardised education programmes
- Competency-based credentialing
- Clinical governance and safety monitoring
- Strong interdisciplinary collaboration

References

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Prescribing in North America

Dr. Karen Moore
Secretary
ICN NP/APN Network

International Council of Nurses
NP / APNN
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DNP, PhD, APRN, ANP-BC, CGNC, FNP-C, FAANP, FAAN
Professor; Director of D.N.P. Program, Coordinator of Global and Planetary Health
Trudy-Busch Valentine School of Nursing
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North America

Prescribing for nurses who are not Advanced Practice Nurses in the US and Canada:

- Generally limited to specific, often episodic, conditions, whereas NPs have a broader, autonomous scope of practice.
- May vary by role (e.g., public health), jurisdiction (e.g., state/province), and requires specialized education (e.g., prescribing coursework), and delegation/supervision.

North America

Advanced Practice Nursing in North America

- Long history - Over 60 years
- Key components of the Role
  - Advanced Education
  - Certification of Competence
  - Advanced Clinical Practice

Education

- MSN as minimum level
- Some will have a DNP (Doctor of Nursing Practice)
- Must have coursework in:
  - Advanced Health Assessment
  - Advanced Pathophysiology
  - Advanced Pharmacology

Prescribing

- Medications/Pharmaceuticals
- Durable Medical Equipment (devices, equipment)
- Specialist Care (Physical / Occupational Therapy)
- Radiologic procedures (Xray, CT, MRI)

Is Full Independent Prescribing Occurring in the US and Canada?

- YES and NO
- All NPs have been trained to provide full autonomous healthcare services for patients including prescribing
- All regions allow some level of prescribing
  - In addition to federal laws, States and Provinces have legislative authority over prescribing
  - Some provide full autonomy in prescribing
  - While others have more restrictive regulations

United States

NURSE PRACTITIONERS are the PROVIDERS OF CHOICE for MILLIONS OF AMERICANS.

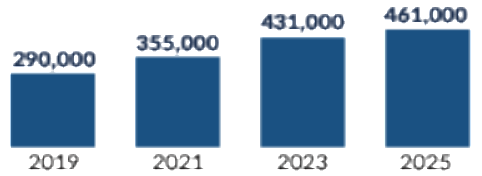
NPs evaluate, diagnose, write prescriptions and bring a comprehensive perspective to health care.

GROWING TO MEET HEALTH CARE NEEDS

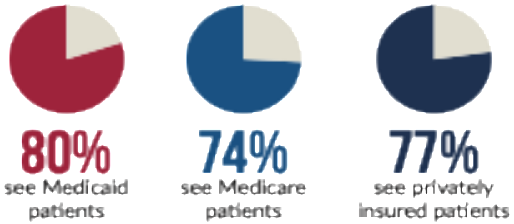
NPs are the **FASTEST-GROWING** primary care provider

461,000 SOLUTIONS
for addressing health care needs in the U.S.

NPs THROUGH THE YEARS



BROADENING ACCESS TO CARE



80% see Medicaid patients

74% see Medicare patients

77% see privately insured patients

NEARLY 1 BILLION
patient visits annually

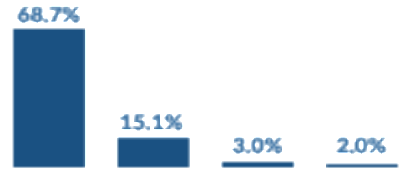
OVER 42%
of Medicare patients receive services from a nurse practitioner

EXCELLING IN EDUCATION

NPs typically complete at least **6+ YEARS** of undergraduate and graduate academic and clinical education

In 2024, approximately **87% OF NPs** were prepared in primary care

AREA OF PRIMARY CARE PREPARATION



Some NPs hold multiple primary care certifications.

MEETING PATIENTS WHERE THEY ARE

NPs hold prescriptive privileges, including controlled substances, in all **50 STATES AND D.C.**

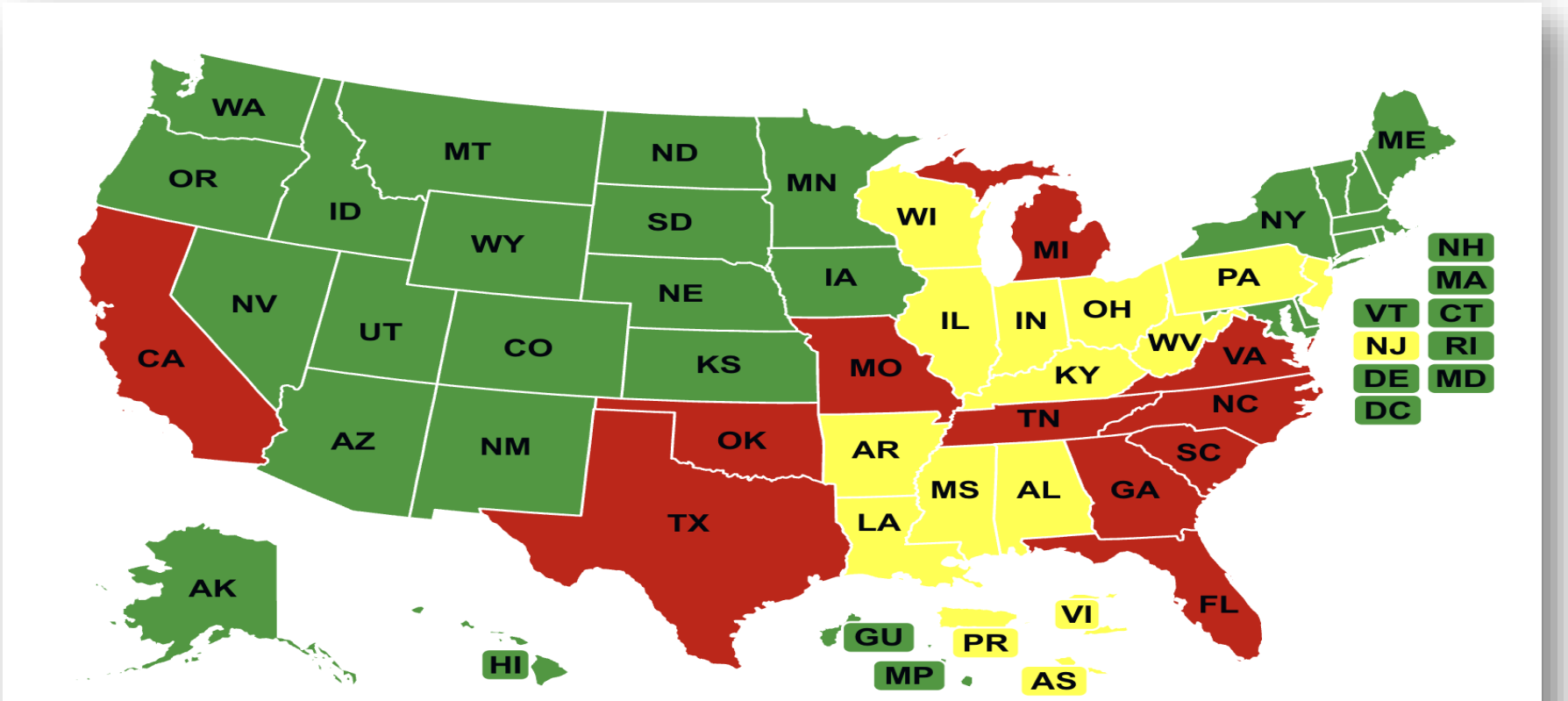
Nearly **3 OUT OF 4** patients support legislation for greater access to NP services

October 2025 | Sources: AANP National Nurse Practitioner Database, 2025; 2024 AANP Workforce Survey; 2024 AANP Omnibus Survey; and 2021 CMS Program Statistics

United States

Federal law governs prescribing of controlled substances

Schedule	Description	Examples
I	High potential for abuse No medically accepted use	Heroin, Ecstasy, LSD
II	High potential for abuse Potential for severe dependence Dangerous	Cocaine, Methamphetamine, Hydromorphone Meperidine, Oxycodone, Fentanyl, Adderall, Ritalin, Hydrocodone combo products (<15mg)
III	Moderate to low potential for abuse and dependence	Ketamine, anabolic steroids, testosterone, Codeine combo products (<90mg)
IV	Low potential for abuse and dependence	Xanax, Soma, Valium, Ativan, Ambien, Tramadol
V	Lower potential for abuse	Lomotil, Motofen, Lyrica, Cough preparations of codeine less than 200mg/100ml



Legend

- Full Practice
- Reduced Practice
- Restricted Practice

Nurse Practitioner Scope of Practice Canada 2024

	YK	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL	NT	NU
Independently autonomously care for patients	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Comprehensive advanced health assessment and diagnosis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Order & interpret diagnostic tests	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribe medication	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribe controlled drugs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribe medical marijuana	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribe medical supplies/devices	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Refer to other health professionals	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Assistance in Dying (MAID)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Biopsy, mole removal, cast, suture	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete disability forms	✓	✓	⊘	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete drive's health exam	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital admit/discharge	✗	✓	⊘	✓	✓	✓	⊘	✗	✓	✓	✓	✗	✗
Long-term care admit	✗	✓	✗	✓	✓	✓	⊘	✓	✓	✓	✓	✗	✓
Involuntary Mental Health Certificate	✗	✓	✓	⊘	✗	✗	✗	✗	✗	✗	✓	✗	✗

✓ No restriction ✗ Restriction ⊘ Partial restriction

Source: Nurse Practitioner Regulatory College scopes of practice and Provincial & Territorial Legislation/Regulation

Updated as of: October 19, 2024

Barriers and Encouragers

- Regardless of the years of NP practice, challenges will exist
- State/provincial/local regulations will need to be addressed
- Federal / Ministry of Health level of legislation as well
- Requires consistent advocacy, educational and practice expertise, vigilance for challenging certification and legislative issues.

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