



COLLEGE OF
REGISTERED NURSES
OF BRITISH COLUMBIA

Legislation Relevant to Nurses' Practice

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About this document

This document provides a general, non-exhaustive overview of various provincial and federal laws that may be relevant to the practice of registered nurses, licensed graduate nurses and nurse practitioners in British Columbia.

This document does not establish standards, limits or conditions for nurses' practice, or standards of professional ethics for nurses for the purposes of the Health Professions Act or CRNBC's bylaws. The information presented here is not comprehensive. You should not rely on this document as the complete text of the laws and regulations referred to in it, or as a complete statement of the law.

The information on each piece of legislation has been updated as of the date indicated beside the title of each Act. However, keep in mind that statutes and regulations may be amended at any time, and CRNBC makes no warranty or representation as to the currency, completeness or accuracy of any information contained here. Errors or omissions in this document do not affect nurses' legal obligations under any of the legislation referred to.

To better understand the practical application of the legislation reviewed in this document, you may wish to consult organizational policies and publications released by the responsible ministries and agencies. We encourage you to obtain legal advice, whenever appropriate, about the effect of any laws that are relevant to your practice.

Information that is particularly relevant to nurse practitioners is set off in a shaded box under each piece of legislation, where applicable. Further information for nurse practitioners is also included in a separate section at the end of this document, entitled "Additional Legislation Relevant to Nurse Practitioners' Practice."

For more information, contact CRNBC's Practice Support Service at 604.736.7331 (ext. 332) or 1.800.565.6505. A list of resources is on page 49.



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Legislation Relevant to Nurses' Practice

ACCESS TO ABORTION SERVICES ACT

Current to January 1, 2017

This Act authorizes abortion services. It creates “access zones” and restricts certain activities within those zones (e.g., harassment). Access zones include certain facilities that provide abortion services (prescribed by regulation), doctors’ offices, and residences of physicians and other service providers. A nurse¹ who helps provide abortion services is included in the definition of “service provider” under this Act and is protected by its provisions. Patients who receive abortion services and anyone who accompanies them for emotional support are also protected.

ADOPTION ACT

Current to January 1, 2017

This Act establishes who has care and custody of a child during various stages of the adoption process. Care and custody may be with the birth parent, the prospective adoptive parent, the director of adoption, or the administrator of an adoption agency. The person with care and custody of a child may authorize a health care provider to examine the child and consent to any necessary health care that the health care provider recommends. A health care provider is anyone who is licensed or registered to provide health care, including a nurse.

Note to Nurse Practitioners

Anyone applying to court for an adoption order relating to a child who is seven to 12 years old must arrange for a written report to be prepared on the child’s views about being adopted. The Adoption Regulation under this Act does **not** authorize nurse practitioners (or other nurses) to meet with a child to make such a report. The authority to make that report is limited to *psychiatrists, psychologists, social workers, and other persons approved for adoption work by the College of Social Workers*.

As well, nurse practitioners (and other nurses) are **not** authorized to provide a signed statement giving an opinion that an adopted person is incapable of managing his or her affairs in order to allow the parent or guardian to file a “veto” (to prevent the person from accessing birth registration or adoption records) or a “no-contact” declaration (to prevent contact by a birth parent). The parent or guardian must provide the Registrar General of Vital Statistics with signed statements of *independent opinions from two medical practitioners* for that purpose.

¹ “Nurse” in this document refers to the following CRNBC registrants: registered nurses, licensed graduate nurses and nurse practitioners.

ADULT GUARDIANSHIP ACT

Current to January 1, 2017

Support and Assistance for Abused and Neglected Adults

Part 3 of this Act provides for support and assistance for adults who are abused or neglected and who are unable to ask for help themselves because of a physical or mental handicap or other condition that affects their ability to make decisions.

Abuse means the deliberate mistreatment of an adult that causes physical, mental or emotional harm, or damage or loss with respect to the adult's financial affairs. Such mistreatment includes intimidation, humiliation, physical assault, sexual assault, over medication, withholding needed medication, censorship of mail, invasion or denial of privacy, and denial of access to visitors.

Neglect means failing to provide necessary care to an adult, resulting in serious physical, mental or emotional harm, or substantial damage or loss with respect to the adult's financial affairs within a short period of time. Neglect includes self-neglect.

Under this Act, it is not abuse or neglect for a representative or guardian to refuse health care for an adult if doing so follows the wishes the adult expressed while he or she was capable, even if refusing care results in death.

Anyone who has information about an adult who is abused or neglected and who is unable to ask for help may report the circumstances to an agency designated by the Public Guardian and Trustee. Designated agencies include the provincial health authorities, Providence Health Care and Community Living BC. In practice, those agencies may also require their own employees to make such reports. Anyone who makes such a report is protected by the Act.

Once a report has been made, the agency must determine whether the adult needs support and assistance. It does this by using the investigative powers granted under the Act, which include obtaining reports from health care providers who have examined the adult or from agencies that have provided health services to the adult. The agency may also provide emergency assistance without the adult's consent.

If a designated agency believes that someone has committed a criminal offence against an adult, the agency has a duty to notify the police.

Statutory Property Guardians

Part 2.1 of this Act and the Statutory Property Guardianship Regulation establish a framework for appointing the Public Guardian and Trustee to act as a "statutory property guardian" for adults who are unable to manage their financial affairs.

This framework includes a process for "qualified health care providers" to assess an adult's financial incapability. An assessment must include separate medical and functional components.

If an assessment determines that an adult is incapable of managing his or her financial affairs, the report of the assessment is reviewed by a person designated by a health authority. That person may

require further assessments and additional opinions before a certificate of financial incapability is issued.

An adult who has a statutory property guardian may also be entitled to a reassessment of financial incapability in the following situations:

- If the adult is to be discharged from a mental health facility (subject to certain exemptions under the Regulation)
- If the adult's statutory property guardian informs the applicable health authority that a reassessment should occur
- If the adult has not been reassessed within the previous 12 months, and asks for a reassessment
- If the court requires a reassessment.

The **medical component** of a financial incapability assessment (or reassessment) may only be conducted by a physician.

The **functional component** of a financial incapability assessment (or reassessment) may be conducted by the following "qualified health care providers":

- A physician
- A registered nurse, nurse practitioner, registered psychiatric nurse, occupational therapist, registered psychologist or social worker who meets conditions established by his or her regulatory college.

CRNBC has established standards, limits and conditions for registered nurses and nurse practitioners to conduct the functional component of a financial incapability assessment under the Statutory Property Guardianship Regulation. (See CRNBC's scope of practice standards documents for registered nurses and nurse practitioners.)

Right to Information

Qualified health care providers conducting assessments under Part 2.1, designated agencies, and the Public Guardian and Trustee have a right to all information necessary to enable them to perform their functions under the Act. This means that anyone who has custody or control of such information must disclose it for that purpose.

It is also an offence to obstruct a person who is conducting an investigation under Part 3.

ASSISTED HUMAN REPRODUCTION ACT (FEDERAL)

Current to December 31, 2016

This Act sets out a list of prohibited and controlled activities that relate to assisted human reproduction. Prohibited activities include:

- Paying for sperm, eggs or in vitro embryos

- Paying for the services of a surrogate mother
- Arranging for payment for the services of a surrogate mother
- Predetermining the sex of an embryo, except when it is done to prevent a sex-linked disease or genetic condition
- Using human reproductive material to create an embryo without the donor's written consent in accordance with the Assisted Human Reproduction (Section 8 Consent) Regulations

Anyone who engages in a prohibited activity under this Act is guilty of an offence and may be fined or imprisoned. In addition, the federal Minister of Health may notify a person's professional licensing or disciplinary body, such as CRNBC, of that person's identity if he or she is charged with an offence or there are reasonable grounds to believe that he or she may have breached any professional code of conduct.

CHILD, FAMILY AND COMMUNITY SERVICE ACT

Current to January 1, 2017

This Act protects the safety and well-being of children.

When a child is in temporary custody

When a child is in temporary custody of someone other than a parent, the person who has custody of the child is authorized to consent to health care for the child. In this case, the child's parent may retain the right to consent to health care if the court has ordered that right. Usually, where no special provision is made, the rules of consent in the Infants Act apply (see below).

When a child is in the director's care

The Director of Child Protection is a person designated by the Minister of Children and Family Development. The director may authorize a health care provider, including a nurse, to examine a child who is in the director's care. If the health care provider believes that the child needs immediate attention, the director may consent to the necessary health care for the child. In cases where a child or a child's parent refuses to consent to health care that two medical practitioners say is necessary to preserve the child's life, or to prevent serious or permanent impairment of the child's health, the court may authorize the health care.

Duty to report

Anyone who believes that a child needs protection is obligated to report this information to the director. The circumstances that require such a report include the following:

- If the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by a parent or other person
- If the child needs protection because he or she has been, or is likely to be, physically harmed because of neglect by the parent

- If the child is emotionally harmed by the parent's conduct, or by living in a situation where there is domestic violence
- If the child is not receiving necessary health care
- If the child's development is likely to be seriously impaired by a treatable condition and the parent refuses to provide or consent to treatment
- If adequate provision has not been made for the child's care in cases where the child has been abandoned, or if the parent is dead or is unable or unwilling to care for the child
- If the child is or has been absent from home in circumstances that endanger his or her safety or well-being

The Act protects a person from legal liability for reporting information about a child in need of protection, unless that person has acted in bad faith (e.g., by knowingly giving false information). In addition, the identity of anyone who makes a report is protected under the Act, unless that person agrees to be identified.

If the director believes that a person or organization has information that would help decide whether a child needs protection, but has neglected or refused to produce it, the director may apply to court to have that information released. If the information the director needs is in the custody or control of a "public body," such as a hospital, that public body must disclose the information to the director. In this case, a court order is not required. However, a public body must not disclose information that could reasonably be expected to reveal that a child is in the custody, care or guardianship of the director or reveal the identity of an individual who has reported information about a child who needs protection.

Note to Nurse Practitioners

As noted above, if a child or a parent of a child refuses to give consent to health care that *in the opinion of two physicians* is necessary to preserve the child's life or to prevent serious or permanent impairment of the child's health, a director may apply to the court for an order for that health care. Nurse practitioners (and other nurses) **cannot** provide such an opinion.

COMMUNITY CARE AND ASSISTED LIVING ACT

Current to January 1, 2017

This Act regulates the licensing and operation of community care facilities and the registration of assisted living residences.

The Act does **not** apply to schools, hospitals (including complex care facilities designated by the Minister of Health under the Hospital Act – see below), foster homes, correctional and youth custody centres, schools for children under the age of six, designated facilities under the Mental Health Act (see below) and certain other facilities.

Community care

A *community care facility* provides care to three or more people who are not related to the operator by blood or marriage. The Director of Licensing is responsible for overseeing these residences. Among other things, the director has the power to inspect and investigate these facilities, to make orders about how they are operated and to enforce standards.

The Act requires a community care facility to be open at all times to visits and inspections by the Director of Licensing or a medical health officer. A medical health officer may impose conditions on a facility's licence in certain circumstances, and may also suspend or cancel conditions.

The Act also includes a "bill of rights" for adults residing in community care facilities. These rights are described in detail and refer to transparency and accountability; a commitment to care; the health, safety and dignity of the adult; and the adult's right to participate and freely express his or her views on health care. The facility must display these rights prominently and must make the adult and his or her family members aware of them.

The Act and the Residential Care Regulation also establish standards for these facilities. These standards cover the physical characteristics of the facility, staffing, programs, nutrition, and medication management requirements. It also states what must be reported in cases of abuse of residents and other situations. A person who makes a report under this Act is protected from retaliation.

Employees and licensees of community care facilities are not allowed to persuade or induce, or attempt to persuade or induce, a person in care to do any of the following:

- Make or alter a will
- Give a gift
- Provide a benefit for the employee or licensee or his or her spouse, relative or friend
- Conduct the patient's financial affairs for the benefit of the employee or licensee or his or her spouse, relative or friend

Employees and licensees of community care facilities are also not allowed to:

- Require a person who is seeking admission to the facility to make a payment or donation as a condition of admission, other than as specified in a written contract
- Act under the authority of a power of attorney granted by a person in care
- Act as executor of a will, a trustee of an estate, an attorney under a power of attorney or a committee under the Patients Property Act (see below) for a person in care or formerly in care who is not the licensee or employee's parent, child or spouse
- Act as a representative under an agreement made under the Representation Agreement Act (see below) by a person in care or formerly in care

Assisted living

An *assisted living residence* provides housing or hospitality services and not more than two supportive services to seniors and/or people with disabilities who can live independently, but who require help with daily activities. To be designated as an assisted living residence, the facility must provide services to three or more adults who are not related by blood or marriage to the operator. The Assisted Living Registrar registers and monitors assisted living residences and has developed a comprehensive Health and Safety Standard in a policy.

Note to Nurse Practitioners

The Child Care Licensing Regulation and Residential Care Regulation under this Act do **not** authorize nurse practitioners (or other nurses) to give an opinion that the mental and physical health of an employee of a licensed community care facility is adequate for the duties assigned (Child Care Licensing Regulation) or that an employee is medically capable of carrying out his or her assigned duties (Residential Care Regulation). Only *physicians* are given this authority.

However, under the Residential Care Regulation a nurse practitioner may:

- Direct the licensee of a facility to send a person in care to a hospital
- Approve meals to be provided by ongoing room tray service
- Reassess ongoing room tray service for a person in care (this may also be done by a dietitian)
- Order nutrition supplements for a person in care
- Order tube feedings for a person in care
- Prescribe or order medications for a person in care
- Approve a plan for self-medication for a person in care
- Change the direction for use of a medication for a person in care
- Agree to the use or continued use of a restraint on a person in care

CONTINUING CARE ACT

Current to January 1, 2017

This Act deals with special health care services that are prescribed as “continuing care services.” These are services that may be provided to a person who is frail or who suffers from an acute or chronic illness or disability that does not require admission to a hospital. Continuing care programs include home support services, adult day services, meal programs, continuing care and case management services, home care nursing and home oxygen delivery. Operators of these services are paid by the government on behalf of those people who are receiving care. The operators are regulated by this Act and by the terms of their agreements with the government.

CONTROLLED DRUGS AND SUBSTANCES ACT (FEDERAL)*Current to December 31, 2016*

It is an offence for anyone to possess controlled drugs and substances listed in Schedules I, II or III of this Act. There are exceptions that allow specified practitioners to possess narcotics set out in the schedule, as long as the practitioner possesses the drugs according to the regulations.

It is an offence to traffic in any substance set out in Schedules I, II, III or IV. Trafficking includes selling, administering, giving, transferring, transporting, sending or delivering a banned substance. However, a practitioner may administer or give a narcotic listed in the schedule to a patient who is under the practitioner's care if the narcotic is required to treat the patient's condition.

Although the Act and regulations do not specifically refer to registered nurses, in practice registered nurses administer narcotics on orders from physicians, dentists and nurse practitioners following the allowed exemptions for hospitals and for agents of physicians, dentists and nurse practitioners. According to Health Canada, these exemptions allow registered nurses to conduct activities with controlled substances when they are working in a hospital setting and acting under a prescription or order from a specified practitioner (e.g., a physician, dentist or nurse practitioner).

There is also a special exemption for registered nurses working in health facilities in remote or isolated communities, which allows them to conduct activities with controlled substances when they are providing primary health care services to patients, subject to certain conditions. A prescription or order from a specified practitioner (e.g., a physician, dentist or nurse practitioner) is still needed for a registered nurse to provide or administer controlled substances, unless otherwise provided in the facility's policies or procedures. Under this exemption, records of all activities conducted with controlled substances must be kept for at least two years. There are also rules about keeping controlled substances secure when storing, receiving and returning them, and for reporting to Health Canada if any controlled substances are lost or stolen.

Under the Narcotic Control Regulations, the person in charge of a hospital must keep records of narcotics received and certain details of their use for two years. Both the person in charge of a hospital and a pharmacist must take all necessary steps to protect narcotics against loss or theft. The person in charge must also report to the federal Minister of Health any loss or theft of a narcotic within 10 days of the discovery.

The Access to Cannabis for Medical Purposes Regulations under this Act allows a person, including a nurse, to be in possession of a limited amount of medical cannabis for the purpose of providing assistance in the administration of that medical cannabis to a client who is authorized under the Regulations to use it for their own medical purposes. However, the Regulations do not authorize a registered nurse to directly administer medical cannabis to a client or to perform any other activities with medical cannabis.

Note to Nurse Practitioners

The New Classes of Practitioners Regulations under this Act allow nurse practitioners to prescribe, possess or perform activities with certain controlled drugs (in accordance with designated drug schedules) in certain circumstances, as permitted by the provincial government and CRNBC effective July 26, 2016. Nurse practitioners who provide such services must comply with all applicable

standards, limits and conditions in CRNBC's *Scope of Practice for Nurse Practitioners*. They must also comply with the requirements of the Controlled Prescription Program of the College of Pharmacists of BC, and all applicable requirements in the relevant regulations under this Act (e.g. the Narcotic Control Regulations, the Benzodiazepines and Other Targeted Substances Regulations, and Part G of the Food and Drug Regulations).

At CRNBC's request, Health Canada is required to issue a notice against a named nurse practitioner to all licensed dealers of controlled drugs, pharmacies, and various other recipients, prohibiting the sale or supply of controlled drugs to that nurse practitioner, or the filling of prescriptions or orders for controlled drugs from that nurse practitioner, where the nurse practitioner has admitted to breaching, or has been found by CRNBC's Discipline Committee to have breached, any CRNBC standard, limits or condition relating to controlled drugs.

Health Canada is also required to issue such a notice against a nurse practitioner who is found guilty by a court of law of committing a designated drug offence identified in the regulations, and Health Canada may choose to issue a notice against a nurse practitioner in various other situations, including if there are reasonable grounds to believe that any of the following has occurred:

- The nurse practitioner has administered a controlled drug to anyone other than a patient under her or her professional treatment who requires the drug for that treatment
- The nurse practitioner has failed to keep required records under the Narcotic Control Regulations or Part G of the Food and Drug Regulations with respect to the provision of more than three times the recommended or generally recognized maximum daily dosage of a narcotic or controlled drug to a person for self-administration
- The nurse practitioner has failed to keep required records under the Benzodiazepines and Other Targeted Substances Regulations with respect to transactions involving more than five times the usual daily dose for a targeted substance
- The nurse practitioner has failed to provide required information requested by Health Canada under the regulations
- The nurse practitioner has, on more than one occasion, self-administered a controlled drug under a self-directed prescription or order or, in the absence of a prescription or order, contrary to accepted medical or dental practice
- The nurse practitioner has, on more than one occasion, prescribed, provided or administered a controlled drug to their spouse, common-law partner, parent or child contrary to accepted medical or dental practice
- The nurse practitioner is unable to account for the quantity of a controlled drug for which he or she was responsible under the regulations

At present, nurse practitioners (and other nurses) **cannot** prescribe, dispense or administer cannabis in British Columbia. However, nurse practitioners may in future acquire that authority in certain circumstances, if permitted by the provincial government and CRNBC, in accordance with the Access to Cannabis for Medical Purposes Regulations (which replaced the previous Marijuana for Medical Purposes Regulations on August 24, 2016).

As with other nurses, the Regulations do still allow a nurse practitioner to be in possession of a limited amount of medical cannabis for the purpose of providing assistance in the administration of that medical cannabis to a client who is authorized under the Regulations to use it for their own medical purposes, provided that the nurse practitioner does not directly administer the medical cannabis to the client or perform any other activity with medical cannabis.

CORONERS ACT

Current to January 1, 2017

Under this Act, a death must be reported to a coroner or a peace officer if a person has died under the following circumstances:

- Due to violence, accident, negligence, misconduct or malpractice
- As a result of self-inflicted illness or injury
- Suddenly and unexpectedly, when the person was apparently in good health and not under the care of a medical practitioner or nurse practitioner
- From disease, sickness or unknown cause for which the person was not treated by a medical practitioner or nurse practitioner
- During or following pregnancy in circumstances that might be attributable to pregnancy
- Under a class of deaths for which the chief coroner has issued a notice that such deaths must be reported
- There is reason to believe that the person received medical assistance in dying that was purportedly provided in accordance with the June 17, 2016 amendments to the Criminal Code (see below)
- In any other prescribed circumstances

The Act also states that individuals in charge of certain institutions must report a death to a coroner if a person has died under the following circumstances:

- While the person was a patient of a designated facility or private mental hospital within the meaning of the Mental Health Act (see below)
- While the person was committed to a correctional centre, youth custody centre, penitentiary, police prison or lockup, whether or not the death occurred on the premises or while the person was in custody
- While the person was a patient of a hospital under the Hospital Act (see below) if the person was transferred from one of the facilities listed above

If someone believes that a person has died in any of these circumstances, he or she must not move, alter or destroy the body, its immediate environment or any wreckage in which the body is located

without authorization from a coroner, unless doing so is necessary to prevent loss of life or relieve human suffering.

Under the Act, a coroner has the power to investigate deaths. The Coroners Service does not find fault, but it is authorized to disclose to the public the relevant facts of a death after a coroner's judgment or an inquest. An inquest is a public quasi-judicial hearing before a five-person jury to review the circumstances of a death and, whenever possible, to make recommendations to prevent future deaths in similar circumstances. An inquest must be held if the deceased was in the care or control of a police officer or in a police lockup at the time of death.

The Act also requires the chief coroner to establish a Child Death Review Unit to review all child deaths in British Columbia. A medical practitioner must immediately report a child death.

Note to Nurse Practitioners

During an investigation, a coroner may authorize a *medical practitioner or any other "qualified person"* to do one or more of the following:

- A post-mortem examination, with or without dissection of the body
- An analysis of the blood, urine or contents of the stomach and intestines
- Any other examination or analysis the coroner considers necessary for the purposes of the investigation

The Act does not specify whether a nurse practitioner is a "qualified person." Presumably, a coroner could determine that, based on nurse practitioners' scope of practice and the individual's education, training and experience.

A person who performs such an examination or analysis must promptly report his or her findings in writing to the coroner who authorized the examination or analysis and to the person who performed the post-mortem examination (if that is a different person). A person who performs the examination or analysis may keep all or part of a body until the examination or analysis is complete, and must not dispose of any part of the body without the coroner's approval.

Note also that, on May 29, 2014, the Act was amended to remove the requirement to report a death to the coroner or a peace officer if a person dies while under the care of a nurse practitioner.

CRIMINAL CODE (FEDERAL)

Current to December 31, 2016

The Criminal Code of Canada lays out what constitutes a federal offence. Under the Code, it is against the law for any person to:

- Commit a listed offence
- Do or omit to do anything that helps another person to commit an offence

- Assist any person to commit an offence

The Criminal Code does **not** impose a general obligation on a person who knows about a crime to report it.

Medical Assistance in Dying

On June 17, 2016, the Criminal Code was amended, in response to the decision of the Supreme Court of Canada in *Carter v. Canada (Attorney General)*, to allow a person to allow physicians and nurse practitioners, under certain limited circumstances, to provide a person with medical assistance in dying (MAiD).

Only two forms of MAiD are permitted under the Criminal Code:

- The administering by a physician or a nurse practitioner of a substance to a person, at their request, that causes their death
- The prescribing or providing by a physician or a nurse practitioner of a substance to a person at their request, for their self-administration in order to cause their own death

A person is eligible for MAiD only if they meet **all** of the following criteria:

- They are eligible for publicly funded health-care services in Canada
- They are at least 18 years of age and capable of making decisions with respect to their health
- They have a grievous and irremediable medical condition
- They have made a voluntary request for MAiD that, in particular, was not made as a result of external pressure
- They have given informed consent to receive MAiD after having been informed of the means that are available to relieve their suffering, including palliative care

A person has a grievous and irremediable medical condition only if **all** of the following criteria apply:

- They have a serious and incurable illness, disease or disability
- They are in an advance state of irreversible decline in capability
- Their illness, disease or disability or their state of decline causes them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions they consider acceptable
- Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining

Registered nurses (other than nurse practitioners) do **not** have any authority under the Criminal Code to provide MAiD, or to determine a person's eligibility for MAiD. Their role is **strictly limited to aiding** in

the provision of MAiD by a physician or nurse practitioner. As such, they are strictly prohibited from prescribing, compounding, dispensing or administering any substance specifically intended for the purpose of providing MAiD.

The Criminal Code also continues to prohibit anyone, including a physician, a nurse practitioner or any other health professional, from counselling or abetting a person to die by suicide, under any circumstances. However, it is not an offence for a health professional, including a registered nurse, merely to provide information to a person on the lawful provision of MAiD.

Anyone, including a nurse, who owns or operates a health care facility at which a person is being treated or a facility where they reside, or who is directly involved in providing health care services to a person or otherwise directly provides personal care to a person, also cannot act as an independent witness to the person's request for MAiD.

Nothing in the Criminal Code compels nurses to aid in the provision of MAiD. Nurses who have a conscientious objection to MAiD may arrange with their employer to refrain from aiding in the provision of MAiD, provided that they take all reasonable steps to ensure that the quality and continuity of care for clients are not compromised, and, if needed, to ensure a safe transfer of the client's care to another health care provider that is continuous, respectful and addresses the unique needs of the client.

Registered nurses who are considering whether to aid a physician or nurse practitioner in the provision of MAiD need to confer with their employer. CRNBC also encourages them to seek the guidance of the Canadian Nurses Protective Society.

Any registered nurse who aids a physician or nurse practitioner in the provision of MAiD must follow the applicable standards, limits and conditions established by CRNBC as set out in the *Scope of Practice Standard for Registered Nurses: Standards, Limits and Conditions*.

Blood Samples

The Criminal Code also contains provisions about taking blood samples in certain circumstances. For example, a peace officer who reasonably believes that a person has committed a drinking-and-driving offence may demand that the suspect provide a blood sample. If a suspect is unable to agree to the taking of a blood sample, and anyone has died or been injured, the peace officer may seek a warrant requiring the sample to be taken. Blood samples may be taken by a qualified medical practitioner or by a qualified technician under the direction of a qualified medical practitioner. Nurses **are** included in the definition of "qualified technician." The blood sample may be taken only if the qualified medical practitioner is satisfied that by doing so the health or life of the suspect will not be endangered.

It is not an offence for a nurse to refuse to take a sample of blood even if there is a warrant. If the nurse does take a blood sample, he or she is protected under the Code from criminal and civil liability for anything necessarily done with reasonable care and skill during the process.

Note to Nurse Practitioners

On July 27, 2016, CRNBC's Board approved and put into immediate effect standards, limits and conditions related to the role of nurse practitioners in determining eligibility for and providing MAiD, in accordance with the June 17, 2016 amendments to the Criminal Code and corresponding amendments made to the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act on July 26, 2016.

With these changes, nurse practitioners in British Columbia are now recognized as having the following role in MAiD:

- Determining the eligibility of the person requesting MAiD based on the eligibility criteria established in the Criminal Code
- Providing MAiD by administering a medical assistance in dying substances to a person, at their request, that causes their death
- Providing MAiD by prescribing and/or providing medical assistance in dying substances to a person, at their request, so that they may self-administer the substances and in doing so cause their own death
- Aiding in the provision of MAiD by a physician or other nurse practitioner

The process for determining a person's eligibility for MAiD requires the assessment of two independent medical assessors, one of whom must be the person prescribing and administering the medical assistance in dying substances. Only a nurse practitioner registered in British Columbia or a physician may be a medical assessor.

To ensure their independence, each medical assessor must meet all of the following criteria, and must be satisfied that the other medical assessor meets **all** of the following criteria:

- They must not be a mentor to the other medical assessor or responsible for supervising their work
- They must not know or believe that they are a beneficiary under the will of the person making the request, or that they will otherwise receive any financial or other material benefit resulting from that person's death (other than standard compensation for their services)
- They must not know or believe that they are connected to the other medical assessor or to the person making the request for MAiD in any other way that would affect their objectivity

Both of the medical assessors must agree in writing that the person requesting MAiD meets the eligibility criteria set out in the Criminal Code (as outlined above). A medical assessor who provides MAiD by administering, prescribing or providing medical assistance in dying substances to a person must also take **all** of the following steps before doing so:

- Ensure that the person's request for MAiD was made in writing, and signed and dated by the person or, if the person is unable to sign, by another person in their presence who is authorized to do so under the Criminal Code, on the person's behalf and under their express direction

- Ensure that a physician or nurse practitioner informed the person that they have a grievous and irremediable medical condition (as outlined above) before their request for MAiD was signed
- Ensure that the person's request for MAiD was signed in the presence of two independent witnesses, who also then signed and dated the request, and who are authorized to do so under the Criminal Code
- Ensure that the person has been informed that they may, at any time and in any manner, withdraw their request for MAiD
- Ensure that MAiD is not provided until at least the 11th day after the person's request for MAiD, unless both medical assessors are of the opinion that the person's death or loss of capacity to provide informed consent is imminent and they agree that a shorter period is appropriate in the circumstances
- Immediately before providing MAiD, give the person an opportunity to withdraw their request, and ensure that the person gives express consent to receive MAiD
- If the person has difficulty communicating, take all necessary measures to provide a reliable means for the person to understand the information provided to them and communicate their decision

A person who signs a request for MAiD on another person's behalf, or who acts as an independent witness of a request for MAiD, must be at least 18 years of age and must understand the nature of the request for MAiD. Also, they must not know or believe that they are a beneficiary under the will of the person making the request, or that they will otherwise receive any financial or other material benefit resulting from that person's death.

In addition, a person cannot act as an independent witness of a request for MAiD if they own or operate any health care facility where the person making the request is being treated or any facility in which they reside, if they are directly involved in providing health care services to the person making the request, or if they directly provide personal care to the person making the request.

Before any pharmacist dispenses a medical assistance in dying substance, the physician or nurse practitioner who prescribes or obtains the substance for the purpose of MAiD must also inform the pharmacist that the substance is intended for that purpose.

A physician or nurse practitioner who provides MAiD must do so with reasonable knowledge, care and skill, and in accordance with all applicable provincial laws, rules or standards. In particular, a nurse practitioner who provides MAiD must follow all applicable standards, limits and conditions established by CRNBC that are set out in the *Scope of Practice Standard for Nurse Practitioners*. This includes additional education requirements established by CRNBC for any nurse practitioner who provides MAiD.

Nothing in the Criminal Code compels nurse practitioners to determine a person's eligibility for MAiD, or to provide or aid in the provision of MAiD. Nurse practitioners who have a conscientious objection to MAiD may arrange with their employer to refrain from assessing eligibility for MAiD, or providing or aiding in the provision of MAiD, provided that they take all reasonable steps to ensure that the quality and continuity of care for clients are not compromised, and, if needed, to ensure a safe transfer of the

client's care to another health care provider that is continuous, respectful and addresses the unique needs of the client.

Nurse practitioners who are considering whether to assess a person's eligibility for MAiD, or whether to provide MAiD or aid a physician or another nurse practitioner in providing MAiD, need to confer with their employer. CRNBC also encourages them to seek the guidance of the Canadian Nurses Protective Society.

Additional information for MAiD providers can be found on the Ministry of Health's MAiD resource page on its website:

<http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/information-for-providers>

CRIMINAL RECORDS REVIEW ACT

Current to January 1, 2017

The intent of this Act is to help prevent the physical and/or sexual abuse of children and the physical, sexual and/or financial abuse of vulnerable adults. It does this by requiring certain individuals to undergo criminal record checks.

Under this Act, every registrant of CRNBC and every person who applies to CRNBC for registration must undergo a criminal record check. Further, every registrant must provide CRNBC with a criminal record check authorization at least once every five years. (CRNBC does not accept criminal record check verifications in place of a criminal record check.) If a registrant fails to comply with this requirement, his or her registration status with CRNBC may be affected.

After undergoing a criminal record check, nurses also have an ongoing obligation to inform CRNBC of any subsequent charge or conviction related to offences designated by the Act. The requirement to report a conviction includes a conditional discharge, a peace bond or the use of alternative measures under Section 717 of the Criminal Code. Nurses in this situation will be required to consent to undergo a new criminal record check.

If an adjudicator determines that a nurse presents a risk to children or vulnerable adults because of an outstanding charge or conviction, the nurse has a right to be notified of the determination and to appeal it. CRNBC must investigate or review the case and take appropriate action under the Health Professions Act (see below). CRNBC must inform the nurse's employer that these actions are being taken and, once notified, the employer must ensure that the nurse does not work with children or vulnerable adults, as applicable.

If an employer becomes aware that a nurse who works with children or vulnerable adults has an outstanding charge or conviction related to an offence designated by the Act, the employer may require the nurse to provide a criminal record check authorization. An employer who takes such action is also required to notify CRNBC.

DIVORCE ACT (FEDERAL)

Current to December 31, 2016

This Act gives a person who is entitled to access to a child the right to ask about and receive information concerning the child's health, unless a court orders otherwise.

E-HEALTH (PERSONAL HEALTH INFORMATION ACCESS AND PROTECTION OF PRIVACY) ACT

Current to January 1, 2017

This Act authorizes the Ministry of Health and certain other health care bodies to collect, use and disclose personal health information in designated health information banks. The Act also authorizes the collection of personal health information from sources other than a patient, and establishes an arm's-length system of "independent stewardship" of secondary uses of the information by government and others to protect privacy.

Information about the type of data contained in a health information bank, its source and the purposes for which it may be collected, used and disclosed must be made available to the public. Data can be collected only for the purposes set out in the Act, which include addressing public health needs and engaging in health system planning, management, evaluation or improvement. The Act also establishes a system to investigate complaints, including establishing a stewardship committee that is authorized to make directives to control the process.

EMERGENCY PROGRAM ACT

Current to January 1, 2017

Nurses possess special skills that may require them to provide services in an emergency. This Act provides for emergency plans to be created when preparing for, responding to and recovering from emergencies and disasters at the local and provincial level. When a state of emergency has been declared or appears imminent, a provincial or local authority may authorize or require any person to provide help according to the person's qualifications. The Act states that a person may not be fired from his or her employment for providing the assistance required, and the person is protected from liability as long as he or she acts in good faith and is not grossly negligent.

EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES ACT AND EMPLOYMENT AND ASSISTANCE ACT

Current to January 1, 2017

These two Acts address income assistance for eligible people. The Employment and Assistance for Persons with Disabilities Act deals with disability assistance, hardship assistance and supplements provided to designated persons with disabilities, and their families. The Employment and Assistance Act deals with income assistance, hardship assistance and supplements provided to other eligible persons with persistent multiple barriers to employment, and their families.

A person who is 18 years of age or older may be designated as a person with disabilities for the purpose of the Employment and Assistance for Persons with Disabilities Act if **both** of the following conditions apply:

- A physician or (as of September 1, 2016) a nurse practitioner gives an opinion that the person has a severe mental or physical impairment that is likely to continue for at least two years
- A physician, nurse practitioner, registered nurse or other prescribed professional gives an opinion that the person's impairment directly and significantly restricts his or her ability to perform daily living activities for either continuously, or periodically for extended periods, and therefore requires help to perform those activities

Under the Employment and Assistance Regulation, only *physicians* are authorized to give an opinion that a person has a medical condition that qualifies the person as having persistent multiple barriers to employment for the purpose of the Employment and Assistance Act. This authority is **not** given to nurses or nurse practitioners.

Note to Nurse Practitioners

Effective September 1, 2016, nurse practitioners have the authority to fully complete the Person with Disabilities (PWD) Designation Application for patients under their care, under the Employment and Assistance for Persons with Disabilities Act.

The Employment and Assistance for Persons with Disabilities Regulation and the Employment and Assistance Regulation also authorize nurse practitioners to:

- Confirm that a person needs a special diet for the purpose of receiving a diet supplement
- Confirm that a person is being treated for a chronic, progressive deterioration of health, with symptoms including two or more of malnutrition, underweight status, significant weight loss, significant muscle mass loss, significant neurological degeneration, significant deterioration of a vital organ, and moderate to severe immune suppression, and that failure to obtain one or more nutritional supplements will result in imminent danger to the person's life, for the purpose of the person receiving nutritional supplements
- Confirm that a person requires a high-protein diet for cancer (during radiation therapy, chemotherapy, surgical therapy, or ongoing medical treatment), chronic inflammatory bowel disease, Crohn's disease, ulcerative colitis, HIV positive diagnosis, AIDS, chronic bacterial infection, tuberculosis, hyperthyroidism, osteoporosis, hepatitis B or hepatitis C, for the purpose of receiving a high-protein diet supplement
- Confirm that a person or his or her dependent child has an acute short-term need for caloric supplementation to prevent critical weight loss while recovering from surgery, a severe injury, a serious disease, or side effects of medical treatment, for the purpose of receiving a short-term nutritional supplement
- Confirm that a person's primary source of nutrition is through tube feeding for the purpose of receiving a tube feed nutritional supplement

- Confirm that a person is pregnant for the purpose of receiving a pre-natal shelter supplement to the person's monthly shelter allowance, or a natal supplement to the person's disability or income assistance
- Confirm that a person's dependent child under 12 months of age requires a specialized infant formula to treat a medical condition, or that the dependent child is at risk of contracting a disease that is transmissible through the mother's breast milk, for the purpose of receiving an infant formula health supplement
- Confirm that a person has an acute need for acupuncture, chiropractic, massage therapy, naturopathy, non-surgical podiatry, or physiotherapy services, for the purpose of the person requesting reimbursement
- Prescribe certain medical or surgical supplies for the purposes of wound care, ongoing bowel care required due to loss of muscle function, catheterization, incontinence, skin parasite care or limb circulation care, and certain medical equipment and devices, such as canes, crutches, walkers, wheelchairs, scooters, bathing and toileting aids, hospital beds, pressure relief mattresses, floor or ceiling lift devices, positive airway pressure devices, and orthoses, that may be eligible for reimbursement
- Confirm that a custom-made orthosis is medically required for the purpose of reimbursement

EVIDENCE ACT

Current to January 1, 2017

Section 51 of the Evidence Act sets out criteria that exempt certain documents produced in the health care sector from being admissible in a court proceeding. Most commonly, these are reports prepared to evaluate care provided by health care professionals in a hospital.

FAMILY LAW ACT

Current to January 1, 2017

This Act governs guardianship of children, parental responsibilities for children, and the allocation of "parenting time" that a parent or guardian is entitled to have with a child. It also governs how parentage is determined, including where children are born through assisted reproduction and/or a surrogacy arrangement.

Note to Nurse Practitioners

In family law matters involving a claim that a parent or guardian has been wrongfully denied parenting time or contact with a child to which he or she was entitled under an agreement or court order, a *physician* or a *nurse practitioner* may provide a statement indicating it was not appropriate for parenting time or contact with the child to be exercised at the time in question because the child was suffering from an illness.

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

Current to January 1, 2017

This Act creates the Office of the Information and Privacy Commissioner of British Columbia and sets out rules for collecting, using and disclosing personal information by “public bodies,” which include provincial government ministries, provincial agencies, boards, Crown corporations, municipalities, school boards, hospitals and professional regulatory bodies such as CRNBC. A list of public bodies is included in a schedule to the Act.

Personal information includes anything that uniquely identifies a person, such as his or her name, address, age, sex, religion and information about health care, education, financial, criminal or employment history.

The Act also gives members of the public the right to access records in the custody or control of a public body. Individuals may access personal information about themselves, including information about their health care history. They may also request that their personal information be corrected. There are, however, exceptions to a person’s right to access information under the Act, including, for example, restrictions on the disclosure of records that would result in an unreasonable invasion of a someone else’s personal privacy.

A public body may also refuse to disclose an applicant’s own personal information if doing so could reasonably be expected to result in immediate and grave harm to the applicant’s safety or mental or physical health. To help make this decision, the head of the public body may disclose the information to a health professional, including a nurse, and ask for an opinion on whether disclosure could reasonably be expected to result in such harm.

The Act also prevents the unauthorized collection, use or disclosure of personal information by public bodies; establishes a complaint system; and requires public bodies to appoint an information and privacy officer to ensure compliance with FOIPPA.

GOOD SAMARITAN ACT

Current to January 1, 2017

This Act protects a person, including a nurse, who provides emergency medical services at the immediate scene of an accident or emergency. In these circumstances, the nurse will not be liable for damages caused by providing assistance, so long as he or she is not grossly negligent. This protection covers only those people who are not employed to provide the emergency medical services, or who do not provide the services with a view to gain.

GUNSHOT AND STAB WOUND DISCLOSURE ACT

Current to January 1, 2017

This Act requires health care facilities and emergency medical assistants to report gunshot wounds and stab wounds, except those stab wounds that are self-inflicted or accidental. A health care facility or emergency medical assistant who treats a person for a gunshot wound or a stab wound must verbally disclose certain information to the local police. (This requirement does not apply to an emergency medical assistant who **delivers** the injured person to a health care facility.)

The information that must be disclosed includes:

- The injured person's name, if known
- The fact that the injured person is being treated or has been treated for a gunshot or stab wound
- In the case of a health care facility providing the treatment, the name and location of the health care facility
- In the case of an emergency medical assistant providing the treatment, the location where the treatment occurs

This information must be disclosed as soon as it is reasonably practicable to do so without interfering with the injured person's treatment or disrupting the regular activities of the health care facility or emergency medical assistant. Anyone associated with the health care facility may do the reporting.

The Act provides protection from personal liability to anyone acting under its authority.

HEALTH CARE (CONSENT) AND CARE FACILITY (ADMISSION) ACT

Current to January 1, 2017

Consent required to provide health care to adult patients

Part 2 of this Act deals with adults or their representatives consenting to health care. It outlines the scope and elements of consent; the requirement for health care practitioners, including nurses, to seek consent to treatment (other than to a preliminary examination); how consent is obtained; and when consent may be dispensed with. It also confirms the right of a capable adult to give or refuse consent to health care even if the refusal will result in death.

Note that this Act does not apply to psychiatric treatment and care for patients under the Mental Health Act (see below), nor does it apply to care provided for patients under the age of 19, which is governed by the Infants Act (see below).

A health care provider must decide whether an adult is capable of giving valid consent to health care. In making this decision, the health care provider must determine whether the adult demonstrates that he or she understands:

- The information provided about the proposed health care, including the condition for which the health care is proposed, the nature of the care, the risks and benefits of the care, and any alternatives; **and**
- That the information applies to his or her situation

If the adult is not capable of giving valid consent to health care, the Act sets out circumstances in which consent can be given by a different person or in a different way.

Advance directives

Under Part 2.1 of the Act, a capable adult may make an advance directive. An advance directive is a written instruction that gives or refuses consent to health care in the event the adult later becomes incapable of giving the instruction at the time the health care is required. Note that a person who provides personal care, health care or financial services to the adult for compensation cannot be a witness to the signing of an advance directive.

Generally, a health care provider **may** provide health care to an adult if he or she consented to the health care in an advance directive, but **must not** provide health care to an adult if the adult refused consent to the health care in an advance directive.

Where an adult has an advance directive, and that adult becomes incapable, only in very limited circumstances will a substitute decision maker be asked to make decisions on behalf of the adult about the specified health care. However, if a health care provider believes there are grounds not to follow an advance directive, he or she must obtain substitute consent (see sections on substitute consent below).

Substitute consent provided by representative or personal guardian

If a health care provider believes that an adult needs health care but is incapable of giving or refusing that consent, the health care provider may seek substitute consent—but **only** after every reasonable effort to obtain a decision from the adult has been made. Substitute consent may be given (or refused) either by a person authorized by a representation agreement under the Representation Agreement Act (see below), or by a personal guardian appointed as a committee under the Patients Property Act (see below).

Depending on its terms, a representation agreement may also supersede instructions given by the adult under an advance directive. However, the instructions given in the advance directive are to be treated as the wishes of the adult, expressed while capable, for the purposes of the Representation Agreement Act.

Temporary substitute decision makers

If an adult is not able to give informed consent, and the adult does not have a personal guardian or representative who is authorized and capable of providing substitute consent, a system of temporary substitute decision making applies. The Act lists who may act as such a decision maker, along with that person's duties, rights and authority, which include the right to all information necessary to make an informed decision to give or refuse substitute consent.

A health care provider may approach the following people, in the order listed, to determine if they meet the criteria to provide substitute consent:

- The adult's spouse
- The adult's child
- The adult's parent

- The adult's brother or sister
- The adult's grandparent
- The adult's grandchild
- Anyone else related by birth or adoption to the adult
- A close friend of the adult
- A person immediately related to the adult by marriage

To act as a substitute decision maker, a person must meet these criteria:

- Be at least 19 years of age
- Have been in contact with the adult during the preceding 12 months
- Have no dispute with the adult
- Be capable of giving, refusing or revoking substitute consent
- Be willing to comply with applicable duties under the Act

If there is no qualified person, or if there is a dispute about who is to give consent, substitute consent must be obtained from a person authorized by the Public Guardian and Trustee.

The Act also distinguishes between "major health care" and "minor health care." Major health care means any of the following:

- Major surgery
- Any treatment involving a general anesthetic
- Major diagnostic or investigative procedures
- Certain services designated by regulation as major health care (i.e., radiation therapy, intravenous chemotherapy, kidney dialysis, electroconvulsive therapy, laser surgery)

Minor health care means any health care that is not major health care, and includes routine tests to determine if health care is necessary and routine dental treatment that prevents or treats a condition or injury caused by disease or trauma.

In certain circumstances, a health care provider may obtain temporary substitute consent to provide major health care to an adult without the adult's consent. The health care provider must first consult (or make a reasonable effort to consult) the adult's spouse, near relative, close friend or other person who has relevant information, and must determine that the adult does not have a personal guardian or representative who is authorized to consent to major health care, is capable of doing so and is available. The health care provider must also decide that the adult needs major health care but is incapable of giving or refusing consent to it, and he or she must identify a temporary substitute decision maker with authority to provide substitute consent under the Act. The health care provider

must then inform the adult, as well as any spouse, near relative or close friend who accompanies the adult, of the decision or assessment that the adult is incapable, the name of the temporary substitute decision maker, and the decision the temporary substitute decision maker has made about giving or refusing substitute consent.

A health care provider may obtain temporary substitute consent to provide minor health care to an adult without the adult's consent, if the health care provider believes that the adult is incapable of giving or refusing consent, and the adult does not have a personal guardian or representative who is capable of giving or refusing consent.

Before giving or refusing substitute consent, a temporary substitute decision maker must consult with the adult to the greatest extent possible. The temporary substitute decision maker must also comply with any instructions or wishes the adult expressed while he or she was capable. If the adult's instructions or wishes are not known, the temporary substitute decision maker must decide to give or refuse consent in the adult's best interests.

When considering the adult's best interests, a temporary substitute decision maker must consider the following factors:

- The adult's current wishes, and known beliefs and values
- Whether the adult's condition or well-being is likely to be improved by the proposed health care
- Whether the adult's condition or well-being is likely to improve without the proposed health care
- Whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm
- Whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care

A temporary substitute decision maker does not have authority to give or refuse substitute consent to certain types of health care prescribed in the regulations. In addition, although a temporary substitute decision maker has authority to refuse substitute consent to health care necessary to preserve life, he or she can only do so if there is substantial agreement among the health care providers caring for the adult that this decision is medically appropriate and that it was made in accordance with the temporary substitute decision maker's duties under the Act.

Court order

A health care provider responsible for the care of an adult who is incapable of giving or refusing consent to health care may apply to the court for an order confirming, reversing or varying a decision to give or refuse consent to health care by an adult's representative, personal guardian or temporary substitute decision maker.

Urgent or emergency health care

A health care provider may provide urgent or emergency health care to an adult without the adult's consent if **all** of the following conditions exist:

- The health care needs to be provided without delay in order to preserve the adult's life, to prevent serious physical or mental harm or to alleviate severe pain
- The adult is apparently impaired by drugs or alcohol, or is unconscious or semi-conscious for any reason, or is, in the health care provider's opinion, otherwise incapable of giving or refusing consent
- The adult does not have a personal guardian or representative who is authorized to consent to the health care, is capable of doing so and is available (or if the personal guardian or representative refuses consent in breach of his or her duties under the Act or other applicable legislation)
- Where practicable, a second health care provider confirms the first health care provider's opinion about the need for the health care and the incapability of the adult
- The health care provider does not have reasonable grounds to believe that the adult, while capable, expressed an instruction or wish to refuse consent to the health care applicable to the circumstances

However, if a personal guardian or representative becomes available, or a temporary substitute decision maker is chosen, after a health care provider provides urgent or emergency health care to an adult, the personal guardian, representative or temporary substitute decision maker may refuse consent for continued health care. In this case, the health care must be withdrawn.

Note to Nurse Practitioners

The Health Care Consent Regulation under this Act does **not** give nurse practitioners (or other nurses) the authority to give a second opinion to that of a treating physician to satisfy the requirements to allow a temporary substitute decision maker to give substitute consent to an abortion or electroconvulsive therapy for a mentally incapable patient. Only another *physician* can give such a second opinion.

HEALTH PROFESSIONS ACT

Current to January 1, 2017

This Act regulates 25 health professions that are governed by 22 designated colleges, including CRNBC. Each health profession college established under this Act regulates its registrants' practice and professional conduct in accordance with the Act, the applicable regulations and the college's bylaws. The regulation establishing each college also prescribes reserved titles and sets out the scope of practice for the designated profession. Matters addressed in college bylaws include educational and other requirements for registration in the profession; internal governance and administration of the college, including board elections, committee structures and general meetings; continuing competence and quality assurance; and certain aspects of professional conduct review and discipline. Colleges also establish standards of practice and professional ethics governing the conduct of their registrants.

Every health profession college has a duty to serve and protect the public, and to exercise its powers and carry out its responsibilities in the public interest.

Each health profession college has a registration committee, responsible for granting registration to registrants.

Part 3 of the Act establishes a complaint procedure and gives authority to each college's inquiry committee to investigate and dispose of complaints against its registrants. Following an investigation, the inquiry committee may also direct the college's registrar to issue a citation for the registrant to appear before the college's discipline committee for a hearing.

Part 4.2 of the Act establishes the Health Professions Review Board, an independent tribunal with authority to review whether a college adequately investigates and reasonably disposes of complaints against its registrants. The Review Board may also review a college's compliance with timelines prescribed under the Act for completing investigations, and has authority to review most college registration decisions.

Duty to report

Registrants of every college established under the Act have a duty to report in writing to the appropriate health profession college if they have good reason to believe that the public might be in danger because of the continued practice of another health professional: for example, if the other health professional continues to practise when he or she is:

- Not competent to do so
- Suffering from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practise

Registrants also have a duty to report if they have good reason to believe that another health professional has engaged in sexual misconduct. However, if concerns about sexual misconduct are based on information from a patient, the registrant must obtain the patient's consent before making a report. If the patient does not have the capacity to consent to health care treatment, consent to make the report must be obtained from the patient's parent, guardian or substitute decision maker.

Employers, health care facilities and other people associated with a health professional also have a duty to report under the Act in certain circumstances. A report must also be made when a health professional is hospitalized for psychiatric care or treatment for drug or alcohol addiction and is therefore unable to practise.

More information about the duty to report as it applies to nurses can be found in CRNBC's *Duty to Report Practice Standard*.

Note to Nurse Practitioners

The Nurses (Registered) and Nurse Practitioners Regulation sets out the scope of practice for nurse practitioners, subject to the standards, limits and conditions established by CRNBC's Board on the recommendation of the Nurse Practitioner Standards Committee. Detailed information about nurse practitioners' scope of practice can be found in CRNBC's *Scope of Practice for Nurse Practitioners: Standards, Limits and Conditions*.

The Health Professions Act exempts nurse practitioners from the Labour Mobility Act. This means that nurse practitioners registered in another Canadian province or territory are not eligible for registration as nurse practitioners in British Columbia unless they meet CRNBC's registration requirements.

Under the Midwives Regulation under this Act, a registered midwife **must** consult with a *medical practitioner or nurse practitioner* regarding any deviations from the normal course of pregnancy, labour, delivery and the post-partum period that indicate pathology, and transfer responsibility for care to another health professional when necessary or appropriate.

HOSPITAL ACT

Current to January 1, 2017

This Act governs hospitals and sets out how they are to be managed and operated.

Part 2 of the Hospital Act provides for the licensing and operation of private hospitals. The person in charge of a private hospital (the superintendent) must be a physician or a nurse. This person is responsible for the care of patients and the supervision of staff.

Part 2 also prohibits a patient's body from being removed from a private hospital until a medical practitioner or nurse practitioner has certified that the patient is dead.

The Minister of Health has authority to designate a non-profit facility as a hospital if the facility provides extended care to residents at a higher level than what is generally provided in private hospitals licensed under Part 2.

The Act also establishes a "bill of rights" for adult patients in public or private hospitals on the same terms as described under the Community Care and Assisted Living Act (see above). As well, the Act prohibits employees of an extended care facility or private hospital from persuading or inducing, or attempting to persuade or induce, a patient to do any of the following:

- Make or change the patient's will
- Give a gift
- Provide a benefit for the employee, his or her spouse, relative or friend, or another employee
- Conduct the patient's financial affairs for the benefit of the employee, his or her spouse, relative or friend, or another employee

Employees of an extended care facility or private hospital are also prohibited from:

- Requiring a person seeking admission to make a payment or donation as a condition of admission, other than as specified in a written contract
- Acting as a committee under the Patients Property Act (see below), an attorney under a power of attorney, a representative under the Representation Agreement Act (see below), an executor of a will, or trustee of an estate for a patient or former patient who is not the employee's parent, child or spouse

The Hospital Act Regulation outlines the responsibilities of the governing body and medical staff, and requires that medical staff bylaws set out procedures to determine the responsibility for a patient's care. It also contains provisions relating to patient admission and discharge, and it states how long a hospital must retain various types of records.

Note to Nurse Practitioners

Under the Hospital Act Regulation, nurse practitioners can become members of the medical staff of a hospital, and they are entitled to attend or treat patients in a hospital if they hold a valid permit, issued by the hospital's board of management, to practise in the hospital.

The responsibility for medical care of a patient who is admitted to the hospital by a physician may be transferred to a nurse practitioner on the medical staff when necessary and appropriate. A transfer of responsibility must be made according to the procedures established in the bylaws of the hospital's board of management.

Nurse practitioners may also admit patients to, or discharge patients from, a hospital if they are authorized to do so by the hospital's board of management. The responsibility for nurse practitioner care of a patient who has been admitted by a nurse practitioner is assumed by an attending nurse practitioner on the medical staff for the duration of the patient's stay in the hospital. Responsibility for patient care may be transferred from one nurse practitioner on the medical staff to another, or to a physician on the medical staff, if necessary, or to a midwife on the medical staff, if necessary and appropriate.

If a hospital's board of management modifies, refuses, suspends, revokes, or denies the renewal of a nurse practitioner's permit to practise in the hospital, the nurse practitioner may appeal that decision to the Hospital Appeal Board established under the Hospital Act.

Part 2 of the Hospital Act was amended on May 29, 2014, to give nurse practitioners the authority to certify the death of a patient so that the patient's body may be removed from a licensed private hospital. The Act does not give other nurses this authority.

HUMAN RIGHTS CODE

Current to January 1, 2017

The Code is aimed at preventing discrimination on various grounds, such as race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex or sexual orientation, and age. It prohibits a person, without reasonable justification, from denying anyone any service generally available to the public on any of the listed grounds. It also protects a person from being discriminated against by a union, employers' organization, occupational association or employer.

The Code's prohibitions and protections apply to nurses in the same manner as to the general population.

HUMAN TISSUE GIFT ACT*Current to January 1, 2017*

This Act, along with the Consent to Donation Regulation, regulates organ and tissue transplants in British Columbia. This system depends entirely on donations of tissue and organs that may be transplanted into a living body.

The BC Transplant Society has been created to develop standards for these services. It contracts with three hospitals for transplant surgeries, and a registry system has been established for individuals who wish to register their consent to donate their tissue or organs when they die. The legislation permits spouses and others to consent to donate on behalf of adults and infants who have not registered under the system.

Certain designated hospitals and facilities are required to notify the Transplant Society of an impending death or death of a person under 75 years of age. Further, they must approach next-of-kin in certain circumstances to obtain consent to an organ or tissue transplant. The Regulation recognizes registered nurses as health care professionals who may be designated to obtain such consent in accordance with the applicable protocol and after appropriate training.

INFANTS ACT*Current to January 1, 2017*

This Act deals with several issues, including consent to health care for infants. Infants are defined as individuals under 19 years of age. The Act imposes obligations on health care providers, including nurses, to obtain valid consent from an infant. In certain circumstances described in the Act, an infant may give valid consent, in which case it is not necessary to obtain consent from the infant's parent or legal guardian.

An infant's consent to health care is valid only if the health care provider has done both of the following:

- Explained to the infant the nature and consequences of the health care as well as the reasonably foreseeable benefits and risks and is satisfied that the infant understands this information
- Made reasonable efforts to determine, and has concluded, that the health care is in the infant's best interests

LABORATORY SERVICES ACT*Current to January 1, 2017*

Under this Act, a "referring practitioner" may refer a person who is eligible to receive benefits under the Medical Services Plan (MSP) to an approved laboratory facility to receive medically necessary outpatient laboratory services. Laboratory services include the taking or collecting, or the analysis, of specimens for the purpose of preventing, diagnosing or treating human injury, disease or illness.

When considering laboratory services for which a patient will be referred, referring practitioners must consider all relevant guidelines and protocols established by the Ministry of Health.

Referring practitioners must not refer patients to an approved laboratory facility in which the practitioner has a financial or other interest, except in one the following situations:

- If there is no other public laboratory facility that provides the service in question in the same catchment area
- If the Ministry of Health has provided prior written consent for the referral (which may be necessary, for example, in certain rural or remote communities)

A referring practitioner must not knowingly refer a patient to any laboratory facility that is not approved under this Act, to receive any service that would otherwise be a benefit covered by MSP, unless the practitioner first informs the patient, in a manner the patient can understand, of **all** of the following:

- That the patient will be receiving services from a laboratory facility that is not approved
- That MSP will not pay for those services
- That the patient will be required to pay the cost of those services
- The amount the patient will be required to pay

Registered nurses with CRNBC certification (RN(C)) may apply to enrol with MSP and to obtain an MSP billing number, for the purpose of acting as a referring practitioner under this Act. As a referring practitioner, they may refer a patient who is eligible to receive benefits under MSP to an approved laboratory facility to receive selected medically necessary laboratory tests that are included in the CRNBC-approved Decision Support Tools for certified practice categories.

Additional information for referring practitioners, including information specific to certified practice registered nurses, can be found on the Ministry of Health website:

<http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/laboratory-services-diagnostic-services/laboratory-services/practitioner-information>

Note to Nurse Practitioners

Nurse practitioners who are enrolled with MSP and have an MSP billing number are authorized to act as referring practitioners under this Act, and may refer any person who is eligible to receive benefits under MSP to an approved laboratory facility for any fee-for-service outpatient laboratory service listed in the Ministry of Health's Schedule of Fees for Laboratory Services, provided that the service falls within nurse practitioner scope of practice.

As with any other referring practitioner under this Act, a nurse practitioner must consider all relevant guidelines and protocols established by the Ministry of Health. In particular, the nurse practitioner must specifically consider the Guidelines and Protocols Advisory Committee's clinical practice guidelines in determining whether the outpatient laboratory services are medically necessary for the patient. Nurse practitioners are also expected to comply with all guidelines and billing rules established by the Ministry of Health, as well as the patterns of practice that apply to family practice physicians as outlined in the Laboratory Services Schedule of Fees.

Additional information specific to nurse practitioners can be found on the Ministry of Health website: <http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/laboratory-services-diagnostic-services/laboratory-services/practitioner-information/nurse-practitioners>

LIMITATION ACT

Current to January 1, 2017

Health care records should be retained as long as there is the possibility of legal action being taken against any person, facility or agency in the health care field, including a nurse. The possibility of legal action exists up to the time the limitation period expires.

The Limitation Act establishes limitation periods for initiating different kinds of legal actions. The basic limitation period that applies to most claims arising from an act or omission occurring after June 1, 2013, is two years from the date the claim is “discovered.” (Note that claims arising from acts or omissions occurring before June 1, 2013, may be governed by different limitations periods established under a previous version of the Act.)

Most claims are deemed to have been “discovered” on the first day on which the claimant knew or reasonably ought to have known **all** of the following:

- That injury, loss or damage had occurred
- That the injury, loss or damage was caused by or contributed to by an act or omission
- That the act or omission was that of the person against whom the claim is made
- That having regard to the nature of the injury, loss or damage, a court proceeding would be an appropriate means to seek to remedy the injury, loss or damage

However, the Act establishes special rules about the date of discovery that apply in certain circumstances, such as for claims made by minors or by mentally incapable adults. The discovery date for a claim by a minor may be postponed until the minor reaches the age of majority (19 years). The discovery date for a claim by a mentally incapable adult may be postponed until the adult is no longer incapable, unless a notice to proceed is given to the claimant’s caregiver and to the Public Guardian and Trustee.

Regardless of the date a claim is “discovered,” the Act specifies an ultimate limitation period of 15 years from the occurrence of the act or omission on which the claim is based. This period may also be extended, however, for a claimant who is a minor or a mentally incapable adult.

MEDICARE PROTECTION ACT

Current to January 1, 2017

The regulations under this Act allow a registered nurse with CRNBC certification (RN(C)) to apply to the Medical Services Commission to enrol as a practitioner for the purposes of the Medicare Protection Act. If enrolled, an RN(C) may refer a patient who is eligible to receive benefits under the Medical

Services Plan (MSP) for selected medically necessary laboratory tests, without an order having been made by a physician, nurse practitioner, dentist, podiatrist or midwife. These tests are restricted to those included in the CRNBC-approved Decision Support Tools for certified practice categories.

A registered nurse may also be eligible to be paid through MSP for extended role services if an arrangement for rendering and payment of those services is approved by MSP, if a medical practitioner is not normally available at the place in British Columbia where the services are rendered, and if the services are described in an adequate clinical record.

Note to Nurse Practitioners

Nurse practitioners are eligible to enrol with MSP and obtain an MSP billing number. Additional information can be found on the Ministry of Health website:

<http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/nurse-practitioners>

Enrolled nurse practitioners are authorized to independently refer a person who is eligible to receive benefits under MSP for diagnostic radiology and imaging services that are associated with nurse practitioner scope of practice.

MENTAL HEALTH ACT

Current to January 1, 2017

The main purpose of the Mental Health Act is to regulate the admission, detention and treatment of psychiatric patients to mental health facilities, psychiatric units or observation units. A person may be admitted to a designated facility under the Mental Health Act either voluntarily or involuntarily. A list of hospitals and other designated facilities is contained in Appendix 1 of the *Guide to the Mental Health Act, April 2005*, published by the Ministry of Health and available on its website.

A nurse in charge of a ward in a designated facility must ensure that each patient who was admitted voluntarily is able to communicate to the director of that facility, without delay, any desire to leave, and the nurse must promptly notify the director of the patient's wish. The Mental Health Act prohibits any person from assisting or counselling a patient to leave a provincial mental health facility without proper authority.

Involuntary admission

The Act deals specifically with involuntary admission for a person with a mental disorder who needs care. A person with a mental disorder is defined as someone who has a disorder of the mind that requires treatment and that seriously impairs the person's ability to react appropriately to the environment or to associate with others. The Act states that the director of a designated facility may admit a person and detain him or her for up to 48 hours for examination and treatment as long as the director has received a medical certificate completed by a physician stating that the physician has examined the person. This examination must be done not more than 14 days before the date of admission. The person may be detained and treated past 48 hours if the director receives a second

medical certificate, which must be completed within 48 hours of admission. The authority for a patient's detention must be reviewed at the end of stipulated time periods under the Act.

The Act provides for the review process. The patient or a person acting on the patient's behalf may, at prescribed times, ask for a hearing by a review panel to decide whether detention should continue. At the hearing, the review panel must consider all reasonably available evidence about the patient's history. The panel must assess whether there is a significant risk that the patient will fail to follow the prescribed treatment plan if he or she is discharged.

In an emergency, a police officer may apprehend a person and take him or her to a physician to be examined. In this case, the officer must be satisfied that the person is acting in a manner likely to endanger his or her own safety or the safety of others and is apparently a person with a mental disorder. If the physician completes a certificate, the person may be admitted and treated. The person must be released if no supporting medical certificate is completed within 48 hours.

A person may also be involuntarily admitted if a judge or justice of the peace issues a warrant because there are reasonable grounds to believe that the person has a mental disorder and likely satisfies the criteria for being admitted. When admitted under a warrant, a person must be discharged after 48 hours unless the director of the facility receives two medical certificates as described above.

In some cases a person may be released from a facility but may still be under its authority. When this happens, certain conditions may be imposed, such as a plan to treat the patient in the community. In addition, the Act provides for involuntary patients to leave the designated facility for different periods of time for various purposes.

When a person is involuntarily admitted to a facility, the director of the facility must notify both that person and a near relative of the person the reason for the detention. In this case, a near relative may include a friend, caregiver or companion designated by the patient. The director must also provide the person's right to review under the Act and the right to legal advice.

A person who has been involuntarily detained in a designated facility is deemed to have given consent to having psychiatric treatment. However, in practice, the signing of consent forms for involuntary treatment is often delegated to specific individuals, including the senior registered nurse on duty. A patient, or a person on behalf of the patient, may request a second medical opinion on whether the treatment authorized by the director is appropriate.

Admission of minors

The Act sets out specific consent requirements for admitting minors. Anyone under the age of 16 may be admitted and treated at the request of that person's parent or guardian if the director is satisfied the person has a mental disorder. Only those minors who have reached the age of 16 may be admitted upon their own request. A person 16 years or older who has been admitted may authorize his or her treatment in the facility. These specific consent provisions override the general consent provisions relating to minors under the Infants Act (see above).

Note to Nurse Practitioners

Nurse practitioners (and other nurses) do **not** have the authority to examine a person and give an opinion that the person has a mental disorder for the purpose of admission to or discharge from a

designated mental health facility. This authority is given only to *physicians*.

MOTOR VEHICLE ACT

Current to January 1, 2017

A registered nurse may take a blood sample from a person if it has been demanded by a peace officer who believes that the person who has had care or control of a motor vehicle has a blood alcohol content greater than 80 mg of alcohol in 100 mL of blood. The sample may be taken without consent if the person is incapable of understanding the demand because of physical or mental trauma. The Act does not, however, require nurses to take blood samples, and specifically provides that a nurse may decline to take a blood sample from a person (regardless of any other requirement) if it is the opinion of a medical practitioner or nurse practitioner that doing so would endanger the person's health or life. The Act also protects a nurse taking a blood sample from liability, unless he or she is negligent.

This Act also requires a psychologist, optometrist, medical practitioner or nurse practitioner (but not a registered nurse), to report to the Superintendent of Motor Vehicles any patient who has a medical condition that makes it dangerous to drive, and who continues to drive after being warned of the danger. However, subject to the note below, nothing in the Act prevents anyone else (including a registered nurse) from making such a report.

Note: Typically, the Freedom of Information and Protection of Privacy Act (FOIPPA – see above) or the Personal Information Protection Act (PIPA – see below) would apply when a nurse reports an unsafe driver, depending on whether the nurse is working in the public or private sector.

In the public sector, FOIPPA authorizes a nurse employed by a public body to disclose an individual's personal information if the head of the public body (e.g., the CEO of a health authority – usually delegated to a manager) determines that there are compelling circumstances to do so affecting anyone's health or safety. Notice of a disclosure must be mailed to the individual in question, unless the head of the public body considers that giving this notice could harm someone's health or safety. It is strongly recommended that public bodies, such as health authorities, have a process in place to support the decision of the nurse, and that the written notice to the client be signed by the CEO or manager.

For nurses working in the private sector, there is a similar provision under PIPA, which includes a requirement that a written notice always be sent to the individual in question.

Note to Nurse Practitioners

Nurse practitioners are authorized to carry out the following activities under the Motor Vehicle Act:

- Issue a certificate stating that a person was incapable, due to physical or mental trauma, of comprehending a demand for a sample of blood to determine whether he or she was under the influence of alcohol as evidence in a proceeding
- Determine that taking a blood sample for the purposes of the Motor Vehicle Act would endanger a person's life or health

However, only a *physician* may undertake the activities listed below. Nurse practitioners (and other nurses) **cannot**:

- Issue a certificate or advise the Department of Motor Vehicles Branch Superintendent to issue a certificate stating that a person is unable for medical reasons to wear a seatbelt for the purpose of exempting the person from the seatbelt requirements under the Act
- Recommend to the Superintendent to issue a certificate that a person is unable for medical reasons to wear a bicycle safety helmet and is therefore exempt from this requirement
- Certify that a child is unable for medical or physical reasons to wear a required restraint system in a motor vehicle

OMBUDSPERSON ACT

Current to January 1, 2017

Members of the public may complain to the BC Ombudsperson about certain decisions, recommendations, acts, omissions or procedures of a health authority, hospital, university or college, or another authority identified in this Act.

When investigating a complaint, the Ombudsperson has various powers, including the power to require persons to produce relevant information or documents. In some circumstances, these powers may override other confidentiality requirements.

PATIENT CARE QUALITY REVIEW BOARD ACT

Current to January 1, 2017

This Act establishes a Patient Care Quality Review Board for each health authority region. These boards deal with complaints from patients about the delivery and quality of health care and health care services. When a Patient Care Quality Office receives a complaint, it is processed according to directions from the Minister of Health. After the complaint has been processed, a report must be given to the patient about the circumstances, policies involved and any action taken. If a patient is not satisfied with the result, he or she may seek a review by the Review Board in the health authority. The Review Board has some investigative powers and may recommend to the Minister and health authorities that improvements be made to patient care. The Minister may also refer matters to a Review Board for consideration.

PATIENTS PROPERTY ACT

Current to January 1, 2017

This Act allows the court, under certain circumstances, to appoint a committee to act as a representative for a person who is incapable of managing himself or herself, or his or her own legal and financial affairs.

If the Public Guardian and Trustee is appointed to act as a person's statutory property guardian under Part 2.1 of the Adult Guardianship Act (see above), the Public Guardian and Trustee is deemed to be the person's committee under the Patients Property Act.

Before December 1, 2014, the director of a mental health facility or psychiatric unit also had authority to appoint a committee for a patient in certain circumstances. A committee who was previously appointed in that manner may continue to act in that capacity; however, the patient may be entitled to a reassessment of his or her incapability under Part 2.1 of the Adult Guardianship Act, in the situations described in that Act (see above).

Where the patient is incapable of managing his or her legal affairs, the committee assumes the rights, powers and privileges of the patient's estate. Where the patient is incapable of managing himself or herself, the committee has custody of the patient, and may give or refuse consent to health care services on behalf of the patient.

Note to Nurse Practitioners

Only a *physician* can swear an affidavit containing his or her opinion that a person is mentally incapable of looking after his or her own financial affairs or making personal decisions so that the court can make a declaration of incapability and appoint a committee for the person. Nurse practitioners (and other nurses) **cannot** do this.

PERSONAL INFORMATION PROTECTION ACT (PIPA)

Current to January 1, 2017

PIPA is the companion legislation to FOIPPA (see above) and applies to private organizations, including corporations, unincorporated businesses, trade unions and non-profit organizations. It therefore applies to nurses running a business.

PIPA governs the collection, use and disclosure of personal information by the private sector. The Privacy Commissioner has jurisdiction over the private sector, and over a similar system of investigation and hearings as what is set out in FOIPPA.

Personal information means information that can identify an individual, such as a name, home address and telephone number. It also means information about an identifiable individual, such as employee information. It does not include business contact information and work product information.

Generally, PIPA gives individuals the right to access personal information about themselves, including information about their health care history. They may also request that their personal information be corrected. However, unlike FOIPPA, PIPA does not give individuals the right to access other records not involving their own personal information.

A private sector organization governed by PIPA may refuse to disclose an individual's own personal information to the individual if such disclosure could reasonably be expected to result in immediate and grave harm to the applicant's safety or mental or physical health. To help decide if this is the case, the organization may disclose the information to a health care professional, including a nurse, and ask for an opinion on whether disclosing the information could reasonably be expected to result in such harm.

Private sector organizations must appoint a privacy officer to ensure they comply with this Act.

PERSONAL INFORMATION PROTECTION AND ELECTRONIC DOCUMENTS ACT (PIPEDA) (FEDERAL)

Current to December 31, 2016

PIPEDA is the federal counterpart to FOIPPA and PIPA (see above). It governs the collection, use and disclosure of personal information in much the same way as the provincial laws. It applies to organizations that are federal in scope, such as banks and telecommunications companies. It may also apply to personal information collected, used or disclosed in interprovincial or international transactions, in the course of commercial activities, by organizations otherwise subject to the provincial laws.

PHARMACEUTICAL SERVICES ACT

Current to January 1, 2017

The Pharmaceutical Services Act governs BC PharmaCare, a provincial program that provides benefits to eligible BC residents to help cover the cost of certain prescription drugs and medical supplies.

The Information Management Regulation under this Act also governs access to PharmaNet, a secure computerized database which records information about prescriptions dispensed in British Columbia. Under the Regulation, physicians and nurse practitioners may apply for access to patient record information on the PharmaNet system for therapeutic treatment purposes. Other persons (including registered nurses) acting on behalf of a physician or nurse practitioner may also obtain access to PharmaNet, upon signing an undertaking of confidentiality.

Under this Act, the Ministry of Health may collect, use and disclose personal information for a variety of purposes. The Act requires “providers” and employees or agents of providers, including nurses, to keep prescribed records and to produce those records in the manner required by the Ministry. A provider is defined as an owner of a pharmacy, facility or other place where drugs, devices, substances or related services are provided to persons, other than on a wholesale basis.

A provider, or a practitioner who is authorized to prescribe drugs under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, may ask the Ministry of Health to authorize payment for all or part of a drug provided to a person or class of persons that would not otherwise be paid for by PharmaCare. As of December 3, 2015, such “practitioners” include both nurse practitioners and registered nurses (as registered nurses, on that date, were given prescribing authority under the Nurses (Registered) and Nurse Practitioners Regulation over Schedule II drugs and, for certain limited purposes, Schedule I drugs).

Practitioners may also issue electronic prescriptions, but only through PharmaNet.

In some circumstances, an inspector appointed under this Act may require a practitioner to produce or give electronic access to relevant records for the purposes of an audit of a current or former provider. A practitioner must comply with such a requirement.

Note to Nurse Practitioners

Additional information for nurse practitioners about applying for access to PharmaNet can be found online at <http://www.medi.net/pharmanet-home.htm>.

A nurse practitioner may provide the following certificates under the Drug Plans Regulation under this Act:

- Certifying that a person under their care has been diagnosed as having an illness or condition that will likely result in the person's death within 6 months, and that the person is receiving health care primarily for the purpose of palliative care rather than treatment of the illness or condition, for the purposes of the person's enrollment in the Palliative Care Drug Plan ("Plan P")
- Certifying that the nurse practitioner has prescribed a psychiatric drug to a person who has previously been hospitalized for treatment related to a psychiatric condition, and that, without the prescribed drug, the person would likely require hospitalization or the person, or another person, would likely suffer serious physician or psychological harm or economic loss, for the purposes of the person's enrollment in the Psychiatric Medications Drug Plan ("Plan G")

PHARMACY OPERATIONS AND DRUG SCHEDULING ACT

Current to January 1, 2017

This Act regulates the licensing and operation of pharmacies. Under this Act, drugs are classified by drug schedules, and conditions are placed on their sale. The drug schedules categorize drugs by type and whether a prescription is needed to obtain them.

Schedule I drugs require a prescription for sale, and are provided to the public by a pharmacist following the diagnosis and professional intervention of a health care practitioner who has the authority to prescribe them, such as a physician, dentist, midwife or nurse practitioner. As of December 3, 2015, registered nurses and registered psychiatric nurses also have limited authority to prescribe Schedule I drugs for certain specified purposes listed in the Nurses (Registered) and Nurse Practitioners Regulation and the Nurses (Registered Psychiatric) Regulation.

Schedule IA drugs are narcotics and controlled drugs that may only be prescribed by an authorized class of practitioner (such a physician or dentist, or, as of July 26, 2016, a nurse practitioner) in accordance with the Controlled Prescription Program of the College of Pharmacists of BC and all applicable requirements under the Controlled Drugs and Substances Act and its regulations (see above).

Schedule II drugs may be sold by a pharmacist on a non-prescription basis, but must be kept within the professional service area of a pharmacy where there is no public access and no opportunity for patient self-selection. Schedule II drugs may also be prescribed by an authorized practitioner, such as a physician, dentist, midwife or nurse practitioner, or, as of December 3, 2015, a registered nurse or registered psychiatric nurse.

A pharmacist must dispense prescription drugs in the manner and quantity set out in the prescription unless authorized by the Act to do otherwise. Pharmacists may make some limited changes to the ordered medication (e.g., substituting a generic for a brand name medication).

POWER OF ATTORNEY ACT

Current to January 1, 2017

Under this Act, an adult may create an “enduring power of attorney” authorizing another person (the “attorney”) to make decisions for the adult about the adult’s financial affairs. These decisions will continue to have effect while the adult is incapable of making such decisions on his or her own.

An enduring power of attorney takes effect when it is signed both by the adult and the attorney, unless it states that it does not take effect until:

- A specified date; or
- A specific event occurs (e.g., when the adult becomes incapable)

If the enduring power of attorney specifies that it will take effect when the adult is incapable of making decisions about his or her own financial affairs, but the person named to confirm the adult’s incapability is incapable, unwilling or unable to act at that time, then a physician may confirm whether the adult is incapable.

PRIVACY ACT

Current to January 1, 2017

In British Columbia, a person can sue under this Act for breach of privacy. Although “privacy” is not defined, the courts will consider the circumstances and the relationship between the parties when considering whether a person’s privacy rights have been violated. Under this legislation, a nurse who breaches the duty to maintain confidentiality of information about a patient, without the patient’s consent or other lawful or ethical excuse, may be liable for damages.

PUBLIC GUARDIAN AND TRUSTEE ACT

Current to January 1, 2017

The Public Guardian and Trustee has a broad mandate. Duties include serving children and vulnerable adults by protecting their legal and financial interests, administering the estates of deceased and missing persons, and investigating financial abuse of children and vulnerable adults. The Public Guardian and Trustee may also investigate whether personal care and health care decisions made by a representative or guardian are in compliance with the Act. In such an investigation, the Public Guardian and Trustee may require a person, institution or other body to produce relevant personal care or health care records, including any report or information relevant to the incapability of an adult.

If the Public Guardian and Trustee is the committee or a temporary substitute decision maker for an adult, it may give consent to health care under the Health Care (Consent) and Care Facility (Admission) Act (see above).

PUBLIC HEALTH ACT

Current to January 1, 2017

The Public Health Act enhances the ability of public officials to respond to the threat or reality of major health hazards, including communicable diseases. It creates a system for making public health plans, identifying urgent public health issues and assessing public health. For example, a public health plan may identify the needs of a specific population such as mental health patients, or may prevent and mitigate the effects of diseases or facilitate the delivery of public health functions.

This Act contains mandatory reporting requirements for health care professionals, including nurses, of prescribed infections or hazardous exposures. The list of reportable communicable diseases is set out in a schedule to the Health Act Communicable Disease Regulation.

This Act also sets up a framework to prevent and control the spread of infectious diseases. For example, mandatory vaccination and other preventive measures can be ordered. In the case of disease outbreak, the medical health officer may issue quarantine and isolation orders to entire groups of people, such as travellers, and can adjust the order to add people to or release them from its effect.

A system to regulate health hazardous activities is also established in the Act. Swimming pools, tattoo parlours, body-piercing operations and suntanning salons are examples of the kinds of facilities that are subject to operational regulations. Other health risks such as hazardous foods and inadequate rental accommodations are also regulated. In addition, a system of regulations for health impediments is established. For example, the Public Health Impediments Regulation regulates the amount of trans fat in food.

The Minister and health officers are authorized to conduct inspections and make and enforce orders in situations where infectious or hazardous agents are spreading, and to deal with health hazards generally.

Note to Nurse Practitioners

Under this Act, a nurse practitioner is authorized to:

- Specify preventive measures to be followed by an infected person or a person having custody or control of an infected person, including measures to prevent transmitting an infectious agent
- Provide a certificate of compliance to show that a person is following an order of the medical health officer

A nurse practitioner must report to a medical health officer if an infected person, or a person with custody or control of an infected person, does not comply with the nurse practitioner's advice under section 17 of the Act, including instructions regarding diagnostic examinations and preventive measures.

Nurse practitioners (and other nurses) **cannot** provide a written notice stating that the health of a person who must comply with an order to take preventive measures in an emergency would be seriously jeopardized if the person did comply. This authority is restricted to *physicians*.

REPRESENTATION AGREEMENT ACT

Current to January 1, 2017

Representation agreements are designed to allow adults to arrange in advance how, when and by whom decisions about their health care, personal care and routine financial affairs will be made if they become incapable of making decisions independently. The powers of a representative under the Representation Agreement Act are broader than the powers of an attorney under the Power of Attorney Act, which are limited to managing an adult's financial and legal affairs.

This Act creates two types of legal planning documents in which an adult may designate a representative to manage his or her financial, legal, personal and/or health care decisions:

- *A standard representation agreement* permits the representative to make daily living decisions and most health care decisions for the incapable adult, but not a decision to refuse health care necessary to preserve life. An adult may make a standard representation agreement even if he or she is incapable of making a contract or incapable of managing his or her health care, personal care, legal matters or routine financial affairs.
- *A non-standard representation agreement* expands a representative's authority to include decision-making powers about specific health care decisions, such as refusing consent to life-supporting care and treatment, or giving or refusing consent to health care in specified circumstances even though the adult refuses to give consent at the time the health care is provided. To make a non-standard representation agreement, an adult must be capable of understanding the nature and consequences of the proposed agreement.

A representation agreement may provide for an alternate representative to make decisions when the first representative is unavailable or unwilling to act. The agreement may also appoint a monitor to ensure that the representative is acting properly, and, in some circumstances, the Act directs that a representation agreement must appoint a monitor.

An adult who has made a representation agreement may still continue to give, refuse or revoke consent to health care on his or her own behalf if he or she is capable of doing so under the Health Care (Consent) and Care Facility (Admission) Act (see above). The Representation Agreement Act confirms that an adult who is capable may do anything that he or she has authorized a representative to do.

This Act also imposes a number of duties on representatives, including the duty to follow the wishes or instructions expressed by the adult while capable, or, if the adult's instructions or expressed wishes are not known, to act on the basis of the adult's known beliefs and values, or if the adult's beliefs and values are not known, to act in the adult's best interests. When deciding whether it is in the adult's best interest to give, refuse or revoke substitute consent, a representative must consider the same factors as a temporary substitute decision maker under the Health Care (Consent) and Care Facility (Admission) Act (see above).

A representative may request information and records about the adult if they relate to the incapability of the adult or to an area of authority granted to the representative. A representative has the same right to information and records as does the adult for whom he or she is acting.

Any person may report to the Public Guardian and Trustee any of the following situations:

- If he or she believes that fraud, abuse or neglect of the adult is occurring
- If the representation agreement appears to be contrary to the wishes or best interests of the adult
- If the representative is failing to comply with the representation agreement or his or her duties

The Act also gives the Public Guardian and Trustee the authority to apply to court for an order cancelling all or part of a representation agreement.

REPRESENTATIVE FOR CHILDREN AND YOUTH ACT

Current to January 1, 2017

This Act establishes the independent office of the Representative for Children and Youth, whose mandate is to advocate on behalf of children, young adults and their families, and to ensure that “designated services” meet their needs and are accessible to them. Designated services are government-funded services or programs for children, young adults and their families.

The Representative also has the authority to investigate or review and report where a child has been critically injured or died when that child or the child’s family was receiving a “reviewable service” at the time of, or within one year of, the incident. Reviewable services are services or programs under the Child, Family and Community Service Act (see above) and the Youth Justice Act. Mental health and addiction services for children are also reviewable services.

The Representative may initiate a review if the policies or practices of a public body or a director may have contributed to the injury or death of a child and if the critical injury or death was due to abuse or neglect, occurred in unusual or suspicious circumstances or was self-inflicted or inflicted by another person. The Representative has the right to information in the custody and control of public bodies necessary to carry out this role.

SCHOOL ACT

Current to January 1, 2017

Under this Act, a school medical officer must be appointed for each school district. The school medical officer has duties and powers relating to inspecting and closing schools, as well as examining the general health of students within a school district. In addition, the school medical officer has the power to remove a student or employee who might endanger the health or welfare of students.

This Act also obliges the board of school trustees to provide health services in accordance with orders from the Minister of Education.

Note to Nurse Practitioners

Under this Act, a physician or other qualified person designated by the Minister of Health—which could include a nurse practitioner—can be asked to certify the physical, mental or emotional health of a school employee or a contractor who has contact with students. (After a pending amendment to the Act is brought into force, this authority will be extended generally to nurse practitioners.)

This Act authorizes nurse practitioners to provide a certificate to a school that a student is not suffering from a communicable disease or other health condition that would endanger the health or welfare of others in the school. *School medical officers* and *physicians* are also given this authority.

VITAL STATISTICS ACT

Current to January 1, 2017

Births

This Act requires every medical practitioner, nurse practitioner or midwife who attends a birth to give notice of the birth to the district registrar. If no medical practitioner, nurse practitioner or midwife attends the birth, a nurse or other person attending must give notice of the birth.

Deaths

This Act lists procedures that must be taken when a person dies, including pronouncing and certifying death.

A pronouncement of death is the opinion or determination that life has ceased based on a physical assessment. Nurses may pronounce death, but registered nurses (other than nurse practitioners) **cannot** certify a death. It is the legal responsibility of physicians, nurse practitioners or coroners to certify a death.

Note to Nurse Practitioners

A certificate of death is the legal document setting out the cause of death. The death certificate must be completed by a physician or a nurse practitioner if the physician or nurse practitioner attended the patient during his or her last illness, is able to certify the cause of death with reasonable accuracy, and has no reason to believe that the patient died under circumstances that require a coroner's inquest or investigation.

A death certificate may also be completed by a physician or a nurse practitioner if the death was natural, the physician or nurse practitioner is able to certify the medical cause of death with reasonable accuracy, and a coroner has consented to the physician or nurse practitioner completing and signing the medical certificate.

In either situation, the death certificate must be completed, if possible, within 48 hours of the patient's death. If for any reason it is not possible to complete the certificate within that time, the attending physician or nurse practitioner must promptly notify the coroner.

A funeral director, physician or nurse practitioner must also promptly notify the coroner if a death occurs without a physician or nurse practitioner in attendance during the last illness of the deceased.

The Act also requires a statement to be completed and delivered to a funeral director or a vital statistics registrar within 48 hours of a stillbirth, either by the father or mother or by another adult person who has knowledge of the relevant facts (who could be a nurse practitioner). In addition, if

there was no physician in attendance at the stillbirth, it is the responsibility of either a nurse practitioner or coroner or a non-attending physician to complete a certificate setting out the cause of the stillbirth and deliver it to a funeral director or a vital statistics registrar.

A physician or a nurse practitioner may obtain a copy of a registration of a death or stillbirth from the registrar general if it is needed to treat an immediate family member of the deceased who is suffering from an illness which, in the opinion of the physician or nurse practitioner, may be life threatening.

This Act also authorizes a nurse practitioner to examine a foundling to determine, as nearly as possible, the date of the child's birth.

Nurse practitioners **cannot** provide a statement confirming that the sex designation on a person's birth registration does not correspond with the person's gender identity, in support of an application to amend the person's sex designation. Such a statement must be completed by a *physician* or a *psychologist*.

WORKERS COMPENSATION ACT

Current to January 1, 2017

A physician or qualified practitioner attending or consulting on a case of injury or alleged injury to a worker in particular industries must provide extensive medical reports to WorkSafeBC. A qualified practitioner is defined as a chiropractor, dentist, naturopath, podiatrist or nurse practitioner. A qualified practitioner must give all reasonable and necessary information, advice and assistance to the injured worker and the worker's dependants who are applying for compensation.

In practice, WorkSafeBC uses nurses as advisors, and they prepare reports for the board.

Under this Act, if a nurse (or certain other health professionals) determines that a medical emergency exists or that information regarding a hazardous substance is needed for the purpose of diagnosing or providing medical treatment or first aid, an employer, supplier or chemical manufacturer is required to give the nurse (or other health professional) all applicable information in their possession, including confidential business information. The nurse (or other health professional) must keep the information confidential (if it is specified as being confidential), except for the purpose for which the information was provided.

Note to Nurse Practitioners

As of January 1, 2015, nurse practitioners are included in the list of qualified practitioners authorized to attend or consult on a case of injury or alleged injury to a worker (which includes issues of mental stress and emergency services).

Nurse practitioners who provide treatment to injured workers are deemed to have accepted the terms of WorkSafeBC's Nurse Practitioner Fee Schedule, and are expected to submit invoices to WorkSafeBC within 90 days of the date of service. They are also required to make reports to WorkSafeBC within 3 days of first attending on a worker, and follow-up reports every 4 weeks or earlier where there is a change in the worker's medical condition, treatment plan, or return to work status, including a report within 3 days after the worker is, in the nurse practitioner's opinion, able to return to work.

Additional information about the Nurse Practitioner Fee Schedule and billing and reporting requirements, including required forms, can be found on WorkSafeBC's website:

<https://www.worksafebc.com/en/health-care-providers/provider-types/nurse-practitioners>

Despite being recognized as qualified practitioners under the Workers Compensation Act, nurse practitioners are **not** authorized to provide certain specified services under the Occupational Health and Safety Regulation. For example, only *physicians* have authority to undertake the following activities:

- Examine a worker for the purpose of advising an employer whether the worker has the ability to use a respirator
- Examine workers who carry out work in air pressure greater than 7 kPa (1 psi) above atmospheric pressure for the purposes of the Workers Compensation Act
- Provide medical certification for a person employed as a diver for the purposes of the Workers Compensation Act
- Provide a certificate of fitness for the use of a self-contained breathing apparatus under the Workers Compensation Act (for a firefighter who experiences breathing difficulty while using the apparatus, or is known to have heart disease impaired pulmonary function, or any other condition that might make it dangerous for the firefighter to use self-contained breathing apparatus)

Additional Legislation Relevant to Nurse Practitioners' Practice

BRITISH COLUMBIA TRANSIT ACT

Current to January 1, 2017

Nurse practitioners **cannot** confirm that a person's disability is severe enough that the person is physically unable to use conventional transit service without assistance, for the purpose of determining the person's eligibility for custom transit service. The British Columbia Transit Regulation under this Act gives this authority only to *physicians*.

BUSINESS PRACTICES AND CONSUMER PROTECTION ACT

Current to January 1, 2017

Nurse practitioners are authorized to substantiate a medical reason for a consumer to cancel a continuing services contract. A consumer may cancel a continuing services contract by, among other methods, giving notice of a physical, medical or mental disability, substantiated in writing by nurse practitioner, showing that the consumer's continued participation is unreasonable because of the condition or is likely to endanger the consumer's health. A physician also has this authority.

COMMUNITY LIVING AUTHORITY ACT

Current to January 1, 2017

Only a *psychologist* or a *physician* (specializing in pediatrics or psychiatry) can diagnose a person with Fetal Alcohol Spectrum Disorder or Pervasive Developmental Disorder for the purposes of the Community Living Authority Act. A nurse practitioner **cannot** make such a diagnosis.

CORRECTION ACT

Current to January 1, 2017

Nurse practitioners are authorized to certify the state of health of a person in custody, that the person is fit for transfer, and that the person is free from any infectious or contagious disease, for the purpose of conveying him or her to a correctional centre. The person in charge of a correctional centre is not required to accept a person into custody under a warrant of committal without such a certification. A physician is also authorized to provide this certification.

CRIME VICTIM ASSISTANCE ACT

Current to January 1, 2017

Nurse practitioners are authorized to diagnose psychological harm in an individual who has a strong emotional attachment to a victim of crime resulting from witnessing, in close proximity, the life threatening injury of a victim, or the immediate aftermath of certain offences that causes the victim's

death for the purpose of receiving benefits. The Act also gives this authority to physicians and registered psychologists.

EMERGENCY HEALTH SERVICES ACT

Current to January 1, 2017

The Emergency Medical Assistants Regulation under this Act allows an emergency medical assistant on an infant transfer team or an advanced care paramedic to administer drug therapy only if a *physician designated by an employer as a "Transport Advisor"* orders him or her to do so. This authority is **not** given to nurse practitioners; nurse practitioners **cannot** provide an order for drug therapy in this situation.

EMPLOYMENT STANDARDS ACT

Current to January 1, 2017

This Act authorizes nurse practitioners (as well as physicians) to provide certificates that:

- Outline the expected or actual birth date, or the date a pregnancy terminated, or state the reasons for requesting additional leave for an employee for the purpose of requesting extended leave
- Entitle an employee to parental leave (if required by the employer)
- State that an employee is able to resume work if the employee wishes to return to work earlier than six weeks after the date of giving birth
- State that a family member of an individual has a serious medical problem that carries a significant risk of death (within a specified period) for the purpose of compassionate care leave

FOOD AND DRUGS ACT (FEDERAL)

Current to December 31, 2016

Drugs listed in the Prescription Drug List established by Health Canada under this Act may be prescribed by a practitioner who is authorized to do so under provincial law (see the Pharmacy Operations and Drug Scheduling Act and the Health Professions Act above).

The New Classes of Practitioners Regulations also allows nurse practitioners to prescribe, possess or perform activities with certain controlled drugs (in accordance with designated drug schedules) in certain circumstances, as permitted by the provincial government and CRNBC effective July 26, 2016. This includes controlled drugs that are regulated under Part G of the Food and Drug Regulations under this Act. For additional information, see the Controlled Drugs and Substances Act above.

Detailed information about nurse practitioners' scope of practice, including information about nurse practitioners' authority to prescribe drugs, can be found in CRNBC's *Scope of Practice for Nurse Practitioners Standards, Limits and Conditions*.

Nurse practitioners do **not** have authority under the Food and Drug Regulations to accept or sign for drugs distributed by a pharmaceutical representative. Only *physicians, dentists, veterinarians* and *pharmacists* have this authority.

Note: CRNBC advises registrants that the authorized individual who receives the drugs is responsible for keeping a tracking record/system, and nurse practitioners are advised to follow the authorized individual's system. Once the samples have been received into the clinical setting, the nurse practitioner does have authority to prescribe and dispense samples in accordance with relevant CRNBC standards, limits and conditions for prescribing and dispensing drugs.

GUIDE DOG AND SERVICE DOG ACT

Current to January 1, 2017

The Guide Dog and Service Dog Regulation under this Act authorizes nurse practitioners to complete a medical form providing the following written certification:

- Certification that a person is a blind or visually impaired and requires the assistance of a guide dog for daily living, in support of the person's application for a guide dog team certificate where the person has not completed an accredited guide dog training program together with their dog
- Certification that a person has a disability (other than blindness or visual impairment) and requires the assistance of a service dog for daily living as a result of that disability, in support of the person's application for a service dog team certificate where the person has not completed a service dog training program together with their dog

This authority is also granted to physicians.

HOME OWNER GRANT ACT

Current to January 1, 2017

The Home Owner Grant Regulation under this Act authorizes nurse practitioners to file a certificate confirming the truth of information required in support of an application for a grant for "persons with disabilities," including confirmation that the applicant is a person with disabilities, confirmation of the nature and extent of the disability, and confirmation that the disability is sufficiently severe that the person requires physical assistance in the form of regular and extensive supervision or care or structural modifications to his or her home. This authority is also granted to physicians.

HOSPITAL INSURANCE ACT

Current to January 1, 2017

A nurse practitioner who is a member of a general hospital's medical staff can recommend that certain general hospital services be provided to a patient who requires in-patient treatment. A nurse practitioner can also provide written certification of a patient's admission to the hospital for the purpose of the patient qualifying for benefits under the Hospital Insurance Act Regulations. A nurse practitioner who attends a patient may also be required by the Ministry of Health to provide a written statement regarding the patient's condition and the necessity for the patient to receive health care for any specified portion of his or her stay in the hospital.

A nurse practitioner can also recommend that certain general hospital services be provided to a patient who requires active rehabilitative treatment in a rehabilitation hospital, or to a patient who requires skilled nursing care and continuing medical supervision in an extended care hospital. A nurse practitioner is authorized to supply a case history and complete diagnosis for a patient in a rehabilitation hospital or an extended care hospital, for the purpose of the patient applying for benefits under the Hospital Insurance Act Regulations.

If a dispute arises between a beneficiary and the Ministry of Health over whether the beneficiary requires hospital services, the beneficiary may be required to be examined by a physician appointed by the Ministry. This authority to examine an individual for the purpose of settling a dispute with the Ministry of Health regarding whether the individual requires hospitalization is **not** given to nurse practitioners.

INSURANCE (VEHICLE) ACT

Current to January 1, 2017

The Insurance (Vehicle) Regulation under this Act authorizes only *physicians* to certify that an insured person requires more than 12 months of physical therapy, for the purpose of the person qualifying for payment for that additional therapy from the Insurance Corporation of British Columbia (ICBC). Nurse practitioners are **not** given that authority.

However, nurse practitioners are authorized to provide reports to ICBC on the nature and extent of insured persons' injuries, and the treatment, current condition and prognosis of the injuries. (This authority is also given to physicians, dentists, physiotherapists and chiropractors.)

LAND TAX DEFERMENT ACT

Current to January 1, 2017

The Land Tax Deferment Regulation does **not** give nurse practitioners the authority to provide a medical certificate as proof of a severe mental or physical impairment for the purpose of deferring taxes under this Act. This authority is given only to *physicians*.

LEGAL PROFESSION ACT

Current to January 1, 2017

Under this Act, the "Benchers" (i.e., the board of directors of the Law Society of British Columbia) may make rules allowing a lawyer or articulated law student to be ordered to undergo a medical examination conducted by a *physician* who will report to the Benchers on the lawyer's ability to practise law or the articulated student's ability to complete his or her articles. This authority is not given to nurse practitioners, who **cannot** conduct an assessment for the purpose of providing such a report.

LIQUOR CONTROL AND LICENSING ACT

Current to February 1, 2017

This Act generally regulates the use, sale, supply or purchase of liquor, including restrictions on the sale or supply of liquor to minors. However, as of January 23, 2017 (when a new version of this Act was brought into force), nothing in the Act prevents a physician or nurse practitioner from providing liquor or a preparation containing liquor for medical purposes, including to a minor (for example, as a harm reduction strategy for clients with alcohol use disorders), provided that the physician or nurse practitioner complies with any applicable limits or conditions on their scope of practice. Although the provision of liquor is not a restricted activity under the Nurses (Registered) and Nurse Practitioners Regulation, a nurse practitioner who provides or orders the use of liquor for medical purposes would be required to follow any relevant scope of practice standards in CRNBC's *Scope of Practice for Nurse Practitioners*.

The Act does not exempt nurse practitioners from any restrictions that may be imposed by his or her employer on providing liquor for medical purposes.

The Liquor Control and Licensing Regulation under this Act authorizes a nurse practitioner to purchase ethyl alcohol without a licence or permit if it is for use only in connection with his or her practice.

MILK INDUSTRY ACT

Current to January 1, 2017

The Milk Industry Standards Regulation under this Act does **not** give nurse practitioners authority to certify that an applicant for a tank milk receiver licence or a dairy plant process worker licence is in good health for the purposes of the application. This authority is given only to *physicians*.

MOTOR FUEL TAX ACT

Current to January 1, 2017

Nurse practitioners are authorized to certify that an individual suffers from a permanent impairment of locomotion or from a permanent mental disability to the extent that it would be hazardous for the person to use public transportation, or suffers from a permanent sight impairment to the extent that the person would not be eligible to hold a driver's licence for the purpose of defining "persons with disabilities" under the Motor Fuel Tax Act. This authority is also granted to physicians.

OFFENCE ACT

Current to January 1, 2017

Nurse practitioners are authorized to provide evidence to support the opinion of a justice that there is reason to believe a defendant is mentally ill and that an order should be made remanding the defendant to custody for observation.

PASSENGER TRANSPORTATION ACT

Current to January 1, 2017

For the purpose of defining a passenger-directed vehicle (which includes certain commercial vehicles used for transporting persons with disabilities), nurse practitioners **cannot** confirm that an individual has disabilities so severe that he or she is physically unable, without assistance, to use conventional transit service. The Passenger Transportation Regulation under this Act gives only *physicians* this authority.

PENSION BENEFITS STANDARDS ACT

Current to January 1, 2017

Nurse practitioners **cannot** certify that a terminal illness or disability is likely to considerably shorten a person's life for the purpose of the person electing to vary the payment of benefits under this Act. This can be done only by a *physician*.

WILDLIFE ACT

Current to January 1, 2017

Nurse practitioners are authorized to certify that a person's blood alcohol content is less than 50 mg of alcohol in 100 mL of blood for the purpose of requiring a conservation officer or constable to return a firearm and hunting licence surrendered by that person. This authority is also granted to physicians.

YOUTH JUSTICE ACT

Current to January 1, 2017

Nurse practitioners are authorized to certify the health of a young person (aged 12 to 17) for the purpose of conveying him or her to a youth custody centre. The person in charge of a youth custody centre is not required to accept a young person into custody under a warrant of committal unless a *physician or nurse practitioner* certifies the state of health of the young person, that the young person is fit for transfer, and that the young person is free from any infectious or contagious disease.

A nurse practitioner **cannot** excuse a youth from a program in a youth custody centre unless the nurse practitioner is a staff member. Under the Youth Custody Regulation, a youth must participate in a youth custody program as directed by a person in charge of the youth custody centre unless the youth is excused by a *staff member or physician*, or the program is a religious program in which the youth chooses not to participate, or the program conflicts with a recognized day of religious observance of the youth's religious faith.

Resources

LEGISLATION AND REGULATIONS

Legislation and regulations available online:

Provincial: www.bclaws.ca

Federal: www.laws.justice.gc.ca/eng/

CRNBC RESOURCES

Overview of Health Professions Act, Nurses (Registered) and Nurse Practitioners Regulation and CRNBC Bylaws www.crnbc.ca/crnbc/documents/324.pdf

Documents in the Standards of Practice series also reference various Acts and Regulations (e.g., Practice Standard *Consent; Scope of Practice for Registered Nurses: Standards, Limits and Conditions*). These documents are available on the CRNBC website at www.crnbc.ca/Standards/Pages/Default.aspx