College of
Registered Nurses
of Manitoba

Practice Direction:

RN(NP) Practice and Prescribing Expectations

The College of Registered Nurses of Manitoba (the College) Council must, by regulation, establish standards of practice to regulate the quality of practice of registered nurses (RNs).

The Council approves practice directions which are written statements to enhance, explain, add or guide RNs with respect to matters described in the College of Registered Nurses General Regulations or any other matter relevant to registered nursing practice. Compliance with practice directions are required; these expectations also serve as a legal reference to describe reasonable and prudent nursing practice.

It is the responsibility of all RN(NP)s in Manitoba to understand all practice expectations and be accountable to apply them to their own nursing practice, regardless of roles or practice settings. Responsibility is the duty to satisfactorily complete your obligations. Accountability means being capable of explaining why you did or did not meet these expectations.

The policies of employers do not relieve individual RN(NP)s of accountability for their own actions or the primary obligation to meet practice directions. An employer's policies should not require an RN(NP) to practise in a manner that violates practice directions.

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Purpose

The College exists to serve and protect the public interest to achieve the outcome of accountable, quality, professional nursing practice. As such, this practice direction enhances and explains what the public can expect of all RN(NP)s in all domains of practice. The Practice and Prescribing Expectations for RN(NP)s build upon the RN Practice Expectations (crnm.mb.ca). They set the expectations of RN(NP)s in all domains of practice. Practice Expectations for RN(NP)s are based on the current entry-level competencies for RN(NP)s. That is, the entry-level competencies capture the knowledge, skill, and judgement that RN(NP)s possess on entry-to-practice and practice expectations establish the standards that the RN(NP) must meet. In addition to upholding all Practice Directions including the Practice Expectations for RNs and the Code of Ethics, RN(NP)s are expected to meet the following expectations.

Critical Thinking and Inquiry

RN(NP)s apply advanced knowledge, skill and judgment to address the health needs of clients.
RN(NP)s must:

1. Apply the Entry-level Competencies for RN(NP)s while synthesizing relevant knowledge with use of critical inquiry.
2. Conduct thorough accurate and requisite assessments, history taking, health status examination and consultation with clients.
3. Apply diagnostic reasoning to develop differential diagnosis and final diagnosis for the client's health/ illness condition.
4. Use collaboration and communication skills to create an appropriate care plan in consultation with the client, and, as needed, family and healthcare providers, including follow-up/ evaluation plan.
5. Use current evidence to support safe practice functioning within the scope of RN(NP) practice.

Ordering Screening and Diagnostic Tests

RN(NP)s order specific screening and diagnostic tests relevant to their client population in accordance with relevant provincial and federal legislation and standards, as well as evidence informed decision-making.
RN(NP)s must:

6. Apply evidence informed decision-making regarding appropriateness, contraindications, safety and cost-effectiveness of screening and diagnostic tests to either confirm/rule out a diagnosis, assess/monitor ongoing conditions of clients with chronic illnesses, or carry out screening.
7. Explain to clients the reasons for screening and diagnostic tests and the associated risks/benefits.
8. Adhere to jurisdictional, provincial and agency standards for ordering, documenting and reporting results of screening and diagnostic tests
9. Ensure a process is in place for receiving and tracking the results of screening and diagnostic tests.
10. Seek information to ensure understanding and follow-up as necessary with test results and diagnostic interpretation by specialist(s).

Consultation and Collaboration

RN(NP)s consult and collaborate with other healthcare providers as appropriate and in accordance with competencies for the RN(NP)s in Manitoba to ensure that the overall health-care needs of their clients are met.
RN(NP)s must:

11. Consult with other health-care providers at any stage in the care of a client from initial assessment to evaluation of treatment effectiveness, as required for the client's health care needs.
12. Ensure communication and appropriate documentation of consultations to keep health-care professionals informed of health conditions and/or treatment decisions pertaining to mutual clients.

Prescribing Drugs and Devices

RN(NP)s prescribe drugs and devices relevant to their client population in accordance with relevant provincial and federal legislation and standards, as well as evidence informed decision-making. RN(NP)s must:

13. Prescribe any device listed in the Specified Drugs Regulation, M.R. 6/95, or drug, as indicated by the client's diagnosis and care plan, ensuring they have relevant knowledge of the client's health history and have conducted an assessment obtained through direct client contact.
14. Consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs.
15. Decide whether to facilitate access to care based on a timely assessment and recommendation of another regulated health-care provider in circumstances where direct client contact is not feasible for the client. In these circumstances, the RN(NP) must:
    a. only prescribe if satisfied that the prescription is appropriate for the client,
    b. document provision of client care, and
    c. provide timely access for the client to follow-up.
16. Complete prescriptions accurately, completely and legibly including:
    a. date of issue, name, date of birth, personal identification number (e.g. PHIN) and address of the person for whom the drug is prescribed,
    b. weight of client if client is a child or weight has bearing on the dosage of the prescribed drug,
    c. age of the client if age has bearing on the dosage of the prescribed drug,
    d. name, strength and quantity and formulation (e.g. tablet, liquid, patch) of the prescribed drug,
    e. directions for use, including the dosage, frequency, route of administration, duration of drug therapy, and special instructions,
    f. direction for number of allowable refills and interval between refills (where applicable), and:
        - clear identification of the number of allowable refills for each drug, when a prescription includes more than one drug, and
        - total quantity and interval between part-fills for any medication on the CPhM M3P drug list and any medications that are federally classified as a narcotic or a controlled substance (refer to the CPhM for a complete listing of these medications),
    g. prescribing only one drug per prescription form for M3P drugs and advising client the prescription is only valid for three days after its issuance,
    h. the treatment goal and/or diagnosis and/or clinical indication,
    i. prescriber's name, regulated title, CRNM registration number, practice address, telephone number and fax number, and
    j. the name and address of the one pharmacy intended to receive the prescription, when the medication is classified as a controlled substance.
17. Sign prescriptions with:
    a. hand-written signature, or
    b. an electronic image of the RN(NP)'s signature but only if the prescription is sent through an approved electronic medical record, that meets the expectations for sending electronic prescriptions (outlined below).
18. Send prescriptions to the client's choice of pharmacy, considering treatment plan and drug availability, by either:
    a. Providing the client with a written prescription to bring to a pharmacy,
    b. Verbal prescription (new and refills directly to the pharmacist,
    c. Following the current Manitoba Prescribing Practice Program (M3P) process, or
    d. Electronic transmission to a single pharmacy ensuring:
        - Prescription is transmitted directly to the pharmacist,
        - Mode of transmission is secure and maintains confidentiality (either facsimile or closed e-prescribing system), and
        - After transmission, invalidation of the original prescription so that it cannot be re-transmitted elsewhere.

19. Educate clients about prescription and nonprescription drugs, including:
    a. Expected action of the drug,
    b. Importance of compliance with prescribed frequency and duration of the drug therapy,
    c. Potential side effects, signs and symptoms of adverse effects and actions to take if they occur (e.g. allergic reactions),
    d. Potential for abuse, tolerance, or addiction as indicated by the drug's profile,
    e. Potential interactions between the drug and certain foods, other drugs or substances such as natural health products or herbal remedies,
    f. Specific precautions to take or instructions to follow, and
    g. Recommended follow-up.
20. Monitor the client's response to drug therapy. Based on the client's response, decide to continue, adjust, or withdraw the drug, or to consult with another health professional.
21. Conduct record keeping according to legislation including but not limited to Health Canada reporting requirements for adverse drug reactions. Record keeping includes documentation in the client's health care record including a diagnosis, differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information.
22. Securely store blank prescriptions.
23. Not provide any person with a blank, signed prescription.
24. Not prescribe for yourself or family members.

Prescribing Opioids for Non-Cancer Pain

Acute Pain or Post-Operative Analgesia Client

25. When deciding whether to prescribe an opioid for clients with acute pain or who require post-operative analgesia, the RN(NP) must:
    a. Note that much acute and post-operative pain can be managed with non-steroidal anti inflammatories and acetaminophen alone or in combination.
    b. Prescribe only the lowest effective dose of immediate release opioids preparations limited to what the client will need before community follow up will be resumed (E.g. three days or less will often be sufficient; more than seven days will rarely be needed).
    c. When discharging clients from acute-care or post operatively, prescribe only the quantities of opioids that the client will need before community follow-up will be resumed.
    d. Prior to continued opioid prescribing beyond 30 days, consult with other health-care provider(s) if the client's acute pain does not resolve in the expected timeframe given the pain's etiology.
    e. Assess the client's risk of opioid misuse and substance abuse history, optimizing non-opioid treatment options.
    f. Discuss the risks of opioids with the client.

Initial Trial for Non-Acute Non-Cancer Pain in Opioid Naïve Clients up to 50 MME/Day

26. To determine if an opioid trial is clinically appropriate for non-cancer pain treatment for an opioid naïve client, the RN(NP) must:
    a. Conduct a comprehensive history and physical examination, including:
    i. Pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, psychosocial history, and previous non-pharmacological treatment,
        ii. Client's risk for opioid misuse, abuse, or diversion with use of appropriate screening tool(s) to determine the client's risk for addiction to opioids, and
        iii. Acquisition and review of applicable health care records.
    b. Optimizing available treatment options, including non-opioid pharmacotherapy and non pharmacological treatment modalities.

c. Reviewing the client's current/past medications utilizing Drug Programs Information Network (DPIN) or the electronic health record (eChart) or pharmacist. If no access is available to DPIN, eChart, or a pharmacist, then a one-time maximum three-day prescription may be written.
d. Only start with a trial of opioids as a therapeutic trial of less than three months. If therapeutic goals are not met or the harms outweigh the benefits, then discontinue opioids as a slow taper.
e. Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerability checks and clinical reassessments.
f. Conduct a reassessment, including assessment of benefits and risks to the client for both pain and function, according to the following timeframes: at least twice in the first month, monthly for the next two months, thereafter at least every three months.
g. Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible. Excluding acute and time-limited indications, do not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances.
h. In addition to above expectations for education with client, discuss with the client:
    i. Treatment goals including specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, social and functional states.
    ii. Potential benefit of long-term use of opioid treatment is modest, and
    iii. The end of treatment, including decreasing dosages and returning unused opioids to a pharmacy for safe disposal.
i. Require baseline urine drug testing prior to initiating an opioid trial. Require random and/or periodic urine drug testing on an annual basis, or more frequently if there are concerns. When ordering a urine drug screen, ask clients about all medications/drugs recently taken, and be aware of resources to assist assessment for potential false positive or false negative results.
j. Not prescribe opioids for clients with an active substance use disorder (excluding nicotine) without considering guidance from a health care prescriber specializing in addiction.

Clients Currently Prescribed between 50 and 90 MME per Day

27. A RN(NP) who prescribes or is considering prescribing opioids between 50 and 90 MME per day, must:
    a. Maintain vigilance for potential diversion and other substances of concern by verifying the client's current and past medications utilizing DPIN, eChart, pharmacist or previous prescriber at least every three months. If no access to verifying current/past medications, a one-time maximum three-day prescription can be written.
    b. Order an initial urine drug screen if one was not done in the past year, and at least yearly thereafter.
    c. Conduct a comprehensive history and physical examination if documented current history and physical examination is not available.
    d. Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to, and documenting, the following:
        i. Reassessment of the dose including discussion of specific and realistic goals of reduced pain (not elimination), and improved physical, psychological, and social functioning,
        ii. Careful reassessment of individual client's benefits and risks when considering dosage more than 50 MME per day, and

iii. Maximum three-month prescription with monthly dispensing. For clients in remote communities, dispensing may be for up to three months. For travelling clients, dispensing up to three months, only if the client receiving a stable long term prescription.

e. Taper benzodiazepine(s) slowly to the lowest functional dose, or zero.

f. Consider optimizing available non-opioid treatment options.

Clients Prescribed More Than 90 MME per Day

28. A RN(NP) that has prescribed or is considering prescribing more than 90 MME per day, must:
    a. Perform each of the practice expectations in the above sections.
    b. Not abruptly discontinue medications– "Bridging" prescriptions during assessment of the client is acceptable to avoid dangers of withdrawal.
    c. Determine the lowest effective dose of opioid needed to achieve and/or maintain the goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning, and consider a trial of slow tapering of the opioids. When tapering, if the client has a substantial increase in pain and decrease in function that persists more than one month after a dose reduction, tapering may be undertaken more slowly, paused or potentially abandoned in such clients.
    d. Consult with an appropriate specialist and/or multidisciplinary program (e.g. practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor, occupational therapist, dietitian) when the client receives a 90 MME dose daily for longer than 90 days, the client experiences serious challenges tapering off opioids, or opioid use disorder is suspected.
    e. Except in exceptional need and clearly documented benefit, restrict prescription to 90 MME or less per day. Seek a second opinion if considering doses beyond 90 MME per day.

Clients Prescribed More Than 90 MME per Day

29. For clients with long-term opioid use that are new to the RN(NP)'s practice, the RN(NP) must:
    a. Maintain vigilance for potential diversion and verify the current opioid prescription by:
        i. Obtaining collateral information from both the previous prescriber(s) and dispensing pharmacy(s) confirming the clinical indication and current opioid dosage,
        ii. Reviewing the client's current and past medications utilizing DPIN, eChart or previous prescriber, pharmacist, and
        iii. Ordering a urine drug screen.
    b. If no access to DPIN, eChart, or a pharmacist, a one-time maximum three-day prescription may be written until access to client's medication history obtained.
    c. Conduct and document a comprehensive history and physical examination including:
        i. Pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, and psychosocial history, and previous non pharmacological treatment/therapies,
        ii. Assessing the client's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the client's risk for addiction to opioids,
        iii. Obtaining applicable health care records, and
        iv. Verifying the client's identity.

d. Prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to the following:
    i. Carefully reassess evidence of individual benefits and risks when considering increasing dosage to more than 50 MME per day.
    ii. If the client is on more than 90 MME per day, careful reassessment of the dose including discussion of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning.
    iii. To determine the lowest effective dose of opioid needed to achieve and/or maintain these goals, consider a trial of slow tapering of the opioids. When tapering, if the client has a substantial increase in pain and decrease in function that persists more than one month after a dose reduction, then tapering may be undertaken more slowly, paused, or potentially abandoned in such clients
    iv. In those rare circumstances where tapering is not appropriate and there is documented benefit to the client, then continue treatment.
    v. Medications must not be abruptly discontinued – consider short term prescriptions during client assessment to avoid withdrawal.
    vi. Maximum three-month prescription with monthly dispensing. For clients in remote communities, dispensing may be for up to three months.
    e. Taper benzodiazepine(s) slowly to the lowest functional dose or zero.
    f. Optimize available non-opioid treatment options.

Continued Prescribing of Opioids for Clients with Non-Cancer Pain

30. Continued prescribing of opioids for clients with non-cancer pain applying the practice expectations in the above sections must only occur if there is documentation of:
    a. Measurable clinical improvement in pain, function, and/or quality of life, and
    b. Maintenance of a satisfactory level of improvements in these parameters, which outweigh the risks of continued opioid treatment.

Benzodiazepine and Z-drug Prescribing

To prescribe benzodiazepines and/or z-drugs, the RN(NP)s must meet these additional expectations.

31. Optimize non-pharmacological treatment modalities first (e.g. Cognitive Behaviour Therapy, sleep habits, elimination of caffeine).
32. Complete a medication reconciliation and best medication history including addiction screening and current opioid use, with the client, accessing data from available sources such as DPIN, client and the client's health care record.
33. Prescribe only the lowest effective benzodiazepine/z-drug dosages for the shortest possible duration.
34. Discuss with the client treatment goals, non-pharmacological therapies, modest benefit of long-term benzodiazepines and z-drugs, treatment risks, and dangers of cognitive decline, memory loss, impaired driving, under the influence of benzodiazepine/z-drugs while operating machinery, or performing safety sensitive tasks, and/or providing child or elder care.
35. Only write a prescription for a maximum of one-month interval, with dispensing to be authorized for no more than a one-month supply unless it is for intermittent use.

36. Due to risks of abuse and diversion, prescribe alprazolam rarely if at all, only if
    a. Current clinical evidence that benefits outweigh all potential risks,
    b. Urine drug screens results are available, and
    c. There are efforts to replace existing alprazolam prescriptions with other treatment options.
37. Consider all concurrent medical conditions (e.g. heart failure, obesity, sleep apnea, substance use disorders, renal or hepatic insufficiency, other chronic conditions, or pregnancy).
38. Regularly screen for the presence or emergence of mental health disorders (particularly mood and substance use disorders) using evidence informed screening tools.
39. Periodically attempt a trial of slow tapering. Appropriate care management does not include abrupt discontinuation or rapid decrease of these drugs after long-term use.

Continued Prescribing of Opioids for Clients with Non-Cancer Pain

40. In addition to the above, when considering prescribing for older adult clients, recognize and discuss with the client the additional risks, including but not limited to:
    a. Benzodiazepines and z-drugs are not used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium,
    b. Falls and fractures related to sedation, confusion, drowsiness, and postural instability, and
    c. Negative effects on cognition, memory, delirium and a link to cognitive decline and dementia.

Glossary

Anxiety disorder: A group of mental illnesses that cause constant fear and worry. Characterized by sudden feeling of worry, fear, and restlessness.

Consultation: An explicit request by an RN(NP) for another health-care provider to become involved in a client's care in which the RN(NP) has primary responsibility for care at the time of the request. Consultation can occur in various ways including face-to-face discussion, by telephone and in writing.

Diagnostic Reasoning: process to collect, process and interpret information to develop a diagnosis.

Direct Client Contact: Any activity in which the client and RN(NP) engage in the nursing process including face-to-face, hands-on, telephone, video conferencing or other forms of contact with the client if the RN(NP) can perform the requisite assessment, diagnosis, treatment, and follow-up.

Drug program information network (DPIN): an electronic, on-line, point-of-sale drug system linking all community pharmacies (but not pharmacies in hospitals or nursing homes/personal care homes) to capture information about all Manitoba residents. DPIN is maintained by the Government of Manitoba.

Electronic transmission: Communication of an original prescription or refill authorization by electronic means including computer-to-facsimile machine, facsimile machine to facsimile machine, facsimile machine to computer, or via a closed e-prescribing system. It does not include verbally transmitted prescriptions or prescriptions transmitted by email.

Evidence informed decision-making: A continuous interactive process involving the explicit, conscientious and judicious consideration of the best available evidence to provide care.

Manitoba Prescribing Practices Program (M3P): a prospective at-source risk management system to minimize drug diversion for Controlled and Narcotic medications and facilitate communication among health care professions, regulatory authorities, and federal, provincial, and territorial governments regarding drug utilization issues and information.

Milligrams morphine equivalent (MME): the conversion of an opioid dose to the equal or equivalent morphine dose using a conversion ratio. Also referred to as morphine milligram equivalent.

Long-term use: Drug therapy for longer than four weeks.

Opioid: a broad group of drugs that interact with opioid receptors used for treating moderate to severe pain as well as coughing and diarrhea. E.g. heroin, fentanyl, morphine, codeine.

Polypharmacy: The simultaneous use of multiple drugs to treat a single ailment or condition.

Registered nurse (nurse practitioner) or RN(NP): A registered nurse on the extended practice register who has successfully demonstrated the competencies identified for the RN(NP) and has provided evidence of meeting the application requirements in accordance with The Regulated Health Professions Act (C.C.S.M. c. R117) College of Registered Nurses of Manitoba General Regulations, in addition to upholding the Practice Expectations for RNs and the Code of Ethics for Registered Nurses.

Urine drug screen: tool to set a baseline measure of substance use that may help assess risk for addiction, and/or monitor on an ongoing basis, the client's use of prescribed opioids.

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