BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
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DECISION SUPPORT TOOL

FOR RN AND RPN PRESCRIBING OF BUPRENORPHINE/NALOXONE

August 2021
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The Scope of Practice for registered nurses (RNs) and registered psychiatric nurses (RPNs) can include prescribing buprenorphine/naloxone when education and preceptorship requirements established by the British Columbia Centre on Substance Use (BCCSU) related to buprenorphine/naloxone and opioid use disorder (OUD) are met. Registered nurses and registered psychiatric nurses must also comply with all other applicable British Columbia College of Nurses and Midwives (BCCNM) limits and conditions that apply to buprenorphine/naloxone and OUD and to the prescribing of medications. Registered nurses and registered psychiatric nurses must also:

- Meet the employment requirements set out in the Order of the Provincial Health Officer: Registered Nurse and Registered Psychiatric Nurse Public Health Pharmacotherapy.
- Be recognized by their organization/employer as a buprenorphine/naloxone prescriber.
- Follow the clinical guidelines established by the BCCSU related to buprenorphine/naloxone and opioid use disorder.
- Prescribe buprenorphine/naloxone in accordance with the British Columbia Controlled Prescription Program.
- Have access to PharmaNet for medication reconciliation and prescription monitoring.
- Prescribe only when the Order of the Provincial Health Officer: Registered Nurse and Registered Psychiatric Nurse Public Health is in effect.

This decision support tool (DST) outlines how RNs and RPNs who have completed the education pathway will approach care and when they will need to refer to or consult another provider. Employers are required to set up clear referral pathways to support this practice. This DST is intended to be used alongside applicable BCCNM standards, and within the context of trauma-informed and culturally competent care.

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DEVELOPING THIS DECISION SUPPORT TOOL

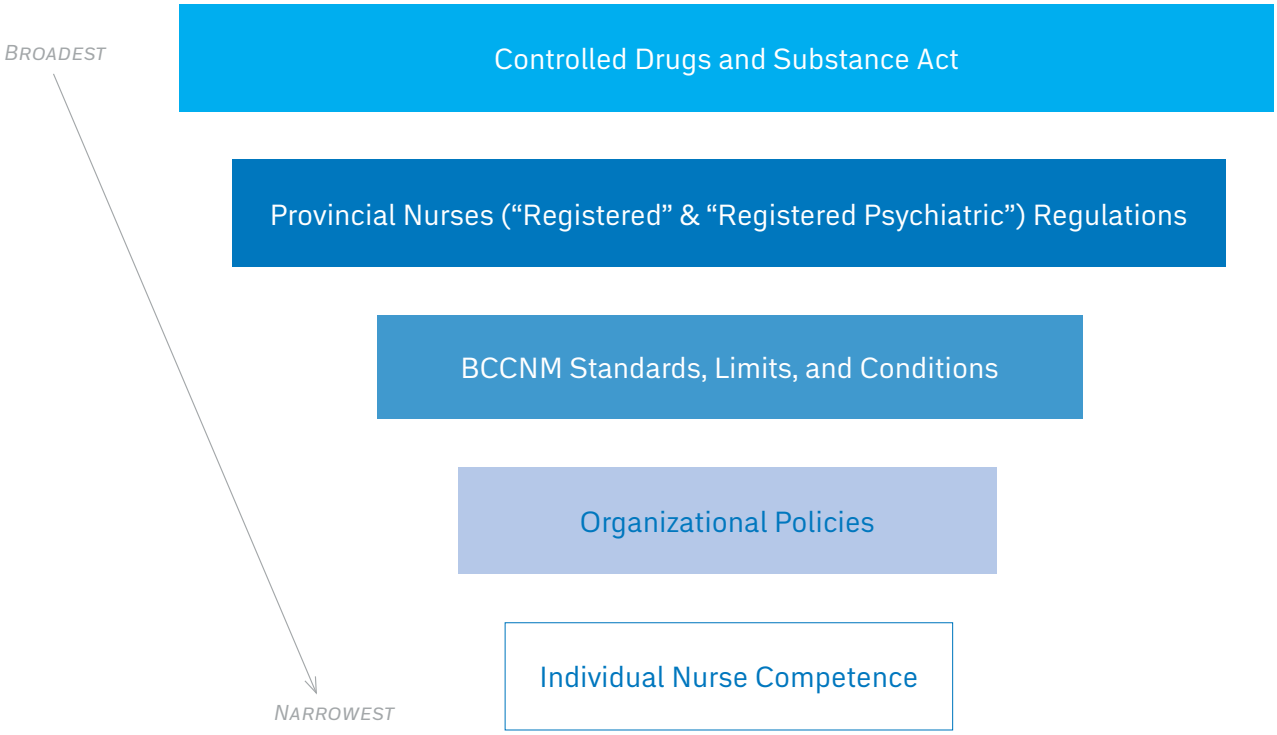
The BCCSU led the development of this DST, in alignment with the provincial *Guideline for the Clinical Management of Opioid Use Disorder* and in collaboration with a number of key partners, including the BC College of Nurses and Midwives and Ministry of Mental Health and Addictions. Consultation included input and review by practicing clinicians across the province, including prescribers with addiction expertise.

SCOPE OF PRACTICE

The scope of practice for RNs and RPNs in British Columbia is set out in the Nurses ("Registered" and "Registered Psychiatric") and Nurse Practitioners Regulations under the *Health Professions Act*. The BCCNM Scope of Practice for RNs (pg. 44) and RPNs (pg. 32) sets out Standards, Limits, and Conditions for nurse prescribing, including prescribing of **buprenorphine/naloxone (bup/nlx)** for the treatment of opioid use disorder (OUD).

CONTROLS ON PRACTICE FOR PRESCRIBING BUPRENORPHINE/NALOXONE FOR OUD

Registered nurses and registered psychiatric nurses are subject to the following controls on their practice, all of which must be met in order to prescribe bup/nlx.



Temporary exception that allows for RN/RPN prescribing of bup/nlx:

- Order of the Provincial Health Officer

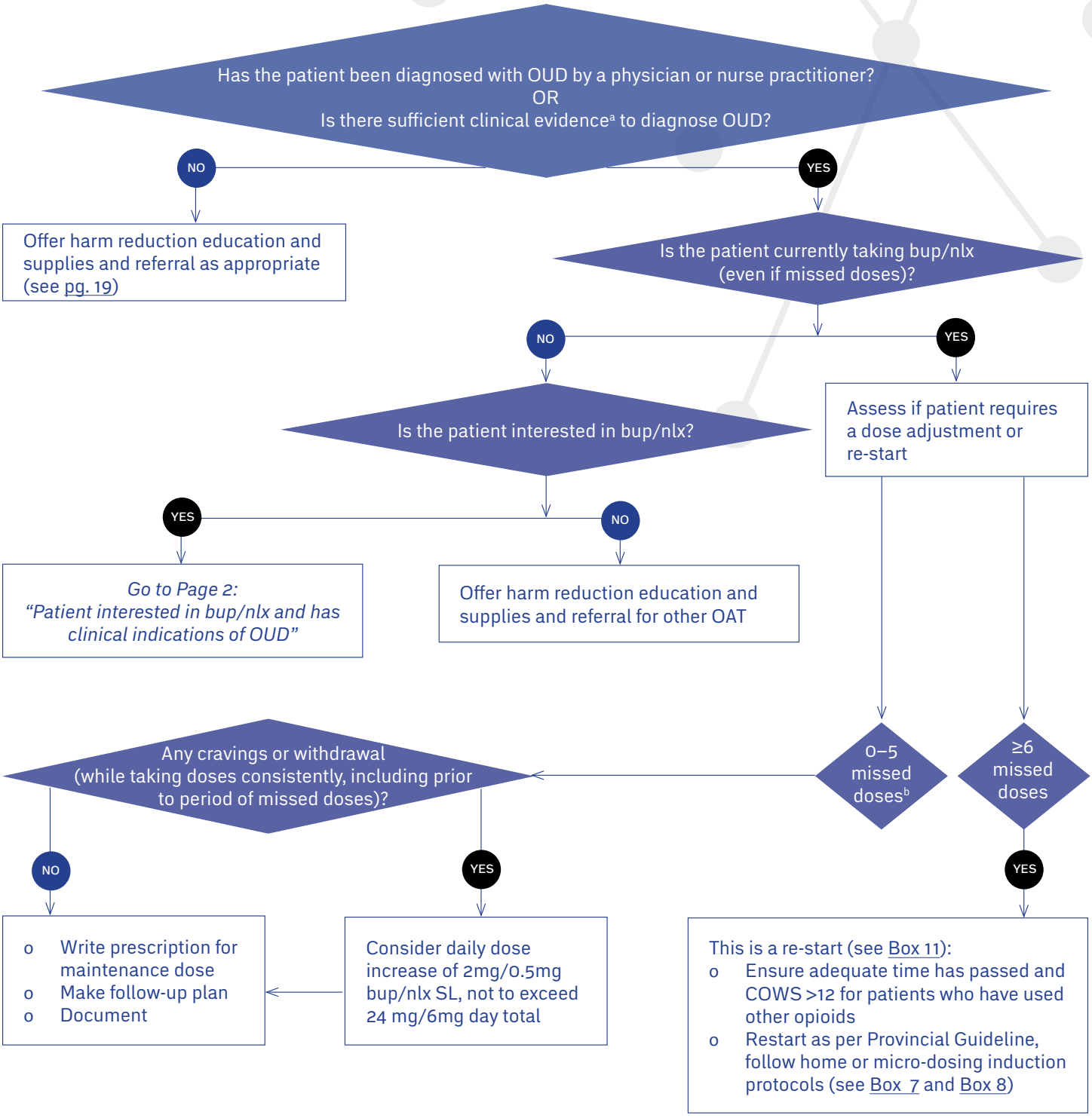
The temporary regulatory exception, combined with changes to BCCNM standards, limits, and conditions, supports an expanded scope of practice for RNs and RPNs in OUD care and allows RNs and RPNs, with the appropriate training and organizational support, to diagnose OUD, order and interpret certain tests, and prescribe bup/nlx for OUD.

DOCUMENTATION WHEN FOLLOWING THIS DECISION SUPPORT TOOL SHOULD INCLUDE:

1. Adherence to BCCNM Documentation Standards
2. Baseline assessment and PharmaNet check
3. Medication prescribed, dose, indication, and patient education
4. Length of the prescription
5. Follow-up plan
6. Other relevant information for care team
7. Any consultation or referral done in relation to the patient's care
8. Rationale for prescribing decisions

Decision Support Tool

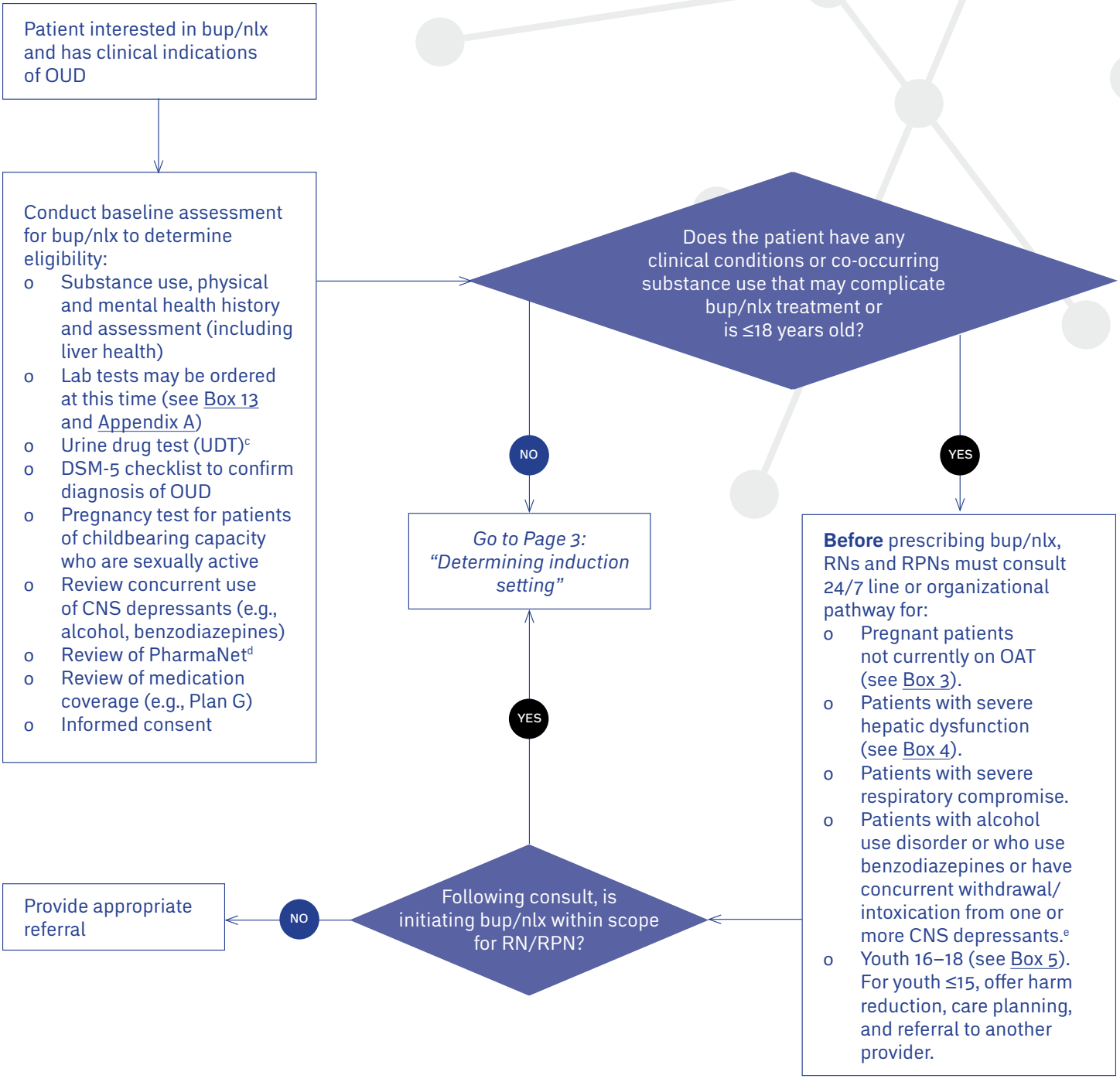
for RN and RPN Prescribing of Buprenorphine/naloxone



[a] *Clinical evidence to support a diagnosis of OUD may include past hospital records, a clinical history where the patient describes cravings, tolerance, and/or withdrawal.*

[b] *If the patient has not consistently been taking their doses prior to period of missed doses, precipitated withdrawal is still possible if the patient has missed 0-5 doses. If unsure about the risk of precipitated withdrawal, RN/RPN can call 24/7 line or give test dose of 2mg/0.5mg of bup/nlx to ensure tolerability, and consider UDT.*

Patient interested in bup/nlx and has clinical indications of OUD

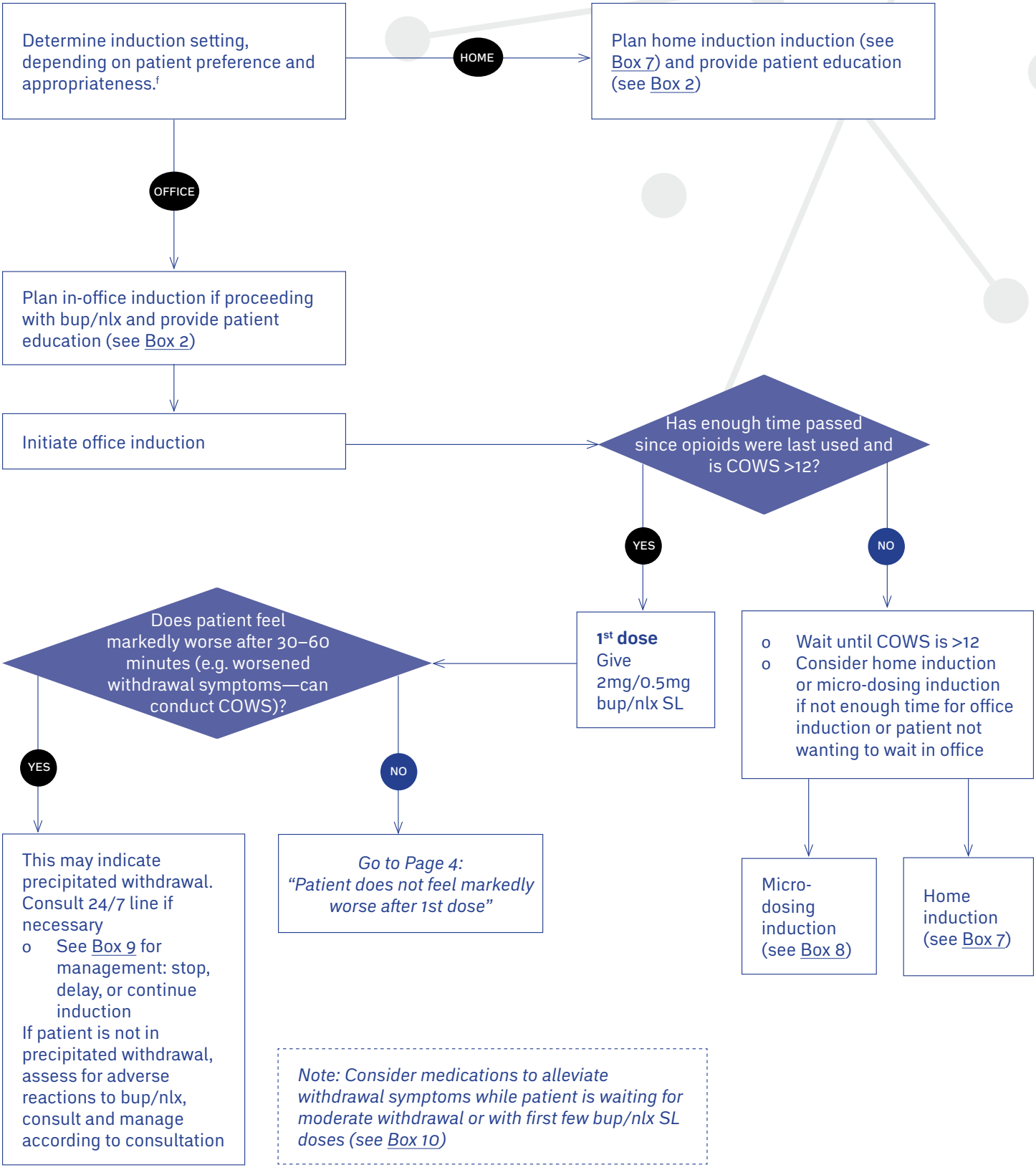


[c] Although best practice, there may be situations in which it is reasonable to forgo a UDT or pregnancy test prior to initiating bup/nlx (e.g., telehealth in a remote setting with significant collateral information, where requiring UDT or pregnancy test would constitute an unreasonable barrier; a patient who has been abstinent but is at risk of relapse). The clinical rationale, including bup/nlx's superior safety profile and decreased risk of diversion should be recorded.

[d] If you see a recent OAT prescription, contact the care provider to ensure collaboration.

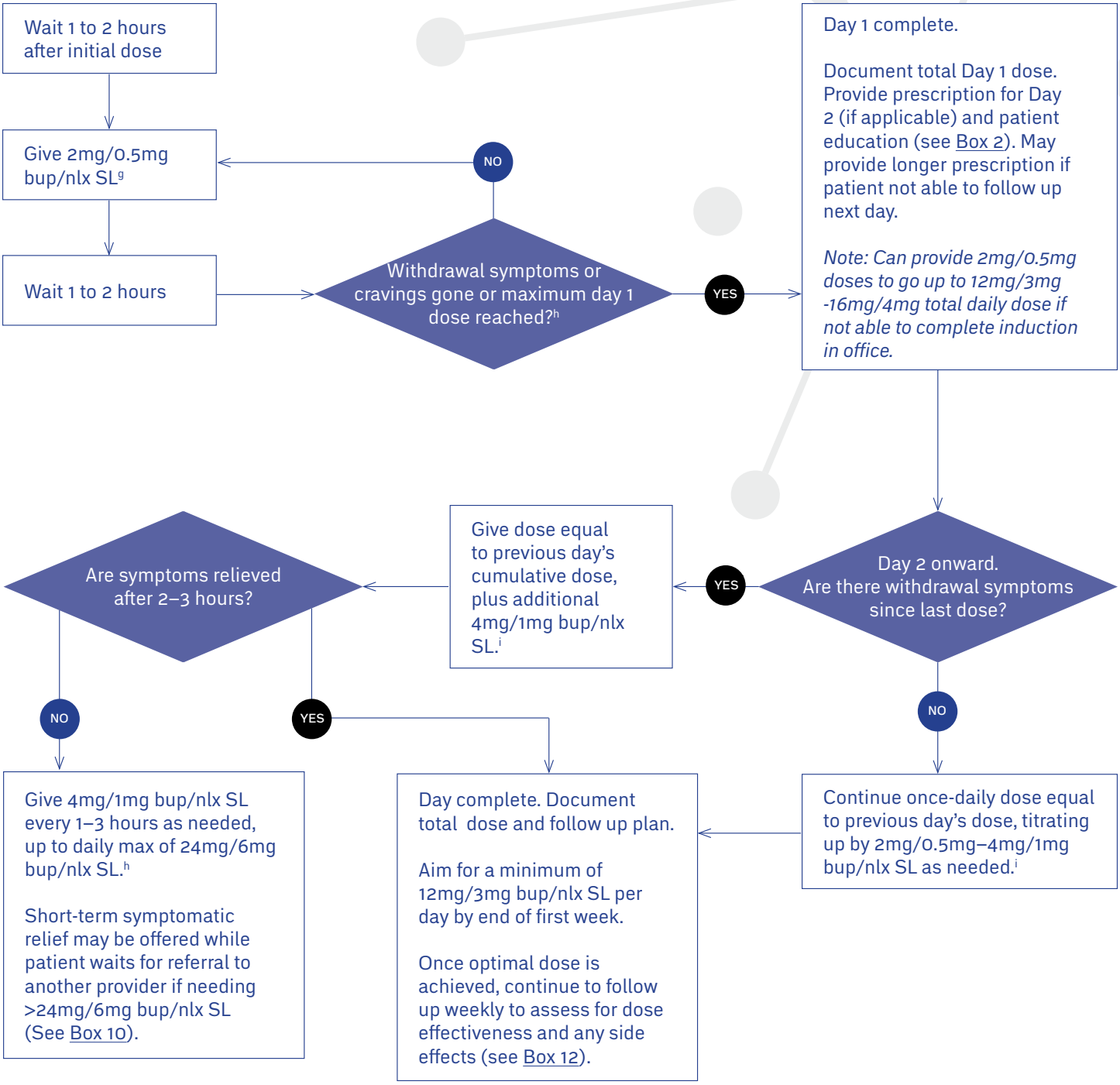
[e] Counsel patients on the increased risk of overdose when CNS depressants are used while on OAT and refer patient to specialist to begin benzodiazepine taper or alcohol use disorder treatment after initiating bup/nlx.

Determining induction setting



[f] *Patients with concurrent AUD or benzodiazepine use may be candidates for home induction if there is adequate monitoring by a responsible caregiver.*

PATIENT DOES NOT FEEL MARKEDLY WORSE AFTER 1ST DOSE



[g] Once the patient reaches 6mg/1.5mg bup/nlx SL, their COWS has consistently decreased, and there is no sign of precipitated withdrawal, it may be appropriate to increase to 4mg/1mg bup/nlx SL per hour.
[h] Bup/nlx SL can be titrated up to a total first day dose of 12mg/3mg to 16mg/4mg bup/nlx SL.
[i] After Day 1, the maximum daily dose is 24mg/6mg bup/nlx SL. Registered nurses and registered psychiatric nurses must refer patients to another provider if they require more than 24mg/6mg bup/nlx SL.

BOX 1: PATIENT ELIGIBILITY FOR BUP/NLX

1. Presence of an opioid use disorder
2. Informed consent
3. No contraindications for bup/nlx: allergy or hypersensitivity, severe respiratory distress, delirium tremens, acute alcohol intoxication
4. Adequate time since last opioid use to prevent precipitated withdrawal (for traditional inductions)

BOX 2: PATIENT EDUCATION

1. Prior to initiation, discuss treatment options, including the risks and benefits of treatment, and the patient's treatment goals.
2. For traditional inductions, whether in office or at home, provide education on precipitated withdrawal and how to prevent it. See GPAC handout.
3. All patients starting bup/nlx treatment should receive training and a take-home naloxone kit (or information on where to acquire one) and information about harm reduction strategies, including supervised consumption for ongoing opioid use or Lifeguard app. Suggest education and training on take-home naloxone for any relevant supports (e.g., family, friends, support staff).
4. All patients should should receive the following information about taking bup/nlx:
    - The tablet needs to fully dissolve under the tongue to work properly—it will not be absorbed if swallowed.
    - Do not consume food or drink while the tablet is dissolving. Avoid smoking.
    - The naloxone in the medication is not active if taken under the tongue, but may cause withdrawal symptoms if the medication is crushed and snorted or injected
    - Risks of using sedatives concurrently with bup/nlx (e.g., alcohol, benzodiazepines, or z-drugs).
5. Provide education materials to the patient, where appropriate (e.g., Opioids: A Survivors Guide).
6. Refer to outreach support services as required or requested.
7. Provide the patient with information on available community resources as required or requested.

BOX 3: CONSIDERATIONS FOR BUP/NLX PRESCRIBING IN PREGNANCY

1. All patients of childbearing capacity who are considering starting bup/nlx or re-starting bup/nlx should be offered a pregnancy test. Note that a pregnancy test is not required to initiate bup/nlx.
2. Registered nurses and registered psychiatric nurses can continue bup/nlx prescriptions for patients who are pregnant, but should ensure these patients are being followed for perinatal and primary care. Where possible, these may be arranged through organizational consults.
3. **Registered nurses and registered psychiatric nurses should consult the 24/7 line for pregnant patients who are not on OAT, as these patients may require a referral to another prescriber, as per organizational processes.** Bup/nlx is not considered first-line treatment for OUD during pregnancy; however, if a patient prefers bup/nlx then a micro-dosing induction can be considered in consultation with the 24/7 line or organizational pathway.
4. Registered nurses and registered psychiatric nurses may consult the 24/7 line at any point for questions about pregnant patients and bup/nlx.
5. Further guidance can be found in the Treatment of Opioid Use Disorder Pregnancy Guideline Supplement.

BOX 4: CONSIDERATIONS FOR BUP/NLX PRESCRIBING FOR PATIENTS WITH POOR HEPATIC FUNCTION

1. Registered nurses and registered psychiatric nurses should screen patients for hepatic disease and order laboratory tests related to liver health (albumin, bilirubin, ALT) at initiation of treatment and repeat 4 weeks after initiation. Note that these tests are not required to initiate bup/nlx.
2. **If the patient has severe hepatic dysfunction, as determined by results >3x normal upper limit, and is not currently taking bup/nlx, the RN/RPN must consult another prescriber using the 24/7 line or organizational pathway before initiating a bup/nlx prescription and document this consultation.**
3. If the patient has severe hepatic dysfunction and is currently on or has previously taken bup/nlx, the RN/RPN may restart bup/nlx for the patient but should seek consultation with another prescriber using the 24/7 line or organizational pathway; however, this is not required before providing the prescription.

BOX 5: CONSIDERATIONS FOR BUP/NLX PRESCRIBING FOR YOUTH

1. In caring for youth, RNs and RPNs must have competence not only related to prescribing medications for the client, but other considerations such as obtaining consent and meeting applicable BCCNM standards.
2. Registered nurses and registered psychiatric nurses should follow the *Treatment of Opioid Use Disorder Youth Guideline Supplement*, which advises initiating OAT for youth ≥16 with a preference for bup/nlx as first-line pharmacological treatment when indicated.
3. Registered nurses and registered psychiatric nurses are advised to consult with a prescriber with experience in addiction medicine for youth aged 16–18, through the 24/7 line or organizational pathways and to document this consultation, as the product monograph for bup/nlx indicates use for individuals ≥18
4. For individuals ≤15, RNs and RPNs should facilitate referral to another provider and provide other interventions within their scope, including safety planning and harm reduction supplies and education.
5. Further guidance can be found in the *Treatment of Opioid Use Disorder Youth Guideline Supplement*.

BOX 6: CONSIDERATIONS FOR INDUCTION

1. To prevent precipitated withdrawal, patients should be advised to avoid opioids before bup/nlx induction (≥12h heroin, oxycodone, hydromorphone; ≥24h slow-release oral morphine; confirmed, suspected, or uncertain fentanyl; 24–72 h methadone)
2. Patients should be in moderate withdrawal before starting bup/nlx (i.e., COWS >12)
3. For office inductions: if possible, patients should begin induction early in the day to allow enough time for dose titration through the day

BOX 7: CONSIDERATIONS FOR HOME INDUCTIONS

1. Follow traditional induction or micro-dosing induction protocols.
2. Consider home induction for patients with previous bup/nlx experience, demonstrated reliability, sufficiently stable home environment, ability to safely store medication, or with barriers to retention in care.
3. If offering home induction, RNs and RPNs should be able to provide regular follow-up and support via telephone.
4. Prior to initiating bup/nlx, discuss the risks and benefits of home induction and document and obtain informed consent from the patient.
5. Provide patients with clinic/office contact information and in-person education and written instructions for dosing and timing, including use of the SOWS to assess withdrawal symptoms and determine when to start induction, if appropriate. Instructions should include:
    - Wait until moderate withdrawal occurs to prevent precipitated withdrawal (SOWS score ≥17 and sufficient time has passed since last opioid use).
    - Do not use opioids during initiation to relieve symptoms.
    - Do not use sedatives during initiation (e.g., alcohol, benzodiazepines, or z-drugs).
    - Put the tablet under your tongue and let it dissolve completely or it will not work.
    - Do not consume food or drink while the tablet is dissolving. Avoid smoking. Do not give up if symptoms persist after the initial doses. After taking 4 or more tabs, most people will start feeling improvement of withdrawal symptoms.
    - Return to care (specialist, general practitioner, or emergency department) if symptoms of precipitated withdrawal or other adverse reaction develop and you are unable to cope.
6. Instruct patients and/or caregivers to contact the office immediately in the event of any problems and to come in for clinical assessment as required.
7. Provide patient education handout.

BOX 8: CONSIDERATIONS FOR MICRO-DOSING INDUCTIONS

1. Usually started at home, but the initial dose may be given in office.
2. Patients are not required to stop opioids or be in withdrawal before beginning a micro-dosing induction.
3. Slowly up-titrates micro-doses of bup/nlx while continuing prescribed or illicit opioid use until therapeutic dose is reached, which typically occurs in community settings over 5–10 days. Clinicians may use clinical judgment as to whether their patient requires a longer or shorter micro-dosing induction period.
4. Follow the above considerations for home inductions, including:
    - Providing regular follow-up and support
    - Discussing risks and benefits
    - Obtaining consent
    - Providing patients with clinic information
    - Providing verbal and written instructions for dosing and timing, taking the medication correctly, and to contact the clinic if there are any problems during the induction.

Sample Micro-dosing Induction Protocol

Day	Order	Other Opioids
1	0.5mg /0.125mg bup/nlx SL BID	Continue use
2	0.5mg /0.125mg bup/nlx SL TID	Continue use
3	1mg /0.25mg bup/nlx SL BID	Continue use
4	2mg /0.5mg bup/nlx SL BID	Continue use
5	2mg /0.5mg bup/nlx SL TID	Continue use
6	4mg /1mg bup/nlx SL TID	Continue use
7	12mg /3mg bup/nlx SL daily	Stop use

BOX 9: MANAGING PRECIPITATED WITHDRAWAL DURING BUP/NLX INDUCTION

1. Explain to the patient what has occurred.
2. Discuss the options below for management.
3. Call 24/7 line.
4. Obtain informed consent for the agreed-upon option.
5. Offer non-opioid adjuncts to treat withdrawal symptoms.

Option 1: Continue induction

1. Administer additional doses of 2mg/0.5mg bup/nlx SL every 1–2 hours.
2. Continue up to the Day 1 maximum or until withdrawal symptoms are resolved.

Option 2: Delay induction

1. If patient chooses to continue, consider waiting a few hours to allow full agonist to clear opioid receptors before administering the next bup/nlx SL dose.
2. Continue up to the Day 1 maximum or until withdrawal symptoms are resolved.

Option 3: Stop induction

- Provide reassurance that symptoms will resolve as opioid withdrawal runs its course.

BOX 10: MEDICATIONS TO ALLEVIATE WITHDRAWAL SYMPTOMS

Prior to the first dose or during the first few doses of bup/nlx, consider providing medications to alleviate withdrawal symptoms. Registered nurses and registered psychiatric nurses should be aware of which medications they can and cannot prescribe. Consider providing (if supported by employer policies and processes):

- Acetaminophen
  - 325–1000mg every 4 to 6 hours
  - Maximum 4,000mg/day; 2,000mg for the elderly or those with liver impairment
- Clonidine
  - 0.1–0.2mg, depending on patient weight, every 4 to 6 hours for up to 12 hours
- Dimenhydrinate
  - 50–100mg every 6 hours, but can be administered as needed
- Ibuprofen
  - 400mg every 4 hours
  - Maximum 2,400mg/day
- Loperamide
  - 2–4mg, as needed, following loose stools
  - Maximum 16mg/day

BOX 11: ASSESSING PATIENT WITH MISSED DAYS

1. Review PharmaNet.
2. Ask patient if they have missed bup/nlx doses. If the patient reports missing doses, ask the patient why they have missed doses. Patients who report missed doses may require additional support (e.g., consider take-home dosing if daily witnessed ingestion is a barrier due to employment or school).
3. Ask patient about any ongoing substance use.
4. Conduct UDT, if appropriate.
5. Document findings.
6. Inform other members of the patient's care team.
7. If patient is pregnant, consult another prescriber before re-starting. If the patient has severe hepatic dysfunction, consultation is recommended but not required before re-start.
8. Follow missed-doses protocol: 0–5 missed doses, continue at same dose (unless patient was not consistently taking doses prior to missed doses, then a test dose may be given); ≥6 doses, re-start patient on bup/nlx.

BOX 12: ASSESSING PATIENT WITH MISSED DAYS

1. Once patient is stabilized on bup/nlx, continue to assess at least every 1–2 weeks with the option to decrease follow-up visits as increased clinical stability is achieved.
2. Follow-up assessments should include adequacy of dosage (e.g., patient report of withdrawal symptoms or cravings), side effects, drug–drug interactions, substance use (via patient report and, when indicated, UDT), patient goals, physical and mental health, and psychosocial domains including housing, relationships, and finances.
3. For clinically stable patients at stable doses, one can consider:
    - Take-home doses.
4. The following are considerations for follow up and reassessment:
    - Self-reported or other indication of non-medical opioid use.
    - Missed appointments or doses, or repeated reports of lost or stolen doses.
    - Requests to increase a previously stable dose.
    - Unable to attend the clinic for random urine drug tests.
    - Unable to attend the clinic or pharmacy for random pill counts or evidence of tampering with blister-pack.
5. Urine drug tests are recommended monthly or more or less frequently during stabilization and at the prescriber's discretion during maintenance for patients on daily witnessed ingestion. For take-home doses, at least 4 random 48-hour UDT are recommended per year.
6. **Evidence of other non-medical opioid use or other substance use should prompt reassessment of treatment plan, but not automatic discontinuation of take-home doses.** Before take-home prescriptions are discontinued, the prescriber must balance the risks of destabilizing patients by enforcing daily dispensation of medication. Non-medical opioid use or other substance use to address withdrawal and cravings may indicate that a higher dose is needed.
7. **For patients prescribed take-home bup/nlx showing signs of major instability,** individual patient circumstances should be considered. Appropriate responses may include:
    - Reducing the number of take-home doses (e.g., 1–2 days at a time) with return to more frequent witnessed ingestion.
    - Increasing the frequency of clinical appointments in order to provide more intensive support, monitoring and assessment.
    - Reassessing dose, especially if patient reporting cravings or withdrawal.
8. Providing referrals to adjunct psychosocial and community-based supports, as appropriate.
9. Evidence of diversion (e.g., UDT negative for buprenorphine) should prompt immediate reassessment of the treatment plan. In some cases, take-home doses should be discontinued. If doses have been missed, follow missed doses protocol.

BOX 13: LABORATORY AND POINT-OF-CARE TESTS

Registered nurses and registered psychiatric nurses may order a number of laboratory and point-of-care tests to support decision making and for health promotion in OUD care. These may be ordered at baseline or follow up. See Appendix A for a list of these tests and information on when to consult with another provider and Box 6 for considerations for bup/nlx and hepatic function.

BOX 14: CONSIDERATIONS FOR PRESCRIBING TAKE-HOME DOSES OF BUP/NLX

1. Take-home doses (or "carries") of bup/nlx may be considered once a patient is clinically stable (e.g., UDT consistently positive for bup/nlx) and able to safely store medication at home (e.g., secure, locked containers or cabinets). Take-home doses may also be considered immediately, where clinically indicated. Safe storage should be reviewed at each visit and this discussion should be documented.
2. Health Canada recommends that bup/nlx doses should be daily witnessed ingestion until the patient has demonstrated sufficient clinical stability and is able to safely store take-home doses.
3. It is the RN or RPN's responsibility to decide if and when take-home dosing is clinically appropriate and whether ongoing daily witnessed ingestion of bup/nlx is optimal from a patient and public safety perspective. The rationale for decisions on daily-witnessed ingestion, take-home dosing, or a combination of witnessed and take-home doses should be carefully documented in the medical record.
4. **If the patient is using alcohol or other CNS depressants (e.g., benzodiazepines), the RN/RPN should not provide take-home doses.**
5. Generally, take-home doses are dispensed for a period of 7–14 days. Clear instructions should be included on the prescription for take-home doses. Blister-packing may be used initially to help the patient keep track of their doses and to reduce the chance of diversion.
6. Registered nurses and registered psychiatric nurses should continually monitor for signs of return to opioid use, use of sedating agents (e.g., alcohol, benzodiazepines), social instability, and diversion.
7. Up to 4 random (48-hour notice) urine drug tests are recommended, when clinically indicated, during the first year of receiving take-home doses. Evidence of other non-medical opioid use or other substance use should prompt reassessment of treatment plan, but not automatic discontinuation of take-home doses.
8. For patients prescribed take-home bup/nlx showing signs of major instability, individual patient circumstances should be considered when revising their treatment plan. Treatment plan adjustments may include decreasing the number of take-home doses and increased daily witnessed ingestion, limiting the number of take-home doses dispensed per visit, increasing the frequency of appointments, increasing the dose, or increasing psychosocial supports.

BOX 15: CONSIDERATIONS FOR INITIATING A BUP/NLX TAPER

1. If a patient requests a bup/nlx taper, consult with the 24/7 line or another prescriber.
2. Evidence on successful bup/nlx tapers, including ideal candidates and speed is lacking.
3. Bup/nlx tapers are not generally recommended, due to the high likelihood of return to substance use; however, if the patient requests a taper, then a gradual tapering regimen over more than 52 weeks is recommended. It is known that individuals who receive OAT for at least a year have better outcomes than those who receive it for shorter periods.
4. Registered nurses and registered psychiatric nurses should counsel the patient on the risks of return to substance use and overdose, and offer information on harm reduction strategies including access to take-home naloxone.

ABBREVIATIONS

BID: twice a day
Bup/nlx SL: buprenorphine/naloxone sublingual
COWS: Clinical Opiate Withdrawal Scale
N: no
OAT: opioid agonist treatment
OUD: opioid use disorder
q1h: quaque hora (every hour)
QD: once a day
QID: four times a day
SOWS: Subjective Opiate Withdrawal Scale
TID: three times a day
THN: take-home naloxone
UDT: Urine drug testing
Y: yes

24/7 ADDICTION MEDICINE CLINICIAN SUPPORT LINE

24/7 ADDICTION MEDICINE CLINICIAN SUPPORT LINE

To speak to an addiction medicine specialist, call 778-945-7619.

Provides telephone consultation from an addiction medicine specialist to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment. Consultation can include support in screening, assessment, treatment, and management of substance use and substance use disorder(s).

ADDITIONAL RESOURCES

Guideline for the Clinical Management of Opioid Use Disorder: Provincial guideline for the management of OUD in BC.

Treatment of Opioid Use Disorder During Pregnancy Guideline Supplement: Supplement to the provincial guideline focused on management of OUD during pregnancy.

Treatment of Opioid Use Disorder for Youth Guideline Supplement: Supplement to the provincial guideline focused on the management of OUD for youth (age 12–25).

Provincial Opioid Addiction Treatment Support Program: Mandatory online training program offered by the BCCSU and UBC CPD for prescribing OAT in BC.

Clinics accepting new OAT patients: Contact information for OAT clinics across BC currently accepting new OAT patients.

Toward the Heart: Current listing of harm reduction services in BC that provide needles, syringes, and other injection supplies, overdose prevention training, and take-home naloxone kits.

Lifeguard Digital Health: App that is activated by a person before they use opioids and alerts emergency medical dispatchers to a potential overdose.

APPENDIX A

Summary of laboratory and point-of-care tests RNs and RPNs are authorized to order

TESTS	FOLLOW-UP
TESTS PERFORMED PRIOR TO INITIATING OAT *If performing prior to initiation presents a barrier to care, these tests should be ordered as soon as reasonably possible*	
Immunoassay urine drug test (UDT) (either POC or lab-tested immunoassay)- urine	o To confirm patient-reported substance use and prescribed medication in conjunction with patient report. o False-positive and false-negative results are possible for opioids and benzodiazepines, and false-positive results are possible for amphetamines. o See POATSP module for more information; can consult within organization or 24/7 line.
Pregnancy test	o A pregnancy test should be performed on patients of child-bearing capacity, to ensure patient is connected to appropriate follow-up care and guide treatment plan.
TESTS THAT HAVE IMPLICATIONS FOR OAT CARE *Performed prior to initiation when feasible, should not be a barrier to starting care*	
Complete Blood Count (CBC); Creatinine - serum/plasma; Liver enzyme: glutamyl transpeptidase (GGT), alanine aminotransferase (ALT), albumin, total bilirubin; prothrombin time/INR	o Value outside of normal range: consult with an MD or NP as per organizational processes to determine a plan of care. o The 24/7 line can be consulted in the case of severe hepatic dysfunction (ALT or GGT >3x the upper limit of normal) and concern around bup/nlx prescribing.
HEALTH PROMOTION TESTS *Additional tests that may be appropriate following treatment initiation*	

Hepatitis A, B, and C serology	o Review BC Centre for Disease Control (BCCDC) resources for interpretation of chronic or active infection.
	o Registered nurses and registered psychiatric nurses who have completed the BCCDC's Immunization Competency Course can:
	  o Use Hep A and B serology to determine patient immunity
	  o Recommend vaccination where appropriate
	RNs and RPNs can call the BCCDC line for support with interpretation but may need to refer to another provider for management that requires treatment.

HIV test	o Registered nurses and registered psychiatric nurses should complete the HIV Point of Care Testing Online Course prior to conducting point-of-care tests or ordering HIV serology, and be familiar with organizational pathways for care referrals.
Sexually transmitted infections	o Gonorrhea and chlamydia (GC/CT urine or swab): Registered nurses and registered psychiatric nurses with STI Certified Practice can manage positive results. o Syphilis serology: RNs and RPNs can call the BCCDC line for support with interpretation but may need to refer to another provider for management that requires treatment.