NCSBN GUIDELINES FOR THE BOARDS OF NURSING

for Complaints Involving Marijuana

NCSBN
Leading Regulatory Excellence

Mission Statement

The National Council of State Boards of Nursing (NCSBN®) provides education, service and research through collaborative leadership to promote evidenced-based regulatory excellence for patient safety and public protection.

Guidelines for the Board of Nursing Regarding Licensees and Marijuana

Background

Currently, 33 jurisdictions (including the District of Columbia), Guam, Puerto Rico, and all provinces/territories of Canada allow for the medical use of cannabis. An increasing number of jurisdictions allow for various forms of legal or decriminalized recreational use of cannabis. There are evolving public health, nursing practice, science, legal, educational, ethical and social issues involving the use of either medical or recreational cannabis. Of significance, there is a contradiction between the federal law classifying cannabis as a Schedule I Controlled Substance, while various jurisdictions have legalized its use medically or recreationally or both.

The federal and state governments' divergent laws and perspectives cause complicated regulatory issues for boards of nursing (BONs). The NCSBN Board of Directors, in 2016, created a committee to develop guidelines to assist BONs in managing the many regulatory issues resulting from medical and recreational cannabis. Since various stakeholders require differing guidelines, five separate sets of guidelines were developed after a thorough review of the literature. The guidelines for licensees and educators are included in the NCSBN National Nursing Guidelines for Medical Marijuana published in the *Journal of Nursing Regulation* July 2018 Supplement (NCSBN, 2018).

The information in this document serves to inform BONs of the current evidence related to cannabis and provides guidelines for BON assessment and decision making for complaints involving cannabis. Specifically, these guidelines address the following issues:

A. A licensee who tests positive for Tetrahydrocannabinol (THC) or its metabolite
B. An APRN licensee's improper certifying of a Medical Marijuana Program qualifying condition
C. A licensee's administration of cannabis to a patient outside of designated caregiver provisions of the Medical Marijuana Program

Introduction

Prior to 1936, cannabis was sold over the counter and used for a variety of illnesses in the United States (Marijuana Policy Project, 2014). By 1936, every state had passed a law to restrict possession of cannabis, thus eliminating its availability as an over-the-counter drug. Then in 1970, the Comprehensive Drug Abuse Prevention and Control Act (1970) provided a classification of controlled substances; cannabis was included in the list of Schedule I Controlled Substances, thereby continuing the restriction of the use of cannabis by prohibiting health care practitioners from prescribing cannabis. This federal classification also limits the scope and type of research on Schedule I Controlled Substances; effectively preventing open and unlimited research on cannabis.

Use of cannabis remained restricted until the first legalization of medical cannabis was approved by voters in California in 1996, effective in 2000 (Marijuana Policy Project, 2014). Since then, an increasing cultural acceptance of cannabis has prompted many jurisdictions to pass legislation legalizing medical cannabis and an increasing proportion of jurisdictions have also decriminalized and legalized recreational cannabis use.

Federal and State Legislation through 2018

Over the past few decades, the federal government and individual states have instituted varying legal approaches regarding the availability of cannabis for medical purposes.

Federal Legislation

The U.S. federal government, through Title 21 United States Code (Comprehensive Drug Abuse Prevention and Control Act, 1970) (hereinafter referred to as Act), has the authority to evaluate drugs and other substances. This Act created a classification, or schedule, of substances. Those that are classified as Schedule I Controlled Substances are considered to have no accepted medical value and present a high potential for abuse. Cannabis and its derivatives have been classified as Schedule I Controlled Substances since the Act's genesis despite some moderate- to high-quality evidence that indicates effectiveness for certain conditions. Limited research has been completed on cannabis effectiveness as the Act's classification as Schedule I not only prohibits practitioners from prescribing cannabis; it also prohibits most research using cannabis except under rigorous oversight from the government's National Institute on Drug Abuse. The process for obtaining cannabis for federally funded research purposes is cumbersome and unlike other medical research.

The federal government's position on prosecuting the use of cannabis that is legal under the law of the applicable state jurisdiction has been set out in U.S. Department of Justice (DOJ) position papers. In 2009, the U.S. Attorney General took a position that discouraged federal attorneys from prosecuting people who distribute or use cannabis for medical purposes in compliance under the law of the applicable jurisdiction (U.S. Department of Justice [DOJ], 2009); additional guidance was given in 2011, 2013, and 2014 (DOJ, 2011, 2013, 2014). In January 2018, the U.S. Office of the Attorney General rescinded the previous nationwide guidance specific to marijuana enforcement (DOJ, 2018). The 2018 memorandum provides that federal prosecutors follow the well-established principles in deciding which cases to prosecute, namely, the prosecution is to weigh all relevant considerations, including priorities set by the attorneys general, seriousness of the crime, deterrent effect of criminal prosecution, and cumulative impact of particular crimes on the community (DOJ, 2018).

Although the use of cannabis pursuant to authorized Medical Marijuana Programs (MMPs) conflicts with federal law and regulations, at present there is no controlling case law holding that Congress intended to preempt the field of regulation of cannabis use under its supremacy powers (Beek v. City of Wyoming, 2014; Mikos, 2012).

State Legislation

Each jurisdiction's MMP has unique characteristics. The statutes governing MMPs are most easily located through the jurisdiction's Department of Health and MMP website; useful links to locate statutes are provided by the National Council of State Legislatures (NCSL, 2018).

MMPs include various provisions for procuring a medical cannabis certification, the amount of cannabis distributed to an individual, and legal protections extended to patients, designated caregivers, and health care providers. Each jurisdiction has statutes that list the qualifying conditions that can be used for certification (NCSL, 2018). This legislation includes qualifying conditions based on the best available scientific information, as well as conditions that have limited research. Again, the Act's restriction on cannabis research severely limits necessary cannabis research.

Some MMPs require a bona fide health care provider–patient relationship in order to certify a patient's qualifying condition. Other MMPs require health care providers to have a preexisting and ongoing relationship, while some note that the relationship may not be limited to issuing a written certification for the patient or a consultation simply for that purpose. Additionally, a few MMPs specify that an advanced practice registered nurse can certify a qualifying condition (NCSL, 2018).

Patients with a certification of a qualifying condition must register with the local MMP. A registered patient can obtain cannabis from an authorized cannabis dispensary. Procurement and administration of cannabis for medical purposes are limited to the patient and/or the patient's designated caregiver.

The MMP will specify whether designated caregivers are allowed by statute and will outline the process for registering a designated caregiver (NCSL, 2018). In some jurisdictions, the MMP allows an employee (of a hospice provider, nursing facility, or medical facility), a visiting nurse, personal care attendant, or home health aide to act as a designated caregiver for a particular patient (NCSL, 2018). These designated caregivers must meet specific qualifications and be registered with the MMP.

A nurse shall not administer cannabis to a patient unless specifically authorized by jurisdiction law. An exception to this rule is any administration of FDA approved cannabinoid products (dronabinol, nabilone, and Epidiolex) to a patient as per facility formulary and policy.

Registered designated caregivers can only administer medical cannabis to the specific patient that they have been designated (NCSL, 2018). In addition, some MMPs limit the number of patients for which an individual may act as designated caregiver. Health care facility policies may override designated caregiver provisions regarding medical cannabis administration. Specifically, caregiver provisions for administration of medical cannabis do not apply within a federal facility or to federal employees.

Table 1 displays the differences in jurisdictional legislation regarding cannabis. Legislation is an ever-evolving process. This summary is current as of October 2018.

Table 1. Cannabis Legislation

Type of Provision	Jurisdictions
Medical Marijuana Program	AK, AR, AZ, CA, CO, CT, DC, DE, FL, HI, IL, LA*, MA, MD, ME, MI, MN, MO, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, UT, VT, WA, WV
MMP allows an APRN to certify a qualifying condition	HI, ME, MA, MN, NH, NM, NY, VT, WA
MMPs which extend protections for healthcare practitioners or facilities caring for one or more patients authorized for medical cannabis (must review provisions for specifics).	CA, IL, MA, MN, MT, NH, NJ, OR, RI
Allow cannabidiol (CBD) products (often for intractable seizures and often the use is restricted to clinical studies)	AL, GA, IA, IN, KY, MO, MS, NC, OK, SC, TN, TX, UT, VA, WI, WY
Recreational use of cannabis	AK, CA, CO, DC, MA, ME, MI, NV, OR, VT, WA
No cannabis statutes	ID, KS, NE, SD

* Louisiana lacks the necessary infrastructure to enact its MMP and the state's previous statutory language failed to grant necessary protections to physicians and users. Legislators have yet to decide who will be the legal cultivators for the state and how to regulate pharmacies that will distribute medical cannabis.

Guidelines for the Nursing Care of Patients using Medical Marijuana

Research on the efficacy of marijuana for treatment of certain medical conditions is limited and lacking when compared to the expanding list of therapeutic claims. This limited research has therefore impeded the education of nurses regarding the medical use of marijuana. The committee convened by the NCSBN Board of Directors assessed the educational gap and performed an integrative literature review. This evidence base provided the foundation for the NCSBN National Nursing Guidelines for Medical Marijuana (NCSBN, 2018) which provide direction for licensees and educators:

- Medical Marijuana Education in Pre-Licensure Nursing Programs
- Nursing Care of the Patient Using Medical Marijuana
- Medical Marijuana Education in Advanced Practice Nursing Programs
- APRNs Certifying a Medical Marijuana Qualifying Condition.

Standards and Limitations of Current Laboratory Testing Related to Cannabis Use

Tetrahydrocannabinol (THC) is the primary major psychoactive component of the cannabis plant and is the primary substance responsible for cognitive impairments associated with cannabis. THC ingestion "transiently impairs cognitive function on a number of levels—from basic motor coordination to more complex tasks, such as the ability to plan, organize, solve problems, make decisions, remember, and control emotions and behavior" (Crean, Crane, & Mason, 2011).

A 2017 report to Congress entitled "Marijuana-Impaired Driving" (hereinafter referred to as the Congressional Report) summarizes what is known about marijuana use and driving. The Congressional Report compares current knowledge about alcohol-impaired driving to marijuana-impaired driving. The physiological basis for alcohol-impairment is described by the "pharmacokinetics (the absorption, distribution and elimination of a drug from the body) and pharmacodynamics (how a drug affects physiological process and behaviors)" (NHTSA, 2017). The Congressional Report outlines how the pharmacokinetics and pharmacodynamics differ for alcohol and marijuana.

Alcohol is a relatively simple, water-soluble substance "whose absorption, distribution and elimination from the body along with the behavioral and cognitive effects are fairly well documented"(NHTSA, 2017). It is proven that impairment from alcohol increases with rising alcohol concentration and declines with dropping alcohol concentration (NHTSA, 2017). Alcohol and marijuana differ in their metabolic rate; marijuana is a fat-soluble substance and is not metabolized at a steady rate (NHTSA, 2017). This means that THC, stored in fatty tissues, can be released back into the blood long after ingestion. The slow release of THC does not correlate to prolonged or resurgent impairment as "the acute psychoactive effects of marijuana ingestion last for mere hours, not days or weeks" (NHTSA, 2017).

There are a limited number of studies on THC blood levels and the degree of impairment, but research consistently indicates that "the level of THC in the blood and the degree of impairment do not appear to be closely related. Peak impairment does not occur when THC concentration in the blood is at or near peak levels. Peak THC level can occur when low impairment is measured, and high impairment can be measured when THC level is low" (NHTSA, 2017).

Therefore, a laboratory test for THC examines the biological specimen only for the presence or absence of THC or THC metabolites. Current laboratory tests cannot indicate when the individual ingested cannabis, nor can they establish a level of THC that can determine impairment. Based on the evidence, the Congressional Report concluded that current laboratory tests cannot provide any objective threshold that establishes impairment based on a specific level of THC or THC metabolite concentration.

Right Touch Regulation

Regulatory oversight in complaints involving cannabis should receive the same due process and principles of good regulation used with other complaints to the BON. Right Touch Regulation recommends that minimum regulatory force be used to achieve the desired result. In the context of the BONs mission to protect the public, Right Touch Regulation requires consideration of the risk the BON is trying to regulate, as well as proportionate, consistent, targeted, transparent, accountable, and agile discipline as warranted (Professional Standards Authority, 2015).

Since the regulatory body's decisions affect the safety of the public, a delicate balance must be maintained between mitigating the risk of harm and applying discipline in a fair and consistent manner (Professional Standards Authority, 2015). Using all necessary background information and an evaluation of the mitigating and aggravating factors, the disciplinary decision should be appropriate to the circumstances, have a minimal effect on the nurse's practice beyond what is necessary, and be justifiable under scrutiny.

Guidance for the BONs Regarding Licensees and Cannabis

Three types of complaints to the BON involving licensees and cannabis are addressed in the *NCSBN Guidelines for the Board of Nursing: Complaints Involving a Licensee and Cannabis* included at the end of this document:

A. A licensee who tests positive for THC or its metabolite
B. An APRN licensee's improper certifying of a Medical Marijuana Program qualifying condition
C. A licensee's administration of cannabis to a patient outside of designated caregiver provisions of the Medical Marijuana Program

Each of these complaints requires knowledge of the current state of legalization of medical and recreational cannabis use in the jurisdiction, as well as right touch regulation. Other important information may include the following based on the type of complaint:

- Knowledge of standards and limitations of current laboratory testing related to cannabis use
- NCSBN National Nursing Guidelines for Medical Marijuana - APRN Certifying a Medical Marijuana Qualifying Condition (NCSBN, 2018)
- NCSBN National Nursing Guidelines for Medical Marijuana - Nursing Care of the Patient Using Medical Marijuana (NCSBN, 2018)
- Knowledge of the jurisdiction's MMP's designated caregiver provisions

The *NCSBN Guidelines for the Board of Nursing: Complaints Involving a Licensee and Cannabis*, found below, utilizes the current evidence regarding state and federal legislation, scientific literature regarding cannabis, standards and limitations of THC testing, as well as right touch regulation. This evidence base is necessary when reviewing and determining nursing regulatory actions for complaints involving licensees and cannabis.

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NCSBN GUIDELINES FOR THE BOARDS OF NURSING for Complaints Involving Marijuana

NCSBN Guidelines for the Board of Nursing: Complaints Involving a Licensee and Marijuana

Purpose of the Guidelines

Over 33 jurisdictions (including the District of Columbia), Guam and Puerto Rico passed legislation legalizing cannabis for medical use. Each Medical Marijuana Program has unique characteristics. In the U.S., cannabis is a Schedule I Controlled Substance. Therefore, cannabis use medically is unlike most other therapeutics, in that providers cannot prescribe cannabis, nor can pharmacies dispense cannabis. However, applicable jurisdiction statutes and rules provide for the manufacture, distribution and use of cannabis for medical or recreational use.

These guidelines provide necessary information for BONs regarding matters involving licensees and cannabis, specifically including complaints to the board of nursing involving:

A. A licensee who tests positive for THC or its metabolite
B. An APRN licensee's improper certifying of a Medical Marijuana Program qualifying condition
C. A licensee's administration of cannabis to a patient outside of designated caregiver provisions of the Medical Marijuana Program

Definitions

Cannabis. Any raw preparation of the leaves or flowers from the plant genus, *Cannabis*. This report uses "cannabis" as a shorthand that also includes cannabinoids.

Cannabidiol (CBD). A major cannabinoid that indirectly antagonizes cannabinoid receptors, which may attenuate the psychoactive effects of tetrahydrocannabinol.

Cannabinoid. Any chemical compound that acts on cannabinoid receptors. These include endogenous and exogenous cannabinoids.

Cannabinol (CBN). A cannabinoid more commonly found in aged cannabis as a metabolite of other cannabinoids. It is non-psychoactive.

Certify. The act of confirming that a patient has a qualifying condition. Many jurisdictions use alternative phrases such as 'attest' or 'authorize;' however, 13 of 29 jurisdictions use 'certify' language in their statutes.

Clinical research. An activity that involves studies that experimentally assign randomized human participants to one or more drug interventions to evaluate the effects on health outcomes.

Designated Caregiver. An individual who is selected by the Medical Marijuana Program qualifying patient and authorized by the Medical Marijuana Program to purchase and/or administer cannabis on their behalf. Also sometimes referred to as an "alternate caregiver."

Dronabinol. The generic name for synthetic THC. It is the active ingredient in the FDA approved drug, Marinol®.

Endocannabinoid System. A system that consists of endocannabinoids, cannabinoid receptors and the enzymes responsible for synthesis and degradation of endocannabinoids.

Epidiolex®. First in a new class of antiepileptic drugs that contains highly-purified cannabidiol (CBD); indicated for the treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients 2 years of age and older. Epidiolex® is a Schedule V controlled substance and has a low potential for abuse.

Marijuana. Marijuana refers to a cultivated cannabis plant, whether for recreational or medicinal use. The words marijuana and cannabis are often used interchangeably in various lay and scientific literature. These guidelines will primarily use the word "cannabis." When referring to Medical Marijuana Program, the guidelines will use the word "marijuana," as it is often used within program references.

Medical Marijuana Program (MMP). The official jurisdictional resource for the use of cannabis for medical purposes. Search the jurisdiction's website or Department of Health for "medical cannabis program" or "medical marijuana program."[1]

Nabilone. The generic name for a synthetic cannabinoid similar to THC. It is the active ingredient in the FDA-approved drug, Cesamet™.

Per se violation. Makes a certain act a violation without needing proof of any surrounding circumstances.[2]

Right-touch Regulation. Suggests the minimum regulatory force required to achieve the desired result. In the context of the BONs mission to protect the public, right-touch regulation requires consideration of proportionate, consistent, targeted, transparent, accountable, and agile regulatory discipline.[3]

Schedule I Controlled Substance. Defined in the federal Controlled Substances Act[4] as those substances that have a high potential for abuse; no currently accepted medical use in treatment in the U.S.; lack of accepted safety for use of the substance under medical supervision.

Tetrahydrocannabinol (THC). One of many cannabinoids found in cannabis; THC is believed to be responsible for most of the characteristic psychoactive effects of cannabis.[5]

Recommendations

A. Guidelines for the evaluation of a complaint regarding a licensee who tests positive for THC or its metabolite

1. The BON should have a working knowledge of the current state of legalization of medical and recreational cannabis use for the jurisdiction.
   - *The Drug Enforcement Agency (DEA) classifies cannabis as a Schedule I Controlled Substance. This classification not only prohibits practitioners from prescribing cannabis, it also prohibits most research using cannabis, except under rigorous oversight from the government.[6]*
   - *Over 33 jurisdictions (including the District of Columbia), Guam and Puerto Rico passed legislation legalizing cannabis for medical purposes. In these laws, the jurisdiction has adopted exemptions legalizing the use of cannabis for medical purposes. Although the use of marijuana pursuant to authorized MMPs conflicts with federal law and regulations, at present, there is no controlling case law holding that Congress intended to preempt the field of regulation of cannabis use under its supremacy powers.[7]*
   - *The federal government's position on prosecuting the use of cannabis that is legal under applicable jurisdiction law has been set out U.S. Department of Justice position papers. In 2009, the U.S. Attorney General took a position that discourages federal prosecutors from prosecuting people who distribute or use cannabis for medical purposes in compliance with applicable jurisdiction law; further similar guidance was given in 2011, 2013 and 2014.[8]*

In January 2018, the U.S. Office of the Attorney General rescinded the previous nationwide guidance specific to marijuana enforcement. The 2018 memorandum[9] provides that federal prosecutors follow the well-established principles in deciding which cases to prosecute, namely the prosecution is to weigh all relevant considerations including priorities set by the attorneys general, seriousness of the crime, deterrent effect of criminal prosecution and cumulative impact of particular crimes on the community.

- *MMPs are defined and described within the statute and rules of the specific jurisdiction. These statutes include specific conditions that qualify an individual to participate in a jurisdiction's MMP, as well as the process to become qualified. The relevant statute is most easily located through the jurisdiction's Department of Health and MMP.[10] The law of the jurisdiction's MMP will specify the qualifying conditions, certification process, and length of time certification is valid.*
- *An increasing proportion of jurisdictions have also decriminalized or legalized recreational cannabis use.[11]*

2. The BON should have a working knowledge of the standards for, and limitations of, current laboratory testing related to cannabis use and impairment.
   - *THC is the primary psychoactive component of the cannabis plant and is believed to be primarily responsible for the cognitive effects of cannabis. THC ingestion "transiently impairs cognitive function on a number of levels—from basic motor coordination to more complex tasks, such as the ability to plan, organize, solve problems, make decisions, remember, and control emotions and behavior."[12]*
   - *A 2017 report to Congress entitled "Marijuana-Impaired Driving"[13] concluded that current laboratory tests cannot provide any objective threshold that establishes impairment based on a specific level of THC or THC metabolite concentration.*
     - *A laboratory test for THC examines the biological specimen for the presence or absence of THC or THC metabolite.*
     - *A screening test is completed first to determine if there is detectable presence of THC or its metabolite; if positive, a second test using a gas chromatograph with mass spectrometry (GC/MS) is necessary to determine the precise concentration of THC or its metabolite.[14]*
     - *Current laboratory tests can positively indicate whether there is THC or its metabolite in the specimen, but can only indicate concentration according the equipment's capability or threshold.[15]*
     - *Current laboratory tests cannot indicate when the individual ingested cannabis.[16]*
   - *Unlike alcohol, a water-soluble substance with steady metabolism, THC is a fat-soluble substance that is not metabolized at a steady rate and therefore can be detected in the blood long after ingestion.[17]*
   - *Current laboratory tests cannot provide any objective threshold that establishes impairment based on THC or THC metabolite concentration.[18]*
   - *Peak impairment does not occur when THC concentration in the blood is at or near peak levels. Peak THC levels can occur when low impairment is measured, and high impairment can be measured when THC levels are low.[19] The level of THC in the blood and the degree of impairment do not appear to be closely related.[20]*
   - *The acute psychoactive effects of cannabis ingestion last for hours and do not closely correlate to the concentration of THC in the blood.[21]*
   - *Peak and duration of psychoactive effects of THC vary with concentration and method of ingestion. For example, the psychoactive*

effects of smoked cannabis are experienced within minutes after smoking, with peak levels occurring after approximately 30 minutes. THC concentration declines rapidly over 1-3 hours. With oral ingestion, peak concentrations occur over 1–3 hours.[22]

- *Despite the lack of scientific evidence for an objective threshold which establishes impairment based on THC concentration, some jurisdictions have adopted a per se limit while performing specific activities. Per se laws are not necessarily based on scientific evidence of impairment, instead they are based on laboratory threshold or cut-off values. These laboratory cut-offs are based on analytical capability of current equipment and are irrespective of impairment.*[23]
  - *For example, per se laws make it a criminal offense for an individual to have a specific drug or the drug's metabolite in his/her body while performing specific activities. Some jurisdictions have a per se law which specifies that it is illegal to drive with any or more than a specific concentration of a specific drug(s) in blood or urine.*[24] *This type of test is evidence based. A per se law regarding THC is not evidence-based at this time.*

3. The BON should have a working knowledge of right touch regulation.
   - *Right touch regulation suggests the minimum regulatory force be used to achieve the desired result. In the context of the BONs mission to protect the public, right-touch regulation requires consideration of the risk the BON is trying to regulate, as well as proportionate, consistent, targeted, transparent, accountable, and agile discipline as warranted.*[25]
   - *When a regulatory body's decisions affect the safety of the public, a delicate balance must be maintained between mitigating the risk of harm and applying discipline in a fair and consistent manner.*[26] *After evaluation of the mitigating and aggravating factors, the disciplinary decision should be appropriate to the circumstances, have a minimal effect on the nurse's practice beyond what is necessary, and be justifiable under scrutiny.*

4. Case Examples

Case A

- ✓ A licensee tests positive for THC or its metabolite
- ✓ Allegations of impairment or lack of fitness to practice while working

The BON should follow established board processes for evaluation of impairment/lack of fitness to practice at the workplace.

- *Nursing, by its nature requires adequate cognitive ability for critical decision making that is typical for assessments, diagnosis of patients, interventions, reassessments and other appropriate or necessary actions, sometimes occurring in stressful situations.*[27] *Accordingly, there is a direct and immediate nexus between the nurse's job duties and a significant safety risk.*[28] *A nurse impaired on-the-job carries a risk of causing a significant incident affecting the health or safety of the public.*
- *Legal use notwithstanding, the ingestion of cannabis can be a violation of nurse practice act or rules where on-the-job impairment creates an actual or potential impairment of the ability to practice nursing with reasonable skill and safety to patients by reason of the use of alcohol, drugs, chemicals, or any other material.*[29]
- *Evaluations of workplace impairment/fitness to practice can confirm actual or potential inability to practice nursing with reasonable skill and safety.*

Case B

- ✓ A licensee tests positive for THC or its metabolite
- ✓ Licensee used cannabis in a state where use is LEGAL (legal use in state of licensure or proof of travel to a state where legal)
- o *NO allegations of impairment or lack of fitness to practice while working*

The BON should use right touch regulation in the resolution of the complaint considering the following:

- *Current laboratory tests cannot indicate time of ingestion.*
- *THC, stored in fatty tissues, can be released back into the blood long after ingestion.*
- *Current laboratory tests cannot provide any objective threshold that establishes impairment based on THC or THC metabolite concentration.*[30]
- *A per se law regarding THC is not evidence-based at this time.*
- *All aggravating and mitigating factors.*
- *Absent impairment, principles of public protection may not be served by a per se violation requiring a substance use evaluation/ fitness to practice evaluation for the legal use of marijuana. A per se violation may subject the nurse to burdensome licensure requirements without enhancing public protection.*
- *Instances without aggravating factors may not require any consequences by the BON.*

Case C

- ✓ A licensee tests positive for THC or its metabolite
- ✓ Licensee used cannabis in a state where use is NOT legal
- o *NO allegations of impairment or lack of fitness to practice while working*

The BON should use right touch regulation in the resolution of the complaint considering the following:

- *Current laboratory tests cannot indicate time of ingestion.*
- *THC, stored in fatty tissues, can be released back into the blood long after ingestion.*
- *Current laboratory tests cannot provide any objective threshold that establishes impairment based on THC or THC metabolite concentration.*[31]
- *A per se law regarding THC is not evidence-based at this time.*
- *Absent impairment, principles of public protection may not be served by a per se violation requiring a substance use evaluation/ fitness to practice evaluation for the legal use of marijuana. A per se violation may subject the nurse to burdensome licensure requirements without enhancing public protection.*
- *All aggravating and mitigating factors.*
  - o *Use of cannabis in a jurisdiction where NOT legal is an aggravating factor*
- *Instances with aggravating factors may require action by the BON.*
  - o *A non-disciplinary letter of concern and/or administrative fine may serve to warn the licensee of the BON's concern regarding use of cannabis in a state where not legal.*
  - o *The non-disciplinary letter of concern should include specific warnings regarding that future positive THC testing may result in a substance use evaluation or BON discipline.*

B. Guidelines for the Evaluation of a Complaint Regarding APRN Certification of a Medical Marijuana Program Qualifying Condition

1. The BON should have a working knowledge of the current state of legalization of medical and recreational cannabis use.
   - *The Drug Enforcement Agency (DEA) classifies cannabis as a Schedule I Controlled Substance.*

This classification not only prohibits practitioners from prescribing cannabis, it also prohibits most research using cannabis, except under rigorous oversight from the government.[32]

- *The process for obtaining cannabis for federally funded research purposes is a cumbersome process and unlike any other drug research. The DEA sets a quota for cannabis that can be grown for research studies.*[33] *Applications to use cannabis must be made to the U.S. Food and Drug Association (FDA), DEA and National Institute on Drug Abuse.*[34]
- *Over 33 jurisdictions including the District of Columbia), Guam and Puerto Rico passed legislation legalizing cannabis for medical purposes. In these laws, the jurisdiction has adopted exemptions legalizing the use of cannabis for medical purposes. Although the use of marijuana pursuant to authorized MMPs conflicts with federal law and regulations, at present, there is no controlling case law holding that Congress intended to preempt the field of regulation of cannabis use under its supremacy powers.*[35]
- *The federal government's position on prosecuting the use of cannabis that is legal under applicable jurisdiction law has been set out U.S. Department of Justice position papers. In 2009, the U.S. Attorney General took a position that discourages federal prosecutors from prosecuting people who distribute or use cannabis for medical purposes in compliance with applicable jurisdiction law; further similar guidance was given in 2011, 2013 and 2014.*[36] *In January 2018, the U.S. Office of the Attorney General rescinded the previous nationwide guidance specific to marijuana enforcement. The 2018 memorandum*[37] *provides that federal prosecutors follow the well-established principles in deciding which cases to prosecute, namely the prosecution is to weigh all relevant considerations including priorities set by the attorneys general, seriousness of the crime, deterrent effect of criminal prosecution and cumulative impact of particular crimes on the community.*

2. The BON should have a working knowledge of the jurisdiction's MMP.
   - *MMPs are defined and described within the statute and rules of the specific jurisdiction. The relevant statute or rules are most easily located through the jurisdiction's Department of Health and MMP.*[38] *Laws and rules regarding MMPs are an evolving process. Always confirm use of the most recent versions.*
   - *A health care provider does not prescribe cannabis.*
   - *The MMP will specify the qualifying conditions and the certifying process, as well as the type of health care provider who can certify a qualifying condition.*[39]
   - *The MMP will specify whether an APRN can certify a qualifying condition and whether a specific course or training is required in order to participate in certifying a MMP qualifying condition.*[40]
   - *After the qualifying condition is certified, the patient registers with the MMP. Once registered, the patient can obtain cannabis from a jurisdiction authorized cannabis dispensary.*[41]
   - *Specific MMP statutes define the bona fide health care provider-patient relationship necessary required for authorization to certify a patient as having a qualifying condition. Some statutes require a pre-existing and ongoing relationship with the patient at as a treating health care provider; others note that the relationship may not be limited to issuing a written certification for the patient or a consultation simply for that purpose. Verification of the existence of the required provider-patient relationship and documentation of the certification within the jurisdiction's MMP is essential.*
   - *Procurement and administration of cannabis for*

medical purposes is limited to the patient and/or the patient's designated caregiver. The MMPs will specify whether designated caregivers are permissible, as well as the applicable process for registration as a designated caregiver.[42]

- *In some jurisdictions, the MMP allows an employee of a hospice provider, nursing, or medical facility or a visiting nurse, personal care attendant, or home health aide to act as a designated caregiver for the administration of medical cannabis.*[43]

3. The BON should be aware of the NCSBN National Nursing Guidelines for Medical Marijuana - APRN Certifying a Medical Marijuana Qualifying Condition when evaluating whether the APRN violated the nurse practice act or the jurisdiction's MMP.
   - *The NCSBN National Nursing Guidelines for Medical Marijuana - APRN Certifying a Medical Marijuana Qualifying Condition*[44] *include information on the following:*
     - o *Essential knowledge*
     - o *Clinical encounter and identification of a qualifying condition*
     - o *Informed and shared decision making*
     - o *Documentation and communication*
     - o *Ethical considerations*
     - o *Special considerations*

4. The BON should have a working knowledge of right touch regulation.
   - *Right touch regulation suggests the minimum regulatory force be used to achieve the desired result. In the context of the BONs mission to protect the public, right-touch regulation requires consideration of the risk the BON is trying to regulate, as well as proportionate, consistent, targeted, transparent, accountable, and agile discipline as warranted.*[45]
   - *When a regulatory body's decisions affect the safety of the public, a delicate balance must be maintained between mitigating the risk of harm and applying discipline in a fair and consistent manner.*[46] *After evaluation of the mitigating and aggravating factors, the disciplinary decision should be appropriate to the circumstances, have a minimal effect on the nurse's practice beyond what is necessary, and be justifiable under scrutiny.*

5. The BON should consider an APRN's certification of a qualifying condition for medical cannabis outside of the provisions of the MMP in the context of the nurse practice act
   - *Certification of a qualifying condition for medical cannabis outside of the provisions of the MMP exceeds the nurse's scope of practice and does not conform to prevailing standards of safe nursing care.*

C. Guidelines for the Evaluation of a Complaint Regarding a Licensee's Administration of Cannabis to a Patient Outside of Medical Marijuana Program Designated Caregiver

1. The BON should have a working knowledge of the current state of legalization of medical and recreational cannabis use.
   - *The Drug Enforcement Agency (DEA) classifies cannabis as a Schedule I Controlled Substance. This classification not only prohibits practitioners from prescribing cannabis, it also prohibits most research using cannabis, except under rigorous oversight from the government.*[47]
   - *Over 33 jurisdictions (including the District of Columbia), Guam and Puerto Rico passed legislation legalizing cannabis for medical purposes. In these laws, the jurisdiction has adopted exemptions legalizing the use of cannabis for medical purposes. Although the use of marijuana pursuant to authorized MMPs conflicts with federal law and regulations, at present, there is no controlling case law holding that Congress intended to preempt the field of regulation of cannabis use under its supremacy powers.*[48]

- *An increasing proportion of jurisdictions have also decriminalized or legalized recreational cannabis use.*[49]
- *The federal government's position on prosecuting the use of cannabis that is legal under applicable jurisdiction law has been set out U.S. Department of Justice position papers. In 2009, the U.S. Attorney General took a position that discourages federal prosecutors from prosecuting people who distribute or use cannabis for medical purposes in compliance with applicable jurisdiction law; further similar guidance was given in 2011, 2013 and 2014.*[50] *In January 2018, the U.S. Office of the Attorney General rescinded the previous nationwide guidance specific to marijuana enforcement. The 2018 memorandum*[51] *provides that federal prosecutors follow the well-established principles in deciding which cases to prosecute, namely the prosecution is to weigh all relevant considerations including priorities set by the attorneys general, seriousness of the crime, deterrent effect of criminal prosecution and cumulative impact of particular crimes on the community.*

2. The BON should have a working knowledge of the jurisdiction's MMP, specifically related to administration of marijuana.
   - *MMPs are defined and described within the statute and rules of the specific jurisdiction. These statutes include lists of conditions that qualify an individual to participate in a jurisdiction's MMP, as well as the process to become qualified. The relevant statute is most easily located through the jurisdiction's Department of Health and MMP.*[52]
   - *A nurse shall not administer cannabis to a patient unless specifically authorized by jurisdiction law.*[53]
   - *Instances where the nurse may administer cannabis or synthetic THC to a patient.*
     - o *Administration of FDA approved synthetic THC drugs (dronabinol, nabilone or Epidiolex) as per facility formulary and policy*
     - o *As a registered MMP designated caregiver*
   - *The majority of jurisdictions allow a designated caregiver to assist a patient with the medical use of cannabis.*
   - *These designated caregivers must meet specific qualifications and be registered with the MMP and must not practice outside of the limits of the caregiving statute.*[54]
   - *Some jurisdictions allow an employee of a hospice provider, nursing, or medical facility or a visiting nurse, to assist in the administration of medical cannabis.*[55]
   - *Check the most current MMP statute or rules.*[56]
   - *Facility policies may exist regarding medical cannabis administration. Caregiver provisions for administration of medical cannabis do not apply within a federal facility or to federal employees.*

3. The BON should be aware of the NCSBN National Nursing Guidelines for Medical Marijuana - Nursing Care of the Patient Using Medical Marijuana
   - *The NCSBN National Nursing Guidelines for Medical Marijuana - Nursing Care of the Patient Using Medical Marijuana*[57] *include the following:*
     - o *A working knowledge of the current state of legalization of medical and recreational cannabis use*
     - o *General knowledge of the principles of a MMP*
     - o *Specific knowledge of the MMP designated caregiver provisions*

4. The BON should have a working knowledge of right touch regulation.
   - *Right touch regulation suggests the minimum regulatory force be used to achieve the desired result. In the context of the BONs mission to protect the public, right-touch regulation requires consideration of the risk the BON is*

trying to regulate, as well as proportionate, consistent, targeted, transparent, accountable, and agile discipline as warranted.[58]

- *When a regulatory body's decisions affect the safety of the public, a delicate balance must be maintained between mitigating the risk of harm and applying discipline in a fair and consistent manner.*[59] *After evaluation of the mitigating and aggravating factors, the disciplinary decision should be appropriate to the circumstances, have a minimal effect on the nurse's practice beyond what is necessary, and be justifiable under scrutiny.*

5. The BON should consider the administration of cannabis outside of the designated caregiver provision of the MMP in the context of the nurse practice act.
   - *Administration of cannabis without a designated caregiver registration exceeds the nurse's scope of practice and does not conform to prevailing standards of safe nursing care.*
   - *Administration of cannabis beyond the designated caregiver provisions exceeds the nurse's scope of practice and does not conform to prevailing standards of safe nursing care.*

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