Delegation of Controlled Acts

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Controlled Acts[1]: Controlled acts are specified in the *Regulated Health Professions Act, 1991 (RHPA)* as acts which may only be performed by authorized regulated health professionals.[2]

Delegation: Delegation is a mechanism that allows a regulated health professional (e.g., a physician) who is authorized to perform a controlled act to temporarily grant that authority to another person (whether regulated or unregulated) who is not independently authorized to perform the act.

For the purposes of this policy, delegation does not include assigning a task that does not involve a controlled act (e.g., taking a patient's history), nor does it include ordering the initiation of a controlled act that is within the scope of practice of another health care professional. For example, nurses are legally authorized to "administer a substance by injection" when the procedure has been ordered by a specified regulated health professional (e.g. a physician). Therefore, a nurse would require an order to perform this procedure, but this would not be considered delegation.[3]

Direct Order: Direct orders are written or verbal instructions from a physician to another health care provider or a group of health care providers to carry out a specific treatment, procedure, or intervention for a specific patient, at a specific time. Direct orders provide

[1] See the *Advice to the Profession: Delegation of Controlled Acts* for a list of controlled acts defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 *(RHPA)*.

[2] Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it permits performing controlled acts if the person performing the act is doing so to render first aid or temporary assistance in an emergency, or if they are fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is performed under the supervision or direction of a member of the profession (*RHPA*, s. 29(1)(a,b)).

[3] For additional information about what is not considered "delegation" as defined in the policy, see the *Advice to the Profession: Delegation of Controlled Acts* document.

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the authority to carry out the treatments, procedures, or other interventions that have been directed by the physician and generally take place after a physician-patient relationship has been established.

Medical Directive[4]**:** Medical directives are written orders by physician(s) to other health care provider(s) that pertain to any patient who meets the criteria set out in the medical directive. When a medical directive calls for acts that need to be delegated, it provides the authority to carry out the treatments, procedures, or other interventions that are specified in the directive, provided that certain conditions and circumstances exist.

Policy

Delegation is intended to provide physicians with the ability to extend their capacity to serve patients by temporarily authorizing an individual to act on their behalf. Delegation is intended to be a physician extender, not a physician replacement. Physicians remain accountable and responsible for the patient care provided through delegation.

When to Delegate

In the patient's best interest

1. Physicians **must** only delegate controlled acts when doing so is in the best interest of the patient. This includes only delegating when the act can be performed safely, effectively and ethically. Therefore, physicians **must** only delegate when:

    a. the patient's health and/or safety will not be put at risk;
    b. the patient's quality of care will not be compromised by the delegation; and
    c. delegating serves one or more of the following purposes:
        i. promotes patient safety,
        ii. facilitates access to care where there is a need,
        iii. results in more timely or efficient delivery of health care, or
        iv. contributes to optimal use of health-care resources.

When not to delegate

2. Physicians **must not** delegate where the primary reasons for delegating are monetary or physician convenience.

[4] For examples of prototype medical directives, please consult the Emergency Department Medical Directives Implementation Kit which has been developed jointly by the Ontario Hospital Association (OHA), the Ontario Medical Association, and the Ministry of Health and is available on the OHA website.

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3. Physicians **must not** delegate the performance of a controlled act to a person whose certificate to practise any health profession is revoked or suspended at the time of the delegation.

4. Physicians **must not** delegate the controlled act of psychotherapy.[5]

What to Delegate

5. Physicians **must** only delegate the performance of controlled acts that they can personally perform competently (i.e., acts within their scope of practice).[6]

How to Delegate

Use of direct orders and medical directives

6. Physicians **must** delegate either through the use of a direct order or a medical directive that is clear, complete, appropriate, and includes sufficient detail to facilitate safe and appropriate implementation (see the *Documentation* section of this policy for more information).

In the context of an established physician–patient relationship

7. Physicians **must** only delegate in the context of an established physician-patient relationship and where they have current and sufficient knowledge of a patient's clinical status (i.e., following a clinical assessment[7]), unless a patient's best interests dictate otherwise (e.g., in a hospital emergency room, where it is common for some tests to be ordered before a physician has seen the patient).

8. Where a patient's best interest permits delegating prior to establishing a physician-patient relationship, physicians **must** assess the patient as soon as possible afterward, unless the delegation is occurring as part of a public health initiative,

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[5] This does not prohibit health care professionals who are authorized to perform the controlled act of psychotherapy from providing psychotherapy.

[6] O. Reg. 865/93, *Registration*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30, s. 2(5) requires physicians to only practise in the areas of medicine in which they are trained and experienced. For more information see the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy and the *Delegation of Controlled Acts*: *Advice to the Profession* document.

[7] Physicians who use telemedicine to conduct a clinical assessment prior to delegating must also comply with the College's *Telemedicine* policy.

other public safety program, or as part of established protocols in a hospital setting.[8]

9. Where delegation is occurring on an ongoing basis, physicians **must** ensure that patients are informed of who the delegating physician is and that they have the option of speaking with the physician if they wish to.

10. Where delegation is occurring on an ongoing basis, physicians **must** re-assess the patient to ensure that delegation continues to be in the patient's best interest, including when:

    a. there is a change in the patient's clinical status or treatment options; or
    b. the patient has requested to see the physician.

Ensure consent to treatment is obtained

11. Physicians **must** ensure informed consent is obtained and documented, in accordance with the *Health Care Consent Act, 1996* and the College's *Consent to Treatment* policy, for any treatments that are delegated.[9]

    a. In circumstances where the delegation takes place pursuant to a medical directive, physicians **must** ensure the medical directive includes obtaining the appropriate patient consent.[10]

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[8] Examples of appropriate circumstances in which delegation may occur in the absence of a traditional physician patient relationship include, but are not limited to:

- the provision of care by paramedics under the direct control of base hospital physicians;
- the provision of primary care in remote and isolated regions of the province by registered nurses acting in expanded roles;
- the provision of public health programs operated under the authority of a Medical Officer of Health, such as vaccinations;
- post-exposure prophylaxis following potential exposure to a blood borne pathogen or the provision of the hepatitis B vaccine in the context of occupational health medicine; and
- hospital emergency room settings for routine protocols.

[9] Please see the *Health Care Consent Act, 1996* and the College's *Consent to Treatment* policy for more information.

[10] Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate.

Quality Assurance

Identifying and mitigating risks

12. Prior to delegating, physicians **must** identify any potential risks and mitigate them appropriately.

Resources and environmental supports

13. Physicians **must** only delegate controlled acts if the necessary resources and environmental supports are in place to mitigate any risks associated with the performance of the act.

Evaluating delegates and establishing competence

14. Physicians **must** be satisfied that individuals to whom they delegate have the knowledge, skill, and judgment to perform the delegated acts competently and safely. Prior to delegating physicians **must**:

    a. review the individual's training and credentials, unless the physician is not involved in the hiring process and it is reasonable to assume that the hiring institution has ensured that its employees have the requisite knowledge, skill, and judgment[11]; and
    b. observe the individual performing the act, where necessary (i.e., where the risk is such that observation is necessary to ensure patient safety).

Ensuring delegates can accept the delegation

15. Physicians **must** only delegate to individuals who are able to accept the delegation.[12] In particular, physicians **must not:**

    a. delegate to an individual if they become aware the individual is not permitted to accept the delegation; or
    b. compel an individual to perform a controlled act they have declined to perform.

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[11] In some cases, the physician may not personally know the individual to whom they are delegating. For example, medical directors at base hospitals delegating to paramedics or in hospital settings, where the hospital employs the delegates (nurses, respiratory therapists, etc.) and the medical staff is not involved in the hiring process. For additional guidance about ensuring competence when a physician has not personally employed a delegate, see the *Advice to the Profession: Delegation of Controlled Acts* document.

[12] In addition to the limitations set out in the *RHPA*, some regulatory colleges in Ontario place limits on the types of acts that their members may be authorized to carry out through delegation. The delegate is responsible for informing the delegating physician of any regulations, policies, and/or guidelines of their regulatory body that would prevent them from accepting the delegation.

Supervision and support of delegates

16. Physicians **must** provide a level of supervision and support that is proportionate to the risk associated with the delegation and that is reflective of the following factors:

    a. the specific act being delegated;
    b. the patient's specific circumstances (e.g., health status, specific health-care needs);
    c. the setting where the act will be performed and the available resources and environmental supports in place; and
    d. the education, training and experience of the delegate.

17. If on the basis of the risk assessment onsite supervision is not necessary, physicians **must** be available to provide appropriate consultation and assistance (e.g., in person, if necessary or by telephone).

18. Physicians **must** be satisfied that the individuals to whom they are delegating:

    a. understand the extent of their responsibilities; and
    b. know when and who to ask for assistance, if necessary.
        i. Where a medical directive is implemented, physicians **must** ensure an individual implementing the directive is able to identify the physician responsible for the care of the patient.

19. Physicians **must** ensure that the individuals to whom they are delegating accurately identify themselves and their role in providing care to patients and that patients with questions about the delegate's role are provided with an explanation.

Managing adverse events

20. Physicians **must** ensure that any adverse events that occur are managed appropriately and **must**:

    a. be available to provide assistance in managing any adverse events, if necessary;
    b. be satisfied that the delegate is capable of managing any adverse events themselves, if necessary; and
    c. have a communication plan in place to keep informed of any adverse events that take place and any actions taken by the delegate to manage any adverse events.

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Ongoing monitoring and evaluation

21. Where acts are routinely delegated, physicians **must** have a reliable and ongoing monitoring and evaluation system for both the delegate(s) and the delegation process itself.

22. As part of this system, physicians **must**:

    a. confirm currency of the delegate's knowledge and skills; and
    b. evaluate the delegation process to ensure it is safe and effective; and
    c. review patient medical records to ensure the care provided through delegation is appropriate and meets the standard of practice.
        i. What is necessary will depend on the specific acts being delegated and the other quality assurance processes in place to ensure safe and effective delegation.

Documentation

Medical Directives

23. Physicians **must** ensure the following information is included in the medical directive[13]:

    a. The name and a description of the procedure, treatment, or intervention being ordered;
    b. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
    c. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
    d. A comprehensive list of contraindications to implementation of the directive;
    e. Identification of the individuals authorized to implement the directive;[14]
    f. A description of the procedure, treatment, or intervention itself that provides sufficient detail to ensure that the individual implementing the directive can do so safely and appropriately;[15]
    g. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and

[13] A comprehensive guide and toolkit was developed by a working group of the Health Profession Regulators of Ontario (HPRO) in 2006 and is posted on their website.
[14] The individuals need not be named but may be described by qualification or position in the workplace.
[15] The directive may call for the delegate to follow a protocol that describes the steps to be taken in delivering treatment if one has been developed by the physician or the institution.

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h. A list of the administrative approvals that were provided to the directive, including the dates and each Committee (if any).

24. Each physician responsible for the care of a patient who may receive the proposed treatment, procedure, or intervention **must** review and sign the medical directive each time it is updated.[16]

Medical Records

25. Physicians **must** ensure that:

a. the care provided through delegation is documented in accordance with the College's *Medical Records Documentation* policy, including that each entry in the medical record is identifiable and clearly conveys who made the entry and performed the act;
b. it is clear who the authorizing physician(s) are (e.g., the name(s) of the authorizing physician(s) are captured in the medical record); and
c. verbal direct orders are documented in the patient's medical record by the recipient of the direct order and are reviewed or confirmed at the earliest opportunity by the delegating physician.[17]

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[16] It is acceptable for physicians working at institutions with multiple directives to receive copies of each directive and sign one statement indicating that they have read and agreed with all the medical directives referred to therein. This can be done as part of the annual physician reappointment process.
[17] Physicians practising in hospitals may be subject to additional requirements under the *Public Hospitals Act, 1990*.