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.

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.

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,

[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]

[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.

[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.

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.

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]

[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*.

Advice to the Profession: Delegation of Controlled Acts

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Introduction

Under Ontario law, certain acts, referred to as "controlled acts," may only be performed by authorized health professionals. Of the 14 controlled acts, physicians are authorized to perform 13 of them and under appropriate circumstances, physicians may delegate these acts to others.[1] While the term "delegation" can have multiple meanings, for the purposes of the policy, "delegation" is defined as 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. Delegating controlled acts in appropriate circumstances can result in more timely delivery of health care, promote optimal use of healthcare resources and personnel, and increase access to care where there is a need.

The *Delegation of Controlled Acts* policy sets expectations for physicians about when and how they may delegate controlled acts, through either direct orders or medical directives. It also sets expectations about the use, development, and contents of medical directives. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the *Delegation of Controlled Acts* policy and provide guidance around how these expectations may be effectively discharged.

Delegation Fundamentals

How do I know which acts are "controlled acts"?

Controlled acts are defined in the *Regulated Health Professions Act, 1991*[2] *(RHPA)* and include the following:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

[1] Physicians are not permitted to delegate the controlled act of psychotherapy.

[2] Controlled acts are defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 *(RHPA).*

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the *RHPA*.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.[3]
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

What should I do if I'm not sure whether a procedure, treatment, or intervention requires the performance of a controlled act?

Physicians with questions about whether a procedure, treatment or intervention involves the performance of a controlled act can consult the Canadian Medical Protective Association (CMPA) or seek an independent legal opinion.

[3] This is the only controlled act that physicians are not authorized to perform.

What are some examples of instances that would <u>not</u> require delegation? In what circumstances does the policy not apply?

"Delegation" occurs only when a physician directs an individual to perform a controlled act that the individual has no statutory authority to perform. However, the term "delegation" is often used liberally to refer to instances that would not require delegation as defined in the policy. For example, the following would not require delegation as defined in the policy:

1) Assigning tasks to staff or other health care professionals that do not involve the performance of controlled acts (e.g., history-taking, administering a test that does not involve a controlled act, taking vitals, or obtaining consent).

2) Performing a controlled act in one of the permissible circumstances listed under the *RHPA*[4] (e.g., when providing first aid or temporary assistance in an emergency or when fulfilling the requirements to become a member of a health profession (e.g., medical students)).

3) Ordering the initiation of a controlled act that is within the scope of practice of another health professional (e.g., an order for a nurse to "administer a substance by injection" is not delegation as nurses are legally authorized to perform this act when ordered to do so by a physician).[5]

Considering and Evaluating Delegates

Can I delegate to individuals who are not members of a regulated health profession?

Yes. The policy permits delegating to individuals who are not members of a regulated health profession, provided the policy requirements are met. For example, Physician Assistants and Paramedics are skilled health care providers who regularly provide safe and effective care entirely through delegation.

[4] The *RHPA* sets out a number of exceptions that allow individuals who are not members of a regulated health profession to perform some controlled acts, in certain circumstances. A comprehensive list of the exceptions can be found under Section 29 (1) (2) of the *RHPA*.

[5] In order to determine whether an act requires delegation, physicians need to be aware of the scope of practice of the individual who will perform the act and whether it includes the controlled act in question. Regulated health professions have their own professional statutes (e.g., the *Nursing Act, 1991*), that define their scopes of practice and the controlled acts they are authorized to perform. Physicians with additional questions can consult the CMPA or obtain an independent legal opinion.

Physicians are ultimately responsible for the acts they delegate and must be satisfied that the individual to whom they are delegating has the requisite knowledge, skill, and judgment to perform the act(s).

Where can I find information about delegating to Physician Assistants (PAs)?

The Canadian Medical Association and the Canadian Association of Physician Assistants have developed a Physician Assistant Toolkit for Canadian physicians looking to delegate to PAs. The CMPA's article *Working with physician assistants: Collaborating while managing risks* also contains helpful information.

How do the policy expectations apply when delegating to International Medical Graduates (IMGs) who have credentials or licences obtained in other jurisdictions but who do not have certificates of registration in Ontario?

The same protocols that apply when delegating to any other individuals apply to IMGs. In particular, physicians cannot rely exclusively on credentials or licences obtained in other jurisdictions to ascertain whether an IMG has the requisite knowledge, skill, and judgment to safely perform a controlled act and must be equally diligent in evaluating and establishing the IMG's competence to perform the controlled acts.

What are my responsibilities for ensuring competence if I am not involved in the hiring of the individual to whom I will be delegating (e.g., in an institutional setting)?

As part of establishing and ensuring a delegate's competence the policy requires physicians to review the delegate'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. It is reasonable to rely on the diligence of the institution's process for hiring unless there are reasonable grounds to believe otherwise. Physicians must still be satisfied that the individuals to whom they are delegating have the knowledge, skill, and judgment to perform the delegated acts competently and safely and would need to take appropriate action if they had concerns about a delegate's competence (e.g., notifying the individual to whom the individual is accountable).[6]

[6] For additional information see the College's *Mandatory and Permissive Reporting* policy.

Scope of Practice

What does it mean to only delegate acts which are in my scope of practice? If I have a practice restriction, am I permitted to delegate?

Physicians are required by the policy to only delegate acts that they are competent to perform personally (i.e., those within their scope of practice). This means that physicians must only delegate acts that are within the limits of their knowledge, skill and judgment and any terms, limits, and conditions of their practice certificate. Physicians are not permitted to delegate acts that contravene their practice restrictions.

Delegating in the Context of an Established Physician-Patient Relationship

The policy requires delegating in the context of an established physician-patient relationship, while permitting some exceptions. Can you elaborate on the exceptions?

The policy permits delegating prior to establishing a physician-patient relationship where it would be in a patient's best interest and identifies a few circumstances in which delegation may occur in the absence of a traditional physician-patient relationship altogether. An example of when it would be in the patient's best interest to delegate prior to establishing a physician-patient relationship is in a hospital emergency room, where it is common for some tests to be ordered before a physician has seen the patient. In this case, the timely delivery of treatment is required to ensure patient safety and thus the patient's best interests will be served by having the controlled act performed prior to assessment by the physician.

Though the policy permits delegating in advance of a physician-patient relationship where it is in a patient's best interests to do so, delegating in this context is the exception not the rule. It is generally in a patient's best interest for a physician to conduct a clinical assessment and gather the necessary clinical information prior to delegating, so they can determine whether delegation is appropriate.

Physicians who are considering whether it would be appropriate to delegate prior to establishing a physician-patient relationship need to be prepared to justify delegating in this context and be able to illustrate why it is in the patient's best interest, should a complaint arise.

Is it appropriate to delegate a cosmetic procedure (e.g., botulinum toxin (Botox) and fillers) without first establishing a physician-patient relationship?

Generally, no. As the policy states, delegation must occur within the context of an existing physician-patient relationship and following a clinical assessment. The only

exception to this is where the patient's best interests would dictate otherwise. As in all instances of delegation, a physician would have to justify why delegating in advance of a physician-patient relationship is in a patient's best interest and it is not clear that this exception would apply in the context of cosmetic procedures.

Assessment of Risk

What are the risks involved in delegating? How does risk factor into decisions related to delegation?

By law, controlled acts may only be performed by authorized regulated health professionals due to the potential harm that could result if performed by someone who does not have the knowledge, skill, and judgment to perform them. As such, the performance of any controlled act has been identified by the legislature as carrying some risk.

Risks vary depending on the specific acts being performed and the circumstances under which they are performed and thus must be considered prior to each instance of delegation and mitigated appropriately. Physicians must then only delegate if the patient's health and/or safety will not be put at risk by the delegation. Physicians who require additional assistance determining the appropriateness of delegating in a specific circumstance can contact the CMPA or obtain independent legal advice.

Appropriate Supervision and Support

Delegation is intended to be a physician extender, not a physician replacement. What does this mean and how can I apply this principle when delegating?

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. It is meant to be a tool to extend physician services, where appropriate, as opposed to replacing the physician altogether. In accordance with the policy, this requires physicians to appropriately supervise and support delegates, and not allow a delegate to practise independently without any physician involvement or beyond the scope of their individual knowledge, skills, and judgement. Ensuring appropriate parameters are placed around what a delegate is permitted to do, that are based on the individual's education, training and experience is vital for safe and effective delegation.

I am required to appropriately supervise individuals to whom I am delegating. Am I required to be onsite when supervising a delegate?

Generally speaking, by fulfilling the requirements in the policy physicians will often already be onsite to supervise delegates. For example, when establishing a physician-patient relationship, providing an appropriate clinical assessment prior to delegating, re-assessing a patient as a result of a change in clinical status or treatment options, or when a patient has requested to see the physician.

Notwithstanding the above, the requirement to be onsite is case specific and dependent on the circumstances of the delegation. Supervision must be proportionate to the risks associated with the delegation and physicians need to be available to provide whatever support is required by the delegate. In some instances this will require you to be onsite, or to be available to come onsite if necessary, and in other instances you can provide assistance remotely, provided the right supports are in place in the setting where the delegation is occurring.

It is not appropriate for physicians to leave a delegate to manage a practice or their patient population on their own. Onsite supervision will help ensure the policy expectations are met.

What are some examples of circumstances where it might be appropriate to be offsite when supervising a delegate?

It may be appropriate for physicians to supervise delegates while offsite where the risk of the delegation is low, and/or the circumstances make it impractical or impossible to be onsite. For example, where delegation is occurring for the purpose of facilitating access to care where there is a need, it may not be possible for supervising physicians to be physically present at the location in which a delegate is providing care. Additionally, paramedicine is structured in a way that permits Base Hospital physicians to provide remote assistance where necessary and does not require onsite supervision. Lastly, physicians delegating in the context of long-term care homes may not always be onsite.

Ultimately, whether it is appropriate to be offsite at any given moment is case specific and physicians must be available to provide assistance to delegates, when necessary.

Quality Assurance

What are some best practices for monitoring and evaluating the delegation process?

Tracking or monitoring when medical directives are being implemented inappropriately or are resulting in unanticipated outcomes can help monitor the effectiveness of the delegation process.

Delegating Prescribing

Am I permitted to delegate the controlled act of prescribing?

Yes, where appropriate. As with the delegation of all controlled acts, physicians must consider whether it is in the patient's best interest to delegate prescribing, in the circumstances. Factors for consideration include the risk profile of the drug, the patient's specific condition, whether the drug has been previously prescribed (repeats or renewals), whether the prescription requires adjustment, etc.

Can medical directives be used to implement orders for prescriptions?

Yes. Medical directives can be used to implement orders for prescriptions. Any prescriptions completed pursuant to a medical directive need to specifically identify the medical directive (name and number), the individual responsible for implementing the directive (name and signature), and the name of the prescribing physician, along with contact information to clarify any questions. If a request is received, a copy of the medical directive can be forwarded to further demonstrate the integrity of the order.

Documentation

How do I ensure appropriate documentation of delegation?

Medical records can provide indication of whether delegation is being done appropriately and in accordance with the policy. Therefore, in keeping with the principles and expectation of the College's *Medical Records Documentation* policy, it is important for the medical records of patients who received care through delegation to accurately and comprehensively reflect the care that was provided (e.g., evidence of an appropriate history-taking, any relevant assessments that were done prior to delegating, informed consent in accordance with the policy, etc.). Additionally, where medical directives are implemented, physicians may wish to capture the name and number of the directive in the medical record.

Liability and Billing

Are there liability issues that arise from delegation?

Physicians are accountable and responsible for the acts that they delegate. In particular, they are responsible for making the choice to delegate, and for ensuring that the delegation is taking place safely, effectively, and in accordance with the policy expectations.

Physicians with questions about liability or liability coverage can consult the CMPA.

If I am fulfilling the CPSO's expectations with respect to the delegation of controlled acts does that mean I have fulfilled the Ontario Health Insurance Plan (OHIP) billing requirements for delegated services?

No. Fulfilling the College's expectations with respect to the delegation of controlled acts does not entail that physicians have fulfilled Ontario Health Insurance Plan (OHIP) billing requirements for delegated services. Physicians who bill OHIP and who are considering delegating performance of controlled acts to others need to carefully review the provisions of the OHIP Schedule of Benefits. The Ontario Medical Association and the Provider Services Branch at OHIP can answer questions and give advice about such matters and a joint bulletin developed by the Ministry of Health and the OMA provides additional information on Payment Requirements for Delegated Services.