



Delegation of Controlled Acts

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COLLEGE CONTACT:	Physician Advisory Service

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INTRODUCTION

The College is committed to ensuring that physicians in Ontario provide the highest quality care to their patients. Under Ontario law, certain acts, referred to as “controlled acts,” may only be performed by authorized health-care professionals. However, under appropriate circumstances, these acts may be delegated to others. Delegating controlled acts in appropriate circumstances can result in more timely delivery of health care, and can promote optimal use of health-care resources and personnel.

This policy sets expectations for physicians about when and how they may delegate controlled acts, through either direct orders or medical directives.

PRINCIPLES

In accordance with *The Practice Guide*, the professional expectations in this policy are based on the following principles:

1. In every instance of delegation, the primary consideration must be the best interests of the patient.
2. An act undertaken through delegation must be as safe and effective as if it had been performed by the delegating physician.
3. Responsibility for a delegated controlled act always remains with the delegating physician.

TERMINOLOGY

Controlled Acts

Controlled acts are specified in the *Regulated Health Professions Act, 1991 (RHPA)* as acts which may only be performed by authorized regulated health professionals.¹ Of the 14 controlled acts,² physicians are authorized to perform 13 and may, in appropriate circumstances, delegate the performance of those acts to other individuals who may or may not be members of a regulated health

profession. A list of controlled acts set out in the *RHPA* can be found at Appendix A.

Delegation

Delegation is a mechanism that allows a physician who is authorized to perform a controlled act to confer that authority to another person (whether regulated or unregulated) who is not independently authorized to perform the act.³

It is not considered delegation to authorize the initiation of a controlled act that is within the scope of practice of another health professional.⁴ It is also not considered delegation to refer a patient to another physician or health professional for care. For the purposes of this policy, “delegation” occurs only when a physician directs an individual to perform a controlled act that the individual has no statutory authority to perform.

Delegation can take place through either a direct order or a medical directive. In most cases, these are used to facilitate the efficient delivery of health care to patients. They are commonly used in institutional settings.⁵

Direct Order

A direct order provides instructions from an individual physician to another health care provider or a group of health care providers. The order relates to *only one patient* and initiates a specific intervention or treatment to be delivered at a specific time. It may be verbal (over the telephone, via videoconferencing, or in person) or written. A direct order is to take place after a physician-patient relationship has been established.

Medical Directive

Medical directives are written orders by physicians (often more than one) to other health care providers that pertain to *any patient* who meets the criteria set out in the medical directive. When the directive calls for acts that will require delegation, it provides the authority to carry out the treat-

1. Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it does not apply 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)).
2. At the time of writing, the amendment to Section 27(2) of the *RHPA* deeming treatment by psychotherapeutic technique a controlled act was not yet proclaimed and therefore not yet in force. Upon proclamation, the expectations in this policy with respect to this controlled act will apply to physicians.
3. While the term “delegation” can have multiple meanings, for the purposes of this policy, “delegation” refers to the delegation of controlled acts as defined under the *RHPA*.
4. For example, nurses are legally authorized to “administer a substance by injection” when the procedure has been ordered by a specified regulated health professional. Therefore, a nurse would require an order to perform this procedure, but would never require delegation.
5. Not all direct orders and medical directives contain delegation of controlled acts. A health professional may require a medical order to initiate a controlled act that he or she is already authorized to perform. In such situations, the direct order or medical directive will contain the order to perform the controlled act, but will not delegate it. In order for a physician to know whether they are delegating a controlled act or merely providing an order to initiate the performance of a controlled act, he or she must be aware of whether the scope of practice of the individual who will perform the procedure includes the controlled act in question. Ideally, this will be specified in medical directives.



ments, procedures, or other interventions that are specified in the directive, provided that certain conditions and circumstances exist.

This policy sets expectations about the use, development, and contents of medical directives. For examples of prototype medical directives, physicians are encouraged to 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 Long-Term Care and is available on the OHA website.

Scope

This policy applies to all physicians who delegate controlled acts.⁶

POLICY

1. Patient Best Interests

In every instance of delegation, the primary consideration must be the best interests of the patient. In making the decision to delegate controlled acts, the physician will consider how to achieve an appropriate balance of patient need, quality and access. Controlled acts must not be delegated solely for monetary or convenience reasons and quality patient care must not be compromised by the delegation.

2. Physician-Patient Relationship

In most situations where a physician delegates the performance of controlled acts, he or she should have current knowledge of a patient's clinical status. Therefore, delegation must only occur in the context of an existing physician-patient relationship, unless patient safety and best interests dictate otherwise. This will usually mean that the physician has interviewed the patient, performed an appropriate assessment, made recommendations, obtained

an informed consent to proceed, and ordered a course of therapy.⁷

In some instances, the patient's best interests will be served by having the controlled act performed prior to assessment by the physician (in a hospital emergency room, for example, where it is common for some tests to be ordered before a physician has seen the patient). In such circumstances, the delegation may take place pursuant to a medical directive. When this happens, it is expected that a delegating physician under whose authority the controlled act has been performed will meet and assess the patient as soon after it has been performed as possible.

3. Scope and Training

The *Medicine Act, 1991* requires the physician to confine medical practice to those areas of medicine in which he or she is trained and experienced.⁸ A physician must not delegate the performance of an act that he or she is not competent to perform personally.

4. Evaluation of the Delegate

i. Ensure the delegate has the appropriate knowledge, skill and judgment to perform the delegated act.

The physician must be satisfied that the individual to whom the act will be delegated has the appropriate knowledge, skill and judgment to perform the delegated act. *The delegate must be able to carry out the act as competently and safely as the delegating physician.*

Since delegation of controlled acts involves ordering acts that are not within the scope of practice of the individual accepting the order (whether the individual is regulated or unregulated), a physician must not assume that the individual has the knowledge, skill and judgment required to perform the act. As such, a physician who elects to delegate controlled acts to any individual must be especially

6. Physicians should note that fulfilling the College's expectations with respect to the delegation of controlled acts does not entail that they 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 should carefully review the provisions of the OHIP Schedule of Benefits. The OMA and the Provider Services Branch at OHIP are available to answer questions and give advice about such matters.

7. Examples where the College has explicitly identified appropriate circumstances in which delegation may occur in the absence of a physician-patient relationship include:

- the provision of care by paramedics under the direct control of base hospital physicians;
- the administration 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; and
- 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.

8. O. Reg. 865/93, *Registration*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30, s. 2(5).

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diligent in ensuring that the delegate is capable of performing the act competently and safely.⁹

If physicians choose to delegate controlled acts to international medical graduates (IMGs) who have credentials or licences obtained in other jurisdictions but who do not have certificates of registration in Ontario, they must follow the same protocols that apply when delegating to any other individuals. *Physicians cannot rely exclusively on such credentials or licences to ascertain whether an IMG has the requisite knowledge, skill and judgment to safely perform a controlled act.*¹⁰

ii. Ensure the delegate is able to accept the delegation.

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 his or her regulatory body that would prevent him or her from accepting the delegation. Where the physician becomes aware that the delegate is not permitted for any reason to perform a controlled act, the physician must not delegate the act to that individual. Moreover, if a potential delegate declines to perform a controlled act for any reason, he or she cannot be compelled by the delegating physician to accept the delegation.

Because quality care is the primary concern, physicians must not delegate the performance of a controlled act (or direct any activity related to patient well-being or health care) to a person whose certificate to practise any health profession is revoked or suspended by the governing body of his or her discipline at the time of the delegation.

5. Consent

The physician must confirm that patients provide informed consent for the performance of controlled acts,

whether consent is obtained by the physician him or herself or by the delegate.¹¹ This will include providing the patient with appropriate information about the person who will be performing the controlled act (i.e., the delegate). If the patient requests information about how the delegate has obtained authorization to perform the controlled act, an explanation must be provided to the patient. In circumstances where the delegation takes place pursuant to a medical directive, the protocol for the directive must include obtaining the appropriate patient consent.¹²

The patient's consent must be documented in the medical record.¹³

6. Quality Assurance

i. Identification of risk involved in delegating the act

The physician must analyze the potential harm associated with the performance of the delegated act and be satisfied that delegating the act does not increase the risk to the patient. Some procedures in some circumstances carry such a high risk that only a physician should perform them. In such instances, the physician must not delegate.

ii. Psychotherapy¹⁴

The controlled act of psychotherapy, as defined in the *RHPA*, relies upon the psychotherapeutic relationship that is established between the physician and the patient. Delegating the controlled act of psychotherapy to someone outside of the psychotherapeutic relationship could not only reduce quality of care and negate treatment benefits, but also present an unduly high level of risk to the patient. As such, physicians must not delegate this controlled act under any circumstances.

iii. Resources and equipment required

As part of the risk analysis undertaken to determine whether the act can be appropriately delegated, the physi-

9. In some cases the physician may not personally know the individual to whom he or she is delegating. For example, in a hospital setting, the hospital employs the delegates (nurses, respiratory therapists, etc.) and the medical staff is not involved in the hiring process. In this case, it is reasonable to assume that the institution has ensured that its employees have the requisite knowledge, skill and judgment.

10. Delegation is not intended to provide IMGs who do not have certificates of registration with opportunities to gain credentials for their application for certification, nor to allow physicians to delegate controlled acts to IMGs for monetary or convenience reasons. As with any delegate, activities of the IMG must only substitute for the direct care of the physician when this is in the patient's best interests.

11. See CPSO policy Consent to Medical Treatment for further detail.

12. 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.

13. See CPSO policy Medical Records for further detail.

14. See supra note 2.



cian must identify any resources and equipment necessary to reduce risk. The physician must ensure that such resources and equipment are available on site where the delegated act is being performed.

iv. Supervision of the delegation

The accountability and responsibility for the act that has been delegated remain with the delegating physician. A physician delegating a controlled act must provide the appropriate level of supervision to ensure that the act is performed properly and safely. The nature of the supervision will vary according to the assessment of risk, taking into account the specific act being delegated, the circumstances under which the act will be performed, and the knowledge, skill, and judgment of the person performing it.

Physicians must ensure there is a communication path that will enable the individual implementing a directive to identify the physician responsible for the care of the patient in order to contact him or her immediately, if necessary.

Prior to the delegation of a controlled act, physicians must ensure that any adverse event that occurs will be managed appropriately, either by the delegate or by the delegating physician, and that there is a communication plan in place so that the delegating physician is informed of any actions taken by the delegate to manage the adverse event.

v. Ongoing monitoring and evaluation

If the particular act is routinely delegated (for example, pursuant to a medical directive in a hospital or in an office setting where staff roles include performance of delegated acts), the physician must ensure there is ongoing monitoring and evaluation of the act being performed. This would include ensuring the currency of the delegate's knowledge and skills. It would also include periodic evaluation of the delegation process itself to ensure it is safe and effective. Physicians should also consider tracking or monitoring methods to identify when medical directives are being

implemented inappropriately or are resulting in unanticipated outcomes.

vi. Documentation

The physician should ensure that there is appropriate documentation of all steps taken to meet the expectations in this policy. This documentation is necessary to answer any concerns or questions about the delegation process.¹⁵

Verbal direct orders should be noted in the patient's chart by the recipient of the direct order and must be reviewed or confirmed at the earliest opportunity by the delegating physician and in accordance with the policy of the institution in which they are used.

Where medical directives are implemented, the patient's record must include documentation of the name and number of the directive, the name and signature of the delegate, and the name(s) of the authorizing physician(s).

A medical directive must include sufficient detail to ensure that it can be implemented. The following information must be included in a medical directive:

1. The name and a description of the procedure, treatment or intervention being ordered;
2. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
3. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
4. A comprehensive list of contraindications to implementation of the directive;
5. Identification of the individuals authorized to implement the directive;¹⁶
6. A description of the procedure itself that provides suffi-

15. For further guidance, physicians are encouraged to consult the CPSO policy on Medical Records.

16. The individuals need not be named but may be described by qualification or position in the workplace.

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cient detail to ensure that the individual implementing the directive can do so safely and appropriately;¹⁷

7. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and
8. A list of the administrative approvals that were provided to the directive. The dates and each Committee (if any) should be specifically listed.¹⁸

Each physician responsible for the care of a patient who will receive the proposed treatment, procedure, or intervention must sign the medical directive. Medical directives must be updated each time there is a medical staff change within the department or division to which the directive applies.¹⁹

17. 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.

18. A more comprehensive guide and toolkit is posted on the website of the Federation of Health Regulatory College of Ontario (FHRCO). This guide was developed by a working group of FHRCO in 2006.

19. Where it is impractical for an institution to have all medical staff sign a copy of each medical directive, it is acceptable for these individuals 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. Many institutions have accomplished this by requiring acknowledgement of familiarity with and agreement to medical directives as part of their annual physician reappointment process and by creating mandatory eLearning sign-off programs for physician staff. Unless all physicians in the department are signatories to the directive, it will be administratively difficult to institute. Hospital staff should not be expected to determine whether the physician on call is or is not a signatory to a particular medical directive. If administrative simplicity is not possible, it is likely that the risk of relying on the medical directive is too high to justify its use.

Appendix A

CONTROLLED ACTS UNDER THE *RHPA*

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.
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.²⁰
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.²¹

20. This is the only controlled act that physicians are not authorized to perform.

21. Physicians are not permitted to delegate this controlled act. See section 6.ii. above.

DELEGATION OF CONTROLLED ACTS



COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

80 COLLEGE STREET, TORONTO, ONTARIO M5G 2E2