

Authorizing Mechanisms

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Introduction

An authorizing mechanism—an order, initiation, directive or delegation—is a means specified in legislation, or described in a practice standard or guideline, through which nurses¹ obtain the authority to perform a procedure or make the decision to perform a procedure.

The College of Nurses of Ontario (the College) is responsible for providing clear, concise and up-to-date guidance to nurses. As self-regulating professionals, nurses are responsible for practising in accordance with the practice documents that the College publishes and with relevant legislation. Understanding legislative responsibilities is critical for nurses to make decisions about how to perform procedures safely. It is also important to ensure that nursing practice is consistent with the College's practice documents.

Authorizing mechanisms are complex concepts that are covered in a number of College documents. To create this practice guideline, the College has consolidated and condensed information in its *Decisions About Procedures and Authority* practice standard and *Working With Unregulated Care Providers* practice guideline.²

This practice guideline provides nurses with expectations about delegation. It is intended to help nurses provide efficient, timely access to health care by helping them understand authorizing mechanisms, as well as their accountabilities when using them. However, nurses should still consult *Decisions About Procedures and Authority* for more information on authorizing accountabilities.

Legislation Governing Nursing Practice

The *Regulated Health Professions Act, 1991* (RHPA) sets out a framework for Ontario's regulated health professions.³ It provides a common set of rules of procedure for the colleges and is linked to each profession-specific act, including the *Nursing Act, 1991*. The RHPA framework sets out two elements: a scope of practice statement, and a series of controlled or authorized acts for each profession. Under these acts, nurses are given the authority to perform controlled acts and provide client care.

There are other acts that govern the practice of health care, including nursing, in Ontario. Each sets out requirements for practice in the settings and circumstances to which it applies. They include (but are not limited to) the:

- *Public Hospitals Act*;
- *Healing Arts Radiation Protection Act*;
- *Laboratory and Specimen Collection Centre Licensing Act*;
- *Mental Health Act*; and
- *Long-Term Care Homes Act, 2007*⁴

Scope of practice and controlled acts

The scope of practice statement for nursing is as follows:

*The practice of nursing is the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.*⁵

Controlled acts are defined as acts that could cause harm if performed by those who do not have the knowledge, skill and judgment to perform them.⁶ A regulated health professional is authorized to perform

¹ Nurse refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) or Nurse Practitioner (NP).

² These documents are available on the College's website at www.cno.org/docs.

³ For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* document at www.cno.org/docs.

⁴ For more information on these and other acts, visit the Ontario Statutes and Legislation website at www.e-laws.gov.on.ca.

⁵ From the *Nursing Act, 1991*.

⁶ The RHPA includes exceptions that permit individuals who are not members of regulated health professions to perform controlled acts in defined circumstances.

a portion or all of the specific controlled acts that are appropriate for her/his profession's scope of practice. Because some scopes of practice overlap, some professionals are authorized to perform the same, or parts of the same, controlled acts.

Controlled acts authorized to nursing

Performing controlled acts represents only a small portion of nursing practice. It is important to note that:

- controlled acts are not the only procedures that can cause harm;
- having the authority to perform a procedure does not automatically mean it is appropriate to do so; and
- each nurse is accountable for her/his decisions and actions.

All nurses are authorized to perform the following controlled acts:

1. Performing a prescribed procedure below the dermis or a mucous membrane.
2. Administering a substance by injection or inhalation.
3. 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 into the body.
4. Dispensing a drug.
5. 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.

A Registered Nurse (RN) or Registered Practical Nurse (RPN) is authorized to perform these controlled acts under the following two conditions:

- if initiated in accordance with the conditions identified in the regulation;⁷ or

- if ordered by a physician, dentist, chiroprapist, midwife or Nurse Practitioner (NP).

Controlled acts authorized to NPs

NPs can perform the following controlled acts:

1. Communicating to a client or client's representative a diagnosis made by the NP identifying as the cause of a client's symptoms, a disease or disorder.
2. Performing a procedure below the dermis or a mucous membrane.
3. 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 of the body.
4. Applying or ordering the application of a prescribed form of energy.
5. Setting or casting a fracture of a bone or dislocation of a joint.
6. Administering a substance by injection or inhalation, in accordance with the regulation, or when it has been ordered by another health care professional who is authorized to order the procedure.
7. Prescribing, dispensing, selling and compounding a drug in accordance with the regulation.
8. 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.

Authorizing Mechanisms

Authorizing mechanisms provide nurses with the authority to implement treatment plans and protocols. Choosing the appropriate authorizing mechanism depends on the nurse's category or class, role and practice setting.

⁷ See Conditions for Initiating Controlled Acts on page 5.

Orders

An order is a prescription for a procedure, treatment, drug or intervention.⁸ An order is required when:

- a procedure falls within one of the controlled acts authorized to nursing, when a nurse has not initiated the act;⁹
- a procedure does not fall within any controlled act, but is part of a medical plan of care;
- a procedure falls within one of the controlled acts not authorized to nursing; or
- a procedure/treatment/intervention is not included in the RHPA, but is included in another piece of legislation.¹⁰

Direct orders

A direct order is client-specific. A health care professional—such as a physician, midwife, dentist, chiropodist or NP, or an RN who is initiating a controlled act—can give a direct order for a specific intervention to be administered at a specific time or times.

A direct order may be written or verbal (oral). Verbal orders must only be used in emergency situations or when the prescriber is unable to document the order, such as in the operating room. There is an inherent risk in accepting a verbal order, and nurses should advocate for systems that allow their use only in emergency situations or when the order is unable to be documented. Procedures that necessitate direct assessment of the client by the authorizer, such as when the client's condition becomes unstable, require direct orders.

Directives

A directive is an order for a procedure or series of procedures that may be implemented for a number of clients when specific conditions are met and specific circumstances exist. A directive is always written by a regulated health professional who has the legislative authority to order the procedure for which she/he has ultimate responsibility.

Although a directive is a medical document by definition, the College recommends that every health care professional who is affected by the directive be involved in its development to determine whether a directive is most appropriate for the client, or if direct assessment of the client by the authorizer is required before treatment proceeds.

Initiation

Under the Act, RNs or RPNs who meet certain conditions have the authority to initiate specific controlled acts. This means that RNs or RPNs can decide independently that a specific procedure is required, and they may initiate that procedure in the absence of a specific order or directive from an authorizing professional. When initiating a controlled act, an RN or RPN must:

- assess the client and identify the problem;
- consider all of the available options to address the problem;
- weigh the risks and benefits of each option considering the client's condition;
- decide on a course of action;
- anticipate the management of potential outcomes; and
- accept accountability for deciding that the particular procedure is required and for ensuring that any potential outcomes are managed appropriately.

RNs or RPNs who consider initiating procedures are advised to clarify with their colleagues and employers the scope of their roles and responsibilities within the health care team. If initiating is within the scope of the RN or RPN's role and competence, and is not prohibited by legislation or organizational policy, the initiating RN or RPN may perform the procedure, or an RN may write the order for the procedure and another nurse may perform it.¹¹

⁸ The use of the term standing order is not supported by the College. No order, regardless of how routine it may seem, should be automatically implemented without the appropriate knowledge, skill and judgment. Standing orders should not be confused with preprinted orders that are signed by the authorized person before being implemented.

⁹ For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at www.cno.org/docs.

¹⁰ For example, X-rays are not included in the RHPA, but they are included in the *Healing Arts Radiation Protection Act*.

¹¹ For more information, refer to Appendix A: Procedures That RNs and RPNs May Initiate According to the *Nursing Act, 1991* on page 12.

Conditions for initiating controlled acts

1. Competence

The person who is initiating must have the knowledge, skill and judgment to:

- perform the procedure safely, effectively and ethically
- determine whether the client's condition warrants the performance of the procedure.

2. Client factors

The person who is initiating must:

- have a nurse-client relationship with the client
- determine that the client's condition warrants the performance of the procedure having considered:
 - the known risks and benefits to the individual
 - the predictability of the outcomes of performing the procedure, and
 - other relevant factors specific to the situation.

3. Environmental supports

The person who is initiating must have the appropriate resources to perform the controlled act safely and manage reasonably expected outcomes.

4. Documentation requirements

The person who is initiating must document the initiation and outcome in the client chart.

5. A nurse's accountabilities

The person who is initiating must accept accountability for the decision to initiate the procedure and ensure that any potential outcomes are managed.

Restrictions on initiating controlled acts

Although RNs and RPNs have the legal authority to initiate a controlled act, in practice the opportunity to initiate may be limited by other legislation or practice-setting policies. A specific facility may not permit its nursing staff to initiate controlled acts. For example, RNs and RPNs cannot initiate treatments in a hospital setting because the *Public Hospitals Act* grants only physicians, NPs, midwives and dentists the authority to order treatments.

Delegation

Delegation is a formal process through which a regulated health professional (delegator) who has the authority and competence to perform a procedure under one of the controlled acts delegates the performance of that procedure to another individual (delegatee). To ensure nurses have clear guidance on how to delegate and accept delegation and to more effectively practise in an interprofessional setting, the College's expectations are set out in this practice guideline.

A nurse's responsibility is to delegate activities and accept delegation of activities according to regulation¹², which specifies requirements that must be met. When accepting delegation or when delegating, it could be considered professional misconduct if the nurse:

- contravenes a standard of practice of the profession or fails to meet the standard of practice of the profession
- directs a member, student or other member of the health care team to perform nursing functions for which she/he is not adequately trained or competent to perform
- fails to inform the member's employer of her/his inability to accept specific responsibility in areas in which specific training is required, or for which the member is not competent to function without supervision, and/or
- contravenes a provision of the *Nursing Act*, the *Regulated Health Professions Act, 1991* or regulations under either of those acts.

Who can delegate, which acts can be delegated and who can accept delegation

Nurses can delegate and accept delegation if they are registered in the General, Extended or Emergency Assignment Classes. Nurses in the Temporary Class cannot delegate or accept delegation. Nurses in the Special Assignment Class cannot delegate the authority to perform controlled acts to others, but may be able to accept delegation.

¹² Ontario Regulation 275/94 under the *Nursing Act, 1991*.

A nurse may need additional preparation to delegate or accept delegation competently, depending on her/his nursing experience and the type of procedure being delegated.

All of the controlled acts authorized to nursing can be delegated with the exceptions described below.

Restrictions on delegating

RNs and RPNs cannot delegate the controlled act of dispensing a drug.

NPs cannot delegate:¹³

- prescribing, dispensing, selling or compounding medication
- ordering the application of a form of energy
- setting a fracture or joint dislocation.

Sub-Delegation

Nurses can only delegate those acts which they have the authority to perform. They cannot delegate an act that has been delegated to them. This is referred to as sub-delegation.

Nurses can only accept delegation from regulated health professionals who are authorized to perform those controlled acts by a health profession act governing their profession. They cannot accept delegation from anyone who is not authorized to perform controlled acts through a health professions act.

Delegation and orders

Delegation and orders are two distinct authorizing mechanisms. However, not all health profession acts make this distinction. To address any confusion between orders and delegation, nurses must understand that delegation may or may not include an order, and an order may or may not indicate a delegation. Delegation provides the legal authority to perform a controlled act, whereas an order outlines how to perform it.

For example, an RN or RPN may obtain the authority to adjust a cardiac pacemaker through delegation. When the process includes parameters for adjusting the pacemaker and the expectations for delegation have been met, this is considered an order within delegation.

However, if the delegation document does not include this information, then it is not an order. The RN or RPN would then require a direct order to perform the adjustment.

Delegation by nurses

Nurses delegate controlled acts within most practice environments, most commonly to UCPs (unregulated care providers), such as family members of clients. They also delegate certain controlled acts to other regulated health professionals who do not have legal authority to perform a controlled act that is authorized to nursing.

A nurse who delegates a controlled act is responsible for the decision to delegate the controlled act. For example, a nurse is responsible for the decision to delegate the care of a wound to a UCP or family member; and she or he must meet all of the requirements for delegating before the authority for that care is transferred. Delegation can be oral or written, and appropriate documentation of the particulars of the delegation must be maintained.

The RHPA includes an exception allowing UCPs to perform some controlled acts as long as they are considered to be routine activities of living.¹⁴ Procedures are considered to be routine activities of living when the need for, response to, and outcome of the procedure have been established over time and are predictable. For instance, administering the same dosage of insulin to a person with well-controlled diabetes over an extended period of time is a routine activity of living. It is not a routine activity if the dosage or type of insulin requires frequent adjustment.

¹³ For more information, refer to the *Nurse Practitioner* practice document at www.cno.org/docs.

¹⁴ The RHPA also includes an exemption allowing a client's family members to perform some controlled acts. For more information, see the *Working With Unregulated Care Providers* practice document at www.cno.org/docs.

Requirements for delegating

A nurse may delegate when all the following requirements have been met:

Requirement 1

The nurse has the authority under the *Nursing Act* to perform the controlled act.

Requirement 2

The nurse has the knowledge, skill and judgment to perform the controlled act safely and ethically.

Requirement 3

The nurse has a nurse-client relationship with the client for whom the controlled act will be performed.

Requirement 4

The nurse has considered whether the delegation of the controlled act is appropriate, keeping in mind the best interests and needs of the client.

Requirement 5

The nurse takes reasonable steps to ensure that she/he is satisfied that sufficient safeguards and resources are available to the delegatee so that the controlled act can be performed safely and ethically.

Requirement 6

The nurse has considered whether the delegation should be subject to any conditions¹⁵ to ensure that it is performed safely and ethically, and has made the delegation subject to conditions, if applicable.

Requirement 7

After taking reasonable steps, the nurse is satisfied that the delegatee is a person who is permitted to accept the delegation and is:

- a nurse¹⁶ who has a nurse-client relationship with the client
- a health care provider who has a professional relationship with the client
- a person in the client's household, or

- a person who routinely provides assistance or treatment for the client.

Requirement 8

When the delegatee is a nurse or other regulated health professional, the nurse must be satisfied that the delegatee has the knowledge, skill and judgment to perform the controlled act safely and ethically.

When the delegatee is not a regulated health professional, the nurse must be satisfied that the delegatee has the knowledge, skill and judgment to perform the controlled act safely and ethically and that the delegation is appropriate for the client.

Requirement 9

If the nurse has delegated a controlled act but has reasonable grounds to believe that the delegatee no longer has the ability to perform the controlled act safely and ethically, the nurse must immediately cease to delegate the controlled act to that delegatee.

Requirement 10

The delegating nurse shall:

- a) ensure that a written record of the particulars of the delegation is available in the place where the controlled act is to be performed, before it is performed
- or**
- b) ensure that a written record of the particulars of the delegation, or a copy of the record, is placed in the client record at the time the delegation takes place or within a reasonable period of time afterwards
- or**
- c) record particulars of the delegation in the client record either at the time the delegation takes place or within a reasonable period of time afterwards.

The particulars of delegation must include those mentioned in “Documenting the particulars of delegation” below.

¹⁵ Nurses can place specific conditions on the delegation if they do not want a delegated act to be performed in specific circumstances. For example, a nurse can note that the delegation of an act applies only to a specific client when the nurse is present in the care setting.

¹⁶ NPs may delegate certain controlled acts to RNs and RPNs.

Accepting delegation

Nurses who perform controlled acts that are delegated to them are responsible for the decision to carry out the controlled act and for the performance of the act.

Requirements for Accepting Delegation

A nurse may accept delegation when all the following requirements have been met:

Requirement 1

The nurse has the knowledge, skill and judgment to perform the controlled act safely and ethically.

Requirement 2

The nurse has a nurse-client relationship with the client for whom the controlled act is to be performed.

Requirement 3

The nurse has considered whether performing the controlled act is appropriate, keeping in mind the best interests and needs of the client.

Requirement 4

After taking reasonable steps, the nurse is satisfied that there are sufficient safeguards and resources available to ensure that the controlled act can be performed safely and ethically.

Requirement 5

The nurse has no reason to believe that the delegator is not permitted to delegate that controlled act.

Requirement 6

If the delegation is subject to any conditions, the nurse has ensured that the conditions have been met.

Requirement 7

Nurses who perform a controlled act that was delegated to them must record the particulars of the delegation in the client record, unless:

a) a written record of the particulars of the delegation is available in the place where the controlled act is to be performed

or

(b) a written record of the particulars of the delegation, or a copy of the record, is in the client record

or

(c) the particulars of the delegation have already been recorded in the client record.

Documenting the particulars of delegation

Any record of the particulars of a delegation must include:

(a) the date of the delegation

(b) the delegator's name, if the controlled act was delegated to the nurse

(c) the delegatee's name, if the controlled act was delegated by the nurse, and

(d) the conditions, if any, applicable to the delegation.

Tools for Delegating, Accepting Delegation and Developing Directives

The Federation of Health Regulatory Colleges of Ontario has developed resources to facilitate collaboration among health care providers when using authorizing mechanisms. *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario*¹⁷ includes statements, principles and definitions regarding the use of authorizing mechanisms, and a tool kit for developing authorizing mechanisms. These resources are congruent with the College's expectations.

¹⁷ *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario* is on the Federation of Health Regulatory Colleges of Ontario's website at www.regulatedhealthprofessions.on.ca.

Assigning, Supervising or Teaching a Procedure

A nurse who assigns, supervises or teaches a procedure has a unique role on the health care team. Because these activities do not require the formal transfer of authority, they may be perceived as being less important. However, in all roles the nurse is accountable for determining that the person who is being assigned, supervised or taught to provide care is competent to provide that care and manage outcomes. The nurse's priority is to ensure that the client receives safe and ethical care.¹⁸

Assigning a procedure

Assigning is determining or allocating responsibility for particular aspects of care that may include controlled and non-controlled act procedures. Assigning care may require nurses to supervise aspects of care or teach procedures.

Depending on the responsibilities of their positions, RNs, RPNs and NPs with the necessary knowledge, skill and judgment may assign care to other nurses or UCPs. Ideally, a range of care needs, rather than specific isolated procedures, is assigned. For example, assigning the complete care of certain clients on a unit to one nurse is likely preferable to assigning all dressing changes for all clients on the unit to one nurse.

Supervising a procedure

Supervising is monitoring and directing specific activities of others for a defined period. Supervising does not include ongoing managerial responsibilities.

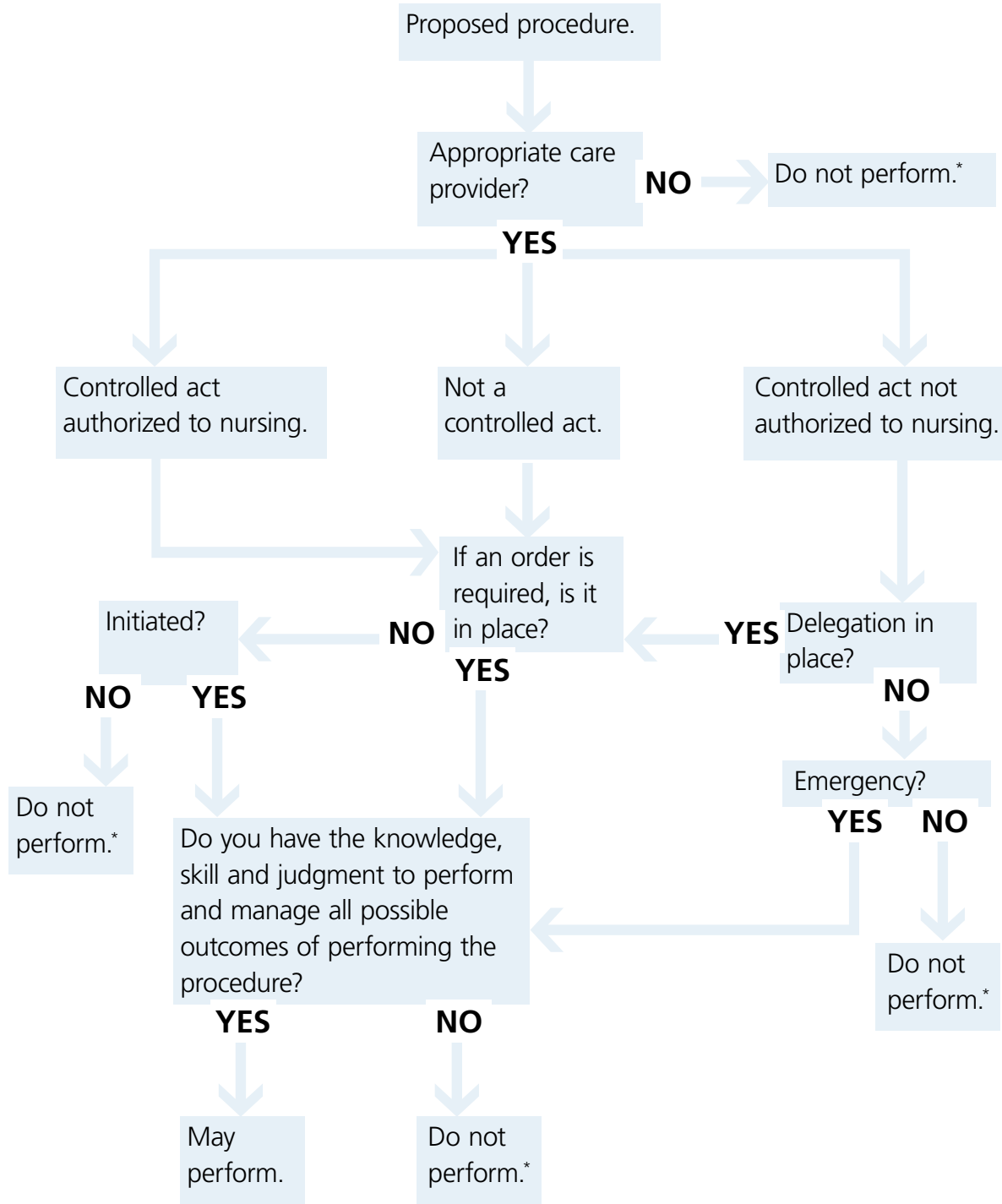
Depending on the responsibilities of their positions, RNs, RPNs and NPs may supervise others. This role includes providing the appropriate degree of either direct or indirect supervision to the individual being supervised. It is based on the client's condition, the nature of the procedure(s), the resources available in the setting and the degree of competence of the person being supervised.

Teaching a procedure

Teaching is providing instruction, determining that a person is competent to perform a procedure and evaluating the learning. Teaching is not equivalent to delegation because it does not involve the transfer of authority to perform a controlled act.

¹⁸ See Decision Tree #2: Assigning, Supervising or Teaching a Procedure on page 14.

Decision Tree #1: Deciding to Perform a Procedure



* The nurse should take appropriate action to safeguard client interest and ensure continued care.

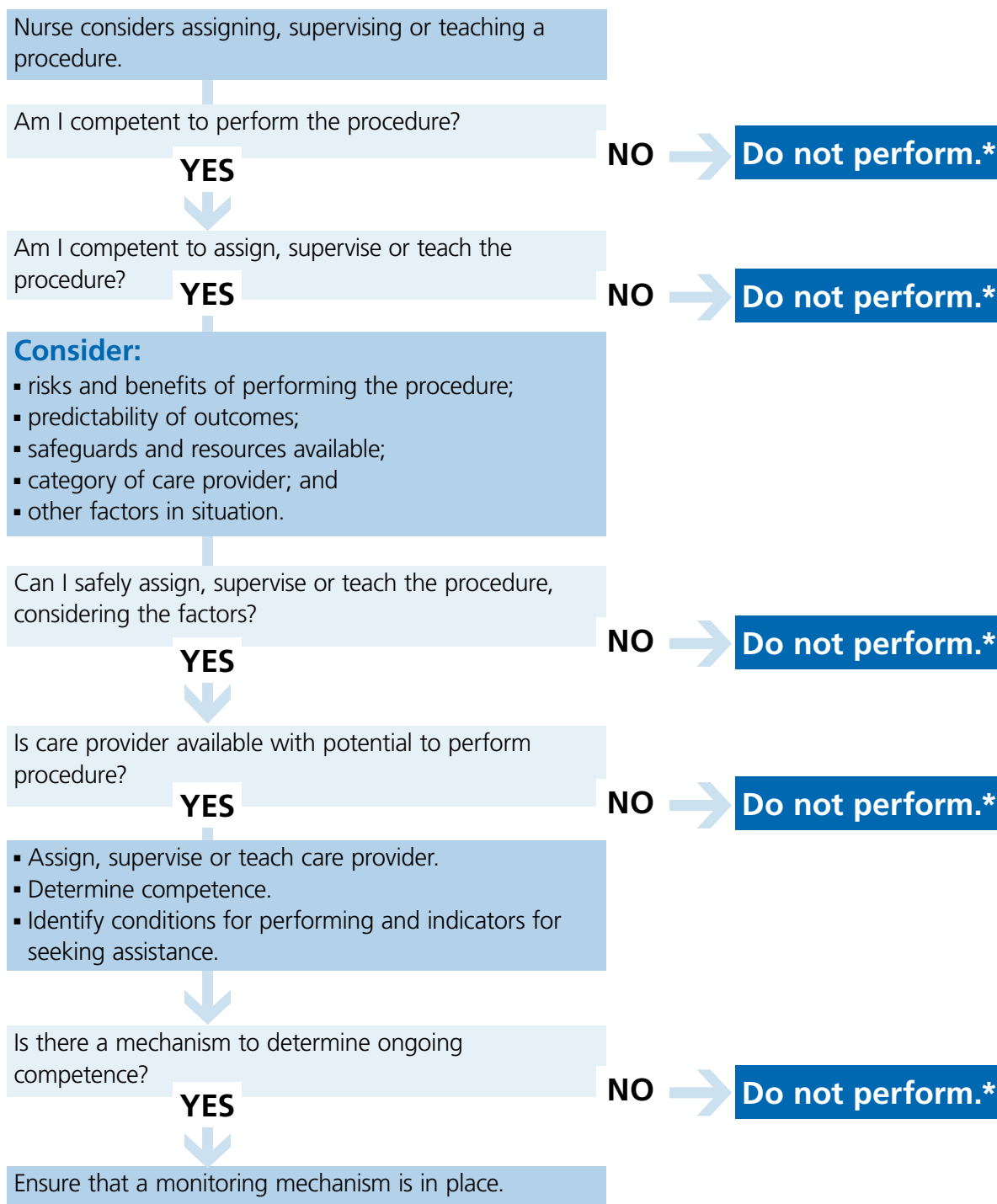
Appendix A: Procedures RNs and RPNs May Initiate According to the Nursing Act, 1991

| An RPN may initiate but cannot provide an order for another nurse to perform | An RN may initiate and/or provide an order for an RN or RPN to perform |
|--|---|
| Care of a wound below the dermis or below a mucous membrane: <ul style="list-style-type: none"> ▪ cleansing ▪ soaking ▪ dressing | Care of a wound below the dermis or below a mucous membrane: <ul style="list-style-type: none"> ▪ cleansing ▪ soaking ▪ irrigating ▪ probing ▪ debriding ▪ packing ▪ dressing |
| | Venipuncture to: <ul style="list-style-type: none"> ▪ establish peripheral venous access and maintain patency when client requires medical attention and delaying venipuncture is likely to be harmful <ul style="list-style-type: none"> • 0.9% NaCl only |
| For the purpose of assisting client with health management activities that require putting an instrument beyond the: <ul style="list-style-type: none"> ▪ point in the nasal passages where they normally narrow ▪ larynx ▪ opening of the urethra | For the purpose of assisting client with health management activities that require putting an instrument beyond the: <ul style="list-style-type: none"> ▪ point in the nasal passages where they normally narrow ▪ larynx ▪ opening of the urethra |
| For the purpose of: <ul style="list-style-type: none"> ▪ assisting client with health management activities Procedure that requires putting a hand or finger beyond the: <ul style="list-style-type: none"> ▪ labia majora | For the purpose of: <ul style="list-style-type: none"> ▪ assessing client ▪ assisting client with health management activities Procedure that requires putting an instrument, hand or finger beyond the: <ul style="list-style-type: none"> ▪ labia majora |
| For the purpose of: <ul style="list-style-type: none"> ▪ assessing client ▪ assisting client with health management activities Procedure that requires putting an instrument or finger beyond the: <ul style="list-style-type: none"> ▪ anal verge | For the purpose of: <ul style="list-style-type: none"> ▪ assessing client ▪ assisting client with health management activities Procedure that requires putting an instrument or finger beyond: <ul style="list-style-type: none"> ▪ the anal verge ▪ an artificial opening into client's body |
| 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. | 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. |

RNs and RPNs cannot initiate procedures that involve putting an instrument or finger into one of the body openings or into an artificial opening of the body for the purpose of treating a health problem. Authorized procedures are also limited to those procedures that do not require the use of a prescribed drug, as nurses in the General Class are not authorized to prescribe drugs.

For information about controlled acts that NPs can perform, refer to the *Nurse Practitioner* practice document at www.cno.org/docs.

Decision Tree #2: Assigning, Supervising or Teaching a Procedure



*The nurse should take appropriate action to safeguard client interest and ensure continued care.



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