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*Authorizing Mechanisms* Pub. No. 41075

ISBN 978-1-897308-90-5

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First published in October 2007. Updated in May 2008, June 2009, July 2009 (ISBN 1-897308-33-7). Updated November 2011 for Bill 179 changes.

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Ce fascicule existe en français sous le titre : *Les mécanismes d'autorisation*, n° 51075

## 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 nurses<sup>1</sup> 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, Revised 2006* practice standard and *Working With Unregulated Care Providers* practice guideline.<sup>2</sup> Authorizing Mechanisms provides nurses with new information on delegation. However, nurses should still consult *Decisions About Procedures and Authority, Revised 2006* for more information on authorizing accountabilities.

*Authorizing Mechanisms* is intended to help nurses provide efficient, timely access to health care by facilitating their understanding of the processes of authorizing mechanisms, as well as their accountabilities when using them.

## Legislation Governing Nursing Practice

The *Regulated Health Professions Act, 1991* (RHPA) sets out a framework for Ontario's regulated health professions.<sup>3</sup> 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 Act). 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 the:

- *Public Hospitals Act*;
- *Healing Arts Radiation Protection Act*;
- *Laboratory and Specimen Collection Centre Licensing Act*;
- *Mental Health Act*; and
- *Nursing Homes Act*.<sup>4</sup>

### 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.*<sup>5</sup>

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.<sup>6</sup> A regulated health professional is authorized to perform

<sup>1</sup> In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

<sup>2</sup> These documents are available on the College's website at [www.cno.org/docs](http://www.cno.org/docs).

<sup>3</sup> For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at [www.cno.org/docs](http://www.cno.org/docs).

<sup>4</sup> For more information on these and other acts, visit the Ontario Statutes and Legislation website at [www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca).

<sup>5</sup> From the *Nursing Act, 1991*.

<sup>6</sup> The RHPA includes a number of 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 three 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.

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;<sup>7</sup> 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.

### 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.

### Orders

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

- a procedure falls within one of the three

<sup>7</sup> See Appendix A: Conditions for Initiating, Delegating and Accepting Delegation of Controlled Acts on page 11.

<sup>8</sup> The use of the term *standing order* is not supported by the College of Nurses of Ontario. 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 prior to implementation.

controlled acts authorized to nursing, when a nurse has not initiated the act;<sup>9</sup>

- 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 10 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.<sup>10</sup>

### Direct orders

A direct order is client-specific. A health care professional—such as a physician, midwife, dentist, chiropractor 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.<sup>11</sup> 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.

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. For example, a specific facility may not permit its nursing staff to initiate controlled acts.

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

<sup>9</sup> For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at [www.cno.org/docs](http://www.cno.org/docs).

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

<sup>11</sup> For more information, refer to the College's *Medication, Revised 2008* practice document at [www.cno.org/docs](http://www.cno.org/docs).

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.<sup>12</sup>

### Delegation

Delegation is a formal process by which a regulated health professional who has the authority and competence to perform a procedure under one of the controlled acts delegates the performance of that procedure to others under certain conditions. 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 Appendix A on page 11.

A nurse's responsibility is to delegate activities and accept delegation of activities in accordance with specified conditions. In accepting a delegation or 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; and/or
- 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.

### Who can delegate? Which acts can be delegated?

RNs and RPNs can delegate and accept delegation if they hold a General, Special Assignment or Transitional Class Certificate of Registration. Nurses in the Retired Class cannot delegate or accept delegation. Registrants in the Temporary Class cannot delegate the authority to perform

controlled acts to others, but may be able to accept delegation provided appropriate supports are in place. All of the controlled acts authorized to nursing can be delegated with the exceptions described in the following paragraphs. However, 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.

NPs can accept delegation of controlled acts and delegate controlled acts authorized to them. NPs are restricted from delegating certain controlled acts<sup>13</sup>

Nurses cannot delegate an act that has been delegated to them. This is referred to as sub-delegation. Nurses can only delegate those acts which they have the authority to perform and can only accept delegation from regulated health professionals who have the authority to perform those controlled acts through the RHPA. A nurse cannot accept delegation from anyone, including regulated health professionals and unregulated care providers (UCPs), not authorized to perform controlled acts through a health profession act.

### Delegation and orders

According to the Act, delegation and orders are two distinct authorizing mechanisms. However, not all health profession acts (including medicine) 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.

<sup>12</sup> For more information, refer to Appendix A: Conditions for Initiating, Delegating and Accepting Delegation of Controlled Acts on page 11 and Appendix B: Procedures That RNs and RPNs May Initiate According to the *Nursing Act, 1991* on page 13.

<sup>13</sup> For more information, refer to the *Nurse Practitioner* practice document at [www.cno.org/docs](http://www.cno.org/docs).

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

### Delegation by nurses

Nurses delegate controlled acts within most practice environments, most commonly to UCPs, such as family members of clients. They also delegate certain controlled acts to other regulated health professionals; for example, nurses might delegate oxygen administration to a physiotherapist or a dressing change to an occupational therapist.

A nurse is accountable for the decision to delegate and responsible for ensuring that the appropriate safeguards are in place to provide safe, effective and ethical care. Delegation can be verbal or written, but appropriate documentation must be maintained. For example, a nurse is accountable for the decision to delegate the care of a wound to a UCP or family member and must meet all of the conditions before the authority for that care is transferred.<sup>14</sup>

The RHPA includes an exception allowing UCPs to perform most controlled acts as long as they are considered routine activities of daily living.<sup>15</sup> Procedures are considered to be routine activities of daily 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 adjusting.

If a nurse is delegating a controlled act to a UCP, such as a personal support worker or a member of the client's household, then she/he should use additional safeguards to ensure the

public is protected. The nurse must ensure that the individual to whom she/he is delegating the authority to perform the controlled act has the knowledge, skill and judgment to perform it safely and effectively for that client. That is, the nurse must ensure that the delegation is client-specific in the following ways:

- the procedure being delegated is appropriate for the client; and
- the act is not performed on clients for whom it is not intended.

Nurses can place specific limits on the delegation if they do not want a delegated act to be accessed in specific circumstances. For example, a nurse can note that the delegation of an act applies only to a specific client when that client remains stable.

### Accepting delegation

In many practice environments, nurses accept delegation of controlled acts from other regulated health professionals. For instance, RNs and RPNs working in a public health unit often receive delegation from pharmacists or physicians to gain the authority to dispense medication.

As self-regulating professionals, nurses who accept delegation are accountable for their decision to do so and for the performance of the controlled act on a client. Nurses may accept the delegation of a controlled act provided they meet all of the requirements before the act is performed.<sup>16</sup>

### 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*

<sup>14</sup> See Appendix A: Conditions for Initiating, Delegating and Accepting Delegation of Controlled Acts on page 11.

<sup>15</sup> The RHPA also includes an exemption allowing a client's family members to perform some controlled acts. For more information, refer to the College's *Working With Unregulated Care Providers* practice document at [www.cno.org/docs](http://www.cno.org/docs).

<sup>16</sup> See Appendix A: Conditions for Initiating, Delegating and Accepting Delegation of Controlled Acts on page 11.

for *Regulated Health Professionals in Ontario*<sup>17</sup> 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.

The guide includes documents and tools that nurses can use to develop directives and delegate appropriately. Here are some of the available templates:

- **Performance Readiness Assessment.** To determine the appropriateness of developing directives and delegations and performing procedures that are beyond the scope of practice of the health care provider.
- **Performance Readiness Plan.** For use when in-depth education is needed to obtain necessary competencies to perform the procedure(s).
- **Medical Directive and/or Delegation.** For use by authorizers with ordering authority. For example, NPs who order and/or delegate procedures that they have the legislative authority to order, such as making a diagnosis based on laboratory tests in a sexual health clinic.
- **Delegation.** For use by authorizers without ordering authority. For instance, a nurse who delegates oxygen administration to a physiotherapist or wound care below the dermis to a UCP on condition of an order from a physician.

Delegation and directives can enable nurses to provide timely, effective and efficient client care. This occurs when the regulated health professional authorized to order the directive uses her/his expertise appropriately, and the health care practitioner who implements the directive uses her/his knowledge, skill and judgment.

## 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, effective and ethical care.<sup>18</sup>

### 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.

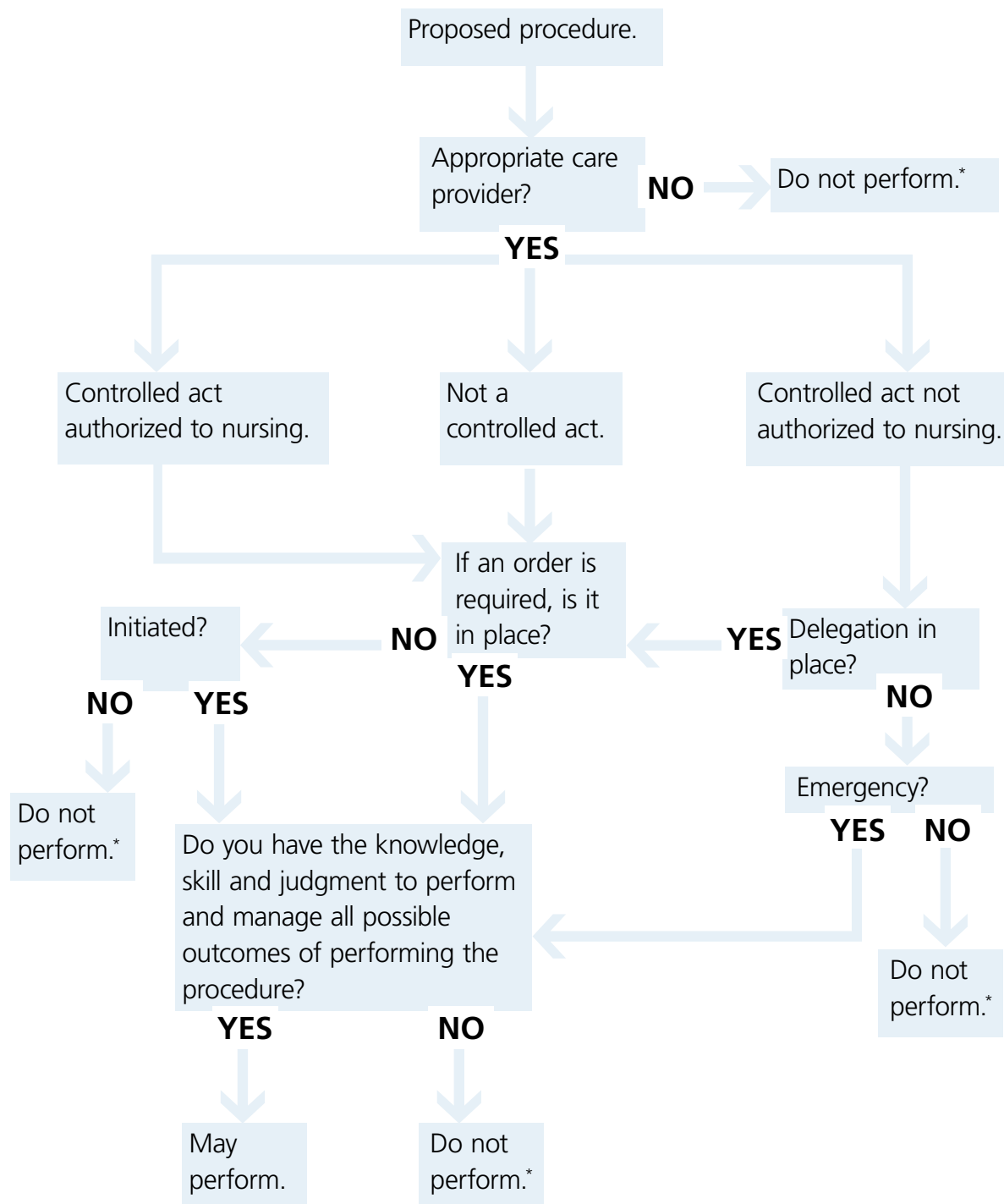
<sup>17</sup> *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario* is on the Federation of Health Regulatory Colleges of Ontario's website, [www.regulatedhealthprofessions.on.ca](http://www.regulatedhealthprofessions.on.ca).

<sup>18</sup> See Decision Tree #2: Assigning, Supervising or Teaching a Procedure on page 15.

**Teaching a procedure**

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

## Decision Tree #1: Deciding to Perform a Procedure



\*The nurse should take appropriate action to safeguard client interest and ensure continued care. For more information, refer to the College's *Disagreeing With the Plan of Care* practice document at [www.cno.org/docs](http://www.cno.org/docs).

## Appendix A: Conditions for Initiating, Delegating and Accepting Delegation of Controlled Acts

Conditions	The person initiating must	The person delegating must	The person accepting delegation must
Competence	<p>Have the knowledge, skill and judgment to:</p> <ul style="list-style-type: none"> <li>▪ perform the procedure safely, effectively and ethically; and</li> <li>▪ determine whether the client’s condition warrants the performance of the procedure.</li> </ul>	<p>Have the knowledge, skill and judgment to:</p> <ul style="list-style-type: none"> <li>▪ perform the procedure safely, effectively and ethically;</li> <li>▪ complete a personal evaluation of the competence of the person to whom the delegation is made; and</li> <li>▪ believe that the person has the continued ability to perform the controlled act.</li> </ul>	<p>Have the knowledge, skill and judgment to:</p> <ul style="list-style-type: none"> <li>▪ perform the procedure safely, effectively and ethically;</li> <li>▪ determine whether the client’s condition warrants the performance of the procedure; and</li> <li>▪ meet all specific conditions outlined in the delegation document by the authorizing person.</li> </ul>
Client factors	<p>Have a professional relationship** with the client.</p> <p>Determine that the client’s condition warrants performance of the procedure having considered:</p> <ul style="list-style-type: none"> <li>▪ the known risks and benefits to the individual;</li> <li>▪ the predictability of the outcomes of performing the procedure; and</li> <li>▪ other relevant factors specific to the situation.</li> </ul>	<p>Have a professional relationship** with the client, be a member of the client’s household, or be a person who routinely provides assistance or treatment for the client.</p> <p>Consider the client’s needs and best interests when determining if the performance of the act by another person is appropriate.</p> <p>Consider any client conditions that may restrict the implementation of the delegation.</p> <p>Specify which client the delegation is for when delegating care to a UCP.</p>	<p>Have a professional relationship** with the client.</p> <p>Consider the client’s needs and best interests when determining if the performance of the act is appropriate.</p> <p>Know the client meets the requirements outlined in the delegation document.</p>
Environmental supports	<p>Have the appropriate resources to perform the controlled act safely and manage reasonably expected outcomes.</p>	<p>Have the appropriate resources to perform the controlled act safely and manage reasonably expected outcomes.</p>	<p>Have the appropriate resources to perform the controlled act safely and manage reasonably expected outcomes.</p>

\*\*Professional relationship is a broad term that refers to an association, in some way, of a nurse to a client.

Conditions	The person initiating must	The person delegating must	The person accepting delegation must
Documentation requirements	Document the initiation and outcome in the client chart.	Document the delegation (including the date, to whom the delegation is made and any applicable conditions) in the client record or place of delegation.***	Document the delegation (including the date, from whom the delegation is made and any applicable conditions) in the client record or place of delegation.***
A nurse's accountabilities	Accept accountability for the decision to initiate the procedure and ensure that any potential outcomes are managed.	Accept accountability for the decision to delegate the authority and ensure the appropriate checks are in place to provide the client with safe, effective and ethical care.	Accept accountability for the decision to perform the controlled act and for the performance of the controlled act that has been delegated.  Know that the delegation comes directly from a member of a regulated health profession who has access to that controlled act.

\*\*\* *Place* refers to the location where the controlled act is to be performed.

## Restrictions on Initiating, Delegating and Accepting Delegation of Controlled Acts

Initiation	Delegation	Accepting delegation
The <i>Public Hospitals Act</i> , 1990 grants only physicians, NPs, midwives and dentists the authority to order treatments.	NPs cannot delegate the prescribing of a drug or the application of a form of energy prescribed under the RHPA.  The person delegating cannot delegate a controlled act that has been delegated to her/him to another person (sub-delegation).	Members who hold a Temporary Class Certificate of Registration cannot delegate, but may be able to accept delegation. Members who hold a Retired Class Certificate cannot delegate or accept delegation.

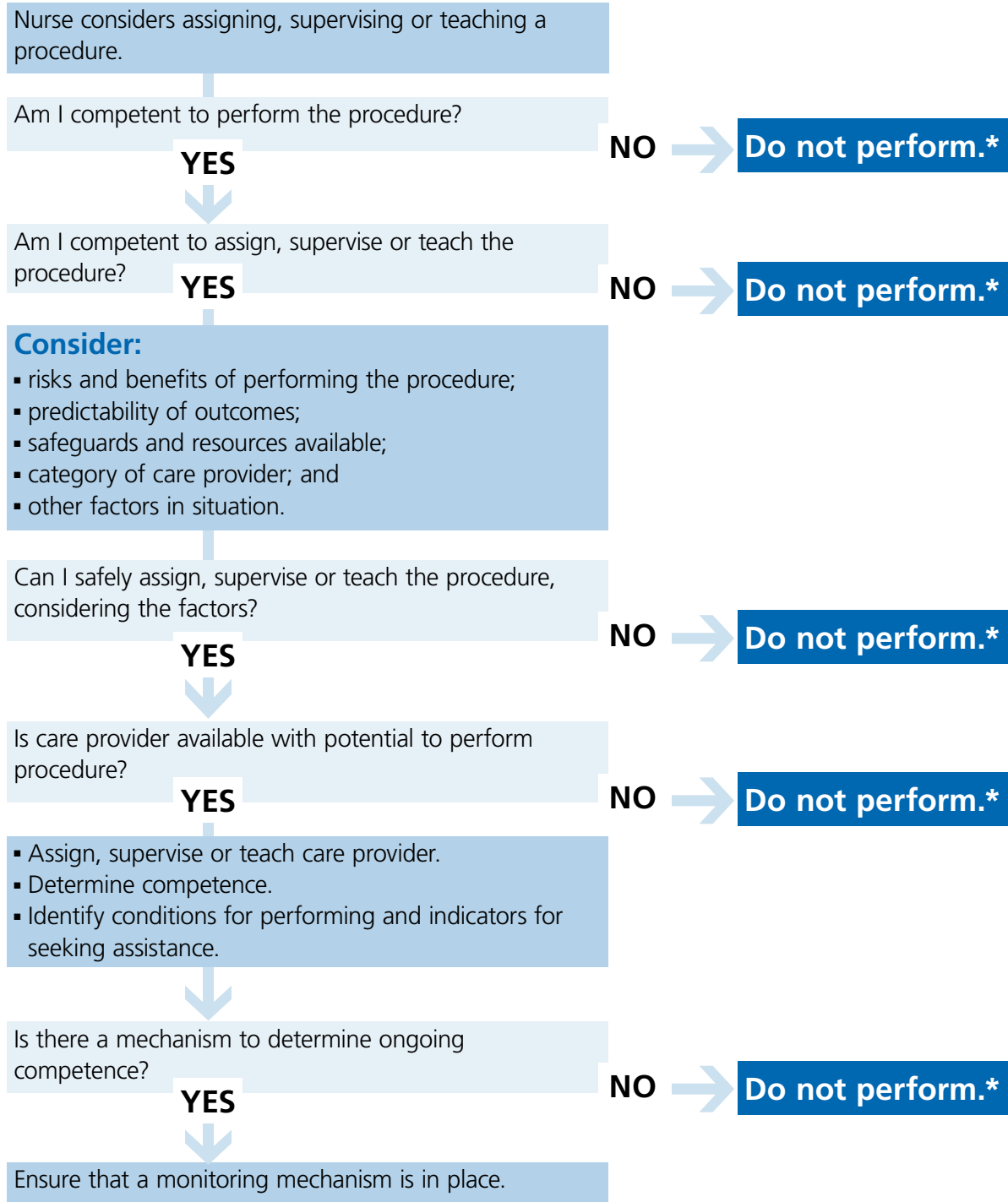
## Appendix B: Procedures RNs and RPNs May Initiate According to the Nursing Act, 1991

<b>An RPN may initiate but cannot provide an order for another nurse to perform</b>	<b>An RN may initiate and/or provide an order for an RN or RPN to perform</b>
<p>Care of a wound below the dermis or below a mucous membrane:</p> <ul style="list-style-type: none"> <li>▪ cleansing</li> <li>▪ soaking</li> <li>▪ dressing</li> </ul>	<p>Care of a wound below the dermis or below a mucous membrane:</p> <ul style="list-style-type: none"> <li>▪ cleansing</li> <li>▪ soaking</li> <li>▪ irrigating</li> <li>▪ probing</li> <li>▪ debriding</li> <li>▪ packing</li> <li>▪ dressing</li> </ul>
<p>For the purpose of assisting client with health management activities that require putting an instrument beyond the:</p> <ul style="list-style-type: none"> <li>▪ point in the nasal passages where they normally narrow</li> <li>▪ larynx</li> <li>▪ opening of the urethra</li> </ul>	<p>Venipuncture to:</p> <ul style="list-style-type: none"> <li>▪ 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"> <li>▪ 0.9% NaCl only</li> </ul> </li> </ul>
<p>For the purpose of:</p> <ul style="list-style-type: none"> <li>▪ assisting client with health management activities</li> </ul> <p>Procedure that requires putting a hand or finger beyond the:</p> <ul style="list-style-type: none"> <li>▪ labia majora</li> </ul>	<p>For the purpose of assisting client with health management activities that require putting an instrument beyond the:</p> <ul style="list-style-type: none"> <li>▪ point in the nasal passages where they normally narrow</li> <li>▪ larynx</li> <li>▪ opening of the urethra</li> </ul>
<p>For the purpose of:</p> <ul style="list-style-type: none"> <li>▪ assessing client</li> <li>▪ assisting client with health management activities</li> </ul> <p>Procedure that requires putting an instrument or finger beyond the:</p> <ul style="list-style-type: none"> <li>▪ anal verge</li> </ul>	<p>For the purpose of:</p> <ul style="list-style-type: none"> <li>▪ assessing client</li> <li>▪ assisting client with health management activities</li> </ul> <p>Procedure that requires putting an instrument, hand or finger beyond the:</p> <ul style="list-style-type: none"> <li>▪ labia majora</li> </ul>
<p>For the purpose of:</p> <ul style="list-style-type: none"> <li>▪ assessing client</li> <li>▪ assisting client with health management activities</li> </ul> <p>Procedure that requires putting an instrument or finger beyond the:</p> <ul style="list-style-type: none"> <li>▪ anal verge</li> </ul>	<p>For the purpose of:</p> <ul style="list-style-type: none"> <li>▪ assessing client</li> <li>▪ assisting client with health management activities</li> </ul> <p>Procedure that requires putting an instrument or finger beyond:</p> <ul style="list-style-type: none"> <li>▪ the anal verge</li> <li>▪ an artificial opening into client’s body</li> </ul>

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](http://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. For more information, refer to the College's *Disagreeing With the Plan of Care* practice document at [www.cno.org/docs](http://www.cno.org/docs).





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