PRACTICE STANDARD

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Decisions About Procedures and Authority

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College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

VISION
Leading in regulatory excellence

MISSION
Regulating nursing in the public interest

Decisions About Procedures and Authority Pub. No. 41071

ISBN 978-1-77116-147-3

First published July 1995 as *A Guide to Decide: Revised Decision Tree for Performance of Procedures*
Reprinted January 2000 as *A Guide to Decide: A Decision Tree for Performance of Procedures*
Reprinted October 2000, December 2002, Revised for Web June 2003, Reprinted January 2004, December 2005. Revised October 2006. Reprinted May 2008. Updated June 2009 (ISBN 1-897308-14-0). Updated November 2011 for Bill 179 changes. Revised 2013 for Delegation Regulation. Revised 2014 for Dispensing (ISBN 978-1-77116-021-6). Updated dated February 2017, removed emergency procedure pg17 (ISBN 978-1-77116-054-4). Revised January & March 2018 for *Controlled Act of Psychotherapy.* (ISBN 978-1-77116-096-4) Revised January 2020 for the *Controlled Act of Psychotherapy* initiation regulation.

Additional copies of this document may be obtained by contacting CNO's Customer Service Centre at 416 928-0900 or toll-free in Canada at 1 800 387-5526.

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Ce fascicule existe en français sous le titre : *La prise de décisions sur les interventions*, n° 51071

Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— College of Nurses of Ontario

Introduction

As knowledge and technology advance and health care environments change, nursing practice evolves. Increasingly, nurses[1] face decisions about performing procedures that are new, or were previously the responsibility of other professionals. This practice document outlines the expectations of nurses when determining if:

- they have the authority to perform a procedure;[2]
- it is appropriate for them to perform a particular procedure; and
- they are competent to perform the procedure.

This document allows for flexibility in nursing roles while protecting the public interest. It facilitates timely, efficient access to health care and fosters effective interprofessional collaboration, while ensuring that appropriate measures are in place to promote safe, effective and ethical client[3] care.

Nurses may consider accepting **delegation**[4,5] of any controlled act procedure not authorized to nursing as long as they comply with requirements in regulation.

Nurses must adhere to this practice standard when performing any procedure related to nursing practice. This includes procedures authorized to nurses in the *Nursing Act, 1991*, those delegated, those carried out in emergencies and those that do not fall within a controlled act.

The College of Nurses of Ontario (the College) publishes practice standards to:

- outline the generally accepted expectations of nurses and set out the professional basis of nursing practice;
- provide a guide to the knowledge, skill, judgment and attitudes that are required to practise safely;
- describe what each nurse is accountable for in practice; and
- achieve public protection when adhered to.

College practice documents apply to all nurses regardless of their roles or areas of practice. This practice document helps nurses, nursing administrators and employers to make appropriate decisions about nurses performing procedures, including procedures that require additional authority (e.g., delegation). If standards are breached, it could be **professional misconduct**.

Making decisions about procedures and authority is a complex issue that can have serious ramifications. This document has organized the factors that a nurse has to consider when making a decision about performing a procedure.

There are four standard statements with indicators that describe a nurse's accountabilities when performing any procedure. Use the Decision Tree on page 10 and the Decisions About Performing Procedures chart on page 11 to work through a procedure relevant to your individual practice.

Appendix A contains an overview of the relevant legislation concerning authorization and the performance of procedures, the *Regulated Health Professions Act, 1991* (RHPA) and the *Nursing Act, 1991*. These acts acknowledge the overlapping scopes of practice among regulated health professionals. They also provide a flexible framework for changes in practice to accommodate advances in technology and health care.

[1] In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[2] The word *procedure,* for the purpose of this document, includes controlled acts and non-controlled act procedures, as well as actions, activities and/or measures that nurses use in the course of providing client care.

[3] In this document, *client* may be an individual, family, group or community.

[4] See Ontario Regulation 275/94 under the *Nursing Act, 1991*, and *Authorizing Mechanisms* at **www.cno.org/docs**.

[5] Bolded words are defined in the glossary, which begins on page 4.

Glossary

This section defines terminology that is used throughout this practice standard. Many of these words have specific meanings in legislation, and their meanings can differ from the general understanding of the words in everyday use.

Authorizing mechanism. An authorizing mechanism is a means by which the authority to perform a procedure is obtained or the decision is made to perform a procedure. The appropriate authorizing mechanism depends on the nurse's category or class, role and practice setting. Examples of authorizing mechanisms include orders, initiation, directives and delegation.

Delegation and orders are distinct authorizing mechanisms, but a delegation may include an order. For example, an RN or RPN obtains the authority to adjust cardiac pacemakers through a formal delegation process. The RN or RPN also needs to know the parameters to adjust the cardiac pacemaker for a particular client. The delegation could include criteria describing when it is appropriate to perform the controlled act. (This would replace the need for client-specific orders.) Alternatively, an order for a particular client could provide this information. See the *Authorizing Mechanisms* practice document for more information.

Delegation. Delegation is a formal process that transfers the authority to perform a controlled act. A regulated health professional who has the legislated authority and competence to perform a procedure within one of the controlled acts can delegate that procedure to others. See the *Authorizing Mechanisms* practice document for the requirements for nurses who delegate or accept delegation.

Direct client order. A client-specific order can be an order for a procedure, treatment, drug or intervention for an individual client. An individual practitioner (e.g., physician, midwife, dentist, chiropodist or NP) directs a specific intervention to be performed at a specific time(s) for a specific client. A direct order may be written or oral; for example, given by telephone. Preprinted orders are supportive tools that require a client's name, the date and an authorizing signature before implementation.

Directive. A directive is an order for a procedure, treatment, drug or intervention that may be implemented for a number of clients when specific conditions are met and specific circumstances exist. Most often a directive is a physician's order, and it is always written. For more information, refer to the College's practice guideline *Directives*.

Initiation. Regulations under the *Nursing Act* give RNs and RPNs who meet certain conditions the authority to initiate specific controlled acts. These nurses may independently decide that a specified procedure is required and initiate that procedure in the absence of a direct order or directive. The conditions are outlined in Appendix D.

While RNs and RPNs have the authority to initiate, the opportunity may be limited in practice by legislation, role or practice-setting policy. For example, the *Public Hospitals Act,* regulation 965 requires an order from an identified practitioner, such as an NP or a physician, for patient treatments and diagnostic procedures.

Order. An order is a prescription for a procedure, treatment, drug or intervention. The RHPA, *Nursing Act* and other legislation, such as the *Public Hospitals Act*, identify the health care providers who can provide orders for client care. The order is the decision to perform the procedure for a particular client or group of clients. Orders are required when:

- a procedure falls within one of the controlled acts authorized to nursing when the nurse does not have the authority to independently decide to perform (i.e., initiate) the procedure;
- required under the *Public Hospitals Act*, *Healing Arts Radiation Protection Act* or other legislation governing client services; and
- required by a practice-setting policy or as agreed on within the physician's plan of care.

Professional misconduct. The *Nursing Act* includes regulations that identify professional misconduct. Some of the professional misconduct regulations relevant to a nurse's decision to accept delegation and perform procedures include the following.

1. Contravening a standard of practice of the profession or failing to meet the standard of practice of the profession.

2. Directing a member, student or other health care team member to perform nursing functions for which she or he is not adequately trained or competent to perform.

3. Failing to inform the member's employer of her or 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.

4. Contravening a provision of the *Nursing Act*, the R*egulated Health Professions Act, 1991* or regulations under either of those acts.

Standard Statements

There are four standards, each with accompanying indicators, that describe a nurse's accountabilities when performing any procedure, whether or not it requires delegation.

Indicators

1. Appropriate health care provider

Nurses must consider each situation to determine if the performance of the procedure promotes safe client care, and if it is appropriate for a nurse to perform the procedure.

The nurse meets the standard by:

- having sufficient knowledge, skill and judgment to determine the appropriateness of performing the procedure at a given time for a particular client, considering the:
  - client's overall condition,
  - risks and benefits (e.g., predictability and severity of possible outcomes, risk of harm arising from performing or not performing the procedure),
  - available resources to support the performance of the procedure (e.g., emergency equipment, cardiac arrest team) and manage outcomes;
- advocating for the appropriate health care provider to perform the procedure;
- ensuring that the rationale for performing the procedure is based on achieving the best outcomes for the client;
- determining whether the procedure fits within a professional nursing role (e.g., requires nursing assessment, health teaching, counselling, discharge planning);
- ensuring that practice setting policies support the nurse in performing the procedure;
- performing procedures at the point of client care in practice settings where health services are routinely performed;
- declining to perform the procedure when it does not support safe and ethical client care; and
- ensuring that informed consent includes the information that a nurse is performing the procedure.

In addition, the nurse in an administrative role meets the standard by:

- using knowledge, best evidence, skill and judgment to determine whether a nurse is the appropriate practitioner to perform the procedure after considering the:
  - specialized knowledge required and whether nurses can develop the necessary knowledge, skill and judgment to perform the procedure safely,
  - qualifications required (e.g., the category[6] and class of nursing registration [NP, RN or RPN]), education and related experience,
  - overall care needs of the client population,
  - risks and benefits (e.g., predictability of outcomes, risk of harm arising from performing or not performing the procedure), and
  - whether the rationale for a nurse to perform the procedure supports timely access to care, continuity of care and client care that focuses on the whole person;
- ensuring that sufficient nursing resources are available to incorporate the procedure into the practice (e.g., if nurses take on the procedure, considering how workload is affected and planning to offset additional responsibilities);
- mobilizing sufficient resources to support the safe performance of the procedure;
- providing educational resources to support nurses learning to perform the procedure safely; and
- evaluating client outcomes in relation to nurses performing the procedure.

[6] For more information, refer to the *RN and RPN Practice: The Client, the Nurse and the Environment* practice document at **www.cno.org/docs**.

2. Authority

Nurses ensure that they have the appropriate authority before performing procedures.

Indicators

The nurse meets the standard by:

- knowing the scope of practice of nursing, the legislated authority and what the practice setting has approved as a nurse's role and responsibilities;
- knowing when additional authority is required in the form of delegation[7], and proceeding with delegation according to regulation;
- knowing when specific direction for client care is required in the form of **orders**, **directives**, protocols or recommendations;
- obtaining **direct client orders** or implementing directives appropriately;
- ensuring that client records reflect the procedures that were performed;
- **initiating** the performance of controlled act procedures within the boundaries of legislation, competence and agency policy; and
- ensuring that client records reflect the initiated procedures.

In addition, the nurse in an administrative role meets the standard by ensuring that:

- a functional conflict-resolution mechanism exists for nurses to resolve issues/disagreements regarding performing procedures
- quality assurance mechanisms monitor the impact of the **authorizing mechanism** on client care and ensure that required changes are made in a timely manner, and
- documentation of authorizing mechanisms are maintained.

[7] For more information, see the *Authorizing Mechanisms* practice document at **www.cno.org/docs**.

3. Competence

Nurses ensure that they are competent in both the cognitive and technical aspects of a procedure prior to performing it.

Indicators

The nurse meets the standard by:

- demonstrating cognitive and technical competence to perform the procedures;
- declining to perform procedures that she/he is not competent to perform;
- determining the appropriateness of the procedure for the specific client in a specific situation;
- demonstrating knowledge of the following components of procedures:
  - purpose (assessment or treatment),
  - indications,
  - contraindications,
  - risk to the client,
  - expected outcomes,
  - actions to take if complications occur, and
  - health teaching and decision support;
- applying knowledge, best evidence, skill, judgment and appropriate authority to make and act on decisions required during the procedure;[8]
- consulting when she/he reaches the limits of her/his knowledge, skill and judgment;
- communicating with other health care team members as necessary for safe, effective and ethical client care; and
- reflecting on and continuously improving knowledge, skill and judgment in relation to practice.

In addition, the nurse in an administrative role meets the standard by:

- ensuring that resources support the delivery of initial and ongoing education to support nurses in attaining and maintaining competence.

[8] The ability to make decisions during a procedure and then to act on those decisions involves interpreting and analyzing information as it is gathered and using knowledge, skill and judgment. It also involves having the appropriate authority to act on the information gained during the procedure. In many instances, the need to interpret and analyze information in this manner does not rest solely with the nurse; rather, it is a collaborative process involving other health care providers.

4. Managing outcomes

Prior to performing procedures, nurses ensure that they are able to identify the potential outcomes of procedures, have the authority and competence to manage the outcomes, or have the resources available to manage those outcomes.

Indicators

The nurse meets the standard by:

- identifying the potential risks and outcomes related to performing a procedure;
- determining whether the management of the possible outcomes is within her/his knowledge, skill, judgment and authority;
- identifying the required resources (present and future) to manage outcomes before performing a procedure;
- managing outcomes independently within her/his abilities and authority;
- advocating for and accessing required resources; and
- declining to perform procedures when she/he cannot manage the outcomes or does not have the required resources available to manage the outcomes[9] and communicating that decision appropriately.

In addition, the nurse in an administrative role meets the standard by:

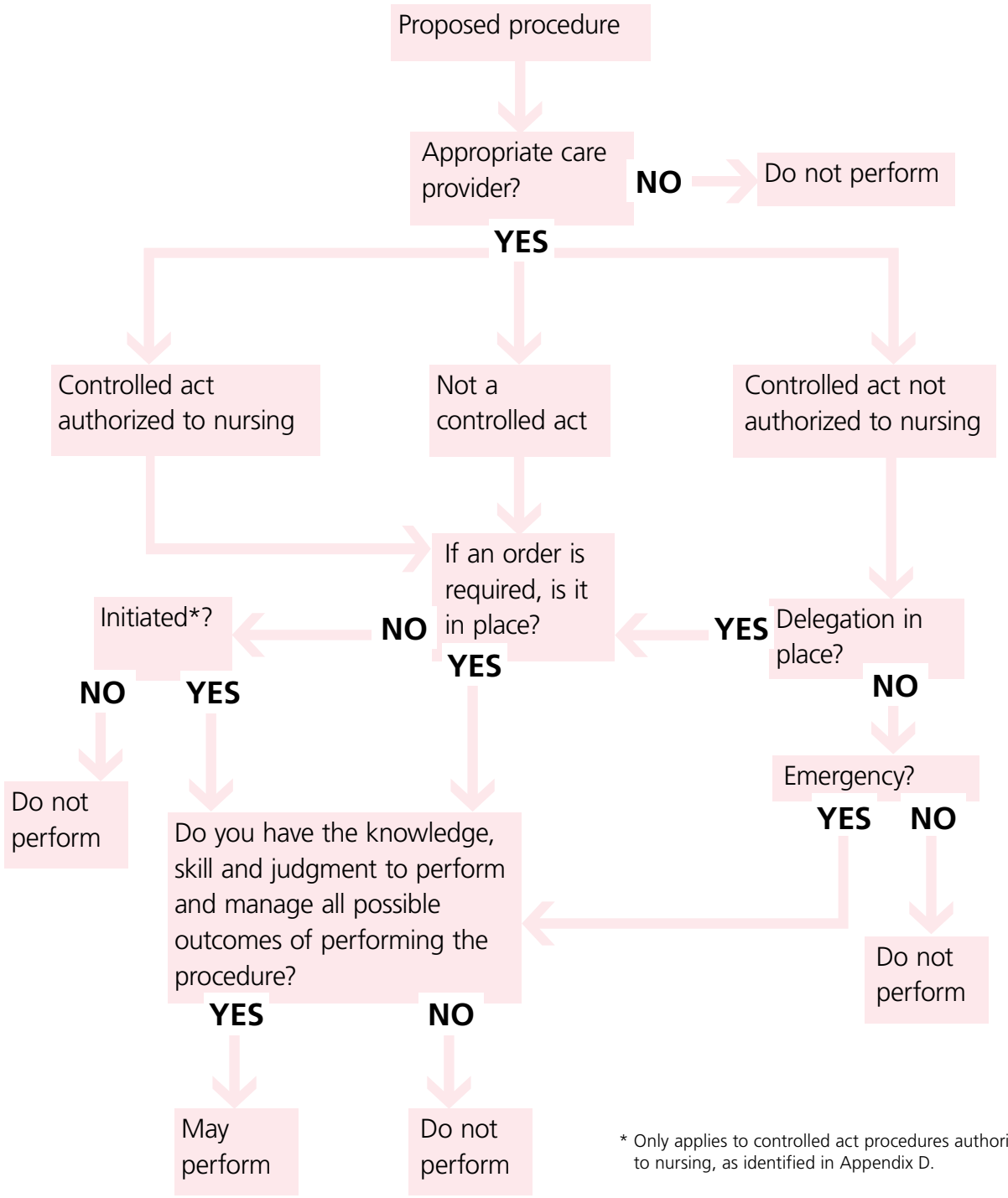
- ensuring that the required resources are available to manage outcomes at all times when the procedure is performed; and
- supporting a nurse when she/he declines to perform procedures for which she/he does not have the knowledge or skill to manage the outcomes and/or does not have the required available resources.

[9] In some situations, nurses may be faced with an ethical dilemma regarding whether they should refrain from providing care when doing so will likely cause a greater risk of harm for the client than if the nurse intervened. Wherever possible, such situations should be anticipated to allow for appropriate problem-solving, decision-making and advocacy.

How To Apply This Standard

Using the knowledge gained from reading this document, work through a procedure relevant to your individual practice with the help of the following two charts.

Decision tree



* Only applies to controlled act procedures authorized to nursing, as identified in Appendix D.

Decisions about performing procedures

	Practice setting planning considerations	Individual nurse considerations
Client	▪ What are the care requirements of the client population? ▪ What are the associated benefits and risks? ▪ Will nursing involvement support safe, effective and ethical client care?	▪ Is this procedure appropriate for this client at this time in this situation? ▪ What are the associated benefits and risks?
Nurse	▪ What competencies are required to perform the procedure safely, effectively and ethically? ▪ Can nurses develop the necessary knowledge, skill and judgment to perform the procedure safely? ▪ Which nursing category and what level of experience and education are necessary? ▪ Will there be support for continuing education programs for nurses to attain and maintain competence? ▪ If the procedure is added, what impact will it have on the nurses' ability to provide nursing services (health teaching, emotional support)? ▪ How will this impact be addressed?	▪ Do I have the necessary knowledge, skill and judgment to: a. assess the appropriateness of performing the procedure? b. perform the procedure? c. manage the client during and after the procedure? ▪ How will I attain/maintain my competence? ▪ Do I have the authority to perform the procedure? ▪ Do I have the authority to manage the client's care while performing the procedure?
Environment	▪ Is the procedure within the documented role description of the provider identified to perform the procedure? ▪ What authorizing mechanisms are needed to perform the procedure? ▪ What value does nursing add to the performance of the procedure? ▪ Are the necessary human and material resources available and accessible now and in the future to support safe, effective and ethical client care?	▪ Is the performance of the procedure supported in my practice setting's role expectations? ▪ Are the necessary resources available to support me in providing safe, effective and ethical client care during and after performing the procedure? ▪ Will these resources continue to be available whenever the procedure is performed?

Maintaining a Quality Practice Setting

As partners, both employers and nurses share responsibility for creating environments that support quality practice. The following strategies can help you develop and maintain a quality practice setting that supports nurses in providing safe, effective and ethical care.

Care delivery processes

Care delivery processes support the delivery of and access to nursing care and services, including the appropriate use of delegation and other authorizing mechanisms. Possible strategies include:

- quality assurance processes that acknowledge positive outcomes and address negative outcomes or critical incidents; and
- client care processes and policies that support nurses in meeting this practice standard.

Leadership

Leadership is the process of supporting others to improve client care and services by promoting professional practice. Possible strategies include:

- assessing procedures appropriate for nurses to perform, including those delegated to nurses;
- supporting nurses in situations in which they decline to perform a procedure on the basis that it is not safe for the client; and
- proactively identifying situations in which delegation or directives may be required and planning to develop the necessary tools.

Organizational supports

Organizational supports include the policies, procedures, norms and values of the organization. Possible strategies include:

- promoting consistency in delegation processes, including documentation and educational requirements;
- establishing a clear reporting structure for a nurse who needs to decline performing a procedure; and
- ensuring that the defined nursing role enables flexibility to meet the changing practice realities while maintaining the integrity of nursing.

Communication systems

Communication systems support information-sharing and decision-making about the performance of procedures in the context of care delivery. Possible strategies include:

- encouraging communication systems that promote the sharing of information among all of the interdisciplinary team members; and
- establishing policies to assist nurses in effectively managing conflict when declining to perform procedures that they are not competent to perform.

Facilities and equipment

The physical environment and access to equipment supports nurses in the performance of procedures. It is important to ensure the availability of appropriate equipment and other resources to support the safe performance of procedures. Possible strategies include:

- ensuring that resources (both physical and human) are available and will be available in the future; and
- assessing if required resources, such as physician consultation, are available during the entire course of treatment.

Professional development systems

Nurses need professional development systems to attain and maintain competence. Professional development systems need to include orientation programs, educational opportunities, positive learning environments and professional practice procedures. Possible strategies include:

- offering educational opportunities to meet the needs of nurses expected to perform new procedures and to support nurses in maintaining competence; and
- providing an orientation to the process and the requirements of delegation, including the specific documentation requirements of delegation processes.

Suggested Reading

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Appendix A: Understanding the *Regulated Health Professions Act, 1991* and the *Nursing Act, 1991*

Nurses are expected to practise in accordance with both the practice standards published by the College and relevant legislation. The following overview of the RHPA and the *Nursing Act* focuses on controlled acts and the authority of nurses to perform controlled acts. Understanding the legislative framework is critical to being able to make safe decisions about performing procedures and ensuring that nursing practice is consistent with the College's practice documents.

Regulated Health Professions Act: Scope of practice, controlled acts model

The scope of practice model set out in the RHPA contains two elements:

1. a scope of practice statement; and
2. controlled acts authorized to the profession.

This model provides a flexible framework that facilitates the evolution of the roles of health professionals and their respective scopes of practice.

Nursing Act: Scope of practice statement

All regulated health professions have a profession-specific act with related regulations that govern the profession. In the case of nursing, the *Nursing Act* contains a scope of practice statement that describes in a general way what the profession does and the methods that it uses. The scope of practice is not exclusive or protected; it does not prevent others from performing the same procedures. The RHPA acknowledges that the scopes of practice of various health professions overlap.

The scope of practice statement for nursing is:

> *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*.

Controlled acts

The RHPA established 14 controlled acts. (See Appendix B.) Controlled acts are considered potentially harmful if performed by unqualified people.[10]

A regulated health professional is authorized to perform a portion or all of the specific controlled acts that are appropriate for that professional's scope of practice. Because of overlaps in practice, some professionals are authorized to perform the same, or parts of the same, controlled acts.

While nursing practice includes the performance of authorized controlled acts, the nursing role and scope of practice is broader than executing controlled acts. *Performing controlled acts represents only a small portion of professional nursing practice.*

It is important to note that:

- controlled acts are not the only procedures that may 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.

Controlled acts authorized to RNs and RPNs

RNs and RPNs are authorized to perform the following controlled acts under the *Nursing Act*.

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.

[10] The RHPA includes a number of exceptions that permit persons who are not members of a regulated profession to perform controlled acts in defined circumstances. These exceptions are described in Appendix C.

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.

An RN or RPN is authorized to perform a procedure within the other controlled acts authorized to nursing:

- if initiated (see Appendix D) in accordance with conditions identified in the regulation; or
- if the procedure is ordered by a physician, dentist, chiropodist, midwife or NP.

Controlled acts authorized to NPs

NPs have successfully completed an approved education program and passed an examination to give them the authority under the *Nursing Act* to perform the following controlled acts.

1. Communicating to a client or a 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 extarenal 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 or energy.
5. Setting or casting a fracture of a bone or disclocation 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 or 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.

Appendix B: Controlled Acts Established in the *Regulated Health Professions Act, 1991*

The RHPA established 14 controlled acts. A regulated health care professional is authorized to perform a portion or all of the specific controlled acts that are appropriate for the professional's scope of practice.

1. Communicating to the individual or his/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 possible that the individual or his/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 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 into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in clause 113(1)(d) of 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 a device used inside the mouth to protect teeth from abnormal functioning.

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.

Appendix C: Exceptions to the Need for Authorization

The *Regulated Health Professions Act, 1991* provides several exceptions that allow persons who are not authorized as members of a regulated profession to perform controlled acts. They are as follows:

- when providing first aid or temporary assistance in an emergency;[11]
- when, under the supervision or direction of a member of the profession, a student is learning to become a member of that profession and the performance of the procedure is within the scope of the professional's practice;
- when treating a member of a person's household and the procedure is within the second or third controlled act authorized to nursing;
- when assisting a person with his/her routine activities of living[12] and the procedure is within the second or third controlled act authorized to nursing; or
- when treating a person by prayer or spiritual means in accordance with the religion of the person giving the treatment.

In addition, a person who performs the following procedures is not considered to be in contravention of the RHPA: ear piercing or body piercing for the purpose of accommodating a piece of jewelry, electrolysis and tattooing. Other exceptions include male circumcision as part of a religious tradition or ceremony, and taking a blood sample by a person employed by a laboratory licensed under the *Laboratory and Specimen Collection Centre Licensing Act*.

Emergency situations

The RHPA allows members of the public and regulated health care providers to perform controlled acts without authorization when providing first aid or temporary assistance in an emergency. The College maintains, however, that in situations in which it is anticipated that emergencies will likely occur, such as in a hospital or long-term care facility, it is necessary to have a standardized process to enable nurses to attain and maintain competence in performing emergency procedures that are outside the controlled acts authorized to nursing. This process includes the:

- education and ongoing assessment of competence with the involvement of a health professional authorized and competent to perform the procedure;
- documentation of the process;
- written criteria to select appropriate clients and identify treatment parameters; and
- necessary authority and/or resources to manage client outcomes.

Such a process helps to ensure that nurses have the necessary preparation to perform a procedure that carries a risk of harm. This process is in keeping with the intent of the controlled acts model and the College's mandate to protect the public.

[11] Emergency exemption applies to anyone, including nurses, when providing first aid or temporary assistance in an emergency.

[12] Procedures are considered to be routine activites of living when the need for the procedure, the response to the procedure and the outcomes of performing the procedure have been established over time and, as a result, are predictable.

Appendix D: Initiation of Controlled Acts

Regulations under the *Nursing Act, 1991* give RNs and RPNs who meet certain conditions the authority to initiate specific controlled acts. RNs and RPNs may independently decide that a specific procedure is required and initiate the procedure in the absence of a specific order or directive (e.g., from a physician or NP).

While RNs and RPNs have the authority under the regulations to initiate, in practice the opportunity to initiate may be limited by other legislation or practice setting policy. For example, regulation 965 of the *Public Hospitals Act* requires an order for treatment and diagnostic procedures.

If initiating is within the scope of the RN or RPN's role and competence, the initiating RN or RPN may perform the procedure, or an RN may write the order and another nurse may perform it. Safe, appropriate initiation of a procedure involves:

- assessing the client and identifying a problem;
- considering all of the available options to address the problem;
- weighing the risks and benefits of each option considering the client's condition;
- deciding on a course of action;
- anticipating the management of potential outcomes; and
- accepting sole accountability for deciding that the particular procedure is required and ensuring that any potential consequences are managed appropriately.

Any RN or RPN who initiates a procedure must meet all of the following conditions:

- has the knowledge, skill and judgment to perform the procedure safely, effectively and ethically;
- has the knowledge, skill and judgment to determine whether the client's condition warrants the performance of the procedure;
- determines that the client's condition warrants performance of the procedure having considered:
  - the known risks and benefits to the individual,
  - the predictability of the outcomes of performing the procedure,
  - the safeguards and resources available in the circumstances to safely manage the outcomes of performing the procedure, and
  - other relevant factors specific to the situation; and
- accepts accountability for determining that the client's condition warrants the performance of the procedure.

Not all RNs or RPNs will be competent to initiate controlled act procedures, and not all nursing roles will include initiation. RNs or RPNs who consider initiating procedures are advised to clarify the scope of their roles and responsibilities within the health care team and with their employers.

The chart on page 19 lists the procedures that may be initiated (performed and/or ordered) by RNs and RPNs who meet the conditions described above.

Procedures that may be initiated by RNs and RPNs according to the *Nursing Act*

An RPN may initiate but cannot order 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: ▪ cleansing ▪ soaking ▪ dressing	Care of a wound below the dermis or below a mucous membrane: ▪ cleansing ▪ soaking ▪ irrigating ▪ probing ▪ debriding ▪ packing ▪ dressing
	Venipuncture to: ▪ establish peripheral venous access and maintain patency when client requires medical attention and delaying venipuncture is likely to be harmful ‣0.9% NaCl only
For the purpose of assisting client with health management activities that involve putting an instrument beyond the: ▪ 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 involve putting an instrument beyond the: ▪ point in the nasal passages where they normally narrow ▪ larynx ▪ opening of the urethra
For the purpose of: ▪ assisting client with health management activities Procedure that requires putting a hand or finger beyond the: ▪ labia majora	For the purpose of: ▪ assessing client ▪ assisting client with health management activities Procedure that requires putting an instrument, hand or finger beyond the: ▪ labia majora
For the purpose of: ▪ assessing client ▪ assisting client with health management activities Procedure that requires putting an instrument or finger beyond the: ▪ anal verge	For the purpose of: ▪ assessing client ▪ assisting client with health management activities Procedure that requires putting an instrument or finger beyond: ▪ 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.

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 cannot be initiated by a General Class RN or RPN. 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**.

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JAN 2020
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