



College of
Medical Radiation
Technologists of
Ontario

Ordre des
technologues en
radiation médicale
de l'Ontario

Comprehensive Guidelines

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For acting in accordance with the Regulated Health Professions act scope of practice/ controlled acts model

This publication contains the following sections:



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Agency Practices

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Please note that the guidelines contain a description of certain provisions of the *Regulated Health Professions Act* and related health profession Acts.

The guidelines are not intended as a definitive legal analysis of the legislation nor to provide legal advice. The reader is advised to consult the actual legislation for specific wording and terminology and, where appropriate, seek legal advice.

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1 Overview



In this section the following topics will be covered:

- The Regulated Health Professions Act
- Overall expectations for professional practice under the RHPA
- Relationship between the RHPA and the HARP Act
- Scope of practice / controlled acts model
- What MRTs need to know about the scope of practice statement



Purpose

The purpose of these practice guidelines is to establish:

- a reference for medical radiation technologists (MRTs) performing controlled act procedures authorized to MRTs and accepting delegation of controlled act procedures; and
- a decision-making framework for determining the appropriateness of performing services or procedures that are beyond the principal expectations of MRT practice.

In developing these guidelines, the College of Medical Radiation Technologists of Ontario (CMRTO) hopes to assist MRTs in:

- understanding how the scope of practice/controlled acts model of the *Regulated Health Professions Act* (RHPA) works and how it applies to practice;
- practicing safely, effectively and ethically when performing controlled act procedures;
- responding appropriately to requests or proposals for providing procedures or services that are beyond the principal expectations of MRT practice;
- performing appropriately those services or procedures that are beyond principal expectations; and
- taking appropriate action when unable to implement services or procedures safely, effectively and ethically, in compliance with legislated and professional practice requirements.

These guidelines are also intended to assist managers with responsibility for MRT practice to understand MRT expectations for practice, to make appropriate decisions in relation to that practice, and to provide policies and procedures that support MRTs in providing safe, effective and ethical care.

The College will review these guidelines in 2001, evaluating a number of factors, including the implementation process, the decision-making models and the evolution of College approaches to delegation and front-line MRT practice. After this evaluation, the guidelines will be updated accordingly and, by 2002, will be incorporated into the Standards of Practice.

The CMRTO has developed two versions of the guidelines: this comprehensive version and a condensed version. The condensed version provides an overview of basic concepts to clarify practice expectations and the summaries of practice guidelines - an “at-a-glance” approach. This version provides more background information and full explanations of how to implement the practice guidelines, along with suggestions for agency practices. It will be useful to those who require more in-depth information to carry out their roles; for example, those involved in MRT administration, or front-line MRTs who wish to obtain more background information or who have a greater need for detail regarding the practice guidelines.

A note on competencies to perform specific procedures

Due to the ever-evolving nature of health care and the challenges in maintaining an accurate and up-to-date list of the competencies necessary to perform specific controlled act procedures, the CMRTO has opted to identify the conditions that must be met when performing procedures, instead of identifying the specific competencies.

It is expected that MRTs performing, or accepting delegation of, a procedure will maintain current competencies and best practice methods when implementing that procedure.



The Regulated Health Professions Act

The *Regulated Health Professions Act* (RHPA) and the companion health profession Acts govern the practice of regulated health professions in Ontario. They protect the public through the regulation of those health professions. Proclaimed or enacted into law on December 31, 1993, they replaced the *Radiological Technicians Act* and other legislation, including the *Health Disciplines Act*. The RHPA introduces a number of reforms that deal with public protection and participation in health care and with competence, accountability and evolution of regulated professions. Chief amongst the reforms is the establishment of the scope of practice/controlled acts model, which is the focus of this publication.

Another aspect is the structure of the Act. The RHPA consists of different parts: a Main Part and a Procedural Code that includes the administering bodies, the controlled acts and requirements for all the Colleges. These parts constitute the RHPA proper and apply to, or are deemed to apply to, all the regulated health professions. In addition, there are 21 health profession Acts that apply to specific regulated professions. The health profession Acts list profession-specific provisions, such as the profession's scope of practice statement and authorized acts. The health profession Act for MRTs is the *Medical Radiation Technology Act* (MRTA).

The primary body responsible for administering the RHPA, and the companion health profession Acts, is the regulatory College of the profession. For MRTs, this is the College of Medical Radiation Technologists of Ontario (CMRTO).

Overall expectations for professional practice under the RHPA

Under the RHPA, regulated health professionals are expected to be:

Competent:

i.e., to have the necessary knowledge, skills and judgement to perform safely, effectively and ethically and to apply that knowledge, skill and judgement to ensure safe, effective and ethical outcomes for the patient. This means that MRTs must maintain current competence in their area of practice, to refrain from acting if not competent and take appropriate action to address the situation.

Accountable:

i.e., to take responsibility for decisions and actions, including those undertaken independently and collectively as a member of a team. This means that MRTs must accept the consequences of their decisions and actions and act on the basis of what they, in their clinical judgement, believe is in the best interests of the patient. MRTs must take appropriate action if they feel these interests are being unnecessarily and unacceptably compromised. This includes not implementing ordered procedures or treatment plans that, from their perspective, appear to be contraindicated, and taking appropriate action to address the situation.

Collaborative:

i.e., to work with other members of the health care team to achieve the best possible outcomes for the patient. This means MRTs are responsible for communicating and coordinating care provision with other members of the team and taking the appropriate action to address gaps and differences in judgement about care provision.



Relationship between the RHPA and the HARP Act

Both the RHPA and the *Healing Arts Radiation Protection Act* (HARP Act) govern MRT practice. Both regulate applying or ordering the application of energy. However, they deal with different types of energy: the RHPA deals with energy as defined under its regulations and the HARP Act deals with ionizing radiation.

Under the RHPA, the application of energy falls within Controlled Act 7, “applying or ordering the application of a form of energy prescribed by regulation.” The regulations defining what constitutes energy, for purposes of the controlled act, can be found in Appendix C. To date, the list does not include ionizing radiation. That is because ionizing radiation is regulated under the HARP Act and other legislation. The manner in which the HARP Act regulates the ordering and application of ionizing radiation is through the regulation of the use and operation of X-ray machines and equipment. As a result, the application or ordering of the application of ionizing radiation is not a controlled act procedure, and it is not referred to in these terms.

Therefore, when looking at the list of controlled acts authorized to MRTs (i.e., taking blood samples from veins, administering substances by injection or inhalation, administering contrast media through or into the rectum or an artificial opening into the body, and tattooing), you will not see the application of ionizing radiation. However, for practical purposes, the rules governing MRTs when applying ionizing radiation are similar to those governing the performance of authorized act procedures: both require an order from an authorizing professional. (In the case of performing an authorized act procedure under the MRTA, the MRT needs an order from a physician. In the case of applying ionizing radiation under the HARP Act, the MRT needs an order from a physician, dentist, designated chiropodist, chiropractor, osteopath or, under certain circumstances, a nurse who holds an extended certificate of registration). Failure to obtain a proper order, when performing an authorized act or applying ionizing radiation, constitutes professional misconduct.

There is one notable difference between the RHPA and the HARP Act. Under the RHPA, controlled acts can be performed if they have been properly delegated. There is no such provision under the HARP Act. *Therefore, ionizing radiation can only be applied by those who are specifically named in the HARP Act.*

For the remainder of this document, we will be referring only to the controlled acts under the RHPA, and not to ionizing radiation. Requirements and guidelines for the application of ionizing radiation can be found in the HARP Act and its regulations and guidelines and other legislation.

Scope of practice / controlled acts model

The scope of practice/controlled acts model is one of the main reforms and innovations under the RHPA. This model enhances public protection and choice by specifically identifying and controlling the performance of those procedures that pose risk of harm (the 13 controlled acts), without giving any profession an exclusive or licensed area of practice. Instead, each profession has a scope of practice statement, which describes in general terms what the profession does. The controlled act procedures are authorized for specific health professions. Procedures that are not controlled acts are in the “public domain” and may be performed by regulated health professions or by unregulated individuals. In this model, therefore, controlled act procedures may be likened to “licensed” procedures, because only persons authorized under the RHPA may perform them. The scope of practice statements, however, are not “licensed”, and elements of the scope statements may overlap between professions. The regulated health professions, therefore, are registered, not licensed.

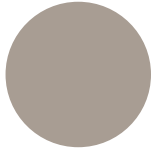


The intent of this model is to provide the public with protection and choice amongst regulated health care professions who may provide a range of health care services, subject to scope, standards and competence. A more detailed explanation of the model follows.

Elements of the model

This model consists of a number of elements, the main ones being:

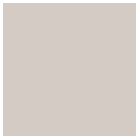
Scope of Practice Statement:



Scope of Practice

A general statement describing what the profession does and the methods it uses (see Appendix A for a list of all the scope of practice statements of the regulated health professions). The scope of practice statement corresponds to what members of the profession learn in their programs of preparation and sets out the areas of expected competency. It establishes the foundation for the practice of the profession and serves as a frame of reference for such things as entry to practice requirements, the performance of authorized acts, the standards of practice of the profession and decision-making on responsibilities beyond principal expectations. The scope of practice statements do not establish a licensed area of practice (i.e., the area of practice is not restricted to a particular profession), and elements of the statements of the different health professions overlap, so that various professions may provide similar health care services. The MRT scope of practice statement is unique in that it identifies activities that may only be performed by those designated in the HARP Act, including MRTs. Therefore, under the RHPA, there are no “licensed” areas of practice; it is the controlled acts that are regulated or, in a manner of speaking, “licensed.”

Controlled Acts:



Controlled Acts

13 procedures, listed in the RHPA, that are deemed to pose risk of physical harm if performed by unqualified persons. (See Appendix B for a list of the 13 controlled acts). Under the profession-specific health profession Act, the professions are authorized to perform, either in full or in part, the controlled acts, depending on the profession’s scope of practice and expected competencies. In addition to permitting performance of controlled act procedures, the RHPA also gives the option to delegate or transfer the authority to perform the controlled acts from those authorized to perform them under their health profession Act to others who are not. Therefore, professions have the option to delegate procedures within their authorized acts to others and to accept delegation of controlled act procedures not authorized for them from others. Only those authorized to perform controlled act procedures, either through legislation or delegation, may do so; however, there are limited exceptions set out in the legislation that identify circumstances when someone who is not authorized may perform a controlled act (See Appendix E for a list of exceptions).

Authorized Act:

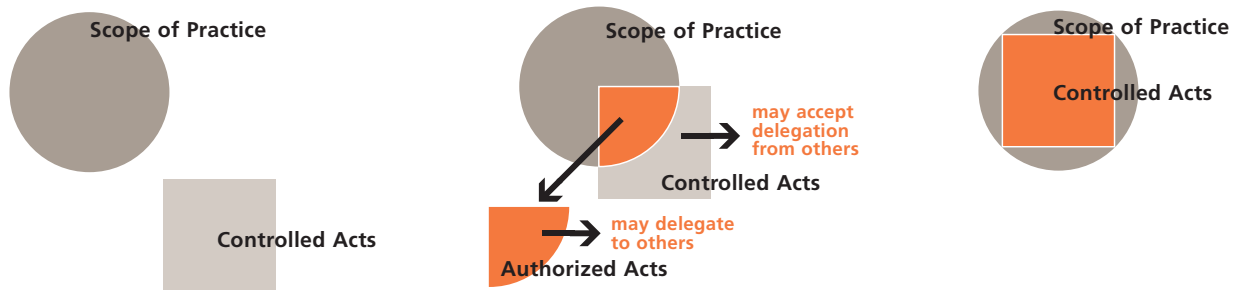


Authorized Acts

Is a controlled act, or portion of a controlled act, that is authorized for a specific profession to perform under its health profession Act. Each regulated health profession is authorized to perform from 0 to 12 of the 13 controlled acts, either in full or in part, depending on the scope of practice and competencies of the profession. (See p.12 for MRT authorized acts and Appendix D for a summary of each profession’s authorized acts). As an example, in relation to Controlled Act 2, “performing a procedure on tissue below the dermis, below the surface of a mucous membrane, cornea, surfaces of the teeth, including scaling”: physicians are authorized to perform all of this controlled act except for scaling; nurses are authorized to perform part of the controlled act (performing a procedure beneath the dermis or mucous membrane); and MRTs are authorized to perform two specific procedures that fall within this controlled act (taking blood samples from veins and tattooing). MRTs may perform four authorized acts, which fall within three of the 13 controlled act procedures. (See p.12 for MRTs list of authorized acts). Some professions are authorized to perform procedures outright, without any conditions, while others [MRTs, Medical Laboratory Technologists (MLTs), Respiratory Therapists (RTs), Dental Hygienists (DHs), Opticians, Registered Nurses (RNs) and Registered Practical Nurses (RPNs)] have additional requirements that must be met prior to implementation, such as the requirement for an order or prescription from another profession or requirements set out in regulations.



The following diagram illustrates how the above elements and provisions relate to each other:



1 Professions with no Controlled Acts authorized to them

2 Professions with some Controlled Acts authorized to them

3 Professions with most Controlled Acts authorized to them

Risk of harm clause

In addition to the above elements, the RHPA also contains what is known as a risk of harm clause or “basket clause.” It states that:

“No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.”

This means that whether a procedure is a controlled act or not, if a person who is not a member of a regulated health profession provides advice or treatment from which serious physical harm could result, it is a contravention of the RHPA. In addition, if a member of a regulated health profession provides advice or treatment from which serious physical harm could result and the advice or treatment is outside the scope of practice for the profession, this is also a contravention of the RHPA.

Penalties for contravention

Anyone performing a controlled act procedure who is not authorized (either through his or her authorized acts, or through delegation, or as a result of an exemption or exception under the legislation) may be found guilty of an offence and liable to a fine of up to \$25,000 or a jail term of up to six months, or both. Employers may also be found guilty of an offence and liable to a fine if an employee, while acting within the scope of his or her employment, performs a controlled act procedure and is not authorized to do so.

In addition, if a regulated health professional performs a controlled act procedure when not authorized, this may constitute professional misconduct. For MRTs, this includes performing an authorized act procedure without an order or performing a controlled act not authorized to MRTs without proper delegation.



Scope of practice for MRTs

MRT scope of practice statement

In the MRTA, the scope of practice statement for MRTs is as follows:

The practice of medical radiation technology is the use of ionizing radiation and other forms of energy prescribed under subsection 12(2) to produce diagnostic images and tests, the evaluation of the technical sufficiency of the images and tests, and the therapeutic application of ionizing radiation.

Subsection 12(2) of the MRTA states:

Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations prescribing forms of energy, other than ionizing radiation, for the purposes of section 3.

This provision was intended to enable the inclusion of other forms of energy under the MRT scope of practice statement, subject to approval by the Lieutenant Governor.

What MRTs need to know about the scope of practice statement

The scope of practice statement identifies what can be expected of MRTs in practice. It corresponds to what members of the profession learn in their programs of preparation and sets out the areas of expected competency. It establishes the foundation for the practice of the profession and serves as the frame of reference for such things as entry to practice requirements, the performance of authorized acts, the standards of practice of the profession and decision making regarding responsibilities beyond principal expectations of practice. As such, it clarifies MRT practice and provides a window for the evolution of that practice.

2 Authorized Acts



In this section the following topics will be covered:

- What MRTs need to know about authorized acts
- What is an order?
- Procedures and concerns
- Recommended agency practices



What MRTs need to know about authorized acts

Controlled acts authorized to MRTs (authorized acts)

Under the MRTA, MRTs are authorized to perform four authorized acts (which fall within three of the 13 controlled acts) as follows:

In the course of engaging in the practice of medical radiation technology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

- 1. Taking blood samples from veins**
(Authorized Act 1 for MRTs falls within Controlled Act 2 of RHPA: an example of a procedure falling within this authorized act would be taking blood samples for the purpose of assessing effective renal plasma flow).
- 2. Administering substances by injection or inhalation**
(Authorized Act 2 for MRTs falls within Controlled Act 5 of RHPA: examples of procedures falling within this authorized act include an intravenous, subcutaneous or intramuscular injection; starting peripheral intravenous lines; or establishing saline locks for the purpose of administering substances, such as radiopharmaceuticals or contrast media for IVPs. Procedures falling within Authorized Act 2 are not specifically defined in the legislation. In order to enable all the specialties to practice, CMRTO has interpreted the authorized act to include the aforementioned procedures).
- 3. Administering contrast media through or into the rectum or an artificial opening into the body**
(Authorized Act 3 for MRTs falls within Controlled Act 6 of RHPA: an example of a procedure falling within this authorized act would be inserting an enema tip into the rectum for a barium enema procedure).
- 4. Tattooing**
(Authorized Act 4 for MRTs falls within Controlled Act 2 of RHPA: an example of a procedure falling within this authorized act would be radiation therapy marking).

MRT performance of an authorized act

- 1. There must be an order from a physician.**
Under the MRTA, MRT are only permitted to perform a procedure falling within an authorized act if there is an order for the authorized act from a physician. The exact wording of this requirement is as follows:

“A member shall not perform a (authorized act) procedure...unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario.”

In the practice of medical radiation technology, orders may also be known as requisitions and doctor's notes. An order must be obtained for each procedure the MRT is to perform. For example, if an MRT is to administer contrast media and apply ionizing radiation, the MRT requires an order for each procedure. Exactly what constitutes a proper order is discussed in the following sections, along with a determination of which type of order - a direct order, a directive or protocol - is appropriate.



In summary, members may not perform a procedure that falls within medical radiation technology's four authorized acts unless there is an order from a physician. If an MRT performs an authorized act without an order, he or she has committed an act of professional misconduct and may be subject to disciplinary action by the College.

2. Authorized acts can only be performed in the course of engaging in the practice of medical radiation technology.

MRTs are authorized to perform procedures falling within the four authorized acts in the course of engaging in the practice of the profession. MRTs are not authorized to perform authorized acts outside the course of practice of the profession. In this way, MRTs are only permitted to administer substances by injection or inhalation and establish IVs in the context of performing a radiological, nuclear medicine or radiation therapy procedure.

If an MRT is asked to perform an authorized act outside the practice of the profession, the MRT should refrain from performing the procedure and take the necessary action to address the situation. This may vary, but generally involves discussing any concerns with the person who has requested performance of the procedure to clarify and resolve the situation.

3. An MRT must not be acting contrary to terms, conditions and limitations placed upon his or her certificate of registration when performing authorized acts.

If there are any terms, conditions or limitations placed upon an MRT's certificate of registration that regulate the performance of authorized acts, such as restricting performance to certain circumstances or prohibiting performance outright, then these must be adhered to.

4. An MRT must be competent to perform the authorized act in light of the circumstances in the situation in which the procedure is to be performed. This includes having the ability to manage the outcomes of performing the procedure.

The legislation permits, but does not require performance of authorized acts. Having the authority to perform an authorized act does not automatically mean it is appropriate to do so. MRTs will have different competencies within the overall MRT scope of practice, depending on qualifications and practice setting requirements. MRTs may only perform authorized acts if there is an order from a physician and if they have the necessary knowledge, skills and judgement to perform the procedure safely, effectively and ethically, given the circumstances in the situation.

For further discussion and direction, see the section "What MRTs should do if they are not competent to perform an authorized act" on p. 16.

What is an order?

An order is an authorizing statement, from a regulated health professional with prescribing authority, permitting an MRT to implement a procedure that falls within the MRT scope of practice. Under the MRTA, an order from a physician is necessary to permit MRTs to implement authorized act procedures. (Under the HARP Act, an order from a physician, dentist, chiropractor, designated chiroprapist, osteopath or, under some circumstances, a nurse who holds an extended certificate of registration, is necessary to permit MRTs to apply or administer ionizing radiation).

An order may also be known as a:

- Prescription
- Requisition
- Request for consultation
- Doctor's note



An order may be one of two types:

1. Direct order (for one specific patient)
2. Directive or protocol (for a number of patients under specific circumstances)

An order may also be used to prompt performance of a procedure that is neither a controlled act nor ionizing radiation, but which falls within patient procedures or treatments (e.g., taking blood pressure).

Authorized acts are ordered, not delegated

Delegation is the transfer of authority by a regulated health professional who is authorized to perform a controlled act procedure, to someone (another regulated health professional or an unregulated health care provider) who is not authorized to perform it. Since MRTs are already authorized under the MRTA to perform the four authorized acts, delegation to an MRT is not necessary and such procedures are ordered, not delegated.

Types of orders

Direct Order

An order or prescription, for a specific procedure, treatment or intervention, for a specific patient, written by an individual physician directly in the patient record. To be complete, the order must include:

- Name of patient
- Date and time
- Name of procedure or substance being ordered; and, when a substance is being ordered, the order must include:

<ul style="list-style-type: none"> • the dosage; • the route of administration; • the frequency with which the substance is to be administered; and • the signature of the ordering physician. 	<p>This information may appear in the written order itself or it may exist in protocols, that have been developed in the department by the appropriate authorizing physician.</p>
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Direct orders are generally written. Under the *Public Hospitals Act* (PHA), physicians (and dentists, midwives or registered nurses in the extended class) may dictate an order for treatment or for a diagnostic procedure by telephone. The requirements respecting such orders include that they must be signed by the physician on the first visit to the hospital after dictation. (See Appendix F, regulation 965/98 made under the Public Hospitals Act).

In order to deal properly with telephone orders or requests, MRTs are expected, if working in hospitals governed by the PHA, to:

- ensure they have been designated by the administrator as someone who can accept telephone orders;
- transcribe the order along with the name of the physician who dictated it, and the date and time of its reception;
- sign the order;
- be reasonably assured that any physician who dictates an order will sign it on the first visit to the hospital after dictation; and
- ensure that if someone else has transcribed a telephone order, the person has the authority to accept such orders before implementing them.

Directive or protocol

An order or prescription for a procedure, treatment or intervention for a range of patients who meet specific conditions (in some instances this may have been known as a “standing order”). Directives or protocols are always written and must contain:

- a standardized reference number;
- identification of the specific procedure or treatment or range of treatments being ordered;
- identification of who specifically may implement the procedure under the authority of and according



- to the directive;
- specific patient conditions that must be met before the procedure(s) can be implemented;
- any circumstances that must be met before the procedures can be implemented;
- any contraindication for implementing the procedures;
- documentation requirements;
- quality monitoring mechanisms;
- the name and signature of the physician authorizing the directive; and
- the date and signature of the administrative authority approving the directive.

The establishment of directives and protocols is the responsibility of physicians who have the authority to order procedures. However, MRTs should be involved in the decision regarding whether or not the use of a directive or protocol is appropriate. In addition, safeguards and mechanisms should be in place to ensure that effective channels of communication exist between those involved in the care of the patient and that quality monitoring occurs. For further information on the safeguards and mechanisms necessary to ensure appropriate use of directives or protocols, please see the section entitled “How quality practice settings support MRT practice” on page 29.

An example of a procedure that may be performed under the authority of a directive is inserting an enema tip into the rectum for a barium enema procedure or administering a radiopharmaceutical by injection for a thyroid scan.

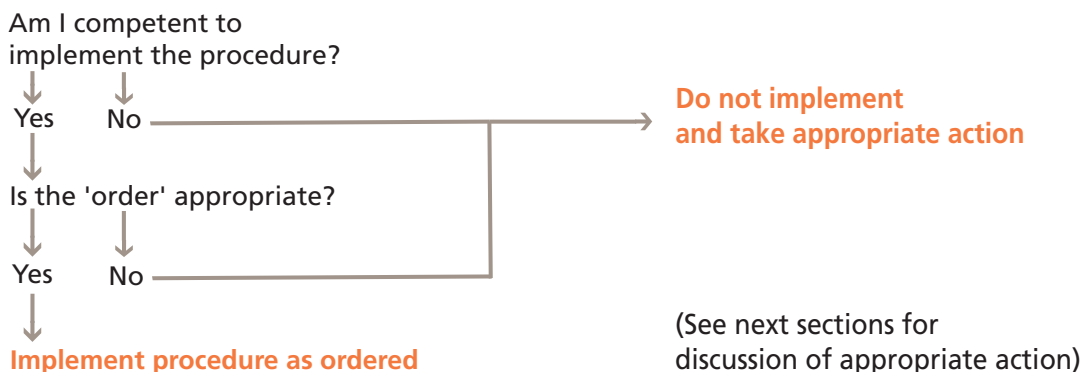
(CMRTO has developed a joint policy with CNO and CPSO regarding medical directives for ordering X-rays. This joint policy should be reviewed before developing a medical directive for administering X-rays).

When to use a directive or protocol

In general, directives or protocols may be used as the authority for performing procedures when a health professional has the necessary competencies to determine that the conditions and circumstances identified in the directive have been met. Procedures that require direct assessment of the patient by the physician require direct orders and are not appropriate for implementation under a directive. For example, nuclear medicine requires a direct order, while injection of the radiopharmaceutical to complete the scan may be covered under a directive or protocol. In deciding whether to use a directive, it may be useful to refer to the Decision-making Guide in Appendix G and to apply the relevant questions from that guide.

Procedures are ordered, not MRTs

When thinking about orders, an important distinction must be made: a procedure is being “ordered” for a patient; an MRT is not being “ordered” to perform the procedure. MRTs cannot be “ordered” because regulated health professionals are accountable to implement only those measures that they, in their clinical judgement, believe are in the patient’s best interest. If you do not believe an ordered procedure is in the patient’s best interest, you should not implement it and should take appropriate action. If you believe the ordered procedure is in the patient’s best interest, you should implement it. Therefore, prior to proceeding with implementation of an ordered procedure, an MRT must determine:





What MRTs should do if they have concerns about an order or a treatment plan

Because MRTs are obliged to implement only those procedures and treatment plans which in their clinical judgement, are in the patient's best interest, they should not implement any procedure they have concerns about and take appropriate action to address the situation. This may vary from situation to situation, but in general, if an MRT has concerns about an order or treatment plan, resolving the concern will involve the following steps:

1. The MRT should discuss the concern directly with the responsible health care provider to:
 - a) identify the concern clearly and concisely;
 - b) support it with a rationale and best practice evidence;
 - c) identify outcomes desired for resolution; and
 - d) use effective communication methods.

(This may follow consultation with the patient (as appropriate), MRT colleagues, other knowledgeable professionals, reference materials and any other resources necessary to clarify and verify the nature of the concern).
2. If unable to resolve the concern, the MRT should inform the responsible health provider and discuss the concern with his or her immediate manager.
3. If the manager shares the concern,
 - a) the MRT should contact the responsible health care provider for further discussion, but
 - b) if the health care provider remains decided about the original treatment plan, the MRT should refer back to the manager and agency policy to determine how to bring the concern to the attention of a higher management authority in the agency.
4. If the manager does not share the concern and cannot provide information that will dispel it, the MRT should decide whether to report to a higher management authority.
5. The MRT should report to higher authorities in the facility until convinced of the appropriateness of treatment, or until the treatment is changed.
6. If the decision is to refuse to implement the ordered procedure or treatment plan, the MRT should inform the health care provider of the decision and the action taken to date.
7. The MRT should document the concern and the steps taken to resolve it that directly relate to patient care, in the health care record. If necessary, the MRT should refer to agency policy for the appropriate format to document information not directly related to patient care.

*(Adapted from College of Nurses of Ontario materials -
Standards for Nurses Disagreeing with the Multidisciplinary Plan of Care, 1997)*

What MRTs should do if they are not competent to perform an authorized act

The authorized acts enable all MRTs, across a broad range of practice settings, to provide procedures that fall within those authorized acts. This does not mean that all MRTs are expected to be competent to perform all the procedures that fall within the acts. On the contrary, it is acknowledged that MRTs will have different competencies within the overall MRT scope of practice, depending on qualifications and practice setting requirements. Therefore, if an MRT is not competent to perform an authorized act procedure, even though legally authorized to do so under the legislation, he or she must refrain from performing it and take the appropriate action to address the situation.



The appropriate action will vary from situation to situation, as follows:

- *If performing the procedure is part of an MRT's regular role expectations* within a practice setting, the MRT should obtain the competencies necessary to provide safe, effective and ethical services to patients in his or her care. The MRT may consult with his or her manager to determine how this may be achieved. In making this decision, the MRT is ultimately responsible to be competent to provide services required by patients within the practice setting. Quality practice settings foster the acquisition, maintenance and continuing improvement of competence.
- *If performing the procedure is **not** part of an MRT's regular role expectations*, the appropriateness of obtaining the necessary competencies should be evaluated. In order to assist with such an evaluation, it may be useful to refer to the "Decision-making Guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of MRT practice" and apply the relevant questions from that guide.

Recommended agency practices

In practice settings, where MRTs perform authorized acts, there should be mechanisms in place to enable MRTs to practice safely, effectively and ethically, according to the expectations identified above. Such mechanisms may include those that:

- ensure the requisites permitting performance of authorized acts by MRTs are in place (physician order, the MRT is performing the procedure in the course of engaging in the practice of medical radiation technology, in accordance with his or her certificate of registration, and is able to perform the procedure safely, effectively and ethically);
- ensure directives and protocols are established and used appropriately (see the section entitled "How quality practice settings support MRT practice" on page 29 for guidelines);
- establish agency practices or policies and procedures consistent with the expectations for MRT practice regarding dealing with concerns about an order or a treatment plan;
- establish agency practices or policies and procedures consistent with the expectations for dealing with situations when an MRT identifies that he or she is not able to perform an authorized act safely, effectively and ethically, either because the MRT lacks the necessary competencies (as identified in the guidelines above) or because the circumstances in the situation or agency practices do not permit the MRT to implement the procedure safely, effectively and ethically (see the section entitled "How quality practice settings support MRT practice" on page 29 for guidelines).

Summary of Practice Guidelines for MRTs performing authorized acts

An MRT may perform an authorized act procedure when all the following conditions have been met:

1. An appropriate order is in place from a physician authorizing performance of the procedure;
2. The procedure will be performed in the course of engaging in the practice of medical radiation technology;
3. Performance of the procedure is not restricted by the terms, conditions or limitations placed upon his or her certificate of registration;
4. The MRT ensures that he or she has and applies the necessary knowledge, skill and judgement to perform and manage the outcomes of performing the procedure safely, effectively and ethically;
5. Patient consent has been obtained;



6. Responsibility and accountability for performing the procedure are accepted by the MRT, having considered:
 - a) the known risks to the patient in performing the procedure;
 - b) the predictability of the outcomes in performing the procedure;
 - c) whether the management of the possible outcomes is within the MRT's knowledge, skill and judgement given the situation; and
 - d) any other factors specific to the situation to ensure the procedure is implemented safely, effectively and ethically;
7. Implementation of the procedure and/or actions taken is documented; and
8. The MRT refrains in from performing the procedure if the above conditions are not met and takes appropriate action to address the situation.

3 Delegation



In this section the following topics will be covered:

- What MRTs need to know about delegation
- When delegation is and is not required
- Delegator qualifications
- Delegation and consent
- Recommended agency practices



What MRTs need to know about delegation

Definition of delegation

Delegation is the transfer of authority from a member of a regulated health profession, authorized by his or her health profession Act to perform a controlled act procedure, to someone who is not authorized, either another regulated health professional or an unregulated person. Only regulated health professionals, authorized under their health profession Act to perform a controlled act procedure, may delegate the procedure to another, subject to the standards and any applicable guidelines or regulations of the profession.

Delegation is a systematic process consisting of the following steps:

- An initial evaluation of whether it is appropriate to consider delegation under the circumstances in the situation;
- Completion of a delegation program established by the delegator, which includes:
 - a theoretical and practical educational component;
 - supervised practice (assisting and observing the person who will be performing the delegated act to acquire the knowledge, skill and judgement necessary to perform the procedure safely and effectively); and
 - a formal, written transfer of authority to perform the procedure; and
- Ongoing evaluation of the appropriateness of delegation and performing a delegated act.

A delegated act is a procedure that falls within a controlled/authorized act that is performed under the authority of delegation. For example, if an MRT is authorized through delegation to perform the controlled act of urinary catheterization, then urinary catheterization becomes a delegated act procedure.

Under the RHPA, regulated health professionals are given the option of delegating or accepting delegation of controlled act procedures.

When delegation is and is not required

Delegation is required when:

- the procedure is a controlled act procedure and the person is not authorized to perform it under a health profession Act.

Delegation is not required when:

- a procedure is not a controlled act;
- the health professional is authorized to perform the controlled act in the health profession Act, with or without an order; or
- the procedure falls within one of the exemptions, exceptions, or the person is exempt (see Appendix E for the list of exceptions and exemptions).

Therefore, in practice, if an MRT is assigned to work with a patient who requires a controlled act procedure that is not within the four controlled acts authorized to MRTs (e.g., urinary catheterization), the MRT must not accept the assignment unless the authority to perform the procedure has been delegated to him or her by a regulated health professional who is authorized to perform it (e.g., a physician or nurse).

MRT delegation of authorized acts to others

MRTs cannot delegate authorized acts at this time. This policy decision is based on public protection considerations and current practice patterns. As practice patterns evolve, this decision may be reviewed. If MRTs wish to discuss this further, they may contact the CMRTO.



MRT acceptance of delegation

MRTs may accept delegation of controlled acts from another regulated health professional authorized to perform and delegate the procedure (most likely a physician or nurse), subject to the guidelines described below.

Deciding whether to accept delegation and perform a delegated act

In order to determine whether it is appropriate to accept delegation or perform a delegated act, MRTs and those making decisions about MRTs accepting delegation need to answer the following question:

Given the patient's condition and needs and the circumstances, in the situation, is the MRT competent to perform the delegated act safely, effectively and ethically, in accordance with legal requirements and standards of practice?

To assist MRTs and those making such decisions, the CMRTO has developed a decision-making framework entitled the “Decision-making guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of MRT practice” (see Appendix G). MRTs and others may use the guide or another framework of their choice to address the question, as long as it covers the same factors set out in the guide. The guide is described in more detail in the section entitled “Deciding whether to perform procedures or services that do not fall within principal expectations of MRT practice.”

Delegator qualifications

In order to accept delegation, MRTs must be certain the delegating regulated health professional is acting in accordance with any applicable guidelines, policies or regulations of his or her College or any other applicable legislative regulations to delegate the procedure. This includes confirming that the College of the delegator has not prohibited or restricted delegation.

The MRT must also reasonably believe that the delegator has the competence to delegate the procedure. Competence to delegate includes the competence both to perform and to delegate the procedure, and MRTs must be reasonably assured of this prior to accepting delegation from a proposed delegator.

An order is necessary to perform delegated acts

When MRTs have been authorized through delegation to perform a controlled act procedure, there must be an order in place to permit them to perform the procedure. Whether the order is an individual order, a directive or protocol will depend on the situation (see the section above, “When to use a directive or protocol,” for further discussion of when to use either individual orders or directives).

Delegation and consent

As stated in a March 1995 Ontario Hospital Association (OHA) fact sheet on delegation, under the *Consent to Treatment Act* (CTA), revised as the *Health Care Consent Act* (the HCCA), it is generally accepted that :

“The professional who delegates performance of the procedure will be the practitioner proposing the treatment to the patient. He or she will therefore be the practitioner responsible for ensuring that the CTA [now the HCCA] has been complied with in relation to rights notification and consent. However, the practitioner who has the authority to perform the act by means of delegation, may in some circumstances also be responsible for proposing the treatment to the patient...[and is] responsible for ensuring the act (CTA) [now the HCCA] has been complied with...In either case, the proposer must obtain an informed consent to the procedure... No health practitioner should begin a procedure without prior discussion with the patient and confirming that the patient has consented and continues to consent.”¹

¹ The rights notification requirements under the CTA were substantially amended by the HCCA.



If an MRT has accepted delegation of a controlled act procedure and is implementing a delegated act under the HCCA, the MRT may be responsible for confirming informed consent prior to the implementation of the procedure and for confirming that the patient continues to consent. (For example, if an MRT accepts delegation of urinary catheterization as part of a voiding cystourethrogram, then the MRT may be responsible for ensuring informed consent for the overall treatment, including the urinary catheterization component, and will be responsible for confirming that the patient continues to provide informed consent.)

If the patient does not have appropriate information to provide informed consent, and it is beyond an MRT's your scope and competence to provide the information (for example, information regarding alternative diagnostic tests or treatments), then the MRT should refrain from administering the procedure and take the appropriate action to resolve the situation.

Acceptable delegation programs

It is the responsibility of the delegator to establish a delegation program, in accordance with any applicable guidelines, policies or regulations, having considered the condition and needs of the patient(s) and the competencies necessary to meet those needs under the circumstances in the situation.

From an MRT's perspective, an acceptable delegation program enables the MRT to accept delegation and perform a delegated act according to the standards of practice of the profession. This means that the program enables an MRT to obtain the necessary theoretical and practical knowledge, skills and judgement to perform, and manage the outcomes of performing the delegated procedure safely, effectively and ethically, given the circumstances in the situation.

The content and extent of the program may vary, depending on the patient, circumstances and competencies of the MRTs. Who teaches the program and how it is delivered may also vary (e.g. an authorized delegator may approve a program offered at a community college as the means of acquiring the necessary knowledge, skill and judgement). However, regardless of variances, the actual transfer of authority must come from an authorized delegator satisfied with the competency of the specific MRT to perform the delegated act, given the circumstances in the situation. The program or authorization process will consist of more than simply providing an order for performance of the delegated procedure. In general, acceptable programs will involve:

- provision of a theoretical and practical educational component;
- provision of supervised practice (assistance with and observation of the acquisition of the knowledge, skill and judgement necessary to perform the procedure safely and effectively); and
- determination of the initial and the continuing delegation through:
 - a formal decision by the delegator that each individual MRT is competent to perform the procedure under the specified conditions (certification process); and
 - a formal process and system for ensuring the continuing competence of each individual MRT to perform the delegated procedure (re-certification processes).

It is essential that the decision to transfer authority to the MRT be documented. The documentation is the basis for the MRT to demonstrate that he or she was properly authorized to perform the delegated act.

Ultimately, if MRTs do not believe they have the necessary competencies to perform the delegated act, they must refrain from accepting delegation.



MRT assistance in the delegation program

Some Colleges have made provision for the members of the profession receiving delegation to assist in the delegation program by providing, either in whole or in part, the educational component of the program. The CMRTO has established the following position in relation to this practice:

The CMRTO will permit MRTs to assist in the delegation program as long as the MRT has acquired the necessary competencies, and the responsibility for the standards for certification of competence and the procedures for evaluating, whether or not the standards have been met, remain with the delegator.

These conditions are outlined below in the “Summary of Practice Guidelines for MRTs accepting delegation,” under the section on assisting in the delegator’s delegation program.

MRT responsibility and accountability when accepting delegation

The decision to delegate a controlled act procedure rests solely with the delegating health professional. When accepting delegation of a controlled act procedure, MRTs are responsible

- for the decision to accept delegation;
- to have the knowledge, skill and judgement to perform the delegated procedure, given the patient’s conditions and needs and the circumstances in the situation;
- to act in accordance with the CMRTO professional practice guidelines; and
- to act in accordance with any requirements imposed by the delegator as a condition of transferring the authority to perform the delegated act.

Although the decision to delegate a controlled act procedure rests solely with the delegating health professional, any decisions about delegating to MRTs should be made in collaboration with MRTs. MRTs are responsible for determining whether or not accepting delegation lies within their practice and competencies, given the patient’s condition and needs as they know them, and the circumstances in the situation. This requires MRTs to know their limits of practice. Determining limits of practice includes an examination of the extent to which their foundation of knowledge, skills and judgement can support taking on additional acts.

Recommended agency practices

Agencies that are quality practice settings will provide structures and processes to support MRTs in accepting delegation safely, effectively and ethically. Such structures and processes include mechanisms to determine the appropriateness of delegation and to ensure that the appropriate people are involved in the decision, that effective channels of communication exist between those involved in delegation and the performance of delegated acts, and that quality monitoring of delegation occurs. Please see the section entitled “How quality practice settings support MRT practice” on page 29.



Summary of Practice Guidelines for MRTs accepting delegation

An MRT may accept delegation of a controlled act procedure within the controlled acts not authorized to MRTs when all of the following conditions have been met:

1. It is appropriate to accept delegation given the factors identified in the “Decision-making guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of MRT practice;”
2. The delegator is acting in accordance with any applicable guidelines and policies of the regulatory body or regulations under the specific health profession Act governing the delegator, and has not been restricted or prohibited from delegating the procedure;
3. The delegator has the knowledge, skill and judgement to perform and delegate the procedure;
4. The MRT has the knowledge, skill and judgement to perform the procedure safely, effectively and ethically, given the circumstances in the situation;
5. A written record of the transfer of authority and certification of the MRT’s competence is maintained;
6. The conditions established by the delegator for maintaining the authority to perform the delegated act are adhered to;
7. It is appropriate to perform the delegated act, given the factors identified in the “Decision-making guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of MRT practice;”
8. Patient consent has been obtained;
9. The MRT accepts full responsibility and accountability for accepting delegation and performing the delegated act;
10. Implementation of the delegated act and/or actions is documented; and
11. If any of the above conditions are not met, the MRT will refrain from accepting delegation and performing the delegated act.

Additionally, an MRT may assist in the delegation program established by the delegator, when all the following conditions have been met:

1. The MRT reasonably believes the delegation program has been developed and approved by a regulated health professional authorized by his or her health profession Act to perform the controlled act (e.g., a physician authorized by the *Medicine Act*) who has the knowledge, skill and judgement to perform and delegate the procedure safely, effectively and ethically in accordance with any applicable guidelines or regulations;
2. The MRT has the knowledge, skill and judgement to perform and teach the procedure safely, effectively and ethically, in consideration of the patient’s condition and needs and the circumstances in the situation;
3. The MRT assists in the educational component of the program, but does not become involved in the determination of competence or transfer of authority to perform the delegated act, either during the initial delegation (certification) or subsequent determinations of competence to continue to perform the delegated act (re-certification); and
4. The MRT refrains from participating in the program if the above conditions are not met.

4 Agency Practices



In this section the following topics will be covered:

- Deciding whether to perform procedures or services which do not fall within principal expectations of MRT practice
- Case studies
- How quality practice settings support MRT practice



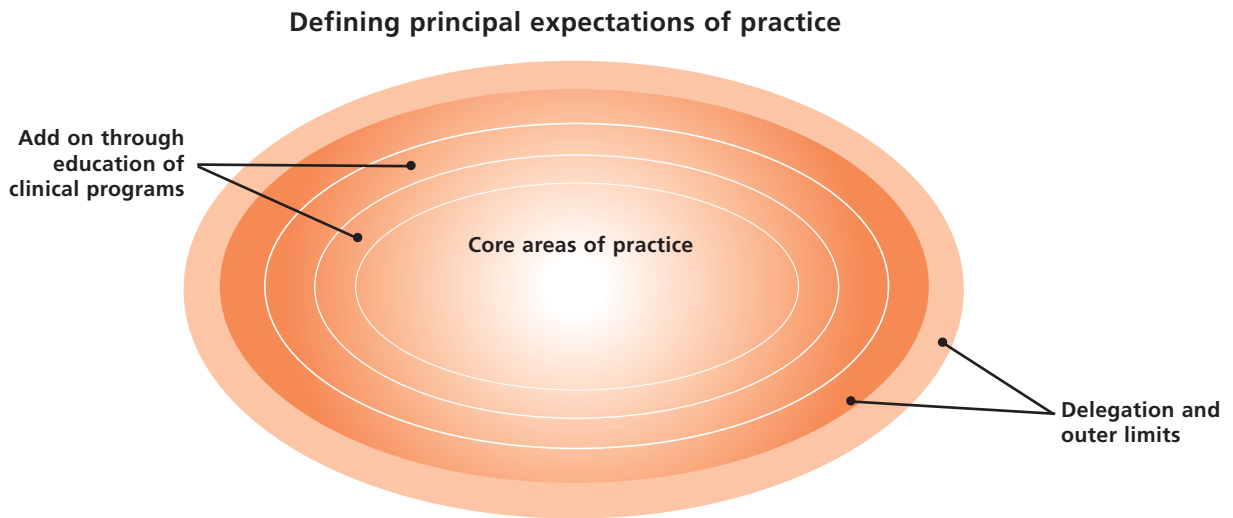
Deciding whether to perform procedures or services which do not fall under within principal expectations of MRT practice

Identifying the field: principal expectations of practice clarified

By the CMRTO definition, “principal expectations of practice” refers to those services and procedures that fall within the scope of practice for MRTs. It includes those taught in MRT entry level programs, where students are provided with the knowledge base and clinical practice to perform them competently. It also includes those services and procedures that MRTs acquire competence to perform by expanding on the foundation of knowledge, skills and judgement obtained in entry level programs through formal or informal education, clinical experience, or through on-the-job training as a graduate MRT. An example of “expanded” services or procedures that fall within principal expectations of practice would include mammography, CT scans and cardiac stress testing.

From time to time, particularly in today’s ever-evolving health care environment, MRTs may be asked to provide or may propose providing services or procedures that have not traditionally been considered to fall within the principal expectations of MRT practice. Services or procedures beyond principal expectations of practice are at the outer limits of or outside the MRT scope of practice. In some instances, they may be at the outer limits of the MRT scope of practice because they are confined to highly specialized areas; for example, the performance of haemodynamics. In other instances, they may be at the outer limits because very few patients require them; for example, the administration of strontium-89 treatments for palliative relief of bony metastases for patients with prostate cancer.

The following diagram illustrates how principal expectations of practice are conceptualized:



In order to perform services or procedures beyond principal expectations of practice, MRTs generally require “skills upgrading” or “cross-training.” Further, if the service or procedure falls within a controlled act procedure not authorized to MRTs, delegation of the procedure would be necessary. If the service or procedure (although not a controlled act) could cause serious physical harm to the patient and is outside the MRT scope of practice, then the MRT cannot perform the service or procedure. An exception would be if the MRT is acting under the direction of or in collaboration with a health professional, if the service or procedure is within that health professional’s scope of practice.

When services or procedures are beyond principal expectations of practice, the appropriateness of performing them must be carefully considered to ensure the public is protected, the limits of practice and competence are not exceeded and professional standards are adhered to. Fundamental to the decision regarding appropriateness, is the underlying principal that an MRT must have the necessary knowledge, skill



and judgement to perform an act safely and effectively before implementing any procedure or treatment plan. In order to assist MRTs and agencies to determine whether it is appropriate for MRTs to provide such services or procedures, a decision-making guide has been developed. The guide can be found in Appendix G and a description of it follows.

Overview of the decision-making guide

When making decisions about whether to perform services or procedures beyond MRT principal expectations, the question is:

Given the patient's condition and needs and the circumstances in the situation, does the MRT have the competence to perform the procedure or service safely, effectively and ethically, in accordance with legal requirements and standards of practice?

The factors to consider in answering this question have been incorporated into the "Decision-making guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of practice" found in Appendix G.

An overview of the factors is as follows:

- What is the exact nature of the service or procedure being proposed and what are the circumstances in which it would be performed?
- Is providing the service or procedure possible, given legal requirements and MRT practice and competence?
- Is providing the service or procedure in the situation within an MRT's practice, competencies and the legal requirements, given the patient's overall condition and care needs and the circumstances in the situation (such as the degree of independence of the MRT when performing the procedure and the safeguards in place to ensure safe, effective and ethical practice)?
- Does performance of the procedure by an MRT make sense?

Overall, when deciding whether to provide services or procedures beyond principal expectations of practice, MRTs must know the limits of their practice. Determining limits of practice includes examining the foundation for practice: one's basic educational preparation and the extent to which one's knowledge, skills and judgement can support taking on additional services and procedures that are at the outer limits or outside the MRT scope of practice, authorized acts and personal competencies.

Assumptions underlying the decision-making guide

The assumptions underlying the guide (found in Appendix G) include:

- Careful consideration and analysis before performing services or procedures beyond principal expectations of practice, in the interests of public protection;
- Analysis of any proposal to practice beyond principal MRT expectations;
- Careful analysis of the appropriateness of performing such services or procedures, supported by quality practice settings;
- The outcomes of care for the patient should be the same, regardless of who provides it, in situations where more than one health care provider is eligible to provide care;
- Cost should not be a primary determinant of whether MRTs provide services or procedures beyond principal expectations of practice. The primary determinant is whether the needs of the patient can be met safely, effectively and ethically. Cost may only be factored in after this initial determination; and
- The CMRTO's role in clarifying scope of practice for MRTs and its availability to consult with MRTs, agencies and the public to assist in decision-making and clarification.



Applying the Guide: Case studies

The following case studies are not intended to be a complete application of the decision-making guide in Appendix G; rather, they are examples of some of the questions to be considered in an analysis of the issues.

CASE STUDY 1

An MRT, working at night, has completed radiographs of an MVA victim's cervical spine, along with other body parts. The patient is semi-conscious and has multiple injuries. The emergency physician has ordered supine flexion and extension views of the cervical spine to rule out vertebral subluxation. As the emergency department is very busy, the emergency physician has requested that the MRT move the patient's head and neck to attain the required positions. Should the MRT position the patient's head and neck to achieve the flexion and extension views, as requested?

Applying the decision-making guide in Appendix G and responding to the series of questions and considerations listed there might result in the following decision making process:

Positioning a patient to obtain the required radiographs is within an MRT's scope and principal expectations of practice. Obtaining flexion and extension views are in the patient's best interest, and an order is in place to authorize the procedure. However, positioning patients for flexion and extension views when they are unable to sit and move their own heads is not within principal expectations of practice. The risks of performing such a procedure are high, because the requested positioning and movement necessary to demonstrate or rule out a spinal cord injury put the spinal cord at risk and could produce permanent disability. In addition, the outcomes of performing such a procedure are unpredictable and the MRT does not have the knowledge, skill and judgement to manage the possible outcomes of the procedure.

Therefore, using the decision-making guide in this particular scenario, one would expect that the MRT would conclude that it is not appropriate for the MRT to position the patient's head and neck in order to achieve the flexion and extension positions as requested. Instead, the MRT should speak with the physician requesting the procedure and take appropriate action to address the situation.

CASE STUDY 2

The radiological procedures of voiding cystography (to investigate recurrent urinary tract infections) and defecography (to investigate difficulties with bowel elimination) are provided in a Medical Imaging Department of a large tertiary care hospital. Both procedures require urinary catheterization to infuse contrast media into the bladder. In order to reduce the number of health care professionals involved in the care of the patients during the procedures, the department is investigating the possibility of an MRT catheterizing patients. Medical and nursing staff are available to delegate and provide back-up. Is it appropriate for an MRT to catheterize patients during these procedures?

Applying the decision-making guide in Appendix G and responding to the series of questions and considerations listed there might result in the following decision making process:

Urinary catheterization is a controlled act procedure not authorized to MRTs. However, it is being proposed to be implemented in the context of radiological procedures and may therefore be within the range of the MRT scope of practice; consideration may be given to accepting delegation. The goal of minimizing the number of staff involved in care is of benefit to patients.

Patients are assessed by physicians prior to undergoing the procedure. They are generally healthy, with anatomically predictable and structurally intact urinary tracts, and the outcomes of the procedure, when performed competently, are quite predictable. The risk factors include infection, misplaced insertion and damage to the urinary tract. MRTs have preparation in



anatomy, physiology and aseptic technique that provides a foundation of knowledge to acquire the additional knowledge, skills and judgement necessary to safely and effectively catheterize such patients. The prevention and management of risks can be dealt with in a training program and by having nursing and medical back-up readily available (e.g., if any resistance is encountered when inserting the catheter, the MRT would not proceed and would obtain medical or nursing back-up). The procedures are done often enough to enable designated MRTs to maintain competence. The medical and nursing authorities in the hospital have agreed in principal to delegation, and qualified and competent medical and nursing staff are available to implement delegation processes and provide readily available back-up.

Therefore, using the decision-making guide in this particular scenario, when patients are undergoing voiding cystography or defecography under the described circumstances, it may be appropriate for MRTs who have completed a delegation program to perform urinary catheterization, in accordance with the guidelines for accepting delegation set out in this publication.

Summary of Practice Guidelines for MRTs performing services or procedures beyond principal expectations of practice

An MRT may perform a service or procedure that does not fall within principal expectations of practice when all the following conditions have been met:

1. It is appropriate to perform the service or procedure given the factors identified in the “Guidelines for decision-making when determining the appropriateness of accepting delegation and providing services or procedures beyond principal expectations of practice (Appendix G)”;
2. If the service or procedure falls within a controlled act procedure not authorized to MRTs, the service or procedure has been delegated appropriately;
3. If the service or procedure (although not a controlled act) could cause serious physical harm to the patient and is outside the MRT scope of practice, then the service or procedure is not performed unless an exception to the ‘risk of harm’ clause applies;
4. The service or procedure is performed according to relevant practice guidelines; and
5. Performance of the service or procedure and/or action taken is documented.

The MRT refrains from performing the service or procedure if the above conditions are not met and takes appropriate action to address the situation.

How quality practice settings support MRT practice

Recommended agency practices to support safe, effective and ethical MRT practice in relation to performing authorized acts, using directives or protocols, accepting delegation and performing beyond principal expectations of practice

Agencies that are quality practice settings provide the structures and processes to enable MRTs to fulfill professional standards of practice and provide safe, effective and ethical care. In relation to performing authorized acts, using medical directives or protocols, accepting delegation from others, and performing services or procedures that do not fall within principal expectations of practice, the following mechanisms are recommended:



1. Ensure appropriate health professionals are involved in the consideration and development of proposals and policies related to directives or protocols, delegation and performing beyond principal expectations. Generally:
 - a) The establishment of directives and protocols are the responsibility of physicians who have the authority to order procedures. The establishment of a delegation process is the responsibility of the profession authorized to perform and delegate an authorized act procedure (e.g., medicine or nursing). However, a collaborative process enabling any health profession, affected directly or indirectly in the implementation of a directive or delegation, to be part of the decision making regarding establishing those directives or delegation practices is strongly encouraged; and
 - b) Those involved in making decisions about the establishment of directives and delegation practices must know how to analyze the fit between the patient's condition and needs properly, have the competencies necessary to meet those needs in the given situation, and know which health care provider can be expected to have those competencies.
2. Establish a structure and process to determine the appropriateness of using a directive, accepting delegation, delegating to others or performing beyond principal expectations. The framework in the "Decision-making guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of MRT practice" in Appendix G sets out factors to take into account and offers a foundation to draw upon.
3. Ensure that all staff, particularly physicians involved in the care of patients who may receive MRT procedures or treatments on the authority of a directive or delegation, are aware exactly what procedures and treatments patients will be receiving. For example, under some agency directives or protocols, when a physician orders an upper gastrointestinal follow-through and small bowel series to rule out Crohn's disease, this includes a pneumocolon.
4. Establish feedback mechanisms, including a defined communication path, to enable the MRT to identify and, if necessary, obtain clarification from the physician or other team members responsible for the care of the patient.
5. Establish quality monitoring systems to track the use of directives, the performance of delegated acts and performance beyond principal expectations, to determine when these practices are being implemented inappropriately or are resulting in unanticipated outcomes and to ensure practices are updated.
6. Ensure that when MRTs are performing procedures on the authority of a directive or delegation or are performing beyond principal expectations, agency practices are such that MRTs are able to fulfill standards of practice and provide safe, effective and ethical care (e.g., are able to appropriately monitor patients to manage outcomes and are able to adhere to practice guidelines).
7. Provide structures and processes to enable MRTs to advocate for agency practices that enable them to fulfill standards of practice and provide safe, effective and ethical care. The process set out below offers a framework to draw upon.



What MRTs should do if agency practices compromise their ability to practice safely, effectively and ethically

Agency practices may compromise an MRT's ability to meet professional standards of practice and provide safe, effective and ethical care. Examples of possible situations that may give rise to concerns of this nature include inadequate or unavailable channels of communication to clarify concerns about orders, lack of appropriate back-up, inability to appropriately supervise unregulated care providers, or MRTs being asked to provide services that are beyond principal expectations of practice with no evaluation of the appropriateness of doing so.

In such situations, MRTs are expected to advocate for changes that will enable the delivery of safe, effective and ethical care. The specific methods for doing this may vary from setting to setting, but in general will involve the following steps:

1. Identifying the concern and providing suggestions for dealing with it. The MRT consults and works with all relevant stakeholders (colleagues, patients, administrators) to address and resolve the concern;
2. Meeting with the immediate manager to identify:
 - the nature of, and rationale for, the concern;
 - the MRT's suggestions for dealing with the concern; and
 - a mutually established date by which the concern should be addressed;
3. If the manager disagrees with the concern and is unable to dispel it or does not address it by the agreed date, scheduling a meeting to discuss why and to determine the next step, including a new target date for resolution;
4. If the new date passes and/or the issue is not resolved to the MRT's satisfaction, forwarding the concern in writing to the manager, including the information in #2;
5. If the issue continues to remain unresolved, deciding whether to:
 - take the concern to a higher authority, informing the manager; or
 - implement other dispute resolution mechanisms; and
6. Maintaining a record of actions taken.

(Adapted from CNO materials)

Summary

These guidelines are presented to assist MRTs to provide safe, effective and ethical care.

If there are any questions, please feel free to contact the College of Medical Radiation Technologists of Ontario at (416) 975-4353 or toll-free at 1-800-563-5847.

Appendices

In this section the following topics will be covered:

Appendix A – Scope of practice statements for all regulated health professions

Appendix B – 13 controlled acts

Appendix C – RHPA regulation defining the forms of energy and the controlled act of applying or ordering the application of “energy”

Appendix D – Summary of controlled acts authorized to each profession under the profession-specific Acts

Appendix E – Exceptions and Exemptions under RHPA

Appendix F – Orders for treatment

Appendix G – Decision-making guide for determining the appropriateness of accepting delegation and performing services or procedures beyond principal expectations of MRT practice

Appendix A

*“The excerpts from the following statutes or regulations are current to May 12, 1999.
Please refer to the official statute or regulation for the authoritative text.”*

Scope of Practice Statements for all Regulated Health Professions

AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY ACT • 1991

The practice of audiology is the assessment of auditory function and the treatment and prevention of auditory dysfunction to develop, maintain, rehabilitate or augment auditory and communicative functions. The practice of speech-language pathology is the assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communicative functions.

CHIROPODY ACT • 1991

The practice of chiropody is the assessment of the foot and the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means.

CHIROPRACTIC ACT • 1991

The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment, of

- a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
- b) dysfunctions or disorders arising from the structures or functions of the joints.

DENTAL HYGIENE ACT • 1991

The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services.

DENTAL TECHNOLOGY ACT • 1991

The practice of dental technology is the design, construction, repair or alteration of dental prosthetic, restorative and orthodontic devices.

DENTISTRY ACT • 1991

The practice of dentistry is the assessment of the physical condition of the oral-facial complex and the diagnosis, treatment and prevention of any disease, disorder or dysfunction of the oral-facial complex.

DENTURISM ACT • 1991

The practice of denturism is the assessment of arches missing some or all teeth and the design, construction, repair, alteration, ordering and fitting of removable dentures.

DIETETICS ACT • 1991

The practice of dietetics is the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means.

MASSAGE THERAPY ACT • 1991

The practice of massage therapy is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissues and joints by manipulation to develop, maintain, rehabilitate or augment physical function, or relieve pain.

MEDICAL LABORATORY TECHNOLOGY ACT • 1991

The practice of medical laboratory technology is the performance of laboratory investigations on the human body or on specimens taken from the human body and the evaluation of the technical sufficiency of the investigations and needs.

MEDICAL RADIATION TECHNOLOGY ACT • 1991

The practice of medical radiation technology is the use of ionizing radiation and other forms of energy prescribed under subsection 12(2) to produce diagnostic images and tests, the evaluation of the technical sufficiency of the images and tests, and the therapeutic application of ionizing radiation.

MEDICINE ACT • 1991

The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction.

MIDWIFERY ACT • 1991

The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.

NURSING ACT • 1991

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.

OCCUPATIONAL THERAPY ACT • 1991

The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders that affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure.

OPTICIANRY ACT • 1991

The practice of opticianry is the provision, fitting and adjustment of subnormal vision devices, contact lenses or eye glasses.

OPTOMETRY ACT • 1991

The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:

- a) disorders of refraction;
- b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and
- c) prescribed diseases.

PHARMACY ACT • 1991

The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use.

PHYSIOTHERAPY ACT • 1991

The practice of physiotherapy is the assessment of physical function and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain, to develop, maintain, rehabilitate or augment function or to relieve pain.

PSYCHOLOGY ACT • 1991

The practice of psychology is the assessment of behavioral and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions, and the prevention and treatment of behavioral and mental disorders and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning.

RESPIRATORY THERAPY ACT • 1991

The practice of respiratory therapy is the providing of oxygen therapy, cardio-respiratory equipment monitoring and the assessment and treatment of cardio-respiratory and associated disorders to maintain or restore ventilation.

Appendix B

13 Controlled Acts

Controlled acts are procedures that are considered to be potentially harmful if performed by unqualified persons. The 13 controlled acts are:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger...
 - i. beyond the external ear canal
 - ii. beyond the point in the nasal passages where they normally narrow,
 - iii. beyond the larynx,
 - iv. beyond the opening of the urethra,
 - v. beyond the labia majora,
 - vi. beyond the anal verge, or
 - vii. into an artificial opening 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 subsection 117(1) 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.

Appendix C

*“The excerpts from the following statutes or regulations are current to May 12, 1999.
Please refer to the official statute or regulation for the authoritative text.”*

RHPA Regulation defining the forms of energy and the controlled act of applying or ordering the application of ‘energy’

ONTARIO REGULATION 107 / 96
Made under the
REGULATED HEALTH PROFESSIONS ACT • 1991

Made: March 20, 1996
Approved: March 28, 1996
Filed: March 29, 1996

Controlled Acts

Forms of Energy

1. The following forms of energy are prescribed for the purpose of paragraph 7 of subsection 27(2) of the Act:
 1. Electricity for:
 - i. aversive conditioning,
 - ii. cardiac pacemaker therapy,
 - iii. cardioversion,
 - iv. defibrillation,
 - v. electrocoagulation,
 - vi. electroconvulsive shock therapy,
 - vii. electromyography,
 - viii. fulguration,
 - ix. nerve conduction studies, or
 - x. transcutaneous cardiac pacing.
 2. Electromagnetism for magnetic resonance imaging.
 3. Soundwaves for:
 - i. diagnostic ultrasound, or
 - ii. lithotripsy.

Exemptions set out in Ontario Regulation 107/96. (See Appendix E)

Appendix E

Exceptions to Subsection 27(1) of RHPA

*“The excerpt from the following statutes or regulations are current to May 12, 1999.
Please refer to the official statute or regulation for the authoritative text.”*

RHPA Section 29(1) and (2)

- 29(1) An act by a person is not a contravention of subsection 27(1) if it is done in the course of:
- rendering first aid or temporary assistance in an emergency;
 - fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession;
 - treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;
 - treating a member of the person's household and the act is a controlled act set out in paragraph 1, 5 or 6 of subsection 27(2); or
 - assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27(2).

(2) Subsection 27(1) does not apply with respect to a communication made in the course of counseling about emotional, social, educational or spiritual matters as long as it is not a communication that a health profession Act authorizes members to make. 1991, c. 18, s. 29.

Exemptions to Subsection 27(1) of RHPA

*“The excerpt from the following statutes or regulations are current to May 11, 1999.
Please refer to the official statute or regulation for authoritative text.”*

ONTARIO REGULATION 107 / 96
Made under the
 REGULATED HEALTH PROFESSIONS ACT • 1991

Made: March 20, 1996
Approved: March 28, 1996
Filed: March 29, 1996

Forms of Energy (See Appendix C)

Exemptions

- A member of the College of Chiropractors of Ontario is exempt from subsection 27(1) of the Act for the purpose of applying electricity for electrocoagulation or fulguration.
- (1) A member of the Royal College of Dental Surgeons of Ontario is exempt from subsection 27(1) of the Act for the purpose of applying electricity for defibrillation or electrocoagulation.
 - (2) A member of the Royal College of Dental Surgeons of Ontario is exempt from subsection 27(1) of the Act for the purpose of applying electricity for electromyography or nerve conduction studies, in the course of conducting research.
- A member of the College of Midwives of Ontario is exempt from subsection 27(1) of the Act for the purpose of ordering the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound.

5. (1) A member of the College of Physicians and Surgeons of Ontario is exempt from subsection 27(1) of the Act for the purpose of applying, or ordering the application of, electricity for a procedure listed in paragraph 1 of section 1 or soundwaves for a procedure listed in paragraph 3 of section 1.

(2) A member of the College of Physicians and Surgeons of Ontario is exempt from subsection 27(1) of the Act for the purpose of applying in a public hospital, or ordering the application in a public hospital of, electromagnetism for magnetic resonance imaging.
6. A member of the College of Psychologists of Ontario is exempt from subsection 27(1) of the Act for the purpose of applying, or ordering the application of, electricity for aversive conditioning.
7. A person is exempt from subsection 27(1) of the Act for the purpose of:
 - a) applying soundwaves for diagnostic ultrasound if the application is ordered by a member of the College of Physicians and Surgeons of Ontario;
 - b) applying soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound if the application is ordered by a member of the College of Midwives of Ontario;
 - c) applying electromagnetism for magnetic resonance imaging in a public hospital if the application is ordered by a member of the College of Physicians and Surgeons of Ontario; and
 - d) applying electricity for aversive conditioning if the application is ordered and directed by a member of the College of Physicians and Surgeons of Ontario or by a member of the College of Psychologists of Ontario.
8. The following activities are exempt from subsection 27(1) of the Act:
 1. Acupuncture.
 2. Ear or body piercing for the purpose of accommodating a piece of jewelry.
 3. Electrolysis.
 4. Tattooing for cosmetic purposes.
9. Male circumcision is an activity that is exempt from subsection 27(1) of the Act if the circumcision is performed as part of a religious tradition or ceremony.
10. A naturopath is exempt from subsection 27(1) of the Act for the purpose of carrying on, in accordance with the Drugless Practitioners Act and the regulations under that Act, activities that are within the scope of the practice of naturopathy.
11. The taking of a blood sample from a vein or by skin pricking is an activity that is exempt from subsection 27(1) of the Act if the person taking the blood sample is employed by a laboratory or specimen collection centre licensed under the *Laboratory and Specimen Collection Centre Licensing Act*.
12. (1) A medical geneticist who holds a doctorate is exempt from subsection 27(1) of the Act for the purpose of communicating to an individual or his or her personal representative a diagnosis identifying a genetic disease or genetic disorder as the cause of the symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis, if,
 - a) the disease or disorder identified is within the geneticist's area of expertise; and
 - b) the geneticist is employed by a university or a health care facility and the communication of the diagnosis is performed in accordance with the university's or facility's guidelines or protocols.

(2) In this section "health care facility" means a facility governed by or funded under an Act set out in the Schedule.

13. A member of the College of Nurses of Ontario who holds a general certificate of registration as a registered nurse is exempt from subsection 27(1) of the Act for the purpose of prescribing a solution of normal saline (0.9 per cent) for venipuncture performed to establish peripheral intravenous access and maintain patency.

Schedule

- | | |
|---|--|
| 1. <i>Alcoholism and Drug Addiction Research Foundation Act</i> | 11. <i>Independent Health Facilities Act</i> |
| 2. <i>Cancer Act</i> | 12. <i>Mental Health Act</i> |
| 3. <i>Charitable Institutions Act</i> | 13. <i>Mental Hospitals Act</i> |
| 4. <i>Child and Family Services Act</i> | 14. <i>Ministry of Community and Social Services Act</i> |
| 5. <i>Community Psychiatric Hospitals Act</i> | 15. <i>Ministry of Correctional Services Act</i> |
| 6. <i>Developmental Services Act</i> | 16. <i>Ministry of Health Act</i> |
| 7. <i>General Welfare Assistance Act</i> | 17. <i>Nursing Homes Act</i> |
| 8. <i>Homes for Retarded Persons Act</i> | 18. <i>Ontario Mental Health Foundation Act</i> |
| 9. <i>Homes for Special Care Act</i> | 19. <i>Private Hospitals Act</i> |
| 10. <i>Homes for the Aged and Rest Homes Act</i> | 20. <i>Public Hospitals Act</i> |

Appendix F

“The excerpt from the following statutes or regulations are current to May 12, 1999. Please refer to the official statute or regulation for the authoritative text.”

Orders for Treatment - Section 24 of the Public Hospitals Act

Made under the Public Hospitals Act, 1990, Ontario Regulation 965/98

24 (1) Every order for treatment or a diagnostic procedure of a patient shall, except as provided in subsection (2), be in writing and shall,

- a) in the case of an order for treatment, be dated and authenticated by the physician, dentist or midwife giving the order; and
- b) in the case of an order for a diagnostic procedure, be dated and authenticated by the physician, dentist, midwife or registered nurse in the extended class giving the order.

ONT. REG. 518/88, s. 23, part ONT. REG. 761/93, s. 11, part ONT. REG. 45/98, s. 9(1)

(2) A physician, dentist or midwife may dictate an order for treatment or for a diagnostic procedure by telephone to a person designated by the administrator to take such orders and a registered nurse in the extended class may dictate an order for a diagnostic procedure by telephone to any such person.

ONT. REG. 518/88, s. 23, part ONT. REG. 761/93, s. 11, part ONT. REG. 45/98, s. 9(2)

(3) Where an order for treatment or for a diagnostic procedure has been dictated by telephone,

- a) the person to whom the order was dictated shall transcribe the order, the name of the physician, dentist, midwife or registered nurse in the extended class who dictated the order, the date and the time of receiving the order and shall authenticate the transcription; and
- b) the physician, dentist, midwife or registered nurse in the extended class who dictated the order shall authenticate the order on the first visit to the hospital after dictating the order.

ONT. REG. 518/88, s. 23, part ONT. REG. 761/93, s. 11, part ONT. REG. 45/98, s. 9(3,4)

Appendix G

Decision-making Guide for Determining the Appropriateness of Accepting and Performing Services or Procedures Beyond Principal Expectations of MRT Practice

Decision-Making Steps

1 Is it appropriate to begin to consider having an MRT accept delegation or perform the service or procedure?

Yes No Do not perform procedure Uncertain Consult with CMRTO

2 Is it possible for an MRT to accept delegation or perform the service or procedure given scope of practice and legal requirements under the RHPA, HARP Act, HCCA, PHA, LSCCLA, IHFA, and any other relevant legislation?

Yes No Do not perform procedure Uncertain Consult with CMRTO

3 Is accepting delegation or performing the service or procedure within an MRT's competencies and legal requirements given:

- How known and predictable the patient's condition, needs, and outcome are?
- The circumstances in the situation including:
 - the degree of independence when performing the procedure;
 - the resources and safeguards available;
 - the opportunities to maintain competence;
 - the structures, processes and authorizing mechanisms in place enabling an MRT to meet legal and practice requirements?
- Any other factors specific to the situation?

Yes No Do not perform procedure Uncertain Consult with CMRTO

4 Does having an MRT accept delegation or perform the service or procedure make sense?

Yes No Do not perform procedure Uncertain Consult with CMRTO

Implement measures to enable MRTs to perform procedure

Issues to Consider

- What is the exact nature of the service? Is it a controlled act? Who is to perform it? Upon whom? Where?
- What are the necessary competencies in providing the service?
- Is performance of the procedure warranted and in the patient's best interests?

- Does the procedure fall within the parameters of the MRT scope of practice statement or is it related enough to consider having an MRT perform the procedure?
- Is the procedure being performed in the course of engaging in the practice of the profession?
- If the procedure falls within a controlled act not authorized to MRTs, is it possible to establish a proper delegation program that corresponds to the CMRTO's practice guidelines? Can or has the MRT completed such a program and received written authorization to accept delegation of the procedure?
- Is performance of the procedure consistent with the provisions of HARP, HCCA, PHA, LSCCLA, IHFA ?
- If the procedure does not fall within a controlled act but could cause serious physical harm, is the procedure within the parameters of the MRT scope of practice? If not consider the "risk of harm clause" of RHPA

How known and predictable are the patient's condition, needs and the outcomes:

- How effectively controlled is the patient's condition? How well can the type and timing of changes be predicted? To what degree are needs known and established?
- How accurately can outcomes be predicted when the procedure is performed competently?
- What are the risks in performing the procedure? Can they be minimized? What actions are necessary to deal with them? What are the benefits of performing the procedure?
- What knowledge, skills and judgement are necessary to perform the procedure and manage the outcomes safely, effectively, and ethically?
- If more than one type of care provider can provide care, will the outcome of care be the same if the MRT provides it? (Outcome of care must be the same regardless of who provides it).

What are the circumstances in the situation:

- To what extent is the MRT expected to perform the procedure independently? Are policies in place to guide practice? To what degree is the MRT expected to use judgement in implementing or adjusting the policies? How much independent judgement is necessary in deciding when to consult or seek out assistance? Can this be clearly outlined?
- What are the resources and safeguards in the situation or what is the availability of back-up? How available is a qualified person to intervene? Are there qualified people available to teach and establish policies to guide practice? Is the appropriate equipment available?
- Will there be enough opportunity in practice to maintain competence? If not, can alternative mechanisms be provided? Do these make sense from an organizational and fiscal perspective?
- Can the MRT ensure that legal and practice requirements are complied with: e.g. is an order in place; if supervision or delegation is necessary can these be carried out appropriately; can the MRT assume appropriate responsibility for performance of the procedure; can informed consent be obtained?
- Are there mechanisms in place for quality monitoring, for the MRT to communicate and collaborate with other members of the team and for the MRT to advocate effectively for safe, effective, and ethical care?
- Are there any other factors specific to the situation that need to be considered?
- Given the responses to the above questions, does an MRT have the knowledge, skill and judgement, or have the foundation of knowledge, skill and judgement to reasonably acquire the competencies to accept delegation or perform the service or procedure safely, effectively and ethically?

- What is the extent of need?
- Does it make sense from a patient satisfaction perspective, a provision of care perspective, rationalization of services perspective, fiscal perspective, organizational perspective (e.g. is it reasonable to expect a newly hired person to perform the procedure with similar training)?
- If MRTs perform the procedure, will this detract from their ability to appropriately provide services needed by patients that only MRTs can provide?

List of acronyms

CMRTO	College of Medical Radiation Technologists of Ontario
CNO	College of Nurses of Ontario
CPSO	College of Physicians and Surgeons of Ontario
DH	Dental Hygienists
HARP Act	Healing Arts Radiation Protection Act
HCCA	Health Care Consent Act
IHFA	Independent Health Facilities Act
IHF	Independent Health Facility
IVP	Intravenous Pyelogram
LSCCLA	Laboratory and Specimen Collection Centre Licensing Act
MLT	Medical Laboratory Technologist
MRT	Medical Radiation Technologist
MRTA	Medical Radiation Technology Act
OHA	Ontario Hospital Association
PHA	Public Hospitals Act
RHPA	Regulated Health Professions Act
RN	Registered Nurse
RNEC	Registered Nurse, Extended Class
RPN	Registered Practical Nurse
RT	Respiratory Therapist

Glossary

Accountability:

means being responsible for one's decisions and actions, including those undertaken independently or collectively as a member of a team. This means that MRTs must accept the consequences of their decisions and actions and act on the basis of what they, in their clinical judgement, believe is in the best interests of the patient. MRTs must take appropriate action if they feel these interests are being unnecessarily and unacceptably compromised. This includes refusing to implement ordered procedures or treatment plans that, from the MRT's perspective, appear to be contraindicated, and taking appropriate action to address the situation.

Competent:

means having the necessary knowledge, skills and judgement to perform safely, effectively and ethically and applying that knowledge, skill and judgement to ensure safe, effective and ethical outcomes for the patient. MRTs must maintain current competence in their area of practice and, if not competent, refrain from acting and take appropriate action to address the situation.

Circumstances in the Situation:

refers to those factors related to the patient and the environment, which affect one's ability to perform an act safely and effectively. They include, but are not limited to, the patient's condition, the predictability of the outcomes of performing the procedure, the known risks and benefits to the patient, the patient's wishes, and the safeguards and resources available.

College or Regulatory Body:

is the organization responsible for governing a health profession under the Regulated Health Professions Act. For medical radiation technologists in Ontario, the governing body is the College of Medical Radiation Technologists of Ontario (CMRTO).

Controlled Acts:

are the 13 procedures, listed in the RHPA, deemed to pose risk of physical harm to the public if performed by unqualified persons. Controlled act procedures can only be performed if the authority is given under a specific health profession Act or if the authority is delegated. The 13 controlled acts are listed in Appendix B.

Authorized Act:

is a controlled act procedure, or a portion of a controlled act procedure, that is authorized to a specific profession to perform under the appropriate health profession Act. MRTs are permitted to perform the following authorized acts if there is an order in place from a physician:

1. Taking blood samples from veins;
2. Administering substances by injection or inhalation;
3. Administering contrast media through or into the rectum or an artificial opening into the body; and
4. Tattooing.

Delegated Act:

a controlled act procedure, that is performed under the authority of delegation.

Delegation:

is the transfer of authority from a member of a regulated profession, authorized by the specific health profession Act under RHPA to perform a controlled act procedure, to someone who is not authorized (another regulated health professional or an unregulated person). Delegation does not refer to instances when an MRT is authorized by the Medical Radiation Technology Act (MRTA) to perform a controlled act on the order of a physician. In this case, no transfer of authority is required; the medical radiation technologist has the authority to carry out the controlled act procedure on the condition of an order.

Exceptions and Exemptions:

specific circumstances listed either in the regulations under the RHPA or in the RHPA, respectively, identifying when someone who is not authorized under subsection 27(1), may perform a controlled act procedure and not be in contravention of the legislation. For the list of exceptions and exemptions, see Appendix E.

Medical Radiation Technology (MRT) Scope of Practice:

“The practice of medical radiation technology is the use of ionizing radiation and other forms of energy prescribed under subsection 12(2) of the RHPA to produce diagnostic images and tests, the evaluation of the technical sufficiency of the images and tests, and the therapeutic application of ionizing radiation” (MRTA).

The three medical radiation technology specialties are:

- Radiography
- Radiation Therapy
- Nuclear Medicine

Medical Radiation Technologist(s) (MRT or MRTs):

member(s) of the College of Medical Radiation Technologists of Ontario. The title “medical radiation technologist” is a protected title and may only be used by those registered with the College of Medical Radiation Technologists of Ontario. The titles Medical Radiation Technologist - Radiography, or M.R.T.(R.), Medical Radiation Technologist - Radiation Therapist or M.R.T.(T.) and Medical Radiation Technologist - Nuclear Medicine, or M.R.T.(N.) are also protected. Previous titles, such as radiological technician, radiographer or radiological technologist no longer apply.

Order:

an authorizing statement from a regulated health professional with prescribing authority permitting an MRT to implement a procedure. Under the MRTA, an order from a physician is necessary to permit MRTs to implement authorized act procedures. Under the HARP Act, an order from a physician, dentist, chiropractor, designated chiropractist, osteopath or, under some circumstances, a nurse who holds an extended certificate of registration, is necessary to permit MRTs to apply or administer ionizing radiation.

An order may also be known as a:

- Prescription
- Requisition
- Request for consultation
- Doctor’s note

An order may be one of two types:

- Direct order (for one specific patient)
- Directive or protocol (for a number of patients under specific circumstances)

An order may also be used to prompt performance of a procedure that is neither a controlled act nor ionizing radiation, but falls within patient procedures or treatments (e.g. taking blood pressure).

Principal Expectations of Practice:

refers to services and procedures that clearly fall within the scope of practice for MRTs. It includes those taught in MRT entry level programs where students are provided with the knowledge base and clinical practice to perform them competently. It also includes those services and procedures which MRTs acquire competence to perform, by expanding on the foundation of knowledge, skills and judgement obtained in entry level programs through formal or informal education, clinical experience or on-the-job training as a graduate MRT. Examples of “expanded” services or procedures that fall within principal expectations of practice would include mammography, CT scan and cardiac stress testing. Services or procedures beyond principal expectations of practice are at the outer limits of or outside the MRT scope of practice. In some instances, they may be at the outer limits because they are confined to highly specialized areas; for example, the performance of haemodynamics. In other instances, very few patients require the services or procedures; for example, the administration of strontium-89 treatments for palliative relief of bony metastases in patients with prostate cancer.

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