



College of Occupational
Therapists of Ontario

STANDARDS FOR CONSENT





STANDARDS FOR CONSENT

Store at Tab #2 of your Registrant Resource Binder

Introduction

The *Regulated Health Professions Act, 1991* acknowledges occupational therapists as autonomous practitioners. Regulation of the profession requires that occupational therapists practice according to established standards and principles of practice, and apply these consistently in a responsible and intentional manner within the health care environment. Although each area of practice has its own unique characteristics, the principles that guide practice are constant and apply across all environments. This document describes the standards of practice for obtaining consent.

It is the responsibility of the occupational therapist to determine the legislative, regulatory, and organizational requirements relevant to his/her practice and service delivery. Occupational therapists work in different areas of practice and therefore should ensure they are complying with the Standards of Consent in each unique environment.

The *Health Care Consent Act, 1996*, (HCCA), and the *Personal Health and Information Protection Act, 2004*, (PHIPA), reinforce the principles of effective and transparent communication with clients, and the requirement to obtain informed consent before providing service and/or collecting, disclosing, or using personal health or other confidential information. These standards describe the minimum expectations of occupational therapists with respect to consent.

The term “intervention” has been used in these standards to encompass the various intervention activities performed by occupational therapists, including consultation. It is important to recognize that the HCCA does not and cannot deal with every aspect of consent because the law is constantly evolving in this area.

The HCCA has three components: consent for intervention, consent for admission to a facility, and consent for the provision of a personal assistance service. While this document refers to the first component, that of consent for intervention, occupational therapists are professionally accountable for obtaining consent for all services including: **assessment, intervention, or consultation**. Occupational therapists have an obligation to obtain consent in all circumstances, including those not specifically covered by the HCCA.

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For information on the following key aspects of the HCCA, occupational therapists are referred to the Act and to *A Guide to the Health Care Consent and Substitute Decisions Legislation for Occupational Therapists, 1996*¹, for further information regarding:

1. Guidelines for providing information to incapable patients;
2. Indicators of client capacity and incapacity;
3. Other key aspects of the HCCA, such as:
 - Emergencies;
 - Non-Intervention Decisions;
 - Substitute decision-makers, (SDMs);
 - Consent and Capacity Board;
 - Notification of Incapacity Findings.

Consent is a process which requires a dialogue between the person proposing the assessment or intervention and the person giving the consent for the assessment or intervention. This dialogue must provide opportunities for the occupational therapist and the client to discuss the risks and benefits, consider intervention options, ask questions and have them answered. Consent can be written or oral, expressed or implied.

College publications contain practice parameters and standards which should be considered by all Ontario occupational therapists in the care of their clients and in the practice of the profession. College publications are developed in consultation with occupational therapists and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

¹This document can be found on the COTO website, in the Resource Room.

DEFINITIONS

Following are definitions of terms used frequently throughout the Standards. Additional definitions can be found in the Glossary.

Assessment:

“Is the process of gathering sufficient information about individuals and their environments to make informed decisions about interventions.” (Christiansen & Baum, 1992, p.376). It is an ongoing, fluid process throughout service delivery that may be applied in a variety of settings.

Capacity:

A person is deemed capable with respect to an intervention/decision if the person is able to understand the information relevant to making a decision about the intervention, and able to appreciate the reasonably foreseeable consequences of a decision, or lack of decision. People:

- (i) are presumed capable unless there is information to lead the OT to think otherwise;
- (ii) may be capable with respect to one intervention/decision but not another; and

(iii) may be capable with respect to an intervention/decision at one time and incapable at another.

Informed Consent:

Consent is informed if, before voluntarily agreeing to the intervention, the person making the intervention decision received the information that a reasonable person in the same circumstances would require in order to make a decision about the intervention. This information would also include responses to requests for additional information, including information about the nature, benefits, material risks and side-effects of the intervention, alternative courses of action, and the likely consequences of not having the intervention. It must be obtained, recorded, dated, and maintained as part of the client record.

Intervention:

Services provided for a therapeutic, preventive, palliative, diagnostic, cosmetic, educational, or other health-related purpose, including a course of intervention or plan of intervention or Mental Health Community Treatment Plan.

APPLICATION OF THE CONSENT STANDARDS FOR OCCUPATIONAL THERAPY

- The following **standards** describe the minimum expectation for each stage of the consent process.
- The **performance indicators** listed beneath each standard describe more specific behaviours that demonstrate the standard has been met.
- There may be some situations where the occupational therapist determines that a particular performance indicator is not relevant due to client factors and/or environmental factors.
- It is not expected that all performance indicators will be evident all the time, but could be demonstrated if requested.
- It is expected that occupational therapists will always use their clinical judgement to determine how to best complete the consent process based on specific client needs.
- It is also expected that occupational therapists will be able to provide the rationale for any variations from the standard.

OVERVIEW OF THE STANDARDS FOR CONSENT

Standard 1	Determining Capacity
Standard 2	Consent for Assessment
Standard 3	Consent for Intervention
Standard 4	Consent to Collect, Use and Disclose Personal Health Information
Standard 5	Consent for the Participation of Support Personnel, Students and Others
Standard 6	Withdrawal of Consent
Standard 7	Third Party Consent
Standard 8	Documenting Consent

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1. Determining Capacity

Consent is a process, which begins with determining capacity. A variety of factors may present as barriers to the client's understanding information in relation to determining capacity. The occupational therapist must be satisfied that the client understands the relevant information and appreciates the consequences of his/her decision. The client's age or language barriers should not impact the occupational therapist's conclusion regarding the client's capacity.

Standard 1

The occupational therapist will determine that the client or substitute decision-maker (SDM), understands the information provided and is capable of giving consent when obtaining consent for assessment and interventions.

Performance Indicators

An occupational therapist will:

- 1.1 Assume the client is capable of providing consent, unless there is information that would lead the occupational therapist to think otherwise;
- 1.2 Consider factors that may indicate that the client is incapable;²
- 1.3 Utilize interpreters, if necessary, to ensure that the client understands the consent process;
- 1.4 When there is an indication to do so, follow a process to determine capacity:
 - a) Gather objective and subjective information to determine the client's capacity to give consent;
 - b) Analyze the information gathered to determine the ability of the client to make the required assessment and or intervention decision;
 - c) Not make presumptions of incapacity based on:
 - (i) Diagnosis of a psychiatric or neurological condition;
 - (ii) Communication impairment;
 - (iii) Disability;
 - (iv) Refusal of intervention;
 - (v) Age;
 - (vi) The fact that there is a guardian or substitute decision-maker in place;

² Some indicators of incapacity may: be evidence of confused or delusional thinking; inability to make a settled choice; severe pain, or acute fear or anxiety; severe depression; impairment by alcohol or drugs; or any other observations which give rise to a concern about the person's ability to understand information relevant to making a decision.

- 1.5 Engage the client and other stakeholders in a collaborative approach regarding the capacity process, as appropriate;
- 1.6 Upon determining incapacity, communicate to the client the finding of incapacity, the reasons, and his/her right of a review of this finding;
- 1.7 Upon determining incapacity, take reasonable measures to confirm the substitute decision-maker, and inform the client that the substitute decision-maker will make the final decision related to the occupational therapy services;
- 1.8 Utilize the hierarchy of substitute decision-makers, (Appendix 1), if a substitute decision-maker has not been identified;
- 1.9 Involve the client in discussions with the substitute decision-maker whenever possible.

2. Consent for Assessment

Informed consent is an ongoing process to be re-evaluated throughout the assessment process. While not specifically included in the HCCA, it is expected that occupational therapists will obtain consent for all aspects of assessment.

Standard 2

The occupational therapist will ensure informed consent is obtained from the client or substitute decision-maker at the start of the assessment process and throughout the assessment process.

Performance Indicators

An occupational therapist will:

- 2.1 Apply the informed consent process for assessment of the client, including discussing the following as appropriate:
 - a) The scope and reason of the referral;
 - b) The financial arrangements regarding payment for the assessment;
 - c) The purpose and nature of the assessment including whether information will be obtained from other individuals or site visits;
 - d) The legal authority (e.g. voluntary, contractual, legislative provision) for conducting the assessment;
 - e) The identity, professional qualifications and role of individuals who will be involved in the assessment (e.g. other team members, students etc., see also Standard #5);
 - f) The potential benefits and limitations of completing the assessment;

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- g) The risks associated with completing or not completing the assessment;
 - h) The expected outcomes of the assessment(s), how the information may be used, and with whom it will be shared;
 - i) The right of the client to withdraw consent at any time during the process;
 - j) Where appropriate, the option of the client to request another occupational therapist to perform the assessment.
- 2.2 Provide an opportunity for the client or substitute decision-maker to ask questions and respond to them in a manner that the client understands;
- 2.3 When moving from one component of the assessment to another, confirm consent;
- 2.4 Utilize interpreters to ensure that the client or substitute decision-maker understands the consent process.

3. Consent for Intervention

Informed consent is an ongoing process to be re-evaluated throughout the intervention process. A client can be capable of consenting to some interventions and not others. Moreover, a client may be incapable with respect to an intervention decision at one time and capable at another time. If a client regains capacity, his or her own decisions take precedence over any decisions made by a substitute decision-maker.

Standard 3

The occupational therapist will ensure informed consent is obtained on an ongoing basis for each component of the intervention plan.

Performance Indicators

An occupational therapist will:

- 3.1 Apply a similar informed consent process to that as outlined in the assessment standard, including discussing the following as appropriate:
- a) The scope and reason for the referral;
 - b) The financial arrangements regarding payment for the intervention;
 - c) The nature, scope of service, plan, goals and objectives of each specific intervention;
 - d) The identity, professional qualifications and role of individuals who will be involved in the intervention (e.g. other team members, students, support personnel, etc.);
 - e) The potential benefits and limitations of each intervention;
 - f) The risks associated with participating or not participating in the intervention(s);

- g) The expected outcome(s) of the intervention(s);
 - h) The right of the client to withdraw consent at any time during the process;
 - i) Where appropriate, the option of the client to request another occupational therapist to carry out the intervention(s).
- 3.2 Ensure that each component of the plan is explained and that consent is specific to each component, when proposing a global intervention plan;
- 3.3 Seek ongoing consent, if the scope of the involvement includes ongoing service;
- 3.4 For a client who has a Community Treatment Order, obtain consent from the client or substitute decision-maker for the community intervention/plan prescribed.

4. Consent to Collect, Use and Disclose Personal Health Information

Personal health information may include audio-visual materials.

Standard 4

The occupational therapist will ensure that informed consent is obtained to collect, use, and disclose personal health information, unless consent is not legally required.

Performance Indicators

An occupational therapist will:

- 4.1 Apply the informed consent process for collecting, using, and disclosing personal health information, including discussing with the client:
- a) The purpose and method of the collection, use, and disclosure of personal health information, including audio-visual materials;
 - b) The legal authority (e.g. voluntary, contractual, legislative provision) for the collection, use, and disclosure of personal health information, as appropriate;
 - c) The potential benefits and risks of consenting or not consenting to the collection use, and disclosure of personal health information;
 - d) The right of the client to withdraw consent at any time during the process.
- 4.2 Identify who is in the Circle of Care;

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- 4.3 Apply the concept of putting specific health information into a “lock-box”³, when the client has expressly requested information not be disclosed to another custodian for the purpose of providing health care:
- a) When the occupational therapist considers some of the locked information to be reasonably necessary for the provision of health care, inform the recipient custodian that some personal health information is inaccessible as a result of it having been “locked” by the client;
 - b) The occupational therapist may disclose the locked information in certain circumstances, in which the occupational therapist’s professional opinion determines the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to an individual or a group of persons.

5. Consent for the Participation of Support Personnel, Students and Others

Standard 5

The occupational therapist will obtain informed consent for the participation of students, support personnel, and others in the provision of occupational therapy services.

Performance Indicators

An occupational therapist will:

- 5.1 Obtain consent by providing detailed and specific information to enable the client’s understanding of the role and activities that support personnel, students and others will perform related to occupational therapy services;
- 5.2 Provide information to the client about the method of supervision;
- 5.3 Document that consent was obtained for participation of support personnel, students, and others;
- 5.4 Obtain and document consent when involving other persons who are not in the Circle of Care (e.g. vendors).

³A “lock-box” is a term of reference used to describe the right of an individual to instruct a health information custodian not to disclose specified personal health information to another custodian for the purpose of providing health care. An individual can be said to have placed his/her personal health information into a lock-box by expressly withholding or withdrawing consent for his/her health information to be collected, used or disclosed.

6. Withdrawal of Consent

A client or SDM may withdraw consent at any time. However, due to specific clinical and ethical factors, ie: an immediate and serious risk, the occupational therapist may continue the intervention until the problem or threat has passed. The occupational therapist will advise the client that he/she is required to complete the intervention and the reasons for doing so, at least in circumstances where that is possible.

Standard 6

The occupational therapist will ensure that the client/or substitute decision-maker understands the right to, and the implications of withdrawing consent.

Performance Indicators

An occupational therapist will:

- 6.1 Ensure the client or SDM understands his/her right to withdraw consent;
- 6.2 Ensure the client or SDM understands the implications of withdrawing consent;
- 6.3 Determine why the client is withdrawing consent;
- 6.4 Document any intervention provided prior to the consent being withdrawn;
- 6.5 Continue the intervention if immediate withdrawal would be life threatening or pose immediate or serious problems to the health of the individual or the occupational therapist;
- 6.6 Submit the portion of the report to which the client consents;
- 6.7 Neither complete, nor submit a report if the client or SDM withdraws consent to do so unless the occupational therapist is legally required to do so;
- 6.8 Document any reason given for the consent being withdrawn and any relevant discussions with the client/substitute decision-maker.

7. Third Party Consent

There are situations where one health care practitioner obtains consent on behalf of all health practitioners involved, e.g. a physician, or a case manager.

Standard 7

The occupational therapist will ensure consent for assessment and intervention, when obtained by a third party, has been acquired utilizing an informed consent process.

Performance Indicators

An occupational therapist will:

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- 7.1 Take reasonable measures to:
 - a) ensure that the third party applies the informed consent process;
 - b) ensure that consent was obtained prior to initiating services;
 - c) ensure that a process for ongoing consent is followed.
- 7.2 Identify and document that a third party has obtained consent for assessment and/or intervention. Also identify who confirmed that the third party obtained consent;
- 7.3 Obtain informed consent if it is determined that the consent process obtained by the third party was not complete.

8. Documenting Consent

Documentation of consent is a minimum expectation of occupational therapists. Consent should be documented at the time of the assessment and after proposing an intervention plan. Consent should be documented again, if any changes are made as the assessment or intervention progresses.

Occupational therapists will take into account the needs of the practice environment and level of risk associated with the assessment or intervention to determine the documentation required. A signed consent form does not necessarily indicate that there is informed consent. Consent forms should not be a substitute for the verbal or alternate communication process. Forms can be used to augment the process and offer a standard method of obtaining consent from each client. For example, a practice environment policy and procedure may exist to support the process of obtaining written consent using a standardized form.

Standard 8

The occupational therapist will document the consent process.

Performance Indicators (Documenting Consent)

An occupational therapist will:

- 8.1 Document:
 - a) The client's apparent understanding of the proposed assessment/intervention(s);
 - b) Whether or not the client agreed to all, some, or none of the proposed assessments/interventions;
 - c) That risks, limitations and benefits were discussed and provided to the client;
 - d) Any modifications to the consent;

- e) Whether the client or SDM agreed to the collection, use, and/or disclosure of the client's personal health information and any limits imposed;
- f) When consent was obtained through the use of an interpreter, alternate means of communication, or a substitute decision-maker;
- g) The identity of the SDM, the legal entitlement of the SDM (documentation on file, copy of Power of Attorney for personal care provided, etc.);
- h) That the client withdrew consent, why he/she did so, and what specifically was withdrawn.

8.2 The documentation can take any of the following forms:

- i) A note in the client record, and/or;
- ii) A consent form, that is dated, signed, and witnessed, and/or;
- iii) A consent policy/procedure or a guideline that is referenced in the client's record.

References

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10. Practice guidelines: Client Records, COTO January, 1999.
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12. Standards for Occupational Therapy Assessments, COTO May, 2007.
13. The Health Care Consent Act and the Substitute Decisions Act – Who Decides What When? 25 Common Misconceptions about the Substitute Decisions Act and Health Care Consent Act. Advocacy Centre for the Elderly. Accessed November 20, 2007.
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APPENDIX 1

Hierarchy of Substitute Decision-makers

When a health care practitioner is proposing an intervention and is of the opinion that the person is not capable of making a decision about the assessment, intervention, admission to a care facility, or personal assistance, consent must be obtained from a substitute decision-maker (unless the circumstances warrant urgent intervention).

In most situations, a substitute decision-maker does not have to be appointed by the courts. However, the substitute decision-maker must be at least 16 years old, unless the substitute is the parent of the individual. The substitute decision-maker must also be capable, himself or herself, to give consent. The HCCA provides a hierarchy of persons who can provide substitute consent. Generally, the practitioner must obtain consent from the highest available and willing potential substitute (unless a lower substitute is present and the higher level substitute would not object to the lower level substitute making the decision). Therefore, it is important that health practitioners understand the hierarchy.

The HCCA defines the hierarchy of substitute decision-makers as:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the intervention;
2. The incapable person's attorney for personal care, if the power of attorney for personal care confers authority to give or refuse consent to the intervention;
3. The incapable person's representative appointed by the Consent and Capacity Board, if the representative has authority to give or refuse consent to the intervention;
4. The incapable person's spouse or partner;
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the intervention in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the intervention in the place of the parent, this paragraph does not include the parent;
6. A parent of the incapable person who has only a right of access;
7. A brother or sister of the incapable person;

8. Any other relative of the incapable person;
9. The Public Guardian and Trustee, if none of the above meets the qualifications, or in the event two or more equally ranked substitutes cannot agree.

GLOSSARY

Power of Attorney	A legal document in which a capable person gives someone else the authority to make decisions about the person, often in the event the person becomes incapable. Not all powers of attorney relate to personal care. The document could also contain specific instructions about particular treatment decisions if it is a power of attorney for personal care.
Attorney for Personal Care	A power of attorney that deals with the issue of personal care given under the <i>Substitute Decisions Act, SDA, 1992</i> .
Best Interests	Best interests means the consideration of: <ul style="list-style-type: none">• the incapable person's values, beliefs and expressed wishes;• whether the intervention will benefit the incapable person;• whether the incapable person's condition or well-being is likely to be improved by the intervention;• whether the incapable person's condition or well-being is likely to improve without the intervention;• whether the benefit the incapable person is expected to obtain from the intervention outweighs the risks of harm to him or her; and• whether a less restrictive intervention would be as beneficial as the proposed intervention.
Capacity	A person is capable with respect to an assessment/intervention if the person is able to understand the information relevant to making a decision about the matter and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
Capacity Assessors	A person who assesses a person's mental capacity for making decisions about property or personal care over the long term under the SDA.

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Circle of Care	A term of reference used to describe health information custodians and their authorized agents who are permitted to rely on an individual's implied consent when collecting, using, or disclosing personal health information for the purpose of providing health care or assisting in providing health care.
Component	A discrete part or entity of a plan of intervention, contributing to the whole plan.
Consent	The agreement of the client to a procedure. To be valid, consent must be informed, must relate to the intervention, must be given voluntarily and must not be obtained through misrepresentation or fraud.
Consent and Capacity Board	Established by, accountable to, and appointed by the government. The Board considers applications for review of findings of incapacity, applications relating to the appointment of a representative (e.g. substitute decision-maker), and applications for direction regarding the best interests and wishes of an incapable person.
Course of Intervention	A series or sequence of related interventions administered to a person over a period of time for a particular health issue.
Express Consent	Express consent to the collection, use or disclosure of personal health information by a health information custodian is explicit and direct, and may be given verbally, in writing or by electronic means.
Global Treatment Plan	An inclusive plan of intervention covering a wide scope, comprised of separate parts or components.
Guardian of the Person	A guardian of the person appointed under the <i>Substitute Decisions Act, 1992</i> for a person who is incapable of personal care and, as a result, needs decisions to be made on his or her behalf by a person who is authorized to do so.

Implied Consent

For health information, implied consent permits a health information custodian to infer from the surrounding circumstances that an individual would reasonably agree to the collection, use or disclosure of his/her personal health information. For assessment or interventions, implied consent has a similar meaning, where the surrounding circumstances indicate that a client consents to the procedure even though there is no expressed consent.

Informed Consent

Consent is informed if, before voluntarily agreeing to the intervention, the person making the intervention decision received the information that a reasonable person in the same circumstances would require in order to make a decision about the intervention. This information would also include responses to requests for additional information, including information about the nature, benefits, material risks, and side-effects of the intervention, alternative courses of action, and the likely consequences of not having the intervention. It must be obtained, recorded, dated, and maintained as part of the client record.

Intervention

Anything that is done for a therapeutic, preventive, palliative, diagnostic, educative, cosmetic or other health-related purpose, including a course of intervention or plan of intervention or mental health Community Treatment Plan; does not include assessment of capacity or general nature of a person's condition, the taking of a person's health history, the communication of an assessment or diagnosis, the admission of a person to a hospital or other facility (with some exceptions), a personal assistance service, or an intervention that in the circumstances poses little or no risk of harm to the person.

Partner/Spouse

Either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

Plan of Intervention

A plan that is developed by one or more health practitioners, which deals with one or more health problems of a person (and may, in addition, deal with health problems the person is likely to have in the future). Provides for the administration of various interventions or courses of intervention and may, in addition, provide for the withholding or withdrawal of intervention in light of the person's current health condition.

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Public Guardian and Trustee, (PGT)	The PGT is the substitute decision-maker of last resort for a mentally incapable person. Under the amendments to the <i>Substitute Decisions Act, 1992</i> the court will not appoint the PGT as guardian of property or guardian of the person unless there is no other suitable person available and willing to be appointed.
Relative	A person related by blood, marriage, or adoption.
Substitute decision-maker	A person who makes decisions for someone who is incapable of making his/her own decisions, and who is authorized to give or refuse consent to an intervention on behalf of a person who is incapable with respect to the intervention. In most cases this will be a family member or partner. In others, this may be an individual specifically selected by the client, or appointed by the Court, the Board or Public Guardian and Trustee Office. <i>See Appendix.</i>

Practice Examples

Example One

Mrs. J. has been in hospital for 2 weeks following a Right CVA. John, the OT, was concerned with the functional impact of the stroke, and spoke with Mrs. J. about an assessment of her physical status. Mrs. J. appeared to understand this discussion and was able to appreciate the information relevant to making the decision of consenting to the assessment. She was deemed capable and consented to this assessment. After some time and with further recovery, the health care team wanted to determine if Mrs. J. could be safely discharged home alone and therefore, requested an assessment for this purpose. What should John, the OT, consider prior to performing another assessment?

Discussion:

Issue: A person deemed capable of making decisions related to one assessment or intervention, may not be capable for other assessments or interventions, at a later time.

If a person has been assessed as being capable of making decisions related to some components of an assessment, due to the possible cognitive symptoms of a CVA, it should not be presumed that the individual is capable for other components. Capacity is issue-specific, and it relates to a particular task at hand. For example, it is not uncommon to find that a person is not capable of making decisions related to his/her finances, but still retains capacity to make decisions related to OT intervention and homemaking.

Capacity can alter over time. The client may be incapable of making decisions at one time, but at a later time is found to be capable. When deemed capable, the client would make the assessment/intervention decision, even if the SDM previously had given or refused consent.

In this practice scenario, the OT, John, should consider that the second assessment has different implications than the first assessment (implications for returning home). Therefore, consent would need to be obtained for this specific assessment's scope and purpose. As well, John should reconfirm capacity, given that there was a time lapse and the potential for further cognitive recovery between the first and second assessment.

Example Two

Jack, a 17-year-old adolescent, is an up and coming hockey and soccer player. Jack was in a car accident and sustained a soft tissue back injury and multiple fractures to his right arm, shoulder, clavicle, and both legs. He has been discharged from hospital wearing casts and in a wheelchair. He is expected to progress to full weight-bearing over a period of time. Jack will require in-home OT for ADLs and, attendant care services both at home and at school. He will attend out-patient physiotherapy. The insurance company has agreed to fund all of his attendant care, and rehab needs.

Due to the uncertainty of his future in professional sports, Jack is exhibiting signs of depression, through acting out, anger and irritability with his family. He will require a psychological assessment and possibly treatment to address his emotional (or psychosocial needs). To simplify the management of his rehabilitation program, Andrea, the OT will be acting as the Case Manager and as the treating OT.

As a treating practitioner, Andrea proposes a global plan of intervention and will determine Jack's capacity to consent to the global plan. As the case manager in this case, Andrea is also responsible for obtaining consent on behalf of all the treating practitioners involved in his care.

Discussion:

Issue: Consent for Global Intervention Plans, Third Party Consent

Jack's global intervention plan includes multiple components to address current, as well as one or more of the health related problems that he is likely to experience in the near future. Consent for an intervention plan must relate to the current health condition of the client. Therefore, Andrea should not propose a plan that is general, and should not request that the client consent to interventions not related to his current condition.

As the case manager, Andrea can propose a plan of intervention on behalf of all practitioners on the team. It is appropriate for the OT in this role to determine Jack's capacity to make decisions related to the plan of intervention, and obtain consent for the plan. To obtain consent on behalf of other health practitioners, the OT must provide information on all aspects of the plan and answer all of Jack's questions, not only the OT portion. The health practitioners on the team can rely on the consent received by the OT for the global plan, if the proper consent is obtained to the plan of care. It is the responsibility of the other health practitioners to reconfirm the client's consent if there is any concern that the complete process of informed consent was not followed.

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Example Three

Lisa is an OT independent contractor working with a Service Provider Organization which is contracted with a Community Care Access Centre. She often assesses children who attend a community-based special needs day care centre. Part of her role is providing strategies to early childhood educators to assist the children in the day care environment.

A five-year-old child Lisa has worked with over the previous two years while in day care, has entered the school system. The child will continue to attend the day care centre for half days and will be in school the rest of the day. The child's mother has provided his schoolteacher with a copy of the OT assessment report completed while her child was in day care. The teacher consulted with the school board OT, Jane, to assist her in understanding and implementing the recommendations.

1. Can Jane, the school board OT, discuss the report with the teacher without first contacting the parent for consent?
2. Can Lisa, the day care OT, contact Jane, the school board OT, to collaborate and facilitate the transition of care, or does she need the parent's consent prior to making the call?

Discussion:

Issues: Consent to Collect, Use, and Disclose Personal Health Information, Circle of Care, Information Falling within Two Legislations, as in School Health

1. Under the HCCA and PHIPA, the client's or his/her SDM's consent, is required in order for an OT to give information about the client to another person. Under PHIPA, the CCAC is the Health Information Custodian (HIC), and Lisa, the OT who works as an independent contractor in providing services on behalf of the CCAC, is an agent of the CCAC.

As the primary function of the school board staff is **not to provide** health care, it is not subject to PHIPA. The privacy of the school board's information is protected by the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA). Jane, the OT, however, employed by the school board, is a health care provider, who falls under PHIPA, and is the HIC.

MFIPPA allows the teacher **to disclose** the report to Jane, the school board OT, if it is for the same or consistent purpose, as the purpose the **parent disclosed** it to the teacher (similar to the Circle of Care). The OT could reasonably assume that the report was given to the teacher by the parent, so that the recommendations provided in the report could be carried out in the school environment. As such, it is appropriate for Jane to review the report with the teacher, without seeking express consent from the mother.

2. Discussions **between** the teacher and Jane, the school-based OT, do come under PHIPA. This is different than the information **given** to the teacher by the parent that falls under MFIPPA. PHIPA allows a HIC to collect, use and disclose information for the purposes for which the information was collected, even if that use is covered by another act. The information, **initially protected** by MFIPPA, when in the teacher's possession, is now protected through PHIPA when **in the OT's possession**. PHIPA permits the HIC and agents to rely on an individual's implied consent when collecting, using,

or disclosing health information for the purpose of providing direct health care (Circle of Care). The two OTs, therefore, are **permitted to share information** and collaborate without seeking express consent from the mother. Even though an OT has the ability to act on implied consent, the College advises OTs to ensure that the family understands how implied consent can be implemented.⁴

⁴ Adapted from and used with permission of the College of Physiotherapists of Ontario

Example Four

Donna is an OT working on an acute inpatient service. She received a referral for a 70-year-old female involved in a motor vehicle accident resulting in a spinal cord injury. The client is a recent immigrant to Canada and speaks very limited English. The family is unable to act as interpreters due to their limited English. The OT, who has previously met the client, feels that the client could benefit from occupational therapy intervention to provide adaptive feeding devices, as she has been indicating extreme frustration with her inability to feed herself. The OT and nursing staff state that while the client cannot understand much English, she communicates very well with gestures and modeling behaviour.

Can consent be obtained through the use of gestures when the client has limited use of English, or does the OT need to obtain the services of an interpreter?

Discussion:

Issues: Need for and use of interpretation services to determine capacity and obtain consent.

Consent is informed if: the patient has been deemed capable, has received the information relating to the nature of the intervention, the expected benefits, material risks, side-effects of the intervention, alternative courses of action, and the likely consequences of not having the intervention. The patient must be able to ask questions and receive answers related to the intervention.

There may be times when the OT, through the use of gestures along with minimal language, may be able to ascertain that the patient is capable of giving consent, and of understanding the steps in the process of obtaining informed consent. This would depend upon the OT's clinical judgement that the areas of informed consent have been understood sufficiently, and that the patient is capable and has given consent for the intervention. This would require documentation of the mode of communication and the evidence that the patient understood and agreed to the intervention.

If the OT believes that there is any part of the consent process that the patient does not understand, he/she should ensure that there is a way to make the process understandable to the patient. This could be through the services of an interpreter, a member of staff of the facility who speaks the patient's language and who can be trusted to correctly interpret the information, or if possible, through the exploration of translation tools, such as computer programs or symbol boards.

STANDARDS FOR CONSENT

Example Five

Karen is an OT in a busy, orthopaedic program of a rehab hospital. There are two OTs working on the unit, along with two OT Support Personnel. The OT Support Personnel take an active part as support personnel in the rehab program service delivery. Karen is preparing for two OT students, who will be having a placement with the program.

1. Does Karen have to apply the consent process and receive consent from the clients to permit student to work with them?
2. Does Karen need to receive consent from the clients in order for the OT Support Personnel to work with the clients?

Discussion:

Issues: Does consent apply to OT students and OT Support Personnel?

The OT is required to obtain consent from the client for the participation of the students and the OT Support Personnel in the client's care. The client should be given information describing the role and activities that the students and OT Support Personnel will perform, and about the supervision which the OT will undertake with the students and OT Support Personnel. This information should be clear and transparent. The client should be given the opportunity to ask questions and receive answers from the OT. This process should be documented.

As Karen is obtaining the consent on behalf of the students and OT Support Personnel. Upon meeting the client, they should confirm with the client that he/she has previously given consent for the student and OT Support Personnel to work with the client, and undertake to answer any further questions the client may have.

