

# A Guide to the Health Care Consent and Substitute Decisions Legislation for Occupational Therapists



College of Occupational Therapists of Ontario

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***THIS WILL BE YOUR ONLY COPY OF THE COLLEGE'S INTERPRETATION OF THE HEALTH CARE CONSENT ACT AND THE SUBSTITUTE DECISIONS ACT AS IT APPLIES TO OCCUPATIONAL THERAPISTS IN ONTARIO.***

***WE SUGGEST YOU KEEP THIS GUIDE FOR EASY REFERENCE. THE COLLEGE WILL PROVIDE ADDITIONS OR CLARIFICATIONS TO THIS GUIDE AS NECESSARY.***

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## **INTRODUCTION**

On March 29, 1996, the previous Consent to Treatment Act was replaced with the Health Care Consent Act, 1996 (HCCA), the Substitute Decisions Act was amended, and the Advocacy Act was repealed (eliminated).

Occupational therapists have always been accountable for obtaining consent. These new pieces of legislation add legal obligations to the practice of health practitioners. It is important to be familiar with this guide and the fundamental elements which will affect daily practice.

This guide replaces the one published and circulated in April, 1995.

# HEALTH CARE CONSENT ACT, 1996

## Overview

Of the new legislation, The **Health Care Consent Act** (HCCA) is most relevant to the day to day practice of occupational therapists. The principle of informed consent is firmly entrenched in the common law and in occupational therapy models and theories of practice. The HCCA, which is administered by the Ministry of Health, sets out more explicit rules on when consent is required for treatment, admission to a care facility, or seeking personal assistance service.

Major features of the legislation which have implications for occupational therapy practice include:

- individual authority and autonomy is promoted, including ensuring a significant role for family members.
- consent to treatment, consent to admission to a care facility and consent to a personal assistance service are all dealt with separately. All require consent given by a capable person.
- occupational therapists are listed as “evaluators” in the Act.
- consent can be achieved verbally or in writing; it can be expressed or implied.
- a signed consent form does not necessarily mean informed consent has been achieved.
- providing consent is a dynamic action. Consent can be provided or withdrawn at any time in the treatment process. A signed form obtained is not sufficient.
- consent is treatment specific, not global or “blanket” in nature.
- the incapable individual’s best interests are expressed by the substitute decision maker not the practitioner.
- capacity is not determined by age but rather by an ability to understand the decision required.

## OVERVIEW CONT'D...

- incapacity is treatment specific, not global and can change over time.
- there is a clear hierarchy of substitute decision makers.
- advance wishes and directives expressed verbally, in writing or in any form, are now legally recognized. Wishes and directives speak to the substitute decision maker, not the practitioner.
- consent to treatment and assessing the capacity to consent to treatment must relate to a specific treatment or plan of treatment. For example, a person could be capable with respect to one treatment, but not capable with respect to another.

## NEED FOR CONSENT

Occupational therapists are professionally accountable for obtaining consent whether the intervention or service relates to treatment, admission to a facility, or the provision of a personal assistance service. Each circumstance is dealt with differently in the HCCA.

***Consent to Treatment:*** Consent is required for any treatment except treatment provided in certain emergency situations. The health practitioner who proposes the treatment is responsible for taking reasonable steps to ensure that treatment is not administered without consent.

***Consent to Admission to a Care Facility:*** If consent to admission to a care facility is required by law (e.g. under the Nursing Homes Act), consent is needed in all cases except in a crisis situation.

***Consent to Personal Assistance Service:*** The HCCA does not specify that consent to a personal assistance service is required. It does provide, however, that if an evaluator finds a recipient of personal assistance service incapable of giving consent, it may be obtained from a substitute decision maker. Regardless of the lack of specific direction on consent in this section, the College expects that individuals' rights and decisions about personal services will be respected.

# INFORMED CONSENT

Fundamental to the HCCA is the question of whether the individual is capable of providing consent. A health practitioner should presume that a person is capable of making a treatment decision unless, in his or her professional judgement, there is some reason to believe otherwise. Under the *Health Care Consent Act* no health practitioner in Ontario can give treatment without informed consent. The consent must:

- relate to the treatment being proposed,
- be informed,
- be voluntary, and
- not have been obtained through misrepresentation or fraud.

Consent is required for all “treatment” provided by health practitioners except in an emergency situation.

## WHAT IS INFORMED CONSENT?

Informed consent under the Act means that before agreeing to the treatment, the person making the treatment decision receives information that a reasonable person in the same circumstances would require in order to make a decision; and that the person received responses to his or her requests for additional information about matters related to the treatment.

Treatment matters are:

- the nature of the treatment;
- expected benefits of the treatment;
- the material effects, risks and side effects of the treatment;
- alternative courses of action;
- the likely consequences of not having the treatment.

Material effects, risks and side effects are:

- those which are probable or likely to occur;
- those which are possible rather than probable but can have serious consequences;
- and anything else which would be considered relevant to know by a reasonable person in the same circumstances.

## **INFORMED CONSENT CONT'D...**

Consent can be written or oral; expressed or implied. Organizations/agencies may require a written form in specific situations where increased risk to individuals is evident.

An individual is capable of giving informed consent if he or she is able to understand the information that is relevant to making a decision concerning the treatment; and appreciate the reasonably foreseeable consequences of a decision or lack of decision.

### **WHO IS RESPONSIBLE FOR OBTAINING CONSENT?**

The health practitioner who is proposing the treatment is responsible for obtaining informed consent to the proposed treatment. The proposer is the practitioner who:

- has the responsibility for deciding what specific treatment should be offered (this includes implementation of treatment proposed within an identified protocol);
- is able to provide information which a reasonable person needs to give informed consent, and
- is able to answer questions about the information.

One health practitioner can propose a plan of treatment and obtain consent on behalf of all health practitioner involved, if the proposer can address all points raised above with the specific treatment.

In most situations the Occupational Therapist will be the proposer for any occupational therapy treatment. In cases where a specific treatment is a controlled act and has been delegated by another professional (e.g., splinting an unhealed fracture), the occupational therapist may rely on the informed consent having been obtained by the treatment proposer (e.g., the physician). Nevertheless, the occupational therapist should begin the procedure acknowledging the individual's informed consent.

Consent can be withdrawn at anytime by the individual if they are capable or by the individual's substitute decision maker if the individual is incapable.

If consent is withdrawn in midtreatment and immediate withdrawal would be life threatening or pose immediate or serious problems to the health of the individual, the practitioner, with consideration of clinical and ethical factors, may continue treatment until the threat or problem has passed.

## **INFORMED CONSENT CONT'D...**

### **HOW DO I DOCUMENT CONSENT?**

As stated earlier, consent can be written or oral. In most circumstances verbal consent for occupational therapy treatment is sufficient. The occupational therapist is advised to indicate within regular record keeping practices that informed consent was obtained or acknowledged. Where informed consent is not secured, or where consent is withdrawn it is recommended that the occupational therapist record the details of the events leading to the lack of consent.

Occupational therapists are urged to consider those activities within their practice that may be considered areas where potential risk of harm to an individual is evident (e.g., home visit, splint). In such circumstances a written consent form may be of value. A sample has been included as Appendix C.1 for your reference. It is important to keep in mind that a signed form is not singular evidence that informed consent occurred; informed consent as outlined in this section is a process of understanding, not a signed document.

# TREATMENT

"Treatment" is anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose. It includes a course of treatment or a plan of treatment.

According to the regulations under the Act, treatment for purposes of the Act does not include:

- an assessment of a person's capacity to make an informed decision about treatment, admission to a care facility, or personal assistance services;
- assessing the person's capacity to manage property;
- taking a person's health history;
- assessing or examining a person to determine the general nature of a person's condition;
- communicating an assessment or a diagnosis;
- admitting a person to a hospital or other facility;
- a personal assistance service;
- a treatment that in the circumstances poses little or no risk of harm; or
- anything prescribed by the regulations.

Occupational therapy assessments do not require informed consent under the *Health Care Consent Act*. However, occupational therapists should strive to achieve informed consent for all interactions with individuals. For incapable clients those procedures not included under the HCCA do not require consent from a substitute decision maker.

## **MUST CONSENT BE OBTAINED FOR EVERY INDIVIDUAL TREATMENT PROCEDURE?**

Consent can be obtained for a "plan" or "course" of treatment. Where the intervention is a single intervention, however, and not part of a larger "plan" or "course", consent must be obtained separately.

If the occupational therapist is in doubt whether a reasonable person would consider a specific treatment as part of the plan of treatment for which prior consent had been obtained, the practitioner should obtain separate informed consent for the treatment.

## TREATMENT CONT'D...

1. A plan of treatment is one which is developed by one or more health practitioners, dealing with one or more of the health problems that a person has and is likely to have. It provides for the administration of various treatments or courses of treatment. It may include the withholding or withdrawal of treatment in light of the person's current health condition.

Examples include:

- an interdisciplinary care plan for treatment of a hip fracture may include x-rays, surgery, mobilization, prescribing adaptive equipment, and a home visit.
- a plan for occupational therapy treatment might include ADL retraining, cognitive retraining, life skill programming, and a home visit.

2. A course of treatment is a series or sequence of similar treatments administered to a person over a period of time for a particular health problem.

Examples include:

- a work hardening program
- ADL retraining
- splint application and readjustments
- a course of hand therapy
- attendance at a group program

In seeking informed consent for a plan or course of treatment, where the occupational therapist will not be providing the treatment directly, the occupational therapist must clearly indicate who will be providing the treatment (e.g., OTA, registered nurse, RPN, etc.). Informed consent includes consenting not only to the action to be taken, but also to who will carry out the treatment. For occupational therapy intervention, when the occupational therapist is the proposer of the treatment, and where an individual subsequently withdraws consent, the professional assigned to implement the treatment must notify the occupational therapist of the change in consent.

## TREATMENT CONT'D...

### WHEN IS TREATMENT CONSIDERED AN EMERGENCY, AND IS CONSENT STILL NECESSARY?

Treatment in an emergency can be provided immediately if the person is:

- capable of giving consent and provides the consent
- apparently capable but:
  - communication can't take place because of a language barrier or disability;
  - reasonable efforts to overcome the barrier or disability have been made but a delay will prolong the suffering the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and
  - there is no reason to believe the person does not want the treatment.
- incapable with respect to the treatment decision but a substitute decision maker is available to give consent.
- incapable with respect to a treatment, a substitute decision maker is not readily available, it is not reasonably possible to obtain a consent or refusal from the substitute, and a delay will put the person at risk of sustaining bodily harm.

An examination or diagnostics procedure that is a treatment may be conducted without consent if it is reasonably necessary to determine if there is an emergency.

Admission to a care facility without consent may be authorized if :

- the incapable person requires immediate admission as a result of a crisis; and
- it is not reasonably possible to obtain immediate consent or refusal on the incapable person's behalf.

In both cases, reasonable efforts must continue to find a substitute decision maker, and obtain consent or refusal to consent to the treatment or admission.

# ASSESSING CAPACITY

Capacity is defined as the ability of an individual to understand the information that is relevant to making a specific treatment decision; and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

The health practitioner who proposes the treatment is responsible for determining if someone is capable of making a treatment decision. In the case of admission to a care facility or personal assistance service, the Act does not specify which discipline must determine capacity (see glossary for definition of evaluator). The evaluator may be the person proposing the admission or service or may be identified by agency policy.

Health practitioners and evaluators should use professional judgement, taking into account the circumstances and the client's condition, to determine whether the individual has the capacity to understand and appreciate the information relevant to making the decision.

The College suggests the following three step analysis be used by occupational therapists to assist in assessing an individual's capacity.

Step one: When to Assess

The practitioner should presume that a person is capable of making a treatment decision unless - in his or her professional judgement - there is some reason to believe otherwise. Indications which may lead to this belief include, but are not limited to:

- 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 behaviour.

Any one or more than one of these factors may lead to the belief that the person may not be capable of making a decision about the proposed treatment.

The regulation explicitly states that a practitioner should not make any presumption of incapability solely because the person:

- has a diagnoses of a psychiatric or neurological condition;
- is disabled, including a speech or hearing impairment;
- refuses the proposed treatment against advice;
- requests an alternative treatment.

Additionally, there can be no automatic presumption of incapability just because of a person's age.

## Step Two: Understanding the Information

If the practitioner believes the person may not be capable of giving consent, the practitioner must assess whether the person understands:

- the condition for which the treatment is proposed; and
- the nature of the proposed treatment; and
- the risks and benefits of the treatment; and
- the alternative to the treatment, including the alternative of not having the treatment.

## Step Three: Appreciating Consequences

If the practitioner has determined the person is able to understand the information, the practitioner must also assess whether the person is able to appreciate the reasonably foreseeable consequences of a decision. In reaching this decision, the practitioner must be of the opinion that:

- the person is able to acknowledge that the condition may affect him or her; and
- the person is able to assess how the treatments or lack of treatments discussed by the practitioner could affect the person's life or quality of life; and
- the person's choice is not substantially based on a delusional belief.

If the person cannot appreciate any one of these factors, the person is not capable of giving consent.

*Note: If the individual already has a guardian or a validated power of attorney for personal care the determination of capacity is not required. Those individuals have already officially been found to be incapable. See the discussion on Substitute Decision Makers.*

An individual can be capable with respect to some treatments and not others. An individual may be incapable at one time and capable at another time. An individual who regains capacity has the right to again make their own decisions unless their substitute decision maker has a validated power of attorney or is a guardian appointed under the *Substitute Decisions Act*.

## **MUST THE PATIENT BE NOTIFIED OF THEIR INCAPACITY?**

The requirement for formal rights advice under the previous consent legislation has been removed. Health practitioners are now required to follow guidelines issued by their regulatory body when providing information to an individual that the practitioner has found to be incapable of making a decision in relation to a specific treatment, admission or personal assistance.

# PRACTICE GUIDELINE

## *Provision of Information to Clients Found Incapable of Making Treatment, Admission to Care Facilities or Personal Care Decisions*

### **Background:**

The *Health Care Consent Act* (HCCA), 1996 requires health practitioners to comply with guidelines set by their respective College regarding the provision of information to persons found to be incapable of consenting to treatment.

Occupational therapists, when obtaining consent for treatment, must use professional judgement to determine whether the client is able to understand the information provided. The occupational therapist has a professional and legal responsibility to be satisfied that the client is capable of giving consent. These guidelines, developed by the College of Occupational Therapists of Ontario, outline the occupational therapist's role in assisting clients found incapable of making their own decisions related to treatment, and extends the responsibility to provide information, as an evaluator, to clients incapable with respect to admission to a care facility or a personal assistance service.

### **Practice Guideline:**

- 1.0** Upon determining the client is incapable of making a decision related to a proposed occupational therapy treatment, admission to a care facility or personal assistance service, the occupational therapist will:
- determine/identify the substitute decision maker and inform the client;
  - inform the client that the substitute decision maker will make the final decision related to the client's occupational therapy treatment, admission to a care facility or personal assistance service;
  - involve the client in discussions with the substitute decision maker whenever possible;
  - inform the client that a review process is available should he/she be concerned about either the finding of incapacity or the choice of substitute decision maker.

***PRACTICE GUIDELINE CONT'D..***

- 2.0** When the client disagrees either with the finding of incapacity or does not accept the identified substitute decision maker, the occupational therapist will clarify the nature of the client's concerns, inform the client of the therapist's concerns related to the client's capacity for decision making, and inform the client of his/her options to apply to the Consent and Capacity Board for a review of the finding and/or for the appointment of a representative of the client's choice. The occupational therapist will assist the client to exercise his/her options, as necessary.
- 3.0** When the client disagrees with the finding of incapacity or to the identified substitute decision maker when the finding/identification was made by another health care practitioner, the occupational therapist will clarify the nature of the client's concern. The occupational therapist will then inform the health care practitioner who made the finding/identification of the client's concern.
- 4.0** An occupational therapist will not proceed with treatment until a substitute decision maker is identified and consent to the treatment is obtained, and/or a review by the Consent and Capacity Board is complete, unless the treatment is required as part of emergency care. However, if treatment was started in compliance with the HCCA, it may continue, pending the result of a review by the Consent and Capacity Board.

## SUBSTITUTE DECISION MAKERS

When a health care practitioner is proposing a treatment and is of the opinion that the person is not capable of making a decision about the treatment admission to a care facility or personal assistance, consent must be obtained by a substitute decision maker.

The HCCA provides a hierarchy of persons who can provide a substitute consent. Generally, the practitioner must obtain consent from the highest available substitute. Therefore, it is important that practitioners understand the hierarchy. The hierarchy, from highest to lowest, is as follows:

- a. **An official guardian appointed by the court**
- b. **An attorney for personal care**
- c. **Board appointed representative.** An incapable person has the power to apply to the Consent and Capacity Board to appoint a representative to provide consent on his or her behalf. If the Board appoints such a representative, he or she would be next in line to give consent.
- d. **Spouse, partner or relative in the following order**
  - i) **Spouse or partner.** The patient's spouse means a person of the opposite sex to whom the patient is married or to whom the patient is living in a conjugal relationship for at least a year, are together the parents of a child, or have entered into a cohabitation agreement. The individual's partner is a person with whom the individual has lived with for at least one year and where the two have a close personal relationship that is of primary importance in both persons' lives. A partner need not be a sexual partner.
  - ii) **Child, if 16 or over; custodial parent**
  - iii) **Parent who has only a right of access.**
  - iv) **Brother or Sister.** The individual's brother or sister can give consent.
  - v) **Any other relative.** Any other relative of the incapable person can give consent.

The substitute decision maker must be at least sixteen years old unless the substitute is the parent of the individual. The substitute decision maker must also be capable to give a consent.

Practitioners would normally determine who is the highest ranked substitute by asking the people with the individual if they are aware of any higher ranked substitute. Normally, the practitioner can rely upon the answers received unless he or she has a reason to doubt the accuracy of the information. The occupational therapist can always call the office of the Public Guardian and Trustee ((416) 314-2800); 1-800-366-0335; Fax: (416) 314-6190 to verify the registration of a guardian or validate power of attorney if they feel it is appropriate.

Consent must be given by a person. A "living will" or other evidence of the intention of the individual cannot be relied upon by the practitioner directly. Rather, the advance directive gives direction to the substitute decision maker, who will actually make the decision. Substitute decision makers are required to consider the wishes of the individuals, while capable, to the extent that those wishes are known and, failing that, the best interests of the patient.

Where no substitute is available or where two equally ranked substitutes give conflicting instructions, then the Public Guardian and Trustee must make the decision.

The practitioner should obtain consent from the substitute decision maker in the same manner he or she would have obtained information from a capable patient. The practitioner would disclose all relevant information to the substitute decision maker and obtain the substitute decision maker's informed consent or refusal.

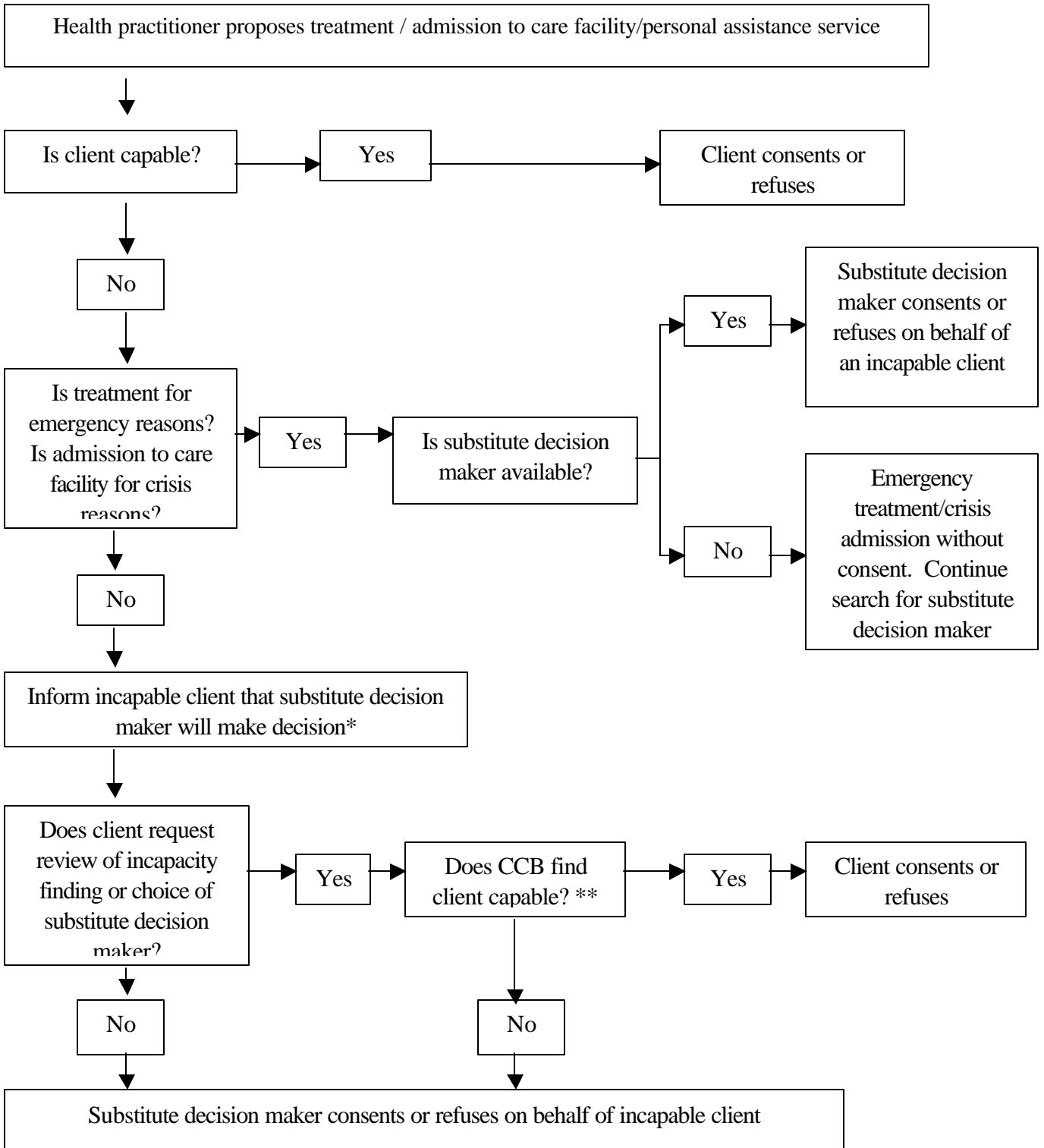
### **WHAT IF IT APPEARS THE SUBSTITUTE IS NOT ACTING APPROPRIATELY ?**

The *Health Care Consent Act* gives little guidance as to what practitioners should do if they are uncertain that a substitute is acting appropriately. With rare exceptions, the practitioner cannot render treatment contrary to the instructions of a substitute decision maker. In essence, the practitioner has two choices.

- (a) The practitioner can inform the substitute of what the substitute's obligations are and try to persuade the substitute to act appropriately.
- (b) If informal discussion fails, the only option for the practitioner in most cases is to notify the Public Guardian and Trustee of the situation.

Practitioners can take some solace in the fact that they are provided statutory protection from legal liability if they act on a consent that they, in good faith, believed on reasonable grounds was sufficient. In particular, practitioners are protected if they rely on a statement given by a family member unless it was not reasonable to do so.

# DECISION TREE FOR OBTAINING CONSENT UNDER THE HEALTH CARE CONSENT ACT



\* See College guideline: *Provision of Information to Clients Found Incapable of Making Treatment, Admission to Care Facilities or Personal Care Decisions* (pp 13-14 of this document).

\*\* CCB – Consent and Capacity Board.

# **SUBSTITUTE DECISIONS ACT (SDA)**

## **Overview**

The Substitute Decision Act deals with decision making about personal care or property on behalf of incapable persons. While the Health Care Consent Act is concerned with the capacity to make decisions in relation to specific treatment, admission to care facilities, or personal assistance services, the SDA is concerned with persons who need decisions made on their behalf on a continuing basis.

The office of the Public Guardian and Trustee (PGT) is the government department which deals with personal care and property matters. Through the PGT, an individual may designate a specific person to make decisions about his or her personal care, or treatment in the event he or she becomes incapable. The person may also express his or her wishes about the kind of decisions to be made, or factors to guide decisions. A power of attorney for personal care or property comes into effect when the person who granted it becomes mentally incapable. There can be more than one power of attorney for personal care, naming different attorneys for different personal care decision making roles. Individuals can also make a special power of attorney in which he or she waives in advance the right to ask for a review of the finding of incapacity, or to object to a treatment. Such a waiver is often called a Ulysses contract and is most often seen in circumstances related to mental health.

Determining capacity under the SDA is a different process than in the HCCA. Only designated capacity assessors may determine capacity for instituting either a power of attorney for personal care or property. The health care practitioners able to apply to be capacity assessors have been designated in regulation - occupational therapists are included, along with nurses, doctors, psychologists and social workers. Designation requires the successful completion of a capacity assessor training program required by the Attorney General. The regulation can be found in Appendix D.

A power of attorney for personal care or property may come into effect if the decision to be made is governed by the HCCA and the individual has been found incapable of making a decision by a practitioner or an evaluator. If the HCCA does not apply to the decision, the power of attorney comes into effect if the attorney has reasonable grounds to believe the person is incapable of making a decision. If the incapacity is to be confirmed, most usually this will be done by a capacity assessor hired specifically to complete a capacity assessment.

## **CONCLUSION**

The *Health Care Consent Act, 1996* and the *Substitute Decisions Act* are complex pieces of legislation. All occupational therapists are strongly encouraged to take the time to develop a working knowledge of this legislation prior to being confronted with complex consent issues in their practice.

## GLOSSARY OF TERMS

Advocates	Help vulnerable people express their wishes and ensure their wishes and rights are upheld.
Attorney	An individual named by a person in a power of attorney for personal care, or a continuing power of attorney for property, to make decisions on his or her behalf, in the event the person becomes incapable. (Note: ‘attorney’ does not mean the person must be a ‘lawyer’.
Capacity	The ability to understand the information that is relevant to making a treatment decision; and appreciate the reasonably foreseeable consequences of a decision or lack of a decision.
Capacity Assessors	Asses a person's mental capacity for making decisions about property or personal care over the long term. - SDA defined.
Care Facility	An approved charitable home for the aged, a home for the aged, a rest home, a nursing home, or a facility prescribed by the regulations.
Consent and Capacity Board	A board established by and accountable to the government. Its members are appointed by the government. The Board considers applications for review of findings of incapacity, applications relating to the appointment of a representative (eg. substitute decision maker), and applications for direction regarding the best interests and wishes of an incapable person.
Continuing Power of Attorney for Property	The same as the power of attorney for personal care, except relating to decisions about property.
Evaluator	A person specified in the HCCA who determines the capacity of a client to make a decision about admission to a care facility or a personal assistance service. Specified persons are: members of the Colleges of Audiology and Speech Language Pathologists, Nurses, Occupational Therapists, Physicians and Surgeons, Physiotherapists, and Psychologists. Others are identified in regulation and include members of the Ontario College of Social Workers & Social Service Workers.

## **GLOSSARY OF TERMS CONT'D...**

Health Practitioner	A person who is a member of a health regulatory college in the HCCA (all regulated health professions except members of the Colleges of Dental Technologists, Opticians, and Pharmacists), naturopaths registered as drugless therapists under the Drugless Practitioners Act, and members of other categories identified by regulation.
Informed Consent	Before agreeing to a proposed treatment the person making the treatment decision receives information that a reasonable person in the same circumstances would want about: <ul style="list-style-type: none"><li>. the nature and purpose of the treatment;</li><li>. the material risks and side effects of the proposed treatment;</li><li>. alternative courses of action;</li><li>. the consequences of not having the treatment;</li></ul> more detailed information about these things is given if requested.
Personal Assistance Service	Assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning, or any other routine activity of living. It may also include a group or plan of personal assistance services.
Power of Attorney for Personal Care	A legal document in which a capable person gives someone else the authority to make decisions about the person's personal care in the event the person becomes incapable. The document could also contain specific instructions about particular treatment decisions.
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 Substitute Decisions Act, 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.
Substitute Decision Makers	Make decisions for someone who is incapable of making their own decisions. 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 or Public Guardian and Trustee Office.

## COMMON QUESTIONS

### WHERE CAN I GET A COPY OF THE ACT?

Copies of the Health Care Consent Act and the Substitute Decisions Act can be ordered directly from Publications Ontario toll free at 1-800-668-9938 or write:

Publications Ontario  
50 Grosvenor Street  
Toronto, Ontario  
M7A 1N8

Legislation can be accessed on-line at:

[http://192.75.156.68/DBLaws/Statutes/English/96h02\\_e.htm](http://192.75.156.68/DBLaws/Statutes/English/96h02_e.htm)

### WHAT DOES BEST INTEREST MEAN?

It is the consideration:

- of the incapable person's values and beliefs, and expressed wishes; and
- whether the treatment will benefit the incapable person.

It is also the substitute decision maker's consideration of whether:

- the incapable person's condition or well-being is likely to be improved by the treatment;
- the person's condition or well-being is likely to improve without treatment;
- the benefit the person is expected to obtain from the treatment outweighs the risk of harm to him or her; or
- a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

## CONSENT FORM

I hereby consent to the following treatment; [describe treatment as specifically as possible but in words that are understandable to lay people]. I have been told about the following:

- what the treatment is;
- who will be providing the treatment;
- the reasons why I should have the treatment;
- the alternatives to having the treatment;
- the important effects, risks, and side-effects of the treatment; and
- what would happen if I do not have the treatment.

I understand the explanation and have no further questions. My consent is voluntary.

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**(witness signature)**

\_\_\_\_\_  
**(signature of client)**

\_\_\_\_\_  
**(print name of witness)**

\_\_\_\_\_  
**(print name of client)**

Application to the Board to Review a  
Finding of Incapacity under subsection  
32(1), 50(1) or 65(1) of the Act.



## FORM A

**My name is:** \_\_\_\_\_ . I apply to the Board for a review of:

- an evaluator's finding that I am incapable with respect to my admission to a care facility.  
 an evaluator's finding that I am incapable with respect to a personal assistance service.  
 a health practitioner's finding that I am incapable with respect to the following treatment,  
 course of treatment or plan of treatment:

\_\_\_\_\_  
 \_\_\_\_\_

**NOTE: AN APPLICATION MAY ONLY BE MADE IF A HEALTH PRACTITIONER OR EVALUATOR HAS MADE A RELEVANT FINDING OF INCAPACITY.**

Please provide the name, address, telephone and fax numbers of the health practitioner or evaluator who made the finding of incapacity: \_\_\_\_\_

\_\_\_\_\_

Are you currently an inpatient or resident at a health or residential facility?

- NO**  
 **YES** Please provide the name, address and telephone number of the facility:

\_\_\_\_\_  
 \_\_\_\_\_

Your home address and telephone number: \_\_\_\_\_

\_\_\_\_\_

Name, address, telephone number and fax number of your lawyer or agent (if any): \_\_\_\_\_

\_\_\_\_\_

If this application refers to admission to a care facility, please provide the name, address, telephone and fax numbers of the person responsible for authorizing admissions to the facility: \_\_\_\_\_

\_\_\_\_\_

If this application refers to a personal assistance service, please provide the name, address, telephone and fax number of the staff member responsible for the service: \_\_\_\_\_

\_\_\_\_\_

If someone helped you to fill out this application form, please provide his/her name, address, telephone and fax numbers:

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**Have you applied to the Board during the past year for a review of a finding regarding your capacity to consent to treatment, admission to a long term care facility or personal care service?**

**NO**

**YES** If known, provide place and date of last hearing:

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**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**SEND THIS FORM BY FAX TO THE REGIONAL OFFICE OF THE BOARD OR CALL  
TOLL FREE: 1 800 461-2036 FOR ASSISTANCE**

Collection of this information is for the purpose of conducting a proceeding before this board. It is collected / used for this purpose under the authority of subsection 32 (1) / 50 (1) / 65 (1) of the *Health Care Consent Act*. For information about collection practices, contact the office of the Regional Vice-Chair of the Board or call toll free at 1 800 461-2036.

### **For Your Information**

**What will happen if I don't apply to the Board?** If you have been found incapable of consenting to a treatment, admission to a long term care facility or a personal assistance service. Someone else will be asked to make the decision for you. This is usually a close family member. If you have a court-appointed guardian or attorney for personal care with the authority to make the decision, that person will make it for you.

**Who may apply to the Board?** Anyone who has been found incapable of consenting to a treatment, admission to a long term care facility or a personal assistance service may apply unless:

- they have either a court-appointed guardian for personal care with the authority to make the required decision, or
- they have signed a special kind of power of attorney for personal care in which they waive their right to apply to the Board and which meets specific procedural requirements found in Section 50 (1) of the Substitute Decisions Act.

**When and Where will the hearing be?** The hearing will be held somewhere close to where you are. It will probably take place within a week after the Board receives your application.

**When will the Board make its decision?** The Board will base its decision on whether or not it believes that you are:  
able to understand the information that is relevant to making a decision concerning the treatment, admission to a long term care facility or personal assistance service, and

- able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

FORM A - PAGE 2

## **REGULATION MADE UNDER THE SUBSTITUTE DECISIONS ACT, 1992**

### **CAPACITY ASSESSMENT**

- 1. (1) A person is qualified to do assessments of capacity if he or she,**
  - (a) is a member of the,**
    - (i) College of Physicians and Surgeons of Ontario,
    - (ii) College of Psychologists of Ontario,
    - (iii) Ontario College of Social Workers & Social Service Workers,
    - (iv) College of Occupational Therapists of Ontario, or
    - (v) College of Nurses of Ontario;
  - (b) has successfully completed a training course for assessors,**
    - (i) given or approved by the Attorney General, as described in section 3, or
    - (ii) given by the Attorney General under Ontario Regulation 29/95 before this Regulation comes into force; and
  - (c) is covered by professional liability insurance of not less than \$1,000,000.00**
- (2) Despite subsection (1), a person is qualified to do assessments of capacity until the earlier of April 2, 1997 and the termination of the person's agreement with Her Majesty the Queen in right of Ontario concerning his or her designation as an assessor if he or she,
  - (a) holds a valid certificate of designation as an assessor that was issued before this Regulation comes into force; and
  - (b) is covered by professional liability insurance of not less than \$1,000,000.00.
2. An assessor shall perform assessments of capacity in accordance with the "Guidelines for Conducting Assessments of Capacity" established by the Attorney General and dated June 7, 1996.

3. The training course required under subclause 1 (1) (b) (i) shall include,
  - (a) instruction in the *Substitute Decisions Act, 1992*;
  - (b) instruction in the procedures established by the Attorney General for the conduct of assessments of capacity, as set out in the guidelines referred to in section 2;
  - (c) instruction in the procedures for determining if a person needs decisions to be made on his or her behalf by a person authorized to do so, as set out in the guidelines referred to in section 2; and
  - (d) an evaluation of the trainee's mastery of the training at the conclusion of the course.
  
4. The following forms provided by the Attorney General are prescribed:
  1. "Form A: Statement of Assessor - Determination of Capacity/Incapacity or Certificate of Incapacity- Property" for the purpose of subsection 9 (3), subsection 16 (3), section 72 or section 73 of the Act, dated May 30, 1996.
  2. "Form B: Statement of Assessor - Determination of Capacity/Incapacity- Personal Care" for the purpose of subsection 49 (2), section 74 or section 75 of the Act, dated March 29, 1996.
  3. "Form C: Assessment Form" for the purpose of subsection 78 (4) of the Act, dated May 30, 1996.
  4. "Form D: Statement of an Assessor Confirming Capacity" for the purpose of paragraph 2 of subsection 50 (1) of the Act, dated March 29, 1996.
  5. "Form E: Statement of an Assessor Confirming Capacity to Revoke a Power of Attorney for Personal Care" for the purpose of subsection 50 (4) of the Act, dated March 29, 1996.
  
5. Ontario Regulation 29/95 is revoked.
  
6. This Regulation comes into force on July 31, 1996.

**CONSENT AND CAPACITY BOARD****www.ccboard.on.ca****REGIONAL OFFICES****(AS AT JUNE 5, 2001)****CHAIR'S OFFICE**

10th Floor  
 151 Bloor Street West  
 Toronto, ON M5S 2T5  
 Phone: ..... (416) 327-4142  
 Fax: ..... (416) 327-4207

**HAMILTON / GUELPH**

Regional Vice-Chair  
 25 Main Street West, Suite 810  
 Hamilton, ON L8P 1H1  
 Phone: ..... (905) 308-9612  
 Fax: ..... (905) 522-4357

**KINGSTON**

Regional Vice-Chair  
 780 Midpark Drive, Suite 102  
 Kingston, ON K7M 7P6  
 Phone: ..... (613) 389-2851  
 Fax: ..... (613) 389-7354

**LONDON**

Regional Vice-Chair  
 300 Dundas Street  
 P.O. Box 3131  
 London, ON N6A 4H9  
 Phone: ..... (519) 438-7811  
 Fax: ..... (519) 660-1525

**NORTH BAY**

Regional Vice-Chair  
 140 Main Street West  
 P.O. Box 97  
 North Bay, ON P1B 8G8  
 Phone: ..... (705) 474-1220  
 Fax: ..... (705) 474-5630

**OTTAWA**

Regional Vice-Chair  
 427 Laurier Avenue W - 9th Floor  
 Ottawa, ON K1R 7Y2  
 Phone: ..... (613) 565-6368  
 Fax: ..... (613) 565-9605

**PENETANGUISHENE**

Regional Vice-Chair  
 34-A Clapperton Street  
 Barrie, ON L4M 3E7  
 Phone: ..... (705) 733-3959  
 Fax: ..... (705) 733-8268

**SUDBURY**

Regional Vice-Chair  
 164 Elm Street  
 Sudbury, ON P3C 1T7  
 Phone: ..... (705) 673-4614  
 Fax: ..... (705) 673-7293

**THUNDER BAY**

Regional Vice-Chair  
 235 Syndicate Avenue South  
 P.O. Box 125  
 Thunder Bay, ON P7E 1E1  
 Phone: ..... (807) 625-0264  
 Fax: ..... (807) 625-0265

**TORONTO**

Regional Vice-Chair  
 10th Floor  
 151 Bloor Street West  
 Toronto ON, M5S 2T5  
 Phone: ..... (416) 924-4961  
 Fax: ..... (416) 924-8873