College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

PREP

Are you PREP'd for Consent and Record Keeping?

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CONTENTS SUMMARY

Introduction

The College of Occupational Therapists of Ontario (the 'College') recently revised its Standards for Consent and Standards for Record Keeping. The updated standards contain several changes. It is the occupational therapist's (OT's) responsibility to review these changes and modify his or her practice to meet the new requirements.

While the overall expectations are consistent with the previous versions, the revised standards reflect evolutions in practice, update the language, clarify expectations and address the gaps that were present in the previous versions.

Standards for Record Keeping has been reorganized to clarify documentation for group interventions, and establish consistent expectations for both electronic and paper documentation. The revised Standards for Consent defines "services" to include assessment, treatment and/or consultation; reviews and addresses common issues that arise with consent in third party referrals and independent evaluations; clarifies the required components of informed consent; and introduces the requirements of knowledgeable consent related to personal health information.

The College's standards of practice describe the acceptable level of performance for an OT practising in Ontario. However, use your clinical judgement to determine how best to obtain consent and document an intervention. Every practice setting, client population and stakeholder has different characteristics that affect your judgement and practice; you are expected to be able to apply the standards differently if the situation requires it.

In some practice settings, certain performance indicators will be less relevant because of client factors and the environment, and you may determine that you will not perform all of the behaviours outlined in the standards. It is expected that an OT can provide reasonable rationale for any variation from the standards and be able to demonstrate all performance indicators and behaviours, if required.

Consent and all manners of occupational therapy service need to be documented in a clear, transparent way. Documentation is a health professional's way of indicating what was and was not done. It's a way to ensure client safety and to protect your practice from complaint.

Exploring the Consent-Documentation Relationship

OTs in both clinical and non-clinical practice raise questions that probe the relationship between obtaining consent and record keeping.

If you have a clinical practice, you may ask:

- Is the client capable of providing consent?
- If not capable, how do I document incapacity?
- Who is the substitute decision-maker (SDM) and how do I identify him or her?
- What information about conversations with the SDM must be included in the client chart?
- What and how much information needs to be shared with a client or SDM to ensure that he or she is adequately informed to provide consent?

- What aspects of my interventions need to be recorded in the client chart?
- How should I manage the withdrawal of consent?
- How do I document withdrawal?

In non-clinical roles, OTs need to set policies and procedures for determining client capacity, obtaining informed consent and record keeping. If you practise in an administrative role, for example, you may ask:

- Is a form sufficient for obtaining and documenting informed consent?
- How can OTs document more efficiently?
- Can an electronic documentation system comply with the "lock-box" requirements?
- How can complaints and near-misses be decreased?
- Can risks be reduced when OTs perform activities such as acupuncture, psychotherapy and splinting, and while performing assessments for falls risk, capacity/cognition and driving?

The *Health Care Consent Act, 1996* (HCCA) is the legislation that directs all health care providers through the consent process. It, along with the profession's standards of practice, forms the basis for the College's Standards for Consent. The legislation states:

A consent to treatment is informed if, before giving it,

a. the person received the information that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
b. the person received responses to his or her requests for additional information about those matters. (1996, c. 2, Sched. A, s. 11 (2)).

Consent is informed if the information received includes:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. (1996, c. 2, Sched. A, s. 11 (3)).

A risk is deemed "material when a reasonable person, in the client's position, would find that information important when making decisions about medical treatment.

The *Personal Health Information Protection Act, 2004* (PHIPA) is the legislation that directs all health care providers in the management of personal health information. It describes the responsibilities of health information custodians and agents for the collection, use and disclosure of personal health information. The legislation states:

A consent to the collection, use or disclosure of personal health information about an individual is knowledgeable if it is reasonable in the circumstances to believe that the individual knows:

a. the purposes of the collection, use or disclosure, as the case may be; and
b. that the individual may give or withhold consent. (PHIPA, 2004, c. 3, Sched. A, s. 18 (5)).

This Prescribed Regulatory Education Program (PREP) module uses scenarios to demonstrate how to apply the Standards for Consent and Standards for Record Keeping. The module intersperses the reflection scenarios, answers and rationales with the core content to be consistent with adult learning principles and engage OTs in self-directed learning.

The module provides additional information to help you make decisions and respond to the questions that follow the scenarios. You are encouraged to review all of the relevant information before proceeding to the next scenario; the information will help you to answer the questions that will be asked later in the module.

Learning Objectives

When you have completed this module, you will be able to:

1. Understand the interaction between record keeping and consent in occupational therapy practice.
2. Demonstrate knowledge of relevant legislation and standards for occupational therapy practice.
3. Recognize ethical issues that appear in practice and apply a decision-making process to address them.
4. Relate the standards to a variety of settings, including your own.

Scenario #1: Determining capacity and obtaining consent

You practise in a hospital's acute care stroke unit. Your client, Mr. Joshi, has had a stroke affecting his middle cerebral artery, causing aphasia. He is able to nod his head to indicate "yes" or "no." You have received a doctor's order for the "occupational therapist to assess and treat." You plan on seeing Mr. Joshi to obtain informed consent.

> To obtain informed consent, you are expected to adhere to the HCCA and the College's standards of practice and obtain consent in all circumstances when providing services, including assessments, treatments and consultations.
>
> Consent is an ongoing process between the OT and client. The dialogue about consent provides opportunities for the client to ask questions; discuss the purpose of the intervention as well as its risks and benefits; and explore alternative options.
>
> The first step in obtaining consent is to determine the client's capacity. OTs are expected to determine if the client is able to understand the information that's relevant to making a decision about the intervention and able to appreciate the reasonably foreseeable consequences of that decision.
>
> The use and signing of a consent form by itself is insufficient for gaining consent. Informed consent is a process that allows the client to think about the intervention before it takes place. However, the client's signature on a form may act as evidence that the consent process has taken place.

Before you proceed to obtain consent, consider Mr. Joshi's capacity to provide consent to participate in the assessment. (See Appendix 1: Decision Tree for Obtaining Consent.) He has had a stroke that has limited his communication abilities. You may want to explore how Mr. Joshi can express himself by:

- Asking open-ended questions
- Providing a picture board so he can point to various images to express himself
- Alternating between “yes” and “no” questions to ensure that he is not just nodding his head when answering questions
- Providing him with an opportunity to write his responses
- Reviewing previous interprofessional documentation and trying the techniques that other team members have used.

If you deem a client incapable of making a decision, then consent must be obtained from a Substitute Decision-Maker (SDM). The SDM must be capable of giving consent and at least 16 years old (unless he or she is a parent of the client). The HCCA lists the hierarchy of SDMs. (See Appendix 2: The Hierarchy of Substitute Decision-Makers or visit www.ontario.ca/laws/statute/96h02.)

In this scenario, you would check the client record to review the list of personal contacts and determine if anyone has been appointed a power of attorney (POA). If there is no POA, refer to the SDM hierarchy.

If Mr. Joshi doesn’t have a guardian, POA or representative appointed by a Consent and Capacity Board, you would determine if he has a spouse, which is next on the SDM hierarchy list. If he doesn’t have a spouse, you would continue down the SDM hierarchy list. After establishing the SDM, you inform Mr. Joshi that the SDM has been identified and will be involved in his care. Then, you would contact the SDM to ask if he or she is available and willing to make decisions on behalf of the client. Occasionally a person who is higher in the hierarchy is not available or willing to provide consent or a person who is lower in the hierarchy is present and assures the OT that no one who is higher on the list would wish to give consent. In those circumstances, an OT can obtain consent from someone who is not the highest in the hierarchy.

From Mr. Joshi’s chart, you determine that he is married. The client record also states that he is on a stroke pathway. The goal for functional mobility is to sit at the edge of the bed for five minutes. As he is currently immobile and may require two people to sit him at the edge of the bed, you plan to see him in the morning with the unit’s physiotherapist (PT), Kyle.

The next day, you and Kyle knock on Mr. Joshi’s door and enter his room. Mr. Joshi is awake and in an upright position in bed, and his wife is present. You introduce yourself to both Mr. and Mrs. Joshi and state that you are an occupational therapist. You say that you are aware that he has had a stroke and is having difficulties with speaking and moving. You ask Mr. Joshi to nod his head “yes” if he understands; he nods “yes.”

You explain the role of occupational therapy and the assessment process, as well as the risks and benefits of participating in the assessment. Then, you tell Mr. Joshi what you would like to accomplish with him today: have him sit on the edge of the bed for five minutes.

You ask Mr. Joshi if he has any questions; he nods “no.” You ask if it’s OK to proceed with the assessment, and he nods “yes.” You explain that you will need to obtain information about his prior level of functioning and ask him if you can speak to his wife to obtain this information. He nods “yes.”

Kyle then follows the same process to obtain consent for his physiotherapy assessment.

Have you adequately assessed Mr. Joshi’s capacity? The answer is no.

Question: What was required to obtain informed consent but was missed?

a. A review of the alternative services that are available
b. A thorough assessment of capacity
c. Consent to share information with members of the circle of care
d. A review of the funding sources covering your services
e. All of the above

The best answer is (b).

Mr. Joshi has had a stroke and is experiencing difficulty speaking, but you have only asked him closed-ended questions. By answering this type of question it would be difficult to know if he understands the information and appreciates the consequences of receiving an occupational therapy assessment.

To demonstrate understanding, Mr. Joshi needs to remember the information that you provided him. To appreciate the consequences, he needs to be able to weigh the importance of this information in relation to his life circumstances.

A complete assessment would involve collecting as much information as possible about the client. You could have asked Mrs. Joshi what strategies she has used to communicate with her husband since the stroke, and her perception of his current cognitive status. Other strategies may include the use of a picture board, letting Mr. Joshi write his responses (if he is able) and asking open-ended questions.

A review of alternative services may or may not be required.

While it is not essential that you obtain consent to disclose information to members within the circle of care, it may be best practice to do so.

You and Kyle work with Mr. Joshi and sit him at the edge of the bed, supported, for five minutes and then return him to his upright position in bed. You also check his muscle strength and sensation. You speak to his wife to obtain information about his previous functioning at home. You inquire about his cognition and if she has noticed any changes since the stroke. Mrs. Joshi explains that she has not identified changes to his cognition, only to his ability to speak. You and Kyle thank Mr. and Mrs. Joshi and explain that you will return the next day to help him stand at the edge of the bed.

Informed consent is an ongoing process that is to take place throughout the entirety of the service provision. A client's capacity may fluctuate; that is, a client can be capable of consenting to an intervention at one point but not at another. Therefore, OTs are expected to obtain informed consent on an ongoing basis for each component of the intervention. Also, a client or SDM can withdraw consent at any time.

OTs need to seek consent for providing assessment and treatment, any changes in the service plan, the need to share information with others and anything that was not included in the initial consent discussion. (See Standards for Consent, Standard 3.)

Scenario #2: Interprofessional Collaboration

Continuing on from Scenario #1, Mr. Joshi has been on the unit for a week and you have confirmed he is capable of providing consent for OT services. Kyle, the physiotherapist, and you discuss the use of support personnel (SP) to assist Mr. Joshi in achieving his goals. Supervised by OTs, SPs can perform activities that are part of the overall occupational therapy service. SPs may or may not be regulated by a college, and are referred to by a variety of titles including rehabilitation therapist and occupational therapist assistant. Student OTs and volunteers are not considered SPs. When a SP is working under the direction of an OT, the OT is accountable for the overall quality and standard of care.

You visit Mr. Joshi to explain the role of the SP and ask for his consent for John, an SP, to be part of the treatment plan and work with him on his goals. Mr. Joshi nods "yes" to confirm his consent.

It is your responsibility to oversee the occupational therapy components that you assign to John. You need to ensure that John is competent in the tasks that you assign him. Document the occupational therapy components you assign and the frequency that John is to meet with Mr. Joshi. Monitor Mr. Joshi's progress and response to the components that John is providing. You, not John, are responsible for making recommendations and forming opinions on the therapy.

Regularly reading the chart entries that John has made to confirm that the initial expectations are being met is another responsibility for the OT. You are also responsible for overseeing the quality and quantity of John's work. Put a process in place for when you are away by making another OT aware of your role in supervising the SP.

In the client record, you complete the OT portions on the Interdisciplinary Stroke Initial Assessment form. You place a check mark in the box that states "informed consent obtained."

You assign the task of standing for five minutes to John and sign the form with your name and designation, and the date. As you follow the set stroke care pathway, you place your initials beside the goal for functional mobility. You sign the signature page with your full name and designation. Kyle also places his initials beside the goal for functional mobility, and signs the signature page with his full name and designation.

In filling out the Interdisciplinary Stroke Initial Assessment form and other interprofessional forms, the questions you need to answer include:

- Does the format of the form separate accountability for each discipline?
- Does the form meet the College's requirements specified in the Standards for Record Keeping?

A combined form should clearly identify the sections that are relevant to each discipline; this can be accomplished by incorporating defined headings. Use of the form should be part of new staff orientation, and existing staff should be provided with an education session on how to use the form.

In this case, you complete the OT portions on the form, and Kyle documents in the PT portions. If sections such as "Client issues" and "Discharge plans" have shared accountabilities or individual sections are not possible, there could be a comment section at the end of the entry that allows each clinician to document the part(s) that he or she completed and thus what his or her accountabilities include.

You indicated a check mark for "informed consent obtained." Is this sufficient documentation? The answer is maybe.

Question: When would this check mark be sufficient documentation?

a. When there is a signed consent form that is also stored in the client record
b. When the SDM provides consent for your intervention
c. When there is a policy or procedure in place describing the informed consent process that corresponds with the use of the check mark.
d. When the client's or SDM's initials appear beside the check mark

The best answer is (c).

Other people reading the chart may find it challenging to know what was discussed when informed consent was obtained. If the OT is called into question, he or she should be able to confirm that the informed consent process has taken place.

Organizations may have a consent process or policy that the OT must follow to mark a check mark and the process may be referenced by a title or number within the client record.

As previously discussed, a consent form does not substitute for the informed consent process, which must include a two-way dialogue. Any discussion, questions or exceptions to the consent need to be documented. When an SDM is required, consent needs to be complete and transparent, and documentation should be consistent with that used when obtaining consent from a capable client.

College Standards to Reference

- Standards for Consent
- Standards for Record Keeping
- Standards for the Supervision of Support Personnel
- Standards for Occupational Therapy Assessments

Relevant Legislation

- *Health Care Consent Act, 1996* (HCCA): covers capacity, informed consent, SDMs
- *Substitute Decisions Act, 1992*: covers power of attorney for personal care
- *Personal Health Information Protection Act, 2004* (PHIPA): covers sharing of information, circle of care

Scenario #3: Substitute Decision-Makers, the Public Guardian and Trustee, and Power of Attorney

Ms. Hsu lives in a residential care facility but was recently admitted to the hospital after falling and sustaining a hip fracture. As the hospital Community Care Access Centre (CCAC) care coordinator, you are asked to assess Ms. Hsu and determine if she is able to return to her residence. Ms. Hsu has moderate cognitive impairments, and through a brief cognitive assessment you determine that she is currently unable to provide consent for an assessment and recommendations. You need to determine who to contact.

You consult the HCCA to check the order in which to select the appropriate decision-maker. You then refer to PHIPA that indicates if an individual is determined incapable of consenting to the collection, use or disclosure of personal health information by a health information custodian (HIC) or his or her agent (in this case you), one of the following people may give, withhold or withdraw consent on the individual's behalf and in the place of the individual:

1. The individual's guardian
2. The individual appointed as attorney for personal care or attorney for property
3. The individual's representative appointed by the Consent and Capacity Board
4. The individual's spouse or partner
5. A child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in place of the parent. This does not include a parent who only has right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, #5 does not include the parent.
6. A parent of the individual who only has a right of access
7. A brother or sister of the individual
8. Any other relative of the individual

Attorney for personal care: The individual(s) appointed to make decisions related to personal care, such as housing and health care. A legal document called the Power of Attorney for Personal care indicates this individual(s).

Attorney for property: The individual(s) appointed to make decisions relating to financial affairs. A legal document called the Power of Attorney for Property indicates this individual(s). It allows this person to act for an individual even if the individual becomes mentally incapable.

If Ms. Hsu has an attorney for property or personal care, or a competent spouse or partner, you would approach him or her first. Ms. Hsu, however, does not have a power of attorney or spouse. She does, though, have four children who equally share in the decision-making duties for their mother. The children have all provided informed consent for the OT assessment. You have proceeded to complete the assessment and determined Ms. Hsu's functional needs and indicate that her care needs have increased significantly; she is now dependent for all self-care activities including transfers, dressing, bathing, eating and ambulation.

You bring the four children together for a case conference to discuss their mother's increased needs. You ask them if they would like their mother to go to her previous residential care facility or a facility with a higher level of care. You describe the pros and cons of each facility and stress the importance of considering Ms. Hsu's safety. The children are unable to agree on a discharge plan.

You offer to gather additional information for the children and meet with them again tomorrow. This is an atypical situation, and you want to discuss the difficulties with your manager, Philip, but wonder if you are able to share the details with him. Does Philip fall within the circle of care? Do you need consent to share information with your manager?

"Circle of care" is defined as the ability of certain Health Information Custodians (HICs) to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in the *Personal Health Information Protection Act, 2004* (PHIPA). Six criteria must be met to assume implied consent for sharing information.

For more information, visit www.ipc.on.ca/wp-content/uploads/Resources/circle-of-care.pdf

According to the definition of circle of care, you would be able to speak with your manager without consent because the manager falls within the description of a health practitioner within a hospital, and the information being shared was provided by the client and the SDMs, for the purposes of health care provision. Also, it was collected, used and disclosed within the purposes intended; that is, to assess Ms. Hsu's needs and arrange discharge planning. Although you are not required to get consent from the client or SDM to share information with your manager in this scenario, you could ask for consent if you are concerned.

You discuss the case with Philip who agrees to attend the next family conference. At the meeting, you present the additional information regarding your recommendation to discharge Ms. Hsu to a facility with a higher level of care supports. The children discuss the issue and only three of the children agree to the recommendations. You inform the children that they can appoint one SDM to represent them. The children discuss the options and decide to appoint one person among themselves to make the decision.

Question: What criteria must you meet to involve the Public Guardian and Trustee? Select all that apply.

a. You don't know how to identify the SDM
b. There is disagreement among equally ranked decision-makers that cannot be resolved
c. You have reason to believe the SDM is not acting in the best interests of the client
d. There is no SDM or other contact identified in the client chart

The best answers are (b) and (c).

When equally ranked decision-makers cannot agree on a decision or when an SDM is not acting in the best interests of the individual, it may be appropriate to contact the Public Guardian and Trustee. The HCCA states:

> In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration:
>
> a. the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
> b. any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed (that was expressed when the individual was competent); and
> c. the following factors:
> 1. Whether admission to the care facility is likely to,
> i. improve the quality of the incapable person's life,
> ii. prevent the quality of the incapable person's life from deteriorating, or
> iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.
> 2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.
> 3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.
> 4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances. (HCCA, 1996, c. 2, Sched. A, s. 42 (2)).

Options a) and d) are not the best answers because the hierarchy of decision-makers already exists and would assist you to identify the apporpriate SDM. The Public Guardian and Trustee would not be the most approprioate resource to access this information.

Throughout the process, you document all information with respect to the assessment findings and recommendations, discussions at the family conferences, the information shared with the family, your discussion with Philip and the outcomes. You document that consent was obtained initially, prior to assessment, and throughout the process. As well, you document consent to share information with the facility where Ms. Hsu will be discharged.

Scenario #4: Health Information Custodian or Agent?

This scenario looks at a situation through two different lenses. As you read through the scenario, consider the responsibilities of the OT as an HIC and then as an agent to the HIC.

Definition of Health Information Custodian (HIC)

An HIC is a person or organization who has custody or control of personal health information as a result of or in connection with performing their duties. May include:

1. A health care practitioner or a person who operates a group practice of health care practitioners; for example, a doctor's office.
2. A service provider who provides a community service; for example, VHA, St. Elizabeth, ComCare.
3. A community care access corporation; for example, CCAC.
4. A person who operates one of the following facilities, programs or services:
   i. A hospital, a private hospital, a psychiatric facility, or an independent health facility.
   ii. A long-term care home, a placement coordinator who determines eligibility for long-term care residency, or a care home.
      ii.1. a retirement home
   iii. A pharmacy.
   iv. A laboratory or a specimen collection centre.
   v. An ambulance service.
   vi. A home for special care.
   vii. A centre, program or service for community health or mental health whose primary purpose is the provision of health care.
5. An evaluator within the meaning of the HCCA or an assessor within the meaning of the *Substitute Decisions Act, 1992.*
6. A medical officer of health of a board of health.
7. The Minister, together with the Ministry of the Minister.
8. Any other person prescribed as an HIC if the person has custody or control of personal health information as a result of or in connection with performing prescribed powers, duties or work. (PHIPA, Part 1, s. 3. (1)).

Definition of Agent

A person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated (for example a therapist in a hospital) (PHIPA, Part 1, s. 2).

Situation #1

You are an OT who works with Tiger Therapy Services as a self-employed contractor. You practise in the School Health Support Services program, providing fee-for-service consultations to children aged four to 18. You are responsible for maintaining electronic client records that are turned over to Tiger Therapy Services within seven days after a child has been discharged. A teacher tells you that the father of a client you discharged one month ago, Cameron, wants a copy of the occupational therapy chart. Cameron's parents are divorced, and the father has "right of access" only and is not the legal guardian.

Question: Can you provide the record directly to Cameron's father?

a. No, the father is not the child's legal guardian, therefore he cannot access the information
b. Yes, as long as the mother has the right to access information about the health and/or education of his child
c. Yes, the father has the right to access the information
d. No, you must direct the father to Tiger Therapy because the organization has custody and control over the record as the health information custodian

The best answer is (d).

You are an agent of Tiger Therapy Services and must follow their procedures to access information.

Continue to Situation #2 to determine how the remaining options may be relevant if you are the HIC instead of the agent.

Situation #2

Now imagine that you are an employee of the school board. The school board falls under the *Education Act, 1990*, which primarily focuses on the privacy of personal information, such as names, birth dates, telephone numbers, addresses and education history.

Section 2 of the *Freedom of Information and Protection of Privacy Act, 1990* (FIPPA) identifies the information that falls within a school board's protection. In this scenario, you would be the HIC because the school board does not meet the HIC requirements.

You identify that the father has "right of access" and consider the legislation that may apply, including the provincial *Children's Law Reform Act, 1990* (section 20(5)) and federal *Divorce Act, 1985* (section 16(5)), which states that "Unless the court orders otherwise, a spouse who is granted access to a child of the marriage has the right to make inquiries, and to be given information, as to the health, education and welfare of the child." You understand that this access to information is different from the father providing consent for services as the custodial parent (in this case the mother) is ranked higher on the hierarchy of substitute decision-makers and would need to be contacted for the purpose of obtaining informed consent for assessment or treatment.

You realize that the father would also have access to Cameron's Ontario School Record (OSR). If your report was placed in the OSR, the father could access it through the school. The *Education Act, 1990* refers to the child's

personal information contained in the OSR and states that "A pupil, and his or her parent or guardian where the pupil is a minor, is entitled to examine the record of such pupil." (*Revised Statutes of Ontario*, 1990, c. E.2, s. 266 (3)).

You determine that you can provide the report to the father but ask him to put the request in writing so you can keep it in Cameron's record. You arrange a time to sit with the father as he reviews the record so you can answer any questions he may have.

At the school board, you may decide to discuss the HIC record management responsibilities with your occupational therapy co-workers. If you decide to share these responsibilities, identify one person as the privacy officer. The privacy officer will have several responsibilities including arranging for secure storage space for the client records (both active and discharged), maintaining client records for the minimum required time (in paediatrics it's 10 years past the date when the child does or would have turned 18 years of age) and ensuring that these records are secure. When the time limit is reached, the privacy officer is responsible for the proper destruction of the records.

For more information, refer to the Ontario Information and Privacy Commissioner's *Guide to Ontario Legislation Covering the Release of Students' Personal Information* at www.ipc.on.ca/wp-content/uploads/2003/07/educate-e.pdf.

Scenario #5: Changing Capacity

Zena, 34, is on a *Mental Health Act* Form 1 and admitted to the hospital after experiencing a traumatic family event and attempting to exit a car that a friend was driving on a busy highway. Diagnosed with paranoid schizophrenia at age 19, Zena has been in and out of hospital for most of her adult life. Zena states that she is well enough to return home and expresses concern that she may lose her part-time job at a thrift store if she remains in the hospital.

Zena lives alone. The Assertive Community Treatment (ACT) team is concerned that if she is discharged to her current home she will return to engaging in recreational drug use. The social worker has obtained information that Zena is at risk for eviction because she is significantly behind in her rent payments and has hoarding behaviours. The ACT team feels Zena would benefit from a more supportive home environment. During team rounds in which Zena's medical record is reviewed, it's noted that Zena has been threatening other clients on the unit. On the unit she has been uncooperative with medication, hygiene and social activities, and her capacity and judgement is being questioned. At times, Zena is able to make simple decisions, but she has difficulty understanding and appreciating complex questions related to safety risks.

A **Form 1** is a legal document that a doctor signs which can require an individual to stay in a psychiatric hospital for up to 72 hours.

www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-6427-41~1/$File/6427-41_.pdf

You are asked to assess Zena's cognition and ability to manage her activities of daily living (ADLs) and instrumental activities of daily activities (IADLs). Zena refuses to participate in the occupational therapy assessment. You continue to attempt to engage Zena in conversation but she refuses to maintain eye contact and demands that she speak to a lawyer. The team is eager to start discharge planning and encourages you to keep trying to assess Zena.

You know that you need to determine if Zena is capable of consenting to your services, including assessing her cognitive abilities. The HCCA sets out principles for consent to treatment and, except in an emergency, you must obtain informed client consent for any assessment or treatment.

Before determining capacity, consider factors that may affect capacity; for example, physical, psychological and environmental conditions such as depression, pain and anxiety. You may consider if Zena's capacity is affected by conditions such as mental disorders, neurological disorders, metabolic impairments, head trauma, medications, substance abuse, and/or an emotional or physical crisis. In some situations, these conditions may produce a substantial impairment of capacity and affect the individual's understanding of the required elements of informed consent.

If a client makes an ill-advised decision or begins to act out of character, it does not prove incapacity. Client-centred practice and respect for client autonomy recognizes an individual's right to make decisions that others might view as ill-advised or irrational.

Use your clinical judgement. Explore any conditions or behaviours – such as confused and irrational thinking, the inability to retain information, and fluctuating wishes and alertness – that give rise to doubts about the client's ability to understand and appreciate the consequences of treatment or lack of treatment.

Capacity focuses on the ability to understand and appreciate the consequences of a decision or lack of decision. If a client is passive, it does not mean that he or she understands and appreciates the decision that is being made, and the OT must not presume that the person is capable. Similarly, passivity does not mean that the client is incapable.

As the health professional proposing the treatment, you need to decide whether Zena has the capacity to consent. You need to determine if she can appreciate the risks and benefits of the assessment, and the risk of not participating in the assessment. Zena tells you, "I don't want to see you, I don't want your stupid assessment, but the doctor says if I don't, he won't let me go home."

You are unable to proceed with the assessment or treatment if the client is refusing; however, Zena needs sufficient information to determine if she will participate. Zena and you should review what is involved in the assessment, including what the risks and benefits are, and how and by whom the assessment results will be used. You indicate that you will return tomorrow. Then, document the outcome of this discussion. Coercion is not permitted and would be cause for concern.

The HCCA clearly outlines the requirement to obtain informed consent before providing service. It states:

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

    a. he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
    b. he or she is of the opinion that the person is incapable with respect to the treatment, and the person's SDM has given consent on the person's behalf in accordance with this Act. (HCCA 1996, c. 2, Sched. A, s. 10 (1)).

You review Zena's medical history and clinical notes and note that she has been deemed incapable to make health care decisions on previous admissions. Does this mean that Zena is currently incapable of providing consent? No. OTs should not make assumptions about capacity based on previous assessments.

Capacity relates to a specific assessment or intervention. One health practitioner may find a client incapable of consenting to an intervention that he or she is proposing, but another practitioner may deem the client capable of consenting to the assessment that he or she is suggesting. It is the responsibility of the OT proposing the intervention to decide if the client has the capacity to consent to that particular intervention.

> You need to ensure that the client understands the implications of an assessment, how the information will be used and the risks of not participating, as well as appreciates the reasonable, foreseeable consequences of a decision or lack of decision; do not presume that a person understands and appreciates what is being explained.

During the morning team rounds, the nurse practitioner reports that Zena has been disruptive during the nights. She has been screaming and banging on the radiator, refusing to stop at the request of staff. Zena, though, reports that she is managing well and does not need to be in the hospital. She states that she wants to go home and is being held against her wishes.

The team wonders about Zena's fluctuating capacity and cognition. You go to speak with Zena again to obtain consent to proceed with the assessment. When you enter the room, you observe Zena in bed conversing with herself. When Zena sees you, she turns her back to you and clearly states that she is not participating in occupational therapy. Then, she continues to speak to herself.

You note that at times Zena's thought processes are coherent and clear. As capacity is treatment specific and can change over time, fluctuating cognitive status may allow for intact moments in which a client may have the capacity to consent to a specific health care treatment. The client may be able to make a simple, uncomplicated decision but unable to make a more difficult decision that has implications for safety and/or has significant consequences.

You consider administering standardized assessments to measure cognition and, if necessary, referring Zena to a psychiatrist or psychologist for a second opinion. You may consider assessing capacity over a period of time, and reconfirm capacity if there is the potential for further cognitive recovery between assessments. At this point, you may use your clinical judgement to identify that Zena is not medically stable and bring this finding back to the team to determine next steps. If she is medically stable there are two options: you can conclude that Zena is capable or incapable of providing consent.

Option #1: Concluding that Zena is Capable of Consent

You explain to Zena that the purpose of your visit is to speak with her about how she was managing at home. Since Zena seems to be responding appropriately to you and says "OK," you decide to move forward with gaining consent for the occupational therapy assessment. You understand that consent must be specific to the treatment or service, and that it must not be obtained through misinterpretation or fraud. Be clear and explicit in your communication about how the service or assessment is conducted and how the information is gathered to come to a conclusion and make recommendations.

Obtaining verbal consent can be as simple as the client stating his or her agreement; for example, saying "OK" or "Let's proceed." If the presumption is that the client is capable, the client's decision must be respected. Document that the proposed occupational therapy service was explained to the client and the outcome of the discussion. Then, date and sign the note.

If the client has capacity but does not provide consent, the OT must respect the client's informed decision. The OT will ensure that the client understands the right to withdraw consent as well as the implications of withdrawing consent. Document that the client has not provided consent and the reason why the client is withholding or withdrawing consent. If the client is not deemed capable of withdrawing consent, then discuss the treatment plan with the SDM and ask him or her for consent.

Option #2: Concluding that Zena is Incapable of Consent

If you believe that Zena is not capable of providing consent, you must advise Zena of the finding of incapacity and her right to a review of this finding. Document that the proposed occupational therapy service was explained to the client and the outcome of the discussion. Also, record any unusual circumstances; for example, communication barriers and how they were managed, and stipulations or restrictions the client placed in relation to the consent for assessment or treatment. Then, date and sign the note.

Since you have deemed Zena incapable at this time, you must seek an SDM. You consult with the health care team about your finding of incapacity. The ACT team reports that Zena has one sibling, Gayle, who lives in New Brunswick. When you contact Gayle, she reports that Zena has been estranged from her for years and that she does not wish to be her sister's SDM.

In this situation, you consult the hierarchy of SDMs in the HCCA and identify that the next appropriate SDM is the Public Guardian and Trustee (PGT). Any health professional may contact the PGT to report that he or she believes that an incapable adult's interests are in need of protection.

> The best interests of the client are not to be confused with the client's cognitive capacity. Occasionally, the court will order the PGT to make decisions of a personal nature for an incapable person to protect him or her from extreme physical risk. In this role, the PGT will typically also be responsible for making decisions about health care, place of residence, nutrition, hygiene and clothing. The PGT also manages the financial affairs of incapable people who have no one else authorized to do so.

Question: What would you do if Zena challenges your determination of incapacity?

a. Re-assess her on another day
b. Contact the Consent and Capacity Board (CCB)
c. Contact the ACT team social worker to re-assess Zena's capacity
d. Proceed with your intervention since you have the PGT in place

The best answer is (b).

If Zena does not agree with your finding of incapacity, the CCB is responsible for deciding whether Zena is or is not incapable. An OT, client or SDM may apply to the CCB when a decision relating to a client's consent or capacity needs to be made.

While (a) and (c) may be possible, these options would not be acting in Zena's best interests because they would delay the intervention. (D) is not the best answer because Zena has the right to appeal your determination of incapacity.

College Standards to Reference

- Standards for Consent
- Standards for Record Keeping

Relevant Legislation

- *Mental Health Act, 1990*
- *Health Care Consent Act, 1996* (HCCA): covers capacity, informed consent, SDMs
- *Substitute Decisions Act, 1992*: covers power of attorney for personal care

Scenario #6: Third-Party Consent

Mia, a 72-year-old retired social worker, had a major fall while walking her dogs. She tells her family doctor that she is having difficulty managing with her self-care tasks and the steps into her home. The family doctor suggests a referral for an OT to visit Mia in her home. Mia tells her doctor that she has excellent health care benefits with Goodwill Insurance and that occupational therapy services are covered. When Mia had a previous slip-and-fall accident, Goodwill covered all of her rehabilitation services.

The Goodwill Insurance intake coordinator explains to Mia that occupational therapy services are covered under her plan. Mia is told that she is entitled to an initial occupational therapy assessment and may be approved for up to three additional treatment sessions. The intake coordinator asks Mia for her consent for an occupational therapy assessment. Mia agrees. The intake coordinator tells Mia that the preferred vendor for occupational therapy services is 123 Rehab and that an OT will contact her shortly to schedule the assessment.

You are an OT who works as an independent contractor for 123 Rehab. You receive and review the referral and see that the client has consented to an occupational therapy in-home safety assessment. You contact Mia and schedule an assessment for the following week. Goodwill Insurance faxes the referral to you and a few reports related to the client's current hospitalization as a result of the fall but not the complete medical file.

You arrive at Mia's home and begin to explain the purpose of your visit: to complete a home safety assessment and provide recommendations for equipment and/or personal care support. Mia reports that she is having difficulty with her ADLs. You explain the process for obtaining equipment and additional occupational therapy sessions, and tell her that a report, including recommendations, will be sent within two weeks to Goodwill Insurance for review. Mia is quite shocked that the process for assessment and review will take so long. You assumed that the intake coordinator had explained the process to Mia.

You are responsible for ensuring that Mia understands the occupational therapy intervention that you are proposing. In this situation, consent was obtained through a third party.

Question: You are responsible for ensuring that (select all that apply):

a. The third party applies the informed consent process
b. Consent was obtained prior to initiating services
c. A process for ongoing consent is followed
d. The third party had Mia sign the consent form

The best answers are (a), (b) and (c).

Consent must be obtained by the health practitioner providing the service. Or, it can be obtained by one health practitioner on behalf of all involved providers if she or he can address all of the issues related to all of the proposed treatments.

In this scenario, you need to ensure that the intake coordinator had determined capacity and communicated an understanding of the nature and expected benefits of the assessment, alternative courses of action and the likely consequences of not having the assessment. As well, you need to ensure that the intake coordinator provided Mia with an opportunity to have her questions answered.

(D) is not the best answer. While consent should be recorded in a signed document, the use of a form in and of itself does not demonstrate that a thorough informed consent process has taken place. There must be a mechanism to ensure that the client understands the components of consent and has the opportunity to ask questions, express concerns and/or place limitations on his or her consent.

Mia provides consent and participates in the home safety assessment. She reports that her legs are getting weaker and says that a walk-in tub with whirlpool jets would help her with pain management. You would like to refer Mia to a PT to address strengthening and walking/standing tolerance but referral was not covered when consent was obtained. Mia realizes she does not have enough funding to cover both the PT services and the walk-in tub. You realize that the HCCA and PHIPA require you to obtain consent from the client or his or her authorized representative to give information about a client to another person.

Under PHIPA, 123 Rehab is the HIC and you, as an independent contractor providing services, are 123 Rehab's agent. Before making the referral, you must obtain informed consent from Mia. To obtain informed consent, you must also provide Mia with alternative options. Mia provides consent and you recommend a PT from 123 Rehab.

Mia asks that you withhold the referral to PT for strengthening and walking/standing tolerance from the insurance company because she would like the walk-in tub due to limited funding. As the funding source for your services, can Mia impose conditions on disclosure of this information?

When contractual obligations exist for disclosing the personal health information contained in reports, the OT should ensure that the client is aware of the expectations for disclosure or non-disclosure as part of the informed consent process.

In this situation there is a contractual obligation for you to share information with Goodwill Insurance, so Mia must decide, based on the risks and benefits of participating in the assessment, whether she will consent or not. Should she consent, Mia has the right to put limits on the disclosure of her personal health information in the report submitted to the insurance company. Should Mia choose to put limits on the disclosure of the information you submit to the insurance company, you are ethically required to provide your professional opinion and to represent her needs in a transparent way.

Scenario #7: Lock-Box and Withdrawal of Consent

You are an OT contracting your services to YYZ Rehab, a private company that conducts independent medical assessments for personal injury law firms and auto insurers. You have been referred a client, Mrs. Pereira, who recently had a motor vehicle accident (MVA). You are asked to conduct an independent examination (IE) assessment of Mrs. Pereira to determine her future care needs. The YYZ Rehab staff have sent you the client file; it includes medical reports, details about the MVA, Mrs. Pereira's information and a copy of a consent form for the assessment that Mrs. Pereira has signed.

> Under the HCCA, informed consent is required before proceeding with a client treatment. While the Act does not specifically state that consent for all assessment is required, the College expects all OTs to obtain consent for all services: assessments, treatments and consultations.
>
> Informed consent can be attained verbally or in writing. While it may be prudent practice to have written consent, the client's signature should not substitute for the process and actions that need to take place for informed consent to be valid.

In this scenario, YYZ Rehab has supplied a generic consent form for the client to sign. Without knowing the exact process that has taken place between the administrator and the client, you should not assume that informed consent has been appropriately obtained. You need to confirm the consent with the client by reviewing all of the necessary components, either on the phone or in person, before conducting the IE assessment.

You review the referral, client file and signed consent form, and then call Mrs. Pereira to schedule a date and time for the assessment. You see Mrs. Pereira on the scheduled assessment date and determine that she is capable of providing consent based on her presentation, and her ability to comprehend and acknowledge the assessment process including the consequences of her decision. You explain what the assessment entails, and the risks and benefits of participating. You explain the right to withdraw consent at any time during the process and with who you will be sharing the assessment. You obtain consent to communicate and share information with Mrs. Pereira's lawyer, the insurance adjuster and her son. You document this information in the client record. You ask if she has any questions; she replies "no."

Question: What components were missing from your informed consent process? Select all that apply.

a. A discussion about alternative options
b. A discussion about the other services that YYZ Rehab offers at an additional cost
c. A discussion of what consequences would follow if the client decides not to proceed with the assessment
d. A discussion about the potential treatment options available should Mrs. Pereira require follow up

The best answers are (a) and (c).

The outcome of the assessment could have a significant impact on the client. The risks of not participating in the assessment may, in fact, outweigh the results of the assessment itself because all funding and services could be automatically withdrawn. Mrs. Pereira should be aware of alternatives to participating in the assessment to determine if she wishes to continue with it.

(B) and (d) are not the best answers because if you promote other, potentially unnecessary, services prior to the completion of your assessment, it may be seen as a conflict of interest. It may, though, be appropriate to discuss these options later.

The College's Standards for Record Keeping indicate that all types of consent should be documented, including informed consent. In this case, you would record that Mrs. Pereira is capable of providing consent to:

- Participating in the IE assessment
- Understanding and appreciating the risks, limitations, benefits and consequences of participating in the assessment
- Agreeing to the collection, use and/or disclosure of her personal health information

If you use a consent form, include the form in the client's clinical record. When applicable, OTs may reference the consent policy that their organization uses.

Mrs. Pereira participates in the three-hour assessment, taking breaks as needed. During the assessment, she explains that she has been feeling depressed and has contemplated harming herself. When probed further, you determine that she has a plan in place to harm herself. The duty to warn is a mandatory obligation that OTs need to follow when a client makes a clear threat of harm or death. OTs need to weigh the risks against their professional obligations for maintaining client confidentiality. This can be a difficult decision to make.

> "A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons." PHIPA, 2004, c. 3, Sched. A, s.40 (1).

You discuss your obligations to report risk of harm and advise her that you will contact her doctor to share this information. Mrs. Pereira indicates that she does not want you to contact her doctor. Since you have reasonable grounds to believe that Mrs. Pereira is at significant risk of serious bodily harm to herself, disclosure is permissible for eliminating or reducing a risk.

To help assess risk of harm, ask the following questions:

- Is the threat imminent?
- Does the client have a plan of action?
- Who would be the most appropriate individual to contact with respect to managing this risk?
- Have discussions been held with the client to obtain consent to share the information?

You inform the doctor of your interaction with Mrs. Pereira and the details of the plan to harm herself. You intend to document this information according to lock box requirements. The doctor thanks you and states that he will call her immediately to discuss this with her.

PHIPA, Section 20(2), clearly states that individuals may withhold or withdraw their consent to the collection, use and disclosure of personal health information for the purposes of health care provision. In this circumstance, an OT can initiate a lock-box provision. The College does not prescribe the format of a lock-box nor does PHIPA define this term. When complying with the lock-box provision, an OT may need to consider:

- Reviewing existing organizational policies, procedures or manual processes
- Discussing with the employer the possibility of creating a protocol if no such policy exists
- How information can be withheld through a written or electronic format, and what steps need to be in place to maintain consistency, security and confidentiality

OTs are expected to document what steps they have taken to invoke the lock-box provision. In addition, if you deem the withholding of the information necessary for the provision of care, include a note in your documentation that the client has withheld information.

Mrs. Pereira contacts you two days later and states that she does not want the information you shared with the doctor to be contained in the report that you are writing. Furthermore, she no longer wants the report to be released to the insurance adjuster and withdraws her consent.

Since Mrs. Pereira has requested that part of her information be withheld, and the report has not yet been released, you have the responsibility to respect her decision.

You acknowledge that Mrs. Pereira can invoke a lock-box and explain that the information will not be in the report and will be kept confidential in her file in an envelope labelled “Lock-box information.” You further explain that she had consented to the completion of the assessment, and that you are obligated to summarize your findings and document her withdrawal of consent in the client record. To access the locked content, the insurance company would then need to seek consent directly from the client who has withheld the information.

A client can withdraw their consent for the release of a report unless there is a legal requirement for the OT to release the report. The College’s Standards for Consent, Standard 5, describes the actions that OTs must take when ensuring that a client understands the right to and the implications of withdrawing consent.

Since you have previously explained the risks involved in not submitting the report to the insurance adjuster; that is, Mrs. Pereira’s benefits could be affected and Mrs. Pereira acknowledged this potential risk, you explain that your involvement in Mrs. Pereira’s file is finished.

You document the lock-box information and the steps you took regarding the duty to warn and place the envelope in the client’s record. You have a responsibility to record all of the interactions, including phone calls and conversations that you had with Mrs. Pereira, in addition to the consent processes that took place. You need to document that Mrs. Pereira has withdrawn her consent to share the report with the insurance adjuster. You also need to notify your company of her request.

As the agent, you would then transfer the file and lock-box documentation to the HIC (YYZ Rehab); custodians are ultimately responsible for the collection, maintenance and uses of personal health information when assisting with the provision of care.

College Standards to Reference

- Standards for Consent
- Standards for Record Keeping
- Standards for Occupational Therapy Assessments

Relevant Legislation

- PHIPA: covers sharing and releasing information, circle of care, lock-box
- Statutory Accident Benefits Schedule
- *Insurance Act, 1990*

Scenario #8: Managing Sources of Data

Alvin, a five-year-old boy who has cerebral palsy, has been referred to Shooting Star Rehab for an occupational therapy assessment. You are assigned Alvin's assessment.

You review the client chart and obtain consent over the phone from Alvin's mother, Emma, who is the primary contact and only SDM. You explain that you typically record sessions with children so you can focus on the child. Making a video allows you to review the information after the session to ensure that you observed all of the relevant behaviours and skills.

Prior to introducing video in your practice, you considered the benefits and risks of using video recordings. The benefits include help in identifying information that you may have missed and the ability to use videos taken over time to measure progress. The risks include concerns relating to their storage because they cannot be included in a client's paper record, and they can be a potential liability to you as an OT.

> The College takes the position that, ideally, the OT discusses video recording with the client prior to recording and receives informed consent to record. The client needs to understand how the information will be used, the risks and benefits of the process, and the alternative options.
>
> The College does not have a position on how organizations govern where media formats are kept, but the client record should clearly state where the raw data can be found. However, the College does state that clinical records are to be retained for at least 10 years and maintained in accordance with the organization's policies and procedures.
>
> The video title should include the client's name, unique identifier and the date of the filming.

You meet Alvin and Emma on the day of the assessment and proceed to obtain informed consent. You explain the benefits, risks, consequences and alternatives to videotaping the sessions. Emma likes the idea of video recordings and asks that the remainder of Alvin's therapy sessions be recorded so she can view them at home.

Before recording, you ensure that the client is in an area where all movements can be recorded, no objects block the camera and there is adequate lighting. Then, you place a "Do not disturb" sign on the door.

You give Alvin an array of toys to play with and notice that he has poor fine motor skills. His gait is unsteady and his current walker is too small. You note some spasticity in his hip adductors, and that Alvin has a short standing and walking tolerance.

In the next session, you collaborate with Emma to create a plan for Alvin that includes the use of a taller walker, positioning pillows for decreasing hip spasticity, and a pencil grip and adapted scissors to improve his fine motor skills. You also link Emma with community groups that offer children's sports programs.

Emma asks to borrow the walker to use at home. To ensure that the equipment you use is safe, you keep maintenance records and inspection reports. These are documented by the OTs who use the equipment as part of their service delivery.

> OTs are responsible for ensuring the equipment they provide to their clients is safe. Equipment records are to be kept for a minimum of five years from the date of the last entry even if the equipment has been discarded.

You refer to the organizational policies for equipment loans and ask Emma to sign a sheet before taking the walker home. You explain to Emma that charges will be applied if the equipment is returned damaged, and that the loan is on a week-by-week basis. You also disinfect the equipment in front of Emma and Alvin to comply with the organization's infection control protocol.

Next week, when the walker is returned, you inspect it with the client present. You ask Emma to sign on the same equipment loan sheet and then record in the clinical record that the equipment has been returned. You will now arrange for a walker to be loaned through a vendor for a longer duration.

Emma is eager to purchase a walker like the one she borrowed, and you suggest applying for funding from the Assistive Devices Program (ADP). With Emma's consent, you complete the paperwork and send the relevant information to ADP. You explain that the process can take a while and that Alvin may be discharged by the time you receive a response.

Question: What should you do with the ADP application form? Select all that apply.

a. Provide a copy to the parent and mail the original to ADP
b. Make a copy for the client record and mail the original to ADP
c. Give a copy to the parent, document that you have provided a copy to the parent in the client record and mail the original to ADP
d. Provide a copy to the parent, save a copy in the client record and mail the original to ADP

All of the answers may be correct.

The College does not prescribe how OTs should store funding applications. However, if a copy of the funding application is not included in the client chart, the OT must make a note of what it contains.

Your organization may require you to follow a different procedure, and it is the OT's responsibility to be aware of and comply with his or her organization's policies and procedures as well as ADP's requirements.

When you receive a response from ADP, document the response in the record.

College Standards to Reference

- Standards for Record Keeping
- Standards for Consent
- Guidelines: Use of Surveillance Material in Assessments

Relevant Legislation

- PHIPA: covers sharing and releasing information, circle of care, lock-box

Scenario #9: Documenting Consent

As the manager on an in-patient spinal cord unit in a rehabilitation hospital, you are asked to investigate an incident between two clients that occurred during the Activity Tolerance Group program that two OTs run. The clients, Paul and Dmitri, were leaving the treatment room when Dmitri noticed that Paul had tucked one of the game controllers they were using into the side of his wheelchair.

Dmitri confronted Paul about stealing the device. Paul responded by smashing his wheelchair into Dmitri with such force that Dmitri's chair spun around and slammed his leg and hand into a table. Paul shouted profanities at Dmitri and immediately left the room.

Dmitri was helped back to the unit, and a physician assessed and treated his injuries. He asks to see you immediately to inform you that he will be contacting the police to press assault charges against Paul.

After hearing Dmitri recount the events and addressing his concerns about his personal safety on the unit, you arrange to speak with the OTs who run the group. You review the incident with the OTs and ensure that an incident report is completed in the electronic incident reporting system. The two OTs had jointly completed the incident report immediately after the event and both had signed off on it.

During the discussion, you learn that only one of the OTs was in the room at the time of the incident. This is not clear from the information in the incident report, and you are concerned that both OTs signing off on the report is misleading.

Question: How would you address the incident report?

a. Require the OTs to make an amendment to the incident report to accurately reflect their involvement in the incident
b. Recognize that the co-signing of the incident report is not an issue because it is not public; only hospital staff can access it
c. Confirm that the OTs have accurately documented the incident in each client's clinical record so you don't have to be concerned about the incident report
d. Ask the OTs to print a copy of the incident report to be included in the clinical records

The best answer is (a).

It is expected that any documents signed by OTs are accurate and clearly assign accountability for actions. Organizations rely on incident reports for high-stakes investigations and should be able to rely on the information that OTs provide.

Answer (b) is inaccurate because the incident report may become relevant if legal action or court proceedings follow. Amending the report will ensure that the events are accurately reported should the information be required in the future.

(C) and (d) are not the best answers because the incident report typically captures more information than would be reported in a client record. Also, some of the information, such as the name of the other client involved, is not appropriate content for a client record. The client record is not a substitute for the incident report. In fact, an incident report should not reference a clinical record, nor should a copy of the incident report be placed in the clinical record.

In response to your concerns about the incident report, the OTs indicate that they have also completed documentation describing the incident in each of the client's health records. As part of the protocol for an incident review and in preparation for any questions that you may receive from the police, you review Paul and Dmitri's health records.

As the manager, you are acting as an agent of the HIC and are permitted to access the records of clients with whose care you are involved. In some organizations, though, it's best to notify the health records department to inform them that you will be accessing the records. This will assist the health records department should these client records be selected for a privacy audit.

A record can only be accessed by agents who are directly involved in the delivery or management of a particular individual's care. Any employee working as an agent of an HIC cannot access any record that he or she chooses.

When reviewing Paul's record you note that in addition to his spinal cord injury, Paul sustained a traumatic brain injury. Paul's record indicates that he is not capable of making treatment decisions and that his brother, Jeff, has been identified as his SDM. Also in the file is an Admission Agreement signed by Jeff. It outlines the goals for the program, the expected length of stay and a declaration that Paul understands and consents to the standard care plan outlined in the agreement.

The police will likely interview Paul as part of the investigation. You realize that it may not be in Paul's best interests to be interviewed alone because of his cognitive status and inability to appreciate the consequences of his actions.

You inform Paul that you will be contacting Jeff to tell him about the incident and the potential involvement of the police. Paul adamantly states that he can "deal with the cops" and demands that you not contact his brother. He says that if you tell Jeff, his brother will decide that he will be unable to manage him after he is discharged and send him to a long-term care home.

Question: How should you respond to Paul's request?

a. Respect Paul's request because he has explicitly withdrawn consent for you to communicate with his brother on this matter, and doing so would constitute a breach of privacy
b. Contact Jeff and inform him of the issue because he is the SDM and must be involved in any decision-making regarding Paul
c. Inform the police of Paul's medical condition and the impact it may have on his decision-making capacity
d. Inform the police that they must contact Jeff and provide the police with Jeff's contact information

The best answer is (b).

Based on your record review, you have reason to believe that Paul is not capable of understanding or appreciating the potential consequences of his participation in a police interview. Jeff, as the SDM, needs to be informed of the situation.

(A) is not the best answer. Since Paul is not capable, it is in his best interests that you contact his SDM.

(C) and (d) are not the best answers. It would be a breach of privacy under PHIPA if you gave the police any information about Paul's health status, hospitalization or capacity. You are only permitted to release personal health information without express client consent when you are required to do so by law.

On returning to your office, you complete a more comprehensive review of the OTs' documentation in Paul and Dmitri's client records. You see a significant difference in the volume and content of information contained in each of their chart entries.

You have concerns about whether the OTs received informed consent for the occupational therapy assessment and treatment plan. You are also concerned about the appropriateness of the content in one of the OT's notes. In particular, you observe that other than the "informed consent obtained" box that's ticked at the top of the assessment and progress notes, there is no reference to Paul's inability to provide informed consent and no record of the OT obtaining informed consent from Paul's SDM, Jeff.

Knowing that every client is asked to sign the Admission Agreement, does the written consent in this form meet the requirements for informed consent? A consent form, such as the Admission Agreement that contains elements of consent, does not in and of itself meet the requirements for informed consent. It does not permit the client to ask and receive responses to the questions that he or she may have regarding the proposed treatment or plan of care.

This Admission Agreement is also missing key pieces of information that a reasonable person in the same circumstance would require to make an informed decision about his or her care; for example, knowing the risks and benefits of the proposed treatment, and the alternatives. This consent form also does not inform the client of his or her right to withdraw consent.

Finally, as the OT proposing the intervention (participation in the Activity Tolerance Group), the OT should have obtained informed consent. Although OTs can rely on a third party to obtain consent, there is no evidence that an informed consent process was followed. The consent obtained from Jeff on the Admission Agreement is insufficient for informed consent pertaining to the OTs' services.

You also notice that there are only two occupational therapy notes in Paul's record from the time of his admission three weeks ago. There is no reference to his participation in the Activity Tolerance Group although the progress report for July 20, 2016 briefly describes the incident.

In Dmitri's record you notice that the last entry provides a comprehensive recount of the incident. It includes Paul's full name and refers to Paul's behaviour as being due to a head injury.

The variation in documentation between the OTs, the limited information in Paul's record, and the inclusion of another client's name and personal health information in Dmitri's health record concerns you.

Before discussing your concerns with the OTs, you ask Tasneem, the professional practice leader for occupational therapy, to review the OTs' documentation to see if she thinks the documentation complies with the record keeping and consent standards for OTs. To assist with her chart review, Tasneem refers to the College's Consent Checklist and Record Keeping Checklist.

Review the last progress notes from Paul and Dmitri's charts and see if you can identify some of Tasneem's recommendations for improvement.

Sample documentation

In Paul's record:
OT Progress Note
June 20, 2016

☑ Informed Consent Obtained

Subjective: Client reports that he is frustrated that he cannot go outside by himself to sit in the sun because he has been identified as at risk for leaving hospital property.

Objective: Client seen as per treatment plan.
Client involved in an altercation with another client during the OT group that resulted in injuries to the other client. Incident report filed. Refer to incident report for further information.

Analysis: Client appears to have behaviour management issues resulting from his traumatic brain injury. Client may benefit from further cognitive assessment and remediation of the aggressive behaviours.

Plan: 1. Complete cognitive assessment.
2. Continue to see client three times per week in Group program.

Shandi Steele, OT Reg. (Ont.)

Tasneem recommends the following changes to improve record keeping:

- Refer to protocol that describes your consent process including what is discussed.
- Document anything out of the ordinary that was discussed/asked that is not covered in the protocol for obtaining consent.
- Identify the location where the incident report is stored.
- Describe the behaviours that lead to your identification of "behaviour management issues" rather than labeling.
- Provide detail as to what was done in the group session (e.g. activities, topic discussed, etc.).
- Detail the cognitive assessment you plan to use and the remediation activities in more detail.
- Set SMART goals for the "Plan" section.

In Dmitri's record:
OT Progress Note
June 20, 2016

☑ Informed Consent Obtained

Consent comment: OT discussed client participation in the Activity Tolerance Group for the first time today. OT addressed all matters pertaining to informed consent as per the consent protocol. Client raised concerns about expectations to interact with other clients while participating in the group. OT described typical group experience and reiterated client's right to withdraw from the group at any time. The client indicated he understood and verbally consented to participate in the group.

S: Client reported he was feeling tired today after having a visit from his family on Sunday. Client states that he is frustrated by how tired he gets by the end of the day and that he notices his pain increases when he gets tired. Client reported looking forward to participating in the new group to build increased strength and endurance. Following an incident with another client, this client stated that he will only return if Paul Henderson is banned from participating in the group.

O: Client received lying supine in bed in hospital gown at the beginning of the appointment. Client required moderate assist x1 to transfer from bed to wheelchair. Client able to propel wheelchair to elevator independently. Client participated in the group and a baseline for activity tolerance was established.

At the end of the group, the client was involved in an altercation with another client, Paul Henderson. The client reports he saw Paul trying to steal one of the game controllers from the therapy room. When he approached Paul about the game controller, Paul got angry and slammed his wheelchair into the client. Client sustained minor injuries. OT explained to client that some other clients have problems managing their behaviours as a result of their injuries. OT assisted client back to unit to have injuries assessed and addressed. Minor swelling and bruising noted on right hand. Injuries were assessed by the physician.

OT completed an incident report in the electronic reporting system as per the protocol.

A: Client would benefit from ongoing involvement in the group to build activity tolerance and endurance; however, client is concerned about personal safety.

P:
1. Follow up with client tomorrow during individual OT assessment to discuss client's participation in the Activity group.
2. Continue to work on dressing and toilet transfers.
3. Provide client with additional strengthening exercises.
4. Monitor impact of injuries on participation in OT treatment plan.

Dan Dodger, OT Reg. (Ont.)

Tasneem recommends the following changes to improve record keeping:

- Do not name other clients involved in the altercation
- Remove details of altercation and indicate that details are included in the incident report
- Set SMART goals
- Provide details on next steps in the "Plan" section (for example, what is being done to "work on dressing and toilet transfers"?)

Scenario #10: Documenting a Group Intervention

You provide back education to groups of new employees working at various assembly plants across Ontario. During these sessions you go through a PowerPoint presentation and then ask the employees to demonstrate and practise safe movements.

For this employer, you also provide the occasional individual ergonomic assessment that result in recommendations, primarily for equipment purchases.

You review your process for documenting the group sessions and consider the following:

- Human Resources sends you the list of attendees.
- The participants sign an agreement to attend the session as part of their employment contract. (Your session is part of their basic orientation and training.)
- You are not given any personal or health information about the participants.
- You provide a copy of the PowerPoint presentation slides to the attendees.
- You inform the attendees that if they need a one-on-one consultation or an ergonomic assessment, they can discuss it with their supervisors.

The nature of this therapeutic relationship is educational only. If an attendee needs additional support or assessment, you would receive a referral from the company and create a client record. The objective of the group is to provide general strategies for back safety and does not consider the individuals' pre-existing medical conditions, their tasks on the assembly line or any other factors.

Based on the nature of the therapeutic relationship and objectives of the group, you determine that you should maintain the list of attendees as well as the PowerPoint slide deck, which includes the date and location of the sessions and is stored electronically. You also decide to document anything unusual or unexpected that may occur; for example, if anyone has difficulty demonstrating the proper lifting techniques or complains of pain when performing any of the activities.

The employer asks you to present to a group of five employees who have had previous work-related back injuries. You are provided with a brief overview of the participants' injuries and their work restrictions. You are asked to make recommendations for strategies and/or equipment to both the individuals and their supervisors. You wonder if any of your processes need to change for this group.

Question: What processes may need to change?

a. No processes need to change because you are still providing education to a group about back safety and will not be treating them individually.
b. You now need to obtain informed consent because you will be providing recommendations specific to their individual needs.

c. You now need to create individual records because you have specific information about each participant that you will need to document separately.
d. You now need to obtain informed consent, create individual files and document the group in each participant's record.

The best answer is (d).

Since you now have personal health information about each individual, the nature of the therapeutic relationship and objectives of the group have changed. You are being asked to address individual needs and develop recommendations and/or a service plan. You need to obtain and document individual informed consent, as well as document the content of the education session (or make a reference to where this information can be found) in each client record.

Key Points

You should be able to apply the following key points to your own practice setting:

1. Consent to treatment is informed if a) the person received the information that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and b) the person received responses to his or her requests for additional information about those matters.
2. Consent is informed if the information received includes:
    a. The nature of the treatment.
    b. The expected benefits of the treatment.
    c. The material risks of the treatment.
    d. The material side effects of the treatment.
    e. Alternative courses of action.
    f. The likely consequences of not having the treatment.
3. The Hierarchy of Substitute Decision-Makers identifies the order in which an individual is identified to provide consent for assessment and/or treatment when a client is deemed incapable of providing consent themselves.
4. It is important for you to determine your role as a Health Information Custodian (HIC) or the agent of a HIC.
5. Capacity relates to a specific assessment or treatment. It is the responsibility of the OT proposing the service to decide if the client has the capacity to consent to that particular service.

Optional Exercise: Application of the Conscious Decision-Making in Occupational Therapy Framework

Select a situation that you have experienced or are currently facing and work through the Conscious Decision-Making Framework. The situation should involve professional judgement and decision-making pertaining to consent and/or record keeping. Potential situations include:

- Determining client capacity
- A challenge to a determination of incapacity
- Documenting lock-box information

- A withdrawal or denial of consent
- Establishing policies or procedures for consent or record keeping
- Difficulties with electronic documentation systems that prevent you from meeting the standards of practice
- The amount of information that needs to be documented for group interventions
- How to identify interprofessional members' contributions in a record or report

Step 1: Describe the situation

Potential questions to ask include:

1. What are the facts of the situation?
2. What is the scope of the referral?
3. What are your responsibilities in the situation?
4. Who is the client?
5. Who are the other stakeholders?
6. What are the underlying issues?

Step 2: Identify the principles related to the situation

The principles may include client-centred practice; respect for autonomy, collaboration and communication (the principles promoting the value of respect); and honesty, fairness, accountability and transparency (which all promote the value of trust).

Step 3: Identify the relevant resources to assist with the decision-making

1. Is there any relevant legislation, regulations, standards and/or guidelines?
2. Are there any individuals with expertise in the area?
3. Is there any relevant evidence; for example, literature, research, best practice guidelines?

Step 4: Consider if you need further information or clarification

1. Do you understand the intent of the legislation, standard and/or guideline?
2. What evidence exists in literature, research and/or best practice guidelines?
3. Are there any missing facts?
4. Have you identified the client's best interests and/or public risk?
5. Are all of the stakeholders and their interests identified?

Step 5: Identify the options

Describe a range of reasonable and realistic options to address the different aspects of the situation. Your plan may ultimately include a set of options.

Step 6: Choose the best option

Apply the principles and any legislation, standard, guideline and/or policy. Consider the expected outcome and potential impact of each option.

Step 7: Take action

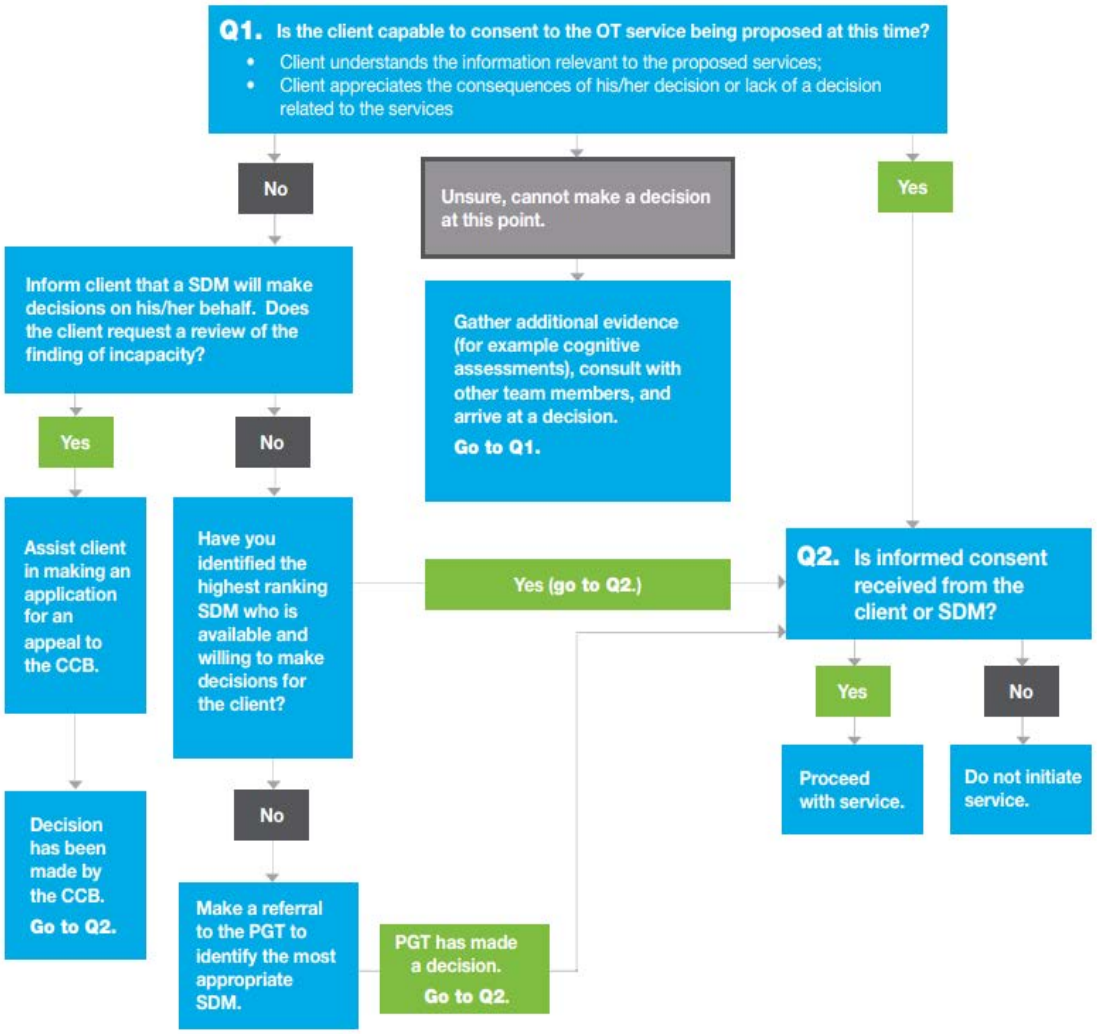
Select an option or set of options that you believe will offer the best approach to the situation, given the relevant principles. Decide on how best to take action.

Step 8: Evaluate the decision

1. How confident are you that you chose the best option?
2. What was the impact of your decision on those involved?
3. Did you achieve the expected outcome?
4. Would you make the same decision again or do something differently?
5. Is there anything in your practice that needs to be adjusted now or in the future?
6. Is there any amends or reparations that need to be made?

Appendix 1: Decision Tree for Obtaining Consent

For use by OTs when determining the most appropriate individual to provide informed consent for occupational therapy services under the *Health Care Consent Act, 1996.*



SDM – Substitute decision-maker
CCB – Consent and Capacity Board
PGT – Public Guardian and Trustee

College of Occupational Therapists of Ontario, 2017

www.coto.org/docs/default-source/PDFs/decision-tree-for-obtaining-consent.pdf?sfvrsn=20

Appendix 2: The Hierarchy of Substitute Decision-Makers

List of persons who may give or refuse consent

20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
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 treatment 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 treatment 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. (HCCA, 1996, c. 2, Sched. A, s. 20 (1)).

Appendix 3: Consent for assessment and treatment

If you require consent of an individual to collect, use or disclose personal health information about the individual, a person described in one of the following paragraphs may give, withhold or withdraw the consent:

1. If the individual is capable of consenting to the collection, use or disclosure of the information,
   i. the individual, or
   ii. if the individual is at least 16 years of age, any person who is capable of consenting, whom the individual has authorized in writing to act on his or her behalf and who, if a natural person, is at least 16 years of age.
2. If the individual is a child who is less than 16 years of age, a parent of the child or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent unless the information relates to,
   i. treatment within the meaning of the *Health Care Consent Act, 1996*, about which the child has made a decision on his or her own in accordance with that Act, or
   ii. counselling in which the child has participated on his or her own under the *Child and Family Services Act, 1990*.
3. If the individual is incapable of consenting to the collection, use or disclosure of the information, a person who is authorized to consent on behalf of the individual.
4. If the individual is deceased, the deceased's estate trustee or the person who has assumed responsibility for the administration of the deceased's estate, if the estate does not have an estate trustee.
5. A person whom an Act of Ontario or Canada authorizes or requires to act on behalf of the individual. 2004, c. 3, Sched. A, s. 23 (1); 2007, c. 10, Sched. H, s. 5.

(3) If the individual is a child who is less than 16 years of age and who is capable of consenting to the collection, use or disclosure of the information and if there is a person who is entitled to act as the substitute decision-maker of the child under paragraph 2 of subsection (1), a decision of the child to give, withhold or withdraw the consent or to provide the information prevails over a conflicting decision of that person. (PHIPA, 2004, c. 3, Sched. A, s. 23 (3)).

Requirements

(2) A person described in subsection (1) may give or refuse consent only if he or she,

a. is capable with respect to the treatment;
b. is at least 16 years old, unless he or she is the incapable person's parent;
c. is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
d. is available; and
e. is willing to assume the responsibility of giving or refusing consent. (HCCA, 1996, c. 2, Sched. A, s. 20 (2)).

Personal information is defined as:

"Personal information" means recorded information about an identifiable individual. PIPEDA, 2000, c.5. Part 1, s. 2(1) http://laws-lois.justice.gc.ca/eng/acts/P-8.6/page-1.html#h-1

Personal health information is defined as:

"Personal health information," subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,

a. relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
b. relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,
c. is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the individual,
d. relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual,
e. relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,
f. is the individual's health number, or
g. identifies an individual's substitute decision-maker. (PHIPA, 2004, c. 3, Sched. A, s. 4 (1); 2007, c. 8, s. 224 (6); 2007, c. 10, Sched. H, s. 2.)

Acronyms used in this PREP Module

ACT:	Assertive Community Treatment
ADL:	Activities of Daily Living
ADP:	Assistive Devices Program
CCAC:	Community Care Access Centre
CCB:	Consent and Capacity Board
FIPPA:	*Freedom of Information and Protection of Privacy Act, 1990*
HCCA:	*Health Care Consent Act, 1996*
HIC:	Health Information Custodian
IADL:	Instrumental Activities of Daily Living
IE:	Independent Examination
MVA:	Motor Vehicle Accident
OSR:	Ontario School Record
PGT:	Public Guardian and Trustee
POA:	Power of Attorney
PREP:	Prescribed Regulatory Education Program
PT:	Physiotherapist
SDM:	Substitute Decision-Maker
SP:	Support Personnel

References

College of Occupational Therapists of Ontario

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www.coto.org/resources/conscious-decision-making-in-occupational-therapy-practice

Consent Checklist, 2011.
www.coto.org/docs/default-source/PDFs/consent-checklist.pdf?sfvrsn=4

Guideline: Use of Surveillance Material in Assessment, 2012.
www.coto.org/docs/default-source/guides-guidelines/practice_guideline.pdf?sfvrsn=2

Record Keeping Checklist, 2016.
www.coto.org/resources/standards-for-record-keeping

Standards for Consent, 2017.
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Standards for Occupational Therapy Assessments, 2013.
www.coto.org/resources/standards-for-occupational-therapy-assessments

Standards for Record Keeping, 2016.
www.coto.org/resources/standards-for-record-keeping

Standards for the Supervision of Support Personnel, 2011.
www.coto.org/docs/default-source/standards/standards_supervision_personnel.pdf?sfvrsn=2

Legislation and Related Resources

Children's Law Reform Act, 1990.
www.ontario.ca/laws/statute/90c12

Divorce Act, 1985.
http://laws-lois.justice.gc.ca/eng/acts/d-3.4/page-1.html

Education Act, 1990.
www.ontario.ca/laws/statute/90e02?search=Education+Act

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www.ontario.ca/laws/statute/90f31?search=Freedom+of+Information

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Personal Information Protection and Electronic Documents Act, 2000. https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/

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