



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

Standard

Standards for Consent

Revised March 2017

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Introduction

Occupational therapists (OTs) have ethical and legal obligations for obtaining consent. The ethical obligations of OTs are discussed in the Code of Ethics and are based on the fundamental values of trust and respect and the principles of client-centred practice, respect for autonomy, collaboration and communication. As regulated health professionals, OTs are also legally accountable for obtaining consent for the provision of care and for the collection, use and disclosure of personal health information. The Standards for Consent describe the minimum expectations for OTs with respect to obtaining consent.

The term “**service**” will be used throughout these standards to encompass all aspects of occupational therapy service delivery including assessment, treatment and consultation for which an OT must obtain consent. OTs are accountable for obtaining consent for all services and for the collection, use and disclosure of personal health information.

Consent is a process that requires a dialogue between the person proposing the service and the person giving consent for that service or service plan. Consent is informed if, before voluntarily agreeing to the service provision, the person making the decision received the information that a reasonable person in the same circumstances would require in order to make a decision about that service.

Consent can be written or oral, express or implied. OTs are strongly encouraged to obtain express consent whenever possible. Regardless of the format in which consent is obtained, there should be documentation about consent in the client record.

The *Health Care Consent Act, 1996* (HCCA), and the *Personal Health Information Protection Act, 2004* (PHIPA), emphasize the principles of effective and transparent communication with clients, and the requirement to obtain consent before providing services and/or collecting, using, or disclosing personal health information.

The purpose of the HCCA is to:

- establish rules for the consistent application of consent;
- enhance autonomy of clients;
- promote communication and understanding between health practitioners and their clients;
- facilitate care for persons lacking capacity to make decisions;
- ensure a role for family members in decision-making for clients lacking capacity; and,
- permit intervention by the public guardian and trustee.

The HCCA addresses consent as it applies to:

- consent for treatment
- consent for admission to a care facility
- consent for the provision of a personal assistance service.

It is **important** to recognize that the HCCA does not and cannot deal with every aspect of consent as the law is constantly evolving in this area. This means that **in circumstances that are not specifically covered by the HCCA, OTs still have an obligation to obtain consent.**

PHIPA defines the requirements for the collection, use and disclosure of personal health information and the responsibilities of health information custodians and agents. It is essential that OTs understand their role in the management of personal health information to ensure client privacy is respected and 'knowledgeable' consent¹ is obtained for the collection, use and disclosure of personal health information.

The purpose of PHIPA is to:

- establish rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care;
- provide individuals with a right of access to personal health information;
- provide individuals with a right to require the correction or amendment of personal health information; and,
- provide for independent review and resolution of complaints with respect to personal health information.

Expectations regarding consent may vary according to practice setting, area of practice and client population. Additional legislation, such as the *Substitute Decisions Act, 1992*, the *Mental Health Act, 1990* and the *Insurance Act, 1990* may apply. In some circumstances OTs may be accountable to additional regulators, for example, the Financial Services Commission of Ontario, and need to consider other consent legislation. It is the responsibility of the OT to determine the legislative, regulatory, and organizational requirements relevant to obtaining consent in the context of their practice setting.

Occupational therapists obtaining consent for the purpose of conducting research involving human subjects must have approval from a valid research ethics board for their proposed study including the process and format for obtaining consent. In addition, OTs must comply with their legal obligations under PHIPA when collecting, using or disclosing personal health information in relation to all research initiatives.

¹ According to PHIPA, 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. 2004, c. 3, Sched. A, s. 18 (5)".

Informed consent is an ongoing process that starts with the researcher's first contact with the individual and continues until the study is complete or the participant withdraws. Any discussion of informed consent with the participant, the written informed consent form and any other written information given to participants should provide adequate information for the participant to make an informed decision about their participation (Health Canada, 2016).

For OTs working in non-clinical roles, it is important to understand the requirements for obtaining consent for access and disclosure of information contained in client and/or business records to maintain the privacy and confidentiality of clients and the workplace. As a manager, a business owner, a professional practice leader or a consultant, non-clinical OTs may be required to access and manage clinical records for several different reasons. Prior to accessing or disclosing any information, an OT must be certain they have the appropriate legal authority to do so and that consent has been obtained when necessary.

Application of the Standards for Consent

- The following **standards** describe the minimum expectations for OTs.
- The **performance indicators** listed below each standard describe more specific behaviours that demonstrate the Standard has been met.
- It is not expected that all performance indicators will be evident all the time. It is expected performance indicators could be demonstrated by the OT if requested.
- There may be some situations where the OT determines that a particular performance indicator has less relevance due to client factors or environmental factors. Such situations may call for the OT to seek further clarification.
- It is expected that OTs will always use their clinical judgement to determine how best to obtain consent based on the scope of the practice, practice setting, client and stakeholder needs.
- It is expected that OTs will be able to provide reasonable rationale for any variations from the Standard.

In the event of any conflict or inconsistency in these Standards for Consent with any other College standards, the standards with the most recent issued or revised date prevail.

College publications contain practice parameters and standards which all OTs practising in Ontario should consider in the care of their clients and in the practice of the profession. College Standards are developed in consultation with OTs and describe current professional expectations. College Standards

may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Pursuant to the *Regulated Health Professions Act, 1991* (RHPA), the College is authorized to make regulations in relation to professional practice. The College's Professional Misconduct Regulation establishes that "contravening, by act or omission, a standard of practice of the profession or failing to maintain a standard of the profession" constitutes grounds for professional misconduct.

Overview of the Standards for Consent

1. Determining Capacity
2. Consent for Occupational Therapy Service
3. Consent to Collect, Use and Disclose Personal Health Information
4. Consent for the Participation of Support Personnel, Students and Others
5. Withdrawal of Consent
6. Third Party Consent
7. Referrals from Third Party Payers and Independent Evaluations
8. Documenting Consent

1. Determining Capacity

Consent is a process, which begins with determining capacity to give consent. The OT must be satisfied that the client understands the information relevant to the proposed services and appreciates the reasonably foreseeable consequences of his/her decision or lack of decision related to the services.

Recognizing that an OT will only be evaluating capacity when the OT has reasonable grounds to suspect incapacity, the OT is not required to obtain consent from the client to assess capacity. However, it is expected that the OT will explain the process and address any questions the client may have regarding the assessment.

The OT must be aware that consent is situation-specific and that a client may be capable to provide consent with respect to a specific service and incapable with respect to another service. A client's ability to provide consent may also fluctuate, meaning the client may be capable at one point in time and incapable at another.

The *Health Care Consent Act, 1996* (HCCA) does not specify any age restrictions related to an individual's ability to provide informed consent. The client's age, diagnosis, language barriers or communication impairments should not result in any presumption of incapacity by the OT.

Standard 1

When obtaining consent for service, the OT will ensure that the client is capable of giving informed consent.

Performance Indicators

An OT will:

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| 1.1 | Engage the client and other stakeholders in a collaborative approach to determine capacity; |
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| 1.2 | Assume the client is capable of providing consent, unless there is information that would lead the OT to think otherwise;

Note: Consider factors that may indicate that the client is incapable to provide informed consent. ¹ |
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| 1.3 | Follow a process to determine capacity, when there is an indication to do so:

a. Gather objective and subjective information to determine the client's capacity to give consent;

b. Analyze the information gathered to determine the ability of the client to make a decision about the proposed service care;

c. Avoid presumptions of incapacity based on:

i. Diagnosis of a psychiatric or neurological condition

ii. Communication impairment or language barrier

iii. Disability

iv. Refusal of intervention

v. Age

vi. The fact that there is a guardian, power of attorney (POA) or substitute decision-maker (SDM) in place. The existence of a guardian, POA, or SDM does not automatically imply a client is incapable.

d. Apply clinical reasoning and judgement to arrive at a determination of the client's capacity to provide informed consent for OT service, |
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Note: Steps in the process to determine capacity may occur in any order.

¹ Some indicators of incapacity may be evidence of confused or delusional thinking; inability to make a settled choice; severe pain, or acute fear or anxiety; severe depression; impairment by alcohol or drugs; or any other observations which give rise to a concern about the person's ability to understand information relevant to making a decision.

1.4	<p>Upon determining incapacity to provide consent:</p> <ul style="list-style-type: none"> a. communicate to the client the finding of incapacity, the reasons, and their right to a review of this finding; and, b. take reasonable measures to confirm the SDM, and inform the client that the SDM will make the final decision related to the occupational therapy services;
1.5	Use the hierarchy of substitute decision-makers to determine the most appropriate decision-maker (Appendix 1) if a SDM has not been identified;
1.6	Involve the client in discussions with the SDM whenever possible;
1.7	Use interpreters or augmentative communication tools, if necessary, to ensure that the client understands the consent process.

2. Consent for Occupational Therapy Service

It is expected that OTs will obtain consent for all aspects of occupational therapy service (assessment, treatment and consultation).

Informed consent is an ongoing process to be re-evaluated throughout the course of occupational therapy service delivery.

In seeking consent, OTs must use their professional judgement to determine what is appropriate and reasonable given the level of risk involved in the proposed service delivery. When determining risk, OTs should consider the nature of the service (for example, implications related to client safety or access to resources for future care), client factors (such as the stability of the client's condition and the client's expectations for service) and/or the requirements of the practice environment (for example, organizational policies that exceed College expectations).

Depending on the nature of the proposed services, the OT must use their discretion in determining whether it would be most appropriate to obtain consent separately for a specific component of the proposed service such as an assessment or for a plan of service which may include assessment and treatment.

Standard 2

The OT will ensure informed consent is obtained from the client or substitute decision-maker (SDM) at the start and throughout service delivery.

Performance Indicators

An OT will:

Ensure the client has been given all the information a reasonable person in the same circumstances would require in order to make a decision about the services including:

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| 2.1 | a. Scope and reason for the referral;
b. Purpose and nature of the service;
c. Expected benefits and relevant risks of proceeding with the service;
d. Likely consequences of not proceeding with the service;
e. Expected outcomes of the service(s);
f. Alternative courses of action;
g. The right of the client to withdraw consent at any time during the process;
h. Financial arrangements regarding payment for the service; and,
i. Legal authority of the OT for conducting the service. |
| 2.2 | Provide an opportunity for questions from the client or SDM and respond in a manner that the client understands; |
| 2.3 | Ensure that each component of the plan is explained and consent obtained when proposing a service plan or course of action; |
| 2.4 | When moving from one component of the service to another, confirm consent; |
| 2.5 | Use interpreters or augmentative communication tools to ensure that the client or SDM understands the consent process. |
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3. Consent to Collect, Use and Disclose Personal Health Information

According to PHIPA, personal health information 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 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 SDM.

When referring to personal health information, OTs are required to obtain **knowledgeable consent**. Consent is knowledgeable if it is reasonable in the circumstances to believe that the individual knows the purpose of the collection, use and disclosure and is aware that they have the right to give or withhold consent for the collection, use or disclosure of personal health information. (PHIPA, s. 18(5)).

Standard 3

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

Performance Indicators

An OT will:

- 3.1 Know his or her responsibilities for the management of personal health information as the health information custodian or agent of the health information custodian;
 - 3.2 Apply a consent process for collecting, using, and disclosing personal health information, including discussing with the client:
 - a. The purpose and method of the collection, use, and disclosure of personal health information;
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- b. The nature of information to be collected during the intervention, how the information may be used, and with whom it will be shared, including whether information will be obtained from other individuals or sources such as written reports, surveillance materials or site visits;
 - c. The potential benefits and risks of consenting or not consenting to the collection, use, and disclosure of personal health information;
 - d. The right of the client to withdraw consent at any time during the process;
 - e. The legal authority that permits the OT to collect, use, and disclose personal health information, as appropriate;
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3.3 Identify who is in the circle of care;³

3.4 Develop and/or implement policies and procedures for appropriate management of ‘**lock box**’ information (paper or electronic) to prevent unauthorized access and ensure that;⁴

- a. When the client has expressly requested specific information be withheld and not disclosed to another individual, custodian or agent, the ‘lock box’ concept is applied to secure the personal health information;
- b. All ‘locked’ information is maintained in the record, retained for the required period of time and accessible to the client or other individuals who are legally authorized to access the information;
- c. When the OT deems the withheld information is reasonably necessary for the provision of care, the OT will inform the custodian or agent receiving the record that some personal health information is inaccessible as a result of it having been “locked” by the client;

Note: In this circumstance the OT will not disclose the content of the ‘lock box’ only that the client has ‘locked’ or restricted access to some personal health information.

- d. When the OT believes on reasonable grounds that disclosure of the personal health information is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to an individual or a group of persons, the OT will disclose relevant ‘lock box’ information.
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³ A term of reference used to describe health information custodians and their authorized agents who are permitted to rely on an individual’s implied consent when collecting, using, or disclosing personal health information for the purpose of providing health care or assisting in providing health care.

⁴ “Lock box” is a term of reference used to describe the right of an individual to instruct a health information custodian or agent not to disclose specified personal health information to another custodian or agent for the purpose of providing health care. An individual can be said to have placed his/her personal health information into a lock box by expressly withholding or withdrawing consent for his/her health information to be collected, used or disclosed.

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

Standard 4

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

Performance Indicators

An OT will:

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| 4.1 | Obtain consent by providing detailed and specific information to enable the client's understanding of the role and activities that support personnel, students and/or others will perform related to occupational therapy services;
Note: Refer to the Standards for the Supervision for Support Personnel and the Standards for the Supervision of Students for additional information. |
| 4.2 | Provide information to the client about the method of supervision; |
| 4.3 | Document that consent was obtained for participation of support personnel, students, and others; |
| 4.4 | Obtain and document consent when involving other persons who are not in the circle of care. |

5. Withdrawal of Consent

A client or SDM may withdraw consent at any time. The OT must respect the client's decision.

Standard 5

The OT will ensure that the client or substitute decision maker (SDM) understands the right to, and the implications of, withdrawing consent.

Performance Indicators

An OT will:

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| 5.1 | Ensure the client or SDM understands his/her right to withdraw consent; |
| 5.2 | Ensure the client or SDM understands the implications of withdrawing consent; |
| 5.3 | Continue the service if immediate withdrawal would be life-threatening or pose immediate or serious risk to the health or safety of the client, the OT or others. The OT will advise the client when they are required to continue the service for safety reasons and provide the rationale; |
| 5.4 | Document any service provided prior to consent being withdrawn and securely maintain any information in the client's record collected prior to the withdrawal of consent; |
| 5.5 | Document any rationale provided by the client for the withdrawal of consent for service or disclosure of personal health information as well as any relevant discussions with the client/SDM. |
| 5.6 | Only release information for which the client consents and reference withdrawal of consent for full disclosure, as appropriate; |
| 5.7 | Refrain from releasing information if the client or SDM withdraws consent for disclosure of that information, unless the OT is legally required to do so.
Note: Withdrawal of consent for disclosure of information cannot be applied retroactively. A client cannot withdraw consent for disclosure of information, to which the client previously consented, after the information has been disclosed. |
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6. Third Party Consent

There are situations where one health care practitioner may obtain consent on behalf of other health care practitioners involved in the service delivery.

Standard 6

The OT will ensure consent for occupational therapy service obtained by a third party has been acquired using an informed consent process.

Performance Indicators

An OT will:

Take reasonable measures to:

6.1

- a) ensure that the third party applies the informed consent process;
- b) ensure that consent was obtained prior to initiating services;
- c) ensure that a process for ongoing consent is followed.

6.2

Confirm and document that a third party has obtained consent for service including the name or role of the individual who obtained the consent;

6.3

Obtain informed consent if it is determined that the consent process obtained by the third party was not complete.

7. Referrals from Third Party Payers and Independent Evaluations

Referrals from third parties describes circumstances where the OT receives a request and payment for service from a third party (someone other than the client or SDM) to assess a client, evaluate a proposed service plan, or to provide treatment. Referrals from third party payers or requests for independent evaluations often occur for employment, legal, financial, or insurance reasons. The OT performing the role on behalf of a third party payer is expected to be objective, impartial, fair and transparent throughout the service delivery and is accountable to ensure informed consent has been obtained prior to intervening with a client.

Although the referring third party may have the authority to oblige a person to participate in specific processes or evaluations, the OT is expected to obtain informed consent from the client for the specific

OT services being proposed (assessment, treatment or consultation) and knowledgeable consent for the collection, use and disclosure of any personal health information associated with the OT services. Where the OT has not been identified as the party responsible for the management of personal health information contained in specific reports, the OT should ensure the client is aware of the expectations for requesting access, disclosure or non-disclosure as part of the informed consent process. **The consent requirements for OT services in the context of third party payers are consistent with the consent requirements for OT services performed in any other practice context.**

When there is a request for the OT to review additional information, such as medical reports or surveillance material, about the client after the in-person service (evaluation) has occurred, the OT is expected to obtain the client's consent prior to using the material if this information was not explicitly addressed during the initial consent process. Whenever possible, the OT should review the additional material with the client to allow the client an opportunity to respond and to put the additional information into context. The process for how the material will be reviewed is at the discretion of the OT. In some cases, the OT may determine that they are not in a position to review the additional information.

File reviews, also known as paper-based reviews, where the OT has no direct contact with the client as part of the evaluation and reporting process, do not require the OT to obtain informed consent from the person whose file is being reviewed. The OT should clearly document the format of the evaluation and any potential limitations associated with the file review process.

Standard 7

The OT will ensure informed consent is obtained from the client or SDM for occupational therapy services (including independent evaluations) delivered at the request of a third party payer and that knowledgeable consent is obtained for the collection, use and disclosure of personal health information associated with the service delivery.

Performance Indicators

An OT will:

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| 7.1 | Apply an informed consent process for occupational therapy service (refer to Standard 2) including confirmation that the service is occurring at the request of the third party payer, the nature and extent of the OT's role and the reporting responsibilities; |
| 7.2 | Ensure knowledgeable consent has been obtained for collecting, using, and disclosing personal health information (refer to Standard 3) including consultation with relevant stakeholders, unless not required under law; |
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| 7.3 | Inform the client that consent may be withdrawn at any time prior to the completion of the service delivery or reporting and ensure that the client understands the implications of withdrawing consent; |
| 7.4 | Obtain client consent to use additional health information such as medical reports or surveillance material when the additional information becomes available after the in-person service delivery has occurred, if not explicitly addressed during the initial consent process. |
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8. Documenting Consent

Consent for all aspects of occupational therapy service delivery should be documented in a timely manner after the consent process has occurred with the client or SDM. Documentation of consent may refer to a specific service or to a plan of care. Consent should be obtained and documented again, if any changes are made over the course of occupational therapy service delivery.

The OT will consider the level of risk associated with the service within the context of their practice to determine the frequency of documentation required regarding consent.

A signed consent form does not necessarily indicate informed consent has been obtained. Consent forms should not be a substitute for the oral or alternate communication process. Forms can be used to augment the process and offer a standard method of obtaining consent from each client. The existence of a policy or protocol describing the process for obtaining consent may address some of the documentation requirements.

Standard 8

The OT will document the receipt, refusal or withdrawal of consent for occupational therapy service delivery and the collection, use and disclosure of personal health information.

Performance Indicators

An OT will:

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| 8.1 | Document in a timely manner: <ol style="list-style-type: none">a. The client's apparent understanding of the proposed service(s) which may include a plan of care;b. Whether or not the client agreed to all, some, or none of the proposed services; |
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- c. That material risks, limitations and benefits of the service were discussed with the client;
 - d. Any modifications or limitations to the client's/SDM's consent;
 - e. Whether the client or SDM agreed to the collection, use, and/or disclosure of the client's personal health information and any limits imposed;
 - f. When consent was obtained through the use of an interpreter, alternate means of communication, or a SDM;
 - g. The identity of the SDM, and as applicable, any reference to the legal entitlement of the SDM (documentation on file, copy of Power of Attorney for personal care provided, etc.);
 - h. Client's withdrawal of consent and any rationale provided by the client for the withdrawal.

Note: The documentation can take any of the following forms:

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

1. College of Occupational Therapists of Ontario (2012). *Conscious Decision-Making in Occupational Therapy Practice*. Toronto, ON.
2. College of Occupational Therapists of Ontario (2008). *Prescribed Regulatory Education Program: Consent*. Toronto, ON.
3. College of Occupational Therapists of Ontario (2014). *Prescribed Regulatory Education Program: Privacy & Confidentiality*. Toronto, ON.
4. College of Occupational Therapists of Ontario (2013). *Standards for Occupational Therapy Assessments*. Toronto, ON.
5. College of Occupational Therapists of Ontario (2016). *Standards for Record Keeping*. Toronto, ON.
6. Health Canada (2016). Science and Research: Requirements for Informed Consent Documents. Retrieved from <http://www.hc-sc.gc.ca/sr-sr/advice-avis/reb-cer/consent/index-eng.php> September 24, 2016.

Appendix 1

Hierarchy of Substitute Decision-Makers

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

In most situations, a SDM does not have to be appointed by the courts. However, the SDM must be at least 16 years old, unless the SDM is the parent of the individual. The SDM must also be capable, himself or herself, to give consent. The *Health Care Consent Act, 1996* provides a hierarchy of persons who can provide substitute consent. Generally, the practitioner must obtain consent from the highest-ranking available and willing substitute unless a lower-ranking substitute is present and believes that the higher-ranking substitute would not object. Where a substitute decision-maker from the first three on the hierarchy is available and willing to make the decision, then he or she must be used.

The hierarchy of individuals who may give or refuse consent on an incapable person's behalf ranked highest to lowest:

1. Guardian of the person appointed by the courts, if the person has the authority to give or refuse consent to treatment;
2. Attorney for personal care conferred by a written form when the client was capable;
3. Representative appointed by the Consent and Capacity Board;
4. Spouse or partner;
5. Child or parent (custodial parent if the child is a minor);
6. Parent of the incapable person who has only a right of access;
7. Brother or sister;
8. Any other relative;
9. Public Guardian and Trustee.

Glossary

Attorney for Personal Care

A power of attorney that deals with the issue of personal care given under the *Substitute Decisions Act, 1992 (SDA)*.

Capacity

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

People:

- i. are presumed capable unless there is information to lead the OT to think otherwise;
 - ii. may be capable with respect to one intervention/decision but not another; and
 - iii. may be capable with respect to an intervention/decision at one time and incapable at another. (*Health Care Consent Act, 1996*)
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Capacity Assessor

Someone who is qualified and designated by the Ontario Ministry of the Attorney General to determine whether an individual is mentally incapable of certain types of decision-making as described in the *Substitute Decisions Act*. In some circumstances, the *Substitute Decisions Act* gives capacity assessors the exclusive authority to make such determinations.

Circle of Care

A term of reference used to describe health information custodians and their authorized agents who are permitted to rely on an individual's implied consent when collecting, using, or disclosing personal health information for the purpose of providing health care or assisting in providing health care.

Component

A discrete part or entity of a plan of intervention, contributing to the whole plan.

Consent

The agreement of the client to a service. To be valid, consent must be informed, must relate to the proposed service, must be given voluntarily and must not be obtained through misrepresentation or fraud.

Consent and Capacity Board

Established by, accountable to, and appointed by the government. The Board considers applications for review of findings of incapacity, applications relating to the appointment of a representative (e.g. SDM), and applications for direction regarding the best interests and wishes of an incapable person.

Course of Intervention	A series or sequence of related interventions administered to a person over a period of time for a particular health issue.
Express Consent	Express consent for intervention or for the collection, use or disclosure of personal health information by an OT and/or Health Information Custodian is explicit and direct, and may be given verbally, in writing or by electronic means.
Guardian of the Person	Under <i>the Substitute Decisions Act, 1992</i> , a guardian of the person is appointed by the Court for a person who is incapable of personal care and, as a result, needs decisions to be made on his or her behalf by a person who is authorized to do so.
Implied Consent	<p>In relation to service, implied consent is inferred from the words or behavior of the patient, or surrounding circumstances, such that a reasonable person would believe that consent for the service has been given, although no direct, explicit words of agreement have been given. Although the HCCA states that consent to treatment may be express or implied, the College advises OTs to obtain express consent.</p> <p>In relation to health information, implied consent permits a health information custodian to infer from the surrounding circumstances that an individual would reasonably agree to the collection, use or disclosure of his/her personal health information.</p>
Informed Consent	Consent is informed if, before voluntarily agreeing to the service, the person making the intervention decision received the information that a reasonable person in the same circumstances would require in order to make a decision about the intervention. This information would also include responses to requests for additional information, including information about the nature, benefits, material risks, and side effects of the intervention, alternative courses of action, and the likely consequences of not having the intervention. The informed consent must be obtained, recorded, dated, and maintained as part of the client record.
Service	Includes all aspects of occupational therapy including assessment, treatment and consultation for which an OT must obtain informed consent.
Knowledgeable Consent	<p>According to PHIPA, “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,</p> <p>(a) the purposes of the collection, use or disclosure, as the case may be; and</p>

(b) that the individual may give or withhold consent. 2004, c. 3, Sched. A, s. 18 (5)".

Partner/Spouse

According to the HCCA two persons are spouses for the purpose of consent to treatment if,

- (a) they are married to each other; or
- (b) they are living in a conjugal relationship outside marriage and,
 - i. have cohabited for at least one year,
 - ii. are together the parents of a child, or
 - iii. have together entered into a cohabitation agreement under section 53 of the *Family Law Act*.

Power of Attorney (POA)

A legal document that gives someone else the right to act on your behalf. A Power of Attorney for Personal Care is a legal document in which one person gives another person the authority to make personal care decisions on their behalf if they become mentally incapable.

Public Guardian and Trustee, (PGT)

The PGT is the SDM of last resort for a mentally incapable person. Under the amendments to the *Substitute Decisions Act, 1992* the court will not appoint the PGT as guardian of property or guardian of the person unless there is no other suitable person available and willing to be appointed.

Relative

A person related by blood, marriage, or adoption.

Substitute Decision-Maker (SDM)

A person who makes decisions for someone who is incapable of making their own decisions, and who is authorized to give or refuse consent to an intervention on behalf of a person who is incapable with respect to the intervention. In most cases this will be a family member or partner. In others, this may be an individual specifically selected by the client, or appointed by the Court, the Board or Public Guardian and Trustee Office. *See Appendix.*

College of Occupational Therapists of Ontario
20 Bay St, Suite 900, PO Box 78, Toronto, ON M5J 2N8
T 416.214.1177 • 1.800.890.6570 F 416.214.1173
www.coto.org

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