COTNS COLLEGE of OCCUPATIONAL THERAPISTS of NOVA SCOTIA

Practice Guideline:
Informed Consent

Members of the College of Occupational Therapists of Nova Scotia are accountable for the practice they provide to the public. Guidelines are issued by the College for the assistance of the professional. They represent guidance from the College on how members should practice. Guidelines are intended to support, not replace, the exercise of professional judgment by therapists in particular situations.

Statement of Purpose

The purpose of this document is to act as a guideline to help occupational therapists use best practice to obtain and document informed consent. The College of Occupational Therapists of Nova Scotia endorses clients' choice in all occupational therapy services. Consent is a process which requires a dialogue between the person proposing the service and the person giving the consent for the service. This document outlines the necessary components of informed consent.

Practice Guideline Organization

The Informed Consent Guideline is divided into the following headings:

1. Key Responsibilities
2. Definitions
3. Criteria:
    a. Determining Capacity to Give Consent
    b. Obtaining, Maintaining, & Documenting Informed Consent
    c. Ensuring all Elements of Informed Consent are Met
    d. Third Party Informed Consent
    e. Withdrawal of Informed Consent
    f. Documenting Informed Consent
4. Appendix
5. References

1. Key Responsibilities

Obtaining consent is an ongoing communication process that enables the client to make the decision to accept or refuse occupational therapy services. As regulated health care professionals, occupational therapists are required to obtain consent for occupational therapy services.

The client's right over his or her own body, and the right not to have his or her body interfered with is considered so important that the occupational therapist must be able to prove that the client provided consent. Consent can be withdrawn at any time, and the decision must be

respected. The client has the right to give or refuse consent on any grounds, including moral or religious grounds.

This document outlines the key responsibilities of the Occupational Therapist in obtaining informed consent.

2. Definitions

A working understanding of the following definitions is essential for the appropriate interpretation of this document.

Capacity
The ability to understand information that is relevant to the making of a personal care decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision (Personal Directives Act 2008)

Client
An individual, group, agency, organization, business, or other that forms a partnership with an occupational therapist. This includes individuals with occupational performance issues arising from physical, cognitive, psychosocial, social, and/or environmental barriers.

Informed consent
An ongoing communication process that enables the client to make the decision to accept or refuse occupational therapy services.

Occupational Therapy Assessment
An ongoing process of collecting, analyzing and interpreting information obtained through observation, interview, record review and testing. Occupational Therapists gather information through standardized, informal, or qualitative methodology in addition to report(s) from various other health disciplines, clients and others.

Occupational Therapy Intervention
A process in which two (client and occupational therapist) or more parties participate in a joint effort to promote, establish, maintain, and/or increase the level of occupational performance of a particular client. Some service components may be assigned to support personnel but the occupational therapist is identified as having ultimate responsibility for the quality of service to that client.

Occupational Therapist
For the purpose of this document occupational therapist refers to an individual who is registered with COTNS. The occupational therapist is responsible and accountable for the development and implementation of an individual plan of care for his/ her clients. This may include assignment of OT plan components to support personnel.

Substitute Decision Maker (SDM)
A person authorized under a personal directive to make, on a client's behalf, decisions regarding the client's health care, home care or placement in a continuing care home. A SDM can either be a delegate or statutory decision maker under the Personal Directives Act. (For more information see Appendix) (Personal Directives Act 2008)

3. Criteria

a. Determining Capacity to Give Consent

1. When to Assess

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

- Evidence of confused or delusional thinking;
- Inability to make a settled choice;
- Severe pain or acute fear or anxiety
- Severe depression;
- Impairment by alcohol or drugs; or
- Any other observations which give rise to a concern about the person's behaviour.

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

An occupational therapist should not make any presumption of incapability solely because the person:

- Has a diagnosis of a psychiatric or neurological condition;
- Is disabled, including a speech or hearing impairment;
- Refuses the proposed treatment against advice;
- Requests an alternative treatment;
- The fact that there is a guardian or substitute decision maker in place

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

2. Understanding the Information

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

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

3. Appreciating Consequences

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

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

If the person cannot appreciate any one of these factors, the person is not capable of giving consent (COTO, 1996).

b. Obtaining, Maintaining, & Documenting Informed Consent

As regulated health care professionals, occupational therapists are required to obtain informed consent. It is important to obtain informed consent prior to and during the occupational therapy assessment and intervention.

The client always has the right to consent or refuse assessment and/or treatment. Informed consent can be withdrawn at any time, and the decision must be respected. If the client does not have the capacity to give informed consent then it must be received from a substitute decision maker. If a client regains capacity, his or her own decisions take precedence over any decisions made by a substitute decision-maker. Informed consent (or refusal) must be recorded, dated, and maintained as part of the client record.

c. Ensuring All Components of Informed Consent Are Met

Once it has been determined who can give informed consent, the occupational therapist addresses the following:

1. The informed consent must be given voluntarily.

2. The informed consent must be specific to the proposed occupational therapy services. It should address the scope and reason of the referral including referral source, the nature, purpose, benefits, and risks of the assessment and/or intervention, alternative treatments, and the consequences of refusing assessment and/or intervention. Informed consent to treatment may include minor variations or adjustments in the treatment.

3. Any personal commitment and/or financial costs associated with the proposed assessment and/or intervention including anticipated frequency and duration of services.

4. The identity, professional qualifications and role of individuals who will be involved in the assessment and/or intervention (i.e. other team members, support personnel, students etc.). Also provide information to the client about the method of supervision of students and/or support personnel; the parameters of the health information that is being disclosed to the other individuals involved in occupational therapy service must also be discussed with the client.

5. The expected outcomes of the assessment and/or intervention, how the information may be used, and with whom it will be shared;

6. The right of the client to withdraw informed consent at any time during the process;

7. Where appropriate/possible, the option of the client to request another occupational therapist to perform the assessment and/or intervention.

8. The Occupational Therapist has an ethical duty to document the receipt of informed consent. The best practice is to document in the client's chart the receipt of informed consent including all requisite elements (client is competent to give informed consent, advised the client of the proposed treatment and its purpose, treatment options, potential risks/benefits, etc.).

d. Third Party Informed Consent

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

The occupational therapist will take reasonable measures to ensure that the third party applies the informed consent process and document appropriately.

e. Withdrawal of Informed Consent

A client or SDM always has the right to withdraw informed consent. When a client or SDM withdraws informed consent, the occupational therapist will:

1. Ensure the client or SDM understands the implications of withdrawing informed consent;
2. Document any intervention that was provided;
3. Continue the intervention if immediate withdrawal would be life threatening or pose immediate or serious problems to the health of the individual or the occupational therapist;
4. Submit the portion of the report to which the client provided informed consent;
5. Not complete, or submit a report if the client or SDM withdraws informed consent to do so unless the occupational therapist is legally required to do so;
6. Document any reason given for the informed consent being withdrawn and any relevant discussions with the client/substitute decision-maker.

f. Document Informed Consent

The occupational therapist will document informed consent for assessment and intervention and will include the following:

1. The client's apparent understanding of the proposed assessment/intervention(s);
2. Whether or not the client agreed to all, some, or none of the proposed assessments/interventions;
3. That the risks, limitations and benefits were discussed with the client; if there may be specific high risk, high probability situations, further detail may be warranted.
4. That informed consent was obtained to involve other persons who are not in the circle of care (e.g. vendors).
5. Any modifications to the original plan to which informed consent was given;
6. Whether the client or SDM agreed to the collection, use, and/or disclosure of the client's

personal information and any limits imposed;

7. When informed consent was obtained through the use of an interpreter, alternate means of communication, or a substitute decision-maker;

8. Document the identity of the SDM and their legal entitlement (documentation on file, copy of Power of Attorney for personal care provided, etc.);

9. Document that informed consent was obtained for the participation of support personnel, students, and others;

10. That the client withdrew informed consent, why he/she did so, and what specifically was withdrawn.

The documentation can take any of the following forms:

- A note in the client record, and/or;

- An informed consent form, that is dated, signed, and witnessed, and/or;

- An informed consent policy/procedure or a guideline that is referenced in the client's record.

4. Appendix

Substitute Decision Maker

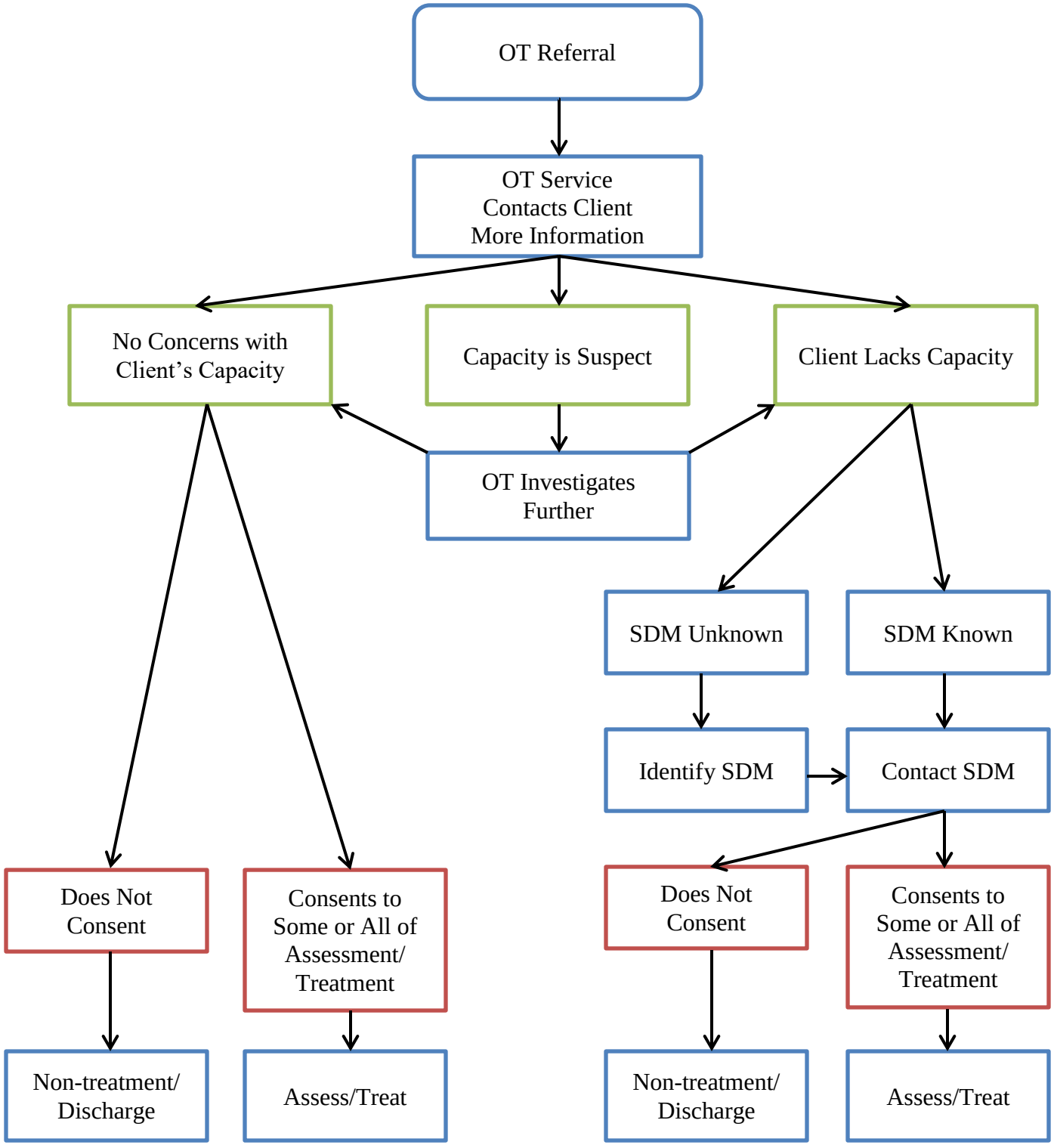
The only difference between a statutory decision maker and a delegate is that a delegate is determined by the client. A statutory decision maker is determined by the care provider through the established process outlined in the Personal Directives Act.

Public Trustee can be determined as substitute decision maker as the last resort of the statutory decision maker appointment process.

For the purposes of this guideline the order of priority of substitute decision-maker is as follows*:

1. A person who is authorized by or required by law to act on behalf of the individual;
2. A guardian appointed by a court of competent jurisdiction;
3. Spouse;
4. Adult child;
5. Parent;
6. Adult;
7. Grandparent;
8. Adult grandchild;
9. Adult aunt or uncle;
10. Adult niece or nephew;
11. Any other adult next of kin;
12. The Public Trustee.

* *Hospitals Act, 1989*, subsection 54(2); Personal Health Information Act, 2010, subsection 21(2)


OT Referral
OT Service Contacts Client More Information
No Concerns with Client's Capacity
Capacity is Suspect
Client Lacks Capacity
OT Investigates Further
SDM Unknown
SDM Known
Identify SDM
Contact SDM
Does Not Consent
Consents to Some or All of Assessment/ Treatment
Does Not Consent
Consents to Some or All of Assessment/ Treatment
Non-treatment/ Discharge
Assess/Treat
Non-treatment/ Discharge
Assess/Treat

Informed Consent Checklist

Practice Expectations	Yes	No	N/A
I am responsible for obtaining informed consent.			
I obtain informed consent through discussion with the client or the substitute decision maker for all assessment/treatment.			
I have documented obtaining informed consent.			
I obtain informed consent regularly if occupational therapy services are ongoing.			
Clients have the opportunity to ask questions and receive answers, and time to consider the proposed services.			
I provide information required to understand the assessment/treatment:			
• Occupational performance issues to be addressed			
• Purpose of assessment/treatment			
• Nature of proposed assessment/treatment, including any use of support personnel, students, or other occupational therapists			
• Benefits/Risks of assessment/treatment			
• Alternative care, including option of no service			
I provide additional information when appropriate.			

5. References

Personal Directives Act (2008).

Ontario Standards for Consent

COTBC – Practice Guideline for Consent

COTO – Standard for Consent

Nova Scotia College of Physiotherapists – “Informed Consent Policy”

Determination of Capacity and Consent for Service Flow Chart – Continuing Care Nova Scotia