College of
HEALTH AND CARE
PROFESSIONALS OF BC

Practice Standards for Consent

Applies to Occupational Therapists

The College of Health and Care Professionals of BC was created on June 28, 2024 through the amalgamation of seven health regulatory colleges:

- College of Dietitians of British Columbia
- College of Occupational Therapists of British Columbia
- College of Optometrists of British Columbia
- College of Opticians of British Columbia
- College of Physical Therapists of British Columbia
- College of Psychologists of British Columbia
- College of Speech and Hearing Health Professionals of British Columbia

All current requirements for standards of clinical and ethical practice issued by the seven colleges remain in place upon amalgamation.

This document was created by the College of Occupational Therapists of British Columbia and will be updated to reflect the amalgamation.

College of
Occupational Therapists
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COTBC Practice Standards for Consent

Overview

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Note to Readers

Throughout these practice standards, reference is made to the support documents listed on the next page. Please check that you have the most recent versions, and if necessary, download these from the College website or contact the College for updates.

To ensure timeliness and accuracy, updates to practice standards will be made when necessary. Suggestions and questions regarding the content or application to practice should be forwarded to:

practice@cotbc.org

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Note to Readers, continued

ACOTRO, ACOTUP & CAOT. (2021). *Competencies for occupational therapists in Canada.* Retrieved from https://acotro-acore.org/wp-content/uploads/2021/11/OT-Competency-Document-EN-HiRes.pdf

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Practice standards in this series:

1. Obtaining and Maintaining Consent, p. 11
2. Determining Capability to Give Consent, p. 19
3. Documenting Consent, p. 24

Preamble

COTBC practice standards are published by the College to assist the occupational therapist in meeting the *Competencies for Occupational Therapists in Canada* by

- defining registrant responsibilities;
- describing minimal expectations for occupational therapy practice; and
- defining safe, ethical, and competent occupational therapy practice.

The *COTBC Practice Standards for Consent* were developed by occupational therapists in British Columbia who work in a variety of practice settings and serve on COTBC's Patient Relations, Standards and Ethics Committee (formerly the Standards Committee). The committee reviewed parallel documents from Canadian and international occupational therapy and health regulatory organizations, and considered practice questions, issues, and concerns presented by registrants and others.

Statement of Purpose

The College of Occupational Therapists of British Columbia (COTBC) regulates the practice of British Columbia occupational therapists to "serve and protect the public" under the *Health Professions Act*, RSBC 1996, c. 183; the *Occupational Therapists Regulation;* and the College bylaws.

These *Practice Standards for Consent* assist the occupational therapist to understand the legal and ethical obligations related to obtaining consent for occupational therapy services. Used alongside COTBC's Bylaws and Code of Ethics, as well as the *Competencies for Occupational Therapists in Canada* and relevant statutory requirements, these practice standards serve to clarify the occupational therapist's accountabilities and the College's expectations regarding obtaining and maintaining consent, determining capability to give consent, and documenting the consent process and outcomes. Note that these practice standards are not a substitute for reading the relevant Acts referred to throughout the document. Rather, they are meant to be read in conjunction with them.

Please note that these *Practice Standards for Consent* do not address consent related to

- the collection and disclosure of client information,
- participation in research, and
- admission to a care facility.

The occupational therapist is encouraged to refer to the *Practice Standards for Managing Client Information* (revised 2023) and their organization's policies and required ethics review processes for guidance in these respective areas.

Overview

An occupational therapist respects the clients' right to make decisions about the management of their own health care. According to the Ministry of Health (2011), "Consent is a process that results in a voluntary agreement to permit the delivery of health care to a person" (p. 3). The occupational therapist has both ethical and legal obligations for obtaining valid consent. Ethical obligations are outlined in COTBC's Code of Ethics and are most strongly reflected in three of its values:

- Dignity and Worth
- Individual Autonomy, and
- Honesty and Transparency.

Overview, continued

Legal obligations for obtaining consent from adults and minors are outlined in two key statues, the *Health Care (Consent) and Care Facility (Admission) Act* (*HCCCFAA)* and the *Infants Act*. Other relevant Acts include but are not limited to

- *Adult Guardianship Act,*
- *Mental Health Act,*
- *Patients Property Act,*
- *Representation Agreement Act,*
- *Child, Family and Community Service Act,*
- *Family Law Act,* and
- *Residential Care Regulation* under the *Community Care and Assisted Living Act.*

Obtaining consent is a dynamic, ongoing communication process that ensures that clients have adequate information to make informed decisions about their care and that clients' wishes are respected and followed. Every adult is presumed to be capable of giving, refusing, or revoking consent to health care until the contrary is demonstrated. Section 4 of the *HCCCFAA* outlines clients' rights related to consent:

- the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,
- the right to select a particular form of available health care on any grounds, including moral or religious grounds,
- the right to revoke consent,
- the right to expect that a decision to give, refuse or revoke consent will be respected, and
- the right to be involved to the greatest degree possible in all case planning and decision making.

Overview, continued

The *HCCCFAA* also outlines the necessary elements of consent, which include that

- the consent relates to the proposed health care,
- the consent is given voluntarily,
- the consent is not obtained by fraud or misrepresentation,
- the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,
- the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about
  - the condition for which the health care is proposed,
  - the nature of the proposed health care,
  - the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and
  - alternative courses of health care, and
- the adult has an opportunity to ask questions and receive answers about the proposed health care (section 6).

Overview, continued

The *HCCCFAA* further provides that when "seeking an adult's consent to health care or deciding whether an adult is incapable of giving, refusing, or revoking consent, a health care provider

- must communicate with the adult in a manner appropriate to the adult's skills and abilities, and
- may allow the adult's spouse, or any near relatives or close friends, who accompany the adult and offer their assistance, to help the adult to understand or to demonstrate an understanding of the [information given by the health care provider]" (section 8).

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COTBC Practice Standards for Consent

Practice Standard #1:
Obtaining and Maintaining Consent

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Practice Standard #1: Obtaining and Maintaining Consent

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

Practice Expectations

The occupational therapist must do the following:

1. Respect the client's right to make decisions regarding their own health care.

2. Presume that the client is capable of giving, refusing, or withdrawing consent for occupational therapy services until the contrary is demonstrated.

3. Determine the client's capability to give consent when a potential concern is identified (Refer to Standard #2).

4. Identify the person who is authorized to make a decision on the client's behalf (i.e., substitute decision maker) when necessary.

Practice Standard #1: Obtaining and Maintaining Consent, continued

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

5. Obtain consent directly from the client or substitute decision maker prior to providing occupational therapy services, unless there is an exception in legislation. Examples of exceptions include

   - when urgent or emergency health care is required, the adult is incapable of consenting, and a substitute decision maker with authority to consent is not available (HCCCFAA, section 12); and
   - for preliminary assessment or examination, such as triage, where the client indicates that they want to receive care or, "in the absence of any indication by the client, the client's spouse, near relative or close friend indicates that he or she wants the client to be provided with care" (HCCCFAA, section 13).

Practice Standard #1: Obtaining and Maintaining Consent, continued

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

6. Provide the client and/or substitute decision maker with the information a reasonable person would require to make a decision regarding proposed occupational therapy services. The information provided is specific, sufficient, and evidence based and includes details regarding
   - the condition for which the services are proposed;
   - the nature of the proposed services, including but not limited to details such as the background and skills of the occupational therapist, the involvement of any support personnel and students, and the timing, length, costs, and expected outcomes of the services;
   - the risks and benefits of the proposed services; and
   - alternatives to the proposed services.

Practice Standard #1: Obtaining and Maintaining Consent, continued

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

7. Ensure that consent is given voluntarily, without coercion, fraud, or misrepresentation.

8. Provide the client an opportunity to ask questions and receive answers about proposed health care. This includes respecting the client's wishes to seek further information or involve others when making their decision.

9. Consider factors such as culture, language, abilities, and preferences when providing timely and appropriate information regarding proposed occupational therapy services to the client and/or substitute decision maker.

Practice Standard #1: Obtaining and Maintaining Consent, continued

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

10. Recognize that consent can be given orally, in writing, or through alternative communication systems, or inferred from behaviour that implies consent.

11. Revisit consent if there are doubts regarding the client or substitute decision maker's wishes, when the client is moving from one component of occupational therapy service to another, or when there are changes to the nature or scope of the proposed services.

12. Respect the right of the client or substitute decision maker to withdraw consent at any time and for any reason, provided that they are capable of doing so and there is no legislation that removes that right. When consent is withdrawn, the occupational therapist will seek to understand the reasons. The occupational therapist will ensure that the client or substitute decision maker understands their right to withdraw consent and the implications of withdrawing consent.

Practice Standard #1: Obtaining and Maintaining Consent, continued

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

13. In very limited circumstances, base the decision about a client's health care on what is in the best interests of that client, as the occupational therapist can best determine and in consultation with others. This occurs only when all of the following conditions apply:
    - The client is unable to provide consent.
    - There is no advance directive.
    - No substitute decision maker is readily available.
    - The care or treatment must be provided without delay (e.g., in order to preserve life or to prevent serious physical or mental harm).

Practice Standard #1: Obtaining and Maintaining Consent, continued

Principle Statement:

The occupational therapist will ensure that valid consent is obtained from the client or substitute decision maker at the start of and throughout service delivery.

14. Recognize that the occupational therapist is responsible for ensuring that valid consent was obtained when initial access to occupational therapy services was obtained through a third party consent process. This includes ensuring that the elements of consent were met and may require the occupational therapist to speak directly with the client.

15. Take action if there is concern related to obtaining consent, including seeking assistance as needed.

16. Apply any workplace consent policies and procedures provided that they are consistent with legal and ethical requirements. Where they do not exist or are insufficient, advocate for, or participate in, their development.

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COTBC Practice Standards for Consent

Practice Standard #2: Determining Capability to Give Consent

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Practice Standard #2: Determining Capability to Give Consent

Principle Statement:

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

Practice Expectations

The occupational therapist must do the following:

1. Presume that the client is capable of giving, refusing, or withdrawing consent for occupational therapy services until the contrary is demonstrated.

2. Avoid presumptions of incapability based on factors such as a diagnosis of a psychiatric or neurological condition, a communication disorder or impairment, a disability, the client's age, or a client's decision to refuse an intervention.

Practice Standard #2: Determining Capability to Give Consent, continued

Principle Statement:

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

3. When a concern is identified, apply a variety of strategies to determine a client's capability to provide consent. This includes but is not limited to using a variety of communication strategies (e.g., using an interpreter or alternative communication systems), collaborating with the client and those close to the client, using a functional approach, assessing the client more than once to accommodate fluctuations in cognitive abilities, and consulting with other health professionals. When possible, the occupational therapist will support the client to make decisions that are within their capability.

4. Use clinical reasoning and base decisions regarding a client's capability of consenting to services on whether or not the client understands the information that is relevant to make a decision regarding the proposed services, including how the information applies to their situation.

Practice Standard #2: Determining Capability to Give Consent, continued

Principle Statement:

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

5. Use clinical reasoning and base decisions regarding a minor's capability of consenting to services on whether or not the occupational therapist has
   - explained to the minor and has been satisfied that the minor understands the nature, consequences, and the reasonably foreseeable benefits and risks of the health care, and
   - made reasonable efforts to determine and has concluded that the health care is in the minor's best interests.

Practice Standard #2: Determining Capability to Give Consent, continued

Principle Statement:

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

6. Communicate to the client any findings of incapability to provide consent, the reasons, and process for challenging the determination.

7. Engage the client to the greatest degree possible when a substitute decision maker is involved. This includes telling the client about any care or treatment before it is undertaken, regardless of their ability to provide consent.

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COTBC Practice Standards for Consent

Practice Standard #3: Documenting Consent

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Practice Standard #3: Documenting Consent

Principle Statement:

The occupational therapist will document the receipt, refusal, or withdrawal of consent for occupational therapy service delivery, consistent with requirements outlined in COTBC's *Practice Standards for Managing Client Information*.

Practice Expectations

The occupational therapist must document the consent process including the following:

1. Date consent was obtained.
2. How consent was obtained (e.g., orally, in writing, through alternative communication systems, or inferred).
3. Confirmation that the elements of consent were met (e.g., per section 6 of the *HCCCFAA* or section 17(3) of the *Infants Act*).
4. Reasons for refusal or withdrawal from some or all of the services.
5. Any concerns raised during the consent process and actions taken to address them (e.g., if the client was determined to be incapable of providing consent and an authorized substitute decision maker was identified).

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COTBC Practice Standards for Consent

Risk Assessment and Management

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Risk Assessment and Management

Risk management is “nothing more than a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm” (Health and Safety Executive, 1999, p. 1).

Obtaining consent is not always straightforward. The process requires that the occupational therapist use professional knowledge and critical thinking to ensure that the client or substitute decision maker make informed decisions. The occupational therapist can benefit from using a risk management approach to assist with the consent process.

Risk Assessment and Management, continued

Step One: Identify Potential Risk Factors

Risk factors are circumstances and/or facts that influence the probability that valid consent will not be obtained and the impact if this occurs. Examples of relevant risk factors include the following.

Nature of the Referral

- Referral source's power to influence funding of services.
- Perception that client is under pressure, even coerced, to respond or behave in a certain way.
- Assessment consented to by client but refused by client's lawyer.
- Referral for specific services that are not appropriate for the client at the time.

Client's Presentation and Vulnerability

- Highly complex and/or unstable client condition.
- Cultural beliefs and lifestyle values.
- Fluctuating cognitive abilities due to fatigue, pain, medications, stress, distractions, or nature of illness.
- Communication challenges or barriers (e.g., language barriers, aphasia, dysarthria, visual impairments, hearing impairments, difficulty understanding or retaining complex information, difficulty writing or signing).

Risk Assessment and Management, continued

Step One: Identify Potential Risk Factors, continued

Practice Setting and Environmental Conditions

- Existing organizational policies that require only one consent to cover all services (i.e., blanket consent). However, consent for a team approach is inadequate to cover consent for occupational therapy services.
- Sharing a caseload with another occupational therapist.
- Pressures from others (e.g., family, other team members) for the client to refuse or accept services that the client may or may not want, and that may not be in the client's best interest.
- High workload demands, limiting time to obtain consent.

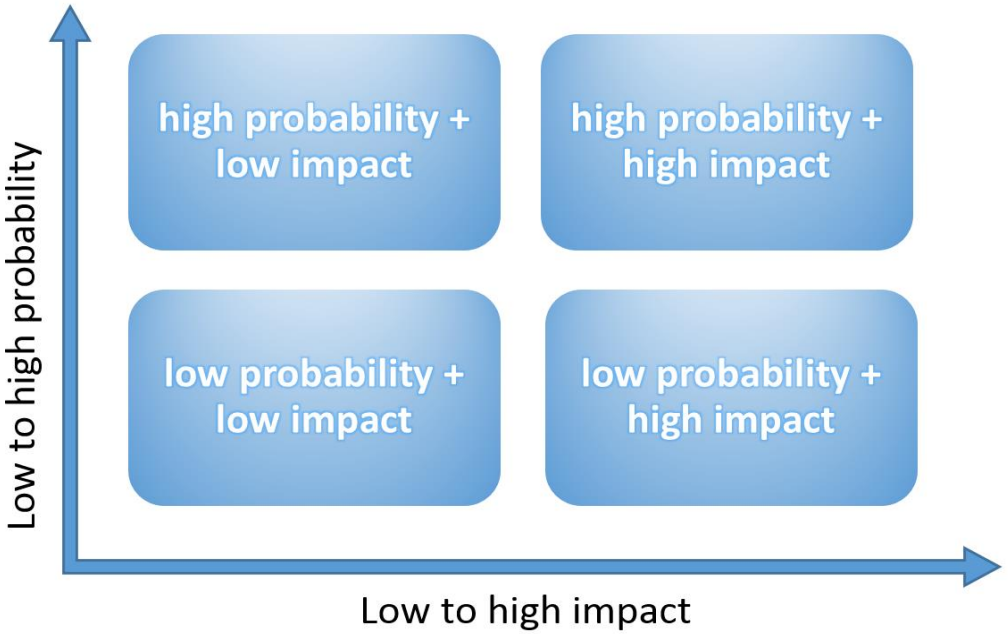
Occupational Therapist's Skills and Knowledge

- Difficulty identifying whether the client may have impaired capability to provide consent.
- Lack of knowledge of current, relevant legislation and consent language and requirements.
- Difficulty communicating with the client, client representative, or other stakeholders.
- Lack of knowledge of employer's policies and procedures.
- Lack of knowledge of various cultural and social norms.
- Lack of experience with documentation of consent process.

Risk Assessment and Management, continued

Step Two: Consider the Probability and Severity of Impact

Note that the *impact* of not obtaining consent is always high because a health care provider who provides treatment without consent may face legal consequences. The occupational therapist must ensure that consent is obtained consistent with legislative obligations.



Risk Assessment and Management, continued

Step Three: Take Action

It is the occupational therapist's legal and ethical responsibility to obtain consent. At times, this can be challenging, given the complexity of the situation. The goal is to choose actions or precautions that help to minimize the risks as much as possible.

Actions could include but are not limited to the following:

- Recommending the use of an interpreter or using communication aids to increase the likelihood that the client understands the information needed to make an informed decision.
- Assessing a client's capability at different times, using various approaches.
- Privately discussing with the client their preferences with respect to involving others in the decision making process or occupational therapy service.
- Strategizing various culturally and socially acceptable approaches to talking about consent.
- Requesting the client's written consent versus obtaining oral consent.
- Increasing the frequency with which consent is revisited.
- Collaborating with colleagues and leadership to develop or amend organizational consent policies.
- Reviewing related legislation and regulations.

Risk Assessment and Management, continued

Step Four: Record Your Actions

The risk management process is dynamic and ongoing throughout the care continuum.

It is important to record the risk management actions taken, to demonstrate that precautions were taken to protect the client from harm and minimize risk; regardless of whether written or oral consent was obtained, consent must be documented.

Definitions

Advance Directive is a consent or a refusal in advance of the need for health care arising and that complies with the requirements of the *Health Care (Consent) and Care Facility (Admission) Act* (CRNBC, 2013, p. 6).

Committee of person is a person or agency who is appointed by the court, under the *Patients Property Act*, who has the authority to make health care decisions on behalf of the client.

Definitions, continued

Health care means "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes

a) a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,

b) a plan for minor health care that

(i) is developed by one or more health care providers,

(ii) deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and

(iii) expires no later than 12 months from the date consent for the plan was given, and

c) participation in a medical research program approved by an ethics committee designated by regulation" (*Health Care (Consent) and Care Facilities (Admission) Act*, section 1).

Infant means an individual who is under the age of 19 years old. For the purposes of this document, infant is synonymous with minor. The *Infants Act* deals with consent for infants or minors.

Definitions, continued

Patient[1] means an individual, family, group, agency, or organization receiving care and/or services from a registered occupational therapist and includes a client or consumer.

Public Guardian and Trustee is "a corporation … established under the *Public Guardian and Trustee Act* with a unique statutory role to protect the interests of British Columbians who lack legal capacity to protect their own interests" (Public Guardian and Trustee of British Columbia, 2014a, para. 1).

Representative means "a person who has legal authority under the *Representation Agreement Act* to make health-care decisions on behalf of an incapable adult" (College of Physicians and Surgeons of British Columbia, 2017, p. 3).

[1] The word *patient* has been used here to support consistency with language presented in the *Health Professions Act*.

Definitions, continued

Substitute decision maker means an individual who is authorized to make the particular health care decision. This includes the parent or guardian of a minor who is not capable of providing his or her own consent under the *Infants Act*. For adults, the hierarchy of decision makers is as follows:

1. Court-appointed committee of person.
2. Representative that has specific permission to make health care decisions.
3. Advance Directive.
4. Temporary substitute decision maker, per section 16 of the *HCCCFAA*.
5. Public Guardian and Trustee of British Columbia.

Valid consent means "consent that has been voluntarily given by a patient (or authorized decision maker) who is legally capable of giving consent, who has been fully informed about the nature of the proposed care (including how it relates to the patient's condition), the risks, benefits and any available alternatives of the proposed care (including the option of no care); and who has been given an opportunity to ask questions and receive answers about the proposed care" (College of Physicians and Surgeons of British Columbia, 2017, p. 4).

References & Resources Used in These Practice Standards

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Relevant Acts and Regulations

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Relevant Acts and Regulations, continued

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Practice standards in this series: *Consent* (Revised May 2023, Originally Issued April 2019)

1. **Obtaining and Maintaining Consent**
2. **Determining Capability to Give Consent**
3. **Documenting Consent**

For more information regarding this series of practice standards, or other practice supports, please contact the College at
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