



College of Occupational  
Therapists of Manitoba

Quality Occupational Therapy - Accountable to Manitobans

# Practice Guideline

## Informed Consent in Occupational Therapy

A COTM guideline sets forth principles to assist members in assessing situations which they encounter in practice and provides a recommended approach. Guidelines are intended to support, not replace, the exercise of professional judgment by the therapist in particular situations.

COTM practice guidelines are prepared to assist occupational therapists in meeting the *Essential Competencies of Practice for Occupational Therapists in Canada* through;

- increasing member knowledge of responsibilities,
- describing expectations of practice,
- defining safe, ethical, competent practice, and
- guiding critical thinking for everyday practice.

Store at tab #4 in your “member Information & Resources” binder.

## NOTE TO READERS

This guideline was developed under *The Occupational Therapists Act (1983)*; the legislation that preceded the current occupational therapy legislation was *The Occupational Therapists Act (2002)*, by the Association of Occupational Therapists of Manitoba, AOTM. AOTM continues as a body corporate as the College of Occupational Therapists of Manitoba. Amendments to the guideline in 2006 were limited to name changes and the insertion of the relevant excerpts from the *Essential Competencies of Practice for Occupational Therapists in Canada, 2003*.

Throughout the guideline, reference is made to the following documents. Please ensure you have the most recent versions.

*Essential Competencies of Practice for Occupational Therapists in Canada*, Third Edition 2011, Association of Canadian Occupational Therapy Regulatory Organizations

- Tab 3 of your “Member Information and Resources Binder”
- Available on the COTM website at:  
[http://www.cotm.ca/index.php/quality\\_practice/practice\\_guidelines](http://www.cotm.ca/index.php/quality_practice/practice_guidelines)

*Code of Ethics*, 2010, College of Occupational Therapists of Manitoba

- Tab 3 of your “Member Information and Resources Binder”
- Available on the COTM website at: <http://www.cotm.ca/publications.html>

Questions regarding the content or application of these guidelines should be made to:

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## **PREAMBLE**

The College of Occupational Therapists of Manitoba (COTM) regulates the practice of occupational therapists in Manitoba. The college is granted this authority under *The Occupational Therapists Act* with the duty to serve and protect the public interest.

## **INTRODUCTION**

The act of acquiring the Informed Consent of a client serves four main purposes:

- to protect an individual's right to "security of the person" according to the Canadian Charter of Rights and Freedoms
- to enhance communication and the special relationship of trust between therapist and client (legally called a fiduciary relationship)
- to avoid litigation as a risk management measure
- to assist individuals to make decisions about their care.

Apart from the legal requirements, the process of acquiring informed consent is one that demonstrates respect for the person.

The process of acquiring consent is one involving an exchange of information between the professional and the client whereby the client learns about the planned therapeutic intervention and the professional learns about the client; this allows the information to be meaningful to both so that the professional can provide needed information in a manner that is meaningful to the client and the client can make an informed decision about their care – keeping in mind that this informed decision can include an informed refusal.

Clients/patients have the right to refuse treatment or withdraw consent for treatment at any time.

In the process of working with clients, occupational therapists are frequently engaging clients in a therapeutic process, without the need to seek formal consent for treatment. Client involvement is essential in the occupational therapy practice process therefore there is very little that occupational therapists "do" to their clients without their active participation. Nevertheless, the occupational therapist must continuously reflect on the required level of consent that is acceptable based on the degree of risk involved in the intervention and / or significance of the impact of the outcomes, with consideration for the level of mental competence of the client.

It is recognized that many agencies have policies and processes related to consent such as a blanket consent that all clients sign upon admission to the facility. It is critical that you are cognizant of these procedures and determine the validity of this practice as "informed consent" in the particular nature of your work. In many cases this practice would not be considered informed consent; for consent to be meaningful and informed it must relate to a context and particular circumstance.

The following information relates to consent within the context of providing assessment and/or treatment. This Guideline does not extend to the specific provisions of provincial and federal legislation regarding the requirement for consent in specific situations such as those found in the *Personal Health Information Act (PHIA)* regarding release of documents. Consent to release information and to engage in communication with others is a critical part of practice but is not within the scope of this COTM Guideline. Further it does not relate to the consent required when conducting research. There are local

research ethics board policies that would govern the consent requirements for your research.

One will find that determining capacity to provide consent is referenced a number of times in this guideline; informal assessment of capacity is an important issue that is not the subject of this guideline. For that reason you may find that you are may continue to have ongoing questions regarding capacity.

## **RELEVANT MATERIAL**

The College of Occupational Therapists of Manitoba *Code of Ethics* 2010 states;

### **B. Individual Autonomy**

Occupational therapists recognize and respect that every client has the right to self-determination.

4. Provide complete and accurate information to enable the client to make an informed decision regarding the need for, and nature of, occupational therapy services, including information about the anticipated benefits and risks of accepting or refusing such services.
5. Respect the wishes of those who refuse, or are not ready, to receive information about their health condition. Occupational therapists are sensitive to the timing of providing information and how the information is presented.
6. Respect the informed choices of those with the decisional capacity to be independent, to choose lifestyles not conducive to good health, and to direct their own care as they see fit. However, occupational therapists are obliged not to comply with a person's wishes when this is contrary to the law or will harm another individual.
7. Obtain and document informed consent for occupational therapy services. Consent can be established orally, or in writing, or where this is not possible it may be implied. Occupational therapists recognize that persons have the right to refuse or withdraw consent for care or treatment at any time.
8. Recognize the presence of coercion and work to minimize its impact.
9. Obtain informed consent for occupational therapy services provided by those under the occupational therapist's supervision, such as students and support personnel.
10. Recognize clients' support network, and where appropriate and with clients' permission, include their participation in occupational therapy services.
11. Provide opportunities for people to make choices and maintain their capacity to make decisions, even when illness or other factors reduce the client's capacity for self-determination. Occupational therapists seek assent of the client when consent is not possible.
12. Respect a client's advance care directives about present and future health care choices that have been given or written by the client prior to loss of decisional capacity.

13. Respect a client's method of decision-making, recognizing that different cultures place different weight on individualism and often choose to defer to family and community values in decision-making.
14. Advocate for the individual if that client's well-being is being compromised by family, community or other health professionals.
15. When a client lacks decision-making capacity, confirm the scope and authority of alternative decision makers and obtain consent for occupational therapy services from the alternate decision-maker, subject to the laws in the jurisdiction. Commit to building trusting relationships with alternative decision makers as one would with the client.
13. When prior wishes for treatment and care of an incompetent client are not known or are unclear, advocate for decisions to be made based on what the client would have wanted as far as is known, or, failing that, advocate that decisions be made in the best interest of the client in consultation with the family and other health care providers.

C. Competent, Caring and Ethical Services

Occupational therapists recognize and respect that every client has the right to competent, caring and ethical occupational therapy services that promote health and well-being.

The *Essential Competencies of Practice for Occupational Therapists in Canada* Third Edition 2011 states;

Unit 3 Demonstrates practice Knowledge

- 3.4 Demonstrates awareness of legislative and regulatory requirements relevant to the province and area of practice.

Unit 4 Utilizes an Occupational therapy Practice Process to Enable Occupation

- 4.3 Ensures informed consent prior to and throughout service provision.

Unit 5. Communicates and Collaborates Effectively

Occupational therapists use effective communication and collaboration approaches for safe, ethical, and effective practice.

- 5.1 Communicates effectively with client, inter-professional team and other stakeholders using client-centred principles that address physical, social, cultural, or other barriers to communication.
- 5.2 Communicates using a timely and effective approach.
- 5.3 Maintains confidentiality and security in the sharing, transmission, storage, and management of information.
- 5.4 Collaborates with client, inter-professional team, and other stakeholders.
- 5.5 Works effectively with client, inter-professional team, and other stakeholders to manage professional relationships.

## GUIDELINE

### Four Requirements for Valid Consent

1. Capacity: consent is given by a person who has capacity.  
There is provincial legislation and much common law that speaks to the matter of consent as it relates to mental capacity, (for e.g. the Mental Health Act) or age, (for e.g. the Mature Minor Doctrine). It is critical that you understand how these apply to your particular area of practice.  
Flowing from common law, the Mature Minor Doctrine states that regardless of age, a child is capable of consent (or refusing consent) to treatment if he/she is able to appreciate the nature and purpose of the treatment and consequences of giving or refusing treatment.  
Capacity takes into account age, maturity, understanding of treatment and potential outcomes, nature and complexity of procedure/treatment, language, lack of impairment.
2. Voluntary: the client must voluntarily give consent.  
Consent must be given without undue promise of favourable outcome or threat of penalty for non-compliance.
3. Specific: the information given when obtaining consent must be specific to treatment provided; therefore consent is specific to both the treatment and to the person who is to administer that treatment.
4. Informed: an individual must have sufficient information about the treatment and its potential consequences in order to allow him or her to make the decision. Before agreeing to a proposed treatment the person making the treatment decision should receive information that a reasonable person in the same circumstances would want about:
  - The nature and purpose of the treatment including the likely benefit(s) or hoped-for benefit(s);
  - The material risks and side-effects of the proposed treatment;
  - Alternative courses of action;
  - The consequences of not having the treatment;
  - More detailed information about these matters, if requested.

### General Principles

1. The person must be legally competent to consent. The age of majority is not required to provide consent to treat in Canada.
2. The person must possess the mental capacity to authorize care. This refers to the “intellectual ability to reach a reasoned choice about treatment”. Everyone is presumed mentally capable unless there is some reason to question this. It refers strictly to the person’s ability to make a treatment decision. The test of capacity is whether the person has “the ability to understand (and appreciate) the nature and effect of the treatment being proposed”. Should the professional obtaining consent determine that the client is incapable of giving consent, a substitute decision maker must be identified and give proper informed consent for the treatment before it can begin. The judgment of incapacity is not a permanent assessment, with fatigue, pain, medications, etc. affecting capacity.
3. The person must receive proper disclosure of information from the professional. The information must be what a reasonable person in the client’s position would want to know to make decision: anticipated benefits and risks (including all

- probable/material risks and unlikely but potentially serious risks) specific to that particular client.
4. Consent must be specific to the treatment to be given. The consent can be for a course of treatment providing that the main elements are identified. It must be clear as to who will administer the treatment (including assistants and/or students). Significant amendments or additions to the originally agreed upon plan of care would require a new consent.
  5. The person must have the opportunity to ask questions and receive understandable answers. The information needs to be given in the language the client can understand, with lay terms and language translation as required.
  6. The consent must be voluntary, without undue influence or coercion.
  7. The consent must not be obtained by misrepresentation of information. Accurate and impartial information on all treatment alternatives must be provided. This is not to say that the practitioner may not express an opinion as to the best course of action.
  8. The act of engaging the client in a meaningful discussion regarding the goals and processes of the therapeutic interventions can be delegated to a student, with the awareness that the professional directing the treatment is accountable for ensuring the client gave informed consent for the treatment before it was initiated.

#### **Guidelines for Informed Consent**

1. In common law, it is unclear if informed consent is required for assessment. Therefore, it is prudent to obtain consent for assessment as well as treatment.
2. As capacity for decision making can fluctuate, it is recommended that when an occupational therapist is unsure of the client's capacity to give consent for treatment that the occupational therapists revisit the client at least once, preferably when s/he is most rested and comfortable, to see if the client is capable of providing consent under more optimal conditions.
3. Occupational therapists may also need to consider if any of the following information is important for the client to have in order to make informed decisions: information regarding the treatment / services approach and any risks involved, background of the therapist including a description of training, credentials, specialized skills, any costs involved in therapy, length of therapy, process of termination, consultation with colleagues, client's right of access to their medical record, nature and purpose of confidentiality, handling of multiple relationships with clients. Depending on the setting, one or more of these may need to be addressed initially, or on further questioning by the client.

#### **Documentation of Consent**

1. There are two forms of consent:
  - Implicit (e.g. holding out a limb for examination)
  - Explicit (verbal or written).
  - Both are legally acceptable, but should questions arise later, implicit or implied consent is more difficult to prove. For this reason documentation is of value. Documentation can take the form of a note in the formal client record or completion of a form, signed by the client. The form is in addition to, and not a substitute for, the discussion.
2. A documentation note by the occupational therapist regarding consent can be brief and should include:
  - the nature and purpose of the proposed treatment,
  - the probable risks and benefits

- reasonable alternative(s),
  - confirmation that the criteria for valid consent were met.
3. Documentation should also note if the client refuses or withdraws consent. There may be a number of factors to consider in determining the type of documentation that best suits the situation of refusal or withdrawal. In some circumstances the therapist may wish to have the client sign a written statement regarding his or her refusal or withdrawal.
  4. Documentation is also of particular importance if it is determined that in the occupational therapist's opinion, the client is not capable of giving consent; the note should include the basis of that judgment. It is essential to document decisions related to identifying an appropriate third party or substitute decision-maker.

## DEFINITIONS

**assent:** To evidence a choice.

**capacity:** The ability to understand the information that is relevant to making a treatment decision; and appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

**explicit consent:** Expressly stated voluntary agreement, permission, compliance

**fiduciary duty:** Moral or legal obligation of trust.

**implicit consent:** Implied, though not plainly expressed voluntary agreement, permission.

**informed consent:** A legal doctrine based on respect for the principle of autonomy of an individual's right to information required to make decisions; also a matter of respect for personal self-determination.

**mental competence:** Adequately qualified or capable mental abilities; decision-making capacity.

**substitute decision-maker:** Person designated to make a decision on behalf of a client who is deemed as incapable of giving consent.



## **REFERENCES**

(Used to develop the original 2005 guideline.)

Association of Canadian Occupational Therapy Regulatory Organizations  
*Essential Competencies of Practice for Occupational Therapists in Canada*, Third Edition  
2011.

College of Occupational Therapists of Manitoba, *Code of Ethics*, 2010

*The Occupational Therapists Act*, 2005.

## **RESOURCES**

(Used to develop the original 2005 guideline.)

College of Registered Nurses of Manitoba, Nursing Practice Expectations.

Hobson, Sandra, Informed Consent for Occupational Therapy Treatment: Do you Have It?, OT NOW, September/October, 2001.

MB Law Reform Commission Report on The Informal Assessment of Mental Competence, 1999.