PRACTICE GUIDELINE

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Consent

Table of Contents

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

VISION
Leading in regulatory excellence

MISSION
Regulating nursing in the public interest

Consent Pub. No. 41020

ISBN 978-1-77116-056-8

First Published June 1996 as *A Guide to Health Care Consent and Substitute Decisions Legislation for RNs and RPNs*
Revised January 2000 as *A Guide to Consent* (ISBN 0-921127-93-6)
Reprinted October 2000, December 2002, Revised for Web June 2003, Reprinted January 2004, December 2005. Updated May 2008. June 2009. Updated 2013 (ISBN 1-894557-51-4).
Updated February 2017 removed RPN from Role of Capacity assessors p6 & updated expectations of consent for MAID p3.

Additional copies of this booklet may be obtained by contacting CNO's Customer Service Centre at 416 928-0900 or toll-free in Canada at 1 800 387-5526.

College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1

www.cno.org

Ce fascicule existe en français sous le titre : *Le consentement*, n° 51020

Introduction

Nurses have ethical and legal obligations for obtaining consent. The ethical obligations related to consent are discussed in the *Ethics* practice standard under the section Client Choice. This practice guideline replaces and updates the guide produced in June 1996 after the legislation, the *Health Care Consent Act, 1996* (HCCA) and the *Substitute Decisions Act, 1992* (SDA), was enacted. This practice guideline provides an overview of the major features of the legislation, pertinent definitions and the steps nurses need to take to obtain consent. It does not address consent under the *Mental Health Act*. It also does not address consent for medical assistance in dying. For more information read *Guidance on Nurses' Role in Medical Assistance in Dying* at **www.cno.org/standards**.

The principle of informed consent is entrenched in common law and nursing standards. The HCCA sets out explicit rules on when consent is required for treatment or admission to a care facility, and who can give the consent when the client is incapable of doing so. As well, it sets out rules for when a practitioner wants to obtain consent from a substitute decision-maker for personal assistance services (i.e., activities of daily living).

Major Features of the Legislation

The *Health Care Consent Act* (HCCA)

- The goals of the HCCA include promoting individual authority and autonomy, facilitating communication between health care practitioners and their clients, and ensuring a significant role for family members when the client is incapable of consenting.
- The HCCA deals separately with consent to treatment, consent to a care facility and consent to a personal assistance service. In all cases, consent must be given by a capable person.
- Consent to treatment, and assessing the capacity to consent to treatment, must relate to a specific treatment or plan of treatment. A person could be capable of giving consent to one treatment, but incapable with respect to another.
- Consent to treatment involves an ongoing process that can change at any time.
- Health care practitioners have no authority to make treatment decisions on behalf of clients, except in an emergency when no authorized person is available to make the decisions. Similarly, they have no authority to make a decision to consent to the admission of a client to a care facility, except in a crisis.
- Assessing the client's capacity to make a treatment decision is the responsibility of the health care practitioner proposing the treatment.
- An evaluator determines client capacity to make a decision about admission to a care facility or a personal assistance service. Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Nurse Practitioners (NPs) may be evaluators.
- The client has the right to ask the Consent and Capacity Board (CCB) to review the finding of incapacity.
- Minor adjustments to a treatment plan for an incapable client can be made without having to seek repeated consent from a substitute decision-maker.
- One health care practitioner can propose a plan of treatment and obtain consent to the plan on behalf of all the health care practitioners involved in the plan.
- When a health care practitioner finds a client is incapable of making a treatment decision, the legislation requires the practitioner to provide the client with information about the consequences of the finding. This provision of information must be performed in accordance with guidelines established by the practitioner's governing body. The guidelines for nurses are in Appendix A.
- A family member acting as a substitute decision-maker is not required to make a formal statement verifying his/her status. The legislation does contain a hierarchy of substitute decision-makers.
- A person's wishes about treatment, admissions or personal assistance services may be expressed orally, in writing, in any other form, or they may be implied.

The *Substitute Decisions Act* (SDA)

The SDA deals with decision-making about personal care or property on behalf of incapable persons. Whereas the HCCA is concerned with the capacity to make decisions in relation to specific treatment, admission to care facilities or personal assistance services, the SDA is concerned with persons who need decisions made on their behalf on a continuing basis. It involves the formal appointment of a decision-maker through a power of attorney document, through the Office of the Public Guardian and Trustee (PGT) or through a court appointment.

Here are some of the major features of the SDA:

- An individual may designate a specific person to make decisions about his/her personal care or treatment in the event that he/she becomes incapable. The person may also express his/her wishes about the kinds of decisions to be made or factors to guide decisions.
- The Office of the PGT is the government department that deals with personal care and property matters.
- Only trained capacity assessors may determine capacity for the purpose of the SDA (i.e., the capacity to make decisions on an ongoing basis). The HCCA requires assessment of capacity to make decisions about a specific treatment.
- A power of attorney for personal care comes into effect when the person who granted it becomes mentally incapable, unless it states otherwise.
- A person under statutory guardianship may apply to the CCB for a review of a finding of incapacity.

Definitions

Substitute decision-maker: A person identified by the HCCA who may make a treatment decision for someone who is incapable of making his/her own decision. The HCCA provides a hierarchy to determine who is eligible to be a substitute decision-maker. The substitute decision-maker is usually a spouse, partner or relative. A power of attorney for personal care is not necessarily required to act as a substitute decision-maker.

Consent and Capacity Board (CCB): A board established by and accountable to the government. Its members are appointed by the government. The Board considers applications for review of findings of incapacity, applications relating to the appointment of a representative, and applications for direction regarding the best interests and wishes of an incapable person.

Spouse: Two persons who are married to each other, or who are living in a conjugal relationship and have cohabited for at least a year, or who are the parents of a child or who have a cohabitation agreement under the *Family Law Act*.

Partners: Two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

Relatives: Two persons related by blood, marriage or adoption.

Public Guardian and Trustee (PGT): The PGT is the substitute decision-maker of last resort for a mentally incapable person. 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.

Treatment: Anything done for a therapeutic, cosmetic or other health-related purpose. It includes a course of treatment or plan of treatment. The legislation does not include the following activities in the definition of treatment:

- assessing the person's capacity to make decisions about treatment, admission to a care facility or personal assistance services;
- assessing the person's capacity to manage property;
- taking a health history;
- assessing or examining a person to determine the general nature of the person's condition;
- communicating an assessment or a diagnosis;
- admitting a person to a hospital or other facility;
- providing a personal assistance service;

- providing a treatment that in the circumstances poses little or no risk of harm; or
- performing anything prescribed by the regulations.

Standards and expectations of common law still require consent for the activities not considered as treatment under the HCCA.

Plan of treatment: A plan that is developed by one or more health care practitioners, dealing with one or more of the health problems that a person has and is likely to have. It provides for the administration of various treatments or courses of treatment. It may include the withholding or withdrawal of treatment in light of the person's health condition.

Course of treatment: A series or sequence of similar treatments administered to a person over a period of time for a particular health problem.

Personal assistance service: Assistance with, or supervision of, hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulating, positioning or any other routine activity of living. It may also include a group or plan of personal assistance services.

Power of attorney for personal care: A legal document in which a capable person gives someone else the authority to make decisions about his/her personal care in the event that he/she becomes incapable. The document could also contain specific instructions about particular treatment decisions.

Continuing power of attorney for property: The same as the power of attorney for personal care, except relating to decisions about property.

Basic Facts About Obtaining Consent

The need for consent

According to College of Nurses of Ontario (CNO) standards, nurses are accountable for obtaining consent whether the intervention or service relates to a treatment (as defined in the HCCA or as required in common law), admission to a facility, or the provision of a personal assistance service. The HCCA, however, deals with these three circumstances differently.

1. Consent to treatment: Consent is required for any treatment except treatment provided in certain emergency situations. The consent must:
   - relate to the treatment being proposed;
   - be informed;
   - be voluntary; and
   - not have been obtained through misrepresentation or fraud.

The health care practitioner who proposes the treatment is responsible for taking reasonable steps to ensure that treatment is not administered without consent.

2. Consent to admission to a care facility: If consent to admission to a care facility is required by law, then consent is needed in all cases except in a crisis situation.
3. Consent to personal assistance services: The HCCA does not specify that consent to a personal assistance service is required. It does, however, provide that if an evaluator finds a recipient of a personal assistance service incapable of giving consent, and the person providing the service wants to obtain consent, it may be obtained from a substitute decision-maker using the hierarchy set out in the Act.

What is informed consent?

Consent is ***informed*** if, before giving it:

- the person received the information about the treatment that a reasonable person in the same circumstances would require to make a decision; and
- the person received responses to his/her requests for additional information about the treatment.

The information must include the:

- nature of the treatment;
- expected benefits of the treatment;
- material risks and side effects of the treatment;
- alternative courses of action; and
- likely consequences of not having the treatment.

Steps to obtaining consent

Step 1 Assess capacity.

a) Definition of capacity

Under the HCCA, the health care practitioner who proposes the treatment is responsible for determining capacity for consent to treatment. The client is presumed to be capable of making decisions about treatment, admission and personal assistance services, and a health care practitioner or evaluator is entitled to rely on this presumption of capacity unless she/he has reasonable grounds to believe otherwise. If the client is capable, then the client makes the decision.

A person is capable of giving consent to a treatment, admission to a care facility and personal assistance services if he/she:

- understands the information that is relevant to making a decision concerning the treatment, admission or personal assistance service; and
- appreciates the reasonably possible consequences of a decision or lack of a decision.

b) Age of consent

There is no minimum age for giving consent. Health care practitioners and evaluators should use professional judgment, taking into account the circumstances and the client's condition, to determine whether the young client has the capacity to understand and appreciate the information relevant to making the decision.

c) Role of evaluator

An evaluator must determine capacity in the case of admission to a care facility or provision of personal assistance services. The evaluator may be the person proposing the admission or services, or the evaluator may be identified by facility or agency policies. Nurses and some other health care professionals may be evaluators.

d) Role of capacity assessor

A capacity assessor conducts assessments of capacity on persons who need decisions made on their behalf on a continuing basis. NPs and RNs are eligible to become capacity assessors. Designation will require the successful completion of a capacity assessor education or training course approved or required by the attorney general.

e) Incapable person

If a person is incapable, the consent (or refusal to give consent) is to be obtained from the highest-ranked available substitute decision-maker from the HCCA hierarchy who is willing to make the decision. If there is no other substitute decision-maker, the PGT is the substitute decision-maker of last resort.

Step 2 Provide emergency treatment or crisis admission.

a) Treatment in an emergency can be provided immediately:

- if the person is capable of giving consent and provides the consent;
- in situations where:
  - communication can't take place because of a language barrier or disability, and
  - reasonable efforts to overcome the barrier or disability have been made, but a delay will prolong the suffering the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm, and there is no reason to believe the person does not want the treatment;
- incapable with respect to the treatment decision but a substitute decision-maker is available to give consent; or
- incapable with respect to a treatment, a substitute decision-maker is not readily available, it is not reasonably possible to obtain a consent or refusal from the substitute, and a delay will put the person at risk of sustaining serious bodily harm.

What is an emergency?

There is an emergency if the person is experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly. An examination or diagnostic procedure that is a treatment may be conducted without consent if it is reasonably necessary to determine if there is an emergency.

b) Crisis admission

For the purpose of an admission to a care facility without consent, a crisis relates to the condition or circumstances of the person who is to be admitted to the care facility.

Admission to a care facility without consent may be authorized if:

- the person who has been deemed incapable requires immediate admission as a result of a crisis; and
- it is not reasonably possible to obtain immediate consent or refusal on the incapable person's behalf.

In both cases, reasonable efforts must continue to find a substitute decision-maker and obtain consent, or refusal to consent, to the treatment or admission.

Step 3 Inform the client that a substitute decision-maker will make decision.

When the decision is made that the client is incapable and a substitute decision-maker will make the treatment decisions, or the decision to admit to a care facility, a nurse needs to follow the specific guidelines relating to advising clients of their rights. See CNO's guidelines in Appendix A.

Step 4 Identify a substitute decision-maker.

If a health practitioner or evaluator finds that a person is incapable of making a decision about a treatment or admission to a care facility, consent must be obtained from a substitute decision-maker.

Hierarchy of substitute decision-makers

1. Guardian of the person — appointed by the court.
2. Someone who has been named as an attorney for personal care.
3. Someone appointed as a representative by the CCB.
4. Spouse, partner or relative in the following order:
   a. spouse or partner,
   b. child if 16 or older; custodial parent (who can be younger than 16 years old if the decision is being made for the substitute's child); or Children's Aid Society;
   c. parent who has only a right of access;
   d. brother or sister;
   e. other relative.
5. PGT is the substitute decision-maker of last resort in the absence of any more highly ranked substitute, or in the event two more equally ranked substitutes cannot agree.

A spouse, partner or relative who is present when the treatment is proposed may make the decision unless:

- a specially appointed substitute is available; or
- a spouse, partner or relative with a higher priority is available and willing to assume the responsibility to give or refuse consent.

Health care practitioners are permitted to rely on an assertion from a person that he/she is the substitute decision-maker. A formal statement that the person is the substitute decision-maker is not necessary to give or refuse consent to a treatment, admission to a care facility or a personal assistance service on behalf of an incapable person.

Step 5 Obtain consent from the substitute decision-maker.

The substitute decision-maker giving or refusing consent is expected to make decisions based on the client's known wishes, which the client expressed when he/she was 16 years of age or older and capable. If such wishes are not known, or are impossible to comply with, then the substitute decision-maker decides in the client's best interests, taking into account:

- the client's values and beliefs;
- the impact of the treatment on the client's condition or well-being;
- whether the benefit outweighs the risk of harm; and
- whether a different treatment would be as beneficial.

In the case of a decision relating to admission to a care facility or a personal assistance service, the substitute decision-maker assesses the impact on the quality of the incapable person's life.

Summary

Nurses should keep the following principles in mind when in doubt about how to interpret the legislation.

- Clients have a legal and ethical right to information about their care and treatment, and a right to refuse that treatment.
- Regardless of whether consent has been obtained by the nurse, nurses should always explain to

the client the treatment or procedure they are performing.

- Nurses should not provide a treatment if there is any doubt about whether the client understands and is capable of consenting. This applies whether or not there is an order, or even if the client has already consented. It does not apply if a substitute decision-maker has consented.
- A substitute decision-maker has the right to access the same information that a capable client would be able to access.
- Consent can be withdrawn at any time.
- Nurses need to advocate for clients' access to information about care and treatment if it is not forthcoming from other care providers.
- Informed consent does not always need to be written, but can be oral or implied.

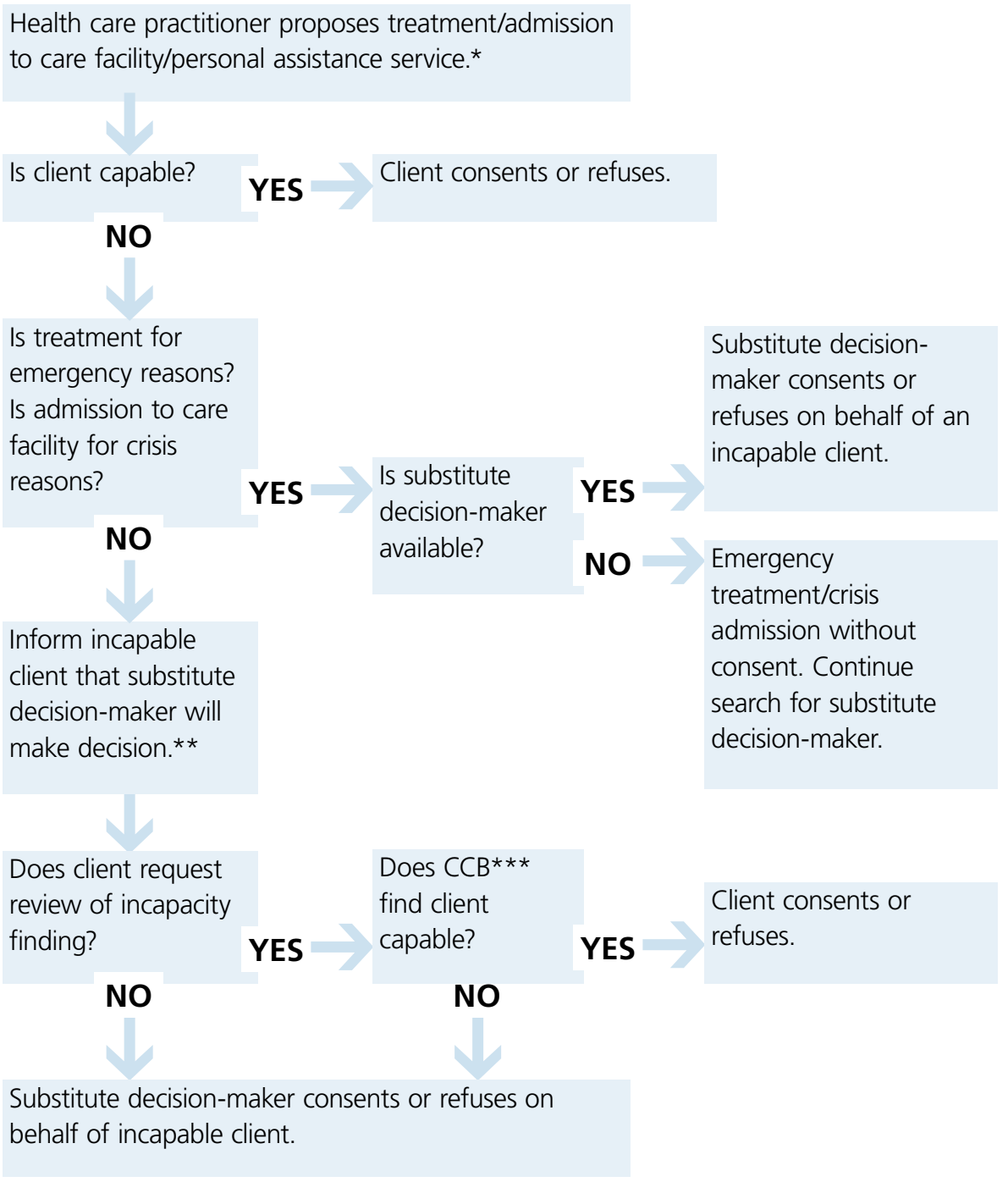
For further details about the legislation, contact the Consent and Capacity Board (1 800 461-2036; there is also a direct line to the Consent and Capacity Review Board in Toronto: 416 327-4142) or the Office of the Public Guardian and Trustee (1 800 366-0335).

Appendix A: Advocating for Clients

Nurses who obtain consent have a professional accountability to be satisfied that the client is capable of giving consent. Also, nurses are professionally accountable for acting as client advocates and for helping clients understand the information relevant to making decisions to the extent permitted by the client's capacity. CNO has developed these guidelines to assist nurses in carrying out their advocacy role as required by legislation.

1. If the nurse proposing a treatment or evaluating capacity to make an admission or personal assistance service decision determines the client is incapable of making the decision, then the nurse informs the client that a substitute decision-maker will be asked to make the final decision. This is communicated in a way that takes into account the particular circumstances of the client's condition and the nurse-client relationship.
2. If there is an indication that the client is uncomfortable with this information, then the nurse explores and clarifies the nature of the client's discomfort. If it relates to the finding of incapacity, or to the choice of substitute decision-maker, then the nurse informs the client of his/her options to apply to the CCB for a review of the finding of incapacity, and/or for the appointment of a representative of the client's choice.
3. If there is an indication that the client is uncomfortable with the finding of incapacity when the finding was made by another health care practitioner, then the nurse explores and clarifies the nature of the client's discomfort. If it relates to the finding of incapacity, or to the choice of substitute decision-maker, then the nurse informs the health care practitioner who made the finding of incapacity and discusses appropriate follow-up.
4. The nurse uses professional judgment and common sense to determine whether the client is able to understand the information. For example, a young child or a client suffering advanced dementia is not likely to understand the information. It would not be reasonable in these circumstances for the nurse to inform the client that a substitute decision-maker will be asked to make a decision on his/her behalf.
5. The nurse uses professional judgment to determine the scope of advocacy services to assist the client in exercising his/her options. The nurse documents her/his actions according to CNO's *Documentation, Revised 2008* practice standard and agency policy.

Appendix B: Decision Tree for Obtaining Consent Under the *Health Care Consent Act, 1996*



* Not mandatory to seek consent under the HCCA, but mandatory if consent from a substitute decision-maker is required.

** See Appendix A.

*** CCB — Consent and Capacity Board.

Notes:

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

101 Davenport Rd.
Toronto, ON
M5R 3P1
www.cno.org

Tel.: 416 928-0900
Toll-free in Canada: 1 800 387-5526
Fax: 416 928-6507
E-mail: cno@cnomail.org

FEB 2017
41020
2016-163