The College of Physiotherapists of Ontario presents the Health Care Consent E-Learning Module. This module provides users with an interactive opportunity to learn. Test your knowledge questions are located throughout the chapter. This section is the third of four chapters.

Chapter 1 provided an overview of the Health Care Consent Act and the Substitute Decisions Act. Chapter 2 highlighted the key principles of consent.

In this chapter, we will examine several practice scenarios that will discuss common situations encountered by physiotherapists as a way to facilitate application into practice.

The questions found in chapters 1, 2, and 3 have been combined in chapter 4 as an opportunity to review the material from previous chapters and can be used to test your knowledge.

At any time, please exit this module if you would like to review the other chapters.
To help you with chapter 3, we will guide you through a brief review of the first two chapters. As noted, you may exit this chapter at any time if you would like to repeat or review the previous chapters.

Chapter 3 will highlight various consent issues that may arise in the day to day practice of a physiotherapist.
In chapter 1 we learned that the Health Care Consent Act provides explicit rules about when consent is required for treatment, who can give consent and the role of the substitute decision-maker in the consent process.

The Act ensures that health care practitioners do not have the authority to make decisions for their patients. Additionally, the Act provides a hierarchy of substitute decision-makers.

To learn more about substitute decision-makers or to understand the definition of the term “treatment”, please return to chapter 1. The glossary at the end of this chapter will also provide you with definitions of the terms from chapter 1.
Chapter 1 also reviewed the purpose or intent of the Health Care Consent Act. Take a moment to review the items on the screen.

Other points made in chapter 1 include the following:

- Consent can be written, oral, or implied, and

- When obtaining consent, health care practitioners should initially assume the patient is capable.
The requirement for obtaining consent under the Health Care Consent Act can be summarized into 10 principles.

In chapter 2 you were guided through each principle and in some cases, you were also provided with a scenario to emphasize the meaning of the principle.

Please take a few moments to review the principles. At any time you may exit this chapter and return to chapter 2 to learn more about these principles.
Key Principles of Consent Cont’d:

4. For consent to be informed, adequate information must be provided, including risks, benefits, side effects and treatment alternatives.

5. Only a health care practitioner with the knowledge and ability to answer questions related to the proposed treatment can obtain informed consent.

6. A physiotherapist performing treatment proposed by another health care practitioner should be able to rely on the informed consent obtained by that practitioner when it is reasonable to do so.
Key Principles of Consent Cont’d:

7. Treatment should not begin prior to reviewing the plan with the patient, even if consent was previously obtained.

8. Do not proceed if you are unsure about whether consent was obtained or the patient refuses.

9. Expressed wishes must be honoured.

10. A person at any age can provide informed consent if they have the capacity to do so.
In this chapter five scenarios have been developed to further assist with the application to practice.

Scenario 1 demonstrates that not only can capacity fluctuate, but consent is not a one time event.

In the second scenario we will learn that having a patient sign a consent form is not the same as obtaining informed consent.

Scenario 3 relates to the difference between obtaining and documenting consent. Although this may appear similar to scenario 2, this has a different meaning that you will discover.

Consent and emergency situations will be explained in scenario number 4.

And in scenario number 5, we will consider communication barriers and consent for treatment.
In scenario 1, Peter obtains informed consent from Jacob, a patient with early Alzheimer’s. Although Jacob is forgetful, Peter deems him capable to provide consent for the following course of treatment:

- Strengthening exercises for the lower extremities
- ROM exercises for the upper and lower extremities
- Balance exercises

Peter’s discussion includes how treatment will progress, the equipment to be used (weights and resistance band) and the personnel that will be involved in treatment. During this session Jacob’s wife, Irene, is also present.
After several treatments, Peter believes that Jacob will benefit from walking on a treadmill. Does Peter need to obtain informed consent for this treatment?

- A) Yes
- B) No

Correct. Although this may be a natural progression for Jacob, Peter did not discuss the use of a treadmill as part of the original plan. Consent is an ongoing process and requires additional discussion as new treatments are being proposed.

After several treatments, Peter believes that Jacob will benefit from walking on a treadmill.

Does Peter need to obtain informed consent for this treatment?

Select your answer and click on submit.
The next time Peter sees Jacob he attempts to explain the new activity. Peter notices that Jacob seems confused and he doesn’t remember that Peter is the physiotherapist. Irene tells Peter that Jacob is having a ‘bad spell’ and his medications are being adjusted by the doctor.

Peter explains to Jacob that he will need to involve Irene in making a decision about his treatment because he has determined that Jacob does not have the capacity to provide informed consent on this particular day.

To ensure that Peter obtains valid consent, he explains to Irene why he is recommending the treadmill, including all of the components that fulfill the requirements of obtaining informed consent (risks, benefits, side effects, treatment alternatives).

After Peter answers her questions, Irene provides consent to use the treadmill.

For a reminder about what behaviours could indicate incapacity, click [here](#).
Lessons Learned...

- While obtaining consent for a plan of treatment is possible, it is necessary to also obtain consent for any new treatments added to the plan.
- Capacity can vary over time and with the complexity of treatment being provided.
- Findings of incapacity need to be explained to the patient.

The first scenario demonstrates the following lessons:

- While obtaining consent for a plan of treatment is possible, it is necessary to also obtain consent for any new treatments added to the plan.

- Capacity can vary over time and with the complexity of treatment being provided.

- Findings of incapacity need to be explained to the patient.
In the second scenario we meet Mrs. Smith who arrives for her first visit at a clinic. She has never seen a physiotherapist before this day. The friendly receptionist hands her a clipboard and politely asks her to fill out the forms while she waits for the physiotherapist.

Mrs. Smith takes a look at the five detailed sheets and feeling a bit overwhelmed, sits down to start on the paperwork.

Have you ever experienced this scenario as a patient or a practitioner?
One of the forms relates to consent for the assessment and treatment. Mrs. Smith signs a statement that she agrees to the care that the physiotherapist will provide, she will ask questions if necessary and she can withdraw consent at anytime.

Reid, her physiotherapist, escorts Mrs. Smith from the waiting room to an assessment room and starts taking Mrs. Smith’s history.

Mrs. Smith does not want to interrupt Reid so she doesn’t bother asking any questions about the forms she completed.
In the next two slides you have been provided with statements about scenario 2. After reading the statement, please select ‘true’ or ‘false’ then click submit to continue.

Statement 1:
The obligation for the physiotherapist to obtain consent has been fulfilled because Mrs. Smith signed the consent form.
Scenario 2 - Question 2
The obligation for the physiotherapist to obtain consent for treatment has been fulfilled because Mrs. Smith signed the consent form.

A) True
B) False

Correct. Having the patient sign a consent form does not replace the discussion that the physiotherapist needs to have with the patient. The patient must be able to make an informed decision and this can only occur through a meaningful discussion.

In the next two slides you have been provided with statements about scenario 2. After reading the statement, please select ‘true’ or ‘false’ then click submit to continue.
Scenario 2 – Question 3

Informed consent was obtained because Mrs. Smith was informed that she could ask questions at any time and withdraw consent at any time.

- A) True
- B) False

Correct.
Although she signed a statement acknowledging that questions could be asked and consent withdrawn, without discussing the risks, benefits, side effects and alternatives of the treatment being proposed, the process is incomplete and not truly informed.
Several lessons have been provided in this scenario.

• Consent is required for both assessment and treatment activities.

• Signing a form may not provide adequate information about the risks, benefits, side effects, etc. of the treatment when it is not yet determined what treatment would be in this case.

• Consent must be specific to the proposed intervention, not generic.

• A signed consent form does not ensure that consent was truly informed. While it may be acceptable to use a form to document that consent was obtained, it does not replace a meaningful discussion.

• Patients must have the opportunity to ask questions.
The next scenario highlights the issues of obtaining consent when assigning treatment to support personnel and the documentation of consent.

Katie provided information about the treatment plan to Sue, the patient. She included the possible risks, benefits, side effects and alternatives to the proposed treatment. As well, Katie gave Sue information about the role of the support person that Katie planned to assign portions of care.

Sue consented to the treatment, including the use of support personnel. Following this process, Katie documented the following: “Consent was discussed and obtained”.
Discussion:

Did Katie document enough information in the chart to indicate that informed consent was obtained?

While the Standard for Professional Practice – Record Keeping indicates that physiotherapists must document that consent for the assessment and treatment was obtained, the standard does not indicate how this should appear in the patient’s record.

Physiotherapists should follow a consistent consent process and consider documenting that process in a policy and procedure manual.

For treatments of higher risk, more details about the consent process may be warranted.
Physiotherapists must:

- Obtain consent for the involvement of the physiotherapist support personnel before the treatment is initiated.

- Follow a process to ensure all aspects of consent are covered.

- Document in the patient record that consent was obtained.

- Consider the risk involved in the proposed treatments. The amount or type of information you document could vary related to this.
The next scenario investigates a situation that could be interpreted as an emergency that requires immediate treatment. Under the Health Care Consent Act, if a patient is incapable or unable to communicate to provide informed consent or there is no substitute decision maker available, emergency treatment can be provided until the patient is capable to provide consent or refuse treatment or a substitute decision maker can be located.

An emergency is an event where a patient is at risk of serious bodily harm or prolonged suffering. Consider this when listening to this scenario.
Robert, a nurse, contacts Seema, the physiotherapist that covers a complex continuing care floor, to let her know that Marc, one of her patients, is having difficulty breathing and his oxygen saturation has fallen below 80%.

Marc is on a significant amount of medication and he is not able to communicate with Robert or Seema.
When Seema arrives, she observes that Marc’s breathing is laboured, secretions are audible and the oxygen saturation is at 78% despite supplemental oxygen. Typically, Seema does not provide chest treatment to Marc as part of the regular course of treatment, but in this situation, Seema would like to assess, and perhaps treat Marc’s chest, if warranted.

Marc is not able to provide informed consent and there is no substitute decision maker available at this time.
There are several possible courses of action that Seema could take in this scenario.

The next slides will investigate the options available. After reviewing each option, think about any other possible courses of action you could take to address this situation.
The first option presented is to do nothing. Marc is not able to consent and there is no substitute decision maker available. Seema could suggest that Robert contact Marc’s physician to inform him/her of the change in status.

By not taking any action, Seema may think she is in compliance with the Health Care Consent Act but Marc’s needs are not being addressed. Certainly, informing the physician regarding Marc’s change in status may be relevant, but to walk away is not necessarily in his best interest. Should Marc’s status worsen, it may be necessary to call an ambulance or 911.
Option 2

Recognize the potential urgency and risk of deterioration. Assess immediately without consent, under the emergency provisions of the HCCA to determine the need for treatment.

The second option for Seema is to recognize the potential urgency of the situation and the risk for Marc to further deteriorate. She may determine that the situation is life-threatening and conduct a formal assessment immediately without consent, to determine the next steps and the need for treatment.

It is possible that Seema will identify this situation as requiring emergency treatment, but Marc will need to be assessed first. She will need to contemplate why this is considered an emergency and if she can justify providing treatment without consent.
The third option for consideration involves finding the substitute decision-maker. Once the substitute decision maker is available, Seema can explain the situation and obtain informed consent to assess and treat Marc.

In practice, Seema might determine that this was not truly an emergency; perhaps Marc's oxygen saturation is chronically low; perhaps a spontaneous strong cough will resolve the symptoms and therefore, she should not provide treatment without obtaining the necessary consent from a substitute decision-maker. Seema is aware of Marc's vulnerability, which is why she is trying to find the substitute decision-maker.
The Health Care Consent Act has provisions in place to ensure that patients receive immediate treatment when it is necessary.

In an emergency situation, health care practitioners can assess, then provide treatment immediately if the patient:

- is capable and consents;
- the patient is incapable and the substitute decision-maker consents; or
- the patient is incapable and the substitute decision-maker is unavailable and the patient is at risk of serious bodily harm or prolonged suffering.

Once the emergency treatment has been provided, consent should be obtained for ongoing treatment when a substitute decision-maker can be located or the patient becomes capable.
Lessons Learned...

• Be aware of the circumstances and the requirements of obtaining consent from the patient or the substitute decision maker.

• Use your professional judgment and justify the decisions you make.

• There may not be a specific ‘right’ or ‘wrong’ approach.

There may not be a specific ‘right’ or ‘wrong’ approach; consider what action you think would be most appropriate for your practice.

Whatever choice Seema makes in this circumstance, she needs to use her professional judgment and justify the decision she makes.

When a health care practitioner acts in the best interests of the patient, the Health Care Consent Act has liability protections in place to protect the health care practitioner. For more information about this topic please refer to the Briefing Note to the Health Care Consent Act or the Act itself.
In scenario 5 we will explore considerations related to consent when a language barrier may exist.

You have received an order to see an elderly gentleman who initially came unaccompanied to the emergency department with a productive cough and fever. Medical examination and tests confirm a diagnosis of right lower lobe pneumonia.

You enter the room and observe an older, frail looking gentleman who is nodding pleasantly as you enter the room. It becomes quickly apparent that he does not understand or speak any English.
You approach the bedside and the patient takes his arms from his gown and leans forward in the bed implying that you can listen to his chest.

You conduct a respiratory assessment and identify abnormal breath sounds and determine that ‘chest physiotherapy’ is indicated for this patient.

Under the Health Care Consent Act, you are obligated to obtain informed consent for treatment from the patient prior to initiating treatment.
Scenario 5 - Question 1

This patient could be incapable.

☐ A) True
☐ R) False

Correct.
This patient could be incapable but it cannot be determined because the physiotherapist cannot communicate with the patient.

Read the statement on the slide and decide if it is accurate by selecting either True or False. Once you have made your selection, click submit.
Scenario 5 - Question 2
The patient’s age and the language barrier indicate that he is likely incapable to provide consent.

- A) True
- B) False

Correct. Age and the inability to communicate do not constitute incapacity on the part of the patient.
Scenario 5 - Question 3

The PT should find someone to interpret to obtain informed consent.

- A) True
- R) False

Correct.
Before providing treatment the physiotherapist needs to find an interpreter to obtain informed consent from the patient. If the physiotherapist determines via the interpreter that the patient is incapable, then the physiotherapist will need to obtain consent from a substitute decision-maker.
Read the statement on the slide and decide if it is accurate by selecting either True or False. Once you have made your selection, click submit.
From this scenario the following lessons were learned:

• Assessing a patient when the patient implies consent may be appropriate in low risk situations.

• Providing treatment when a communication barrier exists would require consent aided by the use of an interpreter.

• Advanced age or communication barriers do not necessarily indicate incapacity.

• The role of the interpreter is to facilitate communications between the health care practitioner and the patient.
We have reviewed five scenarios that relate to consent. Now that you have completed this part of the module we will take some time to help you understand the role of the Consent and Capacity Board.

The Consent and Capacity Board plays a number of roles under the Health Care Consent Act:

- If a patient does not agree with a finding of incapacity he or she can apply to the Consent and Capacity Board.
- If a patient does not agree as to who should act as the substitute decision-maker, he or she can apply to the Consent and Capacity board to apply for an alternate decision-maker to be appointed to make decisions on his or her behalf.
- Health care practitioners can access the Consent and Capacity Board if they believe that the substitute decision-maker is not acting in accordance with the patient’s expressed wishes or best interests.
- The Consent and Capacity Board can assist health care practitioners and substitute decision-makers in assessing the incapable patient’s previously expressed wishes.
- Assist the substitute decision-maker to support expressed wishes that decline needed treatment.

For more information about the Consent and Capacity Board please refer to the Briefing Note to the Health Care Consent Act. You can also visit the Consent and Capacity Board website at www.ccboard.on.ca.
This slide and the next two slides provide a glossary of terms used in this chapter of the Consent E-Learning Module.
Glossary Cont’d

Course of Treatment
A series or sequence of similar treatments administered to a patient over a period of time for a particular injury or problem. For example, obtaining consent for stretching and strengthening exercises.

Health Information
Includes: health history, physical or mental health, individual plan of service under the Long Term Care Act, payments for health care or eligibility for health care, the donation, testing or examination of any body part or fluid, health number, the name of the substitute decision-maker.

Partner
Defined as 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.

Personal Assistance Services
In the Health Care Consent Act this phrase means ‘assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person.’
Glossary Cont’d

Personal Information
Any information about an identifiable individual that relates to their personal characteristics (e.g., gender, age, ethnic background), their health or their activities and views (e.g., dealings with the physiotherapist, opinions expressed by an individual, religion, political involvement, a physiotherapist’s view or evaluation of an individual).

Plan of Treatment
A plan of treatment may be developed by one or more practitioners addressing a patient’s single problem or multiple problems. The plan of treatment may also address problems the patient may have in the future based on their current condition. This type of plan may include varied treatments but allow for the withholding or withdrawal of these treatments depending on the patient’s current health condition. For example, a care plan or care map following a total joint replacement.

Relative
Two persons are relatives if they are related by blood, marriage or adoption

Spouse
The HCDA defines a person as a spouse if they are married to the person, living in a conjugal relationship outside of marriage having lived together for at least one year, together the parents of a child, or are living in a cohabitation agreement as defined in the Family Law Act.
References and Resources

- Health Care Consent Act, 1996
- Health Care Consent Act Briefing Note
- Personal Health Information Protection Act (PHIPA)
- Personal Information Protection and Electronic Documents Act (PIPEDA)
- Briefing Note for Physiotherapists – Privacy Requirements in Ontario
- College of Nurses of Ontario – Consent E-Learning module
- Standard for Professional Practice – Record Keeping
- Guide to the Standard for Professional Practice – Record Keeping

Click on the references to be linked to the corresponding documents.
If you have any questions related to this module, please contact the Practice Advisor.
You have now completed Chapter 3. To work through another chapter in this module, close this presentation and return to the E-Learning section of the College's website.
We are very interested to hear your feedback on this chapter of the Consent E-Learning Module. Please use the link on the screen to complete a very short online survey.

Thank you.