College of Occupational Therapists of British Columbia

Practice Guideline

March 2008

Obtaining Consent to Occupational Therapy Services

COTBC practice guidelines are published by the college to assist occupational therapists in meeting the *Essential Competencies of Practice for Occupational Therapists in Canada* through:

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

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Note to Readers

Throughout this guideline, reference is made to the following support documents. Please check that you have the most recent versions, download these from the college website, or contact the college to receive updates.

Assigning of Service Components to Unregulated Support Personnel. (COTBC, 2004).
Stored in your college binder under Tab 5

Collecting, Recording and Protecting Client Information. (COTBC, 2006).
Stored in your college binder under Tab 5

College of Occupational Therapists of British Columbia Bylaws. (COTBC, 2001).
Stored in your college binder under Tab 2

College of Occupational Therapists of British Columbia Code of Ethics. (COTBC, 2006).
Stored in your college binder under Tab 3

Essential Competencies of Practice for Occupational Therapists in Canada, 2nd Ed. (ACOTRO, 2003).
Stored in your college binder under Tab 4

Documents above are available for download from the college web site at:
http://www.cotbc.org/resources.php

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

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Preamble

The College of Occupational Therapists of British Columbia (COTBC) regulates the practice of BC occupational therapists. The college is mandated under the *Health Professions Act (1996)* "to serve and protect the public".

This guideline was developed by occupational therapists from across the province who work in a variety of practice settings and serve on the COTBC Standards Committee. The committee began by reviewing 56 documents relating to consent. Some of these documents were guidelines developed by other Canadian occupational therapy and health professional regulatory organizations. Position statements, scholarly papers and practice articles were also reviewed and rated, and pertinent information was noted for inclusion in the present guideline.

This guideline is intended to support occupational therapists' decision making, across practice settings, regarding the process of obtaining consent.

The final document was approved by the COTBC Board in January, 2008.

Statement of Purpose

This guideline outlines legal requirements and clarifies the occupational therapist's accountability and the college's expectations regarding the process of obtaining consent for all occupational therapy services.

The process of consent involves *all* of the following:

1. Establishing the trust necessary for effective professional relationships;
2. Promoting involvement of clients in all care planning;
3. Respecting clients' rights to self-determination;
4. Enabling clients to make informed decisions regarding their care;
5. Respecting client representation of either a representative or a substitute decision maker; and
6. Advancing safe, ethical and competent care.

Limitations

This guideline does not cover the following:

1. Consent to release client information.

   Please refer to the college guideline on *Collecting, Recording and Protecting Client Information* (2006) for assistance.

2. Consent to participate in research.

   This is considered consent over and above consent to occupational therapy services. Occupational therapists are advised to consult with their employer or refer to any required ethics review process for additional requirements.

Occupational therapists are strongly encouraged to familiarize themselves with the *Health Care (Consent) and Care Facility (Admission) Act* (1996). Sections of the act appear throughout this guideline.

Definitions

Client
'Clients' may be individuals, families and/or groups, agencies or organizations receiving care and/or services from a registered occupational therapist. It is synonymous with 'patient' or 'consumer'.

Client representative (CR)*
The person authorized by a representation agreement to make or help in making decisions on behalf of another, and includes designation of an alternate representative if the first client representative is not available. A client representative may be a person who has power of attorney, a substitute decision maker or the Public Guardian and Trustee.

Consent
A contractual agreement whereby a client agrees to submit to certain interventions or procedures to be carried out by the occupational therapist, who in turn agrees to perform the specified intervention or procedures within the limitation and under the conditions set down by both parties.

Occupational therapy services
Occupational therapy services may encompass direct care, consultation, research, education, and/or administration.

Power of Attorney
This is a written instrument which confers authority upon another person (an agent) to perform general or specific acts on behalf of the individual who grants it. This agent may be the individual's representative for general and/or specific acts, depending on what is contained in the written instrument.

Public Guardian and Trustee (PGT)
A corporation established under the *Public Guardian and Trustee Act* which provides services to people requiring assistance in decision-making through protection of their legal rights, financial interests and person care interests. A PGT is usually appointed when there is no one else designated as a client representative; the act sets out what general or specific actions he or she can take as the client's representative.

Substitute decision maker (SDM)*
The person appointed under the *Adult Guardianship Act* as a substitute decision maker.

Urgent/emergent care*
Care that is necessary to preserve life, prevent serious physical or mental harm, and/or alleviate severe pain.

* As per sections of the *Health Care (Consent) and Care Facility (Admission) Act* (1996).

Key Responsibilities

Obtaining consent is an ongoing communication process that enables the client to make the decision to accept or refuse occupational therapy services. As regulated health care professionals, occupational therapists are required to obtain consent for occupational therapy services and comply with the *Health Care (Consent) and Care Facility (Admissions) Act (Consent Act).*

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

The client has the right to give consent or refuse consent on any grounds, including moral or religious grounds [s.4 (a)].

Under the *Consent Act*, the occupational therapist <u>must obtain</u> consent directly from the client. There are a few exceptions, including:

1. When an occupational therapist has decided that a client is incapable of providing consent, and consent is provided by a representative or a committee;
2. when there is an urgent or emergency health care situation; and
3. when a client is thought by others to be incapable, and a spouse or relative of the client gives substitute consent.

The *Health Care (Consent) and Care Facility (Admissions) Act* [s. 6] considers consent to be valid only if <u>*all*</u> of the following elements are present:

a) Consent relates to the proposed health care (occupational therapy services);

b) Consent is given voluntarily;

c) Consent is not obtained by fraud or misrepresentation;

d) The person is capable of making a decision about whether to give or refuse consent to the proposed health care;

e) The health care provider gives the individual the information a reasonable person would require to understand the proposed health care and to make a decision, including information about:

i. the condition for which the health care is proposed,

ii. the nature of the proposed health care,

iii. the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and

iv. alternative courses of health care; <u>*and*</u>

f) The person has an opportunity to ask questions and receive answers about the proposed health care.

Consent and Minors

The law distinguishes between infants (children up to the age of approximately 6), immature minors and mature minors. Parental consent is required for infants and immature minors but not for mature minors who have capacity to consent to most forms of health care.

The Infants Act [s. 17] states that a mature minor's consent is sufficient if the health care provider is satisfied that he or she understands the nature, consequences and reasonably foreseeable benefits and risks of the proposed health care. However, the mature minor's right to self-determination is limited by the requirement that the health care provider make reasonable efforts to ensure that the treatment serves the minor's best interests.

Competence Check

Refer to our practice standards: *Essential Competencies* #1.2.2, 1.6.5.3, 2.3.1, 3.4.1-3.4.4, 3.7.2, 5.2.7.

Ethics

The *Code of Ethics* offers further guidance to the consent process. Refer to the values and responsibilities expressed in the code such as dignity and worth, individual autonomy, honesty and transparency.

Additional Resources

Occupational therapists are encouraged to familiarize themselves with other statutes that are pertinent to their specific area of practice such as the *Mental Health Act*, the *Patients Property Act*, the *Adult Guardianship Act*, the *Public Guardian and Trustee Act*, and the *Representation Agreement Act*.

Practice Expectations

Communicating Consent

Consent can be provided orally, in writing, through non-verbal communication, through an interpreter, and/or through alternative and augmentative communication.

Communicating the Details of the Service

In addition to the elements of consent outlined on page 4 from the *Health Care (Consent) and Care Facility (Admissions) Act* [s. 6], provide as much detail as possible regarding the proposed services. Consider sharing the following information to enable the client to make a decision:

- Background of the occupational therapist, credentials and skills.
- Other occupational therapists who may also provide services, e.g. a shared caseload or vacation relief arrangements.
- Use of support personnel and/or students in the delivery of occupational therapy services.
- Relationship of occupational therapy services to overall team approach.
- Reasoning to support the proposed service.
- Any costs involved in therapy.
- Timing and length of therapy.
- Process of termination and/or discharge.
- Client's right to access his/her occupational therapy record.
- Nature and purpose of confidentiality.
- Alternative services if there is a dual or multiple relationship with the client, e.g. the client is a friend or family member.

Determining Capacity to Give Consent

The occupational therapist must presume that a client is capable of "giving, refusing, or revoking consent to health care" [*Health Care (Consent) and Care Facility (Admissions) Act)* s. 3] unless there is a reason to believe otherwise. A client is seen to be capable of giving consent if he or she is able to:

- understand the information that is relevant to making a decision regarding the proposed services, including how the information applies to his or her situation; and
- appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Practice Points

Use a qualified interpreter whenever possible, especially when there is suspicion that the discussion is not being understood by either the client or the health care provider.

Use a variety of communication methods such as visual aids.

Practice Points

Consent must be specific to the service that is to be provided, i.e. occupational therapy. Do not rely on blanket or program consent.

Obtain new consent whenever a significant change in the care plan or a new intervention is to occur. Clients may also choose to consent to only a portion of the proposed services, and the consent and services provided should reflect this.

Practice Point

Assessing capacity to give consent applies to the decision regarding the occupational therapy services to be provided. For example, a person who is involuntarily detained in a mental health facility can likely still make a decision to accept or not to accept occupational therapy services.

Consent Strategies

- Use a functional approach to determine capacity. Incapacity in one legal area does not necessarily imply incapacity in another.
- Assess capacity more than once to accommodate fluctuations in the person's cognitive abilities.
- Assessing capacity may require consultation with other health professionals.
- Seek assistance from family, friends, the client's regular physician or anyone else who may assist in the communication process.
- Consider the need for a client representative (CR) or a substitute decision maker (SDM)

Client Representatives (CR) and Substitute Decision Makers (SDM)

If and when a CR or SDM is appointed, the occupational therapist follows the same process for obtaining consent, but with the CR or SDM, i.e. he or she...

- Informs the client of the appointment of the CR or SDM.
- Includes the client in discussions with the CR or SDM whenever possible.
- Informs the client regarding the process of challenging the determination of his or her decision-making capacity and the appointment of the CR or SDM.

Practice Point

A signed consent form without prior discussion is not considered valid consent. Obtaining written consent from the client is the safest method for proving that valid consent was obtained.

Documenting Consent

Documentation should reflect the consent process, and include:

- Confirmation that criteria for valid consent were met (see page 4).
- When and how consent was obtained.
- Concerns raised during the consent process, and actions taken to address concerns.
- Reasons for refusal or withdrawal from occupational therapy services.
- Reasons for determining that a client was not capable of making an informed decision, and action taken.

Critical Thinking and Decision Making

Obtaining consent is not always straightforward. The process requires that occupational therapists use professional knowledge, critical thinking and risk management to ensure clients make informed decisions.

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).

To prevent harm to the client, the occupational therapist identifies and manages the risk factors that may prevent a client from giving valid consent. The suggested Risk Management Decision Making Tool is designed to help the occupational therapist manage risk.

In Step One, the occupational therapist identifies potential risk factors. Examples of these are listed on pages 9-10 and grouped into four main categories:

1. nature of referral,
2. complexity of client's presentation,
3. environmental conditions, and
4. the occupational therapist's skills and knowledge.

In Step Two, the occupational therapist assesses the risk factors in terms of:

1. the probability of the client not providing valid consent, and
2. the impact of not obtaining valid consent.

Although the risks can be classified from *low probability and low impact* to *high probability and high impact*, the impact of not obtaining valid consent is always high. Valid consent must be received. If not obtained, the delivery of occupational therapy services can be seen as a violation of the client's rights.

In Step Three, the occupational therapist manages the risk factors to reduce the risk of not receiving valid consent. The Practice Expectations section lists several strategies. Once these are in place, the probability of invalid consent should be reduced, and the occupational therapist may wish to re-assess the factors (Step Two) to ensure this.

In Step Four, the occupational therapist chooses a documentation method to support the claim that valid consent was obtained.

The process is dynamic and continues throughout the care continuum, requiring ongoing discussion with the client and/or the individual responsible for making the decision on behalf of the client (client representative).

By anticipating the potential risk factors in your practice you can develop strategies to manage the risk and be more confident in your ability to obtain valid consent, and to determine sufficient documentation.

Potential Risk Factors

Nature of Referral

- Accuracy and quality of information from other sources, e.g. other professionals, clients, significant others.
- Client is perceived to be under pressure, even coercion, to respond and/or behave in a certain way.
- Referral source has power to influence funding of services.
- Client consents to assessment but client's lawyer refuses.
- Client consents to occupational therapy services provided by therapist in the hospital but not to community therapist retained by an insurance provider.
- Referral for specific services that are not appropriate for the client at the time.
- Referral agent has vested interest.

Complexity of Client's Presentation

- Complexity of condition including physical, mental, and social dimensions.
- Stability of condition.
- Capacity to make informed health-care decisions fluctuating and substitute decision maker reverses decisions made by client.
- Fluctuating performance in different situations due to fatigue, pain, medications, stress, and/or distractions, etc.
- Cultural beliefs and values.
- Ability to give and receive accurate information: compromised language barriers, aphasia, dysarthria, other speech deficits.
- Dominant hand function impaired, preventing proper signature.
- Problems with vision, reading, understanding complex information, retaining information.
- Client refusal of services affects comfort of other clients.

Environmental Conditions

- Organization's policy often requires only one consent form to cover all services (blanket consent). However, consent for team approach is inadequate to cover consent for occupational therapy services, e.g. schools
- Services provided by occupational therapists who share a caseload.

- Client agrees to see the occupational therapist but family refuses to let therapist see the client.
- Family is pressuring client to accept occupational therapy services.
- Family member acts as translator and may not be accurately translating client's wishes
- Facility and/or family pressure to manage client is not in client's best interest, e.g. use of restraints to prevent falls.
- Care plans do not match client's wishes or occupational therapist's recommendations, e.g. team pressure to discharge client.
- Team does not value client autonomy.
- Work pressures limit time to obtain consent.

Occupational Therapist's Skills and Knowledge

Lack of, or insufficient:

- Knowledge of current legislation, e.g. when consent is or is not required.
- Knowledge of professional and/or ethical responsibilities with respect to consent.
- Knowledge of client conditions that may jeopardize the client's ability to provide consent.
- Knowledge of specific intervention and so unable to fully describe risks and benefits to the client.
- Comfort with consent language to communicate clearly to clients or client representatives.
- Therapeutic or trusting relationship with client.

1. What are the risk factors that would affect your ability to obtain valid consent?
2. What is the probability (chance/likelihood) that you may not be able to obtain valid consent given each category of risk factors? (Remember the impact of *not* receiving consent is always high.)
3. What measures could you put in place to ensure you obtained valid consent? (Review Practice Expectations)
4. Given the factors affecting the ability to obtain consent, choose from the suggested documentation options.

Decision Making Tool

A Risk Management Approach to Obtaining Consent

STEP ONE

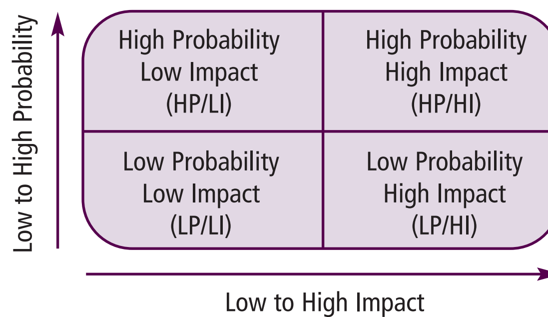
Identify Potential Risk Factors for Your Client

Consider risks in all four areas when obtaining consent.

Nature of Referral	Complexity of Client's Needs	Environmental Context	Occupational Therapist's Skills and Knowledge

STEP TWO

Assess risk factors in all areas and classify risk of harm. However, note that the impact of not obtaining consent is always high.



STEP THREE

Manage or Control the Risk

Choose from strategies listed under practice expectations
Revisit Step Two to assess level of risk

STEP FOUR

Choose Documentation Method

Low Probability/High Impact

Oral consent may be sufficient but document discussion, and how consent was obtained

High Probability/High Impact

Obtained written consent

Obtain written consent and revisit obtaining consent frequently

OBTAIN CONSENT & DOCUMENT
Continue to monitor the risks. Repeat the process.

Decision Making Tool

A Risk Management Approach to Obtaining Consent

Example #1. Client Consents to Assessment

Client Presentation

Client is a 65-year-old male, recovering from elective total right hip arthroplasty surgery. He consented to the occupational therapy assessment and is to be discharged home where he lives with his wife.

STEP ONE

Identify Potential Risk Factors for Your Client

Nature of Referral	Complexity of Client's Needs	Environmental Context	Occupational Therapist's Skills and Knowledge
• Referred by orthopaedic surgeon. • Client signed consent form for OT assessment in pre-op clinic.	• Healthy status apart from right hip pain. • Leads an active lifestyle. • Understands protocol as explained in pre-op clinic.	• Lives with supportive wife who performs IADL activities. • Lives in a 2-storey home but bathroom and bedroom are accessible and on main floor. • Front entrance has five steps and a railing leading to door. • Assistive devices in place as recommended in pre-op clinic.	• Post total hip arthroplasty protocol well established. • OT has worked in this area for two years and can explain all elements of consent.

1. What are the risk factors that would affect your ability to obtain valid consent?

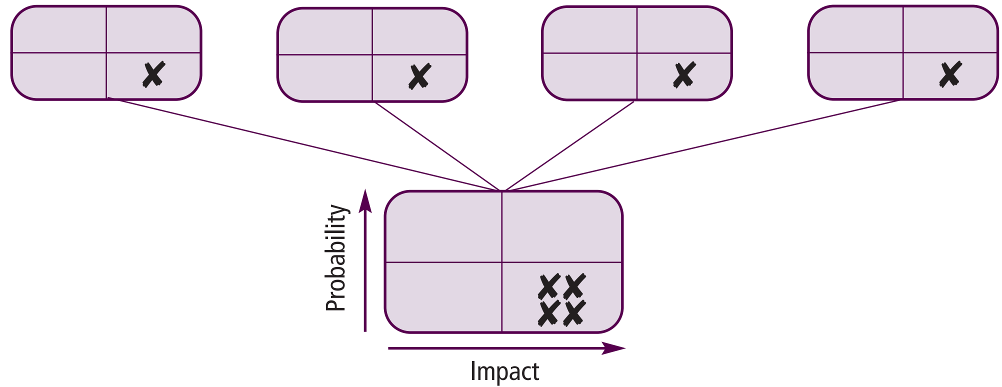
2. What is the probability (chance/likelihood) that you are *not* able to obtain valid consent given each category of risk factors? (Remember the impact of not receiving valid consent is always high.)

3. What measures could you put in place to ensure you obtained valid consent? (Review Practice Expectations)

4. Given the factors affecting your ability to obtain valid consent, choose from the three documentation options.

STEP TWO

Assess risk factors in all areas and classify risk of harm. However, note that the impact of not obtaining consent is always high.



STEP THREE

Manage or Control the Risk

No measures needed as long as all elements of consent were obtained.

STEP FOUR

Choose Documentation Method

Low Probability/High Impact

Oral consent may be sufficient but document discussion, and how consent was obtained

High Probability/High Impact
Obtain written consent

Obtain written consent as well as revisit obtaining consent frequently

Decision Making Tool

A Risk Management Approach to Obtaining Consent

Example #2. Client is a minor

Client Presentation

Client is a 15-year-old young woman who was recently diagnosed with Rheumatoid Arthritis. She consented to an occupational therapy assessment. The suggested intervention is hand splints to prevent deformity. The client does not wish to consent to the splints but her father is insisting.

STEP ONE

Identify Potential Risk Factors for Your Client

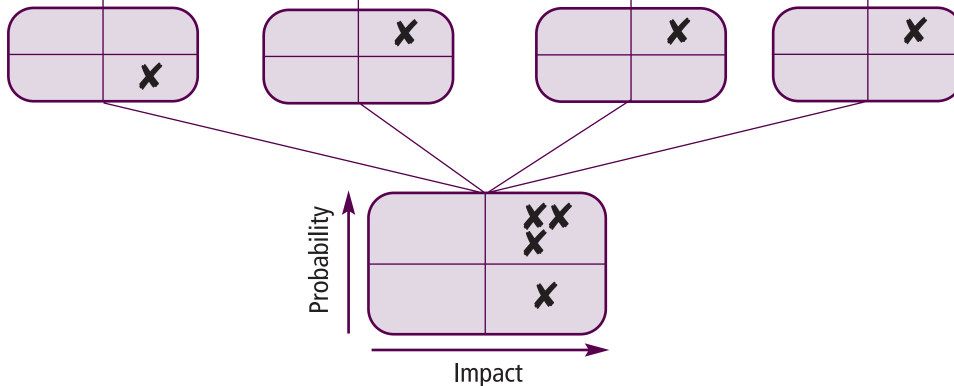
1. What are the risk factors that would affect your ability to obtain valid consent?

Nature of Referral	Complexity of Client's Needs	Environmental Context	Occupational Therapist's Skills and Knowledge
• Referred by supportive doctor. • Outpatient referral. • Client signed consent for referral & assessment.	• New diagnosis. • Long term condition. • Client is not seeing long-term consequences. • 15 year old minor • Very conscious of her appearance.	• Father's English is limited. • Culture values male opinion. • Peer pressure not to wear splints.	• Evidence inconclusive re: splints preventing deformity. • Alternative approaches are available. • OT can explain consent.

STEP TWO

Assess risk factors in all areas and classify risk of harm. However, note that the impact of not obtaining consent is always high.

2. What is the probability (chance/likelihood) that you are *not* able to obtain valid consent given each category of risk factors? (Remember the impact of not receiving valid consent is always high.)



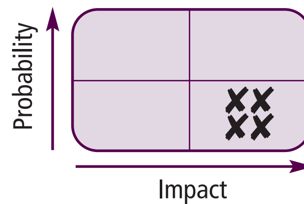
3. What measures could you put in place to ensure you obtained valid consent? (Review Practice Expectations)

STEP THREE

Manage or Control the Risk

1. Solicit doctor's support in education of client regarding illness and precautions needed. Ensure client understands the risks of not having splints versus the risks of having them.
2. Suggest client attend peer counseling or a peer support group prior to assist with decision making.
3. Explain alternatives (e.g. night splints) and the risks and benefits to these.
4. Recommend interpreter for father to increase likelihood that he understands the risk and benefits, as well as his daughter's wishes.

If all of these strategies were implemented, the overall assessment of risk may change to:



4. Given the factors affecting your ability to obtain valid consent, choose from the three documentation options.

STEP FOUR

Choose Documentation Method

Low Probability/High Impact	High Probability/High Impact
Oral consent may be sufficient but document discussion, and how consent was obtained	Written Consent Obtain written consent and revisit obtaining consent frequently

OBTAIN CONSENT & DOCUMENT

Continue to monitor the risks. Repeat the process.

Decision Making Tool

A Risk Management Approach to Obtaining Consent

Example #3. Transfer of Care from Inpatient Unit to Community

Client Presentation

Client was diagnosed with multiple sclerosis and the disease has developed to an extent that the client will need a wheelchair to maintain independence in his activities of daily living, work and leisure activities. The wheelchair assessment began in the hospital and once discharged, the client was referred to a community occupational therapist who is to continue with the assessment and prescription. One-time funding for the wheelchair comes from the Ministry of Health.

STEP ONE

Identify Potential Risk Factors for Your Client

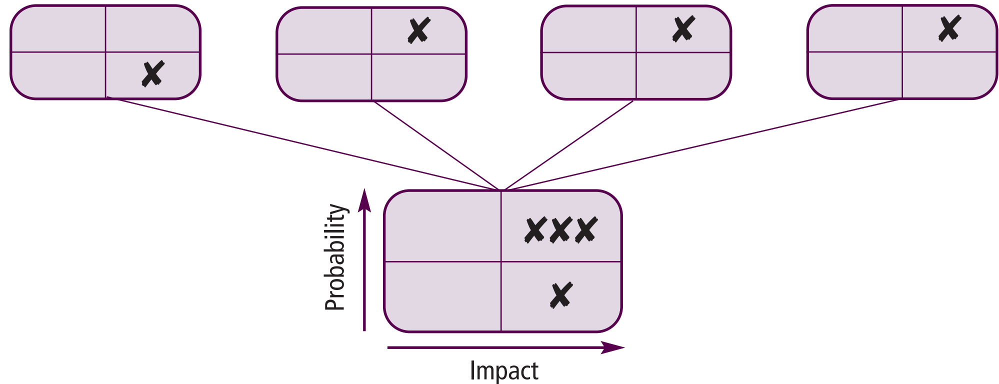
1. What are the risk factors that would affect your ability to obtain valid consent?

Nature of Referral	Complexity of Client's Needs	Environmental Context	Occupational Therapist's Skills and Knowledge
• Referred by occupational therapist from hospital. • Consent for referral was obtained from inpatient occupational therapist and received by community therapist.	• Long term, progressive condition. • Client has some ideas for wheelchairs that do not match what the results of the assessment indicate. • Once at home, client is not sure he needs an occupational therapist to help him with his wheelchair selection.	• Ministry funded chair means that it needs to last as long as possible. • A trial wheelchair was ordered by the inpatient therapist. • Vendor has contacted client directly with subtle pressure to buy the trial chair. • Home has structural barriers making trial wheelchair unsuitable.	• Limited knowledge of wheelchairs for clients with multiple sclerosis

2. What is the probability (chance/likelihood) that you are *not* able to obtain valid consent given each category of risk factors? (Remember the impact of not receiving valid consent is always high.)

STEP TWO

Assess risk factors in all areas and classify risk of harm.
However, note that the impact of not obtaining consent is always high.



3. What measures could you put in place to ensure you obtained valid consent? (Review Practice Expectations)

STEP THREE

Manage or Control the Risk

1. Consult with OT expert re: choices of wheelchairs given client's assessment.

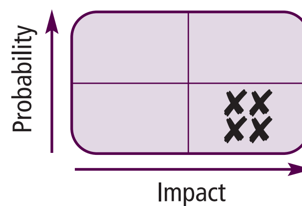
2. Client education re:

   a. Benefits and risks of recommended wheelchair and one he prefers, including long terms needs and ministry restrictions.

   b. Structural barriers and how these impact on the choice of wheelchair.

   c. Set boundaries with vendor.

If all of these strategies were implemented, the overall assessment of risk may change to:



4. Given the factors affecting your ability to obtain valid consent, choose from the three documentation options.

STEP FOUR

Choose Documentation Method

Low Probability/High Impact	High Probability/High Impact
	Written Consent
Oral consent may be sufficient but document discussion, and how consent was obtained	Obtain written consent and revisit obtaining consent frequently

OBTAIN CONSENT & DOCUMENT

Continue to monitor the risks. Repeat the process.

Consent Checklist

Use this checklist to review your obtaining consent practices.

Practice Expectations	Yes	No	N/A
I obtain consent through discussion with the client, client representative or substitute decision maker for *assessment, intervention* and/or *consultation.*			
I obtain consent in writing whenever possible, especially in high-risk cases.			
I obtain consent regularly if occupational therapy services are ongoing.			
I am responsible for obtaining consent and do not delegate this task.			
I obtain valid consent according to the *Health Care (Consent) and Care Facility Admissions) Act:*			
Consent relates to the specific OT services provided.			
Consent is voluntary.			
Consent is obtained without duress or misinterpretation.			
Consent is obtained from a client who is considered capable of giving, refusing or revoking consent.			
I provide information a reasonable person would require to understand the proposed service:			
- Occupational performance problem to be addressed.			
- Purpose of the proposed service, i.e. why it is needed.			
- Nature of the proposed services, including any use of support personnel, students or other occupational therapists.			
- Benefits of the proposed service.			
- Risks of the proposed service and chance of harm.			
- Alternative care, including the option of no services.			
Client has the opportunity to ask questions and receive answers, and time to consider the proposed services.			

Other Service Details (optional)	Yes	No	N/A
I provide additional information when appropriate:			
My background, credentials and skills.			
Reasoning to support the proposed service.			
Any costs involved in the service.			
Timing and length of the service.			
Process of termination and/or discharge.			
Client's right to access his/her occupational therapy record.			

Determining Capacity	Yes	No	N/A
I assume the client has capacity unless there is a reason to believe otherwise.			
I assess the client's ability *to understand* the information relevant to making a decision regarding the proposed services.			
I assess the client's ability *to appreciate* the foreseeable consequences in making a decision to receive, refuse or revoke services.			
If I am unsure of the client's capacity:			
I assess capacity more than once to accommodate fluctuations in the person's cognitive abilities.			
I consult with other health professionals to help determine capacity.			
I seek assistance from family, friends, the client's regular physician and anyone else who may assist in the communication process.			
I consider the need for the appointment of a client representative (CR) or substitute decision maker (SDM)			
I involve the client in discussions with the CR or SDM whenever possible.			
I inform the client of how to challenge determination of capacity and appointment of the CR or SDM.			

Documentation of Consent	Yes	No	N/A
I include on the client record:			
Confirmation that criteria for valid consent were met.			
When and how consent was obtained.			
Concerns raised during the consent process and actions taken to address concerns.			
Reasons for refusal or withdrawal from occupational therapy services.			
Reasons for judging the client not capable of giving consent, and action taken.			
Information provided to the client regarding the process of challenging the determination of capacity and appointment of the CR or SDM.			

Additional Resources

Adult Guardianship Legislation

Representation Agreement Act

Health Care (Consent) and Care Facility (Admission) Act

Adult Guardianship Act

Public Guardian and Trustee Act

Infants Act

Mental Health Act

A Primer to British Columbia's New Health Care Legislation: The *Health Care (Consent) and Care Facility (Admission) Act*

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Notes

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