College of Dietitians of Ontario

Professional Practice Standard

Consent to Treatment and for the Collection, Use and Disclosure of Personal Health Information

Contents

Glossary

Informed consent to treatment: "A consent to treatment is informed if, before giving it,

a) the person received the information[1] that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
b) the person received responses to his or her requests for additional information about those matters." (*Health Care Consent Act, 1996*)

Express consent: Refers to consent that is direct and given explicitly, either orally or in writing.

Implied consent: Refers to consent that may be inferred from the words or behaviour of an individual such that a reasonable person would believe that consent has been given, although no direct or explicit words of agreement have been given.

Knowledgeable consent: Consent for the "collection, use or disclosure of personal health information about an individual if it is reasonable in the circumstances to believe that the individual knows,

a) the purposes of the collection, use or disclosure, as the case may be; and
b) that the individual may give or withhold consent." (*Personal Health Information Protection Act, 2004*)

Emergency: There is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly. (*Health Care Consent Act, 1996*)

Nutrition Assessment: Determining an individual's nutritional status for the purpose of establishing nutritional requirements. Methods may include a review of the client health record for medical history, eating patterns, biochemical and anthropometric indices, discussions with clients/substitute decision-makers/caregivers related to nutrition status/intake, and physical assessments to determine clinical condition(s) related to nutritional health.

Personal Health Information: Identifying information about an individual in oral or recorded form if the information relates to the physical or mental health of the individual, providing health care to the individual, payments or eligibility for health care for the individual, the individual's health number and identification of the individual's substitute decision-maker *(Personal Health Information Protection Act, 2004).*

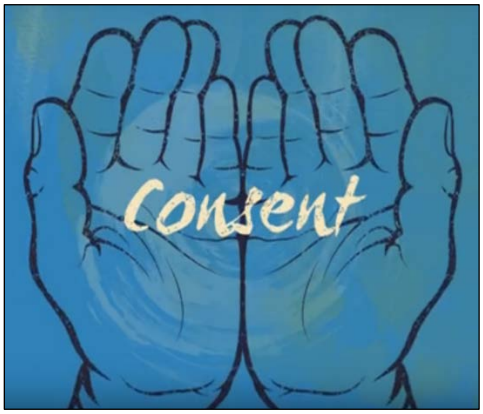
Treatment: "Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan." (*Health Care Consent Act, 1996*) Outside of a chart review, the College has confirmed through legal interpretation that this definition of *treatment* includes nutrition assessments.

[1] 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 (*Health Care Consent Act, 1996*).

Introduction

In keeping with the *Health Care Consent Act, 1996* (HCCA), and the *Personal Health Information Protection Act, 2004* (PHIPA), as health practitioners, Registered Dietitians (RDs) have a legal and professional responsibility to obtain informed consent for nutrition treatment and knowledgeable consent for collecting, using and disclosing personal health or other confidential information. This professional obligation is also articulated in the College's Professional Misconduct Regulation.

The fundamental principles and laws about consent are all based on respect for a client's right to make informed decisions about their health care and personal health information. Obtaining consent is iterative; it's a process that may involve one or more health practitioners in one or more conversations with the client or their substitute decision-maker at different times as the client's care progresses. True informed and/or knowledgeable consent is at the heart of client-centred care.



a. Consent to treatment includes consent for reasonable changes to the nutrition care plan.

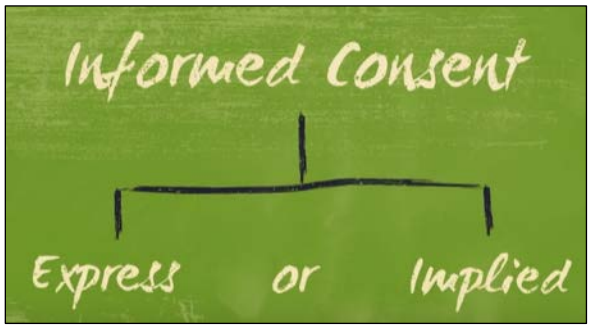
RDs can obtain consent for a multi-faceted nutrition treatment plan that includes several components (e.g. diet, supplements, and/or texture). Once consent has been obtained for the plan, RDs can assume they have consent for changes, provided the nature, expected benefits, risks, and side effects of the original treatment do not significantly differ. This is explicitly outlined in Section 12 of the HCCA which states:

"Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes, (a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and (b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered."

b. When to rely on express or implied consent.

RDs can rely on express (oral or written) or implied consent. Based on professional judgment, the type of consent obtained (express or implied) will usually depend on the context in which the treatment is provided and the degree of risk to the client for following or refusing treatment or for the collection, use and disclosure of personal health information.

Unless otherwise specified, RDs have implied consent to screen or review client health records as part of the nutrition assessment process. Under PHIPA, this is permitted as the information was received and will be used for the purpose of providing health care to the individual. This is referred to sharing personal health information within the 'Circle of Care.' At their discretion, RDs may inform clients/substitute decision-makers of the health care providers within the Circle of Care with whom their personal health information may be shared without express consent.



c. Obtaining consent in interprofessional teams.

The delivery of dietetic services is often done in collaboration with other health care providers. The HCCA states that if a treatment plan is proposed for a client, one health practitioner may obtain consent on behalf of all practitioners involved in the treatment plan. Therefore, RDs can rely on another practitioner to obtain consent for nutrition treatment (which may include assessments) that is part of a treatment plan, so long as this other practitioner is sufficiently knowledgeable about the treatment.

In interprofessional teams, if another provider proposes nutrition treatment and obtains informed consent, RDs should be reasonably confident that adequate informed consent has been obtained prior to providing any nutrition treatment.

d. These Standards of Consent apply to all practice settings where treatment is given or personal health information is collected, used and disclosed.

The Standards of Consent apply to all practice settings where treatment is given or personal health information is collected, used and disclosed. However, as each area of dietetic practice has its own unique characteristics the specific application of the Standard Statements will depend on the practice setting and whether an RD works in an individual or team-based environment. In addition to complying with the College's Standards for Consent, organizational policies and protocols for obtaining consent should also be followed by RDs in their workplace.

The Standard Statements below articulate the minimum level of performance expected from RDs for obtaining informed consent for nutrition assessment, initial treatment, for making significant changes to existing treatment plans, and for collecting, using and disclosing personal health or other confidential information.

Standard Statements

Standard 1: RDs must obtain informed consent for nutrition treatment.

A registered dietitian demonstrates the standard by ensuring the following:

I. RDs obtain informed consent for:

a) Nutrition treatment; and
b) Significant changes to nutrition treatment plans, different from the nature, expected benefits, material risks and material side effects of the original treatment.

II. RDs exercise professional judgment to determine when informed consent can be express (oral or written) or implied.

III. RDs discuss the following with clients/substitute decision-makers to obtain informed consent for nutrition treatment:

a) The nature of the treatment being proposed;
b) Who will be providing the treatment;
c) Reasons for the treatment;
d) Material effects, risks and side-effects of the treatment;
e) Alternatives to the treatment;
f) Consequences of declining the treatment;
g) The right to refuse or withdraw consent at any time; and
h) Specific questions or concerns expressed by the client/substitute decision-maker.

IV. When another health care practitioner proposes nutrition treatment and obtains informed consent, RDs must:

a) Be reasonably confident that the practitioner obtained informed consent;
b) Obtain informed consent if it is determined that the informed consent process for treatment was incomplete; and
c) Answer any additional questions that clients/substitute decision-makers may have regarding the nutrition treatment being proposed.

V. RDs recognize the limits of their knowledge and seek out additional information and/or consult with other health care practitioners to ensure informed consent for nutrition treatment is obtained.

Standard 2: RDs must ensure that knowledgeable consent is obtained for collecting, using, and disclosing personal health information.

A registered dietitian demonstrates the standard by ensuring the following:

I. RDs discuss with clients/substitute decision-makers:

   a) The purpose and method of the collection, use, and disclosure of personal health information;
   b) The legal authority (e.g. voluntary, contractual, legislative provision) for the collection, use, and disclosure of personal health information, as appropriate; and
   c) If the client/substitute decision-maker refuses to consent to the collection, use and/or disclosure of personal health information, the potential risks of not consenting, as applicable.

II. RDs exercise professional judgment to determine when knowledgeable consent can be express (oral or written) or implied.

III. RDs obtain knowledgeable consent directly or verify that another member of the health care team obtained knowledgeable consent for the collection, use and disclosure of personal health information.

IV. RDs apply the concept of the lock-box provision when a client/substitute decision-maker has requested information not be disclosed to another health care provider, group of health care providers, or other third party.

Standard 3: RDs must assume clients are capable of providing consent unless there is reason to believe otherwise.

A registered dietitian demonstrates the standard by ensuring the following:

I. RDs understand that the ability to provide consent is based on capacity, not age.

II. In assessing capacity to consent, RDs determine if clients understand the information that is relevant to making a decision and whether the client appreciates the reasonably foreseeable consequences of a decision or lack of decision.

III. RDs recognize that clients may be incapable of providing consent to some treatments and for the collection, use and disclosure of personal health information and capable with respect to others.

IV. RDs recognized that clients may be incapable of providing consent at one time and capable at another.

Standard 4: RDs must use the appropriate substitute decision-maker to obtain consent on a client's behalf, if a client is not capable of providing consent.

A registered dietitian demonstrates the standard by ensuring the following:

I. RDs determine if the client has a designated Power of Attorney for Personal Care or substitute decision-maker established on record to provide consent on the client's behalf.

II. RDs collaborate with the health care team (as applicable) to:

   a) Identify the highest-ranked substitute decision-maker as outlined in Appendix I;
   b) Verify that the substitute decision-maker is willing, capable and available to provide, withdraw or refuse consent;
   c) Where there are no other substitute decision-makers available, assist with the application of a client's friend (as applicable) to the Consent and Capacity Board to be appointed as a client's representative for personal care decisions; and/or
   d) Contact the Office of the Public Guardian and Trustee, Ontario if there is no family member or representative available to be appointed as a substitute decision-maker.

III. RDs communicate with the substitute decision-maker to obtain informed consent/refusal for nutrition treatment and knowledgeable consent for the collection, use and disclosure of personal health information.

Standard 5: RDs must keep incapable clients involved as much as possible.

A registered dietitian demonstrates the standard by ensuring the following:

I. Where possible, inform incapable clients that they require a substitute decision-maker to assist them in understanding the proposed nutrition treatment and the purpose of the collection, use and disclosure of personal health information, and that their substitute decision-maker will be responsible for these decisions.

II. Inform clients of their substitute decision-maker's name.

III. Involve incapable clients, to the extent possible, in discussions with the substitute decision-maker.

IV. If clients express concern, RDs collaborate with the health care team (as applicable) to inform clients of their rights to apply to the Consent and Capacity Board for:

   a) The appointment of an alternate substitute decision-maker; and
   b) To appeal findings of incapacity.

Standard 6: RDs must apply a culturally appropriate approach for obtaining informed consent for nutrition treatment and knowledgeable consent for the collection, use and disclosure of personal health information.

A registered dietitian demonstrates the standard by ensuring the following:

I. RDs strive to understand the client's cultural beliefs and values in relation to health and nutrition treatment to facilitate an unbiased approach for obtaining informed and knowledgeable consent;

II. RDs clarify with clients/substitute decision-makers, as applicable, whether their cultural practices involve other people in making consent decisions (e.g. spouse, parent, child, friend, spiritual leader, other);

III. RDs use language interpreters, as necessary, to assist in the informed and knowledgeable consent process;

IV. RDs use relevant audio-visual materials to assist in the informed and knowledgeable consent process, as appropriate; and

V. RDs exercise sensitivity, respect and understanding of the varying age and cross-cultural communication needs and practices among clients/substitute decision-makers.

Standard 7: RDs must respect client's/substitute decision-maker's right to refuse all or part of the nutrition treatment or refuse all or part of the collection, use and disclosure of personal health information or withdrawal of such consent at any time.

A registered dietitian demonstrates the standard by ensuring the following:

I. Where clients/substitute decision-makers refuse or withdraw their consent, RDs:

   a) Ensure the client or substitute decision-maker understands the implications of refusing or withdrawing consent;
   b) When consent to treatment is withdrawn, RDs discontinue the intervention as soon as possible and advise the client or substitute decision-maker on any necessary steps to stop the treatment safely; and
   c) Respect the client's or substitute decision-makers choice to refuse or withdraw consent, provided the consent is informed. *

* Except under s. 37 of the HCCA which permits a health practitioner to apply to the Consent & Capacity Board if they are of the opinion that the substitute decision-maker is not acting in the client's best interests.

Standard 8: RDs must only provide treatment without consent in the case of an emergency.

A registered dietitian demonstrates the standard by ensuring the following:

I. RDs understand the definition of emergency under the HCCA.

II. RDs recognize that under the HCCA emergency treatment may be provided without consent to incapable clients if:

   a) There is an emergency; and
   b) The delay required to obtain a consent or refusal from the substitute decision-maker will prolong the suffering of the client or will put the client at risk of sustaining serious bodily harm.

III. RDs recognize that under the HCCA emergency treatment may be provided without consent to capable clients if:

   a) There is an emergency;
   b) The communication required for the client to give or refuse consent to the treatment cannot take place because of a language barrier or because the client has a disability that prevents the communication from taking place;
   c) Steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means have been found;
   d) The delay required to find a practical means of enabling the communication to take place will prolong the suffering of the client or will put the client at risk of sustaining serious bodily harm; and
   e) There is no reason to believe that the client does not want the treatment.

IV. Where RDs provide treatment in an emergency to an incapable client, they (or another member of the health care team) obtain consent to subsequent treatment from the substitute decision-maker at the earliest available opportunity.

V. Where RDs provide treatment in an emergency to a capable client, and the client is subsequently incapable of providing consent on a temporary or go-forward basis, they (or another member of the health care team) identify a substitute decision-maker at the earliest available opportunity.

VI. RDs document when they provide treatment without consent in the case of an emergency.

Standard 9: RDs must document when they receive express consent or the refusal or withdrawal of consent for nutrition treatment or for the collection, use and disclosure of personal health information.

A registered dietitian demonstrates the standard by ensuring the following:

I. When documenting express consent or the refusal or withdrawal of consent for nutrition treatment or knowledgeable consent for the collection, use and disclosure of personal health information, RDs include in the health record:

a) A note about the consent;
b) The reasons why the client or substitute decision-maker is refusing or withdrawing consent (as applicable);
c) A consent form (as applicable), that is dated and signed by the client/substitute decision-maker; and/or
d) A consent policy/procedure or a guideline (as applicable) that is referenced in the client's health record.

II. RDs use their professional judgment to determine when implied consent should be documented for nutrition treatment or for the collection, use and disclosure of personal health information.

Conclusion

RDs must understand the legal and professional requirements for consent to treatment as well as for the collection, use and disclosure of personal health/confidential information. It is expected that all RDs will comply with the *Professional Practice Standard for Consent to Treatment and for the Collection, Use and Disclosure of Personal Health Information* when practising dietetics.

RDs are required to practice within their individual level of competence and meet the Standards that are relevant to their practice environment and practice functions. Where RDs fall below the College's expectations, Standards of Professional Practice will be used as a basis for quality assurance assessments or investigations and may guide the development of remediation plans.

APPENDIX I

When a client is incapable of giving consent, it must be obtained from a substitute decision-maker, unless there is an emergency.

The substitute decision-maker must:

- Be capable;
- Be at least 16 years old (unless the substitute decision-maker is the parent of the client);
- Not be prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
- Be available and willing to make the decision; and
- Act in accordance with either the last capable wishes of the client, if any, or in the best interests of the client.[1,2]

Substitute Decision-Makers Ranked Highest to Lowest:[1]

1. Guardian of the person appointed by the courts, if the person has the authority to give or refuse consent to treatment;
2. Attorney for personal care conferred by a written form when the client was capable;
3. Consent and Capacity Board appointed representative;
4. Spouse or partner;
5. Child or parent (custodial parent if the child is a minor);
6. Access parent (if the child is a minor);
7. Brother or sister;
8. Any other relative;
9. Public Guardian and Trustee.

Where a substitute decision-maker from the first three on this list is available and willing to make the decision, then he or she must be used. At the family level, any available substitute on the list can be relied upon, as long as no same or higher-ranked substitute decision-maker exists or, if exists, would not object to the family member making the decision. The Public Guardian and Trustee, a government official, is relied upon as a last resort.[2]

For more information on the Office of the Public Guardian and Trustee visit:

http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/

An RD has an obligation to intervene if it is clear that the substitute decision-maker is not fulfilling their obligations. In some cases, explaining the obligations to the substitute decision-maker is sufficient. In other cases, if the substitute decision-maker is culpable of misconduct or is not otherwise acting in the best interests of the client, the RD (or a designate within the health care team) may be required to make a report to the Consent and Capacity Board for review.[1,2]

1 Health Care Consent Act, 1996. Available from: http://www.ontario.ca/laws/statute/96h02

2 Steinecke, R., & College of Dietitians of Ontario. (2015). *Jurisprudence Handbook for Dietitians in Ontario*, Chapters 6 & 7. Available from: https://www.collegeofdietitians.org/Resources/Publications-CDO/Jurisprudence-Handbook-for-Dietitians-in-Ontario-(.aspx

Additional Resources

R. Steinecke and the College of Dietitians of Ontario. Jurisprudence Handbook for Dietitians in Ontario (2015) Chapter 6 & 7.

College of Dietitians of Ontario.

- E-learning modules on Consent to Treatment and for the Collection, Use and Disclosure of Personal Health Information (2017).
- Member education videos (2016)
  - Always Get Consent
  - Express vs. Implied Consent
  - Obtaining Consent in an Interprofessional Environment

résumé articles:

- Here's What Health Professionals are Asking About Ontario's New Health Privacy Legislation (2005)
- Circle of Care & Consent to Treatment (2005)
- What is the Lock-Box Provision? (2006)
- Changes in the Plan of Treatment & Consent (2007)
- Documenting Consent (2009)
- Managing Conflicts Between RDs & Substitute Decision-Makers (2009)
- Consent to Treatment Based on Capacity, Not Age (2011)
- Consent Basics (2013)
- Complex Issues & Consent to Treatment (2013)
- Cultural Competence & Informed Consent (2013)
- Are You a Health Information Custodian? (2013)
- PHIPA A Guide for Regulated Health Professionals (2013)