ALBERTA COLLEGE of OCCUPATIONAL THERAPISTS

Practice Guideline

Informed Consent

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1. Background

ACOT's Informed Consent practice guideline has been developed to support registrants in understanding the informed consent process to ensure their clients receive meaningful opportunities to consent, assent or dissent to **occupational therapy services**.

The guidance offered in this practice guideline elaborates on the expectations for **informed consent** as outlined in ACOT's *Standards of Practice F. Informed Consent*. Related expectations are woven throughout ACOT's *Standards of Practice* (SoP), *Code of Ethics* (CoE) and the nationally adopted *Competencies for Occupational Therapists in Canada* (see Appendix A for the full listing of related clauses and indicators).

In preparing the practice guideline ACOT consulted or referred to several pieces of legislation, as well as guidelines and standards of practice from regulators across Alberta and Canada, Government of Alberta resources and Alberta Health Services resources. See Appendix B for the list of relevant legislation and the References and Additional Resources section for the full list of documents.

This guideline does not address consent requirements set by research and ethics boards. For research specific requirements, refer to the research ethics board(s) governing the specific research project. Similarly, this guideline does not address consent requirements set by legislation for the collection, use and disclosure of information. For more on this, refer to ACOT's *Practice Guideline: Information Privacy and Management Legislation*.

According to Standard A. Accountability and Professional Responsibility clauses 4 and 5, registrants are expected to take reasonable steps to ensure their employer's or contracting organization's policies, procedures or processes (or their own, if self-employed) do not prevent them from meeting or exceeding the expectations outlined in this guideline.

If your employer's or contracting organization's informed consent policies, procedures or processes exceed what is outlined in this guideline, you should follow their guidance.

Contact ACOT if you have any questions or would like to discuss informed consent for your specific workplace – info@acot.ca or 780.436.8381.

2. Relevant Definitions

The terms most relevant to this guideline are defined below:

Informed Consent is an agreement or permission to proceed with a service following a process of information exchange and confirmation of mutual understanding, leading to an informed choice. In order to be valid, the client or substitute decision-maker must have the capacity to give consent; the consent must also be given voluntarily and be specific to the proposed service and service provider. The consent provided may be explicit or implied from the circumstances and should be sought on an ongoing basis.

> **Explicit consent** (sometimes referred to as express consent) is the direct, expressed agreement for a specific service.
>
> **Implied consent** is agreement for a specific service that is inferred from the behaviours, actions or inactions, and/or surrounding circumstances which demonstrate a client's willingness to receive services.
>
> **Ongoing consent** confirms consent to proceed or continue with services even if informed consent to services has been previously provided. It acknowledges a client's right to withdraw consent at any time. Ongoing consent is particularly important if a registrant has doubts about a client's wishes; if there is a change in the client's personal or health status, service plan or mode of service delivery; or if the services involve touch, disrobing, or potential physical or psychological discomfort.

Other relevant terms are **bolded** the first time they are used in this document, and their definitions can be found in the glossaries of ACOT's *Standards of Practice* and *Code of Ethics*.

3. Informed Consent Expectations

Registrants are responsible and accountable for ensuring that informed consent has been received from a client (or if applicable, their substitute decision maker) prior to the delivery of occupational therapy services (SoP A.3, SoP F, CoE B.4).

The obligation to obtain and maintain informed consent in a way that is appropriate for the client and the practice **context** is set out in Standard of Practice F. Informed Consent and is a core competency of occupational therapists (Competency E1.3; See also competencies A1.4, A4.1, A5.1)[1]. Standard of Practice F sets the expectation that:

> *A **registrant** respects a client's autonomy and provides the information required to support a **client** in making an informed choice about proceeding or continuing with **occupational therapy service**.*

Enabling client participation in the informed consent process

Registrants are expected to enable their client's participation in the informed consent process. Informed consent is an ongoing and interactive process. It will vary not only with the nature of the proposed service and the practice context, but also with the unique circumstances of each client. It is important to be sensitive to the many factors that can impact the client's experience of an informed consent discussion. This includes addressing any power imbalance between the registrant and the client. Building relationships of trust and respect allows information about the proposed service to be shared in a meaningful way and creates conditions whereby a client can come to an informed decision about whether to proceed. Registrants working with clients impacted by experiences in un-welcoming systems will need to pay particular attention to their consent processes to ensure that the consent discussion aligns with the client's needs and circumstances. It is foundational to the informed consent process to listen to the client and tailor the consent process to best support the client's understanding of the information they need. These principles are essential to the promotion of client autonomy, and to upholding the dignity of all clients (CoE B.1, B.2, B.5).

The following list of reflective questions is intended to prompt registrants to consider and address factors that can affect a client's or substitute decision maker's ability to effectively participate in the informed consent process. This list is not exhaustive nor listed in order of importance.

[1] ACOTRO, ACOTOP & CAOT (2021/2024). Competencies for Occupational Therapists in Canada. (Versions available in English and French).

Reflective Questions:

- Have I created an environment that supports clients to take part in the consent process to the best of their abilities?
- Have I tailored my informed consent process to be respectful of the client's world views and ways of knowing, being or doing, or their prior experiences?
- How can I incorporate a trauma-informed approach into my informed consent process?
- Have I acknowledged and taken action to address any power imbalances between myself and my client? What steps can I take to mitigate the impact of power differences on the consent process?
- Does the client feel safe expressing their concerns or asking questions?
- Are there financial, medical or other reasons why a client may feel pressured to go ahead with or decline the service (e.g., being cut off from benefits)? What steps can you take to address any resulting power imbalance?
- Would the client like to have a friend, family member or carer with them for support in making their decision?
- Is my language appropriate to the age and abilities of the client?
- Would language interpretation services be of benefit?
- Does the client's nonverbal communication match with their direct, expressed communication? Have I taken the steps to explore any discrepancies observed?
- Is my informed consent process commensurate with the level of risk to my client?
- Does the client have a hearing impairment that is impeding their ability to understand the information provided?
- Would the client benefit from having augmentative communication technology available?
- Would the client benefit from having information provided to them in an alternate, accessible format?
- Is the client's current physical and emotional state conducive to making an informed decision? If not, can I reschedule to a better time?
- Does the client require more time to process the information?
- Although a client might not have the capacity to consent, what am I doing to promote their participation in decision-making and to recognize and respect their assent or dissent?

The key question is: *Have I created an environment where clients feel comfortable seeking clarification, asking questions and/or refusing consent?*

Valid informed consent

Registrants are expected to ensure they obtain *valid* informed consent. Valid consent is:

- Specific to the proposed service;
- Informed;
- Given by a person with **capacity**; and
- Given voluntarily.

These four elements are described in more detail in the following sections.

4. Consent Must be Specific

Consent must relate to the specific occupational therapy service being proposed. This means that consent provided for one health service, setting or health care provider does not automatically extend to other services, health care providers or future stages of care. If the nature, purpose or provider of the service changes in a meaningful way, the registrant must revisit the informed consent process and obtain informed consent specific to the current context.

5. Consent Must be Informed

Consent is considered informed when a client (or substitute decision maker) agrees to a proposed occupational therapy service after a process of:

- information exchange and
- confirmation of mutual understanding.

This process enables clients to make an informed choice about whether to proceed with occupational therapy services (SoP F). The informed consent process involves a two-way conversation: the client learns about the specific service proposed and the registrant learns about the client's needs and expectations.

Standard of Practice F.3 requires registrants to provide: "the information needed for a client or their substitute decision maker to make an informed choice to proceed with, decline or stop occupational therapy services." The depth and detail of information shared should reflect the nature of the proposed service, the level of risk involved and the client's individual needs and circumstances.

Standard of Practice F also requires registrants to provide clients or substitute decision makers with opportunities to ask questions and receive answers about proposed services and repeat or adapt the information as required (SoP F.3(c)). For this reason, obtaining a signature on a consent form alone does not constitute *informed* consent.

The key question is: *What would a reasonable person want or need to know in the circumstances?*

What information does a client need to know?

Consider whether the client has enough information about the following topics to come to an informed decision about whether to proceed, decline, continue or stop services:

- Scope and reason for the referral or services
- Service options (i.e., alternative courses of action)
- Possible risks and benefits of the services
- Potential outcomes or possible consequences of refusing services
- Right to refuse or withdraw consent
- Involvement of other service providers (e.g., which care team members will have access to client information and contribute to care?)
- Permission to communicate with others (e.g., explain when client consent would be required to share health or personal information with care partners or other service providers; and when it would not be required) [2] (SoP I.2)
- Limits of confidentiality[3] (e.g., explain circumstances in which confidentiality doesn't apply) (SoP I.3)
- The registrant's reporting requirements to third parties, such as to third-party payors
- Cross jurisdictional considerations[4]
- Any other terms of agreement for the services (e.g., fees, financial arrangements, cancellation policies, mode of service delivery) (SoP L.3)

When exchanging information with the client, the registrant should verify mutual understanding and clarify any points needed, adjusting as necessary considering the client's communication preferences and styles (SoP C.5).

[2] See also ACOT's *Practice Guideline: Information Privacy and Management Legislation*
[3] See also ACOT's *Practice Guideline: Duty to Report*
[4] See ACOT's *Practice FAQs: Registration Requirements for Practice Across Jurisdictions*

6. Consent Must be Given by a Person with Capacity

Consent is sought directly from the client whenever they have the capacity to consent (SoP F.2). When a client does not have the capacity to make decisions for themselves, respect for client autonomy and dignity is upheld by involving an appropriate **substitute decision maker** (CoE B.3 and B.4). See Appendix C for a decision tool that assists registrants to determine when a substitute decision maker may be required.

In Alberta, the types of substitute decision makers with legal authority to provide informed consent on a client's behalf include:

- Agents[5] (i.e., person named in an enacted personal directive);
- Guardians[6] (i.e., a parent(s) with guardianship or a legally appointed guardian);
- Specific decision-makers;[7] or
- A nearest relative or person designated to act as a nearest relative[8] (i.e., with respect to a person subject to an admission certificate or a community treatment order under the *Mental Health Act*), subject to legislation granting the decision-making authority.

Children

The age of capacity to consent to healthcare services in Alberta is 18 years of age. Clients under the age of 18 years of age will require a guardian to provide informed consent on their behalf unless they are determined to be a mature minor. Even though a minor may not have the capacity to provide informed consent, it is important to engage them in a developmentally appropriate manner and recognize and acknowledge their assent or dissent.

Identifying the appropriate substitute decision maker for a child

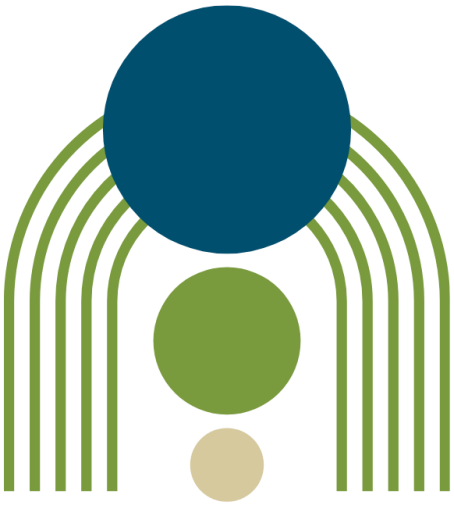
In general, a minor client's parent is also their guardian, and as such, can provide informed consent on behalf of their child. In some situations, the registrant will need to confirm that a parent is a guardian and where there is no parent, will need to identify who the guardian is. Guardians can include a divorced parent with custody of the child, or a person (e.g., stepparent, grandparent, friend) appointed pursuant to a will, personal directive, court order, agreement or by authorization of legislation. A foster parent can

[5] *Personal Directives Act*, R.S.A. 2000, c. P-6, s. 1(b).
[6] *Family Law Act, SA 2003, c F-4.5 and Adult Guardianship and Trustee Act*, R.S.A. 2008, c. A-42, s. 1(d).
[7] Government of Alberta: *Specific decision-making (Part of Alternate personal decision-making options for adults)*
[8] *Mental Health Act*, RSA 2000, c M-13

only gain guardianship through a court order or agreement with a director of the child welfare authority.[9]

If both parents retain all rights of guardianship, either parent can consent to the service. If one parent consents to the proposed services, the other parent does not have the authority to prevent or override the other parent's consent so long as the proposed service is in the best interests of the child. When there is disagreement between the guardians, this can place the registrant in a challenging position. Therefore, it is often prudent to work with both guardians to come to a consensus if possible. The registrant should consider whether proceeding with the service in the face of disagreement would be in the child's best interest or whether to discontinue services until an agreement may be reached. Consider seeking legal advice in this type of scenario.

In situations involving parental separation, divorce or death, or where there is a change in guardianship, the registrant should confirm who has the authority to provide consent on behalf of the client. If uncertain whether the adult presenting with the child is a guardian, registrants should request a copy of the court order, separation agreement or will/grant of probate declaring guardianship. Consent must then be obtained from the guardian(s) in accordance with the terms of the legal documentation. If a copy of the guardianship document is not available, the registrant should document the terms of the order/agreement/will/context as described by the guardian who brought the child for treatment.



[9] Government of Alberta: The Foster Care Handbook: A Guide for Caregivers (2021)

Mature Minors

While the age of capacity to consent to healthcare services in Alberta is 18 years, the law recognizes that some children are sufficiently mature to make their own healthcare decisions and provide their own informed consent.[10] This is referred to as the 'mature minor' doctrine. A healthcare provider proposing a healthcare service is responsible for assessing and determining whether a client under the age of 18 is a mature minor. The decision and the reasoning for making this determination should be clearly documented.

Factors to consider in determining whether a client is a mature minor include:

- The client's age, intelligence and maturity;
- The complexity and seriousness of the healthcare service;
- Their understanding of the risks, alternatives and consequences of proceeding with, or refusing the service; and
- Indications of independence that may support a minor's increased level of maturity (e.g., self-supporting, married, has children).

Where a registrant determines that a child is a mature minor for the purpose of accepting or refusing the proposed occupational therapy service, they may proceed with the informed consent process with the mature minor. Where a child is deemed a mature minor for the purposes of accepting or refusing occupational therapy services, the registrant would need the child's consent to involve parents/guardians in their care.

Adults

Adults are presumed to have the capacity to consent to healthcare services. This means that the registrant should seek consent from adult clients directly unless the registrant has a reason to believe that they lack capacity. Even though an adult may not have the capacity to provide informed consent, it is important to seek their assent and recognize and acknowledge their dissent.

A client's decision that is unanticipated or in disagreement with the registrant's recommendation is not a reason to doubt a client's capacity. In such situations the registrant should clarify the client's response and, where appropriate, engage in further discussion to better understand the client's rationale.

[10] The "mature minor" doctrine was initially adopted by the Alberta Court of Appeal in JSC v Wren, 1986 ABCA 249, and is applied as part of the common law. Subsequent case law from the Supreme Court (AC v Manitoba (Director of Child and Family Services), 2009 SCC 30) further affirmed that a minor's thoughts of what is in their best interest becomes increasingly determinative as they mature.

Given that capacity can fluctuate (and that incapacity may be transient), consideration should be given to revisiting the informed consent process at a later time, to see whether the client is more capable of providing consent under better conditions. If concerns persist, consult the client's physician who can assist in determining if the client's decision-making ability is being affected by a medical condition, substance use or adverse reaction to a medication that may be temporary or reversible.

Some reasons to question capacity include:

- A client struggling to understand information relevant to the decision to be made or to appreciate the reasonably foreseeable consequences of a decision;
- Notable behavioral changes such as having significant difficulty remembering how to engage in activities that were formerly familiar to the client;
- Significant changes in the client's choices about services or tolerance for risk
- Inconsistencies in what the client tells you; or
- The client is or appears to be under the influence of alcohol or drugs (prescription or illicit).

When the registrant has cause for concern about a client's capacity, they should not provide services to the client until questions of capacity and consent can be addressed. If a transient cause for a client's incapacity has been ruled out, a capacity assessment should be initiated (if one has not already been initiated/completed). In Alberta, a formal capacity assessment can only be performed by a physician, psychologist or designated capacity assessor. [11]

The capacity assessor will identify any domains in which the client lacks capacity. The assessment may show that the client has lost the capacity to make some choices, but not others. For example, a client may still have the capacity to determine who they want to live or associate with, and/or to make legal decisions, but not retain the capacity for healthcare or financial decisions.

If the capacity assessment indicates that the client does not have the capacity to consent to the proposed occupational therapy service, informed consent must be sought from a substitute decision maker. The basis of any concerns about a client's capacity, along with decisions related to identifying a substitute decision maker need to be documented in the client record.

[11] For more information on capacity assessment, who can be a designated capacity assessor and enacting a personal directive see: https://www.alberta.ca/capacity-assessment.aspx and https://www.alberta.ca/personal-directive.aspx.

Identifying the appropriate substitute decision maker for an adult

To identify the appropriate substitute decision maker for an adult (and to determine the substitute decision maker's authority), the registrant can ask to review the document(s) granting the decision-making authority. This will either be an enacted personal directive (in the case of an agent) or the guardianship paperwork (in the case of a court appointed guardian). These formal documents give a specific person the authority to make personal decisions for someone and will outline the domains in which a person lacks capacity.

If an adult without capacity does not have a personal directive or court appointed guardian, a health care provider (physician, nurse practitioner or dentist as designated in the *Adult Guardianship and Trusteeship Regulation*) can choose one of the adult's relatives to act as a specific decision maker, for a one-time decision.[12] Specific decision makers must be 18 years of age or older, be available, willing and able to make the decision, have had contact with the client within the past 12 months, have no disputes with the client, and have knowledge of the client's wishes, beliefs and values.[13] If no one meets these criteria, the Office of the Public Guardian and Trustee can be asked to be the decision maker. Note that the *Adult Guardianship and Trusteeship Act* places limits on the authority of specific decision makers. Please refer to section 88(1) of this act for further information.

Co-decision maker, as defined in the *Adult Guardianship and Trustee Act*, is a person selected by the client and appointed by the Court to make personal, non-financial decisions in partnership with the client when the client has significantly impaired capacity but can still participate in decision-making. Co-decision makers and the client work through decisions together, but the client makes the final decision. This includes decisions relating to consent and signing consent forms. A co-decision maker cannot refuse to sign forms unless it might harm the client.[14]

All substitute decision makers must make decisions that are in the client's best interest. If concerned that an adult client's substitute decision maker is not acting in the client's best interest, is acting outside their authority, is not reachable, or no longer has capacity themselves, the registrant can seek further guidance from colleagues or the Office of the Public Guardian.[15]

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[12] Government of Alberta: *Specific decision-making (Part of Alternate personal decision-making options for adults)*

[13] See sections 88(1) and 89(1) of the *Adult Guardianship and Trustee Act*.

[14] For more information on co-decision-making, refer to the Government of Alberta: *Your responsibilities as a co-decision-maker*

[15] Office of the Public Guardian and Trustee: *Complaints about decision-makers*

Where there is more than one decision maker in place for an adult client and they disagree, they should be encouraged to come to a consensus. Where agreement cannot be reached, consult with colleagues, the Office of the Public Guardian and Trustee, or seek legal advice where appropriate.

7. Consent Must be Voluntary

Consent must be freely given (SoP F.4). If the client's consent is coerced, provided out of duress, undue influence, compulsion, or intentional misrepresentation, the registrant has not obtained informed consent. In circumstances where the client is under the influence of another person, or if the registrant feels that the client is fearful of expressing their concerns or questions to them, care must be taken to ensure the client is making a voluntary decision. Reflect on whether the client retained meaningful agency in deciding whether to proceed with the occupational therapy services.

8. Importance of Ongoing Consent

Although the client may have previously provided informed consent to services, they have the right to withdraw consent at any time. The registrant has an obligation to ensure the client's continued informed consent (i.e., ongoing consent).

9. Explicit vs Implied Consent

The registrant should explicitly revisit informed consent in situations where:

- It is uncertain whether the client still consents to the service.
- The plan for service changes.
- There is a change in diagnosis, symptoms or circumstances.
- There is a change in occupational therapy service provider, including assignment to a supervised person (e.g. student occupational therapist, therapy assistant, provisional occupational therapist) (SoP M.6).
- The service poses new material or special risk.
- The service involves touch, disrobing, or potential physical discomfort or psychological discomfort.
- The client or substitute decision maker is no longer capable of giving consent.

If the client has already provided informed consent to begin services, the registrant may be able to rely on **implied consent** for subsequent appointments (e.g., the client

continues to show up for appointments) if there are no changes in the agreed nature of the service or client's health condition/status. However, caution should always be used when relying on implied consent. It is best practice to reaffirm the client's ongoing and informed consent by asking for their **explicit consent**. This can often be accomplished without repeating the information exchanged when receiving initial informed consent. Rather, the registrant can speak directly about the specific changes in services and the service agreement and give the client the opportunity to make an informed choice to continue, decline or stop the service (SoP F.3).

10.Emergency Situations

Where a delay in obtaining consent would prolong suffering or place the client at risk of serious mental or physical harm, a healthcare provider can provide services even if the client lacks capacity or if the substitute decision maker cannot be reached. In such situations, services should only be provided to the extent necessary to alleviate the risk of serious mental or physical harm. Details of the mental or physical risk should be communicated and documented clearly in the client record. As soon as practical after the services have been provided, the registrant should make and document reasonable efforts to inform the client and substitute decision maker as to what has occurred. If the occupational therapy service can wait until the client regains capacity or a substitute decision maker can be reached, the service should be delayed so that valid consent is received.

11. Documenting Informed Consent

Registrants are expected to document the informed and ongoing consent process in an accurate, truthful, respectful and timely manner, keeping in mind how the information documented will be received by a client or others who read it (SoP E.1, E.3 (a)). Subject to employer policies, registrants should use their independent judgment (CoE A.4, SoP E.3(i)) to determine what level of detail to include in their informed consent documentation.

A registrant's decisions and reasoning regarding issues of capacity and informed consent as they relate to mature minors, adults and in emergency situations, need to be well documented in the client record. Similarly, in the case of a child, situations involving changes to guardianship should be documented accordingly. Please refer to those relevant sections of the practice guideline for specific documentation guidance.

Consent forms

While a formal consent form may be used, signing the form alone does not constitute *informed* consent. The form may not contain adequate information to support the client to make an informed decision. As well, a client could sign a consent form without understanding the information it contains. What ensures valid informed consent is following a process of information exchange and confirmation of mutual understanding leading to an informed choice regarding the specific service proposed. When a consent form is used as part of the informed consent process, the form must be added to the client's written or electronic record.

References and Additional Resources

Alberta College of Social Workers (ACSW). *Guidelines on the Management of Consent and Confidentiality When Working with Minors*.

Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA). *Informed Consent for Service Guideline*.

Alberta Health Services Resources:

- *Competency and Consent – Formal Patient Flowchart Mental Health Act of Alberta*
- *Consent to Mental Health Treatment/Procedure(s): Formal Patients and Persons Subject to Community Treatment Orders Under the Mental Health Act*
- *Consent Policy Resources for Practitioners*
- *Consent to Treatment/Procedure(s): General*
- *Consent to Treatment/Procedure(s): Minors/Mature Minors*
- *Consent to Treatment/Procedure(s): Adults with Impaired Capacity and Adults who Lack Capacity*

Boivin, L., & MacLachlan, J. (2021). Reflecting on Indigenous access to informed consent. *Occupational Therapy Now*, *21*(4), 11-12.

College of Alberta Psychologists. *Informed Consent Practice Guideline*.

College of Health and Care Professionals of BC. (2023). *Practice Standards for Consent*.

College of Occupational Therapists of Manitoba. (2012). *Practice Guideline – Informed Consent in Occupational Therapy Practice*.

College of Occupational Therapists of Ontario. (2023). *Standards for Consent*.

College of Physicians and Surgeons of Alberta. Advice to the Profession *Informed Consent for Adults* and *Informed Consent for Minors*.

College of Physiotherapists of Alberta. (2018, October). *Consent Guide for Alberta Physiotherapists*.

College of Physiotherapists of Alberta. (2025). *Standards of Practice: Informed Consent*.

Government of Alberta. *About Capacity Assessment*.

Government of Alberta. *The foster care handbook: a guide for caregivers [2021]*

Government of Alberta - Office of the Public Guardian and Trustee *(OGPT) Supports*,. *OPGT Forms*, and *Educational Material.*

Government of Alberta. *Alternate personal decision-making options for adults*.

Government of Alberta. *Personal Directive*.

Government of Alberta. *Specific Decision-Making.*

Office of the Information and Privacy Commissioner of Alberta.

Appendix A: Relevant Clauses and Indicators in ACOT's *Standards of Practice*, *Code of Ethics* and *Competencies for Occupational Therapists in Canada*

Standards of Practice

Standard	Applicable Section(s)
A. Accountability and Professional Responsibility	*3. Is responsible and accountable for the occupational therapy services provided by themselves and any person(s) they are responsible for supervising.*

Standard	Applicable Section(s)
C. Communication	*5. Verifies understanding of the information being communicated and adjusts as necessary considering the recipient's communication preferences and styles.*
E. Documentation and Record Retention	*1. Documents truthfully, respectfully and in a timely manner, keeping in mind how the information documented in a client record will be received by a client or others who read it.* *3. Documents within the client record details of the service provision process such as the* *(a) informed and ongoing consent process.* *(b) details of the service plan such as the client's priorities and the goals for service, the rationale for service plan, mode of service delivery (i.e., in-person or virtual), anticipated timeframes for service delivery, participation of supervised persons in service provision, and/or any modifications to the service plan based on monitoring and evaluation of services…* *(g) terms of the service agreement including but not limited to billing provisions.* *(i) other information a registrant deems is relevant to the service provision process.*
F. Informed Consent	Full standard.

Standard	Applicable Section(s)
I. Privacy and Confidentiality	*2. Only accesses, collects and discloses client information that they have permission or a client's informed consent to access, collect and disclose, and is* *(a) relevant to occupational therapy service provision,* *(b) only to the extent necessary for the circumstances, and* *(c) only disclosed to persons who reasonably need to know.* *3. Informs a client of the limits of confidentiality. Client information may be disclosed without client consent only if* *(a) access to information and privacy legislation permits release without client consent;* *(b) a legal duty to report obligation requires disclosure of information for client and public safety; or* *(c) a registrant has reasonable and probably grounds to believe that disclosure of information without client consent is necessary to respond to an emergency that threatens the life, health or security of a person or the public.*
L. Service Provision	*3. Discuss the terms of agreement for the services to be provided.*
M. Supervision	*6. Communicates to clients about the roles, responsibilities and accountability of supervised persons participating in the delivery of occupational therapy services and obtains and documents the client's informed consent for the services to be performed under supervision.*

Code of Ethics

Code	Ethical Responsibility
A. Responsibilities for Self	*Registrants have an ethical responsibility to…* *4. Exercise independent judgment.*
B. Responsibilities to Clients	*Registrants have an ethical responsibility to provide services that incorporate equity-focused approaches and…* *1. Provide occupational therapy services that uphold the dignity of each client.* *2. Provides services to all clients in a respectful manner. This entails not discriminating or refusing to provide services, including based on grounds protected under the Alberta Human Rights Act…* *4. Respect and support a client's autonomy to choose whether to proceed with, decline or stop occupational therapy services, including in situations when a client does not have capacity to provide informed consent.* *5. Recognize the power imbalance inherent in the therapist-client relationship and determine and communicate boundaries appropriate for the practice situation.*

Competencies for Occupational Therapists in Canada

Domain A: *Occupational Therapy Expertise* (p. 10)

The unique expertise of occupational therapists is to analyze what people do and what they want or need to do, and help them to do it. Occupational therapists co-create approaches with their clients. They are mindful of people's rights, needs, preferences, values, abilities, and environments. They work with clients to support their health and well-being.

A1.4 *Support clients to make informed decisions, discussing risks, benefits, and consequences.*

A4.1 *Agree on the assessment approach.*

A5.1 *Agree on the service delivery approach.*

Domain E: *Professional Responsibility* (p.16)

Occupational therapists are responsible for safe, ethical, and effective practice. They maintain high standards of professionalism and work in the best interests of clients and society. The competent occupational therapist is expected to…

E1.3 *Obtain and maintain informed consent in a way that is appropriate for the practice context.*

Appendix B: Relevant Legislation

Registrants are required to be knowledgeable of and practice in accordance with legislation relevant to their practice situation. It is beyond the scope of this guideline to address all the legislation relevant to the informed consent process. Below is a list of legislation that may be relevant to the informed consent process in a registrant's practice situation.

- *Adult Guardian and Trustee Act*, SA 2008, c A-4.2
- *Children's First Act*, SA 2013, c C-12.5
- *Child Youth and Family Enhancement Act*, RSA 2000, c C-12
- *Divorce Act*, RSC 1985, c 3
- *Family Law Act*, SA 2003, c F-4.5
- *Health Information Act*, RSA 2000, c H-5
- *Health Professions Act*, RSA 2000, c H-7
- *Mental Health Act*, RSA 2000, c M-13
- *Personal Information Protection Act*, SA 2003, c P-6.5
- *Personal Directives Act*, RSA 2000, c. P-6

Appendix C: Who to Engage in the Informed Consent Process?