

Responsibilities Under Consent Legislation

PROFESSIONAL PRACTICE GUIDELINE



College publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their clients and in the practice of the profession. College publications are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

DECEMBER 2011

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INTRODUCTION

The [Health Care Consent Act \(HCCA\)](#) and the [Substitute Decisions Act \(SDA\)](#), describe the legislative requirements for **Respiratory Therapists** (RTs) in regards to obtaining consent. The HCCA specifies that regulated health professionals are to follow their College's guidelines relating to obtaining consent and the provision of information to patients/clients who are found to be incapable.

The HCCA deals with obtaining consent in the following circumstances:

- for treatment,
- for admission to a care facility and
- for receiving personal assistance services.

In the context of the scope of practice of respiratory therapy, RTs are generally accountable for obtaining consent (or ensuring that consent has been obtained) from patients/clients with respect to treatment.

ABOUT THIS DOCUMENT

Obtaining consent to treat a patient/client is embedded within the College's standards of practice, in other words, it may be professional misconduct to proceed to treat a patient/client without consent. The **College of Respiratory Therapists of Ontario's (CRTO) Standards of Practice** and [A Commitment to Ethical Practice](#) documents provide further guidance to RTs with respect to their obligation and accountability in obtaining consent. This Professional Practice Guideline (PPG) provides an overview of the legislation specifically, the HCCA and SDA for RTs. The information is structured to first describe how to obtain consent for treatment from a **capable** person and then how to proceed with obtaining consent for an **incapable** person. The key terms in **bold** are defined in the Glossary.

Obtaining consent can be guided by a step by step process that RTs should consider each time they are faced with obtaining consent for treatment. A decision tree is included as a visual aid to assist RTs in their process of obtaining consent and to compliment the outline of the PPG. RTs must remember to act within their scope of practice and use their professional judgement to advocate for the best interests of their patients/clients at all times.

THE HEALTH CARE CONSENT ACT (HCCA)

The purposes of the HCCA are:

- (a) to provide rules with respect to consent to treatment that apply consistently in all settings;
- (b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;
- (c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,
 - (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
 - (ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and
 - (iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;
- (d) to promote communication and understanding between health practitioners and their patients or clients;
- (e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and
- (f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1 [HCCA, Section 1].

THE SUBSTITUTE DECISION ACT (SDA)

The SDA deals with decision making about personal care (and/or property) on behalf of incapable persons and involves the appointment of substituted decision makers (SDMs) (see page 15 for information on SDMs).

TREATMENT

Generally speaking, RTs will be accountable for obtaining consent for treatment however, the underlying principle of obtaining consent also applies to obtaining consent for admission to a care facility and for receiving personal assistance services.

The HCCA defines a treatment to mean 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. In this context treatment does not include,

- (a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,
- (b) the assessment or examination of a person to determine the general nature of the person's condition,
- (c) the taking of a person's health history,
- (d) the communication of an assessment or diagnosis,
- (e) the admission of a person to a hospital or other facility,
- (f) a personal assistance service,
- (g) a treatment that in the circumstances poses little or no risk of harm to the person,
- (h) anything prescribed by the regulations as not constituting treatment [HCCA, section 2].

The HCCA defines the plan of treatment to mean a plan that

- (a) is developed by one or more health practitioners,
- (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
- (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition [HCCA, section 2].

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A patient/client comes to your laboratory for pulmonary function tests and says “My doctor sent me here for some tests.”

What would be the best action to take?

Determine your patient/client’s understanding of the tests and verify his/her consent.

It is your obligation is to determine his/her understanding and appreciation of the tests, and to verify s/he consents to the tests.

TREATMENTS (continued)

RTs are responsible for obtaining consent when they are proposing a treatment or plan of treatment. The HCCA also allows for a plan of treatment to be proposed by one health care practitioner on behalf of the health care team involved in the plan. In this case, the health care practitioner proposing the plan may obtain consent for the plan of treatment and is likely the individual responsible for initially determining if the patient/client is capable of consenting. It is likely that the person proposing the treatment or plan of treatment will be the physician who orders the treatment. However, it may not always be the physician — it may be you. If you have any doubt whether or not informed consent has been obtained, it is your professional obligation to obtain it, or to not proceed. The definitions of consent and informed consent are discussed in detail in the section about Consent.

CAPACITY

Once the treatment has been ordered, an RT must decide if consent has been obtained or if it needs to be obtained before proceeding. In some situations, RTs may find themselves needing to determine whether or not a patient/client is in fact **capable** to consent to a treatment or not and what to do if they suspect the patient/client is **incapable**.

There are many underlying and sometimes ethical principles involved in obtaining consent and determining a person’s capacity to consent. One of the first principles to remember is the presumption of capacity. The HCCA states:

“A person is presumed to be capable with respect to treatment,” and

“A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment” [HCCA, section 4]

In other words, patients/clients, are presumed capable unless in your professional judgement you have reasonable grounds to believe that they are incapable of consenting to the treatment or treatment plan you are proposing. The HCCA clearly states, “no treatment without consent” [HCCA, section 10]. If you believe your patient/client to be incapable your next step would be to find a substitute decision maker.

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CAPACITY (continued)**Capacity depends on the treatment and the timing**

Since informed consent is based on the patient/client receiving and understanding the information necessary to give consent, it is possible for an individual to be capable of giving consent for some treatment(s), while at the same time, may be incapable of giving consent for other treatment(s) [HCCA, section 15].

Patients/clients may also be able to give consent at one time but not another.

If an individual becomes capable after consent has been given or refused, the individual's choice then supersedes the previous decision [HCCA, section 16].

A Case of COPD Exacerbation

A COPD patient who presents to the Emergency Department with COPD exacerbation may be capable to consent to an ABG and the administration of oxygen, but may not understand the complexities of intubation.

This patient with COPD exacerbation may have been able to consent to an ABG when they arrived in the ED but may lose the capacity to consent as their condition worsens and there is evidence of impending respiratory failure.

Let's assume that with the administration of oxygen, the condition of this patient with COPD exacerbation improves. The hypoxemia is corrected and in your professional judgement, their capacity to consent has returned. You are very concerned that this patient may require intubation in the future.

What should you do?

In this case, the RT has made a professional judgement that their patient who has presented with COPD exacerbation is capable but does not understand the treatment – intubation. In addition, the patient's condition is unstable and their capacity to consent is dependent on their condition at any given time. In order to act in the best interest of the patient the RT is obligated to seek help from the most responsible physician (and/or other members of the health care team) to discuss their clinical recommendations and findings of capacity. It may be necessary to seek consent from a Substitute Decision Maker (SDM) or to appoint a SDM for the patient. In addition, there is a need to discuss the treatment of intubation with the patient or SDM to ensure that the treatment is understood and informed consent for treatment (or withholding of treatment) has been received. Finally, it may be an opportune time to discuss the patient's wishes with the patient or SDM surrounding intubation and end of life decision making.

Wishes

Individuals may express wishes, while they are capable and at least 16 years old, in any written form, orally or in any other manner [HCCA, section 5]. Expressed wishes must be followed even if the patient/client subsequently becomes incapable.

WHAT ARE THE ELEMENTS OF CONSENT?

Once you have determined that your patient/client is capable to consent to treatment, you must ensure that the four elements of consent are achieved.

The following are the elements required for consent to treatment:

- Consent must relate to the treatment.
- Consent must be informed.
- Consent must be voluntary.
- Consent must not be obtained through misrepresentation or fraud [HCCA, section 11].

Informed Consent

Informed consent is based on the concept that every person has the right to determine what will be done to his or her body. This is the principle of autonomy. Informed consent means that the information relating to the treatment has to be received and understood by the patient/client. This may include communication other than by speaking. For example, a patient/client with a hearing impairment may need the information provided in writing or by sign language. When a language barrier exists, an interpreter may be needed. It is your responsibility to meet your patient/client's communication needs to the best of your ability. Using plain language in your explanation of the treatment is one way to facilitate understanding and appreciation of the information relayed.

Consent is informed if:

- the person received information about the treatment or procedure that a reasonable person in the same circumstances would require in order to make a decision about the treatment, including:
 - the nature of the treatment;
 - the expected benefits of the treatment;
 - the material risks of the treatment;
 - the material side effects of the treatment;
 - alternative courses of action;
 - the likely consequences of not having the treatment; and
 - the person received answers to any questions they had about the treatment [HCCA, section 11].

WHAT ARE THE ELEMENTS OF CONSENT? (continued)**Consent may be implied or expressed.**

Implied consent is determined by the actions of the patient/client. Implied consent may be inferred where you are performing a procedure with minimal risk that the patient/client has consented to previously and acts in a manner that implies their consent. For example, if you inform your patient/client that you would like to auscultate his/her chest and he/she unbuttons his/her shirt, it may be reasonable to infer that he/she consents. If you have any doubt at all, you must ensure that the patient/client or his/her representative consents.

Expressed consent is more official and may be written or oral. For example, having a signed consent form or, having the patient/client consent to treatment verbally in front of another health care provider are expressed forms of consent. Unless circumstances dictate otherwise, you may presume that consent to a treatment includes consent to a variation in that treatment, provided that the nature, expected outcome, risks and side effects are not significantly different from the original proposed treatment. This presumption is also appropriate where the treatment is being continued in a different location [HCCA, section 12].

It is important to remember that consent may be withdrawn at any time and depends on the context of the situation (nature of the treatment, time and place) and the patient/client's capacity to consent.

If you have reasonable grounds to believe your patient/client is incapable of giving informed consent you will have to obtain informed consent from a Substitute Decision Maker (SDM). Please refer to page 15 for information on *Substitute Decision Makers*.

RTs who are unsure whether or not a patient/client is capable to consent should seek assistance, likely from the prescriber of the treatment. Your employer may set out additional policies and procedures to direct your conduct in circumstances where you believe the patient/client is not capable of giving or withholding consent. Where those policies and procedures require you to refer your concerns to a physician or other health care professional then you may defer the finding of incapacity to that health care provider.

For more information on Capacity Assessments you can visit the Ministry of The Attorney General's Capacity Assessment Office at:

www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp

For more information on Evaluators and Assessors of Capacity in the *Health Care Consent Act*:

www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

A CASE OF QUESTIONABLE HOME O₂

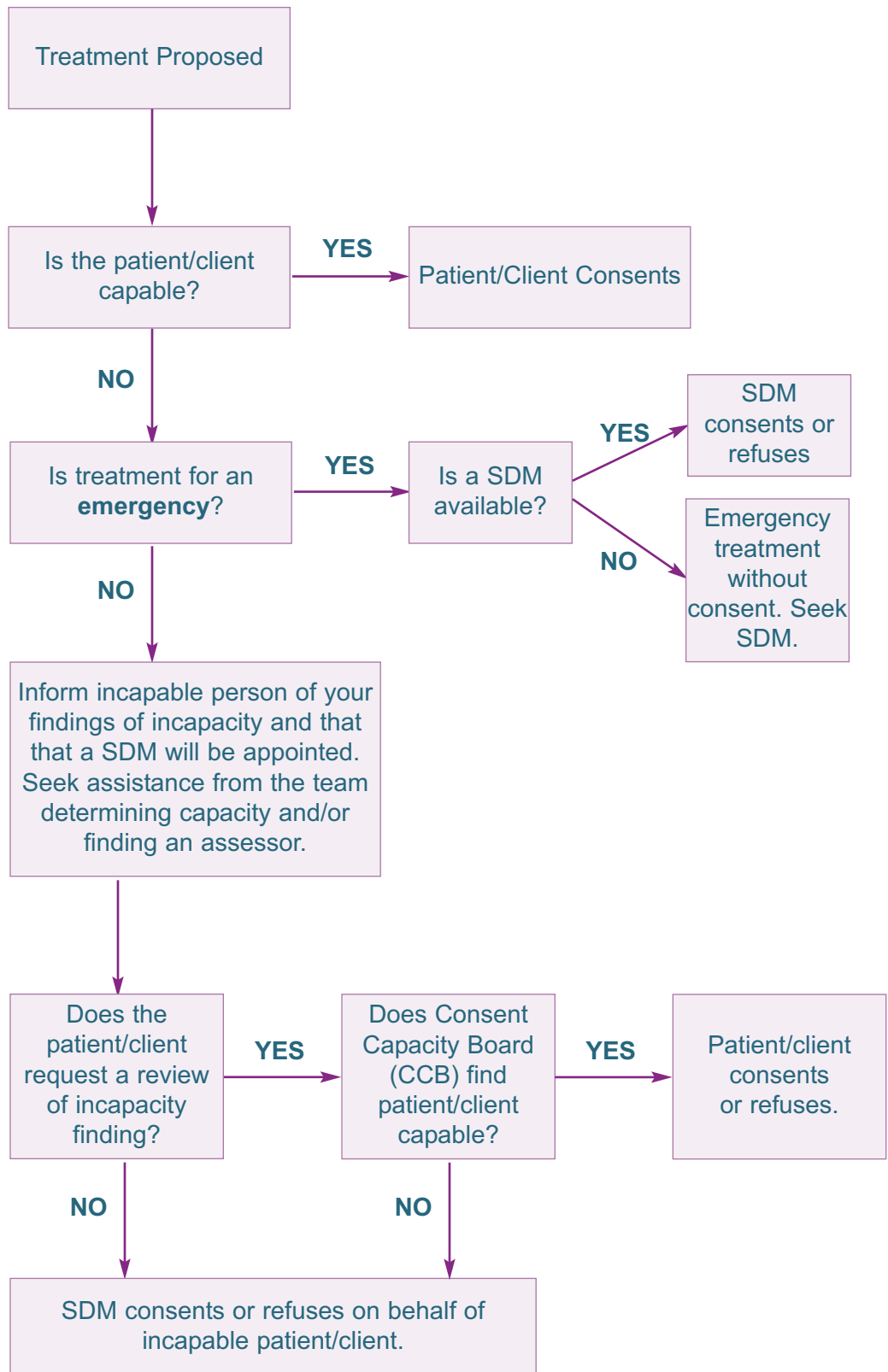
Mr. Smith has just been discharged from hospital to home with an order for oxygen at 5pm by nasal prongs at all times. You are the RT working for the local home oxygen service provider who has received the referral for this new patient/client. You arrange with the discharge planning team at the hospital to meet Mr. Smith at his home to set up his oxygen system and to provide education and training. When you arrive at Mr. Smith's home, you meet up with the transfer team and they assist Mr. Smith into the home where you take over. Mr. Smith seems confused and disoriented. He asks who you are and why the ambulance attendant has left their tank and why they did not remove the tubes from his nose. After you introduce yourself, you ask Mr. Smith if the RT at the hospital did any home oxygen teaching. He replies that he cannot remember and that he "never agreed to home oxygen or any such thing". You spend some time explaining home oxygen, safety and teaching Mr. Smith how to use his concentrator and nasal prongs but you remain unsure if Mr. Smith has actually provided informed consent to this treatment plan. In the middle of your demonstration, Mr. Smith abruptly gets up and proceeds to put the kettle on his gas topped stove for tea. You avert the danger in the nick of time but decide that in your professional judgement, Mr. Smith is not capable of providing informed consent for home oxygen; you are genuinely concerned for his safety.

What should you do?

You share your concerns with Mr. Smith and ask him about a substitute decision maker. After a bit of questioning you find out that Mr. Smith is a widower, with no family or friends nearby. He has an estranged son who you try to get a hold of unsuccessfully. Mr. Smith is now indicating to you that he is "afraid of the oxygen machine" and that he wished he had someone to help him think straight. You contact the CCAC, but they are not scheduled to visit and conduct an assessment for three days, however they will try to move up the appointment and get back to you as soon as possible. The ordering physician who is also the most responsible physician (MRP) is not available. You are in a dilemma, you have another client to see but you can't leave Mr. Smith alone.

In this scenario, the RT has taken all of the right steps to consider the welfare of the patient/client above all else (see [Standards of Practice](#) p.14). He has deemed the patient/client incapable of providing informed consent, informed the patient/client of his findings, attempted to contact an SDM, and attempted to engage the health care team for assistance in determining capacity and consent. RTs are not authorized to perform official capacity evaluations or assessments under the HCCA or SDA respectively. At this time, the best actions for the RT would be to either ensure contact with the ordering/MRP before leaving to arrange an alternate treatment plan or to arrange for the client to return to the hospital from which he has been discharged. It may be a difficult decision and action to take but the RT is ultimately accountable to acting in the best interest of the patient/client. For more information on ethical decision making, please see [A Commitment to Ethical Practice](#).

FIGURE 1.
DECISION TREE FOR OBTAINING CONSENT TO TREATMENT



INCAPACITY

If you believe a patient/client is incapable with respect to a proposed treatment or treatment plan, then you must tell him/her that you find him/her to be incapable. If your patient/client regains capacity with respect to a specific treatment or plan of treatment, after consent was obtained from a Substitute Decision Maker, then you must tell him/her that he/she was found to be incapable to consent at that time.

If at any time your patient/client is sufficiently aware and communicative to understand, you must tell him/her if he/she had been found to be incapable. You are not required to tell your patient/client of a finding of incapacity if you believe he/she would not understand the information due to his/her age (e.g. newborn) or health condition (e.g. obtunded).

When you inform a patient/client that there has been a finding of incapacity, you must:

1. tell him/her who believes he/she is not capable of making his/her own decisions with respect to the proposed treatment;
2. tell him/her who the Substitute Decision Maker (SDM) is who is making treatment decisions on his/her behalf;
3. tell him/her that he/she may appeal the finding of incapacity or the choice of Substitute Decision Maker to the:
Consent and Capacity Board
151 Bloor Street West, 10th Floor
Toronto, Ontario M5S 2T5
www.ccboard.on.ca
4. help the patient/client exercise his/her rights by (as a minimum) referring the patient/client to the staff person in the hospital or health facility who can provide assistance or by advising the patient/client to contact a lawyer; and
5. provide this information in a very helpful manner that is non-condescending, non-judgmental and non-confrontational.

The information must be properly communicated to the patient/client. Using an interpreter or communication aid may be necessary.

WHEN CAN YOU TREAT A PATIENT/CLIENT WITHOUT CONSENT?

1. A treatment may be administered to an **incapable** patient/client without obtaining consent **only** if:
 - i. there is an **emergency**; **AND**
 - ii. the delay to obtain consent will prolong the suffering that the patient/client is apparently experiencing or will put the patient/client at risk of serious bodily harm [HCCA, section 25].
2. A treatment may be administered to an apparently **capable** patient/client without obtaining consent **only** if:
 - i. there is an emergency; **AND**
 - ii. the communication required to obtain informed consent is not possible due to a language barrier or communication disability; **AND**
 - iii. reasonable steps have been taken to enable communication; **AND**
 - iv. the delay to further means of enabling the communication will prolong the suffering that the patient/client is apparently experiencing or will put the patient/client at risk of serious bodily harm; **AND**
 - v. there is no reason to believe the person does not want the treatment [HCCA, section 25].
3. An examination or diagnostic procedure may be performed without obtaining consent provided that:
 - i. the examination or diagnostic procedure is necessary to determine whether or not there is an emergency; **AND**
 - ii. the health care provider believes the patient/client is incapable or that there is a communication barrier that reasonable efforts have not been able to alleviate [HCCA, section 25].

In any case where treatment is given without obtaining consent, you must:

- i. document your opinions with respect to capacity and all actions taken (see [PPG Documentation](#)) ; **AND**
- ii. continue the treatment only as long as it is reasonably necessary to find a substitute decision maker or to find a practical means to enable communication; **AND**
- iii. ensure that reasonable efforts are made to find a substitute decision maker or a means of enabling communication [HCCA, section 25].

SPECIAL CONSIDERATIONS

CPR & Consent:

What should I do if a capable patient/client indicates to me that they would not want any heroic measures to save their life, such as cardiopulmonary resuscitation (CPR), and before the attending physician can write a “Do not resuscitate” order, the patient/client suffers a cardiac/respiratory arrest?

In order to follow-through on patient/clients' wishes regarding CPR, it is imperative that the attending physician has a discussion with the patient/client as soon as possible. In the meantime, the College recommends that a member take the following actions:

1. Notify the attending physician immediately and describe what the patient/client has stated.
2. Ask another health care professional, preferably the patient/client's nurse to witness what the patient/client has just articulated.
3. Briefly explain to the patient/client the nature of the treatment intervention (CPR), expected benefits, risks and the consequences of not receiving CPR if it is required. You may also want to very briefly explain what is meant by CPR: e.g. intubation, ventilation, compressions, and defibrillation/cardioversion to establish that the patient/client has made an informed decision about what treatment they are declining.
4. Document in the patient/client's chart a description of the conversation you have had with the patient/client.
5. Follow-up with the attending physician and confirm the resuscitation status of the patient/client.

N.B.: Understanding and appreciating information are different concepts. Understanding is cognitive. Appreciating information means that patient/client grasps the practical implications of his or her decision. Informed consent requires both understanding and appreciating the consequences of the decision.

It is important to recognize and acknowledge that patients/clients may not fully understand or appreciate the consequences of not having this life saving intervention. To that end, it is very important that the patient/client's attending physician has the opportunity to discuss the likelihood of requiring CPR, the nature of the treatment, expected benefits, risks, alternative treatment options and the consequences of not receiving CPR if required.

In the unfortunate circumstance where this conversation between the patient/client and attending physician does not occur and you are confident that the patient/client made an informed decision with respect to CPR, then under your professional obligation, College policy and the College's understanding of the intent of the *Health Care Consent Act*, you have an obligation **not** to initiate this intervention, namely CPR, and to express the patient/client's wishes to the health care team. Conversely, if you are not confident that the patient/client made an informed decision, then you would participate in CPR.

WHO CAN BE A SUBSTITUTE DECISION MAKER (SDM)?

A Substitute Decision Maker (SDM) is an individual who may give or withhold consent on behalf of an incapacitated patient/client. The following list of SDMs is in order of priority rank:

1. **guardian of the person**, if he/she has authority to give or refuse consent to the treatment,
2. **attorney for personal care**, if he/she has the authority to give or refuse consent to the treatment,
3. representative appointed by the **Consent and Capacity Board**, if the representative has the authority to give or refuse consent to the treatment,
4. **spouse or partner**,
5. child or parent of the incapable person or children's aid society or other guardian in place of a parent — this does not include a parent who only has right of access,
6. a parent with right of access only,
7. a brother or sister,
8. any other **relative**, or
9. the Public Guardian and Trustee [HCCA, section 20].

The Substitute Decision Maker must be:

- capable;
- at least 16 years old, unless he/she is the parent of the incapable person;
- not prohibited by court order or separation agreement from having access or giving or refusing consent;
- available; and
- willing to assume responsibility [HCCA, section 20].

The SDM must also:

- believe that no other person from a higher priority of Substitute Decision Maker exists or if they exist, that they would not object to him or her making the decision — if there is an individual who is from priority rank 1, 2, or 3 then this decision-maker must be the one making decisions;
- give or refuse consent in accordance with any known wishes expressed by the incapable person when capable and at least 16 years old; and
- act in the best interests of the incapable person, if no wishes are known or it is impossible to comply with them [HCCA, section 21].

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WHO CAN BE A SUBSTITUTE DECISION MAKER (SDM)? (continued)

Where there are two individuals of the same priority of Substitute Decision Maker who disagree about whether or not to give or refuse consent for a treatment, and if their rank is ahead of any other potential Substitute Decision Maker, then the Public Guardian and Trustee must make the decision.

WHAT DO I DO WHEN THERE IS AN APPEAL TO THE CONSENT AND CAPACITY BOARD?

A person who is found to be incapable may apply for a review of the finding to the Consent and Capacity Board [HCCA, section 32]. The only exception to this right is if the person has a guardian with the authority to give or refuse consent to treatment or the person has an attorney for personal care and the power of attorney waives the person's right to apply for a review [HCCA, section 32].

Except in an emergency, you must not begin a treatment or procedure, and you must take reasonable steps to ensure that the treatment or procedure is not started, following a finding of incapacity until:

- 48 hours after you were first informed of an intended application to the **Consent and Capacity Board**, without an application to the Board being made;
- the application to the **Board** has been withdrawn;
- the **Board** has rendered its decision and none of the parties [HCCA, section 32 and 33] have indicated their intention to appeal;
- the time for initiating an appeal from a **Board** decision has expired without an appeal being launched after a party to the application has informed you that he/she intends to appeal; or
- the appeal of the **Board** decision has been finally disposed of. [HCCA, section 18].

WHAT ARE THE PENALTIES FOR FAILURE TO COMPLY WITH THE CONSENT LEGISLATION?

The HCCA provides protection from liability for health care practitioners who act on their belief, on reasonable grounds and in good faith, that there was consent for the actions they took [HCCA, section 29]. While it may be reasonable to presume that consent has been given unless you have overt signs that it wasn't, the College recommends that you, as a minimum, verify consent for any controlled act you perform.

It may be considered to be professional misconduct to do “anything to a patient or client for a therapeutic, preventative, palliative, diagnostic, cosmetic or health-related purpose in a situation in which a consent is required by law, without such a consent” [O. Reg 753/93 - Professional Misconduct, paragraph 3].

A Member found guilty of professional misconduct may be subject to any one or more of the following:

1. revocation of the registrant's certificate of registration;
2. suspension of the registrant's certificate of registration for a specified period of time;
3. imposition of terms, limitation or conditions on the registrant's certificate of registration;
4. appearance before the panel for a reprimand;
5. a fine of up to \$35,000 [HPPC, section 51(2)].

GLOSSARY

Attorney for Personal Care	An attorney under a power of attorney for personal care given under the <i>Substitute Decisions Act</i> .
Board	The Consent and Capacity Board.
Capable	Means mentally capable; a person is capable if they are able to understand the information that is relevant to making a decision about the treatment and are able to appreciate the reasonable foreseeable consequences of a decision or lack of decision — capacity has a corresponding meaning.
CERTO	College of Respiratory Therapists of Ontario
Emergency	When the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.
Guardian of the Person	A guardian of the person appointed under the <i>Substitute Decisions Act</i> .
HPPC	Health Professions Procedural Code — Schedule 2 of the <i>Regulated Health Professions Act</i> .
Incapable	Mentally incapable with incapacity having a corresponding meaning.
Partners	Individuals who have lived together for at least one year and have a close personal relationship that is of primary importance in both lives.
Relatives	Are related by blood, marriage or adoption.
Respiratory Care	Equivalent to Respiratory Therapy.
Respiratory Therapist (RT)	Is a Member of the CERTO and includes RRT, GRT, PRT
Spouses	Are individuals who are married to each other, or who are living in a conjugal relationship and have lived together for at least one year, have a cohabitation agreement or are the parents (together) of a child. Individuals living apart and separate are not spouses.

NOTES:



College of Respiratory Therapists of Ontario
Ordre des thérapeutes respiratoires de l'Ontario

May 1999
Revised June 2002
September 2005
October 2010

This practice guideline will be updated as new evidence emerges or as practice evolves. Comments on this practice guideline are welcome and should be addressed to:

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