



NUTRITION, FOOD SERVICE & DINING IN LTC

The best practices within this document are recommendations to support regulatory compliance to Ontario LTC legislation, promote optimal nutrition and hydration care and support person centered care. It is important to note, however, that residents' rights and preferences are paramount and should be respected regardless of legislation or best practice. The best practice document is based on resources and expertise from industry professionals and where applicable, are evidence-based. This is a living document that will transition with the evolution of the industry over time.

SUBJECT: CONSENT TO TREATMENT	Revised: 2023-03-06
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ONTARIO REGULATION 246/22 made under the FIXING LONG-TERM CARE ACT, 2021

Nutrition Care and Hydration Programs

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Purpose & Scope

- Registered Dietitians (RD) have a legal and professional responsibility to obtain consent for treatment when practicing dietetics, and to provide residents with clear and complete information relating to the risks, benefits, and consequences of giving or refusing consent. This document is a guide to ensuring consent to treatment has been obtained.





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- Provincial and other regulatory authorities may supersede these guidelines.
- Once provided with clear and complete information, residents, their power of attorney (POA) or substitute decision maker (SDM), are then able to make informed decisions regarding any treatment done for a therapeutic, preventative, palliative, diagnostic, or health related purpose; this includes a course of treatment or plan of treatment.
- A SDM is the person appointed to make health care decisions. A POA is the legal document stating who is appointed to make those decisions. A person holding the POA can also make decisions concerning personal care, such as clothing, housing, nutrition, etc. ([POA vs SDM link](#))

1. Key Concepts

- RDs exercise professional judgment to determine when informed consent can be expressed (oral or written) or implied. ([College of Dietitians of Ontario - Consent](#))
- Unless otherwise specified, RDs have implied consent to screen or review resident health records as part of the nutrition assessment process.
- Lack of informed consent may constitute negligence or battery.
- Consent is based on capacity, not age.
- The consent must come from a person, not a piece of paper, unless it is an emergency.
- There is an emergency if the person for whom the treatment is proposed is experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly. ([Health Care Consent Act, 1996](#))
- If possible, include all discussions about key areas such as therapeutic diets, modified textured diets, thickened fluids, commercial supplements, enteral feeding, and interventions for end-of-life care early in the admission process as some residents may be capable of expressing wishes at time of admission but incapable after decline occurs.
- The process of consent and goals of care should begin early with advance care planning. ([Advanced Care Planning Ontario](#)) Once illnesses are understood, goals of care discussions should guide the residents' goals and values. Finally, consent to treatment provides the residents with the risks, benefits and alternatives proposing treatment or care by the RD and care team ([Pallium Canada Resource](#))





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Outcomes

- SDM is identified
- Patient & SDM are prepared for decision-making (illness understanding, values & goals)
- Illness is understood
- Decisions are guided by patient values and goals
- Risks, benefits and alternatives are fully explored by the clinician proposing treatment or care

- 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.
- Residents have the right to refuse nutrition/hydration care intervention and treatment.
- RDs discuss the following with residents/POAs/SDMs to obtain informed consent for nutrition treatment:
 - The nature of the treatment being proposed;
 - Who will be providing the treatment;
 - Reasons for the treatment;
 - Material effects, risks, and side-effects of the treatment;
 - Alternatives to the treatment;
 - Consequences of declining the treatment;
 - The right to refuse or withdraw consent at any time; and
 - Specific questions or concerns expressed by the client/substitute decision-maker.



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- Document the discussion and outcome in the resident record.
- Waiver documents are intended to be legally binding contracts in which a person waives their right to bring a lawsuit against an individual or organization for any injuries or losses sustained. Signing a waiver may not necessarily release the homes or healthcare workers of the responsibility to properly protect and get informed consent. It is not recommended to utilize waivers instead of comprehensive documentation and consent.

2. Practice Recommendations

a. How to Determine if a Resident is Capable

- Residents are deemed capable if they are able to:
 - Understand the information that is relevant to making a decision about the treatment, admission, or personal assistance service they receive and,
 - Appreciate the reasonably foreseeable consequences of a decision or lack of decision.
- Does the resident:
 - Have realistic expectations?
 - Understand the nature of the treatment?
 - Have the ability to communicate his or her choice?
 - Know how to discuss the received information rationally?
 - Have awareness of the possible outcomes of treatment or lack thereof?
 - Understand the condition for which treatment is being offered?
- A capable resident gives consent directly and does not redirect the RD to a family member to make a decision unless the capable resident wishes a family member to be involved.
- Residents may be able to make decisions related to the care and services they are receiving including aspects such as nutrition and food choices but may not have the capacity in other aspects of their lives. This may change over time so capacity should be reassessed as changes occur.
- Members of the interdisciplinary care team determine whether an individual resident is deemed “capable” to understand information that is provided for decision-making. However, RDs can determine capacity for nutrition related activities.



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b. Obtaining Consent

- To obtain consent, the health professional and the resident discuss nutrition interventions and the reasons for them.
- The health professional provides ample time and clear explanations and repeats up to three times, in three different ways to fully explain the nutrition intervention or plan.
- Education, good observational skills, strong advocacy, and consistent relationships with caregivers enable a resident with impaired decision-making capacity to make choices.

c. Residents Deemed Capable

- The information about the treatment preferences and/or decision is discussed amongst the team, including the resident (and POA/SDM if agreeable to the resident) and only then is an agreed upon choice made.
- After informing the resident of the risks and benefits of a proposed intervention or treatment, the RD must respect the residents' decision if they choose to refuse the recommendation.
- Each capable resident has the right to disregard clinical advice, and not be labelled as "non-compliant."
- When a resident makes a "risky" decision, the plan of care is adjusted to honour informed choice and provide any support available to mitigate the risks. The RD advises administration and/or director of care/nursing, and care team when there is a risk situation.

d. Residents Deemed Not Capable

- If the RD believes the resident is not capable, they can ask for informed consent from the resident's POA for care, and if there is no POA, then informed consent is given by the resident's specified SDM.
- It is important that the RD and care team educate the POA/SDM on the same recommendations, risks, and benefits to allow them to make an informed decision regarding the plan of care for this resident.
- It is important to ensure that the POA/SDM is acting in the best interest of the resident and not making decisions based on their own desires or preferences. Involving the care team and other disciplines such as social worker or ethicist may be advisable.





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e. Documentation

- Ensure all discussions are well documented as part of the resident's medical record. These documented responses may aid the POA/SDM in making nutrition and hydration decisions that will reflect the desire of the resident.
- The RD documents each step of the process in detail, being specific and including trials, agreements and refusals for care or treatment.
- The agreed upon care plan is monitored and revised on a regularly determined frequency or when there is a change in a resident's status. Written blanket consent forms do not release responsibility of the care team to assess and reassess capacity and care decisions.
- The documentation is legally binding and can be used in legal proceedings.

3. Home Specific Policies, Roles & Responsibilities

- Processes are established for receiving consent to treatment, to ensure residents are appropriately informed about their care.
- Utilize these Best Practices to guide your home specific policies, roles, and responsibilities. Home specific policies take precedence over this document.





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4. Resources & Tools

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5. Evidence & References

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