Practice Direction: Obtaining Informed Consent for Service

The *College of Audiologists and Speech-Language Pathologists of Manitoba* (CASLPM) offers practice advice on matters pertaining to Standards of Practice, Legislation and College expectations. It is granted this authority under *The Regulated Health Professions Act* with the duty to serve and protect the public. Practice directions are provided in response to specific inquiries and may not be relevant in all circumstances. The intention is to support practice but does not replace professional judgement nor legal advice. All practice directions should be read in conjunction with *The Regulated Health Professions Act* and regulations, the by-laws, and The Code of Ethics.

An individual must have the capacity to give consent. It is the responsibility of the registered member to make a reasonable judgement of the individual's capacity to give consent based on the information available to them. The person consenting must have the legal and mental capacity to do so. If the client lacks capacity, consent must be given by a substitute decision maker with the authority to do so. *The Mental Health Act* (MHA) presumes that a person who is 16 years of age or more is competent to make treatment decisions and to provide consent. *The Health Care Directives Act* (HCDA) further indicates that individuals who are 16 years of age or older, have the right to consent, or refuse health care services. That is, anyone under the age of 16 years of age must have the consent of a parent/guardian for services. CASLPM's *Code of Ethics* also states that the registrants must engage clients and their designates as active and informed participants in clinical decision-making which pertains to their care. CASLPM has determined that members must obtain consent for all health care services and registered members must apply the principles of the HCDA and the MHA in obtaining consent for those services.

This guide is intended to help members understand the necessary steps to obtaining consent. It represents CASLPM's interpretation and does not supersede the provisions contained in the HCDA, the MHA or the policies or directives of your employer if the age of consent is older than the age of 16.

DEFINITIONS

Client: an individual, family, substitute decision maker, group, agency, government employer, employee, business, organization, or community who is the direct or indirect recipient of the regulated member's expertise.

Express Consent: an expression of consent provided by a client, or substitute decision maker, either verbally or in writing.

Health Care Service: any screening, assessment, or treatment of a client in any practice setting (school settings, hospitals, or clinics, etc).

Implied Consent: consent that can be inferred based on the client's actions or behaviour.

Informed Consent: a client's agreement to undergo or decline, at any time, in part or in whole, a health care service after meeting the following requirements:

1. The consent is given either by a client with the capacity to make decisions or the client's substitute decision maker. A client has the capacity to make a healthcare decision when the client:
    a. understands the condition for which a health care service is proposed;
    b. understands the nature of the health care service and the health care service options;
    c. understands the risks, benefits and efficacy involved in undergoing the health care service;
    d. understands the risks and benefits involved in declining the health care service; and
    e. has the ability to appreciate the consequences of making such decisions.

2. The consent is given after having been properly informed of the:
    a. condition for which the health care service is proposed;
    b. nature of the health care service and the health care service options;
    c. risks, benefits, and efficacy involved in undergoing the health care service; and,
    d. risks and benefits involved in not undergoing the health care service.
3. The consent is not provided as a result of fraud or misrepresentation.
4. The consent is given regarding the specific service being provided.
5. The consent, in part or in whole, can be withdrawn at any time.

Registered member/registrant: an individual who meets the CASLPM regulatory requirements to practice as an Audiologist or Speech-Language Pathologist in Manitoba.

Substitute decision maker: a person designated to make healthcare decisions on behalf of a client who does not have the capacity to provide consent.

Triage: the review or taking of a client's health history; the consideration of general information shared between health care professionals about possible hearing, communication, swallowing disorders

PERFORMANCE REQUIREMENTS

1. **All registrants must obtain informed consent from a client or the client's substitute decision maker prior to providing a health care service.**
2. **A registrant must obtain informed consent:**
    a. for an initial health care service;
    b. when there has been any significant change in risk or benefit to a health care service;
    c. at other times as appropriate.
3. **Informed consent could be verbal, written, or implied.**
4. **The registrant must properly document instances of obtaining informed consent.**
    4.1 A registrant is required to document each instance of obtaining informed consent.
        4.1.1 In all instances of verbal consent, the nature of the conversation, the information provided, and the client's and/or substitute decision maker's decision must be documented.
        4.1.2 A registrant must document if consent was implied.
        4.1.3 A registrant must document if consent was refused.
    4.2 Each written informed consent record must be kept on a client's record in accordance with "Practice Direction: Record Keeping".
5. **A registered member is not required to personally obtain the required consent.**
    5.1 A registered member can assign the task of obtaining consent for services to another person. However, the registered member maintains the full responsibility of ensuring that the consent obtained is valid and informed.
6. **The registrant must ensure that the manner in which a client offers informed consent or declines a specific health care service after having been informed, respects the client's communication needs, cultural traditions, preferences, and values while upholding the client's autonomy (See Appendix A).**

7. **The registrant may provide a health care service to a client without informed consent in an urgent or emergency health situation:**
   - 7.1 if it is necessary to provide the health care without delay in order to preserve the client's life, to prevent serious physical or mental harm or to alleviate severe pain,
   - 7.2 if the client is apparently impaired by drugs or alcohol or is unconscious or semi-conscious for any reason or is, in the health care provider's opinion, otherwise incapable of giving or refusing consent,
   - 7.3 if the client does not have an available substitute decision maker who is authorized to consent to the health care where practicable, and a second health care provider confirms the first health care provider's opinion about the need for the health care service and the incapability of the client.
   - 7.4 However, if a substitute decision maker later becomes available or a person is designated after a health care provider provides health care to a client, the substitute decision maker may refuse consent for continued health care, and, if consent is refused, the health care must be withdrawn.
   - 7.5 However, the same requirements regarding documentation around consent apply.
8. **The registrant may undertake triage or another form of preliminary examination prior to obtaining informed consent.**

REFERENCES

- College of Speech and Hearing Health Professionals of British Columbia. Client Consent SOP-PRAC-06. CSHBC-SOP-PRAC-06-Client-Consent.pdf
- Health Care (Consent) and Care Facility (Admission) Act, BC Laws. Health Care (Consent) and Care Facility (Admission) Act (gov.bc.ca)
- College of Audiologists and Speech-Language Pathologists of Ontario.
- Obtaining Consent for Services: A Guide for Audiologists and Speech-Language Pathologists. GU_EN_Obtaining_Consent_for_Services.pdf (caslpo.com)
- College of Audiologists and Speech-Language Pathologists of Manitoba. Practice Direction: Record Keeping. THE COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF MANITOBA (caslpm.ca)
- The Child and Family Services Act (C.C.S.M. c.C80) C.C.S.M. c. C80 (gov.mb.ca)
- The Health Care Directives Act (C.C.S.M. c.H27). C.C.S.M. c. H27 (gov.mb.ca)
- The Mental Health Act, CCSM c M110 https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=m110
- The Regulated Health Professionals Act. The Regulated Health Professions Act (RHPA) | Health | Province of Manitoba (gov.mb.ca)

CASLPM
THE COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF MANITOBA

Practice Direction: Obtaining Informed Consent For Service
Frequently Asked Questions

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FREQUENTLY ASKED QUESTIONS

Can I obtain consent for any and all services that will be anticipated? For example, can I present all the families with a consent form at the start of the school year in the event that I may need to see their child at some point?

No. It would not be valid for a CASLPM registrant to obtain blanket consent for any and all services ahead of time as the client/substitute decision maker has not given their informed consent. However, it is valid to obtain consent for specific services that may be administered over one visit, or over a specified period of time. Reminder: the consent needs to relate to the service being proposed.

In the hospital setting a patient is requiring an urgent videofluoroscopic swallowing study but the patient is not able to provide consent and no family/substitute decision maker is available. Is this allowed?

Registrants have no authority to make service decisions on behalf of patients/clients except in an emergency when no authorized person is available to make the decision. A situation can be considered an emergency if the person for whom the service is proposed is experiencing severe suffering or is at risk, if the service is not administered promptly, of sustaining serious bodily harm. In such cases, service can be administered without consent from the client but would require consultation with the physician. It is highly unlikely that the services provided by CASLPM members would qualify as emergency services.

Is it enough that the client has obtained an initial appointment at the office of a registrant to be considered informed consent?

Even though the client has initiated the initial appointment and has come to the office, the client has not yet provided informed consent because the client has not been provided with the required information to do so. However, an example of implied consent would be that this same person, after being provided information, for example about hearing aids, proceeds to make another appointment for a hearing aid evaluation.

In the case parents are no longer together but have shared custody is it enough to have the informed consent of one parent?

Only one parent/guardian is required to provide consent. Registered members should have the parent/guardian confirm in writing that they have the requisite decision-making responsibility to consent to treatment. However, if the registered member has reason to believe that the consent is not sufficient, or that the other parent may take issue with the care being administered, then the member may wish to take extra steps to obtain this consent. Additionally, if another parent/guardian requests information about the services being provided, the registrant must provide this information.

If there is a circumstance where a child is not living with a parent/guardian, should services be withheld?

The appropriate approach will depend on specific circumstances. The child may consent to services on their own behalf if the registered member determines that the child has capacity to give consent, they are 16 years of age or older, and the services are in the child's best interests. If the child is not considered capable, and consent cannot be obtained from the person or CFS agency who has decision-making responsibility for the child, services should generally not be provided.

Can I release information to a family member/next of kin/Power of Attorney (POA) of an adult client who is able to provide consent?

Consent must be obtained from the client. An exception would be if the POAs rights have been activated due to the inability of the client to provide consent.

What happens in cases where the client disputes that consent was given after the fact? (For example, if a guardian has provided consent and a parent resumes custody after the services have been provided)

Refer to the documentation where consent was given, and dialogue around risks and benefits regarding continuing/withdrawing intervention. Services may be withdrawn if requested.

I work for a school division that sets the age of consent at 16, what should I do?

This is consistent with *The Mental Health Act*. Follow your school policy as long as the policy is for consent above the age of 16.

Would a referral from a physician count as obtaining consent?

No. The registered member cannot assume that the information provided to the client was enough to obtain informed consent.

However, the task of obtaining consent for services can be tasked to another professional but the registered member remains fully responsible for ensuring that the information required for consent was accurately presented and that any requests for further information have been met.

For example, when the unit charge nurse at a long-term care facility seeks consent from the client or substitute decision-maker for the health care service, the nurse could also present the necessary information regarding, for example, the speech-language pathology services that could be provided. If the patient/client or substitute decision-maker then consents, the registered member is not required to seek consent again prior to initiating services.

Similarly, where services are offered by a school board, a member could assign the task of obtaining the consent to the proposed services to another person, such as a special education teacher or a teacher of the deaf and hard of hearing. Here again, however, the member must ensure that the consent obtained is valid and informed.

As an audiologist there are a myriad of procedures that potentially could be offered and often you may not know if you need to perform them until that moment in question. Do I need to continually ask for permission for each individual procedure?

A registrant is entitled to presume that consent to service includes:

- Consent to variations or adjustments in the service if the nature, expected benefits, material risks and side effects are not significantly different from those of the original service.
- Consent to the continuation of the same service in a different setting if there is no significant change in the nature, expected benefits, material risks and side effects of the original service as a result of the change in the original setting.

Registrants should explain what they are doing throughout the process and clients may withdraw consent at any given time.

Facilitating Informed Consent for Service Discussions with Individuals with a Communication Impairment

Adapted with permission from CASLPO (2006) Obtaining Consent for Services: A Guide for Audiologists and Speech-Language Pathologists.

For individuals with a communication impairment, giving consent may pose a significant challenge. Registered members must ensure that all reasonable steps are taken to allow a client to fully understand the service options and express their wishes in the process of obtaining consent for audiology and speech-language pathology services. The existence of a disability, including a speech, language, or hearing impairment, is not sufficient to presume a client is incapable of giving consent.

A client is presumed to be capable of giving consent unless the registered member has reasonable grounds to assume otherwise. The Health Care Directives Act (HCDA) requires that a client must have the ability to understand the information provided and appreciate the consequences of the decision in order to be considered capable of giving consent.

It is important to recognize that when a client makes a decision that is unanticipated or disagrees with the registered member's recommendations, the registrant cannot assume there is a lack of competence. The registrant must respect the client's wishes and may engage in further discussion to increase understanding of the client's rationale.

SUGGESTIONS FOR FACILITATING AN INFORMED CONSENT DISCUSSION

Provide patients/clients with every opportunity to use their most effective mode of communication. Members should make every effort to obtain appropriate training and skills in communication techniques and use appropriate materials.

The following are examples of techniques to facilitate comprehension:

- Use language that is appropriate to the age and abilities of the client.
- Use language that is appropriate to the linguistic and cultural background of the client.
- Ensure the client can hear sufficiently to participate in the discussion. Provide accommodations as necessary such as assistive listening devices, supplementary written information, adequate lighting, and a quiet environment.
- Provide alternative methods of communication for patients/clients whose competence to provide consent may be masked by a communication disorder.
- Provide visual aids throughout the discussion to support conversation, accommodating for any visual difficulties.
- Allow the client to paraphrase the discussion to confirm comprehension.
- Provide the client with sufficient time to process the information and ask any questions. In some instances, it may be helpful to allow the client to contact you following the session to review any issues or ask about issues that did not come up during the face-to-face session.

- Verify that the client has demonstrated comprehension after each component has been presented, to minimize the effect of memory difficulties.
- Encourage the client to allow others to participate in these discussions for support but ensure that the discussion is targeted to the client. It is the client who must ultimately make the informed decisions regarding the services offered.

Draw on some of the following techniques to facilitate expression as appropriate:

- Structure the dialogue to allow the patient/client every opportunity to ask questions and add perspectives to the discussion. Techniques to facilitate this may include (a) numerous direct ("What do you think?") and indirect ("I wonder what you are thinking?") invitations to participate in the discussion; and (b) pausing frequently for sufficient durations to allow an unsure or reluctant patient/client the opportunity to participate and ask questions.
- Use techniques to support communication, such as interactive drawing, pointing to relevant pictorial or symbolic representations, pointing to key words provided, gesturing, age-appropriate play activity or enactment, use of yes/no responses.
- Allow the patient/client to express their understanding of the assessment and treatment alternatives at each stage of the discussion (e.g., present each option visually and allow the patient/client to indicate what was understood using his or her preferred communication modality).

SUMMARY

Audiologists and speech-language pathologists, by virtue of their unique and specialized training in communication disorders, have a responsibility to ensure that patients/clients are able to give informed consent to the services provided by members, independent of their communication difficulties. Clients must be given every opportunity to engage in a partnership with the member when intervention decisions are made.

The Health Directives Act, May 2022. C.C.S.M. c. H27 (gov.mb.ca)