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

Obtaining Informed Consent for Service
Frequently Asked Questions

Introduction

This companion document to the *Obtaining Informed Consent for Service Standard of Practice* and guidelines on obtaining informed consent has been developed to support registrants in gaining a clearer understanding and interpretation of the Standard. It is intended to be read alongside the Standard and is not designed to serve as a stand-alone document.

An individual must have the capacity to give consent. It is the responsibility of the registrant to make a reasonable judgement of the individual's capacity to give consent based on the information available to them. The person who is 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.

Frequently Asked Questions

General questions about consent and documentation

QUESTION:
What is the most important action I can take to ensure I am following the Standard of Practice for Obtaining Informed Consent for Service?

ANSWER:
Documentation of a professional's best efforts to obtain consent is a fundamental piece of obtaining consent.

QUESTION:
What is the most appropriate way to document consent?

ANSWER:
There is no specific way to document consent; however, using a single "yes/no" checkbox does not allow for the key information such as who consented (patient/client or substitute decision maker) and the type of consent (verbal or implied) obtained for a specific healthcare service. Each setting must determine the most appropriate manner to document consent, and it is in your best interest to be as thorough as possible in your documentation.

QUESTION:
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?

ANSWER:
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.

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

ANSWER:
Even though the client has initiated and attended the initial appointment, the client has not yet provided informed consent because the client has not been provided with the required information to do so.

Examples of Implied consent:

- A person having received information about hearing aids and proceeds to make another appointment for a hearing aid evaluation.
- A health service provider explains a procedure while continuing to work and no concerns are registered by the client.
- In these examples, and all cases, it is important to note that consent can be withdrawn at any time.

QUESTION:
Can the task of obtaining consent be assigned to another professional or staff person?

ANSWER:
The task of obtaining consent for services can be assigned to another professional/team member. In these cases, 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 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 a reminder, blanket consent for any and all services ahead of time is not a valid form of consent. It is valid to obtain consent for specific services that may be administered over one visit or over a specified period of time. Consent must be related to the services being proposed.

QUESTION:
There may be myriads 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?

ANSWER:

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.

QUESTION:
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?

ANSWER:
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.

QUESTION:
If a new substitute decision maker is in place, do I need new consent?

ANSWER:
It is best practice to advise a new substitute decision maker of the healthcare services being provided and to obtain consent.

QUESTION:
If I join a group with an existing caseload having never received consent personally, do I need to obtain a new consent?

ANSWER:
The client/substitute decision maker should be informed of the change in healthcare service provider. However, if a treatment plan was agreed to previously, there is no need to reestablish consent for service. Each situation should be reviewed on an individual basis to determine the appropriate steps and documentation of steps taken is important.

QUESTION:
My workplace dictates that we must update consent annually. Do we need to do so under this PD?

ANSWER:
Professionals should follow workplace policy as long as the policy meets the minimum standard outlined in these documents.

Working with minors

QUESTION:

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

ANSWER:
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.

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

ANSWER:
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.

QUESTION:
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).

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

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

ANSWER:
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.

Working in healthcare settings

QUESTION:
Would a referral from a physician or other outside source count as obtaining consent?

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

QUESTION:
Does having a standing order exempt registrants from obtaining consent?

ANSWER:
Having a standing order at a healthcare facility does not necessarily exempt you from obtaining consent. While standing orders typically apply to routine tasks (hearing screenings, vaccinations, lab tests, etc.), this does not replace the need for consent. Informed consent is still required for medical intervention that carries risks or side effects, requires client understanding and agreement, and involves personal autonomy. Hearing screenings that are carefully regulated and communicated are an example of standing orders.

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

ANSWER:
Registrants have no authority to make service decisions on behalf of clients when no authorized person is available to make the decision except in an emergency. A situation may be considered an emergency if the person for whom the service is proposed is experiencing severe suffering or is at risk of sustaining serious bodily harm if the service is not administered promptly. 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. Documentation of attempts to contact a substitute decision maker is important in all cases.

A swallowing assessment is not considered urgent.

QUESTION:
What if I am unable to gain consent after attempts to do so in an emergency situation?

ANSWER:

In the rare case of an emergency, professionals in healthcare environments must weigh the benefits of proceeding without consent with the benefit of not getting consent.

CASLPM is unable to comment on specific situations and trusts the professional judgement of registrants to determine what an urgent or emergency health situation constitutes. In all cases, these situations require documentation. Clients/substitute decision makers can withdraw from services at any time.

QUESTION: What considerations should I make for consent for procedures that are considered invasive?

ANSWER: Refer to the *CASLPM Guidelines for audiologists and speech-language pathologists on Invasive Procedures.*