



Alberta College of
Speech-Language Pathologists
and Audiologists

Guideline

Informed Consent for Service

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INFORMED CONSENT FOR SERVICE

Guideline: Provides recommendations to regulated members that are deemed to be acceptable practice within regulatory requirements. Regulated members are afforded reasonable use of their professional judgment in the application of a guideline

1. Introduction

Informed consent for service (ICS) refers to the situation when “a client¹ gives consent to receive a proposed service following a process of decision-making leading to an informed choice” (ACSLPA Code of Ethics, 2009, p. 7). The intent is to protect and respect the integrity and autonomy of the client, to ensure that they are informed and understand the services and options for service available to them, and to ensure they understand their right to refuse consent or withdraw consent for service once given.

All speech-language pathologists (SLPs) and audiologists in Alberta, regardless of practice setting, are regulated under the *Health Professions Act* (HPA). As such, all are considered to be “health care providers,” and are subject to the provisions and requirements of the HPA. The HPA (2000) states the key regulatory responsibilities of a college, including those relating to professional practice standards and professional conduct. As per the HPA, colleges are directed to establish, maintain and enforce both a Code of Ethics and a Standards of Practice for their regulated members, both of which address the requirements for obtaining informed consent for service.

Consistent with Standard 3.2 (*ACSLPA Standards of Practice*, 2015), this guideline provides information applicable to all SLPs and audiologists practicing in Alberta. SLPs and audiologists also have a professional responsibility to be aware of employer and/or agency policies, and any additional legislation or provincial standards regarding informed consent, where they exist. Although employer/agency policies may vary, Standard 3.2 sets the minimum requirements expected of all regulated members.

This guideline focuses exclusively on ICS; it is not intended to address other forms of consent, such as consent for the sharing or disclosure of information. Please refer to ACSLPA’s *Clinical Documentation and Record Keeping Guideline* (2011) for information related to the management, security and confidentiality of records.

2. Principles

This guideline is based on the following principles:

1. ICS is tied to the value of *autonomy*, where we respect and promote clients’ rights and ability to make informed decisions. Indeed, respect for autonomy forms the primary ethical foundation for informed consent. The autonomous choice of the client must be respected even if that choice does not result in maximum benefit to the client (Stewart Muirhead, Wilkin, and James, 1994).

¹ For the purposes of this guideline, “client” refers to an individual who is the direct recipient of a regulated member’s expertise, or to an alternate or substitute decision maker, providing consent on another individual’s behalf. For minors other than mature minors, this would include a parent or guardian.

Related elements of informed consent include concepts such as *dignity* – respecting the inherent worth of clients by demonstrating sensitivity to their individual needs, values, and choices; and *veracity* – truth-telling, and the expectation that health care professionals tell the truth to their clients.

2. ICS is required prior to providing any professional service, which may include, but is not limited to clinical screening, assessment, interventions, participation in clinical research activities, etc. Obtaining ICS from a client is a process rather than an event, and it involves working collaboratively rather than simply signing a form. To that end, an agreed-upon plan of service and client involvement in discussions and decision-making should serve as the foundation of consent. Refer to Appendix A for a list of questions developed to promote self-reflection related to the ICS process.
3. Consent must be given voluntarily, free of coercion, undue influence, or intentional misrepresentation.
4. An individual must have the capacity to give consent. It is the responsibility of the clinician to make a reasonable judgment of the individual’s capacity and authority to give consent based on the information available to them.
 - a. The person consenting must have the legal and mental capacity to do so. According to Section 26 of the *Alberta Mental Health Act (2000)*, a person is mentally competent to make treatment decisions if the person is able to understand the subject matter relating to the decisions and able to appreciate the consequences of making the decisions.
 - b. If a client lacks capacity, consent must be given by a family member or designate with legal authority to do so, a legally appointed guardian, or the court.
 - c. If a client is under the age of 18, consent must be obtained from the parent/guardian and, when possible and appropriate, from the minor as well. A client under the age of 18 is presumed to be a minor without capacity and requiring a parent’s/guardian’s consent unless they have been deemed to be a *mature minor*.

Several factors are considered when assessing whether someone can be deemed a mature minor, including age, intelligence, maturity, the complexity and seriousness of the procedure, an understanding of the risks, alternatives, and consequences of their consent for, or refusal of service, and indications of independence that may support a minor’s increased level of maturity (e.g., self-supporting, married, has children). If a professional decides that a minor is sufficiently mature, steps should be taken to document the basis for this finding. In such circumstances, consent from parents is not required; parents also may not override the decision of their child. Please refer to Jackson (2014) for a discussion regarding minor clients. A *Mature Minor Algorithm (2010)* is also available from Alberta Health Services.

5. In speech-language pathology and audiology practice, there may be rare circumstances where an alternate decision maker's refusal to consent for services places an individual at significant risk of harm (i.e., failure to provide the necessities of life). In such circumstances, the clinician should consider whether an application to obtain protection for the individual is warranted. Specifically, an application may be made for a court order authorizing services according to the *parens patriae* principle. Under the *Child, Youth and Family Enhancement Act* (2000), for example, child welfare authorities may apprehend a child considered to be in need of protective services, including a child in need of life-sustaining medical treatment.
6. Typically, the speech-language pathologist or audiologist most responsible for the provision of care is responsible to obtain the ICS.
 - a. ICS normally authorizes a specific person to carry out a specific service. This person is in the best position to answer any questions regarding the service or procedure.
 - b. Clients should consent to the speech-language pathologist's or audiologist's assignment of activities to another individual (e.g., aide or assistant).
 - c. Clients should be informed and have the opportunity to give consent for students and/or volunteers to be present during any service.
7. ICS, irrespective of communication mode (i.e., face-to-face, telephone, electronic correspondence), should address the following considerations:
 - a. The nature or purpose of the activity;
 - b. The name of the person most responsible for providing the service;
 - c. The intended duration (i.e., day, number of weeks, months) of the service ;
 - d. The benefits, risks, and alternatives to the service;
 - e. Any likely consequences of delaying or refusing the proposed service;
 - f. The option to refuse or withdraw at any time without fear of reprisal;
 - g. The opportunity to ask and be given answers to questions about the service, its risks, benefits, or alternatives.

It may be prudent to confirm the plan, restating your name, role, and objectives, as appropriate, at the beginning of each session (e.g., "Hi Mrs. Smith, it's Jane Doe again. I'm the speech-language pathologist who helps with your swallowing. We were planning to ... today. Are you okay to go ahead with this plan? Do you have any questions or is there anything new I should know about?", "Hi Johnny, do you remember me? It's Megan and we're going to work on your sounds today. We're going to play a fun game. Mrs. Jones, shall we go ahead with the session? How has practice been going at home? Any updates?")

In relation to item d., risks may be deemed *material*, being those that are known to be associated with the activity and can commonly occur. Risks deemed *special* are those that may be highly unlikely but have severe consequences or have special relevance to that particular client.

When determining whether ICS was established, the question is asked as to whether a reasonable person in the client's position would consent to the service, having been made aware of both the associated material and special risks.

8. Any new information relevant to the original or ongoing ICS is to be provided to the client in a timely manner.
 - a. ICS should be obtained anytime there is a substantial change in the plan of care and considered if there is a change in diagnosis, symptoms, or circumstances.
9. Consent can be expressed or implied.
 - a. Expressed consent can be written or verbal. If consent is verbal, then a notation should be made to that effect in the client's file (see item 10 below).
 - b. Implied consent can be implied from the client's words or actions (e.g., the client continually attends ongoing sessions).
 - c. It is noteworthy that written consent may be advantageous in providing further evidence that the process took place, but a signed form does not in and of itself provide evidence of the process.
 - d. Lack of refusal (sometimes referred to as *negative consent*) is not the same as consent and should not be used as justification to proceed with the delivery of a service.
10. Regardless of whether it is expressed or implied, ICS is to be documented in the client file, including the date, signed name of the person obtaining the consent, how consent was obtained (e.g., expressed, implied), and whether consent was limited or refused.
 - a. Various strategies should be used to ensure client understanding of the information being shared. Refer to Appendix B, *Facilitating Consent to Service Discussions with Individuals with Communication Impairment*, adapted from CASLPO's (2006) *Obtaining Consent for Services: A Guide for Audiologists and Speech-Language Pathologists*.
11. Translators are required if any doubt exists about a client's ability to understand the language.
12. In the event of an emergency situation, ICS is not required if the delay in obtaining the consent would prolong suffering or place the client at risk of sustaining serious harm. It is unlikely that the services provided by ACSLPA regulated members would qualify as emergency services.
13. Clients have the right to refuse service or discontinue participation at any time. In the event that consent is withdrawn, this should be documented in the client file, including the date and initials of the service provider.
14. Special circumstances regarding consent may arise that warrant consultation on a case-by-case basis. In these instances, regulated members are urged to consult with their employer regarding ICS policies. Regulated members are also encouraged to contact the College with any specific questions they may have.

3. Clinical Application

Please refer to Appendix C for a list of Frequently Asked Questions (FAQs) regarding ICS.

APPENDIX A

Reflective Questions for Regulated Members to Consider as Part of the Informed Consent for Service Process

Adapted from College of Alberta Psychologists (2014) *Practice Guideline: Informed Consent for Services*.

Although this guideline provides information, directions and recommendations to assist ACSLPA regulated members in the informed consent for service (ICS) process, it is not possible to provide a prescriptive and comprehensive set of guidelines that will address ALL situations encountered by SLPs and audiologists. Therefore, a series of questions has been provided to guide self-reflection regarding ICS. SLPs and audiologists may use the questions as a prompt to affirm or change their practice as appropriate. The purpose is to provide regulated members with a tool to enable responsible and ethical practice, and to ensure due diligence has been done in the consideration of ICS.

Reflective Questions

Consent Considerations and Overall Process

1. Does a defined ICS process exist in my practice setting?
 - What does this process consist of? Implied or explicit consent?
 - If consent is implied, has information regarding the service or procedure been provided to the client, and have they been given the opportunity to ask questions?
2. Does the current ICS process include all of the services I might provide to a client?
 - Is there an agreed-upon plan of care?
 - Particularly with respect to restricted activities which may pose a risk of harm to the client and may be embedded within a clinical procedure that I am completing, do I have a process to ensure that I provide a description of the activity, its benefits and risks; and, have I provided the opportunity to ask and be given answers to questions about the activity, its risks, benefits, or alternatives?
3. Have I defined, for my practice, what information a “reasonable” person might need to know in order to give consent? Have I considered what they need to know regarding my qualifications, theoretical foundations, choice of interventions, and any other relevant issues?
 - Does the definition of “reasonable” reflect the needs and abilities of the population that I serve?

Participants

1. Who is involved in the ICS process?
2. Is there a process to determine who has legal authority to give ICS?
3. Is there a process to determine who can give ICS in unusual circumstances?
4. What challenges in determining who can give ICS might arise in my practice?

Competency, Capacity, and Understanding

1. Does a process for making decisions regarding competency exist in my practice? How do I determine that a person is competent to provide ICS?
2. What types of competency concerns regarding ICS might present themselves in my practice?
3. How do I confirm that a client understands the information provided to them?
4. What process is in place if feedback confirms that the client does not understand the information provided?
5. Do I have access to translation services, if needed? Do I know how to access them?

Documentation

1. Have I considered what level of documentation, in terms of legal and professional requirements, is appropriate in my setting?
2. What is the minimum level of documentation of ICS in my practice?
3. Do I have a format/method of documenting ICS in my practice?

External Influences

1. How do the practices and demands of other team members or third parties impact my ICS process?
2. Have I consulted with other professionals in my area of practice?

Changing Needs

1. How does the ICS process address changing/emerging client needs in my setting? For example, am I providing services not discussed in the original discussion of ICS?
2. Do I revisit aspects of the ICS process, as needed?

Emergent Situations

1. How do I define an emergency situation in my practice? Is there such a situation?
2. How do I ensure that services provided in an emergency are provided only to the extent necessary to reduce/alleviate the emergency?

APPENDIX B

Facilitating Informed Consent for Service Discussions with Individuals with Communication Impairment

Adapted 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. As communication professionals, ACSLPA regulated members must ensure that all reasonable steps are taken to allow a client to understand the service options and express their wishes in the process of obtaining informed consent for service (ICS).

A client is presumed to be capable of giving ICS unless the regulated member has reasonable grounds to assume otherwise. Accordingly, when a person makes a decision that is unanticipated or disagrees with the regulated member's recommendations, the member cannot assume there is a lack of competence. The regulated member should clarify and confirm the client's response, as appropriate. They 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

1. Draw on some of the following techniques to facilitate comprehension as appropriate:
 - 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 that the client can hear sufficiently to participate in the discussion. Provide accommodations as necessary, such as assistive listening devices (e.g., Pocketalker), supplementary written information, adequate lighting, and a quiet environment.
 - Provide alternative methods of communication for 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.
 - Encourage the client to paraphrase the discussion to confirm comprehension. Techniques to facilitate this expression are below, listed in point 2.
 - 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 initial session.
 - Consider whether you need to 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.

- Provide communicatively accessible handout information following the discussion to allow the client to review the material in their own environment and own time. This material should reflect a level of complexity that matches the client’s cognitive skills.

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

- Structure the dialogue to allow the 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 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; and, use of yes/no responses.

Allow the client to express their understanding of the assessment and intervention alternatives at each stage of the discussion (e.g., present each option visually and allow the client to indicate what was understood using their preferred communication modality).

When in doubt...touchstones of ICS include the following:

- What would a reasonable person expect to be told about this treatment/procedure?
 - o Nature of the condition, nature of proposed treatment/procedure, risks/benefits, anticipated consequences of acceptance/refusal, and alternatives.
- Is the right person providing the information?
 - o Is he/she responsible for the treatment/procedure; does he/she have the expertise to answer any questions the patient may have?
- Is the right person making the decision?
 - o Patient has capacity
 - o Alternate decision maker (has legal authority to make decision for incapable adult)
 - o Legal representative (e.g., parent) for minor or minor deemed a *mature minor*
- Is there opportunity for the decision maker to ask questions?

APPENDIX C

Informed Consent for Service – Frequently Asked Questions (FAQs)

The clinical scenarios below are illustrative of informed consent for service (ICS) situations that SLPs and audiologists have reportedly encountered in their practice. While not exhaustive, they represent some of the more commonly encountered questions by ACSLPA regulated members.

Please note that the recommendations provided within these FAQs meet the minimum requirements expected of all ACSLPA regulated members. SLPs and audiologists practicing in Alberta are reminded that they also have a professional responsibility to be aware of employer and/or agency policies regarding informed consent, where they exist.

Classroom-based Activities and Consent

Q: Mary, an SLP, provides speech-language services to several elementary schools. One of the teachers would like her to come in during a specific activity and provide feedback on the skills of students, including strategies that the classroom staff could use to help the students. What type of ICS does Mary require to be involved in this manner? If the school informs parents in their “beginning of the year” package that SLPs may be involved in their child’s class, is that sufficient? If Mary thinks that a particular child would benefit from individualized services, then what?

A: In this situation, it might be helpful to consider whether Mary is providing commonly used strategies that could be applied to *any* student with a similar presentation, or whether information might be moving into the realm of child-specific assessment and intervention. For example, if a teacher has concerns about some students’ abilities to follow instructions and listen while transitioning to the gym every day, Mary could observe during a transition, and provide information and strategies that may be helpful in facilitating improved transitions. In this context, she does not require a child-specific referral as the strategies being offered are not child specific. Information provided to the families at the beginning of the year indicating that an SLP may be present in the classroom from time to time during the year would suffice. If, however, it appears that the general strategies provided have not been particularly helpful and there are additional questions regarding the child’s comprehension or classroom performance, then individualized strategies, assessment, and follow-up may be warranted. In this case, ICS would be required.

Consent in the Absence of a Parent/Guardian

Q: A family friend presents to an initial appointment with a client who is a minor. By showing up to the appointment at the scheduled time, one might consider that implied consent for service has been obtained. Although signed ICS is not required, the professional involved must ensure a discussion regarding ICS takes place with the parent/guardian, and that a notation to this effect is provided in the client file. Can the SLP or audiologist complete the assessment in the parent/guardian’s absence?

A: At the time the appointment is scheduled, consider having booking staff relay to the parent that they must be present at the appointment or send a parent/guardian who is capable of making health care decisions for the child. If the party responsible for the provision of service schedules their own appointments, and they are notified that the parent/guardian will not be in attendance at the appointment, they may be able to provide the necessary information about the assessment/intervention such that the parent can provide verbal consent at the time of scheduling. This conversation would then be documented in the client chart.

Sometimes, situations arise on short notice where the parent is not able to attend a long-awaited appointment and will ask an alternate adult to bring the child for them. In this case, the service provider should contact the parent by phone to obtain verbal consent for the assessment. If contact cannot be made, then the appointment will need to be rescheduled.

Occasionally, children will arrive at an appointment and be accompanied by a foster parent or a kinship care provider (a family member who has a formal agreement to provide care for the child).

Personal communication with the Policy, Practice and Program Development Branch of the Child and Youth Services Division, Alberta Human Services (Kimberly Spicer, Senior Manager, personal communication, May 6, 2016) indicates that, in most instances, these are individuals who have been given delegated authority to make day-to-day decisions for the child, including the authority to legally consent to basic, non-invasive services. These caregivers receive their legal authority by way of a formal delegation by a Director within Human Services (delegated within Child Intervention Programs) who has authority as a legal guardian to make decisions pursuant to a court order, (a Temporary or Permanent Guardianship Order). The Director permits by way of a written delegation day-to-day decision-making authority, which is a legal form of authority, to the child's caregiver, the foster parent or the kinship care provider.

The health care provider may wish to ask the caregiver what their relationship is to the child and if they have delegated authority to provide consent pursuant to a written delegation. If this is confirmed to the health care professional (i.e., the adult verbally advises he/she is a foster parent or kinship care provider arranged by Children's Services and confirms they have delegated authority to consent to non-invasive services for the child), the health care professional should note this on their file and may proceed with the service. If the health care professional does not believe he/she has enough information to be confident with the verbal consent given, he/she can call the child's Caseworker and have the Caseworker confirm over the telephone that the adult accompanying the child does, in fact, have delegated authority to provide consent.

From time to time, if a child is in the care of the Director of Children's Services pursuant to an Agreement entered into by the parents and the Director (not a court order), the biological parent can explicitly state in the Agreement entered into that they wish to be consulted in specific areas or retain some of their decision-making authority. If this is the case, the health care professional will want to ensure they are clear as to who has the authority to provide the consent and who is to be consulted. In these circumstances, the health care provider will likely want to involve both the biological parent and the caregiver to discuss the service and obtain the appropriate consent. If a professional is concerned about the caregiver's ability to provide consent in the situation where a biological parent has been indicated as involved in medical decisions, they should talk to the caregiver about their understanding of the parameters of the duties they have regarding medical care and if still concerned, should connect with the caseworker. This will ensure everyone knows the reason for the involvement and plan to support the child through any services planned. Unfortunately, this may delay services.

Where possible, contacting the caregiver very early in the referral process to determine whether they can provide consent and whether biological parents are also involved in these decisions may reduce the likelihood of service delays.

Hard to Reach Families and Consent

Q: Joanne, a private-practice SLP, has been contracted by a school division to provide services to students in the classroom. As per ACSLPA guidelines, she has attempted to contact Katie’s parents on three separate occasions in order to obtain their ICS to proceed with speech-language intervention, but has been unable to reach them. The school is wanting Joanne to “just get started” as they feel she has been contracted to provide services to teachers and the parents have consented to “all educational services.” Thus, they feel that ICS has already been obtained. What should Joanne do?

A: These situations can be difficult since one can appreciate the school’s perspective in terms of wanting to get moving with programming that will benefit both the child and the teacher. ACSLPA guidelines are clear, however, regarding the need to obtain ICS for any individualized services. Although a family may have consented to “educational services” for their child at the beginning of the year, this is not the same as having obtained *informed* consent for the particular services of the SLP. Sometimes having a conversation with school personnel and informing them regarding one’s responsibilities as a self-regulated professional may be all that is required to clarify this situation. At other times, however, some decision-making may need to take place. What level of services are being requested by the school? What level of services are required?

Classroom-based activities such as a module on listening skills or phonological awareness activities will not require consent, which is in contrast to services involving an individualized speech-language intervention plan with specific goals and objectives. In the former case, it would be prudent to provide information to families; however, ICS would not be required. Joanne could send a letter home providing information about dates, general programming goals and strategies, including her contact information, should there be any questions. Of note, a letter sent via mail may be more likely to reach the parents vs. sending it home in the child’s backpack. Where individualized services are being provided (including informal assessment and intervention in the classroom) ICS is required.

When parents are hard to reach, it may be helpful to ask the school how they have typically managed these situations. They may suggest a different phone number, an email address, connecting through a social worker who can facilitate communication (remember to follow employer’s policies re: use of these communication methods with clients and consider the parents’ privacy). It may also be possible to find out whether the parents typically visit the school at predictable times (e.g., drop-off or pickup) when one might be able to touch base.

Refusing Consent – Audiology Scenario

Q: Jacob was diagnosed with a mild-moderate sensorineural hearing loss at four years of age. His speech and language skills were subsequently evaluated, and he was found to present with mild receptive and moderate expressive language delays, coupled with some minor articulation errors. Although Laura, the audiologist, explained and demonstrated in the sound booth that Jacob was missing audibility of certain phonemes, which was likely contributing to his speech and language delays, his parents are reluctant to consider hearing aids for Jacob. They wish to proceed with speech-language intervention only at this time. What can Laura do?

A: Although Laura may have strong feelings about how intervention should proceed for Jacob, it is ultimately the parents’ decision as to whether they proceed with binaural amplification at this time.

Audiologists typically engage families in discussions regarding the benefits of amplification as well as the risks associated with not pursuing amplification. A trial period of amplification is always offered in Alberta and can be used as a tool to provide parents the opportunity to observe their child’s responses in aided and unaided situations.

Should the parents choose not to pursue amplification for their child, Laura should document the fact that a discussion took place, and what the parents' choice was at that time.

Ensuring that the SLP involved with the family is aware of discussions regarding amplification would also allow a discussion regarding approaches to speech-language intervention, including the potential effectiveness of particular interventions, dependent on the presence or absence of amplification.

Refusing Consent Feeding and Swallowing Scenario – Adult

Q: Jack, an SLP in a feeding and swallowing program, met with Mr. Richardson (aged 75 years and a cancer survivor) and his wife. His assessment reveals that Mr. Richardson is a candidate for a feeding tube, known as a percutaneous endoscopic gastrostomy (PEG). In conjunction with the feeding and swallowing team and physician, Jack explained the assessment results, the recommendation for a PEG, and the risks and benefits associated with and without the PEG. Mr. Richardson stated that he did not want a PEG. After reviewing Mr. Richardson's file and finding that he had the capacity to make decisions regarding his treatment, Jack scheduled a follow-up meeting with Mr. Richardson. He reviewed the relevant information again and asked Mr. Richardson several questions that indicated he understood the risks and benefits of a PEG. Mr. Richardson once again stated that he did not want a PEG. Furthermore, he indicated that he holds a spiritual belief in bodily integrity and as a result has previously refused any medical intervention that would violate his strongly held belief. Jack is feeling uncomfortable about Mr. Richardson's choice. What should he do?

A: According to the available information, Mr. Richardson has the capacity to make decisions in the course of his treatment and we must respect his choice. He is entitled to eat at risk. After open discussion about the benefits, risks and options available, Jack can leave the door open for additional discussion, at Mr. Richardson's request.

Jack should document the discussions he has had with Mr. Richardson in the client chart, including his decisions regarding services. Further, Jack may also find it helpful to discuss the situation and his own discomfort with a trusted colleague, supervisor, or counsellor.

Refusing Consent Feeding and Swallowing Scenario – Pediatric

Q: The Garcia family has an eight-year-old daughter, Gabriela, who has severe spastic cerebral palsy. The results of the feeding and swallowing assessment show that Gabriela is not safe with oral feeding. Sara, the SLP, explained the assessment results, taking time to outline with diagrams the process of swallowing and how a feeding tube or percutaneous endoscopic gastrostomy (PEG) would benefit Gabriela. Sara also explained the risks associated with and without the tube (PEG). Mr. and Mrs. Garcia stated that they did not want a PEG for Gabriela. They felt that Gabriela would be harmed by the surgery and that she had already been through enough medical procedures with little or no benefit to her. How could Sara explore this issue further?

A: In working with the Garcia family, Sara engaged respectfully and decided to ask Gabriela's parents additional questions about their fears surrounding a PEG. As a result, she gained important information about their fears, namely, that they had an elderly family member who had been given a PEG and who had subsequently died.

The respectful tone of a conversation lays an important foundation for trust. Ongoing dialogue will allow Gabriela's parents time to absorb the information and consider how a PEG would impact Gabriela's health, overall well-being, and the family's circumstances. An ongoing dialogue may reveal alternative interventions that the family would accept.

It is likely that Gabriela is receiving services from a team who works toward an integrated plan of care. Her parents will be part of the team and any discussions that occur about her health and wellness, including her growth and development, over time. If her weight and health are concerning, the health care team will likely revisit the PEG issue.

Screening and Consent

Q: Mark, a school-based SLP, is expected to conduct screenings of all students in the kindergarten classes that he serves. Is he expected to obtain ICS prior to proceeding with the screenings? If consent is required, can he rely on the educational assistant to assist him with this process?

A: Speech, language and hearing screening can take place in the form of a mass screening campaign, as mentioned above, or may target individual children or groups of children to determine which students require higher level services. Both mass screening and targeted individualized screening require the consent of a parent/guardian in order to proceed. In terms of mass screenings, ICS can be obtained by contacting families and obtaining verbal authorization to proceed, or can involve the development of a health screening information sheet and consent form that is sent to families for their review and signature. The information sheet should outline the purpose of the procedure, scheduled dates, and who to call if there are questions. Although direct contact with families to obtain consent is arguably the most prudent, in the case of a mass screening, the minimal level of “intrusion” into the child’s or parent’s autonomy can justify a consent process involving an information sheet and consent form, as outlined above.

The distribution of information regarding the screening campaign could certainly be handled by school staff or by support personnel; however, the SLP or audiologist responsible should be involved in developing the information about the process that is shared with families. Support personnel may then participate in implementing the screening procedures, also under the direction of the supervising SLP or audiologist.

Uncomfortable Procedures

Q: Mrs. Smith appears for her scheduled appointment with John, an audiologist, providing her consent to proceed with a hearing assessment. Partway through the immittance assessment, she states that the procedure “hurts” and she doesn’t want to proceed. What should John do?

A: An audiology assessment will almost always include the activity of inserting air, water or gas into the ear canal (i.e., tympanometry and acoustic reflex threshold testing), which is considered to be a restricted activity (RA) as outlined in the *Health Professions Act* and *Government Organization Act*. As such, restricted activities are invasive procedures and carry with them some risk of harm. For example, sensitivity to pressure changes in the ear canal may vary across clients, in some cases resulting in physical discomfort. In these situations, although verbal consent to carry out the assessment may have been obtained at its outset, it may be necessary for the audiologist to provide additional explanation and possibly obtain consent to specifically proceed with the more invasive activity.

For any procedure that results in discomfort or the possibility of injury, extra procedural description can be helpful to promote client awareness and confidence. Ultimately, the client has the right to withdraw their consent should they choose not to proceed with the procedure.

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