Alberta College of
Speech-Language Pathologists
and Audiologists

*Guideline*

# Informed Consent for Service

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Alberta College of Speech-Language Pathologists and Audiologists

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## Contents

# INFORMED CONSENT FOR SERVICE

**Guideline**: Provides guidance to regulated members to support them in their clinical application of Standards of Practice

## Introduction

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.

Informed consent for service refers to the situation when "a client[1] gives consent to receive a proposed service following a process of decision-making leading to an informed choice" (ACSLPA Standards of Practice, 2022). The intent of obtaining informed consent for services 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.

Consistent with ACSLPA Standard of Practice 2.3 Informed Consent (2022), 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 2.3 sets the minimum requirements expected of all regulated members.

This guideline focuses exclusively on informed consent for services; 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* (2021) for information related to the management, security, and confidentiality of records.

## Principles of Informed Consent for Service

### Who can Provide Informed Consent for Service?

Informed consent for service must be obtained from the client or a legally authorized representative for the client. The client or representative must have the capacity to consent to proposed services.

Regulated members should be mindful that while the law in Alberta dictates that only the client or a legally authorized representative may give consent for services, some clients may wish to have family members involved in their care and in their decision making regarding their care. Wherever practical, regulated members should respect the client's wish to have their family members involved in the information sharing process, including having opportunities to ask questions, in order to assist the client's decision making.

[1] Refers to a recipient of speech-language pathology or audiology services, and may be an individual, family, group, community, or population. An individual client may also be referred to as a patient.

In the event of an emergency situation, informed consent for service 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.

## Determining Capacity for Making Informed Consent for Service Decisions

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. 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.

When determining whether capacity for informed consent for service was established, regulated members should consider the following:

- Whether a reasonable person in the client's position would consent to the service, having been made aware of the nature of the condition, the nature of the proposed treatment/procedure, any associated material and special risks[2], the benefits of the proposed service, anticipated consequences of acceptance/refusal, and alternatives to the service.
- Whether the right person is providing the necessary information to the client (i.e., are they responsible for the treatment/procedure, and do they have the expertise to answer any questions the client may have?).
- Whether opportunities have been provided for the client to ask questions and get more information about the proposed service as needed.

A regulated member of ACSLPA must not presume incapacity with respect to decision making, including informed consent decisions, based solely on any one or a combination of the following:

- The existence of a psychiatric or neurological diagnosis,
- Client refusal of or withdrawal from a service that is contrary to the advice of a health practitioner,
- The client's age,
- A request for an alternative service, or
- The presence of a disability, including a speech, language, or hearing impairment. Please see Appendix A of this guideline for suggestions for facilitating informed consent for service discussions with individuals with communication impairments.

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. Regulated members should note that capacity to provide informed consent can change over time, and with respect to the type of service proposed. Members may also wish to consult with the client's family or physician(s) if having difficulties making capacity determinations for a particular client. A capacity assessment, which must be conducted by a physician or psychologist, can also be requested.

[2] Material risks are 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 those that have special relevance to the client.

## Mature Minors

In the province of Alberta anyone under the age of 18 is considered a minor. Typically, informed consent for service for minor clients must be obtained from the parent/guardian of the child and, when possible and appropriate, from the minor as well. However, it is recognized that as minors age they develop a greater ability to make independent decisions about their bodies and their well-being. As such, clients who are deemed ***mature minors*** are entitled to give or refuse consent for services. In such circumstances, consent from parents/guardians is not required, and the parents/guardians may not override the decision of the mature minor.

Alberta does not have an established set age for an individual to be considered a mature minor. Several factors must be considered when assessing whether someone can be deemed a mature minor, including:

- The complexity and seriousness/severity of the proposed treatment/procedure,
- The age and maturity of the child,
- The child's understanding of the information relevant to making the decision, i.e., of the risks, alternatives, and consequences of their consent for, or refusal of service,
- Indications of independence that may support a minor's increased level of maturity (e.g., they are self-supporting or living independently), and
- Any other relevant information form adults who know the child, e.g., parents, caregivers, teachers, or other health professionals.

The decision to designate a minor as mature should be made prior to the provision of services. The rationale for the determination that a minor is mature should be clearly documented in the client file.

Please refer to the Mature Minors Algorithm (Alberta Health Services, 2010) for more information on the informed consent process for mature minors in Alberta.

## Who is Responsible for Obtaining Informed Consent for Service?

Typically, the SLP or audiologist most responsible for the provision of care is responsible for obtaining informed consent for service from the client. As informed consent normally authorizes a specific person to carry out a specific service, the regulated member responsible for services is in the best position to answer any questions regarding the service or procedure. See Appendix B for a list of reflective questions for regulated members to consider when obtaining informed consent for service.

While regulated members are ultimately responsible for obtaining informed consent for service, certain aspects of the process of obtaining consent may be performed by others, for example the distribution and collection of an agency's informed consent for service form. When procedural steps are assigned to another person, it remains the responsibility of the regulated member to ensure that consent is valid and informed, and that they are available to answer any questions the client may have about the proposed service.

## When Should Informed Consent for Service be Obtained?

Informed consent 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. The requirement to obtain informed consent for service applies equally to all practice settings.

Informed consent for service must be obtained:

- Prior to the implementation of any service plan (e.g., completing an assessment or starting treatment),
- Whenever there is a substantial change in the plan of care, and
- If there is a change in diagnosis, symptoms, or circumstances. Any new information relevant to the original or ongoing informed consent for service must be provided to the client in a timely manner.

Regulated members may find it prudent to the review the session plan, restating their name, role, and objectives, as appropriate, at the beginning of each session (e.g., "Hi Mrs. Smith, it's Yori again. I'm the SLP who helps with your swallowing. We were planning to do X today. Are you okay to go ahead? Do you have any questions or is there anything new I should know about?"; or "Hi Johnny. It's Indira and we're going to work on your sounds today. We're going to play a fun game. Mrs. Muller, shall we go ahead with the session? How has practice been going at home? Any updates?").

Clients must consent to the SLP's or audiologist's assignment of activities to another individual (e.g., an aide or assistant), and must be informed and have the opportunity to give consent for students and/or volunteers to be present during any service.

## How Should Informed Consent for Service be Obtained?

Consent must be given voluntarily, and free of coercion, undue influence, or intentional misrepresentation. Obtaining informed consent for service from a client is a process rather than an event, and it involves working collaboratively with the client 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.

Informed consent for service, irrespective of communication mode (i.e., face-to-face, telephone, electronic correspondence), should address the following considerations:

- The nature or purpose of the activity,
- The name of the person most responsible for providing the service,
- The intended duration (i.e., day, number of weeks, months) of the service,
- The benefits, risks, and alternatives to the service,
- Any likely consequences of delaying or refusing the proposed service,
- The option to refuse or withdraw at any time without fear of reprisal, and
- The opportunity to ask and be given answers to questions about the service, its risks, benefits, or alternatives.

Consent can be expressed or implied, according to the following principles:

- 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.
- Implied consent can be implied from the client's words or actions (e.g., the client continually attends ongoing sessions).

- 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.
- 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.
- Clients have the right to refuse service or discontinue participation at any time.

Regardless of whether it is expressed or implied, a client's consent to service must 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. In the event that consent is withdrawn, this should be documented in the client file, including the date and initials of the service provider. Translators are required if any doubt exists about a client's ability to understand the language spoken by the provider.

There may also be rare circumstances where a legally authorized representative'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 service 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.

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 informed consent policies, or to contact their profession's ACSLPA Practice Advisor with any specific questions they may have.

# APPENDIX A

## Facilitating Informed Consent for Service with Individuals with Communication Impairments

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

For individuals with communication impairments, 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.

A client is presumed to be capable of giving consent 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

- 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.
- 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.

- 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).

If it is ultimately determined that 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.

# APPENDIX B

## Reflective Questions for the Informed Consent for Service Process

Adapted from College of Alberta Psychologists (2019) *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 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 informed consent. 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 informed consent.

### Reflective Questions

**General Considerations:**

- Does a defined informed consent process exist in my practice setting?
- Does the informed consent process need to address clinical, administrative, legal, and financial issues?
- Do I have a process to determine who has the legal authority to give consent?
- Have I defined what information a 'reasonable' person might need to know/understand in order to give consent?
- How do I determine that a client understands the information provided to them?

**Decision-Making Capacity:**

- What types of client capacity issues might I encounter in my practice setting?
- How do I define capacity to give consent within my practice setting? What is the process for determining decision making capacity?
- Is there a defined process in place if it is determined that a client does not understand the information provided?

**Diversity and Cultural Sensitivity:**

- Have I considered the literacy, language, culture, degree of detail, attitudes to authority, etc., in my informed consent process?
- Do I have access to translation services, if required?

**Documentation:**

- What level of documentation, in terms of legal and professional requirements, is appropriate for my practice setting?
- Do I have a format/method of documenting informed consent in my practice?
- Does my informed consent process address record retention (e.g., storage post-discharge) and distribution of clinical information (e.g., reports) to third parties?

**Collaborative/Organizational Requirements:**

- How might the practices of team members or other third parties impact my informed consent process?

**Emergencies:**

- How do I define an emergency situation in my practice?
- Do I have a process to ensure that professional services provided in an emergency are provided only to the extent required to reduce/alleviate the emergency?

# APPENDIX C
# Informed Consent for Service Common Scenarios – Best Practice

The clinical scenarios below are illustrative of informed consent for service situations that SLPs and audiologists have 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 this appendix 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.*

## Informed Consent for Minors

### *Children in Foster or Kinship Care*

**Q**: I work for a school board. One of the children on my caseload is in foster care. Who do I need to obtain informed consent for service from? Can the foster parent provide consent in this situation? Do I need to contact the child's caseworker for consent?

**A**: Typically for children in foster or kinship care, a Director under the Child, Youth, and Family Enhancement Act will delegate responsibility to the child's foster or kinship parent through a 'Delegation of Powers and Duties to a Child Care Giver'. This written, legal documentation is executed by the child's caseworker and allows the foster or kinship parent to make some daily decisions for the child and will include a checklist of duties for which the foster or kinship parent is responsible. This delegation typically includes decision-making authority to provide consent for 'ordinary medical or dental care', which would include SLP or audiology services.

However, depending on the type of custody agreement or order that is put into place for the child, the child's biological parent ***may*** retain decision-making authority, and therefore must be consulted to obtain permission to proceed with service delivery.

When making the determination about who to obtain informed consent for service from for a child in care, the healthcare provider should find out from the child's foster or kinship caregiver who is the authorized decision maker for the child. The provider may also wish to request a copy of the delegation order for the child's file. In situations where the foster or kindship parent or the healthcare provider are unsure about who has legal authority to consent for service for the child, the provider should contact the child's caseworker to determine this.

### *Children of Separated or Divorced Parents*

**Q**: The parents of one of the children on my caseload are divorced. According to the custody arrangement provided, there is a joint custody agreement in place, whereby the parents share decision making authority for the child. I obtained one parent's informed consent for service, but do I need to obtain consent from the other parent in order to proceed with service?

**A**: Under joint custody agreements, both separated or divorced parents retain full guardianship rights, which includes decision making authority for their child(ren) and the right to consent to treatment. Therefore, both parents can provide consent for ***and*** refuse treatment. Hence, best practice would be to obtain informed consent for service from ***both*** parents where reasonably practicable.

### *Disagreement Between Parents/Caregivers*

**Q**: The parents of a child on my caseload are divorced and share custody of the child. I obtained informed consent for service from one of the parents, but the other parent has indicated to me that they do not consent for their child to have speech and language therapy. What are the options for service provision in this situation?

**A**: This can be a very difficult situation to manage. Under joint custody agreements, both parents retain decision making authority, including the right to consent to and refuse treatment for their child(ren). In situations where parents disagree regarding consent for service for a minor client, they should be encouraged to come to a consensus on the matter. In such circumstances, it would be appropriate to pause service provision until such time as a consensus is reached, or until direction through a Court Order is provided, which indicates that services can proceed.

### *Informed Consent in the Absence of a Custody Agreement*

**Q**: The parents of a new child on my caseload recently separated, and there is no custody agreement in place yet. Do I need to obtain informed consent for service from both parents in this situation?

**A**: In situations where separated parents do not yet have a custody agreement in place, a reasonable assumption would be that both parents retain decision making authority and the right to consent or refuse treatment for their child(ren). Therefore, best practice would be to obtain informed consent from both parents where reasonably practicable.

The service provider should also ask to be updated once an agreement is reached about custody of the child(ren), to find out if one parent will have sole decision-making authority or whether both parents will retain this right. Providers should be aware that this agreement may be informal (i.e., a verbal agreement between parents), or a formal contract in the form of a 'Parenting Agreement', or a 'Parenting Order', which is determined by the Courts.

### *Consent in the Absence of a Parent/Guardian*

**Q:** At an intake assessment appointment for a minor client, the child was accompanied by an extended family member who reported that the child's parents were not able to attend the appointment. What are the informed consent requirements in this situation? Can an SLP or audiologist complete an assessment in the absence of a parent/guardian?

**A**: Situations may arise where a parent or guardian is not able to attend a scheduled assessment appointment and will ask an alternate adult to take the child to their appointment. While consent for service may be implied in these situations, the SLP or audiologist is still required to obtain informed consent for service from a legally authorized representative for the child. 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.

SLPs and audiologists may also want to consider having booking staff relay to the parent that they must be present at the appointment or send a parent/guardian who is legally authorized to make health care decisions for the child. If the person scheduling the appointment is 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 such that the parent can provide verbal consent at the time of scheduling. This conversation would then be documented in the client chart.

### *Hard to Reach Families and Consent*

**Q:** I work as a private-practice SLP and have been contracted by a school division to provide services to students in the classroom. I am having difficulties contacting the parents of one of the children on my caseload. I have tried to contact them on three separate occasions in order to obtain their consent to proceed with speech-language intervention, but I have been unable to reach them. Since the parents signed the school's general consent for educational services form, the school is wanting me to "just get started". Can I proceed with SLP services since the general consent form has been signed?

**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 Standards of Practice are clear, however, regarding the need to obtain informed consent for service 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.

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 predicable times (e.g., drop-off or pickup) when one might be able to touch base.

## Client Withdrawal from or Refusal of Service

### *Parental Refusal of Service for a Minor Client*

**Q:** One of my clients is an eight-year-old with severe spastic cerebral palsy. The results of their feeding and swallowing assessment show that they are not safe with oral feeding. I have explained the assessment results to the child's parents, taking time to outline with diagrams the process of swallowing and how a feeding tube or percutaneous endoscopic gastrostomy (PEG) would benefit the child. I also explained the risks associated with and without the tube (PEG). The client's parents stated that they did not want a PEG for their child, as they felt that their child would be harmed by the surgery and that they had already been through enough medical procedures with little or no benefit. In my professional opinion, I think it's important to explore this issue further with the family. How can I approach this?

**A:** The ACSLPA standard of practice on informed consent for service is clear that regulated members must respect the client's (or their legally authorized representative's) right to refuse interventions. Given that obtaining informed consent for service is a process, rather than an event, in situations such as this, respectful ongoing dialogue and engagement may give clients and/or their caregivers time to process the information shared and to engage the provider in more discussion that may help address their concerns about their child's health and overall well-being. Ongoing dialogue may also reveal alternative interventions that the family would accept.

### *Clinician Disagreement with Refusal of Service for a Minor Client*

**Q:** One of the children on my caseload was diagnosed with a mild-moderate sensorineural hearing loss at four years of age. Their speech and language skills were subsequently evaluated, and they were found to present with mild receptive and moderate expressive language delays, coupled with some minor articulation errors. Although I have demonstrated and explained to his parents that their child is missing audibility of certain phonemes, which is likely contributing to their speech and language delays, their parents are reluctant to consider hearing aids for their child. They wish to proceed with speech-language intervention only at this time. What can I do?

**A:** Although an audiologist or SLP may have strong feelings about how intervention should proceed for a client, as per ACSLPA standards of practice, it is ultimately the parents' decision as to whether they proceed with recommended intervention for their child, and their wishes must be respected.

Should the parents choose not to pursue amplification for their child, the audiologist should document the fact that a discussion took place, and what the parents' choice was at that time. Ongoing dialogue, particularly regarding the benefits of amplification as well as the risks associated with not pursuing amplification, may assist the parents in making an informed decision later on. 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.

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.

### *Clinician Disagreement with Refusal of Service for a Geriatric Client*

**Q:** I am an SLP in a feeding and swallowing program. One of my patients has been identified through assessment as a candidate for a feeding tube/PEG. In conjunction with the feeding and swallowing team and physician, I explained the assessment results, the recommendation for a PEG, and the risks and benefits associated with and without the PEG. The patient stated that they did not want a PEG, as they indicated that this intervention would violate their spiritual belief in bodily integrity.

Despite multiple follow up discussions, the patient maintains that they do not want a PEG. My impression is that they do understand the risks and benefits of a PEG, and the physician has confirmed that this client has the capacity to make decisions regarding their treatment. I feel very uncomfortable with the patient's choice, and the risks that it presents to their health. What can I do?

**A:** Since it has been determined that this patient has the capacity to understand the risks and benefits of the proposed intervention, their decision to refuse a PEG tube must be respected. It would be prudent in this situation to leave the door open for additional discussion, at the patient's request.

The SLP should document the discussions they had with the patient in the patient's chart, including his decisions regarding services. Further, the SLP may also find it helpful to discuss the situation and their own discomfort with a trusted colleague, supervisor, or counsellor.

### *Withdrawing Consent During Uncomfortable Procedures*

**Q:** I recently saw a client for a hearing assessment. While they initially provided informed consent to proceed with the assessment, partway through the immittance assessment, they stated that the procedure was painful and that they did not want to proceed. What would be the most appropriate course of action in this situation?

**A:** Ultimately, according to ACSLPA standards of practice on informed consent, ***a client has the right to withdraw consent for service at any time***. Although the client initially provided consent to proceed prior to the assessment, the audiologist must immediately and safely cease the assessment once the client has indicated that their consent to proceed is withdrawn.

For any procedure that results in discomfort or the possibility of injury, extra procedural description can be helpful to promote client awareness and confidence. For example, 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*. 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.

## Informed Consent for Universal Versus Individualized Services

### *Universal Classroom-based Activities and Consent*

**Q:** I am an SLP providing services to several elementary schools. One of the teachers has concerns about some students' ability to follow directions during transitions and would like me to observe and provide some general strategies to them that may help facilitate their classroom's transitions. As I will not be providing individualized services to any one child, what type of informed consent is required in this situation? Would the consent for general educations services provided by parents/caregivers to the school at the beginning of the school year, which indicates that an SLP may be involved with classroom programming, be sufficient?

**A:** In this situation, since the SLP will be providing commonly used strategies that could be applied to ***any*** student with a similar presentation, the 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 a particular child's comprehension or classroom performance, then individualized strategies, assessment, and follow-up may be warranted. In this case, the SLP is responsible for obtaining informed consent for service from the child's guardian.

### *Consent for Screening Services*

**Q:** I am a school based SLP, and this year I am expected to conduct screenings of all students in the kindergarten classes on my caseload. Do I need to obtain informed consent prior to proceeding with the screenings? If consent is required, can I rely on the educational assistant to assist me 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, informed consent 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.

# Acknowledgements

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