College of Speech and Hearing Health Professionals of British Columbia

Standard Category:	Standard Title:	Standard #:
Clinical Practice Standard	Client Consent	SOP-PRAC-06
Statute Reference:		**HPA Reference:**
Health Care (Consent) and Care Facility (Admission) Act		
Authorization:	**Date Approved:**	**Date Revised:**
CSHBC Board	June 15, 2018	June 29, 2020

DEFINITIONS

In this standard:

"Express Consent" means express consent provided by a client, either verbally or in writing.

"Informed Consent" means an ongoing dialogue that begins at the initial visit and continues throughout the health care process.

"Implied Consent" means consent that can be inferred by the client's actions.

"Health care" means anything being done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health.

"Major health care" means significant health care interventions which may involve major surgery, risky or complex tests, treatment requiring general anesthetic, radiation therapy, chemotherapy, kidney dialysis, and any health care designated by regulation as major health care.

"Minor health care" means regular or routine tests, immunizations, medications of any kind, and other care that is not major.

SCOPE

All registrants of CSHBC.

STANDARD

All registrants must comply with BC's *Health Care Providers' Guide to Consent to Health Care* (ACPG-12). Other pertinent BC legislation includes: the *Health Care (Consent) and Care Facility (Admission) Act* and the *Infants Act* for individuals under 19 years of age.

Under the BC legislation, Registered Audiologists (RAUD), Hearing Instrument Practitioners (RHIP), and Speech-Language Pathologists (RSLP) are considered health care providers regardless of their practice setting.

It is a registrant's responsibility to understand and adhere to the clients' rights as outlined in ACPG-12.

The guide includes aspects of:

- Obtaining and documenting informed consent;
- Client rights regarding consent;
- Exceptions to consent rules;
- Substitute decision makers;
- Capability to provide consent;
- Consent process and expiration of the consent;
- Advanced directives

Registrants who work with children must also be aware of the parameters of informed consent for those persons under 19 years of age, considering that there is no age of consent in British Columbia. Specific information can be found in the Infants Act which explains the legal position of children. One of the topics covered in the *Infants Act* is the health care of children. The *Infants Act* states that children may consent to a medical treatment on their own if the health care provider is sure that the treatment is in the child's best interest, and that the child understands the details of the treatment, including risks and benefits. It is up to the health care provider to assess and ensure the child's understanding of the treatment.

Health care provided by CSHBC registrants is considered minor health care under the *Health Care (Consent) and Care Facility (Admission) Act*. There may be interventions that are closely aligned with major health care, such as the surgery required for cochlear implants or for the insertion of a voice prosthesis. It is unlikely that registrants would need to be involved in obtaining the consent for provision of the major health care.

NOTE*: *'client' includes Substitute Decision Makers (SDM) in this document.

Obtaining Implied consent:
Implied consent may be sufficient if the client has voluntarily attended an appointment for a simple examination or non-invasive procedure that poses NO RISK of harm to the client (ACPG-12).

1. Obtaining Informed, Express Consent

Express consent should be obtained when any assessment or treatment is required that poses a potential risk to the client, even if the likelihood for potential complications is low. This can include low risk tests or interventions (e.g. speech and language assessments) to more complex tests or interventions (e.g. vestibular testing).

Express consent must be informed. This is what a reasonable person, in the client's position, would need to know to make a decision. It is imperative that CSHBC registrants know their clients and tailor the information to the needs of each patient. It is prudent for a registrant to clearly explain all aspects

of any interventions or treatment plan, including any physical contact, that may be necessary during treatment (see *Professional Boundaries – Where's the Line?* (CPG-05)).

Non-practising registrants, HIP Interns, and Communication Heath Assistants (CHAs) may assist in the consent process but must not be responsible for the overall process of consent and must not be the signatory for the consent documentation.

2. *Obtaining Express Consent Verbally*

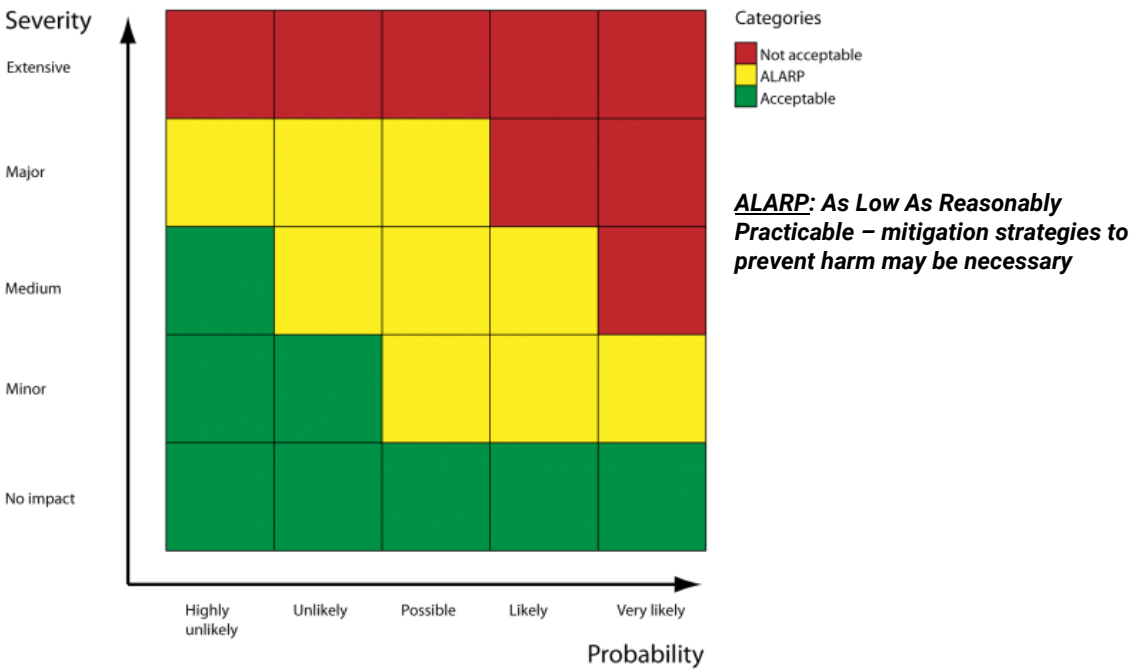
For the provision of minor health care, **verbal consent** may be sufficient. In ALL instances of verbal consent, the nature of the conversation, the information provided, and the client's decision must be documented.

3. *Obtaining Express Consent in Writing*

Registrants may prefer to obtain **express consent in writing**. This does not negate the necessity of continuing dialogue.

4. *Assessing Risk & Probability of Occurrence*

It is imperative that registrants can articulate, in clear terms, the level of risk and the likelihood of occurrence for all services that they provide. The following chart is a guide to assessing risk and probability of occurrence.



***ALARP*: As Low As Reasonably Practicable – mitigation strategies to prevent harm may be necessary**

SOURCE*: CGE Academy *www.cgerisk.com/knowledgebase/Risk_matrices

5. *Validity of Informed Consent for Clients who have Communication and Related Delays and Disorders*

The *Health Care (Consent) and Care Facility (Admission) Act* outlines the conditions necessary for an adult's capability to make a health care decision. Clients with communication and related disorders

pose special challenges to CSHBC registrants. A communication or related disorder does not mean that a client is incapable of making a health care decision. It is imperative that registrants know their client's: level of understanding and language comprehension, usual mode and method of communication, necessary communication aids and equipment, and any other supports that may be necessary for effective communication (e.g. interpreter).

Registrants may be called upon to share their information (with the client's consent) regarding the client's communication status and to inform others about the client's capability for making health care decisions.

6. Violations of the Client Consent Standard and the Associated Clinical Practice Guideline

Registrants may be asked by the Quality Assurance & Professional Practice (QAPP) Committee or the CSHBC Board to provide verification of obtaining and documenting informed consent. In instances where consent is unsubstantiated, a registrant will be asked to obtain and document the required consent. Should a registrant fail to comply, the matter can be referred to the Inquiry Committee (IC) for follow-up.

REFERENCES

CGE Academy.

Health Care (Consent) and Care Facility (Admission) Act, BC Laws.

Infants Act, BC Laws.

CSHBC Related Documents

Documentation & Records Management (CPG-04)

Documentation & Records Management (SOP-PRAC-01)

Health Care Providers' Guide to Consent to Heath Care (ACPG-12)

Professional Boundaries – Where's the Line? (CPG-05)