



College of Audiologists and  
Speech-Language Pathologists of Ontario

Ordre des Audiologistes et  
des Orthophonistes de l'Ontario

# OBTAINING CONSENT FOR SERVICES

## A GUIDE FOR AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS

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# TABLE OF CONTENTS

Introduction .....	1
GENERAL PRINCIPLES.....	2
WHAT IS SCREENING? ASSESSMENT? TREATMENT? .....	3
WHAT IS NOT TREATMENT?.....	4
WHAT ARE THE ELEMENTS OF A VALID CONSENT?.....	5
WHAT IS INFORMED CONSENT?.....	6
IS PATIENT/CLIENT CONSENT REQUIRED IN ALL SERVICE SETTINGS? .....	7
DOES CONSENT HAVE TO BE WRITTEN? .....	8
HOW DOES ONE DOCUMENT CONSENT? .....	9
HOW DOES ONE JUDGE A PERSON TO BE CAPABLE? .....	10
MUST PATIENTS/CLIENTS BE INFORMED OF THEIR INCAPACITY? .....	12
THE CONSENT AND CAPACITY BOARD .....	13
SUBSTITUTE DECISION MAKERS.....	14
GUIDELINES FOR SUBSTITUTE DECISION MAKERS .....	15
WHAT DO I DO IF I FEEL WHAT THE SDM IS NOT ACTING IN THE BEST INTEREST OF THE INCAPABLE PERSON?.....	16
EMERGENCY SERVICES .....	17
PROTECTION FROM LIABILITY .....	18
ADDITIONAL RESOURCES .....	19
REFERENCES .....	20
APPENDIX .....	21
A. Facilitating Consent to Service Discussions with Individuals with Communication Impairment .....	21
Suggestions for Facilitating an Informed Consent Discussion .....	21
Summary .....	23
Further Reading.....	23

# INTRODUCTION

*The Health Care Consent Act, (1996)* (HCCA) indicates that consent is required for treatment services. As of June 2006, the Council of the [College of Audiologists and Speech-Language Pathologists of Ontario \(CASLPO\)](#) has determined that members must also obtain consent for all screening and assessment services and those members must apply the principles of the HCCA in obtaining consent for those services.

This guide is intended to help members understand the necessary steps to obtaining consent. It represents CASLPO's interpretation and does not supersede the provisions contained in the Act.

# GENERAL PRINCIPLES

Below is a list of the general principles that CASLPO members should remember whenever they are obtaining consent for service. Each of these is discussed in detail elsewhere in this guide.

- Consent must relate **specifically** to the service proposed. **Blanket consents for audiological or speech-language services are not acceptable.**
- Consent must be given **voluntarily**.
- The patient/client must be **fully informed** of the risks and benefits of the proposed service.
- Consent is not required to be in a **written** format ; it can also be provided **verbally**.
- Consent must be **documented**.
- Consent, even if it is signed, is not valid unless the patient/client was **fully informed**.
- Consent, signed or **verbal**, can be **withdrawn** at **any time**.
- Consent can be **expressed** or **implied**.
- A person providing consent must have the **capacity** to do so, that is the ability to understand the information provided and appreciate the consequences of making the decision.
- The capacity to provide consent is **not determined by age**; therefore a child could be considered to be capable of providing consent. There is no fixed age at which a child becomes capable of providing consent.
- The responsibility of **determining** whether a patient/client has the **capacity** to consent to the services rests with the **audiologist or speech-language pathologist** providing the services.
- The capacity to provide consent can change with respect to the type of service being provided. A **patient/client can be considered to be incapable with respect to some services and capable with respect to others**.
- The **capacity to provide consent can change over time**. A patient/client may be incapable with respect to service at one time and capable at another.
- If the patient/client is unable to provide consent the member must obtain valid and informed consent from the **substitute decision maker (SDM)**. There is a clear hierarchy of substitute decision makers.

# WHAT IS SCREENING, ASSESSMENT, AND TREATMENT?

CASLPO has defined **screening** as a process where a member applies certain measures that are designed to identify patients who may have a hearing, balance, communication, swallowing or similar disorder[s], for the sole purpose of determining the patient's need for a speech-language pathology assessment, an audiological assessment, or both. This does not include:

- Inadvertently noticing possible hearing, balance, communication, swallowing or similar disorder[s], or
- Considering information that is shared about an individual's possible hearing, balance, communication, swallowing or similar disorder[s], for the purpose of providing general educational information and/or recommending a referral for a speech-language pathology screening or assessment, an audiological screening or assessment, or both.

Screening may be conducted by a member or support personnel. Interpretation and communication of the results are made **by the member**. Screening results are limited to advising the patient/client/SDM on whether or not there is a need for a speech-language pathology assessment and/or an audiology assessment. Results must not be used for treatment planning.

CASLPO has defined **assessment** as the use of formal and/or informal measures by an audiologist or speech-language pathologist, in accordance with the member's scope of practice, to determine a patient/client's functioning in a variety of areas of functional communication and/or swallowing or hearing, resulting in specific intervention recommendations.

Under the HCCA, **treatment** is defined as anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a Course of Treatment or Plan of Treatment. A Plan of Treatment means a plan that:

- is developed by one or more health practitioners,
- deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current condition, and
- provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of a person's current health condition.

# WHAT IS NOT TREATMENT?

According to the HCCA, the following activities do not constitute treatment:

- The **assessment** of a person's capacity:
  - to **consent** to service, admission to a care facility or a personal assistance service,
  - to **manage property,**
  - to be able to perform personal care,
  - for any other purpose.
- The assessment or examination of a person to determine the general nature of a person's condition.
- The taking of a person's **health history.**
- The admission of a person to a **hospital or other facility.**
- A personal **assistance service.**

# WHAT ARE THE ELEMENTS OF A VALID CONSENT?

Before an audiologist or speech-language pathologist begins to provide screening, assessment and/or treatment services, it is necessary to obtain valid consent. To be valid, the consent must:

- Be informed.
- Be given voluntarily.
- Not be obtained through misrepresentation or fraud.
- Relate to the service being proposed.

For example, it would not be valid for a CASLPO member to obtain consent for any and all services for a given year. However, it is valid to obtain consent for specific services that may be administered over a month, year, or even longer.

# WHAT IS INFORMED CONSENT?

Informed consent under the HCCA means that before agreeing to the service, the patient/client or SDM has received information that a reasonable person in the same circumstances would require. In addition, the person must have received responses to his or her requests for further information. Necessary information includes:

- The nature of the service.
- The expected benefits of the service.
- The material risks of the service.
- The material side effects of the service.
- Alternative courses of action.
- The likely consequences of not having the service.

Material risks and side effects are:

- Those which are probable or likely to occur.
- Those that are possible rather than probable, but can have serious consequences.
- Anything else which would be considered relevant by a reasonable person in the same circumstances.

**EXAMPLE:** A patient/client has obtained an appointment at the office of a member and arrived at the office. Even though the patient/client has initiated the appointment and come to the office, the patient/client has not provided valid and informed consent because the patient/client has not been provided with the required information.

An audiologist or speech-language pathologist 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.



# IS PATIENT/CLIENT CONSENT REQUIRED IN ALL SERVICE SETTINGS?

The requirement to obtain consent to service applies equally to all service settings. In a hospital setting, a referral from a physician does not eliminate the necessity to obtain consent. In a community setting, a referral from an agency such as a Community Care Access Centre (CCAC) is not sufficient. Requirements for consent also apply to CASLPO members in the education system, who provide services to children attending school. In all cases, consent must be obtained for the specific services being offered.

However, a member is not required to personally obtain the required consent; rather a member can assign the task of obtaining the consent to the member's services to another person. Nevertheless, the member maintains the full responsibility of ensuring that the consent obtained is valid and informed.

For example, in a CCAC setting, when the CCAC administrator obtains consent from the patient/client or substitute decision-maker for the CCAC services, the administrator could also present the necessary information regarding the speech-language pathology services that will be provided. If the patient/client or substitute decision-maker then consents, the member is not required to seek consent again when initiating services. However, the member remains fully responsible for ensuring that the information required for consent was accurately presented by the CCAC administrator and that any requests for further information have been met.

Similarly, where member 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.

## DOES CONSENT HAVE TO BE WRITTEN?

A valid consent can be verbal or written. Written consent is not required. Consent, even if it is signed, is not valid unless the client was fully informed.

Please also note there is no requirement for the member to speak to or meet with the patient/client or substitute decision-maker to obtain consent. The CASLPO member however must be satisfied that consent, as defined by the HCCA, has been obtained.

The consent may be expressed or implied. An example of implied consent would be that a person, after having been provided information about hearing aids, proceeds to make another appointment for a hearing aid evaluation.

## HOW DOES ONE DOCUMENT CONSENT?

Under CASLPO's Proposed Regulation for Records (2011), members must document every significant verbal or written consent provided by the patient/client. When documenting verbal consent, CASLPO members must indicate that the required information pertaining to the proposed service was discussed and that consent was received from the patient/client.

Documentation of consent must be retained as indicated in the Proposed Regulation for Records (2011).

# HOW DOES ONE JUDGE A PERSON TO BE CAPABLE?

It is the responsibility of the audiologist or speech-language pathologist to determine if a person is capable of consenting to the proposed service. A person is capable with respect to a service if the person:

- **Understands** the information about the proposed service that is being presented. This information will include, but is not limited to, the nature of the proposed service, the benefits, expected risks and side effects, and alternative services, and
- Is able to **appreciate the reasonably foreseeable consequences** of either making a decision or not making a decision.

*Example: An audiologist recommends a hearing aid for a 10 year old child with a moderate hearing loss. The audiologist explains what a hearing aid does, and its risks and benefits in a language that is appropriate for the child. The child appears to understand this information, but refuses to consent to using a hearing aid. The child bases his decision on the cosmetics of the device, but does not appreciate the effects that not using amplification will have on his language development and academic performance. Thus the child would be considered to be incapable, and consent would be obtained from the substitute decision makers, his parents.*

A CASLPO member may not presume that a person is incapable with respect to a proposed service based solely on one or more of the following factors:

- The existence of a psychiatric or neurological diagnosis.
- A refusal of a proposed service that is contrary to the advice of a CASLPO member, or other practitioner.
- A request for an alternative service.
- The person's age.
- The existence of a disability, including a speech, language or hearing impairment.

*Example: A speech-language pathologist cannot presume that a person is incapable of consenting to an assessment based solely on the fact that the person has a diagnosis of depression, aphasia or that the person is 13 years old.*

By virtue of their training, audiologists and speech-language pathologists recognize that the existence of a communication difficulty is not sufficient to presume a patient/client is incapable of giving consent. However, providing consent may pose a significant challenge for individuals with communication impairment.

The document "Facilitating Consent to Service Discussions with Individuals with Communication Impairment" (see Appendix A) provides some suggestions on obtaining consent from patients/clients with communication difficulties, to assist in ensuring that patients/clients are given every opportunity to engage in a partnership with the member when service decisions are made.

A person may be incapable with respect to some services, such as major surgery, but be capable of consenting to speech-language therapy or the use of a hearing aid. A person may also be incapable of consenting at one time but capable at another.

*Example: A patient/client who recently experienced a cerebral vascular accident may be incapable of consenting to service initially, but become capable later. Patients/clients with psychiatric disorders may be capable at some times but not others.*

If a person was judged to be incapable, and a substitute decision maker provided consent, and the person later becomes capable, then the person's own decision to give or refuse consent governs.

# MUST PATIENTS/CLIENTS BE INFORMED OF THEIR INCAPACITY?

Under the HCCA, when a person is found to be incapable of consenting to service, all practitioners are required to follow guidelines established by their governing bodies as to the information to be provided to their patients/clients about the consequences of findings of incapacity.

It is recognized that when incapable persons are able to understand such matters, they have a right to be informed. The CASLPO member has an obligation to inform the patient/client in a manner appropriate to the patient/client's capacity.

CASLPO is recommending the following guidelines for informing incapable persons:

- The CASLPO member must tell the incapable person that a substitute decision maker will assist the patient/client in understanding the proposed service and will be responsible for making the final decision.
- The CASLPO member should still involve the incapable person, to the extent possible, in discussions with the substitute decision maker.
- If the patient/client disagrees with the finding of incapacity, the CASLPO member must advise the patient/client of their right to apply to the Consent and Capacity Board (CCB) for a review of the finding of incapacity.
- The CASLPO member should assist the person in exercising these options if he or she indicates a wish to do so.

# THE CONSENT AND CAPACITY BOARD

All persons who have been found incapable have a right to challenge this finding before a tribunal called the Consent and Capacity Board (CCB). Provision of the service must not begin until:

- 48 hours have passed since the CASLPO member was first informed of the intended application to the Board without such an application being made.
- The application to the Board has been withdrawn by the person.
- The Board has rendered a decision and no party has indicated that he or she plans to appeal.
- One or more of the parties to the application before the Board has informed the CASLPO member that they intend to appeal the Board's decision and the time period for appeal has expired without an appeal being commenced.
- The appeal of the Board's decision has been completed.

# SUBSTITUTE DECISION MAKERS

When a CASLPO member is proposing a service and does not believe that the person is capable of being able to provide consent, a substitute decision maker would be called upon. The hierarchy of substitute decision makers is as follows:

1. Guardian
2. Attorney for personal care.
3. A representative appointed by the Consent and Capacity Board.
4. Spouse or partner.
5. Child, parent or children's aid society. This does not apply to a parent who has only a right of access.
6. Parent with right of access only.
7. A brother or sister.
8. Any other relative.
9. The Public Guardian and Trustee.

In order to qualify as a substitute decision maker, a person must meet all of the following criteria:

- Be capable to consent to service.
- Be at least 16 years old. The only exception is if the person under 16 is the incapable person's parent.
- Not be prohibited by a court order or separation agreement from having access to the incapable person or from giving or refusing consent on the incapable person's behalf.
- Be available.
- Be willing to assume the responsibility of giving or refusing consent.

In order to determine who the highest ranking substitute decision maker is, the CASLPO member must ask the person if they are aware of any higher ranked substitute.

Normally one gets consent from the highest ranked substitute unless:

1. The highest ranked substitute is not capable, available or willing to act in this role. In such a case, one seeks consent from the next highest ranked substitute.
2. If two or more persons of equal rank disagree about service and if their claims rank above all others, then the Public Guardian and Trustee shall make the decision.



# GUIDELINES FOR SUBSTITUTE DECISION MAKERS

The Substitute Decision Maker (SDM) must decide what the incapable person's best interests are. In doing so, the SDM must take into consideration the following:

- The values and beliefs of the incapable person.
- Any prior wishes expressed by the incapable person when capable.
- Whether the service will improve the incapable person's condition or well-being, prevent it from deteriorating, or reduce the rate of deterioration.
- Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the service.
- Whether the expected benefits of service outweigh the risks.
- Whether a less restrictive or less intrusive service would be just as beneficial as the proposed service.

## WHAT DO I DO IF I FEEL WHAT THE SDM IS NOT ACTING IN THE BEST INTEREST OF THE INCAPABLE PERSON?

The HCCA also provides audiologists and speech-language pathologists with the power to make an application to the Consent and Capacity Board if the CASLPO member does not believe that the SDM acted in the best interests of the incapable person as outlined above. The Board will then make a determination if the SDM complied with the legislation. This is a significant change over the previous legislation which did not provide any guidance to practitioners in this situation.

## EMERGENCY SERVICES

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

# PROTECTION FROM LIABILITY

The HCCA provides health care practitioners with protection from liability under a number of circumstances. When a practitioner acts in good faith, then he or she is not liable if:

- A service is administered once consent was given.
- A service is not administered because consent was refused.
- A service is withheld or withdrawn according to a service plan that the person has consented to.
- An emergency service, as defined by the Act, is administered without consent.

## ADDITIONAL RESOURCES

The following articles discussing aspects of consent to service may be assistance to CASLPO members:

- Consent for Screening and Assessment: Quandaries, CASLPO Today, August 2007.
- Consent to Provide Screening and Assessment Services Now Required, CASLPO Today, November 2006
- Confused about Consent? CASLPO Today, August 2006.

# REFERENCES

[Consent to Provide Screening and Assessment Services](#)

[Proposed Regulation for Records, 2011](#)

[Health Care Consent Act, 1996.](#)

# APPENDIX

## A. FACILITATING CONSENT TO SERVICE DISCUSSIONS WITH INDIVIDUALS WITH COMMUNICATION IMPAIRMENT

Obtaining consent from a patient/client is the cornerstone of patient-/client-centred care. However, for individuals with communication impairment, giving consent may pose a significant challenge. As communication professionals, members must ensure that all reasonable steps are taken to allow a patient/client to understand the service options and express his or her wishes in the process of obtaining consent for audiology and speech-language pathology services. The existence of a disability, including a speech, language, or hearing impairment, is not sufficient to presume a patient/client is incapable of giving consent.

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

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

### SUGGESTIONS FOR FACILITATING AN INFORMED CONSENT DISCUSSION

1. Provide patients/clients with every opportunity to use their most effective mode of communication. Members should make every effort to obtain appropriate training and skills in communication techniques and use appropriate materials. The following are examples of such materials:
  - Books Beyond Words is a series of picture books that has been developed to make communicating easier for those with communicative impairments, and includes supporting text and guidelines. This material is suitable for both children and adults. Visit <http://www.rcpsych.ac.uk/publications/bbw/index.htm>.
  - The *Pictographic Communication Resources Binder* (PCR) developed by the Aphasia Institute (<http://www.aphasia.ca/training/index.shtml>) provides a thematic organization of adult subject matter. In addition, a series of booklets designed for conversation with medical and counselling professionals is available. These materials can be used with any individuals with communication impairment and need not be limited to persons with aphasia. The Aphasia Institute also offers courses in Supported Conversation for Aphasic Adults.
2. Draw on some of the following techniques to facilitate comprehension as appropriate:

- Use language that is appropriate to the age and abilities of the patient/client.
- Use language that is appropriate to the linguistic and cultural background of the patient/client as outlined in the Position Statement on Service Delivery to Culturally and Linguistically Diverse Populations.
- Explain all concepts as simply as possible.
- Ensure that the patient/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 patients/clients whose competence to provide consent may be masked by a communication disorder.
- Provide visual aids throughout the discussion to support conversation, accommodating for any visual difficulties. These can include the following: (a) using large materials with sufficient contrast to accommodate acuity or placement to accommodate visual field deficits; (b) providing prepared written materials to support the discussion; (c) writing down the main points during the discussion; (d) providing pictorial support for the discussion using age-appropriate pictographs, symbols, or storybook formats; and (e) using any combination of the above that is best suited for the patient/client.
- Allow the patient/client to paraphrase the discussion to confirm comprehension. Techniques to facilitate this expression are below listed in point #3.
- Provide the patient/client with sufficient time to process the information and ask any questions. In some instances, it may be helpful to allow the patient/client to contact you following the session to review any issues or ask about issues that did not come up during the face-to-face session.
- Verify that the patient/client has demonstrated comprehension after each component has been presented, to minimize the effect of memory difficulties.
- Encourage the patient/client to allow others to participate in these discussions for support but ensure that the discussion is targeted to the patient/client. It is the patient/client who must ultimately make the informed decisions regarding the services offered.
- Provide communicatively accessible handout information following the discussion to allow the patient/client to review the material in his or her own environment and own time. This material should reflect a level of complexity that matches the patient's/client's cognitive skills. Depending on the communication abilities of the patient/client and his or her significant others, such information may be provided in alternative formats such as written, picture symbols, tape recording, and computer-assisted presentation.
- Draw on some of the following techniques to facilitate expression as appropriate:
- Structure the dialogue to allow the patient/client every opportunity to ask questions and add perspectives to the discussion. Techniques to facilitate this may include (a) numerous direct ("What do you think?") and indirect ("I wonder what you are thinking") invitations to participate in the discussion; and (b) pausing frequently for



sufficient durations to allow an unsure or reluctant patient/client the opportunity to participate and ask questions.

- Use techniques to support communication, such as interactive drawing, pointing to relevant pictorial or symbolic representations, pointing to key words provided, gesturing, age-appropriate play activity or enactment, use of yes/no responses.
- Allow the patient/client to express his or her understanding of the assessment and treatment alternatives at each stage of the discussion (e.g., present each option visually and allow the patient/client to indicate what was understood using his or her preferred communication modality).

## SUMMARY

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

## FURTHER READING

Cronk, E. A. (2001). "Informed consent in 2001: don't leave the office without it". *Dispatch*, Royal College of Dental Surgeons of Ontario: Toronto.

Department of Health. (2001). "Seeking consent: working with older people." & "Seeking consent: working with children." London ([www.doh.gov.uk/consent](http://www.doh.gov.uk/consent)).

Kagan, A. & Kimelman, M. D. Z. (1995). "Informed consent in aphasia research: myth or reality?" *Clinical Aphasiology*, 23:65-75.

Small, J. A., Gutman, G., Makela, S., & Hillhouse, B. (2003). "Effectiveness of communication strategies used by caregivers of persons with Alzheimer's Disease during activities of daily living." *Journal of Speech, Language and Hearing Research*, 46: 353-367.