Standards of Consent: You Spoke – We Listened

Thank you to all of the RDs who provided input into the *Draft Professional Practice Standard: Consent to Treatment and for the Collection, Use & Disclosure of Personal Health Information* (Standards) circulated from July 9 to September 9, 2015.

Your feedback was thoughtful and thorough, which has helped the College revise the draft to ensure that the Standards are relevant to safe, ethical and competent dietetic practice in Ontario. The revised draft will be submitted to Council for approval at the next Council meeting in February 2016.

FOUR MAIN ISSUES

1. Many RDs had questions about how to manage consent in acute care settings such as ICU (adults, neonates and pediatrics) where current practice is to assess and provide treatment upon admittance to the unit or upon referral from an MD, especially where timely dietetic treatment, such as nutrition support, is warranted. For example, when a patient was admitted to the hospital or to a specific unit, could an RD rely on implied consent for assessment and treatment?

Consent for treatment is always required, except in an emergency. Check with other members of the health care team to confirm whether consent for nutrition care has been obtained. If in doubt, obtain informed consent before implementing any treatment. If a client is not capable of giving consent, a substitute decision-maker must be found.

2. RDs questioned whether screening or reviewing a patient's chart as part of a nutrition assessment requires

consent, or whether implied consent can be assumed due to facility admission.

Because of this question, we added a statement in the Introduction of the Standards to clarify that as health professionals in the "circle of care" team, RDs have implied consent to screen or review a patient's chart as long as the information is used for the sole purpose of providing health care to that individual.

3. Comments showed that there was confusion among RDs as to whether consent was required for any or all changes being made to a treatment plan, for example, when making adjustments to total parenteral nutrition and enteral nutrition.

Performance indicator i,c) in Standard 1 states that consent is required for, "Significant changes to nutrition care treatment plans, different from the nature, expected benefits, material risks and material side effects of the original treatment." To clarify this statement, the Introduction now quotes Section 12 of the *Health Care Consent Act*, which specifies, "Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes, (a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and (b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered."

4. Some RDs questioned their role in determining capacity or assisting clients in the process of establishing a substitute decision-maker. They felt that other members of the health care team were better suited to these roles.

A statement has been added to the Introduction to clarify that RDs need to exercise professional judgment when applying the standards to their practice. An RD's level of involvement and competence for determining capacity to consent to nutrition treatment or establishing a substitute decision-maker often depends on their practice setting. For example, RDs working in individual vs team-based settings may have different roles. RDs in individual settings may be solely responsible for determining capacity and finding a substitute decision-maker. In team-based settings, RDs may be expected to collaborate with other team members who have the responsibility of assessing clients and establishing the appropriate substitute decision-makers. Depending on the specific setting, RDs must use their professional judgement to determine their own level of involvement in the consent and capacity process. If unsure, they have a professional obligation to clarify their role and, if necessary, to develop the appropriate competence in keeping with the Standards of Consent and the principles of client-centred care.

Additional Educational Materials

In the consultation, there were many requests for more education on the Standards of Consent. To add to the resources that are already on the College's website (enter "consent" in the search box to access them), we will be developing further educational tools surrounding the Standards of Consent to support RDs to provide safe, ethical and quality dietetic practice in Ontario.

Standards of Consent Summary of Survey Results

- 673 members (17% of total membership).
- 84% of respondents felt that the proposed Standards clearly articulated the appropriate behavioural expectations for RDs to fulfill their professional responsibilities when obtaining consent in dietetic practice.
- 89% of respondents agreed with the introduction section.
- There was strong support for the nine specific standard statements with a level of agreement ranging from 84-95%.
- 91% agreed with the conclusion section.
- 28% specified a need for future education materials.
- 8% had additional comments.