Consent Q&A
Updated April 22, 2024

Q1: When is a child considered 'capable' of consenting to care? Does an RD need to tell the child's parents/guardian about the therapeutic relationship? Does the RD need parental consent before providing dietetic care?

Refer to the Dietetic "Where's the Line?" Professional Boundaries in a Therapeutic Relationship document. Page 6 reviews important steps to setting the stage for a therapeutic relationship, including consent to care guidelines.

Consent should be obtained from the minor, given that you are providing a service to them, regardless of whether their parent/guardian is present or not. Consent should be obtained in accordance with Dietetic Standards of Record Keeping, which includes the requirement to comply with part 2 of the Infants' Act.

The following legal resources may be helpful to interpret BC children's rights to consent to care:

- BC Branch of the Canadian Bar Association published The CBA Child Rights Toolkit
- Dial a Law's Children and consent to health care

These two sources interpret key sections of the Infants Act regarding competency, capacity, and consent, which is relevant to all health care providers. Children (anyone under 19) can consent to their own health care if they are "capable" (i.e., if they understand the care requested, the treatment process, and the risks and benefits of care). Children who are capable can normally obtain health care treatment without their parents' or guardian's knowledge or consent. Children who are deemed capable to consent are allowed to disagree with their parents or health care provider regarding their care. In addition, you are unable to discuss a capable child's health care with the parents or guardian unless the child agrees.

It is recommended that you review the Dietetic Privacy Guide along with the Dietetic Standards of Record Keeping, particularly with respect to Standard 3: "*Dietitians ensure a comprehensive client health record is maintained when individual nutrition assessments and interventions are provided*." There is no requirement to have a separate chart for the client's care and one for the client's mother. The child (and not the child's parent) is your client; all documentation related to the care of your client, should be included within one chart.

Q2: When do I need to obtain consent during nutrition care? When is consent required? When is consent not required? When is consent not valid? Is consent required each time a client is seen or (for example) when a change a therapeutic diet is implemented?

Consent is an ongoing voluntary decision where a client agrees to a course of nutrition care* after being provided understandable information. This information must be shared in an honest, transparent way, using plain language (an interpreter may be required in the event of a language barrier), and should include: the nature of the treatment, its risks and benefits, and any

comparable alternative treatment choices. A Dietitian is accountable for ensuring consent remains valid throughout ongoing delivery of care under his/her direct responsibility.

*Nutrition care includes assessment, treatment, intervention, monitoring and evaluation.

Consent may be given by the client if they are capable adults or minors, or by a substitute decision maker, if the client is incapable. In some situations, a capable client is represented by a family member in an appointment (for example, an ALS client who is medically unable to travel). The key issue is to ensure that the client gives consent to the family member to attend a nutrition care session in their stead.

It is the legal and professional responsibility of the Dietitian to obtain consent to nutrition care and for collecting, using, and disclosing any confidential client information to family members, other health care providers and third-parties.

Consent is not required during a preliminary examination or nutrition diagnosis, unless the Dietitian is required to touch the client (e.g., skinfold measurement or subjective global assessment). Consent is not required for urgent health care, when a client is unconscious or semi-conscious, or for unforeseen, medically necessary conditions, where consent had been previously given.

Consent may be removed at any time during a course of treatment or be limited to some part of the care only. It is also not valid when there is a change in a client's medical condition deeming the original consent to care inappropriate. For minor health care treatment, consent is not valid for more than 12 months after consent was first obtained.

Consent continues until it is removed, or when there is a change in the course of treatment (less than 12-month duration). Therefore, once Dietitians have obtained consent to see clients, they do not need to get it every time, unless consent is withdrawn.

A change in the nutrition care plan requires obtaining renewed consent. Formal process and documentation may not need to occur for each small change, but Dietitians are expected to provide and record continuous information on their care and opportunities for questions and discussion with the client or substitute decision maker. Clients need to have a chance to raise their questions, concerns and preferences to make informed decisions. This supports client-centered care where clients are engaged and empowered to make decisions about their health. Although consent can be verbal or implied by gestures, Dietitians are encouraged to document consent/withdrawal of consent in the client's health record in accordance with the Dietetic Standards of Record Keeping. This provides a clear record of a dietitian's actions in case of misunderstandings and ensures good communication and continuity of care with the interprofessional team. Employers may also have additional requirements for consent documentation that Dietitians must follow.

Q3: Do I need to have new clients sign a consent form (in person or tele/virtual)? Or do I just need to document their consent? Or is the fact that they have contacted me and booked an appointment considered consent?

You are encouraged to review Policy Consent to Treatment and its Guideline. Key points in your situation include:

- *Consent/refusal may be obtained in writing, verbally or may be implied from the client's words or actions (e.g. a nod of the head).*
- *Consent/refusal must be documented in the patient's clinical record, according to facility policy.*
- *Consent/refusal to nutrition care is a dynamic process that requires renewal (re-confirmation) as the client's treatment changes. Consent should be renewed if more than 12 months have passed since the last consent was given (e.g. client seen in private practice).*
- *Consent is not required… for preliminary examination, treatment or diagnosis*

While it may seem reasonable to assume consent has been given when a client books an appointment with you, it is important to consider the fourth bullet above, that consent is not required for a preliminary consultation where the client is deciding in entering in a therapeutic relationship with you. You are required to gain consent for any collection of personal information and treatment plan or change in treatment plan.

Please consider that, in the case of virtual care, consent is needed in two aspects of your dietetic care. First, a client must understand the potential risks vs benefits of providing personal information over a virtual platform. Consent must be obtained for using the platform. Second, consent must be obtained for any treatment plan, as per the third bullet above.

Finally, obtaining consent doesn't specifically require "signed consent"; rather, you are required to have a record that informed consent was provided. This can be as simple as a check box, a declaration or a simple clear statement in your documentation. Similarly, it is as crucial for you to document if consent is withdrawn.

Q4: One of the care homes I work in is a privately run facility and I have a contract with them to provide dietitian services. I am being requested to contact the families of residents when I make diet changes. Should I assume "blanket consent" has been given by the families simply because they admitted their loved one to the facility? Some of the residents have dementia so they are unable to give consent.

As you are a private practice dietitian, the Dietetic Privacy Guide applies to you and gives you some useful background information to consider.

Regardless of whether the facility is private (and you are a private practitioner there) or part of a Health Authority (and you are an employee there), the first question to ask yourself is "What is the

capacity of the residents?". Some of them have dementia, which means they may not be capable of making their own medical decisions. In this case, it would be appropriate for you to communicate proposed changes to and obtain consent for a revised nutrition plan of care, such as a change in therapeutic diet, with the Power of Attorney, or Substitute Decision Maker. For a resident that is capable of making their own medical decisions, you are not able to provide any information to the resident's family without consent from the resident.

It is difficult to imagine a setting where a "blanket consent" would be appropriate, or what that would look like. Certainly, any change to a health care plan requires renewed consent and so blanket consent cannot be assumed. Nor can "blanket consent" be assumed for ongoing communication with family members. Consent is required when there is a change to the original nutrition plan of care, as well as when communicating updates to family members. You are encouraged to have a look at Dietetic Consent to Nutrition Care and its Guidelines for additional information to consider with regards to consent.

Q5: My patient consented to treatment in a program that often includes automatic referral to a dietitian. Do I need to obtain consent, or is consent implied again since the patient has already consented to the program?

All patients who are seen by a medical or surgical team must consent to a treatment (for example, chemotherapy/radiation, or a specific surgical intervention). In some cases, patients may be referred directly to other health care providers, such as a dietitian, as part of their consent process.

Consent to medical/surgical treatment and care is *not* the same as consent for a nutrition care plan. Consider a patient you may see for dysphagia care, or poor appetite, during the course of their treatment plan. This patient has consented to be seen by you, as part of their treatment. However, when you do your full assessment and implement a nutrition care plan for this patient, you must get consent for this. Perhaps you are recommending a modified texture to help with diet tolerance and the patient is willing to trial it. This is seen as giving consent. You should document consent at the outset of your nutrition care plan implementation and anytime the plan changes. For example, perhaps this patient has eaten so poorly due to dysphagia and low appetite, that it is deemed necessary to place an enterostomy tube for supplemental tube feeds. Certainly, you cannot assume consent in this case, simply because the patient consented to the original medica/surgical treatment plan and subsequently to a texture modified diet. This situation requires renewed informed consent and is an illustration as to why consent is needed over and above any initial consent.

Consider virtual dietetic care. A patient must consent to be seen virtually, and when they do, this does not mean the patient has consented to a nutrition care plan you recommend implementing. Consider admission to hospital for an acute illness. Under normal circumstances, the patient

consents to the hospital admission by arriving and being admitted, but you must obtain a new consent to your nutrition care plan.

Consent must be obtained for both steps of care, similar to working within a team. In this case, consent is especially important as it demonstrates that you have provided all options for **nutrition care** and also the option of no nutrition care, including risks associated with it.

You should document consent when a nutrition care plan is implemented, when it changes, and when consent is withdrawn (perhaps your tube fed patient no longer wants to be tube fed). If the nutrition care plan hasn't changed in a 12-month period, it is important to renew consent and document this renewal.

You may also use "implied consent" during times when a change in nutrition care plan is small. Consider the example of the patient on a texture modified diet who struggles with poor appetite. Perhaps at a subsequent visit, you discuss ways to increase calories and protein. If the patient seems keen to try this and has input into changes that are feasible for them to try, you may consider this as "implied consent". You would not have to document specifically that the patient consented to nutrition care plan changes, but you might use the terms "patient agreeable to try…" or "patient understood without additional questions…" etc., and you are able to use visual cues to ascertain implied consent.

Q6: What should I do if I feel that a client or potential client is not capable of consenting to my nutrition care plan?

Adults are deemed capable of making decisions about their health until they are assessed to be incapable. Capacity is critical to the provision of consent, in order to be able to provide safe nutrition care. An alternative, such as a Substitute Decision Maker or Power of Attorney for a client who is deemed not capable of consenting to their nutritional care must become part of the client's team and healthcare process. The Health Care (Consent) and Care Facility (Admission) Act reviews elements of consent and what needs to be assessed to determine an adult's incapability to consent to care and admission to a healthcare facility.

Assessment of competence/capacity is NOT within scope for dietitians in BC. Please refer to the Ministry of Health Incapacity Assessment Report, which stipulates that an "assessor" is defined as a medical practitioner, registered nurse, nurse practitioner, registered psychiatric nurse, social worker, occupational therapist, or psychologist (registered with their respective regulatory colleges).

If you question a client's capacity, it is expected that you collaborate with an assessor to contribute your nutrition assessment information and details of your interaction with a client who may need to be assessed for capacity. Capacity may come into question if the conversation does not proceed in a logical manner, if there are sudden or significant changes in the person's mental

status, if the client refuses an obviously beneficial treatment, or readily agrees to an invasive or risky procedure without discussing or considering the risks and benefit. A dietitian's assessment information may be important to inform an assessor's evaluation of capacity as cognition may be influenced by dehydration and malnutrition. If you work in a setting without such support, you need to refer to a professional who is able to assess capacity, per Standard and Indicator of Practice 2.3, where a dietitian determines situations that are beyond their professional scope of practice and refers to another health professional. For optimal risk management, Dietitians should pre-establish which professionals or resources they can refer to in complex care situations where it might not be clear how to support client-centered care and informed consent.

It is also important to note that refusing a treatment or declining consent to share health care information with family members does not systematically mean that a client is incapable of making their own health decisions.

Q7: The Consent to Nutrition Care Guidelines indicates that "consent should not be confused with cooperation". How do I dissociate between inferred consent and cooperation?

A good example to consider is the voluntary offering of a hand for a blood glucose finger prick. Did you provide information about your nutrition care plan that involved obtaining consent for this course of treatment? The difference between willingly providing a fingertip vs a passive cooperation, is the consent process. If the consent process has not occurred, inferred consent cannot be considered. Refer to Q2 and Q3 for details regarding the consent process.

Q8: Do you have an example of a consent form that I can use in my in-person or virtual practice?

The College generally doesn't provide template consent forms because (1) it is possible that the College could incur liability if it is unaware of a specific component of a form that may be needed for specific area of practice (i.e. there is no way to provide a one-size-fits-all template), and (2) the College would be unable to maintain any template forms. Refer to the Consent to Nutrition Care guidelines, page 5 for general considerations.

The administration of different health authorities and different workplaces have policies and procedures in place for privacy protection and the College defers to these employers to determine what works best for them.