Standards of Consent Consultation Results

(Completion rate: 26.45%)

Overall Impresion

Response	Chart	Percentage	Count
Yes		83.9%	255
No		16.1%	49
		Total Responses	**304**

Introduction

Response	Chart	Percentage	Count
Yes		88.6%	210
No		11.4%	27
		Total Responses	**237**

Please indicate what is missing, not needed or needs rephrasing from the Introduction section. (If you do not have any comments for this particular section, please leave blank).

The 21 response(s) to this question can be found in the appendix.

Standard 1: RDs obtain informed consent for nutrition assessment and treatment.

Response	Chart	Percentage	Count
Yes		83.4%	176
No		16.6%	35
		Total Responses	**211**

Please indicate what is missing, not needed or needs rephrasing from Standard 1 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 30 response(s) to this question can be found in the appendix.

Standard 2: RDs rely on consent from a client only if the client has the capacity to give consent.

Response	Chart	Percentage	Count
Yes		94.5%	189
No		5.5%	11
		Total Responses	**200**

Please indicate what is missing, not needed or needs rephrasing from Standard 2 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 19 response(s) to this question can be found in the appendix.

Standard 3: If a client is not capable of providing consent, RDs use the appropriate substitute decision-maker to obtain consent on a client's behalf.

Response	Chart	Percentage	Count
Yes		90.3%	176
No		9.7%	19
		Total Responses	**195**

Please indicate what is missing, not needed or needs rephrasing from Standard 3 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 17 response(s) to this question can be found in the appendix.

Standard 4: RDs keep incapable clients involved as much as possible in their assessment/treatment decisions.

Response	Chart	Percentage	Count
Yes		93.2%	179
No		6.8%	13
		Total Responses	**192**

Please indicate what is missing, not needed or needs rephrasing from Standard 4 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 14 response(s) to this question can be found in the appendix.

Standard 5: RDs ensure that informed consent is obtained from the client/substitute decision-maker for collecting, using, and disclosing personal health information.

Response	Chart	Percentage	Count
Yes		90.1%	173
No		9.9%	19
		Total Responses	**192**

Please indicate what is missing, not needed or needs rephrasing from Standard 5 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 16 response(s) to this question can be found in the appendix.

Standard 6: RDs apply an age and culturally-appropriate process for obtaining informed consent for nutrition assessment/treatment and for the collection, use and disclosure of personal health information.

Response	Chart	Percentage	Count
Yes		93.7%	179
No		6.3%	12
		Total Responses	**191**

Please indicate what is missing, not needed or needs rephrasing from Standard 6 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 10 response(s) to this question can be found in the appendix.

Standard 7: RDs recognize that clients/substitute decision-makers have the right to refuse nutrition assessment/treatment or refuse the collection, use and disclosure of personal health information or withdraw consent at any time.

Response	Chart	Percentage	Count
Yes		95.3%	182
No		4.7%	9
		Total Responses	**191**

Please indicate what is missing, not needed or needs rephrasing from Standard 7 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 12 response(s) to this question can be found in the appendix.

Standard 8: RDs document verbal and written consent for assessment/treatment and for the collection, use and disclosure of personal health information (or refusal/withdrawal of such consent).

Response	Chart	Percentage	Count
Yes		87.8%	165
No		12.2%	23
		Total Responses	**188**

Please indicate what is missing, not needed or needs rephrasing from Standard 8 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 23 response(s) to this question can be found in the appendix.

Standard 9: RDs provide treatment without consent in the case of an emergency.

Response	Chart	Percentage	Count
Yes		93.0%	173
No		7.0%	13
		Total Responses	**186**

Please indicate what is missing, not needed or needs rephrasing from Standard 9 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank).

The 18 response(s) to this question can be found in the appendix.

Conclusion

Response	Chart	Percentage	Count
Yes		91.2%	166
No		8.8%	16
		Total Responses	**182**

Please indicate what is missing, not needed or needs rephrasing from the Conclusion section. (If you do not have any comments for this particular section, please leave blank).

The 13 response(s) to this question can be found in the appendix.

Future Education Materials

Response	Chart	Percentage	Count
Yes		27.5%	50
No		72.5%	132
		Total Responses	**182**

If yes, please specify:

The 46 response(s) to this question can be found in the appendix.

Additional Comments

Response	Chart	Percentage	Count
Yes		8.4%	15

No		91.6%	163
		Total Responses	**178**

The 12 response(s) to this question can be found in the appendix.

Please tell us who you are:

Response	Chart	Percentage	Count
I'm an RD		99.4%	180
I'm another health professional		0.0%	0
I'm a member of the public		0.0%	0
Other, please specify:		0.6%	1
		Total Responses	**181**

Please tell us who you are: (Other, please specify:)

#	Response

Appendix

Please indicate what is missing, not needed or needs rephrasing from the Introduction section. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	Very clear
2.	It seems incredibly detailed... we are providing education (that the patient can decline to follow when they get home) or food interventions (which patients can refuse when it is on their meal trays)....
3.	The term implied consent can be confusing. I'd like to have this defined and examples given. For example - does admission to a hospital mean implied consent for an RD to treat? Does a self referral to an RD practice mean implied consent? Conversely, some examples where consent is required would also be useful.
4.	Need more information concerning implied consent. Situations when it would commonly apply. For example, when an individual has made an appointment to meet with an RD in a primary care setting and has come to the appointment. Is this implied consent?
5.	I am unsure if coming to an outpatient appointment, by virtue that patients knowing they are coming to see an RD whether on their own or is referred by a DR, is implied consent. Is it....or do you have to ask each time if you can ask questions give feedback etc... This would be good to do a Workshop on
6.	When discussing the reason for consent, it should also include liasing with other health professionals and for the request and review of relevant info such as lab and test results
7.	I do not believe that it is necessary to disclose personal information for professional practice. We are in a profession that deals with nutrition, we do not do any hands on assessments or see clients in vulnerable positions (Our clients always have their clothes on).
8.	Too long
9.	more definition on how effective interprofessional collaboration is essential to the informed consent process.
10.	I feel like the college has applied the HCCA consent piece to the RD practice without considering that many parts of our practice do not involve a 'direct intervention with the pt' but rather the assessment of the pt and proposition of interventions. Please see my comments after each bullet has copied/pasted from the proposed Consent Standard

	i. RDs obtain implied, verbal and/or written informed consent for: a) Conducting nutrition assessments;.... This needs reconsideration...in the ICU setting most pts receive an assessemnt by many HCPs (MDs, RTs, RDs PTs etc) and no one, to my knowledge, calls the SDM, the case of an incapable pt, to ask for consent to do so. This would impeed timely care to the pt!! There are many times when an SDM can only be reached on a limited basis. Our assessment does not include usually include an intervention so it is lost on me as to why consent is needed in the critical care setting. On a risk vs benefit basis the benefit for the pt is to allow the RD to assess to pt in a timely manner and propose a care plan to the team. I thinK that calling the SDM every time a HCP needs to assess a pt would be overly burdensome. b) Treatment planning and implementing nutrition care intervention; Treatment panning in critical care can take place with out any intervention, planning out an EN/PN plan after an assessement should not need consent from the pt or SDM . Agaian, this would only hold up timely care and I do not feel that it is a true representation of the intention of the HCCA) Significant changes to nutrition care treatment plans, different from the nature, expected benefits, material risks and material side effects of the original treatment.1 ii RDs must verify that a process is in place to discuss the following with clients/substitute decision-makers to obtain informed consent for nutrition assessment/treatment: a) The nature of the assessment or treatment being proposed; b) Who will be providing the assessment/treatment; c) Reasons for the assessment/treatment; d) Material effects, risks and side-effects of the assessment/ treatment; e) Alternatives to the assessment/treatment; f) Consequences of declining the assessment/treatment; and g) Specific questions or concerns expressed by the client/substitute decision-maker.1...for example if an MD has had a discussion in place about a feeding tube with a pt/SDM what kind of process would i need to have in place to be sure that this was done? Is a consent polciy enough or theprofessionals code of ethics as per their college? RDs document verbal and written consent for assessment...this seems crazy to ask and to document consent every time I assess a sedated pt..does in include reassessemnt? An ICU pt will be assessed daily!! and their care plan changed daily!!
11.	Paragraph 2, last sentence: ...'Above all, clients or their substitute decision makers should have opportunities to ask questions and have their questions answered in the informed consent process.' Question: SUBSTITUTE DECISION MAKERS (would be good to clarify this term. does this term only apply to those what are legally responsible or the client (ie: power of attorney) or not?). If not, then should state so.

12.	the standard is clear and not as gray as before
13.	I work in a neonatal intensive care unit where all infants are outborn - ie. mother is still in another hospital - usually with dad - and consent for treatment would delay care for many preterm and critically ill infants. I feel that this Standards of Consent document was written assuming all dietitians practice with intervention directly with the patient.
14.	Yes, because it is stated clearly that we must make the judgement about whether we need to use implied consent. In my area - ICU - virtually all consent is implied, ie. initial assessment, daily use of info in the chart and daily reassessment and changes to nutrition support or oral diets.
15.	It would be important to define the different types of consent (e.g. implied consent, verbal consent, written consent)
16.	There needs to be more clarity and reconsideration in the cases within the ICU setting/ the unconscious, sedated patients. In cases where there is not a SDM, should we be calling the public trustee to gain consent?
17.	- I agree with obtaining consent to treat. - the hospital I work for has the Pre-Printed Physician Order forms where referring to a Dietitian is part of those orders. When a physician refers patient to the dietitian and the patients are in area i.e. Paediatric, NICU, ICU etc, would "Implied consent" be accepted for collecting information for assessment? I am not very clear about that. - on the 2nd paragraph it stated: it requires a conversation between the person proposing the assessment, treatment or the collection, use and disclosure of personal health information and the person giving the consent.
18.	"The College recognizes that RDs may need to exercise professional judgment as to when they can rely on implied consent or when more formal verbal or written consent should be obtained". I have as yet never heard of or obtained written consent for nutrition intervention in an acute care hospital setting in all my years of practice. "This decision will usually involve some assessment of the risk to the client for following or refusing treatment or for the collection, use and disclosure of personal health information". This would appear to apply exclusively to an outpatient or clinic setting. "Each area of dietetic practice has its own unique characteristics". I work in an ICU. "The underlying principles of consent apply to all practice settings where treatment is given or personal health information is collected, used and disclosed. RDs should ensure that in addition to complying with the College's Standards for Consent in their practice location, that they also follow any additional organizational policies and

	protocols". In my area I am driven by policies and procedures and am under the assumption that any critically ill patient admitted to the ICU that can't speak for themselves and has a full resuscitation order by the admitting physician is an implied consent to all ICU protocols and procedures that include placement of NG tube (that later may be used for enteral support) and or central line(s) that may be used for parenteral support. I have never obtained informed consent from patients or their families for client care. The physicians and RNs inform families of everything that's going on with their loved one. I do collaborate and communicate with both clients and families when possible and other healthcare members daily, using a client-centred approach as is inherent in our ICU team conduct. I sometimes liaise with family only after the fact because of time lines and the nature of the area. "The delivery of dietetic services is often done in a collaborative manner with other health care providers". This is an understatement in a busy ICU. "This may pose some challenges in ensuring informed consent is actually obtained prior to the implementation of any nutrition intervention or for the collection, use and disclosure of personal health information". This is not a realistic expectation and falls under implied consent and as such should be clearly delineated for these circumstance. "Therefore, effective interprofessional collaboration is essential to the informed consent process". This is a reality in a multi-professional dynamic setting.
19.	I feel to it needs more detail to fully cover, the way it is presented it indicating that the RD need to have consent prior to nutrition assessment and prior to initiating nutrition support. there are many times in a downtown Toronto hospital where a patient with no family members, takes social worker two days to find the name, the family member. scenarios like this which are common would delay the initiation of nutrition support. Nutrition support with the intubated patient can help decrease days in the ICU, improve their outcomes. ect. consent from family members is obtained when possible however there are about 50% of case where this is going to increase our time in completing assessments. we as dietitians are already working in overcrowded , stressful, busy environments.
20.	"The College recognizes that RDs may need to exercise professional judgment as to when they can rely on implied consent or when more formal verbal or written consent should be obtained. This decision will usually involve some assessment of the risk to the client for following or refusing treatment or for the collection, use and disclosure of personal health information. " In a hospital setting, would consent be implied that the client's chart can be reviewed if a referral is received? Unless for example, a lock box provision is on their record? My feeling is that the client's chart and other relevant personal health information would need to be reviewed in order to assess the level of risk to the client.
21.	Re: "....requires a conversation with the person proposing the treatment and the person giving consent": In the critical care setting, this is done by the MD (not the RD). The MD collaborates with the RD to then ASSESS for the EN or TPN treatment--the RD is not

proposing the treatment, only following through with the treatment's BEST PRACTICE requirements (the treatment is ordered by the MD). If the SDM is present (as the Pt is often comatose/sedated therefore unable to consent), I will explain to them that I am the RD here to assess the pt for EN or TPN as per the MD's order and tell them that I am taking their weight (via bed scale) as I'm taking it and sometimes ask the SDM a few questions pertaining to the Ax. I MUST rely on implied consent or the verbal consent received by the MD to start EN or TPN, as it would cause delays in me assessing the pt and the RN implementing EN or TPN when the SDM is often not readily available to "re-ask" consent to feed enterally or parenterally (= duplication & SDM may think the Pt care team does not communicate). CRITICAL CARE IS VERY FAST-PACED AND COLLABORATIVE with no room for delays in treatment or duplication of steps in the circle of care process.

Overall, I do NOT agree with the consent process in the critical care setting. When the patient is less critical, then consent for EN or TPN treatment would still be obtained by the MD, but the RD in visiting the Pt for the assessment will state that she is an "RD here to complete the EN or TPN assessment which was ordered by the MD". She may also say, "I require some information (to be kept confidential within your medical chart) in order to complete my assessment; is that O.K. with you?" If it is re: a new oral diet or oral diet change, then of course, the RD must obtain Pt/SDM (if readily available) consent and MD co-signature. IN ORDER TO PREVENT DELAYS IN ENHANCED NUTRITION THERAPY, the MD co-signature may need to be obtained first, followed by confirming consent with the Pt/SDM later (and if the Pt subsequently ends up disagreeing with the diet change, then the RD will need to obtain MD cosignature to change to a Pt/SDM acceptable diet).

Please indicate what is missing, not needed or needs rephrasing from Standard 1 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	it's ok but all of these items are just WAY to long winded and complicated.... they make consent sound more difficult than it needs to be... and that means fewer RDs will actually read this document and learn and implement properly. Cut it to half at least!!!
2.	Examples where consent is required.
3.	In long term care, it may not be practical to call a family member for an incapable resident for every decision. This leaves a lot of judgment calls for the RD and does not really clarify what the RD should do in a given situation. For example, if the resident was very tired, and the RD decided to try a minced texture for a few meals (chewing can be very tiring for some residents), would the RD need to call the family? If the RD is looking after 250 residents, it

	may not be productive or helpful to spend time calling all the families for all small menu changes. The wording of the section allows for RD decisions such as this, but we would not be able to quote the standard as the underlying decision making tool. There would still be a large grey area within the standard.
4.	More info about implied consent.
5.	iv. a) this PI is problematic, if not impossible, in many settings. How can an RD "ensure" that someone else obtained consent using this process if s/he was not present in the room when it happened? S/he might be able to "confirm" with someone else that they obtained consent, but RDs cannot ensure this.
6.	There needs to be presented to the client the option to do nothing. iii. f. does identify: Consequences of declining the assessment/treatment but no where does it state that the RD identify that the client has the option of doing nothing in relation to treatment.
7.	would like to have more explanation of implied consent (concrete examples.)
8.	Sometimes overtly stating the alternatives and consequences of declining the treatment aren't necessarily needed and may scare the patient. i.e. pt requires a fluid restriction via Gtube to help treat hyponatremia and has no problem agreeing to this treatment. Is it really necessary to say "you may get a seizure or die if you don't accept this treatment" ? Also, for small changes to a treatment plan that are non-controvesial to the client (i.e. they understand rationale for change and express no concerns), the RD may not need to discuss everything listed point. What is meant by "RDs must verify that a process is in place to discuss the following with clients/substitute decision-makers to obtain informed consent for nutrition assessment/treatment", specifically what is meant by "a process in place"? What kind of process?
9.	When another interprofessional care team member obtains informed consent for nutrition assessment/treatment, RD must take responsibility to ensure process met standards versus the interprofessional care team member.
10.	as per my comments on the previous page
11.	It is clear and not as gray with regards to consent
12.	Again, working in a NICU, it would be impossible, delay care and increase an already intense workload even further. As well, it would not always be possible to phone referral hospitals to find mothers or fathers for consent to start PN or enteral feeding.

13.	When you work in a hospital setting you need to screen patients in order to determine if they need a nutritional assessment, ie: assess them to see if they need an assessment. In order to do an assessment you need to access PHI. It would not make sense to get consent from each family prior to looking at chart, if they don't need an assessment. Also, by nature we are exposed to PHI as members of the health care team. No other health care professionals need to get consent. Consent is only provided for medical procedures. Is consent not implied when a patient is admitted to the hospital?
14.	as long as the following assumption is correct. Implied consent is in place for sedated patients in critically ill situtations for enteral and parenteral nutrition that nutrition is part of critical care so when a patient consents to critical care they consult to nutrition interventions as part of that care (so implied consent can be assumed)
15.	I do not feel this gives me the information I need working in an acute care setting.
16.	It needs to clearly recognize that implied consent means that decisions and changes to nutritional regimens will take place without contacting a substitute decison maker. Anything else is completely unrealistic and would not be followed.
17.	very lengthy, could be shortened to be more concise agree that consent is important when a nutritional intervention is being done, however when it is only an assessment, the fact that the patient/client has come to their scheduled visit should be consent enough
18.	what can be an example of implied consent? When a patient is admitted to hospital and a lot of times, assessment and treatments are vital to his /her well being, would that be emergency situation? for point iii - RD must verify that a process is in place to discuss the following with clients/ substitute decision-makers to obtain informed consent for nutrition assessment / treatment what is best practice for the following situation 1) preterm neonate born at emergency c-section, needed to be intubated, cannot be NG tube fed and requires TPN treatment. (both parents may not be available) so as a dietitian, I should wait until one of the parents can be reached and explain the treatment before TPN can be started? (there may be a risk of patient being NPO for more than 24 hours - current ASPAN guideline suggests to feed within first 24 hours) I thought we are providing "patient-centered" care

19.	I don't believe it is necessary to get consent for assessment
20.	My professional judgement based on the nature of my services, potential risk and consequences to the clients determines that consent is implied and can not be obtained in advance of assessment and treatment. The RD does not apply the treatment. She responds to a physician's consult. The physician obtains implied consent for nutrition assessment/treatment. The RD than orders it or suggests it to the physician and the RN implements the delivery. I never document anything about implied consent. iv. e) once I meet with the family I can answer any additional questions they may have about the NCP.
21.	I think it needs more detail. without the detail, we now will be spending time calling family members, often family is very hard to reach. I have tried to reach family members now and it takes a lot of time.
22.	Lots of vague information. For example, what are "significant" changes, how does a RD verify that a process is in place to obtain informed consent, how does a RD determine that implied consent is sufficient. Why would consent be needed to assess as this is not considered treatment is it? I work in a critical care setting and have concerns re these standards. Assessing for enteral tube feeding (EN) is done on every critical ,ventilated patient. Tube insertion and EN is a routine part of treatment. Are there different expectations for clients admitted to hospital? ie is there a general consent obtained on admission? It's my understanding that it's the person proposing the treatment that obtains consent.
23.	I have a few comments regarding this section. My understanding working in acute care, most patients receive an assessment by numerous health care practitioners (OT's, RD's, PT's, SLP's, etc) and the SDM is not called to ask for consent if the personal is unable to consent themselves which is common in the critical care setting. This would not only delay the assessment and care for the pt, but also would frustrate the family (I imagine), constantly receiving phone calls etc. At times I am sure the decision maker might not be available, and this is even more complicated if the person doesn't have a defined SDM. To me this will significantly delay care for the pt and seems extremely unnecessary, especially as this is just to assess the pt whether they require intervention. I have to believe most patients admitted to hospital, especially in a critical care setting why having to obtain consent PRIOR to an assessment would be beneficial to them. I think most would want to be assessed and a proposed plan put in place to present to the team to help save their lives. Constantly making phone calls to SDM would require +++ time and take away precious time assessing pt's who require nutritional intervention.

24.	Clarity is needed in section IV which refers to another member of the team conducting an assessment or treatment. Is the RD being asked to follow up on the consent process for a colleague who might be covering the workload, for example? Or does this refer to someone who reports to the RD such as an intern or Diet Technician?
25.	This needs reconsideration...in the ICU setting most pts receive an assessment by many HCPs (MDs, RTs, RDs PTs etc) and no one, to my knowledge, calls the SDM, the case of an incapable pt, to ask for consent to do so. This would impede timely care to the pt!! There are many times when an SDM can only be reached on a limited basis. Our assessment does not include usually include an intervention so it is lost on me as to why consent is needed in the critical care setting. On a risk vs benefit basis the benefit for the pt is to allow the RD to assess to pt in a timely manner and propose a care plan to the team. I think that calling the SDM every time a HCP needs to assess a pt would be overly burdensome.
26.	I agree that it is important to onbtain informed consent for the nutritional assessment and treatment in most clinical areas except critical care. Implied consent may be required in specific situations such as in critical care setting however there are times when POA is not available however MD has ordered initiation of EN this poses challenges as to delay EN may add to this patients risk. I am not sure how realistic it is in the critical care setting to fullfill this detailed list of requirements to obtain consent. There should be a clause or addition to guide us in these specific situations.
27.	RD referral is received, does this mean the RD needs consent BEFORE looking in the chart?
28.	Potentially indicate examples for professional judgement in section 1.ii. (for example, verbal consent obtained through care conferences or phone)
29.	Remove: iii/iv Change - I-c) very difficult in some settings. Could delay treatment if SDM not available, pt in an ICU or LTC setting d/t pt's medical or mental status (dementia/CVA/LOC)
30.	Again, the consent to EN or TPN treatment is obtained by the MD (as per many hospital policies). If the patient is Pt is not critically ill, the RD will obtain consent to ASSESS the patient for the treatment (and the course of treatment--so that time is not wasted trying to obtain consent for daily adjustments in EN or TPN based on clinical data, change in status, etc...) ordered by the MD. For non-critically ill pts, consent will be obtained by the RD to change oral diets or tube-feeding schedules, etc... MD co-signature or Medical Directive is required for RD therapeutic diet recommendations and may be obtained and implemented before consent when the Pt or SDM is not readily available and the recommendation is deemed to REDUCE NUTRITIONAL-RELATED RISK to patient.

Please indicate what is missing, not needed or needs rephrasing from Standard 2 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	doubtful that RD will need to do this - make it short
2.	2. v. 'recognized' should be 'recognize'.
3.	Point V - typing mistake - should be "recognize"
4.	iv - not clear why client could be capable to make a decision on some aspect of care, but not on other aspects; they are either capable or not. Perhaps this could be clarified by an example of a treatment a client would be capable to provide consent for and treatments they would not be capable of?
5.	Need clarification about Performance Indicator ii, regarding age; clarify whether we must obtain consent from legal guardians of minors.
6.	ii. In the case of children, ability to provide consent is based on age. v. Need to clarify this wording -- perhaps "RDs recognize that clients may be capable of providing consent to treatment at one time and incapable at another time."
7.	Who determines capacity?
8.	For iii. Should there be mention made regarding how dietitians are to determine if a client is capable of providing consent?
9.	Assessment of capacity may not be based on clear standards and there could be bias.
10.	In the general sense of needing consent for a treatment or intervention that requires consent I would agree with this
11.	RDs assume clients are capable of providing consent unless there is reason to believe otherwise. The wording assume is very weak, some clients can appear to be more capable then they really are. Is there not a better way for a dietitian to have a measurable way to determine capable so the decisions/ charting made can be clear and concrete.
12.	Again, the assumption here is that dietitians work only with patients who are involved in their own care - the amount of time it might take to find and speak to a SDM prior to implementing a nutrition care plan that has been discussed within the MDT would again, delay timely nutrition plans to be put in place.
13.	When you work in pediatrics, it is difficult to determine if the client has capacity to give consent. Also, the client varies. It is sometimes the infant, child or parent (for example when breast feeding recommendations are being made). This section needs to be reworked for those who work with pediatrics.

14.	agree that consent is based on capacity not age, working in pediatrics and research.
15.	Who is deeming a patient having capacity to give consent, especially a 16 years old? I see patients who come in with weight lost within short period of time queried with eating disorder (but not yet diagnosed by a psychiatrist), would the 16 years old be still considered as capable of giving consent?
16.	This area is irrelevant to an ICU setting. Capacity is determined by the physician in collaboration with the social worker and if needed a capacity assessment is requested from the Capacity Board. In that context a patient will likely already be on nutrition support if part of goals of care determined by team and family.
17.	again provide more detail. provide examples
18.	Are we as Dietitians able to fully determine if a patient is not able to make their own decisions?
19.	Remove PI - iii/iv - in a hospital setting we work as a team, the OT conduct capacity, RDs use that information and discussing with other team members and client to determine capacity. Not sure why this formalization is necessary.

Please indicate what is missing, not needed or needs rephrasing from Standard 3 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	Would delay nutrition assessment and intervention in cases where there are NO POA's or unable to contact the POA. Does this apply to enteral feedings in ICU where intervention is expected with 24-48 hours>
2.	but make it shorter please
3.	3. ii. c) is not clearly formulated
4.	I don't agree that it is the RD role to assist in the below process "Where there are no other substitute decision-makers available, assist a friend (as applicable) to apply to the Consent the Consent and Capacity Board to be appointed as a client's representative for personal care decisions"
5.	I disagree with having to be the professional that contacts and has to deal with contacting or directing the substitute friend to the Consent and Capacity Board . I am not trained in this area and Do not have the expertise nor do I receive updated information from this Board regarding it's contact info etc . I do not have the time to do this during my work day . The

	most we should be required to offer is who the friend needs to contact . More than this should be the role of the Social worker or the friends lawyer.
6.	More definition on what determines capacity-index which could be consistent.
7.	ii. c) Needs clarification. Is it the RDs role to provide this function? Or is this something that the RD would typically consult with the leader of the client care team or other hospital staff about? In the next standard, an incapable client is to be directed to apply to the Consent and Capacity Board (item v) -- this seems inconsistent with this item. A "friend" (presumably competent) gets the RD's assistance in making an application, while an incapacitated client is to be told to apply on his/her own??? Specify that this refers to a client's friend. Remove repeated words "the Consent".
8.	This standard is well worded and clear. An SDM will be determined and clearly documented in the patient's chart
9.	As previously stated, the SDM as a parent is not always possible. In an NICU setting parents never accompany their infant and tracking down a parent is not always possible in a timely manner. Waiting for this consent, for example, mother has HELLP syndrome and is in a coma - father is with mother in ICU - who is going to give consent to start PN and when? This would delay timely nutrition implementation and could adversely affect outcomes for many infants.
10.	I do not feel this gives me the information I need working in an acute care setting.
11.	It is not realistic or necessary to have the dietitian calling substitute decision makers (SDM) for consent to provide nutritional care in the ICU setting. The only time it would make sense is if care is moving to "comfort care only" or withdrawl of life support, and a decision needs to be made as to whether nutriton support will be continued. We would be calling them every day to make simple changes to enteral formulas for example, which would be a burdensome thing to do and unnecessary. All patients are given nutrition support - it is regarded as routine care, no one is asked if they wish to have it started. Also - SDMs are often very difficult to reach, and this would lead to long delays in getting patients fed, which goes against current nutrition support guidelines. No one would withhold nutrition because an SDM was unable to be reached. I would add a phrase saying that if a patient is in an implied consent scenario, that contacting SDM is not necessary except for the example given above.
12.	May be useful to outline requirements for documenting decision to use substitute decision maker and the substiute decision maker chosen.
13.	I believe that this section is not relevant to most multi-professional in patient hospital settings as the Social Worker drives this process for all aspects of care. While the RD is

	informed of these principles I believe it would be rare to have to engage in this process for the sole purpose of nutrition. Perhaps this issue must be addressed in Private Practice settings where RDs may be working in isolation and have to engage in these steps.
14.	subsitute decision makers are very hard to reach , if each health care professional needs to reach them this is going to take more time on the health care professional. we are all working within our boundaries
15.	In ii c of this section not sure if the words "the Consent" needs to be there twice.
16.	I found phrase ii(c) hard to understand: Where there are no other substitute decision-makers available, assist a friend (as applicable) to apply to the Consent the Consent and Capacity Board to be appointed as a client's representative for personal care decisions; and How is this friend identified? Perhaps, "instruct the client to identify a friend" so it doesn't sound like the RD will decide this.
17.	Section ii.c) requires rephrasing: repetition of wording [ie. ...assist a friend (as applicable) to apply to the Consent the Consent and Capacity Board...]

Please indicate what is missing, not needed or needs rephrasing from Standard 4 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	it's unrealistic - we can't do it all, and this isn't a high priority.... chances are that such a client will not even be on the caseload... certainly not in Home Care.... :(
2.	I am unclear as to why the RD needs to fulfill these functions - should it not be a social worker? Offer to assist the client to identify another substitute decision-maker of the same or more senior rank if the client disagrees with the designated substitute decision-maker. v. Inform the client that he/she may apply to the Consent and Capacity Board for the

	appointment of a representative of the client's choice if the client indicates that they are uncomfortable with the substitute decision-maker. vi. Inform the client of the right to appeal the finding of incapacity to the Consent and Capacity Board for review. If the client requests clarification on this finding, the RD will provide the client with the name of the health professional who made the finding of incapacity.6
3.	For each one of the standard's items, such as Standard 4, it would be useful to insert which part of the HCCA it relates to. For this Standard 4, for example, I cannot find the associated part of the HCCA. This is unclear.
4.	In cases where the client has been determined to be incapacitated, is it possible that the client may not be able to provide rational input into the decision making process? v. How can an incapable client apply to the Consent and Capacity Board?
5.	There may be cases where this is not possible or practical.
6.	The standard are build to mostly address patient that are lucid. It seems to not work with the ICU population when are intubated.
7.	'as much as possible' is not very specific. Again, in a NICU setting, parents are not always at the bedside but when they are, plans are discussed as per the rest of the medical team, not just as per the dietitian on the medical team.
8.	Again, this needs to be reworded for pediatrics
9.	I guess so, but again for the majority of patients in ICU , this doesn't apply.
10.	I'm not sure I agree with point V and VI. I think another healthcare professionnal (social worker etc) might be more appropriate?
11.	Quite a loaded statement, realistically will an incapable client be able to be involved in decision making???
12.	Again this is highly unrealistic in my setting.
13.	I hospitals setting, done by others more capable. Ex social worker for CCB application
14.	Point 5-consider including another member of the team such as discharge planners or social workers to assist with obtaining an alternate SDM as these members are more experienced with this process.

Please indicate what is missing, not needed or needs rephrasing from Standard 5 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	way too complex and wordy - pls write this for "on the job" dietitians, not for your office job
2.	ii. b) Have you confirmed that the process outlined here is consistent with the consent processes outlined for use by all other health care providers? If not, how can RDs fulfill this obligation?
3.	RDs should consult the mental health act when sharing health information on behalf of mental health patients.
4.	What provisions are there for an inpatient setting, wherein a patient has already been admitted, with diets already in place as per MD admission orders? Agree with point "i" and "iii". Disagree with "ii" - in an inpatient setting, with a routine nutrition ax - explaining or going into a spiel of all that may or may not be applicable (depending on the situation). RDs are members of the patient's circle of care/interprofessional team.
5.	Daily I use labs and other medical information to formulate my nutrition plan. Obtaining informed consent from a SDM would delay timely nutrition care for a vulnerable population and could impact long term outcomes. I don't think this standard or any of the other standards can be broadly applied to the pediatric population and specifically, the NICU population.
6.	If you work within a hospital, what is the responsibility of the hospital to notify the client of this information? If they sign consent when they are admitted or come to clinic and we practice within the circle of care, is this sufficient?
7.	I do not feel this gives me the information I need working in an acute care setting.
8.	What is meant by #1 - verify that a reliable process is in place to obtain informed consent for the collection, use and disclosure of personal health information? What do you mean by a reliable process? Again in our setting - # 2 is done by a physician or social worker. Since you have the phrase " or another designated person", I guess this phrase is okay, but realize in real life no one is designated with the duties listed in this standard.

9.	I agree with this standard for research, however do not think it is necessary for patients who come to their scheduled visit
10.	Can someone please clarify the part where RD must obtain consent directly or verify that a reliable process is in place to obtain informed consent for the collection ... use of personal health information and also be able to do ii d) the health care providers within the circle of care with whom personal health information may be shared without expressed consent.
11.	Overall these things will take up too much time. There will be no time left for nutrition care
12.	But again it does not apply to my setting. "A reliable process is in place to obtain informed consent for the collection, use and disclosure of personal health information". Admission to the ICU. I collect and use health information obtained from the chart or the patient/family without expressed consent. I do not disclose any information outside of the circle of care.
13.	For sections ii(b) and (c), it would be helpful for the specific sections of references 2 and 7 to be provided so that RD can more easily locate the background content for these areas. b) The legal authority (e.g., voluntary, contractual, legislative provision) for the collection, use, and disclosure of personal health information, as appropriate; c) The potential benefits and risks of consenting or not consenting to the collection, use and disclosure of personal health information; and
14.	Needs clarification for some areas such as critical care. See previous comments.
15.	"RDs must obtain consent directly or verify that a reliable process is in place to obtain informed consent for the collection, use and disclosure of personal health information." Is consent implied in a hospital setting if a referral is received?
16.	Ensure that for section iii, that a statement such as "RDs will discuss with patients the potential health risks associated with creating a lock box" is in place. (Source: http://www.cpso.on.ca/policies-publications/policy/confidentiality-of-personal-health-information)

Please indicate what is missing, not needed or needs rephrasing from Standard 6 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	again - keep it simple

2.	I agree with this standard, but the yes/no button appears to be malfunctioning and will not let me register a "yes" response.
3.	More definition on culturally appropriate process
4.	ii. Need to clarify this. If a client is capable of providing consent, why would you clarify the people involved in making consent decisions with him/her? S/he is the person who will make consent decisions. If someone has already been appointed a substitute decision-maker, why would you clarify the people involved in making consent decisions with him/her? S/he is the person who will make consent decisions. The process outlined here would seem to be potentially confusing to the client/substitute decision maker.
5.	item iii. states: RDs use language interpreters as necessary to assist in the informed consent process. In some cases language interpreters may not be available so to identify to use them "as necessary" should be modified. The language should encompass information re availability of interpreters.
6.	Use of validated tools to use to understand the client's cultural beliefs and values. How to incorporate understanding in standards of care.
7.	as per my other answers
8.	-definition of culturally-appropriate is ambiguous -decision making and the communication of PHI in some cultures can contravene principles and practices of full disclosure to the pt -i.e. in some cultures, the pt does not decide his/her own treatment (rather, this is done by the larger family) and/or families may wish to avoid disclosing some aspects of diagnosis to the pt
9.	I agree that informed consent should be culturally appropriate, however, determining what is considered culturally appropriate is often difficult and sometimes impossible without having been immersed in that specific culture and given the immense diversity within Canada. Instead, I think that RD's should seek to do their BEST to inform in a culturally appropriate way. Ultimately, their efforts may still be deemed by the client as incongruent with their culture despite best efforts.
10.	Does not tend to apply to my area in the context of consent but describes expectations of an RD's conduct in general !

Please indicate what is missing, not needed or needs rephrasing from Standard 7 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	make it snappier - when a client refuses, they should be allowed to refuse without undue

	red tape... it's more respectful. No means no. diet isn't a life threatening decision - we need to let it go and move on to clients who want our counsel... there are more than enough who need and want it.
2.	7.i. 'refuses or withdraws' should be 'refuse and withdraw'
3.	Maybe add a little more about the consequences of refusing consent to include health risks or specify both short term and long term risks.
4.	i. a) It would seem that clients/substitute decision makers should be informed of their right to refuse or withdraw consent AT ANY TIME as part of the initial consent process. This item belongs in Standard 1. It would also be advisable to include a statement that refusal or withdrawal of consent will not negatively impact the client's future interactions with the RD or the institution.
5.	Substitute decision maker may be incompetent to make decision about withdrawal of treatment
6.	it is well worded.simple and clear
7.	A SDM cannot refuse treatment for a small, preterm infant without ethical implications which would need to be handled at a level within the hospital beyond that which can be supported by this standard.
8.	Applys in general when a client refuses to see the RD or accept the diet, or refuses an NG tube be inserted.
9.	most times the subsitute decison maker will agree when they understand the importance that nutrition plays in improving health and treatment.
10.	...for example if an MD has had a discussion in place about a feeding tube with a pt/SDM what kind of process would i need to have in place to be sure that this was done? Is a consent policy enough or the professional's code of ethics as per their college?
11.	"Ensure the client or substitute decision-maker understands the implications of refusing or withdrawing consent" "Document the reasons why the client or substitute decision-maker is refusing treatment or withdrawing consent and any relevant discussions with the client or substitute decision-maker" Personal health information would need to be reviewed in order to assess/determine the implications of refusing or withdrawing consent. This would involve going into a patient's health chart in a hospital setting and reviewing the client; how can that be accomplished if

	the client refuses disclosure of personal health information?
12.	Provide a statement that ensures that "RDs recognize that clients/POA may refuse consent to some treatments and consent to other treatments. RDs to continue discussion with client and find a suitable treatment meeting their needs"

Please indicate what is missing, not needed or needs rephrasing from Standard 8 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	too complex.... no means no, good enough, move on....
2.	Thia standard is essential for protection of both the client and the RD.
3.	More info about implied consent. This would not be documented?
4.	In Standard 1 ii) the RD uses judgment to determine when consent can be implied, verbal or written. Standard 8 refers to verbal and written consent, but not implied consent. Need to clarify this -- is implied consent considered verbal consent?
5.	If the client is a referral from a specialist & the client has been called and asked if they are interested in setting up an apmt to see the RD it seem redundant to need to write it in the chart that the client has given consent to be assessed by the RD etc.
6.	Perhaps attendance at outpatient appointments might be considered consent.
7.	In an inpatient setting, where time is of an essence - documenting a, b, and especially c in a chart note does not make sense. RDs always get consent when doing assessments, BUT recording in the chart that it was obtained and formatted as either a, b or c - in an inpatient setting?!?! In an inpatient setting, do patients provide consent to be provided with a diet order as per MD admission/meal tray? If so, who has to document that? Case to case basis, if its for a feeding tube insertion - obviously, that consent has to be clearly documented, however, for a routine nutrition assessment i.e. in a nursing home, where the patients/SDMs have signed the general consent/admittance form does the consent have to be documented? If yes, does that include all the other routine/quarterly assessments that have to be done on the same patient by the same RD eventhough there are no changes in health status? That means for a patient in LTC, there should be at least be 4 documented consents on the RD notes/yr?

	On the other hand, if it's a refusal or withdrawal of consent - that is something that should always clearly be recorded in the chart!
8.	RDs document verbal and written consent for assessment/treatment.....As previously stated, there are lots of things that an RD does in critial care that should not fall into this big pot....I assess lab work, ins and outs, meds, system status etc etc on a daily basis and adjust PN or EN based on this...this is an assessemnt and and treatment change as defined by the standard...we cannot be getting and documenting consent for all of this on a daily basis...we need to redefine assessemt/ treatment Perhaps RD 'assessment' that requires consent is one where the patient is physically involved in the assessment, or soemhow excludes the daily reassessement of an ongoing care plan ? Perhaps 'treatment' needs to be better defined as well...I know the HCCA defines treatment as....Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan...but can we all be clear that adding changing a feed from a polymenric 1.0 feed to a renal feed on a sedated ICU pt should not inviolve a call to the SDM for consent??? And how can you assure me as an RD that this is the case given the standard as it is written? thank you!
9.	Because verbal or written consent cannot be obtained prior to instituting a nutrition assessment or treatment for infants in a NICU setting, documention would not be possible.
10.	Within a hospital setting, written consent is not required by other health care practitioners except for medical interventions/surgeries. Why would this be required specifically for RD's? This is a huge workload on RD's and unnecessary. This would take time away from providing appropriate nutrition care and due to time constraints, could lead to errors as sufficient time would not be available to perform required tasks.
11.	I do not feel this gives me the information I need working in an acute care setting.
12.	-standard as currently written is unrealistically onerous
13.	Take out the need for a consent form. This is never done, and would never be implemented. When documenting verbal and written consent (or refusal/withdrawal), RDs include: a) A note in the client health record - THIS IS ENOUGH b) A consent form (as applicable), that is dated, signed, and witnessed; and/or - REMOVE THIS - IT IS NOT REALISTIC OR NECESSARY c) A consent policy/procedure or a guideline (as applicable) that is referenced in the client's health record. NOT SURE WHAT YOU WANT HERE - THIS IS NOT THE CASE CURRENTLY IN PATIENTS' CHARTS

14.	do not feel it necessary to include a consent form for patients who are being seen in clinic. Also unnecessary for inpatients as verbal consent with patient/family/caregiver is sufficient. This is a HUGE increase in workload
15.	Should all our assessments document consent if implied?
16.	Must implied consent also be documented? Why only verbal and written? Please clarify.
17.	a) A note in the computerized documentation for refusal /withdrawal is understood, but for consent I don't think I've seen b) Can't say I've ever seen a consent form in my nutrition practice c) Don't know of any such reference in a patient's chart
18.	Agree with the standard WHEN consent is obtained as applicable.
19.	As previously stated, there are lots of things that an RD does in critical care that should not fall into this big pot....I assess lab work, ins and outs, meds, system status etc etc on a daily basis and adjust PN or EN based on this...this is an assessment and treatment change as defined by the standard...we cannot be getting and documenting consent for all of this on a daily basis...we need to redefine assessment/ treatment Perhaps RD 'assessment' that requires consent is one where the patient is physically involved in the assessment, or somehow excludes the daily reassessment of an ongoing care plan? Perhaps 'treatment' needs to be better defined as well...I know the HCCA defines treatment as....Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan...but can we all be clear that adding changing a feed from a polymeric 1.0 feed to a renal feed on a sedated ICU pt should not involve a call to the SDM for consent??? And how can you assure me as an RD that this is the case given the standard as it is written? thank you!
20.	Please detail when a the college would require a written consent form would be required-which situations
21.	Is there implied consent in a hospital setting if a referral is received that the patient's chart can be reviewed?
22.	Indicate if all three are necessary steps when documenting (rephrasing) For example: "When documenting verbal and written consent (or refusal/withdrawal), RDs must include one or more of the following:"
23.	what is missing is an something that reminds clinicians that consent needs to be verified regularly as well as at times that represent significant changes to clients status. For example a Rd working in a dialysis unit often follows clients for several year. The care is very structured e.g. blood work every 6 weeks. The orders for dialysis are routine and are updated at least yearly or at times of change. it has been my experience that dietitians often

	discuss consent at initial visits but do not visit this concept routinely but assume consent because the client reports to dialysis regularly. I believe this is missing from the document overall, the concept of confirmed consent, that consent changes and thus a dietitian must ensure they have consent, not assume.

Please indicate what is missing, not needed or needs rephrasing from Standard 9 and/or the associated performance indicators as outlined in the Draft Standards of Consent. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	really.... how many times would this be necessary??? in such a situation, surely the MD's order will suffice.... it's a dietary treatment, not a potentially fatal treatment. If it really was potentially fatal, it shouldn't be provided without proper assessment.
2.	It might be helpful to have a few emergency cases outlined in Resume, as this will likely be a contentious area.
3.	Could be religious/cultural or ethical reasons why consent would be denied in case of emergency. eg Jehovah Witnesses and blood transfusions.
4.	An example o what would constitute an emergency would be helpful
5.	ii c. There is no reason to believe that the person does not want the treatment. I suggest that this performance indicator be worded a bit differently (rephrased). As the standard is to provide treatment with no consent in case of an emergency, point c. does not emphasize this particularly. It can be misconstrued to allow an RD to provide rx if she/he simply does not believe the person is against it.
6.	Is this within an inter professional context ie by physician order
7.	While there is a definition of an 'emergency', perhaps several short examples would be helpful to further clarify when action is required.
8.	What indicates an emergency ?
9.	Where RDs provide treatment in an emergency, they (or another member of the health care team) need to identify a substitute decision-maker at the earliest available opportunity, as warranted. I keep reading this statement.. thinking it should include the term and will document the SDM in the patients chart...
10.	I will assume all preterm births or infants admitted to a NICU are emergent so I would agree that treatment would be provided without consent in all cases.

11.	"Risk" and "suffering" need to be defined better. I could argue that my patient is at "risk" of me not being able to recommend a change in their nutritional plan as they are small, at risk for dehydration or fluid overload, my interventions prevent other more serious complications/procedures such as inserting an IV or feeding tube or aspiration. This is very subjective.
12.	I think it would be useful to identify the types of emergencies a dietitian could face. What would be considered an emergency that a dietitian would need to address in a hospital (where there are other health professionals)?
13.	Agreed, but may require definition of what constitutes an emergency situation.
14.	Can the college provides some scenario for use to refer to?
15.	i. Can you give me an example of a nutrition emergency? ii. This would appear to apply to most ICU admissions. However the RD does not deliver the nutrition. iii. This is fundamental ICU practice with social worker assisting.
16.	i feel we need to define what is a emergency. provide examples.
17.	Can't think of when this would apply.
18.	It might be helpful to include some clinical and community examples of when an RD has had to provide emergency service without consent.

Please indicate what is missing, not needed or needs rephrasing from the Conclusion section. (If you do not have any comments for this particular section, please leave blank). |

#	Response
1.	it needs to be more realistic to Dietitian practice.... we are different than nurses, other health care professionals.... this could all be simpler
2.	The yes/no button is malfunctioning. I do agree with the conclusion section of the document.
3.	For the major part of the Standards, I agree with the content. Most of it adequately represents the Standard, with the exception of section 4, which needs to better reflect the HCCA. I wondered however if a series of scenarios could better help dietitians understands what' comprised in the HCCA Act than the Standards (unless health professional colleges have to develop such standards). I believe that the standard should have made links with the "circle of care". In many service providing settings, dietitians are working in the client's circle of care, and there is no

	mention or relation made in the Standards text.
4.	Implied consent and "Circle of Care" are often terms used in the clinical/hospital setting, I feel these terms should be included somewhere in the document.
5.	I'm disappointed that this document is generalized to a population of patients where consent is possible. It has not been written for those patients in ICU, NICU settings where consent prior to assessment or treatment would delay timely intervention. This delay could impact long term outcomes including developmental outcomes especially in small, critically ill or premature infants. Consent seems very appropriate prior to assessment for those dietitians working in settings where the patient and/or the SDM is available. Although I know this is a draft, I feel there is a lot of work still to be done to adress the pediatric population especially the NICU population and to look at what negative outomes might be the result of such a Standard. If this is to protect the public, it can possibly do the opposite for the vulnerable pediatric population.
6.	This is not RD focussed. While I appreciate that you are asking for feedback, it has been developed without input to the many realms dietitians practice in and the other adversities they are facing. It is also not in keeping with how other professions practice.
7.	Is it really necessary to have the following: RDs are required to practice within their own level of competence and meet the Standards that are relevant to their practice environment and practice functions. Where RDs are falling below the College's expectations, Standards of Professional Practice will be used as a basis for assessments or investigations and may guide the development of remediation plans. Somewhat condecending no?
8.	It will be risking patient care i.e. in the NICU setting, would that be the emergency situation? I need more "spell out" scenarios.
9.	This whole process is way too time consuming. I understand the intent but the laws go too far and hamper timely nutrition care in our cash strapped over burdened health care system
10.	"RDs are required to practice within their own level of competence and meet the Standards that are relevant to their practice environment and practice functions". This sums up what I think are the expectations of an ICU RD. In my practice I do not obtain the consent to assess and treat. The physician does.
11.	more detail.

12.	Needs more clarification. It's vague with re to "relevant to their practice and practice functions".
13.	Indicate that the RD must continually seek advancement in learning of the topic of informed consent process, through Quality Assurance measures, etc.

If yes, please specify: |

#	Response
1.	if the document was simpler, it could stand alone without wasting more time on developing and asking people to read supporting educational materials..... this is about consent.... important but really??? in the scheme of time spent, we NEED to be more efficient about these things.... everyone in the health care system needs to find ways to be efficient, yet responsible... and less afraid. If we act like we expect to be sued, then maybe that's what we are inviting?
2.	Could clear examples of obtaining consent be included, for different practice settings?
3.	Include specific examples in the educational material to the members of what constitutes an emergency (i.e. not requiring informed consent) as it applies to dietetics practice.
4.	Give examples of "consent" in different situations.
5.	As it is a contentious issue, a few case studies of emergency situations in Resume would be helpful.
6.	Provide specific examples or case studies to provide more guidance on implementing the standards in practice.
7.	More definition on gray areas. such as capacity
8.	Good examples of audio-visual material in order to obtain informed consent that are culturally clear as well as intellectually appropriate for the clients' needs.
9.	Example of the Standards of Consent
10.	It would be very to provide case stories or examples of the various concepts of the Standards, and these should be in both traditional work settings as possible (clinical settings, long term care, public health, community health care settings, food industry, etc.).
11.	Specific examples of when consent is implied,
12.	- provide detailed information on how to institute a "locked box" when client files are shared by many providers and RDs do not have separate storage for files - information should cover both paper files and electronic files
13.	more published questions and answers to help us all, maybe divided into work sections - admin, clinical, long term care, hospital, public health, homecare, etc.

14.	Yes, please do a workshop or on line inservice to explain
15.	I feel that it would be important to have education material available to provide to other health professionals in order for them to understand the importance of obtaining consent for nutritional assessment and/or intervention.
16.	Clarify the relationship between these standards and organizational consent policies with respect to conducting research.
17.	The college needs to be providing RD's with supporting educational materials to use in their practice that reflects these standards of consent. For example, a sample or outlined consent form would deb helpful. A case example of how one would "assume" informed consent versus it be given verbally or in writing etc. Examples for how an Rd can exercise Standard #6: RDs apply an age and culturally-appropriate process for obtaining informed consent for nutrition assessment/treatment and for the collection, use and disclosure of personal health information; would be helpful. Everyone practices differently and in different environments but that does not mean that they will never interact with people of different cultures or change their practice environment so it is nice and important to be well rounded when it comes to this.
18.	1. Provide information on clients right to do nothing, even when consequences of this action are explained. 2. Information re use of language interpreters and what to do if such persons are not available
19.	Sample consent forms would be helpful for use in small or private practice settings. Templates that are customizable to the specific context but that meet the standards of language. For those not covered by a broader consent document such as in a hospital this would be very helpful.
20.	Applied case examples. Our internships may not have provided the opportunity to witness and be involved in a case where a consent issue was discussed and addressed.
21.	Could we have a template form that could be adapted to use?
22.	A few sample consent letters
23.	a list of the types of treaments or or assessments that would or would not require consent
24.	Case studies would be the best learning tools, and having a focus group including members from each area of practice including regulated places would be a good tool to develop case studies, and using them is "Resume" newsletter.
25.	- case studies are very helpful - tips and "did you know" and "how to apply" - I often think of the "crossing boundaries seminar" I attended (so well done) and it still comes up in RD conversations when discussion situations. Something similar re: Standards

	of Consents may be valuable
26.	A "Quick reference Sheet" that can be printed or downloaded or a Q and A with examples/case scenarios
27.	RDs would benefit from case-based scenarios demonstrating the application of the standards
28.	I am hoping that the standard will be amended and that education will be clear and concise as it relates to all populations and not just adult patients as it appears to represent currently.
29.	Case studies
30.	Examples in acute care. Case study examples.
31.	-suggested wording/phrasing for documenting compliance with Standards of Consent in online charting -examples of implied consent
32.	Be specific regarding implied consent. Do not create standards that are impossible to implement in common clinical settings.
33.	This document is long and confusing. There should be a concise flow sheet or diagram explaining how there are different kinds of consent and how they vary and what kind would be required in each situation. I.e. outpatient clinic where patient is coming to see RD for a nutritional assessment - do we need a consent form for formal written consent or is this implied consent because the patient is coming knowing that their diet will be assessed??
34.	Examples of consent that is obtained by another team member- I would be hesitant to rely on this.
35.	POWER POINT PRESENTATIONS.
36.	In a nursing home situation, where POA refuses treatment for e.g; refuses a client to be on a thickened fluid, even though thin fluids puts clients at risk for aspiration. How does an RD deal with such situation.
37.	provide good examples of implied consent. Include an algorithm to guide the process.
38.	Examples of when written (signed) consent may be obtained, vs verbal, vs implied would be helpful.
39.	If it is inevitable, webinar and more scenario based discussion may be helpful
40.	case studies and examples.
41.	please have more key players participate in the decision making, test the education tools with clients , people of the community to assure the understand and clarity
42.	Using summaries and case scenarios. Analyzing "legal speak" documents becomes cumbersome and doesn't have an applied side to it. Need to keep it simple, brief and relevant. Need also to use RD examples outside of clinical (hospital) care.

43.	example mini-cases or scenarios to illustrate application of the standards
44.	Examples of challenging situations that relate to dietitians in various work environments would be helpful.
45.	More information on implied consent with specific practice scenerios or examples. More information on obtaining an alternate SDM and the process.
46.	case studies to review consent in relation to each of the objectives.

#	Response
1.	This is very timely. I often feel that I am asked by NPs/MDs to teach diets and when the patient refuses or does not give consent that they are upset that I didn't "teach it anyway" This is a great resource
2.	the yes/no button is malfunctioning. I do not have anything to add.
3.	Consent should always be obtained. What I believe needs to be rephrased would be under the "documentation of consent" section as it should provide allowances for the different areas of practice.
4.	Please include specifics to a pediatric population where timely nutrition intervention is often necessary prior to receiving any consent. As well, the logistics of documenting each time an assessment is done and/or if a treatment plan changes is next to impossible when writing PN/EN orders for 20-30 patients daily. The risk to the public of not getting appropriate nutrition care or treatment increases as the Standards are currently written.
5.	Thank you for the opportunity to provide input. I thought that this draft was well detailed on this topic.
6.	It is not always possible to obtain written consent for enteral or parenteral nutrition. Would verbal consent be appropriate?
7.	Try to make things more efficient and less complicated so we can get on with caring for our patients. That's why I'm in this business and what I love to do.
8.	I might be speaking out of line but it feels like the expectations for obtaining consent for an RD assessment or treatment is not realistic. The RD is ordered to do the assessment and she would of course introduce herself to the client explain the reason for her visit and if the client continues to engage and be compliant than that would imply consent. I am unaware of any nutrition intervention requiring a written consent form. I think the scenarios for consent should be clearly delineated between outpatient and in-

	patient clinical settings.
9.	Page 7 of this document there is a repeat of words. ii. c) "The consent the consent and capacity board"
10.	Thank you for all this work on our behalf.
11.	In my situation, clients/patients are assessed on an almost daily basis and changes made. Presently, this is done without consultation with the patient who is unresponsive. Occasionally, SDM is consulted but this is not the norm. To involve them every time I reassess seems illogical and unnecessary. Any suggestions for those RD's working in an area such as this?
12.	Please consider providing more information in this scenerio: Do you need to obtain consent with every change although the nature of the intervention remains the same? For example: If consent was obtained for assessment and treatment to start EN. It was explained in detail the expectations that rate changes would be made with the eventual goal towards bolus feeds. Do we need to contact the POA/SDM with each rate change?