Regional Seminar: London

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REGIONAL SEMINAR OUTLINE

1. Welcome and Introduction

2. Self-Regulation: The importance to the public and members

3. The College: How it works

4. Updates from CASLPO

5. Practice Issues

6. Questions
ROLE OF CASLPO
ROLE OF REGULATORY COLLEGES

• To regulate healthcare practitioners in the public interest

• To administer the *Regulated Health Professions Act, 1991* (RHPA)

  The RHPA and Procedural Code provide a framework for regulating the scope of practice of 26 health professions in Ontario, under their respective regulatory Colleges

• Colleges are governed by a Council of elected professional members and government appointed public members
OVERVIEW OF CASLPO

CASLPO develops:

• Regulations: Registration, Professional Misconduct, Quality Assurance, Records and Advertising

• By-laws including the Code of Ethics

• Practice Standards & Guidelines

• Position Statements

• Learning Resources
OVERVIEW OF CASLPO

CASLPO Services:

• Registration, Incorporation and Mentoring advice

• Professional Practice Advice:
  • SLP, AUD, English and French

• Education, Communication
  • Website
  • ‘Did you Know. . .’ e-mail bulletins
  • CASLPO Today
  • Learning resources
OVERVIEW OF CASLPO

College Council: Essence of Self-Regulation

• 18 members:
  9 elected professionals, 6 SLP & 3 AUD representing 5 regions of Ontario and Ontario at Large
    • 2 academics, 1 AUD and 1 SLP
    • 7 public members

• 3-year terms

• 10 committees; some SLP and AUD non-Council members

• Quarterly open meetings
Our Vision:

CASLPO will be an outstanding leader among the regulators of health care professionals.

Our Mission:

The College is committed to ensuring that the people of Ontario receive respectful, effective, high quality audiology and speech-language pathology services provided by competent self-regulated practitioners.

Our Mandate:

The purpose of the College is to regulate the professions of Audiology and Speech-Language Pathology. The College serves and protects the public interest, and governs its members in accordance with the Regulated Health Professions Act, 1991 (RHPA), the Audiology and Speech-Language Pathology Act, 1991 (ASLPA), and the regulations, policies and by-laws of the College.
Regulating and setting standards for professional excellence in audiology and speech-language pathology services.

Do you or does someone you love have a hearing or a speech language problem? Regulated professionals providing care abide by a code of ethics and high standards of practice. To provide public protection for you and your family, the College establishes and enforces professional standards for:

- **Regulation:** Sets rigorous educational requirements and works with universities to ensure programs cover the core competencies.
- **Professional Practice:** Develops and enforces standards of practice to which all audiologists and speech-language pathologists adhere.
- **Quality Assurance:** Requires audiologists and speech-language pathologists to upgrade their knowledge and skills on a regular basis.
- **Complaints:** Responds to complaints from the public concerning care delivered.

**Be an informed patient**

Assist those you care for by learning more about communication disorders. Find out how CASLPO protects the public by visiting our website including a public register of all members.

Visit [www.caslpo.com](http://www.caslpo.com) or call 1-800-993-9459

Nancy Blake, President
Brian O’Riordan, Registrar

**Regional Seminar: London**
IMPORTANCE OF SELF-REGULATION

• Ensures quality practice

• Develops regulations and standards of practice

• Determines who may or may not practice in Ontario (through registration)

• Investigates complaints and reports and addresses cases of professional misconduct

• Protects title: Speech language pathologist, Speech therapist, Audiologist
IMPORTANCE OF SELF-REGULATION

• You can stand for Council

• You elect fellow professionals to Council

• You participate in developing regulations and standards of practice

• You can provide feedback regarding College functions and policies

• You may contribute to the work of the College as a mentor, peer assessor, focus group member, investigator, peer opinion provider, committee member etc.
IMPORTANCE OF **SELF-REGULATION**

**Principle based:**

- You are the knowledgeable professional in your area of practice
- Advice we give regarding legislation, regulations and standards of practice is intended to support your professional judgement
MADAM & EVE

THANDI! WHERE'S YOUR HOMEWORK?
I DIDN'T DO IT.

BUT DON'T WORRY. I'LL GIVE MYSELF DETENTION LATER WHEN I GET HOME.

OBVIOUSLY SOME PEOPLE HAVE NO FAITH IN SELF-REGULATION!
What is the difference between a regulatory college and a professional association?
<table>
<thead>
<tr>
<th>Regulator</th>
<th>Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Acts in the interest of the public</td>
<td>Acts in the interest of the profession</td>
</tr>
<tr>
<td>2 Governed by a Council of professional members and government appointed public members</td>
<td>Governed by a Board of Directors consisting of professionals</td>
</tr>
<tr>
<td>3 Membership is mandatory in order to use protected titles. Registers members based on legislated criteria.</td>
<td>Membership is voluntary. Accepts members based on association-determined criteria.</td>
</tr>
<tr>
<td></td>
<td>Regulator</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4</td>
<td>Requires members to participate in legislated quality assurance programs</td>
</tr>
<tr>
<td>5</td>
<td>Ensures minimum standards of practice are met for safe and competent service to the public</td>
</tr>
<tr>
<td>6</td>
<td>Engages the public to inform them of the value of regulated professionals</td>
</tr>
</tbody>
</table>
### Regulator

| 7 | Required to have a complaints process to respond to members who do not practice to the set standards |

### Association

| 7 | The provincial association is not required to have a complaints process |

| 8 | Advocates for the public to ensure safe, effective and equitable service across the province. |

<p>| 8 | Advocates for the profession in order to effect changes to service delivery, and to increase public awareness of professional services. |</p>
<table>
<thead>
<tr>
<th>Regulator</th>
<th>Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Provides accessible information to the public regarding the professions, the registry of members, expected practice standards and the complaints process</td>
</tr>
<tr>
<td>10</td>
<td>Accountable to the public, the government and its members</td>
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Updates from CASLPO
# CASLPO Updates

## Applications Received in 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Ontario</th>
<th>Other Canadian Provinces</th>
<th>USA</th>
<th>Other International</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>101</td>
<td>33</td>
<td>36</td>
<td>15</td>
<td>0</td>
<td>185</td>
</tr>
</tbody>
</table>

## Applicants who became FULLY registered members in 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Ontario</th>
<th>Other Canadian Provinces</th>
<th>USA</th>
<th>Other International</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>89</td>
<td>40</td>
<td>36</td>
<td>17</td>
<td>0</td>
<td>182</td>
</tr>
</tbody>
</table>
### CASLPO Membership: May 2014

<table>
<thead>
<tr>
<th>Reg Class</th>
<th>Status</th>
<th>Total Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUD</td>
<td>General</td>
<td>628</td>
</tr>
<tr>
<td>AUD</td>
<td>Academic</td>
<td>5</td>
</tr>
<tr>
<td>AUD</td>
<td>Initial</td>
<td>14</td>
</tr>
<tr>
<td>AUD</td>
<td>Non-Practising</td>
<td>16</td>
</tr>
<tr>
<td>SLP</td>
<td>General</td>
<td>2,767</td>
</tr>
<tr>
<td>SLP</td>
<td>Academic</td>
<td>15</td>
</tr>
<tr>
<td>SLP</td>
<td>Initial</td>
<td>96</td>
</tr>
<tr>
<td>SLP</td>
<td>Non-Practising</td>
<td>154</td>
</tr>
</tbody>
</table>

**Total membership 3,775**
CASLPO UPDATES

Processes:

• Revised Self-Assessment Tool submission, 2014
• Online tax receipts and registration card
• Improved online registration renewal
• Members Portal
• Initial Practice Program
CASLPO UPDATES

Documents:

• Practice Standard and Guideline (PSG) on Developmental Stuttering

• Guide for Online Self-Assessment Tool

• Sexual Abuse Prevention Program

• Position Statements:
  • The Use of Support Personnel by Audiologists
  • Professional Relations and Boundaries
  • Consent for Screening and Assessment
PSG for Developmental Stuttering

• Revised and published spring 2014
• Standards not guidelines
• Highlights include:
  • Easier to read format
  • Standards to address risk of not observing dysfluency
  • Standards regarding knowledge of anxiety and impact
  • Standards regarding transfer
Revision Of The Definition Of Screening

- Ministry has changed the wording in the Record’s Regulation

- Clarity needed to distinguish between ‘screening’ and ‘not screening’ situations

- In the past we used the term “Determination of need”

- Revision includes elaboration

- Clarifies when consent to treatment (*Health Care Consent Act, 1996*) is required
Screening is a process where a member applies certain measures that are designed to identify patients who may have a hearing, balance, communication, swallowing or similar disorder[s], for the sole purpose of determining the patient’s need for a speech-language pathology assessment, an audiological assessment, or both. This does not include:
Revision Of The Definition Of Screening

This does not include:

• Inadvertently noticing possible hearing, balance, communication, swallowing or similar disorder[s], or

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

Processes under review:
• Non-clinical Self Assessment Tool (SAT)
• Peer Assessment process

Projects:
• Intercollaboration between Rehab Colleges regarding combined records
• Interprovincial Telepractice
• Mentor training Module
• Integrating Self Assessment Tool into Mentor evaluation
Initial Practice Program

• Minor revisions:
  • No longer specific **amount** of direct observation time (previously 16 hours)
    • Still observation must be direct
  
  • No longer permit those that have done a CFY (ASHA) to reduce their IPP by 50%

• Will pilot use of the online SAT for the IPP
CASLPO UPDATES

Documents under review:

• Professional Misconduct Regulation
• Proposed Advertising Regulation
• PPG/PSG for Cognitive Communication Disorders
• PSGs for the Prescription of Hearing Aids (children & adults)
• Position Statements:
  • Concurrent Intervention
  • Supervision of Support Personnel by SLPs
  • Service Delivery to Culturally and Linguistically Diverse Populations
Redesigning CASLPO’s website

- Make it more ‘user friendly’ for applicants, members and the public
- Improve organization and navigation
- Increase the search function
- Easier to use with mobile devices
CASLPO UPDATES

Education & Communication

E-Learning Modules:
- Pause Before you Post: The Use of Social Media
- *Regulated Health Professions Act, 1991*

E-Learning Modules in development:
- Consent and Capacity
- Record Keeping
• Record Keeping
CAREER ADVICE No 55

Always choose the right tool for the job

A simple blowtorch can solve many of your filing problems

horacek
To understand and apply the regulation, examine the basics:

What is a Record and what is its purpose?
Records

- Official record of events documenting your assessments, plans of care, interventions and clinical decisions and the patient’s/client’s progress

i.e. who did what, why, where, when and to whom
RECORDS

**Purpose** is to protect the public by ensuring minimum standards and supporting safe and ethical practice across all service settings

**CASLPO**
- Accessible
- Complete
- Correct
- Retained

**Member**
- Vehicle of reliable communication
- Clinical judgement
- Demonstrate accountability
- Risk management
RECORDS

• As a member you must adhere to record keeping (electronic or paper) and record retention requirements.

  Proposed Records Regulation 2011

• Not all record systems fulfill these requirements (OSR), a separate records system may be necessary. This is still a health record, and all legislation, regulations and standards of practice apply.
Record Keeping Scenario

At my place of work we are moving to an electronic record system.

I am on the planning committee with other healthcare professionals.

My colleague says that everything from a patient/client chart, including test response forms, has to be kept.

The health records representative says that the goal is not to have any paper charts after the “go live” date.

What should I do?
Record Keeping Scenario

What should I do?

1. Your colleague is correct, everything, including test response forms, has to be kept.

2. You can shred test response forms and informal assessment materials/documentation if you have documented the results in the patient/client chart.

3. You only have to document that you saw the patient/client and make sure that it is dated.
Record Keeping Scenario

What should I do?

Answer:

2. You can shred test response forms and informal assessment materials/documentation if you have documented the results in the patient/client chart.
Record Keeping Scenario

• If information from raw data/test forms has been documented, raw data and test forms do not have to be kept.

Proposed Records Regulation
6 (e) the nature and results of each assessment relating to the patient/client, each clinical finding and any recommendations made by the member

• HOWEVER, you may keep raw data/test forms if, in your professional opinion, it is in the patient’s/client’s best interest, or for risk management.
Record Keeping Scenario 2

- Donna, the SLP, works on a Complex Continuing Care Unit where she has set up a weekly communication group.

- Jodie, the CDA working with Donna, makes a note of the communication group activities for the session and shares them with the volunteers.

- When patients/clients arrive for the communication group, Ira, one of the volunteers, goes around the room to see who is there and takes attendance.

- After the group session, Jodie meets with the volunteers to discuss the progress of members in the group.
Record Keeping Scenario 2

Who can chart?

1. Donna (SLP), Jodie (CDA) and Ira (volunteer) can all document attendance and progress in the patient/client record.

2. Only Donna can chart, as she is the regulated health professional.

3. Donna and Jodi can chart, but Ira is not allowed to chart as he is a volunteer.
Record Keeping Scenario 2

Who can chart?

Answer:

1. Donna (SLP), Jodie (CDA) and Ira (volunteer) can all document attendance and progress in the patient/client record.
Record Keeping Scenario 2

• Both Jodie and Ira are considered support personnel even though one is paid and one is a volunteer. Donna directly supervises both Jodie and Ira.

• Donna may assign the task of charting to support personnel if they have the knowledge, skills and judgement to document.

• Regardless of who makes the chart entry, Donna is responsible for the record. This can be done by reviewing the entries at regular intervals. Co-signing chart entries is one way to demonstrate review and supervision.
Consent
CONSENT

Two Types of Consent:
Both must be obtained when the member is providing services to an individual.

1. Consent to collect, use and disclose personal health information

and

2. Consent to services: screen, assessment and management (including treatment)
CONSENT

The Personal Health Information Protection Act, 2004 (PHIPA) requires members to obtain the patient/client’s knowledgeable consent for the collection, use, and/or disclosure of any personal health information (PHI).
CONSENT

What is PHI?

- Physical or mental health of the individual
- Health history of the individual’s family
- Identification of a person as a provider of health care to the individual
- A plan of service for the individual
- Payments or eligibility for healthcare funding
- Individual’s health number
- Identification of a substitute decision maker (SDM)
CONSENT

Circle of Care

HICs may share information with other HICs involved in the care of the same patient/client without explicit consent, i.e. with **assumed implied consent** for health care purposes.
Circle Of Care

You may assume implied consent if all six conditions are satisfied:

1. You fall within one of the categories of HIC who may rely on assumed implied consent
2. The PHI is from the patient/client, SDM or other HIC
3. The PHI was originally collected for the purpose of providing health care
4. The PHI is being shared for the purpose of providing health care
5. Disclosure is from one HIC to another HIC
6. The HIC receiving information must not be aware of the patient/client withholding or withdrawing consent
CONSENT

Sharing Information

• HICs cannot share information outside the circle of care without express consent.

• If in doubt... obtain and document consent.
Consent Scenario:

• Mrs. Singh is a J.K teacher at Belle St. Public School. She is concerned about Lee’s speech and believes that he is on a waiting list at the local Preschool Speech and Language Centre.

• Mrs. Singh contacts the Centre and asks Donna, the SLP, whether Lee has been ‘picked up’ or if he is still on the waiting list.

• Lee is on the waiting list, but Donna has not spoken to Lee’s parents about this request and is unsure what information she is allowed to give Mrs. Singh.
Consent Scenario:

What information can Donna disclose?

A. Donna is allowed to say if Lee is on the list, and when he will be assessed, but nothing more.

B. Donna can share all of Lee’s information under the ‘Circle of Care’ provision in PHIPA

C. Donna is not allowed to give any information to Mrs. Singh.
Consent Scenario:

What information can Donna disclose?

Answer:

C. Donna is not allowed to give any information to Mrs. Singh.
Consent Scenario:

- PHIPA protects us, the public.
- Lee’s association with the Preschool Speech and Language Centre is personal health information and therefore cannot be shared without knowledgeable consent from the patient/client/SDM.
- Donna should be careful that her response does not inadvertently reveal PHI. She could offer to look at the list and consult the family if Lee is on the list. Advise Mrs. Singh to contact the family.
- There may be reasons why the SDM/parents do not want this information shared with the school.
I’m afraid doctor-patient confidentiality prevents me from saying if your brother cried like a baby during his flu shot.
CONSENT

Consent to Services

The *Health Care Consent Act 1996* directs members to obtain valid and informed consent for treatment.

In 2007, CASLPO determined that members must obtain consent for screening and assessment.
CONSENT

Valid consent

Consent is voluntary, and not obtained through misrepresentation or fraud, relates to the services being proposed, and is informed.

Heath Care Consent Act, 1996
Informed Consent

- The nature of the services
- The expected benefits of the services
- The material risks of the services.
- The material side effects of the services
- Alternative courses of action
- The likely consequences of not having the services
INFORMED CONSENT!
CONSENT

Capacity to Consent

The patient/client/SDM must have the capacity to consent to services, that is:

• The ability to understand relevant information

• The ability to appreciate the reasonably foreseeable consequences of a decision or lack of decision
HCCA Consent Scenario:

• Donna, the SLP from Metropolitan General Hospital, is covering ICU for her colleague who is on vacation.

• Donna has been asked to do a swallowing assessment with a patient on the unit who has been admitted with a severe head injury and no known relatives or SDM.

• Donna meets the patient and quickly establishes that he does not have the capacity to consent to her assessment.

• She returns to the charge nurse and reports that she cannot carry out a swallow assessment without consent from a SDM.

• The charge nurse is very frustrated with Donna as oral medications are being held until the results of the swallow assessment.
HCCA Consent Scenario:

Can Donna assess?

A. It is in the best interests of the patient/client to have a swallowing assessment so that medication can be given - Donna should proceed.

B. Donna has not received consent from the patient/client or the SDM, and the patient can receive medication via I.V. - she should not proceed.

C. This is an emergency - Donna can proceed.
HCCA Consent Scenario:

Can Donna assess?

Answer:

B. Donna has not received consent from the patient/client or the SDM, and the patient can receive medication via I.V. – she should not proceed.

C. This is an emergency - Donna can proceed.
HCCA Consent Scenario:

Consider:

• Is this an emergency?

• Is the patient/client at risk?
Consent is Not Required for Emergency Services

“There is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.” *(Health Care Consent Act 1996, c. 2, Sched. A, s. 25 (1).)*
HCCA Consent Scenario:

• If Donna, after consultation with the charge nurse, decides that the patient is at risk if the swallowing assessment does not proceed, she MUST document that the swallowing assessment took place without consent.

• If Donna does not believe that the patient to be at risk, she should work with the team to identify a SDM.

• The team can contact the Office of the Public Guardian and Trustee (OPGT) for advice.

• The OPGT has a Treatment Decision Unit.
HCCA Consent Scenario: 2

• I am an audiologist who works for an ENT.

• The ENT has agreed to obtain consent on my behalf for all services.

• Does this fulfill my obligations towards obtaining consent for treatment?
HCCA Consent Scenario: 2

Is this consent system ok?

A. Yes, the ENT can get consent from the patient/client for audiology services as well as ENT services.

B. No, the audiologist must personally obtain consent.

C. Neither 1) or 2) because implied consent has been given by the patient/client because they attended the appointment.
HCCA Consent Scenario: 2

Is this consent system ok?

Answer:
A. Yes, the ENT can get consent from the patient/client for audiology services as well as ENT services.
HCCA Consent Scenario: 2

• Other individuals, for example, the ENT may obtain consent for audiology services with the audiologist

Consider:

• Can the audiologist be sure that “informed” consent has been obtained?
HCCA Consent Scenario: 2

• The Audiologist must ensure appropriate and fulsome information is provided by the ENT to the patient/client in the consent process

• The Audiologist remains responsible for consent being obtained
Questions?
Thank you!