

- If you are viewing this course as a recorded course after the live webinar, you can use the scroll bar at the bottom of the player window to pause and navigate the course.
- This handout is for reference only. Non-essential images have been removed for your convenience. Any links included in the handout are current at the time of the live webinar, but are subject to change and may not be current at a later date.

No part of the materials available through the continued.com site may be copied, photocopied, reproduced, translated or reduced to any electronic medium or machine-readable form, in whole or in part, without prior written consent of continued.com, LLC. Any other reproduction in any form without such written permission is prohibited. All materials contained on this site are protected by United States copyright law and may not be reproduced, distributed, transmitted, displayed, published or broadcast without the prior written permission of continued.com, LLC. Users must not access or use for any commercial purposes any part of the site or any services or materials available through the site.

## Technical issues with the Recording?

- Clear browser cache using [these instructions](#)
- Switch to another browser
- Use a hardwired Internet connection
- Restart your computer/device

## Still having issues?

- Call 800-242-5183 (M-F, 8 AM-8 PM ET)
- Email [customerservice@SpeechPathology.com](mailto:customerservice@SpeechPathology.com)



## Ethical and Legal Issues in Dysphagia Management, Part 1

Denise Dougherty, MA, SLP

Moderated by:  
Amy Natho, MS, CCC-SLP, CEU Administrator, [SpeechPathology.com](http://SpeechPathology.com)



### Need assistance or technical support?

- Call 800-242-5183
- Email [customerservice@SpeechPathology.com](mailto:customerservice@SpeechPathology.com)
- Use the Q&A pod





## How to earn CEUs

- Must be logged in for full time requirement
- Log in to your account and go to Pending Courses
- Must pass 10-question multiple-choice exam with a score of **80%** or higher
  - Within **7 days** for live webinar; within **30 days** of registration for recorded/text/podcast formats
- Two opportunities to pass the exam



## Ethical and Legal Issues in Dysphagia Management

Denise Dougherty, MA, CCC-SLP

continued

### Financial Disclosures

- Private Practice

### Non-financial Disclosures

- Governing Body – Anew Home Health
- Quality Insights of Pennsylvania

continued

Speech-language pathologist involved in dysphagia evaluation and therapy face many challenges.

This seminar will cover specific aspects of ASHA's Code of Ethics related to dysphagia as well as completing a thorough dysphagia evaluation including chart review, clinical evaluation and justification of therapy services.

continued

continued<sup>®</sup>

## Learning Outcomes

After this course, participants will be able to:

- Explain how the ASHA Code of Ethics relates to dysphagia practice.
- Describe how to self-assess their own competency related to dysphagia assessment and treatment.
- Describe how to complete a thorough assessment that properly documents the presence of dysphagia and justifies skilled services.

continued<sup>®</sup>

## Providers

- are competent
- will treat them with respect
- will not harm them
- are acting in their best interest

continued

## Healthcare Principles (10)

Autonomy – honor individuals right to make their own decisions

Beneficence – seek the good for the individual

Nonmaleficence – do no harm

Justice – be fair and treat all individuals alike

continued

## Malpractice

- Improper illegal or negligent professional activity or treatment, especially by medical practitioner
- Professional liability – legal obligation of health care professionals or insurers to compensate patients for injury or suffering caused by acts of omission or commission by the professional
- Autonomy can get the best of us as we seek to help or conform to facility productivity requirements

continued

continued

## ASHA Code of Ethics (11)

Applies to:

- Members of ASHA with CCC
- Members without CCC
- Non-members with CCC
- Applicants



continued

- Because dysphagia is a high-risk, specialized area within SLPs' scope of practice, certification and licensure are not enough to ensure competency.
- Speech-language pathologists may engage in only those aspects of the profession that are within their scope of competence (12)
- According to ASHA's Code of Ethics, SLPs should provide all clinical services competently (Principle 1-A) (1)



continued



## ASHA Code of Ethics Principle 1 – 20 Rules

### Principle 1

- How we treat patients, conduct research and protect patient privacy
- Provide services **COMPETENTLY**
- Use every resource including referral

### Principle 2

- **Ensure and maintain competency**
- **Responsibility for one's professional competence**
- No guarantee for progress
- Abandonment law – malpractice red flag
- Record maintenance

### Principle 3

- How we do business
- Fraud, marketing
- Product use and advertising guidelines

### Principle 4

- How we interact with other professionals
- Goal is increased quality of care for the patient

## ASHA Code of Ethics (4)

### Principle of Ethics I

- ...honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities...
- A.....provide all clinical services and scientific activities competently.



## ASHA Code of Ethics (4)

- H...obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed...includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations.
  - If diminished decision-making ability of persons served is suspected ...seek appropriate authorization for services, such as authorization from a spouse, other family member, or legally authorized/appointed representative.

## ASHA Code of Ethics (4)

- L. ...may make a reasonable statement of prognosis, but shall not guarantee—directly or by implication—the results of any treatment or procedure.
- M...Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.
- Q...maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted

## ASHA Code of Ethics (4)

- Principle of Ethics II
- ....honor their responsibility to achieve and maintain the highest level of professional competence and performance.
- A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience

## ASHA Code of Ethics (4)

- D.....enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills
- F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.

continued

## ASHA Code of Ethics (4)

- Principle III (Fraud)
- D....Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.

continued

## ASHA Code of Ethics (4)

- (Fraud)
- E....Individuals' statements to the public shall provide accurate and complete information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
- G....Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission

continued

continued

## ASHA Code of Ethics (4)

- Principle III (Misrepresentation)
- A... Individuals shall not misrepresent their credentials, competence, education, training, experience, and scholarly contributions.
- C... Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.

continued

## ASHA 2017 Health Care Survey

- Dysphagia assessment and management
  - 39% of caseload of responding SLPs in health care settings who treat adults
  - 16% of caseload of responding pediatric SLPs

## ASHA 2017 Health Care Survey

- Over 50% of an SLP's caseload within an acute care setting included individuals w dysphagia
- No longer just encountered by the medical SLP
- ASHA's most recent Schools Survey (2018) indicated 14.5% of an elementary- and secondary-school SLP's caseload included children with dysphagia.

## Dysphagia Competency Survey (1)

- Medical SLPs don't feel consistently competent about when to provide dysphagia services
- Significant differences in amount/type of respondents' graduate coursework, clinical placement experiences, assessment and treatment methods, and competency measurements for dysphagia management.



continued

## Dysphagia Competency Survey (1)

- Supervisors may try to address inconsistencies in skills/service provision, but may be stymied by pressure from administrators who need to efficiently manage their teams



- Administrators may not have time/ability to provide appropriate training to clinicians, & may be less concerned about SLP competency as long as productivity is maintained.

continued

## Dysphagia Therapy (14)

- SLPs commonly use swallow tx techniques that don't directly correspond to pts. Specific symptoms or physiologic abnormality as seen with their videofluoroscopic data!

continued

## Dysphagia Competency Verification Tool (1)

Skills in six categories

Because dysphagia is high-risk, specialized area within SLPs' scope of practice, certification & licensure are not enough to ensure competency. According to ASHA's Code of Ethics, SLPs should provide all clinical services competently (Principle 1-A).

## Dysphagia Competency Verification Tool (1)

- Clinical fellows and new hires
  - ensure they have knowledge, skills to provide dysphagia services safely.
- Experienced clinicians
  - use specialization and professional development section to track specialist-level skills they have attained as they pursue Board Certification Specialization in Swallowing and Swallowing Disorders (BCS-S).





continued

## Dysphagia Competency Verification Tool (1)

- Clinical Swallow Assessment and Treatment
- Video Fluoroscopic Swallow Study (VFSS) Competency
- Fiberoptic Endoscopic Evaluation of Swallow with and without Sensory Testing (FEES/ST) Competency
- High-Resolution Manometry (HRM) Competency\*\*
- Continued Competency Review
- Advanced Competencies – Specialization and Professional Development

continued

**MBS** – oral, pharyngeal & esophageal

<http://www.asha.org/policy/KS2004-00076> American Speech-Language-Hearing Association. (2004). *Knowledge and skills needed by speech-language pathologists performing videofluoroscopic swallowing studies* [Knowledge and Skills].

Available from [www.asha.org/policy](http://www.asha.org/policy).

**FEES** – pharyngeal w suspected esophageal component

<http://www.asha.org/policy/KS2002-00069/> American Speech-Language-Hearing Association. (2002). *Knowledge and skills for speech-language pathologists performing endoscopic assessment of swallowing functions* [Knowledge and Skills].


Available from [www.asha.org/policy](http://www.asha.org/policy)

Some states have laws, regulations, policies related to use of endoscopy for SLPs

<http://www.asha.org/advocacy/state/states-with-specific-endoscopy-requirements/>

continued

continued




**NEW  
CONCERN!!!**

continued

## Impact of PDPM on Workforce (2)

- Reports of termination and/or change in employment contracts of ASHA members & other therapy professionals employed in SNFs without allowing Patient-Driven Payment Model to be implemented as intended by CMS
- SNFs & rehabilitation providers have clear obligation to deliver the same level of care that was justified to be medically necessary under the previous payment system
- Reimbursement from Medicare unchanged under PDPM relative to the previous payment system



continued

- Some facilities implementing reduction in treatment times – sometimes 15 minute sessions!
- Tim Nanof, ASHA's director of health care and education policy:
  - Such a treatment approach is unethical
  - “It violates the clinical judgment of the therapist and cannot meet the individual medically necessary needs of the patient”
  - This type of situation breaches the federal Fair Labor Standards Act. “SNFs and rehab agencies can’t break the law, and our members shouldn’t give away their services for free,” (3)

continued

## Evaluation (15)

- Evaluation report is a reflection on both the professional and the employer
- When writing evaluation reports, consider what it would be like to have to testify and defend your report.
- Can it stand on its own?
- Be sure your report
  - documents suspected areas of need
  - connects to other reports
  - documents current areas of concern
  - written in a professional manner
  - using professional terminology

continued

continued

## How can you know where you're going if you don't know where you've been?

- Medical records
  - combination of both self-reported patient information and physician's notes on diagnoses, care, treatments
- Significant illnesses, medical conditions, including documentation on lab findings, diagnoses, and treatment plans
- Biographical data, history of alcohol use, drug abuse, smoking, physical exams, allergies, medications, and any adverse reactions (16)

continued

## How can you know where you're going if you don't know where you've been?

- Preventive therapies (immunizations, screenings)
- Paperwork to document services performed by medical professionals including
  - dates, times
  - attending medical personnel
  - admittance and discharge reports
  - prescriptions
  - any other related medical and lab reports. (16)

continued

**continued**

- Complete and accurate history is the **foundation for all future patient care**—whether preventive care, diagnosis and treatment of acute or chronic illness, or prescription of medication
- Accuracy and completeness of information contained in a patient's history is **essential** for optimal pt. care
- Ask about changes or additions to history at each visit
  - New/discontinued meds, new conditions, new allergies, or changes in socio- or demographic information <sup>(17)</sup>

**continued**

- Pay particular attention to changes in meds
- Patients seeing other physicians who are prescribing medications or therapies
- Drug-to-drug interactions are significant cause of patient morbidity and mortality and medical malpractice actions against the physician prescribers
- Be aware physicians are still accountable for knowing the information in the patient's chart <sup>(17)</sup>
- Avoid Food-Drug Interactions  
<https://www.fda.gov/media/79360/download>

continued

- Extra time spent on the history is likely to be more profitable than extra time spent on the physical examination. <sup>(18)</sup>
- Thorough chart review
  - Diagnoses and impact on phases of swallow
  - Impact of medications
  - Know what questions to ask
  - What other referrals, assessments may be necessary based on medical history and patient complaints

continued

## Speech-Language Pathology Medical Review Guidelines <sup>(6)</sup>

Non-instrumental, clinical assessment, including:

- a. Structural assessment of face, jaw, lips, tongue, teeth, hard and soft palate, oral, pharynx, and oral mucosa
- b. Functional assessment of physiologic functioning of the muscles and structures used in swallowing, including observations of symmetry, sensation, strength, tone, range and rate of motion, and coordination or timing of movement. Also, observation of head-neck control, posture, developmental reflexes, and involuntary movements
- Note: Direct observations of pharynx (other than the oral pharynx) and larynx are not possible without instrumentation

continued

## Speech-Language Pathology Medical Review Guidelines (6)

Non-instrumental, clinical assessment, including:

- c. Functional assessment of actual swallowing ability, including observation of sucking, mastication, oral containment and manipulation of the bolus; impression of the briskness of swallow initiation; impression of the extent of laryngeal elevation during the swallow; and signs of aspiration such as coughing or wet-gurgly voice quality after the swallow
- d. Impression of adequacy of airway protection and coordination of respiration and swallowing
- e. Assessment of saliva management including frequency and adequacy of spontaneous swallowing and ability to swallow voluntarily.

continued

## Patient Self-Determination Act of 1990

- Brought about requirements for health care agencies receiving Medicare or Medicaid reimbursement to
  - accept that patients may consent to, or refuse interventions
  - advance care plans and power of attorney for health care must be respected
- Act builds upon common-law right of self-determination as guaranteed by the Fourteenth Amendment of the U.S. Constitution (13)

continued

continued

- Patients may decline interventions recommended by SLP
- Often inappropriately labeled “noncompliant”
- Inappropriateness of this label extends beyond the negative charge
  - patient's right to refuse is protected by law.
- Patients who decline to participate in SLP's recommendations are often labeled “noncompliant” or “nonadherent” (13)

continued

- Colodny reported 40% (190 NH residents) were deemed “not compliant” with recommendations for oral diet modification made by SLP
- Figures support significant sense of conflict our colleagues feel while working with this population
- Leading source for patients' “noncompliance” is a poor understanding of one's condition
- Patients often choose not to engage in treatment recommendations because they do not understand rationale. (13)



## Shared Decision Making

- SLP and pt. engage in collaborative decision making process incorporating preferences for intervention and outcomes
- Kaizer, Spiridigloiozzi and Hunt developed framework incorporating healthcare team values, pt. centered care and functional autonomy
- Two major premises
  - Significance of eating in relation to QOL varies between individuals
  - Decisions regarding diet modification must be considered within context of cultural and social values and expectations
- Questions
  - What are ethical implications of restricting pt. autonomy in exercising food preferences
  - How can shared decision making contribute to conflict resolution when pt. food preferences may be harmful (5)

- SLP needs to understand role of food culture and preferences for pts health and well-being and provide intervention within his existing care networks
- Often tension between safety, QOL, pt. choices and rehab goals
- 3 Step Algorithm
  - Quality patient/family education
  - Repeat education to explore and address reasons for noncompliance
  - Team meeting to critically evaluate risks (5)

continued

## 1. Quality Patient/Family Education (5)

- Use appropriate verbal and written materials to support comprehension of key information
  - VFSS
  - Explain stages of swallow
  - How pt's disorder/disease process has affected speed, coordination and safety of swallow
  - Risks & consequences explained
  - Rationales provided for texture modified diet

continued

## 1. Quality Patient/Family Education (5)

- May be compliant as inpatient, but not upon discharge to home
- May be motivated/compliant to prevent health risks that could delay discharge
- Inpatient facilities provide limited opportunities for ignoring dietary recommendation
- Family may have limited visitation during hours of rehab

## Challenges (6)

- Ability to identify meeting time that works for all parties involved
- Pt communication problems, conflict among family/caregivers plus pts. uncertain prognosis impact information sharing
- Benefits and harms related to exercising choice of food preferences change when pt. moves from inpatient setting to home or other living situations
- May be health consequences – but all involved were educated on possible consequences
- Education may be derailed by misperceptions and dysfunctional networks

## Challenges (6)

- 4 key features for shared decision making
  - Communication
  - Imagination – explore alternatives or negotiated compromises that address safety and meet w pts goals – also requires realism
  - Courage – health professionals empowering clients to voice health preferences and ensure this is heard by rehab team; may need to renegotiate when pts choose to opt out of recommendations
  - Reflection
- Important to identify reasons and assumptions that may lead pts to refuse treatment recommendations

## continued

- Decisions made influenced by social, cultural and religious expectations and norms as by clinical status and medical info.
- Best interests of pt. always the aim but negotiation between pt. family and medical team may be required
- Decisions difficult and have profound effect on the person & caregiver
- Conflicts and opinions may have potential for harm
- Bottom line: will life be continued or death postponed for a short period?
- Do no harm – do good – may have to realign treatment from curative to supportive where death is inevitable
- Any intervention must be for benefit of pt. and not just comfort of caregiver (7)

## continued

### Two Facets for Effective Decision Making (7)

- Consideration of all relevant facts – discussion
- May have many discussions
  - Provision of nutrition
  - Symptom relief
  - Right to life
  - Right to die
- Clear communication of the outcome

## continued

- Professional staff and pt./extended circle may not share the same cultural or belief systems
- Difficulties arise when there is no one definitive answers
- Conflicts exist especially when choice is to continue w normal diet despite advice to contrary
- Must arrive at consensus
- Decisions often in shade of gray rather than black or white
- Needs to be accepted balance of risk vs. safety
- Balance between what is right within the spirit of the law and what is best for this pt. (7)

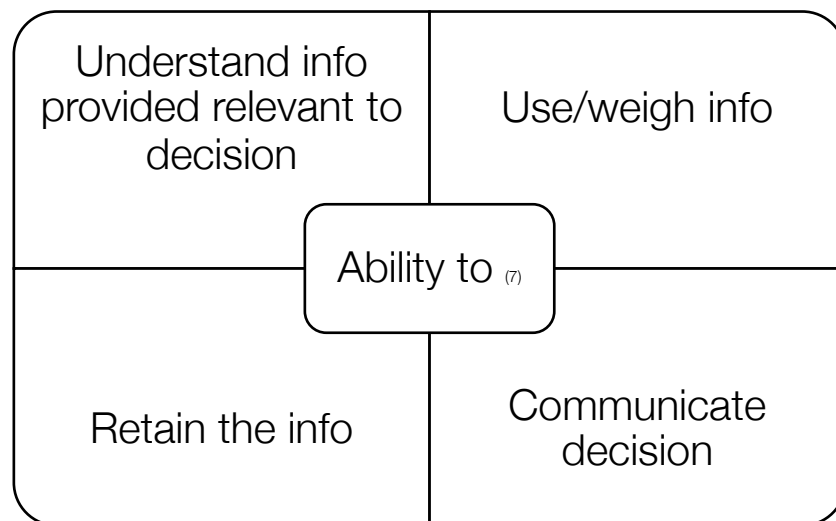
## continued

- Decisions made by pts need to be understood in realism of culture and belief systems
- Support provide to assist pt. and families to come to a decision in conjunction w care staff
- Staff needs to come up with APPROPRIATE treatment plan rather than one they are comfortable with
- Pt needs to be comfortable w decision
- Staff must understand that disagreeing or opting out of particular treatment plan is not non-compliance but a reasoned/informed choice
- Must document and communicate plan to team to ensure consistency of treatment and care, and avoiding scapegoating of colleagues – overtly or inadvertently (7)

continued

- Pts have right to determine their course of treatment
- Autonomy suggests ability to make choice and be responsible for the outcome
- Conflict when delivering care if resulting decision appears to be harmful to person making decision
- Pts. must have mental capacity to make decision and understand consequences
- If pt. has capacity, refusal of treatment has to be accepted
- If not competent, advocate will need to be appointed <sup>(7)</sup>

continued



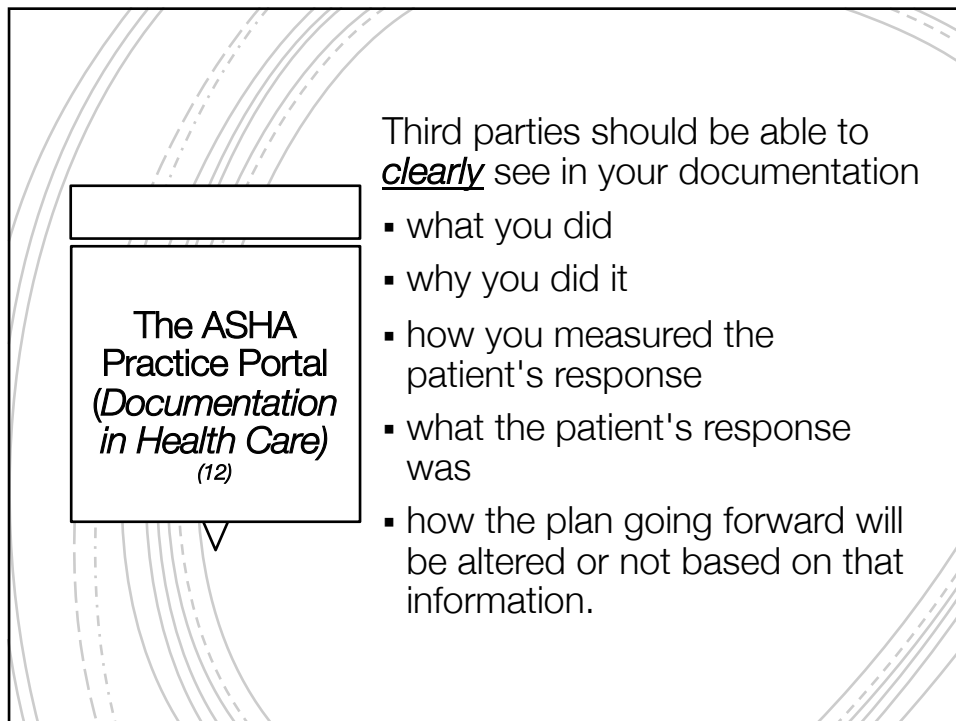
continued

## continued

- Tone of discussion between SLP and patients and strength of recommendations should be highly dependent on quality of evidence
- Should be a sliding scale
  - how strongly SLP should recommend modified diets from urging or pleading w reluctant or non-compliant pt. to accept some modification of food texture if their risk of an asphyxial death is high to, at most, tentative suggestion of trial of therapy if there might be sufficient benefit from a thick fluid consistency to offset risks of dehydration and impact on QOL
- Ultimately, patient must understand that, irrespective of the view of SLP, he or she has a choice. <sup>(9)</sup>

## continued

- To make decision, patient needs and is entitled to information
  - potential for reducing aspiration pneumonia
  - possible risks and hazards, including underhydration and nutrition and impact on quality of life
- Uncertainty (potential cause of stress for patients) is a fair description of current knowledge of potential benefits and risks from modified diets and should be acknowledged/communicated when discussing this intervention
- Unacceptable to withhold information about possible hazards of modified fluids to try and improve adherence to SLP recommendations. <sup>(9)</sup>



The ASHA Practice Portal  
(*Documentation in Health Care*)  
(12)

Third parties should be able to clearly see in your documentation

- what you did
- why you did it
- how you measured the patient's response
- what the patient's response was
- how the plan going forward will be altered or not based on that information.

continued

Work out what patients need

Then create our proposed treatment plan

Creation of plan should be a joint effort with the patient

Must gain pt.'s informed, express permission to carry out intervention (12)



## Common Ethics Problems

- False advertising
- Insurance fraud
- Lapse of license
- Unprofessional conduct
- Refusal of services
- Inadequate record keeping

## Documentation

- Not just for billing
  - must be true reflection of what occurred in session
- If it is not in your documentation, IT DID NOT HAPPEN!!!!
- Legal document
  - Admissible in court of law
- Fraudulent billing #1 reason for losing license



## Common Documentation Errors

- Illegible
- Inconsistent
- Duplicative
- Signatures
- Error correction
- Orders
- Annotations
- Unauthorized abbreviations
- Spelling, grammar
- Incorrect time of service on form
- Personal feelings in documentation
- Blaming other providers in writing
- Recording hearsay
- No informed consent



Q & A

## continued<sup>ed</sup> References

1. Urban, M., & Hazelwood, R. J. (2019). Are You Ready to Manage Dysphagia? A new tool specifies the clinical knowledge and skills SLPs need to assess and treat dysphagia by outlining a method for documenting competency.
2. Impact of PDPM on Workforce. ASHA Headlines Oct. 3, 2019
3. SLPs in SNFs Share Stories of PDPM-Related Layoffs, Treatment and Pay Cuts. Law, B. ASHA LeaderLive, Oct. 7, 2019
4. American Speech-Language-Hearing Association. (2016). *Code of ethics* [Ethics]. Available from [www.asha.org/policy/](http://www.asha.org/policy/).
5. Kenny, B. (2015). Food Culture, Preferences and Ethics in Dysphagia Management. *Bioethics*, 29(9), 646-652
6. [asha.org/practice/reimbursement/SLP-medical-review-guidelines/](http://asha.org/practice/reimbursement/SLP-medical-review-guidelines/)
7. Smithard, D. G. (2017). Ethical Issues and Dysphagia. In *Dysphagia* (pp. 887-903). Springer, Cham.
8. Tan, L., Gan, G., Hum, A., & Lee, A. (2018). A Stepwise, Mixed-Method Study Approach to Identify the Barriers to Dysphagia Care in Hospice Care Nurses. *Journal of Hospice & Palliative Nursing*, 20(1), 88-94.
9. O'Keeffe, S. T. (2018). Use of modified diets to prevent aspiration in oropharyngeal dysphagia: is current practice justified?. *BMC geriatrics*, 18(1), 167.

## continued<sup>ed</sup> References

10. Schwartz, D. B. (2018). Enteral nutrition and dementia integrating ethics. *Nutrition in Clinical Practice*, 33(3), 377-387.
11. American Speech-Language-Hearing Association. (2016). *Code of ethics* [Ethics]. Available from [www.asha.org/policy/](http://www.asha.org/policy/).
12. Leslie, P., & Casper, M. (2015). Ethical challenges: Less about moral wrongdoing and more about communication breakdown. *Perspectives on Gerontology*, 20(3), 72-84.
13. Askren, A., & Leslie, P. (2019, June). Complexity of Clinical Decision Making: Consent, Capacity, and Ethics. In *Seminars in speech and language* (Vol. 40, No. 03, pp. 162-169). Thieme Medical Publishers.
14. Carnaby, G., & Harenberg, L. (2013). What is "Usual Care" in Dysphagia Rehabilitation: A Survey of USA Dysphagia Practice Patterns. *Dysphagia*, 28(4), 567-574.
15. Moore, B. J. (2010). Ethics: If It's Not Documented, It Didn't Happen. *Perspectives on Administration and Supervision*, 20(3), 106-112.
16. <https://www.globalpremeds.com/blog/2014/03/25/the-importance-of-medical-records-a-critical-professional-responsibility/>
17. [https://www.psicinsuranc.com/webres/File/physicians/connection\\_publication/2011\\_Issue4.pdf](https://www.psicinsuranc.com/webres/File/physicians/connection_publication/2011_Issue4.pdf)

## continued<sup>®</sup> References

---

18. Hampton, J. R., Harrison, M. J., Mitchell, J. R., Prichard, J. S., & Seymour, C. (1975). Relative contributions of history-taking, physical examination, and laboratory investigation to diagnosis and management of medical outpatients. *Br Med J*, 2(5969), 486-489.