Informed Consent and Ethical Best Practices in Dysphagia and Diet Consistency Decisions Part 2

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Disclosures

- Mary Casper receives a salary for employment at the American Speech-Language-Hearing Association (ASHA).
- Mary is a Contributing Faculty at the University of Saint Augustine for the Health Sciences, teaching Dysphagia.
- Mary received complimentary registration and travel expenses from SHAV for her participation as an invited speaker.
- She has no non-financial disclosures.

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Components of Dysphagia Decision Making

Comprehensive Evaluation

Clinical "Bedside"

Instrumental Assessment

Determine prognosis, treatment goals, treatment plan

Consider Contextual Features

Quality of Life

Patient Preferences

Determine predicted outcome, *impact* of the plan

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Treatment Recommendations

- What are some of your typical recommendations in your evaluation of a "post-acute" patient?
- Are those typical recommendations different for a "long-term" patient?

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Diet Modification

- Direct intervention? or compensation?
- Why do SLPs recommend diet consistency modifications in the dysphagia plan of treatment?

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Decision Making Considerations

- What other factors besides the presence of aspiration should be considered in making diet consistency recommendations?

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Publication 99-E024, Agency for Health Care Policy & Research, U.S. Department of Health & Human Services, Washington, D.C., USA

"….patients who aspirate have about a 50% greater risk of developing aspiration pneumonia than dysphagia patients who do not aspirate on videofluoroscopy exams."

"However, since other patient characteristics may play equal or greater roles in causing pneumonia aspiration should not be considered a definitive marker for the patient outcomes of pneumonia."

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Predictors of Complications

- In the "landmark" 1998 study, Langmore and colleagues found the best predictors of pneumonia, in elderly outpatients, were:
  - dependent for feeding
  - dependent for oral care
  - number of decayed teeth
  - tube feeding
  - more than one medical diagnosis
  - number of medications
  - smoking

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Predictors of Complications

- According to Langmore et al, 2002, the strongest to weakest predictors of pneumonia in nursing home patients were, respectively:
  - suctioning use
  - COPD
  - CHF
  - presence of feeding tube
  - Bedfast
  - high case mix index
  - Delirium
  - weight loss
  - swallowing problems
  - urinary tract infections
  - mechanically altered diet
  - dependence for eating
  - bed mobility
  - locomotion
  - number of medications
  - age

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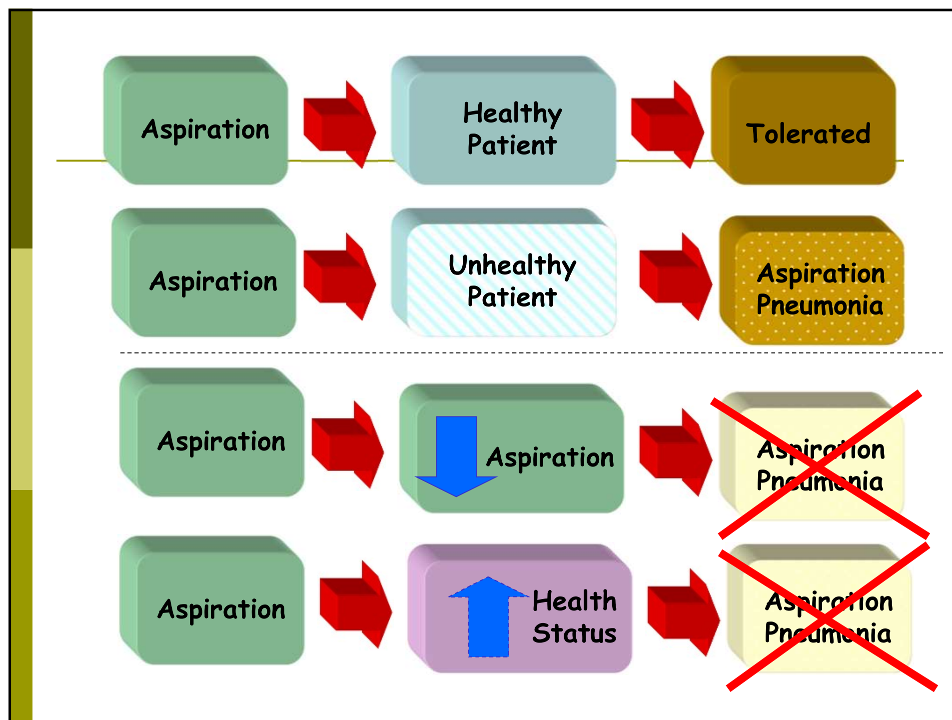

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Myth #1

- *The primary purpose of swallowing intervention is to identify aspiration and aspiration can be prevented.*

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Reality #1

- The purpose of swallowing intervention is to assure adequate hydration and nutrition in individuals whose swallowing is compromised.
  - When aspiration can be minimized, obviously this is a good thing, but aspiration CANNOT be prevented.
  - Oral bacteria, saliva, reflux will still be aspirated even if you change a diet or make a patient NPO.

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Decision Making Considerations

- What influence does "Quality of Life" have on the SLP's recommendation for diet consistency?

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Myth #2

- *Enteral feeding is as good as feeding by mouth and prevents aspiration pneumonia.*

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Reality #2

- Tube feeding increases the risk of reflux, increases the risk of growth of oral bacteria, increases the risk of infection, contributes to malnutrition and dehydration.
  - Tube feed formulas are often NOT well tolerated.
  - Tube feeding does NOT prevent aspiration of secretions, oral bacteria (made worse by lack of mouth care) and INCREASES the risk of aspiration of reflux.

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MBS Recommendations Across Settings

- How do you communicate with the SLP who will perform the study before the study is conducted?
- Are the conclusions reached by the hospital SLP conducting the swallow study reasonable and logical?
- How do you critically analyze the study that was performed and the results that were reported?

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MBS Review

- What information was conveyed about the patient's current status?
- What consistencies / presentations were tested?
- What impairments were noted?
  - Oral
  - Pharyngeal
  - Esophageal
- Was there penetration? Aspiration?
- What strategies / interventions were attempted?
- What were the conclusions reached?
- What were the recommendations?
- Do you agree?

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Myth #3

- Thickened liquids make it safer for all patients to swallow by reducing the likelihood of aspiration.

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Reality #3

- *There is no evidence to support that aspiration can be prevented using thickened liquids.*
- *Thickened liquids introduce additional risks for the patient.*
  - *Hydration (due to acceptance or lack thereof)*
  - *Carbohydrate content*
  - *Increased pressure generation required to move thicker bolus through the oropharynx*

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Decision Making Considerations

- What influence does “patient preference” have on the SLP’s recommendation for diet consistency?
- Let’s talk more about what informed consent means …

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Advance Directives

- A document that enables people to express their wishes about their health care in a form that will tell others how to care for them and to make decisions for them if and when the time comes that they are unable.
  - Living Will
  - Durable Power of Attorney for Health Care

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Informed Consent

- The AMA defines informed consent as:

"a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention."

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Decision Making Scenario #1

- The patient is on a pureed diet and nectar-thick liquids. He is doing well with treatment for his oral and pharyngeal phase deficits. His family members persistently bring in his "favorites" – Big Mac, french fries, and a chocolate shake – despite expressing agreement to follow the prescribed diet.
- How should the SLP document about this?
- Should the SLP continue to treat the patient?
- What other documentation needs to be completed?

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Decision Making Scenario #2

- Based on the clinical and instrumental assessments, the best judgment of the SLP leads to a recommendation for a mechanical soft diet and honey-thick liquids. The patient is aspirating thin liquids and regular textures of foods per the videofluoroscopic swallow study.
- The SLP goes to change the diet and the patient and family say "NO WAY" to the thickened liquids.
- What diet consistency should the SLP recommend to the physician?
- Should the SLP treat this patient?

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Decision Making Scenario #3

- The patient is 92 years old and is diagnosed with Alzheimer’s Disease. She was hospitalized for a UTI and while she was in the hospital, an instrumental assessment of swallowing was conducted. It showed she is aspirating on all consistencies of food and liquid. The hospital SLP’s recommendation was made for NPO, but the patient is returned to you in the SNF before any decisions can be made. Family members say they want her to “enjoy her last days”. She has a living will stating no artificial means of nutrition or hydration.
- What do you do now?
- What diet do you recommend?
- Should the SLP treat this patient?

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Decision Making Scenario #4

- The patient is admitted from the hospital NPO with a g-tube. The patient and family express wishes that the patient be able to eat by mouth. This patient had a CVA 3 weeks ago and was made NPO after an instrumental assessment showed risk of penetration and/or aspiration on all food and liquid consistencies.
- What are the next steps for the SLP?

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THANK YOU!

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