

**To prepare for this event** [Glen Engel-Cox](#) - 03:45pm Sep 20, 2002 EST (#1) [{Bookmark}](#)

For information on the topic of Pediatric Issues in Dysphagia, contact the ASHA Action Center and ask for a free packet with that title (800-498-2071). The packet includes articles written by experts in the field, including Division 13 leaders, and ASHA Practice Policy Documents developed by an ASHA-Special Interest Division 13 Working Group. (The policy documents also can be accessed through the [Online Desk Reference](#)--click on "Knowledge and Skills Needed by Speech Language Pathologists Providing Services to Individuals with Swallowing and/or Feeding Disorders," and see Section 6.0, pages III-4-5, and "Roles of Speech-Language Pathologists in Swallowing and Feeding Disorders: Technical Report," and see pages 4-6.)

**"Pediatric Dysphagia: Practice and Challenges"** [Jean White](#) - 02:58pm Sep 23, 2002 EST (#2) [{Bookmark}](#)

Attached is a copy of an article by Lisa Newman, immediate past Newsletter Editor for Division 13. The article appeared in the June 12, 2001 issue of The ASHA Leader.

**Attachments:** [pediatric dysphagia.pdf](#)

**"Considerations in the Care of the Pediatric Patient"** [Jean White](#) - 03:02pm Sep 23, 2002 EST (#3) [{Bookmark}](#)

Attached is a copy of an article by Lynne Brady Wagner, Division 13 Steering Committee Member. The article was published in the October 1998 issue of the Division 13 Newsletter.

**Attachments:** [the pediatric patient.pdf](#)

**"Ethical Decision Making for Infants and Children With Dysphagia"** [Jean White](#) - 03:04pm Sep 23, 2002 EST (#4) [{Bookmark}](#)

Attached is a copy of an article by Maureen Lefton-Greif, Division 13 Steering Committee Member. The article was published in the June 2001 issue of the Division 13 Newsletter.

**Attachments:** [ethical decision-making.pdf](#)

**Emily Homer** [Emily M. Homer](#) - 06:04am Sep 24, 2002 EST (#5) [{Bookmark}](#)

Hi I am please to be a part of this forum! I look forward to any discussions on implementing a dysphagia team in school systems.

**Jennie Davis** [jbelled](#) - 08:45am Sep 24, 2002 EST (#6) [{Bookmark}](#)

I am excited to have some of these questions answered! My first of many...  
I have had the response that "dysphagia" is a "medical based" problem and therefore is not addressed in the schools since it is not "educational-based". How do we address this or justify this type of therapy in the schools?

**Jennie Davis** [jbelled](#) - 09:38am Sep 24, 2002 EST (#7) [{Bookmark}](#)

For liability of the schools...

Who should be feeding these "at risk" students during lunch/snack? and should there be a "competency" for those feeding if it is not the SLP (ie: classroom aides)?

What do the SLP's need to do feeding eval/tx with students (script, MBS, etc)? and how often should it be updated to cover liability issues?

Thanks for your time...I have more questions to come! jennie

**Alison In Atlanta** [Alison Ogden-Bowles](#) - 09:55am Sep 24, 2002 EST (#8)

[{Bookmark}](#)

I have been practicing in the public schools for about 5 years and was in the medical setting w/dysphagia experience 5 years before. I see a huge need for awareness and proactive education with our fellow school-based SLPs, OTRs, Spec. Ed. Teachers, Parapros, Sp.Ed. Nurses, some M.D.s, Administrators, and Parents re:Feeding/Dysphagia Issues in the schools. I have seen many scary feeding situations during the school day and complete lack of awareness of the risk to the student. Many assume if the food/liquid/medicine goes into the mouth, that mother nature always takes over and sends everything down the right way. This is just not so! Fortunately, my county has allowed us to begin an awareness program as a co-venture between several of our knowledgeable and open-minded OTRs and SLPs who want to keep the kids safe (and prevent the school /staff from court cases). We are lucky though, many counties don't want to touch this issue.

**Suzette Harris** [suzetteharris](#) - 12:56pm Sep 24, 2002 EST (#9) [{Bookmark}](#)

I am working in an outpatient peds. rehab. center. We are receiving more dysphagic kids under the age of 4 years old than before. Here are my questions:

1. When does a referral for a video swallow study become necessary and not overkill?
2. How do I know when to refer to an inpatient feeding program?
3. What are the ethical limits to treating dysphagic kiddos in an outpatient setting in reference to tx. duration and scope of practice?
4. Which feeding conferences provide the most comprehensive information for multi-handicapped dysphagic kids?

Thanks so much for your assistance and time!!

**Lissa Power-deFur** [Lissa Power-deFur](#) - 01:07pm Sep 24, 2002 EST (#10)

[{Bookmark}](#)

Hi,

I'm a speech-language pathologist working at a state education agency. I don't provide clinical services, but I can offer some thoughts on how dysphagia fits in with special education requirements.

I look forward to hearing (reading) your thoughts and questions.

Lissa

**Lissa Power-deFur** [Lissa Power-deFur](#) - 01:22pm Sep 24, 2002 EST (#11)

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Jennie Davis asked about the viewpoint that dysphagia is a medical problem. Special ed law does require that to be eligible the child has to have a disability that "adversely affects a child's educational performance." Since decisions regarding eligibility and services are made by a team, it is up to us to explain that relationship so that other folks understand it. How does the dysphagia affect that child's ability to participate in classroom activities? Is this a child for whom activities of daily living are addressed? Many IEPs do address feeding children (preschool, children with severe disabilities). Perhaps the educators are more used to hearing "feeding" than dysphagia. (Some educators may automatically react that something is medical not educational if medical term is used.)

A valuable resource is your school nurse. The nurse I work with at DOE shared an article recently that was in a nursing journal about children with dysphagia. Working with the nurse, it may be easier to make the case that this is a health issue that must be addressed. Most nurses develop health care plans for the children they serve in schools. It'd recommend talking with her/him about whether dysphagia services might be included in such a plan.

Of course, it is always important to talk to our supervisors about our concerns regarding the school's liability for choking if the dysphagia is not addressed.

**Lissa Power-deFur** [Lissa Power-deFur](#) - 01:30pm Sep 24, 2002 EST (#12)

{Bookmark}

Jenne Davis asked the question about liability and qualifications of personnel. It is generally accepted practice (but not a requirement) that whenever there is a specialized health care procedure that needs to be done in school, that personnel are appropriate trained to do so. For example, when a child is on a ventilator, the best practice is for a nurse will train personnel and observe everyone's competency before the person can work with the child.

I do understand that best practice is not generally common practice. However, I think it's important to explain to supervisors the liability and the importance of providing training and assuring competency. Remembering that supervisors in schools know a lot about education and very little about health, there may be a learning curve here. Don't assume they automatically understand the health and liability issues that are second nature to us. One of the challenges we face is the amount of feeding of children that has taken place in schools for years, without an adverse outcome - well, at least without an adverse outcome that is apparent to the average educator. Many educators may assume that, "we haven't had a problem so far, it's not that big of a deal." All the more reason for a thorough explanation of the implications of inadequately trained personnel feeding children.

I will defer to my colleagues providing services in schools to comment on how they have addressed this issue.

**Maureen Lefton-Greif** [mlefton](#) - 02:29pm Sep 24, 2002 EST (#13) {Bookmark}

I am also excited to be one of the participants during this 2-day event. I am in between patients and will take this opportunity to respond to a few specific questions.

1. When does a referral for a video swallow study become necessary and not overkill? To address this question, I am pulling from materials previously written by Dr. Arvedson and myself. In general, there are three conditions that help determine if/when a VFSS is indicated: (1) the child presents with reasons to suspected oropharyngeal (with an emphasis on pharyngeal) dysphagia, AND (2) the VFSS findings will facilitate the delivery of diagnostic and / or management needs, AND (3) the child is ready, willing, and able to participate in such an examination.

2. How do I know when to refer to an inpatient feeding program? As with many questions re: dysphagia, a simple response to this question is not possible because inpatient programs differ in the type of patients serviced, the disciplines involved in care, their treatment philosophies, and their insurance policies. Therefore, I think a reasonable approach is to work with the primary care providers of the child to identify the feeding/swallowing concerns and to provide information about available programs. I also give the caregivers a list of questions that might be helpful when they explore intensive therapy options.

3. What are the ethical limits to treating dysphagic kiddos in an outpatient setting in reference to tx. duration and scope of practice? I think that the ethical limits to treating dysphagia is consistent with ASHA professional, state (e.g., licensure) and facility ethical constructs. This includes SLPs delivering only services that they are trained and comfortable providing. That said, we are all aware the delivery of dysphagic services requires special skills and knowledge (see ASHA documents linked to this session).

4. Which feeding conferences provide the most comprehensive information for multi-handicapped dysphagic kids? This is again a difficult question. Many conferences are available and each addresses different issues. I have found it helpful to attend conferences by SLPs who have extensive knowledge in the areas that I wish to explore. Annual ASHA and state conventions offer opportunities to obtain a wide range of information and to identify practitioners who might focus more specifically on your areas of interest.

Hope this is helpful. Will be back later.....

**Jennie Davis** [jbelled](#) - 03:49pm Sep 24, 2002 EST (#14) [{Bookmark}](#)

Thanks for your responses, like I mentioned, I have tons of questions. I work in a hospital and am doing an education talk to nurses in a school system. Nurses seem to be the "medical" link a school SLP can connect with to help make the case for feeding therapy.

What do you feel is the nurses role with students with dysphagia?

Do they do the screenings?

Do they make contacts to the physicians and families regarding concerns (along with the slp)?

What is included in a "health plan" that you mentioned and is it part of the IEP?

Of course, the nurses in schools may also need education on the issue along with the teachers and administration. Thanks for your response, I will put my next question in a separate posting. Jennie

**Jennie Davis** [jbelled](#) - 03:59pm Sep 24, 2002 EST ([#15](#)) [{Bookmark}](#)

How is this liability issue addressed...

An MBS shows aspiration with recommendation not to feed by mouth or to use thick liquids and puree only. However, the family refuses these recommendations and wants the school to feed them a regular diet, thin liquids.

What is the schools role for feeding the student?

Especially if the family has refused the g-tube and the school has no other means to feed them?

And how would a school respond if they wanted an MBS and the family refuses?

What if the MD wrote a script saying to feed the student against what the MBS showed?

Thanks again for your time! jennie

**Jennie Davis** [jbelled](#) - 04:04pm Sep 24, 2002 EST ([#16](#)) [{Bookmark}](#)

And hopefully my last one for today, more tomorrow...

What is the school system's responsibility to provide feeding therapy to a student?

"Regular" speech-language is a students "right" and the school system is required to provide that service. How does feeding therapy fall into that "right" of a student?

(I know this is a difficult issue on the slp side of things as well since we are not all trained in feeding/dysphagia...which I see will be changed as a part of graduate curriculum soon.)

Thanks! jennie

**Darrell Dern, M.S., CCC-SLP** [slp250ccc](#) - 04:47pm Sep 24, 2002 EST ([#17](#))

[{Bookmark}](#)

Greetings from the State of Arizona. I am a special education supervisor for a large urban High School district. Our staff of SLP's serve a a wide variety of students, including those with significant swallowing disorders. There has not been a question in the District about dysphagia being a "medical" vs. "educational" issue. To us, because hydration and nutrition are essential life activities, they fall into the educational realm. Our dilemma is when a student has an identified swallowing disorder (via swallowing evaluation by the SLP and an MBS procedure) and it is shown the student aspirates on all consistencies and liquids, and there is no adequate strategy or position to avoid aspiration. We know we cannot safely hydrate or feed the child. The parent is often reluctant to pursue placement of a peg tube, even after physician and SLP consultation. The IEP team has in these instances determined the child's needs cannot be met on the high school campus, and they are put on homebound or sent to a private facility.

What are other districts doing to address these issues?

I look forward to hearing a response.

**Emily Homer** [Emily M. Homer](#) - 06:42pm Sep 24, 2002 EST (#18) [Bookmark](#)

Hi Jenni

I agree with Lisa's answer about dysphagia being a medical issue and the need to address it in the public school. IDEA includes "health services" as a related service. It also requires that school systems provide a Free and Appropriate Public Education to all children. In other words, all children are entitled to FAPE. Anything that interferes with FAPE must be addressed. That is why assistive tech. is so big. If the child is malnourished or sick due to a undiagnosed or untreated swallowing problem then the system needs to address it in order for the student to take advantage of the curriculum.

In response to your question about who is feeding the children and their training, in my system the SLP and OT evaluate the child's swallowing disorder, make necessary recommendations to physicians regarding Modifieds or diet changes, and once all info is received the SLP writes a Feeding and Swallowing Plan. The SLP then trains the teacher and paraprofessionals (aides) in the classrooms to follow the plan. All training is documented with a signature and date. SLP monitors feeding on a regular basis.

**Emily Homer** [Emily M. Homer](#) - 06:53pm Sep 24, 2002 EST (#19) [Bookmark](#)

Darrell

I agree with your school system's philosophy regarding dysphagia in the schools. The problem you presented is one that my system has not had to deal with. My system has a procedure in place that we follow with every student that is suspected of having any type of swallowing concerns. We utilize the IEP as our main documentation. After evaluation by our school team, we are able at the IEP conference to state and document what the team feels is safe feeding for the student at school. When there is a disagreement with parents, we have been told by our supervisor of Special Education that we will not agree to anything that we feel is harmful or potentially harmful to the child. We have had some parents choose homebound because we would not feed the child orally, however, that student did have a tube. Having a set procedure in place for all to follow, helps with some of these issues.

**Christine Hurtubise** [christineh](#) - 07:01pm Sep 24, 2002 EST (#20) [Bookmark](#)

Hi, it's great to be able to participate in this forum. I am a coordinator of speech-language therapy services at a multidisciplinary clinic in California. I was fortunate to be able to present with 2 OTs and 1 PT on Feeding within the Educational Context at the American Occupational Therapy Association conference in May. We have dealt with the educational relevance of addressing feeding in the schools by relating it to their social development, safety and need for adequate nutrition to support learning. Interestingly enough, occupational therapists are more readily supported through IDEA for feeding as their scope of practice includes :

improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning (IDEA Part B, §300.16 (5)(i)(ii)(iii)).

Unfortunately, IDEAs definition of the scope of practice for SLPs is much more narrow. You can sometimes justify services under Section 504 which provides for modifications of

lunches and services for children with any impairment that "substantially limits a major life activity".

Having said this it is incredibly difficult to find support in the school districts in Southern California. Additionally, many local SLPs are not confident/ competent in addressing these areas so they often do not support intervention.

One of the local districts does not even allow their SLPs to "go in" any kids mouths stating liability concerns. How do we respond to this?

Thanks for your patience and insights.

**Emily Homer** [Emily M. Homer](#) - 07:30pm Sep 24, 2002 EST (#21) [Bookmark](#)

Jennie

In response to your liability issue (#15), I find it so hard to believe that this is such an issue but I know it is. We had a lot of cases when we first started our team. It seems to have gotten better. My personal thoughts on this is that we would not feed a child with a peanut allergy, peanuts, nor would we give a diabetic child, the wrong foods, even if parents wanted us to. Why would we give a child that aspirates on thin liquids, water! It does however seem to be a more complicated issue than the other examples. In my system, we will only feed a child what our team has determined to be safe, and the parent is part of the team. If there is a disagreement, we have been told by our supervisors to do what our professionals feel is safe for a child (even when the physician recommends something else). We have had parents put their children on homebound services rather than have us limit their diet.

In the case of the parents who insist on feeding their child a diet that appears to be hazardous to their health, this is abusive and may need to be reported. We must however be certain that the restricted diet that is being recommended is what the student truly needs. We received the results of a MBS study that indicated NPO, for a child that was healthy appearing and had not been sick for a year. The study was done in a 90 degree position when the student usually ate reclined at about a 60 degree angle. This was the difference between aspiration and a very safe swallow. To recommend NPO for this child would have been wrong.

**HKS** [Heidi K. Stringer](#) - 07:43pm Sep 24, 2002 EST (#22) [Bookmark](#)

Hi. I am a new Speech Path in the school system. One of the children on my case load is a multihandicapped four year old boy. He has severe seizures and thus has had the right side of his brain removed. This procedure was performed last summer and he continues to have seizures. He spends most of his day in a wheelchair and shows few signs of purposeful movement. He does have a Peg tube, however I am trying to facilitate oral movement, sensation, strength, and a swallow. My question is what type of prognosis would you expect given your experience and what would be your criteria for dismissal? I hope I provided enough Information.

**Maureen Lefton-Greif** [mlefton](#) - 08:06pm Sep 24, 2002 EST (#23) [Bookmark](#)

Clearly, there are so many challenges in working with children with feeding/swallowing disorders - some of the challenges are unique to specific settings and other occur regardless

of setting. As an SLP working in the hospital setting, I would like to comment on one of the ethical issues that has been raised.

I agree with Emily's statement "we will not agree to anything that we feel is harmful or potentially harmful to the child" which reflects the ethical principle of "nonmaleficence", and other statements suggesting appropriate documentation. I would like to expand this discussion to include the ethical principle of "beneficence" which refers to "promoting well-being, doing good, or taking actions to enhance welfare". We would all agree that we do not wish to provide services that appear to harm our clients. When caregivers or patients/student do not wish to follow the recommendations of a team and these persons are deemed to be competent in their decision-making skills, we are left with attempting to make the situation "as good as possible". For example, I have been in the situation where I recommended the elimination of liquids and then in the next sentence told the caregivers that if the child was to drink, it would be safest to ....(e.g., drink slowly, "sneak" thick liquids, etc.). There are times when the "ideal" situation will not occur and then we are faced with making it "as good as possible" and providing appropriate documentation.

**Maureen Lefton-Greif** [mlefton](#) - 08:21pm Sep 24, 2002 EST (#24) [{Bookmark}](#)  
Jennie, Thanks for your comments and questions.

In my experience nurses have been very important members of feeding and swallowing teams regardless of setting.

"I work in a hospital and am doing an education talk to nurses in a school system". I find them very receptive the learning about swallowing and swallowing disorders. They are particularly interested in observing videos of swallow studies, when available.

"What do you feel is the nurses role with students with dysphagia? ....Do they do the screenings?" In my experience, they want to learn about signs and symptoms of dysphagia and often alert MDs about the need to have a formalized feeding/swallowing evaluation. In the hospital setting they frequently observe a feeding before other health professionals.

Working in a hospital, I frequently get referrals for feeding/swallow evaluations from school nurses because of their concerns or concerns raised by others in the school. I try to educate them about what I do and how they can best use me as a resource person.

Nurses who work with children at home are often able to provide some of the "day-to-day" information that is not available to clinicians in other settings.

**Joan Arvedson** [jcarved](#) - 09:39pm Sep 24, 2002 EST (#25) [{Bookmark}](#)  
Hi, I have finally managed to break free to get in on there interesting and challenging questions and comments. Very few have straight forward answers, because the issues are typically so complex and multi-faceted with these children.

The question posed by Suzette in #9 related to referring to inpatient feeding program is one of those.... Dr. Lefton-Greif has made some helpful comments. I would like to add that

wherever possible, if you can work with an interdisciplinary feeding/swallowing team connected to a medical center, decisions about when and who should be in inpatient programs are likely to yield longer lasting successful outcomes. The team is likely to focus outpatient and inpatient, but not all do. Most teams for children urge and appreciate input and participation by school based therapists/clinicians and families. I will emphasize the importance of sorting out all the medical and developmental considerations. Those include airway and respiratory status, gastroesophageal reflux management, nutrition and hydration, sensory and motor issues, to name some. The decision becomes one from a team with parents as primary participants.

Other possibilities regarding feeding conferences, in addition to those focused specifically for SLP intervention areas, I encourage folk to attend conferences or seminars in which you can increase your knowledge that will in turn help you in the areas SLP focus. One meeting that comes to mind is SENTAC (Society for Ear, Nose, Throat Advances in Children). Other pediatric conferences may be led by physicians, nurses, psychologists, etc.... Expansion of our knowledge of some of the complex condition is extraordinarily helpful in most situations.

**Emily Homer** [Emily M. Homer](#) - 09:56pm Sep 24, 2002 EST (#26) [Bookmark](#)

Another thought Jennie Davis' question on the parent that insists on a specific diet. In most cases the parents are interested in doing what is best for their child. In some cases it is a question of needing to educate parents and even physicians on the risks involved in feeding children with dysphagia an inappropriate diet. Also, feeding is often the last "normal" thing that the child is able to do. It is very difficult for some parents to let go of the nurturing side of feeding. It takes a lot of empathy and education on the part of the school team to ultimately be able to work with the parent. However, the school system is put in a very difficult situation when it is asked to feed a child in a manner that could compromise the health of a child.

**Joan Arvedson** [jcarved](#) - 10:11pm Sep 24, 2002 EST (#27) [Bookmark](#)

Let's see if I can respond to Heidi with the question of the 4-year-old with severe neurologic damage and limited purposeful movement. Actually I will pose questions, rather than answers, which often can be more helpful, since we don't know all the specifics.

1. What are the family goals? Is it realistic to think this child will have the cognitive skills to understand what you are trying to do in stimulating oral-motor function?
2. Are the movements limited because of severe damage to neuro motor pathways? Are they also limited because of severe mental/cognitive deficits?
3. What is the overall prognosis for neurologic improvement for areas of function (e.g., gross and fine motor skills, language & communication, cognition)?
4. How stressful will the intervention be to the child? Whatever we do should not result in negative experiences for children.

Not sure this is as helpful as you had hoped, Heidi. There are tough decisions when trying to "put the pieces together."

**Joan Arvedson** [jcarved](#) - 10:16pm Sep 24, 2002 EST (#28) [Bookmark](#)

One more short message for this evening.. in relation to ethical issues in schools surrounding "to feed or not to feed." There are court judgments that are in the public domain and serve as precedents that may be helpful to some school based SLPs and their teams. I also wonder if your schools have legal consultants available to you. There are differences from state to state, and among school systems in policies and procedures. Some of you have pointed those out very well. It is difficult to make recommendations that could be applicable in multiple settings for some of these reasons.

**Lissa Power-deFur** [Lissa Power-deFur](#) - 10:41am Sep 25, 2002 EST ([#29](#))

{[Bookmark](#)}

What an interesting conversation has developed!

A couple of thoughts from a state education agency perspective on differences of opinion regarding the child's diet.

Most importantly, you would want to try and resolve the differences. In Virginia, I've found that the nurses have good success in resolving comparable differences of opinion between the parents and the physician. The approach many nurses use is to have a conversation with the physician about the parent's position, as the parent may not have shared this with his/her thinking with the physician. (Don't forget to get parental consent to talk to the doctor!) It's possible the physician can talk to the parent or make some modifications in the order.

Another resource is mediation. Special education mediation is available in all states now. This enables a trained mediator to bring the two parties together to listen to one another and develop a solution that both parties can agree to. Check and see if this option is available to you when other methods don't work out.

**Lissa Power-deFur** [Lissa Power-deFur](#) - 10:48am Sep 25, 2002 EST ([#30](#))

{[Bookmark](#)}

Let me offer a few thoughts about qualifications.

Each state education agency has standards for the speech-language pathologists in the schools. If the SLP meets those standards s/he is viewed as "qualified." However, there is a difference between meeting the legal requirements and having the skills for the task at hand.

Dysphagia treatment is an area of practice that demands additional training, including supervised clinical practice. Without the necessary knowledge, skills, and abilities, the potential for harm to the child is significant. Of course, providing services for which we don't have the necessary skills and abilities is a code of ethics issue.

SLPs would be wise to explain the knowledge, skills and abilities needed to provide dysphagia treatment to special education directors, principals, etc. within the school setting. Remembering that their experience with SLPs is primarily associated with providing artic and language therapy, they will need to develop an understanding of how this is part of our scope of practice and of the skills we can bring to the district.

**Alison In Atlanta** [Alison Ogden-Bowles](#) - 10:56am Sep 25, 2002 EST (#31)

{Bookmark}

What is your opinion about using a few dysphagia trained/knowledgeable SLPs and a few OTs as a small core of Dysphagia/Feeding Consultants who may float within a large school system to try and do observations w/ feeding and create feeding plans once sufficient info is gathered?(The plan being to use the floating consultants vs. trying to train all SLPs & OTs, who may have no clinical dysphagia background, in all locations.)

**Jennie Davis** [jbelled](#) - 11:06am Sep 25, 2002 EST (#32) {Bookmark}

Thanks for all the responses to my questions...

Christine from California (#20) stated that one of the local districts did not "allow" for the SLP's to "go-in" the mouth.

Does a school district have the right to limit our practice this way? Whether we are "going in" for oral motor for speech or for feeding, if we are trained and competent regarding feeding/oral motor, can administration limit us from doing this?

I like alison's suggestion. I know some schools do this with aug com/assistive tech.

**Emily Homer** [Emily M. Homer](#) - 11:36am Sep 25, 2002 EST (#33) {Bookmark}

In response to Allison's question about a district team that addresses dysphagia. In most systems this is probably going to be the most practical. Start with the professionals who are most knowledgeable and interested, train them, limit their caseloads (or no caseloads) and they go around to all the schools. This is a good, functional model. In my opinion it will be very important to train the school based SLPs to monitor the feeding and swallowing plans on each campus. The staff on the campus must have a way to contact the dysphagia team in an emergency (they would also have an emergency plan in the class written by the nurse with the input from the team of SLP/OT. There are many benefits to this model including easier training as mentioned and the development of speciality skills due to the numbers of children treated by one team. Because of the nature of this disorder, when possible, if the team can be school based it is beneficial in the case of an emergency. School based teams are only possible when there are a majority of ASHA CCC'd, dysphagia trained SLPs. It is much more difficult to provide additional training, however, when this model is possible, it works very well because the professional who knows the student is also managing the dysphagia. There is constant interaction in the classroom with the teacher and paraprofessionals. In some districts there can be a combination of the two.

**Emily Homer** [Emily M. Homer](#) - 11:41am Sep 25, 2002 EST (#34) {Bookmark}

I agree with Jennie about the SLPs in CA. Wouldn't this also be a Scope of Practice issue? Maybe CA has a limited Scope of Practice. I know in Louisiana dysphagia is within our Scope of Practice for Licensure as well as ASHA's

**Joan Arvedson** [jcarved](#) - 12:20pm Sep 25, 2002 EST (#35) {Bookmark}

I have nothing to add at the moment, except to say thanks for the last few interactions. I do believe that the school based SLPs are faced with some of the biggest concerns because you see the children regularly, have to make decisions and follow through with members of your teams. BUT, you do not have the physicians or other medical personnel available every day. My concept of school teams (as well as medical based teams of children in school programs, which most are) is that we all work together and link our teams in ways that meet the needs of children and fit into varied systems.

**Darrell Dern, M.S., CCC-SLP** [slp250ccc](#) - 02:20pm Sep 25, 2002 EST (#36)

{Bookmark}

It has been very helpful to read the interchange here.

I would like to propose another question regarding waivers of liability.

Has anyone instituted having parents sign a waiver of liability once it has been decided that a student is unsafe to eat and drink orally, and the staff continues to feed and hydrate the student.

One of our staff suggested use of a waiver. My opinion is "no way" should a waiver be offered to the parent, for two reasons. First, the waiver would do nothing to protect the school since the school knows that death and complications can occur from feeding and hydrating the student and they willing proceed with feeding and hydration. Second, if I were a parent of a student with a swallowing problem I would be outraged that such a document would be offered to me to sign.

Any thoughts?

**Christine Hurtubise** [christineh](#) - 02:41pm Sep 25, 2002 EST (#37) {Bookmark}

I would just like to second what Dr. Arvedson stated regarding the importance of connecting with local medical facilities with feeding and dysphagia teams. There definitely needs to be a "team" approach to this complex issue. My only thought/ question is that with limited medical resources (i.e. there are only 2 pediatric feeding/ dysphagia teams in the local hospitals in L.A. that I know of) how can we make and maintain these relationships? Also, the 2 agencies that provide medical management/ assessment for dysphagia are primarily run by OTs- sometimes an issue regarding "turf". FYI-I originally provided dysphagia services within hospital settings (for 4 years) until I moved to L.A. 5 years ago. I was actually surprised at the heavy OT involvement here because my experience in NYC was that feeding/swallowing was more of an SLP domain.

With regards to the school district limitations- I haven't checked state regs./ scope of practice limitations specifically related to this issue, but I will. Thanks for the great insights and discussion.

**Joan Arvedson** [jcarved](#) - 02:59pm Sep 25, 2002 EST (#38) {Bookmark}

Christine's query about how to establish and maintain those relationships when the pediatric medical teams are so limited point out what I perceive as major problems..... and frankly there is no easy answer. The issue about the "turf" with the non-physician therapy disciplines is another tough one. I have been fortunate to be in places where that has not been a big issue, but I know it is huge in many places by what I hear as I talk with folks from not only the U.S., but other countries as well.

Where the pediatric teams are limited, perhaps enlisting primary pediatricians so at least you have good information and can problem solve together about the health issues. Some PMDs are really interested in doing the best possible for these complex children, although they know they don't have the background experience. A dietitian is one other really critical person - again this person has to be interested in complex children. Wish I could come up with some easier means.... we just have to keep thinking about who are the potential resources within the limitations geographically and other wise. Your points are so on target.

**Maureen Lefton-Greif** [mlefton](#) - 03:37pm Sep 25, 2002 EST (#39) [{Bookmark}](#)

There have been so many interesting comments during this web forum. I would like to comment on the discussion about asking caregivers to sign waivers which "allow" clinicians to feed/treat children despite "known" risk factors. I have been in clinic today and one of our consultants is a pulmonologist who has specialized in ethics. I asked him to comment on this issue.

His take is that waivers are not helpful. In agreement with Darrell's comments, he said that waivers do not prevent legal actions. His example was that an amusement park would not be exempt from liability if someone was injured while on a ferris wheel, even after signing a waiver. He also reported a recent situation when a family had a very difficult time when approached with the option of signing a waiver. The family felt that they wanted what was best for the child and that their intention was not planning to sue the school.

That said, concerns need to be openly discussed with families during team meetings and the content of these discussions need to be documented.

These are tough issues.

**Patricia Di+Cesare** [sleuth](#) - 05:41pm Sep 25, 2002 EST (#40) [{Bookmark}](#)

I am a new SLP in a special education preschool. I am looking for someone with experience with the Baclofen pump and it's effects on feeding skills. I have a 4-year old with spastic quadriplegia on my case load who just had one implanted. There have been many feeding "issues" between the family and previous therapist(and me) and my concerns have increased since the pump was implanted (approximately one month ago). Can anyone enlighten me. I have been searching on the web without success. Thank you much, Pat

**Maureen Lefton-Greif** [mlefton](#) - 08:27pm Sep 25, 2002 EST (#41) [{Bookmark}](#)

Pat, your question about the potential impact of a baclofen pump on feeding intrigued me. I did a literature search via pubmed and the only side effects that I saw (quick read of

abstracts) were secondary to surgery or leakage. I am curious about what changes you have observed and whether others have had similar observations.

Thanks

**Patricia Di+Cesare** [sleuth](#) - 10:35pm Sep 25, 2002 EST (#42) [{Bookmark}](#)

Maureen, There is a noticeable increase in coughing on all consistencies during meals. There is increased spillage with straw-drinking (Therapist provides jaw stabilization and physical prompts to close the lips). Once suck-swallow is initiated (sucking with tongue) on straw there is greater difficulty in terminating, requiring a verbal prompt to prepare the child and then removal of the straw. The suck appears stronger, increasing the amount of liquid extracted and therefore increasing the difficulty in managing the bolus.

The most noticeable difference in the child with the pump is an open jaw posture and profuse drooling. The child does not respond to "swallow" . Comprehension is good. Child is high functioning and is using a communication device with voice output.

He can open his hands now, but cannot hold on to objects.

Vowel production is more accurate. Child has vowels and velars.

Feeding safety is my concern right now. Pat

**Joan Arvedson** [jcarved](#) - 11:33pm Sep 25, 2002 EST (#43) [{Bookmark}](#)

Pat and Maureen,

I recall a few children with CP on Baclofen pump and we raised the question about swallowing changes. I don't have specific information in front of me, and the literature search was limited as Maureen indicated. My best recall is that there should not be a significant impact on swallowing. It makes me wonder if there is something else going on. What about the "dosage" of the Baclofen being administered?

Pat, is this child continuing to get worse as time goes by? Is there any chance this is a temporary phenomenon? The usual picture is no effect on swallowing, so this particular child's responses are quite unusual (at least in my limited experience). Guess we'll all be trying to check this out further.

**Thanks to everyone!** [Glen Engel-Cox](#) - 09:19am Sep 26, 2002 EST (#44)

[{Bookmark}](#)

Thanks to all for showing up and entering into a great discussion. This was the first event sponsored by the Special Interest Divisions, and what a great success!

I'd especially like to thank our guest experts--Joan Arvedson, Maureen Lefton-Greif, Emily Homer, and Lissa Power-deFur--for taking time out of their busy schedules to share their knowledge with us!

I'd also like to thank Jean White in the national office and Caryn Easterling and Paula Sullivan for the Special Interest Divisions for putting this together and keeping us all in line!

**Lissa Power-deFur** [Lissa Power-deFur](#) - 11:35am Sep 26, 2002 EST (#45)

{Bookmark}

There was a question posted yesterday that I didn't get a chance to respond to, due to internet access problems. Thank you, Glen, for letting me post this message after the conclusion of the forum.

The question was about schools that tell SLPs they can't "go in the child's mouth." Can they restrict our scope of practice this way?

In general, the employer can restrict what its employees do. However, it would be good to understand the reasoning behind this. The schools generally take the liability for anything that occurs in the school (rather than the SLP). As a result, the schools would be dealing with any lawsuits that may develop, tying up people and financial resources. Schools have been sued over a variety of things that may be misunderstood by the public, even if they were appropriate activities. Many districts, frequently under the advice of their legal counsel, take a conservative position, and limit anything that might cause problems.

Does that mean we just say "okay"? Well, we clearly don't want get in trouble with our employer. However, this could be a great opportunity to help education administrators understand our scope of practice and our training and experience in this area. The state licensure requirements and ASHA CCC requirements would be good tools to use to demonstrate what we are qualified to do. It could be that SLPs could negotiate with the district administrators to enable them to "go in the mouth" under certain situations.

In summary, the educational setting is such a different culture from the medical/health care setting, that there may be misunderstandings that develop on issues that overlap both educational and health. The important thing is to keep the communication doors open with education administrators so we can understand their perspective and give them the opportunity to understand what we can do.