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South African Speech-Language-Hearing Association

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Professional Practice Guidelines

for

PRIVATE HEALTH SECTOR

Ethics and Standards Committee 2023

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Guidelines for the Provision of Speech-Language Therapy in the Private Health Sector

The following guidelines have been updated by the Ethics and Standards Committee of the South African Speech-Language and Hearing Association (SASLHA) to ensure that the highest standards of service provision are maintained. They should be read in conjunction with the Guidelines for Speech-Language Therapy and Audiology Service Provision in the Public Health Sector in South Africa.

Introduction

Provision of speech-language therapy services within the private healthcare sector may take place in acute care hospitals, rehabilitation units, retirement homes or long-term care facilities. The therapist working in this environment will usually function independently and there is thus always the potential for abuse of the private healthcare system, unethical behaviour and unprofessional conduct. It is incumbent on therapists working in these settings to maintain the highest possible ethical and professional standards.

Referrals

- Clients are usually referred by doctors. If other members of the healthcare team make a referral, it is recommended that the therapist should confirm the need for this referral with the treating doctor.
- Clients may also be self-referred, but assessment and treatment should only be conducted with the consent of the doctor or unit manager.
- Therapists may not visit hospitals, rehabilitation units or care facilities, or approach individuals with the aim of recruiting clients.

Consent

- Therapists are ethically obliged to obtain the consent of a client (or family member, if the client does not have decision-making capacity) before embarking on assessment or treatment. Every effort should be made to obtain this consent (particularly when the client or family will be responsible for payment). It is acknowledged, however, that this is not always possible, especially when the referral is considered to be urgent.

- Consent is to be obtained in accordance with the relevant regulations, including the Protection of Personal Information (POPI) Act, the Consumer Protection Act (CPS) and those published by the Health Professions Council of South Africa (HPCSA).
- Consent is to be obtained for (a) treatment and (b) billing. They do not necessarily need to be signed by the same person.
- If consent is expressly withheld for treatment, then the therapist may not proceed with treatment, and must discuss this with the referring doctor. If no consent is obtained for billing, it is at the therapist's discretion to commence with therapy.

Billing and Payment

- Clients may only be charged for services provided, using the appropriate procedural codes.
- All invoices need to clearly specify hospital authorization numbers, the referring doctor and the correct ICD-10 codes.
- Payment is usually made by the client or his/her medical aid, but the facility may also pay the therapist for services as per specific contracts he/she may have with the facility.
- If the client (or his/her medical aid) is responsible for payment, this should be made clear at the outset and formal consent obtained.

Premises

- Therapists may have rooms in a hospital or see clients in hospital wards when called upon.
- Therapists who have consulting rooms within a hospital or other healthcare facility are required to pay a market-related rental.
- Rehabilitation units may employ their own therapists or enter into a contract with a specific practice for the provision of speech therapy services. Under these conditions, clients are admitted to the facility knowing that they are not able to choose their service provider.
- Under any other healthcare conditions, the client has the right to choose his/her own therapist. Renting rooms in a hospital, or receiving regular referrals, does not give the therapist a monopoly as the service provider.

- The physical environment of healthcare settings is often not ideal for therapy. Nevertheless, the therapist should strive to make it as suitable as possible. Examples of this include ensuring that curtains are drawn for privacy, that lighting is adequate, that background noise is kept to a minimum and that no discussions about client progress take place in the presence of other patients or visitors.

Treatment of Ward Inpatients

- Nursing practitioners are responsible for the day-to-day management of the patient, and the therapist must recognise and respect this role. The Unit Manager/Ward Sister oversees all activities in the ward. The therapist should report to her on arrival in the ward. The therapist should be familiar with ward policies, procedures and routines, and fit in with these as far as possible. The speech therapy treatment needs to be scheduled so that it does not interfere with ward routines.
- The therapist must adhere to the ward's infection control procedures. When visiting a hospital where these are not known, she/he must ask the unit manager if there are specific procedures to be followed.
- No changes may be made to patients' medication (e.g., crushing of tablets) without the treating doctor's consent and prescription. Medical permission must be obtained for any procedures which may affect the patient's health status, such as removal of oxygen masks or tracheostomy cuff deflation.

Teamwork

- Shift changes and the use of ad hoc locum therapists make good team communication difficult in many settings. However, the therapist should work towards establishing relationships and channels of communication with other healthcare professionals. Good communication with nursing practitioners is essential.
- All forms of communication need to adhere to the regulations on confidentiality as stipulated in the POPI Act and the HPCSA regulations.
- Every effort should also be made to establish contact with family members and involve them in the treatment.

Communication

- In accordance with the HPCSA regulations, the keeping of detailed patient records is required. Procedures for doing this vary, and the unit manager will advise on the correct procedure.
- The use of abbreviations, other than those in common use in the hospital (some hospitals have a list of permitted abbreviations) should be avoided.
- It is appropriate to provide recommendations or suggestions for feeding or communication to the person directly involved in the patient's care. However, where this is not a registered nurse (RN)/ "Sister", recommendations should be made through the RN responsible for the patient. All instructions/recommendations should be recorded in writing.
- If feeding instructions are to be placed above the patient's bed, consent needs to be obtained from either the patient, or their next-of-kin, in order to do so.
- If the patient is to be transferred to another therapist (e.g., from an acute care hospital to a rehabilitation centre, or from a rehabilitation centre to a therapist in the community), handover of information is required via a report or telephonic discussion.

Assessment and Treatment

- Assessment procedures and intervention techniques selected must be appropriate to the environment, the acuity of the patient's condition, and the patient's culture. Care should be taken in the interpretation of assessment results of acutely ill patients, whose presentation may change on a daily, or even hourly basis.
- The timing and intensity of therapy must be appropriate for the severity and acuity of the patient's condition. The therapy schedule should be clearly communicated to the patient/family and nursing staff. Treatment procedures should be based on evidence-based practice as far as possible. Goals should be specified, and outcomes measured.
- In an acute care environment, the therapist needs to be aware that the first experience of therapy can set the tone for the whole rehabilitation continuum. Creating a supportive, enabling therapeutic alliance is thus of paramount importance.

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