

Welcome to the webinar:

The COVID-19 patient pathway for SLTs

COVID-19: Practical and ethical decisions in adults with COVID-19

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13:00



Welcome



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Housekeeping



- Send in chat messages at any time by using the Chat button
- Send in questions by using the Q&A button
- This event is being recorded. See here for recordings:
<https://www.rcslt.org/webinars>
- Please do fill in the survey that we'll share after the event
- RCSLT staff are on hand to help!

Aims and objectives



By attending this webinar, you will gain an understanding of:

- The types of patients being seen on non-critical care wards
- The types of clinical presentation that these patients have
- Modifications to approaches to management
- Managing eating and drinking for those at risk of aspiration
- Approaches to managing mental capacity assessment
- Using ethical frameworks for decision making

Presentation of patients

- Reason and source of referrals
- Socio-economic status
- Communication
- Swallowing
- Delirium
- Comorbidities and prognosis
- Fatigue and variability



SLT assessment

- Principles of clinical practice
- Following RCSLT guidance
- Indirect preparation
- Risk assessment
- MDT working



Assessment considerations



- Positioning and fatigue
- Oxygen management
 - Impact of desaturation
 - Desaturation concerns/adjusting clinical parameters
- DD between COVID and aspiration pneumonia
- Non-oral feeding

Approach to management

Use of skills we already have - we can do this!



- Hypothesis generation
- Fatigue and delirium
- Dietary modifications & volumes
- Therapy
- Pragmatic decision making



Everyday issues in ethical decision making



- Rapid changes day to day - treating infection vs eating and drinking at risk
- Different staff on wards/community settings - may be less familiar with SLT role re capacity assessments and also of working with people with communication disorders
- Different involvement of families and friends
- Difficult conversations with families eg regarding prognosis
- Different access to Social Workers, IMCAs, Advocates
- Be prepared - think about questions - make resources beforehand

Wider service considerations and impact



- Rapid discharge from hospital (medically stable vs medically fit)
- Discharged home or bed-based services - being run differently with different staff and purposes
- EHCP/Advanced Care Plans - many patients with COVID-19 not being admitted, may not be referred
- Different access for OP and community patients for SLT
- Increased access to telehealth to support services to COVID and non-COVID patients eg HNC, PNC

Case study

- Patient history
 - 89 year old male
 - Independent
 - No history of dysphagia
 - Heart/Lung disease



- Oxygen management
- Anxiety and fears
- Mouth care
- SLT management
- MDT management



Learning points



- Implications of rapid desaturation
 - Patient
 - Clinicians
- Differential diagnosis: aspiration pneumonia vs. COVID-19
- Instrumental assessment
- MDT approach
- SLT team CPD
- AHP forum
- Increased access to telehealth to support services to COVID and non-COVID patients eg HNC, PNC

Ethical considerations



- Ethical decision making is complex
- COVID has brought about uncertainty as it's a new disease which brings further anxiety, clouding our decision making
- Advocacy role, more important than ever
- 'Marry the need to the capacity to benefit' (Baroness Finlay, April 2020)
- Revisiting the 5 guiding principles around decision making for those eating and drinking at risk

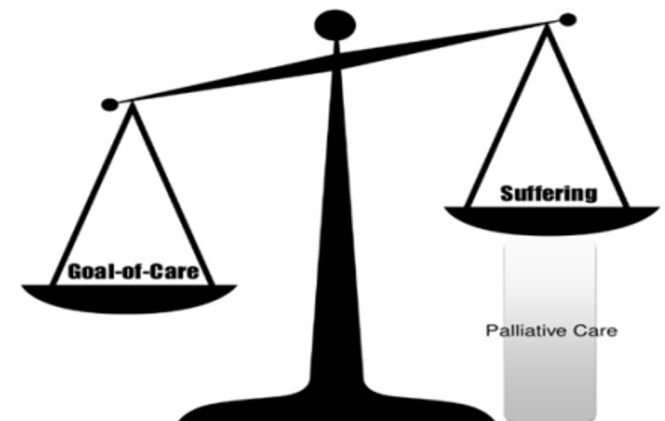
<https://www.mentalcapacitylawandpolicy.org.uk/>

<https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care>

1. What is the goal of intervention?



- COVID diagnosis, comorbidities, personal wishes/interests
- Comfort approach versus alternative nutrition and hydration
- We need to move swiftly and inclusively with our decision making, always keeping the person's wishes firmly at the forefront
- Case example of not being able to engage in a capacity assessment but clearly requesting a drink repeatedly





COVID COMPASSION

When treating your suspected / confirmed COVID patients, be mindful of their experience – PPE can be visually uncomfortable and a barrier to communication. Here are some tips on how you can **show your compassion even when wearing full PPE.**

REMEMBER: KIND EYES, CLEAR VOICE, CALM POSTURE

- Always be respectful, polite and empathetic
- Speak slowly and clearly
- Check that what you have said has been understood
- You can say a lot with your eyes and body language even in PPE – communicate compassion
- Be aware that your patient may be very stressed and afraid
- Listen to their questions and concerns
- Provide correct information – be aware that a lot is still unknown about COVID-19 and it is OK to admit that
- If appropriate, explain the procedure for COVID-19 patients as much as possible so your patient has some information about what to expect (isolation, limited visitors, swabs, moving to ward etc)
- Keep your patients updated
- Remember communication with your colleagues may also be harder for everyone in PPE – be kind and patient with each other and yourself



COVID COMPASSION

We are here for you.

If you need us to speak more slowly or clearly so you can understand us with our masks on, please tell us.

We will always treat you with kindness and compassion.

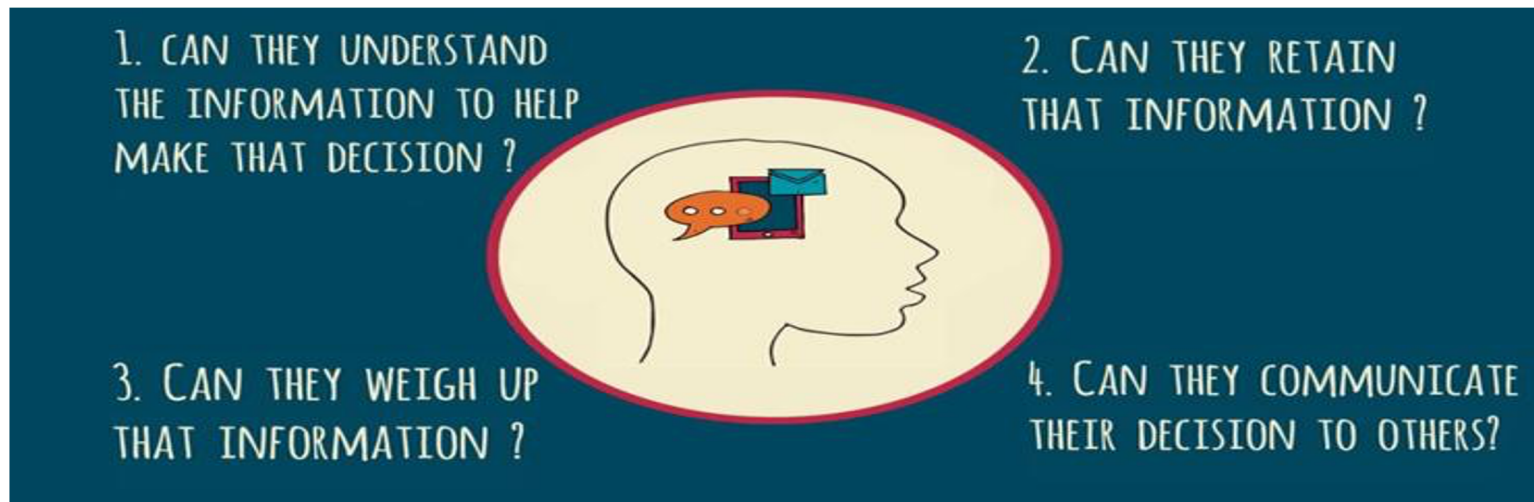
The Imperial College
NHS Trust Emergency Team



2. Mental capacity

- Assumption of intact decision making ability
- Mental capacity assessment if any evidence to suggest person has difficulty making a decision
- Visiting basic human rights, respecting and including individuals in decisions about their care

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7151525/>



Best interest meetings



- AAC to support conversation
- Focus on the purpose of best interest meetings
- Being creative with setting up telehealth options
- Ensure practical, clear justification of the decision is being captured
- Absence of information leaflets means longer conversations or another phone call
- <https://booksbeyondwords.co.uk/downloads-shop/beating-the-virus>

3. Swallow assessment



- Comprehensive clinical assessment of swallowing
- Individualised care
- Variability in presentation, still establishing patterns
- Rapid progression and rapid improvement
- Least distressing consistencies /textures
- For those who are likely to be eating and drinking at risk consider 'out of hours' recommendations, avoid NBM

4.MDT



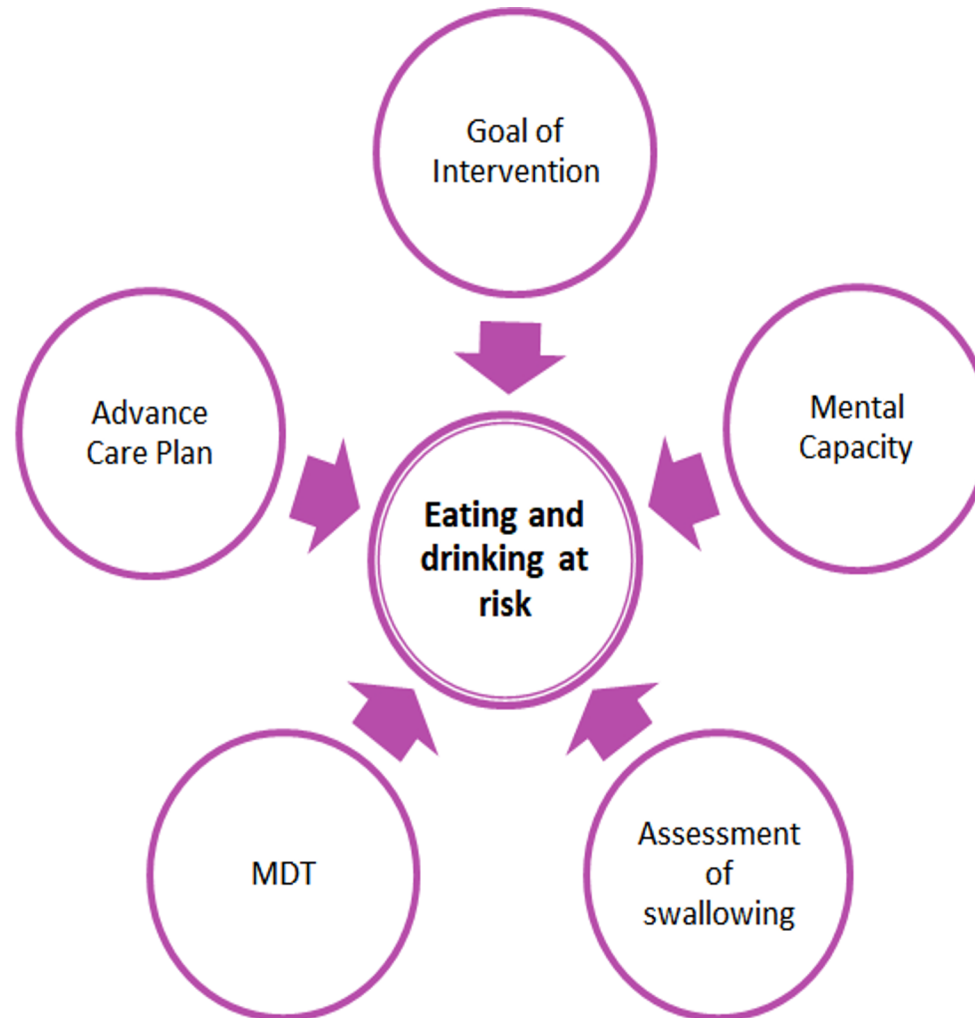
- Collaborative discussions including the nurse, doctor, dietitian, establishing the person's wishes/interests
- Don't forget liaison with pharmacists regarding medicines administration
- Include physiotherapists to decide on the level of chest management
- We facilitate but the consultant makes the overriding decision
- Establish what is within my sphere of influence
- Dignity and comfort at the end of life

5. Advance care plans



- One of the silver linings that has come out from the pandemic is the focus on completion of advance care plans (ACP)
- ACPs outline a clear plan of what should occur should there be a deterioration in health
- Where a person lacks the capacity to engage with this process then it is reasonable to produce such a plan following best interest guidelines with the involvement of family members or other appropriate individuals
- We are spending time establishing wishes so please ensure this is documented
- Please find GMC guidance below <https://www.gmc-uk.org/news/news-archive/statement-on-advance-care-planning-during-the-covid-19-pandemic>

Guiding principles



An ethical framework to support decision making



- Unprecedented situation for SLT services
- It is fluid and evolving; new questions and issues to resolve on a weekly (perhaps even daily) basis
- This requires us to use our expertise and judgement

A (non-exhaustive) list of questions/ dilemmas...



- Should we implement rehabilitation using oral intake, when this could pose a risk to the individual, if not for escalation of treatment?
- I feel uncomfortable requesting from ward staff the PPE I need (according to locally agreed guidelines) to carry out a swallowing assessment
- Other SLT services are able to use full PPE yet we are not, should I be concerned about this discrepancy?
- Am I denying individuals best treatment resulting in poor outcomes by restricting the direct interventions I am providing?
- As other services begin to open up again, how can we balance the demand of this new cohort of patients alongside our existing populations?

RCSLT guidance



- Social distancing and minimal contact with others must be observed in healthcare settings to reduce virus transmission
- SLTs should carefully weigh the risk-benefit of face to face assessments and consultations
- Contact should only be undertaken for urgent care where no alternative is possible
- Use your expertise and clinical judgement*
- Engage with others in the profession and the wider MDT
- Seek alternative ways to deliver care, such as: telehealth, supporting individuals through other professionals in essential contact, delaying interventions

Framework for clinical decision making



- The four principles of biomedical ethics (Beauchamp and Childress; 2001)
- **Respect for autonomy:** respecting the decision making capacities of autonomous persons; enabling individuals to make reasoned informed choices.
- **Beneficence:** this considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient
- **Non maleficence:** avoiding the causation of harm; the healthcare professional should not harm the patient. All treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment
- **Justice:** distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner

Case study



- COVID-19 positive
- Step down from CCU, period of intubation
- Continues to require oxygen
- Fluctuating delirium +/- cognitive difficulties
- Post-extubation dysphonia and dysphagia
- SLT assessment; multiple swallows, airway threat noted, impacted by fatigue and breathlessness. Needs level 1 fluids and level 4 snacks
- Whilst one assessment suggests an improvement to more texture, this has not been consistent
- Had an NG, this has come out. Staff would like to progress diet and prevent the need for further NG insertions

“Should we agree to increase volume of intake, when we know that this may increase additional aspiration risk for the individual, including potential deterioration in health in order to avoid re-insertion of the NG?”

Autonomy

- Reporting dislike of food offered during lucid moments
- Difficult to determine capacity; fluctuating delirium
- potential cognitive issues
- EAL

Beneficence (benefit)

- Enables restoration of eating and drinking
- Progression (rehab, mood, quality of life)
- Potentially supports individual's desire to eat more regular foods
- This could impact nutritional state

Non-maleficence (avoidance of harm)

- Risk of aspiration and obstruction risk
- Potential for chest deterioration and escalation of care
- Prevention of NG insertion

Justice

- Access to PPE for NG insertion and swallowing assessments
- Learning from this case to inform our knowledge of COVID-19 recovery

Conclusions



- Planning and responding to COVID-19 as it develops is requiring us to make difficult decisions under new and exceptional pressures with limited time, resources and information
- Utilising existing skills and sharing experiences of working with this cohort of patients can harmonise and strengthen our approaches to assessment and management
- We need to move swiftly and inclusively with our decision making always keeping the person's wishes firmly at the forefront.
- The tools provided today can provide framework and guiding principles to organise the factors influencing decision making and judgement
- The pandemic has afforded us opportunities that we should seize and take into our practice moving forward

Any Questions?



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