

RCSLT GUIDANCE

Speech and language therapist-led endoscopic procedures: considerations for all patients during the COVID-19 pandemic

Acknowledgements

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1. INTRODUCTION

This SLT-led endoscopy guidance has been revised further (following the previous October 2020 update). Through the pandemic our knowledge and understanding of the risks associated with endoscopy has now facilitated a return to 'business as usual' with key additional precautions in place. These mainly relate to personal protective equipment (PPE), infection, prevention and control (IPC) and training needs.

We also recommend that, along with this guidance, members refer to the updated [RCSLT guidance on the risk of transmission and personal protective equipment](#).

It is acknowledged that the evolving nature of the pandemic necessitates continual review of procedures and risks. This is a working document that will be reviewed and revised in response to any significant new evidence, member queries and feedback.

2. KEY RECOMMENDATIONS

The expert group have made the following key recommendations:

1. This guidance applies to **all patients regardless of their COVID-19 status and care settings**
2. The **standard protocols** for all SLT-led endoscopy procedures should be followed as set out in the relevant RCSLT position papers ([FEES](#), [EEL](#), [Adult Respiratory Care](#)) with additional precautions in relation to PPE and IPC guidance.
3. **PPE requirements** remain in line with the high, medium, and low risk patient pathways as defined by Public Health England (PHE) (see section 5.2)
4. **All levels of practitioners can participate** in SLT led endoscopy, including FEES.
5. A **considered approach to training** is advocated (see section 7).

3. CONTEXT

The RCSLT considers that SLT-led endoscopy for the purposes of upper airway functional assessment is an aerosol generating procedure (AGP) (Bolton et al, 2020).

Endoscopy remains a higher risk procedure for the potential transmission of COVID-19 (Ku et al, 2020; Nguyen et al, 2020) for healthcare workers as the nose and nasopharynx are known to be reservoirs for high concentrations of the virus (Zou et al, 2020; Aggarwal et al, 2020; Campbell et al, 2020).

Upper airway endoscopy has the potential to generate aerosols through sneezing, coughing, and gagging (Lui et al, 2019; Lu et al, 2020; Rameau et al, 2020; Workman et al, 2020). As the pandemic has progressed, risk of virus transmission during AGPs has been mitigated with increased knowledge, safer practices and use of PPE (Vukkadala et al, 2020; PHE, 2021)

4. CLINICAL DECISION-MAKING

It is essential that prior to undertaking any SLT-led endoscopy procedures, members refer to the updated [RCSLT guidance on reducing risk of transmission and use of personal protective equipment \(PPE\) in the context of COVID-19](#) which includes a risk framework to support clinical decision making and full consideration of alternative options.

The decision to perform SLT-led endoscopy should continue to be a multidisciplinary one. In line with current routine clinical practice guidelines, discussion and planning with the patient's clinical team should occur in advance of the procedure.

It is important that steps are taken to establish the patient's current COVID-19 status and level of risk as per government and local guidance prior to undertaking any SLT-led endoscopy procedure.

5. INFECTION PREVENTION AND CONTROL

5.1. Areas where SLT-led endoscopy is performed

National and local infection prevention control guidance for AGPs should be followed (PHE, 2016; PHE, 2021) regarding recommended clinical areas where endoscopy can be performed (eg designated rooms, endoscopy units, ICU). Procedures to be followed include ensuring sufficient ventilation and room air changes to facilitate clearance of any potentially infectious particles. The endoscopy procedure end time should be clearly communicated to appropriate team members.

5.2. PPE

In line with [COVID-19 Guidance for maintaining services within health and care settings](#) (PHE, version 1.1: 21, January 2021), SLTs need to designate patients to the appropriate patient pathway group as defined by PHE (see below) and following assessment using the RCSLT risk assessment framework in Annex 1 of the [RCSLT guidance on reducing the risk of transmission and use of personal protective equipment \(PPE\) in the context of COVID-19](#).

According to PHE guidance patient treatment, care and support should be managed in three COVID-19 pathways:

High Risk Pathway	Medium Risk Pathway	Low Risk Pathway
Patients who have, or are likely to have, COVID-19	Patients who have no symptoms of COVID-19 but do not have a COVID-19 SARS-CoV-2 PCR test result	Patients with no symptoms and a negative COVID-19 SARS-CoV-2 PCR test who have self-isolated prior to hospital admission

(Public Health England, 21 January 2021 (PHE, 2020b))

The PPE requirements for AGPs for low, medium, and high-risk groups are outlined below.

(Please note these are PPE recommendations for SLT led endoscopy/FEES which are based on PHE risk pathways).

PPE AGP High Risk Pathway	PPE AGP Medium Risk Pathway	PPE AGP Low Risk Pathway
FFP3 mask or hood Disposable gloves (single use) Disposable apron/gown (single use gown) Eye protection (single or re-usable)	FFP3 mask or hood Disposable gloves (single use) Disposable apron/gown (single use gown) Eye protection (single use or re-usable)	FRSM mask (Surgical mask Type II for extended use* FRSM Type IIR for direct patient care*) (*extended use of facemasks in England/Scotland for HCW when in any healthcare facility) Disposable gloves (Single use) Disposable apron/gown (Single use apron (gown if risk of spraying / splashing)) Eye protection (Risk assess and use if required for care procedure/task where anticipated blood/body fluids spraying/splashes)

Table adapted from [PHE guidance](#).

Advice should be sought from the local infection prevention and control team regarding the requirements of the procedure room, ventilation and the time required for a 'rest' period.

For AGPs performed as a single procedure, PPE is subject to single use with immediate disposal following completion of the procedure. Strict adherence to PPE donning and doffing procedures according to national guidance is required (PHE, 2020b).

5.3. Equipment and decontamination

National and local IPC guidance on endoscopy decontamination and disposal of equipment and consumables should be followed.

6. PERSONNEL AND ENDOSCOPY PROCEDURES

All levels of practitioners (level 1, 2 and 3) can participate in SLT-led endoscopy, as set out in the following RCSLT position papers:

- [Fibreoptic Endoscopic Evaluation of Swallowing \(FEES\): the role of speech and language therapy](#); and
- [Speech and language therapy endoscopic evaluation of the larynx for clinical voice disorders](#).

For FEES, an abbreviated procedure is no longer indicated, and it is recommended that SLTs utilise the standard protocol and equipment as set out in the RCSLT FEES position paper. Careful assessment of the structures of the larynx and upper airway is required due to the known laryngeal complications associated with COVID-19 disease and intubation trauma, (McGrath et al, 2020; Rouhani et al, 2020).

7. TRAINING

The pandemic has posed challenges in providing support and supervision for competency acquisition. A survey of RCSLT members was carried out in early 2021, which identified the need for additional guidance around training, which is currently in development.

Before commencing endoscopy training within your healthcare or educational institution we recommend a planned approach which follows national and local IPC guidelines.

Following local Trust approval, some of the following solutions may be considered:

- Non-patient volunteers for practicing insertion and manipulation of the scope
- Observation and shadowing in ENT/FEES clinics
- Collaboration with MDT colleagues for endoscopy competency development
- Utilisation of webinars and online resources
- Use of virtual networks to enable peer support and interpretation of images
- Using anatomical models for simulation of endoscopy as a blended approach to education and training

It is acknowledged that during the pandemic not all clinicians will have been able attain the usual standard minimum practice of 12 FEES annually. Where possible practitioners can use pragmatic approaches to maintain assessor competencies.

The RCSLT recommends that members should reflect and document their performance with a peer or supervisor after they resume practice to provide an opportunity for additional support if needed.

8. OUTCOME MEASURES, AUDIT AND RESEARCH

In addition, the RCSLT recommends that members continue to collect and submit clinical outcome data using the [COVID-19 speech and language therapy data collection tools](#) for confirmed COVID-19 patients.

In line with best practice, service evaluations, research and audits for SLT-led endoscopy and training are encouraged with appropriate approvals and governance in place.

9. REFERENCES

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