COVID-19 Dysphagia, voice and communication rehabilitation: clinical update: Q&A document

Please note - This webinar was recorded on Tuesday 26th January and presents the evidence and research available at 25 January 2021.

1. I am very keen to know what high quality headsets are recommended to be able to assess Voice virtually. My trust have given out cheap poor quality devices which is not possible to assess voice. Models and makes would be useful

Gemma Clunie	The headphones we use are Microsoft LifeChat LX-3000. This is the clinical guideline we put together last year - https://www.rcslt.org/wp-content/uploads/2020/11/guidance-on-voice-in-COVID-19.pdf - in particular you need Annex 6 for the work Paul McKenna in Manchester did on the best equipment to use. In terms of voice assessment and therapy over a video call it is really difficult. My colleagues and I all agree the best option would be to see a patient for initial assessment face to face (ideally with endoscopic evaluation of voice) before starting video therapy because no matter how good the technology it can't take the place of face to face perceptual assessment of voice.

2. Did Anusha get any SLT when home?

Sarah Wallace OBE	Yes, she has had seamless care following transition from IP to discharge home and has been followed up by my SLT team for OP voice therapy via telehealth and joint voice clinic and continues to be monitored

3. Please can you let us have a list of the useful references that you have summarised in your valuable presentation.

RCSLT	The presentation slides and resources from webinar will be available on the RCSLT website tomorrow https://www.rcslt.org/events/covid-clinical-update/

4. How have COVID related practices impacted on your faith in clinical swallow evaluations? Has it reinforced the value of observational assessments or not?

Answered live: Yes, I've always supported the perceptual skills of CSE, and the value to assess and manage dysphagia has absolutely been highlighted when we couldn't use FNE/VF, however the silent aspiration facet is important to note-instrumentation has absolutely improved the sensitivity and specificity of our ax in this wave.

Sarah Wallace OBE	Yes, it has shown the value of early clinical swallow assessment but also highlighted the pitfalls. The high proportion of patients

	with laryngeal pathology and subsequent dysphonia accompanying dysphagia in COVID, either as a result of intubation, trache or covid itself has led to an increased need for instrumental evaluation particularly FEES. Without nasendocsopy, which was the situation early on, we missed intubation trauma which has led to some delays to commencement of oral intake, trache wean and some chronic voice and airway complications that I feel may have been treatable earlier. Managing these patients using FEES in 2nd and 3rd wave has meant more efficient, proactive and less cautious treatment of airway issues, aspiration risk and swallowing. Our clinical skills are fundamental to deciding timing and appropriacy but are not enough in this complex caseload with so many laryngeal complications I think.
Gemma Clunie	Absolutely agree with Camilla and Sarah that CSE still has value - I also disagree with its description as an “observational assessment” - a properly conducted CSE is an active assessment of cranial nerve function and swallowing trials, taken alongside thorough patient history and underlying physiological information (for example chest xray findings, blood results) and MDT discussion. However, it has limitations (well-known and documented) that are no different for a COVID patient than any other patient group, and needs to be supported and supplemented where

	possible with instrumental assessment, particularly in a critical care cohort.

5. Any hints or tips for how to complete the RCSLT data set? We are keen to do it but have yet to work out the most efficient way of doing it. Thank you.

RCSLT	The RCSLT COVID-19 dataset and supporting resources can be downloaded here. In particular, we have developed a set of 'top tips' to help services with getting started with collecting the data. Should you have any further questions, please do not hesitate to contact root@rcslt.org.

6. Hello we are experiencing delays with our information governance team trying to gain approval to use Your Covid Recovery website. Do you have any tips?

Answered live: Maybe look at the NHSE publication on the website to answer specific questions

On the RCSLT website there is also a section on information governance you may find useful. It's in the 'delivering quality services' pages.

7. What non-digital support is available for those recovering at home? I'm thinking particularly (though not exclusively) of the many elderly patients who do not have access to such technical things and who often don't even have wifi installed at home?

Gemma Clunie	I don't know of anything specific but the Your COVID website information or other packages developed elsewhere e.g.

	https://covidpatientsupport.lthtr.nhs.uk/#/ could easily be adapted to printable resources for patients who require low-tech options.

8. Is the phase 2 of yourcovidrecovery for SLTs only or wider rehab team - when registering are we registering SLT or the MDT?

Answered live: Its for the whole MDT-but all teams can use it independently for specific patients

Sarah Wallace OBE	You can register your department or MDT

9. Would it be suitable to use the PICUPS tool within a rehab inpatient unit to screen for potential patients needing SLT?

Answered live: Yes definitely!

10. For Sarah: Would it be possible to register to use this tool in other countries?

Sarah Wallace OBE	I'm not sure, you can email them maybe and ask what their data governance framework and data sharing will allow?

11. Was the training to GPs taken up by GPs in Northern Ireland?

RCSLT	It was run by RCGP so was UK wide

12. Is indirect swallow reviews in patients with COVID 19 recommended in acute setting considering the risk of transmissions? such as upgrading diet/fluids over the phone to the wards?

Answered live: If you have suitable PPE, i would avoid indirect reviews. Complex dysphagia presentations require face to face assessment from the slt in our experience

Sarah Wallace OBE	I would avoid distant review now, and resume usual practice using PPE. We know from follow-up that COVID patients can continue to struggle with hard foods and hyperaesthesia of the larynx which are difficult to identify unless by a skilled dysphagia professional.
Gemma Clunie	Our acute teams use a prioritisation/risk matrix to determine review priority (similar to pre-COVID times) so use of PPE and footfall would not factor into decision making about direct assessment. If that is what a patient needs then that is what they should receive as Sarah and Camilla have stated.

13. I wonder which SaLT services long covid patients can access given tight eligibility criteria and lack of mention of SaLT in NICE paper?

Gemma Clunie	It is my understanding that community teams will accept referrals for long COVID patients in the absence of specific provision within long COVID teams (and some services have been successful at winning funding for long COVID provision). The NICE guidance mentions the

	importance of specialist MDT input specific to patient need so this needs to be highlighted to funders and providers even if SLT aren't specifically named.

14. The use of cervical auscultation has been stopped for dysphagia assessments in our trust, is there indication when this could be reintroduced?

Sarah Wallace OBE	This was answered live. If you use a stethoscope don't share equipment and decontaminate it with clinelle wipes as per local IPC guidance

15. Are there any recommendations for those returning to eating and drinking with long-COVID in a care home setting?

Sarah Wallace OBE	Agree with Gemma
Gemma Clunie	I don't know of any specific recommendations, but I don't think they would differ from usual return to E&D following respiratory illness.

16. Any advice on accessing clear masks and if so specific suppliers?

RCSLT	There are no suppliers that have been approved to date.

	RCSLT guidance on transparent face masks https://www.rcslt.org/wp-content/uploads/media/docs/Covid/RCSLT-Transparent-face-masks-Policy-Statement-22-Sept.pdf

17. Are there specifically recommended cognitive communication screens/assessments and treatment programmes?

Gemma Clunie	The La Trobe Communication Questionnaire was referenced as a useful screen in an earlier piece of work related to the PICUPS tool https://www.sralab.org/rehabilitation-measures/la-trobe-communication-questionnaire#non-specific-patient-population

18. Is anyone using silicone single therapist masks as opposed to ffp3? What have local ip&c feedback been on these?

Sarah Wallace OBE	No, not approved in our trust, we use FFP3 as Gemma describes
Gemma Clunie	No, we have to be properly fit tested for any FFP3 we wear, and if the supply to the hospital changes we have to be tested again on the new masks. Some of us have reusable masks because of not fitting the foldable or single use variety and there has

	been a recent IPC update that valved masks have to be used for sterile procedures. All of our HR records now have the masks we do (and don't) fit recorded against them.

19. Once a patient is home, discharged from hospital, should dysphagia resolve naturally over time?

Sarah Wallace OBE	Usually yes but there can be persistent issues particularly in patients with neurological complications of COVID e.g. CVA, myopathy. Also chronic reflux, globus and hyperaesthesia are an issue that need ongoing advice
Gemma Clunie	Agree with Sarah

20. Should we be treating this in a similar way to COPD?

Sarah Wallace OBE	Agree with Gemma, COVID is multi systemic and has many issues with clots which can cause neurological, cognitive and other issues in addition to respiratory concerns related to pulmonary emboli and fibrosis. In other words you might see a multitude of aetiologies causingvoice, swallowing and cog comm problems including respiratory. Of course some of these COVID patients also have COPD premorbidly and so determining if there is exacerbation is even more tricky.

Gemma Clunie	There are parallels in that they are both respiratory illnesses, and silent aspiration and difficulties with breath-swallow coordination are features of both - particularly in an exacerbation for COPD and in the acute stages of COVID. However where COVID is a virus with other systems involvement, COPD (unless occurring with other conditions) is more purely respiratory. If you are wondering about the relapsing-remitting pattern of COVID mimicking a COPD exacerbation pattern I'm not sure we know enough yet. It is probably worth liaising with respiratory physio colleagues to see how their experiences compare.

21. Patients are complaining of very dry mouth/throat – do we know if this resolves?

Sarah Wallace OBE	Agree. Dry mouth as an in-patient is often a result of medications used to dry the patient out and to manage hypertension and renal complications of covid. Long-standing xerostomia might partly be due to ongoing renal issues or disrupted mucosa post intubation. Good advice from Gemma.
Gemma Clunie	This has been an incidental finding in patients we have seen as OPs at least 3 months following their discharge from hospital so it does persist for some. There seem to be some patients who complain of on-going taste changes as well which can

	exacerbate. The best advice we have is similar for other xerostomia patients - have water with you all the time, make sure you are drinking enough fluids, trial saliva replacement (although many people don't like these), steaming (for direct hydration to tissues and trying to maintain a humid environment (bowl of water on the radiator); sugar free sweets or chewing gum can be helpful to stimulate saliva as can pineapple.(see this ref for an RCT on this doi: 10.3390/nu11092020. PMID: 31466334; PMCID: PMC6770241.)

22. I am an ASLTIP SLT. I am currently working with a community client waiting to undergo Cancer surgery in an NHS tertiary centre.

At present, according to their age, they are not classed as high category for the national vaccination programme.

However, the surgery they are about to undergo is expected to impact voice and swallowing significantly, so their clinical vulnerability and need will suddenly change within a few days of hospital admission.

1. **Are hospitals offering Covid vaccinations to patients predicted to become dysphagic/dysphonic through planned admissions for cancer/other surgical treatments?**
2. **If not, can SLTs like myself write to the client's GP to ask them (during these hospital admission delays) to consider elevating such a patient to being a higher priority on their community vaccination programme list??**

This would certainly reduce my client's anxiety!

See link below which should cover your patient. If you are concerned do write to your GP.

Coronavirus (COVID-19) vaccine - NHS (www.nhs.uk)

We have had situations where we have arranged vaccination for patients prior to surgery if they were felt to be high risk, but this has been organised by the Surgical Consultant in liaison

with the vaccination lead for the specific Trust so I wonder if you could also liaise with the hospital team? (GC)

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