RCSLT webinar:

Practical and ethical considerations for patients with Covid-19

Monday 4th May

Q&A

Chair: Kamini Gadhok MBE, CEO RCSLT

Speakers:
Caroline Ewers, Specialist SLT, Sunderland Royal Hospital, South Tyneside and Sunderland
Dharinee Hansjee, Head of Speech & Language Therapy, QEH Lewisham & Greenwich NHS Trust
Kate Harrall, Principal SLT, East Suffolk and North Essex NHS FT

1. **When you see non resolving delirium - are they seeing this from early in covid diagnosis?**

Caroline	Yes
Dharinee	Yes
Kate	When we have experienced individuals who have delirium, they have typically stepped down from Critical Care

2. **How do you pre oxygenate a patient? I don't think this is possible**

Caroline	It is possible; please discuss with your physiotherapy team
Kate	Pre-oxygenation is something that the physiotherapy team have been doing in preparation for tasks that are likely to result in exertion and fatigue. Especially for those that are known to desaturate (some individuals do this 'silently')

3. **Has there been an experience of long term impact on voice secondary to COVID?**

Caroline	We feel this is too early to say however the service is planning for the likelihood of increased referrals to voice services.
Dharinee	We are seeing the impact of prolonged intubation or trauma during extubation

	and have therefore developed a resource for voice care advice to share with patients
Kate	Same as above. We are anticipating potential difficulties in the long term, and have produced advice leaflets with planned follow up clinics (with our AHP colleagues)

4. **How much more were your nurses and care support workers needed to supervise meal times especially in view of the need to monitor oxygen saturation.**

Caroline	This varies from patient to patient; we have been well staffed at the trust to support mealtimes on the wards. It would be difficult to quantify this need and we have not audited this input.
Dharinee	There was definitely a higher need for support during meal times particularly due to patients being on oxygen support. During the peak - all AHPs were offering support to help nurses and HCAs
Kate	Nothing further to add

5. **Question for Caroline Ewers - As you mentioned your discussions with physio were very helpful, you expressed that they suggested an appropriate range for oxygenation maintenance during your assessment that is acceptable for COVID patients. What is this range and is this variable depending on their previous medical history e.g. COPD patients? What is the lowest range that would be acceptable according to your physios? Many thanks**

Caroline	This varies from patient to patient - you would need to speak to your physio team re. This on a case by case basis

6. **Are they dysarthric? I thought they want purée due to decreased appetite, smell and taste- not necessarily CN XII involvement**

Caroline	The main issues we have found are fatigue and delirium / lack of awareness at mealtimes. We feel there has not been enough patients at our trust with this particular issue and we have found it difficult to differentially diagnose this due to other comorbidities (e.g. MS)
Dharinee	We still need to explore data further to see if there is a pattern with prolonged intubation impacting on CN XII or whether its the delirium or confounding variable like medication. More analysis of data is required to draw conclusions.

7. **If conducting dysphagia assessments remotely ie telehealth, how should we be dealing with carers for example facilitating these assessments with a covid positive patient. As we are treating these as a AGP, should we be ensuring that they are wearing the correct ppe, do we have a responsibility to highlight a potential increased risk of transmission at dysphagia assessments?**

RCSLT	The RCSLT has produced some additional guidance to support members with clinical decision making and risk assessment https://www.rcslt.org/rcslt-statement-on-personal-protective-equipment-PPE
Caroline	There continues to be some discrepancies around PPE. RCSLT have submitted a paper for further consideration. In our Trust swallow assessment is not classed as an AGP. We would advise carers should follow the guidance of their organisation and PHE.
Dharinee	As there are local agreements in place, all we can do is draw attention to the guidance.
Kate	As suggested above; localised guidance and PHE should be followed. In addition, I would also encourage risk assessing the situation; for example, is the individual able to feed themselves with carer support from a distance, therefore reducing risk?

8. **What proportion of patients started on puree and thin fluids over a weekend then need direct SLT review vs those who the MDT progress to a normal diet without SLT review?**

Caroline	In our Trust the progression of recommendations would be by SLT; we are finding that patients are not moving on so rapidly. Additionally, to reduce the footfall we are waiting for patients to medically improve and increasing indirect working (looking at is the patient E&D good amounts / is the visit essential?)
Dharinee	All patients started on a pureed diet irrespective of whether this is through the 'eating and drinking at risk' out of hours pathway or those placed on a pureed diet by SLTs will be followed up by SLTs.
Kate	In our Trust, progression of diet will also be SLT led

9. **Are you seeing people with learning disabilities and pre-existing dysphagia who have or have had Covid-19. Are there any insights into the presentation of this population?**

Dharinee	Although this was answered in the webinar, insight was based on one adult. We definitely need to see many more people with LD and COVID to offer more insight.

Kate	We have not experienced individuals with LD who have been COVID positive.

10. In Kate Harrall's case study, would you be able to elaborate on 'airway threat noted'- does this mean increased risk or signs of aspiration?

Kate	This was answered in the webinar. Yes, when I referred to airway threat, this meant coughing and throat clearing (ie overt signs of aspiration)

11. What has been the outcome in Kate's Pt case study?

Kate	This was answered in the webinar. A further attempt of an NG was made, but was unsuccessful so oral intake was 'optimised' as best as possible using supplements as prescribed by Dietetics within the restrictions of SLT recommendations. When able, we progressed volume and texture of intake

12. Are there any recommendations for ongoing management of dysphagia in the community?

Caroline	Increased access to telehealth to support dysphagia management in the community. As services 're-open' we will need to navigate redesign pathways to cope with COVID and Non-COVID patients in the community.
Kate	From the perspective of clinical dysphagia management, some individuals are reporting effects of post-covid weakness and breathlessness, that may continue to impact for a prolonged period when they return home. I think community SLT needs to be aware of this, and potential for dips in health.

13. Curious about the evidence base for restricting volumes for oral intake. Is specific to COVID? Wondering what the outcome measure would be to rationalise increasing this restricted intake?

Caroline	We would not recommend restricting volumes of intake as such unless medically indicated (e.g. refeeding syndrome); we have suggested smaller volumes due to fatigue with some patients (i.e. little and often).
Kate	If this is in response to the case study, smaller amounts of oral intake was initially recommended alongside non-oral feeding, and in response to the individual's inability to manage full portions due to fatigue, weakness and dysphagia.

14. Wondering if the cranial nerve 12 impairments are also seen early on? I'm just trying to get a picture of covid pts at an early stage as I work with vulnerable adults in residential homes.

Caroline	See above response.

15. I would love to know more Caroline about the differential diagnosis that you spoke about for people presenting with feds who have covid

Caroline	It would have to be done in collaboration with the medical team to ensure patients have had the appropriate investigations completed; we advise speaking with the medical team re. Interpretation of investigations. It is a challenging area and even more so without instrumental assessment for objective information to aid differential diagnosis.

16. Have any of the speakers observed patient difficulty with thick pharyngeal secretions or 'plugging off' within the upper respiratory tract with no apparent outward signs?

Caroline	This question was answered in the webinar.
Kate	We experienced plugging off with thick secretions with an individual with a tracheostomy, requiring an inner cannula change

17. Have you seen benefit of IVF for patients who are not drinking enough?

Caroline	This would be best answered by the medical team in your local area.

18. Do we have any sense via clinical info (eg presence/absence of emerging chest infections) of how vulnerable this group might be to silent aspiration? i.e. especially in the context of reduced/no access to instrumental ax?

Caroline	We would not know how vulnerable they are to silent aspiration. This would make a good research question - may be a local audit would be helpful?
Dharinee	FEES is not being conducted and VF within our Trust, on NON COVID patients only so I doubt this data is going to be currently available as you can only objectively assess silent aspiration with objective assessment
Kate	Our experience to date has been that the individuals we have seen have tolerated the recommendations provided and have not seemed to develop chest signs that may suggest silent aspiration. But it is still quite early for us to be sure and, as Dharinee and Caroline have mentioned, we do not have FEES or videofluoroscopy information to know this.

19. Do you think community SLTs should be available at weekends?

Caroline	We have started running a limited service but most of this has been indirect in the community. This would need to be reviewed and funded appropriately going forward. It may be helpful in the future.
Dharinee	Yes absolutely, now more so than ever there is the need to provide a 7 day service
Kate	This could be beneficial, particularly with an increasing rehabilitation demand alongside needing to open up existing services again. However, adequate staffing levels are required to support this.

20. Are therapists anticipating > community referrals to Community service post covid and what forms of difficulty might these seem to be e.g. upgrades, dysarthria, voice difficulties?

Caroline	We don't know yet - we anticipate some increased referrals due to the unmet need as patients have been d/c rapidly from hospital as medically stable (not 'fit') during this period as well as predicted increasing referrals post extubation / critical care stay.
Kate	Rehabilitation demand may increase, as well as the requirement to address the need of our existing populations that we have needed to delay or avoid seeing during the pandemic. Specific to the COVID population; dysphagia assessment and review, potential voice outpatient services, and potential cognitive communication assessment and support is anticipated but we need to monitor closely to see how this develops.

21. Any advice for community SLTs completing risk feeding decisions for patients/families who are shielding so cannot physically see them? Would appreciate any tips on how to go about upholding principles of mental capacity assessments via telehealth. We may be relying on people in the house to explain or translate information to the patient - how can we get around this?

Caroline	If access to telehealth consider patient / family on to facilitate these conversations. Similar to how you may do this in the OP setting prior to Covid - involvement of MDT / provide appropriate resources to facilitate discussions.
Kate	First part of question: Involving family members has proved tricky for us, when they have not been able to see their relative. Make sure that health professionals are providing a similar message so that relatives do not feel confused. Coordinate information delivery though just one or two health professionals if possible. Talk about what the relative's role is; to advocate for the patient rather than being the sole decision maker. Letting us know about their relative and their approach to life

	and health so that we can collectively make appropriate decisions on their behalf (if it is a best interests decision). Second part of question: The process may involve more steps than before. Sending out information in advance to families so they can read and ask questions, with a separate initial call to the family first to ensure they understand the purpose and content may help. You may need to use several calls rather than just one call to complete the assessment.

22. Cranial nerve XII damage is a known rare complication of endotracheal intubation - good to look out for in this population of survivors who are likely to have had 1) prolonged intubation periods than usual, and 2) additional movement and pressure from proning than usual

Caroline	We have limited experience of post intubation patients.
Dharinee	Still need to investigate further to establish trend
Kate	We have not experienced this yet in our post-extubation cohort.

23. I missed the 1st speaker due to technical challenges watching it from home. However, the topics were covered in detail and enjoyed every bit. Because I stopped work voluntarily since 31st March, this was an eye opener. It made me aware of what colleagues are dealing with when managing patients with covid out of critical area. The MDT approach is now robust and supportive documentation for feeding the patient at risk are somehow in place. Management of covid patient is intellectually demanding. My questions are as follows- I am aware the scientists are at the initial stages & not aware of the trajectory of this new virus

1. **Are the neurological presentations likely long term.**
2. **Are these due to covid or some premorbid medical conditions**
3. **Is there a genetic predisposition**

Caroline	We cannot answer these questions - We feel there will be further research into these areas.
Kate	It is not possible to say at this time.

24. One of the speakers spoke about allowing a lower level of desaturation with COVID patients; I wondered If she could specify what levels they are allowing for desaturation?

Caroline	Please see previous responses - case by case basis - discuss with physiotherapy colleagues.

25. **I think one of our issues is that care homes should still refer despite us not being able to do routine visits as yet. We were going to send out a letter saying that we are still accepting referrals and offering phone consult service. Any guidance from RCSLT re: continuity of care for non-covid-19 patients as well would be helpful**

Caroline	We contacted all care homes in our area and sent out information re service / referrals / advice sheets and we have continued to to receive referrals - these can be triaged daily and managed appropriately (i.e. telehealth / direct contact)
Kate	We also contacted the individuals on our caseload and waiting list to explain we were not able to directly assess or review at present, or there could be a delay to accessing our service. We have been telephoning and using video calling, which has allowed us to continue to see a lot of our community caseload despite the pandemic, and we have the option to respond to urgent need. For example, we conducted a videofluoroscopy with a community patient to aid admission avoidance (repeated chest infections requiring instrumental information to ascertain aspiration risk). There is a lot of guidance on the RCSLT website regarding telehealth, and we have used the RCSLT guidance regarding risk assessment to triage workload.

26. **Dysphagia presentations in COVID. Is there any evidence yet on best practice in terms of management?**

Caroline	No - the RCSLT data collection sheet may support this. We feel we are all learning at present!
Dharinee	Currently collecting data using RCSLT spreadsheet
Kate	I think that at present, we are at the stage of sharing our experiences and through this open discussion and collaboration, reaching consensus on best approaches to take. As Dharinee and Caroline have mentioned above, using the RCSLT tools will enable us to collect important data to analyse for learning.

27. **What happens if I go on the ward for face to face with patients who are suspected but have tested negative and the ward staff's use of PPE is relaxed? Should I insist on PPE? Or should the SLT manager insist on PPEs for all SLT staff when face to face with the patients.**

RCSLT	Please see above response regarding the additional RCSLT guidance above. Please also refer to tables 1, 2 and 4 in the national PHE guidance (section 5)

	https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe
Dharinee	Follow local guidance but gloves, goggles, surgical mask and apron should suffice
Kate	RCSLT have been clear about what PPE they recommend for dysphagia interventions but this will depend on your locally agreed guidance. Within our service, we risk assess the need for direct intervention. If direct intervention is required, we try to understand before our intervention whether the person needs assistance with feeding, whether their dysphagia presentation involves coughing (from nurse screen and/or patient report), and their COVID status. We use this information to help guide what level of PPE is required. In this instance, if an individual has tested negative we are more likely to use less PPE, but we do take the other factors into account when making our decision.