IASLT COVID -19
Updated Guidance for IASLT Members

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1</td>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>1.1</td>
<td>What is Covid-19?</td>
<td>4</td>
</tr>
<tr>
<td>1.2</td>
<td>Advice and Guidance</td>
<td>4</td>
</tr>
<tr>
<td>1.3</td>
<td>Information from CORU</td>
<td>5</td>
</tr>
<tr>
<td>1.4</td>
<td>SLT Intervention Considerations</td>
<td>5-6</td>
</tr>
<tr>
<td>Section 2</td>
<td>Personal Protective Equipment (PPE)</td>
<td>6-7</td>
</tr>
<tr>
<td>Section 3</td>
<td>Aerosol Generating Procedures</td>
<td>7-9</td>
</tr>
<tr>
<td>Section 4</td>
<td>Acute Care Settings</td>
<td>10</td>
</tr>
<tr>
<td>4.1</td>
<td>Considerations for Clinical Dysphagia Examination as an AGP</td>
<td>11</td>
</tr>
<tr>
<td>4.2</td>
<td>Videofluoroscopic Swallow Study</td>
<td>12</td>
</tr>
<tr>
<td>4.3</td>
<td>Endoscopy</td>
<td>12</td>
</tr>
<tr>
<td>4.4</td>
<td>Tracheostomy</td>
<td>12-13</td>
</tr>
<tr>
<td>4.5</td>
<td>Rehabilitation in Acute Setting</td>
<td>14</td>
</tr>
<tr>
<td>4.6</td>
<td>Communication/AAC during COVID-19</td>
<td>14</td>
</tr>
<tr>
<td>4.7</td>
<td>SLT led laryngectomy care and management</td>
<td>14-15</td>
</tr>
<tr>
<td>4.8</td>
<td>Laryngectomy/SVR, prosthesis changes</td>
<td>15</td>
</tr>
<tr>
<td>4.9</td>
<td>Palliative care</td>
<td>15-16</td>
</tr>
<tr>
<td>Section 5</td>
<td>Rehab/Residential/Community / Outpatient settings.</td>
<td>16-19</td>
</tr>
<tr>
<td>5.1</td>
<td>Community Referral for Videofluoroscopic Swallow Study (VFSS)</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Accessible information to support service users during COVID</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>References/Supporting documentation</td>
<td>21-22</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Resources</td>
<td>23</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Head and Neck Forum</td>
<td>24</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>List of contributors to Guidance</td>
<td>25 - 26</td>
</tr>
</tbody>
</table>
Section 1: Introduction

The Irish Association of Speech and Language Therapists (IASLT) acknowledges the additional challenges the current COVID-19 global pandemic brings for our Members. We acknowledge the incredible work that is ongoing as our members prepare and plan for a surge in COVID-19 numbers. We also acknowledge the fact that a large number of members are and have been redeployed into new roles in testing and contacting tracing. We are so proud of our members and their willingness to take on new challenges. Members continue to put service users at the centre of care and develop resources to implement nationally such as accessible information for children and adults. Members are also facing challenges in the delivery of direct face-to-face care to service users and are proactively managing this through changes to work practices and alternative modes of service delivery to ensure service user and clinician safety. There are also challenges in relation to new and changing work environments. Speech and Language Therapists continue to play a vital role in supporting patients/service users with dysphagia and or communication impairment and disability and have a vital role in continuing to deliver care to patients presenting with and without COVID-19.

The IASLT have produced this in-principle guidance document to support members in keeping themselves safe and informed while delivering safe, effective, and essential care to patients and service users during the COVID-19 pandemic. The IASLT welcomes member feedback and continues to lobby and advocate for members, and respond to the evolving situation. In addition to this guidance document IASLT members should also refer to local and national policies and guidance for working during the COVID-19 pandemic that are relevant to the context in which they work. As with all practise, ensuring clinical supervision is provided in the context of competency development, is a high priority for all services.

IASLT members should note that this is a working document which will be subject to change and updated accordingly in line with evolving information, data, and feedback.
1.1 What is Covid-19?

A coronavirus is a common type of virus: COVID-19 is a new strain of coronavirus first identified in Wuhan City, China. On 31 December 2019, Chinese authorities notified the World Health Organization (WHO) of an outbreak of suspected pneumonia, which was later classified as a new disease: COVID-19. On 30 January 2020, WHO declared the outbreak of COVID-19 a ‘Public Health Emergency of International Concern’ (PHEIC). On 11 March 2020, COVID-19 was categorised a pandemic by the Director General of the World Health Organisation. The illness can develop over a period of a week or longer. Symptoms are initially mild but may progress in some cases to dyspnoea or shock. Symptoms can range from mild to severe illness. Some people will recover easily, and others may get very sick very quickly. People with coronavirus COVID-19 may experience:

- Cough (typically non-productive)
- Myalgia and fatigue
- Shortness of breath
- Fever
- Another potential sign includes anosmia.

See [www2.hse.ie/conditions/coronavirus/coronavirus.html](http://www2.hse.ie/conditions/coronavirus/coronavirus.html) which covers symptoms, causes and treatment.

1.2 Advice and guidance:

The IASLT recommends that members, in addition to following their local organisation policies, refer to the most up-to-date source of guidance from the Health Protection Surveillance Centre (HPSC), which is the co-ordinating HSE office for COVID-19 ([www.hpsc.ie](http://www.hpsc.ie)). The HPSC provides the latest information for health professionals and the public which is continuously updated. They have developed a helpful FAQ and in addition to general information they also provide information on prevention, signs/symptoms/ travel advice and the global situation. The HPSC’s advice and guidance for healthcare workers, including video posters and video resources, is available here: [https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/guidanceforhealthcareworkers/](https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/guidanceforhealthcareworkers/)
Further resources can be found in the Appendices below.

1.3 Information from CORU:
The IASLT advises its members to maintain up to date with COVID-19 statements and guidelines issued by CORU available here: https://coru.ie/health-and-social-care-professionals/covid-19-updates/covid-19-update/

1.4 SLT Intervention Considerations:
The following principles should be considered by SLTs:

- Use your expertise and clinical judgement.
- Engage in regular communication with colleagues to remain abreast of local issues, information and changes, and to provide support.
- Receive training and/or support to ensure practice is safe and effective.
- Use professional judgement to assess what is safe and effective practice in context.

Where possible, information should be obtained from the referral source, healthcare record and other members of the multidisciplinary team (MDT) before any direct face-to-face contact with any service user. Where possible consent should be sought for discussion with next of kin/family.

It is necessary to risk assess every new referral, assessment, and intervention prior to direct contact. Consideration should be given to:

1. The individual’s current COVID-19 status
2. Personal protective equipment (PPE) requirements
3. The urgency of any assessment or intervention at each planned contact.

This should be done in line with local policies and procedures and the MDT as appropriate.

If a patient/service user is awaiting results of a COVID-19 test triage the urgency of SLT assessment or intervention and the indication for direct (face-to-face) or in-direct contact and discuss with the MDT. Where direct SLT contact is not deemed immediately essential defer where possible until the outcome of the test is known and continue to deliver care indirectly. If immediate direct SLT contact is deemed essential deliver care in partnership with the MDT.
and in line with local policies and procedures, including infection, prevention and control. In this circumstance consideration may be given to cohorting a patient/service user as your last direct contact of the day.

For patients with a confirmed diagnosis of COVID-19 risk assess the urgency of any assessment or intervention at each planned direct contact. IASLT supports the need for local discussion on what is patient need for direct face-to-face contact. This should be done in conjunction with the MDT and in line with local policies and procedures, including infection, prevention and control. Where direct contact is deemed essential following risk assessment see Section 4.

Circumstances may also mean considering delivering care in different modalities, e.g. telehealth. The use of technology should be maximised. Please see IASLT Telepractice Statement, 2020.

SECTION 2: PERSONAL PROTECTIVE EQUIPMENT (PPE)

We recognise that COVID-19 is a new virus and we are researching and learning more about it every day. As a result, advice and guidance is continuously evolving and changing. It is the responsibility of each individual SLT to keep up to date with local policies and procedures around infection, prevention and control and COVID-19 response, as well as changing guidance from the HSE.

IASLT recommends that local policies are developed for SLTs undertaking assessments, including access to PPE in line with local/national HSE and the IASLT guidance.

Prior to any direct face-to-face contact SLTs should confirm the individual’s current COVID-19 status, PPE requirements, and risk assess the urgency of any assessment or intervention at each planned contact.

All staff having clinical contact with patients should be familiar with PPE requirements and trained in donning and removing PPE in line with local policy. Please refer to www.hpsc.ie for PPE guidance and regular updates or changes, and video resources https://youtu.be/BFbcguqWF-oE.
Please see the link below for current PPE guidance for the management of suspected or confirmed COVID-19 cases:


SLTs need to be aware of COVID-19 patient cohorting arrangements in their local setting. In areas that have been assessed as high risk, it is appropriate to ensure the use of a buddy to support putting on and removing PPE.

When working with individuals who do not have a diagnosis of COVID-19, or where it is unknown SLTs, should continue to follow local policy and procedures with regard to infection, prevention, and control including PPE, bearing in mind that individuals may be asymptomatic for COVID-19.

The IASLT recommends members follow HSE and local policy around PPE to ensure safe delivery of SLT care.

**TYPES OF PPE (as per HSE Guidance, 23rd March 2020)**

- Disposable plastic aprons: are recommended to protect staff uniform and clothes from contamination when providing direct patient care and when carrying out environmental and equipment decontamination.
- Fluid resistant disposable gowns: are recommended when there is a risk of extensive splashing of blood and or other body fluids and a disposable plastic apron does not provide adequate cover to protect health care workers (HCWs) uniform or clothing.
- If non-fluid resistant gowns are used and there is a risk of splashing with blood or other body fluids a disposable plastic apron should be worn underneath.
- Eye protection/Face visor: should be worn when there is a risk of contamination to the eyes from splashing of blood, body fluids, excretions or secretions (any AGP)
- Surgical mask with integrated visor
- Full face shield or visor
- Goggles / safety spectacles
- Surgical Face Masks
SECTION 3: AEROSOL GENERATING PROCEDURES (AGPs)

Aerosol-generating procedures (AGP) are procedures that stimulate coughing and promote the generation of aerosols. AGPs can create a risk of airborne transmissions of infections that are usually only spread by droplet transmission. Infection can be by infected droplet contact with mucous membranes (i.e. by breathing in through mouth or nose, by droplets into the eyes, or by droplets picked up on the hands being transferred to mouth, nose or eyes by touching the face).

The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. During AGPs there is an increased risk of aerosol spread of infectious agents irrespective of the mode of transmission (contact, droplet, or airborne), and airborne precautions must be implemented when performing AGPs, including those carried out on a suspected or confirmed case of COVID-19.

IASLT have raised concerns with the HSE that the AGPs included in their PPE Guidance for AGPs in the management of COVID-19 do not include all the procedures and areas of care SLTs consider to be AGPs. The HSE have reviewed this information and have included a number of SLT procedures in the most recent guidance issued. Please see the below link for the current guidance:

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/AGPs%20for%20confirmed%20or%20possible%20COVID19_v2.0_23032020.pdf

Of particular note PPE recommendations for clinical dysphagia examination, including orofacial assessment include:

- Hand Hygiene
- Surgical Face Mask
- Gloves
- Gown OR Plastic Apron

IRISH ASSOCIATION OF SPEECH & LANGUAGE THERAPISTS

COVID-19 APRIL 2020
Risk Assessment re. Eye Protection

IASLT support the use of eye protection when conducting clinical bedside examination. At a minimum a surgical face mask should be worn and there should be risk assessment/consultation with local policy/ infection control regarding use of FFP2/FFP3 respirator masks. SLTs should wear hair up and back and covered as appropriate.

Whilst not all procedures and elements of SLT care are listed as AGPs these areas of care may be considered high risk and require assessment for appropriate PPE. These can include (please note that this is not an exhaustive list):

a) Delivery of mouth care  
b) Videofluoroscopic swallow study (VFSS)  
c) Cough reflex testing  
d) Tracheostomy care and management  
e) SLT-led laryngectomy care and management  
f) Nasendoscopy for FEES or flexible laryngoscopy with or without videostroboscopy

IASLT are continuing to liaise with the HSE in relation to risks associated with these areas of SLT care and will keep members informed of any updates or changes.

IASLT advises that members familiarise themselves with HSE guidance on COVID-19 Guidance and webinars for Infection Prevention and Control


The IASLT holds the position that the use of PPE should apply to all COVID-19 positive and suspected and non-COVID-19 individuals.

Like all guidance at this time, it will be continuously reviewed alongside feedback, emerging information and evidence base.
SECTION 4; ACUTE CARE SETTING

The SLT in acute and critical care is vital to the optimum management of patients who present with dysphagia and or communication impairment and disability. SLTs working in these areas have a vital role in continuing to deliver care to patients presenting with and without COVID-19.

The COVID-19 group are at higher risk of prolonged intubation times and extended episodes of critical care. The current evidence suggests increased likelihood of the following:

- Laryngeal injury associated with prolonged intubation and/or re-intubation
- Oral candida due to difficulties providing oral hygiene during intubation/NIV
- Post extubation Dysphagia
- Post extubation Dysphonia
- Dysarthria and cognitive change associated with Critical Care Myopathy

Communication difficulties frequently co-occur in many patient groups; resulting in vulnerability associated with understanding medical needs and impacting on ability to participate in decision making and/or rehabilitation and recovery. This vulnerability can increase adverse incidents. (Bartlett 2008).

Upon referral/planned contact:
- Determine priority as per local prioritisation system.
- Establish COVID-19 status (unknown, negative, pending results, positive)
- Risk assess for essential direct versus essential indirect contact

4.1 Considerations for Clinical Dysphagia Examination as an AGP

As per other international SLT guidelines (e.g., SPA), specific aspects of the Clinical Dysphagia examination pose greater risk of transmission and should only be included in the Clinical Dysphagia Examination where the benefit outweighs the risk. These include:

- assessment of cough,
- laryngeal palpation,
- oro-motor assessment
Cervical auscultation should not be used on confirmed COVID-19 positive cases, in line with practice by respiratory physicians. This is due to the fact that COVID-19 can survive on surfaces for up to five days. Cervical auscultation carries a risk of transmission of the virus due to the proximity of the stethoscope to the SLT’s face. SLTs should carefully consider whether the benefits of the use of cervical auscultation with patients who are not possible or confirmed COVID-19 cases outweigh the risks of transmission (Adapted from RCSLT guidelines on personal and protective equipment (PPE) & COVID-19, 03.04.2020)

Where direct contact is essential, clinical judgement should be based on referral details and full case history, including discussion with the referring team. Any SLT engaging in essential direct contact should ensure he/she is compliant with local infection control including PPE guidelines. The following additional considerations may be helpful:

- Gain all information you can prior to the assessment; medical notes, phone calls to family and/or carers and discussion with the MDT
- Prepare all materials needed for assessment/contact prior to donning PPE

When a face to face assessment is required, modification may be necessary and such as:

- Make visual and perceptual observations when standing/sitting 2m from the patient.
- Instead of laryngeal palpation, observe how many swallows the patient does.
- Listen for changes in vocal quality.
- Ask the patient themselves for their impressions.
- Observe respiratory rate.
- Use speech to assess oro-motor function as much as possible
- Enable patient to self-feed where possible and consider starting with maximally modified consistencies to minimise coughing
- Limit interactions to 15 minutes or less.

4.2 Videofluoroscopic Swallow Study (VFSS)

Due to the risk of transmission in moving the individual to the radiology suite and the potential need to decontaminate equipment, the following should be considered:
Consider only providing service to urgent VFSS referrals for patients who are COVID-19 positive and suspected where there is a high risk to pulmonary safety and high risk to malnutrition / dehydration due to dysphagia and inability to commence non-oral nutrition. Each VFSS should be risk assessed in line with the requirement to meet the needs of patients and local policies.

Encourage the patient to self-feed where possible

Consider scheduling VFSS procedures at the end of sessions to minimise impact of cleaning times

4.3 Endoscopy
It is essential for SLTs to note the recent guidance from the British Laryngological Association (BLA) who recommend that all therapist-led endoscopy should cease and the IASLT would support this position.

Fiberoptic endoscopic evaluation of swallowing (FEES) is seen as particularly high risk for SLTs. As per guidelines from other professions, all therapy-led endoscopy, including FEES, manometry and videostroboscopy cease for the duration of the pandemic. This position on endoscopy will continue to be reviewed.

4.4 Tracheostomy

Tracheostomy is of particular concern during the COVID-19 outbreak as it is one of the highest aerosol generating procedures (AGP) (Irish Head & Neck Society, 2020). Tracheostomy insertion, open suctioning, and replacement are AGPs (ICSI, 2020). Non-invasive ventilation (NIV) (e.g. BiPAP and CPAP) is an AGP and High Flow Nasal O2 (30-60L) is considered as a potential AGP (ICSI, 2020).

The Irish Head & Neck Society (2020) advises that tracheostomy should be a rare event in individuals confirmed COVID-19 positive. They recommend that tracheostomy should only be considered in individuals where it is likely to bring about a clear benefit for the individual that outweighs the risks of performing the procedure. ENT-UK recommend where tracheostomy insertion is deemed essential to the care of an individual who is COVID-19 positive, a cuffed non-fenestrated tracheostomy should be inserted. The cuff should remain
inflated and the inner cannula changed with reduced frequency until the individual is confirmed COVID-19 negative (NTSP, 2020).

For SLT, the above practice means that speaking valve assessment will not be completed for individuals with tracheostomy suspected or confirmed COVID-19 positive. SLTs should support communication for these individuals (see AAC recommendations below). If direct review is deemed essential, full PPE (disposable long-sleeved water impermeable gown, FFP2/3 mask, eye protection – goggles or visor adjusted to fit, gloves) should be worn.

The National Tracheostomy Safety Project (2020) recommends that all individuals should be treated as positive until proven negative during the peak of the pandemic. This is because there is a high probability that patients from the community who develop respiratory symptoms are COVID-19 positive.

For individuals with tracheostomy where COVID-19 status is negative or unknown (not tested), the decision to deflate the cuff and progress respiratory weaning (including the trial of speaking valve) should be made in consultation with the MDT carefully weighing the benefits to the individual against the risks of the intervention to both the individual and healthcare staff. If SLT tracheostomy care is deemed essential to progressing the individual’s care plan, SLTs should consult with their local IPC teams ensuring they have access and adhere to the appropriate PPE requirements. Full PPE is required - disposable long-sleeved water impermeable gown, FFP2/3 mask, eye protection – goggles or visor adjusted to fit, gloves) when caring for individuals with tracheostomy. ENTUK up to date tracheostomy recommendations (6/4/20) suggest that cuff deflation should ideally be completed on a COVID negative ward

4.5 Rehabilitation in Acute Setting

The SLT is a core member of the MDT in delivering rehabilitation for patients with and without COVID-19. This includes assessment and management of individuals with conditions that are directly, or indirectly, related to COVID-19, the result of critical care interventions, respiratory disease or underlying or co-existing comorbidities.

4.6 Communication/AAC during COVID-19

Where patients are unable to communicate due to ventilation or inflated tracheostomy cuff, low tech AAC may be appropriate. See: www.patientprovidercommunication.org/supporting-communication-covid-19.htm.

Aphasia resources specific to COVID 19 are available here: www.latrobe.edu.au/research/centres/health/aphasia/resources

4.7 SLT – led laryngectomy care & management

i. surgical voice restoration (SVR), including voice prosthesis changes, checking voice prosthesis leakage, cleaning voice prosthesis (voice prosthesis changes; and open stoma inspection)

ii. stoma care, including placement & removal of tracheostomal baseplates & housing, buttons, studs or laryngectomy tubes & performing stoma cleaning & suctioning

iii. management of other aspects of laryngectomy care, including electrolarynx use or oesophageal speech due to risk of coughing

(Adapted from RCSLT guidelines on personal and protective equipment (PPE) & COVID-19, 03.04.2020)

4.8 Laryngectomy/SVR, prosthesis changes

It is important to note that voice prosthesis changes or open stoma inspections are considered high risk and should only be considered if strongly indicated and only after consultation with treating team/ENT of COVID-19. For the duration of COVID-19, people with laryngectomy who are due for regular review should be reviewed via telephone (or telehealth service). Patients who experience valve leakages or dislodgements should be supported to self-manage
at home and they should not visit the hospital setting for “valve services”. Where necessary, they should be advised to make contact with SLT staff for education and support. Self-management strategies may include one or some of the following:

1. Use of a plug device or empty pipette/flushing device when drinking (see Appendix 2)
2. Insertion of patient’s laryngectomy tube when drinking
3. Thickening powder in drinks
4. Self change of voice prosthesis or catheter insertion in skilled patients (See Appendix 2)
5. Use of alternative feeding route (RIG/PEG) if available

The Irish Head & Neck Society (IHNS) (2020) refers to the SLT Head and Neck Forum Guidance document (Version 2, 23.03.20). As per IHNS (2020), if SVR -intervention is deemed unavoidable, and the patients’ COVID -19 status is unknown, testing should be arranged before patient attends the hospital. In circumstances where a patient needs to attend the hospital immediately, the patient should be considered as COVID-19 + with SLT performing the examination in an appropriate clinical setting and wearing full PPE including FFP3/2, long sleeved gown, eye protection, gloves +/- hair protection. The guidance of 15min time should be adhered to as much as possible. Consideration should be given to removal of the voice prosthesis with insertion of a TEP Occluder device/catheter or allowing the TEP to close with the intention of a secondary TEP being performed post COVID-19 pandemic. The clinical setting should be deep cleaned by persons wearing the appropriate PPE. It is critical that the SLT is highly experienced to reduce time and potential complications. In all instances, any SVR related intervention should be discussed with the ENT consultant.

4.9 Palliative Care

In recognition of the high level of mortality associated with COVID-19, there may be an increase in the level of cases of palliative patients as well as a need for the ongoing management of COVID-19 negative palliative patients. In all cases adhere to local guidelines regarding PPE use.
As per the WHO (2003) definition of Palliative Care, the goal of Palliative Care is the improvement of quality of life, relief of suffering and pain and the management of physical, psychosocial, and spiritual problems. The role of SLT for palliative patients at this time may include:

- Provision of advice regarding communication strategies indirectly to staff or the patient’s family.
- Provision of low or high tech communication aids to the patient and instruction in their use. This may include instruction in the use of apps such as Skype, Whatsapp, Zoom, etc. in order to facilitate phone or computer access to distant loved ones. Must comply with local infection control guidelines.
- Advice on fatigue management and how it relates to speech conservation and/or energy for safe swallowing.
- Advice to staff and family regarding feeding issues including addressing family distress/understanding regarding possible swallow changes, nil by mouth status, discontinuation of eating in final stages, risk feeding issues, comfort feeding, secretion management and oral care.
- Direct or indirect management of swallowing and oral care issues affecting speech or swallowing with due care for staff and patient safety and limitations in examinations to minimise AGPs. The goal of SLT intervention may relate to increasing safety, reducing aspiration/choking risk or increasing pleasurable eating and drinking for the patient.
- Advocacy of communication and/or dysphagia related needs or wishes of the patient with the MDT so that comfort of the patient remains a priority.

Section 5: REHAB/RESIDENTIAL/COMMUNITY / OUTPATIENT SETTINGS

The IASLT recognises that individuals with communication and swallowing difficulties in residential, rehabilitation, community and outpatient settings may also present with COVID-19. People living in residential settings are at a higher risk of infection including COVID-19. Up to 50% of adults with an intellectual disability will present with some form of feeding, eating, drinking or swallowing difficulty (IASLT, 2016a; Manduchi, Fainman, & Walshe, 2019). Dysphagia is evident in 15% to 25% of older people living in the community, and up
to 75% of individuals with dementia will have dysphagia, with all individuals’ inevitably developing dysphagia and/or difficulties with oral nutrition in the advanced stages (IASLT, 2016b; Payne & Morley, 2018). People with disability are at a higher risk of choking or aspiration pneumonia related premature deaths (Commissioner, 2018; Heslop et al., 2014; Riquelme et al., 2016; Trollor, Srasuebkul, Xu, & Howlett, 2017).

It is critical that SLTs working in any clinical setting undertake a risk assessment of individuals and develop safe protocols to meet their needs and to help with prioritisation of caseloads. Assessments in residential, community setting or rehabilitation setting which may prevent acute hospital admission or also expedite discharge from acute services may be deemed a priority. PPE measures should be put in place in line with the assessed need and the management of oral secretions and induction of sputum during the assessment process.

Refer to local infection, prevention and control policy, local COVID-19 response plans as well as HSE guidance. See HSE link below on visiting homes:

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventio
andcontrolguidance/healthandsocialcareworkers/V1.0-Guidance-
HealthSocialCareWorkersWhoVisitHomes.pdf

IASLT recommends:

a) All non-urgent direct contacts are reviewed and where possible offered telephone or video contact as an alternative.

b) Clinicians call ahead of seeing any urgent patients to:
   
i. ask if they are self-isolating or if they or a person in the household have any symptoms of COVID-19
   
ii. discuss with the individual whether or not they are happy to be seen given that most individuals may be in the vulnerable/at risk groups. Where an individual is not able to give informed consent, it is essential that local policies with respect to consent and will and preference are followed.

c) If a client living in the community or anyone in the household has been diagnosed with COVID-19, or is in self-isolation, the SLT must carry out a risk assessment to consider delaying the visit to the home during the isolation period.
d) Reviews can be conducted remotely in accordance with IASLT and local telepractice guidelines and as appropriate.

e) For all clients in inpatient rehabilitation settings who have communication impairments and require therapy the IASLT supports the need for risk assessment and caseload prioritisation. Decisions on clinical needs and goals in the context of COVID-19 should be made in conjunction with the MDT. For all direct face-to-face intervention SLTs should adhere to HSE guidance and local infection prevention and control measures. Refer to Section 1.4 above.

f) Provision of advice and supporting materials regarding low and high tech communication aids, social stories and visuals can be provided remotely.

g) When a clinical dysphagia examination is deemed essential,

ii) Any face to face contact in rehabilitation, residential and community settings should be limited to 15 minutes maximum, this reduces the level of exposure to COVID 19 for both the service user and SLT. Adherence of PPE guidance and local infection control procedures is also recommended.

iii) The goal of the swallow assessment will be to provide a diagnosis, help with differential diagnosis whilst also making suggestions around how to maintain a safe swallow function and reduce the risk of choking or aspiration.

h) In rehabilitation settings and residential settings, there should be a division of staff to particular wards/units to maintain consistency of staffing and reduce footfall to the wards/units. SLTs may have to also amend working hours or work base in order to insure adequate social distancing in the work setting.

i) SLTs should support other staff to recognise that a person with a communication impairment prior to COVID 19 may require different communication supports as their illness progresses. These needs should be reviewed by the SLT - as part of the person’s MDT supports – on an ongoing basis (indirectly wherever possible).
J) The SLT also continues to have a role in supporting decision making. These decisions may relate to immediate treatment options or in supporting advance care planning and end of life SLTs, as part of the MDT. This may involve the use of Easy Read information (see links under Section 5.2 for examples) or a variety of other modes within a Total Communication approach as meets the person’s needs.

k) SLTs have an important role to play in offering support and guidance to team members working with people with communication impairments and in facilitating communication between patients and their family members who are unable to visit them in hospital/residential care at this time.

5.1 Community Referral for Videofluoroscopic Swallow Study (VFSS)

Liaise with the local VFSS service for further information on the service during the pandemic. See section 4.2
Accessible information to support service users during COVID

SLT Team Cheeverstown:
https://drive.google.com/open?id=1f1TVERvsjEbaySZQBTWso5VutJGJWQte.


http://nebula.wsimg.com/438514d864d2d7decad3083254de2b35?AccessKeyId=5861B17331
17182DC99B&disposition=0&alloworigin=1

“Make it Easy – A guide to preparing easy read information”
http://www.inclusionireland.ie/sites/default/files/attach/basic-
page/1193/makeiteasyguide2011.pdf

A variety of easy read resources has been circulated via the Adult ID SIG and a dropbox has
been created for members – aidsigslt@gmail.com
References/Supporting Guidelines

- [https://www.asha.org/SLP/healthcare/Service-Delivery-Considerations-in-Health-Care-During-Coronavirus/](https://www.asha.org/SLP/healthcare/Service-Delivery-Considerations-in-Health-Care-During-Coronavirus/)
- Management of Symptoms in Palliative Care: The Role of Specialist Palliative Care Allied Health Professionals March (2018) AHP Better Living Matters and Palliative Care in Partnership, Northern Ireland.
APPENDIX 1: Resources

The HSE website [https://www2.hse.ie/coronavirus/](https://www2.hse.ie/coronavirus/) is another useful resource, which is regularly updated.

The European Centre for Disease Prevention and Control (ECDC) has helpful resources:

- Infographic on how to minimise the spread of the virus: [https://www.ecdc.europa.eu/en/search?f%5B0%5D=diseases%3A2942](https://www.ecdc.europa.eu/en/search?f%5B0%5D=diseases%3A2942)

Posters to display at your clinic/workplace

There are also some posters developed by the HSE and HPSC which may be of help for your practices:

COVID-19 Posters

Hand hygiene poster (PDF, 129KB, 1 page)
[https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/posters/](https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/posters/)

WHO infection control signage for patients and travellers – downloads are available in multiple languages.

WHO Resources

APPENDIX 2; SLT Head and Neck Forum Guidance

SLT HEAD & NECK FORUM GUIDANCE ON TRACHEOESOPHAGEAL VOICE PROSTHESIS MANAGEMENT DURING COVID-19 PANDEMIC

(Please note this is guidance only with current knowledge by consensus of HNC SLTs in acute care only and will be revised as situation & knowledge evolves)

Review all scheduled in & out patient appointments / consultations and unscheduled review requests by telephone.
Routine care

Leaking / Dislodged Prosthesis

Telephone review & advice only. Cancel scheduled appointment.

Determine nature & extent leakage (central or peripheral: timeframe), voice function, chest status & TEP patency. Use video link / FaceTime / Skype if necessary to clarify (with patient or family member).
Significant leakage or dislodgement?

YES: Regardless of Covid-19 status

NO: Telephone review and advice only.

1. Use the following management options to defer prosthesis change during Covid-19 pandemic to mitigate risk to staff & patients:
Thicken fluids to level 2 mildly thick, confirming this eliminates significant leakage.
Instruct patient in plug device insertion if available and has necessary skills.

2. Open stoma / voice prosthesis inspection / care or prosthesis change should be avoided if at all possible. If deemed absolutely essential, following consultation with relevant ENT / medical personnel in all cases:
Equip with FULL PPE for Aerosol Generating Procedure potential (Gloves, long sleeved gown, FFP 2 / 3 mask as per local guidelines & eye protection; See further www.hpsc.ie). If appropriate PPE cannot be supplied, SLTs must not undertake above procedures.
Patient to complete hand hygiene on arrival and departure.
Complete clinical assessment & management, optimally within the shortest contact time possible, in single room with door shut.
Remove PPE with appropriate donning procedure.
Equipment & environmental cleaning/sterilisation as per local Covid-19 guidelines. Document as per usual practices.

USEFUL LINKS:

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Appendix 3

Thank you to the following IASLT members for contributing their time and expertise to the development of this guidance document:

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