IASLT COVID -19
Updated Guidance for IASLT Members (3rd update)

Date of Publication: 28th April 2020
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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. Members have been redeployed to new roles within the health service and are also facing challenges in the delivery of direct face-to-face care to service users. They are proactively managing this through changes to work practices and alternative modes of service delivery to ensure service user and clinician safety. Speech and Language Therapists (SLTs) continue to play a vital role in supporting patients/service users with dysphagia and/or communication impairment and disability across the lifespan and have a vital role in continuing to deliver care to patients presenting with and without COVID-19.

This guidance is provided in the context of a rapidly evolving health care emergency and is subject to change as new data and information becomes available. 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.

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

Potential signs include:

- anosmia and taste changes.
- possible neurological and gastrointestinal symptoms

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 information, guidance and advice from the Health Protection Surveillance Centre (HPSC), which is the coordinating HSE office for COVID-19 ([www.hpsc.ie](http://www.hpsc.ie)). The HPSC’s advice and guidance for healthcare workers, including posters and video resources, is being regularly updated and is available here:

[https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/guidanceforhealthcareworkers/](https://www.hpsc.ie/a-z/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:
Section 2: Personal Protective Equipment (PPE)

COVID-19 is a new virus and as a result, advice and guidance is evolving. 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.

All staff having clinical contact with patients should be familiar with PPE requirements and trained in donning and doffing PPE in line with local policy. Please refer to [www.hpsc.ie](http://www.hpsc.ie) for PPE guidance and regular updates or changes, and video resources [https://youtu.be/BEbcuqWF-oE](https://youtu.be/BEbcuqWF-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 donning and doffing of PPE.

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 Aerosol Generating Procedures).
- Surgical mask with integrated visor
- Full face shield or visor
- Goggles / safety spectacles
- Surgical Face Masks
- Surgical Face Masks (Fluid Resistant Type 11R)
- Respirator Face mask (FFP2/3)

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

Speech and Language Therapists must be aware of and trained in the procedures for **donning and doffing** PPE in such a way as to safely mitigate the risk of contamination, and they should be familiar with decontamination and safe waste disposal procedures.
The appearance of others in PPE may be distressing for some client groups that SLTs work with including individuals with a learning disability, dementia, or individuals with other conditions that make it difficult for them to understand the need for PPE. It may be helpful to place e.g. photographs of who is wearing the PPE or writing their name and roles on the apron. SLTs may be instrumental in developing accessible resources to help individuals understand the reasons why people are wearing PPE.

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 made reference to a number of SLT procedures in the most recent guidance issued. Please see the below link for the current guidance.
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrol/guidance/aerosolgeneratingprocedures/AGPs%20for%20confirmed%20or%20possible%20COVID19_v2.0_23032020.pdf

Of particular note current PPE recommendations from the HSE for clinical dysphagia examination, including orofacial assessment, include:

Hand Hygiene
Surgical Face Mask
Gloves
Gown OR Plastic Apron
Risk Assessment re. Eye Protection

The IASLT holds the position that clinical dysphagia assessment is an AGP and the use of full PPE should apply to all COVID-19 positive and suspected and non-COVID-19 individuals when clinicians are conducting clinical dysphagia assessments. This includes FFP2/FFP3 respirator face masks. This is in line with the guidance of international professional bodies such as the Royal College of Speech and Language Therapists (RCSLT) and is supported by strong theoretical reasons and underpinning empirical evidence (RSCLT, 2020). 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) Voluntary cough reflex testing.

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COVID-19 APRIL 2020
e) Gag reflex assessment  
f) Tracheostomy care and management  
g) SLT-led laryngectomy care and management  
h) 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 current HSE guidance on COVID-19 Guidance and webinars for Infection Prevention and Control  

See Appendix 1 Resources for links to HSE PPE demonstration videos for masks, coveralls and face shields.

Section 4: Dysphagia and Communication Assessment  
Considerations  
Individuals with communication and swallowing difficulties across care settings may present with and without COVID-19 and SLTs continue to manage conditions that are directly, or indirectly, related to COVID-19, the result of disability, critical care interventions, respiratory disease or underlying or co-existing comorbidities.
The following principles should be considered by SLTs across care settings:

- Use personal 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.
- Perform risk assessment in collaboration with colleagues.
- Documentation should be completed in the client’s clinical file to indicate that clinical procedures have been modified and varied as part of risk management approach to COVID-19 pandemic.

For new referrals 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:

**Upon referral/planned contact:**

1. Determine priority as per local prioritisation system.
2. Establish COVID-19 status (unknown, negative, pending results, positive)
3. Personal protective equipment (PPE) requirements.
4. Risk assess for essential direct versus essential indirect contact at each planned contact.

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

Figure 1: Sample Triage Process for New SLT Referrals during COVID-19
Where direct SLT contact is not deemed immediately essential, and the COVID 19 status is unknown pending outcome of the COVID-19 test, defer direct contact where possible until the outcome of the test is known and continue to deliver care indirectly. If immediate direct SLT contact is deemed essential in this circumstance perform a risk assessment and deliver care in partnership with the MDT and in line with local policies and procedures, including infection, prevention and control. In this situation 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.

**Flowchart:**

1. Receive SLT referral
2. Triage based on local policy and MDT discussion
   - Is direct assessment essential?
   - What type of assessment is needed?
   - What is COVID status of person?
3. Complete indirect assessment (consider telehealth)
4. Complete direct assessment
   - High risk (AGP required, COVID positive, suspected or unknown)
     - PPE (FFP2/3 mask)
     - Min 2 metre distance, where possible
     - Modified assessment < 15 mins duration
   - Low risk (COVID negative, no known risk factors, no AGP required)
     - PPE (surgical mask)
     - Min 2 metre distance, where possible
     - Consider modified assessment/length of contact
should be done in conjunction with the MDT, a risk assessment and in line with local policies and procedures, including infection, prevention and control.

4.1 Clinical Dysphagia Examination (as an AGP)

Where direct contact is essential, clinical judgement should be based on referral details, risk assessment, 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 possible information prior to the assessment; review of patient/client medical notes, phone call to family and/or carers, discussion with the MDT
- Preparation of all materials needed for assessment/contact prior to donning PPE

**Modifications to practice for face to face assessment:**

- 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.
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 ensure adequate social distancing in the work setting.

As per other international SLT guidelines (e.g., Speech Pathology Australia) specific aspects of the Clinical Dysphagia Examination pose greater risk of transmission of COVID-19 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
- assessment of gag reflex

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 suspected or confirmed COVID-19 cases outweigh the risks of transmission (Adapted from RCSLT guidelines on personal and protective equipment (PPE) & COVID-19, 16.04.2020)
Figure 2: Sample Dysphagia Assessment Process for COVID-19 individual

1. Direct dysphagia assessment required based on triage/local risk assessment
2. Perform hand hygiene and don surgical mask prior to entering ward/unit
3. Take case history from medical/nursing notes, phonecalls and via MDT discussion
4. Collect items for assessment in a container (e.g., fluids, thickener, food items, cup/beaker, spoons, syringe, laminated AAC chart etc)
5. Don PPE in designated area as per local policy:
   1. long sleeved gown
   2. FFP 2/3 mask (check fit)
   3. visor/goggles
   4. gloves
6. Enter room/area for max 15 minutes and maintain 2 metre distance where possible.
   Try to stand beside person (instead of in front of them)
7. Do not assess volitional cough or gag reflex.
   Complete oro-motor exam by observation of speech
   Avoid laryngeal palpation
   Encourage self feeding
   Do not use cervical auscultation
8. Throw out container of food/utensils into appropriate waste within room (check local policies)
9. Doff PPE as per local policy into assigned bin in designated area post assessment (complete with a buddy if possible).
10. New surgical mask to write notes in ward area and to liaise with MDT post assessment
4.2 Instrumental Dysphagia Evaluations

Videofluoroscopic Swallow Study (VFSS)

VFSS should not be undertaken with clients who are suspected or confirmed COVID-19 positive. This is in line with recommendations made by international colleagues.

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 a service to urgent COVID-19 negative or unknown VFSS referrals for patients 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 or where discharge potential is impacted. 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 VSS procedures at the end of sessions to minimise impact of cleaning times.

SLT’s working in community should liaise with the local VFSS service for specific information on the service during the pandemic.

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.
4.3 Communication Support Considerations

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.

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).

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

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 care, 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.

4.4 Specific Clinical Populations

4.4.1 Tracheostomy

Tracheostomy is of particular concern during the COVID-19 outbreak as it is one of the highest AGPs (Irish Head & Neck Society, 2020) including tracheostomy insertion and replacement and open suctioning (ICSI, 2020). Non–invasive ventilation (NIV) (e.g.
BiPAP and CPAP) is an AGP and High Flow Nasal O2 (30-60L) is considered 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 (2020) 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 SLTs the above practice means that speaking valve assessment will not be completed for individuals with tracheostomy who are 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 https://www.entuk.org/sites/default/files/files/COVID%20tracheostomy%20guidance%20-%20%20April%202020%20update.pdf

4.4.2 Paediatric Tracheostomies and Speaking Valves During COVID-19

In acute paediatric settings, all international Paediatric ENT guidelines and protocols must be followed at this time in relation to timing of interventions and relevant PPE (NTSP April 2020). The consensus in the COVID-19 climate is that any new AGP on a child with a tracheostomy, apart from using the appropriate PPE should (1) be deemed necessary and (2) be advantageous to the child without any deleterious effects. All decisions relating to children with tracheostomies must be addressed with all relevant MDT members on a case by case basis.

Speaking valve assessment/placement is considered an AGP as it redirects airflow to the upper airway which generates increased aerosol generation especially if a cough is elicited, which it often is on the first trial.

In paediatrics however some differences exist in comparison to the critically ill adult acute population in intensive care settings with tracheostomy tubes. Children with tracheostomy

1. Have tracheostomy placed for long term use and must learn to develop feeding and communication skills with a tracheostomy in place.
2. Either require room air tracheostomy only or may require tracheostomy for long term ventilation purposes.
3. Some children manage with room air for periods during the day and require ventilation at other times, especially those weaning from ventilation.

4. Do not typically have cuffed tracheostomy tubes (Pre-COVID 19)

5. Do not typically have closed inline suctioning systems (Pre-COVID 19)

6. Do not have inner cannulas

7. Are typically more medically stable by the time they are ready for SLT engagement

8. Have often moved from the paediatric critical care setting to a step down ward setting.

9. Face longer lengths of stay in the acute setting due to delays in establishing care and equipment packages in the community for transfer to home.

It is generally accepted that in children with tracheostomy who are medically stable, the use of a speaking valve improves cough and swallowing of secretions thereby significantly reducing the amount of suctioning required. This overall reduces the number of AGPs that carers are exposed to for that child. It can also assist with sprinting from ventilation. (Greene et al 2019). [www.passymuir.com](http://www.passymuir.com)

During the COVID 19 Pandemic, it is clinically reasonable to consider a speaking valve assessment on a case by case basis in situations where

1. The child is medically stable
2. The child has an uncuffed tracheostomy tube/tolerating full cuff deflated >1 week
3. The child meets eligibility criteria for speaking valve as per [www.passymuir.com](http://www.passymuir.com)
4. The relevant ENT/Respiratory/Paediatric/Surgical/other medical teams contribute to decision making about timing of and readiness for assessment.
5. The presence of a speaking valve if tolerated can be reasonably expected to promote swallowing of secretions and reduce daily suctioning requirement/potential AGP events for carers.

6. At a local level full PPE is available to clinicians for the duration of the speaking valve assessment as per NTSP guidelines (April 2020), and must be worn by the assessing clinician for all assessments.

4.4.3 SLT – led laryngectomy care & management

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

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

3. management of other aspects of laryngectomy care, including electrolarynx use or oesophageal speech due to risk of coughing
   a. (Adapted from RCSLT guidelines on personal and protective equipment (PPE) & COVID-19, 03.04.2020)

4.4.3.1 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. At present the recommendation for the duration of COVID-19 is that 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 positive 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 contact 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.
Section 5: SLT Intervention Considerations

Prioritise/risk assess and consider alternative options (e.g., telehealth)

Standard precautions:

- Arrange room to sit beside patient instead of opposite
- Maintain 2 metre distance, where possible
- Routine cleaning of room and equipment (SARS-CoV-2 can survive on surfaces for up to 5 days)
- Surgical mask for speech tasks
- Cough etiquette
- High risk interventions such as thermal tactile intervention, expiratory muscle strength training should be avoided

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.

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

5.1. Specific Settings

5.1.1 Considerations for Non Acute settings:
All non-urgent direct contacts are reviewed and where possible offered telephone or video contact as an alternative. Reviews can be conducted remotely in accordance with IASLT and local telepractice guidelines and as appropriate.

SLT calls ahead of seeing any urgent patients to:

1. Check if they are self-isolating or if they or a person in the household have any symptoms of COVID-19. 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.

2. 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.

See guidance from the HSE on visiting homes;

5.1.2 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 those individuals who do not present with COVID-19. 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.
Accessible information to support service users during COVID

SLT Team Cheeverstown:
https://drive.google.com/open?id=1f1TVERvsjEbaySZQ8TWso5VutUJGWQte.


http://nebula.wsimg.com/438514d864d2d7decad3083254de2b35?AccessKeyId=5861B1733117182DC99B&disposition=0&alloworigin=1

“Make it Easy – A guide to preparing easy read information”

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.


 IASLT. (2016) Guidelines for Speech and Language Therapists on Assessment and Management of Eating, Drinking and Swallowing Difficulties (EDS) in Adults with Intellectual Disability (AWID). In. Dublin: Irish Association of Speech and Language Therapists.


 Paediatric Tracheostomy and Tracheostomy Long-Term Ventilated Care during the COVID Pandemic 07/04/2020 C. Doherty, R.Neal, S.Wilkinson, N.Bateman, I,Bruce, J.Russell, B.A.McGrath on behalf of the Paediatric working party NTSP [www.tracheostomy.org.uk](http://www.tracheostomy.org.uk)

https://jamanetwork.com/journals/jamaneurology/fullarticle/2764549


https://doi.org/10.1002/ppul.24209

www.passymuir.com
APPENDIX 1: Resources

HSE Resources:
https://www2.hse.ie/coronavirus/

The HSE’s Health Protection Surveillance Centre is regularly updating guidance for healthcare workers in Ireland: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/guidanceforhealthcareworkers/

The European Centre for Disease Prevention and Control (ECDC) has helpful resources:
• Infographic on hand washing:
• Infographic on how to minimise the spread of the virus:
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/
WHO infection control signage for patients and travellers – downloads are available in multiple languages.
WHO Resources


HSE PPE videos

https://youtu.be/I5S_n_BpTKk

https://youtu.be/PZtL8HtfuOM

https://youtu.be/BEbcuqWF-oE
APPENDIX 2; SLT Head and Neck Forum Guidance

SLT HEAD & NECK FORUM GUIDANCE ON TRACHEOSPHAGEAL 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 & outpatient 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 following management options to defer prosthesis change during Covid-19 pandemic to mitigate risk to staff & patients:
- Thickened fluids to level 2 mildly thick, confirming this eliminates significant leakage.
- Instruct patient in plug device insertion if available and has necessary skills.
- Instruct patient in empty pipette/flushing device insertion into prosthesis to physically prevent leakage during fluid intake.
- Advise prosthesis removal in patient changeable devices and catheter insertion.
- Use of alternative feeding route for fluids if available.

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 doffing procedure.
- Equipment & environmental cleaning/sterilisation as per local Covid-19 guidelines. Document as per usual practices.

USEFUL LINKS:

Last updated 23.03.2020
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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Thank you to Mr John Russell, Consultant Paediatric Otolaryngologist, Children’s Health Ireland at Crumlin

Thank you also to Noreen O Regan, SLT Head and Neck Forum for her support.

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