Allied Health Dysphagia Intervention in the Context of COVID-19

Dysphagia intervention is an essential service that has the potential to prevent negative health outcomes and facilitate timely discharge. This guide intends to support occupational therapists and speech-language pathologists in making clinical decisions regarding dysphagia interventions in the context of COVID-19 that

- target limited resources toward time sensitive, urgent and emergent needs
- ensure the safety of their patients, themselves and those around them

**Note:** Triage criterion are rapidly changing. At this phase there is continued emphasis on urgent procedures that will prevent hospital admission or facilitate discharge for those currently admitted. Some sites and services may have capacity to see patients that do not meet the urgency criterion outlined here. Please consult local leaders for decisions about capacity to provide non-urgent services. This document is up to date as of May 7, 2020.

Refer to the [Covid 19 Resources for Allied Health SharePoint](#) for the most up to date dysphagia resources.

### Patient and Staff Safety

These recommendations were provided by AHS Infection Prevention and Control Surveillance Standards and are based on recommendations of the AHS Personal Protective Equipment Taskforce.

**There is risk of droplet and contact exposure during all clinical dysphagia interventions.** Providers must:

- Use the [Respiratory (ILI) Algorithm](#) to assess patients for ILI/COVID-19.
- Use [Routine practices](#), including hand hygiene, point of care risk assessment prior to patient contact for all patients at all times including those who are asymptomatic.
  - **NOTE:** PCRA requires facial protection (mask and eye) if there is the potential for patient coughing or vomiting within 2 meters of service provider.
  - Point of care risk assessment will help you determine what [Personal Protective Equipment](#) is required.
- For patients suspected/confirmed to have influenza like illness (ILI) or COVID-19 use [Droplet and contact precautions](#) unless the patient is undergoing an AGMP in which case the procedure should be performed in a single room with the door closed, with staff wearing an N95 respirator instead of a surgical/procedure mask.
- Adhere to continuous masking equipment in patient care areas.
- Ensure staff competence in infection prevention and control procedures including donning and doffing [personal protective equipment](#), hand hygiene, cleaning and disinfecting processes, and risk assessment.
- Adhere to physical distancing principles.
- Care for the patient in a space/area that is at least 2 meters away from other patients.
- After the procedure/care episode is complete clean and disinfect all surfaces touched or coughed on by the patient or yourself during care with a [ready to use disinfectant wipe](#).

### Aerosol Generating Medical Procedures

Components of clinical dysphagia intervention including inducing a cough, introducing textures during videofluoroscopic swallowing study (VFSS) and fiberoptic endoscopic evaluation of the swallow (nasopharyngoscopy/flexible laryngoscopy) are NOT considered to be Aerosol Generating Medical Procedures (AGMP).
The list of AGMP was developed by an expert working group made up of infection prevention and control physicians, workplace health and safety physicians, infection prevention and control practitioners, epidemiologists and respiratory therapists. For more information about AGMP visit:
- [ahs.ca/covidppe](https://ahs.ca/covidppe): This link will take you to the PPE page and you will select the Respiratory ILL algorithm and AGMP list is on the second page.
- [ahs.ca/AGMP](https://ahs.ca/AGMP): This web page is a comprehensive listing of many procedures and identifies which are considered AGMP and a link to the Respiratory ILL. The full list of AGMPs can also be found in the Respiratory ILL algorithm and the Acute Care Resource Manual Disease and Conditions Table.

### Inpatient Dysphagia

**Clinical Interventions including assessment, diet modifications and treatment**

**Urgent Triage Criterion**
- Patient is NPO (secondary to swallowing impairment or physician concern) with inadequate alternative to oral feeding
- Patient for whom delaying an assessment will result in an imminent safety concern.
- Patient is not stable on a diet (i.e., decline in status, new diagnosis).
- Discharge is imminent and SLP assessment is necessary to facilitate or support discharge.

**Process**
- Engage the collaborative care team (including the attending physician) to determine intervention options for all patients with ILLI or COVID-19.

**Instrumental Assessment**

**Urgent Triage Criterion**
- Limit procedures to situations where the assessment is critical to the individual’s potential to recover, to facilitating discharge or to reduce length of stay.

**Process**
- Engage the collaborative care team (including the attending physician) for all procedures and to determine potential alternative to VFSS and/or Fiberoptic Endoscopic Evaluation of the Swallow for all patients with ILLI or COVID-19.

### Ambulatory Outpatient Dysphagia and Congregate Living (Lodges, DSL’s and LTC)

- Consult with the collaborative care team and your supervisor prior to scheduling any face to face appointments.
- All non-urgent AHS ambulatory clinic visits are postponed until after April 30, 2020.

**Clinical Intervention (screening, assessment, diet modifications and treatment); includes inducing cough**

**Urgent Triage Criterion**
Intervention would prevent hospital admission. Consider the following indicators:
- Symptoms of oropharyngeal dysphagia during oral intake occurring daily and not managed by consistency modifications and/or compensatory strategies (including a combination of coughing, choking, wet vocal quality, change in respiration, nasal regurgitation, inability to initiate swallow).
- Recent history of aspiration pneumonia (in last six months) with hospital admission(s), recent deterioration in respiratory status and/or recurrence of pneumonia.
- Recent choking episode (i.e., obstructive event requiring abdominal thrusts).
- Acute or progressive deterioration in health status likely attributable to an oropharyngeal swallowing disorder.
- Severely compromised hydration/nutrition status (weight loss >5% in 1 month).

**Process**
- Use virtual technology to meet with patients (phone, Zoom, or Skype) whenever feasible – consider starting with a meal observation
- For ambulatory outpatient visits considerations must be made for continuous masking requirements for patients
- Choose an assessment space that best supports physical distancing and cleaning and disinfecting processes
- Engage the collaborative care team (including the Most Responsible Physician) to determine intervention options for all patients with ILI or COVID-19

**Instrumental Assessment**

**Urgent Criterion**
- Limit appointments to patients who if not assessed in an outpatient setting would likely present to an urgent care center or ER or result in an EMS call.
- The patient must show signs of oropharyngeal dysphagia and is at significant and immediate risk for pulmonary and/or nutritional complications attributable to oral and/or pharyngeal dysphagia that cannot safely be deferred or addressed via virtual consultation. Consider:
  - Signs / symptoms of oropharyngeal dysphagia during oral intake (coughing /choking, wet vocal quality, change in respiration, nasal regurgitation, inability to initiate swallow) occurring daily and not managed by consistency modifications and/or compensatory strategies.
  - Recent history of aspiration pneumonia (in last six months) with hospital admission(s), recent deterioration in respiratory status and/or recurrence of pneumonia.
  - Acute or progressive deterioration in status likely attributed to an oropharyngeal swallowing disorder.
  - Recent choking episode (i.e., obstructive event requiring abdominal thrusts).

**Adult** considerations include evidence of oropharyngeal dysphagia contributing to:
- Severely compromised hydration/nutrition status (weight loss >5% in 1 month).

**Pediatric** risk factors include evidence of oropharyngeal dysphagia contributing to:
- Flat growth curve or decrease of more than 2 percentile.
- Recommendations for enteral feeding.
- An acute change in eating/feeding/swallowing.
- And Below 2 years of age.

**Process**
- All in person appointments are preceded by discussion between the patient and a member of the dysphagia team.
- Engage attending physician and other collaborative care team members in determining the immediate necessity and availability of instrumental assessment (i.e., VFSS and/or FEES. For FEES include otolaryngologist (ENT) in decision making).
- Give consideration to the priority criteria outlined for **Clinical Intervention**.
- Engage a collaborative team (including an otolaryngologist) to determine the necessity of Fiberoptic Endoscopic Evaluation of the Swallow.
Low Priority

- Routine assessments for general dysphagia symptoms, globus sensation or baseline assessment.
- Assessment for the purpose of differential diagnosis/ruling out aspiration - not flagged as urgent.
- Assessment required to determine candidacy for surgery (i.e., pre-pallidotomy, pre – Botox injection for patients with spasticity).
- Inpatient discharged prior to swallowing assessment and not flagged as urgent upon discharge.
- Assessing for oral intake with gastroscopy tube present.
- Request to upgrade diet or advance diet textures
- Patients that can be managed by community stakeholders (i.e. Home Care, Integrative Supportive and Facility Living etc.). In these cases consider virtual options.

References:

- AHS Infection Prevention and Control
- Personal Protective Equipment – Novel Coronavirus
- Aerosol Generating Medical Procedure List – (see Page 2)
- Benchmarking with SLPs and Otolaryngologists in other provinces completed March 24 – 27, 2020