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 only time sensitive, urgent and emergent needs
- ensure the safety of their patients, themselves and those around them

Note: Triage criterion may change through the course of the pandemic. At this phase there is emphasis on urgent procedures that will prevent hospital admission or facilitate discharge for those currently admitted. This document is up to date as of April 6, 2020

### Patient and Staff Safety

According to AHS Infection Prevention and Control Surveillance and Standards:

- Inducing a cough during a clinical dysphagia intervention and videofluoroscopic swallowing study (VFSS) are NOT considered to be Aerosol Generating Medical Procedures (AGMP). See the Respiratory (ILI) Algorithm for a list of AGMP.

- **There is risk of droplet and contact exposure during all clinical dysphagia interventions.** Providers must:
  - Ensure minimum physical distance of 2 metres between patients and cleaning of service areas.
  - 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.
  - 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.
  - 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.

Endoscopic nasopharyngoscopy/flexible laryngoscopy is considered an AGMP. As a result: Assess patients according to the Respiratory Illness Assessment Algorithm.

- Patients with ILI symptoms who urgently require fiberoptic endoscopic evaluation of the swallow (FEES) or any AGMP identified in the Respiratory Illness Assessment Algorithm are placed in a single room with the door closed and staff wear an N95 respirator.
- Visitors and non-essential staff must leave the room.
- If available, within the care unit, place patient in airborne isolation room (AIR); transport of patients to access AIR is not advisable.

Please note: the list of AGMP is currently under review and recommendations may change if new evidence becomes available. This document is up to date as of April 6, 2020
## 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 patient safety concern.
- Patient is not stable on a diet (e.g., 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 ILI 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 reducing 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 ILI or COVID-19

## Outpatient Dysphagia

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

**Urgency 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) with deterioration in respiratory status, and/or recurrence of pneumonia
- Recent choking episode (i.e., obstructive event requiring abdominal thrusts)
- Acute or progressive deterioration in status likely attributed to an oropharyngeal swallowing disorder
- Severely compromised hydration/ nutrition status (weight loss >5% in 1 month)

**Processes**

- Use virtual technology to meet with patients (phone, Zoom, or Skype) whenever feasible.
- Engage the collaborative care team (including the Most Responsible Physician) to determine intervention options for all patients with ILI or COVID-19
**Instrumental Assessment**

**Urgency Criterion**
- Limit appointments to include only those patients who if not assessed in outpatients 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) with 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
- 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 including otolaryngologist in decision making.
- Giving consideration to the priority criteria outlined for **Clinical Swallowing Evaluation**.
- Engage a collaborative team (including an otolaryngologist) to determine the necessity of Fiberoptic Endoscopic Evaluation of the Swallow

**Out of scope in our current context**
- Routine assessments for general dysphagia symptoms, globus sensation or baseline assessment
- Assessment for the purpose of differential diagnosis/ruling our aspiration - not flagged as urgent
- Assessment required to determine candidacy for surgery (e.g. 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

Sources Considered:
- 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
- Speech-Language and Audiology Canada COVID-19 Updates