



How to Talk to Your Team About the Evidence: E-Mail Template

With Contributions from Kelsey Day, M.S., CCC-SLP

Do you encounter colleagues who are not performing evidence-based practice? Are you hesitant to address this issue directly, for fear of his or her reaction? If this applies to you, it sounds like your facility needs a culture change.

We should never be afraid to have professional conversations about research, as long as they are constructive, respectful, and factual! We need to create a culture within our departments where it is encouraged to openly question each other's practice and to expect our colleagues to be receptive to education regarding new evidence. This kind of culture change doesn't happen by only addressing individual cases with individual colleagues, where they might perceive your questioning as a direct attack on their clinical skills. Rather, we should create a culture of evidence-based practice by routinely hosting team meetings and sending departmental emails about literature reviews.

Choose topics that are relevant to your facility (e.g., blue dye testing, ordering instrumental swallow exams, waiting 24 hours post-extubation for clinical swallow evaluations), and host monthly meetings to review related evidence. For example, in this particular facility, some Speech-Language Pathologists have been modifying liquid diet consistencies at the bedside, prior to instrumentation. A team meeting was hosted where four pieces of literature were reviewed on this topic. The quality of the evidence was discussed, and if the research is applicable to the specific patient populations served, then mutually agreed upon clinical practice recommendations were constructed for the department. This information was then synthesized into an email that was sent to the team. All responses received were an overwhelming, "Thank you for the information!" When presented in a professional, respectful way, defensive responses should not happen. Now, if this issue arises again, the SLPs can refer to the departmental practice recommendations and if there is new research that should prompt a re-visit to this topic, then a follow up meeting will occur. If this is done frequently enough, "I've always done it this way," can disappear from your colleagues' vocabularies.

An email template was created for you to use if you are encountering this situation in your workplace. Remember, it's important to also openly critique your own practice patterns in the form of "I used to X until I learned Y; Now I do Z." Don't be afraid to start the conversation – culture change can't happen alone!



How to Talk to Your Team About the Evidence: E-Mail Template

Team,

We held a huddle on the topic of bedside liquid diet modifications, where we reviewed current literature applicable to our patients.

We have had several patients over the past few weeks who have demonstrated some clinical signs of pharyngeal dysphagia, in the setting of significant historical and/or acute dysphagia risk factors, who have been started on modified liquid diets (e.g., nectar-thick or honey-thick liquid) at the bedside prior to any instrumental swallow exam. I am addressing this because several of these patients have decompensated, and this decline may be attributed to a dysphagia-related pulmonary complication.

As we strive for the use of evidence-based practice to protect our patients' safety, I'd like to review the literature regarding accuracy of clinical swallow evaluations, the inconsistency of sensory response to aspiration of thickened liquids, and increased risk of pulmonary complication and mortality with the aspiration of thickened liquid. I encourage you all to find and read these articles in full, as well as to conduct your own literature review on this topic.

Given the evidence below, our department has generated several clinical practice recommendations:

(1) Any patient who demonstrates any clinical signs of pharyngeal phase dysphagia, in the setting of any acute and/or historical dysphagia risk factors, requires instrumental swallow assessment via videofluoroscopy and/or Flexible Endoscopic Evaluation of Swallowing (FEES).

(2) The determination of whether a patient is safe to continue an oral diet prior to instrumental swallow study should be made with consideration of the patient's current level of acuity/medical comorbidities, current pulmonary disease and respiratory status, immune function, oral hygiene, and physical mobility. We use these factors to determine a patient's risk for developing a dysphagia-related pulmonary complication. In general, ICU patients, patients requiring supplemental oxygen delivery (especially high-flow nasal cannula), patients with active pneumonia, cancer patients with compromised immunity, and acute stroke patients with compromised physical mobility are at high risk for aspiration-related pulmonary complication.



How to Talk to Your Team About the Evidence: E-Mail Template

(3) Should a patient demonstrate clinical signs of pharyngeal dysphagia, and be deemed low-risk for an aspiration-related pulmonary complication, then initiating an oral diet prior to instrumentation may be appropriate. In these cases, the solid diet level should be appropriate for the patient's dental and cognitive status. Liquid consistency should be THIN LIQUID prior to instrumental swallow study (barring a known history of dysphagia and prior instrumentation that proved thickened liquids safer for the patient).

These are our department's practice recommendations, not formal policies. Our SLP licenses entitle us to autonomy in this decision-making, however, our department prides itself on the use of evidence to support our practice. If you do choose to modify liquid diets at the bedside prior to an instrumental swallow study, I would like to have an open discussion regarding your decision-making and to see the evidence supporting that judgment for each case.

Please contact me if you have any questions or concerns regarding this information. I hope you find the below research useful. As always, I love to be informed of new research from you as well — please keep me in the loop if you discover new evidence on this topic, so that we can re-evaluate our recommendations. When we know better, we do better!

- Nativ-Zeltzer, N., Kuhn, M. A., Imai, D. M., Traslavina, R. P., Domer, A. S., Litts, J. K., Belafsky, P. C. (2018). The effects of aspirated thickened water on survival and pulmonary injury in a rabbit model. *Laryngoscope*, 128(2), 327-331.
<https://doi.org/10.1002/lary.26698>
- Miles, A., McFarlane, M., Scott, S., & Hunting, A. (2018). Cough responses to aspiration in thin and thick fluids during FEES in hospitalized inpatients. *International Journal of Language & Communication Disorders*, 53(5):909-918
- Lynch et al. (2017). The accuracy of the bedside swallowing evaluation for detecting aspiration in survivors of acute respiratory failure. *Journal of Critical Care*, Volume 39, 143-148.
- Brodsky et al. (2016). Screening accuracy for aspiration using bedside water swallow tests: a systematic review and meta-analysis. *Chest*, 150(1), 148-163.

Sincerely,

[insert your name]