COVID Open Letter to SLPs and Collaborative Work

With contributions from Jackie Danek, MS CCC-SLP

An open letter to my fellow SLPs,

We have heard a lot of talk lately regarding “essential workers." Whether you believe that we, as a profession, have some things to prove before we can consider ourselves essential, or you believe that we are essential in every part of what we do, I believe that we are only as “essential” as we make ourselves and our team. That’s right everyone, *our team*! We are not the only part of the rehabilitation/patient care team. These COVID-19 patients are probably some of the sickest patients your team may have ever cared for, and our teammates are also working tirelessly to keep them alive. This may mean that we “Swallow our Pride” and help our teammates to help our patients.

Let me first start by saying, I believe that our knowledge, assessment, and treatment is imperative for these patients’ progress. But this may initially be provided in a way that we are not used to. If anyone has ever played sports, we all want to be the super star, the standout, the one who scores the most goals, makes the most baskets, and wins the game. I think the same could be said for us in healthcare; we went into our profession because we felt that we could help change lives and want to stand out to our peers. However, in sports, in life, and in our profession, sometimes the most valuable players are the ones who start off on the bench. Seeing the entire game, cheering their teammates on, and providing valuable awareness and knowledge that those in the game may not have!

Who are our teammates you ask? Our physical therapists and occupational therapists who have been assigned to our proning teams, our nurses, our respiratory therapists, our doctors, and many more. I truly believe that we are also a part of this amazing team. However, we are not the entire team. Sometimes our teammates will be working with these patients for days and weeks before we are called in to do our part. Why does this matter you may think? Well, these teammates often do not have the knowledge and skills that we do. This is not bad; it is simply different. Many of them do not understand the anatomy and physiology of the airway and the impact an endotracheal tube may have on our patients' later success or struggles regarding voicing and swallowing. Many of them may not understand how a tracheostomy changes everything regarding upper airway and swallowing. They are not taught the critical components of communication, AAC boards, etc., for our intubated patients. I believe that it is our job to teach them, guide them, and empower them so that our patients have the best chance for the greatest recovery.
I challenge you to educate, support, and cheer your teammates on from the sidelines, before you get thrown into the game. Your support may be the game winning goal!

Be safe, be smart, be supportive.

Love,
Your fellow SLP in the trenches

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Suggestions for how you can support your team

Physical and Occupational Therapy:

Consider showing them videos and diagrams. Discuss the anatomy/physiology of the airway with intubation and with tracheostomy placement. Express your concerns regarding the fragility of the vocal cords with the endotracheal tube in place and encourage them to be mindful of this when turning/proning the patients. Encourage them to utilize AAC boards, when appropriate, or at least formulate a universal yes/no sign (thumbs up/down, eye blinks, etc.). Educate them regarding the importance of avoiding frequent head nods for yes/no, as this may potentially be damaging to the vocal cords.

Great Resources for Education:
https://www.passy-muir.com
https://www.medbridgeeducation.com
https://www.educationresourcesinc.com/
https://www.bluetreepublishing.com (these apps and posters are great to have in general)
https://www.asha.org/eweb/OLSDynamicPage.aspx?webcode=olsASHALearningPass

Nursing:

Say thank you! Bring them a thank you bag! Consider the "Chocolate Swallow Screen" that was posted in The Collective. Let them know you appreciate what they do and encourage them to reach out to you with questions or concerns. Educate them for implementation of a swallow screen. Consider the Yale Swallow Protocol and encourage them to seek a formal swallowing evaluation when necessary (Suiter et al., 2008; Garon et al., 1995; Warner et al., 2014).

Also consider oral care/hygiene education. If you do not have an oral care protocol in your facility, consider printing out the oral care handout from The MedSLP Collective and grabbing a bunch of toothbrushes, toothpaste, etc., from the utility room and make a basket (added chocolate and other goodies are always a plus). This could also be area you could help. If cleared by your administration, you could possibly lead an oral hygiene team (Ashford et al., 2008; Ashford, 2012; Bartlett, 1975)!!

Remember, some of these nurses have never worked with a ventilated patient before. These are not always our typical ICU nurses. Help them, guide them, make sure they know how to get in touch with you if they have any questions or concerns.

Great Resources:
https://www.sassplIc.com/wp-content/uploads/2014/12/Yale-Swallow-Protocol.pdf
The MedSLP Collective for AAC recommendations, oral care program instructions/handouts, and information regarding the Yale Swallow Protocol.

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Doctors:

Be available for questions, say thank you, educate them when appropriate. Also, be aware that these doctors are human, they are exhausted, they are not always thinking clearly. Be patient and take this as an opportunity to teach them something they may not know, and ultimately advocate for our patients. Make handouts regarding the three pillars of aspiration pneumonia, this may help them understand your rationale for certain diet recommendations when we do not always have access to instrumental assessment. Consider including information regarding the potential negative impact of thickened liquids, and the importance of not just putting every patient on an arbitrary puree/honey thick liquids diet after extubation (Robbins et al., 2008; Logemann et al., 2008).

Your Fellow SLPs:

Check in on them. Ask them if they are ok. Ask questions and find out how they are treating and rehabilitating COVID-19 patients. Spread knowledge and kindness. If you know of an SLP who may not typically care for such complex respiratory patients, reach out to them, and offer support and education to them. Lead them to resources, such as The MedSLP Collective, the Facebook group MedSLP Newbies, Medbridge courses, and Passy Muir webinars, and tell them about the ASHALearning Pass (free to ASHA and NSSLHA members for the next few months). Encourage them to stay up to date with state regulations and Centers for Disease Control (CDC) regulations so they can best advocate for themselves and their patients. If applicable share all the same research listed above regarding best practice for oral hygiene, thickened liquids, and swallow screens (Robbins et al., 2008; Logemann et al., 2008; Suiter & Leder,., 2008; Garon et al.,1995; Warner et al., 2014; Ashford & Skelly, 2008; Ashford, 2012; Bartlett & Gorbah, 1975; Suiter et al., 2008; Garon et al., 1995; Warner et al., 2014).

Don't forget to advocate for your own patients as well. Many of these patients are experiencing prolonged intubation; upwards of approximately 16 days. It is known that patients with prolonged orotracheal intubation are at higher risk of aspiration following extubation (Barquist et al., 2001). Also Ajemian and colleagues (2001) determined that, following extubation, 56% of patients were found to aspirate on a completed FEES, and 25% of the patients were silent aspirators. The average time of intubation was 8 days for aspirators and 7.7 days for non-aspirators. Seventy percent (70%) of the patients aspirated thin liquids and 30% aspirated pureed foods. HOWEVER: 63% of the patients who aspirated showed improvement in swallow function and were tolerating an oral diet at the time of discharge.

Stay educated, stay positive, and support your teammates!

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