Speech therapy and your patients

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This presentation

- SALT for palliative care patients, carers, team
- Interim review of SALT project in an Oxford hospice – why and emerging findings
- Communication and swallowing goals of palliative care patients, illustrated with cases

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Speech therapy in palliative care

Questions that SALT can help you answer

How can the patient best understand and express themselves?

What can the team do to get over diagnosable communication barriers?

What is the patient's mental capacity for this decision?

How can the patient safely and/or comfortably eat and drink?

How feasible is oral medication now?

Priorities for the Care of the Dying Person (2014)

- Recognise approaching death and communicate this
- Communicate sensitively with patient and family
- Involve patient and family in decisions
- Support patient and family
- Plan including eating and drinking

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Evidence

- SALT role in palliative care (e.g. Kelly et al 2016) – acknowledged but often not well defined
- Unmet need in communication identified in the past (Salt & Robertson 1998)
- Variable referral rates between hospices for patients with aphasia (Shelley & Holt 2019)
- Lack of certainty about when to refer to SALT in palliative care teams (Colclough, 2015)
- Voices of caregivers discussing their observations on changes in their family members' eating and drinking; often worrying (Bogaardt et al 2015) or reflecting on these issues having a significant impact on them (Rajimakers et al 2013)
- *Do patients feel SALT helps? Timing – earlier/later in pathway? Negative and positive impacts? What do palliative care teams expect when referring to SALT, and what are the outcomes of these referrals?*

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Questions for you –

Do you have a speech and language therapist as part of your palliative care MDT?

If yes – how long have they been part of the MDT?
6 mo – 6 mo to a year – 1–3 years – 3+ years

Where does the therapist work?
Hospice inpatients/Hospice outpatients/Community/Hospital team

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How SALT works

- Referral and history
- Clinical bedside assessment
  - Swallowing
    - Is there a breakdown and where in the process does this happen?
    - Why? Neurological status? Are cognition, sensation and motor function intact?
    - What are the risks of aspiration and how could these be managed?
    - Is an instrumental assessment justified?
    - What is the swallow prognosis?
- Communication – informal, formal assessment of function
  - Cognition
  - Voice
  - Language – understanding and expression
  - Speech
  - Capacity

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Sobell House

- 18 inpatient beds
- Caring for 80% of Oxfordshire referrals to palliative care

- SALT at Sobell – before the project
  - Covered by Churchill Hospital SALT (180+18 beds, 12 hours a week)
  - No MDT attendance
  - Referrals – usually single session, assessment and advice; some patients known to the Churchill team, some not
  - Communication referrals very rare

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Once upon a time there was a incident

- Jan 2019: Patient with dysphagia on the acute ward
- Assessed by SALT: recommendations made for modified diet, thickened fluids, swallow safety strategies
- Transferred within an hour to hospice
- No verbal or paper handover of recommendations between teams. Electronic SALT note completed.
- Inconsistent use of thickened fluids
- Patient developed aspiration pneumonia and subsequently died.

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Project

- How can SALT and palliative care team work together better?

- Sept 2019–Feb 2020
- NIHR research internship
- Intervention project: 8 hours a week based at Sobell House, plus some work with the day services
- Attending MDT weekly; training and information sessions to nursing and medical staff; seeing patients
- More reviews, changes to recommendations
- Semistructured interviews with hospice staff to explore their views on SALT referrals

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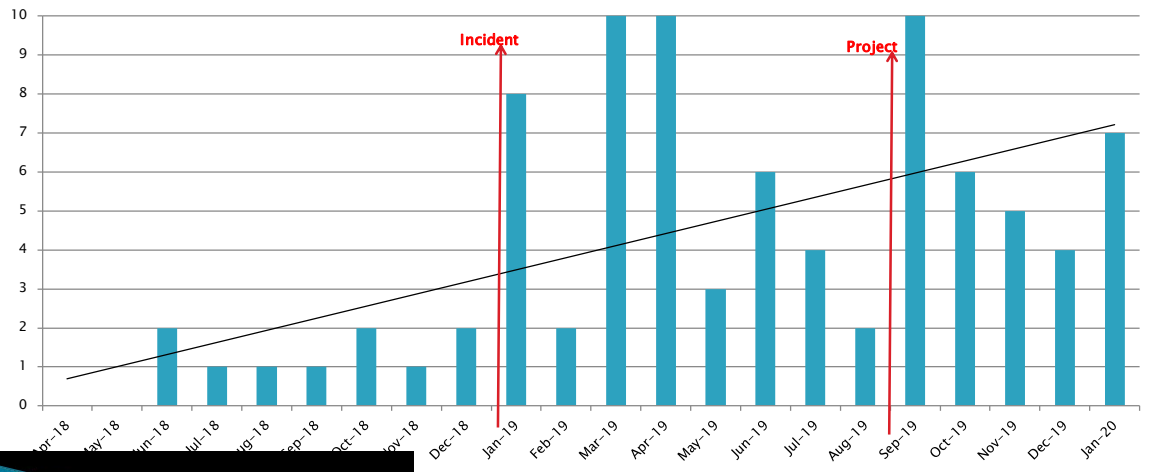
Referrals: Sobell to acute SALT Apr 18–Jan 20



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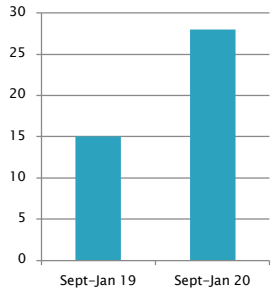
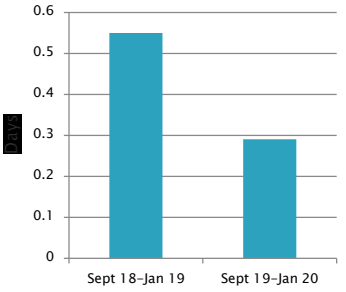
Before and during project:
Sept 18-Jan 19 Sept 19 -Jan 20

Referral numbers

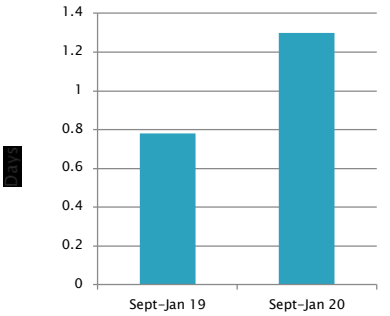


Time to respond*



*Omitting 2 outliers from Sept 2019 - system change

Time on caseload



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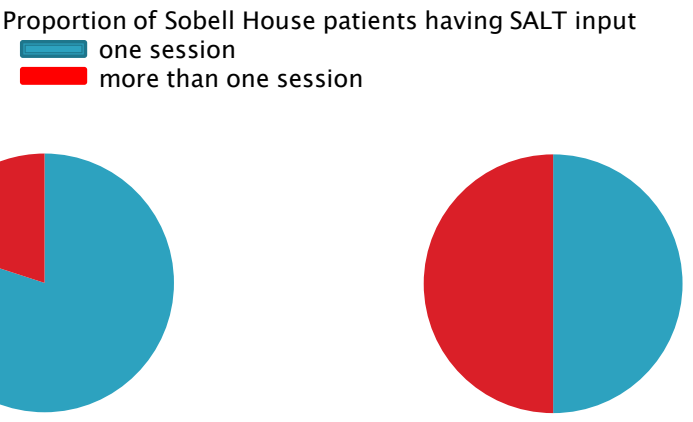
Before and during project:
Sept 18-Jan 19 Sept 19 -Jan 20

Proportion of Sobell House patients having SALT input



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Typical patient goals about swallowing and communication

- Continue oral intake at risk of aspiration ('risk feed')
- Gain clarity about risks and management
  - Instrumental assessment?
- Stay well
- Participate in medical decisions
- Communicate more easily with family and team

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Goal: Continue oral intake at risk of aspiration

- Patient needs to know what the risks are to make this decision
- Mental capacity? Best interests?
- Policy, guidelines, documentation and leaflet
- Individualised approach
- Family may have different views – will need information and discussion
  - Bogaardt et al 2015: caregivers rated symptoms of aspiration in final days of life more severe and worrying than nurses
- Staff may find feeding an aspirating patient difficult; may need additional support and acknowledgement
- This decision can change
- Document!

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Oral intake at risk: case example

- Case background: 93 yr old man with gastric cancer – hospice admission for symptom control.
- Actions: bedside swallow assessment.

Outcome:

Successful! – patient tried an option – chose not to pursue it.
Staff pleased to have done what they could.
Documented

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Goal: Clarity about risks and management

- The transition from active care to palliative care
- Changes in care setting through the pathway
- New teams involved
- Family members – more/less involved

- Accessible information about eating, drinking and communicating – following the patient
- Goals can change

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Clarity – case example

- Case background: 82 yr old man with past stroke, new inoperable ca lung – hospice admission for symptom control incl breathlessness.
- Actions: bedside swallow assessment.

Outcome: Patient came close to discharge but deteriorated and died at hospice.

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Clarity: case example

- Case background: 70 yr old man with metastatic oesophageal cancer.
- Actions: outpatient clinic assessment, videofluoroscopy

https://www.youtube.com/watch?v=i04vq_aYiBg

Outcome: on cruise

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Instrumental assessment

SALT: before, during and after

Objective assessment of swallowing

- Videofluoroscopy ('VF' 'Video swallow' 'Video')
  - https://www.youtube.com/watch?v=i04vq_aYiBg
- Fibreoptic endoscopic evaluation of swallowing (FEES)
  - https://www.youtube.com/watch?v=re5oKdzr2uU

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Goal: stay as well as possible

- Some patients even in late palliative stages want maximum safety from aspiration
- They can only make this choice if they know what aspirating is!

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Stay well: case example

- Case background: 94 year old man with oesophageal ca on a background of past strokes. Some cognitive impairment. No further oncological treatment options.
- Action: bedside assessment.

Outcome:

NBM with NG tube to maximise chances of remaining well; tube removal on discharge and for eating and drinking at risk.

Given advice for initial days after discharge and referred on urgently for community SALT review at home, supported by the community palliative care team

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Communication barriers

- Diagnosable communication barriers
- Aphasia (stroke, brain mets, TBI)
  - Receptive, expressive, slowed language processing
- Cognitive communication disorder (R sided stroke, dementia, brain mets)
- Dysphonia/aphonia
  - Vocal fold palsy
  - Respiratory compromise/breath support
  - MND
  - PD
  - Laryngectomy/tracheostomy
- Dysarthria (unclear speech: stroke, neurological disorders)
- Often masked, at big cost in energy and concentration

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Communicate better: case example

- Case background: 74 yr old woman with recurrent metastatic oesophageal cancer, initially treated with oesophagectomy
- Action: clinic assessment, referral to specialist and followup.
- Recommendation from ENT: for consideration of injection to the L vocal fold with 'filler'.

Outcome: Followed up while awaiting appointment to discuss this. L head turn, modified intake and safety strategies to reduce risks.

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Communicate better: case example

- Case background: 59 yr old man with renal cancer, brain mets with haemorrhagic bleed; language and visual difficulties. BG of COPD.
- Action: Bedside assessment, then reviewed after steroids in hospice. Patient and family most concerned by communication barriers.

Outcome: discharge to community hospital for rehab.

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Communicate better: case example

- Case background: 64 yr old male with recurrent SCC left maxilla extending to the infratemporal region. Palliative CRT stopped May 2019.
- Actions: clinic assessment. Patient expectations https://www.youtube.com/watch?v=H4wmdgSxI0E
- Referral to alternative & augmentative communication SALT and followup.
- https://www.youtube.com/watch?v=1TaUEIJgBU0

Outcome: Patient able to keep iPad and use it until his death some months later as a hospice inpatient.

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Communicating better

Facial expression

Eye contact

Gesture

Quiet room

Intonation

Stating the topic

Keyword emphasis

Chunking/pausing

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Communication aids – low tech, personal tech, specialist tech

Text to speech, e.g. Proloquo 2 Go

https://www.youtube.com/watch?v=1TaUEIJgBU0

Electrolarynx

https://www.youtube.com/watch?v=H4wmdgSxI0E

Writing – e.g. paper, boogie board, text messages

Speech support – e.g. alphabet chart

Letter or phrase scanning e.g. Speakbook

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The project: outcomes so far

- SALT has a clear role supporting care according to the Priorities for Care of the Dying Person
- Twice as many referrals seen Sept-Jan 20 compared with Sept-Jan 19
- More sessions per referral, seen more quickly
- MDT attendance is an efficient use of SALT time – speed of response, ongoing questions for patients on caseload
- Trialling 'goal based swallowing recommendations'

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Interviews

- Initial findings – full analysis to follow
- Medical and nursing staff report –
  - more clarity on when and how to refer – and when not to refer
  - better understanding of what SALT can do for patients
  - better understanding of options for patients with swallowing problems
  - more continuity and collaboration, less ticking boxes

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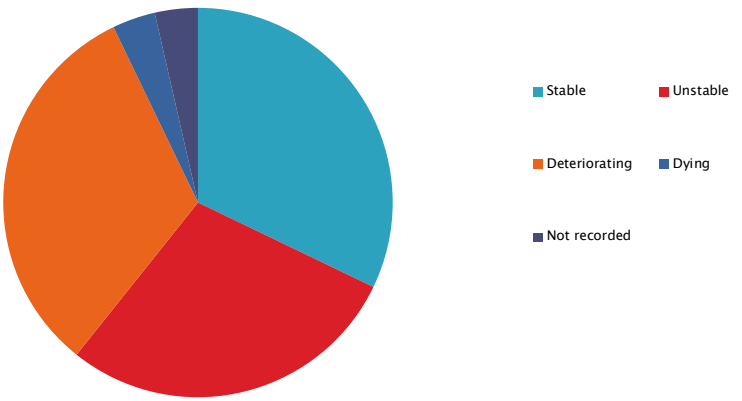
Palliative care stages of illness for a hospice's referrals to SALT: Sept 2019 to Jan 2020



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Research proposal

- How do people over 18 in the last year of life, their families and the clinicians of their palliative care service, manage swallowing and communication problems?
- Semistructured interviews with people across the palliative care pathway: community, acute hospital, day services, hospice
- Thematic analysis

- Application for NIHR predoctoral fellowship 2021

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Outstanding challenges

- Timing of input through the palliative care pathway
- Transition back out of the project to 'normal' provision
- Business case for future service
- Dissemination of findings
- Ongoing training needs

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Comments –

- After this, would you use your SALT service differently?

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References

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