Guideline for Speech Therapy Service in Residential Care Homes for the Elderly

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Content

1. Introduction

With the increase in in-house speech therapy service provision, there is a need to establish a guideline in order to assist Speech Therapists who are delivering communication and swallowing management to the residents in the residential care homes for the elderly (RCHEs).

2. Scope of Service

2.1. The ultimate aim of speech therapy is to improve individuals' quality of life by optimizing his or her communication and swallowing abilities with up-to-date, rational, safe and cost-effective management

2.2. Speech Therapists provide a wide range of clinical and other related services that support individuals with a diversified range of communication and swallowing difficulties. These services complement the World Health Organization (WHO)'s the International Classification of Functioning, Disability and Health (ICF). The ICF provides a conceptual framework that guides clinical and research practices in the field of speech therapy, and it consists of the following key components:

- 2.2.1. Body functions and structures: this relates to the anatomy and physiology of the human body. Examples related to speech therapy in RCHEs are facial asymmetry and vocal fold paralysis.
- 2.2.2. Activity and Participation: activity refers to the execution of a task while participation refers to the individual's involvement in a life situation. Examples related to speech therapy in RCHEs are safe swallowing for independent feeding and active participation in social events.
- 2.2.3. Environmental and personal factors: environment factors include the physical and social environment where individuals live while personal factors include those internal influences of the individuals on their functioning and disability (e.g. age, gender, ethnicity, educational background, etc.) Examples related to speech therapy in RCHEs are the roles of caregivers in creating a facilitative environment for communication and safe swallowing, and the cultural background of the individuals related to their communication with others.

2.3. Professional practice of Speech Therapy in RCHEs includes:

- 2.3.1. Advocacy and outreach
- 2.3.2. Supervision
- 2.3.3. Education
- 2.3.4. Administration and leadership
- 2.3.5. Research

2.4. Clinical service of speech therapy in RCHEs includes:

2.4.1. Screening and identification of communication and swallowing disorders.
2.4.2. Assessment and diagnosis of communication and swallowing disorders.
2.4.3. Intervention for communication and swallowing disorders.
2.4.4. Management of communication and swallowing disorders using instrumental techniques, including but not limited to video-fluoroscopy, electromyography, nasometry, naso-endoscopy, video-stroboscopy, sonography and electrical stimulation
2.4.5. Coordination of care with other professionals
2.4.6. Consultation for individuals and their caregivers
2.4.7. Measurement of therapy outcomes and documentation of therapy progress

2.5. Areas of speech therapy service in RCHEs include:
2.5.1. Airway management
2.5.2. Alternative and augmentative communication
2.5.3. Cognitive communication
2.5.4. Feeding and swallowing
2.5.5. Fluency
2.5.6. Problem solving
2.5.7. Receptive and expressive language
2.5.8. Resonance
2.5.9. Voice

2.6. Potential etiologies of communication and swallowing disorders in RCHEs:
2.6.1. Developmental disabilities (e.g. intellectual disabilities, unspecified neurodevelopmental disorders)
2.6.2. Disorders of respiratory tract function (e.g. irritable larynx, chronic cough, abnormal respiratory patterns or airway protection, paradoxical vocal fold motion, tracheostomy)
2.6.3. Genetic disorders (e.g. Down syndrome, velocardiofacial syndrome)
2.6.4. Laryngeal anomalies (e.g. vocal fold pathology, tracheal stenosis)
2.6.5. Neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebrovascular accident, dementia, Parkinson's disease, and amyotrophic lateral sclerosis)
2.6.6. Oral anomalies (e.g. macroglossia, oral motor dysfunction)
2.6.7. Orofacial myofunctional disorders (e.g., habitual open-mouth posture/nasal breathing, orofacial habits, chewing and chewing muscles, lips and tongue resting position)
2.6.8. Pharyngeal anomalies (e.g. upper airway obstruction, velopharyngeal insufficiency/incompetence)
2.6.9. Psychiatric disorder (e.g. psychosis, schizophrenia)

2.6.10. Respiratory patterns and compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease)
2.6.11. Unknown etiologies (e.g. functional disorders)

3. Roles of Speech Therapists

Speech Therapists are uniquely qualified and should be considered as core members in management of feeding, swallowing, speech and language disorders of residents in RCHEs. Speech Therapists possess in-depth knowledge of anatomy, physiology, and functional aspects of swallowing and speech, and also all aspects of communication disorders that may contribute to the diagnosis and management of swallowing disorders. Speech Therapists work proactively and collaboratively with other professionals, family and caregivers. The role of Speech Therapists should be understood and respected by all multidisciplinary team members. The roles of Speech Therapists are as follows:

3.1. Management of Feeding and Swallowing disorders

Speech Therapists play an essential role in the screening, assessment, diagnosis and management of feeding and swallowing disorders in RCHEs residents. They:

3.1.1. identify the signs and symptoms of dysphagia
3.1.2. perform and analyze information from clinical bedside swallowing assessments, and make referrals for instrumental examinations of swallowing function if appropriate
3.1.3. make diagnosis of dysphagia and feeding problem with consideration of residents' medical history
3.1.4. make recommendations on residents' mode of feeding according to the diagnosis and severity of dysphagia after assessment
3.1.5. ensure residents' safety in feeding and swallowing through modification of diet textures and fluid consistencies, reducing risk of aspiration, choking, malnutrition and dehydration
3.1.6. provide safe and effective treatment to help residents to regain the swallowing function through exercises, maneuvers, techniques and positioning
3.1.7. document progress and determine appropriate discharge criteria
3.1.8. communicate and work collaboratively with other healthcare staff in RCHEs, and medical professionals in hospitals
3.1.9. make appropriate referrals to speech therapists working in hospitals, and other medical personnel if indicative
3.1.10. educate and train RCHEs staff, caregivers and families in identification and management of feeding and swallowing disorders, in order to achieve adequate nutrition and safe swallowing for the residents

3.1.11. promote quality of life, taking into account of respecting residents' and their families' preferences and beliefs, and helping them to adjust in living with swallowing difficulties
3.1.12. advocate for services to individuals with swallowing and feeding disorders
3.1.13. maintain competency of skills and evidence-based practice through reviewing literatures and engaging in continuing education activities

3.2. Management of Communication disorders

Speech Therapists play an essential role in the screening, assessment, diagnosis and intervention of RCHEs residents with developmental or acquired speech and/or language disorders, such as aphasia, cognitive communication disorder, dysarthria, apraxia of speech and voice disorders. They:

3.2.1. provide preventive information to individuals and groups known to be at risk for communication disorders
3.2.2. screen residents who present with speech and/or language difficulties in order to determine for further assessment
3.2.3. administer comprehensive assessment of speech and/or language abilities as appropriate
3.2.4. make diagnosis of speech and/or language disorders with consideration of residents' medical history
3.2.5. make referral to other professionals to rule out other clinical conditions
3.2.6. plan and provide individual-centered treatment with consideration of evidence-based clinical practice
3.2.7. counsel residents and their families about communication strategies and aids to facilitate their participation in community context
3.2.8. collaborate with other healthcare professionals to facilitate intervention program development
3.2.9. educate caregivers and families on the needs of the residents with communication difficulties and the role that Speech Therapists play in meeting those needs

3.3. Management in End-of-life residents

Speech Therapists have roles in different aspects for the end-of-life residents, including:

3.3.1. Enhancement of the residents' overall quality of life
3.3.2. Provision of consultation to residents, families, and members of the team in the areas of communication, cognition, and swallowing function
3.3.3. In communication aspect:

A. To determine the capacity and competency of resident's communication ability in making informed decision
B. To develop alternative communication strategy
C. To enhance the expression of 'wants' and 'needs' in RCHEs effectively
D. To support the resident's role in decision making
E. To maintain social closeness
F. To assist the resident in fulfillment of end-of-life goals

3.3.4. In feeding and swallowing aspect:

A. To assist in optimizing swallowing function in order to improve resident's comfort and eating satisfaction
B. To promote positive feeding interactions for family members
C. To promote regular oral care to reduce discomfort and risk of illness
D. To communicate with members of the interdisciplinary hospice team, to provide and receive input related to overall resident care

3.4. Management in Comfort feeding

Comfort Feeding is a palliative approach of nutritional intake. It can be considered when residents are suffering from irreversible end-stage disease, and the swallowing disorders and / or feeding problems are significant. Given that the resident and family demonstrate full understanding of the aspiration risks (e.g. aspiration pneumonia, suffocation) & malnutrition, Comfort Feeding can be adopted upon physician's approval.

Speech Therapist have different roles in residents' comfort feeding issue including:

3.4.1 Communication and documentation

A. to works with other members in the multidisciplinary team to identify residents whom can be benefited by Careful Hand Feeding approach
B. to communicate with the team on the initiative of Careful Hand Feeding if appropriate resident is being identified
C. to liaise with Medical doctor (preferably specialist in Geriatrics/ Palliative Care / Oncology / Neurology, or other relevant specialties) to invite the resident / family to discuss the options on oral feeding and ANH feeding. Pros and cons of both feeding methods should be thoroughly explained.
D. to document the decision-making process and the reasons for the decision in medical notes is essential

3.4.2 Diet and fluid consistency

A. to recommend choice of diet and fluid consistency should be in balance between swallowing safety and resident's acceptance
B. to suggest alternative feeding utensils (e.g. feeding syringe / feeding bottle) can also be attempted for resident with limited mouth opening or poor bolus anticipation for feeding
C. to conduct regular reviews on diet and fluid consistency

3.4.3 Carer education on Comfort Feeding and feeding skills
A. to educate family members on aim and realistic expectation of Comfort Feeding
B. to explain the possibility of developing malnutrition, dehydration, pneumonia and death due to inadequate oral intake and aspiration

3.4.4 RCHEs nurses and healthcare workers education
A. to deliver education sessions on the concept and administration of Comfort Feeding, and feeding skills periodically
B. to educate the importance of oral hygiene in minimizing the development of aspiration pneumonia

4. **Competency of Speech Therapists**

4.1. Dysphagia Assessment

4.1.1. Theoretical knowledge

A. Comprehensive knowledge of normal anatomy, physiology and neurology of eating, drinking and swallowing, including:
- Anatomical structures involved in the process of sucking, eating, drinking and swallowing
- Physiology of sucking, eating, drinking and swallowing
- Neurology of feeding and swallowing
- Development of swallowing function from pre-birth to adult
- Effects of aging on swallowing

B. Understand and identify the underlying causes and resulting pathological physiology of abnormal eating, drinking and swallowing, including:

● Underlying congenital, developmental (including prematurity), neurological and acquired disorders that may predispose dysphagia	● Physical condition, e.g. sensory and postural state ● Cognitive functioning and developmental stage ● Sensory integration ● Psychological state

● Longstanding but functional, abnormal feeding and swallowing patterns, e.g. adapted and compensatory swallow physiology ● Medical condition ● Medication	● Behavioural issues ● Environmental issues ● Nutrition ● Hydration

C. Understand the signs of abnormal eating, drinking and swallowing, including acute, chronic, silent aspiration and autonomic stress signals and how these impact upon the generation of the hypotheses and subsequent management plan

D. Understand risk severity and how risk impacts upon the individual/carer/organization

E. Understand the rationale for trialing remedial techniques, modification strategies and equipment during the assessment in order to confirm or deny your hypothesis

F. Understand the range and efficacy of instrumental examinations that contribute to the assessment process for dysphagia, e.g. Video-fluoroscopic Swallow Study (VFSS), Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

G. Understand how to use and maintain the equipment and undertake the investigation with due reference to cross-contamination (Mandatory training: Local policy on decontamination of equipment)

H. Understand the interpretation and application of assessment findings to the individual with swallowing difficulties:
- Observational, informal tests
- Formal assessments
- Bedside assessments
- Instrumental examinations, e.g. VFSS, FEES

I. Understand the range of factors you need to consider in order to develop a working hypothesis and deliver a satisfactory diagnosis

4.1.2. Practical competencies

A. Conduct a specialized assessment. This may include:

● Medical state ● Level of alertness ● Ability to co-operate ● Sensory state	● Oral desensitization ● Identification of risk of aspiration

● Oro-motor skills ● Management of secretions ● Oral suction ● Utensils ● Bolus size, characteristics and placement ● Oral preparation ● Oral hygiene	● Identification of overt signs of aspiration ● Underlying cause(s) ● Developing and testing a hypothesis ● Identification of trial intervention ● Hydration screen ● Nutrition screen ● Food preference ● Mealtime behaviour

B. Utilize (or refer to and act upon additional reports) augmentative assessment to complement your assessment. These may include:
   - Cervical auscultation
   - Pulse oximetry
   - Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
   - Video-fluoroscopic Swallow Study (VFSS)
   - Ultrasonography

C. Assimilate, evaluate and interpret the assessment outcomes with the individuals, carers and team

D. Taking into consideration the individual's wishes, inform and discuss the implications of dysphagia assessment outcome for overall management with relevant team members, sharing implications and information with individuals, carers and team

4.2. Dysphagia Management

4.2.1. Theoretical knowledge

A. Recognize the need for a detailed dysphagia management plan, based upon the information and results obtained during the assessment process

B. Understand the components of the dysphagia management plan and how these affect the individuals

C. Understand how developmental, quality of life and end-of-life issues can impinge upon a dysphagia management plan

D. Understand the importance of providing accurate and prompt feedback to the care team to ensure effective management, consistent with the individuals' wishes

E. Understand how to gain agreement from the individuals, carers and team in order to acquire compliance and meet legal obligations to the individual and organization
F. Understand the review process in order to optimize management
G. Be aware of your scope of practice and level of competence

4.2.2. Practical competencies

A. Devise a detailed dysphagia management plan that identifies risk to the individuals' nutrition, hydration and respiratory state. This may consider:

● Diagnosis and prognosis ● Environment ● Positioning ● Oral hygiene ● Feeding equipment and utensils ● Nutrition/hydration support as required, e.g. nasogastric tube/intravenous therapy/percutaneous endoscopic gastrostomy (PEG) ● Modification of consistencies, both diet and medication ● Food preferences ● Bolus size and placement ● Pacing and modification of oral presentation ● Frequency, timing and size of meals ● Sensory integration programmes	● Desensitization programmes ● Oro-aversion programmes ● Techniques for interaction with the feeder (verbal, tactile, written and symbolic prompts) ● Oro-motor therapy exercises ● Compensatory techniques ● Treatment techniques ● Medication ● Discussion of the medical/legal/ ethical issues impinging on the management plan ● Issues regarding compliance, i.e. training individuals and carers/guardians

B. Ensure the dysphagia management plan is evidence-based, specific, measurable, achievable, time-framed and agreed by the individuals, carers and team
C. Ensure review criteria and mechanism exists

D. Seek immediate support if there is a change in the individuals' presentation or the activities are beyond your level of competence or confidence
E. Implement local referral procedures for consultative second opinion and/or specialist investigations

4.3 Assessment of Acquired Communication Disorders

4.3.1 Theoretical knowledge

A. Comprehensive knowledge of normal anatomy, physiology, and neurology of communication, including:
- Anatomical structures involved in the process of communication
- Physiology of language and speech production
- Neurology of language processing and motor speech functioning
- Development of communicative functions from pre-birth to adult
- Effects of literacy and aging on communication

B. Understand and identify the underlying causes and resulting pathological physiology of impaired speech production, language comprehension and expression, including:

● Underlying congenital, developmental, neurological and acquired disorders that may result in communication disorders ● Medical condition ● Medication	● Physical condition, e.g. sensory and postural state ● Cognitive functioning and developmental stage ● Psychological state ● Behavioural issues ● Environmental issues

C. Understand the signs of impaired cognitive communication, speech and voice production, language comprehension and expression (both spoken and written) and how these impact upon the generation of the hypotheses and subsequent management plan
D. Understand the rationale for trialing remedial techniques, modification strategies and equipment

during the assessment in order to confirm or deny your hypothesis

E. Understand the interpretation and application of assessment findings to the individuals with communication difficulties:
   - Observational, informal tests
   - Formal assessments
   - Analyses of language and speech sample
   - Instrumental examination, e.g. IOPI, respirometer

F. Understand the range of factors you need to consider in order to develop a working hypothesis and deliver a satisfactory diagnosis

4.3.2 Practical competencies

A. Conduct a specialized assessment. This may include:

● Medical state ● Level of alertness ● Ability to co-operate ● Cognitive skills ● Visual abilities ● Hearing abilities ● Sensory state ● Oro-motor skills ● Respiratory functions ● Motor-speech functions ● Speech intelligibility ● Language processing in spoken and written modalities	● Non-verbal communication ● Functional communication ● Underlying cause(s) ● Developing and testing a hypothesis ● Identification of trial intervention ● Communication needs ● Communication strategies used by communication partners ● Communication environment

B. Utilize augmentative assessment to complement your assessment. These may include:
   - Discourse analysis
   - Speech analysis
   - Physiological assessment for oral motor & motor-speech skills, e.g. IOPI, respirometer, etc.

C. Assimilate, evaluate and interpret the assessment outcomes with the individuals, carers and team

D. Taking into consideration the individuals' wishes, inform and discuss the implications of communication assessment outcome for overall management with relevant team

members, sharing implications and information with individuals, carers and team

4.4 Management of Acquired Communication Disorders

4.4.1 Theoretical knowledge

A. Recognize the need for a detailed management plan for acquired communication disorders, based upon the information and results obtained during the assessment process
B. Understand the components of the management plan for acquired communication disorders and how these affect the individuals
C. Understand how developmental, quality of life and end-of-life issues can impinge upon a management plan for acquired communication disorders
D. Understand the importance of providing accurate and prompt feedback to the care team to ensure effective management, consistent with the individuals' wishes
E. Understand how to gain agreement from the individuals, carers and team to acquire compliance and meet legal obligations to the individuals and organization
F. Understand the review process in order to optimize management
G. Be aware of your scope of practice and level of competence

4.4.2 Practical competencies

A. Devise a detailed management plan for acquired communication disorders that addresses the needs for social communication and activities of daily living (ADLs). This may consider:

● Diagnosis and prognosis ● Environment ● Communication needs ● Respiratory exercises ● Oro-motor therapy exercises ● Motor-speech treatment ● Compensatory techniques ● Language treatment ● Cognitive communication treatment	● Training of communication partners ● Use of augmentative and alternative communications (AAC) ● Discussion of the medical/legal/ ethical issues impinging on the management plan ● Issues regarding compliance, i.e. training

● Assistive devices, e.g. microphone, pacing board	individuals and carers/guardians

B. Ensure the management plan for acquired communication disorders is evidence-based, specific, measurable, achievable, time-framed and agreed by the individuals, carers and team
C. Ensure review criteria and mechanism exists
D. Seek immediate support if there is a change in the individuals' presentation or the activities are beyond your level of competence or confidence
E. Implement local referral procedures for consultative second opinion and/or specialist investigations

5 Documentation

5.1 Documentation should ensure all medico-legal and accreditation requirements are met *(Chichero, 2012*). All documentation must be signed (with name and rank), dated, legible, and if required, the time should also be recorded. Areas to be documented include:

- 5.1.1 Source and reason of referral
- 5.1.2 Case history
- 5.1.3 History of recent admission
- 5.1.4 Assessment results and management plan
- 5.1.5 Diagnosis and severity
- 5.1.6 Progress
- 5.1.7 Therapy outcome(s)
- 5.1.8 Changes in the resident's condition which may impact on progress
- 5.1.9 Precautions
- 5.1.10 Recommendations or further investigation
- 5.1.11 Advice to staff and/or carers
- 5.1.12 Reasons for ceasing treatment/intervention or discharging from the service

5.2 An appropriate system for the preparation and storage of all documentation is expected.

5.3 General principles in documentation:

- 5.3.1 All clinical notes are prepared by Speech Therapists.
- 5.3.2 Each sheet has residents' identification information.
- 5.3.3 Each sheet is to be numbered.
- 5.3.4 Each entry is within margins of the sheet.
- 5.3.5 Abbreviations used are universally recognized.
- 5.3.6 Errors are to be marked and corrected with signature.
- 5.3.7 Writing is to be done with blue or black non water-soluble pen.

6 Communication / Dual service

Speech Pathology Association of Australia (2015) defines dual servicing as 'a resident accesses speech pathology services from two or more Speech Therapists, frequently from different organizations or services, at the same time.' Dual service is common in the management of residents in residential homes in Hong Kong. For examples, residents in residential homes may receive speech therapy service from public hospitals, non-governmental organizations, and private clinics simultaneously.

When dual service arises, careful planning and coordination are expected to maximize outcomes. Each of the Speech Therapists involved in the dual service should contribute to the development of the residents' service plan. Communication channels should be established between all those involved parties in the service.

7 Texture-modified food and thickened fluid

A systematic review conducted by Andersen et al. (2013) concluded that texture-modified foods (including pureed and minced diet) and thickened fluids (including nectar, honey and pudding consistency) are recommended for elderly with chronic dysphagia to improve nutritional status. Some evidence also suggested that the risk of aspiration pneumonia can be minimized by modifying the diet texture (Garcia et al., 2005; Robbins et al., 2002; Perry & Love, 2001).

The National Institute for Health and Care Excellence (NICE) NG128 'Stroke and transient ischaemic attack in over 16s: diagnosis and initial management' recommends that for people with dysphagia, food and fluids should be given in a form that can be swallowed without aspiration, following specialist assessment of swallowing. Therefore, the recommendation to prescribe thickener should come from an appropriately trained healthcare professional, e.g. a Speech Therapist, after a diagnosis of dysphagia has been made. Thickener users (e.g. staff in the healthcare facilities or caregivers) should always follow the manufacturer's instruction to enable the correct texture to be achieved.

The descriptors below provide standard terminology to be used by all health professionals and food providers in Hong Kong when communicating about individuals' requirements for a texture-modified diet. Both traditional local terminology and the International Dysphagia Diet Standardization Initiative (IDDSI) framework are included.

7.1 Diet types

7.1.1 Regular diet

A. No restriction on choices of food in terms of texture or consistency

7.1.2 Soft diet
- A. Regular rice
- B. Boneless meat

7.1.3 Shredded diet
- A. Regular rice
- B. Recommended size of meat ≤ 0.7 x 0.7 x 6cm OR ≤ 1.0cm^3 (before cooking)
- C. Recommended size of vegetables/ melons ≤ 1.5 x 1.5 x 6cm OR ≤ 1.0cm^3 (before cooking)

7.1.4 Minced diet
- A. Soft rice
- B. Recommended size of meat ≤ 0.4cm diameter (before cooking)
- C. Recommended size of vegetables/ melons ≤ 4 x 4 x 4mm (before cooking)

7.1.5 Congee diet
- A. Congee
- B. Minced meat and vegetables

7.1.6 Smooth Soft diet
- A. Soft rice
- B. Meat and vegetables should be easily smashed without using teeth (e.g. steamed egg and pureed vegetables)

7.1.7 Pureed meat soft rice diet
- A. Soft rice
- B. Pureed meat and vegetables

7.1.8 Pureed meat congee diet
- A. Plain congee
- B. Pureed meat and vegetables

7.1.9 Puree diet
- A. Pureed rice, meat and vegetables with consistency comparable to medium thick liquid

7.1.10 IDDSI level 3-7

For detailed description, please refer to the “Complete IDDSI Framework Detailed definitions” issued by the International Dysphagia Diet Standardization Committee.

7.2 Fluid consistency

7.2.1 Thin liquid / IDDSI level 0

A. E.g. water

7.2.2 Slightly thick liquid

A. 100ml thin liquid with 2 teaspoons (5ml) of starch-based thickener
B. E.g. milk, tomato juice

7.2.3 Mildly thick liquid

A. 100ml thin liquid with 3 teaspoons (5ml) of starch-based thickener
B. E.g. Barbecue honey, sesame puree

7.2.4 Medium thick liquid

A. 100ml thin liquid with 4 teaspoons (5ml) of starch-based thickener
B. E.g. yogurt, apple puree, milkshake

7.2.5 Extra thick liquid

A. 100ml thin liquid with 5 teaspoons (5ml) of starch-based thickener
B. E.g. mashed potatoes, pudding

7.2.6 IDDSI level 1-4

For detailed description, please refer to the "Complete IDDSI Framework Detailed definitions" issued by the International Dysphagia Diet Standardization Committee

Apart from the diet types and fluid consistency above, snacks as well as meals should be available in the appropriate consistency and texture in order to assist in the provision of nutrition and hydration outside of mealtimes.

8 Infection Control

Speech Therapists working in RCHEs perform a wide range of procedures to improve swallowing and communication ability of residents. Therapists and residents are usually in close proximity during assessment and therapy. There exists risk of transmission of diseases through resident contact or contact with resident's body fluid (e.g. saliva). Knowledge on infection control can promote occupational safety and prevent transmission of diseases to other residents.

Different speech therapy procedures require different types of infection control measures and necessary cleansing. Speech Therapists are recommended to observe relevant measures when implementing different procedures according to standard and transmission-based precautions. Infection Control Guidelines for Speech Therapy is published for reference by local speech therapists.

8.1 Standard Precautions

Standard precautions apply to all residents or residents in RCHEs, regardless of their diagnosis or presumed infection status. They apply to

situations when there are contacts with blood, body fluids, mucous membranes, non-intact skin, excretions and secretions except sweat.

8.2 Hand Hygiene

8.2.1 8.2.1 Strictly observe hand hygiene practice according to W.H.O. Five moments recommendations:

8.2.1.1 Before touching a resident

8.2.1.2 After body fluid exposure risk

8.2.1.3 Before clean/ aseptic procedure

8.2.1.4 After touching a resident

8.2.1.5 After touching resident surroundings

8.2.2 Alcohol-based hand rub should be available and readily accessible to all staff at the point of resident care.

8.2.3 Perform hand washing when hands are visibly soiled.

8.2.4 Ensure that soaps and disposable towels are available for handwashing.

8.3 Personal protective equipment

8.3.1 Gloves should be worn when contact with blood, body fluid, secretion, excretion, mucous membrane and non-intact skin. To prevent transmission of the organisms, gloves should be removed from inside properly once the procedure is completed.

8.3.2 When performing resident care activities that are likely to generate splashes of blood, body fluids, excretions or secretions (e.g. saliva, cough, sputum), wear a mask and eye protection or face shield to protect mucous membranes of the eyes, nose, and mouth.

8.3.3 Speech Therapist should wear mask if he/she has respiratory symptoms, or when caring residents with respiratory symptoms.

8.3.4 Gown and eye protection or face shield should be worn to protect the skin and prevent soiling of the clothing when splashing procedure is anticipated.

8.4 Healthcare equipment

8.4.1 Contaminated reusable items should be cleaned and reprocessed accordingly after use.

8.4.2 The contaminated items should be handled with care to prevent exposure to skin or mucous membrane, and contamination of the environment.

8.5 Transmission-based Precautions

In addition to standard precautions, these infection control measures of transmission-based precautions should be followed:

8.5.1 Droplet precautions: put on surgical masks (e.g. Influenza-like illness)

8.5.2 Contact precautions: put on gown and gloves if resident contact is anticipated (e.g. scabies)

9 References

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