A Day in the Life of an SLP in a Long-Term Acute Care Hospital: Another Take

By: Ashley Munoz Lopez, MS, CCC-SLP, CBIS, ASHA SIG 13 Affiliate and Professional Development Committee (PDC) Member

The Texas Speech-Language-Hearing Association (TSHA) Medical Committee continues to work hard to provide clinical practice resources for our speech-language pathologists (SLPs) who are working in, or interested in working in, medical settings. As a part of our efforts, the "Day in the Life" series continues this issue with a Long-Term Acute Care Hospital (LTACH) example. This information along with other resources can be found on the Medical Setting Resources page in the Practice Resources section of the TSHA website. Continue to keep an eye out for more in our "Day in the Life" series in future issues of the Communicologist.

8 a.m. Setting Up for Success

The day begins by getting my temperature checked via infrared cameras and completing a questionnaire at the front door, and then I head to the rehab gym. I greet my colleagues, listen to voicemails, read emails, check the dialysis schedule, and do a brief chart review of all my patients (both new evaluations and treatments) to see what has transpired overnight. With the severity of the patients seen at an LTACH, a lot can change in 12 hours with complex cases. Additionally, I check with the rest of the rehab team to see if co-treats are appropriate and if wound care will be working with the patient that particular day. Sometimes a patient can see up to six therapy disciplines in one day—physical therapy (PT), occupational therapy (OT), speech therapy (ST), music therapy (MT), respiratory therapy (RT), and wound care—so it can be a balancing act to ensure the patient has adequate energy reserves to participate in all interventions. Depending on the patient's individual needs, speech intervention can be a priority or held for the day. The speech department's caseload has tripled since March, so I have two other clinicians assisting with the caseload. We discuss our cases and prepare for the day.

8:30 a.m. Interdisciplinary Communication

Before getting on the floor, I place my hair in a surgical cap and put on my mask and face shield, which are all new precautions enacted since March 2020. There are daily rounds in the intensive care unit (ICU) that involve the physician, nurse practitioner, nurse, and respiratory therapist. At times, I jump in to seek orders or get clarification of orders for my caseload in ICU. On Thursday mornings, we have grand ICU rounds that involve the aforementioned disciplines as well as physical therapy, speech therapy, chaplaincy, case management, social work, dietary, and pharmacy. We discuss the patient's status and/or progress, goals of care, and disposition status for each patient in the ICU. Because of COVID-19 precautions, families are often updated on post rounds via phone or video streaming as they cannot be at bedside with the current precautions in place. On Tuesday mornings, we have a rehab meeting with physical therapy, occupational therapy, speech therapy, and music therapy to discuss patients on the medical surgical floor regarding status, participation in therapies, barriers to discharge, and discharge recommendations including special equipment and their next level of care (i.e., inpatient rehab, skilled nursing, or home). Because a majority of our patients have limited or no resources, the rehabilitation team also discusses possible community resources to assist with continued recovery.

9 a.m. Dysphagia Evaluation

My first patient of the day is a new admission from an outside facility with history of acute brainstem stroke. Unfortunately, her therapy notes regarding speech are not transferred with her. The patient currently has alternative nutrition and hydration via a Dobhoff feeding tube (DHFT). This is a temporary means of nutrition. The patient has refused a percutaneous endoscopic gastrostomy (PEG) tube and is at our facility specifically for dysphagia management. I do a clinical evaluation of

swallow at bedside prior to completing an instrumental assessment of swallow. She does not demonstrate any signs or symptoms of airway invasion with any consistency or viscosity; however, due to the increased incidence of silent aspiration with brainstem strokes, I will proceed with an objective evaluation. The patient refuses Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and states she did not like the insertion of the DHFT and did not want the scope passed through her nose; therefore, I will seek orders for a modified barium swallow study (MBSS), schedule it for this afternoon, and notify the team in addition to completing the documentation.

10 a.m. Functional Communication Evaluation

The second patient of the day is on mechanical ventilation via tracheostomy tube as a result of complications from a chronic respiratory illness. He is at our facility to participate in vent weaning and is cleared to trial an in-line Passy Muir Speaking Valve (PMV) to communicate with medical staff and family. Typically, I like to see these patients early in the day to ensure they are not fatigued by other therapies that could impact their tolerance. We start the evaluation with educating the patient on the reasoning and process of this evaluation as oftentimes patients who have been on the vent for extended periods of time can develop anxiety; therefore, it is imperative that we slowly guide him through the steps and ensure we have informed consent prior to starting. Initially, the respiratory therapist slowly deflates the cuff and allows the patient to habituate. Then, we place the PMV in the circuit. During this evaluation, we practice redirecting exhalation through the oral cavity and working to retrain the patient to utilize their diaphragm for respiration. Depending on the patient's individual vent settings, we may be able to modify the patient's respiratory rate and positive-end expiratory pressure (PEEP). I document immediately after seeing the patient as I take note of their vital signs pre-, peri and post-trials and any remarkable events occurring such as patient report of anxiety, shortness of breath, etc. It is important to document these sessions quickly after completion to ensure all information is in the electronic medical chart to be reviewed if there is a change in patient status. Additionally, I make an assessment of whether this patient would benefit from respiratory muscle strength training (RMST) to assist with liberation from the vent.

11 a.m. Dysphagia Reevaluation via FEES

My third patient has been on the caseload for a little more than a month. Her case is complex, as she is recovering from open heart surgery after a heart attack that caused a stroke during her hospitalization for a broken hip after a fall. Cumulatively, the aforementioned have caused significant debility. She has completed two MBSS in acute care and has had nothing by mouth, outside of therapy, for more than three weeks. She has been participating with therapy but has made slow progress due to her decreased tolerance for sustained activity. However, she is on a free water protocol with a strict oral care regimen to ensure she continues to engage her swallow mechanism and prevents xerostomia, or dry mouth. Yesterday, during our session, I noted she appeared to tolerate some consistencies intermittently and her hyolaryngeal excursion appeared increased upon visualization, so I proceed with FEES, using elevated personal protective equipment (PPE) outlined by our hospital's infection control practitioner, at the patient's bedside to ensure we have an updated plan of care suitable for the patient's current status. The patient provides consent for the exam, a timeout is completed for patient safety, and the scope is inserted. The exam is completed, images are reviewed, and it is recommended the patient can begin a modified diet with strict aspiration precautions and 1:1 assistance. I contact the registered dietitian (RD) to update her on my recommendations. This is a common practice of mine as I want to ensure multidisciplinary collaboration to ensure the patient's nutrition regimen is modified to facilitate optimal oral intake.

12 p.m. Diet Check

I have asked the nurse to hold a patient's lunch tray so I am able to complete a diet check with the new diet recommendations entered the day before. My patient has dysphagia and is 65 years old and at the LTACH for additional care before going to inpatient rehab after a stroke in the cerebellum. The patient has been working hard for the past two weeks and has been completing his daily dysphagia therapy regimen recommended after his most recent FEES in addition to utilizing his dysarthria speech strategies with assistance. He was previously on a minced and moist diet with

mildly thick liquids, following the International Dysphagia Diet Standardization Initiative (IDDSI), and was upgraded to a soft and bite-sized diet with thin liquids using safe swallow precautions and intermittent supervision. The patient tolerates the new diet, so I will contact the RD again to update her on the patient's status so she can continue to monitor the patient's intake with a daily calorie count. Hopefully, the patient will start to eat more orally, and the rate of tube feeding via PEG can be reduced and eventually discontinued.

12:30 p.m. Lunch Time
During lunch, I catch up with my colleagues regarding the day's events and ask if they have any additional information about a particular patient that might be useful to my plan of care for the day. It's not always all business at lunch as we do spend time enjoying each other's company at a social distance. I also write a few notes while I am chowing down.

1 p.m. Rehab Huddle
PT, OT, ST, and MT get together with the rehab manager to discuss updates, discharges, or admissions and if any impending documentation is needed for our patients.

1:15 p.m. Aphasia Treatment
I spend the next 30 minutes working with a patient with expressive language deficits associated with Broca's aphasia. He utilizes compensatory strategies with cueing to complete structured tasks based on recommendations from his initial evaluation using the Western Aphasia Battery (WAB) bedside form. The MT will follow my session to assist with melodic intonation of functional phrases established by my plan of care.

1:45 p.m. Cognitive-Linguistic Treatment
My next patient has a traumatic brain injury after a motor vehicle accident with polytrauma. He sustained a compound fracture of his tibia and is currently in an external fixator with no weight bearing so he is not able to go to inpatient rehabilitation just yet. He is currently at a Rancho Los Amigos Scale stage IV. His therapy objectives are to state orientation information using environmental aids and to recall orientation information after a brief delay/distraction. Additionally, he is working on sustained attention in a controlled environment and awareness building of current deficits and changes to improve safety.

2:15 p.m. PMV Education
This patient's mentation is deemed appropriate for him to wear the PMV during waking hours without supervision on aerosol trach collar (ATC). Therefore, this session is brief and pertains to providing verbal and written education pertaining to speaking valve precautions and proper donning/doffing of the PMV with the patient and care staff.

2:30 p.m. Documentation Time

3 p.m. Patient/Family Conference
The case manager has requested all disciplines participating in care for a patient with advanced muscular dystrophy to attend a meeting via video conferencing to discuss goals of care and to ensure patient autonomy and quality of life. The physician and chaplain lead the meeting. The patient has intact cognition and is able to make his own decisions about his medical care and is able to communicate verbally with the assistance of an inline PMV. He and his family understand the natural progression of the disease and are trying to decide to continue life support. Each of us is charged with stating information regarding evaluation upon admission and status in therapy. These conversations can be intense and filled with emotions; however, it is the duty of the therapist to present the information as objectively as possible to allow the patient and family to understand the complexity of care and prognosis. During this particular meeting, palliative care was recommended.

4 p.m. MBSS
I meet my patient down in radiology. The radiology technician has set up the exam for me, and the radiologist is ready. The patient is placed in lateral position and consumes Varibar barium and solids

coated in barium while the machine takes a moving X-ray using the MBS Impairment Profile (MBSImP) protocol. Compensatory strategies such as chin tuck and supraglottic swallow maneuver are utilized under fluoroscopy to determine their effectiveness. Images are reviewed, and documentation is completed. Recommendations call for a pureed diet with honey thickened liquids. The nurse is called and updated, and diet recommendations and appropriate swallow precautions are posted at the head of bed.

4:30 p.m. Check on HIDU Patients
COVID-19 has caused a change in my daily work routine. To limit the possibility of cross-contamination, I try my best to leave patients in the highly infectious disease unit (HIDU) to the end of the day, when able and appropriate. I change into hospital-issued scrubs, put booties on my shoes, change my surgical cap, and put on a powered air-purifying respiratory (PAPR) to check in on my patients, do reassessments, complete treatments, and/or round with the nursing staff.

6 p.m. Quitting Time

I hope you enjoyed this brief description of a day in the life. If you have any questions for the Medical Speech Pathology Committee, please feel free to contact co-chairs **Suzanne Bonifert** (Suzanne.Bonifert@cookchildrens.org) or **Shannon Presley** (Shannon.Presley@unt.edu). The Medical Speech Committee is here to serve you! *In effort to ensure patient privacy, in accordance with HIPAA, all identifying information has been modified.*