A Day in the Life of an Acute Care Speech-Language Pathologist

By: Ashley Logan, SLPD, CCC-SLP, BCS-S, CLT

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 an acute care 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.

7:30 a.m. All of the new consults automatically print to the printer in my office when they are entered. Each morning, the first step of the day is to check the printer to assess the number of new consults waiting for us. On most days, anywhere from two to six additional consults will come in throughout the morning as physicians are rounding.

The SLP team (two of us) manages a secure document through which we can share notes as to who is taking care of certain tasks for the day. Today, we have 34 total people on our caseload with eight new consults. (Not everyone will be seen today for evaluation or treatment.) I am scheduled to acute care all day, with an additional person to help between 1 p.m. and 4 p.m.

After reviewing the new consults, reviewing charts of those who may need evaluation and treatment, and coordinating times with radiology for videofluoroscopic swallow studies (VFSS), I am looking at a schedule that includes two clinical swallow evaluations, three VFSS, and five flexible endoscopic evaluations of swallowing (FEES). Radiology has time for us during their lunch hour from 12 p.m. to 1 p.m. so the VFSS procedures will wait. The remaining patients are split up by floors to account for efficiency as I move through the 425-bed level-one trauma center.

8 a.m. Our amazing technician has secured four scopes ready to take up to the floor and stocked our "swallow wagon" for me to roll to the bedside to complete the FEES exams. I carry a diaper bag with me stocked with straws, spoons, a flashlight, thickener, syringes, tape, pens, highlighters, head of bed signs, food items of varied textures, and my own pulse oximeter in case I need a quick oxygen saturation read on my patient. Upon ensuring we have all necessary supplies, I get rolling up to the surgical intensive care unit (ICU) to start the day. My first patient* is status post motor vehicle accident (MVA) with multiple orthopedic injuries who was intubated for 12 days. The SLP team was consulted given the high likelihood of dysphagia after the combination of the trauma and prolonged intubation. With the help of the nurse, we get the patient repositioned as upright as possible for the exam. I get my food items prepared and the equipment up and running. Despite the fact that few people enjoy a scope in the nose, my patient tolerated the procedure fairly well. Our exam was limited to just a few trials given overt, silent aspiration. Laryngeal injury from intubation with bilateral vocal process granulomas was observed as well. This gentleman is recommended for a diet of nothing by mouth (NPO) for now and gets added to our list for a planned repeat exam in a few days.

8:45 a.m. My next patient* is just a few doors down in the next ICU over. She too is status post MVA but sustained fewer injuries. Unfortunately, her injuries were in the cervical spine, and she now is two days post-op anterior cervical spine surgery wearing a cervical collar. I repeat the process of setting up equipment and organizing my food items for ease of administration. Sometimes I have assistance in feeding while completing a FEES study; however, for this exam, I am on my own. I have to manage the scope in the right hand while feeding with the left. My exam was limited as the patient continues with post-op edema that is limiting bolus passage through the pharynx and into the

esophagus, resulting in marked pharyngeal residuals and subsequent aspiration. She too will be NPO for now with a planned repeat in the coming days.

9:30 a.m. With two used scopes on my cart, I switch gears to get the clinical swallow evaluations completed. I swing by the clinic to drop off the scopes for cleaning and park the cart temporarily. With my bag and clipboard in tow, I am off to the step-down unit on the sixth floor for my next evaluation.

9:45 a.m. Upon getting up to the sixth floor to evaluate a new cardiovascular accident (CVA) admit, I find that my patient is off the floor for a cardiac study. My next patient is on the third floor, so off I go.

10 a.m. My third-floor patient* is also a new CVA admit, but by the time I arrive, symptoms appear to be resolving. I complete a case history, oral motor/cranial nerve evaluation, and move rather quickly through my bolus trials as the patient is showing no cause for concern. I offer some education to the patient about symptoms of potential difficulty and how to contact her primary care manager and/or speech-language pathology if she has any concerns upon discharge. I alert the nurse of the recommendations for a regular diet and plan to page the team when I return to my office to ensure a speedy change prior to the lunch hour.

10:30 a.m. Back at my desk on the second floor, I quickly page the team for my last patient and alert them to the recommendation for a regular diet. I now have four notes to write—the two FEES from first thing this morning, a contact note for my missed patient, and my clinical swallow. Fortunately, I have taken notes on each patient (that handy clipboard!), and I can work through my note templates, adding the appropriate information.

11:30 a.m. Quick lunch! I prefer a half-hour lunch, and our hospital has an amazing cafeteria. I can pop down for some great food and decompress with my colleagues for a few minutes before getting back to work.

12 p.m. My time in radiology has arrived. This morning I entered all of the necessary orders, completed paperwork, and coordinated with radiology. Now I just need to show up in our fluoroscopy suite. The nursing staff and/or technicians will assist with transporting the patients to me, and I have them scheduled on half-hour rotations in anticipation of some delays. I set up the room with the Modified Barium Swallow Impairment Profile (MBSImP) protocol. We may add trials based on the unique needs of our patients, but with use of a protocol, we can ensure our studies are similar in nature across our team of therapists.

12:10 p.m. My first patient* arrives late. We move her from the bed to the fluoroscopy chair and get her positioned upright. She is a pleasant woman with dementia who has a history of aspiration pneumonias and a current chest X-ray is concerning for another. I move quickly through the exam knowing I have another scheduled immediately after her. Aside from aspirating thin liquids, this woman does quite well with modified textures. I recommended getting her started on a mechanical soft diet with nectar-thick liquids and plan to follow up with her to coordinate further care.

12:30 p.m. My next patient* arrives as I am opening the door to the fluoroscopy suite. We get him situated in the hall while transferring my patient back to her bed before she heads back upstairs. I quickly clean and turn over the room, setting up my new measured barium trials. As I am doing this, the staff brings the next patient around and sets up for transfer. This gentleman is more mobile and, with standby assist, moves from wheelchair to the fluoroscopy chair himself.

12:45 p.m. I get started on my second VFSS. This gentleman has a prior history of radiation to the tongue base and is now complaining of pill dysphagia. Despite his limited complaints, I see the classic signs of late-Radiation Associated Dysphagia (RAD)—poor bolus clearance during the swallow with aspiration after the swallow. I also note some pharyngoesophageal segment (PES) narrowing on first look and plan to dissect this study further back in my office. Given the clear chest X-ray and likelihood that this gentleman has been aspirating for some time, I plan to page his

admitting team to discuss recommendations and options for continued PO intake and to discuss a treatment plan moving forward.

1:25 p.m. My next VFSS patient* is rolling up, 25 minutes late by my scheduling, but nearly perfect timing in real-time as I anticipated some challenges getting down to radiology around the lunch hour for most staff in the hospital. Like the first two, we move the next patient into the chair and roll back into the fluoroscopy suite. My current patient is in his mid-80s and admitted for a COPD exacerbation. Given his oxygen dependence and likely difficulty coordinating respiration and deglutition, I opted for a VFSS to give me a clear picture of all three stages of the swallow. Fortunately for this gentleman, by attending to timing of bolus administration as related to his breathing needs, he was able to continue eating safely without any airway compromise.

2 p.m. With my last patient transferred back to his wheelchair and staff rolling him away, I do a final clean of the suite and put all of my materials and equipment back in the proper storage location. Like my first exams, I took quick notes about my patients, but I plan to go back to my desk and spend some time reviewing these studies.

2:15 p.m. Back at my desk, I begin by paging the team about my second VFSS, the gentleman with late-RAD. I spend the next 45 minutes or so reviewing the VFSS studies and writing up notes to enter into our electronic medical record

3 p.m. While writing, an otolaryngologist pops his head into my office. He has a patient in his clinic who is scheduled to see me as an outpatient consultation prior to an upcoming head and neck surgery for base of tongue cancer extending into the floor of mouth. I pop next door to the otolaryngology clinic and meet with the patient and his family. After initial introductions, I provide basic education and make a plan for the pre-surgery initial evaluation. This will allow me to spend more time with them preparing them for the surgery and the resulting speech and swallowing challenges.

3:30 p.m. Back to my desk to finish notes. Fortunately, my colleague began inpatient time at 1 p.m., and she took the two remaining FEES exams from the morning—the patient who was off the floor and a new FEES exam that was sent to our printer this afternoon. As I finish up my notes, I update our secure spreadsheet. This will allow my colleague, who will be taking over inpatient in the morning, to have the latest information on our patients. I quickly glance at my outpatient schedule for tomorrow morning in order to see how many new evaluations I have and how many returning therapy patients are on my list.

4 p.m. Headed home. Busy inpatient days make for little downtime but very quick work days. No two days are alike, and each day brings a new set of unique and complex medical challenges.

**All patient information has been changed and/or edited to protect patient privacy.*

I hope you enjoyed the summary. 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!