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A Day in the Life of an SLP in a Long-Term Acute Care Hospital (LTACH) Setting

By: Rinki Varindani Desai, MS,CCC-SLP, CBIS, CDP

The 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.

Originally a speech-language pathologist (SLP) from Mumbai, India, and a proud University of Texas-Dallas alumni, I have had the good fortune of working as a medical SLP for nearly a decade now—in acute care, long-term acute care, subacute rehab, skilled nursing, and outpatient medical settings. Each setting has offered a different set of challenges, learning and skill-building opportunities, patient experiences, and a unique perspective on patient care. One wonderful aspect of our professions is that we have many options available to us. Choosing the best setting for you, personally, may take exploration, patience, and experience. This article focuses on what a typical day looks like for an adult SLP in a long-term acute care hospital (LTACH) setting from the time I completed my clinical fellowship and worked at Select Specialty Hospital in Dallas, Texas.

All About LTACHs
For those who may not be familiar, LTACHs are "facilities that specialize in the treatment of patients with serious medical conditions that require acute care on an ongoing basis." These patients are typically discharged from intensive care and acute care units but continue to need more care than they would receive in a rehabilitation center, skilled nursing facility, or at home.

The types of patients typically seen in LTACHs include those requiring:

- Prolonged mechanical ventilation for respiratory failure
- Intensive respiratory care post-tracheostomies
- Ongoing dialysis for chronic renal failure
- Pre- and post-organ transplant care

- Treatment following neurological conditions and/or trauma
- Post-surgical acute care
- Infection management
- Complex wound care, etc.

LTACH patients stay an average of about 25 days, with the goal of optimizing their ability to live independently or to achieve the highest level of wellness possible and then move on to the next level of care. SLPs in LTACHs carry out all the traditional responsibilities of clinicians in typical adult medical settings. However, what makes the role of the LTACH SLP unique is the variable range of services provided to a complex and critically ill patient population whose needs may change on a daily basis.

This is what a day in the life of a LTACH SLP looks like.

8 a.m.: Setting Up for Success
My morning begins with a review of the patient schedule assigned to me by my director of rehab (DOR). I am the only SLP in a rehab team of 10, including occupational therapists (OTs), physical therapists (PTs), and OT/PT therapy assistants. Our caseload fluctuates; at times, it may go up to 14 patients a day, and some days, it may drop to six. Most days begin by reading and responding to emails, checking the patient dialysis/wound care/surgery schedules to better plan my day, and doing a brief chart review of all my patients to see what transpired overnight. With the severity of the critically ill patients in an LTACH, a lot can change in 12 hours. I have a new patient on the trach/vent unit today and a new admission on the med/surg floor, so I spend some additional time reviewing their histories in our electronic medical record (EMR) system.

8:30 a.m.: Morning Huddle
PT, OT, SLP, and the lead nursing staff get together each morning to discuss any new discharges or admissions, major changes in patient status, and impending documentation/information required for our patients.

8:45 a.m.: Clinical Swallow Evaluation
After our morning huddle, I proceed to complete my first evaluation for the day, a middle-aged woman with a history of an acute brainstem stroke. The patient currently has alternative nutrition and hydration via a Dobhoff nasogastric feeding tube. This is a temporary means of nutrition. The patient has refused a percutaneous endoscopic gastrostomy (PEG) tube, and my services were requested for assessment and treatment of dysphagia. I complete a clinical evaluation of her swallow function at bedside and seek orders from the MD for a modified barium swallow study (MBSS) to further evaluate her swallow physiology and help rule out possible silent aspiration using an objective assessment. Depending on the findings, a therapy plan will be initiated targeting her specific swallowing impairments to help her return to an oral diet safely as soon as possible. At this time, due to the severity of her impairments, the patient must remain NPO (nil per os), a medical term that means “nothing by mouth.” I educate the family and nursing staff about my evaluation findings and recommendations.

9:45 a.m.: Functional Communication Evaluation
The second patient of the day is on mechanical ventilation via a tracheostomy tube after acute respiratory failure. He is at our facility for vent-weaning and is cleared to trial an in-line Passy Muir Valve (PMV), a speaking valve to help the patient communicate his wants/needs verbally. We start the evaluation with educating the patient on the reasoning and steps of this evaluation. Patients who have been on mechanical ventilation for extended periods of time can develop anxiety; therefore, it is important we slowly guide him through the process while also assessing language and cognition, as many of these patients may be having delirium acquired from their hospitalization. Initially, the respiratory therapist (RT) slowly deflates the cuff and allows the patient to habituate. Then, we place the PMV in the vent circuit. We help re-train the patient to coordinate and redirect airflow for speech and respiration, using the in-line PMV. 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., in addition to noting PMV tolerance and assessing the quality of his voice. Depending on the patient's performance, a plan of care and goals are developed to target swallowing and communication with a focus on safely weaning the patient off the vent, working closely with the "wean team" throughout this process.

10:30 a.m.: PMV Education
My next session is with a patient I have been following for a week on the trach/vent floor. This patient's mentation is deemed appropriate for him to wear the PMV during waking hours without supervision on an aerosol trach collar (ATC). Therefore, this session is shorter and involves providing verbal and written education pertaining to speaking valve precautions, cleaning, use, and proper donning/doffing of the PMV with the patient and his caregiver.

11 a.m.: Interdisciplinary Team Meeting
Once a week, we have interdisciplinary team (IDT) meetings during which one member from each rehab profession (PT, OT, SLP) meets with members from the nursing, dietary, respiratory therapy, pharmacy, and social work staff to discuss all the patients on the rehab floor of the LTACH. We discuss current barriers, progress, therapy goals, and discharge recommendations for each patient. It is nice to work in a setting where the healthcare team can work together and focus on patient care over productivity.

12 p.m.: Meal-Time Therapy
I have asked the nurse to hold a patient's lunch tray so I am able to pop in and complete a session to assess safety for new diet recommendations that were entered the day before for a patient. I am continuing to train a woman (and the nursing staff) who has just initiated a PO diet with a trach and PMV to use compensatory swallowing strategies to maximize her safety during meals. She has come a long way in the past few weeks of daily intensive dysphagia therapy from relying on a feeding tube for nutrition to enjoying soft solids and thin liquids using safe swallow precautions and intermittent supervision. The patient is able to consume the new upgraded diet safely, so I contact the dietitian to update her regarding the patient's status and request that she continue to monitor the patient's intake.

12:30 p.m.: Lunch
After helping others eat safely, it's time for me to grab a quick bite. Some days, I complete pending progress notes during lunch. I also may use this time to liaise with OT and PT about mutual patients we are treating or respond to emails/messages before heading back out to the floor. It's not always all business at lunch as we do spend time talking about our spouses, kids, shows we're watching on Netflix, or our plans for the weekend. It's fun to be part of an interdisciplinary team!

1 p.m.: Stroke Evaluation
Next, I'm assessing an older gentleman who recently had a stroke and is here for wound care and dialysis. I complete a speech-language and cognitive evaluation, screen his swallowing to ensure he can consume his current diet and medications safely, educate the patient and his son about my plan of care and therapy goals, and request an order to perform a more detailed dysphagia assessment in the next session due to some red flags I noticed during my screen and chart review. The patient presents with expressive aphasia and apraxia but is able to follow basic commands and has relatively intact receptive language skills. I provide the patient and family with a communication board and help them download an app on the iPad to help the patient communicate his wants/needs as we continue to work on improving his expressive language skills and motor speech in future therapy sessions.

2 p.m.: Dysphagia Re-evaluation and FEES
My next patient has been on the caseload for a little over a month. Her case is complex, with multiple medical comorbidities that caused significant debility, in addition to the patient being over the age of 80, which makes it harder for some patients to recover from hospitalization. She has been

participating well in dysphagia therapy. As she has gradually been consuming different food and liquid consistencies by mouth more safely and demonstrating improved performance with swallowing exercises during therapy, we proceed with a fiberoptic endoscopic evaluation of swallowing (FEES) at the patient's bedside to re-evaluate her swallow function and determine if we can advance her diet safely. She is scheduled for discharge in two days to a skilled nursing facility for ongoing rehabilitation since she has been weaned off the trach and is demonstrating increased tolerance for activity. This does not give us sufficient time to schedule and complete an MBSS, so we decide to complete a FEES. The exam is completed, images are reviewed, and it is recommended the patient can be advanced to a regular solids and thin liquids diet prior to discharge. I communicate my recommendations to the MD and family.

2:45 p.m.: Cognitive Therapy and Family Conference

Next up on my schedule is a session for cognitive therapy as well as a family conference for a young patient who had come in after a motor vehicle accident and subsequent traumatic brain injury (TBI). I respond to family questions about his current progress, changes in his therapy goals, and address other concerns they have before proceeding with the session. Our focus today is to improve orientation, build sustained attention, increase awareness of his current deficits, and improve his ability to respond to simple yes/no questions and follow simple single-step commands. With cognitive-linguistic therapy, it helps to make the therapy sessions functional and meaningful for patients, so we spend the last 15 minutes of the session talking about his family and hobbies and use familiar pictures from his phone to help stimulate language recovery.

3:30 p.m.: Modified Barium Swallow Study

I am fortunate to work in a LTACH that is housed within a larger hospital center. This means I can go from the fourth floor to the second floor to complete a Modified Barium Swallow Study (MBSS) and only have to wait a few hours or days (compared to several weeks) to get these completed. I meet my patient down in the radiology fluoroscopy suite. The radiology technician has set up the exam for me, and the radiologist is ready to complete the study with me. The patient is placed in lateral position and consumes Varibar barium and solids coated in barium while the machine takes a moving X-ray as we analyze the patient's oropharyngeal swallow function. Compensatory strategies such as chin tuck and supraglottic swallow maneuver are utilized under fluoroscopy to determine their effectiveness. The patient is also placed in A-P view as we "sweep" the esophagus to screen for possible esophageal impairments. At the end of the study, I review the images with the patient and her family. Recommendations call for a pureed diet with nectar-thick liquids at this time. I work with the nurse, dietitian, and MD to ensure the diet recommendations are updated, and appropriate swallow precautions are posted at the head of her bed.

4:30 p.m.: Palliative Care Discussion

My last patient for the day today is someone who is unfortunately chronically vent-dependent with cancer and advanced dementia and is being evaluated for hospice (end-of-life) care. The case manager has requested all disciplines participating in care for the patient to attend a meeting to help maximize patient autonomy and quality of life. The physician and chaplain are also present. The family understands the natural progression of the disease and is trying to decide to make end-of-life decisions for this patient. I spend my time educating the patient's family about how they can maximize his quality of life by continuing to provide nutrition orally in the safest way, minimize distress, maximize verbal and non-verbal communication, and provide comfort. These conversations are often difficult, requiring a great deal of empathy, patience, compassion, and knowledge to ensure that the family's and patient's final wishes are given utmost importance. They help me appreciate all I have in my own life and reinforce how meaningful our work as medical SLPs can be.

5 p.m.: Done for the Day

As I finish seeing all my patients assigned for today, I use the last half hour of my day to complete some pending therapy notes, email one of the physicians about a patient, and make notes about a few patients I need to follow up with this week. Working with a mix of higher- and lower-level patients and a variety of disorders throughout the day keeps things challenging and fun.

Closing Thoughts

The workplace for medical SLPs is undergoing rapid changes, compelling clinicians to be flexible and expedient in learning new techniques and procedures under high productivity demands. SLPs who can be independent learners, face conflicting situations, and overcome challenges will be better prepared to succeed in this ever-changing workplace. In my four years as an LTACH SLP, I learned not just to manage patients with complex critical illnesses but was fortunate to collaborate with so many different medical professionals, working as an important member of the trach/vent team. Starting out my career in an LTACH was daunting at first but allowed me to step out of my comfort zone and to learn and grow immensely as a medical SLP. I hope this perspective motivates many of you to do the same.

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**To protect patient confidentiality, all identifying information has been changed.*

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!