A Day in the Life of an SLP in the NICU

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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 neonatal intensive care unit (NICU) 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. This is the final installment in our "Day in the Life" series.

7 a.m. I get to my desk, log into the electronic medical record (EMR), and check for new orders that might have come in. I see a near-term baby with a cleft lip and palate was admitted overnight to the newborn nursery. This will be my first stop before going to the neonatal intensive care unit (NICU) to ensure the baby has an appropriate bottle system. I chart review my remaining patients, checking their volumes, feeding orders, and other labs or procedures they might have had since the afternoon before. I write out my list of babies I need to follow up on and head on up to the NICU for the first round of feedings.

7:30 a.m. I make rounds to my team of nurses taking care of the babies I have on my list. I will check with them for feeding times and schedule them for throughout my day. One nurse stops to ask me about a baby who is not on my list asking if someone from speech therapy will see that baby today. The night shift nurse reported the baby is not feeding well at all. I add the baby to my list and note the feeding time.

8 a.m. I make my way to my first baby's feeding for the day. The nurse is running behind already because she had to draw labs on her first baby. She asks if I can help by taking the baby's temperature and changing the baby's diaper. I am happy to do so because it also gives me a chance to assess the baby's feeding readiness. This baby is a late preterm baby, born with a diagnosis of IDM (Infant of a Diabetic Mother). The baby has low tone, is large for gestational age, tires quickly with feedings, has respiratory distress, and thus requires oxygen support. I will be assessing this particular feed to see if a commercial nipple could help this baby succeed with his/her oral attempts. The baby does well with a Dr. Brown's newborn nipple and takes the majority of his volume but does not meet his goal. I report the information to the nurse and change his bedside recommendations.

8:40 a.m. I am running late to the next feeding I scheduled because I wanted to ensure my previous patient was given enough time and support (but not longer than 30 minutes so as to conserve energy). The nurse understands and waited to do her assessment to ensure the baby stayed asleep. With her cares (temperature, diaper, blood pressure, measurement of girth and head circumference, etc.), she notices the baby remains very sleepy. After the nursing assessment is completed and the baby is re-swaddled with no signs of feeding readiness, I am about to head back to my office when the nurse's phone rings. The baby's mother has just checked in and is on her way back to the bedside. Since I have not met mom in person, I stay and introduce myself. I provide her with education and information about typical feeding development for a preterm baby, the supports we can provide to assist with the development of the baby's oral skill, disposable nipple flow rates, and home/commercial bottle options she might use once discharged. I set up a time with her so we can feed together at a later date. Then I help her get the baby skin to skin so the baby is feeling safe, secure, and has a wonderful feeding experience during his gavage (nasogastric tube) feeding over the pump.

9:15 a.m. I walk quickly back to my office so I can document the morning's sessions and check my email. Once my documentation is complete, I note an email from one of our neonatologists. She has

been wanting to implement a specific, multi-disciplinary feeding team that will consist of neonatologist, speech therapist, occupational/physical therapist, dietitian, respiratory therapist when required, and nursing educators/champions. We set up a meeting time to discuss the creation of this team so that we will eventually be able to discuss each high-risk infant's feeding plan as a team.

10:30 a.m. I am on to my next feeding session. This infant was a term baby but required respiratory support at birth and continued that requirement in the supine position. The infant was quickly evaluated by the ear, nose, and throat (ENT) physician and underwent a supraglottoplasty in the operating room (OR) due to severe laryngomalacia (floppiness of the airway). After the infant was provided with time to heal following surgery, the infant began attempting feeds orally. During the feed, the infant continues to make a stridorous noise but is calm, comfortable, shows no clinical signs or symptoms of aspiration, and is demonstrating an adequate suck, swallow, and breathe pattern with a disposable slow flow nipple. I provide recommendations to the nurse and consult with the ENT shortly after the feed to discuss how it went. A FEES (Fiberoptic Endoscopic Evaluation of Swallowing) is scheduled for two days from now. This will help us monitor progress following the supraglottoplasty and the baby's subsequent development of oral skills during PO (by mouth) trials between now and then.

11 a.m. My next feeding is with an infant who is term and has gastroschisis. I expect to spend a good bit of time with this patient as she is now two months old. After her repair, the baby did not tolerate the advancement of enteral feeds well. She has a significant history of vomiting and emesis. Her feeds are provided to her slowly over two and a half hours, but we are finally up to the full volume she needs. She is attempting a small volume orally to work on her oral skills and provide positive experiences by mouth. She tires quickly and thrusts her tongue out after 15ml. After her oral attempt, she is still wide awake. I pull out one of the books stashed underneath her crib. We read a book together and sing songs. Then I rock her back to sleep so her nurse is able to tend to the other babies on her assignment.

12:15 p.m. Lunch time! It's a busy time around the office with everyone coming back from the floors. Our team (OTs/PTs/SLPs) often sits together outside in the cafeteria's courtyard since it is crowded inside. It's a very nice break to sit outside, enjoy the sunshine, warm up from the cold air-conditioning, and talk about things other than work. We also will do a bit of collaborating during this time. Discussions about how OT/PT sessions went as well as how feedings are going are often relayed during this time. These informal meetings are so helpful in coming up with specific plans of care for our patients. After lunch, I write a couple of notes before I head to a new nurse orientation/presentation on developmental care in the NICU hosted by a PT/OT and a SLP.

2 p.m. The new nurse presentation is engaging and so fun to do. The nurses are given opportunities to learn about developmentally supportive positions to help their babies optimally grow and develop their musculoskeletal systems as well as to support lung development. They learn about the sensory system and ways to provide positional support for babies who may have misshapen heads from laying on one side or in one favorable position for too long. They also will learn about safe sleep and that our parents are always modeling what we do. After the PT or OT gives their talk, I get to share about the neurodevelopmental activity of nourishing and feeding infants. I share about how they can empower and support their families so the parents or caregivers can be the experts on their infants. We discuss the therapeutic strategies utilized during feedings to support optimal development and the communicative behaviors babies demonstrate when they are comfortable, stressed, need to take a break, or need to stop feeding altogether. Our team gets great feedback because many of the nurses have never heard about what we are presenting on today.

3:30 p.m. After completion of my notes and checking to see what tomorrow might bring, I grab my things to make my way out. On my way out, I am stopped by one of our nurse practitioners. After rounding for the day, she informs me she has placed an order for a swallow study for a patient we share. I assure her I will be able to complete it the following day. We both say our goodbyes, and I

head to the garage. There's still much work to be done and many more babies to be seen, but tomorrow is another day, and more satisfying work will come of it as well!

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