**ORIGINAL QUESTION: Discipline/Role Delineation in NICU for PT/OT/SLP?**

**ORG A**
 Divided NICU/infant therapists into 2 groups within the same Infant team (seeing all babies IP and OP <12 months):

1. Developmental Therapists (OT and PT interchangeable)
2. Feeding Therapists (OT, PT, and SLP all interchangeable)

**ORG B**

PT/OT have automatic orders. SLP is consulted when there is a specific swallow concern. Often the SLP consult happens at the request of the PT or OT.

PT and OT get automatic orders. If the child has an upper extremity condition such as brachial plexus the OT will take the patient. If they have a club foot then it would be PT. Otherwise, it will get triaged to who has more availability with the other discipline available to consult. If the child is known to a medical condition that will cause significant developmental challenges, then they both may see.  As the child progress and gets closer to 40 wks. then their developmental issues become more apparent, and they may hand off to appropriate discipline based on their needs or they may both see the patient depending on what the patient needs.

**ORG C**
 dedicated OT and PT staff member (Level IV 70 bed)

OT and ST share the responsibility for feeding

PT works on handling, state control and even some neonatal massage

Both OT and PT are certified, and we are working toward training in use of the NNNST as an evaluation tool for all patients.

**ORG D**

 PT, OT, and ST in our NICU

 SLP focuses on feeding but our OT and PT seem to overlap and we’re getting some feedback from physicians that it’s too much.

**ORG E**

At ORG E we delineate our lines of services as follows:

* Speech therapists work on all feeding/swallowing/dysphagia/oral stim etc.
* OT : fine motor/visual
* PT: gross motor

In the NICU, a new infant is assigned a primary developmental therapist upon their birth/arrival to the NICU. This therapist can be an OT or PT by background. The role of this therapist falls in the scope of OT or PT. Once the child reaches 3 months PMA (or if deemed necessary before this time based on presentation or diagnosis) the patient will start to receive both PT and OT services. We are purposeful in our goal writing and ensure that goals are different between PT and OT, so we are not duplicating services. We additionally follow this model in the CICU and PICU.

Benefit to patient: they get a primary therapist that sees them 4x/week for consistency of care. Speech therapy is separate and focuses on feeding as needed.

**ORG F**

ORG F NICU, we are currently transitioning from very discipline specific silos of care to more transdisciplinary model wherein therapists have zones of care that ensure comprehensive care of the infant but also benefit from expertise of other disciplines. We have tailored our primary zones to the expertise of either OT or PT (i.e., high acuity patients encompassing osteopenia protocol and oral motor input would be a PT primary, whereas patients who have oral feeding as a priority have an OT as their primary). All zones who have PT as primary, then have an OT as secondary and visa vera. SLP is secondary to all zones, and in particular our complex care unit which are primarily trach/vent feeders.

**ORG G**

See attached role delineation attachment

Also recommended:

“Risk-adjusted/neuroprotective care services in the NICU: the elemental role of the neonatal therapist (OT, PT, SLP)” Jenene W. Craig and Catherine R. Smith
Journal of Perinatology (2020) 40:549–559

**ORG H**

Our Inpatient PT, OT, and Speech Coordinators (cc:d) came up with the following role differentiation for PT, OT and SLP in the NICU:

PT:

* Gross motor developmental facilitation
* Positioning and positioning devices
* Tolerance to handling
* Gross motor developmental standardized assessments
* LE splinting
* Caregiver education
* Unit education
* Neurodevelopmental rounds
* Neuroprotective committee

OT:

* Sensory Stimulation
* Oral motor stimulation assessment and intervention
* Feeding team assessment and intervention with SLP
* Fine motor developmental facilitation
* UE splinting
* Positioning
* Tolerance to handling
* Collaboration with SLP on MBS positioning, assessment and feeding plan
* Caregiver education
* Unit education
* Neurodevelopmental rounds
* Neuroprotective committee

SLP:

* Feeding team assessment and intervention with OT
* Oral motor eval and treat
* Early language stimulation and intervention
* Instrumental assessments for swallowing (FEES, MBS)
* Caregiver education
* Speaking valve eval and treat
* Neurodevelopmental rounds
* Neuroprotective committee