A Day in the Life

Shana Perman, PA-C

The author examines a 15-day-old 28-week preemie in his isolette.

Once I learned about the PA profession, I knew it was the profession for me. After graduating from the PA program at the Philadelphia College of Osteopathic Medicine in 2005, I started my first, and current, job in the Neonatal Intensive Care Unit (NICU) at the Children's Hospital of Philadelphia (CHOP). I knew that I wanted to work in pediatrics. My only previous NICU experience came during my elective rotation in PA school, but CHOP was willing to hire and train new graduates. I work with a frontline clinician group consisting of PAs, NPs, and house physicians. My work schedule includes days, nights, and weekends—every day is different, yet exciting.

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7:00 AM

I arrive at CHOP and get sign-out on my patients (there are seven today) from the overnight frontline clinician. One of my patients, Baby M, a 4-month-old former 26-week preemie, had increased abdominal girth, irritability, and a low-grade fever overnight. She is post-op day 2 after G-tube placement and Nissen fundoplication for severe reflux. We see a lot of former preemies who need these procedures because of severe gastroesophageal reflux that can cause worsening lung disease.

I record the overnight and morning lab results on all my patients. I also learn that I will be getting a new admission from an outside hospital today.

7:30 AM

I examine my patients and review their flow sheets for the past 24 hours. A lot of numbers are involved in the patients' day-to-day care: new weight for the day; how many grams up or down from the day prior; total fluid intake; urine output per hour; respiratory support; BP; abdominal girth; scores to assess pain; and any apnea, bradycardia, or oxygen desaturation events.

Baby M has already had a blood and urine culture done overnight and is started on vancomycin and gentamicin for a septic rule-out. I give her a dose of fentanyl for pain and update the surgical team that performed her procedure.

8:30 AM

My frontline group meets to look at the radiographs from the morning and start bedside rounds—a total of 17 babies today. We go over the previous days' totals with the attending and decide on our plan for the day. After consultation with the surgical team, the decision is made to send Baby M for an upper GI study through her G-tube to make sure the tube is in the correct position and there is no leak. She is scheduled for 2 PM. Since Baby M is no longer intubated from the surgery, her nurse will take her to the study; patients who are intubated must be accompanied by a frontline clinician.

10:00 AM

I receive a page informing me that my new admission has arrived, so I leave rounds to go to her bedside. The transport team signs out that the ambulance trip was uneventful and gives me a copy of the records from the outside hospital. My new patient is a 2-day-old female infant who was born via C-section at 37 weeks because of worsening bilateral hydronephrosis that was diagnosed on ultrasonography at 24 weeks' gestation. I examine the baby and enter admission orders. After consulting with the urology and nephrology teams, I order a renal ultrasound and a voiding cystourethrogram.

10:45 AM

I rejoin my team to finish rounding. Another one of my patients is Baby S—a full-term male who had significant respiratory distress at birth and was intubated for 5 days. He has since been extubated and is working on feeding by mouth. Babies with feeding difficulties are seen by a speech therapist, who is at the bedside to talk about Baby S's progress. The therapist would like to schedule him for a modified

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barium swallow in the next couple of days to assess his feeding ability and to make sure he can be fed safely by mouth.

11:00 AM
The ophthalmology team notifies me that one of my patient's, Baby C, is going to need laser eye surgery this afternoon. Baby C was transferred to CHOP because of worsening retinopathy of prematurity. The condition is thought to be caused by disorganized growth of retinal blood vessels and, in serious cases, can result in blindness due to retinal detachment. Baby C is currently only on a nasal cannula for respiratory support but now needs to be intubated for the surgery. Her parents are at the bedside, and after Ophthalmology gets consent for the surgery, I talk to Baby C's parents about intubating her.

11:30 AM
I update the attending about Baby C's eye surgery and then enter orders in the computer for the rest of my patients.

12:15 PM
While eating lunch in my work area, I type the admission summary for my new patient. Luckily, she's only 2 days old, so her records from the outside hospital are minimal. Since most of our patients are transferred from other hospitals, we often get 3- or 4-month-old former preemies with multiple medical problems and a stack of paperwork that you cannot imagine! While most of our patients are born at other facilities, CHOP recently opened a Special Delivery Unit where mothers can deliver babies with known birth defects; these babies are a small percentage of our patients. Currently, there are approximately 65 beds in the CHOP NICU, but we are making renovations to accommodate more patients.

1:00 PM
One of the nurses pages me that another one of my patients, a 10-day-old, 24-week preemie, has worsening blood gas results compared to her previous numbers. This baby was transferred to CHOP a couple of days ago for an intestinal perforation after receiving indomethacin to treat her patent ductus arteriosus (PDA). The PDA needs to be treated if it is causing an overcirculation of blood to the lungs. I go to the patient's bedside, increase her ventilator settings, and order a STAT chest radiography. The radiograph shows that her endotracheal tube is a little high, so it is adjusted and retaped. A follow-up blood gas with the adjusted endotracheal tube and increased ventilator settings shows improvement.

2:00 PM
Baby M's nurse lets me know that my patient is back from her upper GI study. Thankfully, Baby M's G-tube is in the correct position and there is no leak. The surgical team is notified. Baby M will stay on antibiotics for a 48-hour septic rule-out.

2:30 PM
I order the rapid-sequence medications that will be given to Baby C prior to intubating her for eye surgery. We try to intubate a baby a couple of hours before surgery to allow time to make any necessary adjustments to the endotracheal tube and ventilator settings. When the nurse and respiratory therapist are ready, I go to Baby C's bedside to intubate her. There are no complications; a chest radiograph will be done to confirm the placement of the endotracheal tube. Baby C is placed on the ventilator and will have a blood gas drawn to make sure she is stable on the current settings. Her surgery will start early this evening at her bedside. The frontline clinician on call for our team will be there during the surgery and will sedate Baby C. The surgery can take 1 to 2 hours when both eyes need to be done, as is the case for this baby.

3:15 PM
When I call to let Baby C's nurse know that the endotracheal tube is in good position, she reads me the blood gas results. They are good–no ventilator adjustments are necessary. I update the summaries for two of my patients who will likely be discharged home in the next couple of days.

4:00 PM
The overnight frontline clinician comes in, and I give her sign-out on each of my patients, including any labs for tonight and the following morning.

4:30 PM
Baby S's nurse pages me. The patient's parents have arrived and would like an update. I talk to the parents about the barium swallow requested by the speech therapist. I will call them tomorrow when I know the scheduled time for the study.

5:00 PM
I leave the hospital and turn off my pager.

Days like these seem to go by quickly and can be draining at times. As with any other area of medicine, there is a constant learning curve. Even though the NICU can take an emotional toll on all involved, the best reward is seeing a baby get better and go home. JAAPA