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Paediatric Horizons and Advances in Neonatal care

Volume 1 Issue 1 - 2025

Short communication

The modern SLP in the NICU

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Received: December 16, 2025 | **Published:** December 24, 2025

Citation: Carmichael CM, Escamilla K. The modern SLP in the NICU. *Paediatr Horiz Adv Neonatal Care*. 2025;1(1):1–2.

Abstract

The American Speech-Language Hearing Association (ASHA) first established primary roles and responsibilities of the speech-language pathologist (SLP) in the neonatal intensive care unit (NICU) in 2004 to include evaluation and intervention of feeding and swallowing, parent and caregiver counselling and education, and collaboration with the neonatal team. In most recent years, time spent in the NICU for the SLP has expanded to include neuroprotective care, family-centered approaches, and extensive responsibilities in communication and feeding intervention promoting child health and development.

Keywords: Speech-language, promoting, neonatal, child health, feeding, collaboration, role

Abbreviations: Neonatal intensive care unit, NICU; Speech-language pathologist, SLP

Role of the SLP

Interdisciplinary team and advanced practice

SLPs serve an integral role as core members of the NICU team. Interdisciplinary collaboration for NICU SLPs is present in case discussions, decision-making, referrals for other services, and discharge planning.[1] Although SLPs are the feeding experts in NICU, most graduate programs in speech-language pathology or communication sciences and disorders do not offer a stand-alone, required course in NICU or paediatric feeding. Working in NICU requires post-graduate specialized training and education[2] which can be achieved through workshops, conferences and conventions, online course offerings, and employer training programs. Neonatal expertise is essential for a family-centred neuroprotective care model.

Neuroprotective care

The most effective care is the highest level that supports family-centered, developmental services focusing on short- and long-term positive outcomes for NICU infants. In the NICU, developmental neuroprotective care forms the foundation of therapeutic practice. The SLP is responsible for helping to create a neuroprotective healing environment for preterm and medically fragile neonates[3] and should focus on the sensory system, especially light (dim light and shield bright light), sound (quiet, soft voices), and touch (gentle, slow movements and swaddling to replicate containment which promotes security and reduces stress).

Instrumental assessment

Evaluation often begins with assessing non-nutritive sucking so that the SLP can test rooting, latching, and sucking with compression. Instrumental evaluations of swallow safety and swallow function include video fluoroscopic swallow study (VFSS) and flexible endoscopic evaluation of swallowing (FEES). Both methods have advantages and disadvantages, offering an internal look at anatomy and physiology involved in feeding and swallowing and visualization of inefficient feeding, loss of fluid, poor coordination of suck-swallow-breathe, or choking/airway compromise if present.[4] Issues during assessment lead to development of therapeutic intervention plans, whether non-nutritive or nutritive.

Non-nutritive interventions and feeding

Non-nutritive therapies like oral-motor and orofacial stimulation techniques can be beneficial to prepare infants for oral feeding while giving sensory input.[5] Nutritive interventions can include adjusting nipple flow rate, positional modifications, pacing the feeding, thickening of feedings, smaller volumes, and more frequent feeds[4,5]It is thought that using a thickener should be a last resort due to infant gut intolerance. Non-nutritive and nutritive interventions are both guided by cues from the baby (signals indicating positive engagement to proceed or stress to scale back). The goal of intervention is always to increase stability and promote skill development with safe feeding and swallowing, often involving parental education and training.[5]

Education

Family-centered approaches like supportive programs, services and practices have shown promising results in reducing parental stress and improving mental health.[6] Parent and caregiver education is an essential task for the NICU SLP because it empowers, provides consistency, trains NICU staff, and ensures a stress-free, bonding activity for the parent and the team. Education and training improve infant and parent satisfaction, promote collaboration, coordination, communication, quality improvement, continuity, and competence for positive feeding experiences.[7] Successful family-centered practices help to integrate the family with the team, standardize practices such as feeding, and improve outcomes for the infant and the family.[8]

Acknowledgments

None.

Conflicts of interests

Authors Christine M Carmichael and Kelly Escamilla have no conflict of interest.

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