2018 Hot Topics in Neonatology Participant Responses to “Are you considering any changes in your practice as a result of attending this activity?”

- Consideration of weight-based dosing of ACS
- Sustained aeration
- Examine the effect of ANS
- Preterm labor and ANS
- Discussion with OB colleagues regarding antenatal steroid
- Antenatal steroids
- Antenatal steroid dosing
- Antenatal steroids, they are not the same
- Decrease use of antenatal steroids beyond 34 weeks
- Improve discussions with OB colleagues regarding need for antenatal steroids and expected timing of delivery.
- Antenatal steroids use in preterm labor
- Rational use of antibiotics in newborns
• Use of antibiotics in the NICU
• Minimizing antibiotic therapy
• Limit antibiotic use (4 participants listed this change statement)
• Minimize antibiotic exposed
• Review antibiotic stewardship practice in NICU
• Monitor and limit when possible antibiotic use and overuse
• Limit use of broad spectrum antibiotics
• Antibiotic stewardship (4 participants listed this change statement)
• Changing antibiotics coverage and duration
• Attention for use antibiotic and antifungic
• Sustained aeration
• Change the BPD definitions (3 participants listed this change statement)
• BPD grading
• Rethink BPD
• Better understand BPD
• Thinking about how to screen for PAH in babies with BPD
• Considering changing how we classify BPD
• Though not changing the BPD classification just yet, keeping in mind the proposed BPD classification to see what the new category-outcomes look like
• Better understanding of how to define BPD
• Screen for bpd related pulmonary hypertension
• May change practice around BPD classification
• Counseling families regarding BPD outcomes
• Follow pulmonary hypertension in BPD
• Better screening for PHTN in BPD
• Bdp definition
• Use new definition discussed for BPD
• BPD classification
• Management of BPD
• Evaluation for PHTN in babies with BPD
• Start using the NICHD BPD risk calculator
• Broadening pharmacological help with symptoms of BPD
• Use new criteria for BPD
• Possible budesonide plus surfactant therapy when/if becomes recommended
• Surfactant with budesonide - join the trial
• Surfactant and budesonide (5 participants listed this change statement)
• Surfactant and budesonide are not ready for prime time, but it might win the future
• Considering implementing surfactant and budesonide to infants identified early for risk of BPD
• Look for more information on Budesonide and surfactant
• Open to using budesonide w surfactant when the study results are available
• Consider early budesonide infusion / inhalation following preterm delivery
• CPAP (2 participants listed this change statement)
• Decrease use of high flow/increase use of CPAP
- CPAP even for our micro preemies
- Better use of CPAP
- Consider bubble CPAP again
- Encouraging extubation sooner
- Extubations
- Stopping Fluconazole use
- Decreasing H2 blocker usage
- Not using H2 blockers.
- HFOV with volume
- Consider getting volume targeted HFOV
- Looking forward to more research in HFVO with VG
- VG w/ HFOV
- Use volume guarantee with HFOV differently
- Sustained inflation
- Considering use of iNO in the preterm
- Looking closer at our iNO use in the critically ill infant
- Ensuring left ventricular function is appropriate before iNO
- Consider INO to premature AA female and trial in responders (2 participants listed this change statement)
- INO in Premature infants
- Use of iNO
- iNO therapy
- When to use iNO
- iNO for African-Americans
- Use of iNO in ELBW infants
- Consider INO in select preterm babies
- Looking more into use of iNO for selective preterm infants when appropriate
- iNO on preterm
- Consideration of iNO after 7 days ventilation for preterm infants
- iNO use in preterms
- Mindfull use of iNO
- Review iNO use
- Reconsider iNO in some premature cases
- iNO
- Consider using INO for preterm neonates
- Want to gain experience with the LISA technique
- using the LISA method for delivery room management
- Introduce LISA for surfactant administration (3 participants listed this change statement)
- Discontinue use of sustained lung inflation
- Respiratory Management DR to Discharge
- Study on extubations
- Maybe budesonide w/ surfactant
- Mixing Steroids with Surfactant
• goal to decrease intubation in DR
• LISA + CPAP
• Bubble CPAP
• Avoiding sustained inflation in the DR
• Not to use high flow, and certainly not early, and to use more CPAP for longer
• Management of pulmonary hypertension
• Use of CPAP in delivery suite in preference to intubation
• SAIL study - sustained inflation
• Conceptos de dysplasia broncopulmonar
• Volume guarantee and HFOV
• Avoid sustained inflations in DR for preterm infants
• Using all Inca prongs with bubble CPAP
• Nitric oxide usage
• PDA Closing vs not closing
• Education regarding ND outcomes from CAP trial
• Antenatal steroid dosing/ timing
• Noninvasive surfactant administration
• Volume guarantee
• Use less pressure in the DR
• Stop sustained inflation in DR
• Sustained inflation discontinued (2 participants listed this change statement)
• Be mindful of pressures I use in the DR
• Surfactant use
• Avoiding sustained inflation in the DR
• No sustained inflation
• Adjusting target spo2 ranges
• Consider more NIPPV
• Nitric oxide usage
• Saturation O2 in bb premature 91 a 95
• Treatment of PDA
• Considering earlier echo assessment for PDA to determine significance in the sick preterm infant
• PDA evaluations by echo (2 participants listed this change statement)
• PDA approach
• Look at acidosis when evaluating PDA
• Reconsidering targeted prophylactic closure of PDA
• Consider less pressure use for PDA
• PDA management (4 participants listed this change statement)
• Better assessment of PDA
• Update PDA handling
• Selective patient management of PDA
• Use hydrolyzed formula
• Reconsider PDA treatment
• PDA treatment
• Decreased treatment of PDA
• Reevaluate PDA treatment
• Change in PDA approach
• Clarification of TIPP trial endpoint regarding PDA
• Not to treat asymptotic PDA
• Screen more ELBW infants prior to discharge for PHT
• POCUS
• Protocol based PPHN management
• How we diagnose and manage PPHN
• Not starting Pulmicort
• more awareness of pulmonary hypertension in preterm infants
• Pulmonary hypertension evaluations
• Higher index of suspicion of Pulmonary hypertension in PT infants
• management of RDS
• Resuscitation changes
• Use postnatal steroids prudently
• Educate OBGY colleagues to be cautious with steroid use
• Steroids time (2 participants listed this change statement)
• Steroid use
• Reevaluate prenatal steroid treatment
• budesonide with surfactant looks promising
• Steroids with surfactant
• Caution on sustained inflation
• Will not use sustained inflation at this time, awaiting more information about a safe way to use
• TIDAL VOLUME USE
• Volume controlled ventilation (2 participants listed this change statement)
• Use of VG with HFOV (2 participants listed this change statement)
• Noninvasive ventilation (5 participants listed this change statement)
• Noninvasive surfactant use
• Surfactant administration
• Continue to work toward minimizing invasive interventions
• Discuss with RT re Vt hfov
• Different approach to ventilation
• Targeted ventilation
• Ventilator management
• Monitor volume um DR
• Sat O2 91 95%
• Not attempt sustained inflation
• Appropriately use of caffeine
• Encouraging broader caffeine use
• Monitor caffeine use in our NICU (6 participants listed this change statement)
• Probably not treat PDA unless cardiopulm compromise.
• Early use of Caffeine citrate in low birth weight NB
• Double-check to make sure babies eligible for caffeine therapy have been started on the medication
• Use caffeine more liberally
• Management adequate CAS
• Considering noninfectious inflammation after suspected chorioamnionitis
• Classification of cld
• Inflammation of the placenta and sterile lack of infectious chorioamnionitis.
• Low threshold for cooling therapy
• Improve treatment in the delivery room. (2 participants listed this change statement)
• Delivery room management - adding additional monitoring
• Delivery room surfactant for ELBW
• Using delivery room respiratory monitors
• Would not support using specialized formula to prevent type I diabetes
• Addressing disparities
• Looking for ways to reduce disparities
• Increased awareness in disparities in care based on race
• Decrease disparity outcome differences
• Applying some advice from disparities in neonatal care
• Formalizing process to address NICU disparities (current discussion with RN and SW at multidisciplinary rounds and twice daily work rounds). Work with team to generate areas to discuss with families in addition to daily baby updates
• Awareness of disparities and conscious effort to improve
• Will begin a discussion in our facility about conscious and unconscious biases w/respect to social strata
• Improve communication with staff and trainees regarding social determinants of health, health care disparities
• Talk to my colleagues about how we can begin to address disparities in medicine in our practice
• Disparities in healthcare
• Consider inhaled nitric oxide in babies of African American ancestry when they remain incubated and ventilated at 7 days.
• NO use in preterm black infant
• Earlier echo for PDA detection (13 participants listed this change statement)
• Routine early echo to screen for pulmonary hypertension
• Consideration of reclassification of BPD and ECHO screening for pulm HTN
• More use of echo in assessing ducts early
• Obtaining echocardiogram at different time points for pulmonary hypertension screening
• ECHO in preterm infants for pHTN
• Echos on BPD babies
• Early consideration of ECHO in suspected BPD
• Early ECHOES for hypoxia Respiratory Failure
• Do different management in EOS due to new AAP algorithm
• reevaluate feeding practices
• Feeding strategies
• Better manage babies
• Prevention of prematurity
• Paying more attention the AA population in my practice
• Be a true advocate for patients, like Dr. Strauss
• Knowledge
• Plan to push for a more data driven approach to care
• More robust determination of which info to collect prospectively.
• Passion
• Consideration of rapid genomic testing for targeted therapies
• Educating parents on GERD in preterm and term infants
• I am changing my practice of managing gastroesophageal reflux
• Not thicken feeds for GER
• GE Reflux treatment
• GER management not using medical treatment
• Not counting reflux as part of apnea/brady cause
• Avoiding prescribing acids suppressants in GERD
• Practice issues with GER
• Tolerate GER
• Approach to reflux
• Not blame A/B/D on GER readily
• Limit use of medical management of GER
• Treatment of GER
• No more hydrolyzed formula for GERD
• Not worry too much about GER in Preterms
• Use of GER treatment
• Not to routinely Rx GER in neonates
• Decrease use of anti-reflux medications
• Discontinue anti-reflux meds
• Reducing GER med treatment
• Change in how we handle and monitor NGT feeds and manage/evaluate GERD
• Continued avoidance of acid suppression in babies with clinical signs of GER
• Change management of GER (3 participants listed this change statement)
• Reinforce the need to not treat GER with medications.
• Avoid using reflux medications
• Limit treatment of GER
• No use of ranitidine in premature babies
• Discontinued use of medications for the treatment of GER
• Further decrease any treatment of reflux
• Education of nursing staff on reflux
• Considering utilizing growthcalculator.org for early VLBW growth reference
• Monitor growth in preemies
• Maximize the use of MIR in HIE
• Consider hypothermia in HIE more than past
- MRI IN HIE
- Management HTP
- Move to exclusive Human milk feedings
- Utilización fortificador leche humana
- Percentage of use of breast milk for preterm infants in the NICU.
- Using donor BM in higher gestations
- Hydrolyzes formula not helpful
- I am going to be paying more attention with encouraging fortification of breast milk to improve growth
- Consider using liquid HMF that is not breast milk based and follow outcomes as compared to previous VON outcomes
- Encourage breastfeeding
- Maybe do not force the human milk formula
- Not using Cow’s milk products in any form (2 participants listed this change statement)
- Feeding practice
- Breastfeed infants as soon as possible
- Utilización leche humana optimizada
- Nutritional Management
- Use donor breast milk at later gestation
- Critical evaluation of feeding practices
- Evaluate use of cow’s milk formula
- Monitoring for adverse effects related to breastmilk fortification
- Support breastfeeding more aggressively
- Earlier HM fortification at 40ml/kg/day
- Less use of donor milk
- Reduce use of bovine milk fortifier
- Continue to not use H Hmf
- Consider changes to use of Prolacta in our unit (2 participants listed this change statement)
- Placing further emphasis on using breast milk exclusively (4 participants listed this change statement)
- HFOV usage
- Give colostrum right away
- Longer use of human milk based fortifier
- May start using routine bmf
- Expand availability of donor milk
- Consider using liquid HMF not breast milk based HMF. Look at outcome and cost data
- Encourage breast feeding
- Fortification of human milk (9 participants listed this change statement)
- Advocating for HMF vs bovine
- Hydrolyzed formula change
- Don’t worry about hydrolyzed formula
- Which HMF I use
- Look into HM HMF
• Screen for hypoglycemia in anc infants
• Type of incubator
• Less indomethacin use
• Re-evaluate indomethacin prophylaxis
• Changes in caffeine management
• Consider metabolic screening more frequently
• consider metabolic disease with sepsis workups
• Do not use prophylactic antifungal
• Consider fetal maturity testing
• AEEg
• Standardization of neuro patient in NICU
• Nutrition-fortifiers
• Nutritional supplementation changes
• Nutrition proactive
• More flexibility with calorie supplementation
• earlier fortification
• Feeding strategies
• Cont. NG feeds
• Rethink use of hydrolyzed formulas
• changing some feeding practices
• Monitoring of mothers of neonates for their health care
• Formalizing discussion of parent's (Mother's) challenges in visiting or caring for her infant. Currently we have multidisciplinary rounds and we discuss this in our twice daily rounds as well; but including on our sign-out list of things to follow up may formalize the process. Will brainstorm with team to formalize process
• Postnatal maternal anticipatory guidance
• Encourage maternal instead of prenatal care
• Sessions for mothers/fathers about nutrition and follow-up care for themselves.
• Better communication with the OB in terms of preterm delivery
• Education
• Discussing maternal follow-up with mother in the NICU
• Advocates for mothers health care
• Discuss with obstetrics about the prevention of prematurity initiative in Australia.
• Discuss with OB regarding BMZ
• Better discussion with mothers about their health
• Follow up of high risk Moms postnatal more closely
• Being more considerate of individual patient needs when considering type of ventilation, oxygen exposure vs risk for hypoxia and pulmonary hypertension monitoring in the BPD patient.
• Coordination with the OB’s to reduce preterm birth, we may suggest establishing special clinics for prevention of premature birth.
• speak to mothers more about their health and social determinants of health
• Improved counseling of mothers post delivery
• Preterm labor prevention advocacy
- Speak to mothers about their needs
- Bilateral renal agenesis -will not say 100% fatal
- Improves communication with families
- Educate parents on associated neurologic morbidities with tracheostomy
- More parents incorporating care
- Engage moms/families in relation to next pregnancy to try and impact premature delivery
- Parental etiquette
- Institute weekly or twice weekly family focused rounds in the NICU
- Discuss treatment option for renal agenesis in prenatal counseling
- Provide ethical & compassionate care
- Improve interaction with parents
- Preterm delivery reduction
- Consider use of probiotics
- Using model for improvement in conjunction with LEAN
- Change in approach to QI
- Will go into nursing informatics
- Investigate use of US by neonatology for procedures in NICU
- Improve therapies with emphasis on do not harm.
- Be more conscious of the effects is what we do.
- Better interaction with PB, MFM and the network teams
- Consider side effects and consequences of our treatment options.
- Think of consequences of everything we do.
- Quality attention
- Further involvement of IRB in qi projects
- Build a IQ Team
- Modify the flow of one of the quality projects
- Involvement in QI
- Believe less in Cochrane
- Do more quality improvement in my unit
- Quality collaborative
- Increase QI
- New change of neonatology
- Greater impact on decreasing prematurity
- Consider QI project
- Less late preterm admissions
- Change to Hudson prongs
- Education regarding SAIL trial outcomes
- Exclusive use of EBM in the NICU
- Standardized PRBC policy by 07/01/19
- Push for a more data driven approach to care decisions
- QI PROJECTS
- Start building a QI Team in my center
- Participate in research (2 participants listed this change statement)
- Organized research
- Diagnosis Sepsis
- Relying on PCR to determine sepsis vs sterile chorio
- Evaluation of sepsis with negative cultures
- Considering different early markers for sepsis
- Treatment of culture negative sepsis
- Transfusions
- Changing transfusion practices
- Check Transfusion protocol
- Learn bedside ultrasound techniques to support procedures
- Renewed energy around solidifying our ultrasound education and training program
- we used to do point-of-care ultrasound, fell out of favor a couple of years ago, may need to reinstitute this practice
- Point of Care ultrasound
- Ultrasound use in NICU
- Utilización ultrasonido diagnóstico e intervención
- I have developed an interest in point of care ultrasound in neonatology and will be looking at attending course to gain skill and competence in performing ultrasounds
- Learn more bedside ultrasound skills
- Using bedside ultrasound for all PICC insertions (4 participants listed this change statement)
- Training ultrasound in NICU
- Using ultrasound guidance for central lines
- Investigate bedside US as aid to placement and management of lines
- Investigate feasibility for training and point of care ultrasound in our community NICU.
- Begin point of care US training and use
- Implement more bedside ultrasonography in diagnosis and therapy
- Plan to attend a course in POC ultrasound
- Consider bedside ultrasound for line placement and position confirmation (3 participants listed this change statement)
- Consider utilizing US for procedures
- Use Ultrasound
- Fine tuning our operational definition of UEs
- Bedside ultrasound (3 participants listed this change statement)
- Introduce ultrasound point of care testing
- Think about training our fellows in bedside ultrasound use
- Use bedside ultrasound for cardiac function evaluation
- Alternate way of securing UVC
- Vision
- Eat more
- Work less