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gain, time to achieve full oral feedings on a weekly basis, and length of stay over the 3-month pilot.

**Results**

Results indicated that infants who were fed using the IDF method demonstrated sufficient weight gain, increased the use of human milk both while in the NICU and as part of their home milk regimen, and reduced the length of stay by 1.3 days. Lactation support for women with NICU infants increased. Bedside caregivers and parents learned to feed infants in a safe and developmentally supportive manner. The unit successfully transitioned from a volume-driven feeding practice to an evidenced-based IDF protocol.

**Discussion/Conclusion**

Using evidenced-based IDF practices and measuring feeding readiness may improve the time to achieve full oral feedings and weight gain and decrease length of stay. The IDF protocol provides guidelines for feeding medically stable, premature infants with adequate nutrition for appropriate weight gain in a developmentally supportive manner.

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**Eat, Sleep, Console—a Quality Improvement Project**

**Introduction**

Due to the opioid epidemic, an increasing number of infants are born with neonatal opioid withdrawal syndrome (NOWS). The aim of the interdisciplinary collaborative quality improvement project was to decrease length of stay (LOS) and need for pharmacological intervention for newborns 35 weeks or greater gestation. Before the project, newborns were treated with pharmacological therapy in a specialized nursery and average LOS was 2–3 weeks. NOWS newborns who room-in with the parent(s) need less pharmacological treatment and have decreased LOSs.

**Methods**

A parent partnership unit (PPU) was implemented to focus on caregiver and newborn using the eat, sleep, console (ESC) assessment and targeted nonpharmacologic soothing strategies to decrease LOS and need for pharmacological treatment. Interdisciplinary meetings used the plan–do–study–act method to discuss project goals and needs and evaluate progress throughout the year. Newborn data were collected from financial reports that included identification of newborns with ICD-10 codes P04.19 and P96.1, LOS, and use of pharmacological treatment.

**Results**

Prior to project implementation, 66% of newborns received medication therapy, with average LOS of 14.6 days. After project implementation, project goals were met: LOS decreased by 5.1 days, and there was a 24% reduction in need for pharmacological therapy.

**Discussion/Conclusion**

This ESC model shifts the emphasis of NOWS to the caregiver and decreases pharmacological measures as the primary treatment plan. Nursing roles shifted to provide support and education to the parents rather than medication and separation for treatment. Keeping the caregiver–infant dyad together is the newborn’s best treatment option. Monitoring LOS and pharmacological treatment continues with the NOWS population and ESC.

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**Overcoming Barriers to Kangaroo Care in a Metropolitan NICU During the COVID-19 Pandemic**

**Introduction**

The benefits of kangaroo care (KC), or skin-to-skin care, for both the neonate and the postpartum woman are well documented and include improving maternal–newborn bonding, which serves as a precursor to successful breastfeeding, improved neonatal neuro-developmental development and physiological stability, and decreased maternal and neonatal stress. Despite an awareness of these benefits, the rate of KC in one metropolitan NICU was lower than the benchmark. Barriers specific to this
Do Prophylactic Antibiotics for Neonates Cause More Harm Than Good?

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**Introduction**

Early neonatal antibiotic exposure causes disruption of the intestinal microbiome, which may lead to lifelong health consequences, including asthma, lung disease, obesity, and inflammatory bowel disease. Standard practice for well-appearing neonates born to women with chorioamnionitis included a blood culture, complete blood count, and four doses of antibiotics over 36 hours. Audits of newborns in 2016 indicated that 100% of well-appearing newborns had negative blood cultures at 36 hours, confirming that they did not have early-onset sepsis. The antibiotics these newborns received were prophylactic and unnecessary. When the American Academy of Pediatrics endorsed the use of a multivariate risk assessment neonatal sepsis calculator, we began formulating our plan for implementation.

**Methods**

Using a 30/60/90-day quality improvement model, the obstetric and neonatal department implemented the use of the neonatal early-onset sepsis calculator. Nurses and health care providers were educated on the use of the calculator, which evaluated specific factors at birth to arrive at a sepsis risk score. The factors included maternal highest temperature during labor, group B Streptococcus status, antibiotic timing in relation to birth, length of rupture of membranes, and neonatal gestational age. The calculator was used for all neonates born at 35-weeks’ gestation and older who were admitted to the mother-baby unit beginning January 2021. Data were manually extracted for neonates born to women with a diagnosis of chorioamnionitis. Data points collected were race, gestational age, blood culture collection, and antibiotic-administration rates.

**Results**

The number of blood cultures collected was reduced by 82% and antibiotic administration reduced by 96% after implementation of the calculator.

**Discussion/Conclusion**

Up to 30,000 infants are born in the United States each year to women with a diagnosis of chorioamnionitis. Universal implementation of the neonatal sepsis calculator among clinically well-appearing neonates 35 weeks of gestation and older who are born to a woman with chorioamnionitis would significantly reduce the number of newborns receiving antibiotics, providing an opportunity at life without the chronic diseases associated with early exposure to antibiotics and saving countless health care dollars.