Chapter 1 : SimilacÂ® | Baby Formula Brand Since | Toddler & Infant Items

*Official Formulae of American Hospitals [Charles Fayette Taylor] on calendrierdelascience.com *FREE* shipping on qualifying offers. This work has been selected by scholars as being culturally important, and is part of the knowledge base of civilization as we know it.*

Abstract Objective To examine trends in the prevalence of hospitals and birth centers hereafter, hospitals distributing infant formula discharge packs to breastfeeding mothers in the United States from to Either a web- or paper-based questionnaire was distributed and completed by the person s most knowledgeable about breastfeeding-related hospital practices. We examined the distribution of infant formula discharge packs to breastfeeding mothers from to by state and hospital characteristics. Results The percentage of hospitals distributing infant formula discharge packs to breastfeeding mothers was Distribution declined across all hospital characteristics examined, including facility type, teaching vs. Conclusions The distribution of infant formula discharge packs to breastfeeding mothers declined markedly from to Discontinuing the practice of distributing infant formula discharge packs is a part of optimal, evidence-based maternity care to support mothers who want to breastfeed. The American Academy of Pediatrics recommends that mothers exclusively breastfeed their infants for about the first 6 months of life. Several studies have shown a decrease in duration of exclusive breastfeeding when breastfeeding mothers are given infant formula discharge packs. Whereas these studies examined the distribution of discharge packs given to all new mothers, we questioned the experiences of breastfeeding mothers. Thus, the purpose of our study is to report national trends in the distribution of infant formula discharge packs to breastfeeding mothers in hospitals and birth centers in the United States from to Methods In , the Centers for Disease Control and Prevention launched Maternity Practices in Infant Nutrition and Care mPINC , a survey of maternity care practices and policies administered every 2 years to all hospitals and birth centers hereafter, referred to as hospitals unless otherwise specified with registered maternity beds in the United States and territories. Detailed methods of the mPINC survey have been described elsewhere. In addition, relevant literature and pilot surveys were used to develop the questionnaire in order to reflect maternity care practices that are known to affect breastfeeding outcomes. Either a web- or paper-based questionnaire was completed by the person s most knowledgeable about breastfeeding-related hospital practices, with input from other staff as needed. Data provide surveillance for maternity care practices in the United States. Additionally, each facility receives a benchmark report which contains a total score and individual scores for seven sub-areas e. This feedback allows facilities to compare the performance of their maternity care practices to their peers and allows facilities to identify areas for improvement. We examined the percentage of hospitals distributing discharge packs containing infant formula to breastfeeding mothers from to by hospital characteristic, including facility type private hospital, government hospital, nonprofit hospital, military hospital, birth center , teaching vs. All analyses were conducted in SAS 9. Because mPINC is a census of hospitals providing maternity care and not a sample of all hospitals, there is no sampling error, and therefore no statistical tests were performed. These 3 states were joined by Oregon, Vermont, and the District of Columbia in the survey.

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Excerpt from Official Formulae of American Hospitals Bellevue Hospital C' out Charity Hospital, Blackwell's Insane Asylum, N inety-ninth Street Reception Hart's Island Hos Infant's Hospital 's Island of the Long Island College Hospital, (brooklyn.

Appointing a single leader responsible for program outcomes. Experience with successful programs show that a physician leader is effective Drug Expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use. Implementing at least one recommended action, such as systemic evaluation of ongoing treatment need after a set period of initial treatment i. Monitoring antibiotic prescribing and resistance patterns Reporting: Regular reporting information on antibiotic use and resistance to doctors, nurses and relevant staff Education: Educating clinicians about resistance and optimal prescribing Leadership Commitment Leadership support is critical to the success of antibiotic stewardship programs and can take a number of forms, including: Formal statements that the facility supports efforts to improve and monitor antibiotic use. Including stewardship-related duties in job descriptions and annual performance reviews, Ensuring staff from relevant departments are given sufficient time to contribute to stewardship activities Supporting training and education Ensuring participation from the many groups that can support stewardship activities. Financial support greatly augments the capacity and impact of a stewardship program and stewardship programs will often pay for themselves, both through savings in both antibiotic expenditures and indirect costs. Identify a single leader who will be responsible for program outcomes. Physicians have been highly effective in this role. Identify a single pharmacy leader who will co-lead the program. Clinicians and department headsâ€" As the prescribers of antibiotics, it is vital that clinicians are fully engaged in and supportive of efforts to improve antibiotic use in hospitals. Infection preventionists and hospital epidemiologists coordinate facility-wide monitoring and prevention of healthcare-associated infections and can readily bring their skills to auditing, analyzing and reporting data. They can also assist with monitoring and reporting of resistance and CDI trends, educating staff on the importance of appropriate antibiotic use, and implementing strategies to optimize the use of antibiotics. Laboratory staff can guide the proper use of tests and the flow of results. They can also guide empiric therapy by creating and interpreting a facility cumulative antibiotic resistance report, known as an antibiogram. Lab and stewardship staff can work collaboratively to ensure that lab reports present data in a way that supports optimal antibiotic use. For facilities that have laboratory services performed offsite, information provided should be useful to stewardship efforts and contracts should be written to ensure this is the case. Information technology staff are critical to integrating stewardship protocols into existing workflow. Examples include embedding relevant information and protocols at the point of care e. In addition, nurses review medications as part of their routine duties and can prompt discussions of antibiotic treatment, indication, and duration. Utilize specific interventions that can be divided into three categories: Policies that support optimal antibiotic use Implement policies that apply in all situations to support optimal antibiotic prescribing, for example: Document dose, duration, and indication. Specify the dose, duration and indication for all courses of antibiotics so they are readily identifiable. Facility-specific treatment recommendations, based on national guidelines and local susceptibilities and formulary options can optimize antibiotic selection and duration, particularly for common indications for antibiotic use like community-acquired pneumonia, urinary tract infection, intra-abdominal infections, skin and soft tissue infections and surgical prophylaxis. Interventions to improve antibiotic use Choose interventions based on the needs of the facility as well as the availability of resources and content expertise; stewardship programs should be careful not to implement too many interventions at once. Stewardship interventions are listed in three categories below: Antibiotics are often started empirically in hospitalized patients while diagnostic information is being obtained. However, providers often do not revisit the selection of the antibiotic after more clinical and laboratory data including culture results become available. All clinicians should perform a review of antibiotics 48 hours after antibiotics are initiated to answer these key questions: Does this patient have an infection that will respond to antibiotics? If so, is the patient on the right

antibiotic s , dose, and route of administration? Can a more targeted antibiotic be used to treat the infection de-escalate? How long should the patient receive the antibiotic s? Prior authorizationâ€" Some facilities restrict the use of certain antibiotics based on the spectrum of activity, cost, or associated toxicities 57 to ensure that use is reviewed with an antibiotic expert before therapy is initiated. This intervention requires the availability of expertise in antibiotic use and infectious diseases and authorization needs to be completed in a timely manner. Prospective audit and feedbackâ€" External reviews of antibiotic therapy by an expert in antibiotic use have been highly effective in optimizing antibiotics in critically ill patients and in cases where broad spectrum or multiple antibiotics are being used. Audit and feedback requires the availability of expertise and some smaller facilities have shown success by engaging external experts to advise on case reviews. Infection and syndrome specific interventions The interventions below are intended to improve prescribing for specific syndromes; however, these should not interfere with prompt and effective treatment for severe infection or sepsis. Interventions for community-acquired pneumonia have focused on correcting recognized problems in therapy, including: Interventions for skin and soft tissue infections have focused on ensuring patients do not get antibiotics with overly broad spectra and ensuring the correct duration of treatment. In many cases, therapy for MRSA can be stopped if the patient does not have an MRSA infection or changed to a beta-lactam if the cause is methicillin-sensitive Staphylococcus aureus. Treatment guidelines for CDI urge providers to stop unnecessary antibiotics in all patients diagnosed with CDI, but this often does not occur. For antibiotic stewardship, measurement may involve evaluation of both process Are policies and guidelines being followed as expected? Antibiotic Use Process measures Perform periodic assessments of the use of antibiotics or the treatment of infections to determine the quality of antibiotic use. Examples include determining if prescribers have: Standardized tools such as those for drug use evaluations or antibiotic audit forms like those developed by CDC can assist in these reviews. These reviews can be done retrospectively on charts which could be identified based on pharmacy records or discharge diagnoses. If conducted over time, process reviews assess the impact of efforts to improve use. For interventions that provide feedback to clinicians, it is also important to document interventions and track responses to feedback e. DOT is an aggregate sum of days for which any amount of a specific antimicrobial agent is administered or dispensed to a particular patient numerator divided by a standardized denominator e. An alternative measure of antibiotic use is defined daily dose DDD. This metric estimates antibiotic use in hospitals by aggregating the total number of grams of each antibiotic purchased, dispensed, or administered during a period of interest divided by the World Health Organization-assigned DDD. Compared to DOT, DDD estimates are not appropriate for children, are problematic for patients with reduced drug excretion such as renal impairment, and are less accurate for between-facility benchmarking. For example, the assessment of an intervention to improve the treatment of community-acquired pneumonia CAP would be expected to impact the use of antibiotics most commonly used to treat CAP on medical wards, rather than surgical wards. To participate in the AU option, facility personnel can work with their information technology staff and potentially with their pharmacy information software providers to configure their system to enable the generation of standard formatted file s to be imported into NHSN. This type of benchmarking has been helpful in improving outcomes in hospital infection control and has been identified by stewardship experts as a high priority for the U. Improving antibiotic use has a significant impact on rates of hospital onset CDI and the current challenge of CDI in hospitals makes this an important target for stewardship programs. Reducing antibiotic resistance is another important goal of efforts to improve antibiotic use and presents another option for measurement. The development and spread of antibiotic resistance is multi-factorial and studies assessing the impact of improved antibiotic use on resistance rates have shown mixed results. Monitoring resistance at the patient level i. If hospitals monitor antibiotic costs, consideration should be given to assessing the pace at which antibiotic costs were rising before the start of the stewardship program. Reviewing de-identified cases with providers where changes in antibiotic therapy could have been made is another useful approach. A variety of web-based educational resources are available that can help facilities develop education content. The integration of IT into the clinical data presentation and decision-making for antibiotic use will expand with increased uptake and capabilities of electronic health records. The role of diagnostic laboratory testing is another area of evolution. Another area of on-going work

is better characterization of the impact of antibiotic stewardship interventions on resistance. As more facilities engage in efforts to optimize antibiotic use, future work is needed to evaluate which interventions or antibiotic targets yield the greatest benefit in combating antibiotic resistance. Impact of an antimicrobial utilization program on antimicrobial use at a large teaching hospital: Infection control and hospital epidemiology: Point-prevalence study of inappropriate antibiotic use at a tertiary Australian hospital. Antimicrobial use in the ICU: Journal of hospital medicine: The Pediatric infectious disease journal. Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America guidelines for developing an institutional program to enhance antimicrobial stewardship. Jan 15 ;44 2: Morbidity and mortality weekly report. Risk of hepatotoxicity associated with fluoroquinolones: A national case-control safety study. American journal of health-system pharmacy: Jan 1 ;71 1: Ceftriaxone-induced hemolysis in a child with Lyme arthritis: Time interval of increased risk for Clostridium difficile infection after exposure to antibiotics. The Journal of antimicrobial chemotherapy. Fluoroquinolones and the risk of serious arrhythmia: Antimicrobial resistance and infection control. Nov 18 ;2 1: Centers for Disease Control and Prevention. Know When Antibiotics Work. Interventions to improve antibiotic prescribing practices for hospital inpatients. The Cochrane database of systematic reviews. American journal of infection control. Journal of the Pediatric Infectious Diseases Society. September 1, ;1 3: Impact of antimicrobial stewardship in critical care: Clinical and economic outcomes of a prospective antimicrobial stewardship program.

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