THE EVOLUTION OF A ROOMING-IN PROGRAM

Adjunct to Modern Obstetric Care

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AS the concept of rooming-in of the newborn with its mother has gradually become accepted as a desirable adjunct to obstetric and pediatric care, experience with a rooming-in program has revealed both shortcomings and unanticipated advantages, which have made necessary a modification of methods, of attitudes, and of facilities to implement and to improve the total care of the obstetric patient. Though rooming-in was originally tried in order to reduce the personnel requirements in large central nurseries, and to reduce the incidence of infection spread within the nurseries, it soon became apparent that the mothers who had rooming-in privileges were more calm and confident upon leaving the hospital and were better prepared to accept the full responsibility of caring for their infants, especially if they were their first.

However, it also was recognized that not all babies are in such satisfactory condition that they can be placed at the mother's bedside soon after birth, and that this plan is not beneficial or acceptable to all new mothers. Some infants will always require the care that is available only in a professionally staffed general nursery or, in some cases, a premature nursery. Most new mothers are not physically or psychologically ready to start the rooming-in process from the moment of birth. Primipara usually need several days to restore the energy expended during labor. Many multipara derive more benefit from the additional rest while in the hospital than from having the baby near them at times other than feeding periods. By continuously reappraising the objectives, and the means best to accomplish them, a modified program of rooming-in has evolved which is currently in successful operation at the Cleveland Clinic Hospital.

Objectives

The primary objective of rooming-in at the present time is to provide an easier transition between the heretofore usual hospital practice of allowing the mother essentially no responsibility in the care of her infant while in the hospital, and having the total responsibility suddenly thrust upon her when she goes home. The confidence that is gained in her ability to care for the newborn with professional assistance close at hand, should the need arise, provides a most helpful measure of psychologic support, and, in some cases, prevents an adverse emotional response. This kind of support is particularly applicable to mothers of first babies, but many multipara can benefit from it as well. Individualization is the key to the success of the entire program, in regard to whether or not to start it, and when to start it.

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Once rooming-in has been started, a new mother no longer worries that every cry she hears from the central nursery is from her baby. It is highly reassuring to her to know that she herself can control the care of her baby's needs, and that they will be fulfilled as soon as they arise and are made known. One result of this personal control is the early establishment of a demand feeding schedule, and an understanding of a baby's individual sleeping habits. Pediatricians have repeatedly pointed this out as an advantage of rooming-in.

The role of the father in the overall program has been previously discussed.[1] His occasional presence in the nursery during visiting hours is a morale builder both for his wife and for himself (*Fig. 1*).

Fig. 1. Photo of husband's participation in the peripheral nursery care of the baby.

The control of nursery-spread infection is no longer the primary reason to have rooming-in, but, since the threat is ever-present, a hospital that is equipped for the disseminated care of babies is in a strong position to deal with it. Should an epidemic threaten to develop, such as when one or several babies are found to have diarrhea, or skin pustules, well babies can be placed in rooming-in units until the central nurseries have been thoroughly cleaned and made ready for use again, and the threat has passed.

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Facilities

Direct rooming-in of the baby at the bedside, unless done in a private room, is disturbing to those mothers who are sharing a room with the rooming-in participant. Under these circumstances, rules governing visiting must be changed, and if only husbands are permitted to visit in such rooms, those mothers not participating would have unfair restrictions of visitors imposed upon them. When these disadvantages became apparent, the need for a new type of hospital facility was recognized in order that the objectives outlined above can best be accomplished. When the maternity section of the Cleveland Clinic Hospital was built in 1956, an arrangement was provided whereby four mothers share two semiprivate rooms and a fully equipped four-bassinet peripheral nursery with access from the rooms on either side (*Fig. 2*). Three such suites provide these facilities for twelve mothers and their infants.

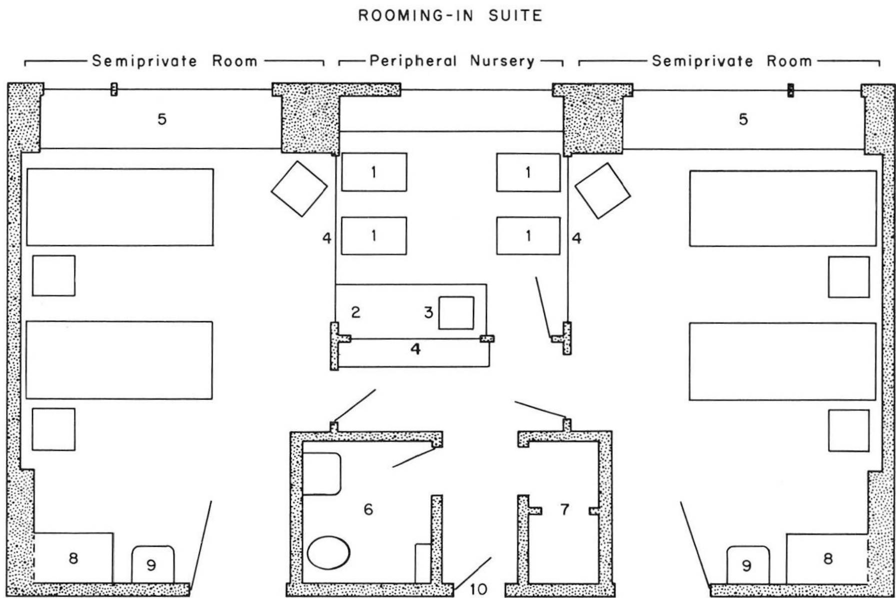

Fig. 2. Diagram of the rooming-in suite showing (1) bassinet, (2) refrigerator, (3) sink, (4) glass partition, (5) desk and storage cabinet, (6) lavatory, (7) shower, (8) clothes locker, (9) sink, and (10) direct access from the main corridor.

For those mothers who do not choose to have rooming-in, and for those whose babies require direct professional care, postpartum rooms without peripheral nurseries, as well as observation, premature, and large central nurseries are provided. It is essential that rooming-in remain optional and elective, and that facilities for all types of postpartum care be available.

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Personnel Requirements

As originally conceived, one purpose of a rooming-in program was to reduce the number of nurses and aides in the central nursery by delegating more responsibility to the mothers. While it is true that since each newborn in a peripheral nursery relieves central nursery personnel of a proportional amount of responsibility, it is difficult to maintain a constant number of babies in the peripheral nurseries in order to reduce staffing requirements in the central nursery. However, personnel in the central nursery do not participate in the rooming-in program, so that the hazards of cross-contamination between central and peripheral nurseries are avoided. The floor nurses must assume additional duties and become the ever-available professional consultants and instructors of the rooming-in mothers.

This is a good example of how attitudes must change, since the role of a floor nurse under these circumstances is much different from formerly, and her enthusiastic cooperation is essential to the success of the program. The elimination of the time-consuming distribution of medication by the nurses, with the use of bedside self-medication by the patient, gives nurses more time for guidance and teaching.[2]

Instruction of Mothers

After the baby has been sufficiently observed and is cleared for rooming-in, by the attending pediatrician, and when the mother wishes to start rooming-in and is considered well enough rested by the attending obstetrician, an indoctrination lecture is given by the floor nurse and rooming-in is started. This seldom occurs before the fourth or fifth hospital day, and a seven-day stay is recommended. This postpartum stay is recognized as being longer than the national average, but has been found to be more desirable than to start rooming-in so soon that mothers are not physically ready for it and thus lose its desired advantages.

During the nurse's lecture the appearance of a normal newborn is described, with its relatively large head, normally protruberant abdomen, and dry wrinkled skin. Infants' habits are discussed, including hiccups, sneezing, sucking, and the Moro reflex. It is pointed out that babies sleep most of the time and, generally speaking, will awaken only when wet, hungry, or otherwise uncomfortable.

The details of feeding are reviewed. The variation in hunger periods in babies is explained and the benefits of a demand schedule are emphasized. Breast feeding is encouraged, and the advantages of early close physical and psychologic relationships of mother and child are pointed out. A high percentage of rooming-in mothers nurse their babies. Positioning of the baby both for feeding and afterward in the bassinet is demonstrated, as is the technic of "bubbling."

Instruction in bathing the baby is given, including such things as cleansing the folds of the neck, groin, and genitalia. Care of the umbilical cord stump, and the circumcision of male babies are discussed. Cleanliness is emphasized, particularly personal hand care on the part of the mother. She is instructed to wash her hands

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each time she enters and also before she leaves the nursery. Each bassinet is separately provided with diapers, linen, blankets, and other items such as pins, in order to avoid cross-contamination with other bassinets in the nursery. The nurse's frequent personal supervision and verification that all is going well are most reassuring.

Within a day or two, new mothers have learned by individual instruction and personal experience what might have taken many frustrating and emotionally upsetting days with trial-and-error methods had they gone home earlier.

Comment

There has been considerable criticism of rooming-in, for example, it is said: that rooming-in is often started too soon after delivery, at a time when rest is essential; that it is an undue drain of energy from the newly delivered mother; that the possibility of cross-contamination is hazardous; that there is often a lack of skilled personnel on the scene in case of need; that husband participation is undesirable; and even that the whole idea is unnecessary. Some of these criticisms have been justified and helpful in that they have led to modifications that have contributed to the evolution of the present successful program.

Though much has been done, new avenues of improvement continue to arise. For example, a nurse whose sole duty would be to orient and to instruct rooming-in mothers would afford more stability and continuity to the program and would enhance current objectives. More women, particularly multipara, would participate if they could have their babies only during the day, and return them to a centrally located nursery at night. This is entirely feasible, though a system must be devised to avoid the potentially increased hazard of cross-contamination that could result. As time goes on, these changes and others will be instituted, always keeping in mind the goal of offering the advantages of rooming-in to those who wish it, while maintaining the high standards of pediatric and nursery care which have been developed through the experience of many years.

References

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