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Innovative Maternity Program

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Abstract

The innovative maternity care program has been recently implemented at the Institute of Mother and Child. The idea is to provide superior service based on family-centered, psychologically oriented, single room maternity care. In one and the same room the woman goes into labor, delivers, recovers and remains with the baby during the entire hospital stay. An extensive prenatal education program is being realized to teach mothers the need to respond to their body signals. The medical and nursing staff is encouraged to change their attitudes, practice psychological childbirth, be sensitive to family needs and to become increasingly sensitive to the celebration of birth rather than considering birth as a medical procedure. This new model should be cost efficient by eliminating patient transfers and shortening the average length of hospital stay.

Zusammenfassung

Ein innovatives Mütter-Versorgungs-Programm ist neuerdings am Institut für Mutter und Kind eingerichtet worden. Die leitende Vorstellung dabei ist, die bestmögliche Unterstützung dadurch zu erreichen, daß die Betreuung, familienzentriert und psychologisch orientiert, in einer Einzelzimmer-Betreuungseinheit erfolgt. Die Frauen bleiben während des ganzen Krankenhausaufenthaltes von Beginn der Wehen an, während der Entbindung und im Wochenbett in ein und demselben Zimmer. Es wird ein ausführliches vorgeburtliches Lehrprogramm verwirklicht, um die Mutter anzuleiten, ihre Körpersignale zu beantworten und sie zu nutzen. Das medizinische Personal und die Schwestern werden dazu ermutigt, ihre Einstellung in dem Sinne zu ändern, daß sie eine psychologische Geburtsbegleitung praktizieren, auf die Bedürfnisse der Familie achten und zunehmend

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das psychologische Ereignis der Geburt sensibel zu begleiten, statt mit der Geburt wie einem medizinischen Ereignis umzugehen. Dieses neue Modell soll dadurch kostengünstig sein, daß es Verlegungen von Patientinnen überflüssig macht und die mittlere Länge des Krankenhausaufenthaltes verkürzt.

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Most human births in our country take place in hospitals, where childbirth is usually perceived as a medical event. There are many features of the contemporary birth environment which increase stressfulness. False labor or a dramatic decrease of uterus contracions after the nother enters the hospital often results from her reaction to the strange, frightening aspects of the hospital environment. The hospital often presents many rules, regulations, customs and rituals which act as stressors. Which the passage of time routine interventions come to be regarded as normal. Some of these interventions are of unproven benefit for the mother and the newborn, others may unfavourably influence the success of first breast-feeding (Harrison 1971, Righard 1990). The main emphasis is usually placed on the medical and scientific aspects of birth, paying less attention to the equally valid social and psychological considerations.

The father is usually not permitted to be present at the birth or to visit his wife. The presence of parents is strongly prohibited at the majority of neonatal intensive care units. The rooming-in system is not being properly used in some places. There is a dichotomy in obstetric units with intensive monitoring systems and a high rate of medical and surgical interventions. To the contrary, the natural childbirth trend is presented to couples planning home delivery in an unfavourable light (Barton, 1980).

Maternity care models have changed recently, particulary over the last 10 years, and continue to change. All over the world maternity care providers are considering the mother more and more in the context of her family and the pregnancy and childbirth experience as a significant life event about which the couple has the right to make choices. Media and community special interest groups reinforce and promote these changes. Maternity caregivers, doctors and midwives, will have to adopt their practices to the new ideas.

Home childbirth is an option possible in some places in Poland. When the pregnancy is normal and there appears to be no foreseable complication, a home birth could prove to be a special and delightful experience in the life of the woman and her family. The outcomes of home deliveries are usually better than average and the complication rates are lower than expected. But these data coming from a self-selected healthy group of women are not directly comparable to state statistics (Mehl 1977, Damstra-Wijmenga 1984, Shy 1980). There are, however, problems with home childbirth because our emergency services and personell are not specifically equipped to deal with certain complications. Fast transportation is not always available and an unavoidable delay before medical help arrives is possible (Mehl 1977).

Out-hospital birth centers are organized to provide maternity care for women judged to be at low risk of obstetrical complications (Rooks 1989, Faison 1979). National Research Institute of Mother and Child have begun to develop licensing procedures and regulations for these nonhospital birth centers in Poland. However the removal of the delivery from hospital seems to be potentially dangerous (Williams 1990).

There is an urgent need to develop and introduce to perinatal care the new system which will provide:

- safety for mother and fetus/newborn
- fulfillment of emotional and medical needs
- lower costs for care

The principles of our in-hospital family-centered maternity program has been established in response to the current trends of obstetric care: the demand from society and patients to change their attitude, to be allowed to take a greater role in the decision-making process; the growing concern for the cost effectiveness of high technology obstetrics directed to "normal" labor.

The main idea of our innovative maternity program is to provide superior service based on family-oriented, single room maternity care. The Maternity Program can be described by the following points:

1. Prepared childbirth education required.
2. Pregnancy, labor and delivery is considered a time of emotional, social and physical change and stress (not illness).
3. Individualized care.
4. Staff uses expertise to inform family of options - family makes decisions, family and staff create the team for treatment.
5. Flexible staff.
6. Mother and infant serve as an unit.
7. Labor, delivery, recovery, postpartum and neonatal care occur in one location.
8. Infant remains with mother
9. Family and friends encouraged to be present at any time mother wishes.
10. The father or a supportive person is actively involved in labor, delivery, postpartum and neonatal care.
11. Follow up of mother and child at home.

The main safety factors of our progrm will be dareful physical screening and selection of families for management according to individual risk factors.

The in-hospital birth centre is localized on the basement level, close to the admission room. It consists of 20 square meters: delivery-recovery room, anteroom, personell room, separate bathroom with shower and toilet. the more traditional delivery ward, the operation theatre and the neonatal intensive care unit are easily and quickly accessible in the case of emergency. In one and the same room the women labors, delivers, recovers and remains with the baby during the entire hospital stay. The interior design creates a pleasant home-like atmosphere. The mother moves about as she feels comfortable. There will be no rou-

tine enemas, intravenous fluids or other routine orders. A special home-like delivery bed will be provided in the room as well as comfortable chairs, stereo, plants and home-like furnishing.

Sterile trays and emergency equipment are housed out of sight until needed. There is a electronic fetal monitor, oxygen and vacuum suction outlets and an infant warmer with resuscitation apparatus. The father or other supportive person is present and is encouraged to be actively involved in labor, delivery, postpartum care and neonatal service. Numerous studies have proved that there may be major perinatal benefits of constant human support during labor (Sosa 1980).

The mother should be shown all the positions which will be helpful. She should be allowed to sit up during labor or assume whatever position is most comfortable. She should be able to change positions as often as necessary. Not only will she be more comfortable and the baby safer but the need for anesthesia can be reduced. It should be stressed that a home-like delivery environment is not incompatible with intensive intrapartum care. Electronic fetal monitoring and even fetal scalp blood sampling or perinatal anesthesia can be provided when proved necessary for selected patients if major complicatons do not supervene (Barton 1980). The mother and newborn will be discharged as early as 6 hours and as late as 24 hours postpartum. If a longer stay is desired both will be transferred to the conventional postpartum. If a longer stay is desired both will be transferred to the conventional postpartum rooming-in unit. Home visits at 24 hours post-discharge and again seeing the mother and newborn on the fourth postpartum day to ascertain their well-being and health are obligatory.

Family centered care begins in the preconception period and extends into the postpartum period with home visits for new families. Preconception care is available to all women and their partners as an integral part of primary care services being offered to the couples. Prenatal care during pregnancy is meant to reduce medical problems as well as psychosocial and environmental risk. Dominated by the "outcomes of pregnancy" or the fetus/infant, care should maximize the woman's health, improve family well-being and dynamics.

The prenatal care is not restricted to medical supervision. The three basic components of this care are: early and continuing risk assessment, health promotion, medico-psychosocial interventions and follow up. The special needs of a mother are being assessed through examining the history of her previous pregnancies and her and the father's desires and plans for the birth experience. These needs can be expressed during discussion before admisson and are taken into acount during perinatal care.

Health education during pregnancy for the majority of pregnant women who will deliver at our center is proposed. The community midwives are asked to counsel mainly those women living within economically deprived conditions. The prenatal classes scheduled are devided into two parts for women during first and third trimester of pregnancy. Conselling in order to promote and support general knowledge of pregnancy and information about the proposed system of care are offered by physicians, midwives, health educators, nutritionists and legal specialists. Besides preparing for childbirth classes and specific health education is being provided. Through education we hope to reduce medication during deliv-

ery, provide an increased sense of self-control and positive attitudes of couples to ward childbirth. The mother is able to turn a passive experience into an active one, to become a participant rather than "victim". An intense prenatal education program is essential to help mothers to respond to the body signals.

Hopefully it is understood that only those women who have no significant history of complications in past pregnancies, had no complications or deviations from normal parameters during the course of present pregnancy, or are anticipated to have a normal full-term spontaneous, vaginal delivery, would be candidates for delivery in the new system. The patient must also agree that if any conditions arise during the course of her labor, which in the opinion of her attendanat would jeopardize either her or her unborn infant, she will be transferred to the traditional maternity unit for appropriate care. After in-depth meetings the couple are asked to give their written consent for delivery within this system. A specific plan for family participation is agreed on in advance of admission.

The medical and nursing staff is encouraged to change their attitude; to be sensitive to all family needs. The midwives are cross-trained in delivery, postpartum and neonatal care. They provide most of the physical care backed by obstetric specialist available within the building. Part of the nursing staff was lost because they did not like the changes.

Women and their families are demanding more personal health care and more respect in the manner in which that care is delivered. Common sense dictates that a maternity patient would prefer to stay in the same home-like room rather than be moved several times through "sterile" rooms. We try to become increasingly sensitive to the celebration of birth rather than considering birth as a medical procedure. We believe that separate birth rooms will ultimately be considered an important step in making the transition to provide a style of maternity care that is identified with sensitivity to humanistic concerns. We hope that the need for such sensitivity will be recognized for all women whether they are classified as high risk or low risk and whether or not they desire anesthesia or anagesia.

Certainly, through our perinatal program the staff will put greater emphasis on the emotional and supportive aspects of care and to include families in decision-making processes to a greater extent than previously.

Our alternative birth center is going to be a rewarding and exciting effort which will have a positive impact on staff attitudes and understanding of humanistic aspects of maternity care. We feel that the accomplishments realized in changing maternity care in our birth center represent only the beginning of a wider recognition by health professionals of the need to respond to the human needs. We believe that our birthing center will bridge the grap between home birth and the usual hospital management. It will meet the needs of the growing number of families who are dissatisfied with hospital birth or are attracted by the idea of home birth (Ballard 1982).

We hope that our new maternity program will be a successful and safe alternative to traditional obstetric care. At this time the movement for home delivery, modern, humanistic, family-centered, physician-supervised obstetrics should be promoted.

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