

Family-Centred Maternity and Newborn Care:
National Guidelines

— CHAPTER 1 —

Introduction and Philosophy

Table of Contents

Introduction	5
Guidelines: History and Context	5
Guidelines: The Purpose	6
Guidelines: The Content	7
What Is Family-Centred Maternity and Newborn Care?	8
The Guiding Principles of Family-Centred Maternity and Newborn Care	8
Implementing the Guidelines: Facilitating Change	12
Specific Steps for Successful Change	14
Support, Education, and Training	14
How Can Women and Families Participate Effectively?	15
In Conclusion	17
Bibliography	18

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Introduction

Guidelines: History and Context

The guidelines for maternal and newborn services, first published in Canada in 1968, were subsequently revised in 1974 and again in 1987. This, therefore, is the fourth edition of these guidelines. Each edition has evolved in response to the changes in Canadian society that have influenced maternal and newborn care in Canada. Over the past 30 years, a number of fundamental changes have influenced the provision of maternal and newborn care in Canada. The current guidelines should thus be considered against the backdrop sketched below.

TECHNOLOGY

It is no secret that an explosion in technology has occurred. New and more sophisticated technological tools have become available for maternal and newborn care; for example, electronic fetal surveillance and invasive pain-relief measures. Clearly, information technology has changed the way communication takes place throughout the health care system.

CONSUMER AND PROFESSIONAL PARTICIPATION

Today, a consumer and professional movement is in place, predicated on the belief that birth is a natural, family event which suffers if an “illness model” is applied to the care of families during the childbearing cycle. Many have questioned the routine application of technology, as well as many other routine practices, in maternal and newborn care. They have insisted that women and families be full participants in decisions regarding their care. This is the group that coined the term “family-centred care.”

HEALTH CARE RESTRUCTURING

A restructuring of the health care system is still under way today, with consequent fiscal constraints. Although this restructuring has varied by region across Canada, some similarities have surfaced. For example, a move has occurred to decentralize services from the provincial level to municipalities, with regionalization emerging in some areas. Institutions are downsizing or closing, and transferring services. Hospital stays are becoming shorter. One stated goal is the integration and the bringing together of community and institutions, in one seamless system.

EVIDENCE-BASED PRACTICE

Increasingly, health care practices are being questioned and evidence-based practices demanded. In effect, maternal and newborn care has played a central role in the development of this evidence-based practice. The *Oxford Database of Perinatal Trials* (now the *Cochrane Collaboration Pregnancy and Childbirth Database*) was the first comprehensive resource to provide systematic, evidence-based reviews concerning the efficacy of interventions. Clinical practice guidelines, based on the evidence, have now proliferated in the fields of medicine, nursing, and midwifery.

DIVERSITY OF THE CANADIAN POPULATION

The Canadian childbearing population has become even more diverse in terms of culture, ethnicity, race, socio-economic status, and age; also affected are the social supports and resource systems for families and communities. Today, more women of childbearing age are employed outside the home. More women are delaying childbearing until an older age. Yet, many families are isolated from the support of extended families. Programs and services must therefore be responsive and accessible to these diverse needs. It is important, too, that all services recognize the special characteristics of the community they are designed to serve. They should be attractive and accessible to women and their families, particularly those who may be least inclined, even reluctant, to use them. This diversity poses a challenge to all involved in maternal and newborn care.

Guidelines: The Purpose

These guidelines are intended to assist hospitals and other health care agencies in planning, implementing, and evaluating maternal and newborn programs and services. Although designed for policy makers, health care providers (e.g. physicians, nurses, midwives), parents, program planners, and administrators, these are not clinical practice guidelines. Current clinical practice guidelines, however, are referred to and abstracted throughout the document.

Because of the diversity of Canada's regions and communities, this document is intended to be sufficiently flexible to encompass the various approaches, policies, and protocols of Canadian institutions, agencies, communities, and regions.

Guidelines: The Content

These guidelines are organized to go from general principles to specific details. Chapter 1 begins with an *introduction* to the concepts of family-centred maternity and newborn care and a description of the basis of this care — the guiding principles. Chapter 2 describes the *organization of services* within a regionalized system of family-centred maternity and newborn care. The next four chapters provide guidelines for providing care during the childbearing cycle: *preconception care*, *care during pregnancy*, *care during labour and birth*, and *early postpartum care of the mother and infant and transition to the community*. The next three chapters address specific topics of concern relative to family-centred maternity and newborn care: *breast-feeding*, *loss and grief*, and *transport*. The final chapter describes the guidelines for the *facilities and equipment* necessary when providing care.

Each chapter begins with the particular guiding principles relevant to the aspect of maternity and newborn care under discussion. Each chapter also includes its own bibliography of references to the literature. The appendices at the end of most chapters provide more detailed information in specific areas.

These guidelines are based on research evidence. If the evidence is unclear or an area of care remains controversial, it is noted. If a clear benefit emerged based on strong research evidence, it is detailed. Where there are risks, they are defined. Finally, if the research is non-existent or limited, it is recommended that evidence be developed.

It is important to be aware of the limitations of evidence-based practice. Clearly, there is much research evidence that has still to be collected, particularly qualitative evidence relating to the psychosocial “experiential” aspects of childbearing. Moreover, major challenges remain in the actual bringing forth of evidence concerning the effectiveness of interventions for the care of women and families. For instance, the well-respected *A Guide to Effective Care in Pregnancy and Childbirth* (Enkin et al., 1995) lists more than 30 areas where there is still insufficient research data to permit conclusions to be drawn.

What Is Family-Centred Maternity and Newborn Care?

Family-centred maternity and newborn care is a complex, multi-dimensional, dynamic process of providing safe, skilled, and individualized care. It responds to the physical, emotional, and psychosocial needs of the woman and her family. In family-centred maternity and newborn care, pregnancy and birth are considered normal, healthy life events. As well, such care recognizes the significance of family support, participation, and choice. In effect, family-centred maternity and newborn care reflects an attitude rather than a protocol (Rush, 1997, p. 1).

The Guiding Principles of Family-Centred Maternity and Newborn Care

Family-centred maternity and newborn care is based on the following guiding principles:

Birth is a celebration — a normal, healthy process.

For most women, pregnancy will progress smoothly to the birth of a healthy, much-welcomed baby.¹ Supported by family and friends, birth can be a time of great happiness and fulfilment. Family-centred maternity and newborn care is based on respect for pregnancy as a state of health and for childbirth as a normal physiological process. It is a profound event in the life of both a woman and her family.

For some women and families, however, pregnancy may be unplanned or unwanted; complications or adverse social circumstances may occur. The birth itself may be complicated and the outcome unexpected. In these situations, in order to support the family's unique needs, family-centred care is even more critical.

1. These guidelines attempt to use the language of women whenever possible. Therefore, we refer to “a woman and her unborn baby,” or “a woman and her baby,” rather than “a woman and her fetus.”

Pregnancy and birth are unique for each woman.

Women have diverse experiences and needs. Women and families hold different philosophies of birth, based on their specific knowledge, experience, culture, social and family background, and belief systems. Support and care should be respectful of such factors. Some women have negative, fearful feelings about birth and are reluctant to take charge of their own care. These feelings need to be acknowledged. The approach to caring for women and families should involve adapting care to meet their needs, rather than expecting women and families to adapt to institution or provider needs.

The central objective of care for women, babies, and families is to maximize the probability of a healthy woman giving birth to a healthy baby.

No one cares more about achieving a safe and happy outcome to a pregnancy than the pregnant woman and her family. Their goal is a positive and fulfilling pregnancy, childbirth, and early postpartum period. Health care providers share this aim. Clearly, it is important to recognize each woman as an individual; each needs clear and unbiased information as to the options available to her.

Family-centred maternity and newborn care is based on research evidence.

Wherever possible, these national guidelines are based on research evidence. As already stated, if the evidence is unclear, it is noted. If a clear benefit based on strong research evidence has emerged, details are provided. If there are risks, these are noted. If no or limited research is available, it is recommended that evidence be developed. Resources for assisting with the evaluation of available evidence, and for planning and implementing research projects, include the Cochrane Library; university departments of nursing, medicine, midwifery and others; regional perinatal centres; public health units; researchers; and consultants. Finally, one should be aware of the limitations of evidence-based practice. Much research evidence has still to be collected.

Relationships between women, their families, and health care providers are based on mutual respect and trust.

It is important for health care providers to respect and support a woman and her family. This will help her to give birth safely, with power and

dignity. As well, it is crucial that a woman and her family respect and trust their health care providers. The provision of family-centred maternity and newborn care depends on such mutual respect and trust.

Women are cared for within the context of their families.

A woman's family is key when she is pregnant and giving birth. It is part of her system of care. It is up to the woman to define her family and supports; she chooses who is included or excluded. Her definition of family may include only one person, or many different people. These may be the baby's father, siblings, and grandparents; the woman's partner; the baby's aunts and uncles; the woman's friends; and so on. Family-centred care treats the family as a unit of care.

In order to make informed choices, women and their families need knowledge about their care.

Enabling a true choice among alternatives means providing information about the real options available, entering into an open dialogue that is respectful of all concerns and opinions, and providing flexible policies that accommodate planning and decision making. Sharing information is a mutual responsibility of health care providers, agencies, women, and families. The benefits and risks of all procedures need to be disclosed, as well as all the options that women and families might consider. It is not enough to expect women to bring their "choices" with them — health care providers need to provide time, support, and encouragement for exploration of the various options.

Women have autonomy in decision making. Through respect and informed choice, women are empowered to take responsibility.

Women are the primary decision makers about their care. Women and families make decisions based on many factors — the expertise of professionals being one. Health care providers can encourage and guide those women and families wishing to seek out resources for such decision making. When all relevant information has been made available to women and families for the achievement of their goals, they are guided, not directed, by the professionals they have chosen to share the responsibility for their care.

Health care providers have a powerful effect on women who are giving birth and their families.

How a woman feels about pregnancy and childbirth is determined by at least two powerful factors: previous life experiences and the emotional support received at those times. Studies of women's satisfaction with the childbirth experience and their perceptions of the personal effects of child-birth show that satisfaction is more highly associated with the emotional care received during labour than with the birth process itself. Women remember the events of birth and their attendant feelings throughout their lives (Simkin, 1996). They remember the specific words and actions of their health care providers. Satisfaction is linked to the type of care received and the feelings of personal control and accomplishment. Health care providers must be aware of their power to influence the long-term impact of the woman's childbirth experience.

Family-centred care welcomes a variety of health care providers.

Women choose from a variety of health care providers of care and support during the pregnancy, birth, and early parenting periods. Health care providers need to communicate with, respect, and trust one another; to work together for the woman, her baby, and her family. Health care providers include physicians, nurses, midwives, labour companions or doulas (a lay person who provides support during labour), childbirth educators, and various others who help with physical or social needs.

Technology is used appropriately in family-centred maternity and newborn care.

Technology is to be used judiciously and appropriately, and only if a benefit has been demonstrated. For example, it is important that technology not be used in place of direct supportive care and observation. As well, the issue of safety should not be viewed as a reason for *unnecessary* intervention and technological surveillance; it only detracts from the experience of the mother and family.

Quality of care includes a number of indicators.

When measuring quality of care, it is important to monitor not only indicators such as morbidity and mortality, but also women's experience of pregnancy, birth, and postpartum care. Measuring a woman's experience during childbirth and the postpartum period is a valuable quality-assurance

activity. Health care providers can use various methods to obtain feedback about staff approaches, personal sense of control, comfort and attitude in the setting, learning, preparation, and so on. Input can be obtained from regular interviews, surveys or questionnaires, and comment cards or suggestion boxes.

Language is important.

The style of language and choice of words used in signs, printed material, and conversation often communicate as powerfully as the information conveyed. Because words can reflect attitudes of respect or disrespect, inclusion or exclusion, and judgment or acceptance, language choices can either ease or impede communication. Such words as “guidelines,” “working together,” and “welcome” convey openness and an appreciation for the position and importance of families. Such words as “policies,” “allowed,” and “not permitted” suggest that professionals are in authority over women and families. Referring to parents and other family members as “partners,” “colleagues,” “joint decision makers,” or “experts” acknowledges that families bring important information and insight to pregnancy and childbirth, and that families and professionals together form a team.

Implementing the Guidelines: Facilitating Change

The culture, attitudes, and norms of organizations — both agencies and institutions — influence the care approaches and practices offered to women and their families. To provide family-centred maternity and newborn care, organizations need to continue to develop and refine a caring culture. Examining and designing their own culture and values is key to making changes. This includes understanding how they, as organizations, fit into the spectrum of a caring culture and how that culture can be improved.

Family-centred maternity and newborn care may require a shift in thinking and practice. In turn, a number of changes may be required. These might include the following:

From	To
a disease and deficit focus	one that identifies and builds on individual and family strengths;
reliance on professional and institutional expertise	partnerships and collaboration with women and families;
practices that foster dependency	those that empower women, families, and community;
a reliance on technology	an awareness of the skills and expertise of the women, families, and professionals; and reserving technology for specific defensible indications;
building isolated centres or programs	rediscovering the importance of community involvement and community partnerships.

Adapted from: Institute for Family-Centered Care, *Advances in family-centered care*, 1995, p. 2.

A family-centred framework can shape institutions and services, in terms not only of organization, but also in how people relate to each other as they work together. Organizations that have already moved toward an increasingly family-centred approach in care and services use the following strategies for success.

They:

- show respect for women and families by asking about their experience, plans, and needs;
- assess existing services and resources and are willing to address families' wishes as a complement to policies and programs;
- clearly identify core values, using a broad-based collaborative process to identify and foster family-centred values;
- recognize that leadership is critical. While individuals within an organization may strive to provide the best in family-centred maternity and newborn care, the degree to which such care is genuinely provided depends upon the priorities and commitment of the governing board, the administration, and the leaders of the medical, nursing, and midwifery sectors. A supportive environment is needed to facilitate change;
- effect change in the decision-making process at the administrative policy level. This means involving women and families at the ground level of decision making — that is, when planning programs, services, and institutions and creating policies; and
- recognize that family-centred change requires persistence, patience, creativity, and vision.

Adapted from: Institute for Family-Centered Care, *Advances in family-centered care*, 1995, p. 3.

Specific Steps for Successful Change

The process of change incorporates specific steps, as outlined in Table 1.1.

Table 1.1 Steps to Successful Change

1. Identify a core group to facilitate change.
2. Involve women and families in all phases of the change process.
3. Create opportunities to develop a shared understanding of family-centred care.
For example, offer shared learning opportunities for caregivers — both family members and professionals across disciplines, departments, and agencies.
4. Encourage people to express their differing points of view.
5. Plan initial changes that can succeed. Don't tackle the most complex or difficult task first. Start small.
6. Have key staff demonstrate new ways of thinking and working. Let them teach by example.
7. Provide education, training, and support for staff and families to work in new ways.
8. Build in ways to measure change and evaluate outcomes.

Adapted from: Johnson et al., *Caring for children and families: guidelines for hospitals*, Association for the Care of Children's Health, 1992.

Support, Education, and Training

The support, education, and training of caregivers is crucial to successfully implementing family-centred maternity and newborn care. The critical issues are attitudes and skills.

Notwithstanding their various care skills, the attitudes of caregivers must correspond with the tenets of family-centred maternity and newborn care. The practice of family-centred care calls for subtle yet substantive changes in professional practice: a shift from the traditional “expert” model of service to a more collaborative one; and one that incorporates ongoing education directed toward values, attitudes, and practice (Cannon and Ploof, 1991). As well, attitudinal explorations by staff members may be necessary, involving the concepts outlined in Table 1.2.

Table 1.2 Concepts for Exploring Attitudes

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- The willingness and strength to let go of control (except in situations of clear health risk)
 - An empathetic and respectful approach to women and families
 - A belief that women and families bring a unique expertise to the caregiver-client relationship
 - A belief that the perspectives and opinions of women and families are as important as those of professionals
 - The presumption that strengths are present in all women, families, and communities, and the willingness to look for these strengths
 - A respect for the primary role of women and families in making decisions at all levels of care
 - The desire and effort to improve interpersonal skills
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How Can Women and Families Participate Effectively?

Women and families can serve as advisors to program planners and services providers in many different ways. Some are formal and ongoing, others are time limited. All are necessary to ensure that the services truly meet family needs. Table 1.3 presents various ways of enabling women and families to participate effectively.

Table 1.3 Enabling Effective Family Participation

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- Hold focus groups for women and families as specific issues arise.
 - Hold a monthly family/staff coffee hour.
 - Solicit family input for community and program needs assessments.
 - Include women and families on the maternal newborn committee or on other committees or boards.
 - Include families in on-site visit teams to other programs.
 - Hold brainstorming sessions with families before developing educational materials.
 - Have families review drafts of all written materials.
 - Include a family panel during orientation for new staff.
 - Develop a woman and family satisfaction survey.
 - Keep a suggestion book handy, so families can record their ideas.
 - Invite families to present at in-service programs for staff.
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Jeppson ES, Thomas J, *Essential allies: families as advisors*. Institute for Family-Centered Care, 1999.

Involving women and parents effectively on committees and boards often requires a shift in former ways of organizing. Some helpful hints are listed in Table 1.4.

Table 1.4 Involving Families Effectively on Committees

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- Develop a plan for identifying which women and families will participate.
 - Help support staff to understand the value of family participation.
 - Provide time to introduce both family members and staff to the issues, participants, and process.
 - Provide convenient meeting times and locations for family members.
 - Compensate families for their time, expertise, and expenses.
 - Provide accurate, timely, clear, jargon-free, and appropriate information prior to meetings.
 - Balance membership on committees between families and professionals. One family member on a committee is not enough.
 - Consider shared leadership; for instance, parent and professional co-chairs.
 - Recognize that some family members may require more support than others to participate in a meaningful way.
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Jeppson ES, Thomas J, *Essential allies: families as advisors*. Institute for Family-Centered Care, 1999.

Encouraging the participation of all community partners on committees requires careful planning. Helpful strategies are outlined in Table 1.5.

Table 1.5 Strategies for Encouraging Community Participation

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- Bring together focus groups or panels to provide input about selected program areas/issues.
 - Clarify membership of committees so that community/parent representatives are formally listed.
 - Advertise in local newspapers, agency newsletters, and departmental posters for community representatives. Attributes to include:
 - willingness to attend meetings
 - ability to bring a consumer perspective
 - ability to function as a member for one year (specify tenure)
 - experience of having used the program within the past year.
 - Assure that the community representatives' role is clear to all.
 - Have a committee member pair with the parent representative for purposes of support, introduction, involvement, orientation, briefing, and debriefing.
 - Consider reimbursement or provision for travel, parking, and child care.
 - Consider other community "consumers": educators of the program's students; selected agencies frequently used (e.g. child protection agencies, women's shelters, maternity homes, public health units); selected groups (e.g. prenatal education, doula, parent support groups, perinatal follow-up clinics); and media/promotion representatives.
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In Conclusion

Increased participation of women and their families in decisions concerning their pregnancy, birth, and early postpartum experiences promotes greater self-confidence in caring for children. Building the foundation for nurturing parent-child relationships begins before pregnancy, continues through the prenatal period, and can extend through the participation of both parents in the birth and care of their infant. Confident and competent parents are a powerful influence in society. Their contribution is critical to the healthy growth and development of their children.

Family-centred care recognizes pregnancy and birth as a time of emotional, social, and physical change, but not as a time of illness. On the one hand, health care providers make their expertise available to parents; on the other, providers and parents work together as a team.

The care described in these guidelines is based on the philosophy of family-centred maternity and newborn care. This chapter provides an overview of the guiding principles of family-centred care. The remainder of the book will help health care providers and parents put these principles into practice.

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