Family Centered Model for Maternal and Newborn Care (FCM): The Sarda Maternity Hospital Case History

Brief Background

The Ramón Sarda Maternal Infant Hospital (HMIRS) is a public facility founded in 1936 and located in the Southern zone of the City of Buenos Aires, Argentina. In contrast to similar tertiary level maternal infant hospitals, HMIRS does not serve a specific programmatic area and is not linked into a hospital coordinated referral system. The majority of HMIRS users arrive on their own or through referrals from other hospitals in the Buenos Aires Metropolitan Area or from other parts of the country on account of its excellent reputation as a critical care maternity hospital. Consequently, a large proportion of the HMIRS births are from women who experience complications during pregnancy and delivery as well as premature births. Patients are from the poor and lower-middle social classes of the city. In the 1990's the Family Centered Model that introduced by Dr Miguel Larguia.

The *Organización Panamericana de la Salud* study (Uriburu et al 2008) documents the development of a Family Centered Model for Maternal and Newborn Care (FCM). It provides a description of how the HMIRS staff created and incorporated a number of essential elements over time to achieve a service that is welcoming and responsive to the needs of the family without affecting the quality of normal and critical neonatal care.

Description of the FCM Model

The Family Centered Model for Maternal and Newborn Care (FCM) was developed by Dr Larguia (Ashoka Fellow[1]) and his team. A core characteristic of the FCM is that maximizes the interactions among the family, the newborn, and the hospital staff. The model followed by the HMIRS evolved overtime with new components integrated into practice in response to observations and innovations made by the staff, feedback from the families, and new international quality standards of neonatal practices. The key components of the model are:

- Unrestricted access of the parents to neonatal services. Parents have 24 hour access to the Neonatal Intensive Care Unit (NICU). The staffs that work with them recognize the irrefutable value of integrating the babies' families into all dimensions of the treatment and care process.
- Periodic removal of the baby from the incubator for skin to skin contact with the parents.
- In addition to involving the parents in care and promoting skin to skin contact, the staff encourages visits from other family members, such as siblings and grandparents. They try to minimize the impact of the preemie's hospitalization on the stability of the family by helping siblings and grandparents to feel part of the treatment process.
- An important dimension of emotional support for the parents also comes from allowing them to be heard. The FCM staff tries to listen and then respond to the needs and opinions expressed by the parents. Without this the model becomes stale and doctrinaire. For example, the NICU adjusted their somewhat overzealous promotion of skin to skin contact when members of a focus group expressed their concerns about discomfort and privacy during the morning hours when many of the medical specialists come through on rounds. The staff obtained more comfortable furniture for the mothers to sit in while they held their babies and allowed them to opt for their skin to skin sessions in the quieter afternoons and evenings when the lights could be dimmed and there was less activity. The nurses also gave the parents control over the length of the sessions.
- Provision of a residence near the neonatal unit for mothers while their newborns are hospitalized.
- Support for parents in crisis. Communication and support for parents whose newborns are at risk of dying.

[1] www.ashoka.org.ar

- Development of a program of volunteers who support the parents of high risk newborns with material and logistical support.
- The nurses guard and transmit the model to new professionals who join the team. All new pediatric and neonatal residents must spend their first month of training with the nurses in the NICU.
- One of the most critical elements of the FCM model is the transfer of knowledge from the medical staff to the parents so that they become an extension of the staff in monitoring the progress of their infant through a series of developmental benchmarks. Mothers are trained in attaching feeding tubes, changing diapers, hygiene, and maintaining skin to skin contact. They learn to identify danger signs and unexpected changes in their newborns, thereby actively contributing to their babies' care and treatment.
- Out-patient services involves the preparation of the parents on how to monitor their high risk newborn after being released from the hospital. Out-patient care at HMIRS includes:
  - Regular visits for healthy newborns (for the first month of life).
  - Consultations for low birth weight babies.
  - Follow up programs for high risk newborns.
  - The role of the parents as partners in care becomes even more important as they move closer to being released. Some key elements are knowledge of cardiopulmonary resuscitation and prevention of respiratory infections, as these are the primary causes of re-hospitalization.
  - Consultations in specialized areas of pediatrics such as cardiology, genetics, neurology, infectious diseases, speech and hearing, psychopathology, early intervention and treatment of neuro-motor development, and help with breast feeding.
- Finally, a major part of the process of preparing the parents and baby for leaving is the care of the mother. During the hospitalization of the baby, the staff helps the mother to set up appointments for her at the HMIRS or other hospitals for any medical problems she may have and to facilitate her access to family planning.

The FCM contributed to the reduction of neonatal mortality rate to 4.5 per 1000 live births (excluding babies with lethal malformations) and to 2/1000 live births (excluding babies weighing less than 750 g. and lethal malformations).