Family-centered Care — Rooming-in
Kathleen J. S. Kolberg, Ph.D., University of Notre Dame

Introduction

The concept of rooming-in began in maternal and pediatric units as a response to consumer/patient request and has become a normal part of practice in those units over the past quarter century. As families became more a part of clinical practice, it became apparent there was real benefit to the patient of having family members present. One example is the reduced need for pain medication and reduced complications with a support person present during labor and delivery.1 Parent “rooming-in” on pediatric units has been shown to significantly shorten hospital stays and improve the emotional well-being of the child.2,3

The NICU has been slower in this transition, partially because of the patient population (ill and premature infants cannot request the presence of a parent) and partially because of the physical design of units, which were, until recently, ward style with little or no space for parents to stay undisturbed. It was also unclear what role the parents could fulfill until the infant was closer to discharge.

The emphasis on family-centered care and the development of care-by-parent paradigms have removed many of the limitations of parents in the NICU and led to increased parental presence and activity. Developmental care stresses the role of the parents as the most important co-regulator for the child and increased parental involvement has led to better short- and long-term outcomes for premature infants.4

This trend has led new construction of NICUs to add more bedside space for expanded parent presence at the bedside.5 In the 1990s, Rainbow Babies and Children’s Hospital Transitional Care Unit in Cleveland, Ohio, added the ability for parents to stay with and care for their baby for the weeks preceding discharge and noticed improvement in parent readiness for discharge, decreased length of stay, decreased maternal anxiety, and fewer readmissions following discharge6. For examples of new unit designs and how they address parent needs refer to “Innovations in newborn intensive care design: a photo tour” by K. Farrell.7

What are the types of rooming-in?

The most commonly used type of rooming-in for NICUs is a parent room in which parent(s) could experience staying the night (for one to two nights) with their infant in preparation for discharge.

Other models include parent rooms near the unit for long-term stays or residency arrangements within the patient care space. Hybrid arrangements combine dedicated parent space with adequate comfort for napping or resting with a parent sleep room and lounge nearby.
Parent rooming-in within the patient care space

Is it better to provide rooming-in space at the bedside or elsewhere in the NICU as a separate “parent room”? This issue has not been resolved. There are advantages and drawbacks to these arrangements.

Rainbow Babies and Children’s Transitional Care Center (Cleveland, Ohio, US) is the most well known model for this type of rooming-in for parents. The rooms have a staff zone, a patient zone, and a family zone in a homelike setting. Their rooms have sleep space and bathrooms. The family lounge provides laundry facilities and a kitchenette. They have had success with their transition to this care-by-parent concept. Auditory and visual privacy for the parents is more difficult in these arrangements and there is the risk of isolation of the parents, but Rainbow has found it to work well.

Separate rooming-in space

Is it better to provide rooming-in space at the bedside or elsewhere in the NICU as a separate “parent room”? This issue has not been resolved. There are advantages and drawbacks to these arrangements.

The Children's Medical Center in Dayton, Ohio (US), is a pinwheel design with space for families to sit at the bedside, which has an active family-centered program with high parent involvement and open hours for families. The sleeping rooms for parents are away from the unit because of space restrictions on the unit and for increased privacy for the parents. The Ronald McDonald House concept of parent rooms has shown benefit to parents by enabling them to provide social support to one another. This may be an important factor in greatly increasing privacy for parents at the bedside.
Hybrid arrangements

Is it better to provide rooming-in space at the bedside or elsewhere in the NICU as a separate “parent room”? This issue has not been resolved. There are advantages and drawbacks to these arrangements.

Seattle Children’s Hospital (Washington, US) has a spacious parent zone within the private or semi-private infant care room and a ceiling mounted delivery unit (instead of a headwall) that can be repositioned to facilitate care of the infant in the arms of the parent, as well as within the incubator/bed. The parent zone has reclining chairs for parents and a “window seat” which has been useful for siblings. Seattle Children’s also has more parent residency space on a separate floor. This space has sleep rooms, kitchen, lounge, garden, laundry facilities, and showers to make a long-term stay more comfortable. They report extended family presence in the infant care room for both parents and siblings. Families appear very comfortable in this room, yet families and staff on their NICU design team felt strongly that the space away from the bedside was necessary. Some of the reasons for this additional space were more amenities (kitchen, shower, etc.), common space for parents to support each other, a retreat for taking a break from the unit, and increased parent privacy for sleeping. For a virtual tour, refer to http://www.chmc.org/tour/tour.asp. Versions of the hybrid model are also used in other new units, such as Blank Children's in Des Moines, Iowa (US), which has both sleep rooms on another floor and patient rooms that can be used as parent-infant rooms. This model provides maximum flexibility for the numbers of parents who wish to be in residence and should provide insight into parental preferences for parent residency arrangements.
What is the evidence that rooming-in improves outcomes?

In the 1990s, Rainbow Babies and Children's Hospital Transitional Care Unit (Cleveland, Ohio, US) added the ability for parents to stay and care for their baby in the weeks preceding discharge and noticed improvement in parent readiness for discharge, earlier discharge, reduced maternal anxiety levels, and reduced number of readmissions after discharge.¹

New construction NICU planning committees that include parents emphasize the inclusion of dedicated parent space and parent residency arrangements either in or near the units. Units that have been built with this dedicated space have reported an increase in parental involvement, which is associated with better outcomes.²,³


In the absence of space at the bedside for a parent to room-in, how many parent rooms are necessary?

This number is unclear until we gather statistics from experiences at hospitals that have incorporated this model. It will certainly depend on demographics (distance from home, other children, etc). PICU parent rooming-in numbers may be a good indication and 20% has been a common number. However, this number may increase as parents are opting for more private NICU rooms. At the past two conferences on the Physical and Developmental Environment of the High Risk Infant, several units shared their experiences with single-room design and increased parental involvement. Lauren Taquino and Phyllis Brown from Seattle Children's Hospital (Seattle, Washington, US) gave presentations showing families settling in for long stretches with their infants. David Alexander and Dennis Alan Rosenblum presented units with extended, dedicated, parent space on the unit at Blank Children's Hospital in Des Moines, Iowa (US), and St. Luke's in Cedar Rapids, Iowa (US). Both reported increased parental presence and satisfaction in these units.

References


http://www.nd.edu/~kkolberg/DesignStandards.htm
At Memorial, we have a few bed spaces that are adequate for parents "rooming in" including two parent sleep rooms immediately adjacent to patient care space. We have traditional sleep rooms down the hall for discharge training and we are building Ronald McDonald rooms down another hall. We feel the need for much more parent space and will be addressing that need in our new unit design. We are very interested in the experience of other units.

What is the parent rooming in arrangement in your unit? How do you feel it is working? Do the parents of your patients want to room in? What percentage?

As we have just begun the process of a new NICU design I am curious if anyone has numbers for the amount of use the family area in the room actually gets and the timing of the use, ie daytime vs nighttime. Also what is the general feel for siblings in the room, are there time limits or age requirements? Thank you, beth

I ask the question of how often the family space is used every place I go; a pretty consistent figure is that 10-20% of kids have a parent rooming in at a minimum when sufficient facilities are available, and it can go as high as 50% on weekends at a center where rooming-in is encouraged. Sibling limitations are quite variable, from no restrictions at all to pretty significant restrictions. Hopefully we can get more specific responses to your question from others with rooming-in capabilities.