



Evaluation of a Designated Family Bonding Time to Decrease Interruptions and Increase Exclusive Breastfeeding

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ABSTRACT

Objective: The purpose of this quality improvement project was to plan and implement a daily family bonding time on our mother/baby care unit and evaluate its effect on interruptions, mothers' perceptions of interruptions, and exclusive breastfeeding rates.

Design: A separate sample pre-/postintervention design conducted in three phases.

Setting/Local Problem: Healthy breastfeeding newborns had double the odds of receiving supplementation before discharge if they stayed more than 1 night or were born at night. Night nurses suggested implementing a daily quiet time as a strategy for limiting interruptions.

Participants: A convenience sample of 60 postpartum women.

Intervention/Measures: During Phases 1 and 3, data were collected on interruptions (number, duration, and by whom), women's perceptions of interruptions, and exclusive breastfeeding rates. Family bonding time was launched in Phase 2 during the hours of 2 p.m. to 4 p.m. Women were encouraged to rest with their newborns in their rooms; interruptions were limited to those that were urgent, medically necessary, or requested by the women.

Results: Outcome data were analyzed using descriptive statistics, a repeated-measures analysis of variance, *t* test, and chi-square test. Analysis of interruptions by the unit nursing staff indicated a decrease in interruptions between 2 p.m. and 4 p.m. that could be attributed to family bonding time ($F_{(1, 58)} = 7.50, p = .008$). Analysis of interruptions by other hospital staff and visitors indicated a significant interaction of time with interruptions; interruptions decreased in both phases between 2 p.m. and 4 p.m. ($F_{(3, 174)} = 4.83, p = .0029; F_{(3, 174)} = 2.95, p = .034$). Exclusive breastfeeding rates increased significantly ($\chi^2_{(4)} = 21.27, p = .0003$); there were no significant differences in women's perceptions of interruptions.

Conclusion: New mothers experience many interruptions during their hospital stays, particularly when visitors arrive in large groups and stay more than 60 minutes. Documenting sources of interruptions before launching family bonding time helps identify hospital staff who need to be informed. Addressing their concerns before implementation can facilitate project sustainability.

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KEYWORDS: breastfeeding, family bonding time, interruptions, postpartum, quiet time

CLINICAL IMPLICATIONS

- Outcomes of this project suggest that family bonding time can improve exclusive breastfeeding rates and make a difference in the number of interruptions mothers experience during a designated time.
- Naming the intervention *family bonding time* places the family at the center.
- Gathering data about interruptions through hallway observations provides important information about the unit environment.
- Visitors may need education about the importance of family bonding time.
- Addressing concerns of unit and hospital staff before implementation can facilitate project sustainability.

Introduction

Only 1 in 5 women and their infants in the United States meet the *Healthy People 2020* goal of exclusive breastfeeding for a minimum of 6 months. More than 19% of healthy breastfeeding newborns receive formula before hospital discharge, which is a significant predictor of shorter breastfeeding duration (Centers for Disease Control and Prevention [CDC], 2014; Nelson, Perrine, Scanlon, & Li, 2016). In a large national survey of hospital maternity practices, more than 23% of hospitals reported that 50% of their healthy term breastfeeding newborns received formula before hospital discharge, citing mother's choice (65%), physician's order (25%), and nurse's recommendation (9%) as reasons (Nelson et al., 2016).

Local Problem

In 2010 we conducted an exploratory study to identify the reasons why 38% of the healthy term breastfeeding newborns within our regional health system received formula supplementation before hospital discharge; the *Healthy People 2020* goal is 14.2% (CDC, 2014). We found that staying more than one night in the hospital and being born at night were two factors associated with double the odds of receipt of supplementation before hospital discharge (Grassley, Schleis, Bennett, Chapman, & Lind, 2014).

In 2014 we conducted a second study with nurses who worked the night shift on our largest mother/baby care unit

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The intervention was called *family bonding time* rather than *quiet time*, because *quiet time* might imply that a woman should send her newborn to the nursery so that she can rest

(MBCU) using institutional ethnography. These nurses related that visitors contributed to the challenges of providing breastfeeding support because they interfered with women's ability to breastfeed and to rest (Grassley, Schleis, & Clark, 2015). A review of the literature supported this observation. Morrison and Ludington-Hoe (2012) reported that new mothers in their study experienced an average of 53 interruptions lasting an average of 19 minutes during day shift hours on Postpartum Day 1. With this many interruptions, it is difficult for women to rest and breastfeed their newborns. In their discussion of the problem of noise on maternity units, Adatia, Law, and Haggerty (2014) concluded that noise and interruptions create a stressful environment that contributes to mothers' sleep loss and delays their recovery from childbirth.

We needed a strategy for reducing interruptions on our MBCU; the night shift nurses suggested implementing a designated quiet time to enable mothers and newborns to rest together without unnecessary interruptions from visitors or hospital staff during the day (Grassley et al., 2015).

Available Knowledge

Evidence from the literature supported this strategy. Unit quiet times have been reported to decrease the stress of unit noise, facilitate patients' sleep, and increase patient and staff satisfaction on medical/surgical and intensive care units (Applebaum, Cato, & Neville, 2016; Gardner, Collins, Osborne, Henderson, & Eastwood, 2009; Maidl, Leske, &

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