

Abstract

Purpose: To describe the social interactions and institutional structures that influence the consistent practice of 24-hour rooming-in of new mothers and newborns in the hospital setting.

Study Design and Method: Using an institutional ethnographic design, data were gathered via semistructured interviews and on-unit observations. Data were recorded, transcribed, and analyzed for themes. Study interviews were conducted between February 2020 and June 2021.

Results: Seven mother–baby nurses were interviewed, and three on-unit observations of 2 hours each were conducted. Analysis of interview data revealed a consensus that Baby-Friendly does not always feel mother-friendly. Three major themes identifying social interactions were identified: the mother as a patient, managing expectations, and inconsistencies in practice. Three themes identified institutional structures that influenced 24-hour rooming-in: rates of induction of labor and cesarean birth, nurse staffing, and monitoring of nursery use.

Clinical Implications: Our findings provide insights about how the everyday work of 24-hour rooming-in is organized and experienced by nurses on the mother–baby units at the study hospital. Themes highlight specific social interactions and institutional structures that affect the practice and can be used by hospital leaders and educators to develop targeted interventions for ensuring consistent 24-hour rooming-in.

Key words: Baby-Friendly hospital; Breastfeeding; Community; Hospitals; Nurse staffing; Nursing staff; Postpartum period; Rooming-in.

SOCIAL INTERACTIONS AND INSTITUTIONAL STRUCTURES THAT INFLUENCE 24-HOUR ROOMING-IN FOR NEW MOTHERS AND NEWBORNS IN THE HOSPITAL SETTING

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The Baby-Friendly Hospital Initiative (BFHI) was started in 1991 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) as a global program to implement *10 Steps for Successful Breastfeeding* and the *International Code of Marketing Breast-Milk Substitutes* (Baby-Friendly USA, 2022). The goal of BFHI is to promote and encourage breastfeeding and encourage and recognize hospitals that implement the evidence-based interventions that assist mothers and families to breastfeed. As per Baby-Friendly USA (2022), ~970,000 babies are born in the United States each year in one of the 596 BFHI hospitals, representing approximately 27% of U.S. births.

In the broad framework that guides the BFHI, there are 10 evidence-based practices that have been shown to promote breastfeeding. To obtain BFH Designation, hospitals must adhere to all 10 of the practices or steps; step number seven is “enable mothers and their infants to remain together and to practice rooming-in 24 hours a day” (Baby-Friendly USA, 2022, p. 1), in part due to the premise that this practice promotes early breastfeeding and maternal–infant bonding. For example, in one hospital, after changes in their maternity care model as part of a New York state perinatal quality improvement project, when rooming-in increased from 0% to 70%, the exclusive breastfeeding rate increased from 6% to 44% during the inpatient postpartum stay (Magri & Hylton-McGuire, 2013). Cohen et al. (2018) in a quantitative meta-analysis reported maternal–infant dyad

connection as one of the six high-impact factors associated with both increased breastfeeding initiation and breastfeeding continuation.

Although 24-hour rooming-in offers many benefits to the mother and baby, there are also some potential disadvantages to the mother, primarily a disruption to the mothers' sleep (McRae, 2019; Theo & Drake, 2017). Some health care providers and the American Academy of Pediatrics have expressed concern for newborn safety and the potential for unsafe sleep practices such as sleeping with the baby (Ball et al., 2006; Feldman-Winter et al., 2016; Merewood, 2014; Theo & Drake, 2017). The American Academy of Pediatrics (Feldman-Winter et al., 2016) offers suggestions to minimize this risk. Hourly rounding on mother-baby couplets provides the opportunity to monitor for safety and provide education focused on safe sleeping practices.

The journey to obtain BFHI designation for the study hospital has been challenging, especially with consistent adherence to the Baby-Friendly Step 7, allowing mothers and infants to remain together for at least 23 hours per day. The ethnography approach studying participants in their real-life workspace was the focus to gain insight into how they interact in their natural environment. The purpose of this study was to describe the social interactions and institutional structures that influence the consistent practice of 24-hour rooming-in at a

community hospital trying to achieve Baby-Friendly Hospital Designation.

Study Design and Methods

An institutional ethnographic approach was used to explore the social interactions and institutional structures that influence the practice of 24-hour rooming-in. The goal of institutional ethnography is to explore the activities of work being done by the people doing the work, and examine the way that work is influenced by organizational processes and social relations (Devault, 2006).

Setting

The study was conducted at a 178-bed Magnet-designated community hospital, with over 3,000 births per year and, at the time of the study, a cesarean birth rate of 29%. The labor and delivery unit has 10 labor beds, 2 triage beds, and 2 operating rooms. The mother-baby

Baby-Friendly is mother-friendly when the mother and nurse collaborate to find a balance between meeting the mother's needs while keeping in mind the best interest of the baby.



unit (MBU) has 28 beds including 20 private rooms, 4 semiprivate rooms, and 40 bassinets. The hospital has a 12-bed level-II special care nursery. The MBU has a nurse manager and three lactation consultants. With a few exceptions, nurses work 12-hour shifts. Lactation consultants work primarily day shifts with occasional coverage on evenings. Couplets are assigned on admission to the MBU with newborns admitted to the unit with their mothers. The nurse-to-mother-baby couplet ratio is often determined by the MBU census and is usually 1 nurse to 4 mother-baby couplets on the day shifts and 1 nurse to 5 mother-baby couplets on the night shifts. Assessments and procedures, except for circumcision, are conducted at the bedside.

Participants

Following Institutional Review Board approval, nurses working on the MBU were recruited using an invitational email sent via a work email distribution list and in-person recruitment discussions at change of shift.

Interviews

As the principal investigator (PI) was a co-worker and interviews were conducted virtually over a video platform, to guarantee anonymity, participants were invited to schedule a recorded interview with the second author. The second author was not employed at the study hospital and had no relationship with the study participants. Interviews occurred in a private meeting space during the nurses' uncompensated time off work. After completion of the first interview, the COVID-19 pandemic required a 2-month halt to all research activity. An interview guide (Table 1) structured the interviews, and questions were designed to allow study participants to explore and describe how they work with peers within their unit to encourage and support the practice of 24-hour rooming-in.

Unit Observations

Several unit observations by the first author were planned over several shifts for the purpose of supporting interview

data and exploring the culture of the unit (traffic patterns, visitors, transport of newborns to and from the nursery by parents, nurses, and physicians, interruptions created by nurses, other team members, and visitors entering patient rooms). Pandemic restrictions enforcing policies of no visitors, mothers and partners confined to their rooms, and monitoring of all unit traffic had a major impact on unit culture. Three observations lasting 2 hours each were conducted at different times over all shifts (6–8 a.m., 7–9 p.m., 11 p.m.–1 a.m.) and at change of shift. Observations needed to be recorded from an isolated area. Field notes were used and included minimal transfers on all shifts to and from the nursery by nurses (parents were not allowed to leave their assigned rooms), several admissions of newly delivered mothers with their newborns being admitted to the MBU from labor and delivery (on all shifts), newborns transferred by nurses to the circumcision room and then returned to their mothers (day shift), lactation nurses making rounds (day shift), minimal communication between masked, socially distanced nurses, and other care providers. It was clear that the impact of pandemic restrictions influenced the goal of exploring unit culture and further observations were abandoned.

Data Analysis

All interviews were transcribed verbatim by the second author and shared with the first author; any data that may have identified the study participant was redacted for confidentiality. Descriptive statistics were used to report participant demographics and work experience. Interview data were analyzed using Rubin and Rubin's (2012) method of data analysis. Then, the authors independently read each interview identifying concepts, subthemes, and examples within the text that addressed the work of encouraging and supporting 24-hour rooming-in. Subthemes were then integrated into major themes that address the social interactions and organizational factors that influence nurses' practice of encouraging and supporting 24-hour rooming-in.

Results

Characteristics of Participants

Seven mother-baby nurses participated in virtual interviews between February 2020 and June 2021. One nurse was between age 20 and 29, one between 40 and 49, and four were over 50 years in age. One had more than 20 years' experience working in maternal child health (MCH) nursing; four had 6 to 15 years of MCH nursing; and two participants had 1 to 5 years of MCH nursing. All but one participant worked full-time, and they represented all shifts: days (4), evenings (1), and nights (2). All were white female and had baccalaureate degrees. Three were certified in the specialty.

Themes

Three themes were identified that address the social interactions that affect the practice of 24-hour rooming-in: the mother as patient, managing expectations, and inconsistencies in practice. Three themes were identified that

TABLE 1. INTERVIEW GUIDE

1. What is your experience with 24-hour rooming-in?
2. What is your comfort level with 24-hour rooming-in?
3. Can you tell me a little bit about the 24-hour rooming-in practice in your clinical practice setting?
4. Do **you** consistently encourage/support/facilitate 24-hour rooming-in for your patients?
 - a. If yes, have you had a mother decline 24-hour rooming-in? How do you handle that?
 - b. If no, what would you need for support/resources to consistently encourage/support/facilitate 24-hour rooming-in?
5. How can nurses best encourage/support/facilitate 24-hour rooming-in for their patients?
6. What are some of the barriers to consistently encouraging/supporting/facilitating 24-hour rooming-in?

highlighted the institutional structures that influence 24-hour rooming-in: the high rate of labor inductions and cesarean birth, nurse staffing, and a lack of monitoring or feedback around the use of the nursery.

Social Interactions that Affect the Practice of 24-hour Rooming-in

Mother as a Patient. There was a consensus among study participants that sometimes Baby-Friendly does not feel mother-friendly. Most described feeling conflicted as they balanced meeting the needs of the mother and promoting 24-hour rooming-in. There was an underlying question; who is my patient, the mother, or the baby? One nurse stated *They call it baby friendly because this is the healthiest thing for the baby, it is not necessarily what you're going to see as in the best interest of the mother. Sometimes it feels like the mother is not going to benefit from this, but ultimately the mother is going to benefit from talking care of her baby and from learning about what her baby needs.*

Concern over maternal exhaustion was raised by all nurses, and as one noted *The moms are just like, I can't handle this anymore and they absolutely hit a wall physically and emotionally.* Nurses were not the only ones concerned about the needs of the mother. Fathers advocated for the baby to go to the nursery so that the mother could get the rest she needed. One nurse said *I find that it is not just the mothers that are asking for babies to go to the nursery. It is fathers. Fathers are asking for babies to go to the nursery. "My wife has gone through so much. She is tired. Is the nursery open tonight?"*

Nurses cited maternal exhaustion as the strongest motivator for wanting to prioritize care of the mother, and the number one reason for separating the baby from the mother and placing baby in the nursery. Although there was a concern about maternal exhaustion, most nurses ultimately communicated the ways that 24-hour rooming-in does provide value for the mother. They reported when newborns are taken to the nursery it is primarily at the parent's request for maternal rest and not for feeding. When a baby is moved to the nursery, mothers are told that their newborns will return to them to breastfeed. No formula or supplements are given in the nursery to breastfeeding newborns.

All nurses discussed ways that 24-hour rooming-in allows the mother-family unit to: learn the baby's cues and techniques for soothing baby; develop their new roles as parents; and prepare for going home by setting up structure and sleeping strategies. One nurse stated *It is really valuable to the family to learn to care for their baby. Prior to going home with their baby to know what their baby's rhythm, patterns, and cues are, their needs and how to soothe them.*

Managing Expectations. When asked how to best support and encourage mothers and family units to practice 24-hour rooming-in, the most common answer was education and setting expectations. The identified gaps in knowledge and expectations were primarily around breastfeeding and sleep. *They do not understand that babies are more awake at night to feed because the prolactin produces milk surges at night, so the baby is just helping put their order in. They don't understand and that is*

Night-shift nurses should not be responsible for making sure mothers and families get all their needed sleep. Day-shift nurses can also prioritize periods of rest.

frustrating. Nurses had common concerns about patients not being prepared for the postpartum journey. *Some of my patients are ill prepared for what is going on. People who have taken prenatal classes and baby care classes and breastfeeding classes are much more prepared for what is going on.* Nurses felt education was the way that parents learn what to expect and what may be abnormal, and that this education was important for all parents, but especially first-time mothers. *Especially for the first-time mom, I think there should be more education in pregnancy on what the expectations are, and the help they are going to need. On what is normal and what is not normal.* Nurses described a lack of appreciation for the normal challenges of breastfeeding and alterations in sleep patterns. The goal of education should be normalizing elements of the postpartum period that are challenging and encouraging mothers and parents to lean into these challenges by developing strategies to manage them. Nurses acknowledged that pandemic restriction of visitors allowed more time for parent teaching, breastfeeding guidance, and maternal rest. It is not clear how the pandemic restrictions affected rooming-in.

There was consensus that education should start prenatally during office visits, in formal childbirth classes, and continue with repetition throughout the birth and postpartum experience. One nurse stated *I think education truly needs to start long before they come into the hospital with realistic expectations.* Nurses identified the impact of sleep deprivation on the ability to hear and learn and felt that education and expectation setting need to occur multiple times throughout the prenatal and postpartum journey. Comments from nurses build the awareness of what it takes to educate postpartum mothers and families. *Education is great on admission so they can hear it once, but they say you have to hear something 3 or 4 times or 5 before you actually take it in, and these parents are baseline exhausted. Now all of a sudden, they are elated because they have this little, tiny thing to focus on. They're not listening at all to what we say.*

Inconsistencies in Practice. When asked about their own practice of supporting or encouraging 24-hour rooming-in, nurses said they routinely promoted and supported keeping the baby in the room and out of the nursery; however, they also acknowledged that it was not for every patient, and the plan to keep baby in the room should be patient-based and promoted only if it is *best for the mother.* Many of the nurses described at times feeling

like they were *pushing* or coaxing the mom to keep the baby in the room: One participant stated *People have issues with this Baby-Friendly, they feel that the mother's choice is being taken away. If the mother wants to send the baby to the nursery, she should be able to send it to the nursery. It shouldn't be a push because Baby-Friendly states that is what is best, it is up to the parent.*

When asked about the culture of 24-hour rooming-in on their units, and among their peers, all but one nurse shared the belief that the practice was inconsistent, and not routinely supported within their clinical practice setting. Many of the inconsistencies were described between shifts, between peers, and between levels of experience. One nurse stated *I don't know if my night peers think it's a good idea. I think there is a lot of ridicule for the idea. I think they think it is silly.* Some of the challenges with 24-hour rooming-in on the night shift were due to concerns about the mother or parents being so tired that they engage in unsafe sleeping practices. This concern caused nurses to round more frequently on the patients, increasing the workload. *There is more vigilance on the night shift. Having a whole assignment of babies rooming-in might not change the workload on day shift, but on the night shift I would check every single hour to make sure everything is ok, baby is not sleeping in bed with mother.* Nurses also stated that 24-hour rooming-in at night was a challenge due to nurse staffing ratios on nights, increased needs for breastfeeding education at night, and fewer lactation consultant resources. Due

to these challenges, one nurse said *I think nurses know it is easier to have a baby in the nursery at night than it is to have the baby in mom's room at night.*

Inconsistencies between staff nurses were thought to be due to several factors. One nurse speculated that perhaps some nurses do not understand the value of rooming-in. *I think that nurses believe they are doing mothers a favor separating the baby so the mother can sleep- I don't think they recognize the problems they create by separating.* Another nurse felt that some nurses related to the age of the mom and were more likely to prioritize rest for the mother and not 24-hour rooming-in. Other inconsistencies between individual nurses' practices were speculated to be related to lack of maternal newborn nursing experience and lack of confidence in providing education and suggestions about how to deal with breastfeeding challenges, fussy babies, and maternal exhaustion. *If you have a novice nurse, possibly second guessing everything she is doing because she is unsure of everything she is doing.... the baby is going to the nursery.* Several nurses stated the habits of experienced nurses may not be consistent with 24-hour rooming-in. They were concerned that newer nurses are watching that behavior and imitating it because they are too intimidated or unsure of themselves.

Institutional Structures that Influence 24-hour Rooming-in Labor Induction and Cesarean Birth Rates. Several nurses indicated the high rates of labor inductions and cesarean



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births interfered with the *normal* birthing process, and left mothers with more than the anticipated amount of exhaustion and pain. It was felt that these birth experiences decreased the ability of the mother to rally to attempt 24-hour rooming-in with her baby, and potentially created additional safety concerns related to exhaustion, decreased mobility, and effects from pain medication. *When patients are induced, or have a C-section, they aren't recovering normal vaginal deliveries. Patients who are struggling with pain management and exhaustion request help -my baby needs to be picked up, but I cannot pick up my baby. It is just easier to take the baby to the nursery so the parents can sleep soundly.*

Nurse Staffing. Another barrier perceived by nurses was nurse staffing. One nurse stated the average assignment of 4 to 5 mother-baby couplets presents a challenge to provide the care and support needed to keep the baby with the mother. All nurses indicated the lack of lactation consultants on the night shift was a challenge. *When the baby is screaming in the middle of the night and you can't get it to feed, it might be nice if we had lactation consultants in the middle of the night.*

Monitoring of Nursery Use. When asked to describe how to increase consistent practice of 24-hour rooming-in on their units, several nurses mentioned that oversight is needed to hold individuals accountable for their practice. One nurse stated *You need management to float through every so often at night to see what is going on.* Another explained that movement of the baby in and out of the nursery should be tracked and audited from medical records. Documentation should include why the baby left the room, education done focused on that reason, and how long the baby was in the nursery. It was felt that feedback to individual nurses would improve consistency of 24-hour rooming-in.

Clinical Implications

Our findings illustrate the complex social interactions and institutional structures that affect exchanges between mother and nurse, often at night, that result in the inconsistent practice of encouraging and supporting 24-hour rooming-in at the hospital. Maternal exhaustion as a motivator for nurses to prioritize the care of the mother and send the baby to the nursery is well established (Grassley et al., 2015; Theo & Drake, 2017). There are strategies to maximize maternal rest on all shifts and increase support on the night shift such as reducing visiting hours during the day, designated daytime quiet times to maximize daytime rest (Grassley et al., 2015), minimizing interruptions, and clustering care (Theo & Drake, 2017). Themes from our study are consistent with themes in literature about the role that prenatal education and expectations play in postpartum newborn care decisions (Burnham et al., 2021; McKeever & St. Fleur, 2012; McRae, 2019; Merewood, 2014). Some newborn care decisions are made by mothers prior to their birth experience (Nickel et al., 2013).

To support mothers in 24-hour rooming-in, it is important to continue prenatal education focused on benefits and value of 24-hour rooming-in as well as anticipatory

CLINICAL IMPLICATIONS

- Prenatal education should provide guidance and expectation setting for parents about 24-hour rooming-in and managing maternal fatigue during postpartum.
- Responsibility of maternal rest should be balanced between nurses on the day and night shifts. Mother-baby units should work to develop strategies that promote daytime rest and minimize nighttime disruptions.
- Initial and continuing education for nurses supporting 24-hour rooming-in should focus on benefits of the Baby-Friendly journey for the mother and family including early initiation and continued breastfeeding, improved maternal-infant bonding, increased maternal confidence, mother's recognition, and response to infant early feeding cues.
- Developing experienced nurses and charge nurses as peer coaches may provide support for less-experienced nurses and build a culture of commitment for 24-hour rooming-in.
- Nurse leaders should consider developing a quality improvement process for monitoring the amount of time a baby is in the nursery and provide feedback to nurses about unit and individual nursery use.
- Implementation of AWHONN (2022) *Standards for Professional Registered Nurse Staffing for Perinatal Units* offers potential to improve nurse satisfaction, patient satisfaction, and compliance with best practice.

guidance for exhaustion, difficulty moving after cesarean birth, and pain after birth. Education should address the misconception that sending the baby to the nursery will result in more (or better quality) sleep for the mother (Grassley et al., 2015; Svensson et al., 2005). Although many of the barriers to 24-hour rooming-in occur at night, the education and guidance to address these barriers cannot effectively happen at night. Daytime hours should be used to provide education and set expectations for anticipated nighttime behaviors that increase the chance of the baby being sent to the nursery (Grassley et al., 2015).

Inconsistent practices between shifts and peers are represented in literature, similar to our findings. It is known that clinician attitudes affect the practice of 24-hour rooming-in, and these attitudes may not be grounded in scientific evidence (McRae, 2019; Nickel et al., 2013; Svensson et al., 2005; Theo & Drake, 2017). It is critical that nurses receive ongoing education about the benefits of rooming-in from clinical specialists, lactation consultants, professional journals, and publications from organizations such as the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) and Baby-Friendly USA. Tools such as scripts, strategy checklists, and unit-based policies may be useful to address some of the barriers to 24-hour rooming-in (Merewood, 2014; Theo & Drake, 2017).

Consistent with the findings of Grassley et al. (2015), who studied rooming-in on the night shift, our study identified nurse staffing, nurse-to-patient ratios, and

lactation support as institutional structures that affect 24-hour rooming-in. Grassley et al. state that 4 to 5 dyads can challenge the resource of time and suggested that nurses should maximize their use of the charge nurse and more experienced nurses. Experienced nurses offer the ability to share extensive experience and can guide newer nurses with offering education and strategies to manage exhaustion, movement challenges, and pain; however, sometimes nurses with longevity are more reluctant to adopt practice changes and may need to be brought on board to encourage and support 24-hour rooming-in with both the mothers as well as their less-experienced peers. Nickel et al. (2013) acknowledged that lactation consultants are critical, but they are not always available and suggest that nurses will have to take more responsibility for breastfeeding support on the night shift.

Limitations

Conducting a qualitative study dependent on interviews for data collection during a worldwide pandemic presented a recruitment challenge and could potentially represent a limitation to the study. Participants were required to complete study interviews during their unpaid, personal time. The sample was homogeneous with respect to age, gender, and ethnicity. Pandemic restrictions limited the number of on-unit observations. It is possible that more observations may have uncovered practices or processes that influenced the way nurses experience the work of 24-hour rooming-in.

Conclusions

Nurse leaders can influence the unit culture and commitment to practice (Nickel et al., 2013). One approach that may assist with inconsistent 24-hour rooming-in is more structure around setting expectations and monitoring and oversight of collective and individual practice. Interventions that address the organization's specific barriers and inconsistent cultural commitment should include following AWHONN (2022) nurse staffing standards. Baker and Hunter (2013), during a 6-week pilot study adhering to the AWHONN (2010) *Guidelines for Professional Registered Nurse Staffing for Perinatal Units* reported that the 1 nurse to 3 couplets postpartum assignment significantly improved patient and nursing satisfaction as well as individual nursing productivity. Education that reinforces the value of 24-hour rooming-in and the benefits to both mother and newborn, the development of scripts, role-playing, and resources that nurses can use to support mothers when they are exhausted and in pain, the adoption of unit-based rooming-in and newborn feeding practices that support expectations, include an element of quality improvement, and reflect the standard of care. Medical record reviews to monitor individual nursing practice may also be beneficial in promoting best practice. ✦

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