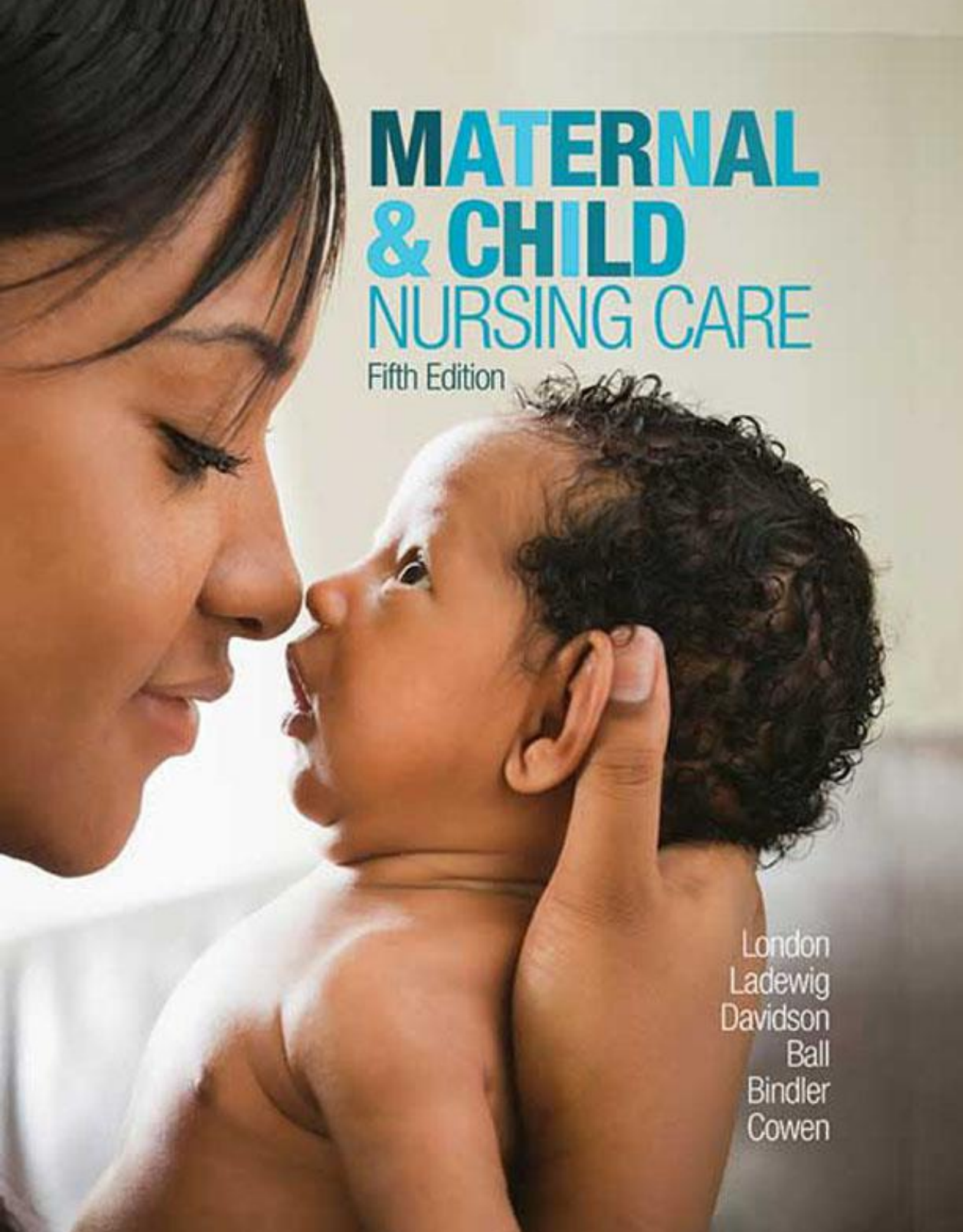

MATERNAL & CHILD NURSING CARE

Fifth Edition

London
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Davidson
Ball
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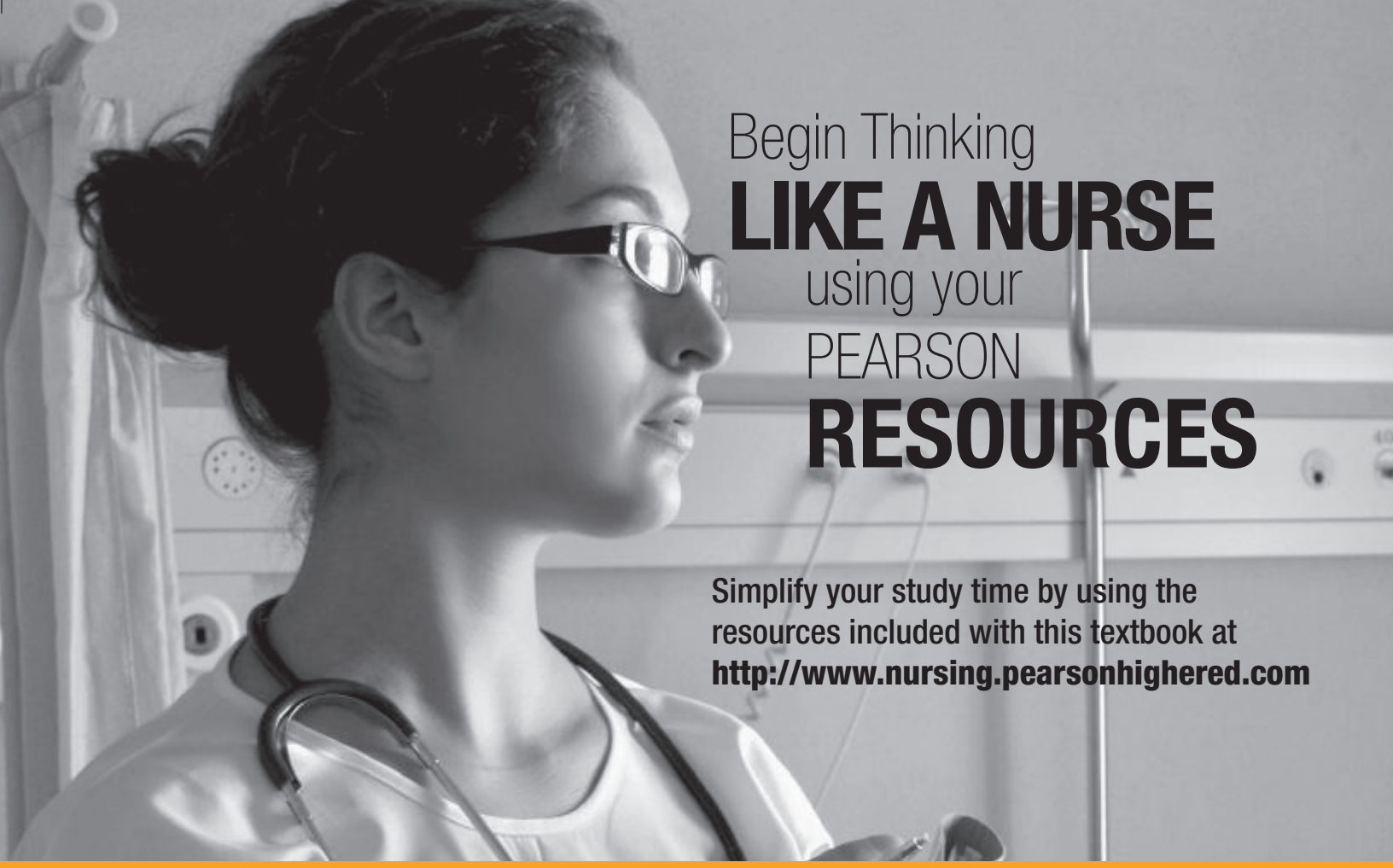
Cowen

Glues to inside cover

Brief Contents



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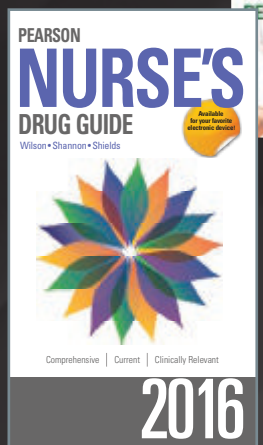

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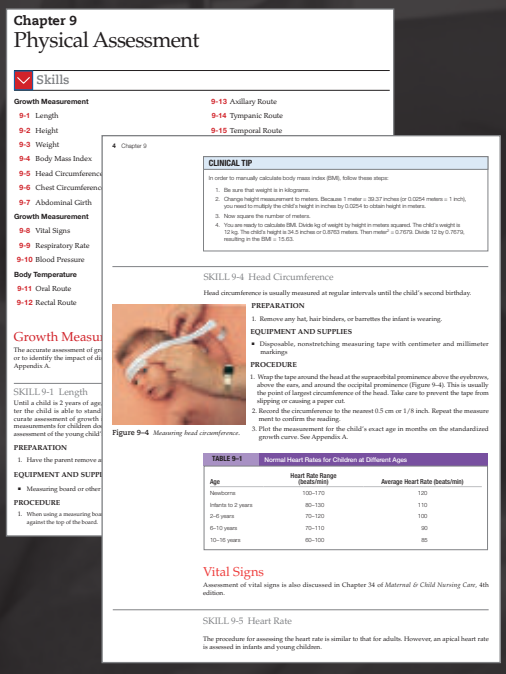

Clinical Skills Manual for Maternity & Pediatric Nursing

ALWAYS LEARNING

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MATERNAL & CHILD NURSING CARE

Fifth Edition

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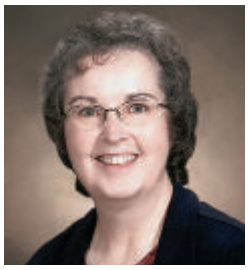
About the Authors

MARCIA L. LONDON received her BSN and School Nurse Certificate from Plattsburgh State University in Plattsburgh, New York, and her MSN in pediatrics as a clinical nurse specialist from the University of Pittsburgh in Pennsylvania. She worked as a pediatric nurse, and began her teaching career at Pittsburgh Children's Hospital Affiliate Program. Mrs. London began teaching at Beth-El School of Nursing and Health Science in 1974 (now part of the University of Colorado, Colorado Springs) after opening the first intensive care nursery at Memorial Hospital of Colorado Springs. She has served in many faculty positions at Beth-El, including assistant director of the School of Nursing. Mrs. London obtained her postmaster's Neonatal Nurse Practitioner certificate in 1983, and subsequently developed the Neonatal Nurse Practitioner (NNP) certificate and the master's NNP program at Beth-El. She is active nationally in neonatal nursing and was involved in the development of National Neonatal Nurse Practitioner educational program guidelines. Mrs. London pursued her interest in college student learning by taking doctoral classes in higher education administration and adult learning at the University of Denver in Colorado. She feels fortunate to be involved in the education of her future colleagues and teaches undergraduate education. Mrs. London and her husband, David, enjoy reading, travel, and hockey games. They have two sons: Craig, who lives in Florida with his wife, Jennifer, and daughter, Hannah, works with Internet companies; and Matthew, who works in computer teleresearch. Both are more than willing to give Mom helpful hints about computers.

PATRICIA A. WIELAND LADEWIG received her BS from the College of Saint Teresa in Winona, Minnesota; her MSN from Catholic University of America in Washington, DC; and her PhD in higher education administration from the University of Denver in Colorado. She served as an Air Force nurse and discovered her passion for teaching as a faculty member at Florida State University in Tallahassee. Over the years, she has taught at several schools of nursing. In addition, she became a women's health nurse practitioner and maintained a part-time clinical practice for many years. In 1988, Dr. Ladewig became the first director of the nursing program at Regis College in Denver. In 1991, when the college became Regis University, she became academic dean of the Rueckert-Hartman College for Health Professions. Under her guidance, the School of Nursing added a graduate program. In addition, the college added a School of Physical Therapy and a School of Pharmacy. In 2009, Dr. Ladewig became Vice President for Academic Affairs, and in 2012, she became Provost at Regis University. She and her husband, Tim, enjoy skiing, baseball games, and traveling. However, their greatest pleasure comes from their family: son Ryan, his wife Amanda, and grandchildren Reed and Addison Grace; and son Erik, his wife Kedri, and grandchildren Emma and Camden.

MICHELE R. DAVIDSON completed her ADN degree from Marymount University in Arlington, Virginia. She has worked in multiple women's health specialty areas including postpartum, newborn nursery, high-risk nursery, labor and delivery, reproductive endocrinology, gynecology medical-surgical, and oncology units as a registered nurse while obtaining a BSN from George Mason University in Fairfax, Virginia. Dr. Davidson earned her MSN and a nurse-midwifery certificate at Case Western Reserve University in Cleveland, Ohio, and continued to work as a full-scope nurse-midwife for 16 years. She has delivered over 1000 babies during her career as a nurse-midwife. She completed her PhD in nursing administration and healthcare policy at George Mason University (GMU) and began teaching at GMU in 1999 while continuing in her role as a nurse-midwife. Dr. Davidson serves as the Coordinator for the PhD program in the School of Nursing. She has an interest in women's mental health and focuses her research on perinatal and postpartum mood and anxiety disorders. Dr. Davidson also has an interest in the care of individuals with disabilities; she serves as a member of the Loudoun County Disability Advisory Committee and is a disability advocate in her community. She was a member of the American College of Nurse-Midwives Certification Council, the body that writes the national certification examination for certified nurse-midwives. She is a member of numerous editorial and advisory boards and has a passion for writing. In 2000, Dr. Davidson developed an immersion clinical experience for GMU students on a remote island in the Chesapeake Bay. In 2003, she founded the Smith Island Foundation, a nonprofit organization in which she served as executive director for 8 years. Dr. Davidson has also completed certifications in lactation consulting, forensic nursing, and surgical first assistant. In 2012, her book, *A Nurse's Guide to Women's Mental Health*, won an American Journal of Nursing Book Award. In her free time, she enjoys spending time with her mother, writing, gardening, Internet surfing, and spending time on Smith Island with her nurse-practitioner husband, Nathan, and their four active children, Hayden, Chloe, Caroline, and Grant. Dr. Davidson and her family love the Eastern Shore of Maryland and continue to be part-time residents of Smith Island.



JANE W. BALL graduated from The Johns Hopkins Hospital School of Nursing in Baltimore, Maryland, and subsequently received a BS from The Johns Hopkins University in Baltimore. She worked in the surgical, emergency, and outpatient units of the Johns Hopkins Children's Medical and Surgical Center, first as a staff nurse and then as a pediatric nurse practitioner. Thus began her career as a pediatric nurse and advocate for children's health needs. She obtained both a master of public health and doctor of public health degree from the Johns Hopkins University Bloomberg School of Public Health with a focus on maternal and child health. After graduation, she became the chief of child health services for the Commonwealth of Pennsylvania Department of Health. In this capacity, she oversaw the state-funded well-child clinics and explored ways to improve education for the state's community health nurses. After relocating to Texas, she joined the faculty at the University of Texas at Arlington School of Nursing to teach community pediatrics to registered nurses returning to school for a BSN. During this time she became involved in writing her first textbook, *Mosby's Guide to Physical Examination*, which is currently in its eighth edition. After relocating to the Washington, DC, area, she joined the Children's National Medical Center to manage a federal project to teach instructors of emergency medical technicians from all states about the special care children need during an emergency. Exposure to the shortcomings of the emergency medical services system in the late 1980s with regard to pediatric care was a career-changing event. With federal funding, she developed educational curricula for emergency medical technicians and emergency nurses to help them provide improved care for children. A textbook entitled *Pediatric Emergencies, A Manual for Prehospital Providers* was developed from these educational ventures. She served as the executive director of the federally funded Emergency Medical Services for Children National Resource Center for 15 years, providing consultation and resource development for state health agencies, health professionals, families, and advocates to improve the emergency healthcare system for children. Dr. Ball is a consultant for the American College of Surgeons, assisting states to develop and enhance their trauma systems. She is also collaborating on a pediatric explosion injury electronic curriculum and virtual pediatric trauma center conceptual design as a consultant to the Uniformed Services University of the Health Sciences.

RUTH C. MCGILLIS BINDLER received her BSN from Cornell University–New York Hospital School of Nursing in New York, New York. She worked in oncology nursing at Memorial–Sloan Kettering Cancer Center in New York, and then moved to Wisconsin and became a public health nurse in Dane County. Thus began her commitment to work with children as she visited children and their families at home, and served as a school nurse for several elementary, middle, and high schools. As a result of this interest in child healthcare needs, she earned her MS in child development from the University of Wisconsin in Madison. A move to Washington State was accompanied by a new job as a faculty member at the Intercollegiate Center for Nursing Education in Spokane, now the Washington State University College of Nursing. Dr. Bindler feels fortunate to have been involved for 38 years in the growth of this nursing education consortium, which is a combination of public and private universities and offers undergraduate and graduate nursing degrees. She taught theory and clinical courses in child health nursing, cultural diversity, graduate research, pharmacology, and assessment; served as lead faculty for child health nursing; was the first director of the PhD program; and served as Associate Dean for Graduate Programs, which include Master of Nursing, Post-Masters certificates, and PhD and Doctor of Nursing Practice (DNP) programs. She recently retired from this position and serves the college and profession as a professor emeritus, continuing work with graduate students and research. Her first professional book, *Pediatric Medications*, was published in 1981, and she has continued to publish articles and books in the areas of pediatric medications and pediatric health. Her research was focused in the area of childhood obesity, type 2 diabetes, and cardiovascular risk factors in children. Ethnic diversity and interprofessional collaboration have been other themes in her work. Dr. Bindler believes that her role as a faculty member and administrator enabled her to learn continually, to foster the development of students in nursing, and to participate fully in the profession of nursing. In addition to teaching, research, publication, and leadership, she enhances her life by service in several professional and community activities, and by outdoor activities with her family.

KAY J. COWEN received her BSN degree from East Carolina University in Greenville, North Carolina, and began her career as a staff nurse on the pediatric unit of North Carolina Baptist Hospital in Winston-Salem. She developed a special interest in the psychosocial needs of hospitalized children and preparing them for hospitalization. This led to the focus of her master's thesis at the University of North Carolina at Greensboro (UNCG), where she received a MS in Nursing Education degree with a focus in maternal–child nursing. Mrs. Cowen began her teaching career in 1984 at UNCG, where she continues today as clinical professor. Her primary responsibilities include coordination of the pediatric nursing course, teaching classroom content, and supervising a clinical group of students. Mrs. Cowen shared her passion for the psychosocial care of children and the needs of their families through her first experience as an author of the chapter "Hospital Care for Children" in *Child Health Nursing: A Comprehensive Approach to the Care of Children and Their Families*, published in 1993. In the classroom, Mrs. Cowen realized that students learn through a variety of teaching strategies, and she became especially interested in the strategy of gaming. She led a research study to evaluate the effectiveness of gaming in the classroom, and subsequently continues to incorporate gaming in her teaching. In the clinical setting, Mrs. Cowen teaches her students the skills needed to care for patients and the importance of family-centered care, focusing on not only the physical needs of the child but also the psychosocial needs of the child and family. During her teaching career, Mrs. Cowen has continued to work part time as a staff nurse, first on the pediatric unit of Moses Cone Hospital in Greensboro and then at Brenner Children's Hospital in Winston-Salem. In 2006, she became the part-time pediatric nurse educator in Brenner's Family Resource Center. Through this role she is able to extend her love of teaching to children and families. Through her role as an author, Mrs. Cowen is able to extend her dedication to pediatric nursing and nursing education.

Thank You!

We are forever grateful to nurse geneticist Linda Ward, PhD, APRN, the author of this book's new genetics chapter, Chapter 3, *Genetic and Genomic Influences in Maternal, Newborn, and Child Health*. We appreciate her expertise in genetic and genomic science, her superb writing skills, and her willingness to contribute such an essential chapter to our text. We also are thankful to Brenda Senger for contributing the content on mitochondrial diseases in Chapter 53 and to Janet Houser for her contribution of the *Evidence-Based Practice* features in the maternal-newborn section of this book.

We are grateful to all of the nurses, both clinicians and educators, who reviewed the manuscript of this text. Their insights, suggestions, and focus on detail helped us prepare a more relevant and useful book, one that focuses on the essential components of learning in the fields of maternal, newborn, and child health nursing.

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Dedication

Throughout the ages, nurses have cared for families, fathers, mothers, and their children—treating, healing, soothing, educating, and advocating.

And so we dedicate this book to nurses—

For their wisdom, expertise, and compassion
For their willingness to challenge the system when necessary
For their ability to remain strong during times of difficulty and stress
And for their unfailing commitment to the families they assist.

And to nursing students everywhere—

For seeking to serve others when so many have become self-serving
For committing their minds and talents to a proud profession
For accepting the challenges posed by the changes in health care
And for daring to envision a brighter tomorrow.

Then, too, as always, we honor our beloved families—

David London; Craig, Jennifer, and Hannah; Matthew
Tim Ladewig; Ryan, Amanda, Reed, and Addison Grace; Erik, Kedri, Emma, and Camden
Nathan Davidson; Hayden, Chloe, Caroline, and Grant
Ronald Ball
Julian Bindler; Dana, Brady, and Ivy; Ross and Cami
Fred Cowen III, Benjamin and Marcia, Michael and Caroline

Preface

Faculty and students in today's maternal–newborn and pediatric nursing courses face a wide variety of issues and challenges. Courses are increasingly shortened, clinical experiences are more limited, and patients in hospitals are often more seriously ill. Time is precious for both students and faculty, and competence in nursing practice is essential. Changes in healthcare delivery stem from the Affordable Care Act, and new regulations offer challenges to the student and faculty member. The primary goal in this edition is to present key content in an accurate, readable format that helps students and faculty focus on what is important. This textbook helps students develop the skills and abilities they need now and in the future in an ever-changing healthcare environment. This is done through the **Learning Outcomes** listed at the beginning of each chapter and the **Focus Your Study** review feature at the end of each chapter, through the illustrations and photographs that clarify concepts more efficiently than words can do, and through the downloadable practice content at www.pearsonhighered.com/nursingresources, which depicts clinical situations and requires students to engage in critical thinking. In its structure, format, and delivery, this text provides a concise look at maternal–newborn, women's health, and pediatric nursing.

Organization

The organization of the text reflects a time-saving approach. As educators and nurses, we know how difficult it is to teach everything that students need to learn in so little time. Consequently, we sought to reduce duplication in the text by carefully integrating relevant nursing topics and cross-referencing to other chapters. For example, three introductory chapters address concepts important for maternal, newborn, and child nursing. Chapter 1 discusses introductory concepts of family-centered care, health promotion, community and home care, evidence-based practice, and legal issues, as well as the complex ethical considerations related to reproductive decisions, stem cell research, terminating life-sustaining treatment, and organ transplantation issues. Chapter 2 addresses concepts that are important for culturally appropriate care for the entire family, such as cultural norms related to childbearing and childrearing, cultural assessment, and complementary and alternative therapies. Chapter 3, written by genetics nurse specialist Linda Ward, PhD, APRN, focuses on the field of genetics and genomics. Students will learn basic concepts and apply them in the critical specialties of maternal–newborn and child nursing. These concepts will be built upon in the students' future careers as genetic causes of disease and treatments that influence the genome are increasingly developed and applied.

Subsequent chapters focus on reproductive issues and women's health, pregnancy, birth processes, postpartum care, and newborn management. The maternal–newborn chapters begin with basic theory followed by nursing assessment and nursing care for essentially healthy women or newborns. Complications of a specific period appear in the last chapter or chapters of each section. The second half of the text transitions into the pediatric care chapters. The pediatric chapters begin with introductory concepts, such as growth and development, nutrition, assessment, health promotion for children ranging from newborn to adolescents, and care of the child in the community and hospital settings. Chapters 44 through 57 cover the nursing care of children with various disorders, organized by body system.

Important Themes in This Edition

Central to this edition are several key themes that are increasingly important in nursing care of childbearing and childrearing families.

Family-Centered Nursing Care

Nursing care for pregnant women and children is a family-centered process, and family focus is essential to providing culturally competent care. The underlying philosophy of *Maternal & Child Nursing Care* is simple: We believe that family members are coparticipants in care during pregnancy, childbirth, and childrearing. Parents must be integrated into the care of an infant or child at any stage of development, as they are the central influence on the child's life. Families experience the excitement and exhilaration of welcoming a healthy infant into their home, but they also experience sorrow and concern when a health problem occurs. Nurses play a pivotal role in helping families celebrate the normal life processes associated with birth, in promoting the health of the family and child, in fostering the child's growth and development from infancy through adolescence, and in caring for the child with any health condition. We are committed to providing a text that integrates the needs of families across the continuum from conception through adolescence.

Health Promotion

As nurses and educators, we are supportive of the goals and objectives of *Healthy People 2020.* This science-based effort provides a 10-year agenda for improving the health and well-being of the nation. Throughout the text, we have incorporated content reflecting the objectives of the project as they relate to childbearing families, newborns, infants, children, and adolescents.

We also subscribe to the paradigm that all childbearing and childrearing families and children need health promotion and health maintenance interventions, no matter where they seek health care or what health conditions they may be experiencing. Families may visit offices or other community settings specifically to obtain health supervision care. Nurses may also integrate health promotion and health maintenance into the care for childbearing and childrearing families and for children with acute and chronic illness in a variety of inpatient and outpatient settings. The inclusion of *Healthy People 2020* initiatives throughout the text integrates the national public health efforts to improve healthcare outcomes and assists nursing students and nurses with integrating healthcare policy into practice. This textbook provides health promotion

and health maintenance content throughout, most visibly in four chapters: Chapter 5, *Health Promotion for Women*; Chapter 34, *Health Promotion and Maintenance: General Concepts, the Newborn, and the Infant*; Chapter 35, *Health Promotion and Maintenance: The Toddler and the Preschooler*; and Chapter 36, *Health Promotion and Maintenance: The School-Age Child and the Adolescent*.

In addition, a feature entitled **Health Promotion** summarizes the needs of women from preconception to postpartum, newborns, and children with specific chronic conditions, such as asthma or diabetes. These overviews teach the student to look at the child with a chronic illness like any other child, with health maintenance needs for prevention, education, and basic care.

Nursing Care in the Community

Most maternity and pediatric nursing care occurs in the community setting, especially since most children and pregnant women are healthy and have only episodic acute health conditions. Even women with high-risk pregnancies and children with serious chronic health conditions are receiving more care in their homes and in the community. This textbook integrates community and home care throughout, including information on long-term management of complex health conditions, which are especially challenging to manage in community settings.

Five chapters provide a theoretical perspective and important tools in caring for childbearing and childrearing families in the community setting: Chapter 9, *Antepartum Nursing Assessment*; Chapter 10, *The Expectant Family: Needs and Care*; Chapter 29, *The Postpartum Family: Early Care Needs and Home Care*; Chapter 37, *Family Assessment and Concepts of Nursing Care in the Community*; and Chapter 38, *Nursing Considerations for the Child and Family with a Chronic Condition*. In addition, **Community-Based Nursing Care** is a special heading used throughout this text.

Patient and Family Education

Patient and family education remains a critical element of effective nursing care, one that we emphasize in this text. Nurses teach their patients during all stages of pregnancy and the childbearing process, during the child's health visits, and while providing care for specific conditions. Throughout the book, we include **Teaching Highlights** that present a special healthcare issue or problem and the related key teaching points for the family.

Clinical Reasoning

Nurses are faced with the responsibility to manage care for multiple families with diverse healthcare needs, and to work collaboratively with other health professionals to enhance care. Thus, nurses must be able to think critically, communicate well, and problem solve effectively.

To promote the development of clinical reasoning skills that will support nurses in challenging situations, **Clinical Reasoning** boxes provide brief scenarios that ask students to determine the appropriate response. Students can test their own decision-making skills by checking their answers to these questions against the suggested answers posted at www.pearsonhighered.com/nursingresources. Students can also access a variety of critical thinking exercises and case studies on this space.

Another feature that emphasizes these skills is the **Clinical Reasoning in Action** feature. This case study at the end of each chapter introduces a patient situation along with questions to enable the student to decide which nursing actions are appropriate. The *Instructor's Resource Manual* has more suggestions for clinical reasoning exercises for both the classroom and the clinical setting.

Evidence-Based Practice

Healthcare providers are increasingly aware of the importance of using evidence-based practice approaches as the foundation for planning and providing skilled, effective care. The approach of evidence-based practice draws on information from a variety of sources, including nursing research. To help nurses become more comfortable integrating new knowledge into their nursing practice, a discussion of evidence-based practice is included in Chapter 1.

A feature entitled **Evidence-Based Practice** further enhances the approach of using research to determine nursing actions. It describes a particular problem or clinical question and investigates the current evidence that suggests solutions to the problem. In these features, we provide an interpretation explaining the implications of the studies and then invite the student to apply clinical reasoning skills to further identify nursing care approaches.

Developing Cultural Competence

The influence of a family's culture on health beliefs and healthcare practices cannot be underestimated. Chapter 1 briefly introduces cultural issues relevant to maternity and pediatric nursing care. Additionally, we include Chapter 2, *Culture and the Family*, to directly and specifically address cultural issues.

We also emphasize cultural competence throughout the text. We highlight specific cultural issues and their application to nursing care in the **Developing Cultural Competence** features.

Other New or Expanded Concepts in This Edition

Many other important concepts are emphasized throughout this text:

- *Assessment* is an essential and core role in nursing management. Several chapters are dedicated to helping the student perform an assessment during the pregnancy continuum, including the fetus and newborn, and later through the stages of childhood. In addition, body system assessment guidelines are provided in many of the pediatric chapters.
- *Communication* is one of the most important skills that students need to learn. Effective communication is the very fiber of nursing practice. This book integrates communication skills in an applied manner where students can most benefit. It is an essential part of the **Clinical Tip** and **Teaching Highlights** boxes. The importance of communication

with families and other health professionals underscores the Collaborative Care sections of this text.

- *Ensuring appropriate nutrition* during pregnancy, the newborn period, infancy, and childhood is important to promote growth, development, and health. A growing national focus on healthy nutrition patterns underscores the importance of this information. Chapters 11, 25, 28, and 32 address nutrition for pregnant women, newborns, and children.
- ***Healthy People 2020*** goals are included as a new feature in this edition. Many of these national goals, which are arranged by categories, have direct relevance for maternal–newborn and pediatric nurses. Relevant goals are cited throughout the text to acquaint students with national public health efforts and to assist them to make connections between care of individual families and broad-based community health care and public policy.
- **Professionalism in Practice**, another new feature, focuses on topics such as legal and ethical considerations, contemporary nursing practice issues, professional accountability, practice guidelines, patient advocacy, and home and community care considerations. This feature reflects our belief that professionalism requires astute nurses to demonstrate professional standards of moral, ethical, and legal conduct and to model the values of the nursing profession as they care for childbearing and childrearing families.
- *Patient safety* is an essential element of effective patient care. It is the focus of the Joint Commission and one of the key elements of the Quality and Safety Education for Nurses (QSEN) project, both of which are discussed in Chapter 1. To help keep safety in the forefront, the feature called ***SAFETY ALERT!*** calls attention to issues that could place a patient (or a nurse) at risk. Another feature, **Clinical Tip**, relates to patient safety and many other nursing concepts by providing readers with concrete suggestions for safe, effective practice.
- *Pain* is considered a vital sign, and pain management is a priority in healthcare settings. All of the chapters in Part 4, *Birth and the Family*, address pain assessment and management, and it is the primary focus in Chapter 19, *Pharmacologic Pain Management*. Pain assessment and management is also a focus in five chapters (Chapters 23, 25, 26, 29, and 30) of Part 5, *The Newborn*, and Part 6, *The Postpartum Family*. In Part 7, Chapter 40, *Pain Assessment and Management in Children*, provides tools and guidance for pain assessment in children of all ages, as well as pharmacologic and complementary therapies for pain management. We discuss applicable pain management when appropriate in other chapters in Part 7 (Chapters 41 and 43) and in each of the chapters in Part 8, *Caring for Children With Alterations in Health Status*. Current research is used as the basis for discussions and nursing management of pain throughout the text.
- A new 2-page, 16-photograph *Birth Sequence* in Chapter 18 provides a moment-by-moment visual presentation of the birth of a baby.
- Chapter 12, *Pregnancy in Selected Populations*, is a new chapter that provides expanded content on nursing care for pregnant women from potentially vulnerable populations, such as adolescents, women over 35 years of age, and those with physical or intellectual disabilities.
- Another new chapter—Chapter 3, *Genetic and Genomic Influences in Maternal, Newborn, and Child Health*, written by Linda Ward, PhD, APRN—was added to this edition to reflect an emerging understanding of genome science, its impact on health and illness in children and childbearing families, and the expanding role that nurses play in applying genetics in clinical practice.
- *End-of-life care* has rightfully gained prominence as a critical component of nursing care. Expanded focus on the care of the family and the child who is dying has been added to Chapter 41, *The Child With a Life-Threatening Condition and End-of-Life Care*. Grief and loss associated with miscarriage are addressed in Chapter 15, *Pregnancy at Risk: Gestational Onset*. Care of the family experiencing perinatal loss is presented in Chapter 21, *Childbirth at Risk: Labor-Related Complications*.

Tools That Focus Student Review to Maximize Time

Both instructors and students value learning aids that unify the objectives and concepts of a chapter as well as reinforce the overall themes in a text. In keeping with our theme of family-centered care, each chapter begins with a **Family Quote** that helps personalize and set the stage for content that follows from the family's perspective. This is followed by a list of **Learning Outcomes.** Throughout the text important terms—**Key Terms**—are bolded when they first appear to emphasize their importance to the content. All of the key terms are compiled in a **Glossary** at the end of the book.

Focus Your Study

This feature is a direct response to instructors' and students' requests that the text provide more opportunities for review. Each chapter ends with **Focus Your Study**, a feature designed to help students retain the most important concepts from a chapter in a short period of time. Students save time by having the important concepts identified for them, allowing them to use more of their study time for reviewing the concepts themselves.

Application of the Nursing Process

Nursing Management

The nursing process is emphasized throughout the nursing care chapters. The heading, **Nursing Management**, highlights nursing assessment, actions, and evaluation. In chapters with frequently seen or high-risk health issues or conditions, the expanded section on nursing management helps students understand and apply care principles more completely. The expanded section includes the subheadings Nursing Assessment and Diagnosis, Planning and Implementation, and Evaluation.

In keeping with changing approaches to nursing care management, we feature **Nursing Care Plans** throughout the text. The Nursing Care Plans address nursing care for patients who have complications, such as a woman with preeclampsia, or health conditions, such as a child with otitis media. We designed this feature to help students approach care from the nursing management perspective.

Visuals That Teach

The conviction that art can teach is evident throughout the book. There are hundreds of contemporary photographs of childbearing and childrearing families and children in healthcare and related settings throughout the textbook, as well as illustrations, all of which serve to display conditions, compare developmental stages, and depict concepts.

In particular, **Pathophysiology Illustrated** figures allow the student to see into the body and to visualize the causes and effects of conditions on childbearing women, newborns, and children. **As Children Grow** illustrations help the student visualize the important anatomic and physiologic differences between a child and an adult. These features illustrate how the child progresses through developmental stages and the important ways in which a child's development influences healthcare needs and how the child progresses through developmental stages.

Resources for Student Success

- **Online Resources** are available for download at www.pearsonhighered.com/nursingresources, which aim to further enhance the student's learning experience, build on knowledge gained from this textbook, prepare students for the NCLEX-RN® examination, and foster clinical reasoning. These resources include:
  - NCLEX-RN® Review Questions
  - Case Studies
  - Care Plans
  - Thinking Critically Questions, and more!
- The ***Clinical Skills Manual for Maternity and Pediatric Nursing*** is a useful resource to assist students in successful planning and performance of essential nursing skills. This manual helps to translate theoretic concepts into performance while caring for patients in a variety of health settings.
- **NEW! Pearson's *Maternity and Pediatric Nursing Reference App***, now available for both iPhone and Android devices, provides a collection of handy tools and additional content for students and professionals looking for a quick reference in maternity or pediatrics nursing. The maternity content includes a section on **Patient/Family Teaching**, which supplies useful information, tips, and strategies for educating parents and families in a variety of situations and settings. The colorful **Maternal–Fetal Growth and Development Timeline** depicts maternal/fetal development month by month and provides specific teaching guidelines for each stage of pregnancy. For pediatrics, the information provided in the **Guidance for Children and Families** section provides insight into the issues related to health maintenance, development, and family that may present from birth to adolescence.

Resources for Faculty Success

Pearson Education is pleased to offer a complete suite of resources to support teaching and learning, including:

- TestGen Test Bank
- Lecture Note PowerPoints
- Classroom Response System PowerPoints
- Instructor's Resource Manual

Nursing is facing many new challenges: an ongoing nursing shortage, dramatic advances in healthcare knowledge, implementation of the Affordable Care Act, reenvisioning of nursing education needs and approaches, and natural and human-made disasters that create a critical need for skilled nurses. We believe that nursing is facing these issues and challenges with enthusiasm and commitment. Many people feel a strong desire to choose professions that make a difference—professions such as nursing. We, like you, know that expert nurses can have a tremendous impact on the lives of childbearing and childrearing families. Our goal in writing this textbook is to help prepare nurses with the skills and knowledge to make a difference—one family at a time.

Marcia L. London

Patricia W. Ladewig

Michele R. Davidson

Jane W. Ball

Ruth C. Bindler

Kay J. Cowen

Features That Help You Use This Textbook Successfully

Instructors and students alike value the in-text learning aids that we include in our textbooks. The following guide will help you use the features and resources from *Maternal & Child Nursing Care*, Fifth Edition, to be successful in the classroom, in the clinical setting, on the NCLEX-RN® examination, and in nursing practice.

Each chapter begins with **Learning Outcomes** and a chapter opening **Quote**. These personal stories illustrate the diversity of cultures, parental concerns, and family situations that nurses will encounter throughout the course of their careers.

Chapter 18

The Family in Childbirth: Needs and Care

Jonathan Nourok/PhotoEdit

For as long as I can remember, I have been fascinated with birth. Currently, I am a labor and delivery nurse at our town's only hospital. I'm still fascinated with birth but a little nervous, too. You see, I was just admitted in early labor with my first child. Before I got here I worried that I would be a "bad" patient or that I would lose my cool. How silly I was. All that matters is that my baby is healthy and that I am able to take care of him effectively. (Yes. We know it is a boy!)

—Amanda, 31

Learning Outcomes

18.1 Identify admission data that should be noted when a woman is admitted to the birthing area.

18.2 Describe the nursing care of a woman and her partner/family upon admission to the birthing area.

18.3 Use assessment data to determine the nursing interventions to meet the psychologic, social, physiologic, and spiritual needs of the woman and her partner/family during each stage of labor.

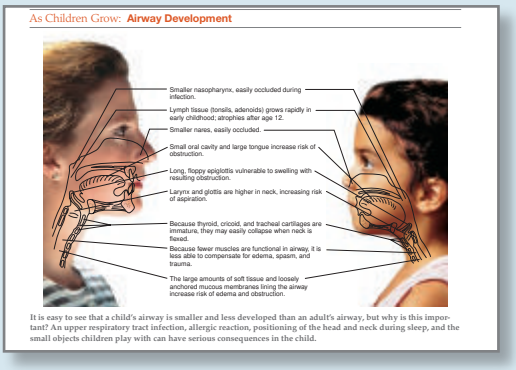
18.4 Compare methods of promoting comfort during the first and second stages of labor.

18.5 Explain the immediate needs and physical assessment of the newborn following birth in the provision of nursing care.

18.6 Examine the unique needs of the adolescent during birth in the provision of nursing care.

18.7 Describe the role and responsibilities of the nurse in the management of a precipitous labor and birth.

As Children Grow boxes illustrate the anatomic and physiologic differences between children and adults. These features illustrate how the child progresses through developmental stages and the important ways in which a child's development influences healthcare needs.



Assessment Guides, found in the maternal–newborn chapters, assist you with diagnoses by incorporating physical assessment and normal findings, alterations and possible causes, and guidelines for nursing interventions. Assessment guides within several chapters of Part 8, *Caring for Children With Alterations in Health Status*, provide a system-oriented approach to assessing the child's health condition.

ASSESSMENT GUIDE | The Child in Respiratory Distress*

Assessment Focus	Assessment Guideline
Position of comfort	• Is the child comfortable lying down? • Does the child prefer to sit up or in the **tripod position** (sitting forward with arms on knees for support and extending the neck)?
Vital signs	• Assess the rate and depth of respirations. See Table 33–9 for age-related respiratory rates. Is **tachypnea** (abnormally rapid respiratory rate) present? • Assess the pulse for rate and rhythm. See Table 33–11 for age-related heart rates.
Lung auscultation	• Are breath sounds bilateral, diminished, or absent? • Are **adventitious sounds** (wheezes, crackles, or rhonchi) present?
Respiratory effort (work of breathing)	• Is **stridor** (audible crow-like inspiratory and expiratory breath sounds) or wheezing present? Is grunting heard on expiration? • Is breathing easy or labored? • Are retractions present or are accessory muscles used to breathe? • Is nasal flaring present? • Can the child say a full sentence or is a breath needed every few words? Is the cry strong or weak? • Do the chest and abdomen rise simultaneously with inspiration or is **paradoxical breathing** present in which the chest and abdomen do not rise simultaneously?
Color	• What is the color of the mucous membranes, nail beds, or skin (pink, pale, cyanotic, or mottled)? • Does crying improve or worsen the color?
Cough	• Is the cough dry (nonproductive), wet (productive, mucousy), brassy (noisy, musical), or croupy (barking, seal-like)? • Is the coughing effort forceful or weak?
Behavior change	• Is irritability, restlessness, or change in level of responsiveness present?

*Refer to Chapter 33 for the assessment techniques mentioned in this table.

Clinical Reasoning Pregnancy Complication

Jillian Rundus is a 31-year-old G1P0 who is 35 weeks pregnant. She presents for a routine office visit with complaints of nausea and abdominal pain rating 7/10. She has had a headache and general malaise for 2 days. She denies visual changes. Upon examination, you find her to be alert and oriented and her physical examination is unremarkable with the exception of abdominal tenderness and a blood pressure of 170/110 mmHg. She has had no previous history of hypertension. Fetal heart rate ranges from 140 to 150 beats per minute.

What should the nurse do at this time?

Clinical Reasoning boxes provide brief case scenarios that ask students to determine the appropriate response.

Clinical Reasoning in Action features at the end of each chapter propose a real-life scenario and a series of clinical reasoning questions so that you can apply to the clinical setting what you learned in class.

Clinical Reasoning in Action

Cindy Bell, a 20-year-old gravida 2, para 1, at 40 weeks' gestation, presents to you in the birthing unit with contractions every 5 to 7 minutes. She is accompanied by her husband. Spontaneous rupture of membranes occurred 2 hours prior to admission. Cindy tells you that the fluid was colorless and clear. You orient Cindy and her family to the birthing room and perform a physical assessment, documenting that vital signs are normal. A vaginal examination demonstrates the cervix is 75% effaced, 4 cm dilated with a vertex at -1 station in the LOP position. You place Cindy on an external fetal monitor. The fetal heart rate baseline is 140 to 147 with accelerations to 156; no decelerations are noted. Contractions are 5 to 6 minutes apart, moderate intensity, and lasting 40 to 50 seconds. Cindy states she would like to stay out of bed as long as possible because lying down seems to make the contractions more painful, especially in her back.

1. Discuss the benefits of ambulation in labor.
2. Cindy would like her 5-year-old daughter to be present for the baby's birth. What would you discuss with her about the impact of having a young sibling present during labor and birth?
3. What fetal heart rate assessment will best ensure fetal well-being during the period Cindy is ambulating?
4. When a nonreassuring fetal heart pattern is detected, what remedial nursing intervention is carried out?
5. What are indications for continuous fetal monitoring in labor?

Clinical Tip

If a woman is experiencing severe fear or anxiety about a vaginal examination, advise her to slowly count to 10 during the examination while continually wiggling her toes. This source of distraction may lessen her fear and anxiety. It also enables the woman to have a sense of control.

Clinical Tip features offer hands-on suggestions and clinical tips. These are placed at locations in the text that will help you apply them. They include topics such as legal and ethical considerations, nursing alerts, and home and community care considerations.

Developing Cultural Competence boxes highlight specific cultural issues and their application to nursing care.

Developing Cultural Competence Using Cultural Information Effectively

Although it is important to avoid stereotyping, race and ethnicity may provide valuable starting information about cultural, behavioral, environmental, and medical factors that might affect a pregnant woman's health. With this general knowledge as a framework, it is essential to ask the woman about specific practices in her culture to determine their meaning for her.

EVIDENCE-BASED PRACTICE | Risk Factors for Adolescent Pregnancy

Clinical Question

What are risk factors for adolescent pregnancy in vulnerable populations?

The Evidence

Unplanned pregnancy for an adolescent can result in a host of adverse outcomes for both mother and baby. These risks are even higher among vulnerable populations. Two research studies focused on identifiable risk factors in specific vulnerable populations in an effort to target preventive efforts effectively. Researchers conducted an integrated literature review of 18 research studies that identified risk factors for teen pregnancy among African American adolescents. A second study used a predictive model to study risk factors among nearly 300 adolescents in the child welfare system/foster homes. Taken together, these studies form a strong basis of evidence. Lee, Cintron, & Kocher (2014) found that five major factors contributed to adolescent pregnancy among African American youth: substance use, gender roles, peer influences, parental involvement, and level of knowledge about sexual health. Of these, substance use was also a predictive factor for teens in the welfare system, but in this population, delinquency was also a risk factor (Helfrich & McWey, 2014). In the latter study, the timing of pregnancy was also identified; pregnancy occurred, on average, within 3 years of a predictive event.

Best Practice

Knowing specific predictive factors for a population enables the development of risk-specific educational programs for the prevention of adolescent pregnancy. These data suggest that supports need to be wide reaching and include reducing substance abuse, encouraging parental involvement, and integration of peer support into interventions.

Clinical Reasoning

How can the nurse determine risk factors of teen pregnancy for a specific population? How can parents and peers be involved in adolescent pregnancy prevention programs?

Evidence-Based Practice boxes present recent nursing research, discuss implications, and challenge you to incorporate this information into your nursing practice through nursing actions.

Growth and Development

Strategies for communicating with school-age children include the following:

- Provide concrete examples of pictures or materials to accompany verbal descriptions.
- Assess knowledge before planning teaching.
- Allow child to select rewards following procedures.
- Teach techniques such as counting or visualization to manage difficult situations.
- Include child in discussions and history with parent.
- Be honest in explanations and all communications.

Growth and Development boxes, found exclusively in the pediatric chapters, provide information about the different responses of children at various ages to health conditions.

Healthy People 2020

(BDBS-18.4) Reduce the proportions of persons who develop adverse events due to alloimmunization among persons with hemoglobinopathies

Healthy People 2020 goals are cited throughout the text to acquaint students with national public health efforts and to assist them to make connections between care of individual families and broad-based community health care and public policy. The coding in front of each objective identifies the specific chapter—for example, "Maternal, Infant, and Child Health" (MICH); "Adolescent Health" (AH); and "Injury and Violence Prevention" (IVP)—and number of the objective for the *Healthy People 2020* initiative. See the *Healthy People 2020* website to find chapter abbreviations for all *Healthy People 2020* objectives listed in our text.

A feature entitled **Health Promotion** summarizes the needs of children with specific chronic conditions, such as asthma or diabetes. These overviews teach you to look at the child with a chronic illness like all children, with health maintenance needs for prevention, education, and basic care.

Health Promotion The Child With Bronchopulmonary Dysplasia

Health Supervision

- Assess blood pressure to detect abnormal findings associated with pulmonary hypertension.
- Coordinate vision screening by an ophthalmologist every 2 to 3 months during the first year of life. Myopia and strabismus are common in premature infants.
- Coordinate pulmonary function tests annually or as needed for clinical condition.
- Perform hearing and other screening tests as recommended for age.

Growth and Developmental Surveillance

- Assess growth and plot measurements on a growth chart corrected for gestational age. Even if length and weight are lower than normal, monitor for continued growth following the growth curves.
- Perform a developmental assessment, correcting for gestational age.

Nutrition

- Review caloric intake. Ensure that increased calories are provided to support growth. Assess feeding difficulties related to oral motor function associated with long-term enteral feeding. Refer to a nutritionist as necessary.

Physical Activity

- Organize care to provide rest periods during the day.
- Give parents ideas for promoting the infant's motor development, such as reaching for and moving toward toys and objects of interest.

Family Interactions

- Identify ways to coordinate nighttime care to reduce child and family sleep disturbances.
- Provide discipline appropriate for developmental age.

Disease Prevention Strategies

- Reduce exposure to infections. Encourage selection of a childcare provider who cares for a small number of children, if one is used. If possible, avoid the use of childcare centers during RSV season.
- Immunize the child with the routine vaccine schedule based on chronologic age.
- Administer the 23-valent pneumococcal vaccine at 2 years of age.
- Provide monthly injections of palivizumab throughout the RSV season.

Condition-Specific Guidance

- Develop an emergency care plan for times when the infant's condition rapidly worsens.

A **Medications Used to Treat** feature in tabular format provides an overview of the types of medications that can be used for a specific condition and nursing considerations associated with their use.

Medications Used to Treat: Asthma

QUICK RELIEF MEDICATIONS, ROUTE, AND ACTION	NURSING MANAGEMENT
Short-acting beta$_2$-agonists (SABA) Albuterol, levalbuterol, pirbuterol *Metered-dose inhaler or nebulizer* Relaxes smooth muscle in airway leading to rapid bronchodilation (within 5–10 min) and mucus clearing. Drug of choice for acute therapy and prevention of exercise-induced bronchospasm.	• Use before inhaled steroid, wait 1–2 min between puffs, wait 15 min to give inhaled steroid. Child should hold breath 10 sec after inspiring. Then rinse mouth and avoid swallowing medication. Use a spacer. • Differences in potency exist, but all products are comparable on a per puff basis. • Dose-related side effects include tachycardia, nervousness, nausea and vomiting, headaches. • Regular use more than 2 days a week for symptom control indicates a loss of control and need for additional therapy.

Nursing Care Plan: The Woman With Preeclampsia

1. Nursing Diagnosis: *Fluid Volume: Deficient*, related to fluid shift from intravascular to extravascular space secondary to vasospasm (NANDA-I © 2014)

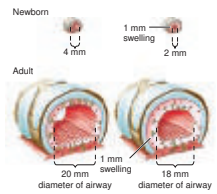
GOAL: Client is restored to normal fluid volume levels.

INTERVENTION	RATIONALE
• Encourage woman to lie in the left lateral recumbent position.	• The left lateral recumbent position decreases pressure on the vena cava, thereby increasing venous return, circulatory volume, and placental and renal perfusion. Angiotensin II levels are decreased when there is improved renal blood flow, which helps to promote diuresis and lower blood pressure.
• Assess blood pressure every 1 to 4 hours as necessary.	• Frequent monitoring will assess for progression of the disorder and allow for early intervention to ensure maternal and fetal health and well-being.
• Monitor urine for volume and proteinuria every shift or every hour per agency protocol.	• Monitoring provides information to assess renal perfusion. Proteinuria is the last cardinal sign of preeclampsia to appear. As the disorder worsens, the capillary walls of the glomerular endothelial cells stretch, allowing protein molecules to pass into the urine. Normally, urine does not contain protein. Readings of 3+ and 4+ indicate loss of 5 g or more protein in 24 hours. Urinary output decreases when there is a reduction of the glomerular filtration rate. Urinary output that falls below 30 mL per hour or less than 700 mL in a 24-hour period should be reported.
• Assess deep tendon reflexes and clonus.	• Hyperreflexia may occur as preeclampsia worsens. Eliciting deep tendon reflexes provides information about CNS status and is also used to assess for magnesium sulfate toxicity. Reflexes are graded on a scale of 0 to 4+ using the Deep Tendon Reflex Rating Scale. A rating of 4+ is abnormal and indicates hyperreflexia. A rating of 0 or no response is also abnormal and is seen with high maternal serum magnesium levels. Clonus, an abnormal finding, is present if the foot "jerks" or taps the examiner's hand, at which time the examiner counts the number of taps or beats. The presence of clonus indicates a more pronounced hyperreflexia and is indicative of CNS irritability.
• Assess for edema.	• Edema develops as fluid shifts from the intravascular to the extravascular spaces. Edema is assessed either by weight gain (more than 3.3 lb (1.5 kg)/month in the second trimester or more than 1.1 lb (0.5 kg)/week in the third trimester) or by assessing for pitting edema (assessed by using finger pressure to a swollen area, usually the lower extremities, and grading on a scale of 1+ to 4+).
• Administer magnesium sulfate per infusion pump as ordered.	• As preeclampsia worsens, the risk of an eclamptic seizure increases. Magnesium sulfate is the treatment of choice for seizures because of its CNS depressant action. As a secondary effect, magnesium sulfate relaxes smooth muscles and may therefore decrease the blood pressure. Magnesium sulfate is contraindicated in women with myasthenia gravis.
• Assess for magnesium sulfate toxicity.	• Side effects of magnesium sulfate are dose related. Therapeutic levels are in the range of 4.8–8.4 mg/dL. As maternal serum magnesium levels increase, toxicity may occur. Signs of toxicity include decreased or absent deep tendon reflexes (DTRs), urine output below 30 mL/hr, respirations below 12, and confusion.
• Provide a balanced diet that includes 80–100 g/day or 1.5 g/kg/day of protein.	• A diet rich in protein is necessary to replace protein that is excreted in the urine.

EXPECTED OUTCOME: The signs and symptoms of preeclampsia will diminish as evidenced by decreased blood pressure, urine protein levels of zero, and a return of the DTRs to normal.

Nursing Care Plans are also provided. They address nursing care for women who have complications such as preeclampsia or diabetes mellitus, as well as for high-risk newborns and children. We designed this information to enhance your preparation for the clinical setting.

Pathophysiology Illustrated: **Airway Diameter**



An infant's airway diameter is approximately 4 mm (0.16 in.), in contrast to the adult's 20-mm (0.8-in.) airway diameter. An inflammatory process in the airway causes swelling that narrows the airway, and airway resistance increases. Note that swelling of 1 mm (0.04 in.) reduces the infant's airway diameter to 2 mm (0.08 in.), but the adult's airway diameter is only narrowed to 18 mm (0.7 in.). Air must move more quickly in the infant's narrowed airway to get the needed amount of air into the lungs. The friction of the quickly moving air against the side of the airway increases airway resistance. The infant must use more effort to breathe and must breathe faster to get adequate oxygen.

Pathophysiology Illustrated boxes feature unique drawings that illustrate conditions on a cellular or organ level, and may also portray the step-by-step process of a disease. These images visually explain the pathophysiology of certain conditions to increase your understanding of the condition and its treatment.

Professionalism in Practice Asthma Management by School Nurses

The National School Nurses Association joined eight organizations in a position statement to improve asthma management in school settings. School nurses are encouraged to implement a comprehensive asthma plan for the management of students with asthma in the school setting that includes identifying and monitoring all students with asthma and obtaining their asthma action plans. School nurses are additionally encouraged to collaborate with school officials to adopt and implement an environmental assessment and management plan that addresses environmental asthma triggers (American Lung Association, 2013). See Chapter 37 for more information on nursing care in the school setting.

Professionalism in Practice focuses on important topics related to contemporary nursing practice issues, including legal and ethical considerations. This feature reflects a commitment to quality improvement in all aspects of care.

SAFETY ALERT!

If there is no fetal reaction to the scalp stimulation test and a Category II or Category III fetal heart rate tracing persists, the nurse should contact the physician/CNM to come to the woman's bedside and perform further evaluation.

The ***SAFETY ALERT!*** features present essential information that calls attention to issues that could place a patient or a nurse at risk and provide guidance on maintaining a safe environment for all patients and healthcare providers.

TEACHING HIGHLIGHTS | Home Care Instructions for the Infant Requiring a Cardiorespiratory Monitor

Apnea Equipment

- Review how the monitor operates, the lead wires, placement of skin electrodes and pulse oximetry sensor, and how to set the event recorder. Keep the battery fully charged, and keep the manual for troubleshooting handy.

Emergency Preparation

- Have an emergency plan and complete an emergency information form about the infant's health problem. Notify the telephone company, electric company, local ambulance service, and the local emergency department (to get priority service status).
- Post the emergency response phone numbers by all phones and save in cell phones, along with the phone numbers for the healthcare provider, medical equipment company, power company, neighbor, and key family members.
- Take a cardiopulmonary resuscitation (CPR) course.

Safety Precautions

- Place monitor on firm surface; keep away from other appliances (television, microwave oven) and water.
- Ensure that alarms are audible from all locations.
- Double-check that the monitor and event recorder are on before putting the infant down for a nap or at bedtime.
- Thread cable and wires through lower end of infant's clothes.
- Ensure integrity of leads, monitor cable, and power cord (replace if frayed).

Routine Care

- Explain the reasons for the apnea monitor and frequency of use. Use it whenever the infant sleeps. Review the manual for troubleshooting.
- Show how to attach and detach infant chest leads and belt. Evaluate the skin for irritation or sores under the electrodes, and move the electrode if skin is irritated. Use no oils or lotions on the chest.

Responding to an Alarm

- Observe the infant for breathing first to determine if this is a real event or a loose lead.
- Stimulate the infant if respirations are absent or infant is lethargic. Start by calling the infant's name and gently touching, proceeding to vigorous touch if needed.
- If no response, proceed with CPR and call 9-1-1.
- If a loose lead is suspected, determine if electrode patches are loose. Check the wires from the electrode or monitor cable. Check the power supply. Is the monitor malfunctioning?

Teaching Highlights present special healthcare issues or problems and the related key teaching points to address with the family.

Women With Special Needs Contraceptive Counseling

Many healthcare providers assume that women with developmental disabilities are not sexually active and, therefore, do not need contraceptive counseling. Women with developmental disabilities need education on sexual issues, including conception and pregnancy prevention. A level of functioning assessment should be performed to determine if the woman is capable of using different types of contraceptives effectively. Contraceptive choices should be discussed and provided as needed.

Women With Special Needs features serve as alerts that women with individualized needs may require modified plans of care.

Each chapter ends with **Focus Your Study**, which outlines the main points of the chapter and a list of **References**.

Where relevant, SKILLS found in the companion book, *Clinical Skills Manual for Maternity and Pediatric Nursing*, are cited.

Focus Your Study

- Major treatment modes for children with mental health disorders include individual therapy, family therapy, and group therapy.
- Therapeutic strategies for treatment of children and adolescents with mental health disorders include play therapy, art therapy, cognitive behavioral therapy (CBT), visualization, and hypnosis.
- Nurses conduct mental health assessments, prevent disorders when possible, participate in intervention to treat disorders, and evaluate outcomes of treatment.
- Autism spectrum disorder is the major type of pervasive developmental disorder and is manifested by abnormal behavior, social interaction, and communication.
- Attention deficit hyperactivity disorder is characterized by developmentally altered behaviors involving inattention and hyperactivity.
- Mood disorders in childhood and adolescence are commonly manifested as depression or bipolar disorder.
- Several anxiety disorders occur in children and adolescents, most notably generalized anxiety, separation anxiety, panic, obsessive-compulsive disorder, social phobia, conversion reaction, and posttraumatic stress disorder (PTSD).
- Behavioral therapy and selective serotonin reuptake inhibitors (SSRIs) are used in treatment of anxiety; prescription drug use in children must be closely monitored.
- Suicide is a significant cause of death among youth; nurses play a key role in identifying youth at risk, instituting prevention programs, and counseling families and friends of suicide victims.
- Nurses play a role in identifying children with potential learning disabilities, referring for diagnosis, and partnering with the family to provide a positive learning experience for the child.
- Intellectual disability is subaverage intellectual and adaptive functioning, and may be caused by chromosomal, genetic, or environmental factors.
- A multidisciplinary team plans the care for children with intellectual disability and periodically evaluates the child's progress and the family's needs.

Acknowledgments

Nursing is a dynamic, exciting healthcare profession. As curricula develop, many nursing programs have begun to teach nursing of childbearing families and nursing of children together in a single course. This combined format requires that faculty approach these two fields with a similar framework and philosophy, and with similar teaching methods, so that students can maximize learning. With this fifth edition, we have created a tool that will enable students to master these two critical areas of nursing—the care of childbearing families and the care of children. Creating a dynamic and integrated text would not be possible without the skill and dedication of a host of people.

We are grateful to the nurses who contributed to this text. Linda Ward, PhD, APRN, is an assistant professor at Washington State University College of Nursing and the author of Chapter 3, *Genetic and Genomic Influences in Maternal, Newborn, and Child Health*. Linda is a graduate of the National Institutes of Health Summer Genetics Institute and has been proactive in integrating genetic and genomic content into nursing curricula. Brenda Senger, PhD, RN, undergraduate program director and assistant professor at the School of Nursing and Human Physiology at Gonzaga University, engages in research about mitochondrial disease and contributed the material on this subject matter in Chapter 53, *The Child With Alterations in Endocrine Function*.

We are also grateful to Janet Houser, PhD, RN, Academic Dean of the Rueckert-Hartman College for Health Professions at Regis University, Denver, Colorado, for developing the **Evidence-Based Practice** boxes that are presented in the women's health and maternal–newborn sections of this textbook.

We would personally like to thank several people. Our thanks go to Julie Levin Alexander, our publisher. Julie is committed to excellence and creativity. She is the driving force behind the exciting changes occurring at Pearson Health Science and is truly a creative futurist in publishing.

For this edition, we have been blessed to have two developmental editors who worked together astonishingly well: Lynda Hatch for the maternal–newborn chapters and Mary Cook for the pediatric chapters. Lynda and Mary challenged us creatively, ensured consistency, and kept us on track. They have been supportive, innovative, and unflappable during the long months of hard work. Thank you both for all you have done!

Special thanks to the people of Cenveo® Publisher Services for coordinating production and moving things forward so effectively.

Finally, we all wish to thank our other coauthors. As six individuals, but two teams, we came together with our own ideas, writing styles, and vision for this book. Over five editions we have grown closer in our collaboration, with productive discussions of important issues that have ultimately resulted in a new and different text for maternal, newborn, and child health nursing. We hope that this book and associated learning aids will be a useful tool for legions of nursing students to come.

Marcia L. London

Patricia W. Ladewig

Michele R. Davidson

Jane W. Ball

Ruth C. Bindler

Kay J. Cowen

Detailed Contents

Chapter 1
Contemporary Maternal, Newborn, and Child Health Nursing

Justin Pumfrey/Getty Images

My younger son turned 21 today—officially a man now. I remember so well the night he was born in a birthing room at our local hospital. I watched my husband rock our baby and talk to him just minutes after his birth. Over the years we sought emergency health care for our son several times—when he was diagnosed with asthma as a high school freshman, when he fell skateboarding and needed surgery to put three pins in his wrist, when he fell snowboarding and dislocated his shoulder. Active kids do get their share of bumps! It is easy to take good health care for granted, but we shouldn't. It can make all the difference.

—Marjorie, 47

Learning Outcomes

1.1 Identify the nursing roles available to maternal-newborn and pediatric nurses.

1.2 Summarize the use of community-based nursing care in meeting the needs of childbearing and childrearing families.

1.3 Summarize the current status of factors related to health insurance and access to health care.

1.4 Relate the availability of statistical data to the formulation of further research questions.

1.5 Delineate significant legal and ethical issues that influence the practice of maternal-child nursing.

1.6 Discuss the role of evidence-based practice in improving the quality of nursing care for childbearing families.

Skilled nurses care for people, care about people, and use their expertise to help people care for themselves. This is the essence of nursing. Most nurses experience special moments professionally; that is, times in which they know that they have practiced the essence of nursing and, in doing so, have touched the lives of others. For nurses who work with childbearing families or with children and their families, the rewards that come from skilled nursing practice can be especially rich.

This chapter focuses on introductory concepts related to the nurse and childbearing families, newborns, infants, children, and adolescents.

Nursing Roles in Maternal-Child Nursing

Traditionally, **maternal-child nursing** refers to the care of women during pregnancy, birth, and postpartum, as well as the care of newborns, infants, children, and adolescents. However, this designation is somewhat misleading because it fails to acknowledge clearly the consideration due to fathers, partners, and family members. As nurses who work with families quickly learn, a holistic, inclusive approach is crucial to effective nursing care.

The nursing process provides the framework for delivery of direct nursing care. The nurse assesses the client—whether childbearing woman, newborn, infant, child, or adolescent—and identifies the nursing diagnoses that describe the responses of the individual and family to the condition or area of needed knowledge. The nurse then implements and evaluates nursing care. This care is designed to meet specific physical and psychosocial needs. For children, the care is tailored to the individual developmental stage, giving the child additional responsibility for self-care with increasing age.

Nurses play a major role in minimizing the psychologic and physical stress experienced by childbearing families and by children and their families. This often involves listening to concerns, being present during stressful or emotional experiences, and implementing strategies to help the individual and family members cope. Nurses help families by suggesting ways to support their loved ones in the hospital, in community settings, and in the home. Nurses also suggest ways to support families with informational resources, family support groups, referral for healthcare services, and, in some cases, respite care.

Client education is a major component of maternal-child nursing. During pregnancy, nurses provide anticipatory guidance to prepare the woman and her partner, if he or she is involved, for the changes that each month brings. For example, the woman is taught self-care measures to relieve personal discomforts and learns to identify the warning signs that she should report. Both partners receive information on the psychologic changes of pregnancy that they may experience. Education for the laboring woman focuses on activities that help her deal successfully with a challenging experience—childbirth—whereas postpartum teaching addresses the needs of the woman and her newborn to prepare them for discharge.

In pediatric nursing, education is especially challenging because nurses must be prepared to work with children at various levels of understanding and to include family members in all aspects of care. As client educators, nurses help children adapt to the hospital setting and prepare them for various nursing and medical procedures.

When a child is ill, most hospitals encourage a parent to stay with the child and to provide much of the direct and the supportive care under the guidance of a nurse. Nurses teach parents to watch for important signs and responses to therapies, to increase the child's comfort, and even to provide advanced care. Taking an active role during hospitalization helps prepare the parent to assume total responsibility for care after the child leaves the hospital.

Nurses also serve as advocates, acting to safeguard and advance the interests of families. To be an effective advocate, the nurse must be aware of the individual's needs, the family's needs and resources, and the healthcare services available in the hospital and the community. The nurse can then assist the family to make informed choices about these services and to act in their best interests. Nurses must also ensure that the policies and resources of healthcare agencies meet the psychosocial needs of childbearing women and of children and their families.

Collaborative practice is a comprehensive model of health care that uses a multidisciplinary team of health professionals to provide high-quality, cost-effective care. In maternal-newborn settings the team generally includes certified nurse-midwives (see later discussion), physicians, nurse practitioners, nurses, and other health specialists such as pharmacists, lactation consultants, or childbirth educators. Similarly, the multidisciplinary team assembled when a child has a significant health problem or handicapping condition may include physicians, nurses, pediatric nurse practitioners, social workers, physical and occupational therapists, and other specialists. The team's goal is to create an interprofessional plan designed to meet the child's medical, nursing, developmental, educational, and psychosocial needs. Because nurses spend large amounts of time providing nursing care for the client and family, they often are better informed than other healthcare professionals about the family's wishes and resources. As a member of the team, the nurse serves as an advocate to ensure that the plan of care considers the family's wishes and contains appropriate services.

Case management is a process of coordinating the delivery of health-care services in a manner that focuses on both quality and cost outcomes. This is often a collaborative practice with other healthcare providers designed to promote continuity of care. The nurse case manager has control over the use of healthcare resources that are considered appropriate for the client's condition and links the client and family to these services. The goal is to help the individual and family have the best healthcare outcome and decrease fragmentation of care, while controlling the cost of healthcare services. In maternal-child nursing, case management is often used for a complicated high-risk pregnancy and for long-term care of children with chronic conditions.

Discharge planning is a form of case management. Effective discharge planning promotes a smooth, rapid, and safe transition into the community and improves the results of treatment begun in the hospital. To be a discharge planner, the nurse needs to know about community medical resources, appropriate

Developing Cultural Competence Adapting the Reading Level of Client Education Materials

Among U.S. adults, 20% read at a fifth-grade level or below; however, this rate varies by cultural group with higher rates of poor literacy being seen among Latinos, Blacks, and Asians (Pontius, 2013). This means that many childbearing women and parents have difficulty using and understanding health information. Healthcare materials need to be provided in the appropriate language and at the appropriate reading level; for example, a sixth-grade reading level for individuals with a low literacy level (Pontius, 2014). Printed materials to educate children and families about a health condition might be readily available, but they often are written at too high a reading level. Even though printed material may be available in the primary language of the client and family, do not assume that the family has reading skills in that language.

When developing client education materials with a lower reading level:

- Use short, familiar words with one or two syllables and short sentences.
- Substitute simple language for a medical term.
- Use pictures or graphics to give directions when possible.
- Use lists and tables to simplify content.
- Use "must" to express a requirement.
- Divide the content into small sections and use headers.
- Color code information to help readers understand its importance.
- Use a computer program to evaluate the reading level of materials you develop.

Figure 1–1 **A certified nurse-midwife confers with her client.**

home care agencies and community resources, reliable Internet sites, educational interventions, and services reimbursed by the individual's health plan or other financial resources.

In addition, several advanced-practice roles are available to maternal-child nurses with additional education. A **nurse practitioner (NP)**, who has specialized education in a **Doctor of Nursing Practice (DNP)** program or a master's degree program, often provides ambulatory care services to pregnant women, newborns, children, adolescents, and families. The area of specialization determines the NP's title, so there are family nurse practitioners, neonatal nurse practitioners, pediatric nurse practitioners, women's health nurse practitioners, and so forth. NPs focus on physical and psychosocial assessments, including history, physical examination, and certain diagnostic tests and procedures. They make clinical judgments and begin appropriate treatments, seeking physician consultation when necessary. A **clinical nurse specialist (CNS)** has a master's degree and specialized knowledge and competence in a specific clinical area. They often are found on mother-baby units, on pediatric units, and in intensive care units assisting staff to provide excellent, evidence-based care. The **certified nurse-midwife (CNM)** is educated in the two disciplines of nursing and midwifery and is certified by the American College of Nurse-Midwives. The CNM is prepared to manage independently the care of women at low risk for complications during pregnancy, birth, and the postpartum period, as well as the care of healthy newborns (Figure 1–1).

The **nurse researcher** has an advanced doctoral degree, typically a PhD, and assumes a leadership role in generating new research. Nurse researchers are typically found in university settings, although more and more hospitals are employing them to conduct research relevant to client care, administrative issues, and the like.

Family-Centered Maternal-Child Care

Family-centered care—that is, nursing care characterized by an emphasis on the family and the family's choices about their birth experience—is a hallmark of contemporary childbirth. Fathers and partners are active participants, not simply bystanders; siblings are encouraged to visit and meet the newest family member, and they may even attend the birth.

New definitions of family are evolving. For example, the family of a single mother may include her mother, her sister, another relative, a close friend, a same-sex partner, or the father of the child. Many cultures also recognize the importance of extended families, and several family members may provide care and support. See Chapter 2 for an in-depth discussion of family and culture.

In pediatric settings, family-centered care is a dynamic, deliberate approach to building collaborative relationships between health professionals and families that is respectful of their diversity and beliefs about the nature of children's health conditions and ways to manage them. It is designed to meet the emotional, social, and developmental needs of children and families seeking health care. The family is the principal caregiver and center of strength and support for the child (Figure 1–2). As partners in the child's care, the family needs to learn about the child's condition and participate in decisions regarding his or her care. The Society of Pediatric Nurses and the American Nurses Association have established practice guidelines for family-centered care (Table 1–1).

Contemporary Childbirth

Contemporary childbirth is characterized by an increasing number of choices about the birth experience. The family can make choices about the primary caregiver (physician, CNM, or certified midwife); the use of a *doula* to provide labor support (see Chapter 10 for more information about doulas); and birth-related experiences such as the method of childbirth preparation, position for birth, and use of analgesia and anesthesia, as well as breastfeeding and child care choices.

Many women elect to have their pregnancy and birth managed by a CNM. Midwives who are not registered nurses but who complete a direct-entry midwifery education program

Figure 1–2 **Many facilities now encourage family visitation for children with health problems who require long-term hospitalization. Extended family visits enable parents to learn about the child's care and provide siblings with opportunities to interact with the hospitalized child.**

TABLE 1–1 Concepts of Family-Centered Care

- The family is acknowledged as the constant in the child's life and a partner in the child's health care.
- The family, child, and health professionals work together in the best interest of the child and the family. Over time, the child assumes a partnership role in his or her health care.
- Health professionals listen to and respect the skills and expertise that the family brings to the relationship.
- Trust is a fundamental element of the relationship between the family, child, and health professionals.
- Communication occurs in an open, unbiased manner and is ongoing.
- Families, children, and health professionals make decisions regarding the child's care in a collaborative manner in all healthcare settings and for all types of health care needed (e.g., health promotion, health maintenance, acute care, chronic condition care, and end-of-life care). Negotiation may be involved in collaborative decision making.
- The child is supported to learn about and participate in his or her health care and decision making. The adolescent is supported to assume a partnership role in his or her health care and in the transition to adult health care.
- The racial, ethnic, cultural, and socioeconomic background of the family and child, as well as family traditions, are honored. Health professionals work to integrate these values and the preferences of the family and child when planning and providing health care.
- Family-to-family and peer support are encouraged.
- Healthcare settings develop policies, procedures, practices, and systems that are family friendly and family centered; they support the choices the family and child will make regarding care.
- Health information for children and families is available and provided to match the range of cultural and linguistic diversity in the community as well as the health literacy levels.

Source: Data from Lewandowski, L. A., & Tesler, M. D. (Eds.). (2008). Family-centered care: Putting it into action. *The SPN/ANA Guide to Family-Centered Care.* Washington, DC: American Nurses Publishing; Committee on Hospital Care, & Institute for Patient and Family-Centered Care. (2012). Patient and family-centered care and the pediatrician's role. *Pediatrics, 129*(2), 394–404; Hughes, D. (2014). *A review of the literature pertaining to family-centered care for children with special health care needs*. Retrieved from http://lpfch-cshcn.org/publications/research-reports/a-review-of-the-literature-pertaining-to-family-centered-care-for-children-with-special-health-care-needs/

that meets the standards established by the American College of Nurse-Midwives (ACNM) may take a certification exam to become a *certified midwife (CM)*. In 2012, CNMs and CMs attended 7.9% of all births in the United States and 11.8% of all vaginal births (ACNM, 2014). Education and certification standards are the same for CNMs and CMs. As of 2010, a graduate degree is required (ACNM, 2014).

The North American Registry of Midwives (NARM) is also a certification agency. Midwives certified through NARM may have been prepared through a formal educational program at a college, university, or midwifery school. NARM also has a path to certification for experienced midwives who have nonconventional or extensive training and experience. These midwives are eligible to use the credential *certified professional midwife (CPM)* (NARM, 2014).

The place of birth is an important decision. Birthing centers and special homelike labor-delivery-recovery-postpartum (LDRP) rooms in hospitals have become increasingly popular. Some women choose to give birth at home, although healthcare professionals do not generally recommend this approach. Most professionals are concerned that, in the event of an unanticipated complication, delay in receiving emergency care might jeopardize the well-being or even the life of the mother or her baby. Some CNMs do attend home births; however, the majority of home births are attended by CMs, CPMs, or lay midwives. In 2012, less than 1% (0.89%) of births occurred at home (MacDorman, Mathews, & Declerq, 2014).

Contemporary Care of Children

As of 2012, more than 83.7 million children under 20 years of age live in the United States, and they account for 26.7% of the population (U.S. Census Bureau, 2013). (See Figure 1–3 for a distribution of the population by age group.)

Pediatric nursing is a specialized area of nursing that focuses on caring for children in many different settings within the hospital and the community. These settings include the following:

- Various hospital units, such as pediatric units, intensive care units, emergency departments, radiology, rehabilitation units, and specialty care clinics
- Physician offices, healthcare centers, and clinics
- Schools, child care centers, detention centers, and camps
- The child's home

Pediatric health care occurs along a continuum that reflects not only the various settings of care, but also the complexity and range of care needed by individual children and their families. For example, all children need health promotion and health maintenance care, but some children need care for chronic conditions, acute illnesses and injuries, and even end-of-life care. See Figure 1–4 for the model of pediatric health care used in this textbook.

Managing the child's transition from the hospital to another setting involves planning the discharge, implementing interdisciplinary plans, ensuring that the family understands the aspects of care they need to provide, helping the family to develop an emergency care plan in the event their child has an unexpected healthcare crisis, and collaborating with a broad range of healthcare professionals.

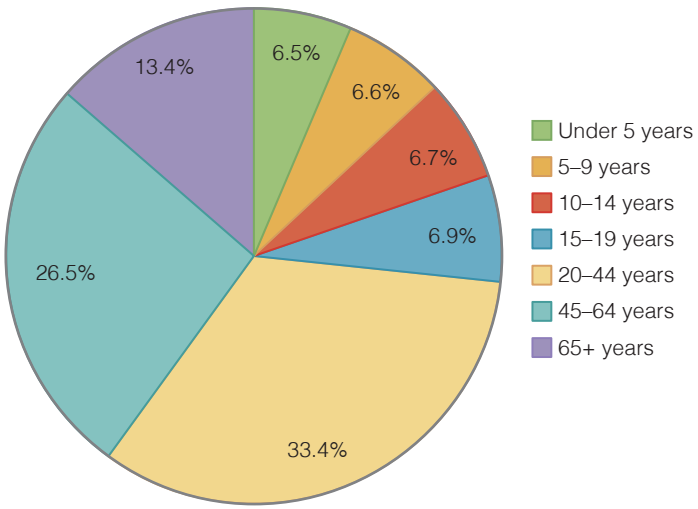


Figure 1–3 In 2012, children from birth to 19 years of age accounted for almost 27% of the total population of the United States.

SOURCE: Data from U.S. Census Bureau. (2013). *Current Population Survey, Annual Social and Economic Supplement, 2012*. Retrieved from http://www.census.gov/population/age/data/2012comp.html

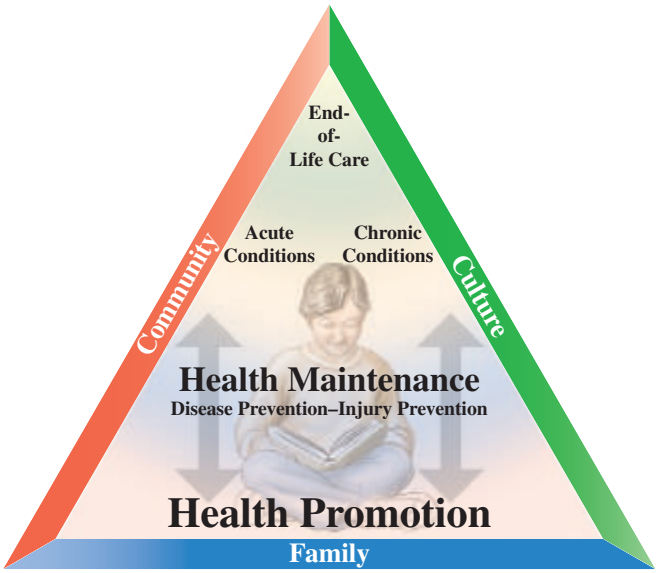


Figure 1–4 **The Bindler-Ball Continuum of Pediatric Health Care for Children and Their Families. The outer bars represent the family, cultural, and community influences on the care that the child receives, either through the services sought by the family or the services provided in the community. Cultural influences include the family's values and beliefs and the cultural competence of the nurse in caring for a child and family.**

The inner categories represent the range of health care needed by children. All children need health promotion and health maintenance services, represented by the base of the triangle. Notice the arrows representing the upward and downward movement between the levels of care as the child's condition changes.

Children may be healthy with episodic acute illnesses and injuries. Some children develop a chronic condition for which specialized health care is needed. A child's chronic condition may be well controlled, but acute episodes (such as with asthma) or other illnesses and injuries may occur, and the child also needs health promotion and health maintenance services. Some children develop a life-threatening illness and ultimately need end-of-life care. A healthy child may also experience a catastrophic injury leading to death and the family needs supportive end-of-life care.

SOURCE: Bindler & Ball, 2007.

Maternal-Child Care in the Community

Primary care is the focus of much attention as caregivers search for a new, more effective direction for health care. Primary care includes a focus on health promotion, illness prevention, and individual responsibility for one's own health. These services are best provided in community-based settings. Healthcare payers are beginning to recognize the importance of primary care in containing costs and maintaining health. Community-based healthcare systems that provide primary care and some secondary care are becoming available in schools, workplaces, homes, churches, clinics, transitional care programs, and other ambulatory settings.

The growth and diversity of health payer plans offer both opportunities and challenges for women's and children's health care. Opportunities for improved delivery of screening and preventive services exist in community-based models of coordinated and comprehensive well-woman and well-child care. A challenge that health payer plans face is how to relate to essential community providers of care, such as family-planning clinics, women's health centers, and child health centers, that offer a unique service or serve groups of women and children with special needs (adolescents, women and children with disabilities, and ethnic or racial minorities).

Community-based care remains an essential element of health care for uninsured or underinsured individuals, as well as for individuals who benefit from programs such as Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). Some of these programs are broad based, such as those offered through public health departments, while others, such as parenting classes for adolescents, are geared to the needs of a specific population.

Maternal-child nurses are especially sensitive to these changes in healthcare delivery because the vast majority of health care provided to childbearing and childrearing families takes place outside of hospitals in clinics, offices, and community-based organizations. In addition, maternal-child nurses offer specialized services such as childbirth preparation classes, sibling classes, and parenting classes.

Healthcare reform has increased the emphasis on the need for individuals to have a *medical home* or *healthcare home*—a continuous, comprehensive, family-centered, and compassionate source of health care. This is especially important for children throughout their developmental years. Criteria for a medical or healthcare home for children include being well known by a physician or nurse who provides the usual source of sick care and having access to specialty care and other services or therapies. In addition, the healthcare provider spends adequate time communicating clearly with the family, provides help with care coordination when needed, respects the family's values and partners with the family in the child's care, and provides interpreters when necessary. An estimated 54.4% of U.S. children have a healthcare home that meets these criteria (Health Resources and Services Administration, 2014).

The current trend toward shorter hospital stays can end in the discharge of individuals who still require support, assistance, and teaching. Health care provided in a client's home helps fill this gap. Home care also enables newborns, infants, children, and women to remain at home with conditions that formerly would have required hospitalization.

Nurses are major providers of home care services. Home care nurses perform direct nursing care and also supervise unlicensed assistive personnel who provide less skilled levels of service. In a home setting, nurses use their skills in assessment, intervention, communication, teaching, problem solving, and organization to meet the needs of childbearing and childrearing families. They also play a major role in coordinating services from other providers, such as physical therapists or lactation consultants.

Postpartum and newborn home visits help ensure a satisfactory transition from the birthing center to the home. This positive trend meets the needs of childbearing families and should become standard practice. See Chapter 29 for discussion of home care and guidance about making a home visit. Information on home care is also provided as appropriate throughout this text.

Many children with serious chronic conditions and disabilities assisted by technology are now cared for at home by families rather than by long-term hospitalization. After studies

EVIDENCE-BASED PRACTICE | Home Visiting Services and Birth Outcomes

Clinical Question
Can prenatal home visiting services improve birth outcomes, even in high-risk populations?

The Evidence
Poor birth outcomes have negative consequences on families and communities. Home nursing visits during the prenatal period have been proposed as one way to achieve better birth outcomes.

Two studies focused on the effects of prenatal home visits on adequacy of prenatal care, low birth weight, preterm labor, initiation of breastfeeding, breastfeeding duration, and preventable risk factors for newborn morbidity, such as smoking. One study was a cross-sectional analysis of data from the state Pregnancy Risk Assessment and Monitoring System (PRAMS) that included 1 year of data and 407 women. The second study focused on high-risk pregnancies in a population of African American women; in this study, monthly home visits were part of a maternal health program emphasizing racial equity and case management. State data representing more than 9300 women were used in the latter study and used a matched-comparison design. These studies, taken together, comprise a strong level of evidence.

Women in both studies had a reduced incidence of low birth weight when compared with mothers who had no home visits. In the population of African American women, better birth weight was achieved even though they had a higher prenatal smoking rate (Kothari, Zielinski, James, et al., 2014). Women with home visits sought out more consistent prenatal care and initiated breastfeeding at a higher rate than their counterparts without home visits. Women in the PRAMS study initiated postnatal contraception at a higher rate than those without home visits, although this result was not detected in the population of African American women (Shah & Austin, 2014).

Best Practice
Home visits during the prenatal period can reduce the incidence of low-birth-weight babies and can support the early initiation of breastfeeding. In high-risk populations, home visits in the context of case management and culturally appropriate care can improve birth outcomes even in the presence of risk factors.

Clinical Reasoning
What might be the elements of a prenatal program that are modified to be culturally appropriate? How can prenatal home visits demonstrate cost effectiveness when designing overall maternal-child care?

in the 1980s found that home health care was substantially less expensive than hospital care, Congress amended laws to permit payment of home care services with federal funds, such as through Medicaid. Children with conditions considered fatal 15 years ago are thriving with home care and are participating in family, community, and school life. See Chapter 38.

Complementary Care

Interest in complementary care, previously termed complementary and alternative therapies (CAM), continues to grow nationwide and affects the care of childbearing and childrearing families. Complementary care includes a wide array of therapies, such as acupuncture, acupressure, therapeutic touch, biofeedback, massage therapy, meditation, herbal therapies, and homeopathic remedies. Concepts related to the use of complementary care by families are presented in more detail in Chapter 2.

Access to Health Care

Healthcare issues are at the top of policy and legislative agendas. Cost, access, and quality of health care have become the "bywords" of the times. In 2011, healthcare expenditures in the United States were $2.3 trillion, a 4.1% increase over the previous year (National Center for Health Statistics [NCHS], 2014).

Almost all adults over age 65 are covered by Medicare; so the vast majority of the uninsured are under age 65. In 2012, the percentage of people ages 18 to 44 covered by private insurance declined from 68.7% in 2002 to 61.4% in 2012. This decrease has been offset, however, by increases in the percentage of people with Medicaid, which increased from 7.1% to 11.6% during this same 10-year period (NCHS, 2014).

The Affordable Care Act bridges a portion of the gap. It ends pre-existing condition exclusions for children, eliminates annual limits on insurance coverage, and keeps young adults covered for a longer period. It also provides more affordable health insurance options including tax credits for middle- and low-income families. These credits cover a major portion of the cost (U.S. Department of Health and Human Services, 2015).

Congress created the Children's Health Insurance Program (CHIP) in 1997 and reauthorized it in 2009 to provide health insurance for children when their family's income is too high to qualify for Medicaid but inadequate to pay for private insurance coverage. An estimated 43 million children have health insurance coverage through Medicaid and CHIP (Centers for Medicare and Medicaid Services, 2014a). The average income eligibility criteria among the states is 241% of the federal poverty level for families to obtain free or low-cost health coverage for their children (Centers for Medicare and Medicaid Services, 2014b).

For women who become pregnant, early prenatal care is one of the most important approaches available to reduce adverse pregnancy outcomes. In 2008, 70.7% of pregnant women in the United States who had live births began prenatal care in the first trimester. However, these percentages vary significantly among groups, with Black or African American, Hispanic or Latina, and Native American women less likely to receive early and adequate prenatal care than White and Asian women (NCHS, 2013).

Healthy People 2020 Goals

For 30 years the federal government's *Healthy People* program has been providing science-based, national agendas for improving the health of all Americans. "The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action, and indeed, in just the last decade, preliminary analyses indicate that the country has either progressed toward or met 71% of its *Healthy People* targets" (U.S. Department of Health and Human Services, 2011, p. 1). In December 2010, the next 10-year effort, *Healthy People 2020*, was launched. *Healthy People 2020* is grouped by topic area and objectives.

Maternal-newborn, pediatric, and women's health nurses focus directly on many of the topics, including the following:

- Maternal, newborn, infant, and child health
- Adolescent health (new)
- Family planning
- Injury and violence prevention
- Lesbian, gay, bisexual, and transgender health (new)
- Sexually transmitted infections

Because of the role women play in maintaining their family's health, many other topics may also be of importance to them, such as immunization and infectious diseases, diabetes, and nutrition and weight status, to name but a few. Nurses of all disciplines will find it helpful to become familiar with the 2020 topics and objectives, which may be found at the *Healthy People* website. To increase your familiarity with the objectives, look for the *Healthy People 2020* feature that identifies relevant objectives for topics presented throughout the text.

Culturally Competent Care

The population of the United States daily becomes more diverse. Approximately 47% of all children younger than 18 years of age are from families of minority populations (Federal Interagency Forum on Child and Family Statistics, 2013). Thus, it is vitally important for a nurse who cares for women and children to recognize the importance of a family's cultural values and beliefs, which may be quite different from those of the nurse.

Specific elements that contribute to a family's value system include the following:

- Religion and social beliefs
- Presence and influence of the extended family, as well as socialization within the ethnic group
- Communication patterns
- Beliefs and understanding about the concepts of health and illness
- Permissible physical contact with strangers
- Education

When the family's cultural values are incorporated into the care plan, the family is more likely to accept and comply with the needed care, especially in the home care setting. It is important for nurses to avoid imposing personal cultural values on the families and children in their care. By learning about the values of the different ethnic groups in the community, nurses can develop an individualized nursing care plan for each child and family.

Because of the importance of culturally competent care, this topic is discussed in more depth in Chapter 2 and throughout the book in special boxed features.

Developing Cultural Competence **Values Conflicts**

Conflicts can occur within a family when the traditional rituals and practices of the family do not conform to current healthcare practices. Nurses need to be sensitive to these potential conflicts when managing a child's health care, especially after the child has been discharged from the hospital. When cultural values are not part of the nursing care plan, parents may be forced to decide whether the family's beliefs should take priority over the healthcare professional's guidance.

Statistical Data and Maternal-Child Care

Health-related statistics provide an objective basis for projecting client needs, planning the use of resources, and determining the effectiveness of specific treatments. Statistics are used to help identify certain healthcare trends and high-risk target groups. The following sections discuss descriptive statistics that are particularly important to maternal-child health care.

Birth Rate

Birth rate refers to the number of live births per 1000 people in a given population. Worldwide, birth rates vary dramatically as Table 1–2 indicates. In the United States in 2013, the birth rate was 12.6. Birth rates decreased for women in all age groups between 15 and 29 years of age. The rate for women ages 30 to 39 increased, the rate for women for women ages 40 to 44 was unchanged, while the rate for women ages 45 to 49 increased (Martin, Hamilton, & Osterman, 2014).

The statistics do raise questions. For example: What is the impact of cultural differences and changing societal values on birth rates? Do birth rates change when access to information on contraception increases? What role does government policy, such as China's legislation limiting births to one child per family, play?

Maternal Mortality

The **maternal mortality rate** is the number of deaths from causes related to or aggravated by pregnancy or the management of pregnancy during the pregnancy cycle (including the 42-day postpartum period) per 100,000 live births. It does not include deaths of pregnant women due to external causes such as accidents, homicides, and suicides. Since 1986, the Centers for Disease Control and Prevention (CDC) has tracked pregnancy-related deaths. **Pregnancy-related deaths** are defined

TABLE 1–2 Live Birth Rates and Infant Mortality Rates for Selected Countries*

COUNTRY	BIRTH RATE	INFANT MORTALITY RATE
Afghanistan	38.8	117.2
Argentina	16.9	10.0
Australia	12.2	4.4
Cambodia	24.4	51.4
Canada	10.3	4.7
China	12.2	14.8
Egypt	23.4	22.4
Germany	8.4	3.5
Ghana	31.4	38.5
India	19.9	43.2
Iraq	26.9	37.5
Japan	8.1	2.1
Mexico	19.0	12.6
Russia	11.9	7.1
United Kingdom	12.2	4.4
United States	12.6*	6.0*

*Based on 2013 final data.

Source: Data from *The World Fact Book 2014.* Washington, DC: The Central Intelligence Agency. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/uk.html

as the death of a woman while pregnant or within 1 year of the termination of pregnancy (regardless of the length of the pregnancy or the site of implantation) from any cause aggravated by pregnancy or related to it (NCHS, 2013). The pregnancy-related mortality rate in the United States in 2009 was 17.8 deaths per 100,000 live births, which was the highest level reported since surveillance began. Black women have a significantly higher risk of maternal death than White women: 35.6 deaths per 100,000 live births as compared to 11.7 deaths for White women and 17.6 deaths for women of other races (NCHS, 2013).

Factors influencing the long-term decrease in maternal mortality include the increased use of hospitals and specialized healthcare personnel by maternity clients, the establishment of care centers for high-risk mothers and infants, the prevention and control of infection with antibiotics and improved techniques, the availability of blood products for transfusions, and the lowered rates of anesthesia-related deaths. Additional factors may be identified by asking the following research questions: Is there a correlation between maternal mortality and age? Is there a correlation between maternal mortality and availability of health care? Is economic status a factor in maternal mortality?

Healthy People 2020

(MICH-5) Reduce the rate of maternal mortality

Infant Mortality

The **infant mortality rate** is the number of deaths of infants under 1 year of age per 1000 live births in a given population. *Neonatal mortality* is the number of deaths of infants less than 28 days of age per 1000 live births, *perinatal mortality* includes both neonatal deaths and fetal deaths per 1000 live births, and *fetal death* is death in utero at 20 weeks or more gestation.

In 2013, the infant mortality rate in the United States was 5.96 per 1000 live births (Figure 1–5) (Kochanek, Murphy, Xu, et al., 2014). Infant mortality rates are higher among infants born in multiple births, infants born prematurely, and those born to unmarried mothers; rates are also higher for infants of teen mothers and mothers 40 years of age and older (Mathews & MacDorman, 2012).

The U.S. infant mortality rate continues to be of concern because the United States' rate is higher than that of most European countries as well as Australia, New Zealand, Japan, Korea, and Israel. Much of the infant mortality rate can be attributed to the high percentage of preterm births in the United States (MacDorman, Mathews, Mohangoo, et al., 2014). Healthcare professionals, policy makers, and the public continue to stress the need for better prenatal care, coordination of health services, and provision of comprehensive maternal-child services in the United States.

Table 1–2 identifies infant mortality rates for selected countries. As the data indicate, the range is dramatic among the countries listed. Information about birth rates and mortality rates is limited for some countries because of a lack of organized reporting mechanisms.

The information raises questions about access to health care during pregnancy and after birth and about standards of living, nutrition, and sociocultural factors. Additional factors affecting the infant mortality rate may be identified by considering the following research questions: What are the leading causes of infant mortality in each country? Why do mortality rates differ among racial groups?

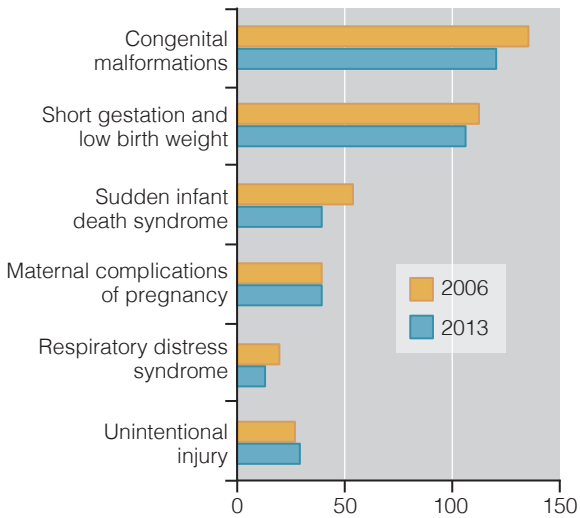


Figure 1–5 Infant mortality rates for the six leading causes of infant death in the United States, 2006 and 2013.

SOURCE: Heron, M., Hoyert, D. L., Murphy, S. L., Xu, J., Kochanek, K. D., & Tejada, B. (2009). Deaths: Final data for 2006. *National Vital Statistics Reports, 57*(14), 1–136; Kochanek, K. D., Murphy, S. L., Xu, J., & Arias, E. (2014). Mortality in the United States, 2013. *NCHS Data Brief*, No. 178. Retrieved from http://www.cdc.gov/nchs/data/databriefs/db178.pdf

Pediatric Mortality

The most common cause of death for U.S. children between 1 and 19 years of age is injury. Congenital malformations, cancer, and diseases of the heart are the most common medical causes of death.

Although unintentional injury is the leading cause of death, it is disturbing that intentional injury (homicide and suicide) is a major cause of death for the nation's children. The major causes of unintentional injury mortality in childhood include motor vehicle accidents (passengers and pedestrians), drowning, fires and burns, suffocation, and poisoning. Table 1–3 illustrates the leading causes of injury deaths by age group. Many injury prevention programs have been implemented by state health departments, healthcare facilities, and national organizations to reduce the number of children who die unnecessarily.

Healthy People 2020

(MICH-3) Reduce the rate of child deaths

Pediatric Morbidity

Morbidity—an illness or injury that limits activity, requires medical attention or hospitalization, or results in a chronic condition—also varies according to the age of the child. In 2011, children under 18 years of age accounted for more than 5.6 million hospitalizations, and the number of hospitalizations in this age group decreased 26% since 1997. Infants less than 1 year of age accounted for 4.2 million of these hospitalizations. Most of these hospitalizations were related to birth, but other leading causes of hospitalization included acute bronchitis, hemolytic jaundice, pneumonia, and short gestation/low birth weight (Pfuntner, Wier, & Stocks, 2013). Figure 1–6 illustrates the five leading causes of hospitalization of children 1 through 17 years of age in 2011. Diseases of the respiratory system account for the greatest number of hospitalizations when pneumonia and asthma hospitalizations are combined. Mood disorders hospitalizations have increased 68% since 1997.

TABLE 1–3 Five Leading Causes of Injury Death by Age Group, 2013*

	RANKING				
AGE GROUP	FIRST	SECOND	THIRD	FOURTH	FIFTH
Under 1 year	Suffocation	Homicide, unspecified cause	Homicide, specified cause	Motor vehicle	Undetermined suffocation
1 to 4 years	Drowning	Motor vehicle	Suffocation	Homicide	Fire, burns
5 to 9 years	Motor vehicle	Drowning	Fire, burns	Homicide, firearm	Suffocation
10 to 14 years	Motor vehicle	Suicide, suffocation	Suicide, firearms	Homicide, firearms	Drowning
15 to 19 years	Motor vehicle	Homicide, firearm	Suicide, suffocation	Suicide, firearms	Poisoning

Source: Data from National Center for Health Statistics. (2015). *10 leading causes of injury deaths, United States 2013*. Retrieved from http://www.cdc.gov/injury/wisqars/fatal.html

*Darker shading indicates unintentional injuries.

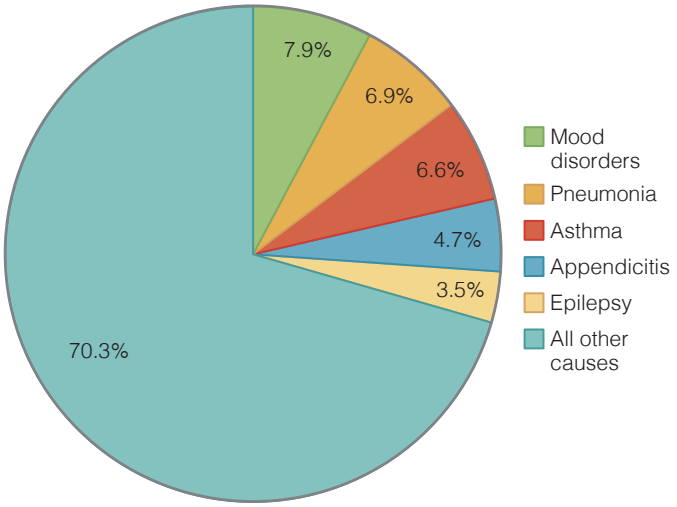


Figure 1–6 The leading causes of hospitalization for children 1 to 17 years of age in the United States in 2011 presented as a percentage of all causes of hospitalization in this age group.

SOURCE: Data from Pfuntner, A., Wier, L. M., & Stocks, C. (2013). Most frequent conditions in U.S. hospitals, 2011. *H-CUP Statistical Brief # 162*. Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb162.pdf

Implications for Nursing Practice

Nurses can use statistics in a number of ways. For example, they can use statistical data to:

- Determine populations at risk.
- Assess the relationship between specific factors.
- Help establish databases for specific client populations.
- Determine the levels of care needed by particular client populations.
- Evaluate the success of specific nursing interventions.
- Determine priorities in caseloads.
- Estimate staffing and equipment needs of hospital units and clinics.
- Apply for funding to support health needs.

Nurses who use statistical information are better prepared to promote the health needs of maternal, newborn, and pediatric clients and their families.

Legal Considerations in Maternal-Child Nursing

Scope of Practice

Scope of practice is defined as the limits of nursing practice set forth in state statutes. Although some state practice acts continue to limit nursing practice to the traditional responsibilities of providing client care related to health maintenance and disease prevention, most state practice acts cover expanded practice roles that include collaboration with other health professionals in planning and providing care, physician-delegated diagnosis and prescriptive privileges, and the delegation of direct care tasks to other specified licensed and unlicensed personnel. A nurse must function within the scope of practice or risk being accused of practicing medicine without a license.

Standards of Nursing Care

Standards of care establish minimum criteria for competent, proficient delivery of nursing care. Such standards are designed to protect the public and are used to judge the quality of care provided. Legal interpretation of actions within standards of care is based on what a reasonably prudent nurse with similar education and experience would do in similar circumstances.

The American Nurses Association (ANA) has published standards of practice for maternal-child health. ANA, the National Association of Pediatric Nurse Practitioners, and the Society of Pediatric Nurses (2008) collaborated on the development of standards for pediatric clinical nursing practice. The ANA and the National Association of Neonatal Nurses also published the scope and standards of practice for neonatal nursing (2008). Specialty organizations such as the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) continue to set the standards of professional nursing practice in the care of women and newborns. Agency policies, procedures, and protocols also provide appropriate guidelines for care standards. For example, **clinical practice guidelines** are comprehensive interdisciplinary care plans for a specific condition that describe the sequence and timing of interventions that should result in expected client outcomes. Clinical practice guidelines are adopted within a healthcare setting to reduce variation in care management, to limit costs of care, and to evaluate the effectiveness of care.

While standards of care do not carry the force of law, they have important legal significance. Any nurse who fails to meet appropriate standards of care invites allegations of negligence or malpractice. Practicing within the guidelines established by an agency or following local or national standards decreases the potential for litigation.

Patient Safety

The Joint Commission, a nongovernmental agency that audits the operation of hospitals and healthcare facilities, has identified patient safety as an important responsibility of healthcare providers and provides an annual list of specific patient safety goals. Specific criteria that healthcare facilities must meet for accreditation can be found on the Joint Commission website.

Safety is a major focus of nursing education programs. The Quality and Safety Education for Nurses (QSEN) project, established in 2005, is designed "to meet the challenge of preparing future nurses who will have the knowledge, skills, and attitudes (KSAs) necessary to improve continuously the quality and safety of the healthcare systems within which they work" (QSEN, 2011, p. 1). The project focuses on competencies in six areas:

1. Client-centered care
2. Teamwork and collaboration
3. Evidence-based practice
4. Quality improvement
5. Safety
6. Informatics

To support the efforts of the Joint Commission and to draw special attention to the importance of the QSEN project's emphasis on safety, key issues related to safety are noted throughout this text with the words **SAFETY ALERT!** in red.

Infants and children are at a higher risk for medical error than adults and also may be more vulnerable to harm from errors made. Most errors in medical care within hospitals are "systems" errors related to equipment, complex procedures, fragmented care, and lack of standardized procedures (see Figure 1–7). Incorrect dosing is a commonly reported medication error and reasons for this increased risk among children include the following:

- Medication dosage is based on weight or body surface area, often making dosage calculations more complex. The misplacement of a decimal point in the medication dosage calculation can result in an overdose that can cause harm to a child or even death.
- Children often need suspensions or liquid preparations, adding to the dosage calculation complexity. Not only must the correct dose be calculated, but also the amount of liquid preparation with that dose. Some medications are in concentrations that require dilution, further complicating the accurate medication dosage calculation.
- Off-label medications (those not yet approved for use in children by the U.S. Food and Drug Administration [FDA]) are sometimes prescribed, thus the appropriate pediatric dose and adverse effects are unknown.
- Young children cannot communicate well if they are having a reaction to the medication.

Limited English proficiency may also be a potential source of medical error for childbearing women and children. In such cases, a risk exists for errors in interpretation—either of what the health professional says or what the family member understands. Healthcare facilities are actively working to implement strategies that will reduce medical errors in all child clients.

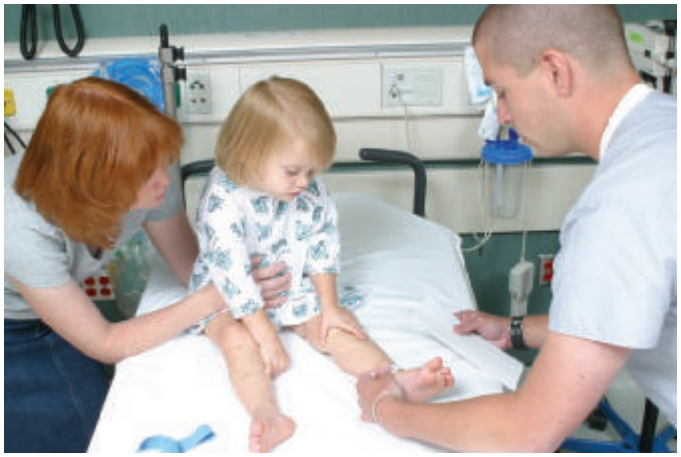


Figure 1–7 **An important client safety action is to verify the identity of the child prior to performing any procedure or administering medication. The nurse needs two forms of identification. In this case, the child's identification bracelet is compared to the name and birth date on the laboratory test form, and the parent also confirms the child's identity.**

Informed Consent

Informed consent is a legal concept that protects a person's right to autonomy and self-determination by specifying that no action may be taken without that individual's prior understanding and freely given consent. Although this policy is actively enforced for major procedures, surgery, or regional anesthesia, it pertains to any nursing, medical, or surgical intervention. To touch a person without consent (except in an emergency) constitutes *battery*. Consent is not informed unless the client, or parent (or guardian) in the case of a child, understands the recommended procedures or treatments, their rationales, the benefits of each, alternative treatments, and any associated risks. When possible, it is important to have translators available for non–English-speaking women and families.

The person who is ultimately responsible for the treatment or procedure, usually the physician, should provide the information necessary to obtain informed consent. In such cases, the nurse's role is to witness the client's signature (or the parent's signature for a child) giving consent. The nurse may also serve as a witness if clients or parents give verbal consent by telephone. If the nurse determines that the individual does not understand the procedure or risks, the nurse must notify the physician, who must then provide additional information to ensure that the consent is informed. The nurse also responds to questions asked by adult clients or by parents and children. Anxiety, fear, pain, and medications that alter consciousness may influence an individual's ability to give informed consent. An oral consent is legal, but written consent is easier to defend in a court of law. Adolescents under 18 or 21 years of age, depending on state law, can legally give informed consent in the following circumstances (American Academy of Pediatrics, 2011):

- The minor is a parent or is pregnant.
- The adolescent is a legally **emancipated minor** (self-supporting adolescent under 18 years of age not subject

to parental control; for example, not living at home, married, on active duty in the military, or incarcerated). In most states, a pregnant teen is considered emancipated.

- In some states, **mature minors** (14- to 18-year-old adolescents who are able to understand treatment risks) can give independent consent for treatment or refuse treatment for some limited conditions such as testing and treatment for sexually transmitted infections, family planning, drug and alcohol abuse, blood donation, and mental health care (Coleman & Rosoff, 2013).

Refusal of a treatment, medication, or procedure after appropriate information is provided also requires that the individual sign a form releasing the physician and clinical facility from liability resulting from the effects of such a refusal. Refusal of blood transfusions by Jehovah's Witnesses is an example of such refusal.

Nurses are responsible for educating clients about any nursing care. Before each nursing intervention, the maternal-child nurse lets the individual and/or family know what to expect, thus ensuring cooperation and obtaining consent. Afterward the nurse documents the teaching and the learning outcomes in the person's record. The importance of clear, concise, and complete nursing records cannot be overemphasized. These records are evidence that the nurse obtained consent, performed prescribed treatments, reported important observations to the appropriate staff, and adhered to acceptable standards of care.

Because children are not considered competent to make healthcare decisions, parents, as the legal custodians of minor children, are customarily requested to give informed consent on behalf of a child. Both children and parents must understand that they have the right to refuse treatment at any time. In an emergency, consent for treatment to preserve life or limb is not required. When parents are divorced, some states limit the parental rights to give informed consent to the parent with custody. When parents have joint custody, in most cases, either parent may give consent. The nurse should obtain legal advice from the facility's designated legal experts for complex family issues related to guardianship, divorced parents disagreeing over care, or a caregiver who is not the legal guardian.

Parents or guardians have absolute authority to make choices about their child's health care except in certain cases. Specifically:

- When the parents' choice of treatment does not permit life-saving treatment for the child
- When there is a potential conflict of interest between the child and parents, such as with suspected child abuse or neglect

In some cases, the court may be requested to appoint a proxy decision maker for the child or to determine that the child is capable of making a major treatment decision.

Children should become more actively involved in decision making about treatment procedures as their reasoning skills develop. Children too young to give informed consent can be given age-appropriate information about their condition and asked about their care preferences. Their parents, however, make ultimate decisions about their care.

With regard to children's participation in research, federal guidelines state that children 7 years of age and older must receive information about a research project and give *assent* (the voluntary agreement to participate in a research project or to accept treatment) before they are enrolled. Children should be given adequate time to ask questions and be told that they have the right to refuse to participate in the study. The child is then asked if he or she wishes to participate. If the child assents, parents then provide signed permission for the child to participate in the research project.

Growth and Development

By 7 or 8 years of age, a child is able to understand concrete explanations about informed consent for research participation. By age 11, a child's abstract reasoning and logic abilities are advanced. By age 14, an adolescent can weigh options and make decisions regarding consent as capably as an adult.

Right to Privacy

The *right to privacy* is the right of a person to keep his or her person and property free from public scrutiny. To protect this right for clients and families, only those responsible for their care should conduct an examination or discuss their case.

The right to privacy is protected by state constitutions, statutes, and common law. The ANA, the National League for Nursing (NLN), and the Joint Commission have adopted professional standards protecting the privacy of clients. Healthcare agencies should also have written policies dealing with client privacy. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was fully implemented in 2002, also has a provision to guarantee the security and privacy of health information.

Laws, standards, and policies about privacy specify that information about an individual's treatment, condition, and prognosis can be shared only by health professionals responsible for his or her care. Information considered vital statistics (name, age, occupation, and so on) may be revealed legally, but is often withheld because of ethical considerations. The client should be consulted as to what information may be released and to whom.

Professionalism in Practice Adolescents and Confidentiality

Breaching confidentiality is a potential problem for adolescents, who are just learning whom they can trust in the healthcare system. Current electronic health records that provide access to parents and adolescents regarding personal health care have no current criteria for limiting access by parents to data regarding care adolescents have sought privately as a mature minor (American Academy of Pediatrics, 2012). Make sure you openly discuss the limits of confidentiality in electronic health records as well as mandatory reporting requirements with the client and family. Inadvertent disclosure of personal information may lead to psychologic, social, or physical harm in some clients.

Patient Self-Determination Act

The federal Patient Self-Determination Act directs healthcare institutions to inform hospitalized clients about their rights, which include expressing a preference for treatment options and making **advance directives** (writing a living will or authorizing a durable power of attorney for healthcare decisions on the individual's behalf). Nurses often discuss these issues with clients and their families. Minor children and their parents should also be informed of their rights. Adolescents with serious acute or

chronic conditions with a higher risk of death should be encouraged to talk with their parents about their healthcare wishes and to prepare advance directives jointly.

Do-not-resuscitate (DNR) (or *allow natural death [AND]*) orders have become more common for children with terminal illnesses in which no further aggressive treatments are available or desired. In many cases, these children are cared for at home or in a hospice program. Implementation of DNR orders for such children then becomes a community issue—to ensure that resuscitation measures are not initiated by any emergency care provider when the child has a life-threatening event. State health policies must be developed so children with these signed orders are easily identified and appropriate documentation of the orders is on file.

Ethical Issues in Maternal-Child Nursing

Although ethical dilemmas confront nurses in all areas of practice, those related to pregnancy, birth, newborns, and children seem especially difficult to resolve.

Maternal-Fetal Conflict

Until fairly recently the fetus was viewed legally as a nonperson. Mother and fetus were viewed as one complex client—the pregnant woman—of which the fetus was an essential part. However, advances in technology have permitted the physician to treat the fetus and monitor fetal development. The fetus is increasingly viewed as a client separate from the mother. This focus on the fetus intensified in 2002 when President George W. Bush announced that "unborn children" would qualify for government healthcare benefits. This move was designed to promote prenatal care, but it represented the first time that any U.S. federal policy had defined childhood as starting at conception.

Most women are strongly motivated to protect the health and well-being of their fetus. In some instances, however, women have refused interventions on behalf of the fetus, and forced interventions have occurred. These include forced cesarean birth, coercion of mothers who practice high-risk behaviors, such as substance abuse, to enter treatment; and, perhaps most controversial, mandated experimental in utero therapy or surgery in an attempt to correct a specific birth defect. These interventions infringe on the autonomy of the mother. They may also be detrimental to the baby if, as a result, maternal bonding is hindered, the mother is afraid to seek prenatal care, or the mother is herself harmed by the actions taken.

Attempts have also been made to criminalize the behavior of women who fail to follow a physician's advice or who engage in behaviors (such as substance abuse) that are considered harmful to the fetus. This raises two thorny questions:

1. What practices should be monitored?
2. Who will determine when the behaviors pose such a risk to the fetus that the courts should intervene?

The American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics has affirmed the fundamental right of pregnant women to make informed, uncoerced decisions about medical interventions and has taken a direct stand against coercive and punitive approaches to the maternal-fetal relationship (ACOG, 2005).

Both ACOG and the American Academy of Pediatrics recognize that cases of maternal-fetal conflict involve two clients, both of whom deserve respect and treatment. Such cases are best resolved by using internal hospital mechanisms, including counseling, the intervention of specialists, and consultation with an institutional ethics committee. Court intervention should be considered a last resort, being appropriate only in extraordinary circumstances.

Abortion

Since the 1973 *Roe v. Wade* Supreme Court decision, elective abortion has been legal in the United States. Abortion can be performed until the period of viability; that is, the point at which the fetus can survive independently of the mother. After that time, abortion is permissible only when the life or health of the mother is threatened. Before viability, the rights of the mother are paramount; after viability, the rights of the fetus take precedence.

Personal beliefs, cultural norms, life experiences, and religious convictions shape people's attitudes about abortion. Ethicists have thoughtfully and thoroughly argued positions supporting both sides of the question. Nevertheless, few issues spark the intensity of response seen when the issue of abortion is raised.

At present, the decision about abortion is to be made by the woman and her physician. Nurses (and other caregivers) have the right to refuse to assist with the procedure if abortion is contrary to their moral and ethical beliefs. However, if a nurse works in an institution where abortions may be performed, the nurse can be dismissed for refusing to assist. To avoid being placed in a situation contrary to personal ethical values and beliefs, it is important to identify the practices of an institution before going to work there. A nurse who refuses to participate in an abortion because of moral or ethical beliefs has a responsibility to ensure that someone with similar qualifications is available to provide appropriate care for the client. Clients must never be abandoned, regardless of a nurse's beliefs.

Intrauterine Fetal Surgery

Intrauterine fetal surgery, an example of therapeutic research, is a therapy for anatomic lesions that can be corrected surgically and are incompatible with life if not treated. Examples include surgery for myelomeningocele and some congenital cardiac defects. The procedure involves opening the uterus during the second trimester (before viability), performing the planned surgery, and replacing the fetus in the uterus. The risks to the fetus are substantial, and the mother is committed to cesarean births for this and subsequent pregnancies (because the upper, active segment of the uterus is entered). The parents must be informed of the experimental nature of the treatment, the risks of the surgery, the commitment to cesarean birth, and alternatives to the treatment.

As in other aspects of maternity care, caregivers must respect the pregnant woman's autonomy. The procedure involves health risks to the woman, and she retains the right to refuse any surgical procedure. Healthcare providers must be careful that their zeal for new technology does not lead them to focus unilaterally on the fetus at the expense of the mother.

Reproductive Assistance

Assisted reproductive technology (ART) is the term used to describe highly technologic approaches used to produce pregnancy. *In vitro fertilization* and *embryo transfer (IVF-ET)*, a therapy offered to selected infertile couples, is perhaps the best known ART technique.

Multifetal pregnancy may occur with ART because the use of ovulation-inducing medications typically triggers the release of multiple eggs that, when fertilized, produce multiple embryos, which are then implanted. Multifetal pregnancy increases the risk of miscarriage, preterm birth, and neonatal morbidity and mortality. It also increases the mother's risk of complications, including cesarean birth. To help prevent a high-order multifetal pregnancy (presence of three or more fetuses), the American Society for Reproductive Medicine (ASRM) has issued guidelines to limit the number of embryos transferred. These guidelines are designed to decrease risk while allowing for individualized care (ASRM & Society for Assisted Reproductive Technology, 2013).

This practice raises ethical considerations about the handling of the unused embryos. However, when a multifetal pregnancy does occur, the physician may suggest that the woman consider fetal reduction, in which some of the embryos are aborted to give the remaining ones a better chance for survival. Clearly this procedure raises ethical concerns about the sacrifice of some so that the remainder can survive.

Prevention should be the first approach to the problem of multifetal pregnancy. It begins with careful counseling about the risks of multiple gestation and the ethical issues that relate to fetal reduction. No physician who is morally opposed to fetal reduction should be expected to perform the procedure; however, physicians should be aware of the ethical and medical issues involved and be prepared to respond to families in a professional and ethical manner (ACOG, 2013).

Surrogate childbearing is another approach to infertility. Surrogate childbearing occurs when a woman agrees to become pregnant for a childless couple. She may be artificially inseminated with the male partner's sperm or a donor's sperm or may receive a gamete transfer, depending on the infertile couple's needs. If fertilization occurs, the woman carries the fetus to term and releases the newborn to the couple after birth.

These methods of resolving infertility raise ethical issues about candidate selection, responsibility for a child born with a congenital defect, and religious objections to artificial conception. Other ethical questions include the following:

- What should be done with surplus fertilized oocytes?
- To whom do frozen embryos belong?
- Who is liable if a woman or her offspring contracts HIV from donated sperm?
- Should children be told about their conception?

Embryonic Stem Cell Research

Human stem cells can be found in embryonic tissue and in the primordial germ cells of a fetus. Research has demonstrated that in tissue cultures these cells can be made to differentiate into other types of cells such as blood, nerve, or heart cells, which might then be used to treat problems such as diabetes, Parkinson and Alzheimer diseases, spinal cord injury, or metabolic disorders. The availability of specialized tissue or even organs grown from stem cells might also decrease society's dependence on donated organs for organ transplants.

Positions about embryonic stem cell research vary dramatically, from the view that any use of human embryos for research is wrong to the view that any form of embryonic stem cell research is acceptable, with a variety of other positions that fall somewhere in between these extremes. Other questions also arise: What sources of embryonic tissue are acceptable for research? Is it ever ethical to clone embryos solely for stem cell research? Is there justification for using embryos remaining after fertility treatments?

The question of how an embryo should be viewed—with the status in some way of a person or in some sense of property (and, if property, whose?)—is a key question in the debate. Ethicists recognize that it is not necessary to advocate full moral status or personhood for an embryo in order to have significant moral qualms about the instrumental use of a human embryo in the "interests" of society. The issue of consent, which links directly to an embryo's status, also merits consideration. In truth, the ethical questions and dilemmas associated with embryonic stem cell research are staggeringly complex and require careful analysis and thoughtful dialogue.

Making Treatment Decisions for Children

Technology makes it possible to sustain the lives of children who previously would have died, thus creating many ethical issues. Conflict often arises between health professionals and parents when parents choose to withhold therapy or to request aggressive therapy on behalf of their child and the health professionals have a different opinion about treatment. Nurses often face ethical dilemmas when providing care to such a child, especially as they witness parents struggling to decide among treatment options.

When making treatment decisions in pediatrics, healthcare professionals need to determine whether their responsibility is limited to the child or includes the interests of the parents. The healthcare institution's ethics committee often plays a role in resolving conflicts about treatment decisions. Courts should make ethical decisions only when healthcare professionals and parents are unable to agree about providing or withholding treatment.

Terminating Life-Sustaining Treatment

The Child Abuse and Treatment Act of 1984, also known as the Baby Doe Regulations, defines withholding of medically indicated treatment for an infant with a life-threatening condition as medical neglect, except when care is futile (Douglas & Dahnke, 2013). Parents of such infants are usually the ultimate decision makers about the infant's care. Factors important to parents in making their decision include the infant's quality of life, degree of pain and suffering, likelihood for improvement, and physician recommendations. Physicians may believe treatment will help the infant and improve the quality of life (sometimes defined as a meaningful existence or an ability to develop human relationships). Conflict may arise when parents choose to withdraw therapy or request aggressive therapy when the healthcare providers' recommendations differ. An ethical consultation may be needed to resolve conflicts.

Organ Transplantation Issues

The death of a child can benefit several other children through organ transplantation, and organ transplantation has become an accepted therapeutic option for some life-threatening conditions. Children between 11 and 17 years of age account for nearly 45% of all children waiting for a transplant (Health Resources and Services Administration & Organ Procurement and Transplant Network, 2011). The National Organ Transplant Act (PL 98-507) generated laws, regulations, and guidelines for organ collection and transplantation. The limited supply of organs has created numerous ethical issues: Which individuals

on a waiting list should receive the organs available? Should a child with multiple congenital anomalies or abnormal chromosomes be eligible for a transplant? Should families be permitted to pay donor families for organs? Should the family's ability to pay for an organ transplant give a child higher priority for an organ? Should parents conceive another child hoping that the new baby is a potential stem cell donor for a child with an illness? If so, what pressures does this knowledge place on each child as he or she grows older?

Genetic Testing of Children

Genetic testing and screening of children are now possible for detection of carrier status or for presymptomatic detection of a specific condition, such as Duchenne muscular dystrophy. When genetic testing is considered, both the risks and benefits of receiving the results of the genetic test should be discussed when seeking informed consent. Genetic screening of newborns, such as for inborn errors of metabolism, cystic fibrosis, sickle cell disease, and other conditions, routinely occurs. In this case, the early identification of the genetic condition will have a clear benefit to the child, a system is in place to confirm the diagnosis, and treatment and follow-up are available for affected newborns. See Chapter 3 for more information on genetic testing.

Evidence-Based Practice in Maternal-Child Nursing

Evidence-based practice—that is, nursing care in which all interventions are supported by current, valid research evidence—is emerging as a force in health care. It provides a useful approach to problem solving and decision making and to self-directed, client-centered, lifelong learning. Evidence-based practice builds on the actions necessary to transform research findings into clinical practice by also considering other forms of evidence that can be useful in making clinical practice decisions. These other forms of evidence may include statistical data, quality measurements, risk management measures, and information from support services such as infection control.

As practicing clinicians, nurses need to meet three basic competencies related to evidence-based practice:

1. Recognize which clinical practices are supported by sound evidence, which practices have conflicting findings as to their effect on client outcomes, and which practices have no evidence to support their use.
2. Use data in their clinical work to evaluate outcomes of care.
3. Appraise and integrate scientific bases into practice.

Nurses need to know what data are being tracked in their workplaces and how care practices and outcomes are improved as a result of quality improvement initiatives. However, there is more to evidence-based practice—competent, effective nurses learn to question the very basis of their clinical work.

Throughout this text we have provided *snapshots* of evidence-based practice related to childbearing women and families. We believe that these *Evidence-Based Practice* features will help you understand the concept more clearly and may challenge you to question the usefulness of some of the routine care you observe in clinical practice. That is the impact of evidence-based practice—it moves clinicians beyond practices of habit and opinion to practices based on high-quality, current science.

Clinical Reasoning

It can be challenging to use evidence, analyze information, and make sound decisions that result in safe, effective client care.

Scenarios provide a realistic way of enabling students to apply concepts. The *Clinical Reasoning* feature found throughout the chapters and the *Clinical Reasoning in Action* feature at the end of every chapter in this text presents a client scenario and asks clinical reasoning questions to help students formulate how they would handle the issues raised and how they would apply concepts they have learned in the chapter.

Focus Your Study

- Many nurses working with childbearing and childrearing families are expert practitioners who are able to serve as role models for nurses who have not yet attained the same level of competence.
- Case management is a process of coordinating the delivery of healthcare services in a manner that focuses on both quality and cost outcomes.
- Contemporary childbirth is family centered, offers choices about birth, and recognizes the needs of siblings and other family members.
- In pediatric settings, *family-centered care* is a dynamic, deliberate approach to building collaborative relationships between health professionals and families that is respectful of their diversity and beliefs about the nature of children's health conditions and ways to manage them.
- The U.S. healthcare system is facing a variety of challenges including the high cost of health care and the need for cost containment while retaining quality, the large numbers of uninsured and underinsured people, high infant mortality rates as compared with other industrialized nations, and a high incidence of poverty, especially among children and households headed by women.
- The nurse who provides culturally competent care recognizes the importance of the family's value system, acknowledges that differences occur among people, and seeks to respect and respond to ethnic diversity in a way that leads to mutually desirable outcomes.
- Statistical data can also reveal trends that require research to determine cause, to analyze the implications of specific

findings for given populations, to explore relationships between specific factors, and to evaluate the success of specific nursing interventions.

- A nurse must practice within the scope of practice or be open to the accusation of practicing medicine without a license. The standard of care against which individual nursing practice is compared is that of a reasonably prudent nurse.
- Nursing standards provide information and guidelines for nurses in their own practice, in developing policies and protocols in healthcare settings, and in directing the development of quality nursing care.
- Informed consent—based on knowledge of a procedure and its benefits, risks, and alternatives—must be secured before providing treatment. Parents have authority to provide informed consent for all their children, except in cases when an adolescent is an emancipated minor or can be treated for specific conditions as a mature minor.
- Maternal-fetal conflict may arise when the fetus is viewed as a person of equal rights to those of the mother and external agents attempt to force the mother to accept a therapy she wishes to refuse or similarly attempt to restrict a mother's actions to support the well-being of the fetus.
- Abortion can be performed until the age of viability. Caregivers have the right to refuse to perform an abortion or assist with the procedure.
- Assisted reproductive technology (ART) is a term that describes the highly technologic approaches used to produce pregnancy. A variety of procedures are available to help infertile couples achieve a pregnancy. However, some of these procedures provoke serious ethical dilemmas.
- Embryonic stem cell research using human stem cells obtained from a human embryo is marked by controversy. On the one hand, it raises the possibility of treatment for a variety of major diseases such as diabetes, Parkinson disease, and Alzheimer disease. On the other hand, ethicists question the ethical implications of using embryonic tissue—especially tissue obtained specifically for stem cell research.
- Federal "Baby Doe" regulations were developed to protect the rights of infants with severe defects.
- Evidence-based practice—that is, nursing care in which all interventions are supported by current, valid research evidence—is emerging as a positive force in health care.

Clinical Reasoning in Action

You are working as a prenatal nurse in a local clinic. Before entering a client's room, you review the medical record for pertinent information such as cultural background, significant family members, weeks of gestation, test results, birth plan, and education for health promotion. You greet each client and family member by name and ask how they are coping with the pregnancy. Depending on the trimester of the pregnancy, you review the discomforts or concerns of the mother and family and what they may expect. You examine the mother, including fundal height, fetal heart rate and fetal position if appropriate, maternal blood pressure, weight gain, and urine analysis. With each client, you discuss the community resources available, such as prenatal classes, lactation consultants, and prenatal exercise or yoga classes. Based on the information you obtain, you might refer the mother to social services or the Special Supplementary Food Program for Women, Infants, and Children (WIC program) as appropriate. At the end of the clinic session, you review the status of the clients you saw with the collaborating physician.

1. How would you define the terms *family* and *family-centered care*?
2. Describe how the nursing process provides the framework for the delivery of direct nursing care.
3. How would you describe the concept of community-based care?
4. How would you describe culturally competent care?

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Chapter 2
Culture and the Family

Ken Usami/Getty Images

My parents came here from China when I was 3. They wanted the chance to make a better life, and they wanted another child. Needless to say, although I have always felt loved and cherished, I know how thrilled they were when my brother was born. Sometimes I feel as though I am walking a line between their ways and the ways I have learned growing up in this country. My husband is Chinese but he, too, grew up here. We are expecting our second baby in a few months. We talk often about which Chinese ways we want to retain and which new ways make more sense. I am not sure that my parents will understand, however. To them, the old ways are always best.

—Li Wei, age 29

Learning Outcomes

2.1 Compare the characteristics of different types of families.

2.2 Identify the stages of a family life cycle.

2.3 Identify prevalent cultural norms related to childbearing and childrearing.

2.4 Summarize the importance of cultural competency in providing nursing care.

2.5 Discuss the use of a cultural assessment tool as a means of providing culturally sensitive care.

2.6 Identify key considerations in providing spiritually sensitive care.

2.7 Differentiate between complementary and alternative therapies.

2.8 Determine the benefits and risks of complementary and alternative therapies.

2.9 Summarize complementary therapies appropriate for the nurse to use with childbearing and childrearing families.

Individuals do not live in isolation. Their values, beliefs, behaviors, decisions, attitudes, and biases are shaped by many factors, including their families, their culture, and their religious beliefs.

This chapter begins with a brief discussion of family types, functioning, and assessment. It then addresses the impact of culture on the family and concludes with a brief examination of some of the complementary and alternative therapies a family might use.

The Family

The U.S. Census Bureau defines a **family** as two or more individuals who are joined together by marriage, birth, or adoption and live together in the same household (U.S. Census Bureau, 2013). More broadly, however, families are generally characterized by bonds of emotional closeness, sharing, and support.

Families are guided by a common set of values or beliefs about the worth and importance of certain ideas and traditions. These values often bind family members together, and these values are greatly influenced by external factors, including cultural background, social norms, education, environmental influences, socioeconomic status, and beliefs held by peers, coworkers, political and community leaders, and other individuals outside the family unit. Because of the influence of these external factors, a family's values may change considerably over the years.

Types of Families

Families are diverse in structure, roles, and relationships. Various types of families—both those considered traditional and nontraditional—exist in contemporary American society. This section identifies common types of family structures.

- In the *nuclear family,* children live in a household with both biologic parents and no other relatives or persons. One parent may stay home to rear the children while one parent works, but more commonly, both parents are employed by choice or necessity. Two-income families must address important issues such as child care arrangements, household chores, and how to ensure quality family time. *Dual-career/dual-earner families* are now considered the norm in modern society.
- The *child-free family* is a growing trend. In some cases, a family is child free by choice; in other cases, a family is child free because of issues related to infertility.
- In an *extended family,* a couple shares household and childrearing responsibilities with parents, siblings, or other relatives. Families may reside together to share housing expenses and child care. However, in many cases, the child may be residing with the grandparent and one parent because of issues associated with unemployment, parental separation, parental death, or parental substance abuse. Grandparents may raise children owing to the inability of parents to care for their own children.
- An *extended kin network family* is a specific form of an extended family in which two nuclear families of primary or unmarried kin live in proximity to each other. The family shares a social support network, chores, goods, and services.
- The *single-parent family* is becoming increasingly common. In some cases, the head of the household is widowed, divorced, abandoned, or separated. In other cases, the head of the household, most often the mother, remains unmarried. Single-parent families often face difficulties because the sole parent may lack social and emotional support, need assistance with childrearing issues, and face financial strain (Figure 2–1).
- The *single mother by choice family* represents a family composed of an unmarried woman who chooses to conceive or adopt without a life partner (Maggio, 2013). Although these families are statistically included in the single-parent family statistics, they differ significantly in that these women typically are older, college educated, and financially stable and have contemplated pregnancy significantly prior to conceiving (Single Mothers by Choice, 2013).
- The *blended,* or *reconstituted nuclear, family* includes two parents with biologic children from a previous marriage or relationship who marry or cohabitate. This family structure has become increasingly common because of high rates of divorce and remarriage. Potential advantages to the children may include better financial support and a new supportive role model. Stresses can include lack of a clear role for the stepparent, lack of acceptance of the stepparent, financial stresses when two families must be supported by stepparents, and communication problems.
- A *binuclear family* is a post-divorce family in which the biologic children are members of two nuclear households, with coparenting by the father and the mother. The children alternate between the two homes, spending varying amounts of time with each parent in a situation called coparenting, usually involving joint custody. Joint custody is a legal situation in which both parents have equal responsibility and legal rights, regardless of where the children live. The binuclear family is a model for effective communication. It enables both biologic parents to be involved in a child's upbringing and provides additional support and role models in the form of extended family members.
- A *heterosexual cohabitating family* describes a heterosexual couple who may or may not have children and who live together outside of marriage. This may include never-married individuals as well as divorced or widowed persons. While some individuals choose this model for personal reasons, others do so for financial reasons or to seek companionship.
- *Gay* and *lesbian families* include those in which two adults of the same sex live together as domestic partners with or without children, and those in which a gay or lesbian single parent rears a child. Children in these families may be from a previous heterosexual union, or be born to or adopted by one or both member(s) of the same-sex couple. A biologic child may be born to one of the partners through artificial insemination or through a surrogate mother. Children who are adopted or born into lesbian and gay families are highly valued, as with heterosexual families. Evidence suggests that children reared by same-sex couples are as well adjusted as those born into heterosexual families and have positive peer relationships (Haney-Caron & Heilbrun, 2014).

Figure 2–1 Single-parent families account for nearly one third of all U.S. families. What types of challenges do single-parent families face?

SOURCE: © Phase4Photography/Fotolia.

Clinical Tip

It is important to establish which parent has legal custody, current visitation policies, and other variables (e.g., restraining orders and supervised visitation) when communicating information to parents about their children. Certain legal issues may prohibit the nurse from sharing some information with the noncustodial parent.

Family Development Frameworks

Family development theories use a framework to categorize a family's progression over time according to specific, typical stages in family life. These are predictable stages in the life cycle of every family, but they follow no rigid pattern. Duvall's (1977) eight stages in the family life cycle of a traditional nuclear family have been used as the foundation for contemporary models of

TABLE 2–1 Eight-Stage Family Life Cycle

STAGES	CHARACTERISTICS
Stage I	Beginning family, newly married couples*
Stage II	Childbearing family (oldest child is an infant through 30 months of age)
Stage III	Families with preschool children (oldest child is between 2.5 and 6 years of age)
Stage IV	Families with schoolchildren (oldest child is between 6 and 13 years of age)
Stage V	Families with teenagers (oldest child is between 13 and 20 years of age)
Stage VI	Families launching young adults (all children leave home)
Stage VII	Middle-aged parents (empty nest through retirement)
Stage VIII	Family in retirement and old age (retirement to death of both spouses)

*Keep in mind that this was the norm at the time the model was developed, but today families form through many different types of relationships.

Source: Adapted from Duvall, E. M. (1977). *Marriage and family development* (5th ed.). Philadelphia, PA: Lippincott; Duvall, E. M., & Miller, B. C. (1985). *Marriage and family development* (6th ed.). New York, NY: Harper Row; Coehlo, D. P. (2015). Family child health nursing. In J. R. Kaakinen, D. P. Coehlo, R. Steele, A. Tabacco, & S. M. H. Hanson, *Family health care nursing: Theory, practice, and research* (5th ed., pp. 387–432). Philadelphia, PA: F. A. Davis.

the family life cycle that describe the developmental processes and role expectations for different family types. Table 2–1 lists Duvall's eight stages to illustrate important developmental transitions that occur at some point in most families.

Other family development models have been developed to address the stages and developmental tasks facing the unattached young adult, the gay and lesbian family, those who divorce, and those who remarry. Textbooks on families and developmental psychology provide further information on this topic.

Family Assessment

The nurse's understanding of a family's structure helps provide insight into the family's support system and needs. A *family assessment* is a collection of data about the family's type and structure, current level of functioning, support system, sociocultural background, environment, and needs.

To obtain an accurate and concise family assessment, the nurse needs to establish a trusting relationship with the woman or child and the family. Data are best collected in a comfortable, private environment, free from interruptions.

Basic information should include the following:

- Name, age, sex, and family relationship of all people residing in the household
- Family type, structure, roles, and values
- Cultural associations, including cultural norms and customs related to childbearing, childrearing, and infant feeding
- Religious affiliations, including specific religious beliefs and practices related to childbearing
- Support network, including extended family, friends, and religious and community associations
- Communication patterns, including language barriers

The nurse also gathers information about the health of individual family members because health status can have a major impact on family functioning. When possible, it is helpful to have information about the family's home environment as well. In many cases, this information is gathered during client interviews. However, a home visit provides far more data about family relationships, roles, needs, and preparation for a new baby. See Chapter 37 for more information about family assessment.

Cultural Influences Affecting the Family

When caring for families, it is critical to consider the influence of culture, which may affect how a family responds to health-related issues. **Culture** has many definitions and is currently described as:

> the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. (National Institutes of Health [NIH], 2013)

Culture is characterized by certain key elements, including the following:

- *Culture is based on shared values and beliefs.* Each culture identifies and articulates its shared values and beliefs. Expected behaviors and roles emerge that are consistent with those values and beliefs. A belief system suggests what preventive health measures and treatment for diseases are sought and accepted. It may also state the importance of children, of the family, of other individuals, and of the collective group, all of which can influence the choices people in the culture make regarding health.
- *Culture is learned and dynamic.* A child is born into a culture and starts learning the beliefs and practices of the group from birth. Children who are members of two cultural groups, such as African and immigrant, learn about both groups as they grow and develop. Immigrants have moved from one country to another to live and may face challenges when integrating the rules of the dominant culture. Children who have family members from two or more cultural groups integrate parts of the worldview from each group. Therefore, although culture is connected with groups, each individual's manifestation of his or her own cultural background will be unique. Culture evolves and adapts as new members are born into or join the group, and as the surrounding social and physical environments change. For example, as first-generation immigrants enter a new country, they generally closely follow the cultural patterns of their native lands. As their children grow, the youth maintain some of the family cultural patterns but begin to incorporate some of the new culture (Figure 2–2).
- *Culture is integrated into life and uses symbols.* Culture is integrated through social institutions such as schools, houses of worship, friendships, families, and occupations. This provides a variety of opportunities for learning about one's culture. The sense of integration may be disrupted or harder to maintain if individuals move frequently and as cultures intertwine with each other. Symbols are an important way that many cultures communicate with each other and with the outside world. Language, dress, music, tools, and nonverbal gestures are symbols a culture uses to display and transmit the culture.

Race refers to a group of people who share biologic similarities such as skin color, bone structure, and genetic traits. Examples of races include White (sometimes called Caucasian

Figure 2–2 **Preschoolers from various cultural backgrounds play together. How can nurses partner with families to assist children to understand and respect cultural differences?**

or European American), Black (sometimes called African American in the United States), Hispanic, natives (such as Native Americans, Alaskan Native, Hawaiian Native, and First Nation people of Canada), and Asian.

Ethnicity describes a "cultural group's sense of identification associated with the group's common social and cultural heritage" (Spector, 2013, p. 357). Examples of ethnic groups include Hmong, Jews, and Irish Americans. Even the mainstream or majority of groups usually identify with an ethnic group. Some beliefs and practices are common among certain ethnic groups, but it is important to avoid **stereotyping** individuals; that is, assuming that all members of a group have the same characteristics. The nurse should assess the woman or child and family to see which characteristics common to a group are possessed by the client rather than assume that because individuals identify themselves as a specific ethnicity they must practice certain customs.

Acculturation refers to the process of modifying one's culture to fit within the new or dominant culture. **Assimilation** is related to acculturation and is described as adopting and incorporating traits of the new culture within one's practice (Spector, 2013). Acculturation frequently occurs when people leave their country of origin and immigrate to a new country. Often acculturation is associated with improved health status and health behaviors, especially if the immigration is associated with improved socioeconomic status, which leads to better nutrition and access to health care. This is frequently true for people who immigrate to the United States from a developing country. On the other hand, health sometimes declines with acculturation. For example, obesity is a problem that is growing rapidly within the United States and particularly among immigrant populations.

Family Roles and Structure

A family's organization and the roles played by individual family members are largely dependent on cultural influence. The family structure defines acceptable roles and behavior of family members. For example, culture may determine who has authority (head of household) and is the primary decision maker for other members of the family. Additionally, the role of decision maker may change according to specific decisions. In some cultures, decisions regarding the family's health care are primarily the responsibility of the female family member, while other decisions are male dominated. Family dominance patterns may be *patriarchal*, as may be seen in Appalachian cultures; *matriarchal*, as may be seen in African American cultures; or more *egalitarian* (equal), as may be seen in European American cultures. Nurses need to be alert to the roles and functions in families since teaching may need to be directed to those responsible for decision making in order to promote health for all family members.

Culture also defines gender roles, the role of the elderly, and the role of the extended family. For example, Native Americans may consult tribal elders (considered part of the extended family) before agreeing to medical care for a pregnant woman or for a child. In some cultures, major decisions for the family, including a child's health care, include input from grandparents and other extended family members (Figure 2–3). Grandparents may even assume responsibility for care of the children in the family. In these cases, nurses must direct teaching for health promotion and demonstration for treatment procedures to the grandparent.

Family goals are also determined by cultural values and practices, as are family member roles and childbearing and childrearing practices and beliefs.

Health Beliefs, Approaches, and Practices

Three views of health described by Andrews and Boyle (2012) are magico-religious, scientific, and holistic. In reality, many people ascribe to a view that combines more than one of these belief systems, but it is helpful to examine them separately.

In the *magico-religious belief paradigm,* health and illness are determined by supernatural forces such as God, gods, magic, spirits, or fate. A miscarriage, for example, or the illness of a pregnant woman or of a child may be perceived as a punishment for actions. Children of preschool age and early school age usually have this view of illness; some adults also believe that higher or supernatural powers determine health and illness. It is wise to ask both children and their families what they think caused an illness or how they believe they can stay well. People who believe in this paradigm may gain comfort from prayer, healing rituals,

Figure 2–3 **Many cultures value the input of grandparents and other elders in the family or group. In this multigenerational family, the grandmother's guidance is highly valued and significantly influences the family's childrearing practices.**

SOURCE: Wong yu liang/Fotolia.