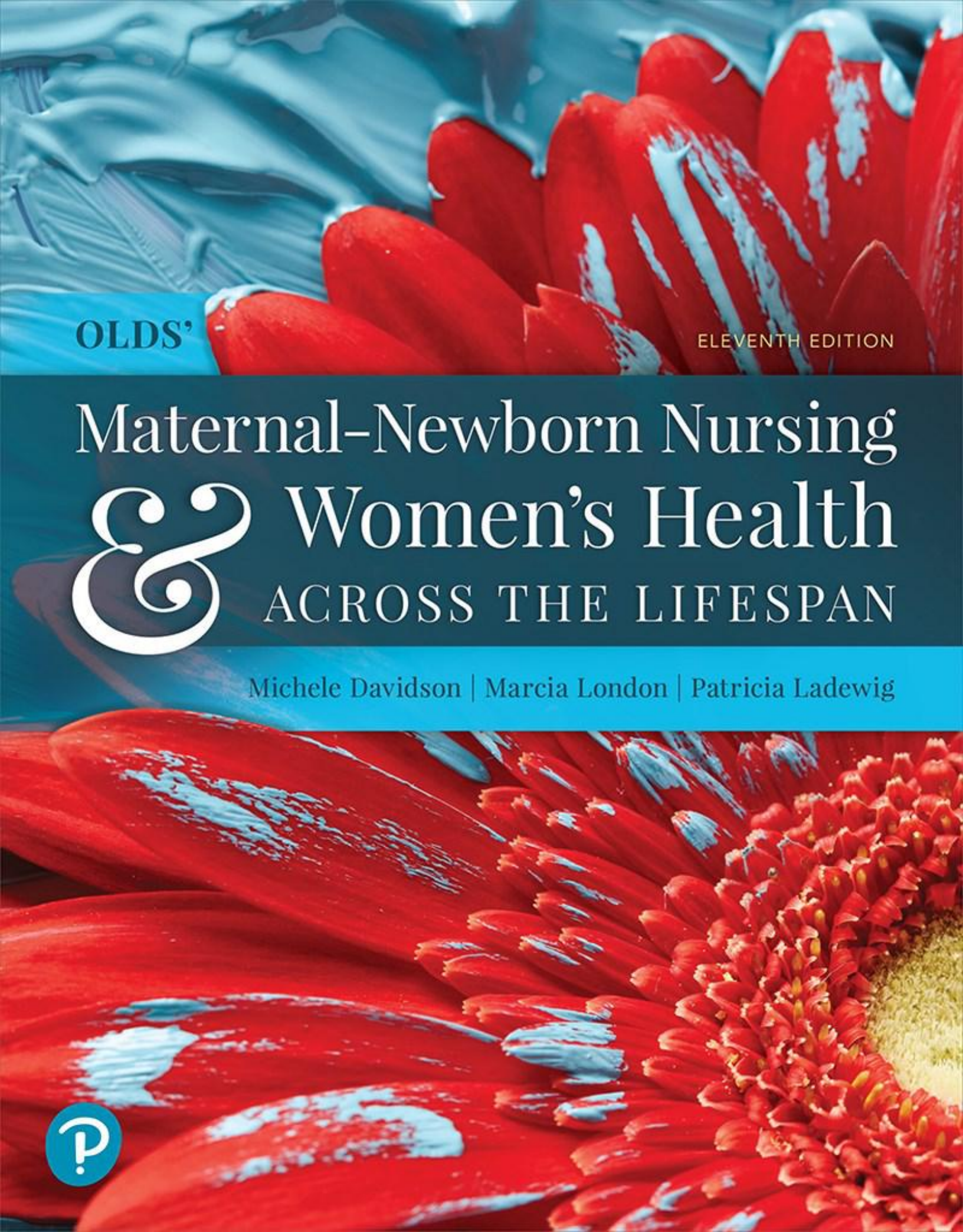
OLDS'
ELEVENTH EDITION
Maternal-Newborn Nursing
& Women's Health
ACROSS THE LIFESPAN
Michele Davidson | Marcia London | Patricia Ladewig

Brief Contents

OLDS'

ELEVENTH EDITION

Maternal-Newborn Nursing & Women's Health ACROSS THE LIFESPAN

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Sally B. Olds was the quintessential nurse and teacher—

She saw possibilities where others saw problems, abilities where others saw limitations.

She cared passionately about childbearing families and had a clear vision of what excellent nursing means.

She stressed the importance of clinical skill and acumen but never lost sight of the human side of caregiving.

She was committed to students, to helping them to learn and grow, to develop their own sense of the difference a nurse can make.

She was the best of the best of nursing.

And so, with the deepest affection and respect we dedicate this book to Sally, who was our dear friend and colleague, who left this world too soon.

We thank her for the inspiration she provided, the warmth she brought, and the expertise she shared.

And, as always, to our beloved families

To Nathan Davidson, Hayden, Chloe, Caroline, and Grant

To David London, Craig, Jennifer, Hannah, and Matthew

To Tim Ladewig, Ryan, Amanda, Reed, and Addison; Erik, Kedri, Emma, and Camden

About the Authors

Michele R. Davidson

Michele R. Davidson completed her ADN degree from Marymount University and 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. She earned her MSN and a nurse-midwifery certificate at Case Western Reserve University and continued to work as a full-scope nurse-midwife for 16 years. Dr. Davidson has delivered over 1,000 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. In 2018, Dr. Davidson earned an additional degree as a psychiatric mental health nurse practitioner (PMHNP). She has an ongoing 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 has served 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. Dr. Davidson was recently appointed to the Virginia State Maternal Mortality Review Board and has served on several federal task forces for the prevention of maternal mortality. She is a member of numerous editorial and advisory boards and has a passion for writing. In 2003, Dr. Davidson founded the Smith Island Foundation, a nonprofit organization in which she served as executive director for 8 years and later held an appointment as the vice-president of Smith Island United, a community advocacy group. Dr. Davidson has also completed certifications in lactation consulting, forensic nursing, and as a 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 children, Hayden, Chloe, Caroline, and Grant. Dr. Davidson and her family love the Eastern Shore of Maryland and Virginia and continue to be part-time residents of Smith Island.

Marcia L. London

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 the 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. Matthew works in computer teleresearch. Both are more than willing to give Mom helpful hints about computers.

Patricia A. Wieland Ladewig

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. 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 retired in 2016. She remains active professionally, serving on the Community Health Values Committee of Centura Health. She and her husband, Tim, enjoy traveling, skiing, and baseball games. 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.

Thank You

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We are grateful to all the nurses, both clinicians and educators, who reviewed the manuscript of this textbook. Their insights, suggestions, and eye for detail helped us prepare a more relevant and useful textbook, one that will prepare caring and competent nurses in the field of maternal-newborn and women's health nursing.

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Acknowledgments

Our goal with every revision is to incorporate the latest research and information from the literature of nursing and related fields to make our text as relevant and useful as possible. This would not be possible without the support and encouragement of our colleagues in nursing. The comments and suggestions we have received from nurse educators and practitioners around the country have helped us keep this text accurate and up to date. Whenever a nurse takes the time to write or to speak to one of us at a professional gathering, we recognize again the intense commitment of nurses to excellence in practice. And so we thank our colleagues.

We are grateful, too, to our students—past, present, and future. They stimulate us with their interest; they reinvigorate us with their enthusiasm; they challenge us with their questions to make each edition of this text clear and understandable. We learn so much from them.

In publishing, as in healthcare, quality assurance is an essential part of the process. That is the dimension our reviewers have added. Some reviewers assist us by validating the accuracy of the content, some by their attention to detail, and some by challenging us to examine our ways of thinking and to develop a new awareness about a given topic. Thus, we extend our sincere thanks to all those who reviewed the manuscript for this book. Their names and affiliations are listed on the preceding pages.

We are also grateful to the contributors to the 11th edition of *Olds' Maternal-Newborn Nursing & Women's Health Across the Lifespan*. Their knowledge of clinical practice and current literature in their areas of expertise helps make the chapters relevant and accurate. They, too, are listed on the preceding pages.

We cannot say enough good things about our development editor, Lynda Hatch. She is a godsend. Her wonderful eye for detail, her truly supportive approach, and her calmness under pressure help us stay focused and on track (mostly!). Thank you, Lynda! We would be lost without you! Without your support in these crucial areas, our work would not be as visually appealing and accurate as it is.

During these times of change in the healthcare environment, we are sustained by our passion for nursing and our vision of what childbirth means. Time and again, we have seen the difference a skilled nurse can make in the lives of people in need. We, like you, are committed to helping all nurses recognize and take pride in that fact. Thank you for your letters, your comments, and your suggestions. We are renewed by your support.

Michele R. Davidson
Marcia L. London
Patricia W. Ladewig

Preface

Nurses play a central role in all aspects of the childbearing experience, from the earliest days of pregnancy, through the moments of birth, and during the early days of parenthood. Most often, pregnancy and childbirth are times of great joy, a celebration of life, and a promise of the future. But they may also be times of deepest sorrow as families deal with illness, complications, and loss. Often the quality of the nursing care that a family receives profoundly influences their perceptions of the entire experience—for better or for worse. However, the changes occurring in the healthcare delivery system are altering the way we practice nursing and have staggering implications for nurses everywhere.

Now, more than ever, nurses must be flexible, creative, and open to change. They must be able to think critically and problem-solve effectively. They must be able to meet the teaching needs of their patients so that their patients can, in turn, better meet their own healthcare needs. They must be open to an increasingly multicultural population. They must understand and use the healthcare technology available in their chosen area of practice. Most crucially, they must never lose sight of the importance of excellent nursing care to promote patient safety and in improving the quality of people's lives.

Important Themes in This Edition

The underlying philosophy of *Olds' Maternal-Newborn Nursing & Women's Health Across the Lifespan* remains unchanged. We believe that pregnancy and birth are normal life processes and that family members are partners in care. We believe that women's healthcare is an important aspect of nursing. We remain committed to providing a text that is accurate and readable—a text that helps students develop the skills and abilities they need now and in the future in an ever-changing healthcare environment.

Partnering with Families Through Health Promotion Education

Developing a partnership with women and their families is a pivotal aspect of maternal-newborn nursing, and one key element of that partnership is patient and family health promotion teaching. It is a crucial responsibility of the maternal-newborn nurse to find opportunities to educate patients and their families, and we continue to emphasize and highlight this in the 11th edition. Again, the focus is on the teaching that nurses do at all stages of pregnancy and the childbearing process, including the important postpartum teaching that is done before and immediately after families are discharged.

In this textbook, we also subscribe to the paradigm that women and childbearing families need health promotion and health maintenance interventions, no matter where they seek healthcare or what health conditions they may be experiencing. Nurses integrate health promotion and health maintenance into the care for women and childbearing families in a variety of birthing and community settings where they go to obtain health supervision care. This textbook integrates health promotion and health maintenance content throughout, most visibly in Part II, *Women's Health Across the Lifespan*, and Chapter 34, *Home Care of the Postpartum Family*.

Because we believe that nursing excellence must include partnering with women and their families for all outcomes, we have included Chapter 36, *Grief and Loss in the Childbearing Family*. It is designed to assist nurses to support families as they deal with the painful losses—maternal, fetal, and neonatal—that sometimes turn expected moments of great joy into times of deep sorrow. We know that it often takes time for nurses to find authentic ways to support grieving families. Our aim in having this chapter is to help you understand the dynamics of loss and to offer concrete guidance about effective nursing approaches.

Women's Healthcare

This edition continues to provide expanded coverage of women's healthcare with updated information on contraception, commonly occurring infections, health maintenance recommendations, menopause, and a variety of gynecologic conditions such as polycystic ovarian syndrome and pelvic relaxation. Special attention is given to violence against women, which is the focus of a separate chapter. Other pressing societal issues are also covered in a separate chapter, as well as throughout the women's health unit. Moreover, because of the text's focus on community-based care, gynecologic cancers are covered briefly.

Nursing Excellence in Maternal-Newborn and Women's Health

Truly effective nurses have both a solid understanding of underlying nursing theory and excellent clinical skills. Perhaps equally important, they have a deep appreciation of the essential need to partner with childbearing women and their families to ensure optimum outcomes for all. But how do we help students develop this level of expertise? We believe that nursing excellence as it relates to women's health and to childbearing families starts here, in the

pages of this text. This book provides essential theoretical content within a contemporary, holistic, family-centered context. Our goal is to lay a foundation that you can build on with each clinical experience you have.

Evidence-Based Practice

Nursing professionals are increasingly aware of the importance of using evidence-based approaches as the foundation for planning and providing effective care and to foster patient safety and quality improvement. 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 brief discussion of evidence-based practice is included in Chapter 1, *Contemporary Maternal-Newborn Nursing*.

A feature titled **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 research evidence from a variety of sources—including systematic reviews of research literature, recent research findings, and national organization policy—that have direct application to nursing practice. The feature asks the student to use clinical reasoning and clinical judgment to determine what additional information is needed and what the evidence shows to be best practice at this time and invites the student to apply critical thinking skills to further identify nursing approaches to meet women's health and maternal-newborn nursing care issues.

Healthy People 2020

At the national level, the government has developed a set of ambitious, measurable goals designed to improve the health of Americans by 2020. Many of these goals, which are arranged by categories, have direct relevance to maternal, newborn, and women's healthcare nurses. To help you become aware of these goals, we have incorporated them at the beginning of each chapter. We hope you will take time to visit the *Healthy People 2020* website and become more knowledgeable about the effort.

Commitment to Diversity

As nurses and as educators, we recognize the importance of honoring diversity and of providing culturally competent care. Thus, we continually strive to make our text ever more inclusive. Chapter 1, *Contemporary Maternal-Newborn Nursing*, briefly introduces cultural issues relevant to maternity and newborn nursing care. Chapter 2, *Families, Cultures, and Complementary Therapies*, provides the theoretical basis for the consideration of cultural factors that influence a family's expectations of their healthcare providers and their experience with the healthcare system. We elaborate upon this information throughout the text in a boxed feature titled **Developing Cultural Competence**. In addition, we have worked hard to ensure that our photos, illustrations, charts, and case scenarios are inclusive in their appearance and in the information they provide. As our society becomes more global in nature, nurses need to cultivate their awareness of these issues because they ultimately do affect how we deliver healthcare in this country.

Women with Special Needs

Women who seek healthcare represent a range of ages, backgrounds, and requirements for effective care. In many cases, women have individualized needs that nurses may not encounter routinely. We are especially proud of a feature titled **Women with Special Needs**, which is designed to help you consider ways in which care must be modified to address the needs of all women regardless of their circumstances.

Case Study

As educators we recognize how crucial it is to help students apply the theory they learn to specific patients—patients with unique needs and concerns. To accomplish this goal, we have developed a new clinical feature for this edition called **Case Study**. In this feature we follow four women through their pregnancies, birth experiences, and postpartum issues. Each Case Study is designed to enable students to consider specific issues that might have implications for patient care. The women are:

- Melissa Bond-James, a 40-year-old Caucasian American who has experienced preterm labor during her pregnancy. She is a lesbian, whose wife, Nancy James, is supportive and extremely excited about the pregnancy.
- Benita Cartier is a 26-year-old, married, African American woman who is being treated for chronic hypertension. Her husband is an airline pilot and they have a toddler daughter.
- Azia Askari is a 32-year-old married woman who immigrated to the United States from Iran in 2014. She has two children and is experiencing an uneventful pregnancy. She is dealing with some cultural issues related to her life in the United States.
- Angelina Newman is a 16-year-old, single Caucasian American young woman who is a sophomore in high school. She has a sexually transmitted infection and possible labor/birth complication.

Nursing Professionalism

Professionalism requires that the astute professional nurse demonstrate professional standards of moral, ethical, and legal conduct and model the values of the nursing profession as he or she cares for women and childbearing families. This requires a commitment to *quality improvement* in all areas of care. With these expectations, the feature called **Professionalism in Practice** focuses on topics such as legal considerations, contemporary nursing practice issues, professional accountability, patient advocacy, and home and community care considerations.

Two features strengthen this emphasis on professionalism:

- **Ethics in Action!** challenges you with thought-provoking questions about many of the ethical dilemmas nurses may face in providing care.
- **Safety Alert!** calls your attention to issues that represent a situation that requires careful attention to avoid putting a patient at risk. Not surprisingly, many of these alerts—but not all—relate to the administration of medications.

Patient Teaching

Patient teaching remains a critical element of effective *patient-centered care*, one that we emphasize in this text. Nurses teach their patients during the care of women, through all stages of pregnancy, during the childbearing process, and while providing care for specific conditions. Throughout the book, we include **Teaching Highlights** features that present a special healthcare issue or problem and the related key teaching points for care by the patient and family.

Pearson Nursing's MAP App includes a section on **Patient/Family Teaching**, which supplies useful information and strategies for educating parents and families in a variety of situations and settings.

Complementary Health Approaches

Nurses and other healthcare professionals recognize that today, more than ever, complementary health approaches have become a credible component of holistic care. To help nurses become more familiar with these therapies, Chapter 2, *Families, Cultures, and Complementary Therapies*, provides basic information on some of the more commonly used therapies. Then throughout the text, we expand on the topic by providing a special boxed feature, **Complementary Health Approaches**, which discusses therapies your patients might be using or therapies you might suggest, keeping patient safety upmost in our thoughts. In all cases, research is cited for safe practice of these therapies.

Community-Based Nursing Care

By its very nature, maternal-newborn nursing is community-based nursing. Only a brief portion of the entire pregnancy and birth is spent in a birthing center or hospital. Moreover, because of changes in practice, even women with high-risk pregnancies are receiving more care in their homes and in the community and spending less time in hospital settings. Similarly, most aspects of women's healthcare are addressed in ambulatory settings.

The provision of nursing care in community-based settings is a driving force in healthcare today and, consequently, is a dominant theme throughout this edition. Four chapters provide a theoretical perspective and important tools in caring for childbearing families in the community setting: Chapter 12, *Antepartum Nursing Assessment*; Chapter 13, *The Expectant Family: Needs and Care*; Chapter 33, *The Postpartum Family: Needs and Care*; and Chapter 34, *Home Care of the Postpartum Family*. We have addressed this topic in a variety of ways. **Community-Based Nursing Care** is a heading used throughout the Nursing Management sections to assist you in identifying specific aspects of this content. Because we consider **Home Care** to be one form of community-based care, it is often a separate heading under Community-Based Nursing Care.

Other New or Expanded Concepts in This Edition

Nursing is a dynamic profession that requires specific information that reflects current practice. As such, we have expanded or added several important areas of content in the 11th edition.

- **NEW! Reproductive Genetics** This chapter was added to the 11th edition to reflect an emerging understanding of genome science, its impact on health and illness in childbearing families, and the expanding role that nurses play in applying genetics in clinical practice.
- **NEW! Genetic Facts** This feature provides information on the genetic implications of topics being addressed in the chapter.
- **NEW! Case Study** This feature shows students how to apply theory to clinical practice as they follow the experiences of four pregnant women with various issues and concerns.
- **NEW!** A two-page, 16-photograph *Birth Sequence* in Chapter 19 provides a moment-by-moment visual presentation of the birth of a baby.
- **Concept maps** provide an algorithm or flow chart to assist nurses in planning and providing care. The map provides a visual description of data to be analyzed in making decisions about care.
- **Key Facts to Remember** is a feature that summarizes major elements related to a specific topic. We believe you will find this feature to be especially helpful.
- **Nutrition** during pregnancy and infancy is important to promote growth, development, and health. A growing national focus on healthy nutrition patterns underscores the importance of this information. Chapter 14, *Maternal Nutrition*, and Chapter 29, *Newborn Nutrition*, address ensuring appropriate nutrition for pregnant women and newborns.
- **Pain management** is a priority in healthcare settings. All of the chapters in Part V, *Labor and Birth*, address pain assessment and management, and it is the primary focus in Chapter 22, *Pharmacologic Pain Management*. We discuss applicable pain assessment and management when appropriate in other chapters in Part VI, *The Newborn*, and Part VII, *Postpartum.*
- **Women with intellectual disabilities** information and specific care has been added to Chapter 7, *Social Issues*. Such women are more commonly choosing to

live independently and even become mothers. Therefore, we have also added coverage addressing the care of mothers with intellectual disabilities in Chapter 33, *The Postpartum Family: Needs and Care*.

Organization: A Nursing Management Framework

Nurses today must be able to think critically and to solve problems effectively. For these reasons, we begin with an introductory unit to set the stage by providing information about maternal-newborn nursing and important related concepts. Subsequent units progress in a way that closely reflects the steps of the nursing process. We clearly delineate the nurse's role within this framework. Thus, the units related to pregnancy, labor and birth, the newborn period, and postpartum care begin with a discussion of basic theory followed by chapters on nursing assessment and nursing care for essentially healthy women or infants. Within the nursing care chapters and content areas, we use the heading **Nursing Management** and the subheadings **Nursing Assessment and Diagnosis**, **Planning and Implementation**, and **Evaluation**.

Complications of a specific period appear in the last chapter or chapters of each unit. The chapters also use the nursing process as an organizational framework. We believe that students can more clearly grasp the complicated content of the high-risk conditions once they have a good understanding of the normal processes of pregnancy, birth, and postpartum and newborn care. However, to avoid overemphasizing the prevalence of complications in such a wonderfully normal process as pregnancy and birth, we avoid including an entire unit that focuses only on complications.

●○● NURSING MANAGEMENT

The ***Nursing Management*** sections delineate the important care management role of the nurse within the organizing framework of the nursing process to help you understand what nursing actions are needed. Numerous special features reinforce the nursing management role.

Nursing Care Plan

Nursing Care Plans address nursing care for patients who have complications, such as a woman with preeclampsia. We designed this feature to help you approach care from the nursing process perspective. These care plans use a nursing diagnosis approach in planning and providing care when pregnancy-related and newborn complications arise.

Assessment Guide

Assessment Guides help you organize your questions and steps during a physical assessment and provide normal findings, alterations, and possible causes, as well as guidelines for nursing interventions.

Resources for Student Success

- **Online Resources** are available for download at *www.pearsonhighered.com/nursingresources*, including:
  - NCLEX-RN®-Style Review Questions
  - Case Studies
  - Care Plans
  - Thinking Critically exercises, and more!
- **NEW! Pearson Nursing's MAP App** provides a collection of handy tools and additional content for students to use while studying maternity or pediatrics or for quick reference in the clinical setting. 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. We are excited to offer students the opportunity to have all of this valuable information in one convenient place for on-the-go reference.

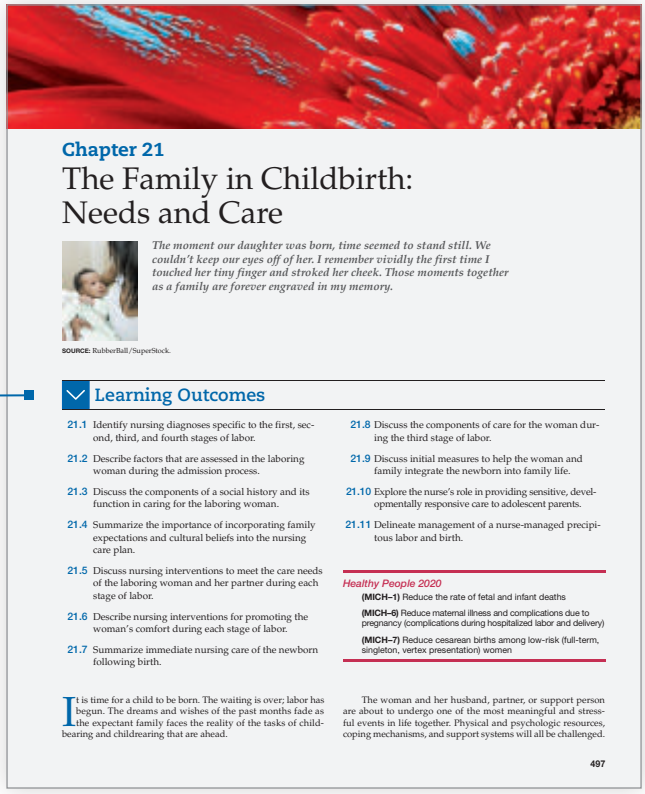
Resources for Faculty Success

Pearson 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**

Features That Help You Use This Text 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 *Olds' Maternal-Newborn Nursing & Women's Health Across the Lifespan*, 11th edition, to be successful in the classroom, in the clinical setting, on the NCLEX-RN® examination, and in nursing practice.



Chapter 21

The Family in Childbirth: Needs and Care

The moment our daughter was born, time seemed to stand still. We couldn't keep our eyes off of her. I remember vividly the first time I touched her tiny finger and stroked her cheek. Those moments together as a family are forever engraved in my memory.

SOURCE: RubberBall/SuperStock.

Learning Outcomes

21.1 Identify nursing diagnoses specific to the first, second, third, and fourth stages of labor.

21.2 Describe factors that are assessed in the laboring woman during the admission process.

21.3 Discuss the components of a social history and its function in caring for the laboring woman.

21.4 Summarize the importance of incorporating family expectations and cultural beliefs into the nursing care plan.

21.5 Discuss nursing interventions to meet the care needs of the laboring woman and her partner during each stage of labor.

21.6 Describe nursing interventions for promoting the woman's comfort during each stage of labor.

21.7 Summarize immediate nursing care of the newborn following birth.

21.8 Discuss the components of care for the woman during the third stage of labor.

21.9 Discuss initial measures to help the woman and family integrate the newborn into family life.

21.10 Explore the nurse's role in providing sensitive, developmentally responsive care to adolescent parents.

21.11 Delineate management of a nurse-managed precipitous labor and birth.

Healthy People 2020

(MICH–1) Reduce the rate of fetal and infant deaths

(MICH–6) Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery)

(MICH–7) Reduce cesarean births among low-risk (full-term, singleton, vertex presentation) women

It is time for a child to be born. The waiting is over; labor has begun. The dreams and wishes of the past months fade as the expectant family faces the reality of the tasks of childbearing and childrearing that are ahead.

The woman and her husband, partner, or support person are about to undergo one of the most meaningful and stressful events in life together. Physical and psychologic resources, coping mechanisms, and support systems will all be challenged.

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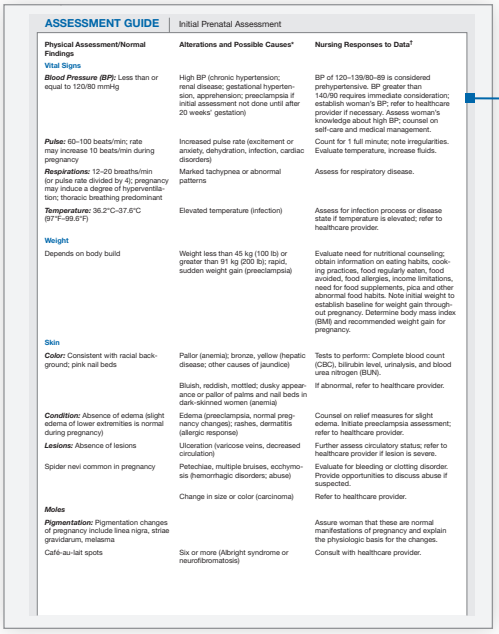
Each chapter begins with a **personal vignette** and photo that sets the tone for the chapter.

Learning Outcomes introduce you to the topics covered in each chapter.

Healthy People 2020 features at the beginning of each chapter assist you in becoming aware of the *Healthy People 2020* goals that have direct relevance to maternal, newborn, and women's healthcare nurses.

The following features are found throughout the text:



ASSESSMENT GUIDE | Initial Prenatal Assessment

Physical Assessment/Normal Findings	Alterations and Possible Causes*	Nursing Responses to Data†
Vital Signs		
Blood Pressure (BP): Less than or equal to 120/80 mmHg	High BP (chronic hypertension; renal disease; gestational hypertension, apprehension; preeclampsia if initial assessment not done until after 20 weeks' gestation)	BP of 120–139/80–89 is considered prehypertensive. BP greater than 140/90 requires immediate consideration; establish woman's BP; refer to healthcare provider if necessary. Assess woman's knowledge about high BP; counsel on self-care and medical management.
Pulse: 60–100 beats/min; rate may increase 10 beats/min during pregnancy	Increased pulse rate (excitement or anxiety, dehydration, infection, cardiac disorders)	Count for 1 full minute; note irregularities. Evaluate temperature, increase fluids.
Respirations: 12–20 breaths/min (or pulse rate divided by 4); pregnancy may induce a degree of hyperventilation; thoracic breathing predominant	Marked tachypnea or abnormal patterns	Assess for respiratory disease.
Temperature: 36.2°C–37.6°C (97°F–99.6°F)	Elevated temperature (infection)	Assess for infection process or disease state if temperature is elevated; refer to healthcare provider.
Weight		
Depends on body build	Weight less than 45 kg (100 lb) or greater than 91 kg (200 lb); rapid, sudden weight gain (preeclampsia)	Evaluate need for nutritional counseling; obtain information on eating habits, cooking practices, food regularly eaten, food avoided, food allergies, income limitations, need for food supplements, pica and other abnormal food habits. Note initial weight to establish baseline for weight gain throughout pregnancy. Determine body mass index (BMI) and recommended weight gain for pregnancy.
Skin		
Color: Consistent with racial background; pink nail beds	Pallor (anemia); bronze, yellow (hepatic disease; other causes of jaundice)	Tests to perform: Complete blood count (CBC), bilirubin level, urinalysis, and blood urea nitrogen (BUN).
	Bluish, reddish, mottled; dusky appearance or pallor of palms and nail beds in dark-skinned women (anemia)	If abnormal, refer to healthcare provider.
Condition: Absence of edema (slight edema of lower extremities is normal during pregnancy)	Edema (preeclampsia, normal pregnancy changes); rashes, dermatitis (allergic response)	Counsel on relief measures for slight edema. Initiate preeclampsia assessment; refer to healthcare provider.
Lesions: Absence of lesions	Ulceration (varicose veins, decreased circulation)	Further assess circulatory status; refer to healthcare provider if lesion is severe.
Spider nevi common in pregnancy	Petechiae, multiple bruises, ecchymosis (hemorrhagic disorders; abuse)	Evaluate for bleeding or clotting disorder. Provide opportunities to discuss abuse if suspected.
	Change in size or color (carcinoma)	Refer to healthcare provider.
Moles		
Pigmentation: Pigmentation changes of pregnancy include linea nigra, striae gravidarum, melasma		Assure woman that these are normal manifestations of pregnancy and explain the physiologic basis for the changes.
Café-au-lait spots	Six or more (Albright syndrome or neurofibromatosis)	Consult with healthcare provider.

Assessment Guides assist you with diagnoses by incorporating physical assessment and normal findings, alterations and possible causes, and guidelines for nursing interventions.

CASE STUDY: Azia Askari

Azia presents to the local hospital with reports of beginning contractions yesterday after walking with her daughters outdoors to a nearby playground. Her sister-in-law has brought her to the hospital and is translating for the nurse. The hospital has an interpreter who speaks Farsi who is en route to the hospital to translate. Her sister-in-law reports that the contractions have increased in frequency, duration, and strength and they are now occurring every 3 to 5 minutes, lasting 45 to 60 seconds, and they are getting stronger. She stresses that the family has a firm preference for female-only care providers based on their cultural beliefs and Muslim religion.

Question to Ponder

What steps would you take to support Azia's cultural beliefs in this situation?

Case Study This feature shows students how to apply theory to clinical practice as they follow the experiences of four pregnant women with various issues and concerns.

Clinical Skill boxes offer step-by-step techniques that show you the tasks expected of a nurse in clinical situations, preparing you for your clinical experiences. Included in each box are the preparation steps with rationales, equipment and supplies needed, and steps for the procedure itself, with rationales for the nurse's actions.

CLINICAL SKILL 21–1

Performing Nasal Pharyngeal Suctioning

NURSING ACTION

Preparation

- Suction equipment is always available in the birthing area to clear secretions from the newborn's nose or oropharynx if respirations are depressed or if amniotic fluid was meconium stained.
- Tighten the lid on the DeLee mucus trap or other suction device collection bottle.

Rationale: *This avoids spillage of secretions and prevents air from leaking out of the lid.*

- Connect one end of the DeLee tubing to low suction.

Equipment and Supplies

DeLee mucus trap or other suction device

Procedure: Clean Gloves

1. Don gloves.
2. Without applying suction, insert the free end of the DeLee tubing 3 to 5 inches into the newborn's nose or mouth (Figure 21–7).

Rationale: *Applying suction while passing the tube would interfere with smooth passage of the tube.*

3. Place your thumb over the suction control and begin to apply suction. Continue to suction as you slowly remove the tube, rotating it slightly.

Rationale: *Suctioning during withdrawal removes fluid and avoids redepositing secretions in the newborn's nasopharynx.*

4. Continue to reinsert the tube and provide suction for as long as fluid is aspirated.

Note: Excessive suctioning can cause vagal stimulation, which decreases the heart rate.

5. If it is necessary to pass the tube into the newborn's stomach to remove meconium secretions that the newborn swallowed before birth, insert the tube through the newborn's mouth into the stomach. Apply suction and continue to suction as you withdraw the tube.

Rationale: *Because the newborn's nares are small and delicate, it is easier and faster to pass the suction tube through the mouth.*

6. Document the completion of the procedure and the amount and type of secretions.

Rationale: *This documentation provides a record of the intervention and the status of the neonate at birth.*

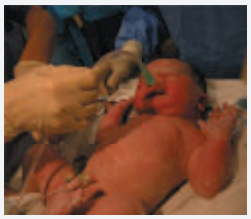


Figure 21–7 DeLee mucus trap being used to suction a newborn's mouth to remove excess secretions. One end of the suction tubing is connected to low suction, and the other end of the tubing is inserted 3 to 5 inches into the newborn's nose or mouth. Suction is applied as the tubing is pulled out. The process is repeated for as long as fluid is aspirated.

SOURCE: Wilson Garcia.

Clinical Tip

Screening for aneuploidy should be presented as an informed choice. The decision to proceed with screening is a personal choice and stems from one's values, beliefs, and interests. The nurse should be knowledgeable about the options available for screening and next steps if an abnormal result occurs.

Clinical Tip features offer hands-on suggestions for specific procedures and interventions. The authors' wealth of clinical knowledge—reflecting many decades of experience—are reflected in these pearls of wisdom.

Complementary Health Approaches have become a credible component of holistic care. We have featured this content to help you to become more familiar with it and to inform you about therapies your patients might be using or those you might safely suggest. In all cases, research is cited for safe practice of these methods.

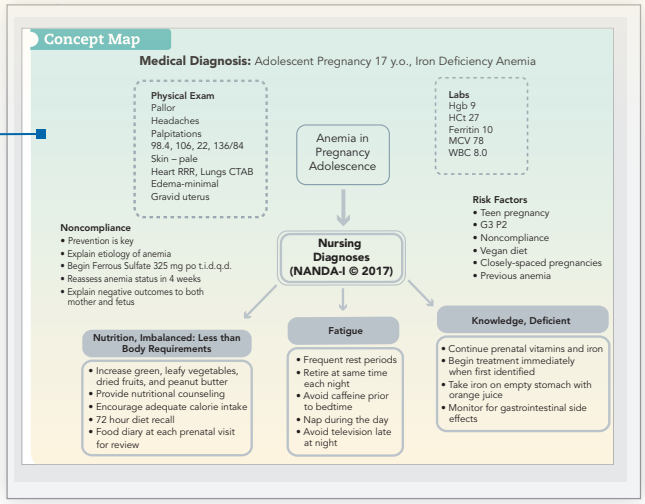
Complementary Health Approaches

Treatment of Endometriosis

Complementary therapies that may play a role in the treatment of endometriosis include (Oyelowo & Johnson, 2018):

- Acupuncture to help with pain control
- Vag Packs (suppositories with vitamins, minerals, and herbs)
- Yoga for relaxation and stress reduction
- Massage
- Traditional Chinese herbal medicine for symptomatic relief
- Spiritual therapies such as prayer, religious rituals, meditation, and support groups.

Concept Maps provide a visual description of data to be analyzed as nurses plan and provide care.



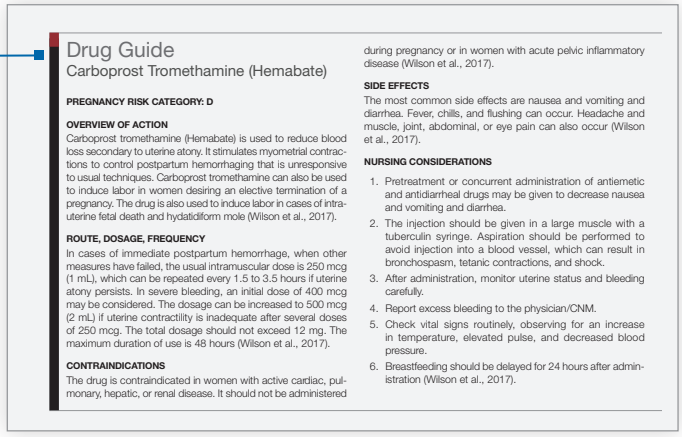
Developing Cultural Competence Home Births in Amish Communities

Approximately 40 to 80% of Amish women give birth at home or in an Amish-run birthing center. The factors for these choices are often driven by costs (the Amish have no commercial health insurance), geographic distance, and preference to be cared for in the home setting. Amish women in the United States, many of whom have eight or more children, are cared for by CNMs, lay midwives, and, in rare cases, physicians who attend home births. Because the Amish do not utilize electricity, caregivers must bring specialized equipment for the birth. At most Amish births, the husband is the only family member in attendance. Many Amish families decline medical interventions, such as vitamin K injections, eye ointment, hepatitis B vaccines, or circumcision. Once an Amish woman gives birth, a young single Amish girl is typically employed as a maid in the home for 4 to 6 weeks to perform household chores for the family (Wente, 2015).

Note: It is unwise to attribute specific attitudes or beliefs to all members of a cultural group. The information in the Developing Cultural Competence boxes offers possible insights into caring for women from different cultural groups.

Developing Cultural Competence boxes foster your awareness of cultural factors that influence a family's expectations of and responses to their healthcare provider and their experiences with the healthcare system.

Drug Guide boxes for selected medications commonly used in maternal-newborn nursing guide you in correctly administering the medications and evaluating your actions.



Drug Guide

Carboprost Tromethamine (Hemabate)

PREGNANCY RISK CATEGORY: D

OVERVIEW OF ACTION

Carboprost tromethamine (Hemabate) is used to reduce blood loss secondary to uterine atony. It stimulates myometrial contractions to control postpartum hemorrhaging that is unresponsive to usual techniques. Carboprost tromethamine can also be used to induce labor in women desiring an elective termination of a pregnancy. The drug is also used to induce labor in cases of intrauterine fetal death and hydatidiform mole (Wilson et al., 2017).

ROUTE, DOSAGE, FREQUENCY

In cases of immediate postpartum hemorrhage, when other measures have failed, the usual intramuscular dose is 250 mcg (1 mL), which can be repeated every 1.5 to 3.5 hours if uterine atony persists. In severe bleeding, an initial dose of 400 mcg may be considered. The dosage can be increased to 500 mcg (2 mL) if uterine contractility is inadequate after several doses of 250 mcg. The total dosage should not exceed 12 mg. The maximum duration of use is 48 hours (Wilson et al., 2017).

CONTRAINDICATIONS

The drug is contraindicated in women with active cardiac, pulmonary, hepatic, or renal disease. It should not be administered during pregnancy or in women with acute pelvic inflammatory disease (Wilson et al., 2017).

SIDE EFFECTS

The most common side effects are nausea and vomiting and diarrhea. Fever, chills, and flushing can occur. Headache and muscle, joint, abdominal, or eye pain can also occur (Wilson et al., 2017).

NURSING CONSIDERATIONS

1. Pretreatment or concurrent administration of antiemetic and antidiarrheal drugs may be given to decrease nausea and vomiting and diarrhea.
2. The injection should be given in a large muscle with a tuberculin syringe. Aspiration should be performed to avoid injection into a blood vessel, which can result in bronchospasm, tetanic contractions, and shock.
3. After administration, monitor uterine status and bleeding carefully.
4. Report excess bleeding to the physician/CNM.
5. Check vital signs routinely, observing for an increase in temperature, elevated pulse, and decreased blood pressure.
6. Breastfeeding should be delayed for 24 hours after administration (Wilson et al., 2017).

Ethics In Action!

A patient in your practice has finally disclosed to you after repeated IPV screenings that her husband is physically abusive to her. You practice in a state where you are covered by the IPV mandatory reporting law, but your patient has asked you to not report as she is scared for her life. How do you respond to this situation?

Ethics in Action! features challenge you with thought-provoking questions that reflect myriad ethical dilemmas that nurses providing care may face.

Evidence-Based Practice boxes relate research evidence to women's health and maternal-newborn nursing. Each feature asks you to use critical thinking skills to analyze the data to best meet women's health and maternal-newborn nursing care needs and to help you understand the use of reliable information to plan and provide effective nursing care.

EVIDENCE-BASED PRACTICE | Ectopic Pregnancy

Clinical Question

What is best practice in diagnosing and treating an ectopic pregnancy?

The Evidence

An ectopic pregnancy is one that occurs outside the uterine cavity. The most common site for an ectopic pregnancy is in the fallopian tube. If these pregnancies progress to the point of rupture, they account for significant morbidity and even maternal death. Suspicion of an ectopic pregnancy, then, is considered a medical emergency. If detected early, ectopic pregnancy can be effectively treated with surgical or pharmacological intervention. More than half of women who receive a diagnosis of ectopic pregnancy do not have any known risk factors. Those at highest risk are those with a previous ectopic pregnancy, damaged fallopian tubes, ascending pelvic infection, or prior pelvic or fallopian tube surgery. Contrary to a widely held belief, women who use an IUD for contraception are at a *lower risk* of ectopic pregnancy because of the effectiveness of this contraceptive method. However, if a woman with an IUD in place becomes pregnant, more than half will have an ectopic pregnancy. No other contraceptive methods have been associated with extrauterine pregnancy (ACOG, 2018c).

The American College of Obstetricians and Gynecologists (2018c) reviewed the evidence related to the diagnosis and treatment of ectopic pregnancy and updated their existing practice guidelines. This type of guideline, created by a professional medical organization evaluating and integrating evidence from randomized trials, systematic reviews, and the opinions of clinical experts, is the strongest evidence for practice.

Every sexually active reproductive-age woman who presents with abdominal pain and bleeding should be screened for pregnancy, regardless of whether she believes she is pregnant. Rupture of an ectopic pregnancy can occur very early in a pregnancy, even before the woman suspects she is pregnant. If a woman is pregnant and presents with an acute abdomen, including severe pain of unknown origin, the minimum diagnostic evaluation is a transvaginal ultrasound evaluation and confirmation of pregnancy through serum hCG-level measurement. However, serum hCG alone cannot be used to diagnose an ectopic pregnancy. The absence of a possible gestational sac on ultrasound examination in the presence of a positive hCG measurement strongly suggests a nonviable gestation. In 50 to 70% of these cases, these findings are consistent with ectopic pregnancy (ACOG, 2018c).

Treatment of a confirmed ectopic pregnancy that has not ruptured may be via laparoscopic surgery or intramuscular administration of methotrexate. Both treatments are safe and effective. The decision for surgical or medical management is guided by clinician assessment as well as patient-informed choice. Surgical management is required if the patient is experiencing hemodynamic instability, symptoms of a ruptured ectopic mass, or signs of intraperitoneal bleeding (ACOG, 2018c).

Best Practice

Women who present with acute abdominal pain and bleeding should be screened for pregnancy. If hCG levels are elevated, then a transvaginal ultrasound is indicated to determine if an ectopic pregnancy exists. An ectopic pregnancy constitutes a medical emergency, as rupture of the fallopian tubes is associated with significant morbidity and mortality. Best practice in treatment of ectopic pregnancy includes laparoscopic surgery or administration of methotrexate. Women suffering from ectopic pregnancy can be counseled that both treatments are safe and effective (ACOG, 2018c).

Clinical Reasoning

What elements of a nursing history could raise suspicion about the potential for an ectopic pregnancy? What questions should be asked of every woman who presents with acute abdominal pain?

Genetic Facts Exposure to Toxins

Environmental factors can impact future generations when people are exposed to toxins. Epigenetic changes in gene expression can occur when a woman is exposed to various environmental toxins. Depending on the agent and exposure, the cell nucleus can be altered at the molecular level and can impact if a gene is expressed or silenced (Stahl, 2017).

Genetic Facts provides information on the genetic implications of various topics being addressed in the chapter.

Health Promotion boxes emphasize the patient teaching that often involves empowering patients in their own health promotion.

Health Promotion Reducing Discomforts of Menopause

A variety of therapeutic modalities have been proposed as treatment or prevention measures for the discomforts and ailments of the perimenopausal, menopausal, and postmenopausal years. These include nutrition supplements, such as a diet rich in calcium and vitamins E, D, and B complex. Mind–body practices, such as yoga, t'ai chi, and meditation, are also helpful in reducing symptoms.

Key Facts to Remember summarize the elements of particular importance related to a specific topic.

Key Facts To Remember

Recommendations for Parents to Help Their Teens Avoid Pregnancy

- Parents should be clear about their own sexual attitudes and values in order to communicate clearly with children.
- Parents need to talk with their children about sex early and often and be specific in the discussions.
- Parents should supervise and monitor their children and teens with well-established rules, expectations, curfews, and standards of behavior.
- Parents should know their children's friends and their families.
- Parents need to clearly discourage early dating as well as frequent and steady dating.
- Parents should take a strong stand against allowing a daughter to date a much older boy; similarly, they should not allow a son to develop an intense relationship with a much younger girl.
- Parents need to help children set goals for their future and have options that are more attractive than early pregnancy and childrearing.
- Parents should show their children that they value education and take school performance seriously.
- Parents need to monitor what their children are reading, listening to, and watching.
- It is especially important for parents to build a strong, loving relationship with their children from an early age by showing affection clearly and regularly, spending time with them doing age-appropriate activities, building children's self-esteem, and having meals together as a family often.

NURSING CARE PLAN: The Woman with HIV Infection

1. Nursing Diagnosis: *Infection, Risk for*, related to inadequate defenses (leukopenia, suppressed inflammatory response) secondary to HIV-positive status (NANDA-I © 2017)

Goal: Patient will remain free of opportunistic infection during the course of pregnancy.

INTERVENTION	RATIONALE
• Obtain a complete health history and physical examination during first prenatal visit.	• A complete health history will help determine risk factors for the development of opportunistic infections, and a physical examination will assist in identifying any underlying problem symptoms or illnesses that may compromise the pregnancy or complicate the treatment of HIV.
• Educate the woman as to the signs and symptoms of infection.	• Early recognition of signs and symptoms of infection will allow for immediate treatment, which may decrease the severity of the infection. Signs and symptoms of infection include fever, weight loss, fatigue, persistent candidiasis, diarrhea, cough, and skin lesions (Kaposi sarcoma and hairy leukoplakia in the mouth).
• Obtain nutritional history and monitor weight gain at each prenatal visit.	• The HIV-infected woman needs to maintain optimal nutritional intake. A compromised nutritional status may affect maternal and fetal well-being. Depleted reserves of protein and iron may decrease the patient's ability to fight infection, thereby making her more susceptible to opportunistic infections.
• **Collaborative:** Monitor the absolute $CD4^+$ T lymphocyte count, erythrocyte sedimentation rate (ESR), complete blood count (CBC) with differential, and hemoglobin and hematocrit (H & H) as indicated.	• Laboratory results provide information about the woman's immune system and the potential for disease progression. Opportunistic infections are more likely to occur when the $CD4^+$ T lymphocyte count drops below a level of 200/mm^3. ESR can rise above 20 mm/hr with anemia and with acute and chronic inflammation. CBC with differential and platelet count helps identify anemia, thrombocytopenia, and leukopenia. H & H can also identify anemia.

EXPECTED OUTCOME: Patient will remain free of opportunistic infection as evidenced by $CD4^+$ T lymphocyte count within normal limits; no complaints of chills, fever, or sore throat; normal weight gain throughout pregnancy.

2. Nursing Diagnosis: *Health Maintenance, Ineffective*, related to a lack of information about HIV/AIDS and its long-term implications for the woman, her unborn child, and her family (NANDA-I © 2017)

Goal: The patient and her family will verbalize the importance of following her medication regimen and of regular prenatal care.

INTERVENTION	RATIONALE
• Assess the patient's and family's level of understanding of HIV infection, its modes of transmission, and the long-term implications.	• Knowledge of the woman's (and her family's) level of understanding about her HIV infection forms a starting point for further health teaching.
• Explain the risks of mother-to-child transmission of HIV infection.	• In untreated women the risk of transmission is 25%. That risk can be reduced to 1% or less with the use of antiretroviral therapy throughout pregnancy, labor, and birth; the use of cesarean birth when indicated; and formula-feeding rather than breastfeeding.
• Describe ART. Include the regimen prescribed, its purposes, and the procedures for taking it.	• ART approaches vary based on the health status of the individual woman and whether she is currently on ART. Generally it includes IV ZDV during labor through birth and therapy for the baby for 6 weeks following birth.
• Discuss signs the woman should be alert for, including fever, fatigue, weight loss, cough, skin lesions, and behavior changes.	• These symptoms may indicate that the woman is developing symptomatic loss, persistent candidiasis, diarrhea, and HIV infection.

EXPECTED OUTCOME: Woman will actively seek information about her condition, her treatment regimen, and her pregnancy and will cooperate with her caregivers.

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

Professionalism in Practice helps you to identify how to remain professional in nursing practice and focus on topics such as legal and ethical considerations, contemporary nursing practice issues, professional accountability, patient advocacy, and home and community care considerations.

Professionalism in Practice Using Contraception Resources During Patient Teaching

In your role as teacher, it is important to have resources on hand for women seeking a method of contraception. Having IUC models or a female condom plus informational handouts for the various methods of contraception is invaluable. Describing correct use of the method along with important tips, its side effects, and the warning signs for serious adverse reactions is essential. Women can refer to the informational sheets at home. Be sure to include the office or clinic phone number, and always remember to mention emergency contraception (EC).

SAFETY ALERT!
Lack of fetal movement can be an indication of chronic placental insufficiency or even fetal death; thus, the woman should be advised how to handle nonreassuring findings. The woman should call her healthcare provider, and if advised she should come in for testing. The need to retain a sense of calm is imperative for the mother who is transporting herself to the medical setting for these tests.

Safety Alert! features bring forward critical information for safe and effective nursing practice.

Teaching Highlights help you to plan and organize your patient teaching. The teaching that nurses do at all stages of pregnancy and childbearing and throughout the life of a woman is one of the most important aspects of their work.

TEACHING HIGHLIGHTS What to Tell the Pregnant Woman About Assessing Fetal Activity

- Explain that fetal movements are first felt around 18 weeks of gestation, but some women may not feel fetal movement until 25 weeks. This is called *quickening*. From that time, the fetal movements get stronger and easier to detect. A slowing or stopping of fetal movement may be an indication that the fetus needs some attention and evaluation. The mother's perception of decreased fetal movement is sufficient in most cases. Formal tracking of fetal movement does not lead to improved outcomes in low-risk pregnancies but may have value in high-risk situations.
- Describe the procedures and demonstrate how to assess fetal movement. Sit beside the woman and show her how to place her hand on the fundus to feel fetal movement. Advise the woman to keep a daily record of fetal movements beginning at about 28 weeks of gestation.
- Explain the procedure for the Cardiff Count-to-Ten method:
  1. Beginning at the same time each day, have the woman place an X on the Cardiff card (Figure 16–11) for each fetal movement she perceives during normal everyday activity until she has recorded 10 of them.
  2. Movement varies considerably, but the woman should feel fetal movement at least 10 times in 12 hours, and many women will feel 10 fetal movements in much less time, possibly 2 hours or less.
- Explain the procedure for the DFMR method:
  1. The woman should begin counting at about the same time each day, after taking food.
  2. She should lie quietly in a side-lying position.
  3. The woman should feel at least three fetal movements within 1 hour.
- Instruct the woman to contact her care provider in the following situations:
  1. Using the Cardiff method: If there are fewer than 10 movements in 12 hours.
  2. Using the DFMR method: If there are fewer than three movements in 1 hour.
  3. Both methods: If overall the fetus's movements are slowing, and it takes much longer each day to note the minimum number of movements in the specified time period, and if there are no movements in the morning.
- Whichever method she is using, encourage the woman to complete her fetal movement record daily and to bring it with her during each prenatal visit. Assure her that the record will be discussed at each prenatal visit and that questions may be addressed at that time if desired.
- Provide the woman with a name and phone number in case she has further questions.

Women with Special Needs Women with Paralysis
Women with paralysis often warrant intermittent fetal surveillance since they are unable to feel fetal movement or premature contractions. These women are at risk for unattended birth since they cannot perceive their contractions. Their partner or care provider should be trained to palpate contractions and observe for fetal movement on a regular basis.

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

Focus Your Study ends each chapter with an outline of the main points of the chapter so that you can review chapter content in an easy, quick-view format.

Focus Your Study

- Nurses often play a key role not only in teaching families about various testing procedures, but also in providing clarity and emotional support to the woman and her family undergoing antenatal testing.
- Ultrasound offers a valuable means of assessing intrauterine fetal growth because the growth can be followed over a period of time. It is noninvasive and painless, allows the practitioner to study the gestation serially, is nonradiating to both the woman and her fetus, and to date has shown no known harmful effects.
- Using ultrasound, the gestational sac may be detected as early as 5 or 6 weeks after the last menstrual period. Measurement of the crown–rump length in early pregnancy is most useful for accurate dating of a pregnancy. The most important and frequently used ultrasound measurements in the second trimester are biparietal diameter, head circumference, abdominal circumference, and femur length.
- Maternal assessment of fetal activity is very useful as a screening procedure in evaluation of fetal status.
- A nonstress test (NST) measures fetal heart rate (FHR) during fetal activity; FHR normally increases in response to fetal activity. The desired result is a reactive test.
- A contraction stress test (CST) provides a method for observing the response of the FHR to the stress of uterine contractions. The desired result is a negative test.
- A fetal biophysical profile (BPP) includes five fetal variables (breathing movement, body movement, tone, amniotic fluid volume, and FHR reactivity). It assesses the fetus at risk for intrauterine compromise.
- Aneuploidy screening includes first-trimester single test screening (nuchal translucency and PAPP-A and beta hCG); stepwise sequential, integrated, or contingent screening; cell-free DNA testing; or quadruple screening of AFP, hCG, diameric inhibin-A, and estriol.
- Amniocentesis can be used to obtain amniotic fluid for testing. A variety of tests is available to evaluate the presence of disease, genetic conditions, and fetal maturity.
- Chorionic villus sampling (CVS) is a procedure that obtains fetal karyotype in the first trimester. It is used to diagnose hemoglobinopathies (e.g., sickle cell disease and alpha and some beta thalassemias), phenylketonuria, alpha antitrypsin deficiency, Down syndrome, Duchenne muscular dystrophy, and factor IX deficiency.
- The lecithin/sphingomyelin (L/S) ratio of the amniotic fluid can be used to assess fetal lung maturity. The presence of phosphatidylglycerol (PG) may also provide information about fetal lung maturity.
- Lamellar body counts (LBCs) testing can be used as a predictive indicator for predicting respiratory distress syndrome (RDS) in preterm newborns. Optical density at 650 nm is an indirect measure of LBCs.

Contents

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Part I Introduction to Maternal-Newborn Nursing

Chapter 1

Contemporary Maternal-Newborn Nursing

SOURCE: Corbis/SuperStock.

Our daughter just told us that she is 3 months pregnant with our first grandchild. As a labor and delivery nurse for 30 years, I've helped with hundreds of births, but it still seems magical to me, especially now. I'm excited for her and a little worried because I know all the risks as well as the joys. She is so happy; when I am with her, I just want to laugh out loud. I already know I love being a grandmother!

Learning Outcomes

1.1 Discuss the impact of the self-care movement on contemporary childbirth.

1.2 Compare the nursing roles available to the maternal-newborn nurse.

1.3 Describe the use of community-based nursing care in meeting the needs of childbearing families.

1.4 Identify specific factors that contribute to a family's value system.

1.5 Delineate significant legal and ethical issues that influence the practice of nursing for childbearing families.

1.6 Evaluate the potential impact of some of the special situations in contemporary maternity care.

1.7 Contrast descriptive and inferential statistics.

1.8 Identify the impact of evidence-based practice in improving the quality of nursing care for childbearing families.

Healthy People 2020

(MICH-10) Increase the proportion of pregnant women who receive early and adequate prenatal care

(MICH-1) Reduce the rate of fetal and infant deaths

(MICH-7) Reduce cesarean births among low-risk (full-term, singleton, and vertex presentation) women

(MICH-5) Reduce the rate of maternal mortality

The practice of most nurses is filled with special moments, shared experiences, times in which they know they have practiced the essence of nursing and, in doing so, have touched a life. What is the essence of nursing? Simply stated, nurses care for people, care about people, and use their expertise to help people help themselves.

"I like working with students. I enjoy the enthusiasm they bring, the questions they ask, the ways they cause me to examine my practice. I love being a nurse. I am passionate about the importance of what I do, and I feel the need to seize every chance to influence those who will be practicing beside me someday. Last week was a perfect example. I had a nursing student working with me in one of our birthing rooms. It was her first day caring for a laboring woman, and she was scared and excited at the same time. We were taking care of a healthy woman who had two boys at home and really wanted a girl."

"As labor progressed, the student and I worked closely together monitoring contractions, teaching the woman and her partner, doing what we could to ease her discomfort. Sometimes the student would ask how I knew when to do something—a vaginal exam,

for example—and I'd have to think beyond 'I just do' to give her some clues. At the birth, the student stayed close to the mother, coaching and helping with breathing. The student was excited but felt she had an important role to play, and she handled it beautifully. At the moment of birth, the student and the dad were leaning forward watching as the baby just slipped into the world. There wasn't a sound until the student said in a voice filled with awe, 'Oh, it's a girl!' Then we all laughed and hugged each other. What a day—using my expertise to help others and helping a future nurse recognize the importance of what we do!"

All nurses who provide care and support to childbearing women and their families can make a difference. Expert nurses, like the nurse in the preceding quotation, have a clear vision of what is possible in a given situation. This holistic perspective that expert nurses develop is based on a wealth of knowledge bred of experience and enables them to act "intuitively" to provide effective care. In reality, nurses' intuition reflects their internalization of information. When faced with a clinical situation, expert nurses draw almost subconsciously on their stored knowledge and judgment. New nurses need time to develop this level of skill and can benefit greatly from mentoring and coaching by their more seasoned colleagues.

This intuitive perception is integral to the "art of nursing," especially in areas such as maternal-newborn nursing, where change occurs quickly and families look to the nurse for help and guidance. Labor nurses become attuned to a woman's progress or lack of progress; nursery nurses detect subtle changes in the newborns under their care; antepartum and postpartum nurses become adept at assessing and teaching. Similarly, nurses who are cross-trained as labor, delivery, recovery, and postpartum (LDRP) nurses become skilled at caring for childbearing families during all phases of childbirth. Thus, skilled nursing practice depends on a solid base of knowledge and clinical expertise delivered in a caring, holistic manner.

"My first pregnancy ended in spontaneous abortion at 8 weeks, so this time I decided not to tell anyone I was pregnant until I was 3 months along. We had just told both families the news the preceding day when it happened again. We rushed to the hospital and, a short time later, I passed a small fetus into the Johnny cap. My poor baby—so tiny, maybe 3 or 4 inches long. My husband sat with his arm around me as I cried while the nurse took our baby out. A few minutes later, she came back and said, 'I saw on your record that you are Catholic. Would you like me to baptize your baby?' I said, 'Oh, yes, please,' and she left. Even in my grief, I recognized the meaningfulness of her act. She showed me so very clearly that I was an individual in need of individualized care. I vowed that I would practice nursing in the same holistic way."

Many nurses who work with childbearing families are sensitive, intuitive, knowledgeable, critical thinkers. They are technically skilled, empowered professionals who can collaborate effectively with others and advocate for those individuals and families who need their support. Such nurses do make a difference in the quality of care that childbearing families receive.

Contemporary Childbirth

The scope of practice of maternal and newborn nurses has changed dramatically in the past 30 years. Today's maternal-newborn nurses have far broader responsibilities and focus more on the specific goals of the individual childbearing woman and her family (Figure 1–1).

Figure 1–1 Individualized education for childbearing couples is one of the prime responsibilities of the maternal-newborn nurse.

SOURCE: Wavebreak Media Ltd/123 RF

Family-centered care, characterized by an emphasis on the family and family involvement throughout the pregnancy, birth, and postpartum period, is accepted and encouraged. Fathers are active participants in the childbirth experience. Families and friends are also often included. Siblings are encouraged to visit and meet their newest family member and may even attend the birth.

As new definitions of *family* evolve, as discussed in Chapter 2, family-centered care changes and evolves as well. For example, the family of the single mother may include her mother, sister, another relative, a close friend, her partner, or the father of the child. Many cultures also recognize the importance of extended families, where several family members often provide care and support.

In addition to the emphasis on the family, contemporary childbirth is also characterized by an increasing number of choices about many aspects of the childbirth experience, including the place of birth (hospital, free-standing birthing center, or home birth); the primary caregiver (physician, certified nurse-midwife, or certified midwife); the use of a *doula* to provide labor support (see Chapter 21 for more information on doulas); and birth-related experiences (methods of childbirth preparation, use of analgesia and anesthesia, and position for labor and birth, for example).

It seems likely that home follow-up nursing care will continue to gain acceptance because it is a cost-effective approach with favorable long-term family outcomes. In addition, families can access a variety of community resources, from local programs focusing on specific topics such as parenting or postpartum exercise to the widely recognized support provided by national organizations such as La Leche League.

For families with access to the internet, a wealth of information and advice is available. For example, the U.S. Department of Health and Human Services' Office on Women's Health offers a wide variety of educational resources designed to help promote women's health and well-being. Web links to a variety of other organizations and consumer publications also exist.

Interest in complementary and alternative medicine (CAM) practices is growing nationwide and is having an impact on the care of childbearing families. In response to this trend, the National Institutes of Health has established the National Center for Complementary and Integrative Health (NCCIH), which is a valuable resource for both families and healthcare professionals. Nurses caring for childbearing families need to recognize that a significant percentage of Americans are using some form of

unconventional or alternative practice, although they may not share this information with their healthcare provider. It is important for nurses to communicate a willingness to work with the women and their families to recognize and respect these alternative approaches. Complementary health approaches are discussed in Chapter 2.

Many women elect to have their pregnancy and birth managed by a certified nurse-midwife (CNM), a registered nurse who is also prepared as a midwife. Midwives who are not registered nurses but who complete a direct-entry midwifery education program that meets the standards established by the American College of Nurse-Midwives (ACNM) may take a certification exam to become a *certified midwife (CM)*. The CM credential is not recognized in all states. In 2014, CNMs and CMs attended 8.3% of all births in the United States and 12.1% of all vaginal births (American College of Nurse-Midwives [ACNM], 2016). Education and certification standards are the same for CNMs and CMs. As of 2010, a graduate degree is required for either credential (ACNM, 2016). Most states mandate that private insurers provide reimbursement for midwifery services; Medicaid reimbursement for these services is mandatory in all states (ACNM, 2016).

The North American Registry of Midwives (NARM) is also a certification agency. NARM midwifery certification is a competency-based model. Midwives certified through NARM may become midwives through a formal educational program at a college, university, or midwifery school or through apprenticeship or self-study. They are eligible to use the credential *certified professional midwife (CPM)* (NARM, 2014).

Traditional midwives, sometimes called *lay midwives*, are midwives who do not become certified or licensed, often for religious or personal reasons. They typically serve a specific community and are a reflection of historical approaches to midwifery (Midwives Alliance of North America [MANA], 2016).

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 that threatens the well-being of the mother or her baby, delay in obtaining emergency assistance might result. Some CNMs do attend home births; however, the majority of home births are attended by CMs, CPMs, or traditional midwives. In 2015, 1.5% of births occurred outside of a hospital. Of these, 63.1% were home births, while the remainder occurred in a freestanding birthing center; this is the highest number of home births reported since this information began to be collected in 1989 (Martin, Hamilton, Osterman, et al., 2017).

The Self-Care Movement

The *self-care* movement began to emerge in the late 1960s as consumers sought to understand technology and take an interest in their own health and basic self-care skills. More and more people have begun to exercise, control their diet, and monitor their psychologic and physiologic status. Thus, they assume many primary care functions. Furthermore, today's healthcare consumers are requiring greater information and accountability from their healthcare providers. These consumers recognize that knowledge, indeed, is power.

Practicing self-care—assuming responsibility for one's own health—often requires patients to be assertive and to take an active role in seeking necessary information. Healthcare providers can help foster self-care by focusing on *health promotion education* during every patient encounter. This may be as simple as discussing actions that foster a healthy lifestyle, such as exercising regularly or wearing a helmet when biking, skiing, or snowboarding, or it may be more involved for a person with a chronic health condition. Health promotion education can be especially effective when it is related to a specific health concern. For example, discussion about the importance of a healthy diet, weight control, and regular exercise may be particularly impactful for a woman who learns she has high cholesterol or who is diagnosed with gestational diabetes mellitus. Nurses can foster self-care by providing information readily and by acknowledging people's right to ask questions and become actively involved in their own care.

Gradually, as more and more people have come to recognize that promoting health can help decrease healthcare costs, health promotion education activities have increased significantly. Literature and handouts are available in offices, pharmacies, stores, and other public places. Television, radio, newspapers, and magazines regularly address health-related topics. Community organizations have become more active in promoting health through events, such as bicycle safety camps for youngsters and by providing car seats to low-income families so that newborns are protected from the moment they leave their places of birth.

Maternal-newborn care offers a special opportunity to promote health-related activities and to foster active participation in healthcare because it is essentially health focused; in most cases, patients are well when they enter the system. The consumer movement, which has already influenced childbirth, encourages people to speak up about their preferences in dealing with healthcare providers.

We believe that health promotion education and its natural outcome, self-care, will be vital parts of healthcare for years to come. Obviously, self-care is not always realistic or appropriate, especially in acute emergencies, but in many situations it is appropriate. With this in mind, throughout this book we have attempted to suggest ways in which nurses might offer health promotion education that would enable the childbearing family to meet its own healthcare needs. We see this as one of nursing's most important functions and one that nurses are especially well qualified to perform. The nursing profession has been at the forefront in recognizing that people who are able to do so should take an active role in their own healthcare, and we agree.

The Healthcare Environment

Healthcare issues are at the top of policy and legislative agendas. Cost, access, and quality of healthcare have become the "bywords" of the times. In 2016, healthcare expenditures in the United States were $2.7 trillion. The healthcare share of the gross domestic product was 17.8% (National Center for Health Statistics [NCHS], 2016).

Almost all adults over age 65 are covered by Medicare, so the vast majority of the uninsured are under age 65. In 2013, the percentage of uninsured individuals was 20.4%; that decreased to 12.4% during the first 6 months of 2016 (NCHS, 2017) (Figure 1–2). The percentage of uninsured people is changing, however, as the Federal government makes changes to healthcare coverage.

For women who become pregnant, early prenatal care is one of the most important approaches available to reduce adverse pregnancy outcomes. In 2016, 77.1% of pregnant women in the United States began prenatal care in the first trimester, 16.7% began prenatal care in the second trimester, and 6.2% began prenatal care in the third trimester or received no prenatal care (Martin, Hamilton, Osterman, et al., 2018).

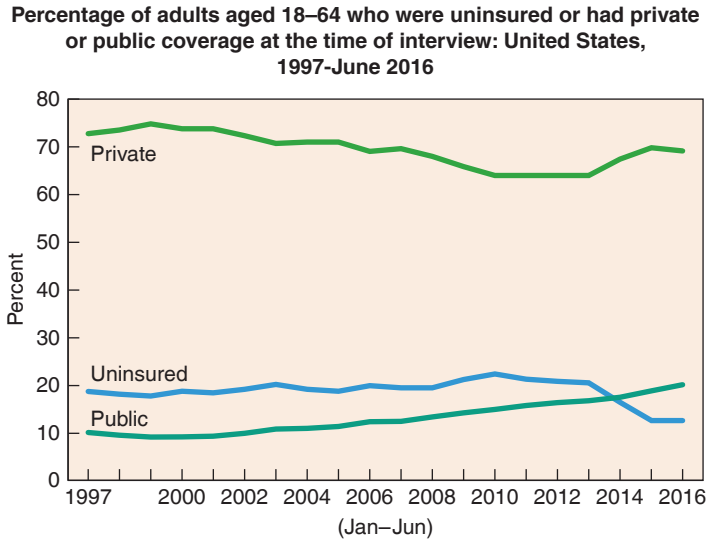

Figure 1–2 Graph showing percentage of U.S. adults 18–64 years of age who either were uninsured, had public insurance coverage, or had private insurance coverage from 1997 through the first 6 months of June 2016.

SOURCE: Centers for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS). (2017). *NCHS Fact Sheet*. Data from the National Health Interview Survey 1997–2016.

Changes in the healthcare environment are influencing women's health and maternal-newborn nursing. Several factors contribute to this, including:

- Demographic changes
- Recognition of the need to improve access to care
- Availability of healthcare
- Public demand for more effective healthcare options
- New research findings
- Women's preferences for healthcare.

Changes are also predicted to occur in clinical procedures, provider roles, care settings, and financing of care. As access to healthcare and the need to control costs increase, so will the need for, and use of, nurses in many roles—especially in advanced practice.

Changing the current system requires a new way of thinking and providing services. Primary healthcare services should be the base on which all other secondary and tertiary services are built. Today in the United States, the opposite is still the case. The system emphasizes high-technology care rather than prevention. However, morbidity and mortality from disease are reduced significantly when people use preventive health services.

Providing all segments of the population with access to primary healthcare should be the chief criterion for meaningful reform of the U.S. healthcare system. This includes a focus on health promotion, prevention, and individual responsibility for one's own health. In this model, secondary healthcare services would use a smaller proportion of the healthcare dollar.

Culturally Competent Care

Culture develops from socially learned beliefs, lifestyles, values, and integrated patterns of behavior that are characteristic of the family, cultural group, and community. The U.S. population has a varied mix of cultural groups with ever-increasing diversity. Estimates suggest that by 2020, fewer than half of all children in the United States will be non-Hispanic White, down from 52% in 2015. By 2050, this number decreases to 39% (Federal Interagency Forum on Child and Family Statistics, 2016). Thus, it is vitally important that nurses who care for women and for childbearing families recognize the importance of a family's cultural values and beliefs, which may be different from those of the nurse (Figure 1–3).

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

- 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.

Specific differences in beliefs between families and healthcare providers are common in the following areas:

- Help-seeking behaviors
- Pregnancy and childbirth practices
- Causes of diseases or illnesses
- Death and dying
- Caretaking and caregiving
- Childrearing practices.

These elements in differing degrees influence the cultural beliefs and values of an ethnic group, making the group unique. Misunderstandings may occur when the healthcare professional and the family come from different cultural groups. In addition, past experiences with care may have made the family angry or suspicious of providers.

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 women and families in their care. By learning about the values of the different ethnic groups in the community—their religious beliefs that have an impact on healthcare practices, their beliefs about common illnesses, and their specific healing practices—nurses can develop an individualized nursing care plan for each childbearing woman and her family. See *Developing Cultural Competence: Values Conflicts*.

Figure 1–3 Nurses who care for childbearing families must recognize the importance of each family's cultural values and beliefs.

SOURCE: Andy Dean/Fotolia.

Developing Cultural Competence

Values Conflicts

Conflicts with a childbearing woman and her family can occur when traditional rituals and practices of the family's elders do not conform to current healthcare practices (Spector, 2017). Nurses need to be sensitive to the potential implications for the woman's health and that of her newborn, especially after they are discharged home. When cultural values are not part of the nursing care plan, a woman and her family may be forced to decide whether the family's beliefs should take priority over the healthcare professional's guidance. Nurses need to be able to recognize, respect, and respond to ethnic diversity in a way that leads to an outcome that is satisfactory to both the patient and the healthcare provider.

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

Professional Options in Maternal-Newborn Nursing Practice

"As a man, I don't always find it easy to be a labor and delivery nurse. I have three children of my own and attended all their births. It meant a lot to me to be there, and I like helping others to have good childbirth experiences, too. I don't fit some people's image of a nurse, so they refer to me as a 'male nurse' as opposed to a real nurse, and they ask why I didn't go into medicine instead. Why can't they understand that I'm a nurse because it's what I really want to be? And I'm darned good at it, too. More men are choosing nursing now, and I think that will help. I hope to see the day when we don't have 'female doctors' and 'male nurses,' but doctors and nurses, period!"

Maternal-newborn nurses are found in the maternity departments of acute care facilities, in physicians' offices, in clinics, in college health services, in school-based programs dealing with sex education or adolescent pregnancies, in community health services, and in any other setting in which a patient has a need for maternity care. The depth of nursing involvement in various settings is determined by the qualifications and the role or function of the nurse employed. Many different titles have evolved to describe the professional requirements of the nurse in various maternity care roles. These titles include:

- A **professional nurse** is a graduate of an accredited basic program in nursing who has successfully completed the nursing examination (NCLEX-RN) and is currently licensed as a registered nurse (RN). Professional nurses are typically educated as generalists.
- A **certified registered nurse (RNC)** has shown expertise in a particular field of nursing such as labor and birth by passing a national certification examination.
- A **nurse practitioner (NP)** is a professional nurse who has received specialized education in either a *Doctor of Nursing Practice (DNP)* or a master's degree program and can function in an expanded role. 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. Nurse practitioners often provide ambulatory care services to the expectant family (women's health nurse practitioner, family nurse practitioner); some NPs also function in acute care settings (neonatal nurse practitioner, perinatal nurse practitioner). NPs focus on physical and psychosocial assessment, including health history, physical examination, and certain diagnostic tests and procedures. The nurse practitioner makes clinical judgments and begins appropriate treatments, seeking physician consultation when necessary.
- A **clinical nurse specialist (CNS)** is a professional nurse with a master's degree who has additional specialized knowledge and competence in a specific clinical area. CNSs assume a leadership role within their specialty and work to improve patient care both directly and indirectly.
- A **certified nurse-midwife (CNM)** is educated in the two disciplines of nursing and midwifery and is certified by the American College of Nurse-Midwives (ACNM). The certified nurse-midwife is prepared to manage independently the care of women at low risk for complications during pregnancy and birth and the care of normal newborns (Figure 1–4).

The term *advanced practice nurse* is used to describe nurses who, by education and practice, function in an expanded nursing role. The term, often used in a legal sense in state nurse practice acts, most frequently applies to NPs, CNSs, certified registered nurse anesthetists (CRNAs), and CNMs. As NPs assume a more prominent role in providing care, the distinctions between the roles of the nurse practitioner and the clinical nurse specialist are beginning to blur, and these roles may ultimately merge.

The **nurse researcher** has an advanced doctoral degree, typically a Doctor of Philosophy (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 patient care, administrative issues, and the like. Nurses who have earned a DNP often participate in nursing research; they also play a key role in advancing evidence-based practices that improve patient outcomes and the quality of patient care.

Interprofessional Cooperation and Collaborative Practice

Managed care has led to a rethinking of care delivery and an increased recognition of the importance of interprofessional care

Figure 1–4 A certified nurse-midwife confers with her patient.

SOURCE: Monkey Business Images/Shutterstock.

and collaborative practice. Most groups that accredit programs in the health professions have developed specific standards that address the importance of this acknowledgment of the complementary roles of the various health professions.

Collaborative practice is a comprehensive model of healthcare that uses a multidisciplinary team of health professionals to provide cost-effective, high-quality care. In maternal-newborn settings, the team generally includes CNMs and NPs in practice with physicians (often obstetricians or family practice physicians) and may include other health professionals, such as lactation consultants, social workers, or CNSs (Figure 1–5).

In a successful team, each individual has autonomy but functions within a clearly defined scope of practice. In such a collaborative approach, no single profession "owns the patient." Rather, the team seeks to empower patients and families and include them as partners in their care and in decision making.

Community-Based Nursing Care

Primary care is the focus of much attention as healthcare professionals search for a new, more effective direction for healthcare. 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. Community-based health services providing primary care and some secondary care will be available in schools, workplaces, homes, churches, clinics, transitional care programs, and other ambulatory settings.

The growth and diversity of healthcare plans offer both opportunities and challenges for women's and children's healthcare. 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 healthcare 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 is also part of a trend initiated by consumers, who are asking for a "seamless" system of family-centered, comprehensive, coordinated healthcare, health education, and social services. This type of system requires coordination as patients move from primary care services to acute care facilities and then back into the community. Nurses can assume this care-management role and perform an important service for individuals and families.

Figure 1–5 A collaborative relationship between nurses and physicians contributes to excellent patient care.

SOURCE: Rido/Fotolia.

Community-based care is especially important in maternal-child nursing because the vast majority of healthcare provided to childbearing women and their families takes place outside of hospitals in clinics, offices, community-based organizations, and private homes. In addition, maternal-child nurses offer specialized services such as childbirth preparation classes and postpartum exercise classes that typically take place outside of hospitals. In essence, we are expert at providing community-based nursing care.

HOME CARE

The provision of healthcare in the home is emerging as an especially important dimension of community-based nursing care. The shortened length of hospital stays has resulted in the discharge of individuals who still require support, assistance, and teaching. Home care can help fill this gap. Conversely, home care also enables individuals with conditions that formerly would have required hospitalization to remain at home.

Nurses are the 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 can use their skills in assessment, therapeutics, communication, teaching, problem solving, and organization to meet the needs of childbearing 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 are becoming a recognized way of ensuring that childbearing families make a satisfactory transition from the hospital or birthing center to the home. We see this trend as positive and hope that this method of meeting the needs of childbearing families becomes standard practice. Chapter 34 discusses postpartum home care in detail and provides guidance about making a home visit. In addition, throughout the text we have provided information on how home care can meet the needs of women with health problems, such as diabetes or preterm labor, which put them at risk during pregnancy. We believe that home care offers nurses the opportunity to function in an autonomous role and make a significant difference for individuals and families.

Healthy People 2020 Goals

For over 30 years, the *Healthy People* initiative has been providing science-based, national agendas for improving the health of all Americans. This effort is based on the recognition that it is possible to motivate action by setting national objectives and monitoring progress. Analysis indicates that this approach has led to significant progress in many areas.

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:

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

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. 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 (U.S. Department of Health and Human Services, 2017). To increase your familiarity with the objectives, we have created a boxed feature at the beginning of each chapter that identifies *Healthy People 2020* objectives that are relevant for the topic presented in the text.

Legal and Ethical Considerations

Professional nursing practice requires full understanding of practice standards; institutional or agency policies; and local, state, and federal laws. Professional practice also requires an understanding of the ethical implications of those standards, policies, and laws that impact care, care providers, and care recipients. Ethical dilemmas are common in maternal-newborn nursing, and often they are especially challenging. To help you begin identifying ethical dilemmas and to prepare you for professional practice, we have added a new boxed feature called *Ethics in Action!* It asks you to consider how you would respond to ethical issues you might encounter in practice.

Scope of Practice

State nurse practice acts protect the public by broadly defining the legal *scope of practice* within which every nurse must function and by excluding untrained or unlicensed individuals from practicing nursing. Although some state practice acts continue to limit nursing practice to the traditional responsibilities of providing patient care related to health maintenance and disease prevention, most state practice acts cover expanded practice roles that include collaboration with other professionals in planning and providing care, diagnostic and prescriptive privileges, and the delegation of patient care tasks to other specified licensed and unlicensed personnel. A nurse must function within his or her scope of practice or risk being accused of practicing medicine without a license.

Correctly interpreting and understanding state practice acts enables the nurse to provide safe care within the limits of nursing practice. State boards of nursing may provide official interpretation of practice acts when the limits are not clear. On occasion, hospital policy may conflict with a state's nurse practice act. It is important to recognize that hospital or agency policy may restrict the scope of practice specified in a state practice act, but such policy cannot legally expand the scope of practice beyond the limits stated in the practice act.

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 professional practice for maternal-child health. Organizations such as the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), the National Association of Neonatal Nurses (NANN), and the Association of periOperative Registered Nurses (AORN) have developed standards for specialty practice. 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 patient 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.

Ethics in Action!

What would you do if you knew that a colleague administered an antibiotic late but recorded it on the electronic health record (EHR) (sometimes called electronic medical record [EMR]) as being administered on time?

Patients' Rights

Patients' rights encompass such topics as patient safety, informed consent, privacy, and confidentiality.

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. These goals and recommendations 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 address " . . . the challenge of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems within which they work" (2014, p. 1). The project focuses on competencies in six areas:

1. Patient-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 in a feature titled **SAFETY ALERT!**

INFORMED CONSENT

Informed consent is a legal concept designed to allow patients to make intelligent decisions regarding their own healthcare. Informed consent means that a patient, or a legally designated decision maker, has granted permission for a specific treatment or procedure based on full information about that specific treatment or procedure as it relates to that patient under the specific circumstances of the permission. Although this policy is usually enforced for such major procedures as 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.

Several elements must be addressed to ensure that the patient has given informed consent. The information must be clearly and concisely presented in a manner understandable to the patient and must include risks and benefits, the probability of success, and significant treatment alternatives. The patient also needs to be told the consequences of receiving no treatment or procedure. Finally, the patient must be told of the right to refuse a specific treatment or procedure. Each patient should be told that refusing the specified treatment or procedure does not result in the withdrawal of all support or care.

The individual who is ultimately responsible for the treatment or procedure should provide the information necessary to obtain informed consent. In most instances, this is a physician. In such cases, the nurse's role may be to witness the patient's signature giving consent. A nurse who knows the patient and the procedure may certainly help the physician obtain the patient's consent by clarifying the information the physician provides. It is also part of the nurse's role to determine that the patient understands the information before making a decision. 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.

Society grants parents the authority and responsibility to give consent for their minor children. Parents are presumed to possess what a child lacks in maturity, experience, and capacity for judgment in life's difficult decisions. Although the age of majority is 18 years in most states, variations in certain states require that nurses be aware of the law in the state where they practice. Children under 18 or 21 years of age, depending on state law, can legally give informed consent in the following circumstances:

- When they are minor parents of the newborn, infant, or child patient
- When they are *emancipated minors* (self-supporting adolescents under 18 years of age, not living at home, married, or on active duty in the military)

In some states, *mature minors* (14- and 15-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 healthcare. Special problems can occur in maternity nursing when a minor gives birth. It is possible, depending on state law, that a minor might be able to consent to treatment for her baby but not allowed to consent to treatment for herself. In most states, however, a pregnant teenager is considered an emancipated minor and may, therefore, give consent for herself as well.

Refusal of a treatment, medication, or procedure after appropriate information also requires that the patient sign a form to release the physician and agency from liability. For example, a person who is a Jehovah's Witness may refuse a transfusion of blood or Rh immune globulin.

Nurses are responsible for educating patients about any nursing care provided. 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.

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. Maternity nurses need to remember that this includes avoiding unnecessary exposure of the childbearing woman's body. In the context of healthcare, the right to privacy dictates that only those responsible for a person's care should examine the person or discuss his or her case.

Most states have recognized the right to privacy through statutory or common law, and some states have written that right into their constitution. The ANA, the National League for Nursing (NLN), and The Joint Commission have adopted professional standards protecting patients' privacy. Healthcare agencies should also have written policies dealing with patient privacy. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 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 the health professionals responsible for his or her care. Authorization for the release of any patient information should be obtained from competent individuals or their surrogate decision makers. Although it may be legal to reveal vital statistics such as name, age, occupation, and prognosis, such information is often withheld because of ethical considerations. The patient should be consulted regarding what information may be released and to whom.

CONFIDENTIALITY

Given the highly personal and intimate information requested of patients, the need for maintaining confidentiality is crucial for the development of trust in the relationship between the individual and the provider. Privileged communications exist between patient and physician, patient and attorney, husband and wife, and clergy and those who seek their counsel. In some states, laws of privilege also protect nurses. Nurses should become well informed about privileged communication laws in their state.

The Federal Patient Self-Determination Act requires all healthcare institutions that are reimbursed by Medicare or Medicaid to provide all hospitalized individuals with written information 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). This often comes as a surprise to young women and couples of childbearing age who may have no experience with hospitals. However, with an advance directive in place, a childbearing woman can be certain that, even if she becomes incompetent, she can retain her autonomy about healthcare decisions. See *Professionalism in Practice: Confidentiality and the Pregnant Adolescent*.

Professionalism in Practice Confidentiality and the Pregnant Adolescent

Breaching confidentiality is a potential problem for pregnant adolescents, who are just learning whom they can trust in the healthcare system. Make sure you openly discuss the limits of confidentiality for such things as mandatory reporting requirements with the patient and family. Inadvertent disclosure of personal information may lead to psychologic, social, or physical harm for some patients.

Special Ethical Situations in Maternity Care

While ethical dilemmas confront nurses in all areas of practice, those related to pregnancy, birth, and the newborn can be especially complex and 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 patient—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 patient separate from the mother, although treatment of the fetus necessarily involves the mother. This type of approach, by nature adversarial, tends to emphasize the divergent interests of the mother and her fetus rather than focus on their shared interests. This focus on the fetus intensified in 2002 when President George W. Bush announced that "unborn children" would qualify for government healthcare benefits. The 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 fetuses. 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, mandating 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 that are considered harmful to the fetus. These forced interventions raise two thorny questions: (1) What practices should be monitored? and (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 (2016b) 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.

Cases of maternal–fetal conflict involve two patients, 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, appropriate only in extraordinary circumstances.

Abortion

Since the 1973 *Roe v. Wade* Supreme Court decision, abortion has been legal in the United States. It can be performed until the *period of viability,* that is, the point at which the fetus can survive independently of the mother. After viability, abortion is permissible only when the life or health of the mother is threatened. Before viability, the mother's rights 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 responses seen when the issue of abortion is raised.

At present, decisions about abortion are made by a 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 avoid being placed in a situation contrary to their values and beliefs, nurses should determine the philosophy and practices of an institution before going to work there. A nurse who refuses to participate in an abortion because of moral or ethical beliefs does have a responsibility to ensure that someone with similar qualifications is able to provide appropriate care for the patient. Patients may never be abandoned, regardless of the nurse's beliefs.

Fetal Research

Research with fetal tissue has been responsible for remarkable advances in the care and treatment of fetuses with health problems and advances in the treatment of progressive, debilitating adult diseases, such as Parkinson disease, Alzheimer disease, and DiGeorge syndrome. Therapeutic research with living fetuses has been instrumental in the treatment of newborns who are Rh sensitized, the evaluation of lung maturity using the lecithin/sphingomyelin ratio, and the treatment of pulmonary immaturity in the newborn. Because it is aimed at treating a fetal condition, therapeutic fetal research raises fewer ethical questions than does nontherapeutic fetal research. To be approved, nontherapeutic research requires that the risk to the fetus be minimal, that the knowledge to be gained be important, and that the information be unobtainable by any other means. Control over research standards and attention to state and federal regulations remain foci of debate regarding fetal research.

Intrauterine fetal surgery, which is generally considered experimental, 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.

Intrauterine fetal surgery involves opening the uterus during the second trimester (before viability), treating the fetal lesion, 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 incised during the surgery. 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 with other aspects of maternity care, caregivers must respect the pregnant woman's autonomy. The procedure does involve 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

The number and sophistication of reproductive assistance techniques continue to grow. Infertile couples now have available a wide range of reproductive options, from intrauterine insemination to in vitro fertilization and beyond. The

ethical dimensions of such techniques are discussed here. The techniques themselves are identified and described in detail in Chapter 6.

Intrauterine insemination (IUI) is accomplished by depositing sperm obtained from her husband or partner into a woman. The term *donor insemination (DI)* is used when the sperm is obtained from a donor rather than the woman's husband or partner. Some women who are single are choosing IUI or DI as a childbearing option. No states prohibit intrauterine insemination using a husband's sperm because there is no question of the child's legitimacy. Legal problems may occur with DI, however. Because the child is the biologic child of the mother, legal concerns center on the donor. A donor must sign a form waiving all parental rights. The donor must also furnish accurate health information, particularly regarding genetic traits or diseases. Donor sperm must be tested for HIV. Husbands/partners are often requested to sign a form to agree to the insemination and to assume parental responsibility for the child. Some men legally adopt the child so there is no question of parental rights and responsibilities. Several states have enacted legislation regarding paternity of the child conceived by insemination with donor sperm.

Assisted reproductive technology (ART) is the term used to describe highly technologic approaches used to produce pregnancy. *In vitro fertilization–embryo transfer (IVF–ET)*, a therapy offered to select 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, which, 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) and the Society for Assisted Reproductive Technology (SART) have jointly issued guidelines to limit the number of embryos transferred. Specifically, women under age 35 and ages 35 to 37 should be strongly encouraged to have a single embryo transferred. The number recommended for transfer increases for women ages 38 to 40 and for women age 41 and older. These guidelines are designed to decrease risk while allowing for individualized care (ASRM & SART, 2017).

This practice raises ethical considerations about the handling of 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 in the first trimester or early in the second trimester 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. Ultimately, the ethical principle of autonomy indicates that it is the woman who needs to assess the issues involved and decide whether to opt for fetal reduction. No physician who is morally opposed to fetal reduction should be expected to perform the procedure; the patient should be referred to a physician who has the necessary expertise. 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, 2016a).

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

These methods of resolving infertility raise many ethical questions, including the problem of religious objections to artificial conception, the question of who will assume financial and moral responsibility for a child born with a congenital defect, the issue of candidate selection, and the threat of genetic engineering. Other ethical questions include:

- What should be done with surplus fertilized oocytes?
- To whom do frozen embryos belong—parents together or separately? The hospital or infertility clinic?
- Who is liable if a woman or her offspring contracts HIV disease from donated sperm?
- Should children be told the method of their conception?

"Our son was born after artificial insemination. Nick, my husband, was sterile because of radiation therapy, so his cousin was the donor for us. I thought that might be awkward but the whole family was so excited that there was a way to help us after Nick's battle with cancer that it has been OK. Every time we look at Vincent Joseph (he is named for his grandfathers) and see him smile, we know that we would do it again in an instant."

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 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.

Implications for Nursing Practice

The complex ethical issues facing maternal-newborn nurses have many social, cultural, legal, and professional ramifications. Nurses, like all healthcare professionals, need to learn to anticipate ethical dilemmas, clarify their own positions and values related to the issues, understand the legal implications of the issues, and develop appropriate strategies for ethical decision making. To accomplish these tasks, they may read about bioethical issues, participate in discussion groups, or attend courses and workshops on ethical topics pertinent to their areas of practice. Most nurses develop solid skills in logical thinking and critical analysis. These skills, coupled with theoretical knowledge about ethical decision making, can serve nurses well in dealing with the many ethical dilemmas found in healthcare.

Evidence-Based Practice in Maternal-Child Nursing

Evidence-based practice—that is, nursing care in which all interventions are supported by current, valid research or other forms of evidence, such as committee opinions or task force recommendations, is emerging as a major force in healthcare. It provides a useful approach to problem solving/decision making and to self-directed, patient-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, for example, statistical data, quality improvement measurements, risk management measures, and information from support services such as infection control.

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

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

Some agencies and clinical units where nurses practice still operate in the old style, which sometimes generates conflict for nurses who recognize the need for more responsible clinical practice. More often, however, market pressures are forcing nurses and other healthcare providers to evaluate routines to improve efficiencies and provide better outcomes for patients.

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 than simply knowing what is being tracked and how the results are being used. 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, children, and families in the *Evidence-Based Practice* features. We believe that these snapshots will help you understand the concept more clearly. We also expect that these examples will 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 reliable, valid, current science.

Nursing Research

Research is vital to expanding the science of nursing, fostering evidence-based practice, and improving patient care. Research also plays an important role in advancing the profession of nursing. For example, nursing research can help determine the psychosocial and physical risks and benefits of both nursing and medical interventions.

The gap between research and practice is being narrowed by the publication of research findings in popular nursing journals, the establishment of departments of nursing research in hospitals, and collaborative research efforts by nurse researchers and clinical practitioners. Interdisciplinary research between nurses and other healthcare professionals is also becoming more common. This ever-increasing recognition of the value of nursing research is important because well-done research supports the goals of evidence-based practice.

Nursing Care Plans and Concept Maps

Nursing care plans, which use the nursing process as an organizing framework, are invaluable in planning and organizing care. Care plans are especially valuable for nursing students and novice nurses. To help organize care, this text provides several examples of nursing care plans.

Concept maps are becoming increasingly popular in planning nursing care. They provide a visual depiction of nursing management. For your reference, we have included several examples throughout the text.

Statistical Data and Maternal-Newborn Care

Nurses are increasingly recognizing the value and usefulness of statistics. Health-related statistics provide an objective basis for projecting patient needs, planning use of resources, and determining the effectiveness of specific treatments.

There are two major types of statistics: Descriptive and inferential. *Descriptive statistics* describe or summarize a set of data. They report the facts—what is—in a concise and easily retrievable way. An example of a descriptive statistic is the birth rate in the United States. Although no conclusion may be drawn from these statistics about why some phenomenon has occurred, they can identify certain trends and high-risk "target groups" and generate possible research questions.

Inferential statistics allow the investigator to draw conclusions or inferences about what is happening between two or more variables in a population and to suggest or refute causal relationships between them. For example, descriptive statistics reveal that the overall infant mortality rate in the United States has declined over the past decade (Mathews, Ely, & Driscoll, 2018). Exactly why that trend has occurred cannot be answered by simply looking at these data, however. More data and inferential statistics using smaller samples of the population of pregnant women are needed to determine whether this finding is because of earlier prenatal care, improved maternal nutrition, use of electronic fetal monitoring during labor, and/or any number of factors potentially associated with maternal-fetal survival.

Descriptive statistics are the starting point for the formation of research questions. Inferential statistics answer specific questions and generate theories to explain relationships between variables. Theory applied in nursing practice can help change the specific variables that may cause or contribute to certain health problems.

TABLE 1–1 Births and Birth Rates by Race, 2016

RACE OF MOTHER	BIRTHS	BIRTH RATE
All races	3,945,875	12.2
White	2,056,332	10.5
Black	558,622	14.0
Native American or Alaska Native	31,452	13.3
Asian	254,471	14.6
Native Hawaiian or Other Pacific Islander	9,342	16.8

SOURCE: Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2016. *National Vital Statistics Reports, 67*(1), 1–55.

This section discusses descriptive statistics that are particularly important to maternal-newborn healthcare. Inferences that may be drawn from these descriptive statistics are addressed as possible research questions that may help identify relevant variables.

BIRTH RATE

Birth rate refers to the number of live births per 1000 people in a given population. In 2016, the U.S. birth rate was 12.2 per 1000. The birth rate fell for women 15 through 29 years of age, increased for women 30 to 49 years of age, and remained unchanged for girls 10 to 14 years of age. The actual number of live births declined in 2016 by 1% to 3,945,875 (Martin et al., 2018). Table 1–1 provides information about the number of births and the birth rate by race in 2016.

In 2016, childbearing by unmarried women was 42.4 births per 1000 unmarried women, a drop of 18% from the high rate of 51.8 in 2007 and 2008. Statistics also indicate that the caesarean birth rate in 2016 was 31.9%, the lowest rate since 2007 (Martin et al., 2018).

Birth rates also vary dramatically from country to country. Table 1–2 identifies the birth rates for selected countries. Factors affecting birth rates may be identified by considering the following research questions:

- Is there an association between birth rates and changing societal values?
- Do the differences in birth rates between various age groups reflect education? Changed attitudes toward motherhood?
- Do the differences in birth rates among various countries reflect cultural differences? Do they represent availability of contraceptive information? Are there other factors at work?

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

COUNTRY	BIRTH RATE*	INFANT MORTALITY RATE
Afghanistan	37.9	110.6
Argentina	16.7	9.8
Australia	12.1	4.3
Cambodia	23.0	47.4
Canada	10.3	4.5
China	12.3	12.0
Egypt	29.6	19.0
Germany	8.6	3.4
Ghana	30.5	35.2
India	19.0	39.1
Iraq	30.4	37.5
Japan	7.7	2.0
Mexico	18.3	11.6
Russia	11.0	6.8
United Kingdom	12.1	4.3
United States	12.5	5.8

*Based on 2017 estimates.

SOURCE: Data from *The World Fact Book.* (2018). Washington, DC: Central Intelligence Agency. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/.

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 newborns less than 28 days of age per 1000 live births. *Postneonatal mortality* refers to the number of deaths of infants between 28 days and 1 year of age. *Perinatal mortality* includes both neonatal deaths and fetal deaths per 1000 live births. (*Fetal death* is death in utero at 20 weeks' or more gestation.)

In 2015, the infant mortality rate in the United States was 5.90 per 1000 live births (Mathews et al., 2018). (*Note:* The federal definition of "infant" includes both neonates and infants.) The neonatal mortality rate was 3.93 while the postneonatal mortality rate was 1.96 (Murphy, Xu, Kochanek, et al., 2017). This rate varied widely by the race of the mother, from 4.82 for non-Hispanic White infants to 5.20 for Hispanic infants to 11.73 for non-Hispanic Black infants (Murphy et al., 2017). It also varied by the state in which the infant was born, ranging from a low of 4.28 per 1000 live births in Massachusetts to 9.08 in Mississippi (Mathews et al., 2018). Infant mortality rates are higher among infants born in multiple births, infants born prematurely, and those born to unmarried mothers. Figure 1–6 shows the changes in infant, neonatal, and postneonatal mortality since 1960. Table 1–3 identifies the five leading causes of deaths of infants in the United States and their respective rates.

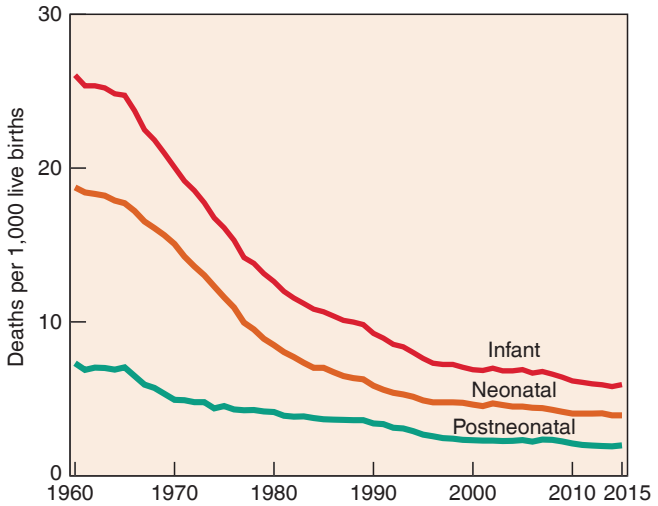

Figure 1–6 Infant, neonatal, and postneonatal mortality rates in the United States from 1960 to 2015. In 2015, the infant mortality rate was 5.90, the neonatal mortality rate was 3.93, and the postneonatal mortality rate was 1.96 per 1000 live births.

Note: Rates are infant (under 1 year), neonatal (under 28 days), and postneonatal (28 days to 11 months) deaths per 1000 live births in the specified group.

SOURCE: CDC/NCHS, National Vital Statistics Report: 2015.

TABLE 1–3 2015 U.S. Infant Mortality Rates for the Five Leading Causes of Newborn/Infant Deaths

CAUSE	RATE PER 100,000 LIVE BIRTHS
Congenital malformations, chromosomal abnormalities	121.3
Short gestation, low birth weight	102.7
Sudden Infant Death Syndrome (SIDS)	39.4
Maternal complications of pregnancy	38.3
Accidents (Unintentional injuries)	32.4

SOURCE: Data from Murphy, S. L., Xu, J., Kochanek, K. D., Curtin, S. C., & Arias, E. (2017). Deaths: Final data for 2015. *National Vital Statistics Reports, 66*(7), 1–75.

The U.S. infant mortality rate continues to be an area of concern because the United States ranks significantly higher than many industrialized nations. Much of this high rate has been attributed to the high percentage of preterm births in the United States. Healthcare professionals, policymakers, 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. Unfortunately, information about birth rates and mortality rates is limited for some countries because of a lack of organized reporting mechanisms.

The information prompts questions about access to healthcare during pregnancy and following birth, standards of living, nutrition, sociocultural factors, and more. Additional factors affecting the infant mortality rate may be identified by considering the following research questions:

- Does infant mortality correlate with a specific maternal age?
- What are the leading causes of infant mortality in each country?
- Is there a difference in mortality rates among racial groups? If so, is it associated with the availability of prenatal care? With the educational level of the mother or father?

MATERNAL MORTALITY AND PREGNANCY-RELATED DEATHS

The **maternal mortality rate** is the number of deaths from any cause related to or aggravated by pregnancy or its management during the pregnancy cycle (including the 42-day postpartum period) per 100,000 live births. It does not include accidental or unrelated causes. Since 1986, the Centers for Disease Control and Prevention (CDC) has tracked pregnancy-related deaths. **Pregnancy-related death** is defined 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, 2016). The pregnancy-related mortality rate in the United States in 2015 was 17.3 deaths per 100,000 live births (Centers for Disease Control and Prevention [CDC], 2017). Black women have 43.5 maternal deaths per 100,000 live births, White women have 12.7 deaths, and women of other races have 14.4 deaths (CDC, 2017) (Figure 1–7).

In general, worldwide, maternal mortality rates fell by nearly 44% over the past 25 years, from an approximate rate of 385 per 100,000 live births in 1990 to an approximate rate of 216 in 2015. Nevertheless, in 2015 an estimated 303,000 women died during and following pregnancy and childbirth (World Health Organization [WHO], 2015). Developing regions accounted for the vast majority (99%) of maternal deaths, especially sub-Saharan Africa, which accounted for 66% of deaths, followed by southern Asia. Among countries, Nigeria and India account for over one-third of worldwide maternal deaths (WHO, 2015).

Factors influencing the overall decrease in maternal mortality worldwide include the increased use of hospitals and specialized healthcare personnel by antepartum, intrapartum, and postpartum maternity patients; the establishment of care centers for high-risk mothers and neonates; the prevention and control of

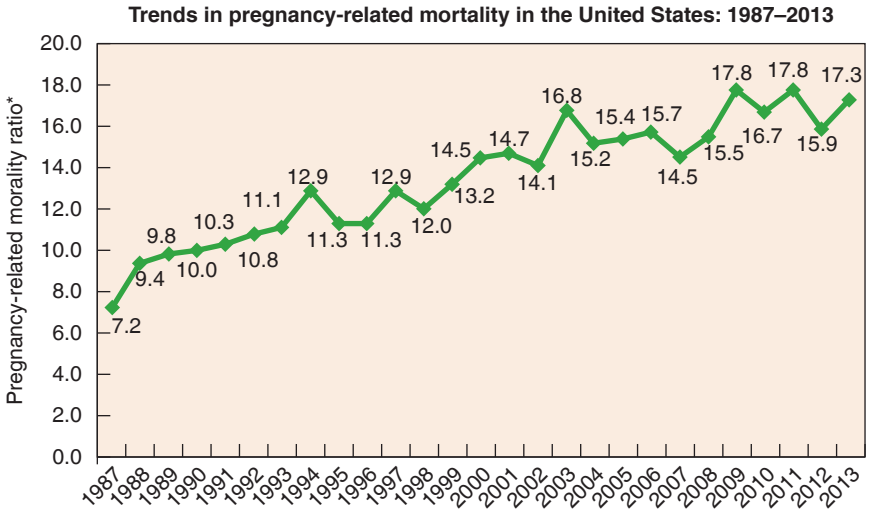

Figure 1–7 Trends in Pregnancy-Related Mortality in the United States, 1987–2013.

**Note:* Number of pregnancy-related deaths per 100,000 live births per year.

SOURCE: National Center for Health Statistics (NCHS). (2017). *Pregnancy Mortality Surveillance System.*

infection with antibiotics and improved techniques; the availability of blood and blood products for transfusions; and the lowered rates of anesthesia-related deaths.

Additional factors to consider may be identified by asking the following research questions:

- Is there a correlation between maternal mortality and age?
- Is there a correlation with availability of healthcare? Socioeconomic status?

IMPLICATIONS FOR NURSING PRACTICE

Nurses can use statistics in a number of ways. For example, statistical data may be used to do the following:

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

Statistical information is available through many sources, including professional literature; state and city health departments; vital statistics sections of private, county, state, and federal agencies; special programs or agencies (family-planning and similar agencies); and demographic profiles of specific geographic areas. Most of these sources are accessible via the internet. Nurses who use this information will be better prepared to promote the health needs of maternal-newborn patients and their families.

Focus Your Study

- Many nurses working with childbearing families are expert practitioners who are able to serve as role models for nurses who have not yet attained the same level of competence.
- Contemporary childbirth is family centered, offers choices about birth, and recognizes the needs of siblings and other family members.
- The self-care movement, which emerged in the late 1960s, emphasizes personal health goals, a holistic approach, and preventive care.
- The U.S. healthcare system is facing a variety of challenges including the high cost of healthcare 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 women-headed households.
- The nurse who provides culturally competent care recognizes the importance of the childbearing 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.
- 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.
- State constitutions, statutes, and common law protect the right to privacy.
- 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.
- 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.
- 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 healthcare.
- Nursing research plays a vital role in adding to the nursing knowledge base, expanding clinical practice, and expanding nursing theory.
- Descriptive statistics describe or summarize a set of data. Inferential statistics allow the investigator to draw conclusions about what is happening between two or more variables in a population.

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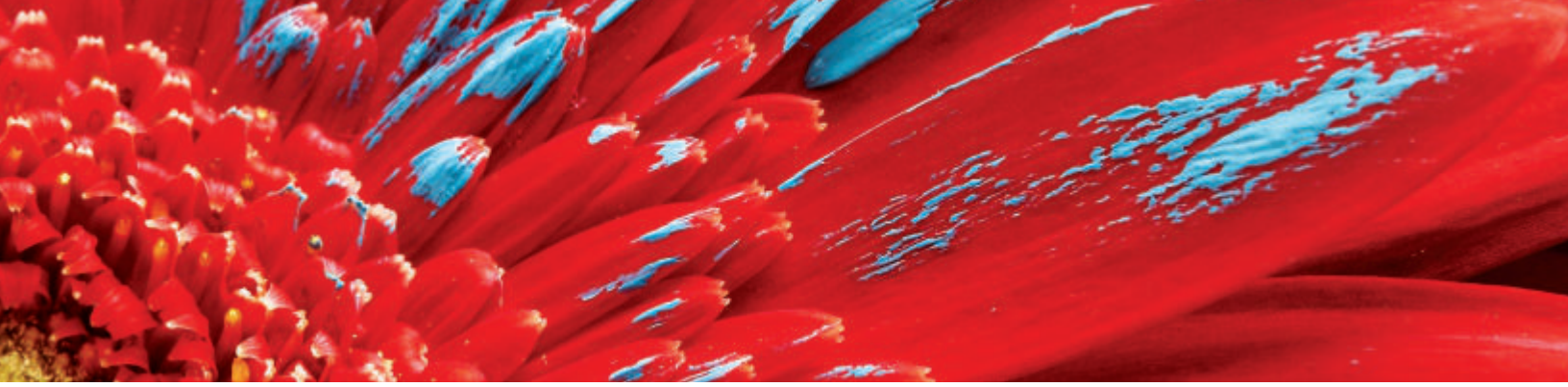

Chapter 2
Families, Cultures, and Complementary Therapies

SOURCE: Purestock/Florian Flake/Superstock.

I can't imagine going through pregnancy, birth, or those initial few weeks after my daughter was born without my family. My brother called regularly throughout my pregnancy to check on me. Dad gave me pep talks on eating right and taking care of myself. My husband and my mom were both with me during my labor and my unexpected cesarean birth. After Rosario was born, my husband accompanied our new daughter to the nursery and mom stayed with me, talking and holding my hand. What a difference a family can make.

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 Summarize the benefits and risks of complementary health approaches.

2.9 Describe 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, cultures, and religious beliefs. Nurses who provide comprehensive, holistic care recognize this reality and seek to learn about and care for the entire family.

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 health approaches a family might use. Also in this chapter, four individual mothers and their families are introduced in a new feature called ***Case Study***: Melissa Bond-James, Benita Cartier, Azia Askari, and Angelina Newman. Throughout the text, you will accompany them as they go through pregnancy, birth, and the postpartum period with various physical, social, emotional, and cultural issues that can occur in real-life pregnancies. Because effective learning involves repetition, application, analysis, and synthesis, these women's experiences appear in various chapters illustrating issues that will allow you to see the true nature and challenges faced by childbearing women and their families, and that will ask you to think critically while applying holistic approaches to caring for them. *Case Study* includes questions for discussion and classroom engagement.

The Family

The U.S. Census Bureau defines **family** as two or more individuals who are joined together by marriage, birth, or adoption and live together in the same household. This definition has remained unchanged since 1930 (U.S. Census Bureau, 2017). Because some contemporary families may not fall within this definition, others define families more broadly by using a definition that characterizes families as individuals who have established 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—those considered both 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. See *Case Study: Introducing Benita Cartier*.
- The *child-free (childless) 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, a child may be residing with a grandparent and one parent because of issues associated with unemployment, parental separation, parental death, or parental substance abuse. Grandparents may raise children due 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. The mother in a single-parent family may be an adolescent or may have had her child(ren) during her teenage years. 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). See *Case Study: Introducing Angelina Newman*.

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.

CASE STUDY: Introducing Benita Cartier

SOURCE: blvdone/Shutterstock

Benita Cartier is a 26-year-old, G2P1 (gravida indicates number of pregnancies, para indicates the number of births), married, African American woman who is being treated for chronic hypertension. In her previous pregnancy with her now 25-month-old daughter, she was treated for chronic hypertension and developed preeclampsia at 31 weeks. Her husband, Gerald, is supportive and helps her at home with their daughter and housework, but he is an airline pilot and is away from home on a regular basis. Because of complications with her previous pregnancy, Benita was seen by the perinatologist at the beginning of her pregnancy and is scheduled for a consult at least every trimester during this pregnancy.

CASE STUDY: Introducing Angelina Newman

SOURCE: WAYHOME studio/Shutterstock

Angelina Newman is a 16-year-old, G1P0, single, Caucasian American young woman who is a sophomore at a local high school. Angelina is an honor student and was on the junior varsity basketball team last year. She lives at home with her mother, stepfather, and younger brother. When Angelina found out she was pregnant, she immediately told her boyfriend, a 17-year-old junior who also plays high school basketball. While he attempts to be supportive, he is spending less and less time with her. Last week, she was diagnosed with chlamydia. When she told her boyfriend, he accused her of cheating on him, and they are no longer speaking.

- The *single mother by choice family* represents a family composed of an unmarried woman who chooses to conceive or adopt without a life partner (Single Mothers by Choice, 2016). Although these families are statistically included in the single-parent family statistics, they differ significantly in that these women are typically older, college educated, and financially stable and have contemplated pregnancy significantly prior to conceiving (Single Mothers by Choice, 2016). While there is currently little or no tracking on the number of these types of families, one organization reports that women who are single mothers by choice are generally in their 30s and 40s at the time of birth. These women enter motherhood in a variety of ways, including donor insemination (60%), adoption (20%), or known donors or sex partners (20%) (Single Mothers by Choice, 2016). While some of these women may later marry or join with a life partner, they enter motherhood with the expectation that they will independently parent.
- 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 due to high rates of divorce and remarriage. Potential advantages to the children 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 postdivorce family in which the biologic children are members of two nuclear households, with parenting by both the father and the mother. The children alternate between the two homes, spending varying amounts of time with each parent in a situation called co-parenting, 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 for companionship.
- *Gay and lesbian families* include those in which two adults of the same sex live together and are married or who live together as domestic partners with or without children. Gay and lesbian families also include gay or lesbian single parents who are rearing children. Children in these families may be from a previous heterosexual union or be born to or adopted by one or both members of the same-sex couple. A biologic child may be born to one of the partners through artificial insemination or through a surrogate mother. See *Case Study: Introducing Melissa Bond-James*.

Clinical Tip

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

CASE STUDY: Introducing Melissa Bond-James

SOURCE: Kinga/ Shutterstock

Melissa Bond-James is a 40-year-old, G1P0. She is a married, lesbian Caucasian American woman who has experienced preterm labor during her pregnancy. Melissa conceived via intrauterine insemination after 4 months of attempting pregnancy and began prenatal care at 7 weeks. Her wife, Nancy James, is supportive and is extremely excited about the pregnancy. Melissa is a successful real estate agent and a long-time runner. She has continued exercising throughout her pregnancy and ran a half marathon when she was 13 weeks pregnant.

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 eight stages in the family life cycle of a traditional nuclear family have been used as the foundation for contemporary models of the family life cycle that describe the developmental processes and role expectations for different family types (Duvall & Miller, 1985). 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 and the family. Data are best collected in a comfortable, private environment, free from interruptions.

Basic information should include:

- 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 newborn/infant feeding

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-age 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.

Sources: Data from Duvall, E. M., & Miller, B. C. (1985). *Marriage and family development* (6th ed.). New York, NY: HarperCollins; White, J. M., & Klein, D. M. (2014). *Family theories: An introduction*. Thousand Oaks, CA: Sage; Allen, K. R., & Henderson, A. C. (2016). *Family theories: Family and applications*. Hoboken, NJ: Wiley-Blackwell; Thomilson, B. (2015). *Family assessment handbook: An introductory practice guide to family assessment* (4th ed.). Boston, MA: Cengage Learning.

- 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
- Disabilities in any family member, including impact on family and caregiving needs

Other factors can play a role in a holistic family assessment, including information on the health of other family members and the home environment, which is ideally assessed during a home visit, when possible.

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. In 2015, the National Institute of Health convened a panel to examine, define, and identify interventions that incorporate culture as a component in the research process.

Culture is a multilevel, multidimensional concept that is fluid and changing. It encompasses a large number of complex variables that impact an individual, family, group, or population. Culture consists of dynamic and ecologically based interrelated elements that function together as a living, adapting system. To delineate culture, multiple variables are considered and include biopsychosocial, ecological, geographic, historical, social, and political realities that vary within diverse communities. All of these elements constitute the cultural framework its members use to "see" the world and attribute meaning to their daily lives (Ellwood, 2016).

Transcultural nursing theory, developed in 1961 by Dr. Madeleine Leininger, has its foundation in anthropology and nursing. Transcultural nursing theory is rooted in the caring that embraces the beliefs and practices of individuals or groups of similar or different cultures. Leininger was a pioneer who recognized that individuals' cultural beliefs greatly influenced their perceptions of health and wellness. Culture is characterized by certain key elements, including:

- ***Culture is based on shared values and beliefs.*** Each culture identifies and articulates its shared values and beliefs. Thus, behaviors and roles emerge that are consistent with those specific values and beliefs.
- ***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 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).

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?

- ***Culture is integrated into life and uses symbols.*** Culture is integrated through social institutions, such as schools, places of worship, friendships, families, and occupations. This provides a variety of opportunities for learning about one's culture. 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. See *Case Study: Introducing Azia Askari*.

Race is a concept that categorizes groups of people who share biologic similarities, such as skin color, bone structure, and genetic traits. Examples of races include White (also called Caucasian or European American), Black (also called African American in the United States), Hispanic, Native (such as Native Americans, Alaskan Native, Hawaiian Native, and First Nation people of Canada), and Asian.

Ethnicity describes a cultural group's identity, which is associated with the group's social and cultural heritage (McFarland & Wehbe-Almah, 2014). Examples of ethnic groups include Hmong, Jewish, Irish, Dutch, Serbs, Koreans, Persians, and so forth. Even the mainstream or majority of groups usually identify with an ethnic group. People sometimes define ethnicity by physical characteristics, such as skin color. However, many people consider themselves to be biracial or multiracial or identify themselves with a specific group not because of skin color but because of a shared ideology or attitudes. More and more, individuals are blends of ethnic and racial backgrounds, and it is often difficult to assign a specific ethnic or racial identity to someone.

While some beliefs and practices are common among certain ethnic groups, it is important to avoid *stereotyping* individuals, that is, assuming that all members of a group have the same characteristics. The term *individuality* describes a person's own unique characteristics, beliefs, and self-perceptions. The nurse should assess the woman and her family to determine her specific cultural beliefs rather than assuming that because she identifies with a specific cultural group or ethnicity that she will automatically practice predetermined customs or hold specific beliefs.

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 (McFarland & Wehbe-Almah, 2014). 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 new country is associated with improved socioeconomic status, which leads to better nutrition and access to healthcare. 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 influences combined with a family's individualized beliefs and past behaviors in earlier generations. 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 healthcare are primarily the responsibility of the female, 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 older adults, 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 newborn. In some cultures, major decisions for the family include input from grandparents and other extended family members (Figure 2–3). Grandparents may even assume responsibility for

CASE STUDY: Introducing Azia Askari

SOURCE: HONGQI ZHANG/123RF

Azia Askari is a 32-year-old, G3P2, married woman who immigrated to the United States from Iran in 2014. Azia speaks some English but is hesitant to do so because she is not confident in her English language skills. She considers herself to be more culturally aligned with her native ancestry and the Muslim religion and beliefs. She wears a hijab and has requested female-only providers in the clinic setting. This has created stress for her on two occasions when male providers were the only clinicians available. On one of these occasions, she was scheduled for a vaginal culture, but the registered nurse advocated for the testing to be delayed until the following week. She has had two normal pregnancies with spontaneous vaginal births in Iran.

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.

care of the children in the family. In these cases, nurses must direct teaching for health promotion and demonstration for treatment procedures to the grandparents. See *Developing Cultural Competence: Including Grandparents and Cultural Health Practices in the Teaching Plan*.

Developing Cultural Competence Including Grandparents and Cultural Health Practices in the Teaching Plan

When you care for a family in which the grandparents play a key role in decision making, be sure that they are present when you are teaching something that is important for the family to understand and act on. This might include, for example, signs of illness in the newborn that need immediate follow-up.

If a specific cultural health practice is important to the family and will not cause harm, such as prayer, chanting, or specific foods, respect the family's beliefs and develop a teaching plan that includes those practices. Respecting a family's values improves the likelihood that the newly recommended healthcare actions will be accepted.

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

The importance of spirituality within healthcare and nursing was identified by early nursing theorists, such as Betty Neuman. She recognized that holistic nursing care incorporated spirituality and that beliefs in God, gods, magic, spirits, or fate had significant impact for many patients. In some cultures or certain religions, a miscarriage or the illness of a pregnant woman may be perceived as a punishment for actions. In other religions, adverse events may be viewed as God's will, not to be questioned. It is wise to ask the woman and her family what they think caused an illness or how they believe they can stay well. People with strong associations with spirituality may gain comfort from prayer, healing rituals, and faith healing.

There are a variety of models and theories that provide evidence of how an individual or family perceives health, illness, and wellness. Some families may believe in a strictly *scientific* or *biomedical health paradigm*, which assumes that physiology explains every aspect of illness and life itself (Andrews & Boyle, 2015). Western medicine is a facet of this paradigm and assumes that all illness results from viruses, bacteria, or bodily damage. Families who hold this view expect a traditional Western medical intervention, such as medication, treatment, or surgery, to treat the specific health problem. Within this belief system, it is very difficult to understand certain health conditions. Families may struggle to "explain" an illness by wondering if the newborn was exposed to something harmful during fetal life or exposed to something in the environment. A physiological reason for the condition is needed in order for the family to understand it. For families with this belief system, health professionals sometimes need to emphasize that certain conditions have no known cause and might suggest treatments other than traditional Western medicine if other approaches may be helpful.

Many nurses in contemporary practice embrace a *holistic health belief* in which biopsychosocial, cultural, and spiritual beliefs guide their practice. They believe these concepts play a primary role in the development and treatment of illness and disease and also heavily influence the foundation for wellness. Many nurse theorists ascribe to holistic models of health and wellness. It is important to remember that cultural, family, and environmental factors are also included within the holistic paradigm. Balance and harmony of the body and nature are important concepts in the holistic health belief. It is believed that illness results when the natural balance or harmony is disturbed. Infections and other illnesses gain entry into the body when it is not in balance. This health belief is most common in North American Native and Asian cultures (Andrews & Boyle, 2015). Increasingly, holistic health practices are being integrated into Western healthcare and combined with other approaches. An example of integration of approaches is use of a medication or radiation for illness in combination with adequate rest and a diet that is designed to increase immune function.

An associated holistic health belief is the hot and cold theory of disease, according to which illnesses and diseases are a result of disruption in the hot and cold balance of the body. Therefore, consuming foods of the opposite variety can cure or prevent specific hot and cold illnesses (Table 2–2). Hot and cold therapies related to healing are practiced in some African American, Asian, Latino, Arab, Muslim, and Caribbean cultures (Andrews & Boyle, 2015).

Healthcare Practitioners

The family seeking care for its members may choose from a variety of healthcare practitioners or a combination of magico-religious, holistic, or biomedical healthcare providers. The use of *folk healers* varies according to the culture. Though the healer's role and position in the community differ among cultures, generally healers do share commonalities. Healers speak the language of the cultural group, use common methods of communication for the culture, and live in the same community.

Hispanic Americans may seek healing by a *curandero* (male healer) or *curandera* (female healer), a holistic healer who deals with physical, psychologic, and social problems (Golden, 2017). The *curandero/a*'s holistic treatment may include use of herbs,

TABLE 2–2 Hot and Cold Conditions and Foods

HOT CONDITION	COLD FOOD USED TO TREAT HOT CONDITION	COLD CONDITION	HOT FOOD USED TO TREAT COLD CONDITION
Diarrhea	Barley water	Cancer	Beef
Fever	Chicken	Earaches	Cheese
Constipation	Dairy products	Headaches	Eggs
Infection	Raisins	Musculoskeletal conditions	Grains (other than barley)
Kidney problems	Fish	Pneumonia	Liquor
Liver conditions	Cucumber	Menstrual cramps	Pork
Sore throats	Fresh fruits	Malaria	Onions
Stomach ulcers	Fresh vegetables	Arthritis	Spicy foods
	Goat meat	Rhinitis	Chocolate
		Colic	Warm water and honey

Sources: Data from Purnell, L. D. (2014). *Guide to culturally competent healthcare* (3rd ed.). Philadelphia, PA: F. A. Davis; Andrews, M. M., & Boyle, J. S. (2015). *Transcultural concepts in nursing care* (7th ed.). Philadelphia, PA: Wolters Kluwer Health; Lincoln, B., & Dodge, J. (2016). *Reflections from common ground: Cultural awareness in healthcare*. Atlanta, GA: Create Space Independent Publishing Platform.

laying-on of hands, massaging the afflicted area, cleansing the body with herbs, preparing an amulet to be worn, burning a candle with a specific prayer printed on the candle jar, or calling the spirit of a saint to bless the individual. Essential to the *curandero/a* and the family is the faith the family has in his or her abilities. Families may combine *curanderismo* (Hispanic medical system) with a Western approach for some conditions. For example, a baby with seizures may be given medications for the disorder obtained from Western care and may be fed a tea that the healer believes will treat the condition.

Espiritistas is the Spanish word meaning "spiritism." In Latin America and the Caribbean, it is used to describe a healer who communicates with spirits for the physical and emotional development of the patient (Spector, 2017). Hispanic Americans may use this type of healer when the ailment is thought to be caused by witchcraft. However, use of an *espiritistas* is frowned on in some Hispanic cultures. A *sobador*, an individual who uses massage and manipulation to treat patients with joint and muscle problems, is another type of healer who might be used by Hispanic Americans (Graham, Sandberg, Quandt, et al., 2016).

People of African heritage may combine Western and traditional beliefs about illness. Some believe in spirits as causes of illness and may use powders, oils, and ceremonies to maintain health.

Native Americans may seek healing from a *shaman*, an individual with "access to, and influence in, the world of good and evil spirits," who often enters a trancelike state during a ritualistic healing practice. Shaman healers are most commonly used in northern Asia and North America (Oxford Dictionaries, 2016). Native Americans generally believe in the balance of nature and a state of harmony and may seek advice to identify potential causes of disruptions in body harmony. The healer will then prescribe the required treatment for restoration of balance and harmony. Teas, other herbal products, sweats, smudges, meditation, and other approaches are common. Returning to one's family, home, and roots may produce a sense of balance.

Impact of Religion and Spirituality

The terms *religion* and *spirituality* mean different things to different people. Many people view religion, which is sometimes termed *faith-based belief*, as an organized system that shares a common set of beliefs and practices about the significance, cause, and purpose of life and the universe. Religion is usually centered on the belief in or worshipping of a supernatural being or Supreme Being (such as God or Allah). **Spirituality** refers to the individual's experience and own interpretation of his or her relationship with a Supreme Being. Prayer, one of the most common expressions of religious faith, is a frequently used therapy in which many families engage (Krause, Pargament, Hill, et al., 2016).

A family's religious beliefs, affiliation, and practices can deeply influence their experiences and attitudes toward healthcare, childbearing, and childrearing. Members of certain religious groups, such as Christian Scientists, may attempt to avoid all medical interventions, whereas others, such as Jehovah's Witnesses, may refuse specific interventions, such as blood transfusions. Roman Catholics may refuse contraception. In most cases, families gain comfort from acknowledgment of and respect for their religious beliefs and practices in the healthcare setting. However, the *agnostic* (one who has doubts about the existence of a transcendent being) or the *atheist* (one who believes that there is no higher power) may be offended if healthcare providers assume that references to God or to a higher power will be comforting.

A religious or spiritual history is often completed when a woman is admitted to a clinic or labor setting. The assessment can include questions about current spiritual beliefs and practices and preferences for religious rituals. Whenever possible the nurse should attempt to accommodate religious rituals and practices requested by the family.

Considering the diversity of religious beliefs, it is not unusual for nurses to encounter childbearing families whose beliefs conflict with their own. This is not problematic as long as the nurse does not attempt to influence the family's decision making. For example, a nurse who does not believe in baptism should avoid revealing this to a Catholic mother seeking baptism for her stillborn baby. Nurses should also examine their religious beliefs related to genetic screening procedures, use of assisted reproductive technology to achieve pregnancy, abortion, use of technology to support life in a severely compromised newborn or a terminally ill baby, and even less dramatic issues, such as methods of contraception, circumcision, and newborn/infant feeding.

Although adherence to a religious tradition is predominant in the United States, it should not be assumed that all individuals believe in or practice organized religion. It is estimated that

20% of Americans do not identify with any religious group nor consider themselves followers of any specific religion; an additional 7% classify themselves as agnostic or atheist (Pew Research Center, 2016). The nurse should always ask the family if they follow a faith tradition and if they would like a leader from that faith to visit when in the hospital. Adolescents may follow different faith traditions than their parents and should be asked the question individually.

Some religions may be unaccepting of homosexual or transgendered persons. In some cultures, homosexual practices may be considered a sin or may be viewed negatively, whereas in other cultures they are accepted as one of many different ways of being human. Sensitivity to lesbian women who might not be "out" to their families is important in establishing trust with the nurse.

Collaboration between the healthcare team and family is essential to providing care congruent with the family's expectations. Although spirituality is important for many families, it is often overlooked as a healing strategy. Illness and injury may cause the family to turn to spiritual guidance as a method of understanding and coping. Assessment of the family's spiritual needs is an important aspect of nursing care (Denham & Eggenberger, 2015). The nurse must respect the family's view and avoid being judgmental about their beliefs. Partnering with the family to incorporate its traditional practices and beliefs with prescribed therapies will help to ensure the delivery of safe and effective care.

Ethics in Action!

You find yourself in a clinical situation that is in direct violation of your own moral or religious beliefs, and there is no other staff member available to care for the family. What are your obligations in providing nursing care to the family?

Childbearing Practices

Children are generally valued all over the world, not only for the joy they bring, but also because they ensure continuation of the family and cultural values. The valuing of children may manifest itself in different ways. Families in the United States and many Western countries commonly have only one or two children out of a desire to provide them with the best home and education they can afford and to spend as much free time with them as possible. In contrast, in many cultures throughout the world, it is common to have as many children as possible. In the western United States, people of the Mormon faith view motherhood as the most important aspect of a woman's life, comparable with the male role of priesthood (Sorenson, 2015). In Mexican American society and among many other Latino groups, having children is evidence of the male's virility and is a sign of *machismo* (manliness), a desired trait.

In some cultures, a woman who gives birth attains a higher status, especially if the child is male. Although known to be prevalent in China, this trend is increasingly becoming common in other parts of the world, including Asia, Southeastern Europe, the Middle East, and some parts of Africa (Hendl & Rothman, 2016). In nature, gender ratios begin with a higher male to female ratio (105:100), but typically equalize by the age of 55. Gender imbalance and gender manipulation (favoring males) can be influenced via advanced technological interventions, ultrasound assessment, and serological testing; female infanticide; and purposeful neglectful care of female babies that leads to death. In 1995, there were six countries with such gender imbalances; however, the number of countries with gender imbalances has increased to 21 in the 21st century (Brink, 2015).

Culture may also influence attitudes and beliefs about contraception. For example, many Muslims from the Middle East may use birth control but do not believe in sterilization because it is a permanent method (Arousell & Carlbom, 2016). Other Muslims might not practice contraception because children are highly valued, and it is believed that the traditional role of women is to bear children. In Chinese society, on the other hand, where government policy limits the number of children a couple can have, contraception is common.

Health values and beliefs are also important in understanding reactions and behavior. Certain behaviors can be expected if a culture views pregnancy as a sickness, whereas other behaviors can be expected if the culture views pregnancy as a natural occurrence. For example, because Native Americans, African Americans, and Mexican Americans generally view pregnancy as a natural and desirable condition, prenatal care may not be a priority. In other cultures, pregnancy may be seen as a time of increased vulnerability. In Orthodox Judaism, for example, it is a man's responsibility to procreate, but it is a woman's right, not her obligation, to do so. This is because, according to Orthodox Jewish law, the health of the mother, both physically and mentally, is of primary concern, and she should never be obliged to do something that threatens her life.

Individuals of many cultures take certain protective precautions based on their beliefs. For example, many Southeast Asian women fear that they will have a complicated labor and birth if they sit in a doorway or on a step. Thus, they tend to avoid areas near doors in waiting rooms and examining rooms. In the Mexican American culture, the belief is common that *mal aire*, or "bad air," may enter the body and cause harm. Preventive measures, such as keeping the windows closed or covering the head, are used. Some Latinos may place a raisin on the cord stump of a newborn to prevent drafts from entering their bodies.

A **taboo** is a behavior or thing that is to be avoided. Many cultures, including those found in the United States, have taboos centered on the unborn baby or newborn that are meant to ensure that the baby will survive. For example, it is common among Muslims to avoid naming the baby until after birth; similarly, many Orthodox Jewish women wait to set up the nursery until after the baby is born.

In developing countries, mortality rates among newborns/infants and young children are extremely high; thus, certain traditions focus on protecting the baby from evil spirits. For example, many Muslim parents will pin an amulet, such as a blue stone or a verse from the Qur'an, to the newborn's clothing as protection. Following birth, it is common for a male family member to whisper prayers in the newborn baby's ear to declare faith and protect the baby (Arousell & Carlbom, 2016).

Culture and Nursing Care

Healthcare providers are often unaware of the cultural characteristics they themselves demonstrate. Without cultural awareness, healthcare professionals tend to project their own cultural responses onto foreign-born patients; patients from different socioeconomic, religious, or educational groups; or patients from different regions of the country. This projection leads healthcare providers to assume that the patients are demonstrating a specific behavior for the same reason that they themselves would. Moreover, healthcare professionals often fail to realize that medicine has its own culture, which has been dominated historically by traditional middle-class values and beliefs.

Ethnocentrism is the conviction that the values and beliefs of one's own cultural group are the best or only acceptable ones. It is characterized by an inability to understand the beliefs and worldview of another culture. To a certain extent, everyone is guilty of ethnocentrism, at least some of the time. Thus, the nurse who values stoicism during labor may be uncomfortable with the more vocal response of some Latin American women. Another nurse may be disconcerted by a Southeast Asian woman who believes that pain is something to be endured rather than alleviated and who is intent on maintaining self-control in labor.

Healthcare providers sometimes believe that if members of other cultures do not share Western values and beliefs, they should adopt them. For example, a nurse who believes strongly in equality of the sexes may find it difficult to remain silent if a woman from a Middle Eastern culture defers to her husband in decision making. It is important to remember that pressure to defy cultural values and beliefs can be stressful and anxiety provoking for these women. See *Developing Cultural Competence: Culture Shock*.

Developing Cultural Competence Culture Shock

The experience that people have in attempting to understand or adapt to a culture that is fundamentally different from their own culture is known as *culture shock*. It may produce feelings of discomfort, powerlessness, anxiety, and disorientation. Immigrants to the United States may experience culture shock when differences or conflicts arise between their own values, beliefs, and customs and the ways of their new surroundings (Spector, 2017). The nurse should assess childbearing women and their families who have recently immigrated for indications of culture shock. Referring the family to counseling or support from representatives of the family's culture, such as a translator or community group, may be helpful (Ono & Aczel, 2016).

To address issues of cultural diversity in the provision of healthcare, emphasis is being placed on developing **cultural competence**—that is, the ability to understand and effectively respond to the needs of individuals and families from different cultural backgrounds. Cultural competence encompasses congruent behaviors, attitudes, and policies that come together, enabling effective interactions in cross-cultural situations. Cultural competence is a unique complex combination of knowledge, attitudes, and skills that evolves and may change over time (Centers for Disease Control and Prevention [CDC], 2017). It involves identifying and integrating a family's health beliefs, practices, and cultural and linguistic needs into patient care (CDC, 2017).

Culturally Influenced Responses

The nurse can begin developing cultural competence by becoming knowledgeable about the cultural differences and practices of various groups. Nurses who are knowledgeable about differences and who take them into account in planning and providing nursing care will be far more effective caregivers than those who do not.

BIOLOGIC DIFFERENCES

Genetic and physical differences occur among cultural groups and can lead to disparity in needs and care. Differences include blood type, body build, skin color, drug metabolism, and susceptibility to certain diseases. Other disparities occur because of fundamental differences between genders, ages, and races. For example, males are more likely to manifest pyloric stenosis and attention-deficit disorder, whereas females more often have congenital hip dysplasia and systemic lupus erythematosus. Age provides another biologic variation, as infants are more likely to manifest the cancer neuroblastoma, whereas adolescents have a higher incidence of Hodgkin disease. Race is also connected with certain disease processes. Sickle cell disease occurs predominantly in African Americans, who also have a higher incidence of hypertension. Native Americans have the highest incidence of diabetes by percentage of population in the United States. However, type 1 diabetes is more common in Caucasian Americans, while type 2 diabetes has a higher incidence in Hispanic Americans and Native Americans. Thalassemia, a type of anemia, and other genetic disorders of the red blood cells are most common in people of Asian, African, and Mediterranean heritage. Lactose intolerance is common in Mexican Americans, African Americans, Native Americans, and Asians (Kuzawa & Gravlee, 2016). See *Genetic Facts: Genetic Variations and Tay-Sachs Disease*.

Genetic Facts Genetic Variations and Tay-Sachs Disease

While an individual's cultural background is imperative to providing competent satisfying nursing care, additional assessments should obtain one's ethnic status because certain genetic variations occur in different ethnic groups. For example, Ashkenazi Jews (90% of the American Jewish population are Ashkenazi) have a higher carrier frequency for Tay-Sachs disease and 16 other genetic diseases. Individuals of Irish, British, French Canadian, or Cajun background also have an increased genetic risk of Tay-Sachs (Genetic Disease Foundation, 2017).

Nurses need to understand other genetic characteristics in order to perform culturally competent nursing assessments and interventions. Differences in skin color and tone may make cyanosis, pallor, and jaundice difficult to recognize and describe. Mongolian spots are darkened skin on the lower back and buttocks of some babies with dark skin tones. Variations in texture of hair require different approaches to hygiene among various racial groups.

COMMUNICATION PATTERNS

Communication is the method by which members of cultural groups share information and preserve their beliefs, values, norms, and practices. To ensure effective care, it is essential for families to be able to communicate with nurses and other healthcare providers. This becomes an issue when the family does not speak the language of the health professionals. In such cases it is best if the healthcare facility provides translators. Children are most likely to speak both the language of the parents and that of the healthcare providers and may appear to be likely interpreters. However, it is recommended that children never be used to interpret in healthcare situations due to the confidentiality needs of both parent and child. Additionally, if children are used as interpreters, it can create an imbalance in power that could adversely affect parental authority. Signs, posted literature, and brochures should also be available in the languages of the families served. Written material must be provided at a level that the family can read and understand.

Language can also affect health literacy skills because a large number of instructions are given in writing, including prescriptions and directions on medication bottles, signs hanging

in health facilities, consent forms for procedures and surgery, insurance forms, directions for techniques or procedures, future appointment dates, and health promotion materials. Nurses need to verify what the patient and family can read and whether alternative ways of providing the information are needed. For example, nurses could verbally give the information and provide paper and pencil so that the family can take notes in their own language. Translation services should be available in all healthcare settings. See *Women with Special Needs: Helping Women Who Are Deaf*.

Women with Special Needs Helping Women Who Are Deaf

Women who are deaf may read lips or may need interpreters to ensure that relevant healthcare assessments and patient teaching can be performed. Ask the woman if she would like an interpreter to be present. If she declines, preferring to read lips, ensure that you are in close contact and facing the woman directly. Use a normal rate and volume of speech. Ask the woman if she has any questions and if she is able to adequately understand what you have said and the information that has been provided.

Variations in communication among cultures are reflected in their word meaning, voice inflection and quality, and verbal styles. Culture influences not only the manner in which feelings are expressed, but also which verbal and nonverbal expressions of communication are considered appropriate. An individual's willingness to discuss certain topics or to express or conceal certain thoughts and feelings is also influenced by cultural norms. Some groups may be expected to remain quiet when experiencing pain, while other cultures may loudly and dramatically express pain.

Clinical Tip

Speaking and reading may not occur in the same language. For example, an immigrant may read and speak fluently in his or her primary language and speak but not read the language of the new country. Always ask about both reading and speaking preferences.

Use of first names and surnames varies among cultural groups, so nurses should not make assumptions because the use of a person's first name may be considered disrespectful. Address family members respectfully, usually using terms such as Mr., Mrs., and Ms. If the person has a title, such as doctor, judge, or senator, it should be used. The nurse should ask what the person prefers to be called and record this in the health record for future reference. In some cultures, such as Korean, Cambodian, and Filipino, the first name used is actually the family name. Asking for the "family name" rather than the "last name" may clarify this practice.

Nonverbal Communication. Nonverbal communication refers to body language, such as posture, gestures, facial expressions, eye contact, and touch, as well as the use of silence. The nurse's use of nonverbal communication may hinder or help communication. Gestures and body language may be misunderstood or misinterpreted. Eye contact has different meanings among different cultures. European Americans, for example, value eye contact with communication and interpret this as a sign of sincerity and interest. In other cultures, such as Asian and Native American, sustained eye contact may be considered rude or disrespectful. Some people of African heritage may misinterpret direct eye contact as aggressive behavior (Purnell, 2013).

Silence is considered a sign of respect in some cultures. Among those groups, offering an immediate response to a question may be viewed as being disrespectful because an instant reply could indicate that no thought was given to the matter. Nurses should watch for patterns in various cultures and alter their approach to be more congruent. For example, many nurses commonly nod and say "Yes" or "Oh, I see" when a patient is speaking. This may seem disruptive to some cultures. If the patient or family member is silent and does not use such patterns of agreement, the nurse should alter his or her response to match more closely the acceptable method of communication for the family.

Touch. The appropriateness of touch varies with each culture. For example, an Asian may consider touching an unfamiliar person of the opposite gender to be inappropriate, whereas touch between men and women may be viewed as appropriate by another culture. Adults commonly feel that it is acceptable to touch children of all ages, but this may not be accurate. It is best to look for responses from the family regarding touch and progress accordingly.

Space. An individual's sense of personal space also differs by culture. Space refers to the physical distance and relationships between the individual and other persons and objects in the environment. Certain cultures may have specific spatial preferences, such as personal distance and social distance. Some cultures tend to prefer close contact with less space since they use touch as a form of communication. The nurse should be aware of how close a patient or her family members come to other individuals and try to maintain this space during interactions. Nursing procedures often cause the space barrier to be broken. Nurses need to touch patients to take vital signs, administer injections, change dressings, and the like. This does not mean that close touch is appropriate at all times. It is essential to tell all patients before touching them for procedures so they understand what is happening.

TIME ORIENTATION

Cultures have specific values and meanings regarding time orientation. Cultural groups may place emphasis on the events of the past, events that occur in the present, or those events that will occur in the future.

Cultures that are oriented predominantly to the past may want to begin healthcare encounters with lengthy descriptions of past healthcare treatments, family history of diseases, or individual past experiences with health. There may be little interest in learning methods of adapting to or maintaining a new plan of care.

For cultures that are oriented predominantly to the present, little consideration may be given to either the past or the future. For example, adolescents commonly focus on the present and may not engage in preventive health practices for long-term health. Therefore, short-term goals often provide more incentive to them.

Cultures that are oriented predominantly to the future may not focus on what is important at the present time. For example, the family focusing on the future may focus on the dreams they had for a new baby's education or talents and have trouble setting present goals for treatment of an at-risk baby. One commonly hears that it is a big adjustment to learn to "take it one day at a time."