Maternal Child Nursing Care

SIXTH EDITION

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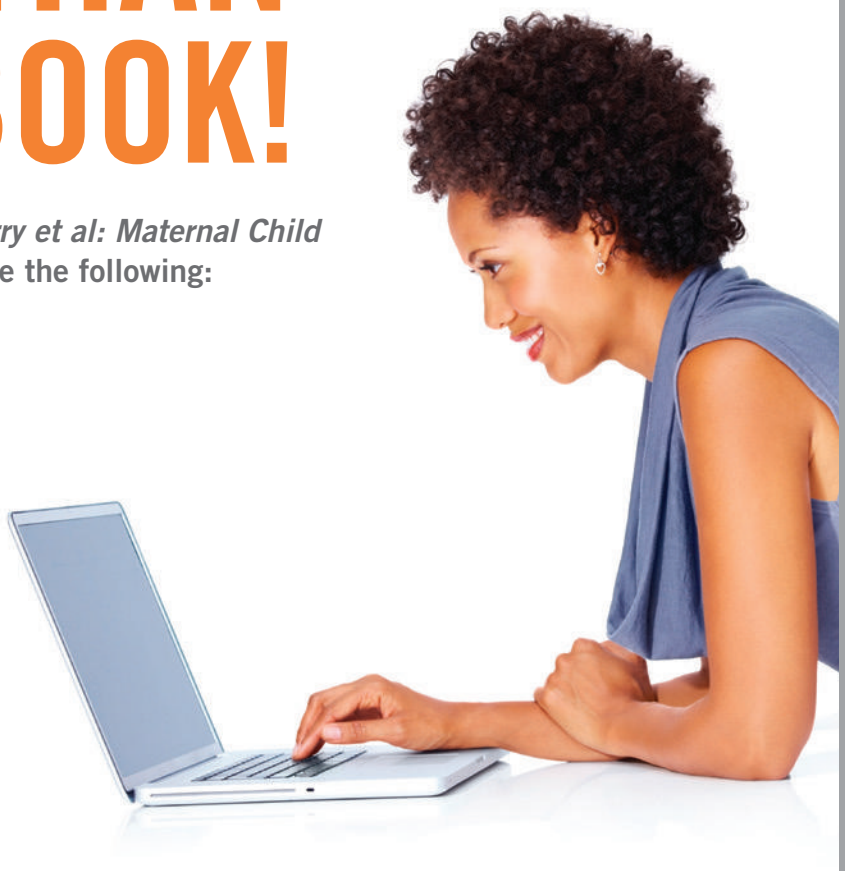

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Maternal Child Nursing Care

SIXTH EDITION

MATERNITY

Shannon E. Perry, RN, PhD, FAAN
Professor Emerita, School of Nursing
San Francisco State University
San Francisco, California

Deitra Leonard Lowdermilk, RNC, PhD, FAAN
Clinical Professor Emerita, School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Kitty Cashion, RN-BC, MSN
Clinical Nurse Specialist, College of Medicine, Department of Obstetrics and Gynecology, Division of Maternal-Fetal Medicine
University of Tennessee Health Science Center
Memphis, Tennessee

Kathryn Rhodes Alden, EdD, MSN, RN, IBCLC
Associate Professor, School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Associate Editor

Ellen F. Olshansky, PhD, RN, WHNP-BC, NC-BC, FAAN
Professor and Chair, Department of Nursing
Suzanne Dworak-Peck School of Social Work
University of Southern California
Los Angeles, California

PEDIATRIC

Marilyn J. Hockenberry, PhD, RN, PPCNP-BC, FAAN
Bessie Baker Professor of Nursing and Professor of Pediatrics
Associate Dean of Research Affairs, School of Nursing
Chair, Duke Institutional Review Board
Duke University
Durham, North Carolina

David Wilson, MS, RNC-NIC (deceased)
Staff
Children's Hospital at Saint Francis
Tulsa, Oklahoma

Cheryl C. Rodgers, PhD, RN, CPNP, CPON
Assistant Professor
Duke University School of Nursing
Durham, North Carolina

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ELSEVIER

3251 Riverport Lane
St. Louis, Missouri 63043

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Debbie Fraser, MN, RNC-NIC
Associate Professor
Director
Nurse Practitioner Program
Faculty of Health Disciplines
Athabasca University
Advanced Practice Nurse
NICU St. Boniface Hospital
Winnipeg, Canada

Pat Mahaffee Gingrich, MSN, RN, WHNP-BC
Assistant Professor
School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Evolve Contributors

Key Points

Joanna Cain, BSN, BA, RN
President and Founder
Auctorial Pursuits, Inc.
Austin, Texas

Review Questions

Daryle Wane, PhD, ARNP, FNP-BC
Baccalaureate Degree Nursing Program Director
Professor of Nursing
BSN Faculty
Pasco-Hernando State College
New Port Richey, Florida

Test Bank

Linda Turchin, RNH, MSN, CNE
Assistant Professor, Nursing
Fairmont State University
Fairmont, West Virginia

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REVIEWERS

Michael D. Aldridge, PhD, RN, CNE
Assistant Professor of Nursing
Pediatric Nursing
Concordia University Texas
Austin, Texas

Sandy Barker, RN, MSN
Master Nursing Instructor
Nursing
Tennessee College of Applied Technology
Elizabethton, Tennessee

Judy Carlyle, MSN, RN
Faculty
Arkansas Rural Nursing Education Consortium
Nashville, Arkansas

Brigit Carter, PhD, RN, CCRN
Assistant Professor
School of Nursing
Duke University
Durham, North Carolina

Janie Corbitt, RN, MLS
Instructor of Nursing (retired)
Milledgeville, Georgia

Stephanie Evans, PhD, APRN, PNP-PC
Assistant Professor
Harris College of Nursing and Health Sciences
Texas Christian University
Fort Worth, Texas

Vanessa Lynn Flannery, MSN, PHCNS-BC, CNE
Associate Professor
Morehead State University
Morehead, Kentucky

Kari Gali, DNP, RN, CPNP
Post-Doctoral Fellow
Case Western Reserve University
Cleveland, Ohio

Terry Hadler, MSN, RN
Assistant Professor
Dakota Wesleyan University
Mitchell, South Dakota

Teresa Howell, DNP, RN, CNE
Department of Nursing
Morehead State University
Morehead, Kentucky

Kathleen S. Jordon, DNP, MS, FNP-BC, ENP-BC, SANE-P
Clinical Assistant Professor
School of Nursing
University of North Carolina at Charlotte
Nurse Practitioner
Emergency Department
Mid-Atlantic Emergency Medicine Associates
Charlotte, North Carolina

Christina D. Keller, MSN, RN, CHS
Instructor
Nursing
Radford University Clinical Simulation Center
Radford, Virginia

Rebecca M. Padgett, MSN, RN
Nursing Faculty
Jefferson Davis Community College
Brewton, Alabama

Latoya Rawlins, DNP, RN-BC, CNE
Assistant Professor
School of Nursing
Rutgers, The State University of New Jersey
New Brunswick, New Jersey

Debra Lee Stayer, RN, PhD, CCRN-K
Assistant Professor
Nursing
Bloomsburg University
Bloomsburg, Pennsylvania

Michelle Van Wyhe, DNP, ARNP-BC
Professor of Nursing
Northwestern College
Nurse Practitioner
Orange City Area Health System
Orange City, Iowa

Donna Wilsker, RN, BSN, MSN
Assistant Professor
Nursing
Lamar University
Beaumont, Texas

ABOUT THE AUTHORS

MATERNITY

Shannon E. Perry is Professor Emerita, School of Nursing, San Francisco State University, San Francisco, California. She received her diploma in nursing from St. Joseph Hospital School of Nursing, Bloomington, Illinois; a BSN from Marquette University; an MSN from the University of Colorado Medical Center; and a PhD in Educational Psychology from Arizona State University. She completed a 2-year postdoctoral fellowship in perinatal nursing at the University of California, San Francisco, as a Robert Wood Johnson Clinical Nurse Scholar.

Dr. Perry has had clinical experience in obstetrics, pediatrics, gynecology, and neonatal nursing. She has taught in schools of nursing in several states for over 30 years and was director of the School of Nursing at San Francisco State University. She is a Fellow in the American Academy of Nursing. Dr. Perry's experience in international nursing includes teaching in the United Kingdom, Ireland, Italy, Thailand, Ghana, and China, as well as participating in health missions in Ghana, Kenya, and Honduras.

Deitra Leonard Lowdermilk is Clinical Professor Emerita, School of Nursing, University of North Carolina at Chapel Hill. She received her BSN from East Carolina University and her MEd and PhD in Education from the University of North Carolina at Chapel Hill. She is certified in in-patient obstetrics by the National Certification Corporation. She is a Fellow in the American Academy of Nursing. In addition to being a nurse educator for more than 34 years, Dr. Lowdermilk has clinical experience in maternity and women's health care.

Dr. Lowdermilk has been recognized for her expertise in nursing education and women's health by state and national nursing organizations and by her alma mater, East Carolina University. A few examples include Educator of the Year by the Association of Women's Health, Obstetric and Neonatal Nurses and by the North Carolina Nurses Association. Dr. Lowdermilk also is co-author of *Maternity and Women's Health Care* (eleventh edition), *Maternity Nursing* (eighth edition), and *Maternal and Child Health* (fifth edition). In Fall 2010, the East Carolina University College of Nursing named the Neonatal Intensive Care and Midwifery Laboratory in honor of Dr. Lowdermilk. In 2011, she was named as one of the first 40 nurses inducted into the College of Nursing Hall of Fame.

Kitty Cashion is a Clinical Nurse Specialist in the Maternal-Fetal Medicine Division, College of Medicine, Department of Obstetrics and Gynecology at The University of Tennessee Health Science Center in Memphis. She received her BSN from the University of Tennessee College of Nursing in Memphis and her MSN in parent-child nursing from the Vanderbilt University School of Nursing in Nashville, Tennessee. Ms. Cashion is certified as a high risk perinatal nurse through the American Nurses Credentialing Center.

Ms. Cashion's job responsibilities at the University of Tennessee include providing education regarding low- and high-risk obstetrics to staff nurses in West Tennessee community hospitals. For over 20 years, Ms. Cashion has been an adjunct clinical instructor in maternal-child nursing at Northwest Mississippi Community College in Senatobia, Mississippi, and Union University in Germantown, Tennessee. Ms. Cashion has contributed many chapters to maternity nursing textbooks over the years and also co-authored several major maternity nursing textbooks.

Kathryn Rhodes Alden is Associate Professor at the University of North Carolina at Chapel Hill School of Nursing, where she has taught clinical and didactic in maternal/newborn nursing for 29 years. She has received numerous awards for excellence in nursing education at the University of North Carolina, being recognized for clinical and classroom teaching expertise as well as for academic counseling. Dr. Alden was instrumental in the adoption of simulation-based learning for nursing education as well as for interprofessional education.

Dr. Alden earned a BSN from University of North Carolina at Charlotte, an MSN from the University of North Carolina at Chapel Hill, and a doctorate in adult education from North Carolina State University. She has clinical experience as a staff nurse in pediatrics, pediatric intensive care, and neonatal intensive care, as well as in postpartum home care of mothers, newborns, and families. She has served as a nursing administrator and coordinator of quality improvement. Dr. Alden has been an international board certified lactation consultant for more than 20 years and has extensive experience working as an inpatient lactation consultant and a lactation educator.

Ellen F. Olshansky is Professor and Founding Chair of the Department of Nursing in the Suzanne Dworak-Peck School of Social Work at the University of Southern California. She earned a BA in Social Work from the University of California, Berkeley, and a BS, MS, and PhD from the University of California, San Francisco School of Nursing. She is a Fellow in the American Academy of Nursing and the Western Academy of Nursing through the Western Institute of Nursing.

Dr. Olshansky is a women's health nurse practitioner, certified through the National Certification Corporation, and her research focuses on women's health across the lifespan, with an emphasis on reproductive health. She is one of the founders of the Orange County Women's Health Project, which promotes women's health and wellness in Orange County, California. She recently completed a 10-year term as editor of the *Journal of Professional Nursing*, the official journal of the American Association of Colleges of Nursing. She has published extensively in numerous nursing and other health-related journals as well as authoring many book chapters and editorials.

PEDIATRIC

Marilyn J. Hockenberry is the Bessie Baker Distinguished Professor of Nursing and Professor of Pediatrics at Duke University. She is the Associate Dean of Research Affairs in the Duke School of Nursing. Her research focuses on symptom management and treatment-related side effects experienced by children who have cancer. Dr. Hockenberry's current National Institutes of Health–funded research studies are evaluating the treatment-related symptoms and neurocognitive deficits of leukemia treatment.

Cheryl C. Rodgers is an Assistant Professor at Duke University School of Nursing in Durham. Her research focuses on symptom assessment and symptom management among children undergoing cancer treatment or stem cell transplant. Dr. Rodgers is certified as a primary care pediatric nurse practitioner and a pediatric oncology nurse. She has over 25 years of clinical experience caring for children with hematologic and oncologic diseases.

PREFACE

This sixth edition of *Maternal Child Nursing Care* combines essential maternity and pediatric nursing information into one text. The text focuses on the care of women during their reproductive years and the care of children from birth through adolescence. The issues and concerns of childbearing women and the health care of children are the primary concentrations. The promotion of wellness and the management of common women's health problems and child development in the context of the family are also addressed. As we move further into the twenty-first century, this edition of *Maternal Child Nursing Care* is designed to address the changing needs of women during their childbearing years and children during their developing years.

Maternal Child Nursing Care was developed to provide students with the knowledge and skills they need to become competent critical thinkers and to attain the sensitivity needed to become caring nurses. This sixth edition has been revised and refined in response to comments and suggestions from educators, clinicians, and students. It includes the most accurate, current, and clinically relevant information available.

APPROACH

Professional nursing practice continues to evolve and adapt to society's changing health priorities. The rapidly changing health care delivery system offers new opportunities for nurses to alter the practice of maternity and pediatric nursing and to improve the way care is given. Increasingly, nursing practice must be evidence based. It is incumbent on nurses to use the most up-to-date and scientifically supported information on which to base their care. To assist nurses in providing this type of care, Evidence-Based Practice boxes with implications for practice are included throughout the text.

Consumers of maternity and pediatric care vary in age, ethnicity, culture, language, social status, marital status, and sexual orientation. They seek care from a variety of health care providers in numerous health care settings, including the home. To meet the needs of these consumers, clinical education must offer students a variety of health care experiences in settings that include hospitals and birth centers, homes, clinics, private physicians' offices, shelters for the homeless or for women and children in need of protection, and other community-based settings.

Care management has been used as an organizing framework for discussion in the nursing care chapters. Interprofessional care is emphasized because this approach demonstrates how nursing must collaborate with other health care disciplines to provide the most comprehensive care possible to women and children. Nursing Care Plans reinforce the problem-solving approach to patient care. In chapters that focus on complications of childbearing, reproductive conditions, and childhood illnesses, medical interventions are included along with nursing care management. Throughout the discussion of assessment and care, we alert the nurse to signs of potential problems and provide informational boxes that highlight warning signs and emergency situations.

Patient education is an essential component of the nursing care of women and children. The chapter on women's health promotion and screening emphasizes teaching for self-care to promote wellness and to encourage preventive care. The chapter on transition to parenthood focuses on teaching for new parents and infants at home. Special boxes highlight community care throughout the text. Family-Centered Care boxes incorporate family considerations important to the care of women and children. Issues concerning grandparents, siblings, and different family constellations are addressed. In the pediatric chapters, these boxes focus on the special learning needs of families. Legal Tips are integrated into the maternity section to emphasize issues related to the care of women and infants. Alerts are located throughout the text to draw attention to important information on medications, nursing care, and safety.

This sixth edition features a contemporary design with logical, easy-to-follow headings and an attractive four-color design that highlights important content and increases visual appeal. Hundreds of color photographs and drawings throughout the text, many of them new, illustrate important concepts and techniques to further enhance comprehension. To help students learn essential information quickly and efficiently, we have included numerous features that prioritize, condense, simplify, and emphasize important aspects of nursing care. In addition, the text encourages students to think critically.

SPECIAL FEATURES

- **Atraumatic Care** boxes emphasize the importance of providing competent care without creating undue physical and psychologic distress. Although many of the boxes provide suggestions for managing pain, atraumatic care also considers approaches to promoting self-esteem and preventing embarrassment.
- **Clinical Reasoning Case Studies** present students with real-life situations and encourage them to make appropriate clinical judgments. A focus on interprofessional care encourages students to think beyond the nursing role to include collaboration with other health care professionals. Answer guidelines are provided in *TEACH for Nurses*.
-  **Community Focus** boxes emphasize community issues, provide resources and guidance, and illustrate nursing care in a variety of settings.
-  **Cultural Considerations** boxes describe beliefs and practices about pregnancy, labor and birth, parenting, and women's health concerns.
-  **Emergency Treatment** boxes alert students to the signs and symptoms of various emergency situations and provide interventions for immediate implementation.
- **Evidence-Based Practice** is incorporated in new boxes that integrate findings from recent studies on selected clinical practices topics; relevant Quality and Safety Education for Nurses (QSEN) competencies are identified in these boxes.
-  **Family-Centered Care** boxes highlight the needs and concerns of families that should be addressed when family-centered care is provided.
-  **Guidelines** boxes provide students with examples of various approaches to implementing care.
- **Legal Tips** are integrated throughout Part 1 to provide students with relevant information to deal with important legal matters in the context of maternity nursing.

- **Medication Guide** boxes and **Medication Alerts** include key information about medications used in maternity and newborn care, including their indications, adverse effects, and nursing considerations.
- **Nursing Alerts** call the reader's attention to critical information that could lead to deteriorating or emergency situations.
- **Nursing Care Plans** are provided for many commonly encountered situations and disorders. Rationales are included for nursing interventions that might not be immediately evident to students. The care plans present a brief case study to help students conceptualize how to individualize patient care.
- **Patient Teaching** boxes assist students to help patients and families become involved in their own care with optimal outcomes.
- **Resources,** including websites and contact information for organizations and educational resources available for the topics discussed, are listed throughout.
- **Safety Alerts** call the reader's attention to potentially dangerous situations that should be addressed by the nurse.
- During assessment, the nurse must be alert for **Signs of Potential Complications;** these are included in chapters that cover uncomplicated pregnancy and childbirth.
- A highly detailed, cross-referenced **Index** allows readers to quickly access needed information.

TEACHING AND LEARNING PACKAGE

Several ancillaries for this text have been developed for instructors and students to use in classroom and clinical settings.

For Students

Evolve: Evolve is an innovative website that provides a wealth of content, resources, and state-of-the-art information on maternity and pediatric nursing. Learning resources for students include Animations, Case Studies, Content Updates, Glossary, Printable Key Points, Nursing Skills, and NCLEX-Style Review Questions.

Simulation Learning System (SLS): The Simulation Learning System (SLS) is an online toolkit that helps instructors and facilitators effectively incorporate medium- to high-fidelity simulation into their nursing curriculum. Detailed patient scenarios promote and enhance the clinical decision-making skills of students at all levels. The SLS provides detailed instructions for preparation and implementation of the simulation experience, debriefing questions that encourage critical thinking, and learning resources to reinforce student comprehension. Each scenario in the SLS complements the textbook content and helps bridge the gap between lectures and clinical practice. The SLS provides the perfect environment for students to practice what they are learning in the text for a true-to-life, hands-on learning experience.

Study Guide: This comprehensive and challenging study aid presents a variety of questions to enhance learning of key concepts and content from the text. Multiple-choice and matching questions and Critical Thinking Case Studies are included. Answers for all questions are included at the back of the study guide.

Virtual Clinical Excursions: Virtual Hospital and Workbook Companion: A virtual hospital and workbook package has been developed as a virtual clinical experience to expand student opportunities for critical thinking. This package guides students through a virtual clinical environment and helps users apply textbook content to virtual patients in that environment. Case studies are presented that allow students to use this textbook as a reference to assess, diagnose, plan, implement, and evaluate "real" patients using clinical scenarios. The state-of-the-art technologies reflected in this virtual hospital demonstrate cutting-edge learning opportunities for students and facilitate knowledge retention of the information found in the textbook. The clinical simulations and workbook represent the next generation of research-based learning tools that promote critical thinking and meaningful learning.

For Instructors

Evolve includes these teaching resources for instructors:

Image Collection, containing more than 700 full-color illustrations and photographs from the text, helps instructors develop presentations and explain key concepts.

PowerPoint Slides, with lecture notes for each chapter of the text, assist in presenting materials in the classroom. ***Case Studies*** and ***Audience Response Questions*** for i-clicker are included.

TEACH for Nurses includes teaching strategies; in-class case studies; and links to animations, nursing skills, and nursing curriculum standards such as QSEN, concepts, and BSN Essentials.

Test Bank in ExamView format contains more than 1850 NCLEX-style test items, including alternate-format questions. An answer key with page references to the text, rationales, and NCLEX-style coding is included.

ACKNOWLEDGMENTS

Thanks to Pat Gingrich for preparing the Evidence-Based Practice boxes in Part 1 and to those parents who permitted us to use photos of their infants and families. Very special thanks to Heather Bays, Clay Broeker, and Laurie Gower, whose support was crucial for the completion of this project. Thanks also to those faculty and students who provided reports and offered suggestions to ensure accuracy.

Shannon E. Perry
Deitra Leonard Lowdermilk
Kitty Cashion
Kathryn Rhodes Alden
Ellen F. Olshansky

We are fortunate to have worked for many years with David Wilson, who served as a co-editor on numerous editions. We miss him greatly with this edition. We are grateful to the many nursing faculty members, practitioners, and students who have offered their comments, recommendations, and suggestions. This edition could not have been completed without the dedication of these special people. We are also grateful to the editorial staff at Elsevier, especially Sandra Clark, Heather Bays, and Clay Broeker, for their support and commitment to excellence.

Marilyn J. Hockenberry
Cheryl C. Rodgers

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CONTENTS

UNIT 10 Special Needs, Illness, and Hospitalization

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21st Century Maternity Nursing

Ellen F. Olshansky

http://evolve.elsevier.com/Perry/maternal

Maternity nursing encompasses care of childbearing women and their families through all stages of pregnancy and childbirth and the first 6 weeks after birth. Some practitioners also include preconception as part of maternity nursing because of the importance of counseling related to planning for pregnancy. Throughout the prenatal period, nurses, nurse practitioners, and nurse-midwives provide care for women in clinics and physicians' offices and teach classes to help families prepare for childbirth. Nurses and nurse-midwives care for childbearing families during labor and birth in hospitals, and nurse-midwives also care for childbearing families in birthing centers (e.g., www.birthcenters.org), and in the home. Nurses with special training may provide intensive care for high-risk neonates in special care units and high-risk mothers in antepartum units, in critical care obstetric units, or in the home. Maternity nurses teach about pregnancy; the process of labor, birth, and recovery; newborn care, and parenting skills. They provide continuity of care throughout the childbearing cycle. This chapter presents a general overview of issues and trends related to the health and health care of women and infants.

Nurses caring for women have helped make the health care system more responsive to women's needs. They have been critically important in developing strategies to improve the well-being of women, their families, and their infants and have led the efforts to implement clinical practice guidelines and to practice using an evidence-based approach. Through professional associations, nurses have a voice in setting standards and influencing health policy by actively participating in the education of the public and state and federal legislators (e.g., www.nursingworld.org; www.can-nurses.ca; www.awhonn.org; www.capwhn.ca). Some nurses hold elective office and influence policy directly. For example, Mary Wakefield, a nurse, served for a time as Acting Deputy Secretary of the Health Resources and Services Administration (HRSA), the agency that oversees approximately 7000 community clinics that serve low-income and uninsured people.

ADVANCES IN THE CARE OF MOTHERS AND INFANTS

Although tremendous advances have taken place in the care of mothers and their infants during the past 150 years (Box 1.1), serious problems exist in the United States related to the health and health care of mothers and infants. Lack of access to prepregnancy and pregnancy-related care for all women and the lack of reproductive health services for adolescents are major concerns. Sexually transmitted infections, including acquired immunodeficiency syndrome (AIDS), continue to adversely affect reproduction.

EFFORTS TO REDUCE HEALTH DISPARITIES

Racial and ethnic diversity is increasing within the United States. It is estimated that by 2060, 43% of the population will be composed of non-Hispanic Whites, resulting in this previous "majority" group no longer being in the majority. Predicted distribution of other ethnic groups is: 14% African-American, 28% Hispanic, 11% Asian-American, 2% American Indians and Alaska Natives, and 0.7% Native Hawaiian and other Pacific Islanders (Colby & Ortman, 2015). These percentages are estimates and therefore do not add up to 100% exactly; the intent here is to show trends.

These trends reflect a slight decrease in non-Hispanic whites and a slight increase in the other ethnic groups: African-Americans, Hispanics, Asian-Americans, Alaskan Natives, Native Hawaiians, and other Pacific Islanders.

African-Americans, Native Americans, Hispanics, Alaska Natives, and Asian/Pacific Islanders experience significant disparities in **morbidity** and mortality rates compared to Caucasians. Shorter life expectancy, higher infant and maternal mortality rates, more **birth defects**, and more sexually transmitted infections are found among these ethnic and racial minority groups. The disparities are thought to result from a complex interaction among biologic factors, environment, socioeconomic factors, and health behaviors. Social determinants of health are those nonbiologic factors that have profound influences on health. Disparities in education and income are associated with differences in morbidity and mortality.

The HRSA Health Disparities Collaboratives are part of a national effort to eliminate disparities and improve delivery systems of health care for all people in the United States who are cared for in HRSA-supported health centers. The National Partnership for Action to End Health Disparities (NPA), sponsored by the Office of Minority Health, has developed priorities to address and end health disparities (NPA, 2016). The Institute for Healthcare Improvement (IHI, 2016) has implemented virtual training sessions on Advancing Safer Maternal and Newborn Care (www.ihi.org/education/WebTraining/Expeditions/AdvancingSaferMaternalandNewbornCare/Pages/default.aspx). The National Institutes of Health (NIH) have a commitment to improve

BOX 1.1 Historic Overview of Milestones in the Care of Mothers and Infants

1847—James Young Simpson in Edinburgh, Scotland, used ether for an internal podalic version and birth; the first reported use of obstetric anesthesia
1861—Ignaz Semmelweis wrote *The Cause, Concept and Prophylaxis of Childbed Fever*
1906—First US program for prenatal nursing care established
1908—Childbirth classes started by the American Red Cross
1909—First White House Conference on Children convened
1911—First milk bank in the United States established in Boston
1912—US Children's Bureau established
1915—Radical mastectomy determined to be effective treatment for breast cancer
1916—Margaret Sanger established first American birth control clinic in Brooklyn, New York
1918—Condoms became legal in the United States
1923—First US hospital center for premature infant care established at Sarah Morris Hospital in Chicago, Illinois
1929—The modern tampon (with an applicator) invented and patented
1933—Sodium pentothal used as anesthesia for childbirth; *Natural Childbirth* published by Grantly Dick-Read
1934—Dionne quintuplets born in Ontario, Canada, and survive partly due to donated breast milk
1935—Sulfonamides introduced as cure for puerperal fever
1941—Penicillin used as a treatment for infection
1941—Papanicolaou (Pap) test introduced
1942—Premarin approved by the Food and Drug Administration (FDA) as treatment for menopausal symptoms
1953—Virginia Apgar, an anesthesiologist, published Apgar scoring system of neonatal assessment
1956—Oxygen determined to cause retrolental fibroplasia (now known as retinopathy of prematurity)
1958—Edward Hon reported on the recording of the fetal electrocardiogram (ECG) from the maternal abdomen (first commercial electronic fetal monitor produced in the late 1960s)
1958—Ian Donald, a Glasgow physician, was first to report clinical use of ultrasound to examine the fetus
1959—*Thank You, Dr. Lamaze* published by Marjorie Karmel
1959—Cytologic studies demonstrated that Down syndrome is associated with a particular form of nondisjunction now known as trisomy 21
1960—American Society for Psychoprophylaxis in Obstetrics (ASPO/Lamaze) formed
1960—International Childbirth Education Association founded
1960—Birth control pill introduced in the United States
1962—Thalidomide found to cause birth defects
1963—Title V of the Social Security Act amended to include comprehensive maternity and infant care for women who were low income and high risk
1963—Testing for PKU begun
1965—Supreme Court ruled that married people have the right to use birth control
1967—Rh_0(D) immune globulin produced for treatment of Rh incompatibility
1967—Reva Rubin published article on maternal role attainment
1968—Rubella vaccine became available
1969—Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG) founded; renamed Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and incorporated as a 501(c)(3) organization in 1993
1969—Mammogram became available
1972—Special Supplemental Food Program for Women, Infants, and Children (WIC) started
1973—Abortion legalized in United States
1974—First standards for obstetric, gynecologic, and neonatal nursing published by NAACOG
1975—The Pregnant Patient's Bill of Rights published by the International Childbirth Education Association
1976—First home pregnancy kits approved by FDA
1978—Louise Brown, first test-tube baby, born
1987—Safe Motherhood initiative launched by World Health Organization and other international agencies
1991—Society for Advancement of Women's Health Research founded
1992—Office of Research on Women's Health authorized by US Congress
1993—Female condom approved by FDA
1993—Human embryos cloned at George Washington University
1993—Family and Medical Leave Act enacted
1994—DNA sequences of *BRCA1* and *BRCA2* identified
1994—Zidovudine guidelines to reduce mother-to-fetus transmission of HIV published
1996—FDA mandated folic acid fortification in all breads and grains sold in United States
1998—Newborns' and Mothers' Health Act went into effect
1998—Canadian Obstetric, Gynecologic, and Neonatal Nurses (COGNN) becomes AWHONN Canada
1999—First emergency contraceptive pill for pregnancy prevention (Plan B) approved by FDA
2000—Working draft of sequence and analysis of human genome completed
2006—Human papilloma virus (HPV) vaccine available
2010—Centenary of the death of Florence Nightingale
2010—Patient Protection and Affordable Care Act signed into law by President Obama
2011—AWHONN Canada becomes the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)
2012—US Supreme Court upheld individual mandate but not the Medicaid expansion provisions of the Patient Protection and Affordable Care Act
2012—Scientists reported findings of the ENCODE (**Enc**yclopedia **o**f **D**NA **E**lements) project showing that 80% of the human genome is active
2016—Zika virus discovered, spread by mosquitos, and sexually transmitted by sperm if a male is infected, affects the fetus/neonate (microcephaly)

the health of minorities and provide funding for research and training of minority researchers (www.nih.gov). The National Institute of Nursing Research includes in its strategic plan support of research that promotes health equity and eliminates health disparities.

The Centers for Disease Control and Prevention (CDC) publishes reports of recent trends and variation in health disparities and inequalities in some social and health indicators and provides data against which to measure progress in eliminating disparities. Topics specific to perinatal nursing that are addressed are infant deaths, preterm births, and adolescent pregnancy and childbirth. In 2015, the US Department of Health and Human Services (USDHHS) released a progress report on its HHS Disparities Action Plan that provides a vision of "a nation free of disparities in health and health care" (USDHHS, 2015). Through this plan, HHS will promote evidence-based programs, integrated approaches, and best practices to reduce disparities. The Action Plan complements the 2011 National Stakeholder Strategy for Achieving Health Equity prepared by the NPA. Since this strategy was developed, much progress has been made in addressing disparities and health equity through a comprehensive, community-driven approach to achieve health equity through collaboration and synergy (NPA, 2016). Through these initiatives, the United States is making a concerted effort to eliminate health disparities.

CONTEMPORARY ISSUES AND TRENDS

HEALTHY PEOPLE 2020 GOALS

Healthy People provides science-based 10-year national objectives for improving the health of all Americans. It has four overarching goals: (1) attaining high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieving health equity, eliminating disparities, and improving the health of all groups; (3) creating social and physical environments that promote good health for all; and (4) promoting quality of life, healthy development, and healthy behaviors across all life stages (www.healthypeople.gov/2020/about/default.aspx). The goals of ***Healthy People 2020*** are based on assessments of major risks to health and wellness, changes in public health priorities, and issues related to the health preparedness and prevention of our nation. Of the objectives of *Healthy People 2020*, 33 are related to maternal, infant, and child health (Box 1.2).

MILLENNIUM DEVELOPMENT GOALS

The United Nations **Millennium Development Goals (MDGs)** are eight goals that were to be achieved by 2015, responding to the main development challenges in the world (www.un.org/millenniumgoals). Goals three through five of the MDGs relate specifically to women and children.

In September 2015, the United Nations site in New York City hosted a conference of world leaders, where they adopted the 2030 Agenda for Sustainable Development. This 2030 agenda consists of 17 Sustainable Development Goals (SDGs), also referred to as Global Goals, which are now replacing the MDGs (United Nations Development Programme, 2016). The majority of these SDGs are related to the environment and eliminating poverty, in many ways collectively encompassing social determinants of health, all of which are relevant to childbearing and childrearing. They are listed in Box 1.3.

INTEGRATIVE HEALTH CARE

Integrative health care encompasses complementary and alternative therapies in combination with conventional Western modalities of treatment. Many popular alternative healing modalities offer human-centered care based on philosophies that recognize the value of the patient's input and honor the individual's beliefs, values, and desires. The focus of these modalities is on the whole person, not just on a disease complex. Patients often find that alternative modalities are more

BOX 1.2 *Healthy People 2020* Maternal, Infant, and Child Health Objectives

- Reduce the rate of fetal and infant deaths.
- Reduce the 1-year mortality rate for infants with Down syndrome.
- Reduce the rate of child deaths.
- Reduce the rate of adolescent and young adult deaths.
- Reduce the rate of maternal mortality.
- Reduce maternal illness and complications caused by pregnancy (complications during hospitalized labor and delivery).
- Reduce the incidence of cesarean births among low-risk (full-term, singleton, vertex presentation) women.
- Reduce the incidence of low birth weight (LBW) and very low birth weight (VLBW). births.
- Reduce the incidence of preterm births.
- Increase the proportion of pregnant women who receive early and adequate prenatal care.
- Increase abstinence from alcohol, cigarettes, and illicit drugs in pregnant women.
- Increase the proportion of pregnant women who attend a series of prepared childbirth classes.
- Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies.
- Increase the proportion of women of childbearing potential who have an intake of at least 400 mcg of folic acid from fortified foods or dietary supplements.
- Reduce the proportion of women of childbearing potential who have low red blood cell folate concentrations.
- Increase the proportion of women delivering a live birth; increase the number of those who receive preconception care services and practice key recommended preconception health behaviors.
- Reduce the proportion of people 18 to 44 years of age who have impaired fecundity (i.e., a physical barrier preventing pregnancy or carrying a pregnancy to term).
- Decrease postpartum relapse of smoking in women who quit smoking during pregnancy.
- Increase the proportion of women giving birth who attend a postpartum care visit with a health worker.
- Increase the proportion of infants who are placed on their backs to sleep.
- Increase the proportion of infants who are breastfed.
- Increase the proportion of employers who have worksite lactation programs.
- Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life.
- Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies.
- Reduce the occurrence of fetal alcohol syndrome (FAS).
- Reduce the proportion of children diagnosed with a disorder through newborn blood spot screening who experience developmental delay requiring special education services.
- Reduce the proportion of children with cerebral palsy born as LBW infants (less than 2500 g).
- Reduce the occurrence of neural tube defects.
- Increase the proportion of young children with an autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in early intervention services in a timely manner.
- Increase the proportion of children, including those with special health care needs, who have access to a medical home.
- Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems.
- Increase appropriate newborn blood-spot screening and follow-up testing.
- Increase the number of states, including the District of Columbia, that verify through linkage with vital records that all newborns are screened shortly after birth for conditions mandated by their state-sponsored screening program.
- Increase the proportion of screen-positive children who receive follow-up testing within the recommended time period.
- Increase the proportion of children with a diagnosed condition identified through newborn screening who have an annual assessment of services needed and received.
- Increase the proportion of VLBW infants born at level III hospitals or subspecialty perinatal centers.

Adapted from HealthyPeople.gov. (2012). *Maternal, infant, and child health*. Retrieved from www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26.

BOX 1.3 United Nations Sustainable Development Goals

1. No poverty
2. Zero hunger
3. Good health and well-being
4. Quality education
5. Gender equality
6. Clean water and sanitation
7. Affordable and clean energy
8. Decent work and economic growth
9. Industry, innovation, and infrastructure
10. Reduced inequalities
11. Sustainable cities and communities
12. Responsible consumption and production
13. Climate action
14. Life below water
15. Life on land
16. Peace, justice and strong institutions
17. Partnerships for the goals

From United Nations Development Programme. (2016). Sustainable Development Goals. Retrieved from http://www.un.org/sustainabledevelopment/sustainable-development-goals/.

consistent with their own belief systems and also allow for more patient autonomy in health care decisions (Fig. 1.1). Examples of alternative modalities include acupuncture, macrobiotics, herbal medicines, massage therapy, biofeedback, meditation, yoga, **chelation therapy**, and guided imagery (See Fig 1.1). Chelation therapy is an alternative therapy that consists of infusing intravenous substances to remove calcium and heavy metals from hardened arteries.

The National Center for Complementary and Integrative Health (NCCIH) (https://nccih.nih.gov) is a US government agency that supports research and evaluation of various alternative and complementary modalities and provides information to health care consumers about such modalities. It is one of the 27 institutes and centers included in the NIH.

INTERPROFESSIONAL EDUCATION

Interprofessional education (IPE) consists of faculty and students from two or more health professions who create and foster a collaborative learning environment. The underlying premise of interprofessional collaboration is that patient care will improve when health professionals work together. Numerous organizations, including the World Health Organization (WHO), the National Academy of Medicine, the National Academies of Practice, and the American Public Health Association, have expressed support of interprofessional education. See Box 1.4 for a description of the practice competencies related to IPE.

FIG 1.1 Nurse and patient during guided imagery session. (Courtesy of Nurses Certificate Program in Interactive Imagery, Foster City, CA.)

BOX 1.4 Interprofessional Education and Collaboration

The Interprofessional Education Collaborative builds on earlier work, in which practice competencies were identified to include the following:

1. Values/ethics for interprofessional practice
2. Roles/responsibilities
3. Interprofessional communication
4. Teams and teamwork

In 2013, The Interprofessional Education Collaborative developed a new collaborative that expands the number of health professionals involved (https://ipecollaborative.org/uploads/IPEC-2016-Updated-Core-Competencies-Report__final_release_.PDF).

Teamwork and communication are key aspects of IPE. Failure to communicate is a major cause of errors in health care. The Situation-Background-Assessment-Recommendation (SBAR) technique provides a specific framework for communication among health care providers about a patient's condition, reducing the potential for errors. SBAR is an easy to remember, useful, concrete mechanism for communicating important information that requires a clinician's immediate attention (Kaiser Permanente of Colorado, 2014) (Table 1.1). A specific program to enhance teamwork and collaboration is TeamSTEPPS, which was developed by the Department of Defense Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality (AHRQ) as a teamwork system for health professionals to provide higher-quality, safer patient care (www.teamstepps.ahrq.gov/about-2cl_3.htm). It provides an evidence base to improve communication and teamwork skills. Through this system, health care teams use information, people, and resources to achieve the best possible clinical outcomes, increase team awareness and clarify roles and responsibilities of team members, resolve conflicts and improve sharing of information, and eliminate barriers to quality and safety.

PROBLEMS WITH THE US HEALTH CARE SYSTEM

Structure of the Health Care Delivery System

The US health care delivery system is often fragmented and expensive and is inaccessible to many. Opportunities exist for nurses to alter nursing practice and improve the way care is delivered through managed care, integrated delivery systems, and redefined roles. Information about health and health care is readily available on the Internet (e-health). Consumers use this information to participate in their own care and consult health care providers with a knowledge base that was previously difficult to access.

Reducing Medical Errors

Medical errors are the third leading cause of death in the United States (Leapfrog Group, 2015; Makary & Daniel, 2016). Since the Institute of Medicine (IOM) released its report, *To Err Is Human: Building a Safer Health System* (IOM, 2000), a concerted effort has been under way to analyze causes of errors and develop strategies to prevent them. Hayes, Jackson, Davidson, and Power and colleagues (2015) explored how nurses can decrease interruptions and distractions that contribute to medical errors. Recognizing the multifaceted causes of medical errors, the Agency for Healthcare Research and Quality (AHRQ) prepared a fact sheet in 2000, *20 Tips to Help Prevent Medical Errors,* which was

TABLE 1.1 Sample SBAR Report to Physician or Nurse-Midwife*

S	**Situation**	Hello, I am Ellen Olshansky on the mother/baby unit, and I'm calling about Mary Smith, who just gave birth 12 hours ago. I have just assessed her, and she saturated a peripad in the last hour. Her blood pressure is 112/62, pulse 86, and respirations 18. I think she is bleeding excessively.
B	**Background**	Mrs. Smith is 12 hours' postpartum after giving birth vaginally to a 9-lb, 12-oz term infant after an uncomplicated pregnancy. She had a rapid labor, just over 4 hours, and had no analgesia. She plans to bottle-feed this baby. She had an IV with 10 units of oxytocin (Pitocin), but it was completed and discontinued about 2 hours ago. This is her sixth birth. All were uncomplicated, and she had an uneventful recovery from them.
A	**Assessment**	Her fundus becomes firm after massage but relaxes again. She has a slightly malodorous vaginal discharge. She has voided, and her bladder feels empty. I think she might have retained placenta and she needs to be examined.
R	**Recommendation**	I would like you to come and examine her immediately. Do you want her IV restarted? Do you want her to have a hemoglobin and hematocrit?

IV, Intravenous infusion; *SBAR,* Situation-Background-Assessment-Recommendation.
*The SBAR tool was developed by Kaiser Permanente, and the example was prepared by Shannon E. Perry.

TABLE 1.2 Selected Safe Practices for Better Health Care

Safe Practice	Practice Statement
Safe Practice 2: Culture Measurement, Feedback, and Intervention	Health care organizations must measure their culture, provide feedback to leadership and staff, and undertake interventions that reduce patient safety risk.
Safe Practice 5: Informed Consent	Ask each patient or legal surrogate to "teach back" in his or her own words key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.
Safe Practice 12: Patient Care Information	Ensure that care information is transmitted and appropriately documented in a timely manner and a clearly understandable form to patients and all of the patients' health care providers/professionals, within and between care settings, who need that information to provide continued care.
Safe Practice 19: Hand Hygiene	Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

CT, Computed tomography.
From National Quality Forum. (2013). *Safe practices for better healthcare—2013 update: A consensus report.* Washington, DC: NQF. In Health Care Facilities Accreditation Program. Retrieved from http://www.hfap.org/pdf/patient_safety.pdf.

BOX 1.5 National Quality Forum Serious Reportable Events Pertaining to Maternal and Child Health

- Maternal death or serious injury associated with labor or birth in a low-risk pregnancy while being cared for in a health care facility
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- Artificial insemination with the wrong donor sperm or wrong egg

From National Quality Forum. (2011). Serious reportable events in healthcare—2011 update: A consensus report. Washington, DC: NQF.

updated in 2014, for patients and the public. Patients are encouraged to be knowledgeable consumers of health care and ask questions of providers, including physicians, midwives, nurses, and pharmacists.

In 2002, the National Quality Forum (NQF) published a list of Serious Reportable Events in Healthcare. The list was most recently updated in 2011 (NQF, 2011), resulting in a total of 29 events. Of these 29 events, three pertain directly to maternity and newborn care (Box 1.5).

The NQF published *Safe Practices for Better Healthcare* in 2003 and updated it most recently in 2013 (http://www.hfap.org/pdf/patient_safety.pdf). The 34 safe practices included should be used in all applicable health care settings to reduce the risk for harm that results from processes, systems, and environments of care. Table 1.2 contains a selection of practices from that document.

High Cost of Health Care

Health care is one of the fastest-growing sectors of the US economy. Currently 17.5% of the gross domestic product is spent on health care (Centers for Medicare & Medicaid, 2015). These high costs are related to higher prices, readily accessible technology, and greater obesity. Most researchers agree that caring for the increased number of low–birth weight (LBW) infants in neonatal intensive care units contributes significantly to overall health care costs.

Nurse-midwifery and advanced practice nursing care have helped contain some health care costs. However, not all insurance carriers reimburse nurse practitioners and clinical nurse specialists as direct care providers, nor do they reimburse for all services provided by nurse-midwives, a situation that continues to be a problem. Nurses must become involved in the politics of cost containment because they, as knowledgeable experts, can provide solutions to many health care problems at a relatively low cost. Nurse practitioners are among the health care providers included in the Affordable Care Act (ACA). Despite this, only 21 states and the District of Columbia allow nurse practitioners to practice to their fullest potential without physician involvement (American Academy of Nurse Practitioners, 2015).

Limited Access to Care

Barriers to access must be removed so pregnancy outcomes and care of children can be improved. The most significant barrier to access is the inability to pay. Some improvement in ability to pay has been seen due to the ACA. The uninsured rate in 2014 was 10.4%, or 33 million people, which was lower than the rate of 13.3%, or 41.8 million people, in 2013 (Smith & Medalia, 2015). Lack of transportation and dependent child care are other barriers. In addition to a lack of insurance and high costs, a lack of providers for low-income women exists because many physicians either refuse to take Medicaid patients or take only a few

such patients. This presents a serious problem because a significant proportion of births are to mothers who receive Medicaid.

Health Care Reform

In early 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, commonly referred to as *Obamacare*. The Act aims to make insurance affordable, contain costs, strengthen and improve Medicare and Medicaid, and reform the insurance market. There are provisions to promote prevention and improve public health; improve the quality of care for all Americans; reduce waste, fraud, and abuse; and reform the health delivery system. There are some immediate benefits, but the fate of the ACA is uncertain in the current political climate.

In 2012, 26 states, several individuals, and the National Federation of Independent Business brought suit challenging the constitutionality of the individual mandate (requirement for most Americans to have minimum essential health insurance) and the Medicaid expansion (expand the scope of coverage and increase the number of individuals the states must cover). The Supreme Court upheld the individual mandate but not the Medicaid expansion. The debate continues on how the plan will be implemented and there is much uncertainty regarding health care reform.

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) advocated successfully for the inclusion in the ACA of contraceptive methods, services, and counseling, without any out-of-pocket costs to women; preventive services such as mammograms, well-woman visits, and screening for gestational diabetes; and providing breastfeeding equipment and counseling for pregnant and nursing women in new insurance plans. Work continues on implementation.

ACCOUNTABLE CARE ORGANIZATIONS

In 2011, the Center for Medicaid and Medicare Services (CMS) finalized new rules under the ACA to help health care providers and hospitals better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). An ACO is a group of health care providers and health care agencies that are accountable for improving the health of populations while containing costs. These groups of health care providers and hospitals voluntarily come together to coordinate high-quality care, eliminate duplication of services, and prevent medical errors, which results in savings of health care dollars.

HEALTH LITERACY

Health literacy involves a spectrum of abilities, ranging from reading an appointment slip to interpreting medication instructions. These skills must be assessed routinely to recognize a problem and accommodate patients with limited literacy skills. Most education materials are written at too high a level for the average adult; e-health literacy has emerged as a concept. Individuals use the Internet for diagnosis, but more than half of these individuals seek the opinion of a medical professional rather than trying to care for themselves based on the information accessed (Dickens & Piano, 2013).

The CDC (2016a) has a health literacy website (www.cdc.gov/healthliteracy) that highlights implementation of goals and strategies of the National Action Plan to Improve Health Literacy. Health literacy is part of the Patient Protection and Affordable Care Act.

As a result of the increasingly multicultural US population, there is a more urgent need to address health literacy as a component of culturally and linguistically competent care. Older adults, racial or ethnic minorities, and those whose income is at or below the poverty level are most vulnerable. Lower health literacy is associated with adverse health outcomes (Dickens & Piano, 2013).

Health care providers contribute to health literacy by using simple, common words; avoiding jargon; and assessing whether the patient understands the discussion. Speaking slowly and clearly and focusing on what is important increase understanding.

BOX 1.6 Maternal-Infant Biostatistical Terminology

Abortus: An embryo or fetus that is removed or expelled from the uterus at 20 weeks of gestation or less, weighs 500 g or less, or measures 25 cm or less

Birth rate: Number of live births in 1 year per 1000 population

Fertility rate: Number of births per 1000 women between 15 and 44 years of age (inclusive), calculated on an annual basis

Infant mortality rate: Number of deaths of infants younger than 1 year of age per 1000 live births

Maternal mortality rate: Number of maternal deaths from births and complications of pregnancy, childbirth, and puerperium (the first 42 days after termination of the pregnancy) per 100,000 live births

Pregnancy-associated deaths: All deaths during pregnancy and within the 1 year following the end of pregnancy

Pregnancy-related deaths (subset of pregnancy-associated): Deaths that are a complication of pregnancy, an aggravation of an unrelated condition by the physiology of pregnancy, or a chain of events initiated by the pregnancy

Neonatal mortality rate: Number of deaths of infants younger than 28 days of age per 1000 live births

Perinatal mortality rate: Number of stillbirths and number of neonatal deaths per 1000 live births

Stillbirth: An infant who at birth demonstrates no signs of life such as breathing, heartbeat, or voluntary muscle movements

TRENDS IN FERTILITY AND BIRTH RATE

Fertility trends and birth rates reflect women's needs for health care. Box 1.6 defines biostatistical terminology useful in analyzing maternal health care. In 2015, the fertility rate in the United States declined by 1% as compared with 2014 (down from 62.9 to 62.5 births per 1000 women ages 15-44). There was a decline in births among Hispanic and non-Hispanic white women, and the rate was unchanged for non-Hispanic black women. Among women in their early 20s, there was a record low birth rate in 2015. There was a lesser decline for women in their late 20s, with an increase for women in their 30s and early 40s. The birth rate also fell among unmarried women, which is notable as this was the seventh year in a row in which this group experienced a decline in birth rate. The teenage birth rate (ages 15-19) decreased by 8% (down to 22.3 births per 1000 young women ages 15 to 19. Fertility rates declined among teenagers in all racial groups (Martin, Hamilton, Osterman, et al., 2017).

LOW–BIRTH WEIGHT AND PRETERM BIRTH

The risks of morbidity and mortality increase for newborns weighing less than 2500 g (5 lb, 8 oz)—**low–birth weight (LBW)** infants. Multiple births contribute to the incidence of LBW. There has been a 9% decline in triplet and higher order multiple births from 2014 to 2015 and a decline in the twin birth rate during this same year. This is particularly significant because the rate of twin births in 2014 had been at an all-time high (Martin et al., 2017).

Non-Hispanic black infants are almost twice as likely as non-Hispanic white infants to be of LBW and to die in the first year of life. Cigarette smoking is associated with LBW, prematurity, and intrauterine growth restriction, with a higher rate among non-Hispanic white women and non-Hispanic black women (Tong, Dietz, Morrow, et al., 2013).

The percentage of infants born preterm (i.e., born before 37 weeks of gestation) was 9.63% in 2015, which is slightly higher than the 2014 rate of 9.57%. Non-Hispanic black and Hispanic black women experienced increased rates of preterm births (Martin et al., 2017).

INTERNATIONAL INFANT MORTALITY TRENDS

In 2010, the infant mortality rate in the United States (6.1/1000) ranked twenty-sixth, when compared with those of other industrialized countries (MacDorman, Mathew, Mohangoo, et al., 2014). Decreases in the infant mortality rate in the United States do not keep pace with the rates of other industrialized countries. One reason for this is the high rate of LBW infants in the United States in contrast with the rates in other countries.

MATERNAL MORTALITY

Worldwide approximately 800 women die each day of problems related to pregnancy or childbirth. In the United States in 2011, the annual **maternal mortality rate** (number of deaths per 100,000 live births) was 17.8; the rate decreased to 15.9 in 2012, and then increased again to 17.3 in 2013 (CDC, 2016b). Although the overall number of maternal deaths is small, maternal mortality remains a significant problem because a high proportion of deaths are preventable, primarily through improving the access to and use of prenatal care services. In the United States, there is significant racial disparity in the rates of maternal death, which are highest in non-Hispanic black women, followed by non-Hispanic white women (CDC, 2016b).

The leading causes of maternal death attributable to pregnancy differ over the world. In the United States, the three major causes are cardiovascular diseases, non-cardisovascular diseases, and infection (CDC, 2016b). Unsafe abortion is an additional cause. Factors that are strongly related to maternal death include age (younger than 20 years and 35 years or older), lack of prenatal care, low educational attainment, unmarried status, and non-Caucasian race. Worldwide strategies to reduce maternal mortality rates include improving access to skilled attendants at birth, providing postabortion care, improving family planning services, and providing adolescents with better reproductive health services.

MATERNAL MORBIDITY

Although mortality is the traditional measure of maternal health and maternal health is often measured by neonatal outcomes, pregnancy complications are important. Currently no surveillance method is available to measure the incidence of maternal morbidity (Firoz, Chou, von Dadelszen, et al., 2013).

Maternal morbidity includes such conditions as acute renal failure, amniotic fluid embolism, cerebrovascular accident, eclampsia, pulmonary embolism, liver failure, obstetric shock, respiratory failure, septicemia, and complications of anesthesia (pulmonary, cardiac, central nervous system). Maternal morbidity results in high-risk pregnancy. The diagnosis of high risk imposes a **situational crisis** on the family. The combined efforts of interprofessional health care teams that includes nurses, physicians, and others are required to care for these patients, who often need the expertise of health care providers trained in both critical care obstetrics and intensive care medicine or nursing.

Obesity

Approximately 25% of women who were pregnant in 2014 in the United States were obese (Branum, Kirmeyer, Gregory, 2016). The two most frequently reported maternal medical risk factors are hypertension associated with pregnancy and diabetes, both of which are associated with obesity. Decreased fertility, congenital anomalies, miscarriage, and fetal death are also associated with obesity. Obesity in pregnancy is associated with higher risks, and there are significant disparities in obesity associated with race and ethnicity (Marshall, Guild, Cheng, et al., 2014).

REGIONALIZATION OF PERINATAL HEALTH CARE SERVICES

Not all facilities can develop and maintain the full spectrum of services required for high-risk perinatal patients. A regionalized system focusing on integrated delivery of graded levels of hospital-based perinatal health care services is effective and results in improved outcomes for mothers and their newborns. This system of coordinated care can be extended to preconception and ambulatory prenatal care services. In 2015, ACOG and the Society for Maternal-Fetal Medicine (SMFM) published a consensus statement on levels of maternal care (ACOG & SMFM, 2015).

Ambulatory Prenatal Care

Guidelines have been established regarding the level of care that can be expected at any given facility. In ambulatory settings, providers must distinguish themselves by the level of care they provide. *Basic care* is provided by obstetricians, family physicians, certified nurse-midwives, and other advanced practice clinicians approved by local governance. Routine risk-oriented prenatal care, education, and support are provided. Providers offering *specialty care* are obstetricians who must provide fetal diagnostic testing and management of obstetric and medical complications in addition to basic care. *Subspecialty care* is provided by maternal-fetal medicine specialists and reproductive geneticists and includes the aforementioned in addition to genetic testing, advanced fetal therapies, and management of severe maternal and fetal complications. Collaboration among providers to meet the woman's needs is the key to reducing perinatal morbidity and mortality.

HIGH-TECHNOLOGY CARE

Advances in scientific knowledge and the large number of high-risk pregnancies have contributed to a health care system that emphasizes high-technology care. Maternity care has extended to preconception counseling, more and better scientific techniques to monitor the mother and fetus, more definitive tests for hypoxia and acidosis, and neonatal intensive care units. The labors of virtually all women who give birth in hospitals in the United States are monitored electronically despite the lack of evidence of efficacy of such monitoring. The numbers of assisted labors and births are increasing. Internet-based information is available to the public that enhances interactions among health care providers, families, and community providers. Point-of-care testing is available. Personal data assistants are used to enhance comprehensive care; the medical record is increasingly in electronic form.

Strides are being made in identifying genetic codes, and genetic engineering is taking place. Women's health has expanded to emphasize care of older women, new cancer-screening techniques, advances in the diagnosis and treatment of breast cancer, and work on an AIDS vaccine. In general, high-technology care has flourished, whereas "health" care has become relatively neglected. Nurses must use caution and prospective planning and assess the effect of the emerging technology.

BOX 1.7 American Nurses Association's Principles for Social Networking and the Nurse

- Nurses must not transmit or place online individually identifiable patient information.
- Nurses must observe ethically prescribed professional patient-nurse boundaries.
- Nurses should understand that patients, colleagues, institutions, and employers may view postings.
- Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
- Nurses should bring content that could harm a patient's privacy, rights, or welfare to the attention of appropriate authorities.
- Nurses should participate in developing institutional policies governing online contact.

From American Nurses Association. (2011). *Fact sheet: Navigating the world of social media.* Washington, DC: Author.

Telehealth is an umbrella term for the use of communication technologies and electronic information to provide or support health care when the participants are separated by distance. It permits specialists, including nurses, to provide health care and consultation when distance separates them from those needing care. This technology has the potential to save billions of dollars annually for health care, but these technologic advances have also contributed to higher health care costs..

Social Media

Social media uses Internet-based technologies to allow users to create their own content and participate in dialog. The most common social media platforms are Facebook, Twitter, and LinkedIn, with others also gaining in popularity. Social media can be integrated into nursing practice, facilitating communication among nurses and between nurses and other health care providers and patients (Casella, Mills, Usher, et al., 2014). However, there are pitfalls for nurses using this technology. Patient privacy and confidentiality can be violated, and institutions and colleagues can be cast in unfavorable lights with negative consequences for those posting the information. Nursing students have been expelled from school, and nurses have been fired or reprimanded by a Board of Nursing for injudicious posts. To help make nurses aware of their responsibilities when using social media, the American Nurses Association (ANA) published six principles for social networking and the nurse (Box 1.7). Brous (2013) referred to the *White Paper: A Nurse's Guide to the Use of Social Media* that was published by the National Council of State Boards of Nursing (NCSBN, 2011; https://www.ncsbn.org/Social_Media.pdf), detailing issues of confidentiality and privacy, possible consequences of inappropriate use of social media, common myths and misunderstandings of social media, and tips on how to avoid problems.

COMMUNITY-BASED CARE

A shift in settings from acute care institutions to ambulatory settings, including the home, has occurred. Even childbearing women at high risk are cared for on an outpatient basis or in the home. Technology previously available only in the hospital is now found in the home. This has affected the organizational structure of care, the skills required in providing such care, and the costs to consumers.

Home health care also has a community focus. Nurses are involved in providing care for women and infants in homeless shelters and adolescents in school-based clinics and in promoting health at community sites, churches, and shopping malls. Nursing education curricula are increasingly community based.

CHILDBIRTH PRACTICES

Prenatal care can promote better pregnancy outcomes by providing early risk assessment and promoting healthy behaviors such as improved nutrition and smoking cessation. Preconception care ideally begins before pregnancy because early decisions lay the foundation for the entire perinatal year. If at all possible, education continues in each trimester of pregnancy and extends through the early postpartum weeks. Some health care providers today promote preconception care as an important component of perinatal services. Preconception or early-pregnancy classes also emphasize health-promoting behavior and choices of care.

In the United States, most women received care in the first trimester. There is disparity, however, in receiving prenatal care by race and ethnicity, with non-Hispanic black women and Hispanic women receiving significantly later prenatal care as compared to non-Hispanic whites. In spite of these statistics, substantial gains have been made in the use of prenatal care since the early 1990s, which are attributed to the expansion in the 1980s of Medicaid coverage for pregnant women.

Women can choose physicians or nurse-midwives as primary care providers. In 2015, doctors of medicine attended 84% of births in hospitals, certified nurse-midwives attended 8.1%, and doctors of osteopathy attended 7.1% (Martin et al., 2017). Women who choose nurse-midwives as their primary care providers participate more actively in childbirth decisions, receive fewer interventions during labor, and are less likely to give birth prematurely (Sandall, Soltani, Gates, et al., 2013). From 2014 to 2015, there was a decline in the rate of cesarean births from 32.2% to 32.0% (Martin et al.), although Thielking (2015) reported that the approximately 1/3 rate for cesarean births is too high for resulting benefits, as benefits usually plateau at about a 19% cesarean birth rate.

INVOLVING CONSUMERS AND PROMOTING SELF-MANAGEMENT

Self-management of health care is appealing to both patients and the health care system because of its potential to reduce health care costs. Maternity care is especially suited to self-management because childbearing is primarily health focused, women are usually well when they enter the system, and visits to health care providers can present the opportunity for health and illness interventions. Measures to improve health and reduce risks associated with poor pregnancy outcomes and illness can be addressed. Topics such as nutrition education, stress management, smoking cessation, alcohol and drug treatment, prevention of violence, improvement of social supports, and parenting education are appropriate for such encounters.

INTERNATIONAL CONCERNS

Access to prenatal care and family planning education, care for women experiencing postpartum hemorrhage, obstructed labors with no access to hospital care or operative birth, fistulas due to obstructed labors, and HIV-positive parents are major international concerns. The high maternal and infant mortality in developing countries is a serious problem with limited resources to address the contributing factors. Two concerns that nurses in the United States and Canada might encounter are female genital mutilation and human trafficking.

Female genital mutilation, infibulation, and *circumcision* are terms used to describe procedures in which part or all of the female external

FIG 1.2 Father "catching" newborn daughter who cried before her lower body had emerged. (Courtesy of Darren and Julie Nelson, Loveland, CO.)

genitalia is removed for cultural or nontherapeutic reasons (WHO, 2016). Worldwide, many women undergo such procedures. The International Council of Nurses and other health professionals have spoken out against procedures that result in mutilation as harmful to women's health. Although it is illegal in the United States to perform female genital mutilation on a person younger than 18 years of age, it is estimated that 513,000 women and girls in the United States have experienced or are at risk for female genital mutilation (Office of Women's Health, 2015).

Human trafficking is a serious crime, an illegal business that exists in the United States and internationally, in which mostly women and children are "trafficked," or forced into hard labor, sex work, and even organ donation (Budiani-Saberi, Raja, Findley, et al., 2014; United Nations Office on Drugs & Crime, 2016). Health care professionals may interact with victims who are in captivity. This provides an opportunity to identify victims, intervene to help them obtain necessary health services, and provide information about ways to escape from their situation (Fig. 1.2) (see Chapter 3). The National Human Trafficking Resource Center (1-888-373-7888) can provide assistance.

THE FUTURE OF NURSING

In 2008, the Robert Wood Johnson Foundation and the IOM initiated a 2-year process to meet the need to assess and transform the nursing profession. The IOM appointed a committee that developed four key messages: (1) nurses should practice to the full extent of their education and training; (2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; (3) nurses should be full partners with physicians and other health care professionals in redesigning health care in the United States; and (4) effective workforce planning and policy-making require better data collection and an improved information infrastructure (IOM, 2010). Throughout the United States individual states and nursing organizations are making concerted efforts to implement the recommendations of the report. In 2015, a meeting was convened to assess the progress toward the goals outlined in the original report (National Academy of Sciences, 2015). Efforts continue toward meeting the recommendations of the original IOM report.

TRENDS IN NURSING PRACTICE

The increasing complexity of care for maternity and women's health patients has contributed to specialization of nurses working with these patients. This specialized knowledge is gained through experience, advanced degrees, and certification programs. Nurses in advanced practice (e.g., nurse practitioners and nurse-midwives) may provide primary care throughout a woman's life, including during the pregnancy cycle. In some settings, the clinical nurse specialist and nurse practitioner roles are blended, and nurses deliver high-quality, comprehensive, and cost-effective care in a variety of settings. In other settings, nurses educated in both critical care and high-risk obstetrics provide care in obstetric critical care units. Lactation consultants provide services in the hospital setting, in clinics and physician offices, and during home visits.

NURSING INTERVENTIONS CLASSIFICATION

When the National IOM proposed that all patient records be computerized by 2000, a need for a common language to describe the contributions of nurses to patient care became evident. Nurses from the University of Iowa developed a comprehensive standardized language that describes interventions that are performed by generalist or specialist nurses. This language is included in the Nursing Interventions Classification (NIC) (Bulechek, Buthcer, Dochterman, et al., 2013). Interventions commonly used by maternal-child nurses include those in Box 1.8.

EVIDENCE-BASED PRACTICE

Evidence-based practice—providing care based on evidence gained through research and clinical trials—is increasingly emphasized. Although not all practice can be evidence-based, practitioners must use the best available information on which to base their interventions. In 2013, AWHONN developed a draft document of quality measures for women's health and perinatal nursing, comparing NQF measures with AWHONN Nursing Care Quality measures (AWHONN, 2013). Discussion of nursing care and evidence-based practice boxes throughout this text provide examples of evidence-based practice in perinatal and women's health nursing (see Evidence-Based Practice box).

Cochrane Pregnancy and Childbirth Database

The Cochrane Pregnancy and Childbirth Database was first planned in 1976 with a small grant from the World Health Organization to Dr. Iain Chalmers and colleagues at Oxford. In 1993, the Cochrane Collaboration was formed, and the Oxford Database of Perinatal Trials became known as the Cochrane Pregnancy and Childbirth Database. The Cochrane Collaboration oversees up-to-date, systematic reviews of randomized controlled trials of health care and disseminates these reviews. The premise of the project is that these types of studies provide the most reliable evidence about the effects of care.

The evidence from these studies should encourage practitioners to implement useful measures and abandon those that are useless or harmful. Studies are ranked in the following six categories:

1. Beneficial forms of care
2. Forms of care that are likely to be beneficial
3. Forms of care with a trade-off between beneficial and adverse effects
4. Forms of care with unknown effectiveness
5. Forms of care that are unlikely to be beneficial
6. Forms of care that are likely to be ineffective or harmful

Joanna Briggs Institute

Established in 1996 as an initiative of the Royal Adelaide Hospital and the University of Adelaide in Australia, the Joanna Briggs Institute (JBI)

BOX 1.8 Childbearing Care Interventions

Level 1 Domain: Family
- Care that supports the family

Level 2 Class: Childbearing Care
- Interventions to assist in the preparation for childbirth and management of the psychologic and physiologic changes before, during, and immediately after childbirth

Level 3: Interventions
- Amnioinfusion
- Birthing
- Bleeding reduction: antepartum uterus
- Bleeding reduction: postpartum uterus
- Cesarean birth care
- Childbirth preparation
- Circumcision care
- Electronic fetal monitoring: antepartum
- Electronic fetal monitoring: intrapartum
- Environmental management: attachment process
- Family integrity promotion: childbearing family
- Family planning: contraception
- Family planning: infertility
- Family planning: unplanned pregnancy
- Fertility preservation
- Genetic counseling
- Grief work facilitation: perinatal death
- High-risk pregnancy care
- Infant care: newborn
- Infant care: preterm
- Intrapartal care
- Intrapartal care: high-risk delivery
- Kangaroo care
- Labor induction
- Labor suppression
- Lactation support
- Lactation suppression
- Newborn care
- Nonnutritive sucking
- Phototherapy: neonate
- Postpartal care
- Preconception counseling
- Pregnancy termination care
- Prenatal care
- Reproductive technology management
- Resuscitation: fetus
- Resuscitation: neonate
- Risk identification: childbearing family
- Surveillance: late pregnancy
- Tube care: umbilical line
- Ultrasonography: limited obstetric

From Bulechek, G. M., Butcher, H. K., Dochterman, J. M., et al. (2013). *Nursing interventions classification (NIC)* (6th ed.). St. Louis, MO: Mosby.

EVIDENCE-BASED PRACTICE

Seeking and Evaluating Evidence: A Necessary Competency for Quality and Safety

Throughout this text you will see Evidence-Based Practice boxes. These boxes provide examples of how a nurse might conduct an inquiry into an identified practice question. Curiosity and access to a virtual or real library are all the nurse needs to be confident that his or her practice has a sound foundation of evidence.

A literature search may reveal up to three levels of evidence. The first layer consists of primary studies. The strongest of these are randomized controlled trials. Well-designed studies, even small ones, add another piece to the puzzle.

These primary studies may be combined into the second level of evidence. In systematic analyses such as those in the Cochrane Database, the researcher uses a methodology to identify all studies relevant to a particular question. If the data are similar enough, they can be pooled into a meta-analysis. If the evidence is strong, some analyses will form the basis for recommendations for practice and guide further inquiry.

At the tertiary level, professional organizations such as the Agency for Healthcare Research and Quality (AHRQ) (www.ahrq.gov) or the National Guidelines Clearinghouse (NGC) (guideline.gov) may decide to address a broad practice question by sorting through all the available primary and secondary evidence and consulting experienced clinicians. After thoughtful review, the committee of experts in the organization crafts its consensus statement. These recommendations for best practice stand on the shoulders of the systematic analysts, who stand on the many shoulders of the primary researchers.

Provided that the professional organization is well-respected and the process is rigorous, these guidelines in the consensus statement carry enormous authority. Individuals and institutions may choose to adopt them with confidence. An example of this is the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) (www.awhonn.org) Late Preterm Infant Initiative. This initiative began in 2005 in response to the confusion that surrounded the care of infants who do not qualify for NICU admission yet require extra vigilance. Nurseries can adapt these recommendations to their specific institutions, enabling nurses to become more effective at caring for the unique problems of this population of neonates. Like AWHONN, most of the professional organizations make their guidelines available free of charge on their websites.

To develop common language and goals for nursing education, the Quality and Safety Education for Nurses (QSEN) (www.qsen.org) Project expert panel identified six competencies necessary to enable the new nurse to continuously improve the health care system: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. Most nursing challenges require a combination of these competencies. Each competency is further defined as having targets for knowledge, skills, and attitude. The Evidence-Based Practice boxes in this textbook include examples that illustrate each of these targets specific to that competency. A mastery of QSEN competencies greatly enriches the nurse's ability to identify and improve patient and health care–system problems and communicate within the interdisciplinary team.

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NICU, Neonatal intensive care unit.

uses a collaborative approach for evaluating evidence from a range of sources (www.joannabriggs.edu.au). The JBI has formed collaborations with a variety of universities and hospitals around the world including in the United States and Canada. The JBI uses the following grades of recommendation for evidence of feasibility, appropriateness, meaningfulness, and effectiveness: *A,* strong support that merits application; *B,* moderate support that warrants consideration of application; and *C,* not supported (JBI, 2013). The JBI provides another source for perinatal nurses to access information to support evidence-based practice.

OUTCOMES-ORIENTED PRACTICE

Outcomes of care (i.e., the effectiveness of interventions and quality of care) are receiving increased emphasis. Outcomes-oriented care measures effectiveness of care against benchmarks or standards. It is a measure of the value of nursing using quality indicators and assesses whether or not the patient benefitted from the care provided (Moorhead, Johnson, Maas, et al., 2013). The Outcome and Assessment Information Set (OASIS) is an example of an outcome system important for nursing. Its use is required by the CMS in all home health organizations that are Medicare accredited. The Nursing Outcomes Classification (NOC) is an effort to identify outcomes and related measures that can be used for evaluation of care of individuals, families, and communities across the care continuum (Moorhead et al.).

A GLOBAL PERSPECTIVE

Advances in medicine and nursing have resulted in increased knowledge and understanding in the care of mothers and infants and reduced perinatal morbidity and mortality rates. However, these advances have affected predominantly the industrialized nations. With more knowledge and implementation of interventions in other countries (e.g., antiretroviral treatment for mother during pregnancy and for baby as well, more education about prevention of transmission), the rates of HIV have the potential to decrease worldwide. Without intervention, rates of HIV transmission to infants range from 15% to 45%, but with interventions it is possible to decrease the rate to 5% (WHO, 2017).

The Zika virus is a recently discovered concern (CDC, 2016c). This is a virus that is spread via bites from infected mosquitos and may be spread through sexual intercourse with an infected partner. The virus can also be spread to a fetus, leading to microcephaly. Currently there is no vaccine for this virus, and much more research is needed to better understand and treat this infectious disease. More discussion about the Zika virus is included in Chapter 4.

As the world becomes smaller because of travel and communication technologies, nurses and other health care providers are gaining a global perspective and participating in activities to improve the health and health care of people worldwide. Nurses participate in medical outreach, providing obstetric, surgical, ophthalmologic, orthopedic, or other services (Fig. 1.3); attend international meetings; conduct research; and provide international consultation. International student and faculty exchanges occur. More articles about health and health care in various countries are appearing in nursing journals. Several schools of nursing in the United States are World Health Organization Collaborating Centers.

FIG 1.3 Nurse interviewing a young girl accompanied by her mother in a clinic in rural Kenya. (Courtesy of Shannon Perry, Phoenix, AZ.)

STANDARDS OF PRACTICE AND LEGAL ISSUES IN DELIVERY OF CARE

Several organizations have described standards of practice in perinatal and women's health nursing. These organizations include the ANA, which publishes standards for maternal-child health nursing; the AWHONN, which publishes standards of practice and education for perinatal nurses (Box 1.9); the American College of Nurse-Midwives (ACNM), which publishes standards of practice for midwives; and the National Association of Neonatal Nurses (NANN), which publishes standards of practice for neonatal nurses. These standards reflect current knowledge, represent levels of practice agreed on by leaders in the specialty, and can be used for clinical benchmarking.

In addition to these more formalized standards, agencies have their own policies, procedures, and protocols that outline standards to be followed in that setting. In legal terms, the **standard of care** is that level of practice that a reasonably prudent nurse would provide in the same or similar circumstances. In determining legal **negligence**, the care given is compared with the standard of care. If the standard was not met and harm resulted, negligence occurred. The number of legal suits in the perinatal area typically has been high. As a consequence, **malpractice** insurance costs are high for physicians, nurse-midwives, and nurses who work in labor and birth settings.

> **LEGAL TIP Standard of Care** When a nurse is uncertain about how to perform a procedure, he or she should consult the agency's policies and procedures documents. These guidelines are the standard of care for that agency.

PREVENTION OF ERRORS IN NURSING CARE

Medical errors are now the third leading cause of death (Makary & Daniel, 2016). To decrease the risk for errors in the administration of medications, in 2009 The Joint Commission (TJC) developed an official list of abbreviations, acronyms, and symbols *not* to use, which was updated in 2013 (Glassman, 2013) (Table 1.3). In addition, each agency must develop its own list.

SENTINEL EVENTS

TJC (2015) revised its definition of a **sentinel event** as any event that is not due to underlying conditions or natural courses of a patient's condition that affects a patient, resulting in death, permanent harm, or severe temporary harm. This refers to perinatal events, specifically the need for receiving 4 or more units of blood products and/or admission to the ICU.

FAILURE TO RESCUE

Failure to rescue is the failure to recognize or act on early signs of distress. Key components of failure to rescue are (1) careful surveillance and identification of complications, and (2) quick action to initiate appropriate interventions and activate a team response. For the perinatal nurse, this involves careful surveillance, timely identification of complications, appropriate interventions, and activation of a team response to minimize patient harm. Maternal complications that are appropriate for process measurement are placental abruption, postpartum hemorrhage, uterine rupture, eclampsia, and amniotic fluid embolism (Simpson, Knox, Martin, et al., 2011). Fetal complications include nonreassuring

BOX 1.9 Standards of Care for Women and Newborns

Standards That Define the Nurse's Responsibility to the Patient

Assessment
- Collection of health data of the woman or newborn

Diagnosis
- Analysis of data to determine nursing diagnosis

Outcome Identification
- Identification of expected outcomes that are individualized

Planning
- Development of a plan of care

Implementation
- Performance of interventions for the plan of care

Evaluation
- Evaluation of the effectiveness of interventions in relation to expected outcomes

Standards of Professional Performance That Delineate Roles and Behaviors for Which the Professional Nurse Is Accountable

Quality of Care
- Systematic evaluation of nursing practice

Performance Appraisal
- Self-evaluation in relation to professional practice standards and other regulations

Education
- Participation in ongoing educational activities to maintain knowledge for practice

Collegiality
- Contribution to the development of peers, students, and others

Ethics
- Use of American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements (ANA, 2015) to guide practice collaboration
- Involvement of patient, significant others, and other health care providers in the provision of patient care

Research
- Use of research findings in practice

Resource Utilization
- Consideration of factors related to safety, effectiveness, and costs in planning and delivering patient care

Practice Environment
- Contribution to the environment of care delivery

Accountability
- Legal and professional responsibility for practice

From Association of Women's Health, Obstetric and Neonatal Nurses. (2009). *Standards and guidelines for professional practice in the care of women and newborns* (7th ed.). Washington, DC: Author.

TABLE 1.3 The Joint Commission "Do Not Use" List

Do Not Use	Potential Problem	Use Instead
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Lack of leading zero (.X mg)	Decimal point is missed	Write "0.X mg"
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate"
MSO_4 and $MgSO_4$	Confused for one another	Write "magnesium sulfate"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)*	Decimal point is missed	Write "X mg"
U, u (unit)	Mistaken for "0" (zero), the number "4" (four), or "cc"	Write "unit"
Additional Abbreviations, Acronyms, and Symbols*		
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L"; confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted because of similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "mL" or "ml" or "milliliters" ("mL" is preferred)
µg	Mistaken for mg (milligrams) resulting in one-thousandfold overdose	Write "mcg" or "micrograms"

*For possible future inclusion in the Official "Do Not Use" List.
From The Joint Commission. The Joint Commission "Do Not Use" list, updated 2012. Retrieved from www.jointcommission.org/PatientSafety/DoNotUseList.
See "dnu_list.pdf" and "Facts about the Official Do Not Use List of Abbreviations." Cited in *Pharmacy Technician*. (2015). Retrieved from http://pharmacytechniciantoday.com/joint-commission-do-not-use-list/.

fetal heart rate and pattern, prolapsed umbilical cord, shoulder dystocia, and uterine hyperstimulation (Simpson et al.).

ETHICAL ISSUES IN PERINATAL NURSING AND WOMEN'S HEALTH CARE

Ethical concerns and debates have multiplied with the increased use of technology and scientific advances. For example, with reproductive technology pregnancy is now possible in women who thought they would never bear children, including some who are menopausal or

postmenopausal. Should scarce resources be devoted to achieving pregnancies in older women? Is giving birth to a child at an older age worth the risks involved? Should older parents be encouraged to conceive a baby when they may not live to see the child reach adulthood? Should a woman who is HIV positive have access to assisted reproduction services? Should third-party payers assume the costs of reproductive technology such as the use of induced ovulation and in vitro fertilization? With induced ovulation and in vitro fertilization, multiple pregnancies occur, and multifetal pregnancy reduction (selectively terminating one or more fetuses) may be considered. Questions about **informed consent** and allocation of resources must be addressed with innovations such as intrauterine fetal surgery, fetoscopy, therapeutic insemination, genetic engineering, stem cell research, surrogate childbearing, surgery for infertility, "test tube" babies, fetal research, and treatment of very low–birth weight (VLBW) babies. The introduction of long-acting contraceptives has created moral choices and policy dilemmas for health care providers and legislators (i.e., should some women [substance abusers, women with low incomes, or women who are HIV positive] be required to take the contraceptives?). With the potential benefits from fetal tissue transplantation, what research is ethical? What are the rights of the embryo? Should cloning of humans be permitted? Discussion and debate about these issues will continue for many years. Nurses and patients, together with scientists, physicians, attorneys, lawmakers, ethicists, and clergy, must be involved in the discussions.

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2

The Family, Culture, Spirituality, and Home Care

Shannon E. Perry

http://evolve.elsevier.com/Perry/maternal

The composition, structure, and function of the American family have changed dramatically in recent years, largely in response to economic, demographic, sociocultural, and technologic trends that influence family life and health. Despite current efforts to improve the overall health of the nation, there is widespread concern about family health and well-being as a reflection of individual, community, and national health status. Recent economic changes have further reduced the ability to access health care. In addition to facing significant barriers in accessing needed services, women and families are faced with the challenge of overcoming discrimination in health care practices. It is critical to consider racial and ethnic differences and sexual orientation when addressing the health status of women. American women with a minority racial or ethnic affiliation share poorer outcomes in a wide variety of conditions. Lesbian women may conceal sexual orientation for fear of discrimination. As cultural diversity increases and demographics change, nurses must become culturally competent in order to recognize and reduce or eliminate health disparities (Freund, 2012).

As perinatal health trends emerge, nurses are assuming greater roles in assessing family health status and providing care across the perinatal continuum. This continuum begins with family planning and continues with the following categories of care: preconception, prenatal, intrapartum, postpartum, newborn, and interconception (between pregnancies). Depending on the needs of the individual family unit, independent self-management, outpatient care, home care, low-risk hospitalization, or specialized intensive care may be appropriate at different points along this continuum.

THE FAMILY IN CULTURAL AND SPIRITUAL CONTEXT

The family and its cultural and spiritual context play an important role in defining the work of maternity nurses. Despite modern stresses and strains, the family forms a social network that acts as a potent support system for its members. Family health-seeking behavior and relationships with health care professionals are influenced by culturally related health beliefs and spiritual values. Ultimately, all of these factors have the power to affect maternal and child health outcomes. The current emphasis in working with families is on wellness and empowerment for families to achieve control over their lives. It is essential that nurses become culturally competent and cognizant of spirituality in its various meanings and interpretations in order to provide appropriate care.

DEFINING FAMILY

The **family** has traditionally been viewed as the primary unit of socialization. The family plays a pivotal role in health care, representing the primary target of health care delivery for maternal and newborn nurses. As one of society's most important institutions, the family represents a primary social group that influences and is influenced by other people and institutions. A variety of family configurations exist. Each of these is characterized by certain structural features.

FAMILY ORGANIZATION AND STRUCTURE

The *nuclear family* has long represented the traditional American family in which husband, wife, and their children (either biologic or adopted) live as an independent unit, sharing roles, responsibilities, and economic resources (Fig. 2.1). Today the number of families living in a nuclear family structure is steadily decreasing in response to societal changes. By race and Hispanic origin, this family structure is represented as follows (Lofquist, Lugaila, O'Connell, et al., 2012):

- Caucasian: 51.1%
- Hispanic: 50.1%
- African-American: 28.5%
- Asian: 59.7%
- American Indian and Alaska Native: 40.1%
- Native Hawaiian and Pacific Islander: 51.3%

Many nuclear families have other relatives living in the same household. These extended family members include grandparents, aunts, uncles, or other people related by blood. Members of extended families can also live in close proximity to the nuclear family. Due to societal changes, Internet access, and increased mobility, these families may also be a long-distance unit (Fig. 2.2). The *extended family* is becoming more common as American society ages. The extended family provides social, emotional, and financial support to one another. It is therefore important for nurses to recognize the desire for people of many cultures to include their family in making important decisions even if extended family members are not physically close. This has implications for privacy and sharing individual health information under the Health Insurance Portability and Accountability Act (HIPAA) rules.

Multigenerational families, consisting of three or more generations of relatives (grandparents, children, grandchildren) are becoming increasingly common. In 2015, they made up 5.9% of all households (US Census Bureau, 2015). This type of arrangement can create stress for some as children must care for their parents as well as their own children. Other types of multigenerational families consist of grandparents supporting children and grandchildren or as sole caregivers for the grandchildren.

No-biologic-parent families are those in which children live independently in foster or kinship care such as living with a grandparent. In 2012, an estimated 7 million children in the United States lived with grandparents (Ellis & Simmons, 2014). Of these grandparents, 2.7 million

FIG 2.1 Nuclear family. (Courtesy of Makeba Felton, Wake Forest, NC.)

FIG 2.2 Extended family. (Courtesy of Makeba Felton, Wake Forest, NC.)

are responsible for most of the basic needs (i.e., food, shelter, and clothing) of one or more grandchildren (US Census Bureau, 2011).

Married-blended families, those formed as a result of divorce and remarriage, consist of unrelated family members (stepparents, stepchildren, stepsiblings) who join to create a new household. These family groups frequently involve a biologic or adoptive parent whose spouse may or may not have adopted the child.

Cohabiting-parent families are those in which children live with two unmarried biologic parents or two adoptive parents. Hispanic children are almost twice as likely as African-American children to live in cohabiting-parent families and about four times as likely as Caucasian children to live in this kind of family arrangement (Lofquist et al., 2012).

Single-parent families comprise an unmarried biologic or adoptive parent who may or may not be living with other adults. The single-parent family may result from the loss of a spouse by death, divorce, separation, or desertion; from either an unplanned or planned pregnancy, including those achieved through reproductive technology; or from the adoption of a child by an unmarried woman or man. This family structure is continually on the rise. In 2012, 24% of children lived with only their mothers, 4% lived with only their fathers, and 4% lived with neither of their biologic parents (America's Children, 2013). The single-parent family tends to be vulnerable economically and socially, creating an unstable and deprived environment for the growth of children. This in turn affects health status, school achievement, and high-risk behaviors for these children (Scharte & Bolte, 2012). Some families become more stable with the absence of drugs, alcohol, and/or physical/emotional abuse.

Lesbian, gay, bisexual, transgender (LGBT) may live together with or without children. Usually formed by same-sex couples, they can also consist of single LGBT parents or multiple parenting figures. Children in LGBT families may be the offspring of previous heterosexual unions, conceived by one member of a lesbian couple through natural or therapeutic insemination, conceived by a gay couple using a surrogate, or adopted. Approximately 594,000 same-sex couple households lived in the United States in 2010, raising about 115,000 children younger than 18 years of age. When these children are combined with LGBT parents who are raising children, almost 2 million children are being raised by LGBT parents in the United States (Siegel & Perrin, 2013).

THE FAMILY IN SOCIETY

The social context for the family can be viewed in relation to social and demographic trends that define the population as a whole. Racial and ethnic diversity of the population has grown dramatically, necessitating consideration of such diversity in provision of health care. According to the 2010 census, approximately 36% of the population belongs to a racial or ethnic minority group (Centers for Disease Control and Prevention [CDC], 2016).

THEORETIC APPROACHES TO UNDERSTANDING FAMILIES

FAMILY NURSING

Family plays a pivotal role in health care, representing the primary target of health care delivery for maternal and newborn nurses. It is crucial that nurses assist families as they incorporate new additions into their family (see Nursing Care Plan). When treating the woman and family with respect and dignity, health care professionals listen to and honor perspectives and choices of the woman and family. They share information with families in ways that are positive, useful, timely, complete, and accurate. The family is supported in participating in the care and decision making at the level of their choice.

Families are viewed as part of the interprofessional health care team and as the unit of care. Because so many variables affect ways of relating, the nurse must be aware that family members may interact and communicate with each other in ways that are distinct from those of the nurse's own family of origin. Most families will hold some beliefs about health that are different from those of the nurse. Their beliefs can conflict with principles of health care management predominant in the Western health care system.

Family nursing interventions occur within nurse-family relationships through therapeutic conversation (Bell, 2013; Wright & Bell, 2009). This necessitates interacting with family members present during caregiving, asking about those who may be absent, and actively listening to words and noting expressions to facilitate understanding. To do this within time constraints, Wright and Leahey (1999, 2013) developed a format for a brief therapeutic interview (Table 2.1).

FAMILY THEORIES

A **family theory** can be used to describe families and how the family unit responds to events both within and outside the family. Each family theory makes certain assumptions about the family and has inherent

NURSING CARE PLAN

Incorporating the Infant Into the Family

Case Study

Corita, who is Mexican-American and 23 years of age, gave birth to her first baby at term, a healthy male infant weighing 3600 grams. Her husband, Juan, also Mexican-American, was present at the birth and is very excited to have a son whom he named Jesus. Soon after birth, the infant latched readily and sucked strongly for 5 minutes before falling asleep. The nurse assisted Juan to hold Jesus in an appropriate position. Juan asked several questions of the nurse: how often should Jesus be fed, what are the red spots on the back of his neck, why is he bundled so tightly in his blanket.

Assessment

What are signs that Corita and Juan have prepared for incorporating the baby into the family?

Defining Characteristics

Corita demonstrates appropriate baby feeding techniques and Juan demonstrates basic baby care techniques
The couple provide safe a environment for the baby
Corita and Juan use support systems appropriately

Nursing Diagnosis

Readiness for Enhanced Childbearing Process

Expected Outcomes

Corita and Juan will convey confidence in their knowledge of newborn care.
Corita and Juan will demonstrate attachment behaviors toward Jesus.
Jesus' physical, nutritional, and social needs will be met.

Nursing Interventions	Rationales
Assess baseline knowledge of newborn care.	To identify knowledge deficits
Provide written literature on newborn care.	To allow time to understand new information
Teach Corita and Juan newborn care.	Demonstrating proper care improves confidence and reduces anxiety

Case Study (Continued)

Corita and Jesus were discharged 2 days after his birth. Corita's lochia was diminishing, her perineum was healing, she was breastfeeding successfully, and both Corita and Juan were comfortable holding Jesus and changing diapers. Corita's mother is planning to stay with them to cook and help as needed for 1 week. Corita and Juan welcome her input about caring for Jesus and interpreting his behavioral cues.

Assessment

What are the signs of enhanced parenting?

Defining Characteristics

Willingness of Juan and Corita to enhance parenting
Bonding and attachment
Fulfillment of emotional and physical needs of Jesus
Realistic expectations of Jesus

Nursing Diagnosis

Readiness for Enhanced Parenting

Expected Outcomes

Corita and Juan express satisfaction in role of parent
Corita and Juan will express confidence in their ability to parent
Baby care routines are adequate
Family will enjoy spending time together

Nursing Interventions	Rationales
Discuss with Corita and Juan their perceptions and philosophy of parenting.	To provide an opportunity to clarify the parent's perceptions
Support Corita and Juan as they adapt to the changing family needs.	Recogning and appreciating the efforts of Corita and Juan enhances their motivation to continue to improve
Explore Juan's and Corita's value system and their spiritual beliefs and practices	Values and spirituality provide a basis for moral and ethical reasoning and enhance the meaning of life

Case Study (Continued)

Corita and Juan have increasing confidence in their infant caregiving skills, and breastfeeding is going well. Jesus is gaining weight and sleeping several hours at a time. Juan is ready to resume their sexual relationship, while Corita is somewhat hesitant, fearing that penile penetration will be painful.

Assessment

What was their usual pattern of sexual relations prior and during pregnancy? Does Corita still have lochia? How comfortable are Corita and Juan discussing their sexual relations?

Defining Characteristics

Demonstrate mutual respect between partners
Demonstrate understanding of partner's hesitance in resuming sexual relations
Understand physiologic changes due to pregnancy and childbirth
Express desire to enhance communication between partners

Nursing Diagnosis

Readiness for Enhanced Relationship

Expected Outcomes

Corita and Juan will communicate effectively.
Corita will articulate ways to mutually meet physical and emotional needs of herself and Juan.
Corita and Juan will understand the changes in sexuality related to pregnancy and childbirth.
Corita and Juan will express satisfaction with sharing of information and ideas between partners.
Corita and Juan's sexual relationship will resume when both partners are ready.

Nursing Interventions	Rationales
Assess communication techniques and effectiveness of couple and family.	To be able to counsel and/or refer appropriately as needed
Encourage Corita and Juan to share information and ideas.	To enhance communication
Teach Corita and Juan normal changes in sexuality due to pregnancy and postpartum status.	So they can better understand what is normal and resume sexual relations when they are both comfortable
Refer as needed to colleagues in other disciplines.	To facilitate enhanced communication

TABLE 2.1 Key Ingredients of a 15-Minute (or Shorter) Family Interview

Ingredient	Exemplars
Manners	Introduce yourself to patients and families, preferably by your full name (i.e., Ms., Mrs., Mr. Jones). Make eye contact with all members of the family. Inquire about relationship of persons with the patient. Always call your patients by name.
Therapeutic Conversations	Interview is purposeful and time-limited Provide opportunity for patient and family to be acknowledged. Involve patients in information giving and decision making. Routinely invite families to accompany the patient to the unit/clinic. Invite families to ask questions during patient orientation. Routinely consult families and patients about their ideas for treatment and discharge.
Family Genograms and Ecomaps	Draw a quick genogram (and if indicated, an ecomap) for all families (see Figs. 2.4 and 2.5). Acknowledge that illness is a family affair. Include essential information such as ages, occupation, school grade, religion, ethnic background, and current health status of all family members.
Therapeutic Questions	Think of at least three questions to routinely ask all families. Basic themes include sharing of information, expectations of hospitalization, clinic, or home care visit, challenges, sufferings, and most pressing concerns/problems.
Commending Family and Individual Strengths	Offer at least two commendations to family on strengths, resources, or competencies that were observed or reported to the nurse. These are observations of behavior patterns rather than one-time occurrences. Evaluate usefulness of the interview and conclude.

From Wright, L. M., & Leahey, M. (1999). Maximizing time, minimizing suffering: The 15-minute (or less) family interview. *Journal of Family Nursing, 5*(3), 259-273.

BOX 2.1 Calgary Family Assessment Model

There are three major categories of the Calgary Family Assessment Model (CFAM)—structural, developmental, and functional. Each category has several subcategories. In this box, only the major categories are included. A few sample questions are included.

Structural Assessment

- Determine the members of the family, relationship among family members, and context of family.
- Genograms and ecomaps (see Figs. 2.4; 2.5) are useful in outlining the internal and external structures of a family.

Sample Questions

- Who are the members of your family?
- Has anyone moved in or out lately?
- Are there any family members who do not live with you?

Developmental Assessment

- Describe the life cycle—that is, the typical trajectory most families experience.

Sample Questions

- When you think back, what do you most enjoy about your life?
- What do you regret about your life?
- Have you made plans for your care as your health declines?

Functional Assessment

- Evaluate the way in which individuals behave in relation to each other in instrumental and expressive aspects. (Instrumental aspects are activities of daily living; expressive aspects include communication, problem solving, roles, etc.)

Sample Questions

- Who in the family is responsible for making sure Grandma takes her medicine?
- Whose turn is it to make dinner for Grandma?
- How can we get Martin to help with Grandma's care?

Data from Wright, L. M., & Leahy, M. (2013). *Nurses and families: A guide to family assessment and intervention* (6th ed.). Philadelphia, PA: FA Davis.

strengths and limitations. Most nurses use a combination of theories in their work with families. For more in depth information about family theories, a textbook describing various family theories can be consulted. Use of a family theory can guide assessment and interventions for the family.

FAMILY ASSESSMENT

When selecting a **family assessment** framework, an appropriate model for a perinatal nurse is one that is a health-promotion rather than an illness-care model. The low-risk family can be assisted in promoting a healthy pregnancy, childbirth, and integration of the newborn into the family. The high-risk perinatal family has illness-care needs, and the nurse can help meet those needs while also promoting the health of the childbearing family.

A family assessment tool such as the Calgary Family Assessment Model (CFAM) (Box 2.1) can be used as a guide for assessing aspects of the family. Such an assessment is based on "the nurse's personal and professional life experiences, beliefs, and relationships with those being interviewed" (Wright & Leahy, 2013) and is not "the truth" about the family but, rather, one perspective at one point in time.

The CFAM comprises three major categories: structural, developmental, and functional. Several subcategories are within each category. The three assessment categories and the many subcategories can be conceptualized as a branching diagram (Fig. 2.3). These categories and subcategories can be used to guide the assessment that will provide data to help the nurse better understand the family and formulate a nursing care plan. The nurse asks questions of family members about themselves to gain understanding of the structure, development, and function of the family at this point in time. Not all questions within the subcategories should be asked at the first interview, and some questions may not be appropriate for all families. Although individuals are the ones interviewed, the focus of the assessment is on interaction of individuals within the family.

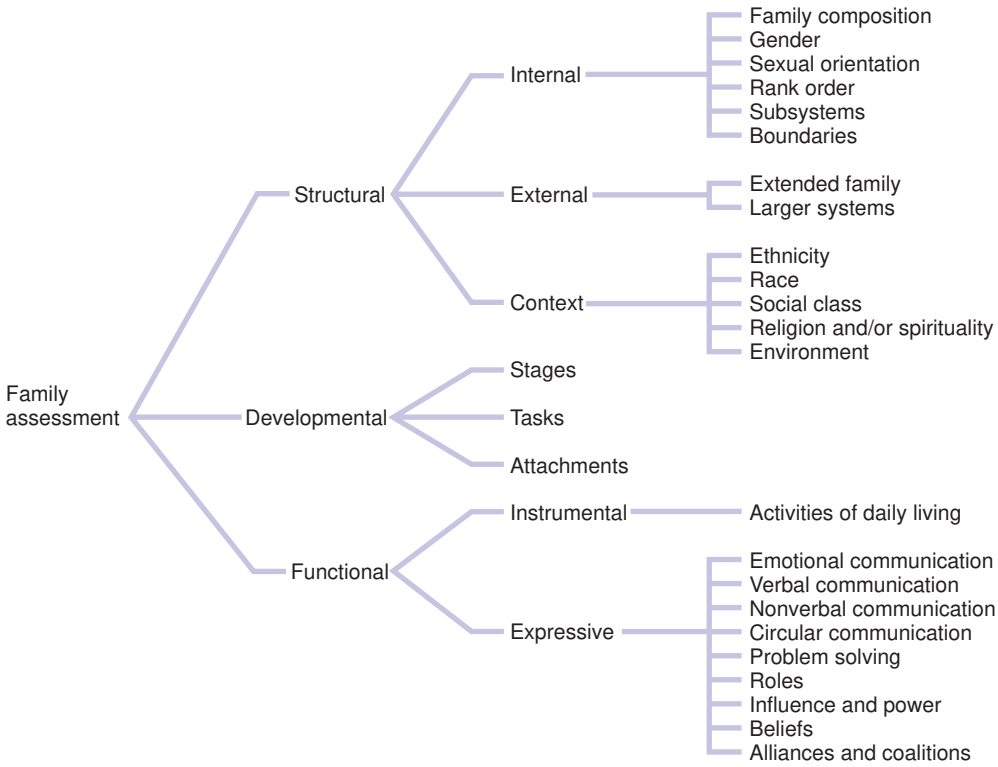

FIG 2.3 Branching diagram of Calgary Family Assessment Model (CFAM). (From Wright, L. M., & Leahy, M. [2013]. *Nurses and families: A guide to family assessment and intervention* (6th ed.) Philadelphia, PA: FA Davis.)

GRAPHIC REPRESENTATIONS OF FAMILIES

A family **genogram** (family tree format depicting relationships of family members over at least three generations) (Fig. 2.4) provides valuable information about a family and can be placed in the nursing care plan for easy access by care providers. An **ecomap**, a graphic portrayal of social relationships of the woman and family, may also help the nurse understand the social environment of the family and identify support systems available to them (Fig. 2.5). Software is available to generate genograms and ecomaps (www.interpersonaluniverse.net).

THE FAMILY IN A CULTURAL CONTEXT

CULTURAL FACTORS RELATED TO FAMILY HEALTH

The **culture** of an individual and a group is influenced by religion, environment, and historic events and plays a powerful role in the individual's and group's behaviors and patterns of human interaction. Culture is not static; it is an ongoing process that influences a woman throughout her entire life, from birth to death. Culture is an essential element of what defines us as people.

Cultural knowledge includes beliefs and values about each facet of life and is passed from one generation to the next. Cultural beliefs and traditions relate to food, language, religion, spirituality, art, health and healing practices, kinship relationships, and all other aspects of community, family, and individual life. Culture has also been shown to have a direct effect on health behaviors. Values, attitudes, and beliefs that are culturally acquired may influence perceptions of illness, as well as health care–seeking behavior and response to treatment. The political, social, and economic context of people's lives is also part of the cultural experience.

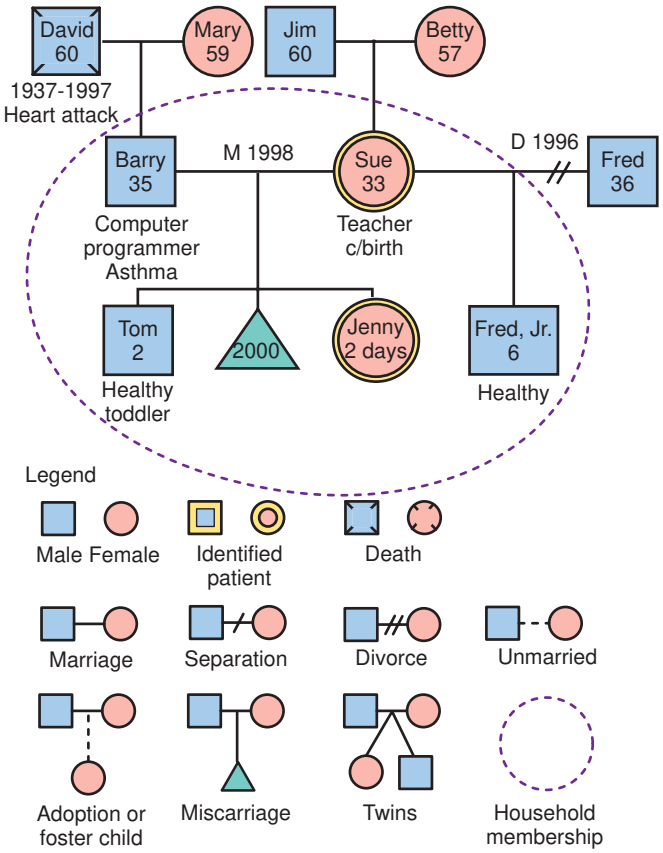

FIG 2.4 Example of a family genogram.

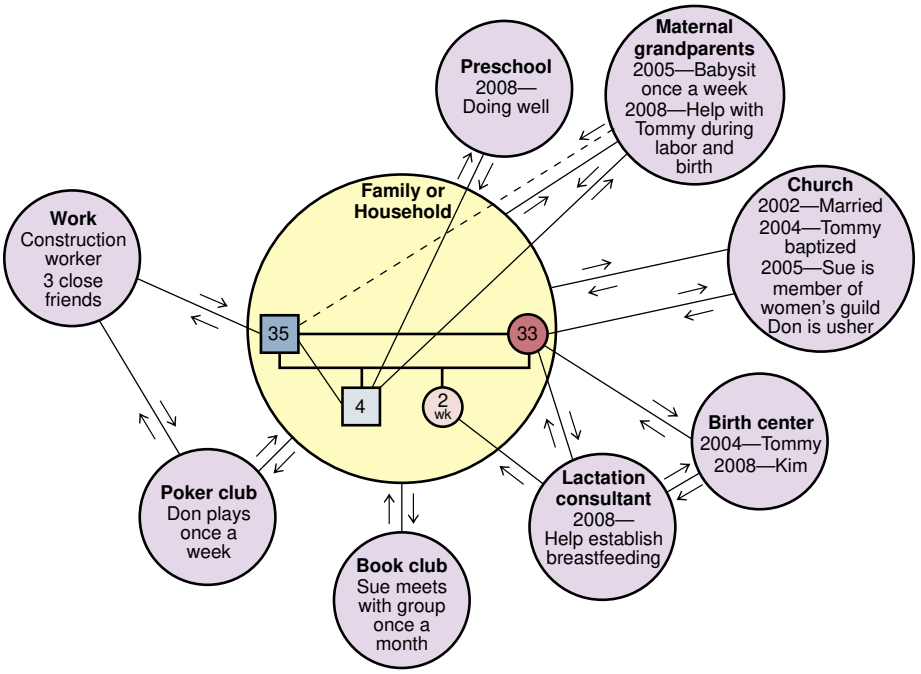

FIG 2.5 Example of an ecomap. An ecomap describes social relationships and depicts available supports.

Culture, shared beliefs, and values of a group play a powerful role in an individual's behavior, particularly when the individual is faced with health care issues. Understanding a culture can provide insight into how a person reacts to illness, pain, and invasive medical procedures, as well as patterns of human interaction and expressions of emotion. The effect of these influences must be assessed by health care professionals in providing health care and developing effective intervention strategies.

Many subcultures are found within each culture. **Subculture** refers to a group existing within a larger cultural system that retains its own characteristics. A subculture may be an ethnic group or a group organized in other ways. For example, in the United States and Canada, many ethnic subcultures such as African-Americans, Asian-Americans, Hispanic-Americans, and Native Americans exist. It is important to note that subcultures also exist within these groups. Because every identified cultural group has subcultures and because it is impossible to study every subculture in depth, greater differences may exist among and between groups than is generally acknowledged. It is important to be familiar with common cultural practices within these subgroups. However, it is also important to avoid the generalization that every person practices every cultural belief within a group because this could lead to stereotyping and misunderstanding of the nuances of various cultural groups.

In a multicultural society, many groups can influence traditions and practices. As cultural groups come into contact with each other, acculturation and assimilation may occur.

Acculturation refers to the changes that occur within one group or among several groups when people from different cultures come into contact with one another. People may retain some of their own culture while adopting some cultural practices of the dominant society. This familiarization among cultural groups results in overt behavioral similarity, especially in mannerisms, styles, and practices. Dress, language patterns, food choices, and health practices are often much slower to adapt to the influence of acculturation. In the United States, second-generation Americans consider themselves to be fully American (Pew Research Center, 2013).

During times of family transitions such as childbearing or during crisis or illness, a woman may rely on old cultural patterns even after she has become acculturated in many ways. This is consistent with the family developmental theory that states that during times of stress, people revert to practices and behaviors that are most comfortable and familiar (Carter & McGoldrick, 1999).

Assimilation occurs when a cultural group loses its cultural identity and becomes part of the dominant culture. Assimilation is the process by which groups "melt" into the mainstream, thus accounting for the notion of a "melting pot," a phenomenon that has been said to occur in the United States. This is illustrated by individuals who identify themselves as being of Irish or German descent without having any remaining cultural practices or values linked specifically to that culture such as food preparation techniques, style of dress, or proficiency in the language associated with their reported cultural heritage. Spector (2013) asserts that in the United States, the melting pot, with its dream of a common culture, is a myth. Instead, a mosaic phenomenon exists in which we must accept and appreciate the differences among people.

IMPLICATIONS FOR NURSING

As our society becomes more culturally diverse, it is essential that nurses become culturally competent. Nurses must examine their own beliefs so that they have a better appreciation and understanding of the beliefs of their patients. To promote culturally congruent practice, a new standard has been added to *Nursing: Scope and Standards of Practice,* 3rd edition (American Nurses Association, 2015b). Standard 8 directs nurses to practice "in a manner that is congruent with cultural diversity and inclusion principles" (Cipriano, 2016, p. 15). Understanding the concepts of ethnocentrism and cultural relativism may help nurses care for families in a multicultural society.

Ethnocentrism is the view that one's own way of doing things is best (Giger, 2013). Although the United States is a culturally diverse nation, the prevailing practice of health care is based on the beliefs and practices held by members of the dominant culture, primarily Caucasians

of European descent. This practice is based on the biomedical model that focuses on curing disease states.

Pregnancy and childbirth in this biomedical perspective are viewed as processes with inherent risks that are most appropriately managed by using scientific knowledge and advanced technology. The medical perspective stands in direct contrast to the belief systems of many cultures. Among many women, birth is viewed as a completely normal process that can be managed with a minimum of involvement from health care practitioners. When encountering behavior in women unfamiliar with the biomedical model or those who reject it, the nurse may become frustrated and impatient and may label the women's behavior as inappropriate and believe that it conflicts with "good" health practices. If the Western health care system provides the nurse's only standard for judgment, the behavior of the nurse is ethnocentric.

Cultural relativism is the opposite of ethnocentrism. It refers to learning about and applying the standards of another's culture to activities within that culture. The nurse recognizes that people from different cultural backgrounds comprehend the same objects and situations differently. In other words, culture determines viewpoint. Cultural relativism does not require nurses to accept the beliefs and values of another culture. Instead, nurses recognize that the behavior of others can be based on a system of logic different from their own. Cultural relativism affirms the uniqueness and value of every culture.

CHILDBEARING BELIEFS AND PRACTICES

Nurses working with childbearing families care for families from many different cultures and ethnic groups. To provide culturally competent care, the nurse must assess the beliefs and practices of patients. When working with childbearing families, a nurse considers all aspects of culture including communication, space, time orientation, and family roles.

Communication often creates the most challenging obstacle for nurses working with patients from diverse cultural groups. Communication is not merely the exchange of words. Instead, it involves (1) understanding the individual's language, including subtle variations in meaning and distinctive dialects; (2) appreciating individual differences in interpersonal style; and (3) accurately interpreting the volume of speech as well as the meanings of touch and gestures. For example, members of some cultural groups tend to speak loudly when they are excited, with great emotion and with vigorous and animated gestures; this is true whether their excitement is related to positive or negative events or emotions. It is important, therefore, for the nurse to avoid rushing to judgment regarding a person's intent when he or she is speaking, especially in a language not understood by the nurse. Instead, the nurse should withhold an interpretation of what has been expressed until it is possible to clarify the patient's intent. The nurse needs to enlist the assistance of a person who can help verify with the patient the true intent and meaning of the communication (see Clinical Reasoning Case Study).

Inconsistencies between the language of patients and the language of providers present a significant barrier to effective health care. For example, there are many dialects of Spanish that vary by geographic location. Because of the diversity of cultures and languages within the US and Canadian populations, health care agencies are increasingly seeking the services of **interpreters** (of oral communication from one language to another) or **translators** (of written words from one language to another) to bridge these gaps and fulfill their obligation for culturally and linguistically appropriate health care (Box 2.2). Finding the best possible interpreter in the circumstance is critically important as well. Ideally, interpreters should have the same native language and be of the same religion or have the same country of origin as the patient.

CLINICAL REASONING CASE STUDY

Providing Culturally Appropriate Care

Elisabeth, a 22-year-old first-generation Mexican-American, comes into your office for her initial prenatal visit. You are concerned because Elisabeth's fundal height is consistent with 32 weeks of gestation and this is her first prenatal visit. Elisabeth, who lives with her husband, four children (ages 6, 4, 3 years, and 15 months), her mother, her aunt, and her uncle, states that she has been doing well this pregnancy and did not start prenatal care in her previous pregnancies until she was almost ready to give birth. She also comments that all the babies were full term with uneventful labors and births. In obtaining the history, you note the presence of a safety pin in Elisabeth's shirt and wonder what this is for. You want to provide culturally appropriate care to this woman and her family.

1. Evidence—Is there sufficient evidence to support the components of culturally appropriate care for Elisabeth?
2. Assumptions—Describe an underlying assumption about culturally appropriate care for Elisabeth in relation to these topics:
   a. The view of pregnancy in Elisabeth's culture
   b. The role of family in Elisabeth's culture
   c. The acceptability for women of Elisabeth's age to begin having children at such young ages
   d. The religious or spiritual beliefs that Elisabeth may have that affect contraception
3. What implications and priorities for nursing care can be made at this time?
4. Does the evidence objectively support your conclusion?

Interpreters should have specific health-related language skills and experience and help bridge the language and cultural barriers between the patient and the health care provider. The person interpreting also should be mature enough to be trusted with private information. However, because the nature of nursing care is not always predictable and because nursing care that is provided in a home or community setting does not always allow expert, experienced, or mature adult interpreters, ideal interpretive services sometimes are impossible to find when they are needed. In crisis or emergency situations or when family members are having extreme stress or emotional upset, it may be necessary to use relatives, neighbors, or children as interpreters. If this situation occurs, the nurse must ensure that the patient is in agreement and comfortable with using the available interpreter to assist. Having a man or a child interpret for a woman can create embarrassment and interfere with obtaining an accurate history or detail of symptoms.

When using an interpreter, the nurse respects the family by creating an atmosphere of respect and privacy. Questions should be addressed to the woman and not to the interpreter. Even though an interpreter will of necessity be exposed to sensitive and privileged information about the family, the nurse should take care to ensure that confidentiality is maintained. A quiet location free from interruptions is ideal for interpretive services to take place. Culturally and linguistically appropriate educational materials that are easy to read, with appropriate text and graphics, should be available to assist the woman and her family in understanding health care information. To ensure understanding and avoid liability issues, it is important to make certain that the material has been translated by someone who is trained appropriately.

PERSONAL SPACE

Cultural traditions define the appropriate **personal space** for various social interactions. Although the need for personal space varies from person to person and with the situation, the actual physical dimensions of comfort zones differ from culture to culture. Actions such as touching,

BOX 2.2 Working With an Interpreter

Step 1: Before the Interview

- Outline your statements and questions. List the key pieces of information you want/need to know.
- Learn something about the culture so that you can converse informally with the interpreter.

Step 2: Meeting with the Interpreter

- Introduce yourself to the interpreter and converse informally. This is the time to find out how well he or she speaks English. No matter how proficient or what age the interpreter is, be respectful. Some ways to show respect are to ask a cultural question to acknowledge that you can learn from the interpreter, or you could learn one word or phrase from the interpreter.
- Emphasize that you do want the patient to ask questions, because some cultures consider this inappropriate behavior.
- Make sure the interpreter is comfortable with the technical terms you need to use. If not, take some time to explain them.

Step 3: During the Interview

- Ask your questions and explain your statements (see Step 1).
- Make sure that the interpreter understands which parts of the interview are most important. You usually have limited time with the interpreter, and you want to have adequate time at the end for patient questions.
- Try to get a "feel" for how much is "getting through." No matter what the language is, if in relating information to the patient, the interpreter uses far fewer or far more words than you do, something else is going on.
- Stop now and then and ask the interpreter, "How is it going?" You may not get a totally accurate answer, but you will have emphasized to the interpreter your strong desire to focus on the task at hand. If there are language problems, (1) speak slowly; (2) use gestures (e.g., fingers to count or point to body parts); and (3) use pictures.
- Ask the interpreter to elicit questions. This may be difficult, but it is worth the effort.
- Identify cultural issues that may conflict with your requests or instructions.
- Use the interpreter to help problem solve or at least give insight into possibilities for solutions.

Step 4: After the Interview

- Speak to the interpreter and try to get an idea of what went well and what could be improved. This will help you be more effective in the future with this or another interpreter.
- Make notes on what you learned for your future reference or to help a colleague.

Remember

- Your interview is a *collaboration* between you and the interpreter. *Listen* as well as speak.

Notes

- The interpreter may be a child, grandchild, or sibling of the patient. Be sensitive to the fact that the child is playing an adult role.
- Be sensitive to cultural and situational differences (e.g., an interview with someone from urban Germany will likely be different from an interview with someone from a transitional refugee camp).
- Younger females telling older males what to do may be a problem for both a female nurse and a female interpreter. This is not the time to pioneer new gender relations. Be aware that in some cultures it is difficult for a woman to talk about some topics with a husband or a father present.

Courtesy of Elizabeth Whalley, PhD, San Francisco State University.

placing the woman in proximity to others, taking away personal possessions, and making decisions for the woman can decrease personal security and heighten anxiety. Conversely, respecting the need for distance allows the woman to maintain control over personal space and supports personal autonomy, thereby increasing her sense of security. Nurses must touch patients. However, they frequently do so without any awareness of the emotional distress they may be causing.

TIME ORIENTATION

Time orientation is a fundamental way in which culture affects health behaviors. People in cultural groups may be relatively more oriented to past, present, or future. Those who focus on the past strive to maintain tradition or the status quo and have little motivation for formulating goals. In contrast, individuals who focus primarily on the present neither plan for the future nor consider the experiences of the past. These individuals do not necessarily adhere to strict schedules and are often described as "living for the moment" or "marching to their own drummer." Individuals oriented to the future maintain a focus on achieving long-term goals.

The time orientation of the childbearing family may affect nursing care. For example, talking to a family about bringing the infant to the clinic for follow-up examinations (events in the future) may be difficult for the family who is focused on the present concerns of day-to-day survival. Because a family with a future-oriented sense of time plans far in advance, thinking about the long-term consequences of present actions, they may be more likely to return as scheduled for follow-up visits. Despite the differences in time orientation, each family can be equally concerned for the well-being of its newborn.

FAMILY ROLES

Family roles involve the expectations and behaviors associated with a member's position in the larger family system (e.g., mother, father, grandparent). Social class and cultural norms also affect these roles, with distinct expectations for men and women clearly determined by social norms. For example, culture may influence whether a man actively participates in pregnancy and childbirth, yet maternity care providers working in the Western health care system expect fathers to be involved. This can create a significant conflict between the nurse and the role expectations of very traditional Mexican or Arabic families, who usually view the birthing experience as a female affair (see Cultural Considerations box). The way that health care practitioners manage such a family's care molds its experience and perception of the Western health care system.

CULTURAL CONSIDERATIONS

Questions to Ask to Elicit Cultural Expectations About Childbearing

1. What do you and your family think you should do to remain healthy during pregnancy?
2. What can you do to improve your health and the health of your baby?
3. What foods will help make a healthy baby?
4. Who do you want with you during your labor?
5. What can your labor support person do to help you be most comfortable during labor?
6. What actions are important for you and your family after the baby's birth?
7. What do you and your family expect from the nurse(s) caring for you?
8. How will family members participate in your pregnancy, childbirth, and parenting?

In maternity nursing, the nurse supports and nurtures the beliefs that promote physical or emotional adaptation to childbearing. However, if certain beliefs might be harmful, the nurse should carefully explore them with the woman and use them in the reeducation and modification process. Table 2.2 provides examples of some cultural beliefs and practices surrounding childbearing. The cultural beliefs and customs in the table are categorized on the basis of distinct cultural traditions and are not practiced by all members of the cultural group in every part of the country. Women from these cultural and ethnic groups may adhere to a few, all, or none of the practices listed. In using this table as a guide, the nurse should take care to avoid making stereotypic assumptions about any person based on sociocultural-spiritual affiliations. Nurses should exercise sensitivity in working with every family, being careful to assess the ways in which they apply their own mixture of cultural traditions.

TABLE 2.2 Traditional Cultural Beliefs and Practices: Childbearing and Parenting

Note: Most of these cultural beliefs and customs reflect the traditional culture and are not universally practiced. These lists are not intended to stereotype patients but, rather, to serve as guidelines while discussing meaningful cultural beliefs with a woman and her family. Examples of other cultural beliefs and practices are found throughout this text.
Variations in some beliefs and practices exist within subcultures of each group.

Hispanic-American

(Based primarily on knowledge of Mexican-Americans; members of the Hispanic community have their origins in Spain, Cuba, Central and South America, Mexico, Puerto Rico, and other Spanish-speaking countries.)

Pregnancy

- Pregnancy desired soon after marriage
- Late prenatal care
- Expectant mother influenced strongly by mother or mother-in-law
- Cool air in motion considered dangerous during pregnancy
- Unsatisfied food cravings thought to cause a birthmark
- Some pica observed in the eating of ashes or dirt (not common)
- Milk avoided because it causes large babies and difficult births
- Many predictions about sex of baby
- May be unacceptable and frightening to have pelvic examination by male health care provider
- Use of herbs to treat common complaints of pregnancy
- Drinking chamomile tea thought to ensure effective labor
- May wear ribbon or band around pregnant belly in belief that baby will be born healthy
- Need a balance of hot and cold

Labor

- Use of *partera* or lay midwife preferred in some places; expectant mother may prefer presence of mother rather than husband
- After birth of baby, mother's legs brought together to prevent air from entering uterus

Postpartum

- Diet may be restricted after birth; for first 2 days only boiled milk and toasted tortillas permitted (special foods to restore warmth to body)
- Avoid cold foods
- Bed rest for 3 days after birth
- Mother's head and feet protected from cold air; bathing permitted after 14 days
- Mother often cared for by her own mother
- Forty-day restriction on sexual intercourse
- Mother may want baby's first wet diaper to wipe her face in belief that it aids in making "mask of pregnancy" go away

Newborn

- Breastfeeding begun after third day; colostrum may be considered "filthy" or "spoiled" or just not enough nourishment
- Need a balance of heat and cold to promote milk flow
- Olive oil or castor oil given to stimulate passage of meconium
- Male infant not circumcised
- Female infant's ears pierced
- Belly band used to prevent umbilical hernia
- Religious medal worn by mother during pregnancy; placed around infant's neck
- Infant protected from *mal de ojo* ("evil eye")
- Various remedies used to treat *mal de ojo* and fallen fontanel (depressed fontanel)

African-American

(Members of the African-American community, many of whom are descendants of slaves, have different origins. Today a number of black Americans have emigrated from Africa, the West Indies, the Dominican Republic, Haiti, and Jamaica.)

Pregnancy

- Acceptance of pregnancy depends on economic status
- Pregnancy thought to be state of "wellness," which is often the reason for delay in seeking prenatal care, especially by lower-income African-Americans
- Old wives' tales include beliefs that having a picture taken during pregnancy will cause stillbirth and reaching up will cause cord to strangle baby
- Pregnancy may be viewed by African-American men as a sign of their virility
- Self-treatment for various discomforts of pregnancy, including constipation, nausea, vomiting, headache, and heartburn

Labor

- Use of "Granny midwife" in certain parts of United States
- Varied emotional responses: some cry out, some display stoic behavior to avoid calling attention to selves
- Woman may arrive at hospital in far-advanced labor
- Emotional support often provided by other women, especially the woman's own mother

Postpartum

- Vaginal bleeding seen as sign of sickness; tub baths and shampooing of hair prohibited
- Sassafras tea thought to have healing power
- Eating liver thought to cause heavier vaginal bleeding because of its high "blood" content

Newborn

- Feeding very important:
  - "Good" baby thought to eat well
  - Early introduction of solid foods
  - May breastfeed or bottle-feed; breastfeeding may be considered embarrassing
- Parents fearful of spoiling baby
- Commonly call baby by nicknames
- May use excessive clothing to keep baby warm
- Belly band used to prevent umbilical hernia
- Abundant use of oil on baby's scalp and skin
- Strong feeling of family, community, and religion
- African-American minister and church important in recovery

Continued

TABLE 2.2 Traditional Cultural Beliefs and Practices: Childbearing and Parenting—cont'd

Pregnancy	Childbirth	Parenting

Asian-American

(Typically refers to groups from China, Korea, the Philippines, Japan, Southeast Asia [particularly Thailand], Indochina, and Vietnam.)

Pregnancy

- Pregnancy considered time when mother "has happiness in her body"
- Pregnancy seen as natural process
- Strong preference for female health care provider
- Belief in theory of hot and cold
- Prefer soup made with ginseng root as general strength tonic
- Milk usually excluded from diet because it causes stomach distress
- Inactivity or sleeping late may cause difficult birth
- Korean women practice Tae-kyo (think about good things and maintain a calm attitude)
- Many diagnostic tests such as amniocentesis, ultrasonography, or drawing blood considered unnecessary and dangerous
- Sexual intercourse in last 2 months of pregnancy may be restricted

Labor

- Mother attended by other women, especially her own mother
- Father does not actively participate
- May moan or grunt
- Cesarean birth not desired

Postpartum

- Must protect self from *yin* (cold forces) for 30 days
- Ambulation limited
- Shower and bathing prohibited for about 10 days
- Warm room
- Diet:
  - Warm fluids
  - Some women are vegetarians
  - Korean mother served seaweed soup with rice
  - Chinese diet high in hot foods
  - Chinese mother avoids fruits and vegetables

Newborn

- Concept of family important and valued
- Father is head of household; wife plays a subordinate role
- Birth of boy preferred
- May delay naming child
- Some groups (e.g., Vietnamese) believe colostrum is dirty; therefore they may delay breastfeeding until milk comes in
- Traditionally Filipino babies are not circumcised at birth

European-American

(Members of the European-American [Caucasian] community have their origins in countries such as Ireland, Great Britain, Germany, Italy, and France.)

Pregnancy

- Pregnancy viewed as a condition that requires medical attention to ensure health
- Emphasis on early prenatal care
- Variety of childbirth education programs available, and participation encouraged
- Technology driven
- Emphasis on nutritional science
- Involvement of the father valued
- Written sources of information valued

Labor

- Birth is a public concern
- Technology dominated
- Birthing process in institutional setting valued
- Involvement of father expected
- Physician seen as head of team

Postpartum

- Emphasis or focus on early bonding
- Medical interventions for dealing with discomfort
- Early ambulation and activity emphasized
- Self-management valued

Newborn

- More women breastfeeding
- Breastfeeding begins as soon as possible after childbirth

Parenting

- Motherhood and transition to parenting seen as stressful time
- Nuclear family valued, although single parenting and other forms of parenting more acceptable than in the past
- Women often deal with multiple roles
- Early return to prenatal activities

Native American

(Many different tribes exist within the Native-American culture; viewpoints vary according to tribal customs and beliefs.)

Pregnancy

- Pregnancy considered a normal, natural process
- Late prenatal care
- Avoid heavy lifting
- Herb teas encouraged

Labor

- Prefers female attendant, although husband, mother, or father may assist with birth
- Birth may be attended by whole family
- Herbs may be used to promote uterine activity
- Birth may occur in squatting position

Postpartum

- Herbal teas to stop bleeding

Newborn

- Infant not fed colostrum
- Use of herbs to increase flow of milk
- Use of cradle boards for infant
- Babies not handled often

Data from Amaro, H. (1994). Women in the Mexican-American community: religion, culture, and reproductive attitudes and experiences, *Journal of Comparative Psychology 16*(1):6–19; D'Avanzo, C. (2008). *Mosby's pocket guide to cultural health assessment* (4th ed.). St. Louis, MO: Mosby; Giger, J. N. (2013). *Transcultural nursing: Assessment and intervention* (6th ed.). St. Louis, MO: Mosby; Mattson, S. (1995). Culturally sensitive prenatal care for Southeastern Asians, *Journal of Obstetric, Gynecologic, and Neonatal Nursing 24*(4):335–341; Spector, R. (2013). *Cultural diversity in health and illness* (8th ed.). Upper Saddle River, NJ: Prentice-Hall

DEVELOPING CULTURAL COMPETENCE

Cultural competence has many names and definitions, all of which have subtle shades of difference but which are essentially the same: multiculturalism, cultural sensitivity, and intercultural effectiveness. Cultural competence involves acknowledging, respecting, and appreciating ethnic, cultural, and linguistic diversity. Culturally competent professionals act in ways that meet the needs of the patient and are respectful of ways and traditions that may be very different from their own. In today's society, it is critically important that nurses develop more than technical skills. At every level of preparation and throughout their professional lives, nurses must engage in a continual process of developing and refining attitudes and behaviors that will promote culturally competent care (Giger, 2013).

Key components of culturally competent care include the following:

- Recognizing that differences exist between one's own culture and that of the patient
- Educating and promoting healthy behaviors in a cultural context that has meaning for patients
- Taking abstract knowledge about other cultures and applying it in a practical way so that the quality of service improves and policies are enacted that meet the needs of all patients
- Communicating respect for a wide range of differences, including patient use of nontraditional healing practices and alternative therapies
- Recognizing the importance of culturally different communication styles, problem-solving techniques, concepts of space and time, and desires to be involved with care decisions
- Anticipating the need to address varying degrees of language ability and literacy, as well as barriers to care and compliance with treatment

In addition to issues of preserving and promoting human dignity, the development of cultural competence is of equal importance in terms of health outcomes. Nurses who relate effectively with patients are able to motivate them in the direction of health-promoting behaviors. Provider competence to address language barriers facilitates appropriate tailoring of health messages and preventive health teaching. Cross-cultural experiences also present an opportunity for the health care professional to expand cultural sensitivity, awareness, and skills (Fig. 2.6).

FIG 2.6 Nurse volunteering in a day care center in Ecuador. (Courtesy of CoraLee Thompson, RN, BA, CNP [ret].)

SPIRITUALITY AND THE FAMILY

Spirituality is an aspect of humans that is above and beyond the mind and body. It "speaks to what gives ultimate meaning and purpose to one's life. It is that part of people that seeks healing and reconciliation with self or others" (Puchalski, 2006). Spirituality is important in all phases of life; it relates to deep and important things and will affect how patients face health issues (Giske & Cone, 2015). While religion is a more organized or rule-driven form of spirituality, one can be spiritual without being a member of an organized religion.

Many studies of religion and health suggest that religious people are healthier and generally live longer than nonreligious people. Those who attend church once a week are less likely to become ill than those who do not. The studies did not control for rates of smoking and alcohol use, so no inference can be made as to whether the improved health status was from better habits or religion. In general, it is known that religious people do tend to have healthier lifestyles overall than people who are not religious (Condon, 2004). Spiritual wellness can be estimated by answering questions such as those suggested in Box 2.3

Spirituality is a component of holistic nursing and thus a professional responsibility. The International Council of Nurses Code of Ethics for Nurses (2012) states that: "In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family, and community are respected" (p. 2). The American Nurses Association Code of Ethics for Nurses With Interpretive Statements states that: "Factors such as culture, value systems, religious or spiritual beliefs, lifestyle, social support system, sexual orientation or gender expression and primary language are to be considered when planning individual, family and population-centered care" (American Nurses Association, 2015, p. 1). NANDA-I includes two nursing diagnoses

BOX 2.3 Spiritual Wellness Self-Assessment

1. How do you describe your purpose in life?
2. What activities do you do regularly that bring you joy?
3. What goals do you have for 6 months from now?
4. What goals do you have for 2 years from now?
5. What activities make you feel nourished?
6. What kinds of things do you do for yourself every day?
7. What do you hope for in the future?
8. Are there people to whom you can reach out?
9. On whom can you count for encouragement and/or support?
10. Are there others to whom you give encouragement and/or support?
11. Who loves you?
12. Whom do you love or care about?
13. In what areas are you growing?
14. How do you go about forgiving yourself?
15. How do you go about forgiving others?
16. To whom do you confide your hopes, dreams, and pain?
17. Do you believe in some kind of higher power?
18. What do you hope for in the future?
19. When do you reach out to people?
20. Do you look forward to getting up in the morning?
21. Would you like to live to be 100?

The more questions you answer in the positive, the higher the level of spiritual wellness.

Adapted from Condon, M. (2004). *Women's health: Body, mind, spirit: An integrated approach to wellness and illness.* Upper Saddle River, NJ: Prentice-Hall.

related to spirituality: Readiness for Enhanced Spiritual Well-Being and Spiritual Distress (Ackley, Ladwig, & Makic, 2017).

Spirituality is a component of basic professional nursing education; graduates are to include spirituality in assessments and provide spiritually and culturally appropriate health promotion (American Association of Colleges of Nursing, 2008). The Joint Commission (2016) includes among patient rights the right to religious and other spiritual services; religion, spiritual beliefs, values, and preferences are to be taken into account in the provision of care. Thus, many health care and nursing organizations and associations recognize the importance of spiritual care and incorporate the provision of such care into their standards.

Spiritual care encompasses those "interventions, individual or communal, that facilitate the ability to experience the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and a higher power" (American Nurses Association and Health Ministries Association, 2005, p. 38). Spirituality is of relevance for all of nursing, not just for those in palliative care or for dying patients (Giske & Cone, 2015).

Religious preference is usually included with demographic information on initial contact with health care organizations. Hospital chaplains and other clergy use the information to arrange visits with parishioners or others who desire their services. Nurses can use the information to pose questions about preferences or requests for prayers, blessings, counseling, or visits from clergy. Taylor (2012) provided a guide for nurses by describing a number of religions and the rituals and relation to health important to those denominations.

Baptisms, b'nai mitzvah, salat, anointings, blessings, communion services, sacrament of the sick, and other religious observances and practices may occur. Memorial services may be held in the hospital chapel or prayer room. Occasionally weddings are performed within a hospital. Nurses may be requested to provide the space and opportunity for such events to occur. At times they may be invited or requested to participate. Depending on preferences, the nurse may choose to remain for the service or decline respectfully. The nurse need not be of the same religion, or any religion, to provide support by his or her presence.

The Pause, which originated in an emergency room after the death of a patient, is a minute or two of taking time to acknowledge a lost human life, and is an example of the recognition of the individual in this sad time as well as giving support to those health care providers who worked to save the life (Bartels, 2014). After a death, the staff are asked to remain and bear witness, to be together and present in this time of grief and loss. The staff is able to be together and achieve some type of closure or resolution surrounding the unsuccessful efforts to resuscitate the individual. Use of the Pause is growing and winning advocates.

Spiritual Assessment

As part of patient assessments, questions related to spirituality and religion should be included. Questions can be directed to patients as well as the family. Examples of such questions are in Box 2.4.

The FICA Spiritual Assessment Tool (Box 2.5) is a short and simple guide for spiritual assessment. Small cards are available to assist health care professionals to guide assessments.

Brussat and Brussat (1996) described characteristics of the spiritually literate person as being present, having compassion, being connected, having hope, being kind and listening, having meaning and openness, and using silence. All of these are characteristics of a nurse who is interested in providing spiritual care.

To provide spiritual care, the nurse must understand the meaning of spirituality to the person for whom care is provided (Gordon, Kelly, & Mitchell, 2011). The nurse must listen attentively to learn what is

BOX 2.4 Spiritual Assessment Questions

- Who or what provides the patient with strength and hope?
- Does the patient use prayer in his or her life?
- How does the patient express his or her spirituality?
- How would the patient describe his or her philosophy of life?
- What type of spiritual/religious support does the patient desire?
- What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?
- What does suffering mean to the patient?
- What does dying mean to the patient?
- What are the patient's spiritual goals?
- Is there a role of church/synagogue in the patient's life?
- How does faith help the patient cope with illness?
- How does the patient keep going day after day?
- What helps the patient get through this health care experience?
- How has illness affected the patient and his or her family?

Adapted from The Joint Commission, *Standards FAQ details, medical record—Spiritual assessment*. Retrieved from https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=765&StandardsFAQChapterId=29&ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=spiritual.

BOX 2.5 FICA Spiritual Assessment Tool*

F - Faith and Belief

"Do you consider yourself spiritual or religious?" or "Is spirituality something important to you" or "Do you have spiritual beliefs that help you cope with stress/difficult times?" (Contextualize to reason for visit if it is not the routine history).

If the patient responds "No," the health care provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

(The question of meaning should also be asked even if people answer yes to spirituality.)

I - Importance

"What importance does your spirituality have in your life? Has your spirituality influenced how you take care of yourself, your health? Does your spirituality influence you in your healthcare decision making? (e.g., advance directives, treatment, etc.)

C - Community

"Are you part of a spiritual community? Communities such as churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients. Can explore further: Is this of support to you and how? Is there a group of people you really love or who are important to you?"

A - Address in Care

"How would you like me, your healthcare provider, to address these issues in your healthcare?" (With the newer models including diagnosis of spiritual distress A also refers to the Assessment and Plan of patient spiritual distress or issues within a treatment or care plan.)

From Puchalski, C. (2006). Spiritual assessment in clinical practice. *Psychiatric Annals, 36*(3), 150-155. Used with permission from George Washington Institute for Spirituality and Health (GWish), Washington, DC.

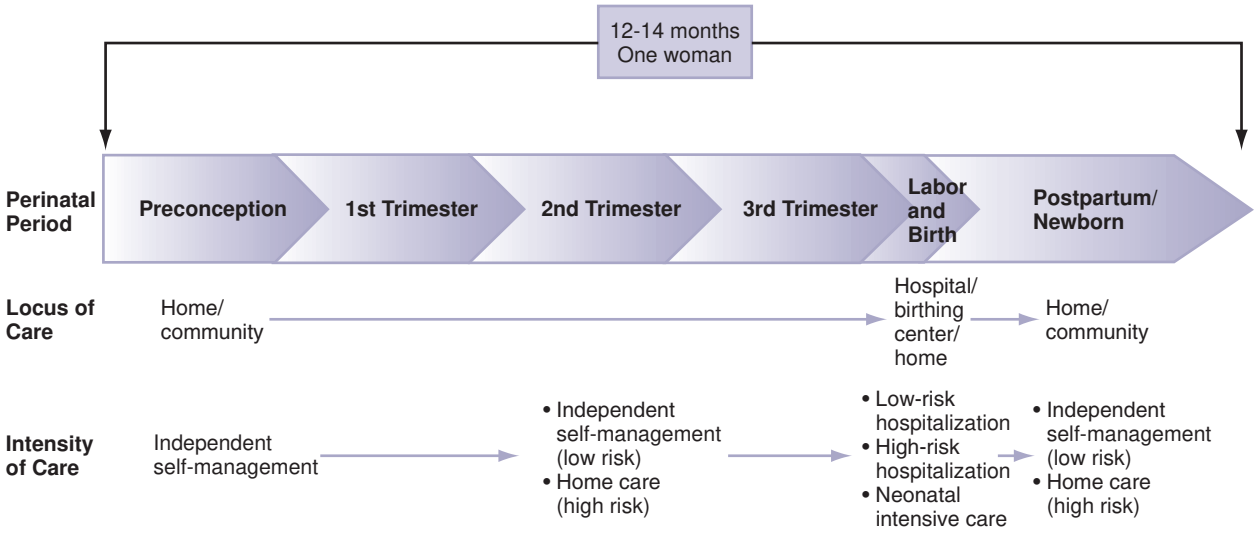

FIG 2.7 Perinatal continuum of care.

important to the patient, what gives meaning to her life, what gives hope and strength, and what are her fears and concerns (Burkhardt & Nagai-Jacobson, 2015). Only then can the nurse respond appropriately and provide spiritual care that is healing.

Parish nursing or faith community nursing is another opportunity to provide spiritual care. Parish nurses work through their church, synagogue, mosque, or faith community to promote health, manage disease, coordinate care, and assist with access to health care through classes, home visits, and other types of outreach (Wordsworth, Moore, & Woodhouse, 2016). These visits do not replace community health visits but supplement them.

HOME CARE IN THE COMMUNITY

Modern home care nursing has its foundation in public health nursing, which provided comprehensive care to sick and well patients in their own homes. Specialized maternity home care nursing services began in the 1980s when public health maternity nursing services were limited and services had not kept pace with the changing practices of high-risk obstetrics and emerging technology. Lengthy antepartum hospitalizations for such conditions as preterm labor and gestational hypertension created nursing care challenges for staff members of inpatient units.

Many women expressed their concerns about the negative effect of antepartum hospitalizations on the family as well as the costs and burdens of lengthy hospitalization. Although clinical indications showed that a new nursing care approach was needed, home health care did not become a viable alternative until third-party payers (i.e., public or private organizations or employer groups that pay for health care) pushed for cost containment in maternity services.

In the current health care system, home care is an important component of health care delivery along the perinatal continuum of care (Fig. 2.7). The growing demand for home care is based on several factors:

- Interest in family birthing alternatives
- Shortened hospital stays
- New technologies that facilitate home-based assessments and treatments
- Reimbursement by third-party payers

As health care costs continue to rise and because millions of American families lack health insurance, there is greater demand for innovative, cost-effective methods of health care delivery in the community. Large health care systems are developing clinically integrated health care delivery networks whose goals are: (1) improved coordination of care and care outcomes; (2) better communication among health care providers; (3) increased patient, payer, and provider satisfaction; and (4) reduced cost. The integration of clinical services changes the focus of care to a continuum of services that are increasingly community based.

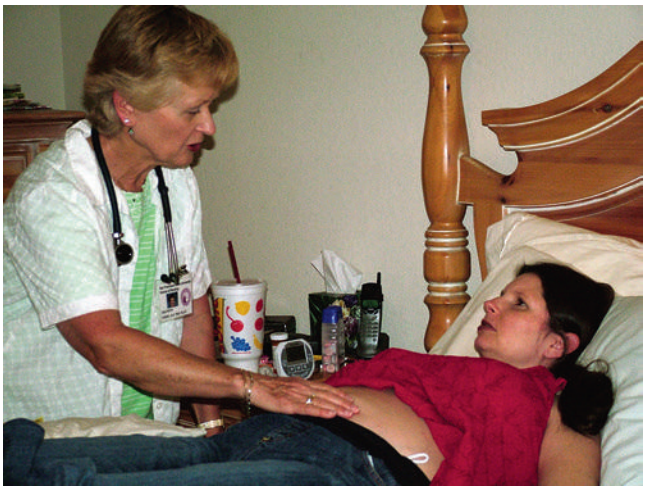

FIG 2.8 Home care nurse visits with a woman in preterm labor at home on bedrest. (Courtesy of Shannon Perry, Phoenix, AZ.)

COMMUNICATION AND TECHNOLOGY APPLICATIONS

As maternity care continues to consist of frequent and brief contacts with health care providers throughout the prenatal and postpartum periods, services that link maternity patients throughout the perinatal continuum of care have assumed increasing importance. These services include critical pathways, telephonic nursing assessments, discharge planning, specialized education programs, parent support groups, home visiting programs, nurse advice lines, and perinatal home care (Fig. 2.8). Hospitals may provide cross-training for hospital-based nurses to