Maternal-Child NURSING

SIXTH EDITION

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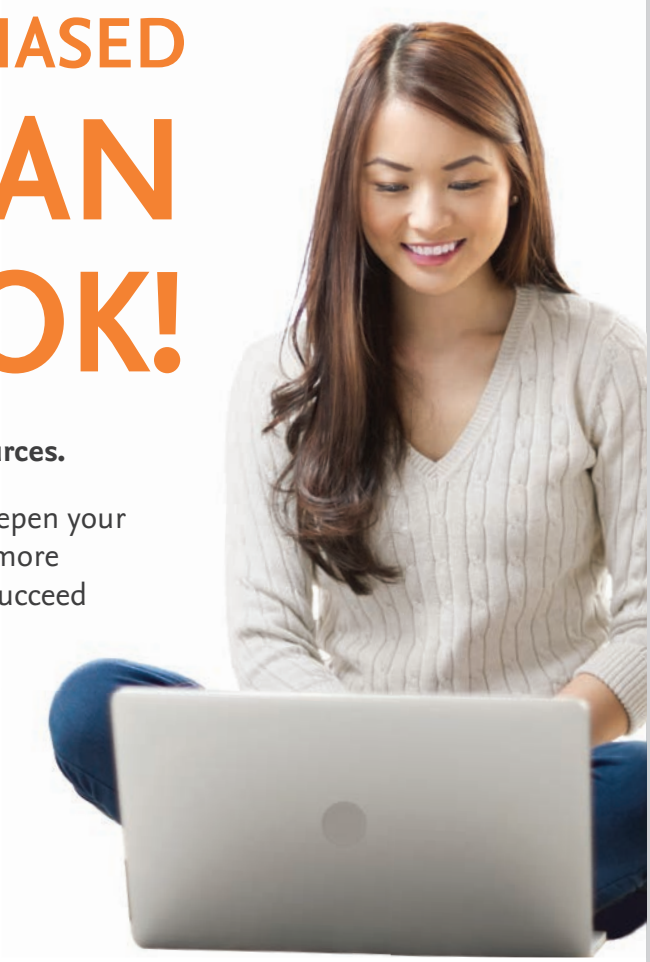

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BRIEF CONTENTS

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Maternal-Child NURSING

SIXTH EDITION

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PREFACE

Children are a precious gift. Some of the most satisfying nursing roles involve helping families bring their children into the world, being a resource as they rear them, and supporting families during times of illness. In addition to providing care to young families as they bear and raise children, nurses play a crucial role in women's healthcare from the teen years through postmenopausal life. The sixth edition of *Maternal–Child Nursing* is written to provide a foundation for care of these individuals and their families and is intended to assist the nursing student or nurse entering maternity and women's health nursing or nursing of children from another area of nursing.

Maternal–Child Nursing builds on two successful texts to combine maternity, women's health, and nursing of children: *Nursing Care of Children: Principles and Practice,* fifth edition, by Susan Rowen James, Kristine Ann Nelson, and Jean Weiler Ashwill and *Foundations of Maternal-Newborn Nursing,* fifth edition, by Sharon Smith Murray and Emily Slone McKinney.

Maternal–Child Nursing, sixth edition, emphasizes evidence-based nursing care. The scientific base of maternal–newborn, women's health, and nursing care of children is demonstrated in the narrative and features in which the nursing process is applied. Physiologic and pathophysiologic processes are presented so the reader can understand why problems occur and the reasons underlying nursing care. Current references, many of them from Internet sources for best timeliness, provide the reader with the latest clinical information. National standards and guidelines, such as those from the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); Society of Pediatric Nurses (SPN); and American Nurses Association (ANA), are used when applicable.

Maternal–newborn, women's health, and nursing of children may be practiced in a wide variety of settings. Where appropriate, our text discusses the care of patients in settings as diverse as acute and chronic care facilities, community, schools, and home. Methods to ease transition among facilities and improve continuity of care are highlighted when appropriate.

Legal and ethical issues add to the complexity of practice for today's nurse. A discussion of nurses' legal obligations when providing healthcare to women, newborns, and children optimizes care for all patients in each group. Legal topics include areas such as standards of care, informed consent, and refusal of treatment. Ethical principles and decision making are discussed in the first chapter of the text. Ethical issues, such as care of babies born at a very early gestation or nursing care at the end of life, are discussed in appropriate chapters.

Nursing students have time demands from work, family, and community activities in addition to their nursing education. For a significant number of nursing students and nurses, English is not their primary language. Considering those realities, we have written the text to effectively convey necessary information that focuses on critical elements and that is concise without the use of unnecessary complex language. Terms are defined throughout the chapter and are included with definitions in a glossary at the end of the book.

CONCEPTS

Several conceptual threads are woven into our book. The *family* is a concept that is incorporated throughout our book as a vital part of maternal–child nursing care and nursing care of women. Family considerations appear in every step of the nursing process. A family may be the conventional mother–father–child arrangement or may be a single parent or multigenerational family. We consider several types of family styles as we present nursing care. We sometimes ask the reader to use critical thinking to examine personal assumptions and biases about families while studying.

Without *communication,* nursing care would be inadequate and sometimes unsafe. Teaching effective communication skills is incorporated into several features of the text as well as into the main narrative. Highlighted text within the narrative contains communication cues to give tips about verbal and nonverbal communication with patients and their families. Children are not little adults, and nowhere is this truer than when communicating with them. Therefore, communicating with children is presented in a separate chapter to supplement information given in other chapters on nursing of children.

Health promotion is obvious in chapters covering normal childbearing, child rearing, and women's health, but we also incorporate it into the chapters covering various disorders. Health promotion during illness may be as simple as reminding the reader that a technology-laden woman in labor is still having a baby, a usually normal process, and thus needs human contact. Sick children need activities to promote their normal growth and development as much as they need the technology and procedures that return them to physical wellness. This edition of *Maternal–Child Nursing* contains health promotion boxes in each of the developmental chapters. The goal of these boxes is to highlight anticipatory guidance appropriate for an infant's or child's developmental level according to the schedule of well visits recommended by the American Academy of Pediatrics (AAP).

Teaching is closely related to health promotion. Teaching is an expected part of nursing care to help patients and their families maintain health or return to health after illness or injury. Several features discussed later help the reader provide better teaching to patients in an understandable form.

Cultural diversity characterizes nursing practice today as the lines between individual nations become more blurred. The nurse must assess for unique cultural needs and incorporate them into care as much as possible to promote the acceptance of nursing care by the patient. Cultural influences are examined in many ways in our text, including clinical judgment exercises to help the student "think outside the box" of his or her own culture.

Growth and development are concepts that appear throughout the book. We cover physical growth and development as the child is conceived and matures before birth and throughout childhood and as the woman matures through the childbearing years and into the climacteric. Specific chapters in the nursing of children section focus on growth and development issues, including anticipatory guidance, specific to each age group from infancy through adolescence.

Advocacy is emphasized in our text. Whether it is advocacy for a woman or family to be informed about their rights or advocacy for child and adult victims of violence, the concept is incorporated in the relevant places.

FEATURES

Maternal–newborn and women's health nursing care differs from nursing care of children and their families in several important respects. Because of this fact, some features in the text appear in one part but not in the other, often with references to the chapter containing related content. Other features appear in both parts of the text.

Visual appeal characterizes many features in the text. Beautiful illustrations and photographs convey developmental or clinical information, capturing the essence of care for maternity, newborn, women's health, and child patients.

OBJECTIVES

Objectives provide direction for the reader to understand what is important to glean from the chapter. Many objectives ask that the learner use critical thinking and apply the nursing process—two crucial components of professional nursing—to care for patients with the conditions discussed in that chapter. Other features within the chapters reinforce these two components of care.

NURSING PROCESS

Several methods help the learner use the nursing process in the care of maternal–newborn, women's health, and child patients. The steps of the nursing process include performing assessment; constructing diagnoses or hypotheses after analysis of the assessment data; planning care; implementing care; and evaluating the nursing interventions, expected outcomes, and appropriate approaches as care proceeds. We address these steps in different ways in our book, often varying with whether the nursing process is discussed in the maternal–newborn, women's health, or nursing of children section. The varied approaches show the student that there is more than one way to communicate the nursing process. These different approaches to the nursing process also provide teaching tools to meet the needs of students' varied learning styles.

In the maternal–newborn and women's health section, the nursing process is presented in two ways. Nursing care is first presented as a *text discussion* that would apply to a typical patient with the condition. In addition, a *nursing care plan* that applies to a patient created in a specific scenario is constructed for many common conditions. This technique helps the student see individualization of nursing care. Many nursing care plans list *additional nursing problems to consider,* encouraging the reader to reflect on patient needs other than the obvious needs. The approach of scenario-based care plans is especially useful for showing learners how to apply the nursing process in dynamic conditions such as labor and birth.

In the nursing care of children section, the nursing process is applied to care for children with the most common childhood conditions by a blend of text discussion similar to the maternal–newborn and women's health section and a generic, rather than scenario-based, nursing care plan. The student thus has the benefit of seeing typical nursing analyses, expected outcomes, and interventions with their rationales discussed in a manner similar to care plans the learner may encounter in clinical facilities or be required to write in school. The evaluation step of the nursing process provides sample questions that the nurse would need to answer to determine whether the expected outcomes were achieved and whether further actions or revisions of nursing care are needed. The application of the nursing process in the nursing care of children provides a framework for the nursing instructor to help students individualize nursing care for their specific patients based on a generic plan of care. *Maternal–Child Nursing* demonstrates not only use of the nursing process when caring for acutely ill children but also emphasizes its application when providing care in the community setting. Community-based use of the nursing process applies to many nursing specialties, including those in both sections of this updated edition of *Maternal–Child Nursing*.

CLINICAL JUDGMENT EXERCISES

Clinical judgment is encouraged in multiple ways in *Maternal–Child Nursing,* but specific Clinical Judgment exercises present typical patient scenarios or other real-life situations and ask the reader to solve nursing care problems that are not always obvious. We use these exercises to help the student learn to identify the answer, choose the best interventions, or determine possible meanings or importance of signs and symptoms. New to this edition is the addition of Next Generation NCLEX® Examination Style Case Studies that will assist students to experience how certain content might appear on their NCLEX® examination. These case studies might be directed toward an individual situation or might be in unfolding format. Answers are provided on the Evolve Web site so that the student can check his or her solutions to these problems.

EVIDENCE-BASED PRACTICE

As nursing care is grounded in evidence, the sixth edition of *Maternal–Child Nursing* continues to present timely evidence-based analyses in chapters where their topic is likely to be relevant to the patient care content. Reports of recent nursing research related to practice are summarized and give the reader a chance to identify possibilities to use the evidence in the clinical setting through questions at the end of each box.

CRITICAL ALERTS

Students always want to know, "Will this be on the test?" The authors cannot answer that question, but consistent with Quality and Safety Education for Nurses (QSEN) terminology and the need to present critical and important information in a summative way, we have included both Safety Alerts and Nursing Quality Alerts that emphasize what is critical to remember when providing safe and optimal quality care.

WANT TO KNOW

Because teaching is an essential part of nursing care, we give students teaching guidelines for common patient and family needs in terms that most lay people can understand. Both the Want to Know and the Patient-Centered Teaching boxes provide sample answers for questions that are most likely to be asked or topics that need to be taught, such as when to go to the birth center or methods of managing diet and insulin requirements for type 1 diabetes at home.

HEALTH PROMOTION

Health Promotion boxes summarize needed information to perform a comprehensive assessment of well infants and children at various ages. Organized around the AAP-recommended schedule for well-child visits, examples are given of questions designed to elicit developmental and behavioral information from the parent and child. These boxes also include what the student might expect to see for health screening or immunizations and review specific topics for anticipatory guidance.

The topic of Health Maintenance is presented with the discussion of Women's Healthcare. Measures that may be taken for prevention of health problems or for early detection of specific diseases are often available to women.

CLINICAL REFERENCE PAGES

Clinical Reference pages provide a resource for the reader when studying conditions that affect children. This feature provides the reader with basic information related to a group of disorders and includes a compact review of related anatomy and physiology; differences between children and adults in the system being studied; commonly used drugs, lab values, and diagnostic tests; and procedures that apply to the conditions discussed in that chapter.

PATHOPHYSIOLOGY

Also present in many chapters in the nursing care of children are pathophysiology boxes. These boxes give the reader a brief overview of how the illness occurs. The boxes provide a scientific basis for understanding the therapeutic management of the illness and its nursing care.

PROCEDURES

Clinical skills are presented in procedures throughout the text. Procedures related to maternal–newborn and women's health are presented in the chapters to which they apply. Because many procedures are common to the care of children with a variety of health conditions, they are covered in a chapter devoted to procedures, Chapter 37. Conditions such as asthma affect adults and children. The reader may find information about procedures that apply to both in a related pediatric chapter.

DRUG GUIDES

Drug information may be presented in two ways: tables for related drugs used in the care of various conditions and drug guides for specific common drugs. Drug guides provide the nurse with greater detail for commonly encountered drugs in maternity and women's healthcare and in the care of children with specific pharmacologic needs.

KEY CONCEPTS

Key concepts summarize important points of each chapter. They provide a general review for the material just presented to help the reader identify areas in which more study is needed.

Materials that complement *Maternal–Child Nursing* include the following:

For Students

- *Evolve:* Evolve is an innovative Web site that provides a wealth of content, resources, and state-of-the-art information on maternity and pediatric nursing. Evolve resources for students include Answers to Clinical Judgment Boxes in the text, Answers to Next Generation NCLEX® (NGN)- Style Boxes in the text, Review Questions, Case Studies, Print Chapter Key Points, Additional Pediatric Next Generation NCLEX®(NGN)- Style Case Studies and Answers, and an Audio Glossary.
- *Study Guide for Maternal–Child Nursing:* This student study aid provides learning exercises, supplemental classroom and clinical activities, and multiple-choice review questions to reinforce the material addressed in the text. Next Generation NCLEX® (NGN)-Style Case Studies are included. An Answer Key is provided at the back of the book.

For Instructors

Evolve includes these teaching resources for instructors:

- *Test Bank* contains 900 test items and answers.
- *TEACH for Nurses* includes teaching strategies; in-class case studies; and links to nursing curriculum standards.
- *Electronic Image Collection,* containing more than 600 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.
- Next Generation NCLEX®(NGN)-Style Cases for Pediatric Nursing (Instructor Only)
- Next Generation NCLEX® (NGN)-Style Cases for Maternity Nursing (Instructor Only)
- Additional Pediatric Next Generation NCLEX® (NGN)-Style Cases

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To Emily, Jean, Sharon, and Kris, with thanks for the many wonderful years of collaboration on this book, and to Jackie – I couldn't have asked for a better colleague. Most of all, I would like to acknowledge my children, who laughed every time I said "just one more", and Bob, who has put up with my crazy ideas for more than 50 years; I couldn't love you more.

Susan Rowen James

I would like to express my heartfelt gratitude to my husband, Steve, my children, Kirsten, Sophia, and Stephen, and all my family for their love and support.

In loving memory of my father, John Loehr, whose passion for reading led me down this path.
To Susan- for the kindness and patience as you mentored me through the years.

Jacqueline Carroll

Thank you to all nursing students from whom I have learned to be a better teacher and a better nurse. Thank you to the colleagues, including the nursing experts who have contributed to this text and the nursing experts with whom I have been honored to work in clinical practice and education. You have demonstrated the beautiful art and science of nursing.

Thank you, Aaron, Molly, Jack, and LeAnn, for the consistent and persistent support. I am forever grateful.

Kari Mau

IN MEMORY OF EMILY S. McKINNEY

Emily McKinney passed away in December 2013. It was my privilege to coauthor six editions of *Maternal-Newborn and Women's Health Nursing* and four editions of *Maternal-Child Nursing* with Emily. She also coauthored study guides for several other obstetric nursing textbooks. In 1999, she was awarded the honor of being included in the Dallas Fort Worth's Great 100 Nurses list. She was on the editorial staff of *JOGNN* (*Journal of Obstetric, Gynecologic, and Neonatal Nursing*) and was named Reviewer of the Year in 2006.

Emily was an excellent obstetric nurse and a talented nursing educator in the hospital as well as the classroom setting. She had an impressive knowledge of the science and the art of maternal-newborn nursing and was able to pass that knowledge on to her students in an easily digestible fashion.

It was Emily's idea to write a textbook that would be comprehensive yet easy to read. She realized that students often juggle several roles other than just being students. They are often parents and hold jobs to pay for their education and support their families. Emily used to say that simple words and short sentences could be just as effective as long, complicated words and sentences and much more easily absorbed by busy learners. When Trula Gorrie and I first met her in 1990, we knew that we shared Emily's vision and a wonderful partnership was formed.

Emily loved learning. She particularly looked forward to the yearly AWHONN (Association of Women's Health, Obstetric, and Neonatal Nursing) conventions. We met there each year and enjoyed hearing about the latest techniques and discoveries to advance obstetric nursing that were discussed. She was eager to find ways to apply new information to her clinical practice and teaching.

Throughout the years she was working on textbooks, Emily faced some difficult health problems. Yet she persevered in writing her chapters. She produced an amazing amount of quality work in short periods in spite of feeling ill. She was determined to do this as a way to advance nursing and nursing education.

Emily was also dedicated to her family. Her many interests included making clothes for her husband and two daughters as well as knitting hats for premature infants. Her daughters are following in her footsteps and are planning to go into nursing.

As an inspired nurse, Emily offered encouragement and practical help to her students and patients each day. Her passion for nursing was obvious to all. Emily is missed by everyone who knew her.

Sharon S. Murray

CONTENTS

UNIT III Pediatric Nursing Care

1

Foundations of Maternity, Women's Health, and Child Health Nursing

http://evolve.elsevier.com/McKinney/mat-ch/

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

- Describe the historic background of maternity and child healthcare.
- Compare current settings for childbirth both within and outside a hospital setting.
- Identify trends that led to the development of family-centered maternity and pediatric care.
- Describe how issues, such as cost containment, outcomes management, home care, and technology, affect perinatal, women's health, and child health nursing.
- Discuss trends in maternal, infant, and childhood mortality rates.
- Identify how poverty and violence on children and families affect nursing practice.
- Apply theories and principles of ethics to ethical dilemmas.
- Discuss ethical conflicts that the nurse may encounter in perinatal, women's health, and pediatric nursing practice.
- Relate how major social issues, such as poverty, homelessness, and access to healthcare, affect nursing practice.
- Describe the legal basis for nursing practice.
- Identify measures used to defend malpractice claims.
- Identify current trends in healthcare and their implications for nursing.

To better understand contemporary maternity nursing and nursing of children, the nurse needs to understand the history of these fields, trends, and issues that affect contemporary practice and the ethical and legal frameworks within which maternity and nursing care of children is provided.

HISTORIC PERSPECTIVES

During the past several 100 years, both maternity nursing and nursing of children have changed dramatically in response to internal and external environmental factors. Expanding knowledge regarding the care of women, children, and families, as well as changes in the healthcare system, markedly influenced these developments.

Maternity Nursing

Major changes in maternity care occurred in the first half of the 20th century as childbirth shifted from a home setting to a hospital setting. Rapid change continues as healthcare reforms attempt to control the increasing cost of care while advances in expensive technology accelerate. Despite changes, healthcare professionals attempt to maintain the quality of care.

Emergence of Medical Management

Before the 20th century, childbirth usually occurred at home with the assistance of a "granny," or lay midwife. In the late 19th century, however, technologic developments that were available to physicians but not to midwives led to a decline in home births and an increase in physician-assisted hospital births. Important discoveries that set the stage for a change in maternity care included the following:

- The discovery by Semmelweis that puerperal infection could be prevented by hygienic practices
- The development of forceps to facilitate birth
- The discovery of chloroform to control pain during childbirth
- The use of drugs to initiate labor or increase uterine contractions
- Advances in operative procedures such as cesarean birth

By 1960, 90% of births in the United States occurred in hospitals. Maternity care became highly regimented. All **antepartum**, **intrapartum**, and **postpartum** care was managed by physicians. Lay midwifery became illegal in many areas, and nurse-midwifery was not well established. The woman delivered her baby, often so heavily medicated that she could not remember the delivery at all. This greatly hindered the bonding between parent and infant. Fathers were not permitted in the delivery room, and infants were cared for in nurseries, separate from the parent.

Despite the technologic advances and shift from home birth to hospital birth, maternal and infant mortality declined but slowly. The slow pace of this decline was caused primarily by preventable problems such as poor nutrition, infectious diseases, and inadequate prenatal care. These stubborn problems remained because of inequalities in healthcare delivery. Affluent families could afford comprehensive medical care that began early in the pregnancy, but poor families had very limited access to care or to information regarding childbearing. Two concurrent trends, federal involvement and consumer demands, led to additional changes in maternity care.

Government Involvement in Maternal-Infant Care

The high rates of maternal and infant mortality among indigent women provided the impetus for federal involvement in maternity

TABLE 1.1 Federal Projects for Maternal-Child Care

Program	Purpose
Title V of Social Security Act	Provides funds for maternal and child health programs
National Institute of Health and Human Development	Supports research and education of personnel needed for maternal and child health programs
Title V Amendment of Public Health Service Act	Established the Maternal and Infant Care (MIC) project to provide comprehensive prenatal and infant care in public clinics
Title XIX of Medicaid program	Provides funds to facilitate access to care by pregnant women and young children
Head Start program	Provides educational opportunities for low-income children of preschool age
National Center for Family Planning	A clearinghouse for contraceptive information
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program	Provides supplemental food and nutrition information
Temporary Assistance to Needy Families (TANF)	Provides temporary money for basic living costs of poor children and their families, with eligibility requirements and time limits varying among states; tribal programs available for Native Americans Replaces Aid to Families with Dependent Children (AFDC)
Healthy Start program	Enhances community development of culturally appropriate strategies designed to decrease infant mortality and causes of low birth weights
Individuals with Disabilities Education Act (PL 94-142)	Provides for free and appropriate education of all disabled children
National School Lunch/Breakfast program	Provides nutritionally appropriate free or reduced-price meals to students from low-income families

care. The Sheppard–Towner Act of 1921 provided funds for state-managed programs for mothers and children. Although this act was ruled unconstitutional in 1922, it set the stage for allocation of federal funds. Currently, the federal government supports several programs to improve the health of mothers, infants, and young children (Table 1.1). Although projects supported by government funds partially solved the problem of maternal and infant mortality, the *distribution* of healthcare remained unequal. Most physicians practiced in urban or suburban areas where the affluent population could afford to pay for medical services, but women in rural or inner-city areas had difficulty obtaining care. The distribution of healthcare services is a problem that currently persists.

The ongoing problem of providing healthcare for poor women and children left the door open for nurses to expand their roles, and programs emerged to prepare nurses for advanced practice (see Chapter 2).

Impact of Consumer Demands on Healthcare

In the early 1950s, consumers began to insist on their right to be involved in their healthcare. Pregnant women wanted a greater voice in their healthcare and wanted information regarding planning and spacing their children; moreover, they wanted to know what to expect during pregnancy. The father, siblings, and grandparents wanted to be part of the extraordinary events of pregnancy and childbirth. Parents began to insist on active participation in decisions concerning how their child would be born. Active participation of the patient is now expected in healthcare at all ages other than the very young or others who are unable to understand.

A growing consensus among child psychologists and nurse researchers indicated that the benefits of early, extended parent-newborn contact far outweighed the risk of infection. Parents began to insist that their infant remain with them, and the practice of separating the healthy infant from the family was abandoned.

Development of Family-Centered Maternity Care

Patient-centered care refers to care where the patient or designee is the source of control and full partner in providing compassionate and coordinated care. The patient's care is based on respect for patient's preferences, values, and needs (Quality and Safety Education for Nurses [QSEN], n.d.). In maternity care, the patient-centered care extends to the family. *Family-centered care* describes the safe, quality care that recognizes and adapts to both the physical and psychosocial needs of the family, including those of the newborn and older children (see also p. 4 for discussion of family-centered child care). The emphasis is on fostering family unity while maintaining physical safety.

Basic principles of family-centered maternity care are as follows:

- Childbirth is usually a normal, healthy event in the life of a family.
- Childbirth affects the entire family and restructuring of family relationships is required.
- Families are capable of making decisions about care, provided that they are given adequate information and professional support.

Family-centered care increases the responsibilities of nurses. In addition to physical care and assisting the physician, nurses assume a major role in teaching, counseling, and supporting families in their decisions.

Current Settings for Childbirth

As family-centered maternity care has emerged, the settings for childbirth have changed to meet the needs of new families.

Traditional Hospital Setting

In the past, labor often took place in a functional hospital room, which was often occupied by several laboring women. When birth was imminent, the mother was moved to a delivery area similar to an operating room. After giving birth, the mother was transferred to a recovery area for 1 to 2 hours of observation and then taken to a standard hospital room in the postpartum unit. The infant was moved to the newborn nursery when the mother was transferred to the recovery area. Mother and infant were reunited when the mother was settled in her postpartum room. Beginning in the 1970s, the father or another significant support person could usually remain with the mother throughout labor, birth, and recovery, including cesarean birth.

Although birth in a traditional hospital setting was safe, the setting was impersonal and uncomfortable. Moving from room to room, particularly during late labor, was a major disadvantage. Each move was uncomfortable for the mother, disrupted the family's time together, and often separated the parents from the infant. Because of these disadvantages, hospitals began to devise settings that were more comfortable and included family participation.

Labor, delivery, and recovery rooms. Currently, most hospitals offer alternative settings for childbirth. The most common is the labor, delivery, and recovery (LDR) room. In an LDR room, labor, birth, and

FIG 1.1 A typical labor, delivery, and recovery room. Homelike furnishings (A) can be adapted quickly to reveal needed technical equipment (B).

early recovery from childbirth occur in one setting. Furniture has a less institutional appearance but can be quickly converted into the setup required for birth. A typical LDR room is illustrated in Fig. 1.1.

During labor, significant others of the woman's preference may remain with her. The nurse often finds it necessary to regulate visitors in and out of the room to maintain safety and patient comfort. The mother typically remains in the LDR room for 1 to 2 hours after vaginal birth for recovery and is then transferred to the postpartum unit. The infant usually stays with the mother throughout her stay in the LDR room. The infant may be transferred to the nursery or may remain with the mother after her transfer to a postpartum room. Couplet care, or the assignment of one nurse to the care of both mother and baby, is common in postpartum units nowadays. The father or another primary support person is encouraged to stay with the mother and infant, and many facilities provide beds so they can stay through the night.

The major advantages of LDR rooms are that the setting is more comfortable and the family can remain with the mother. Disadvantages include the routine (rather than selective) use of technology such as electronic fetal monitoring and the administration of intravenous fluids.

Labor, delivery, recovery, and postpartum rooms. Some hospitals offer rooms that are similar to LDR rooms in layout and in function, but the mother is not transferred to a postpartum unit. She and the infant remain in the labor, delivery, recovery, and postpartum (LDRP) room until discharge.

Birth Centers

Free-standing birth centers provide maternity care outside the acute-care setting to low-risk women during pregnancy, birth, and postpartum. Most provide gynecologic services such as annual checkups and contraceptive counseling. Both the mother and infant continue to receive follow-up care during the first 6 weeks. This may include help with breastfeeding, a postpartum examination at 4 to 6 weeks, family planning information, and examination of the newborn. Care is often provided by certified nurse-midwives (CNMs), who are registered nurses with advanced preparation in midwifery.

Birth centers are less expensive than acute-care hospitals that provide advanced technology that may be unnecessary for low-risk women. Women who want a safe, homelike birth in a familiar setting with staff they have known throughout their pregnancies express a high rate of satisfaction.

The major disadvantage is that most freestanding birth centers are not equipped for obstetric emergencies. Should unforeseen difficulties develop during labor, the woman must be transferred by ambulance to a nearby hospital to the care of a back-up physician who has agreed to perform this role. Some families do not feel that the very short stay after birth, often less than 12 hours, allows enough time to detect early complications in mother and infant.

Because all facilities cannot provide services needed for all obstetric emergencies and high-risk care, regionalization of perinatal health services has been developed. Levels of care for hospital-based perinatal care have been developed and have improved maternal and neonatal patient outcomes.

Home Births

In the United States, only a small number of women have their babies at home. Because **malpractice** insurance for midwives attending home births is expensive and difficult to obtain, the number of midwives who offer this service has decreased greatly.

Home birth provides the advantages of keeping the family together in their own environment throughout the childbirth experience. Bonding with the infant is unimpeded by hospital routines, and breastfeeding is encouraged. Women and their support person have a sense of control because they actively plan and prepare for each detail of the birth.

Giving birth at home also has disadvantages. The woman must be screened carefully to make sure that she has a very low risk for complications. If transfer to a nearby hospital becomes necessary, the time required may be too long in an emergency. Other problems of home birth may include the need for the parents to provide an adequate setting and supplies for the birth if the midwife does not provide supplies. The mother must care for herself and the infant without the professional help she would have in a hospital setting.

Nursing of Children

To better understand contemporary child health nursing, the nurse needs to understand the history of this field, trends and issues affecting contemporary practice, and the ethical and legal frameworks within which pediatric nursing care is provided.

Historic Perspectives

Nursing care for children has been influenced by multiple historic and social factors. Children have not always enjoyed the valued position that they hold in most families nowadays. Historically, in times of economic or social instability, children have been viewed as expendable. In societies in which the struggle for survival is the central issue and only the strongest survive, the needs of children are secondary. The well-being of children in the past depended on the economic and cultural

conditions of the society. At times, parents have viewed their children as property, and children have been bought and sold, beaten, and, in some cultures, sacrificed in religious ceremonies. In some societies, infanticide has been a routine practice. Conversely, in other instances, children have been highly valued and their birth considered a blessing. Viewed by society as miniature adults, children in the past received the same medical remedies as adults and, during illness, were cared for at home by family members, just as adults were.

Societal Changes

As European settlements expanded on the North American continent during the 17th and 18th centuries, children were valued as assets to the community because of the desire to increase the population and share the work. Public schools were established, and the courts began to view children as minors and protect them accordingly. Devastating epidemics of smallpox, diphtheria, scarlet fever, and measles took their toll on children in the 18th century. Children often died of these virulent diseases within 1 day.

The high mortality rate in children led some physicians to examine common child-care practices, such as swaddling infants in three or four layers of clothing, feeding them liquefied cereal within hours of birth, and bottle feeding. Although physicians of the time encouraged breastfeeding and discouraged practices thought to contribute to illness, child-care practices were slow to change. Later in the 18th century, the health of children improved with certain advances such as inoculation against smallpox.

With the flood of immigrants to eastern American cities in the 19th century, infectious diseases flourished as a result of crowded living conditions, inadequate and unsanitary food, and harsh working conditions for men, women, and children. Children frequently worked 12- to 14-hour days in factories, and their earnings were essential to the survival of the family. The most serious child health problems during the 19th century were caused by poverty and overcrowding. Infants were fed contaminated milk, sometimes from tuberculosis-infected cows. Milk was carried to the cities and purchased by mothers who had no means to refrigerate it. Infectious diarrhea was a common cause of infant death.

During the late 19th century, conditions began to improve for children and families. Lillian Wald initiated public health nursing at Henry Street Settlement House in New York City, where nurses taught mothers in their homes. In 1889, a milk distribution center opened in New York City to provide uncontaminated milk to sick infants.

Hygiene and Hospitalization

The discoveries of scientists such as Pasteur, Lister, and Koch, who established that bacteria caused many diseases, supported the use of hygienic practices in hospitals and foundling homes. Hospitals began to require personnel to wear uniforms and limit contact between children in the wards. In an effort to prevent infection, hospital wards were closed to visitors. Because parental visits were noted to cause distress, particularly when parents had to leave, parental visitation was considered emotionally stressful to hospitalized children. In an effort to prevent such emotional distress and the spread of infection, parents were prohibited from visiting children in the hospital. Because hospital care focused on preventing disease transmission and curing physical diseases, the emotional health of hospitalized children received little attention.

During the 20th century, as knowledge regarding nutrition, sanitation, bacteriology, pharmacology, medication, and psychology increased, dramatic changes in child health occurred. In the 1940s and 1950s, medications such as penicillin and corticosteroids and vaccines against many communicable diseases saved the lives of tens of thousands of children. Technologic advances in the 1970s and 1980s allowed more children to survive conditions that previously had been fatal (e.g., cystic fibrosis), thereby increasing the number of children living with chronic disabilities. An increase in societal concern for children brought about the development of federally supported programs designed to meet their needs, such as school lunch programs, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Medicaid (see Table 1.1), under which the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was implemented.

Development of Family-Centered Child Care

Family-centered care for children is based on a philosophy that recognizes and respects the pivotal role of the family in the lives of both well and ill children. Parents and professionals are viewed as equals in a partnership committed to excellence at all levels of healthcare. In some circumstances, nurses need to understand that the parent's preference and expertise might be more valuable to the child than the expertise of the nurse. Family-centered care acknowledges family preferences and values the importance of diversity; coordination, communication, and integration of care are basic principles (QSEN, n.d.).

Family-centered care for children developed from the recognition that the emotional needs of hospitalized children usually were unmet. Parents were not involved in the direct care of their children. Children were often unprepared for procedures and tests, and visiting was severely controlled and even discouraged.

Over the years through the efforts of organizations dedicated to meeting the needs of children and families, increased attention has been paid to the psychological and emotional effects of hospitalization during childhood. In response to greater knowledge about the emotional effects of illness and hospitalization, hospital policies and healthcare services for children have changed. Twenty-four-hour parental and sibling visitation policies and home care services have become the norm. The psychological preparation of children for hospitalization and surgery has become standard nursing practice. Many hospitals have established child life programs to help children and their families cope with the stress of illness. Shorter hospital stays, home care, and day surgery also have helped to minimize the emotional effects of hospitalization and illness on children.

Most healthcare settings have a family-centered philosophy in which families are given choices, provide input, and are given information that is understandable by them. The family is respected, and its strengths are recognized.

CURRENT TRENDS IN CHILD HEALTHCARE

During recent years, the government, insurance companies, hospitals, and healthcare providers have made a concerted effort to reform healthcare delivery in the United States and to control rising healthcare costs. This trend has involved changes in where and how money is spent. In the past, most of the healthcare budget was spent in acute care settings, where the facility charged for services after the services were provided. Because hospitals were paid for whatever materials and services they provided, they had no incentive to be efficient or cost conscious.

More recently, the focus in the United States has been on health promotion, the provision of care designed to keep people healthy and prevent illness. *Healthy People 2020* is a comprehensive, nationwide health promotion and disease-prevention agenda, focused on what are now referred to as "determinants of health," or those physical, social,

emotional, economic, and environmental factors that contribute to keeping people healthy and achieving high quality of life (USDHHS, 2010). (See health.gov/healthypeople to see and download objectives.) *Healthy People 2030*, recently published, builds on the determinants of health and is organized around a framework of promoting development and facilitating healthy practices across the life span, creating access to care that eliminates disparities, and using the political process to ensure the improvement of health and well-being for everyone (USDHHS, 2021). Many of the national health objectives in *Healthy People 2030* are applicable to children and families. National data for measuring progress toward objectives are gathered from federal and state departments and from voluntary private, nongovernmental organizations. In evaluating progress toward meeting targets set in *Healthy People 2020,* the mid-decade review found that targets for reducing the infant and preterm mortality rate, as well as reducing adolescent substance abuse were met; access to health services and childhood immunization are improving; but adolescent mental disorders and suicides, as well as oral health are getting worse (USDHHS, 2020b).

The focus of nursing care for children has changed as national attention to health promotion and disease prevention has increased. Even acutely ill children have only brief hospital stays because increased technology has facilitated parents' ability to care for children in the home or community setting. Most acute illnesses are managed in ambulatory settings, leaving hospital admission for the extremely acutely ill or children with complex medical needs. Nursing care for hospitalized children has become more specialized, and much nursing care is provided in community settings such as schools and outpatient clinics.

Cost Containment

Even with the change in focus to health promotion, healthcare costs continue to rise. Several strategies have been implemented to contain the rising costs. One way in which those paying for healthcare have attempted to control costs is by shifting to a *prospective* form of payment. In this arrangement, third party payers no longer pay whatever charges the agency or provider determines for services. Instead, a fixed amount of money is agreed upon in advance to cover necessary services for specifically diagnosed conditions. Several other strategies and cost savings incentives also have been used to contain the cost of services.

Diagnosis-Related Groups

Diagnosis-related groups (DRGs) are a method of classifying related medical diagnoses based on the amount of resources, severity of disease, and other patient characteristics. This method of cost containment became a standard in 1987, when the federal government set the amount of money that would be paid by Medicare for each DRG (Centers for Medicare and Medicaid, 2020a). If the facility delivers more services or has greater costs than those covered by Medicare, the facility must absorb the excess cost. Conversely, if the facility delivers the care at lower cost than the payment for that DRG, the facility keeps the remaining money. Healthcare facilities working under this arrangement benefit financially if they can reduce the patient's length of stay, thereby decreasing the cost of services. Although the DRG system originally applied only to Medicare patients, most states have adopted the system for Medicaid payments, and most insurance companies use a similar system as well.

Managed Care

Health insurance companies also examined the cost of healthcare and instituted a healthcare delivery system that has been called *managed care.* Examples of managed care organizations are health maintenance organizations (HMOs), point of service plans (POSs), and preferred provider organizations (PPOs). HMOs provide relatively comprehensive health services for people enrolled in the organization for a set fee or premium. Similarly, PPOs are groups of healthcare providers who agree to provide health services to a specific group of patients at a discounted cost. When a patient needs medical treatment, managed care includes strategies such as payment arrangements and preadmission or pretreatment authorization to control costs. Nurses often serve as consultants and case managers for managed care organizations to assist with coordination of care, patient and family education, preventive actions, and referrals.

Capitated Care

Capitation may be incorporated into any type of managed care plan. In a pure capitated care plan, the employer (or government) pays a set amount of money each year to a network of primary care providers. This amount might be adjusted for the age and sex of the patient group. In exchange for access to a guaranteed patient base, the primary care providers agree to provide general healthcare and to pay for all aspects of the patient's care, including laboratory work, specialist visits, and hospital care. In this structure, the lower costs for well patients who require little follow-up balance the costs of ill patients who have complex medical needs.

Capitated plans are of interest to employers as well as the government because they allow a predictable amount of money to be budgeted for healthcare. Patients do not have unexpected financial burdens from illness. However, patients lose most of their freedom of choice regarding who will provide their care. Providers can lose money (1) if they refer too many patients to specialists, who may have no restrictions on their fees, (2) if they order too many diagnostic tests, or (3) if their administrative costs are too high. Some healthcare providers and consumers fear that cost constraints might affect treatment decisions.

Effects of Cost Containment

Prospective payment plans have had major effects on maternal and infant care, primarily with respect to the length of stay. Mothers are typically discharged from the hospital at 48 hours after normal vaginal birth and 96 hours after cesarean birth, unless the woman and her healthcare provider choose an earlier discharge time. This leaves little time for nurses to adequately teach new parents about newborn care and to assess infants for subtle health issues. Nurses find that providing adequate information regarding infant care is particularly difficult when the mother is still recovering from childbirth. Problems with earlier discharge of mother and infant often require readmission and more expensive treatment than might have been required had the problem been identified early. For care of children who spend little time in hospitals and have treatments or surgeries on an outpatient basis, adequate discharge teaching and follow-up also can be a challenge.

Despite efforts to contain costs related to the provision of healthcare in the United States, the percentage of the total government expenditures for services (gross domestic product [GDP]) allocated to healthcare was 17.9% in 2017 (National Center for Health Statistics [NCHS], 2018), markedly higher than most similar developed countries (Organization for Economic Cooperation and Development [OECD], 2019).

In March 2010, the *Patient Protection and Affordable Care Act* (ACA) was signed into law. Designed to rein in healthcare costs while increasing access to the underserved, the provisions of this law have been phased in over several years (USDHHS, 2015). The ACA requires healthcare providers and hospitals to assist in the coordination of care, which helps in the provision of high-quality care, eliminates duplicate healthcare services, and reduces medical errors, all of which result in decreased healthcare costs and improved patient care (USDHHS, 2015). A major goal of the ACA is to provide basic health benefits

at an affordable cost. The law expanded services through increasing the eligibility for non–employer-provided insurance to people whose incomes are up to 400% of the federal poverty level. Important provisions affecting children and families include eliminating denial of coverage for preexisting conditions, improving services for children with complex medical needs, providing home visits to pregnant women and newborns, and increasing access to preventive healthcare (USDHHS, 2021).

Cost-containment measures have also altered traditional ways of providing patient-centered care, with increased focus on ensuring quality and safety through approaches such as **case management,** use of clinical practice guidelines, evidence-based nursing care, and outcomes management.

Case Management

Case management is a practice model that uses a systematic approach to identify specific patients, determine eligibility for care, arrange access to appropriate resources and services, and provide continuity of care through a collaborative model (Grow & Lyon, 2019). In this model, a case manager or coordinator, who focuses on both quality of care and cost outcomes, coordinates the services required by the patient and family. Inherent to case management is the coordination of care by all members of the healthcare team. The guidelines established in 1995 by The Joint Commission (TJC) require an interdisciplinary, collaborative approach to patient care. This concept is at the core of case management. Nurses who provide case management evaluate patient and family needs, establish needs documentation to support reimbursement, and may be part of a long-term care planning at home or a rehabilitation facility.

Evidence-Based Nursing Care

The Agency for Healthcare Research and Quality (AHRQ), a branch of the US Public Health Service, actively sponsors research in health issues that are faced by mothers and children. From research generated through this agency and others, high-quality evidence can be accumulated to guide the best and lowest cost clinical practices. Topics of research for women, infants, and children include such areas as vaccine safety, preventive health services, overdose risks in children, diversity in women's healthcare, and quality of care. AHRQ's overall focus has been to improve patient safety and quality and data tracking. Research in areas such as decreasing hospital acquired infection, reducing readmissions, and rural healthcare has saved the healthcare system billions of dollars (AHRQ, 2017).

Clinical practice guidelines are an important tool in developing parameters for cost-effective, safe, high-quality, and evidence-based care for mothers, infants, children, and families (American Academy of Pediatrics & American College of Obstetricians & Gynecologists, 2017). For many years, AHRQ sponsored a collection of clinical practice guidelines through its National Guideline Clearinghouse; however, lack of funding has halted that program temporarily (AHRQ, 2018). Clinical guidelines are based on collections of evidence that are shown to improve outcomes of care. They include systematic reviews of evidence, recommendations with rationales based on the relative quality of the evidence, external peer review, and statement of conflict of interest. In 2011 the Institute of Medicine, now the National Academy of Medicine (NAM), provided an in-depth road map for guideline developers to ensure consistency among guidelines. A current focus of the NAM incorporates guidelines as part of what is called clinical decision support. Clinical decision support assists providers to use the electronic health record to access up-to-date, data driven, and personalized care within the context of the patient's lifestyle and health goals (Tcheng, Bakken, & Bates, 2017). Specialty nursing organizations, as well as professional groups, publish clinical guidelines in journals and at conferences. Important children's health issues, including quality and safety improvements, enhanced primary care, access to quality care, and specific illnesses, are addressed in the available practice guidelines.

Outcomes Management

The determination of lower healthcare costs while maintaining the quality of care has led to a clinical practice model called *outcomes management*. This is a systematic method to identify outcomes and to focus care on interventions that will accomplish the stated outcomes for children with specific issues, such as asthma or other complex needs, or pregnant women and their newborns.

Nurse-sensitive indicators. In response to recent efforts to address both quality and safety issues in healthcare, various government and privately funded groups have sponsored research to identify patient care outcomes that are particularly dependent on the quality and quantity of nursing care provided. These outcomes, called *nurse-sensitive indicators*, are based on empirical data collected by such organizations as the AHRQ and the National Quality Forum (NQF) and represent outcomes that improve with optimal nursing care (Myers, Pugh, & Wigg, 2018; National Database of Nursing Quality Indicators [NDNQI], 2010). The following topics are in the process of development and delineation for pediatric nurses: adequate pain assessment, peripheral intravenous infiltration, pressure ulcer, catheter-related bloodstream infection, smoking cessation for adolescents, and obesity (Myers et al., 2018). Nurses need to use evidence-based intervention to improve these patient outcomes.

Variances. Deviations or *variances* can occur in either the time line or in the expected outcomes. A variance is the difference between what was expected and what actually happened. A variance may be either positive or negative. A positive variance occurs when a child progresses faster than expected and is discharged sooner than planned. A negative variance occurs when progress is slower than expected, outcomes are not met within the designated time frame, and the length of stay is prolonged.

Clinical pathways. One planning tool that is used by the healthcare team to identify and meet stated outcomes is the *clinical pathway*. Other names for clinical pathways include *critical* or *clinical paths, care paths, care maps, collaborative plans of care, anticipated recovery paths,* and *multidisciplinary action plans.* Clinical pathways are **standardized,** interdisciplinary plans of care that are devised for patients with a particular health problem. The purpose, as in managed care and case management, is to provide quality care while controlling costs. Clinical pathways identify patient outcomes, specify time lines to achieve those outcomes, direct appropriate interventions and sequencing of interventions, include interventions from various disciplines, promote collaboration, and involve a comprehensive approach to care. Home health agencies use clinical pathways that may be developed in collaboration with the hospital staff.

Clinical pathways may be used in various ways. For example, they may be used for change-of-shift reports to indicate information regarding the length of stay, individual needs, and priorities of the shift for each patient. They may also be used for documenting the person's nursing care plan and his or her progress in meeting the desired outcomes. The clinical pathway for a new mother may include care of her infant at term. Many pathways are particularly helpful in identifying families that require follow-up care.

Value-driven healthcare. Nurses have become more increasingly aware of health policies and structures that emphasize value-driven healthcare. Value-driven healthcare is an attempt to balance cost, quality, access to care, and fiscal transparency, allowing patients to become critical consumers of health. It is focused on optimal outcomes and

addresses equitable use and allocation of personal, technical, and financial resources (Blumenthal, Gustafsson, & Seervai, 2019; DeJonge et al., 2019). Value-driven care is based on current evidence, improves care continuity and efficiency, and lowers costs. It gives preference and financial incentives to providers and systems that can demonstrate high-quality outcomes for reasonable cost. Medical homes for the care of children and birthing centers for comprehensive and continuing care for pregnant women and newborns are examples of healthcare structures that are value based.

HOME CARE

Home nursing care has experienced dramatic growth since 1990. Advances in portable and wireless technology, such as infusion pumps for administering intravenous nutrition or subcutaneous medications, and monitoring devices such as telemonitors allow nurses and often patients or family to perform procedures and maintain equipment in the home. Consumers often prefer home care over hospitalization because this arrangement can be less stressful on the family when the patient is able to remain at home rather than be separated from the family support system because of the need for hospitalization. Optimal home care can also reduce readmission to the hospital for adults and children with chronic conditions.

Home care services may be provided in the form of telephone calls, home visits, information lines, developmental surveillance, and **lactation** consultations, among others. Online and wireless technology allows nurses to evaluate data transmitted from home. Greater numbers of technology-dependent infants and children are currently cared for at home, including those requiring ventilator assistance, total parenteral nutrition, intravenous medications, apnea monitoring, and other device-associated nursing care.

Nurses must be able to independently function within established protocols and must be confident of their clinical skills when providing home care. They should be proficient at interviewing, counseling, and teaching. They often assume a leadership role in coordinating all the services a family may require, and they frequently supervise the work of other care providers.

COMMUNITY CARE

A model for community care of children is the school-based health center. These centers provide comprehensive primary healthcare services in the most accessible environment. Students can be evaluated, diagnosed, and treated on site. Services offered include primary preventive care (health assessments, anticipatory guidance, vision and hearing screenings, and immunizations), acute care, prescription services, and mental health and counseling services. Some school-based health centers are sponsored by hospitals, local health departments, and community health centers. Many are used in off hours to provide healthcare to uninsured adults and adolescents.

Access to Care

Access to care is an important component when evaluating preventive care and prompt treatment of illness and injuries. Access to healthcare is strongly associated with having health insurance. The American Academy of Pediatrics (AAP) states that all children through the age of 21 should have access to high-quality, comprehensive healthcare, supplying services to children and adolescents that address preventive (including developmental, vision, and oral screening), acute, and inpatient care, as well as addressing behavioral and mental issues (including substance use), home care, and hospice care. The AAP has demonstrated that quality and cost of care for infants and children occur within the structure of a medical home (AAP, 2020). This care should be ensured through access to comprehensive health insurance that is designed to address the unique developmental and health needs of all children (AAP, 2020).

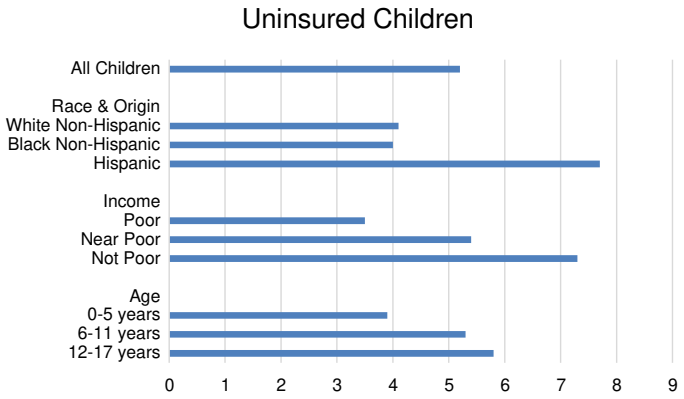

FIG 1.2 Uninsured Children by Race and Origin, Income Status, and Age. (Data from Federal Interagency Forum on Child and Family Statistics. [2019]. *America's children: Key national indicators of well-being, 2019.* Retrieved from http://www.childstats.gov)

Having health insurance coverage, usually employer sponsored, often determines whether a person will seek care early in the course of a pregnancy or an illness. Many private health plans have restrictions such as prequalification for procedures and a set list of any services covered by the plan. People with employer-sponsored health insurance often find that they must change providers each year because the available plans change, a situation that may negatively affect the provider-patient relationship.

Public Health Insurance Programs

Improvements in federal and state programs that address children's health needs have resulted in a decrease of uninsured children in the United States. The percentage of children younger than age 18 years who lack health insurance is 5.2%, which has been relatively stable since 2015 (NCHS, 2018). Health insurance coverage varies among children by poverty, age, race, and ethnic origin (Fig. 1.2). Of the children covered by insurance, 41.6% are covered by public insurance (Medicaid or CHIP) and 55.8% have private insurance. The proportion of children with health insurance is lowest among Hispanic children compared with White or Black children (Cohen, Terlizzi, Martinez, & Cha, 2020; Federal Interagency Forum on Child and Family Statistics, 2019).

Children in poor and near-poor families are more likely to be uninsured (34.2%) (Cohen et al., 2020), as compared with more affluent children (3.7%) (Cohen et al., 2020). Uninsured children are more likely to have unmet medical needs, receive delayed medical care, have no usual provider of healthcare, and have higher rates of emergency room service than those in families that are not poor. Approximately 4% of all children have no usual place of healthcare, and this is more prevalent in children who are uninsured or underinsured (Federal Interagency Forum on Child and Family Statistics, 2019).

Public health insurance for children is provided primarily through Medicaid, a federal program that provides healthcare for certain populations of people living in poverty, or the CHIP (formerly the State Children's Health Insurance Program), a program that provides access for children not poor enough to be eligible for Medicaid but whose household income is less than 200% of poverty level. Medicaid is an entitlement program, meaning that funding occurs routinely, whereas CHIP must be periodically reauthorized.

Medicaid provides healthcare for the poor, aged, and disabled, with pregnant women and young children especially targeted. Medicaid is funded by both the federal government and individual state governments, with the federal government providing matching funds to the state expenditures. The states administer the program and determine which services are offered.

Historically, qualifying for Medicaid has been a lengthy process; a woman not already enrolled at the beginning of her pregnancy is unlikely to finish the process in time to receive early prenatal care. The family must fill out lengthy, complicated forms, provide documentation of citizenship and income, and then wait for determination of eligibility.

Medicaid criteria may deny payment for some services that are routinely provided to those who hold private insurance. Some physicians and dentists are unwilling to care for Medicaid patients who are likely to be at high risk. Many are especially unwilling if reimbursement is slow and lower than that paid by other insurers. Dental services for children are particularly limited.

A provision of the ACA, designed to increase the numbers of the insured, allowed states to expand their Medicaid coverage to include adults with children; it also expanded the overall eligibility requirements to be more inclusive (Ugwi, Lyu, & Wehby, 2019). An effect of the Medicaid expansion was to increase the coverage for children, because when parents were not eligible for insurance, the process and requirements for getting children insured were often too complex and unmanageable (Ugwi et al., 2019). Many states chose to expand their Medicaid programs. In states that did so, the percentage of uninsured children declined to 3.2%, while the uninsured rate in states that chose not to expand is 6.1% (Cohen et al., 2020).

The healthcare landscape seems to be in a period of flux, as political influences change policy. A proposed change to Medicaid funding would have a profound effect on healthcare for infants and children. Instead of providing federal funds to fully fund Medicaid programs in the states, the proposal changes the federal participation to "block grants"; in other words a set amount of money would be provided to each state and not necessarily the amount that is actually needed. Another proposed format is to institute capitation, a similar concept. The result of this action would leave many children without insurance and jeopardize the preventive benefits currently available, as well as decrease access for children with complex medical needs (Artiga & Ubri, 2017). The AAP, National Association of Pediatric Nurse Practitioners, and other organizations concerned with policies affecting the health of infants and children have strongly opposed these proposed changes (Korioth, 2020).

Preventive Health

The oral health of children in the United States has become a topic of increasing focus as more is learned about the relationship between dental caries and overall health. Overall, approximately 90% of children reported having seen a dentist within the previous year (Federal Interagency Forum on Child and Family Statistics, 2019). Services available through Medicaid are limited, and many dentists do not accept children who are insured by Medicaid. Economic, racial, and ethnic disparities exist in this area of health. Children living in poverty or near poverty are less likely to have seen a dentist over the past year than children from more affluent households. Furthermore, a high percentage of non-Hispanic Black school-age children and Mexican-American children have untreated dental caries as compared with non-Hispanic White children (Centers for Disease Control and Prevention [CDC], 2020a). It is particularly important for pregnant women to have adequate dental care because they can communicate dental caries to their infants (CDC, 2019a). In addition, maternal periodontal disease is emerging as a contributing factor to prematurity, with adverse effects on the child's long-term health.

Besides the obvious implication of not having health insurance—the inability to pay for healthcare during illness—uninsured children are less likely to receive immunizations and other preventive care, placing them at increased risk for preventable illnesses. Because practicing preventive healthcare is a learned behavior, these children are more likely to become adults who are less healthy.

HEALTHCARE ASSISTANCE PROGRAMS

Many programs, some funded privately and others by the government, assist in the care of mothers, infants, and children. The WIC program, established in 1972, provides supplemental food supplies to low-income women who are pregnant or breastfeeding and to their children up to the age of 5 years. WIC has long been heralded as a cost-effective program that not only provides nutritional support but also links families with other services such as prenatal care and immunizations.

Medicaid's EPSDT program was developed to provide comprehensive healthcare to Medicaid recipients from birth to 21 years of age. The goal of the program is to prevent health problems or identify them before they become severe. This program pays for well-child examinations and for the treatment of any medical problems diagnosed during such checkups.

Public Law 99-457 is part of the Individuals with Disabilities Education Act that provides financial incentives to states to establish comprehensive early intervention services for infants and toddlers with or at risk for developmental disabilities. Services include screening, identification, referral, and treatment. Although this is a federal law and entitlement, each state bases coverage on its own definition of developmental delay. Thus coverage may vary from state to state. Some states provide care for at-risk children.

The Healthy Start program, begun in 1991, is a major initiative to reduce infant deaths in communities with disproportionately high infant mortality rates. Strategies used include reducing the number of high-risk pregnancies, reducing the number of low birth weight (LBW) and preterm births, improving birth weight–specific survival, and reducing specific causes of postneonatal mortality.

The March of Dimes, long an advocate for improving the health of infants and children, publishes an annual *Prematurity Report Card.* Designed to reduce the devastating toll that prematurity takes on the population, this organization emphasizes education, research, and **advocacy**. Prematurity often results in permanent health or developmental problems for survivors. The current percentage of babies born prematurely (<37 weeks) is nearly 10% in the United States (March of Dimes, 2018b), with obvious regional differences; the lowest rate is in the northwest, while the highest rates are in the midwest and southeast. Racial and ethnic disparities continue to occur, with the highest rate of premature births occurring among Black and Native American populations (March of Dimes, 2018a).

There are other important agencies that facilitate optimal healthcare for children and families. The Administration for Children and Families (ACF), part of the USDHHS, facilitates economic independence and improves access to a variety of providers, as well as community and state resources. Several other organizations such as the Children's Defense Fund, Family Voices, and First Focus on Children address services and influence policy-makers to approve legislation and regulations that improve the status of children and families.

STATISTICS ON MATERNAL, INFANT, AND CHILD HEALTH

Statistics are important sources of information about the health of groups of people. The newest statistics about maternal, infant, and

child health for the United States can be obtained from the NCHS (http://www.cdc.gov/nchs).

Maternal and Infant Mortality

Throughout history, women and infants have had high death rates, especially around the time of childbirth (Petersen et al, 2019). Infant and maternal mortality rates began to decrease when the health of the general population improved, basic principles of sanitation were put into practice, and medical knowledge increased. A further large decrease resulted from the widespread availability of antibiotics, improvements in public health, and better prenatal care in the 1940s and 1950s. Currently, mothers seldom die in childbirth, and the infant mortality rate is decreasing, although the rate of change has slowed for both. Racial inequality in maternal and infant mortality rates continues, with non-White groups having higher mortality rates than White groups.

Pregnancy-Related Mortality

In 2018 the **pregnancy-related death ratio** was 17 per 100,000 live births for all women in the United States. Black or African-American women are more than three times more likely to die from pregnancy-related causes than White women (CDC, 2018a). Although pregnancy-related deaths declined significantly over the past century, there has been a marked increase since 1987; the causes for this increase are unclear (CDC, 2018a; Petersen et al, 2019).

Infant Mortality

The **infant mortality rate** (death before the age of 1 year per 1000 live births) has been decreasing since 2000. Most recent data report an infant mortality rate of 5.67, which has remained stable for several years (NCHS, 2018). The **neonatal mortality rate** (death before 28 days of life) dropped to 3.79 deaths per 1000 live births for the most recent reporting year (NCHS, 2018). Currently, the five leading causes of infant mortality are congenital malformations, deformations, and chromosome abnormalities; disorders related to low birth weight; newborn problems related to maternal complications; sudden infant death syndrome (SIDS); and unintentional injury (Kochanek, Murphy, Xu, & Arias, 2019). The decrease in the infant mortality rate is attributed to better neonatal care and to public awareness campaigns, such as the Back to Sleep campaign to reduce the occurrence of SIDS.

Racial disparity for mortality. Although infant mortality rates in the United States have declined overall, race-based differences remain. The 2017 infant mortality rate was 4.67 for White infants and 10.97 for African-American infants (CDC, 2019a). Fig. 1.3 compares the rates of infant mortality for all races and for Whites and Blacks or African-Americans since 1980. Much of the racial disparity in infant mortality is attributable to premature (born before 37 completed weeks) and LBW infants (<2500 g), both more common among Black infants. Premature and LBW infants have a greater risk of short- and long-term health problems, as well as death (March of Dimes, 2018a & b).

Poverty is an important factor. Proportionally more non-Whites than Whites are poor in the United States. Poor people are less likely to be in good health, to be well nourished, or to get the healthcare they need. Obtaining care becomes vital during pregnancy and infancy, and lack of care is reflected in the high mortality rates in all categories.

International infant mortality. One would expect that a nation such as the United States would have one of the lowest infant mortality rates when compared with other developed countries. However, data from 2019 place the US rate at 34 out of 43 developed countries (OECD, 2020) (Table 1.2). International rankings are somewhat difficult to compare because countries differ in how they report live births.

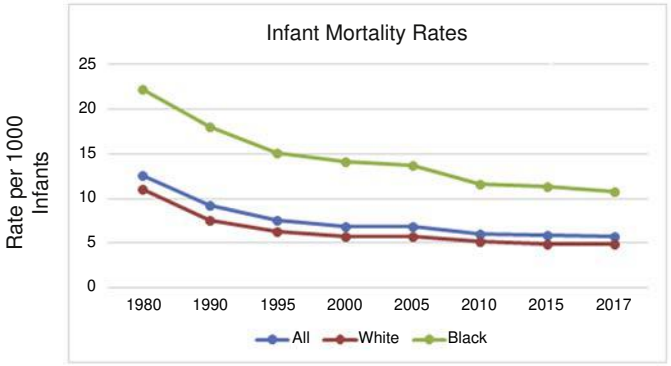

FIG 1.3 Infant Mortality Rates, 1980–2017. (Data from National Center for Health Statistics. [2018]. *Health United States, 2018.* Retrieved from www.cdc.gov/nchs)

TABLE 1.2 Infant Mortality Data for Selected Countries (2019 Data)

Country	Infant Mortality (Per 1000 Live Births)
Japan	1.3
Sweden	2
Finland	2.1
Norway	2.3
Czech Republic	2.6
Austria, Spain	2.7
Italy, Korea	2.8
Ireland	2.9
Israel	3
Australia	3.1
United States	5.8 rated #34 out of 43 countries

From Organization for Economic Cooperation and Development. (2020). *Infant mortality rates indicator.* https://doi.org/10.1787/83dea506-en. Retrieved from data.oecd.org

Adolescent Births

Teenage childbearing has been a long-standing concern in the United States. Young mothers are more likely to deliver LBW or preterm infants than are older women. The babies of teen mothers have a greater risk of dying in infancy (NCHS, 2018). That adolescent birth rates in the United States have fallen to historic lows does not remove the health risks for mother and child.

Births to girls aged 15 to 19 years decreased from a 1991 peak of 61.8 births per 1000 girls to an overall rate of 18.8 per 1000 girls in 1918 (NCHS, 2018). Numbers differ according to age group, but rates have decreased in girls of all ages:

- Teenagers 10 to 14 years: 0.2 per 1000; lowest ever reported
- Teenagers 15 to 17 years 7.9 per 1000
- Teenagers 18 to 19 years 35.1 per 1000

Among girls 15 to 19 years, births are lowest in the non-Hispanic White population and highest in the American Indian/Alaskan Native population; however, rates have declined considerably in all racial and ethnic populations (Federal Interagency Forum on Child and Family Statistics, 2019).

Childhood Mortality

Death rates for children have declined significantly over the past 20 years. Table 1.3 shows the leading causes of death in children. Although death rates attributed to unintentional injury also have dropped, they are still the leading cause of death in children aged 1 to 19 years

TABLE 1.3 Leading Causes of Death Among Children Ages 1 to 14 Years

1–4 Years
Unintentional injury
Malignant neoplasms
Homicide
Heart disease
5–9 Years
Unintentional injury
Malignant neoplasms
Congenital malformations
Homicide
10–14 Years
Unintentional injury
Cancer
Suicide
Congenital malformations
Homicide

From National Center for Injury Prevention and Control. (2020). *10 Leading causes of death by age group, United States—2018.* Retrieved from www.cdc.gov

(National Center for Injury Prevention and Control, 2020b). In all age groups except children 1 to 4 years, motor vehicle crashes lead the causes of death from unintentional injury; in children ages 1 to 4 years, drowning is the leading cause of unintentional death (National Center for Injury Prevention and Control, 2020a). Homicide has become the fourth leading cause of death in children ages 1 to 9 years and is the fifth leading cause of death for children 10 to 14 years. Very concerning is that suicide has become the second leading cause of death for children ages 10 to 14 years as well as older adolescents (National Center for Injury Prevention and Control, 2020b). Other common causes of death in children include congenital malformations, cancer, and cardiac and respiratory diseases. Self-inflicted firearm injury is a leading cause of death in the adolescent population (National Center for Injury Prevention and Control, 2020b).

Morbidity

The **morbidity** rate is the ratio of sick people to well people in a population and is presented as the number of ill people per 1000 people. This term is used in reference to acute and chronic illness as well as disability. Because morbidity statistics are collected and updated less frequently than mortality statistics, the presentation of current data in all areas of child health is difficult. The link between poverty and poorer health outcomes in children is well documented. Children in families with higher incomes and higher educational levels have a better chance of being born healthy and remaining healthy. Access to healthcare, the health behaviors of parents and siblings, and the exposure to environmental risks are among the factors contributing to this disparity in children's health (Federal Interagency Forum on Child and Family Statistics, 2019).

Diseases of the respiratory system, including bronchitis or bronchiolitis, asthma, and pneumonia, are a major cause of physician visits and hospitalization for children younger than 18 years. A reported 8% of children in the United States currently have asthma; approximately 5% of these report having had one or more acute episodes during the previous year (Federal Interagency Forum on Child and Family Statistics, 2019). Obesity is a problem of significant concern. More than 14% of children between the ages of 2 and 5 years are considered to be obese; this percentage increases as children grow, and obesity affects more than 21% of adolescents (CDC, 2019b). Other issues of increasing concern include food allergies, attention-deficit/hyperactivity disorder (ADHD), and childhood and adolescent depression. Statistics regarding morbidity related to particular disorders are presented in this text where the disorders are discussed.

The Youth Risk Behavior Surveillance System conducts a national survey of US students in grades 9 to 12 every 2 years in odd years. The CDC (2018c) has identified the following health behaviors among youth in the United States that contribute to increased mortality, morbidity, and social problems: (1) behaviors that contribute to unintentional injuries and violence; (2) tobacco use; (3) alcohol and other drug use; (4) sexual behaviors related to gender identification, unintended pregnancy, and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection; (5) unhealthy dietary behaviors; and (6) physical inactivity. Many high school students engage in behaviors that place them at risk for the leading causes of morbidity and mortality. Since the earliest year of data collection, the prevalence of most health risk behaviors has decreased (e.g., riding with a driver who had been drinking alcohol, physical fighting, current cigarette use, current alcohol use, and current sexual activity), but the prevalence of other behaviors and health outcomes has not changed or has increased (e.g., suicide attempts treated by a doctor or nurse, vaping, having ever used marijuana, and not attending physical education classes). Other areas of concern include not going to school because of safety concerns, obesity, overweight, not eating vegetables, and not drinking milk. Monitoring emerging risk behaviors (e.g., texting and driving, bullying, and electronic vapor product use) is important to understand how they might vary over time (CDC, 2018c).

ETHICAL PERSPECTIVES ON MATERNITY, WOMEN'S HEALTH, AND CHILD NURSING

Maternal-child health nurses often struggle with ethical and social dilemmas that affect families. Nurses must know how to approach these issues in a knowledgeable and systematic manner.

Ethics and Bioethics

Ethics involves determining the best course of action in a certain situation. Ethical reasoning is the analysis of what is right and reasonable. ***Bioethics*** is the application of ethics to healthcare. Ethical behavior or principle-based ethics for nurses is discussed in various codes, such as the American Nurses' Association (ANA) Code for Nurses. Ethical issues have become more complex as developing technology has allowed more options in healthcare. These issues are controversial because of the lack of agreement over what is right or best and because moral support is possible for more than one course of action.

Ethical Dilemmas

An **ethical dilemma** is a situation in which no solution appears completely satisfactory. Opposing courses of action may seem equally desirable, or all possible solutions may seem undesirable. Ethical dilemmas are among the most difficult situations in nursing practice. Finding solutions involves applying ethical theories and principles and determining the burdens and benefits of any course of action. Decision making in ethical dilemmas may appear straightforward, but it may not result in answers that are agreeable to everyone. Therefore many agencies have bioethics committees to formulate policies for ethical situations, provide education, and help make decisions in specific cases. The committees include various professionals such as nurses, physicians,

BOX 1.1 Ethical Principles

- *Beneficence.* One is required to do or promote good for others.
- *Nonmaleficence.* One must avoid risking or causing harm to others.
- *Autonomy.* People have the right to self-determination. This includes the right to respect, privacy, and the information necessary to make decisions.
- *Justice.* All people should be treated equally and fairly regardless of disease or social or economic status. Rendering to others what is due them.

social workers, ethicists, and clergy members. If possible, the patient and family also participate.

Ethical Principles

Ethical principles are important in solving ethical dilemmas. Four of the most important principles are beneficence, nonmaleficence, autonomy, and justice (Box 1.1). Although principles guide decision making, in some situations, it may be impossible to apply one principle without encountering a conflict with another. In such cases, one principle may outweigh another in importance.

Ethical Concerns in Reproduction

Ethical issues often confront healthcare providers, families, and society at large. For example, conflicts between a woman and her fetus occur when the woman's requirements, behavior, or wishes may injure the fetus. Caregivers and society may respond to issues such as elective termination of pregnancy, substance abuse, or a mother's refusal to follow advice of health professionals. Pediatric ethical and legal issues may include the choice of treatments out of the mainstream or the refusal of medical treatment for a minor child in caregiver custody.

Elective Pregnancy

Terminating a pregnancy, or induced abortion, has been legal in the United States since the Supreme Court's *Roe vs. Wade* decision in 1973. Nevertheless, abortion can raise moral and ethical concerns for nurses. Some nurses believe that abortion, although legal, is taking another's life and are morally opposed. Some nurses believe that it is a woman's private choice to make reproductive decisions. Other nurses have beliefs and values that might differ depending on the specific situation. Despite personal views, nurses have responsibilities when asked to provide compassionate care for a woman who is undergoing or has undergone an abortion and, depending on the particular nurse's belief, might encounter an ethical dilemma to do so. Nurses must:

- Be informed about the induced abortion issue from a legal and ethical standpoint and should know the regulations and laws of their state.
- Realize that abortion can be an ethical dilemma that results in confusion, ambivalence, and personal distress for some.
- Recognize that the issue is not a dilemma for some but is a fundamental violation of personal or religious views that give meaning to their lives.
- Acknowledge the sincere convictions and the strong emotions of people on all sides of the issue.

Nurses have no obligation to support a position with which they disagree. Many states have laws that allow nurses to refuse to assist with the procedure if elective pregnancy terminations violate ethical, moral, or religious beliefs. However, nurses have an ethical obligation to disclose this information before becoming employed in an institution that performs abortions. For a nurse to withhold this information until being assigned to care for a woman having an abortion and then refusing to provide care would be unethical.

Fetal Injury

The question of whether a mother should be restrained or prosecuted for actions that could cause injury to her fetus has both legal and ethical implications. Courts have issued jail sentences to prevent additional harm to the fetus for women who have caused or who may cause fetal injury. Women have been forced to undergo cesarean births against their will when physicians have testified that such a procedure was necessary to prevent fetal injury.

The state has an interest in protecting children, and the Supreme Court has ruled that a child has the right to begin life with a sound mind and body. Many states have laws requiring that evidence of prenatal drug exposure, which is considered child abuse, be reported. Women have been charged with **negligence**, involuntary manslaughter, delivering drugs to a minor, and child endangerment.

Yet forcing a woman to behave in a certain way because she is pregnant violates the principles of autonomy, self-determination of competent adults, bodily integrity, and personal freedom. Women are unlikely to seek prenatal care or treatment for substance abuse unless they feel safe from prosecution.

Ethical Concerns in Child Health Nursing

Ethical concerns can arise in many areas of child healthcare. For example, disclosure of HIV status to HIV-positive children who are entering middle school is an issue that brings up ethical differences between pediatric providers and parents (see Chapter 42). Two additional important areas are withholding life-sustaining treatment and terminating life support.

Withholding or Ceasing Life-Sustaining Treatment

An ongoing legal and ethical conflict has resulted from the case of Baby Doe and other potentially disabled infants, which occurred in the 1980s. This issue concerned an infant with Down syndrome who also was born with a tracheoesophageal fistula, normally treatable with surgery. The infant's parents refused surgery on the advice of the obstetrician, who was discouraging about the child's survival and subsequent quality of life (White, 2011). As a result of the parents' decision in this case and other similar cases in which infants died because of unrepaired defects, at the urging of the then Surgeon General, the Congress amended child abuse legislation to encompass the withholding of life-sustaining treatment from physically or intellectually disabled infants, essentially prohibiting discrimination because of their disability (White, 2011). The Baby Doe rules state that under circumstances in which the physician's reasonable judgment would indicate that an acute medical issue could be resolved, treatment must be provided regardless of the child's disability. The only exceptions to this would be if the treatment prolonged the dying process in a child not expected to survive or if the child was in an irreversible coma (White, 2011). These rules, if applied, effectively remove the parent's or family's decision as to what is best for their child. In circumstances other than disability, when considering parents' rights in decision making about withholding indicated medical treatment, several aspects are important: best interests of the child, the certainty or uncertainty about whether the treatment will be effective, and whether withholding treatment would harm the child (Wilkinson & Savulescu, 2018).

The AAP has issued a guideline that addresses the issue of withholding or ceasing life-sustaining treatments for all infants and children (Weise, 2017). The guideline recommends the use of the "best interests" standard—making recommendations for interventions to families based on what will benefit the child (improving the quality of remaining life, prolonging life so that the parent and child can have the best quality of relationship available until the child's death) versus

what might harm the child (intractable pain and suffering, increased disability, prolonging life unnecessarily). This approach incorporates the consideration of the child's quality of life (Weise et al., 2017). Integral to the success of this approach is an honest and accurate communication between providers, the child, and the parents. Providers must convey realistic information about the likelihood of improvement, anticipated extent of pain, effect on the quality of life, and options for resuscitation.

Terminating Life Support

Similar to withholding treatment, the decision to cease treatment is an ethical situation that is always difficult and seems to be compounded when the patient is an infant or child. Children who would have died in the past can now have their lives extended through the use of life support. Parents must be involved in the decision-making process immediately and informed about available options. Laws in some states permit parents to provide advance directives for their minor children. When older children are involved, their views are considered.

Decisions to terminate life-support systems continue to present gut-wrenching ethical and legal situations to nurses, especially when an infant or child is involved. Contrary to the common belief that such decisions should be determined by *quality of life,* the legal system plays a major role in this area of healthcare.

Frequently, parents become attached to a primary care nurse and request that the nurse participate in the decision as to whether to terminate life support for their child. A nurse might be faced with such a situation in the neonatal intensive care unit (NICU) with a teenage parent of a premature infant with a congenital defect or in a chronic care oncology unit with a terminally ill child.

In such instances, a team conference should be arranged with the parent, primary nurse, physician, clergy (if applicable), and a hospital staff attorney who is knowledgeable about applicable laws in that particular state. Problems may arise when there is a discrepancy among what families, physicians, and nurses think is best.

The issue of when first to discuss with adolescents the idea of cardiopulmonary resuscitation, mechanical ventilation, and do-not-resuscitate (DNR) orders is always sensitive. Adolescents who have reached majority age must give consent if they are of sound mind. In most states, minor status ends at the age of 18 years.

SOCIAL ISSUES

Nurses are exposed to many social issues that influence healthcare and often have legal or ethical implications. Some of the issues that affect maternity and child healthcare include poverty, human trafficking, intimate partner violence (IPV), homelessness, access to care, and allocation of funds.

Human Trafficking

Human trafficking is the act of recruiting, harboring, transporting, providing, or obtaining individuals through the use of fraud, force, or coercion for labor or sex acts. It is a serious public health concern. At least 12 to 30 million individuals are affected by human trafficking, including more than 5 million children. Individuals who are trafficked can be sexually assaulted, starved, and forced to work as prostitutes. They are often required to work with little or no pay. (See Chapter 9 for additional discussion.) Children who are homeless are targets for sex trafficking. Caring for a victim of human trafficking can be traumatic and challenging. Nurses must identify and report human trafficking and connect these individuals with appropriate services and support systems (Byrne, Parsh, & Parsh, 2019).

Intimate Partner Violence (IPV)

IPV is the most common form of violence that is experienced by women. Specifically, IPV refers to physical or sexual violence perpetrated by a partner. It may include psychological harm and stalking. An intimate partner is an individual with whom one has a close personal relationship. This relationship is characterized by emotional connectedness, regular contact, ongoing physical contact, and sexual behavior. The partners may identify as a couple (CDC, 2018b). Terms including wife battering, spousal abuse, domestic violence, or family violence are often used to describe IPV.

IPV is a significant social problem that impacts health. Individuals who have been abused have an increased risk of heart, digestive, reproductive, muscle and bones, and nervous systems disorders. Women may experience chronic pain, headaches, activity limitations, and asthma secondary to IPV (Ballan, 2017). They also can experience mental health problems such as depression and posttraumatic stress disorder (PTSD). Commonly reported effects of IPV include feeling fearful and concern for safety. These individuals are at higher risk for engaging in health risk behaviors such as smoking, binge drinking, and risky sexual behaviors (CDC, 2018b). Women who are pregnant are often victims of IPV. Most women who are abused prior to pregnancy will continue to be abused through pregnancy. Women may also be abused for the first time during pregnancy. Notably, pregnant teens are at a higher risk for abuse compared with other pregnant women (CDC, 2018b).

Poverty

Poverty is an underlying factor in problems such as inadequate access to healthcare and homelessness and is a major predictor for unmet health needs in children and adults. Twenty-one percent of children in the United States live in families below the poverty line; however, the percentage increases to 43% when the near poor are considered (National Center for Children in Poverty, 2019). Different states have different levels of families in poverty. Living in poverty is directly related to unemployment, so in periods of economic downturn, poverty is increased. Children younger than 5 years are more often found in families with incomes less than the poverty line than are older children (Federal Interagency Forum on Child and Family Statistics, 2019). Children in female-headed households and those with less than a high school education are more likely to be living in poverty; the poverty rate is nearly twice as high in Black, Hispanic, and American Indian households than in White non-Hispanic households (National Center for Children in Poverty, 2019).

Poverty affects the ability to access healthcare for any age-group and decreases opportunities linked with health promotion. Nurses can play a role in helping to meet the healthcare needs of mothers and their infants and children by recognizing the adverse effect of poverty on health and identifying poverty as a practice concern.

Poverty tends to breed poverty. Childbearing at an early age interferes with education and the ability to work. In low-income families, children may leave the educational system early, making them less likely to learn skills necessary to obtain good jobs. The cycle of poverty (Fig. 1.4) may continue from one generation to another as a result of hopelessness and apathy.

Homelessness

Unemployment in the United States was 11.1% in mid-2020 but has been fluctuating according to the relative state of the economy (Bureau of Labor Statistics, 2020). Unemployment can greatly increase the risk for or presence of homelessness to many families who were previously middle or low income because of its link to poverty (National Coalition for the Homeless, 2019a). Approximately

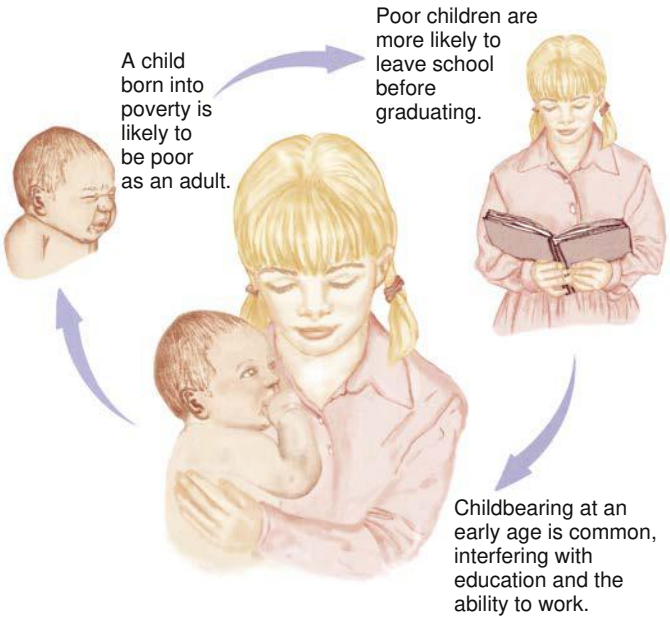

FIG 1.4 The cycle of poverty.

35% of the homeless population are families, and this number has increased markedly; most concerning is that homeless young people (younger than 24 years) comprise 31% of the homeless population (National Coalition for the Homeless, 2019a). More than a third of homeless youths identify as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+), and these frequently are runaways (National Coalition for the Homeless, 2019b) (see Chapter 9 for additional information). In addition to poverty contributing to homelessness among women and their children, other factors include decreasing wages among the employed, lack of affordable housing, domestic violence, substance abuse, and mental illness. Homeless children are poorly nourished and are exposed to violence, experience school absences with subsequent learning difficulties, and are at risk for depression and other emotional consequences (National Coalition for the Homeless, 2017).

Homeless women as well as their children can be poorly nourished and exposed to various infections. Rape and assault are problems, with a high rate of pregnancy among homeless girls. The rate of pregnancy among homeless girls far exceeds the pregnancy rate of other adolescent girls living in stable situations (Dworsky, Morton, & Samuels, 2018). Infants born to homeless women are subject to LBW and have a greater likelihood of neonatal mortality. Pregnancy and birth, especially among teenagers, also are important contributors to homelessness. Adolescent mothers are more likely to be single mothers, have incomplete education, and be poor. Pregnancy interferes with a woman's ability to work and may decrease her income to the point at which she loses her housing. Pregnancy among homeless youth is associated with longer periods of homelessness and may affect obtaining and keeping employment. Pregnant homeless youth often do not access resources for support to which they are entitled, either because those resources are scarce or because they do not have the information needed to do so. Nurses caring for these youth need to assess their knowledge about and access to supportive agencies (Dworsky et al., 2018).

Federal funding has provided assistance with shelter and healthcare for homeless people. However, the homeless have the same difficulties in obtaining healthcare as other poor people because of lack of transportation, inconvenient hours, and lack of continuity of care.

Prenatal Care in the United States

Prenatal care is widely accepted as an important element in improving the health of mothers and infants. More than three-quarters of pregnant women in the United States access prenatal care during the first trimester of pregnancy; younger women are less likely to access prenatal care during the first trimester, and more than a third of pregnant adolescents have little or no prenatal care (Osterman & Martin, 2018). Poor prenatal care often occurs because care is not easily available. Preconception care is currently recommended to provide the ideal circumstances for the mother from the earliest days of pregnancy. Goals for the woman to achieve before conception include identifying health conditions of concern, medication safety, adequate folic acid intake, updating immunizations as needed, and maintaining a healthy weight and healthy behaviors, such as avoiding smoking, alcohol, and the use of illegal and certain legal or therapeutic drugs (National Institute of Child Health and Human Development [NICHD], 2017).

Poor prenatal care access contributes to the infant mortality rate and the large number of LBW infants born each year in the United States. Because preterm infants form the largest category of those needing intensive care, millions of dollars could be saved each year by ensuring adequate prenatal care from the earliest weeks. Even a small improvement in an infant's birth weight decreases complications and hospital time.

In some situations, women can obtain prenatal care but choose not to. These women may not understand the importance of the care or may deny they are pregnant. Some have had such unsatisfactory experiences with the healthcare system that they avoid it as long as possible. Others want to hide substance use or other habits from disapproving healthcare workers. Language and cultural differences also play a part in whether a woman seeks prenatal care. Although these factors are not access issues as such, they must be addressed to improve healthcare.

Allocation of Healthcare Resources

Expenditures for healthcare in the United States in 2016 totaled approximately $3 trillion. Healthcare expenditures are increasing on an annual basis (NCHS, 2018).

Reforming healthcare delivery and financing is a complex area of national concern. How to provide care for the poor, the uninsured or underinsured, and those with long-term care needs must be addressed. In addition, major acute-care facilities often deal with greater financial burdens because of the numbers of uninsured patients who present for treatment with severe illness or injury. Escalating liability costs are another drain on healthcare dollars, leading some states to enact legislation that places a cap on awards for damages in malpractice cases.

Care Versus Cure

One problem to be addressed is whether the focus of healthcare should be on preventive and caring measures or on the cure of disease. Medicine has traditionally centered more on treatment and cure than on prevention and care. Yet prevention not only avoids suffering but is also less expensive than treating diseases once diagnosed.

The focus on cure has resulted in technologic advances that have enabled some people to live longer, healthier lives. However, financial resources are limited, and the costs of expensive technology must be balanced against the benefits obtained. Indeed, the cost of one organ transplant would pay for the prenatal care of many low-income mothers, possibly preventing the births of many LBW infants who may suffer disability throughout life.

In addition, quality-of-life issues are important in regard to technology. Neonatal nurseries are able to keep very LBW babies alive because of advances in knowledge. Some of these infants go on to lead normal or near-normal lives. Others gain time but not quality of life.

Families and healthcare professionals face difficult decisions about when to treat, when to terminate treatment, and when suffering outweighs the benefits.

Healthcare Rationing

Modern technology has had a large effect on healthcare rationing. Some might argue that such rationing does not exist, but it occurs when part of a population has no access to care and there is not enough money for all people to share equally in the technology available. Healthcare also is rationed when it is more freely given to those who have money to pay for it than to those who do not. The distance from the needed care facility may be another factor.

Many questions will need answers as the costs of healthcare increase faster than the funds available. Is healthcare a fundamental right? Should a certain level of care be guaranteed to all citizens? What is that basic level of care? Should the cost of treatment and its effectiveness be considered when one is deciding how much government or third-party payers will cover? Nurses will be instrumental in finding solutions to these vital questions.

Violence

In today's society, women and children are the victims and sometimes the perpetrators of violence. Violence is not only a social problem but also a health problem. Acts of violence can include child abuse, domestic abuse, and murder. Children who live in an environment of violence feel helpless and ineffective. These children have difficulty sleeping and show increased anxiety and fearfulness. They may perpetuate the violence they see in their homes because they have known nothing else in family relationships. Recently, there has been an increase in research into adverse childhood experiences, sometimes called toxic stress. This occurs when children are continually exposed to violence. This could be child abuse and neglect, unstable family situations, domestic violence, substance abuse, and mental illness. Long-term effects of these adverse experiences can lead to long-term physical and emotional problems (Gilgoff, Singh, Koita, Gentile, & Marques, 2020).

Although violent crimes among children have decreased over the past decade, violence in schools continues to rise and is a daily stressor for many children. Bullying by other students, with or without physical violence, has come to the forefront of public awareness because of the increased risk of suicide among adolescent victims. Experts in the field of education cite socioeconomic disparity, language barriers, diverse cultural upbringing, lack of supervision and behavioral feedback, domestic violence, and changes within the family as possible causes for this increased violence. Traditional approaches to aggressive behavior in the school, such as suspension, detention, and being sent to the principal's office, have been ineffective in changing behavior and serve only to exclude the student from education, leading to an increased dropout rate. Nurses need to educate themselves on the issue of violence and to work with schools and parents to combat the problem. In addition, they should not ignore the child who is afraid to go to school or is having other school-related problems.

Findings from a large body of research suggest that exposure to violence via digital or social media is a contributing factor to the occurrence of violent acts by children and adolescents (Guinta & John, 2018). Children and adolescents are exposed to violence via television, movies, video games, social media sites, a variety of digital and photographic media, and youth-oriented music. Cyberbullying is a contributor to emotional distress, particularly in adolescents (Guinta & John, 2018). The AAP (Chassiakos et al., 2016) encourages parents to monitor their children's media exposure and collaboratively develop a family media use plan.

The AAP (Chassiakos et al., 2016) suggests that nurses and clinicians ask parents and children about media exposure at every well visit. Providers also need to be concerned about adolescents who display aggressive or acting-out behaviors such as lying, stealing, temper outbursts, vandalism, excessive fighting, and destructiveness. Also assess for the presence of a gun in the home at every well visit and emphasize the importance of firearm safety.

Nurses working with children should ask them about violence in their school, home, or neighborhood and whether they have had any personal experience with violent behavior. In some cases, it may be necessary to contact parents, human resource departments, police, or other authorities to protect children and adolescents who are in violent situations or at risk for violence.

LEGAL ISSUES

The legal foundation for the practice of nursing provides safeguards for healthcare and sets standards by which nurses can be evaluated. Nurses need to understand how the law applies specifically to them. When nurses do not meet the standards expected, they may be held legally accountable.

Safeguards for Healthcare

Three categories of safeguards determine how the law views nursing practice: (1) state nurse practice acts, (2) standards of care set by professional organizations, and (3) rules and policies set by the institution employing the nurse. Additional information regarding nursing responsibilities is presented in Chapter 2.

Nurse Practice Acts

Every state has a **nurse practice act** that determines the scope of practice for registered nurses in that state. Nurse practice acts define what a nurse is and is not allowed to do in caring for patients. Some parts of the law may be very specific, whereas others are stated broadly enough to permit flexibility in the role of the nurse. Nurse practice acts vary from state to state, and nurses must be knowledgeable about these laws wherever they practice.

In 2000 the National Council of State Boards of Nursing initiated a nurse licensure compact program. A nurse licensure compact allows a nurse who is licensed in one state to practice nursing in another participating state without having to be licensed in that state. Nurses must comply with the practice regulations in the state in which they practice. Thirty-three states have become participants in the nurse licensure compact program (National Council of State Boards of Nursing, 2020).

Laws relating to nursing practice also delineate methods, called *standard procedures* or *protocols,* by which nurses may assume certain duties commonly considered part of healthcare practice. The procedures are written by committees of nurses, physicians, and administrators. They specify the nursing qualifications required for practicing the procedures, define the appropriate situations, and list the education required. Standard procedures allow for flexibility in the role of the nurse to meet changing needs of the community and to reflect expanding knowledge.

Standards of Care

Courts have generally held that nurses must practice according to established standards and health agency policies, although these standards and policies do not have the force of law. Standards of care are set by professional associations and describe the level of care that can be expected from practitioners. For example, perinatal nurses are held to the specialty standards published by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN; http://www.awhonn.org).

The Society of Pediatric Nurses is the primary specialty organization that sets standards for pediatric nurses (http://www.pedsnurses.org).

Other regulatory bodies, such as the Occupational Safety and Health Administration (OSHA), the US Food and Drug Administration (FDA), and the CDC also provide guidelines for practice. Accrediting agencies, such as TJC and the Community Health Accreditation Program, give their approval after visiting facilities and observing whether standards are being met in practice. Governmental programs such as Medicare, Medicaid, and state health departments require that their standards are met for the facility to receive reimbursement for services.

Agency Policies

Each healthcare facility sets specific policies, procedures, and protocols that govern nursing care. All nurses should be familiar with those that apply in the facilities in which they work. Nurses are involved in writing nursing policies and procedures that apply to their practice and in reviewing or revising them regularly.

Accountability

Nursing accountability involves knowledge of current laws. Accountability in child health nursing requires special consideration because the nurse must be accountable to the family as well as the child. For example, the Individuals with Disabilities Education Act (PL 94-142), which mandates free and appropriate education for all children with disabilities, provides for school nurses to be part of a team that develops an individual education plan for each child who is eligible for services. In school districts that are reluctant to involve the school nurse as part of the team, nurses may need to advocate for services for the child and family.

Federal and state legislative bodies have addressed the issue of child abuse. Considerable variation exists among state laws in the investigative authority and procedures granted to child protective workers. When child abuse is suspected, issues often arise as to whether a healthcare provider may investigate the home situation and obtain relevant records.

A recent issue pertaining to nursing accountability is inadequate hospital staffing as a result of budget cuts. A nurse has a duty to communicate concerns about staffing levels immediately through established channels. A nurse will not be excused from responsibility (e.g., late medication administration or injury resulting from inadequate supervision of a patient), just as a hospital will not be excused for insufficient staffing because of budget cuts.

Accountability also involves competency. If a nurse is not competent to perform a nursing task (e.g., to administer a new chemotherapeutic drug), or if a patient's status worsens to the point at which the care needs are beyond the nurse's competency level (e.g., a patient requiring hemodynamic monitoring), the nurse must immediately communicate this fact to the nursing supervisor or physician. Denial of a request for patient transfer to the intensive care unit (ICU) because the ICU is at full capacity is an insufficient defense in a charge of nursing negligence. In addition, the fact that a call was placed to a physician but there was no return call is no excuse for harm caused to a patient because of delayed treatment. The nurse has an obligation to pursue needed care through the established chain of command at the facility.

Malpractice

Negligence is the failure to perform the way a reasonable, prudent person of similar background would act in a similar situation. Negligence may comprise doing something that should not be done or failing to do something that should be done.

! NURSING QUALITY ALERT

Elements of Negligence

Duty. The nurse must have a duty to act or give care to the patient. It must be part of the nurse's responsibility.

Breach of Duty. A violation of that duty must occur. The nurse fails to conform to established standards for performing that duty.

Damage. There must be actual injury or harm to the patient as a result of the nurse's breach of duty.

Proximate Cause. The nurse's breach of duty must be proved to be the cause of harm to the patient.

Malpractice is the negligence by professionals, such as nurses or physicians, in performing their duties. Nurses may be accused of malpractice if they do not perform according to the established standards of care and in the manner of a reasonable, prudent nurse with similar education and experience. Four elements that must be present to prove negligence are duty, breach of duty, damage, and proximate cause (Guido, 2020).

Prevention of Malpractice Claims

Malpractice awards have escalated in both the number and amount of awards to plaintiffs, resulting in high malpractice insurance for all healthcare providers. In addition, more healthcare workers practice defensively, accumulating evidence that they are acting in the patient's best interest. For example, nurses must be careful to include detailed data when they document care. This responsibility is particularly important in perinatal nursing because this is the area in which most nursing lawsuits occur.

There are many reasons that perinatal nurses may become defendants in lawsuits. Complications are usually unexpected because parents view pregnancy and birth as normal. The birth of a child with a problem is a tragic surprise, and they may look for someone to blame. Although very small preterm infants now survive, some have long-term disabilities that require expensive care for the child's lifetime. Statutes of limitations vary in different states and with the cause for action, but plaintiffs may have more than 20 years to file lawsuits that involve a newborn.

The prevention of claims is sometimes referred to as *risk management* or *quality assurance*. Although it is not possible to prevent all malpractice lawsuits, nurses can help to defend themselves against malpractice judgments by following guidelines for informed consent, refusal of care, and documentation; acting as a patient's advocate; working within accepted standards and the policies and procedures of the facility; and maintaining their level of expertise.

Informed consent. When adults receive adequate information, they are less likely to file malpractice suits. Informed consent is an ethical concept that has been incorporated in the law. Patients have the right to decide whether to accept or reject treatment options as part of their right to autonomy. To make wise decisions, they need complete information regarding the treatments offered. Without proper informed consent, assault and battery charges can result.

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Requirements of Informed Consent

- Patient's competence to consent
- Full disclosure of information
- Patient's understanding of information
- Patient's voluntary consent

The law mandates what procedures require informed consent and what to inform about as "risks" specific to each procedure. Nurses must be familiar with the procedures that require consent.

Competence. Certain requirements must be met before consent can be considered informed. The first requirement is that the patient be competent or able to think through a situation and make rational decisions. A patient who is comatose or severely developmentally disabled is incapable of making such decisions. Minors are not allowed to give consent. However, children should have procedures explained to them in age-appropriate terms. In most states, minor status for informed consent ends at the age of 18 years.

A patient who has received drugs that impair the ability to think is temporarily incompetent. In such cases, another person is appointed to make decisions for the patient if the patient has not specified that person in advance.

Most states allow some exceptions for parental consent in cases involving emancipated minors. An *emancipated minor* is a minor child who has the legal competency of an adult because of circumstances involving marriage, divorce, parenting of a child, living independently without parents, or enlistment in armed services. Legal counsel may be consulted to verify the status of the emancipated minor for consent purposes.

Most states allow minors to obtain treatment for drug or alcohol abuse or STIs and to have access to birth control without parental consent. At present, the laws governing adolescent abortion widely vary from state to state.

Patient information about advance directives, such as a living will, durable power of attorney for healthcare, and an alternate decision maker for the person, must be assessed on admission to the healthcare facility. Hospitals are required to inform patients about advance directives, and this is often part of a nursing admission assessment. The person who has not made advance directives must be offered the opportunity to make these choices.

Full disclosure. The second requirement is that of full disclosure of information, including the treatment's purpose and expected results. The risks, side effects, and benefits, as well as other treatment options, must be explained to patients. The person must also be informed as to what would happen if no treatment were chosen.

For example, the National Childhood Vaccine Injury Act mandates that explanations about the risks of communicable diseases and the risks and benefits associated with immunizations should be provided to all parents to enable them to make informed decisions regarding their child's healthcare. Parents need to know the common side effects and what to do in case of emergency. Explanations should also be given to adults who receive these vaccines. The law stipulates that children injured by a vaccine must go through the administrative compensation system (funds from an excise tax levied on the vaccines) and reject an award before attempting to sue either the manufacturer or person who administered the vaccine in a civil suit. Furthermore, the law mandates certain record keeping and reporting requirements for nurses.

Understanding information. The patient, including the parent or legal guardian of a child, must comprehend information about the proposed treatment. Health professionals must explain the facts in terms the person can understand. Nurses must be patient advocates when they find that a person does not completely understand a treatment or has questions regarding it. If the nurse cannot explain it, she or he must inform the physician so that the patient's misunderstandings can be clarified.

During hospitalization and discharge preparations, considerations should be given to people who do not understand the prevailing language and to the hearing impaired. Foreign language and interpreters for the hearing impaired must be obtained when indicated. Provision for those who cannot read any language or adults with a low education level must also be considered.

Voluntary consent. Patients must be allowed to voluntarily make choices without undue influence or coercion from others. Although others can provide information, the patient alone or the parent or legal guardian of a child makes the decision. Patients should not feel pressured to choose in a certain manner or feel that their future care depends on their decision.

Children cannot legally consent for treatment or participation in research. However, they should be given the opportunity to give voluntary assent for research participation. Assent involves the principles of competence and full disclosure. Children should be provided information in a developmentally appropriate format. Patients 18 years and older must provide complete consent. When seeking assent from children, the nurse considers both the child's age and development. In general, when children have reached 14 years old, they are competent to understand the ramifications of a treatment or participation in research; however, recent neurobiologic assessment of adolescent brain development suggests that adolescents are more likely to make decisions based on emotion, rather than fact (Katz, Webb, & AAP Council on Bioethics, 2016); some children are competent at a somewhat younger age. Other factors to consider are the child's physical and emotional condition and behaviors, cognitive ability, history of family shared decision making, anxiety level, and disease context. In some states the child's dissent to participate in research is legally binding; thus nurses need to be aware of the legal issues in the states in which they practice. Parental consent for emergency treatment of children and adolescents might not be available in an emergency. In this instance, stabilization and emergency treatment must not be withheld and can be provided after a medical assessment of the emergency and inability to reach the parent or guardian (Katz et al., 2016).

Refusal of Care

Sometimes patients decline treatment, including hospitalization, offered by healthcare workers. Patients may refuse treatment when they believe that the benefits of treatment do not outweigh its burdens or the quality of life they can expect after treatment. Patients have the right to refuse care, and they can withdraw their agreement to treatment at any time. When a person makes this decision, a number of steps should be taken.

First, the physician or nurse should establish that the patient understands the treatment and the results of refusal. The physician, if unaware of the person's decision, should be notified by the nurse. The nurse documents on the chart the refusal, the explanations given to the patient, and the notification of the physician. If the treatment is considered vital to the patient's well-being, the physician discusses the need with the patient and documents the discussion. Opinions by other physicians may also be offered to the patient.

Patients may be asked to sign a form wherein they indicate that they understand the possible consequences of rejecting treatment. This measure is to prevent a later lawsuit in which the person claims lack of knowledge of the possible outcomes of a decision. If there is no ethical dilemma, the patient's decision stands.

Refusal of care by a pregnant woman involves the life of the fetus, sometimes resulting in legal actions. One example is a woman's refusal to a cesarean birth, although her refusal is likely to cause grave harm to the fetus. The outcomes of legal actions have been divided, some upholding the mother's right to refuse treatment and others ordering a treatment despite the mother's objections. Court action is avoided if possible because it places the woman, family, and caregiver in adversarial positions. In addition, it invades the woman's privacy and interferes with her autonomy and right to informed consent.

When parents refuse to provide consent for what is deemed a necessary treatment of a child, the state may be petitioned to intervene. The court may place the child in the temporary custody of the government or a private agency. The nurse may be asked to witness such a transaction when physicians act in cases of emergencies, such as a lifesaving blood transfusion for a child despite parental objections based on religious beliefs.

Adoption

Nurses may care for infants involved in adoptions. The nurse may need to consult with the birth parents, adoptive parents, social workers, obstetrician, or pediatrician to determine the various rights of the child, birth parents, and adoptive parents (e.g., in matters concerning visitation rights, informed consent, or discharge planning).

In open adoptions, the birth mother may opt to room in with the baby during hospitalization. The birth mother and adoptive parents typically have had contact before the delivery and have an informal agreement regarding shared responsibility for the baby. The birth parent may even participate in discharge planning because she may have extended rights to visit the child after adoption.

Issues may develop as to the state of mind of the birth mother at the time of relinquishing parental rights (which cannot occur until after birth, unlike the relinquishment of the birth father's rights). State laws vary as to the legal time period necessary (1 day to several weeks after the birth of the child) before a birth mother can lawfully relinquish her rights to the child.

Some state laws allow the birth mother to relinquish her rights immediately after birth. In such cases the nurse has the responsibility of protecting the birth mother and child to ensure that the birth mother is not coerced into making a decision while under the effects of medication. Factual documentation of such circumstances may be requested if the birth mother later asserts her rights to the child, claiming "undue influence" or "coercion."

Birth fathers have the same rights as birth mothers. Unless the birth father relinquishes his legal rights to the child, he may later assert his rights to the child after attachment has occurred with the adoptive parents. This situation may occur if the birth mother denies knowledge of the father's identity.

Documentation

Documentation, whether on paper or electronic media, is the best evidence that a **standard of care** has been maintained. All information recorded about a patient should reflect the standard of care at the time of occurrence. This information includes nurses' notes, electronic fetal monitoring records, flow sheets, and any other data in the patient record. In many instances, notations on hospital records, whether print or electronic, are the only proof that care was given. Expert witnesses, often registered nurses in the appropriate specialty, will search for evidence that the standard of care at the time of the incident was met. If not found in case documents, the expert witness must conclude that what should have been done was not done. When documentation is not present, juries tend to assume that care was not given. Documentation is an integral part of the process.

Documentation must be specific and complete. Nurses are unlikely to be able to recall details of situations that happened years ago and must rely on their documentation to explain their care if sued. Documentation must show that the standards of care and facility policies and procedures in effect at the time of the incident were met. Documentation must demonstrate that appropriate patient assessment and continued monitoring, problem identification and provision of correct interventions, and changes in patient status were communicated to the primary care provider. If the nurse believes that the primary care provider has responded inappropriately, the nurse must refer the provider response through the appropriate chain of command for the facility and document the notification.

Documenting discharge teaching. Discharge teaching is essential to ensure that new parents know how to take care of themselves and their newborn after their brief hospital stay. Nurses must document their teaching as well as the parents' degree of understanding of what was taught. The nurse should also note the need for reinforcement and how that reinforcement was provided. If follow-up home care is planned, teaching should be continued at home and documented by the home care nurse. Written documents of discharge teaching are signed by and provided to the patient.

Documenting incidents. A type of documentation used in risk management is the *incident report,* often called a *quality assurance, occurrence,* or *variance report*. The nurse completes a report when something occurs that might result in legal action, such as in injury to a patient or a departure from the expectations in the situation. The report warns the agency's legal department that there may be a problem. It also helps to identify whether changing processes within the system might reduce the risk for similar incidents in the future. Incident reports are not a part of the patient's chart and should not be referred to on the chart. Documentation of the incident on the chart should be restricted to the same type of factual information about the patient's condition that would be recorded in any other situation.

The analysis of medical error from a systems perspective is called a *root cause* analysis. The process involves identifying errors or near misses as soon as they occur, asking relevant questions about the factors that might have contributed to the error, analyzing the contributing causes, and developing interventions to prevent a similar error from occurring in the future. A root cause analysis is not intended to be punitive if an error was made. Instead, root cause analysis is used as a tool to prevent future errors or near misses.

The Nurse as an Advocate

Malpractice suits may be brought if nurses fail in their role of patient advocate. Nurses are ethically and legally bound to act as the patient's advocate. This means that the nurse must act in the patient's best interests at all times. When nurses feel that the patient's best interests are not being served, they are obligated to seek help for the patient from appropriate sources. This usually involves taking the problem through the chain of command established at the facility. The nurse consults a supervisor and the patient's physician or that physician's supervisor. If the results are not satisfactory, the nurse continues through administrative channels to the director of nurses, hospital administrator, and chief of the medical staff, if necessary. All nurses should know the chain of command for their workplace.

In seeking help for patients, nurses must document their efforts. For example, if a postpartum woman experiences excessive bleeding, the nurse documents what was done to control the bleeding. The nurse also documents each time the physician was called regarding the problem, what information was given to the physician, and the response received. When nurses cannot contact the physician or do not receive adequate instructions, they should document their efforts to seek instruction from others, such as the nursing supervisor or chief of medical staff for the specialty. They should also complete an incident report. It is essential that they continue in their efforts until the patient receives the care needed.

Nurses also must be advocates for health promotion and illness prevention for vulnerable groups such as children. Nurses can participate in groups dedicated to the welfare of children and families, such as professional nursing societies, parent support groups, religious organizations, and voluntary organizations. Through involvement with healthcare planning on a political or legislative level and by working

as consumer advocates, nurses can initiate changes for better-quality healthcare (O'Brien-Abel et al., 2021).

Maintaining Expertise

Maintaining expertise is another way for nurses and other health professionals to prevent malpractice liability. To ensure that nurses maintain their expertise to provide safe care, most states require proof of continuing education for renewal of nursing licenses. Nursing knowledge changes rapidly, and staying current is essential for all nurses. Incorporating new information learned by attending classes or conferences and reading nursing journals can help nurses to perform as would a reasonably prudent peer. Journals provide information from nursing research that may be important in updating nursing practice. It is important for all nurses to analyze research articles to determine whether changes in patient care are indicated.

Employers often provide continuing education classes for their nurses. Many workshops and seminars are available on a wide variety of nursing topics. Membership in professional organizations such as state branches of the ANA or specialty organizations such as AWHONN and the Society of Pediatric Nurses gives nurses access to new information through publications as well as nursing conferences and other educational offerings.

Maintaining expertise may be a concern when nurses "float" or are required to work with patients who have needs different from those of their usual patients. In these situations, the employer must provide orientation and education so that the nurse can perform care safely in new areas. Nurses who work outside their usual areas of expertise must assess their own skills and avoid performing tasks or taking on responsibilities in areas in which they are not competent. Many nurses learn to provide care in two or three different areas and are floated only to those areas. This system meets the need for flexible staffing while providing safe patient care.

CURRENT TRENDS AND THEIR LEGAL AND ETHICAL IMPLICATIONS

Recent healthcare changes have affected the way nurses give care and may have legal and ethical implications as well. These changes result from efforts to lower healthcare costs. Two of special concern are the use of unlicensed assistive personnel and early discharge.

Use of Unlicensed Assistive Personnel

In an effort to reduce healthcare costs, many agencies have increased the use of unlicensed assistive personnel to perform direct patient care and have decreased the number of nurses who supervise them. An unlicensed person may be trained to do everything from housekeeping tasks to drawing blood, performing diagnostic tests to giving medications, all in the same day. This practice raises grave concerns about the quality of care patients receive, because the nurse is responsible for the care of more patients but must rely on unlicensed personnel to perform much of the care formerly provided only by professionals. At the same time, use of an expert nurse for housekeeping and other mundane but necessary unit tasks is inefficient and detracts from available professional time for patient care. A balanced approach is needed when incorporating unlicensed assistive personnel into a unit's work.

Nurses must be aware of their legal responsibilities in these situations. They must know that the nurse is always responsible for patient assessments and must make the critical judgments necessary to ensuring patient safety. Nurses must know the capabilities of each unlicensed person caring for patients and must supervise them closely enough to ensure that they can perform their delegated tasks competently. More information about the use of unlicensed assistive personnel is available in a position statement from AWHONN (2015).

One area in which unlicensed assistive personnel may have greater responsibilities is in the school setting. Registered nurses who practice in schools are caring for children with more complex medical and nursing needs, responding to increased requirements for routine health screenings and dealing with budgetary cuts that result in a nurse caring for children in more than one school. These pressures have led to increased use of unlicensed assistive personnel to provide routine care to children with uncomplicated needs, including medication administration. If having a school nurse present at each school is not possible, then the school nurse can consider delegating certain responsibilities to properly trained, competent, unlicensed assistive personnel. Nurses who consider delegation must be familiar with their state's nurse practice act and appropriate professional standards (National Association of School Nurses, 2019). Before delegating, the nurse needs to determine tasks that are appropriate and safe, the complexity of children's needs, the school district policy, and the nurse's state board regulations. The nurse needs to work with the school administration to develop a comprehensive school-based policy (the nurse, not the administrator, decides what responsibilities will be delegated) before any responsibilities are delegated to others. The nurse is also responsible for educating and evaluating the competency of the unlicensed personnel; this includes requiring return demonstrations of procedures and regular onsite supervision. Most important is that delegation does not relieve the nurse from regular assessment of the children's responses to all treatments and medications (National Association of School Nurses, 2019).

Concerns About Early Discharge

Patients are discharged from the hospital quickly, usually no later than 48 hours after vaginal birth and often with minimal recovery time after illness or surgery. Healthcare professionals are concerned about the ability of women to care for themselves or their infant or child when discharge occurs very early. Women may be exhausted from a long labor or complications and unable to take in all the information that nurses attempt to teach before discharge. Once home, many women must care for other children as well, often without family members or friends to help them.

While a patient is in the birth or acute-care facility, professionals may notice indications of complications that may not be apparent to lay people. Mothers at home may not recognize the developing signs of serious maternal or neonatal infection or jaundice, and care may be delayed until the illness is severe. There may be legal issues if a patient develops a complication after early discharge.

Dealing With Early Discharge

Nurses must establish ways of helping patients who go home soon after birth or parents who must take their child home when only slightly less ill or very soon after surgery. New teaching tactics may be necessary, with more teaching taking place during pregnancy when the mother's physical needs do not interfere with her ability to assimilate new knowledge. Parent teaching can be done before actual admission of a child for surgery. If a child is admitted when acutely ill, parent teaching begins almost immediately after admission. Nurses can take advantage of any "teachable moment" to provide patients with the information they need to better care for themselves or their child.

Careful documentation and notification of the primary care provider are essential when abnormal findings develop so that patients are not discharged inappropriately. Methods of follow-up such as home visits, phone calls, or return visits by families to the birth facility for nursing assessments in the first 24 to 48 hours after discharge have become increasingly important. Nursing case managers are often involved to identify and advocate for the best avenues of care and to facilitate extension of stay if the patient's condition warrants.

KEY CONCEPTS

- Maternity and child healthcare in the United States have changed because of technologic advances, increasing knowledge, government involvement, and consumer demands.
- Family-centered maternity and child healthcare, based on the principle that families can make decisions about healthcare if they have adequate information, have greatly increased the autonomy of families and the responsibilities of nurses.
- Prospective payment plans, such as PPOs or HMOs, control healthcare costs by negotiating reduced charges with providers, such as facilities and physicians, and by restricting patient access to a specific list of providers.
- Capitated plans are those in which a group of providers agrees to provide all services for a patient for a set annual fee. If the patient requires more costly care, the provider network pays those added charges. If the patient requires less care than the annual fee, the network keeps the remaining money.
- Case and outcome managements have resulted in new tools to reduce the length of stay for mothers and infants in the birth facility. The preparation for continuation of care at home begins as soon as the mother or child enters the healthcare system.
- Clinical pathways are interdisciplinary guidelines for assessments and interventions that are designed to accomplish the identified outcomes in the shortest time.
- Home care of patients has increased because of the need to control costs and because of the availability of portable technology. The number of uninsured adults and children continues to be excessive, reducing their chances of receiving preventive healthcare and increasing the costs of the late care they often seek.
- Infant and maternal mortality rates have dramatically declined in the past 50 years. However, the United States continues to rank well below other developed nations, and infant mortality rates still widely vary across ethnic groups. Unintentional injuries are the leading causes of death in children aged 1 to 19 years.
- Nurses must examine their beliefs and come to a personal decision about abortion before they are faced with the situation in their practice. Nurses are obligated to share objections related to abortion care with their employer before the need to provide that care arises.
- Punitive approaches to ethical and social problems may prevent patients from seeking care, particularly preventive care.
- Poverty is a major social issue that leads to questions about the allocation of healthcare resources, access to care, government programs to increase healthcare to indigent women and children, and healthcare rationing.
- To give informed consent, the patient must be competent, receive complete information, understand that information, and voluntarily consent. The parents usually give consent for a minor child, although adolescents may be able to consent to their own treatment related to sexually transmitted diseases, contraception, and alcohol and drug abuse.
- Nurses are accountable for their practice and must be acquainted with the laws, standards of care, and agency policies and procedures that affect their practice.
- Nurses can help to defend malpractice claims by following the guidelines for informed consent, refusal of care, and documentation and by maintaining their level of expertise.
- Documentation is the best evidence that the standard of care was met in patient care. Therefore nurses must ensure that their documentation accurately reflects the care given. The nurse is the professional who decides what tasks may safely be delegated to unlicensed assistive personnel. In making such decisions, the nurse is guided by the recommendations of the state licensing board, standards of care, and agency policy.

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2

The Nurse's Role in Maternity, Women's Health, and Pediatric Nursing

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LEARNING OBJECTIVES

After studying this chapter, you should be able to:

- Explain roles the nurse may assume in the practice of maternity nursing, women's health, and nursing of children.
- Explain the roles of nurses with advanced preparation in the practice of maternity nursing, women's health, and nursing of children.
- Explain the incorporation of critical thinking as a part of clinical judgment into nursing practice.
- Describe the aspects and steps of using clinical judgment to provide high-quality care for maternity, women's health, and nursing of children.
- Explain issues surrounding the use of complementary and alternative therapies.
- Discuss the importance of nursing research and evidence-based care in clinical practice.

As care has changed from category-specific care for the woman, newborn, or child to family-centered care, the fields of maternity, women's health, and nursing care of children have entered a new era of autonomy and independence. Women may have unique problems such as menstrual or menopausal issues. However, healthcare research shows that women may not respond to disorders such as cardiovascular disease as a man does; thus, women's healthcare has become a specialty. Nurses today must be able to effectively communicate with and teach people of many ages and levels of development and education. They must be able to critically think and use clinical judgment to develop a plan of care that meets the unique needs of each person and their family. Nurses are expected to use current evidence to solve problems and to collaborate with other healthcare providers.

THE ROLE OF THE PROFESSIONAL NURSE

The professional nurse has a responsibility to provide the highest quality of care to every patient. Codes of ethics emphasize a nurse's accountability to the person, community and profession. Ethical principles form a framework on which ethical codes are developed, and many countries worldwide have ethical code statements for nurses, which are similar in their general approach (Box 2.1). The nurse should understand implications of these codes and strive to practice accordingly. Professional nurses have a legal obligation to know and understand the standard of care imposed on them. It is critical that nurses maintain competence and a current knowledge base in their areas of practice.

Standards of practice describe the level of performance expected of a professional nurse as determined by an authority in the practice (ANA, 2017). For example, perinatal nurses are held to the standards published by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). The most recent edition of AWHONN *Standards for Professional Nursing Practice in the Care of Women and Newborns* and *Standards for Perinatal Nursing Practice and Certification in Canada* were published to guide nursing practice and shape institutional guidelines (AWHONN, 2019; Canadian Association of Perinatal and Women's Health Nurses).

Nurses who care for children in all clinical settings can use the ANA/Society of Pediatric Nurses (SPN) *Standards of Care and Standards of Professional Performance for Pediatric Nurses* and the SPN/ANA *Guide to Family Centered Care* as guides for practice. Other standards of practice for specific clinical areas, such as pediatric oncology nursing and emergency nursing, are available from nursing specialty groups.

As healthcare continues to move toward family-centered and community-based health services, all nurses should expect to care for children, adolescents, and their families at the point of contact. The SPN has issued several position statements regarding the inclusion of pediatric nursing content when planning undergraduate nursing programs in response to changes in settings of care. The statements address such important pediatric issues such as racial inequality in healthcare, tobacco exposure, promotion of breastfeeding, addressing special needs of children and families during a disaster, separation of children from caregivers, and obesity (Society of Pediatric Nurses [SPN], 2020).

Nurses who provide care to women, children, and families function in various roles, including care provider, teacher, collaborator, researcher, advocate, and manager.

Care Provider

The nurse provides direct patient-centered care to women, infants, children, and their families in times of childbearing, illness, injury, recovery, and wellness. Nursing care is provided in a variety of settings and incorporates both critical thinking and clinical judgment. The nurse obtains health histories, assesses patient needs, monitors growth and development, performs health-screening procedures, develops comprehensive plans of care, provides treatment and care, makes referrals, and evaluates the effects of care. Nursing of children is especially based on an understanding of the child's developmental stage and is aimed at meeting the child's physical and emotional needs at that level. Developing a therapeutic relationship with and providing support to patients and their families are essential components of nursing care. Maternity and pediatric nurses practice family-centered care, embracing diversity in family structures and cultural backgrounds. These nurses strive to empower families, encouraging them to participate in self-care and the care of their child. Nurses who practice women's healthcare may need to coordinate care with pediatric nurses for families headed by grandparents rather than parents of the child.

BOX 2.1 Codes of Ethics for Nurses

Principle of Beneficence – Promote good

- A primary commitment for a nurse is to people (individuals, families, communities, and populations) who need care, regardless of care setting.
- Care should be compassionate, person-centered, and within the context of trusting relationships.
- There should be recognition of the relationship between self-care and optimal patient care.
- Provision of guidance and support for coworkers and other colleagues will enhance the work environment.

Principle of Nonmaleficense – Avoid harm

- Nurses should provide a safe, high-quality environment that does not tolerate violence in any form.
- Nurses have accountability for provision of professional care as well as following standards of practice and the law.
- There is a responsibility to intervene where there are unethical or unsafe practices, as well as to create an ethical environment and conditions of employment.
- There should be ongoing involvement in research, evidence-based practice, and policy development.

Principle of Autonomy – Maintain privacy, confidentiality, and enable decision-making

- Nurses provide people with the information they need to make appropriate decisions about their care.
- Maintaining confidentiality is important for patients, families, and colleagues.
- Nurses should respect and support the patient's or family's decision-making.

Principle of Justice – Treat all people fairly, regardless of race, culture, socioeconomic status, gender, and sexual identity

- Nurses, in collaboration with others, need to cultivate an environment of respect, fairness, support for human rights, social justice, and nondiscrimination.
- Nurses should advocate to protect patient rights, to support vulnerable populations, and consider social determinants of health when planning and providing care.
- Nurses need to respect the dignity, integrity, and values of others.

Information from: American Nurses' Association (2015). *Code of ethics for nurses with interpretive statements*. www.nursingworld.org; Canadian Nurses Association (2017). *2017 Code of ethics for nurses*. www.cna-aiic.ca/ethics; International Council of Nurses (2021). *The ICN code of ethics for nurses*. www.icn.ch.

Teacher

Education is an essential role played by today's nurse. Teaching begins early—before and during a woman's prenatal care—and continues through her recovery from childbirth, learning to care for her newborn, and into her care in women's health (Fig. 2.1). Nurses who care for children prepare them for procedures, hospitalization, or surgery using knowledge of growth and development to teach at various levels of understanding. Families need information as well as emotional support so that they can cope with the anxiety and uncertainty of a child's illness. Nurses teach family members how to provide care, watch for important signs and symptoms, and increase the child's comfort. They also work with new parents and parents of ill children so that the parents are prepared to assume responsibility for care at home after the child has been discharged from the hospital.

Education is essential to promoting health. The nurse applies principles of teaching and learning to change the behavior of family members. Nurses motivate women, children, and families to take charge of and make responsible decisions about their own health. Effective teaching must incorporate the family's values and health beliefs.

FIG 2.1 In the prenatal clinic, the nurse teaches a woman one-on-one.

Nurses caring for children and families play an important role in preventing illness and injury through education and anticipatory guidance. Teaching about immunizations, safety, dental care, socialization, and discipline is a necessary component of care. Nurses offer guidance to parents with regard to child-rearing practices and preventing potential problems. They also answer questions about growth and development and assist families in understanding their children. Teaching often involves providing emotional support and counseling to children and families.

Factors Influencing Learning

Numerous factors influence learning at any age. These include:

- *Developmental level.* Teenage parents often have very different concerns than older parents. Grandparents who assume long-term care for a child often need information that may not have been available when their own child was the same age. Developmental level also influences whether a person learns best by reading printed material, using computer-based materials, watching videos, participating in group discussions, play, or other means. Teaching must be adapted to the child's developmental level rather than the child's chronologic age.
- *Language.* Assessment of language needs is crucial in providing high quality care. Healthcare language interpreters should be available; avoid use of family members. An interpreter for the deaf and/or hard of hearing should also be available.
- *Culture.* Nurses must understand cultural beliefs and practices that are different from their own. Patient education can be most effective if cultural considerations are weighed and incorporated into teaching.
- *Previous experiences.* Parents who have other children may need less education about pregnancy care or infant and child care. However,

they may have additional concerns about meeting the needs of several children and about sibling rivalry.
- *Physical environment.* The nurse must consider privacy when discussing sensitive issues such as adolescent sexuality or domestic violence, also called *intimate partner violence.* However, a group discussion may prompt participants to ask questions of concern to all members of the group, such as the experiences they can expect during labor.
- *Organization and skill of the teacher.* The teacher must determine the teaching objectives, develop a plan to meet those objectives, and gather all materials before teaching. The nurse must determine the best way to present the material for the intended audience. A summary of the information is helpful when concluding a teaching session.

Principles of Teaching and Learning

Applying the following principles will help nurses become effective teachers in the childbearing or childrearing setting:
- Real learning depends on the readiness of the family to learn and the relevance of the content.
- Active participation increases learning. Whenever possible, the learner should be involved in the educational process and not act as a passive listener or viewer. A discussion format in which all can participate stimulates more learning than a straight lecture.
- Repetition of a skill increases retention and promotes a feeling of competence.
- Praise and positive feedback are powerful motivators for learning. They are particularly important when the family is trying to master a frustrating task, such as breastfeeding an unresponsive infant or changing a wound dressing on a young child.
- Role modeling is an effective method for demonstrating behavior. Nurses must be aware that their behavior is scrutinized carefully at all times and that it may be copied later.
- Conflicts and frustration impede learning and should be recognized and resolved for learning to progress.
- Learning is enhanced when teaching is structured to present simple tasks before more complex material. For example, the nurse teaches how to care for the umbilical cord, which is simple, before teaching how to bathe and shampoo the newborn, which is more difficult for inexperienced parents.
- Various teaching methods are necessary to maintain interest and to illustrate concepts. Posters, videos, and printed materials supplement lectures and discussion. Models may be especially useful for teaching family planning or the process of labor or for teaching a child how to use a peak expiratory flow meter.
- Information is retained better when presented in small segments over a period of time. Short hospital stays do not support this practice, making follow-up care particularly important for some patients.

Collaborator/Coordinator

Nurses collaborate with other members of the healthcare team, often coordinating and managing the patient's care. The ANA emphasizes that care coordination is an essential function for nurses; appropriate care coordination increases patient satisfaction and contributes to lower healthcare costs (American Nurses Association [ANA], 2018). Care coordination is an integral part of the effectiveness of the Affordable Care Act (ACA). Care coordination can occur on an inpatient or outpatient basis, and within some of the ACA newer delivery models, such as the medical home and accountable care organizations. It is focused on providing the highest-quality care, considering patient and family preferences, over time and across settings (ANA, 2018). Care is improved by an interdisciplinary approach as nurses work together with dietitians, social workers, physicians, and others. Comprehensive and thorough interdisciplinary communication enhances the effectiveness of collaboration, promotes critical thinking skills, and improves situation awareness. Such communication tools as situation, background, assessment, and recommendation (SBAR), hand-off reports, and closed-loop communication (message sent, receiver acknowledges, receiver verifies with sender) facilitate the delivery of reliable and safe care (Stewart & Hand, 2017).

Managing the transition from a hospital or any other acute-care setting to the patient's home or another facility involves discharge planning and collaboration with other healthcare professionals. The trend toward home care makes collaboration increasingly important, especially in preventing hospital readmissions. The nurse must be knowledgeable about community resources, appropriate home care agencies for the type of patient or problem, and social work resources. Cooperation and communication are essential because patients, including parents of children, are encouraged to participate in their care.

Researcher

Nurses contribute to their profession's knowledge base by systematically investigating theoretic or practice issues in nursing. Nursing does much more than simply "borrow" scientific knowledge from medicine and basic sciences. Nursing generates and answers its own questions based on evidence within its unique subject area. The responsibility to provide evidence-based, patient-centered care is not limited to nurses with graduate degrees. It is important that all nurses appraise and apply appropriate research findings to their practice rather than basing care decisions merely on intuition or tradition (Melnyk & Fineout-Overholt, 2020).

Evidence-based practice is no longer just an ideal but an expectation of nursing practice. Nurses can contribute to the body of professional knowledge by demonstrating an awareness of the value of nursing research and assisting in problem identification and data collection. Nurses should keep their knowledge current by networking and sharing research findings at conferences, by publishing, and by evaluating research journal articles (Melnyk & Fineout-Overholt, 2020).

Advocate

An **advocate** is one who speaks on behalf of another. Care can become impersonal as the healthcare environment becomes more complex. The wishes and needs of children and families are sometimes discounted or ignored in the effort to treat and to cure. As the health professional who is closest to the patient, the nurse is in an ideal position to humanize care and to intercede on the patient's behalf. As an advocate, the nurse considers the family's wishes and preferences when planning and implementing care. The nurse informs families of treatments and procedures, ensuring that the families are involved directly in decisions and activities related to their care. The nurse must be sensitive to families' values, beliefs, and customs.

Nurses must be advocates for health promotion and healthcare access for vulnerable groups such as children, victims of domestic violence, and elders in the family. Nurses can promote the rights of children and families by participating in groups dedicated to their welfare, such as professional nursing societies, support groups, religious organizations, and voluntary organizations. Through involvement with healthcare planning on a political or legislative level and by working as consumer advocates, nurses can initiate changes for better quality healthcare. Nurses possess unique knowledge and skills and can make valuable contributions in developing healthcare strategies to ensure that all patients receive optimal care.

Manager of Care

Because stays in acute-care facilities are short, nurses often are unable to provide total direct patient care. Instead they delegate concrete tasks, such as giving a bath or taking vital signs, to others. As a result,

nurses spend more time teaching and supervising unlicensed assistive personnel, planning and coordinating care, and collaborating with other professionals and agencies. Nurses are expected to understand the financial effects of cost-containment strategies and to contribute to their institution's economic viability. At the same time, they must continue to act as patient advocates and to maintain a standard of care.

ADVANCED PREPARATION FOR MATERNITY AND PEDIATRIC NURSES

The increasing complexity of care and a focus on cost containment have led to a greater need for nurses with advanced preparation (ANA, n.d.). Advanced practice nurses are certified nurse midwives (CNMs), nurse anesthetists, nurse practitioners, and clinical nurse specialists. Nurses also may work in advanced roles such as clinical nurse leaders (CNLs), nurse administrators, nurse educators, and nurse researchers. Preparation for advanced practice involves obtaining a master's or doctoral degree.

Certified Nurse Midwives

CNMs are registered nurses who have completed an extensive program of study and clinical experience. They must pass a certification test administered by the American College of Nurse Midwives. CNMs are qualified to provide complete care during pregnancy, childbirth, and the postpartum period in uncomplicated pregnancies. They provide information about preventive measures and preparation for normal pregnancy and childbirth. They spend a great deal of time counseling and supporting the childbearing family. The CNM also provides gynecologic services as well as family planning and counseling.

Despite the proven effectiveness of nurse midwives, they were restricted in the scope and location of their practice for many years. However, many of these restrictions were lifted in 1970 when the American College of Obstetricians and Gynecologists, together with the Nurses Association of the American College of Obstetricians and Gynecologists (now known as the Association of Women's Health, Obstetric and Neonatal Nurses), issued a joint statement that admitted nurse midwives as part of the healthcare team. In 1981, Congress authorized Medicaid payments for the services of CNMs. This measure has greatly increased the use of nurse midwives, particularly by health maintenance organizations (HMOs), in birthing centers and in some hospitals.

Nurse Practitioners

Nurse practitioners are advanced practice nurses who work according to protocols and provide many primary care services once provided only by physicians. Most nurse practitioners collaborate with a physician; depending on their scope of practice and their individual state's board of nursing mandates, they may work independently and prescribe medications. Nurse practitioners provide care for specific groups of patients in various settings (primary care facilities, walk-in clinics, schools, acute care facilities, rehabilitation centers). They may address occupational health, women's health, family health, and the health of the elderly or the very young.

Women's health nurse practitioners provide wellness-focused, primary, reproductive, and gynecologic care over the life span but do not usually manage care of women during pregnancy and birth. Common responsibilities include performing well-woman examinations, screening for sexually transmitted infections, and providing family planning services. Some hospitals employ women's health nurse practitioners to assess and screen women who present to obstetric triage units, many of whom have nonobstetric problems.

Family nurse practitioners are prepared to provide care for people of all ages. They may care for women during uncomplicated pregnancies and provide follow-up care for the mother and infant after childbirth. Unlike CNMs, they do not assist with childbirth. They diagnose and treat patients holistically, with a strong emphasis on prevention.

Pediatric nurse practitioners use advanced skills to assess and treat well and ill children according to established protocols. The healthcare services they provide range from physical examinations and anticipatory guidance to the treatment of common illnesses and injuries. Staffing of newborn nurseries and children's hospital specialty units by neonatal or pediatric nurse practitioners is becoming more common.

School nurse practitioners receive education and training similar to that of pediatric nurse practitioners. However, because of the setting in which they practice, school nurse practitioners receive advanced education in managing chronic illness, disability, and mental health problems in a school setting and learn skills required to communicate effectively with students, teachers, school administrators, and community healthcare providers. School nurse practitioners expand the traditional role of the school nurse by providing on-site treatment of acute problems and providing extensive well-child examinations and services.

Clinical Nurse Specialists

Clinical specialists are registered nurses who, through study and supervised practice at the graduate level (master's or doctorate), have become expert in the care of childbearing families or pediatric patients. Four major subroles have been identified for clinical nurse specialists: expert practitioner, educator, researcher, and consultant. These professionals often function as clinical leaders, role models, patient advocates, and change agents. Unlike nurse practitioners, clinical nurse specialists are not prepared to provide primary care.

Certified Registered Nurse Anesthetists

Certified registered nurse anesthetists (CRNAs) provide anesthesia to a patients in a variety of care settings. They are certified to provide a full spectrum of anesthesia care, including for surgical procedures and in critical care settings.

Clinical Nurse Leaders

The CNL is a master's-prepared nurse generalist whose focus is the quality, safety, and optimal patient outcomes at point of care, regardless of care setting (American Association of Colleges of Nursing [AACN], 2020). CNLs provide direct patient care in a variety of healthcare settings, some providing safe and optimal care to women, children, and families. They ensure continuity of care, apply research findings to care, improve outcomes, and have decision-making authority (AACN, 2020). All CNLs receive the same basic preparation in a master's program, which includes advanced pathophysiology, pharmacology, and health assessment, along with other courses that prepare them to assume leadership roles within their specific practice setting. Extensive practicum experiences assist them with assessing quality and safety at the micro- and macro-systems level to improve direct patient care. A certification examination is available.

IMPLICATIONS OF CHANGING ROLES FOR NURSES

As nursing care has changed, so also have the roles of maternity and pediatric nurses with both basic and advanced preparation. Nurses now work in various areas. Although they previously worked almost exclusively in the hospital setting, many now provide home care and community-based care. Some of the settings for care of maternity and pediatric patients include:

- Acute care settings: general hospital units, intensive care units, surgical units, postanesthesia care units, emergency care facilities, and onboard emergency transport craft

- Clinics and physicians' offices, including ambulatory care settings such as "minute clinics" that are often accessed by families with children
- Home health agencies
- Schools
- Rehabilitation centers and long-term care facilities
- Summer camps and daycare centers
- Hospice programs and respite care programs
- Psychiatric centers

Therapeutic Communication

Regardless of the setting in which nurses practice, therapeutic communication is a skill that nurses must have to carry out their many expected duties within the profession. Therapeutic communication, unlike social communication, is purposeful, goal directed, and focused. It is designed to focus on patient and family acquisition of knowledge, patient well-being, and facilitating the patient's ability to practice self-care. It also requires developing a trusting relationship with the patient (Amoah et al., 2019). Although it may seem simple, therapeutic communication requires conscious effort and considerable practice. Providing therapeutic communication often requires the nurse to be "present." Presence is a holistic model of communication where nurses intentionally connect with patients within an atmosphere of compassion, recognizing both objective and subjective cues, being open and non-judgmental, and together being in the here and now (Hansbrough & Georges, 2019). When the nurse is truly present, the nurse is mindful of the patient's and family's needs and takes the time to listen, empathize, and "be" with them (Hansbrough & Georges, 2019). To an extent, therapeutic communication is "power sharing," meaning there is a reciprocal communication between nurse and patient (Campbell & Angelo Aredes, 2019).

Although nurses recognize the value of therapeutic communication, there are some barriers, not the least of which is lack of time in a fast-paced setting. Other possible barriers to therapeutic communication include changes in the ways people communicate, adaptation to cultural differences, and deciding when to use verbal versus nonverbal interactions (Campbell & Angelo Aredes, 2019).

Guidelines for Therapeutic Communication

Therapeutic communication requires flexibility and cannot depend on a particular set of learned techniques. However, certain guidelines may prove helpful.

- A calm setting that provides privacy, reduces distractions, and minimizes interruptions is essential.
- Interactions should begin with introductions and clarification of the nurse's role. The nurse might say, "My name is Claudia. I am here to complete the discharge teaching that was started yesterday." This introduction describes the nurse's purpose and sets the stage for a discussion of the patient's concerns about what happens when the family is discharged from the hospital.
- Therapeutic communication should focus on meeting the needs expressed by the family. Beginning the interaction with an open-ended question such as "How do you feel about going home with your baby today?" is one method of focusing the interaction. Redirecting the conversation may also be necessary. For example, the nurse might say, "Thanks for showing me the beautiful pictures of the baby. I understand you are having a bit of trouble getting him to nurse." Active listening while the nurse is present requires the nurse to attend to what is being said as well as to nonverbal cues. It is important to recognize cultural differences in the way people communicate, including language as well as sense of personal space and eye contact.
- Nonverbal behaviors may communicate more powerful messages to the patient than the spoken word. For example, facial expressions and eye movements can confirm or contradict what is said. Repetitive hand gestures, such as tapping the fingers or twirling a lock of hair, may indicate frustration, irritation, or boredom. Body posture, stance, and gait can convey energy, depression, or discomfort. Voice tone, pitch, rate, and volume may indicate joy, anger, or fear. Communicating with a young child may require that the nurse sit or squat to get to the child's level.

Therapeutic Communication Techniques

Therapeutic communication involves responding as well as listening, and nurses must learn to use responses that facilitate rather than block communication. These facilitative responses, often called *communication techniques,* focus on both the content of the message and the feeling that accompanies the message. Communication techniques include clarifying, reflecting, being silent, questioning, and directing. A brief review of these and other communication techniques can be found in Box 2.2. In addition to being aware of effective communication techniques, nurses must be aware of behaviors that block communication, as listed with examples and alternatives in Table 2.1. More detailed methods of communicating with children and their families are described in Chapter 4.

Clinical Judgment

Optimal patient- and family-centered care relies on the nurse's expertise in clinical judgment. Clinical judgment uses multiple approaches to thinking about care and is the final outcome of the combination of critical thinking and clinical reasoning (decision-making) (Klenke-Borgmann, Cantrell, & Mariani, 2020; Sherill, 2020). "It is an iterative process that uses nursing knowledge to observe and access presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions to deliver safe client care" (National Council of State Boards of Nursing [NCSBN], 2018, p. 12). Clinical judgment is a problem-solving approach that uses decision-making and incorporates the use of reflection in nursing care (Ignatavicius, 2021). Clinical judgment is a process of recognizing and analyzing cues, prioritizing hypotheses, generating solutions, taking action, and evaluating outcomes in clinical situations. Factors such as the environment, time constraints, task complexity, consequences, and risk are included in clinical judgment (Sherill, 2020).

Critical Thinking as a Component of Clinical Judgment

The critical thinking process begins when a nurse realizes that it is not enough to accumulate a fund of knowledge from texts and lectures. Nurses must also be able to *apply* the knowledge to specific clinical situations, and thus, to reach conclusions that provide the most effective care in each situation.

The nurse begins the process of critical thinking by reflecting on both personal assumptions and possible biases about the patient and family and their situation. Both of these can result in unsound actions based on stereotyping and unrealistic appraisal of the person's actual needs. Another aspect that can result in inappropriate action is the nurse's perception that decision-making must be made quickly, feeling pressure to come to a definite conclusion without considering multiple aspects of a situation.

Critical thinking requires the nurse to gain expertise in collecting, organizing, and analyzing data, which involves developing an attitude of **inquiry** and learning to live with questions. Having comprehensive data assists the nurse to recognize cues that might indicate patient problems.

Collecting data. To obtain complete data, one must develop skill in verbal communication. Asking open-ended questions elicits more information than asking questions that require only a one-word answer. Follow-up questions are often needed to clarify information

BOX 2.2 Communication Techniques

Definition	Examples
Clarifying Clearing up or following up to understand both content and feelings expressed, to check the accuracy of how the nurse perceives the message	"I'm confused about your plans. Could you explain?" "Tell me what you mean when you say you don't feel like yourself." "Are you saying that _____?" "Can you tell me more about _____?"
Paraphrasing Restating in words other than those used by the patient, what the person seems to express; this is a form of clarification.	Example 1 Patient: "My boyfriend won't even come into the room for the birth. I am furious with him." Nurse: "You want him with you, and you are angry because he won't be here?" Example 2 Patient: "My baby cries all of the time. We aren't getting any sleep." Nurse: "You are feeling exhausted, and it seems like your baby cries a great deal? Can you tell me what a typical day is like?"
Reflecting Verbalizing comprehension of what the patient said and what the person seems to be feeling. It is important to link content and feeling and to reflect the patient as a mirror reflects a person. The opinion, values, and personality of the nurse should not be in the reflected image.	Example 1 Patient: "I don't know what to do. My husband doesn't think a cesarean is needed, but the doctor says the baby is showing some stress." Nurse: "You're confused and frightened because they don't agree?" Example 2 Patient (woman in early labor): "It was my husband's idea for me to become pregnant. I wasn't too excited about it at first." Nurse: "I'll bet the dad will be a pushover as a father." The nurse's statement reflects the nurse's opinion and fails to acknowledge the mother's statement. A better response might be: "Your husband was more excited early in the pregnancy than you?"
Silence Waiting and allowing time for the person to continue. Verbal communication need not be constant.	The nurse waits quietly for the person to continue.
Structuring Creating guidelines or setting priorities	"You said you don't know how to take care of the baby and that you are afraid of getting pregnant again. What should we talk about first?"
Pinpointing Calling attention to differences or inconsistencies in statements	Nurse talking to an 8-year-old child: "You said you didn't want your mother to spend the night with you, but you cry every night after she leaves. It can be scary being alone. I will sit with you, and we can talk about asking your mother to stay tomorrow night."
Questioning Eliciting information directly; using open-ended questions to avoid yes or no answers and to prevent controlling the answers	"How do you feel about being pregnant?" instead of "Are you happy to be pregnant?" "Will you tell me how you feel about your brother being very sick?" instead of "Are you frightened because your brother is very sick?"
Directing Using nonverbal responses or succinct comments to encourage the patient to continue	Nodding. "Um mm." "You were saying." "Please go on."
Summarizing Reviewing the main themes or issues that were discussed	"You had two major concerns today." "We have talked about breastfeeding and how to bathe the baby today."

or to pursue a particular train of thought. It is also important to collect historical data that might have bearing on the current clinical situation.

Validating data. Information that is unclear or incomplete should be **validated**. This process may involve rechecking physical signs, collecting additional information, or determining whether a perception is accurate.

Organizing and analyzing data. Data are more useful when organized into patterns or clusters. The first step is to separate data that are relevant from data that may be interesting but that are not related to the current situation. The next step is to compare one's data with expected norms to determine what is within the expected range (normal) and what is not (abnormal).

TABLE 2.1 Behaviors That Block Communication

Behavior	Example	Alternative
Conveying lack of interest	Looking away, fidgeting	Attending behaviors such as eye contact, nodding
Conveying sense of haste	Checking the time, standing near the door	Sitting at bedside
Closed posture	Arms crossed over chest, holding clipboard in front of body	Leaning forward with arms relaxed
Interrupting, finishing sentences	Woman: "I'm not sure how _____." Nurse: "We will have a bath demonstration later."	"Go on _____." "You were saying _____."
Providing false reassurance	"You're going to be okay."	"I sense you are concerned about how to care for the baby. I will help you give the bath today."
Inappropriate self-disclosure	To woman in labor: "I was in labor 12 hours, then had a cesarean."	"What concerns you most about labor?"
Giving advice	"You should _____." "If I were you, I would _____."	"How do you feel about that?" "What do you think is most important?"
Failure to acknowledge comments or feelings	Mother: "Being a parent is hard work. I never have time for myself." Nurse: "It is going to get worse before it gets better. Parenting is hard work."	"Parenting is hard work. Let's talk about some ways that you might get a break."

Evaluating other factors. Various emotions and environmental factors can influence critical thinking, such as the hectic pace of the clinical area, time limitations, distractions, or fatigue that reduces one's ability to concentrate at the end of a 12-hour shift.

CLINICAL JUDGMENT AND NURSING PROCESS IN MATERNITY AND PEDIATRIC CARE

The nursing process consists of five distinct steps: (1) assessment, (2) nursing diagnosis, (3) planning, (4) implementation of the plan (interventions), and (5) evaluation. Nursing process is a systematic method of directing nursing care, and has evolved as an approach that uses a standard terminology that can be understood and followed consistently by all nurses providing individualized care to a specific patient or family. Providing care using the clinical judgment model is similar in many ways to the nursing process; it is organized around specific steps and involves modifying and adapting care as the patient's situation unfolds. The problem-solving steps of clinical judgment are similar, and result in a plan of care that is ongoing and dynamic, and that considers nursing actions within the context of changing patient and family experiences (Box 2.3).

In maternal–newborn nursing, nursing care must be adapted to a population that is generally healthy and is experiencing a life event that holds the potential for growth as well as for problems. Much maternal–newborn nursing activity is devoted to assessing and building upon patient strengths and healthy functioning, and to supporting adaptive responses. This focus is similar to preventive care in both women's health and pediatric checkups and immunizations but differs somewhat from providing care for ill patients of any age.

Nursing of children, including care of a newborn, presents another challenge for many nursing students. While nursing care for adults may involve only the patient, in caring for infants and children the nurse must involve the family as well. Therefore, it is common to identify what the parent is expected to do or to specify actions (such as teaching a parent). The involvement of a third party (the family) may be new to the nursing student who only has had experience in caring for adults.

Recognize Cues (Assessment)

The first step in incorporating clinical judgment in the provision of high-quality care is the systematic collection of relevant data to determine the patient's and family's current health status, coping patterns, needs, and problems. The data collected include not only physiologic data but also psychological, social, and cultural data relevant to life processes. Nurses must assess the belief systems, available support, perceptions, and plans of other family members in an effort to provide the best nursing care. Information about patient and family environment and health history is important also.

Nurses collect data through interview, physical examination, observation, review of records, and diagnostic reports, as well as through the family and interprofessional collaboration. Two levels of comprehensive data collection include: (1) screening (database) assessment and (2) focused assessment.

Screening Data Collection

The screening, or database, assessment is usually performed during the initial contact with the person, whether in a well or inpatient setting. Its purpose is to gather information about all aspects of the adult's or child's health. This information, called **baseline data**, describes the individual's health status before interventions begin. Baseline data provide the basis for identifying both strengths and problems in the person's health. An example of baseline data would be information in a woman's prenatal record or the infant's birth information when beginning well-child checks.

Focused Data Collection

Focused data collection provides information that is specifically related to an actual health problem or a problem that the patient or family is at risk for acquiring. This type of data collection is often performed at the beginning of a shift or provider visit and centers on areas relevant to the patient's diagnosis and current status. For example, the nurse would collect data focused on the respiratory system several times during the child's hospitalization for the child with acute asthma.

Regardless of the type or method of data collection, data provide the nurse with indicators as to what is more or less important to address, depending on the patient or family condition. Referred to as "triggers," these cues assist the nurse to form hypotheses about what is currently happening or what might be expected to happen (Ignatavicius, 2021).

Analyze (Nursing Diagnosis)

The gathered data must be analyzed to identify problems or potential problems. Data are validated and grouped using critical thinking, so that cues and **inferences** (drawing conclusions) can be determined. Analysis also assists the nurse to identify which of the data are most concerning, versus data that would not need immediate attention. The data are analyzed in the context of the patient's current or potential conditions and experiences (Ignatavicius, 2021).

BOX 2.3 Developing Individualized Nursing Care

Achieving high-quality outcomes for women, children, and families, regardless of setting, requires proficiency in collecting and analyzing data, prioritization, recognizing deviations, planning and providing individualized nursing care within the context of the patient's current experience. It might be helpful to think of and pose questions of yourself and others to gain a better understanding of the patients' and families' needs.

Recognize Cues (Assessment)

1. Were there cues that were not within normal limits or expected parameters? *For example, a woman who has recently delivered a baby states that she feels dizzy when she tries to ambulate.*
2. If so, what additional information should be obtained? (What else should I look for? What might be related to this symptom?) *For example, what are the blood pressure, pulse, skin color, temperature, and amount of lochia if the patient feels dizzy?*
3. If the data are not as expected, what might be the cause? *What are the prepregnancy and current hemoglobin and hematocrit values? What was her estimated blood loss (EBL) during childbirth?*
4. Are there other factors? *What medication is the patient taking? How long has it been since she has eaten? Is the environment a related factor (crowded, warm, and unfamiliar)? Is she reluctant to ask for assistance?*

Analyze Cues (Analysis)

1. Are adequate data available to reach a hypothesis about her condition? What else is needed? (What do you wish you had assessed? What would you look for next time?)
2. What is the major concern? (On the basis of the data, what are you worried about?) Does her condition require immediate action? If so, what might that be? *The woman who is dizzy may fall as she walks to the bathroom or she may drop her new baby. Or her dizziness may be a clue that a new complication is developing.*
3. Are there cues that are not relevant to the situation? What might happen if no action is taken? (What might happen to the patient if you do nothing?) *She may suffer an injury or a complication.*
4. Considering the data you collected, what hypotheses have you developed? What are the most important and relevant contributing cues? *Suppose that during analysis you decide the major concern is that the patient will faint and suffer an injury.* Are there any additional hypotheses that, if acted upon, might address the concern?
5. What might be additional risk factors?
6. Is this a problem that nurses can manage independently? Is collaboration with other health professionals needed?

Generate Solutions (Planning)

1. What outcomes are desired? *That the patient will remain free of injury during hospital stay? That she will demonstrate position changes that reduce the episodes of vertigo? That she will request assistance to ambulate until she feels less dizzy?*
2. Would the outcomes be clear, specific, and measurable to anyone reading them?
3. What nursing actions might be initiated and carried out to accomplish these goals or outcomes?
4. Are your possible actions specific and clear? Are action verbs used *(assess, teach, assist)*? Do your proposed actions define exactly what is to be done (when, what, how far, how often)? *Will they prevent the patient from suffering an injury?*
5. Are the interventions based on sound rationale? *For example, blood loss during birth may be excessive, resulting in hypotension that is aggravated when the woman stands suddenly.*

Take Action (Implementation)

1. What are the expected effects of the prescribed actions? Are there potential adverse effects? What are they?
2. Are the interventions acceptable to the patient and family?
3. Are the actions clearly written so that they can be carefully followed?

Evaluate Outcomes (Evaluation)

1. What is the status of the patient right now?
2. What were the goals and outcomes? Are they specific? Can they be measured?
3. Compare the current status of the patient with the stated goals and outcomes.
4. What should be done next?

In the analysis step of the nursing process, the nurse reaches a **nursing diagnosis**, which identifies a person's responses to actual or potential health problems and to normal life processes. Nursing diagnosis provides a basis for developing interventions and outcomes. An *actual nursing diagnosis* describes a human response to a health condition or life process affecting an individual, family, or community; actual diagnoses are supported by data (manifestations, signs, and symptoms) that can be clustered in patterns of related cues or inferences. A *risk nursing diagnosis* describes a human response to a health condition or life process that may develop in a vulnerable individual, family, or community. Such a diagnosis is supported by risk factors that contribute to increased vulnerability. A *wellness nursing diagnosis* describes a human response to levels of wellness in an individual, family, or community that has the potential for improvement.

In the clinical judgment model of nursing decision-making and care, the nurse also makes judgments based on the collected data. Referred to as *hypotheses*, these judgments arise from the critical appraisal of and reflection on the relative urgency or importance of the data's relationship to the patient's or family's needs. As part of the analysis process, the nurse *prioritizes* these hypotheses according to their severity or likelihood of an adverse outcome (Ignatavicius, 2021; NCSBN, 2018). Unlike the standard terminology of nursing diagnoses, hypotheses reflect and express problems in terminology understood by multiple professionals involved in the patient's care (Ignatavicius, 2021).

Generate Solutions (Planning)

The nurse then makes plans to care for the problems identified and prioritized during data analysis. During this step nurses develop goals, or desired outcomes, for the patient and/or family and plan what possible actions might be needed to accomplish them. Goals or outcomes should be specific and stated in a format that can be measured.

- Outcomes should be stated in patient terms. This wording identifies who is expected to achieve the goal (the woman, infant or child, or family).
- Measurable verbs must be used. For example, "identify," "demonstrate," "express," "walk," "relate," and "list" are verbs that are observable and measurable. Examples of verbs that are difficult to measure are "understand," "appreciate," "feel," "accept," "know," and "experience."
- Goals and outcomes must be realistic and attainable by nursing actions.

Because the clinical judgment model responds to unfolding events in the patient's condition, a timeline for goal achievement is not stated, as it is in the nursing process. Generating possible solutions to patient problems also requires the nurse to make judgments about what needs to be addressed immediately, what data are not critically relevant, and what actions could potentially cause harm to the patient (Ignatavicius, 2021).

Take Action (Implementation)

Once the goals and desired outcomes are developed and solutions generated, it is necessary to select nursing actions that will reflect care priorities. During this phase, the nurse is constantly evaluating and reassessing to determine that the actions or interventions remain appropriate. As a patient's condition changes, so does the plan of care. Types of actions or interventions can reduce or eliminate factors exacerbating the patient's problem, monitoring for the appearance of data that put the patient at further risk, or considering actions to prevent current or future health problems. For a woman or children in a wellness setting, actions focus on supporting the individual's or family's coping mechanisms and promoting a higher level of wellness.

As with determining outcomes, actions or interventions should be very specific and spell out exactly what should be done. A well-written nursing intervention is specific: "Provide 200 mL of fluid [water or juice of choice] every 2 hours while the woman is awake," or "give two ounces of Pedialyte an hour, even if the child does not retain it." Vague interventions, such as "assist with breastfeeding," do not provide specific steps to follow.

Evaluate Outcomes (Evaluation)

The evaluation determines how well the plan worked or how well the goals or outcomes were met. To evaluate, the nurse must assess the status of the patient and compare the current status with the goals or outcome criteria that were developed during the planning step. The nurse then judges how well the patient is progressing toward goal achievement and makes a decision. Should the plan be continued? Modified? Abandoned? Are the problems resolved or the causes diminished? What other actions need to be taken to achieve the expected outcomes? The process is dynamic, and the evaluation step frequently results in additional data collection and/or modification of actions.

COMPLEMENTARY, ALTERNATIVE, AND INTEGRATIVE HEALTH

Today's nurse will likely encounter individuals in many different care settings who use complementary health approaches (also referred to as complementary alternative medicine [CAM]). Terms such as "complementary," "alternative," and "integrative" have been used interchangeably for many years; the field of complementary and integrative health is broad and constantly changing. The National Center for Complementary and Integrative Health (NCCIH, 2018) describes complementary, alternative, and integrative approaches as non-mainstream origin that are not generally considered part of conventional medicine (also called Western or allopathic medicine) and practiced by holders of medical doctor (MD) and doctor of osteopathy (DO) degrees and by allied health professionals such as physical therapists, psychologists, and registered nurses. However, the boundaries between complementary health approaches and conventional medicine are not absolute, and some complementary health approaches or practices may, over time, become widely accepted.

The NCCIH (2018) describes complementary therapies as being approaches used in addition to conventional medical therapies, such as use of natural products (probiotics, herbs, dietary supplements), and holistic approaches, such as relaxation, mindfulness, yoga, and tai chi. Alternate therapies are those that replace traditional medicine, such as chiropractic treatments, homeopathy, and acupuncture/pressure. Integrative therapies are holistic, using elements of traditional, complementary, and alternative, and, because of the many aspects involved, integrative therapy requires meticulous coordination among the professionals involved in care.

A major concern in the use of non-mainstream health approaches is safety. People who access these techniques may delay needed care by a conventional healthcare provider, or they may take herbal remedies or other substances that are toxic when combined with conventional medications or when taken in excess. For example, adverse effects of complementary therapies may be unknown for the fetus **(developing baby)** or for children. Safety and effectiveness of botanical or vitamin therapies are often unregulated. Thus, people may take in variable amounts of active ingredients from these substances. Some may not consider these therapies to be medicine and may not report them to their conventional healthcare provider, setting the stage for interactions between conventional medications and complementary health approaches therapies that have pharmacologic properties. Many people may not consider some of these therapies "alternative" at all because the therapy is mainstream in their culture or tradition.

Nurses may find that their professional values do not conflict with many of the complementary health approaches therapies. Nursing as a profession supports a self-care and preventive approach to healthcare in which the individual bears much of the responsibility for his or her health. Nursing practice has traditionally emphasized a holistic, or body-mind-spirit, model of health that fits with complementary health approaches. Nurses already practice complementary health approaches therapies such as therapeutic touch fairly often. The rising interest in complementary health approaches provides an opportunity for nurses to participate in research related to the legitimacy of these treatment modalities. Rigorous objective research is difficult to perform; however, there are many pieces of qualitative research that look at complementary, alternative, and integrative approaches. A pregnant woman, for example, might access practitioners of complementary or alternative therapy during pregnancy and the post-partum period. This "woman-centered care" provides women with education, clarification of expected outcomes, autonomy, and decision-making control (Steel, Diezel, Wardle, & Adams, 2020). There has also been some research conducted on pain relief in children with cancer pain, use in children with disabilities, and those experiencing respiratory distress (Jong et al., 2020).

The NCCIH, a division of the National Institutes of Health, has a website (http://www.nccih.nih.gov) for information about and classification of the therapies.

NURSING RESEARCH AND EVIDENCE-BASED PRACTICE

As nursing and the healthcare system changes, nurses will be challenged to demonstrate that what they do improves patient outcomes and is cost effective. To meet this challenge, nurses must participate in research and use evidence-based research to improve patient-centered care. With the establishment of the National Institute of Nursing Research (NINR) as a member of the National Institutes of Health (https://www.ninr.nih.gov/), nurses now have an infrastructure in place to ensure that nursing research is supported and that a group of well-prepared nurse researchers will be educated. One way of doing this is through using the principles of evidence-based nursing practice.

Evidence-based practices to improve patient outcomes are a combination of the following: asking an appropriate clinical question; acquiring, appraising, and using the highest level of published research; clinical expertise; and patient values and preferences (Melnyk & Fineout-Overholt, 2020). When considering a change in practice, nurses need to take into account both the level and quality (rigor, consistency, and sufficiency) of research to determine the strength of evidence (Melnyk & Fineout-Overholt, 2020). To accomplish this goal effectively, nurses need to be familiar with what constitutes the highest levels of evidence. The evidence level is based on the research design of a study or studies. There are several different approaches to categorizing levels of evidence for nursing, although all are very similar.

While the outcomes of research in nursing are expanding, few randomized controlled trials (RCTs) have been conducted and published by nurses. However, nurses can consider using high-quality evidence presented in integrative or systematic reviews (reviews of collected research on a particular health issue) conducted by various health professionals that include nurses. One source of high-quality systematic reviews is the *Cochrane Database of Systematic Reviews*. Evidence-based clinical guidelines usually are also available through specialty nursing organizations. Nurses should not exclude descriptive or qualitative studies from consideration of a practice change because these studies often provide more in-depth information about a particular clinical issue.

Finally, practice change should not be made without including the nurse's expertise and ability to assess what can or cannot be effective for patient outcomes. In some instances, it is not practical or cost effective to make a particular practice change. Nurses should also strongly consider whether a practice change will be acceptable to patients; if the change is not accepted, patients will not incorporate it into their self-care (Melnyk & Fineout-Overholt, 2020).

The amount of clinically based nursing research conducted is increasing rapidly as nurse researchers strive to develop an independent body of knowledge that demonstrates the value of nursing interventions. AWHONN has an ongoing commitment to develop and disseminate evidence-based practice guidelines through the association's research-based practice program. Implementation of evidence-based guidelines promotes application of the best available scientific evidence for nursing care rather than care based on tradition alone. Professional nurses are also expected to participate in research activities appropriate to their position, education, and practice environment (AWHONN, 2019). The SPN (http://www.pedsnurses.org) also routinely publishes positions that address both clinical and educational issues related to nursing care of children and families. Although students and inexperienced nurses may not directly participate in research projects, they must learn how useful knowledge obtained by the research team is to their practice. Professional journals are the best sources of new information that can help nurses provide better care to specific patients. Searching for information can also identify unrecognized research needs to identify actions for a better practice.

KEY CONCEPTS

- Maternal-newborn nurses, women's health nurses, and nurses who care for children and families function in various roles, including care provider, teacher, collaborator, researcher, advocate, and manager.
- The care settings in which maternity and pediatric nurses may practice include acute care settings, clinics, physicians' offices, home health agencies, schools, rehabilitation centers, summer camps, daycare centers, and hospices.
- Registered nurses with advanced education are prepared to provide primary care for women and children as CNMs, nurse practitioners, and nurse leaders.
- Clinical nurse specialists function as educators, researchers, and consultants to provide in-depth interventions for many problems encountered in maternity and pediatric care.
- Nurses must be adept at communicating and removing blocks to communication to meet their responsibilities as educators and counselors.
- A primary responsibility of nurses is to provide information to childbearing families and to children and their families; nurses must know the principles of teaching and learning to fulfill the role of educator.
- Nurses must learn to think critically by examining their own thought processes for flaws that can lead to inaccurate conclusions or poor clinical judgments.
- Nurses use clinical judgment, which is focused on high-quality outcomes, in their practice. Clinical judgment includes critical thinking and decision making, and, similar to the nursing process, is organized around collecting and analyzing patient cues and data, prioritizing, generating solutions, taking action to intervene, and evaluating the effect of their actions on outcomes.
- Collaborative problems are usually physiologic complications that require both physician-prescribed and nurse-prescribed interventions.
- Nurses must consider the effect of complementary, alternative, and integrative health approaches when assessing the patient and planning care.
- Competence in the collection and application of best evidence for specific care of common problems in nursing practice is now part of the role of every nurse. Relying on traditional care methods rather than determining whether evidence supports the methods is no longer sufficient.

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The Childbearing and Child-Rearing Family

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LEARNING OBJECTIVES

After studying this chapter, you should be able to

- Explain how important families are for the provision of effective nursing care to women, infants, and children.
- Describe different family structures and their effect on family functioning.
- Differentiate between healthy and dysfunctional families.
- List internal and external coping behaviors used by families when they face a crisis.
- Compare Western cultural values with those of other cultural groups.
- Describe the effect of cultural diversity on nursing practice.
- Describe common styles of parenting that nurses may encounter.
- Explain how variables in parents and children may affect their relationship.
- Discuss the use of discipline in a child's socialization.
- Evaluate the effects an ill child has on the family.

No factor influences a person as profoundly as the **family**. Families protect and promote a child's growth, development, health, and well-being until the child reaches maturity. A healthy family provides children and adults with love, affection, and a sense of belonging and nurtures feelings of self-esteem and self-worth. Children need stable families to grow into happy, functioning adults. Family relationships continue to be important during adulthood. Family relationships influence, positively or negatively, people's relationships with others. Family influence continues into the next generation as a person selects a mate, forms a new family, and often rears children.

For nurses in pediatric practice, the whole family is the patient. The nurse cares for the child in the context of a dynamic family system rather than caring for just an infant or a child. The nurse is responsible for supporting families and encouraging healthy **coping** patterns during the periods of normal growth and development or illness.

FAMILY-CENTERED CARE

Family-centered maternity care and family-centered child care are integral for comprehensive care given by maternity and pediatric nurses. Family-centered care can be defined as an innovative approach to the planning, delivery, and evaluation of healthcare that is grounded in a mutually beneficial partnership between patients, families, and healthcare professionals. High-quality family-centered care depends on family presence with the patient, cooperation, appropriate environment, sufficient time, and the experience of the nurse (Smith, 2018). Empathy, accessible and reciprocal communication, and consideration of cultural differences make family-centered care uniquely appropriate for those who participate (Smith, 2018). Some barriers to effective family-centered care are lack of skills in communication, role negotiation, educational preparedness, and developing relationships. Other areas that interfere with the complete implementation of family-centered care are lack of time, fear of losing role, and lack of support from the healthcare system and from other healthcare disciplines. One particularly useful skill in family centered care is validation, which means accepting what the family member says or does as a valid expression of thoughts and feelings. Clearly, there is a need for increased education in this area, based on evidence, to help nurses and other healthcare professionals implement this concept (Clark & Guzzetta, 2017; Kaslow et al., 2020).

FAMILY STRUCTURE

Family structures in the United States are changing. The number of families with children that are headed by a married couple has declined, and the number of single-parent families has increased. In addition, roles have changed within the family. Although the role of the provider was once almost exclusively assigned to the father, both parents now may be providers, and many fathers are active in nurturing and disciplining their children.

Types of Families

Families are sometimes categorized into three types: traditional, nontraditional, and high risk. Nontraditional and high-risk families often need care that differs from the care required by traditional families. Different family structures can produce varying stressors. For example, the single-parent family has as many demands placed on it for resources, such as time and money, as the two-parent family. However, only one parent is able to meet the daily demands, although the other parent might still be actively involved but live elsewhere.

Traditional Families

Traditional families (also called nuclear families) are headed by a male and female who view parenting as the major priority in their lives and whose energies may not be depleted by stressful conditions such as poverty, illness, and substance abuse. Traditional families can be single-income or dual-income families. In general, traditional families are motivated to learn all they can about pregnancy, childbirth, and parenting (Fig. 3.1). Currently, a family structure composed of two married parents and their children represents 65% of families with children; however, this number has been decreasing in the United States. Twenty-two percent of children live with only their mother, 4% live with their father only, 4% live with cohabiting parents, and 4% with no parents (live with grandparents or other family members) (Federal Interagency Forum on Child and Family Statistics, 2019).

FIG 3.1 Traditional, two-parent families typically have the resources to prepare for childbirth and the needs of infants. (© 2012 Photos.com, a division of Getty Images. All rights reserved.)

Most two-parent families depend on two incomes, either to make ends meet or to provide nonessentials that they could not afford on one income. One or both parents may travel as a work responsibility. Dependence on two incomes has created a great deal of **stress** on parents, subjecting them to many of the same problems that single-parent families face. For example, reliable, competent child care is a major issue that has increased the stress experienced by traditional families. A high consumer debt load gives them less cushion for financial setbacks such as job loss. Having the time and flexibility to attend to the requirements of both their careers and their children may be difficult for parents in these families.

Nontraditional Families

The growing number of nontraditional families, designated as "complex households" by the US Census Bureau, includes single-parent families, blended families, adoptive families, unmarried couples with children, multigenerational families, and LGBTQ+ parent families (Fig. 3.2).

Single-parent families. Millions of families are currently headed by a single parent, most often the mother, who must function as homemaker and caregiver and is often the major provider for the family's

Busy parents may rely on grandparents for child care or for an additional measure of love and attention for their children. Some grandparents raise grandchildren because of their own children's inability to do so.

Fathers are the primary child-care providers in a growing number of families. Fathers who are not the primary caregivers often participate more actively in caring for their children than the fathers of previous generations.

A single parent often experiences financial and time constraints. Children in single-parent families are often given more responsibility to care for themselves and younger siblings.

FIG 3.2 A nurse caring for a child needs to know the child's family structure and the identity of the child's primary caregiver. This background becomes the context in which the nurse provides care. If family support is a concern, the nurse can provide information about local community resources. For example, in some communities, after-school programs and "warm lines" can help children with schoolwork and alleviate loneliness and fear.

financial needs. Factors contributing to this demographic include divorce, widowhood, and childbirth or adoption among unmarried women. Single parents may feel overwhelmed by the prospect of assuming all child-rearing responsibilities and may be less prepared for illness or loss of a job than are two-parent families.

Blended families. Blended families are formed when single, divorced, or widowed parents bring children from a previous union into their new relationship. Many times the couple desires children with each other, creating a contemporary family structure commonly described as "yours, mine, and ours." These families must overcome differences in parenting styles and values to form a cohesive blended family. Differing expectations of children's behavior and development as well as differing beliefs about **discipline** often cause family conflict. Financial difficulties can result if one parent is obligated to pay child support from a previous relationship. Older children may resent the introduction of a stepmother or stepfather into the family system. This can cause tension between the biologic parent, the children, and the stepmother or stepfather.

Adoptive families. People who adopt a child may have problems that biologic parents do not face. Biologic parents have the long period of gestation and the gradual changes of pregnancy to help them adjust emotionally and socially to the birth of a child. An adoptive family, both parents and siblings, is expected to make these same adjustments suddenly when the adopted child arrives. Adoptive parents may add pressure to themselves by having an unrealistically high standard for themselves as parents. Additional issues with adoptive families include possible lack of knowledge of the child's health history, the difficulty assimilating if the child is adopted from another country, and the question of when and how to tell the child about being adopted. Adoptive parents and biologic parents need information, support, and guidance to prepare them to care for the infant or child and maintain their own relationships.

Multigenerational families. The multigenerational or extended family consists of members from three or more generations living under one roof. Older adult parents may live with their adult children, or in some cases adult children return to their parents' home, either because they are unable to support themselves or because they want the additional support that the grandparents provide for the grandchildren. The latter arrangement has given rise to the term *boomerang* families. Extended families are vulnerable to generational conflicts and may need education and referral to counselors to prevent disintegration of the family unit.

Grandparents or other older family members currently head a growing number of households with children because of the inability of the parents to care for their children. More than half of children who do not live with either parent live with a grandparent (Federal Interagency Forum on Child and Family Statistics, 2019). The strain of raising children a second time may cause tremendous physical, financial, and emotional stress. In many instances, because the opioid crisis has contributed to parents not being able to parent their children, additional stress is placed on grandparents, not only to care for grandchildren who might be emotionally fragile but also to care for and manage their own adult children who are addicted (American Academy of Pediatrics [AAP], 2018b). These families might need multiple referrals for assistance for the child's care, such as Medicaid for health insurance, school lunch and breakfast programs, and psychological support.

LGBTQ+ parent families. Families headed by LGBTQ+ parents have become increasingly more frequent in the United States. The children in such families may be the offspring of previous heterosexual unions, or they may be adopted children or children conceived by an artificial reproductive technique such as in vitro fertilization. The couple may face many challenges from a community that is unaccustomed to alternative lifestyles. The children's adaptation depends on the parents' psychological adjustment, the degree of participation and support from the absent biologic parent, and the level of community support.

Communal families. Communal families are groups of people who have chosen to live together as extended family groups. Their relationship to one another is motivated by social value or financial necessity rather than by kinship. Their values are often spiritually based and may be more liberal than those of the traditional family. Traditional family roles may not exist in a communal family.

Characteristics of Healthy Families

In general, healthy families are able to adapt to changes that occur in the family unit. Pregnancy and parenthood create some of the most powerful changes that a family experiences.

Healthy families exhibit the following common characteristics, which provide a framework for assessing how all families function (Smith & Hamon, 2016):

- Members of healthy families communicate openly with one another to express their concerns and needs.
- Healthy family members remain flexible in their roles, with roles changing to meet changing family needs.
- Adults in healthy families agree on the basic principles of parenting so that minimal discord exists about concepts such as discipline and sleep schedules.
- Healthy families are adaptable and are not overwhelmed by life changes.
- Members of healthy families volunteer assistance without waiting to be asked.
- Family members spend time together regularly but facilitate autonomy.
- Healthy families seek appropriate resources for support when needed.
- Healthy families transmit cultural values and expectations to children.

FACTORS THAT INTERFERE WITH FAMILY FUNCTIONING

Factors that may interfere with the family's ability to provide for the needs of its members include lack of financial resources, absence of adequate family support, birth of an infant who needs specialized care, an ill child, unhealthy habits such as smoking and abuse of other substances, and inability to make mature decisions that are necessary to provide care for the children. Needs of aging members at the time children are going through adolescence or the expenses of college add pressure on middle-aged parents, often called the "sandwich generation."

High-Risk Families

All families encounter stressors, but some factors add to the usual stress experienced by a family. The nurse needs to consider the additional needs of the family with a higher risk for being dysfunctional. Examples of high-risk families are those experiencing marital conflict and divorce, those with adolescent parents, those affected by violence against one or more of the family members, those involved with substance abuse, and those with a chronically ill child. One of the major long-term consequences for children living in high-risk families is called adverse childhood experiences, leading to what is referred to as "toxic stress" (Gilgoff, Singh, Koita, Gentile, & Marques, 2020). If not addressed, these adverse childhood experiences can contribute to later problems with mental health, including emotional difficulties, substance use, runaway behavior, and potential violence (Wang & Zauszniewski, 2017).

Marital Conflict and Divorce

Although divorce is traumatic to children, research has shown that living in a home filled with conflict can also be detrimental both physically and emotionally (Gilgoffet al., 2020). Divorce can be the outcome of many years of unresolved family conflict. It can result in continuing conflict over child custody, visitation, and child support, changes in housing, lifestyle, cultural expectations, friends, and extended family relationships, diminished self-esteem, and changes in the physical, emotional, or spiritual health of children and other family members.

Divorce is loss that needs to be grieved. The conflict and divorce may affect children, and young children may be unable to verbalize their distress. Nurses can help children through the grieving process with age-appropriate activities such as therapeutic play (see Chapter 35). Principles of active listening (see Chapter 4) are valuable for adults as well as children to help them express their feelings. Nurses can also help newly divorced or separated parents through listening, encouragement, and referrals to support groups or counselors.

Adolescent Parenting

The unintended pregnancy rate among women aged 18–19 declined 20% between 2008-2011, and the unplanned birth rate declined by 21% (Alan Guttmacher Institute [AGI], 2019). Adolescent birth rates vary by race; however, there has been a steady decline in teen birth rates for all racial and **ethnic** groups. The impact of strong pregnancy prevention messages directed to teenagers has been credited with the birth rate declines (Hamilton & Matthews, 2016).

Teenage parenting often has a negative effect on the health and social outcomes of the entire family. Adolescent girls are at increased risk for numerous pregnancy complications, such as preterm birth, low birth weight, and death during infancy (Hamilton & Matthews, 2016). Those who become parents during adolescence are unlikely to attain a high level of education and, as a result, are more likely to be poor and often homeless. An adolescent father often does not contribute to the economic or psychological support of his child. Moreover, the cycle of teen parenting and economic hardship is more likely to be continued because children of adolescent parents are themselves more likely to become teenage parents.

Violence

Violence is a constant stressor in some families. Violence can occur in any family of any socioeconomic or educational status. Children endure the psychological pain of seeing the victimized parent experiencing violence from one who is supposed to provide love and care. Although women traditionally are more victimized by men (see Chapter 24), the reverse is not unlikely (Centers for Disease Control and Prevention [CDC], 2018). In addition, because of the role models they see in the adults, children in violent families may repeat the cycle of violence when they are adults and become abusers or victims of violence themselves.

Abuse of the child may be physical, sexual, or emotional or may take the form of neglect (see Chapter 53). Often one child in the family is the target of abuse or neglect, while others are given proper care. As in adult abuse, children who witness abuse are more likely to repeat that behavior when they are parents themselves, because they have not learned constructive ways to deal with stress or to discipline children.

Substance Abuse

Parents who abuse drugs or alcohol may neglect their children because obtaining and using the substance(s) may have a stronger pull on the parents than does care of their children. Parental substance abuse interrupts a child's normal growth and development. The parent's ability to meet the needs of the child are severely compromised, increasing the child's risk for emotional and health problems (Smith, Wilson, & AAP Committee on Substance Use Prevention, 2016). The AAP recommends screening parents for substance use, especially at the infant's first well visit; children and adolescents are screened for substance use beginning at age 11 years (AAP, 2020; Smith et al., 2016).

The child may be the substance abuser in the home. The drug habit can lead a child into unhealthy friendships and may result in criminal activity to maintain the habit. School achievement is likely to plummet, and the older adolescent may drop out of school. Children, as well as adults, can die as a result of their drug activity, either directly from the drugs or from associated criminal activity or risk-taking behaviors.

Child With Special Needs

When a child is born with a birth defect or has an illness that requires special care, the family is under additional stress (see Chapters 36 and 54). In most cases their initial reactions of shock and disbelief gradually resolve into acceptance of the child's limitations. However, the parents' grieving may be long term as they repeatedly see other children doing things that their child cannot and perhaps will not ever do.

These families often suffer financial hardship. Health insurance benefits may quickly reach their maximum. Even if the child has public assistance for healthcare costs, the family often experiences a decrease in income because one parent must remain home with the sick child rather than work outside the home.

Strains on the marriage and the parents' relationships with their other children are inevitable under these circumstances. Parents have little time or energy left to nurture their relationship with each other, and divorce may add yet another strain to the family. Siblings may resent the parental time and attention required for care of the ill child yet feel guilty if they express their resentment.

However, the outlook is not always pessimistic in these families. If the family learns skills to cope with the added demands imposed on it by this situation, the potential exists for growth in maturity, compassion, and strength of character.

HEALTHY VERSUS DYSFUNCTIONAL FAMILIES

Family conflict is unavoidable. It is a natural result of a perceived unequal exchange or an imbalance in the use of resources by individual members. Conflict should not be viewed as bad or disruptive; the management of the conflict, not the conflict itself, may be problematic. Conflict can produce growth and improve family functioning if the outcome is resolution as opposed to dissolution or continued conflict. The following three ingredients are required to resolve conflict:

1. Open communication
2. Accurate perceptions about the nature and degree of conflict
3. Constructive efforts to resolve the conflict, such as willingness to consider the view of the other, consider alternate solutions, and compromise

Dysfunctional families have problems in any one or a combination of these areas. They tend to become trapped in patterns in which they maintain conflicts rather than resolve them. The conflicts create stress, and the family must cope with the resultant stress.

Coping With Stress

If the family is considered a balanced system that has internal and external interrelationships, stressors are viewed as forces that change the balance in the system. Stressful events are neither positive nor negative but rather neutral until they are interpreted by the individual. Positive and negative events can cause stress (Smith & Hamon, 2016). For example, the birth of a child is usually a joyful event, but it can also be stressful.

Some families are able to mobilize their strengths and resources, thus effectively adapting to the stressors. Other families fall apart. A *family crisis* is a state or period of disorganization that affects the foundation of the family (Smith & Hamon, 2016).

Coping Strategies

Nurses can help families to cope with stress by helping each family identify its strengths and resources. Friedman, Bowden, and Jones (2003) identified family coping strategies as internal and external. Box 3.1 identifies family coping strategies and further defines *internal strategies* as family relationship strategies, cognitive strategies, and communication strategies. *External strategies* focus on maintaining active community linkages and using social support systems and spiritual strategies. Some families adjust quickly to extreme crises, whereas other families become chaotic with relatively minor crises. Family functional patterns that existed before a crisis are probably the best indicators of how the family will respond to it.

CULTURAL INFLUENCES ON MATERNITY AND PEDIATRIC NURSING

Culture is the sum of the beliefs and values that are learned, shared, and transmitted from generation to generation by a particular group. Cultural values guide the thinking, decisions, and actions of the group, particularly regarding pivotal events such as birth, sexual maturity, illness, and death. Culture is not determined by one's appearance or language and cultural traditions are not always practiced by everyone who identify with a particular culture. Ethnicity is the condition of belonging to a particular group that shares race, language and dialect, religious faiths, traditions, values, and symbols as well as food preferences, literature, and folklore. Cultural beliefs and values vary between different groups and subgroups, and nurses need to be aware that individuals often believe their cultural values and patterns of behavior are superior to those of other groups. This belief, termed **ethnocentrism**, forms the basis for many conflicts that occur when people from different cultural groups have frequent contact. Culture can never be assumed by the way an individual looks or talks.

When thinking of culture, nurses can see that culture is composed of visible and invisible layers that could be said to resemble an iceberg (Fig. 3.3). The observable behaviors can be compared with the visible tip of the iceberg. The history, traditions, beliefs, values, and religion are not necessarily observed but are the hidden foundation on which behaviors are based and can be likened to the large, submerged part of the iceberg. To comprehend cultural behavior fully, one must seek knowledge of the hidden beliefs that behaviors express. This knowledge comes from experiencing caring relationships with people of different cultures within the context of mutual respect and a sincere desire to understand the role of culture in another's "lived experiences." One must also have the desire or motivation to engage in the process of becoming culturally competent to be effective in caring for diverse populations (Young & Guo, 2020).

Nurses need to first understand their own culture and recognize their biases before beginning to acquire the knowledge and understanding of other cultures. Cultural self-awareness is acknowledging one's own and family's beliefs and values and examining how these might be different or similar to those of other cultures. A goal of cultural competence in healthcare involves accepting and respecting diversity, examining whether interventions or treatments might not be acceptable to others, and facilitating social justice (Younas, 2020). Applying the knowledge completes the process of providing culturally competent care (Swan, Haas, & Jessie, 2019).

Underlying culture's impact on the provision of nursing care is one's religious or spiritual practices, and the nurse should be ready to do a spiritual assessment as well as a cultural one. Spirituality is defined as one's connection between the inner and outer self and relationship to a higher power (Victor & Treschuk, 2020). Religious practices and prohibitions can affect many areas of healthcare and must be considered when providing culturally competent care. Specific beliefs about the causes, treatment, and cure of illness are important for the nurse to know to empower the family as they deal with the immediate crisis. Table 3.1 describes how some religious beliefs affect healthcare.

Implications of Cultural Diversity for Nurses

Nurses will provide care for families in culturally diverse circumstances regardless of geographical location. To provide effective care, nurses must be aware that culture is among the most significant factors that influence parenthood, health and illness, and aging. Nurses also need to be aware that there may be a dissonance in cultural beliefs

BOX 3.1 Coping Strategies of Families

Internal Coping Strategies

Relationship Strategies

- Family group reliance
- Greater sharing together
- Role flexibility

Cognitive Strategies

- Normalizing
- Controlling the meaning of the problem by reframing and passive appraisal
- Joint problem solving
- Gaining of information and knowledge

Communication Strategies

- Being open and honest
- Use of humor and laughter

External Coping Strategies

Community Strategy: Maintaining Active Linkages With the Community

Social Support Strategies

- Extended family
- Friends
- Neighbors
- Self-help groups
- Formal social supports

Spiritual Strategies

- Seeking advice of clergy
- Becoming more involved in religious activities
- Having faith in God
- Prayer

From Friedman, M., Bowden, V., & Jones, E. (2003). *Family nursing: Theory, research, and practice* (5th ed.). Upper Saddle River: Prentice-Hall.

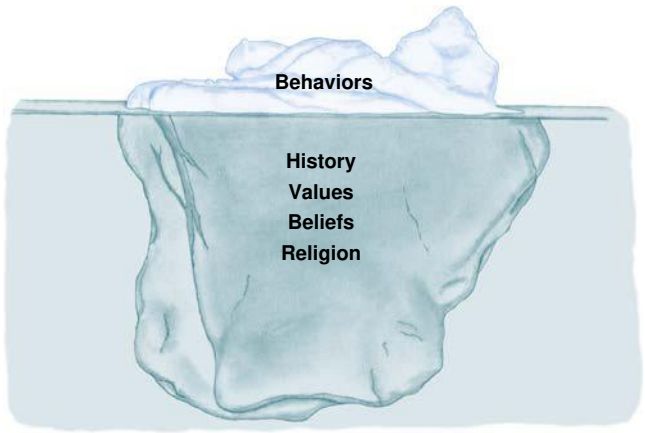

FIG 3.3 Visible and hidden layers of culture are like the visible and submerged parts of an iceberg. Many cultural differences are hidden below the surface.