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# Perry's Maternal Child Nursing Care in Canada

*Third Edition*

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# Perry's Maternal Child Nursing Care in Canada

*Third Edition*


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PERRY'S MATERNAL CHILD NURSING CARE IN CANADA, THIRD EDITION

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We are honoured to have received permission to reproduce the work "A Mother's Love," by Order of Canada award-winning Indigenous artist, Maxine Noel (Ioyan Mani), for the cover of this third Canadian edition of *Perry's Maternal Child Nursing Care in Canada.*

Maxine has lent her voice and art to projects to improve the health and well-being of Indigenous women and girls, in projects related to maternal and infant health and, in collaboration with the Native Women's Association of Canada (NWAC), in their work to raise awareness of the brutal dangers facing Indigenous women.



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Lisa has been an active board member of the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) since its inception and before that was a Section Leader for AWHONN-Canada. She was President of CAPWHN in 2014. Lisa has previously been involved with the Society of Obstetricians and Gynaecologists of Canada (SOGC) as an RN member for the Maternal-Fetal Medicine Committee for many years and has co-authored many SOGC Clinical Practice Guidelines. She maintains her Perinatal Certification through the Canadian Nurses Association and is a member of the Perinatal Exam Committee. Lisa was also a Lamaze-certified childbirth educator for many years.

Lisa is also the editor of *Leifer's Introduction to Maternity and Pediatric Nursing in Canada and* is passionate about providing a Canadian focus to nursing education and textbooks.

**Cheryl A. Sams** is a graduate of Ryerson University (BScN) and D'Youville College (MSN). She has worked at the Hospital for Sick Children (SickKids®) in Toronto since she graduated from nursing school. She has held many positions there, including staff nurse, clinical educator, manager, director, and clinical nurse specialist. Cheryl has held many teaching positions at Ryerson University in the Post RN Program and the Nurse Practitioner Program. She has also taught at the University of Toronto in the BScN program. Cheryl taught at Seneca College in the York University Collaborative BScN program until her recent retirement.

As an author, Cheryl enjoys contributing to the nursing body of literature. She has contributed chapters to the Canadian publication of Lewis et al.'s *Medical-Surgical Nursing in Canada* and Potter and Perry's *Canadian Fundamentals of Nursing*. She was one of the editors for *Mosby's Comprehensive Review for the Canadian RN Exam*.

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**US 6th Edition**
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Dr. Perry has had clinical experience in obstetrics, pediatrics, gynecology, and neonatal nursing. She has taught in schools of nursing in several states for over 30 years and was director of the School of Nursing at San Francisco State University. She is a Fellow in the American Academy of Nursing. Dr. Perry's experience in international nursing includes teaching in the United Kingdom, Ireland, Italy, Thailand, Ghana, and China, as well as participating in health missions in Ghana, Kenya, and Honduras.

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

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

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

Ms. Cashion's job responsibilities at the University of Tennessee include providing education regarding low- and high-risk obstetrics to staff nurses in West Tennessee community hospitals. For over 20 years, Ms. Cashion has been an adjunct clinical instructor in maternal-child nursing at Northwest Mississippi Community College

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

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

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

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

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

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# PREFACE

This third edition of *Perry's Maternal Child Nursing Care in Canada* combines essential perinatal and pediatric nursing information into one text. The text focuses on the care of childbearing persons during their reproductive years and the care of children from birth through adolescence. The first section of the text focuses on important issues related to perinatal and pediatric nursing in Canada, including an overview of family and culture, as well as community nursing care. The second section discusses the promotion of wellness and the care of women experiencing common health concerns throughout the lifespan and care of the childbearing person. The health care of children and child development in the context of the family is the focus for the third section. The text provides a family-centred care approach that recognizes the importance of collaboration with families when providing care. This third edition of *Perry's Maternal Child Nursing Care in Canada* is designed to address the changing needs of Canadian persons during their childbearing years and those of children during their developing years.

*Perry's Maternal Child Nursing Care in Canada* was developed to provide students with the knowledge and skills they need to become competent critical thinkers and to attain the sensitivity needed to become caring nurses. This third edition reflects the Canadian health care system, the importance of family-centred care, the significance of Indigenous health, and the cultural diversity throughout the country. It includes the most accurate, current, and clinically relevant information available.

## APPROACH

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

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

The focus in the chapters is on nursing care, along with collaboration with other health care disciplines, as this combination provides the most comprehensive care possible to childbearing patients and children. Included on the Evolve site for this edition are the Nursing Process boxes and the Nursing Care Plans. The Nursing Process boxes include assessments, analysis, planning, implementation, and evaluation of nursing care, and the Nursing Care Plans reinforce the problem-solving approach to patient care. Throughout the discussion of assessment and care, warning signs and emergency situations are also highlighted, to alert the nurse to signs of potential problems.

Patient education is an essential component of nursing care of childbearing persons and children. Family-Centred Care boxes incorporate family considerations important to care to perinatal patients and children. Issues concerning grandparents, siblings, and various family constellations are also addressed. In the pediatric chapters (Part 3), these boxes focus on the special learning needs of families caring for their child. Legal Tips are integrated throughout the maternity section to emphasize these issues as they relate to the care of childbearing patients and infants.

This third edition features a contemporary layout with logical, easy-to-follow headings and an attractive four-colour design that highlights important content and increases visual appeal. Hundreds of colour photographs and drawings throughout the text illustrate important concepts and techniques to further enhance comprehension. To help students learn essential information quickly and efficiently, we have included numerous features that prioritize, condense, simplify, and emphasize important aspects of nursing care. In addition, students are encouraged to apply critical thinking in real-life scenarios presented in the Clinical Reasoning Case Studies.

## NEW TO THIS EDITION

- A new chapter specifically focused on pediatric health promotion throughout childhood
- A new chapter focused on pediatric mental health
- A specific chapter that focuses on caring for the child with a complex chronic condition or at the end of life, with a focus on providing care in the home
- Expanded coverage with a focus on global health perspectives and health care in the LGBTQ2, Indigenous, immigrant, and other vulnerable populations.
- New and updated references, sources, and guidelines are provided, including the following:
  - Society of Obstetrician and Gynaecologists of Canada (SOGC) guidelines
  - Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)
  - Public Health Agency of Canada, Sexually transmitted infection (STI) guidelines
  - Canadian Paediatric Society (CPS) standards
  - Canadian Association of Midwives (CAM)
  - Health Canada
  - Family-Centred Maternity and Newborn Care Guidelines from the Public Health Agency of Canada
  - Registered Nurses' Association of Ontario (RNAO)
  - Perinatal Services BC
  - American College of Obstetricians and Gynecologists (ACOG)
  - Centers for Disease Control and Prevention (CDC)
  - World Health Organization (WHO)
- There is increased emphasis on health promotion in the Perinatal and Pediatric sections of the text.

- Additional case studies and clinical reasoning/clinical judgement-focused practice questions in the printed text and on the Evolve companion website promote critical thinking and prepare students for exam licensure.
- New Evolve PN Case Studies for Clinical Judgement reflect current PN competencies including for Ontario and British Columbia on Evolve
- Next-Generation NCLEX™ (NGN)-Style Case Studies for Maternity and Pediatric on Evolve

## SPECIAL FEATURES

- **Objectives** focus students' attention on the important content to be mastered.
- **Atraumatic Care** boxes emphasize the importance of providing competent care while minimizing undue physical and psychological distress for the child and family.
- **Community Focus** boxes emphasize community issues, provide resources and guidance, and illustrate nursing care in a variety of settings.
- **Clinical Reasoning Case Studies** present students with real-life situations and encourage students to make appropriate clinical judgements. Answer guidelines are provided on the book's Evolve site.
- **Cultural Awareness** boxes describe beliefs and practices about pregnancy, childbirth, parenting, women's health concerns, and caring for sick children.
- **Emergency** boxes alert students to the signs and symptoms of various emergency situations and provide interventions for immediate implementation.
- **Family-Centred Care** boxes highlight the needs of families that should be addressed when family-centred care is provided.
- **Guidelines** boxes provide students with examples of various approaches to implementing care.
- **Medication Guide** boxes include key information about medications used in maternity and newborn care, including their indications, adverse effects, and nursing considerations.
- **Patient Teaching** boxes assist students to help patients and families become involved in their own care with optimal outcomes.
- **Evidence-Informed Practice** boxes are incorporated throughout the book. Findings that confirm effective practices or that identify practices with unknown, ineffective, or harmful effects are located within the narrative.
- **Legal Tips** are integrated throughout Part 1 to provide students with relevant information to address important legal areas in the context of perinatal nursing.
- **Medication Alerts** provide important information regarding the safety of medications, including interactions with other medications and important nursing considerations.
- **Nursing Alerts** call the reader's attention to critical information that could lead to deteriorating or emergency situations.
- **Safety Alerts** call the reader's attention to potentially dangerous situations that should be addressed by the nurse.
- **Key Points**, located at the end of each chapter, help the reader summarize major points, make connections, and synthesize information. The Key Points are also available in a downloadable format and can be found on this book's Evolve site.
- **Additional Resources**, including websites and contact information for organizations and educational resources available for the topics discussed, are listed throughout.
- A highly detailed, cross-referenced **index** enables readers to quickly access needed information.

## SUPPLEMENTAL RESOURCES

A comprehensive ancillary package is available to students and instructors using *Perry's Maternal Child Nursing Care in Canada*. The following supplemental resources have been thoroughly revised for this edition and can significantly assist in the teaching and learning of perinatal and pediatric nursing in classroom and clinical settings.

### Study Guide – NEW!

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

- *Thinking Critically* case-based activities require students to apply the concepts found in the chapters to solve problems, make clinical-judgement decisions concerning care management, and provide responses to patient questions and concerns.
- *Reviewing Key Concepts* questions in various formats give students ample opportunities to assess their knowledge and comprehension of information covered in the text. Activities, including matching, fill-in-the-blank, true/false, short-answer, and multiple-choice, help students identify the core content of the chapter and test their understanding after reading the chapter.
- *Learning Key Terms* matching and fill-in-the-blank questions let students test their ability to define all key terms highlighted in the corresponding textbook chapter.

### Evolve Website

Located at http://evolve.elsevier.com/Canada/Perry/maternal, the Evolve website for this book includes the following elements.

#### For Students

- More than 500 Review Questions for Exam Preparation
- Answers to Clinical Reasoning Case Studies from the book
- Key Points
- **Nursing Care Plans** provide commonly encountered situations and disorders. Nursing diagnoses are included, as are rationales for nursing interventions that might not be immediately evident to students.
- **Nursing Processes** help students to easily identify information on some major diseases and conditions.
- **Nursing Skills** teach students how to implement concepts presented in the textbook and use them in real-life situations. This will enhance student knowledge and give students a better understanding of concepts they learn while reading the textbook.
- Audio Glossary
- PN Case Studies for Clinical Judgement reflect current PN competencies, including for Ontario and British Columbia

- Next-Generation NCLEX™ (NGN)-Style Case Studies for Maternity and Pediatrics

### For Instructors

- Next-Generation NCLEX™ (NGN)-Style Case Studies for Maternity and Pediatric
- Case studies
- *TEACH for Nurses* Lesson Plans that focus on the most important content from each chapter and provide innovative strategies for student engagement and learning. These new Lesson Plans include strategies for integrating nursing curriculum standards, concept-based learning examples, relevant student and instructor resources, and an original instructor-only Case Study in most chapters.
- ExamView® Test Bank that features more than 1 500 examination-format test questions (including alternate-item questions), rationales, and answers. The robust ExamView® testing application, provided at no cost to faculty, allows instructors to create new tests; edit, add, and delete test questions; sort questions by category, cognitive level, and nursing process step; and administer and grade tests online, with automated scoring and gradebook functionality.
- PowerPoint® Lecture Slides consisting of more than 2 100 customizable text slides for instructors to use in lectures
- An Image Collection with over 500 full-colour images from the book for instructors to use in lectures
- Access to all student resources listed above

## Simulation Learning System (SLS)

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

## Sherpath

Sherpath's book-organized collections offer digital lessons, mapped chapter-by-chapter to the textbook, so the reader can conveniently find applicable digital assignment content. Sherpath features convenient teaching materials that are aligned to the textbook, and the lessons are organized by chapter for quick and easy access to invaluable class activities and resources.

## Elsevier eBooks

This exciting program is available to faculty who adopt a number of Elsevier texts, including *Perry's Maternal Child Nursing Care in Canada*. Elsevier eBooks is an integrated electronic study centre consisting of a collection of textbooks made available online. It is carefully designed to "extend" the textbook for an easier and more efficient teaching and learning experience. It includes study aids such as highlighting, e-note taking, and cut-and-paste capabilities. Even more importantly, it allows students and instructors to do a comprehensive search within the specific text or across a number of titles. Please check with your Elsevier Canada sales representative for more information.

## Next Generation NCLEX™ (NGN)

The National Council for the State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include nursing regulatory bodies. In empowering and supporting nursing regulators in their mandate to protect the public, the NCSBN is involved in the development of nursing licensure examinations, such as the NCLEX-RN®. In Canada, the NCLEX-RN® was introduced in 2015 and is as of the writing of this text the recognized licensure exam required for practising RNs in Canada.

As of 2023, the NCLEX-RN® will be changing to ensure that its item types adequately measure clinical judgement, critical thinking, and problem-solving skills on a consistent basis. The NCSBN will also be incorporating into the examination the Clinical Judgement Measurement Model (CJMM), which is a framework the NCSBN has created to measure a novice nurse's ability to apply clinical judgement in practice.

These changes to the examination come as a result of findings indicating that novice nurses have a much higher than desirable error rate with patients (errors causing patient harm) and, upon NCSBN's investigation, discovering that the overwhelming majority of these errors were caused by failures of clinical judgement.

Clinical judgement has been a foundation underlying nursing education for decades, based on the work of a number of nursing theorists. The theory of clinical judgement that most closely aligns with what NCSBN is basing their CJMM on is the work by Christine A. Tanner.

The new version of the NCLEX-RN® is identified loosely as the "Next-Generation NCLEX" or "NGN" and will feature the following:

- Six key skills in the CJMM: recognizing cues, analyzing cues, prioritizing hypotheses, generating solutions, taking actions, and evaluating outcomes
- Approved item types as of March 2021: multiple response, extended drag and drop, cloze (drop-down), enhanced hot-spot (highlighting), matrix/grid, bowtie and trend. More question types may be added.
- All new item types are accompanied by mini-case studies with comprehensive patient information—some of it relevant to the question, and some of it not.
- Case information may present a single, unchanging moment in time (a "single episode" case study) or multiple moments in time as a patient's condition changes (an "unfolding" case study).
- Single-episode case studies may be accompanied by one to six questions; unfolding case studies are accompanied by six questions.

For more information (and details) regarding the NCLEX-RN® and changes coming to the exam, visit the NCSBNs website: https://www.ncsbn.org/11447.htm and https://ncsbn.org/Building_a_Method_for_Writing_Clinical_Judgment_It.pdf.

For further NCLEX-RN® examination preparation resources, see *Elsevier's Canadian Comprehensive Review for the NCLEX-RN Examination*, Second Edition, ISBN 9780323709385.

Prior to preparing for any nursing licensure examination, please refer to your provincial or territorial nursing regulatory body to determine which licensure examination is required in order for you to practice in your chosen jurisdiction.

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# ACKNOWLEDGEMENTS

The authors and contributors of the text recognize and acknowledge the diverse histories of the First Peoples of the lands now referred to as Canada. It is recognized that individual communities identify themselves in various ways; within this text, the term *Indigenous* will be used to refer to all First Nations, Inuit, and Métis people within Canada.

In the text, gender-neutral language is used, to be respectful of and consistent with the values of equality recognized in the Canadian Charter of Rights and Freedoms. Using gender-neutral language is professionally responsible and mandated by the Canadian Federal Plan for Gender Equality.

This text also recognizes that childbirth is experienced not only by women but also by others who do not identify as female or who find the term *woman* to not be representative of how they identify themselves. The terms *patient*, *person*, and *parent* are used when possible in the text. Woman/women is used when the research is specifically done with a population that identifies as a woman.

I would like to offer thanks to the many perinatal contributors who worked diligently to provide this text with an updated and uniquely Canadian perspective as well as to the perinatal nurses across the country who continue to provide high-quality, family-centred care to childbearing persons and their families. I thank my students, who always keep me on my toes and ensure that I provide the most current information in a way that is engaging. To my family, who always provide their support and encouragement, I thank you. Most importantly I would like to dedicate this text to the memory of both of my parents (Ross and Ruby Keenan), who encouraged me to always strive for the best.

***Lisa Keenan-Lindsay***

I would like to thank the many pediatric experts who have not only contributed to the "peds" part of this text but also made major contributions to the field of pediatric nursing in Canada. You make a difference every day to children and their families. I would also like to thank my husband, Stuart Sams, and my family for cheering me on.

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***Lisa, Cheryl, and Connie***

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PART 1

# Maternal Child Nursing

1

# Contemporary Perinatal and Pediatric Nursing in Canada

*Erica Hurley*

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

## OBJECTIVES

*On completion of this chapter the reader will be able to:*

1. Describe the scope of perinatal and pediatric nursing in Canada today.
2. Examine the historical context of health care in Canada.
3. Identify social determinants of health and other factors that influence the health of childbearing persons, families and children, and explore approaches needed to address health inequities in Canada.
4. Explore trauma-informed care.
5. Describe the impact of colonialism on the health of Indigenous people.
6. Consider the role of research in perinatal and pediatric nursing.
7. Identify strategies to enhance interprofessional communication.
8. Describe how the Sustainable Development Goals (SDGs) are focused on improving the health of people worldwide.
9. Explore ethical issues in contemporary perinatal and pediatric nursing.

The focus of the first part of this book is to provide an overview of perinatal and pediatric nursing in Canada from a national and global perspective. The role of social, cultural, and family influences on health promotion will also be discussed, as will the role of nurses in the community. Chapters 4 through 29 focus on the care of childbearing patients and families, or *perinatal nursing*, as well as women's health promotion (Chapters 5 to 8). Chapters 30 to 55 address the issues and trends related to the health care of children.

## PERINATAL AND PEDIATRIC NURSING

Nurses care for childbearing persons, for children, and for families in many settings, including the hospital, the home, and a variety of ambulatory and community settings. Nurses also work collaboratively with other health and social care providers, such as physicians, midwives, dietitians, doulas, and social workers, to name a few. *Perinatal nurses* are those nurses who work collaboratively with patients and families from the preconception period throughout the childbearing year. Pediatric nurses care for children from birth up to age 18 years. Nurses caring for children also provide care for the family. Nursing care is provided in many settings, including inner-city, urban, or rural communities. The setting where nursing care is provided may have implications for the services that are offered, as remote and rural communities may not have all services necessary to provide comprehensive care (see discussion below). Most nurses working in hospitals provide acute care, while nurses working in a community setting may provide care that focuses on health promotion, rehabilitation, and palliative care.

Nurses who provide care for childbearing persons as well as children can influence the health care system by drawing attention to the needs of the patients in their care. Through professional associations, nurses can have a voice in setting standards and influencing health policy by actively participating in the education of the public and that of local, provincial, and federal legislators. Nurses throughout history have developed strategies to improve the well-being of childbearing persons and their newborns and children, and they have led efforts to develop and implement clinical practice guidelines that draw on current evidence and research.

## THE HISTORY AND CONTEXT OF HEALTH CARE IN CANADA

Canada's government-funded health insurance program (Medicare) provides universal medical and hospital services for all Canadians, although health services in Canada are organized provincially and territorially. Indigenous people within Canada may have different access to services funded through the federal government, although this funding is not at the same level as for provincial health services. Additionally, new immigrants to Canada may have to wait 90 days for

government health coverage, depending on which province or territory they live in. The Interim Federal Health Program provides temporary health coverage for certain groups of refugees before they are covered under provincial or territorial health insurance plans. The principles of the *Canada Health Act* include public administration, comprehensive "medically necessary" care, universality, portability, and accessibility. Home care, extended care, pharmaceuticals, and dental care are not currently covered under Medicare provisions, although different provinces do cover some of these items. For example, the province of Ontario covers the cost of over 4 400 medications for anyone age 24 years or younger who is not covered by a private plan, and Nova Scotia has a provincial drug insurance plan that is designed to help residents with the cost of their prescription medications if needed. Thus, to some extent, Canada's Medicare program shapes the health services offered to Canadians. In an effort to control health care costs, interest has grown in restructuring health services and developing community-based programs and preventive health services. For example, pharmacists in Nova Scotia are able to prescribe birth control, thus eliminating the need for a visit to another health care provider.

Since the Lalonde Report was released in 1974, Canada has been a global leader in health promotion. In 1986, Canada hosted the first international conference on health promotion, which resulted in the Ottawa Charter. Three challenges for Canadians were identified: reducing health inequities, increasing disease prevention, and enhancing people's capacities to live with chronic disease and disability. The Charter also acknowledged the need for intersectoral collaboration, or looking beyond health, to include other sectors (e.g., income security, employment, education, housing, and transportation) (Corbin, 2017). In the late 1990s, interest expanded to creating evidence-informed programs that address all factors that impact health. With the HIV/AIDS epidemic, increasing rates of tuberculosis and other infectious diseases, the threat of bioterrorism, the severe acute respiratory syndrome (SARS) epidemic, and Ebola outbreaks, Canadians were reminded of the importance of immunizations and public health measures. In 2004, the federal government created the Public Health Agency of Canada (PHAC). While the PHAC initially focused on population health and health promotion, the emergence of avian influenza shifted the focus toward planning for a pandemic, such as that with COVID-19, along with health promotion.

The delivery of health care within each community, province, and territory contains unique elements as each level of government tries to balance human resources, funding, and liability concerns with regulatory, educational, political, and demographic issues. Inequities in health care have developed and been identified as existing between rural, remote, inner-city, and Indigenous communities and other Canadian communities.

## CONTEMPORARY ISSUES AND TRENDS

### Social Determinants of Health

The emphasis in health care has shifted from treatment of illnesses to health promotion and disease prevention. In order to promote good health, the many complex influences on health need to be investigated and understood. To this end, the federal government has outlined the *social determinants of health* (Box 1.1). The social determinants of health are the social and economic factors that influence people's health, either positively or negatively. These determinants provide a blueprint for health care policies and help direct population health research with the goal of improving health for its citizens (PHAC, 2016). They relate to an individual's place in society, such as income, education, or employment. Experiences of discrimination, racism, and historical trauma are important social determinants of health for certain groups, such as Indigenous peoples, LGBTQ2 persons, and Black Canadians (Government of Canada, 2020b).

**BOX 1.1 Social Determinants of Health**

The main determinants of health include the following:

- Income and social status
- Employment and working conditions
- Education and literacy
- Childhood experiences
- Physical environments
- Social supports and coping skills
- Healthy behaviours
- Access to health services
- Biology and genetic endowment
- Gender
- Culture
- Race/Racism

Source: Adapted from Public Health Agency of Canada. (2020). *Social determinants of health and health inequalities.* https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

The Canadian Nurses Association (CNA) (2018) position statement regarding the social determinants of health states that nurses in all domains of practice can address social inequities by:

- Addressing policies related to income, employment, education, housing, transportation, and other factors; these should be evaluated in their planning stages for their impact on health
- Collaborating with others both within and outside the health sector, striving to reduce and, ultimately, eliminate health inequity
- Including the social determinants of health in their assessments and interventions with individuals, families and communities
- Incorporating the analysis of the social determinants of health, starting with a critical understanding of the political, economic and social factors that are the root causes of health inequities into nursing education.

*Health inequity* refers to health inequalities that are unfair or unjust, and modifiable. For example, Canadians who live in remote or northern regions do not have the same access to nutritious foods such as fruits and vegetables as other Canadians. *Health equity* is the absence of unfair systems and policies that cause health inequalities (Government of Canada, 2020b). Advocates of health equity seek to reduce inequalities and increase access to opportunities and conditions that are conducive to good health for all. Many health inequities also result from a lack of access to the social determinants of health that promote good health, creating conditions of vulnerability to experiencing poor health. For example, poverty has the most significant influence on the development of compromised maternal and child health (Abraha et al., 2019). Furthermore, continued examination is needed regarding how specific populations, alternate health care practices, and technology differ in terms of health determinants and overall health status.

**Socioeconomic Status.** There is strong and growing evidence that higher social and economic status is associated with better health. The term *poverty* implies both visible and invisible impoverishment. It is a condition in which families live without adequate resources (May & Standing Committee, 2017). *Visible poverty* refers to lack of money or material resources, which includes insufficient clothing, poor sanitation, and deteriorating housing. *Invisible poverty* refers to social and cultural deprivation, such as limited employment opportunities,

inferior educational opportunities, lack of or inferior medical services and health care facilities, and an absence of public services. The sum of all aspects of a low-income family's living situation can contribute to and compound health problems, such as crowded living conditions and poor sanitation, which facilitate transfer of disease (e.g., tuberculosis or COVID-19). Lack of funds or inaccessibility to health services can inhibit treatment for any but severe illness or injury. Sometimes health care is inadequate because of lack of information; individuals may not have information regarding causes, treatment, or outcomes of illness or preventive measures.

Although Canada has no official definition of poverty, it is typically measured using the low income cut-offs (LICO)—before and after taxes, the low income measures (LIM)—before and after taxes, and the market basket measures (MBM) (Statistics Canada, 2015a). The LICO is meant to express the income level at which a family faces constraints because it has to spend a higher percentage of its income on basic resources—for example, shelter, clothes, food—than the average similar-size family. In 2017, Statistics Canada, using the LIM, reported no significantly different rate from 2016 to 2017. However, the LIM for children was significantly lower in 2017 at 12.1%, down 1.9 percentage points from 2016 (Statistics Canada, 2019a). Low-income rates are more prevalent among certain subgroups of women. Poverty rates among Indigenous Canadians are 3.8 times higher than for nonracialized, non-Indigenous children (Beedie et al., 2019). Compared to lone male-parent families, lone mothers are more likely to have incomes that fall below the LICO (Statistics Canada, 2019b).

**Health Inequity Within Certain Populations.** In Canada, survival rates among childbearing patients and infants and children are among the best in the world. This is in part due to relatively high levels of education, economic and social well-being, and an effective universal health care system. However, it is important to recognize that Canada does have vulnerable populations who face significant health inequities. There are many families in this country who do not have ideal outcomes and face considerable challenges and health risks. Rates of adverse pregnancy outcomes, including preterm birth and intrauterine growth restriction, generally rise with greater socioeconomic disadvantage. For example, one contributing factor is that socioeconomically vulnerable patients are less likely to initiate early prenatal care, for a variety of reasons. All of these factors can translate into poor pregnancy outcomes. Poor fetal development is associated with many chronic diseases in later life (Baird et al., 2017). This means that the impact of being disadvantaged can last a lifetime. Vulnerable childbearing patients also face a higher risk of death after birth (Verstraeten et al., 2015). The high burden of illness responsible for premature loss of life arises in large part from the conditions in which people are born, grow, live, work, and age (National Academies of Sciences, Engineering & Medicine, 2017).

Overall, there are significant health inequalities among Indigenous peoples, sexual and racial minorities, immigrants, and people living with functional limitations, as well as inequalities based on socioeconomic status (income, education levels, employment, and occupation status) (PHAC, 2018). People affected include patients with mental health issues, those who work in the sex-trade industry, pregnant and parenting adolescents, and patients whose newborn has been taken into custody by child protection services. The offspring of persons belonging to these populations are also at increased risk for poor outcomes. Many of these poor outcomes are preventable through access to adequate nutrition, good prenatal care, and use of preventive health practices. Clearly, comprehensive, community-based care that is culturally relevant and accessible for all childbearing persons and for children and families is needed.

Health experiences differ within and between social groups. For example, immigrants; Indigenous women; women in remote and rural areas; women with disabilities; women living with mental illness; women living in low-income situations; and lesbian, bisexual, queer, and transgender people have differential access to health services and differing health care needs. Many persons belonging to these vulnerable population groups struggle to find health care practitioners who are knowledgeable and respectful of their specific needs and who provide care that is both culturally and socially sensitive and safe.

***Indigenous people.*** Historical impacts of colonization have had a negative impact on the health of Indigenous people (Truth and Reconciliation Commission of Canada, 2015). Additionally, social determinants of health specific to Indigenous people have been identified that have had a unique impact on this population, such as a history of children being forced to reside at and attend residential schools, poverty, racism, and social exclusion (Figure 1.1). Indigenous families living in poverty consistently have poorer health outcomes and are at greater risk of adverse pregnancy and poor infant and child health outcomes. See further discussion of Indigenous people below.

***Immigrants and refugees.*** While Canada has been home to immigrants and refugees since its creation, within the last decade there has been a steady increase in the number of immigrants moving to Canada. In 2011, 21% of all women living in Canada were born outside the country (Hudon, 2016). Among recent immigrant women, the largest share has come from the People's Republic of China, followed by the United Kingdom, India, the Philippines, and the United States (Hudon, 2016).

New immigrants often find themselves either underemployed or unemployed because of discrimination, complications around accreditation of foreign degrees, lack of available and affordable child care, and social isolation. Immigrant women's rate of participation in the labour force is considerably lower than that of immigrant men and Canadian-born women. For instance, newly arrived immigrant women, those who arrived up to 5 years prior to the 2006 Census, were more likely to be unemployed than those who had spent more time in Canada. However, among immigrant women aged 25 to 54, the challenge of finding work eased the longer they lived in Canada (Hudon, 2016).

Many of the conditions or illnesses that immigrants and refugees acquire contribute to the persistence of disparities in their health outcomes. Refugee status imposes a particular type of vulnerability on affected individuals and groups. Of primary significance are the precipitating factors by which people are displaced suddenly or forced to leave their country of origin: persecution, civil unrest, or war. Families are forced from their homes to seek residence and employment elsewhere. Often these groups are extremely impoverished and face extreme physical and emotional stress and trauma when they arrive in Canada. In general, refugees are more likely to live in poverty than are immigrants.

Immigrants typically arrive in Canada with better health than that of the Canadian-born population. This is because immigrants are screened on medical and other health-related criteria before they are admitted to the country. However, over time, this "healthy immigrant effect" tends to diminish as their health status converges with that of the host population. Some medical problems may arise as immigrants age, as well as when they integrate and adopt behaviours that have negative health impacts. Other health issues may arise from the stress of immigration itself, which involves finding suitable employment and establishing a new social support network. Some immigrants and refugees also have decreased access to social supports and may have a hard time navigating the health care system, often due to language difficulties, which can ultimately impact overall health.

***Adolescents.*** Adolescent girls are considered vulnerable because of the increased probability of being involved in high-risk behaviours.

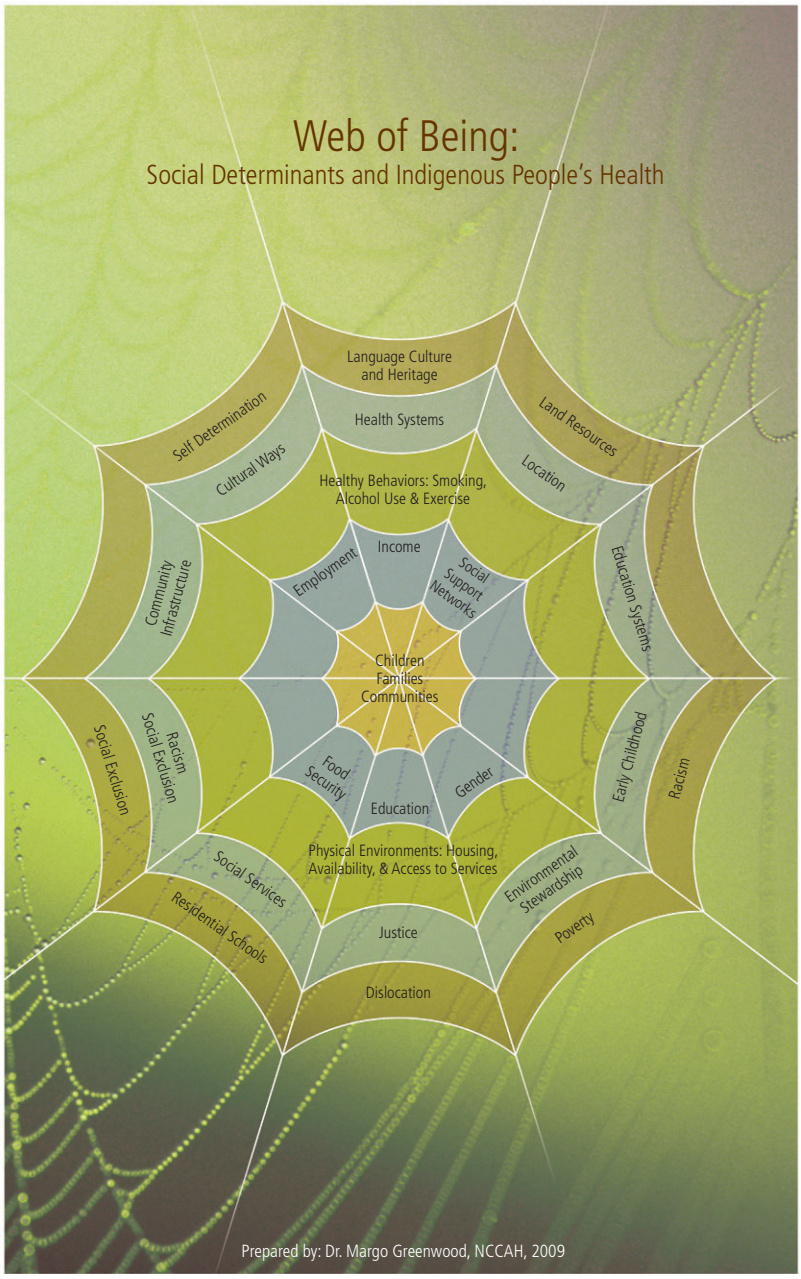


**Fig. 1.1** Social determinants and Indigenous people's health. (From http://www.nccah-ccnsa.ca/docs/1791_NCCAH_web_being.pdf)

Girls from low-income or disrupted families are more likely to engage in early sexual activity and other high-risk behaviours, with both immediate and long-term health consequences (Ryan, 2015). In Canada, 2.9% of women aged 15 to 19 become pregnant each year (Dunn et al., 2019). Declining teen pregnancy rates for Canada in general are indicative of better sexual and reproductive health among young people. This decline in teen pregnancy can be attributed largely to more sexually active young people using reliable contraception such as condoms and birth control pills. However, the incidence of sexually transmitted infections (STIs), primarily chlamydia, syphilis, and gonorrhea, is on the rise in Canada, with the highest rates occurring in adolescents and young adult females (Government of Canada, 2017) (see Chapter 6).

Adolescent health is another broad target area for community health promotion efforts, including health education and policy initiatives. Because adolescents often fail to perceive their own vulnerability, they need help navigating a complex environment and dealing with risky behaviours through preventive strategies that enhance decision making and increase protective factors.

***Older women.*** Women aged 65 and over constitute one of the fastest growing segments of the female population in Canada. In addition, women now predominate in the ranks of Canadian older persons, in large part because the life expectancy of women has risen more rapidly than that of men during most of the last century. The percentage of the female population accounted for by older women is expected to continue to rise during the next several decades. Over 6 million Canadians were aged 65 or older in 2014 (Government of Canada, 2014/2019). The average life expectancy for a 65-year-old is projected to increase by 1.8 years for women (to 88.8 years) between 2014 and 2036. While

this is higher than the life expectancy projected for men (86.5 years), women still tend to be the most vulnerable to serious health conditions and the most likely to experience socioeconomic difficulties.

While most older women report that their overall health is relatively good, almost all have a chronic health condition as diagnosed by a health care provider. Arthritis or rheumatism and high blood pressure are the most common chronic health issues reported by older women. However, there are preventive interventions that are effective in delaying or controlling age-related changes. Improving self-management activities such as diet and exercise are important health-promotion elements for this population.

***Homelessness.*** Homelessness is an increasing social and health challenge in Canada. Women are at increased risk for hidden homelessness, living in overcrowded conditions or having insufficient money for shelter (Gaetz et al., 2013). Family violence is a major cause of homelessness, a significant reason attributing to the use of homeless shelters. Homeless people comprise a population that is at high risk for chronic and infectious diseases and premature death. While both homeless women and men experience similar health issues, homeless women have distinct characteristics, vulnerabilities, and treatment needs. Homeless women may also be pregnant or have young children in their custody. Some of the health issues of particular significance to this group include access to birth control, prenatal care, breast and cervical cancer screening, and STIs. Homeless people are also disproportionately represented among those with mental health challenges and substance use disorders. Poverty is the primary cause of homelessness.

While homeless people are a heterogeneous group, they do share a number of similar features that may contribute to their overall poor health status. These include low income, unemployment, low levels of education, insufficient material resources, fear and mistrust of the health care system and of health care providers, and limited social support. Canada urgently needs to find new and innovative strategies that will address the barriers to health care that homeless people face both in cities and in more remote rural areas.

***Children.*** Research conducted over the past two decades has emphasized the significance of the early years in the growth and development of children. The World Health Organization (WHO) has identified early child development as a social determinant of health and as the most important period of overall development throughout a person's lifespan. The period from prenatal development to 8 years of age is critical for cognitive, social, emotional, and physical development (Lannen & Ziswiler, 2014). All facets of children's early development—those involving physical, social, emotional, and cognitive opportunities for growth—shape children's learning, school success, economic participation, social citizenry, and health. It is important to identify where children are most at risk for adversity and to intervene accordingly.

In terms of child well-being, Canada has room for improvement. UNICEF recently ranked Canada for children's health and well-being at 29 out of 41, of the world's richest nations (UNICEF Office of Research, 2017). In 2017, 622 000 children under 18 years of age, or 9%, lived below the poverty line (Statistics Canada, 2019a). Indigenous children stand out as being disproportionately burdened in Canada. In 2019, 47% of 254 100 First Nations children lived in poverty (Beedie et al., 2019). These children are growing up in deplorable conditions—some without running water, access to affordable nutritious food, housing, and a proper education, all of which are the responsibility of the federal government according to the *Indian Act*.

Clearly, Canadian children are not doing as well as they could be. Of great concern is the high rate of obesity (twenty-ninth of 30 countries) and the high rate of bullying (twenty-seventh of 31 countries). Canada's children also self-report that they have low life satisfaction; in fact, they are among the unhappiest children in the industrialized world (UNICEF Office of Research, 2017).

## Trauma- and Violence-Informed Care

Trauma- and violence-informed care involves an approach that embraces an understanding of trauma and violence at every step in the health care system. This approach recognizes the connections between violence, trauma, negative health outcomes, and behaviours (Government of Canada, 2018b). Many people are at risk of experiencing violence and trauma, making it important for health care providers to gain the knowledge and skills required to assist patients in receiving the best care possible. Box 1.2 outlines the principles of how to integrate trauma-informed care. The goal of trauma- and violence-informed approaches is to minimize harm to all people, whether or not there is a known experience of violence; therefore, a universal trauma-informed approach is key for all people (Government of Canada,

### BOX 1.2 Four Principles of Trauma-Informed Care

Understand trauma and violence and their impacts on people's lives and behaviours:

- Acknowledge the root causes of trauma without probing.
- Listen, believe, and validate victims' experiences.
- Recognize their strengths.
- Express concern.

Create emotionally and physically safe environments:

- Communicate in nonjudgemental ways so that people feel deserving, understood, recognized, and accepted.
- Foster an authentic sense of connection to build trust.
- Provide clear information and consistent expectations about services and programs.
- Encourage patients to bring a supportive person with them to meetings or appointments.

Foster opportunities for choice, collaboration, and connection:

- Provide choices for treatment and services, and consider the choices together.
- Communicate openly and without judgement.
- Provide the space for patients to express their feelings freely.
- Listen carefully to the patient's words and check in to make sure that you have understood correctly.

Provide a strengths-based and capacity-building approach to support patient coping and resilience:

- Help patients identify their strengths, through techniques such as motivational interviewing, a communication technique that improves engagement and empowerment.
- Acknowledge the effects of historical and structural conditions on peoples' lives.
- Help people understand that their responses are normal.
- Teach and model skills for recognizing triggers, such as calming, centring, and staying present.

Source: Adapted from Government of Canada. (2018). *Trauma and violence-informed approaches to policy and practice*. https://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html

2018b). Trauma- and violence-informed approaches are not about "treating" trauma, for example, through counselling. Instead, the focus is on minimizing the potential for harm and re-traumatization and to enhance safety, control, and resilience for all patients (Government of Canada, 2018b). Not all patients will disclose trauma or violence in their lives, but they do require respectful and safe care.

**! NURSING ALERT**

Universal trauma precautions are important for all patients in order to provide safe care. Embedding trauma- and violence-informed approaches into all aspects of policy and practice creates universal trauma precautions that can reduce harm and provide positive supports for **all** people (Government of Canada, 2018b).

## Adverse Childhood Experiences

It is important for nurses to be aware of adverse childhood experiences (ACEs) in their patients. These ACE's are negative, stressful, traumatizing events that occur before the age of 18, and of the effects these can have on health risk across the lifespan (Alberta Family Wellness Initiative, 2021). These experiences can include adversities that children face in their home environment, such as various forms of physical and emotional abuse, neglect, and household dysfunction. Exposure to these experiences cause excessive activation of the stress response system. The more ACEs a child experiences, the more likely they will develop conditions like heart disease and diabetes, will have poor academic achievement, and may develop substance use disorders later in life (Center on the Developing Child at Harvard University, 2020). These experiences can occur across all socioeconomic groups. People who have experienced significant adversity (or many ACEs) are not irreparably damaged; through the implementation of three approaches—reducing stress, building responsive relationships, and strengthening life skills—the long-term effects of ACEs can be prevented or minimized (Center on the Developing Child at Harvard University, 2020). See Chapter 30 for further discussion of ACEs.

## Indigenous People

In 2016, the number of Indigenous people in Canada, which includes First Nations, Métis, and Inuit, was 1 673 785, accounting for 4.9% of the total population (Statistics Canada, 2017a). The average age of Indigenous people was 32.1 years in 2016—almost a decade younger than that of the non-Indigenous population (40.9 years) (Statistics Canada, 2017a). In 2016, around one-third of First Nations people (29.2%) were 14 years of age or younger. For Métis, 22.3% of the population were 14 years of age or younger, and among Inuit, one-third (33.0%) were 14 years of age or younger (Statistics Canada, 2017a).

The history of Indigenous peoples is important to acknowledge, as it is the original history of the country—they are the first peoples of Canada and continue to play important roles in the country's development and its future. They have a vibrant and strong culture, arts practice, and heritage. Indigenous people have their own systems of health knowledge within their own specific ways of knowing and being, thus it is important to acknowledge and utilize this information when providing care.

It is also important to acknowledge the negative impacts that influence the lives of Indigenous people. As stated earlier, colonization continues to have a negative and lasting effect on all aspects of Indigenous people's health, along with specific health determinants that have been identified for Indigenous people (see Figure 1.1). Living in remote locations and lack of access to some of the positive social determinants of health account for some of these health inequities. Improving access to nutritious food, clean water, and safe and secure housing could be fundamental to the improvement of Indigenous people's long-term health.

Beginning in Ontario in 1831 and continuing until the closure of the last school in 1996 in Saskatchewan, the Canadian government, in partnership with a number of Christian churches, operated a residential school system for Indigenous children. The government-funded, usually church-run schools and residences were set up to force Indigenous children to assimilate into the Canadian mainstream by eliminating parental and community involvement in the intellectual, cultural, and spiritual development of Indigenous children in their own communities. More than 150 000 Indigenous children were placed in these residential schools (Truth and Reconciliation Commission [TRC], n.d.). The TRC has worked to reveal the history and ongoing legacy of church-run residential schools in a manner that fully documents the harms perpetrated against Indigenous people and that can lead the way toward respect, through reconciliation (TRC, 2012). In the TRC report, survivors describe what happened after they left the schools: They no longer felt connected to their parents or their families; some said they felt ashamed of themselves, their parents, and their culture; some children found it difficult to forgive their parents for sending them to residential school. Parents also reported the difficulties of having their children away from home and the issues that resulted when they returned home (TRC, 2012).

In these schools, children were often forbidden to speak their Indigenous language or engage in their cultural and spiritual practices. Most children were abused—mentally, spiritually, physically, and/or sexually. Generations of children were severely traumatized by the experience, resulting in an ongoing legacy of intergenerational trauma. *Intergenerational trauma* is defined as untreated trauma that carries through generations and continues to have an impact on subsequent generations. One example of the trauma that was incurred by these children is the abuse they suffered. This abuse by their caregivers was their role model for parenting, one which the victims often repeated when they became parents. Also, when these children got older, they often coped with the post-traumatic stress they suffered by drinking or using other substances. This vicious cycle has continued as individuals, families, and communities cope with intergenerational trauma, leaving its impact on generations of families through parenting difficulties and other stresses.

The TRC highlighted that Indigenous people need specialized health supports available near where they live. Many Indigenous people have to navigate services from the federal and provincial government, specifically those living on reservations. The need for health supports is especially acute in the northern and more isolated regions of Canada. It is imperative that health care providers become knowledgeable of Indigenous health and their view of health and illness, as well as of Indigenous healing practices in order to provide care that is culturally safe. The TRC (2015) final report calls on health care providers to acknowledge the necessity of Indigenous-led health and healing practices and to support these practices when requested. Such recognition is crucial to reconciliation.

## Lesbian/Gay/Bisexual/Transsexual/Queer/2-Spirited (LGBTQ2) Health

LGBTQ2 people have higher rates of illness due to discrimination, minority stress, avoidance of health care providers, and irregular access to health care services (Gahagan & Subirana-Malaret, 2018). This situation may be due in part to negative past experiences. Many LGBTQ2 people may delay or avoid seeking health care or choose to withhold personal information from health care providers.

In general, LGBTQ2 people end up receiving less good-quality health care than the population as a whole (Rainbow Health Ontario [RHO], 2014). People who identify as LGBTQ2 also have some unique health concerns and may be at increased risk for certain health issues,

including mental health challenges; substance use; intimate partner violence; higher rates of smoking and cancer; and diet, weight, and body image concerns (RHO, 2014). Many health care providers are not trained in these LGBTQ2 health needs and may not have the knowledge required in how to care for individuals in this population and are thus unable to provide the safest care possible.

Nurses and other health care providers must provide care that is not seen as heteronormative and that is inclusive of people of any gender or sexuality and of those who choose to not state either. In providing care, questions need to be asked in a manner that does not make assumptions about sexuality or gender. Nurses should also be aware of their use of language and be careful not to genderize patients through the language that is used. They also need to be aware of how to be gender inclusive. Nurses caring for pediatric patients must also be conscious of LGBTQ2 concerns. Children and adolescents may have questions about their sexuality and gender, and if the nurse develops a therapeutic relationship with the child, the child may feel comfortable enough to ask questions and seek appropriate resources.

Throughout this text, an attempt has been made to integrate LGBTQ2 issues into the respective sections. Although a comprehensive discussion is beyond the scope of this text, additional resources are also included, when available.

## Culture

Another factor that affects the delivery and quality of health care is the fact that the Canadian population is diverse in terms of **culture**, **ethnicity**, race, and age. According to the 2016 census, more than one fifth of Canadians were born in another country (Statistics Canada, 2019b). Statistics Canada predicts that by 2031, between 29 and 32% of Canadians will identify as belonging to a visible minority, and as many as three out of five people living in Toronto and Vancouver will identify as visible minorities (Statistics Canada, 2015b).

Significant disparity exists in health outcomes among people of various racial and ethnic groups in Canada. People also have different health needs, practices, and health service preferences related to their ethnic or cultural backgrounds. They may have dietary preferences and health practices that are not understood by their caregivers. To meet the health care needs of a culturally diverse society, nurses must provide culturally safe and responsive care (see Chapter 2).

## Integrative Healing and Alternate Health Practices

Integrative healing encompasses complementary and alternative health modalities (CAM) that are sometimes used in combination with conventional biomedical modalities of treatment. Many popular healing modalities offer human-centred care based on philosophies that honour the individual's beliefs, values, and desires. The focus of these modalities is on the whole person, not just on a disease complex. Many patients often find that integrative modalities are more consistent with their own belief systems and allow for more autonomy in health care decisions. It is important that nurses understand the beliefs of patients to ensure that their health care needs are met.

Individuals may also have health practices based on their spirituality, culture, or race. Health care providers who practise cultural humility and acknowledge that they do not need to know all of these various alternatives but be open and receptive to gaining such knowledge are in a good position to assist in the patient's care.

## High-Technology Care

Advances in scientific knowledge have contributed to a health care system that emphasizes high-technology care. For example, maternity care has extended to preconception counselling, more scientific techniques to monitor the childbearing person and fetus, more definitive tests for hypoxia and acidosis, and neonatal intensive care units, which have often saved the lives of premature children. Enhanced technology has also increased the life expectancy of many children with chronic illnesses. Internet-based information is available to the public that can promote interactions among health care providers, families, and community providers. Point-of-care testing is also available. Personal data assistants are used to enhance comprehensive care; the medical record is increasingly in electronic form.

Health information technology is also having a profound impact on the ways in which health services are delivered. **Telehealth** is an umbrella term for the use of communication technologies and electronic information to provide or support health care when participants are separated by distance. It enables specialists, including nurses, to provide health care and consultation to those needing care. While this technology can increase access to health services for people living in geographically isolated communities, nurses must use caution and evaluate the effects of such emerging technologies. Another Web-based resource is Healthlink, which provides people in several provinces with medically approved information on many health topics, medications, and tips for promoting healthy lifestyles (see Additional Resources).

## Social Media

**Social media** is a form of Internet-based technologies that allow users to create their own content and participate in dialogue. Common social media platforms are Facebook, Instagram, Snapchat, Twitter, and LinkedIn (Tandoc et al., 2019). In addition to their own personal use of these technologies, nurses can connect with nurses with similar interests, share and exchange information about patient care, obtain training, and provide a space for collaboration (Hao & Gao, 2017). However, there are pitfalls for nurses using this technology. Patient privacy and confidentiality can be violated, and institutions and colleagues can be cast in an unfavourable light, with negative consequences for those posting the information. Nursing students have been expelled from school and nurses have been fired or reprimanded by their provincial regulatory body for injudicious posts. To help make nurses aware of their responsibilities when using social media, the International Nurse Regulator Collaborative (INRC) published the six P's for social media use (Box 1.3). Their report details issues of confidentiality and privacy, possible consequences of inappropriate use of social media, common myths and misunderstandings of social media, and tips on how to avoid related problems. The Canadian Nurses Protective Society (2012) states that before nurses communicate on a social media website, it is important to consider what is said, who might read it, and the impact it might have if viewed by an employer, a patient, or licensing body.

### BOX 1.3 Six P's of Social Media Use

**Professional**—Act professionally at all times.
**Positive**—Keep posts positive.
**Patient/Person**-free—Keep posts patient or person free.
**Protect** yourself—Protect your professionalism, your reputation, and yourself.
**Privacy**—Keep your personal and professional life separate; respect privacy of others.
**Pause** before you post—Consider implications; avoid posting in haste or anger.

Source: Adapted from International Nurse Regulator Collaborative. (2016). *Position statement: Social media use: Common expectations for nurses*. http://www.cno.org/globalassets/docs/prac/incr-social-media-use-common-expectations-for-nurses.pdf

While patients may identify social media as having positive benefits, many also know that they are at risk of negative health impacts from social media. Harmful behaviours displayed on social media platforms such as the Tide Pod Challenge and showing condom snorting have resulted in children being harmed. The most documented negative consequences have been cyberbullying, depression, social anxiety, and exposure to developmentally inappropriate content (Subrahmanyam & Smahel, 2011). Health care providers must be aware of social media impacts both positive and negative.

### Health Literacy

**Health literacy** involves the simultaneous use of a more complex and interconnected set of abilities: to read and act on written health information, to communicate needs to health providers, and to understand health instructions. Without adequate health literacy skills, ill-informed decisions may be taken, health conditions may go unchecked or worsen, questions may go unasked or remain unanswered, accidents may happen, and people may get lost in the health care system (Canadian Council on Learning, 2008). Recent findings show that 60% of adults and 88% of older persons in Canada are not health literate (ABC Life Literacy Canada, 2018). People who are not health literate have difficulty using the everyday health information that is routinely available in health care facilities, grocery stores, retail outlets, and schools; through the media; and in their communities. They may also have difficulty reading appointment slips and determining the proper way to take medication.

As a result of the increasingly multicultural nature of the Canadian population, there is an urgent need to address health literacy as a component of culturally and linguistically competent care. Canadians with low health-literacy skills were found to be more likely to be in poorer health (Berkman et al., 2011). Individuals and groups for whom English is a second language often lack the skills necessary to seek medical care and navigate the health care system. Health care providers can contribute to health literacy by speaking slowly and using simple, common words; avoiding jargon; using pictures and diagrams to illustrate key points; and assessing whether the patient understands the discussion. The skillful use of an interpreter or telephone interpretation service can promote understanding and **informed consent** (see Chapter 2).

## SPECIALIZATION AND EVIDENCE-INFORMED NURSING PRACTICE

The increasing complexity of care required by childbearing persons and their newborns, as well as children who are sick, has contributed to the growth of specialized knowledge and skills needed by nurses working in the areas of perinatal and pediatric nursing. This specialized knowledge is gained through experience, advanced degrees, and certification programs.

Advanced practice nurses, such as clinical nurse specialists, provide care for adults as well as children with complex health challenges. Nurse practitioners may provide primary care throughout the life of many patients. Lactation consultants, many of whom are nurses, provide services in the hospital, on an outpatient basis, or in the patient's home. Maternal child nurses work collaboratively with public health nurses and an increasing array of health care providers. An example is working with registered midwives who may provide primary care during pregnancy and the early postpartum period. Public health nurses may also work with teachers in schools to provide quality education experiences for children with a chronic illness that affects their ability to attend school.

### Evidence-Informed or Research-Based Practice

*Evidence-informed practice* (EIP) is the collection, interpretation, and integration of valid, important, and applicable patient-reported, nurse-observed, and research-derived information. Evidence-informed nursing practice combines knowledge with clinical experience and intuition. It provides a rational approach to decision making that facilitates best practice. Although not all practice can be evidence-informed, nurses must use the best available information to guide their interactions and interventions.

Practising nurses should contribute to research because they are the individuals observing human responses to health and illness. The current emphasis on measurable outcomes to determine the efficacy of interventions (often in relation to the cost) demands that nurses know whether clinical interventions result in positive outcomes for their patients. This demand has influenced the current trend toward EIP, which involves questioning why something is effective and whether a better approach exists. The concept of EIP also involves analyzing published clinical research and translating it into the everyday practice of nursing. When nurses base their clinical practice on science and research and document their clinical outcomes, they are better able to validate their contributions to health, wellness, and cure—not only to their patients and institutions but also to the nursing profession. Evaluation is essential to the nursing process, and research is one of the best ways to accomplish this.

Research plays a vital role in establishing perinatal, women's health, and child health science. It can validate that nursing care makes a difference. For example, although prenatal care is associated with healthier infants, no one knows exactly which interventions produce this outcome. In the past, medical researchers rarely included women in their studies; thus more research in this area is crucial. Many possible areas of research exist in maternity and women and children's health care. The clinician can identify problems in the health and health care of childbearing persons and of children. Through research, nurses can make a difference for these patients. Nurses should promote research funding and conduct research on perinatal, pediatric, and women's health, especially concerning the effectiveness of nursing strategies for these patients (see Evidence-Informed Practice box: Searching for and Evaluating the Evidence).

### EVIDENCE-INFORMED PRACTICE

#### *Searching for and Evaluating the Evidence*

Throughout this text you will see Evidence-Informed Practice boxes. These boxes provide examples of how a nurse might conduct an inquiry into an identified practice question. Curiosity, access to a virtual or real library, and research critique skills are needed for nurses to be confident that their practice is informed by a sound foundation of evidence.

Nurses construct their practice informed by research from many different sources. Categorizing evidence by "levels" is being replaced with embracing multiple ways of knowing that include personal knowledge. Experienced nurses have practice knowledge that they need to share with other nurses through publication. Indigenous ways of knowing are increasingly being recognized within Westernized health care, and patients are being acknowledged as experts in their own health care experiences (Hyett et al., 2018). Quantitative and qualitative research has added to our understanding of a patient's experience with the health care system, whether during illness or wellness care.

Provided the professional organization is well respected and the process is rigorous, clinical practice guidelines and consensus statements reflect the current state of knowledge. Nurses need to also develop an inquiring mind and questioning attitude toward all forms of current evidence. In this way, the knowledge base required for perinatal and pediatric nursing will continue to grow and develop.

## Standards of Practice and Legal Issues in Delivery of Care

Nursing standards of practice reflect current knowledge, represent levels of practice agreed on by leaders in the specialty and can be used for clinical benchmarking. In perinatal and women's health nursing, there are several organizations that publish standards of practice and education. These include the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), which publish standards of practice and education for perinatal nurses; and the National Association of Neonatal Nurses (NANN), which publishes standards of practice for neonatal nurses. The Canadian Association of Paediatric Nurses is the voice of pediatric nurses in Canada and has developed national standards.

The Canadian Nurses Association (CNA) Certification Program also has competencies developed for perinatal, community, general pediatric, pediatric critical care nurses, and neonatal nurses that guide certification exams for each of these specialties. Certification with the CNA demonstrates specialized knowledge and enhances a nurse's professional credibility, which is valued by employers.

In addition to these more formalized standards, agencies have their own policy and procedure books that outline standards to be followed in that setting. In legal terms, the **standard of care** is that level of practice that a reasonably prudent nurse would provide in the same or similar circumstances.

**LEGAL TIP: Standard of Care**

When there is uncertainty about how to perform a procedure, the nurse should consult the agency procedure book and follow the guidelines printed therein. These guidelines are the standard of care for that agency.

## Patient Safety and Risk Management

Medical errors are a leading cause of death in the hospital or at home. According to the Canadian Adverse Events Study (Baker Study), the most quoted study in Canada regarding medical errors, 7.5% of hospitalized patients had an adverse event and of these, 16% died as a result (Baker et al., 2004). The cost of adverse events is staggering; the economic burden of adverse events is $1.1 billion, including $397 million for preventable adverse events (Etchells et al., 2012).

The actual numbers of adverse events are difficult to determine, as there is a culture of silence surrounding patient errors. The Canadian Patient Safety Institute (CPSI) was developed as an integrated strategy for improving patient safety in Canadian health care (Box 1.4). The CPSI facilitates collaboration among governments and care providers to enhance patient safety and provides a number of useful resources, including the Canadian disclosure guidelines, an incident analysis framework, and the safety competencies framework. Achieving a culture of patient safety requires open, honest, and effective communication between health care providers and their patients. Patients are entitled to information about themselves and about their medical condition or illness, including the risks inherent in health care delivery (CPSI, 2011).

## Interprofessional Education

Interprofessional education (IPE) consists of faculty and students from two or more health professions who create and foster a collaborative learning environment. The underlying premise of interprofessional collaboration is that patient-centred care will improve when health professionals work together (WHO, 2010). Six competency domains highlight the knowledge, skills, attitudes, and values that shape the judgements essential for interprofessional collaborative practice (Canadian Interprofessional Health Collaborative, 2010). See Box 1.5 for a description of the practice competencies related to IPE.

# GLOBAL HEALTH

As the world becomes a smaller place because of travel and communication technologies, nurses and other health care providers are gaining a global perspective and participating in activities to improve the health and health care of people worldwide. Nurses participate in medical outreach; provide obstetrical, surgical, ophthalmological, orthopedic, or other services; attend international meetings; conduct research; and provide international consultation. International student and faculty exchanges occur. More articles about health and health care in various countries are appearing in nursing journals. The WHO (2020) has stated that nurses and midwives make up about 50% of the global health care workforce. Increasingly, Canadian nurses are working internationally in global health settings (Figure 1.2). This role is supported by the CNA (2012), which believes that nurses have the right and the responsibility to contribute to the advancement of global health and equity.

## Sustainable Development Goals

In the year 2000, the member nations of the United Nations (UN) developed the Millennium Development Goals (MDGs), which were eight international goals that focus on improving the health and education of the global community. The original plan was to reach these by the year 2015. The MDGs were drawn from the actions and targets contained in the Millennium Declaration that was adopted by 189 nations and signed by 147 heads of state and governments during the United

### BOX 1.4 Goals of the Canadian Patient Safety Institute (CPSI)

The CPSI's four goals to improve patient safety:

- The CPSI will provide leadership on the establishment of a National Integrated Patient Safety Strategy.
- The CPSI will inspire and sustain patient safety knowledge within the system and, through innovation, enable transformational change.
- The CPSI will build and influence patient safety capability (knowledge and skills) at organizational and system levels.
- The CPSI will engage all audiences across the health system in the national patient safety agenda.

Source: The Canadian Patient Safety Institute. (2020). *Patient safety forward with four.* http://www.patientsafetyinstitute.ca/English/About/PatientSafetyForwardWith4/Pages/default.aspx

### BOX 1.5 Competency Domains for Interprofessional Education (IPE)

The six competency domains are as follows:

- Interprofessional communication
- Patient/client/family/community-centred care
- Role clarification
- Team functioning
- Collaborative leadership
- Interprofessional conflict resolution

Source: Adapted from Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework.* https://drive.google.com/file/d/1Des_mznc7Rr8stsEhHxl8XMjgiYWzRIn/view

**Fig. 1.2** Canadian Nurses for Africa provide free medical field care and preventative health care to communities in rural Kenya. (Permission Gail Wolters.)

Nations Millennium Summit, in September 2000 (http://www.un.org/millenniumgoals/). These goals were an ambitious pledge to uphold the principles of human dignity, equality, and equity and free the world from extreme poverty. Much work had been done on the MDGs, and they have made a profound difference in the lives of many people across the world (UN, 2015). According to the UN (2015), global poverty has been halved; 90% of children in developing regions now enjoy primary education, and disparities between boys and girls in enrollment have narrowed. There are decreased rates of malaria and tuberculosis, and the likelihood of a child dying before age 5 has been nearly cut in half over the last two decades. The number of people who do not have access to good water sources has also been halved. Despite the significant gains that have been made for many of the MDG targets worldwide, the progress has been uneven across regions and countries, leaving significant gaps (UN, 2015).

In 2015 the UN endorsed the Sustainable Development Goals (SDGs) (Figure 1.3), which are a blueprint to achieve a better and more sustainable future for all. They address current global challenges, including those related to poverty, inequality, climate, environmental degradation, prosperity, and peace and justice, with a target of 2030 for achieving these (Government of Canada, 2018a). SDG #3 focuses on good health and well-being, and many of the goals related to this are focused on improving maternal and child health. Therefore, in the countdown to 2030 the aim is to support the monitoring and measurement of women's, children's, and adolescents' health in 81 countries (Boerma et al., 2018). While acknowledging success in the countdown to 2015, it is clear that there is still much work to be done to improve intervention coverage, equity, and reproductive, maternal, newborn, and child health.


**Fig. 1.3** Sustainable Development Goals. The United Nations has developed 17 goals to improve the health and well-being of the global community. (From United Nations. [2015]. *Sustainable Development Goals kick off with start of new year.* https://www.un.org/sustainabledevelopment/blog/2015/12/sustainable-development-goals-kick-off-with-start-of-new-year/)

In 2010, with the signature of the Muskoka Declaration, the Canadian government promised to assist developing countries in addressing health inequities that affect mothers and infants (Government of Canada, 2014). With its additional $1.1 billion commitment to maternal, newborn, and child health, Canada's total commitment to reducing child mortality and improving maternal health was $3.25 billion from 2015 to 2020 (Government of Canada, 2020a).

## ETHICAL ISSUES IN MATERNAL CHILD NURSING

Ethical concerns and debates have multiplied with the increased use of technology and scientific advances. For example, with reproductive technology, pregnancy is now possible in childbearing persons who thought they would never bear children, including some who are menopausal or postmenopausal. Should scarce resources be devoted to achieving pregnancies in older patients? Is giving birth to a child at an older age worth the risks involved? Should older parents be encouraged to conceive a baby when they may not live to see the child reach adulthood? Should a childbearing person who is HIV positive have access to assisted reproduction services? Who should pay for reproductive technologies, such as the use of induced ovulation and in vitro fertilization? Other examples of ethical dilemmas within nursing include the use of life-saving measures for very low birth weight (VLBW) newborns, the terminally ill child's right to refuse treatment, access to abortion, substance use of patients, informed consent, barriers to services, and confidentiality. Nurses may struggle with questions involving truthfulness, balancing their rights and responsibilities in caring for children with AIDS, whistle-blowing, or allocating resources.

Questions about informed consent and allocation of resources must be addressed with innovations such as intrauterine fetal surgery, fetoscopy, therapeutic insemination, genetic engineering, stem cell research, surrogate childbearing, surgery for **infertility**, "test-tube" babies, fetal research, and treatment of VLBW babies. For example, discussion is required when a 23-week gestation baby is born alive, and decisions need to be made regarding what treatment will be provided, based on the wants of the parents and the knowledge of health care providers. The introduction of long-acting contraceptives has created moral choices and policy dilemmas for health care providers and legislators (e.g., whether some patients [substance users or patients who are HIV positive] should be required to take the contraceptives). With the potential for great good that can come from fetal tissue transplantation, what research is ethical? What are the rights of the embryo? Should cloning of humans be permitted? Discussion and debate about these issues will continue for many years. Nurses and patients, as well as scientists, physicians, lawyers, lawmakers, ethicists, and clergy, must be involved in the discussions.

Nurses must prepare themselves systematically for collaborative ethical decision making. This can be accomplished through taking formal coursework and continuing education, reading contemporary literature, and working to establish an environment conducive to ethical discourse. Moreover, nurses need to be educated in the mechanisms for dispute resolution, case review by ethics committees, procedural safeguards, Canadian legislation, and case law.

The nurse can also use the professional code of ethics for guidance and as a means for professional self-regulation. The *Code of Ethics for Registered Nurses*, by the CNA, provides the framework and core responsibilities for nursing practice. The *Code of Ethics* focuses on the nurse's accountability and responsibility to the patient (CNA, 2017) and emphasizes the nursing role as an independent professional, one that upholds its own legal liability (see Additional Resources).

### Ethical Guidelines for Nursing Research

Research with women and children may create ethical dilemmas for the nurse. For example, participating in research may cause additional stress for a person concerned about outcomes of genetic testing or for one who is waiting for an invasive procedure. Obtaining amniotic fluid samples or performing cordocentesis poses risks to the fetus (see Chapter 13). Research on children must be conducted in ways that ensure informed consent of parents and for children, when possible (see Chapter 44, Consent for Health Research in Children). Nurses must protect the rights of human participants in all research; women and children are already vulnerable, so they need to be reassured that their rights are being protected. For example, nurses may need to collect data on or care for patients who are participating in clinical trials. The nurse should ensure that the participants are fully informed and aware of their rights as participants. The nurse may be involved in determining whether the benefits of research outweigh the risks to the parent and the fetus or to children and needs to ensure that all research conducted has been approved by the appropriate research ethics board. Research involving Indigenous people involves specific ethical guidelines because of their history. The Canadian Institute of Health Research (CIHR) is an example of an organization that outlines ethical guidelines of health research involving Indigenous people in Canada (CIHR, 2013).

## KEY POINTS

- Perinatal nursing focuses on caring for patients and their families throughout the childbearing years, and pediatric nurses care for children from birth to 18 years of age.
- Nurses can play an active role in shaping health policy and health systems to be responsive to the needs of Canadian women and children.
- The social determinants of health have an impact on the health of all people.
- Of the determinants of health, poverty remains the most important factor resulting in conditions of vulnerability such as homelessness.
- Families and children living in rural, remote, and Indigenous communities and in poverty in inner cities experience significant health challenges.
- Universal trauma precautions can assist in providing safe care to all patients.
- Indigenous patients have unique health care issues that require health care providers to understand the historical context and impact of the social determinants of health affecting these patients.
- LGBTQ2 patients require health care providers who understand their specific health care needs.
- Nurses must provide comprehensive, respectful care to all people, and knowledge about different cultural and diversity issues will assist in providing this care.
- Integrative healing combines modern technology with ancient healing practices and encompasses the whole body, mind, and spirit.
- Technology has had a tremendous influence on health care through use of high-technology care modalities as well as access to other health care providers and to patients through social media.
- Perinatal and pediatric nursing practice is increasingly informed by research.
- Nurses must ensure that safe care is provided to childbearing patients and children by communicating with other members of the health care team in a manner that ensures clear understanding.
- While the Millennium Development Goals have improved the health of many people worldwide, much work still needs to be done to reduce poverty, promote gender equality, and improve perinatal

and child health. The Sustainable Development Goals are focused on achieving a better and more sustainable future for all.
- Ethical concerns have multiplied with the increasing use of technology and scientific advances.

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## ADDITIONAL RESOURCES

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Healing the Hurt - Caring for Indigenous Mothers and Infants. https://www.indigenousmomandbaby.org/enter.
Rainbow Health Ontario Resource Database—Reliable, up-to-date health resources to LGBT2SQ communities, service providers, and others with an interest in LGBT2SQ health. https://www.rainbowhealthontario.ca.
St Michael's Hospital—Transgender health resources. https://guides.hsict.library.utoronto.ca/TransgenderHealth.
TransCare BC: *Intro to working with transgender clients*. https://rise.articulate.com/share/9XFuAqbV1rdLa2RaM18h31fK1q6gBk37#/.
Truth and Reconciliation Commission of Canada. http://www.trc.ca.
United Nations: *Sustainable Development Goals*. https://www.un.org/sustainabledevelopment/.
Upstream—Addresses the social determinants of health in order to build a healthier society. http://www.thinkupstream.net/.

2

# The Family and Culture

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## OBJECTIVES

*On completion of this chapter the reader will be able to:*

1. Describe the variety of family forms encountered by nurses in Canada today.
2. Identify the principles that underpin interprofessional family-centred care.
3. Explore and describe theories and models developed as guides to family nursing in Canada.
4. Describe how different lenses or perspectives contribute to our understanding of family health promotion and relational nursing practice.
5. Explore and discuss how spirituality influences the health of individuals and their families.
6. Define culture, ethnocentrism, cultural safety, and cultural humility.
7. Describe what is meant by cultural competence and culturally safe care and reflect on how this will influence nursing practice.
8. Explore ways to provide culturally responsive family nursing care.

## THE FAMILY IN CULTURAL AND COMMUNITY CONTEXT

Perinatal and pediatric nurses have important professional responsibilities to families. Despite modern stresses and strains, the family still forms a social network that acts as a potent support system for its members. Family health practices and relationships with providers are influenced by culturally related health beliefs and values. Ultimately, all of these factors have the power to affect perinatal and child health outcomes. Nurses work collaboratively with families to achieve their goals related to wellness and family development. Because the Canadian population has become increasingly diverse in terms of culture, ethnicity, and socioeconomic status, it is essential that nurses become culturally competent in order to provide appropriate nursing care.

### The Family in Society

The social context for the family can be viewed in relation to social and demographic trends that reflect the population as a whole. Each family sets up boundaries between itself and society. People are conscious of the difference between "family members" and "outsiders," or people without kinship status. Some families isolate themselves from the outside community; others have a wide community network that they can turn to in times of stress. Although boundaries exist for every family, family members set up channels through which they interact with society.

### Defining Family

The family has traditionally been viewed as the primary unit of socialization—the basic structural unit within a community. The family plays a pivotal role in health care and is often the central focus for nursing care. As one of society's most important institutions, the family represents a primary social group that influences and is influenced by other people and institutions. A variety of family configurations exist.

The term **family** has been defined in many different ways according to the individual's own frame of reference, value judgement, or discipline. There is no universal definition of family; a family is what an individual considers it to be. Biologists describe the family as fulfilling the biological function of perpetuation of the species. Psychologists emphasize interpersonal aspects of family and its responsibility for personality development. Economists view the family as a productive unit providing for material needs. In sociology, the family is depicted as a social unit interacting with the larger society, creating contexts within which cultural values and identity are formed. Others define family in terms of the relationships of the persons who make up the family units. Some of the common types of family relationships are *consanguineous* (blood relationships), *affinal* (marital relationships), and *family of origin* (family unit a person is born into).

Earlier definitions of family emphasized that family members were related by legal ties or genetic relationships and lived in the same household with specific roles. Later definitions have been broadened to reflect structural and functional changes. A *family* can be defined as an

institution in which individuals, related through biology or enduring commitments and representing similar or different generations and genders, participate in roles involving mutual socialization, nurturance, and emotional commitment.

**Family Organization and Structure.** Individuals define their own family and support system by choosing who is included and who is excluded. The definition of family may include two or more different people such as parents, siblings, grandparents, partners, aunts and uncles, or friends (Table 2.1).

The **nuclear family** consists of male and female partners and their children living as an independent unit sharing roles, responsibilities, and economic resources (Figure 2.1). In 2016, 73.3% of children under the age of 15 were living with two biological or adoptive parents in a nuclear family structure (Statistics Canada, 2019a).

*Multigenerational or extended families,* consisting of grandparents, children, and grandchildren living in the same household, are becoming increasingly common (Figure 2.2). Caring for aging parents can create stress for parents who are also caring for their own children. In other situations, the grandparents support the children and grandchildren or are sole caregivers for the grandchildren. For some groups, such as Indigenous peoples, the family network is an important resource for promoting health and healing.

**TABLE 2.1 Definitions of Family**

| Type of Family | Description |
|---|---|
| Nuclear | Male and female parents with children<br>May be biological or adoptive parents<br>May be married or common-law |
| Multigenerational or extended family | Grandparents, children, and grandchildren living in same household |
| Blended families | Unrelated family members join to make a new household as result of death or divorce and remarriage |
| Lone-parent families | One biological or adoptive parent living with their child or children. They may or may not be living with other adults. |
| Same-sex parent families | May be married or common-law |

**Fig. 2.1** Nuclear family. (Courtesy Makeba Felton, Wake Forest, NC.)

**Fig. 2.2** Extended (multigenerational) family. (Courtesy Makeba Felton, Wake Forest, NC.)

*Blended families,* those formed as a result of divorce and remarriage, consist of unrelated family members (step-parents, stepchildren, and stepsiblings) who join to create a new household. These family groups frequently involve a biological or adoptive parent whose spouse may or may not have adopted the child. In 2016, almost 10% of Canadian children under 15 were living in blended families (Statistics Canada, 2019a).

*Lone-parent families* comprise an unmarried biological or adoptive parent who may or may not be living with other adults. The lone-parent family may result from the loss of a spouse by death, divorce, separation, or desertion; from either an unplanned or planned pregnancy; or from the adoption of a child by an unmarried person. This family structure has become common, with Statistics Canada (2019a) reporting that 19.2% of all children under the age of 15 were living in a lone-parent family. More than 80% of lone-parent families were female-headed lone-parent families, while 18.7% were headed by males (Statistics Canada, 2019a). This gender difference is significant because female-headed lone-parent families are more likely to have lower incomes and to experience poverty than male lone-parent families, which in turn can affect the health status of family members.

*Same-sex couple families* may live together with or without children. Children in lesbian and gay families may be the offspring of previous heterosexual unions, conceived by one member of a lesbian couple through therapeutic insemination, or adopted. Overall, same-sex couples accounted for 0.9% of all couples in Canada in 2016; this number has increased significantly since 2006. In 2016, 12% of same-sex couples in Canada had children under 15 living with them, compared to about half of heterosexual couples (Statistics Canada, 2019b).

Transgendered couples also form families and often become parents, either through the use of fertility drugs, adoption, or transmen discontinuing the hormones they are taking so they can become pregnant themselves.

## Family Dynamics

Ideally, the family uses its resources to provide a safe, intimate, and nurturing environment that supports the biopsychosocial development of family members. The family provides for the nurturing and socialization of children. Children form their earliest and closest relationships with their parents or parenting persons; these affiliations continue throughout a lifetime. Parent–child relationships may influence self-worth and the child's ability to form later relationships. The family also influences the child's perceptions of the outside world. The family provides the growing child with an identity that has both a past and a sense of the future. Cultural and religious beliefs, values, and rituals are passed from one generation to the next through the family.

Over time, the family develops protocols for problem-solving, particularly those regarding important decisions such as having a baby or buying a house. The criteria used in making decisions are based on family values and attitudes about the appropriateness of the behaviour and influenced by social, moral, political, and economic messages. The power to make critical decisions is given to a family member through tradition or negotiation. All families have strengths and the potential for growth. It is important for the nurse to identify those strengths and potential in order to facilitate the growth of the family (Gottlieb, 2013).

## FAMILY NURSING

Families play a pivotal role in health care, representing the primary focus of health care delivery for perinatal and pediatric nurses. In treating the family with respect and dignity, nurses listen to and honour perspectives and choices of the family. They share information with families in ways that are positive, useful, timely, complete, and accurate. The family is supported to participate in their care and decision making at the level of their choice.

Because so many variables affect ways of relating, the nurse must be aware that family members may interact and communicate with each other in ways that are distinct from those of the nurse's own family of origin. Families may hold some beliefs about health that are different from those of the nurse. Their beliefs can conflict with principles of health care management predominant in the Western health care system. Nurses must learn to incorporate these family beliefs into the care that is provided.

In most perinatal and pediatric contexts family nursing could be understood as nursing *with* childbearing and child-rearing families. Family-focused nursing practice foregrounds the family in relation to the individual person within a holistic orientation to health that recognizes the importance of environmental and community contexts. From this perspective the nurse works *with* families by relating to them as people in a way that is meaningful to them, draws on a relational inquiry stance of learning *with* people, identifies patterns of experience that influence health and well-being, enacts professional responsibilities and social commitments, and addresses social determinants that influence health and result in health inequities.

In summary, family nursing practice is collaborative and directed by the family's needs and goals; growth oriented, building on family and community strengths (capacities and resources); respectful of family knowledge and expertise; and congruent with the principles of multidisciplinary family-centred care (Box 2.1) (Public Health Agency of Canada [PHAC], 2017; Registered Nurses' Association of Ontario [RNAO], 2015). An informed advocacy framework may also be helpful for perinatal and pediatric nurses in advancing the practice of family-centred nursing care (Marcellus & MacKinnon, 2016).

### BOX 2.1 Principles of Family-Centred Interprofessional Health Care

Family-centred care (FCC) is a collaborative, complex, and dynamic process of providing safe, skilled, and individualized care. Such care responds to the physical, emotional, psychosocial, and spiritual needs of the person and family. FCC is health oriented and recognizes the importance of family participation and informed choice.

1. FCC is important in all health care contexts.
2. FCC is informed by research evidence.
3. FCC requires a holistic approach.
4. FCC requires collaboration among care providers.
5. Culturally appropriate care is important in a multicultural society.
6. Indigenous people and communities have distinctive knowledge, health needs, and experiences.
7. Providing care to families as close to home as possible is ideal.
8. The attitudes and language of health care providers affect the family's experiences with health care.
9. FCC functions within a health care system that requires ongoing evaluation.
10. Learning about FCC practices globally may offer valuable options for consideration in Canada.

Adapted from Public Health Agency of Canada. (2017). *Chapter 1: Family-centred maternity and newborn care in Canada: Underlying philosophy and principles.* https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care/maternity-newborn-care-guidelines-chapter-1-eng.pdf

### Theories as Guides to Understanding and Working With Families

A **family theory** can be used to describe families and how the family unit responds to events both within and outside the family. Each family theory makes certain assumptions about the family and has inherent strengths and limitations. Most nurses use a combination of theories in their work with families. A brief synopsis of several theories useful for working with families is given in Table 2.2. Application of these concepts can guide assessment and interventions for the family and can be used when providing care in many perinatal and pediatric situations.

**TABLE 2.2 Theories and Models Relevant to Family Nursing Practice**

| Theory | Synopsis of Theory |
|---|---|
| Family Systems Theory (Wright & Leahy, 2013) | The family is viewed as a unit, and interactions among family members are studied, rather than individuals. A family system is part of a larger supra-system and is composed of many subsystems. The family as a whole is greater than the sum of its individual members. A change in one family member affects all family members. The family is able to create a balance between change and stability. Family members' behaviours are best understood from a view of circular rather than linear causality. |
| Family Life Cycle (Developmental) Theory (Carter & McGoldrick, 1999) | Families move through stages. The family life cycle is the context in which to examine the identity and development of the individual. Relationships among family members go through transitions. Although families have roles and functions, a family's main value is in relationships that are irreplaceable. The family involves different structures and cultures organized in various ways. Developmental stresses may disrupt the life cycle process. |
| Family Stress Theory (Boss, 2002) | This theory is concerned with ways that families react to stressful events. Family stress can be studied within the internal and external contexts in which the family is living. The internal context involves elements that a family can change or control, such as family structure, psychological defences, and philosophical values and beliefs. The external context consists of the time and place in which a particular family finds itself and over which the family |

*Continued*

**TABLE 2.2 Theories and Models Relevant to Family Nursing Practice—cont'd**

| Theory | Synopsis of Theory |
|---|---|
| | has no control, such as the culture of the larger society, the time in history, the economic state of society, the maturity of the individuals involved, the success of the family in coping with stressors, and genetic inheritance. |
| McGill Model of Nursing (Allen, 1997) | This model of situation-responsive nursing has a strength-based focus in clinical practice with families rather than a deficit approach. Identification of family strengths and resources, provision of feedback about strengths, and assistance given to the family to develop and elicit strengths and use resources are key interventions. The McGill model is particularly relevant for working with childbearing families, as pregnancy can be considered a "teachable moment" for promoting the health of the entire family. |
| The Collaborative Partnership Approach (Gottlieb & Feeley, 2006) | This model builds on the McGill model of nursing and more fully develops a collaborative partnership approach to family nursing. A *collaborative partnership* is defined as "the pursuit of person-centred goals through a dynamic process that requires the active participation and agreement of all partners." Features of a collaborative partnership include mutual identification of an agreement on goals; sharing expertise and power; being respectful, accepting, and nonjudgemental; being open to learning together and learning to live with ambiguity; and being reflective and self-aware. |

Another source for information about family nursing practice models is the International Family Nursing Association: https://internationalfamilynursing.org/resources-for-family-nursing/practice/practice-models/

## Family Assessment

When selecting a family assessment framework, it is important to consider the focus of nursing care. An appropriate model for a perinatal nurse is one that is health promoting rather than an illness-care model. The family can be assisted in fostering a healthy pregnancy, childbirth, and integration of the newborn into the family. Patients experiencing perinatal health challenges or conditions of vulnerability (e.g., poverty) or families with ill children have additional needs that the nurse may need to address while also promoting the health of the family.

**The Calgary Family Assessment Model.** A family assessment tool such as the Calgary Family Assessment Model (CFAM) (Box 2.2) can be used as a guide for assessing aspects of the family. Such an assessment is based on "the nurse's personal and professional life experiences, beliefs, and relationships with those being interviewed" (Wright & Leahy, 2013) and is not "the truth" about the family but, rather, one perspective at one point in time.

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

**Graphic Representations of Families.** A *family genogram*, which is a family-tree format depicting relationships of family members over at least three generations (Figure 2.4), provides valuable information about a family and can be placed in the nursing care plan for easy access by care providers. An *ecomap*, a graphic portrayal of social relationships of the individual and family, may also help the nurse understand the social environment of the family and identify support systems available to them (Figure 2.5).

**BOX 2.2 Calgary Family Assessment Model**

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

**Structural Assessment**

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

***Sample Questions***

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

**Developmental Assessment**

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

***Sample Questions***

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

**Functional Assessment**

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

***Sample Questions***

- Which one of the family is best at ensuring that your grandmother takes her medicine?
- Whose turn is it to make dinner for Grandma?
- How can we get Martin to help with Grandma's care?

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

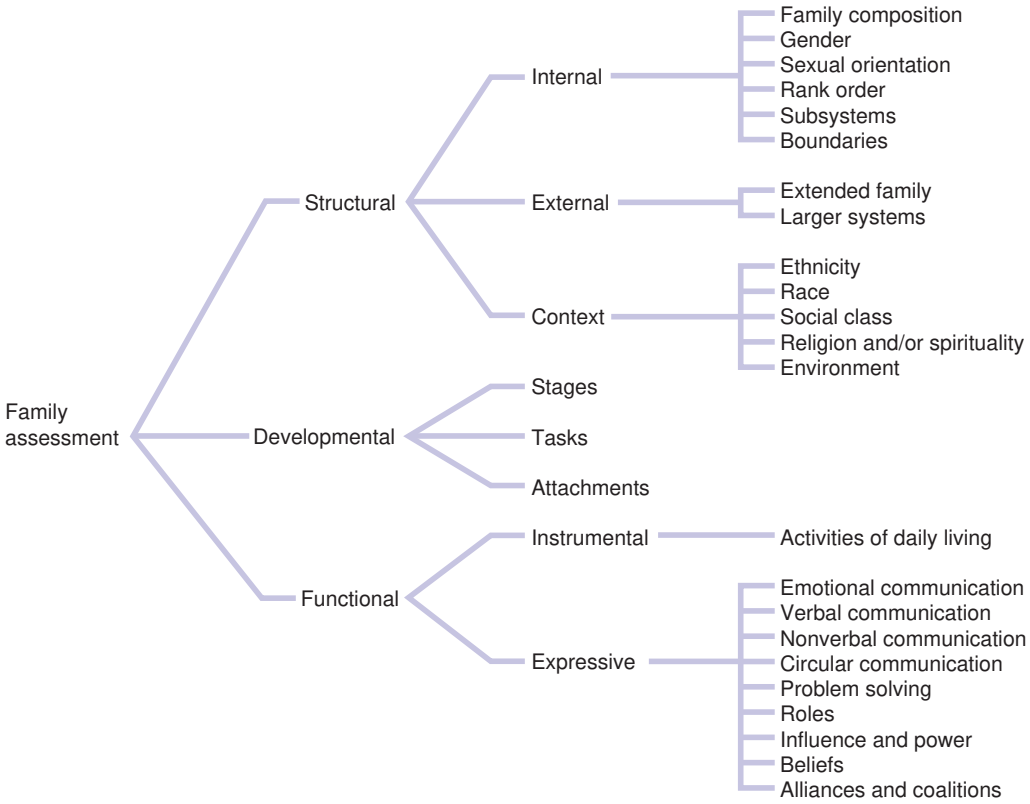


**Fig. 2.3** Branching diagram of Calgary Family Assessment Model (CFAM). (From Leahy, M., & Lorraine, W. [2013]. *Nurses and families: A guide to family assessment and intervention* [6th ed.]. FA Davis, with permission.)

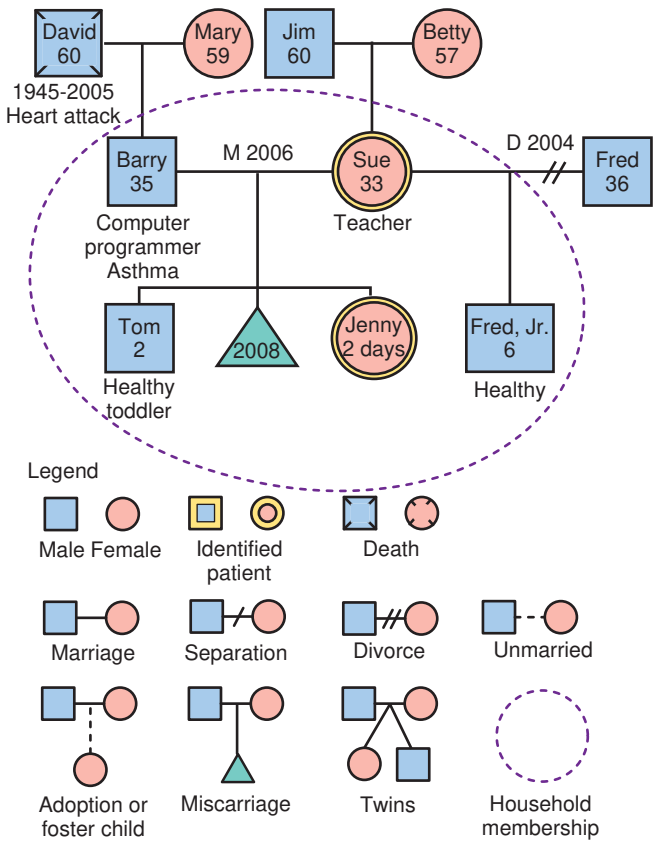


**Fig. 2.4** Example of a family genogram.

## Family Nursing as Relational Inquiry

Relational nursing challenges nursing practices based on structured assessment frameworks and proposes that nurses need to be "in relation" with patients and family members, taking cues from the family and collaboratively identifying capacity and adversity patterns and building knowledge together for health promotion (Doane & Varcoe, 2015). Recognizing that families are socially located in historical, cultural, and environmental contexts helps nurses to understand the factors that have a significant impact on family members' experiences of health and childbearing. Relational nursing moves beyond a health service provision approach toward one that is more congruent with holistic health promotion (Box 2.3). This approach is understood as a process of inquiry, and this process forms the framework for thoughtful, interpretive, critical, and spiritual inquiry. Nurses learn together *with* the family members about what matters most to them, about family strengths and health challenges, and about how to work toward better health for the family.

A relational inquiry approach also considers the family from four lenses or perspectives: (1) a phenomenological lens, (2) a sociopolitical lens, (3) a spiritual lens, and (4) a socioecological health promotion perspective. The phenomenological lens cues the nurse to learn more about the family members' experiences of health and illness. How does the family view illness? What do they do to enhance wellness? What is meaningful and significant to the family? The sociopolitical lens attends to power and gender, class, ethnic, racial, and professional relationships. The spiritual lens reminds us that health (e.g., childbearing or child-rearing) has particular personal, cultural, and religious meanings and significance. A socioecological perspective of health promotion is an understanding of health and health promotion that focuses on the family in their environmental context. It reminds nurses that nursing