Maternal & Child Health Nursing

Care of the Childbearing & Childrearing Family

NINTH EDITION

JoAnne Silbert-Flagg

Wolters Kluwer

Brief Contents

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I dedicate this book to all the children I have cared for over the years at Columbia Medical Practice. I hope I have touched your lives as you have touched mine.

—JoAnne Silbert-Flagg

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Preface

This edition is my second revision of the textbook that is the legacy of Adele Pillitteri. As I have reviewed the submissions by the contributors, I feel that I am looking at it for the first time. It is probably a reflection of how much the world has changed and the words on the pages do not fully reflect the changing world. When life-changing events occur, one often wonders how much should be included in a textbook. Will it be forgotten by the time the students read this book?

It is clear that the COVID-19 pandemic will not be forgotten by anyone living through it. It will have an impact on the health of families and children for the foreseeable future: from the parent who gave birth with only one family member present, worried if they could breastfeed if they had COVID-19, to the children who interact with other children from a distance while wearing masks. As students progress through their nursing programs, I hope they realize how important their contributions as nurses will be to the health of the world, as evidenced by the global nature of this recent health crisis. If you choose to provide maternal and/or pediatric care as a nurse, your contribution to the healing of families may seem small, but collectively, they will make a difference. According to the *Journal of Pediatrics* (2021), from April 1, 2020, through June 30, 2021, COVID-19-associated deaths accounted for loss of parents and caregivers for over 140,000 children. Racial and ethnic disparities in these types of losses were extremely apparent; one in every 753 White children, one in every 412 Hispanic children, one in every 310 Black children, and one in every 168 American Native/Alaska Native children lost a parent or caregiver during this period. These losses are likely to have long-term impacts on the health of these children.

Together with the content experts who assisted in the revision of this edition, I have tried to ensure it is accurate and relevant for the prelicensure nursing student. Based on the recommendation of reviewers, many of the features that have evolved over previous editions continue to appear here with some new changes. As an instructor in the classroom of the content in this textbook, I am acutely aware of the pressure on faculty to present relevant and engaging information to their students. The instructor resources that accompany this edition have been expanded and will promote the acquisition of knowledge for the students and promote their critical thinking and lessen the time required for faculty preparation.

Maternal & Child Health Nursing: Care of the Childbearing & Childrearing Family, Ninth Edition, continues to present maternal–child healthcare not as two separate disciplines but as a continuum of knowledge. Care has been taken to eliminate redundant content. The book is designed for prelicensure nursing students to use either in a combined maternal–child health course or in two separate courses, regardless of the order of the content. It discusses current evidence-based practice related to family-centered maternal–child and pediatric care while also promoting a sensitive, holistic outlook on nursing practice. Basic themes include the experience of wellness and illness as family-centered events, the perception of pregnancy and childbirth as periods of wellness, and the importance of knowing normal child development in the planning of nursing care. Themes also reflect changes in healthcare delivery and the importance of meeting the needs of culturally diverse populations. Care has been taken to present cases with a gender-neutral approach and limit stereotypical family scenarios. With the pediatric content, you will notice there are no names, initials, or gender references to ensure the content is inclusive.

The Changing Healthcare Scene

As this book is being published, Americans face many unknowns in healthcare as legislative changes are debated. Preventive healthcare during pregnancy and throughout childhood is crucial for our nation to survive and prosper. Many diseases and disabilities of adulthood are influenced by the care that pregnant women and their children receive. As healthcare in the United States continues to evolve and change, nurses will retain an integral role in ensuring preventive needs are addressed.

The new *Healthy People 2030* goals are referenced throughout this book. Care has been taken to include content that represents the diversity of the population with regard to race, ethnicity, sexual orientation, and gender identity. Goals for lesbian, gay, bisexual, and transgender (LGBTQ+) persons were added for the first time in 2020 and continue to evolve in the 2030 revisions. This edition sought to respond by addressing recommendations from The Joint Commission for cultural competency when caring for this population. Nurses are taking an ever-increasing role in the provision of healthcare for the maternal and child health population. As the population becomes more diverse, it is imperative that nurses understand the cultural beliefs of all individuals. Nursing care requires a greater focus on care planning, communication, evidence-based therapeutic interventions, and critical thinking.

Nursing issues that grow out of the current climate of change include:

- The accentuation of nursing care planning and the nursing process: The care planning process provides the structuring framework for coordinating communication

that will result in safe and effective care. By structuring the text to reflect this process, students can begin to conceptualize how they will use textbook knowledge in nursing practice to diagnose, plan, deliver, and monitor patients to maximize optimal outcomes. In addition, Nursing Process Overview boxes included at the beginning of each chapter provide a strong theoretical underpinning for nursing process and ways to use the nursing process in clinical practice.

- An emphasis on *Healthy People 2030* goals: As a way to focus care and research, national health goals have gained wider attention at a time when there is a greater need than ever to be wise in the choice of how dollars are spent. Students can familiarize themselves with how these goals can be applied directly to maternal and child healthcare by referring to the Nursing Care Planning based on *Healthy People 2030* goals displays that appear in each chapter.
- Incorporation of the Centers for Disease Control and Prevention (CDC) Maternity Practices in Infant Nutrition and Care (mPINC) Survey that supports hospital practices that create a supportive environment for breastfeeding prenatally and continue through discharge
- The necessity for nurses to be active participants in redefining quality in healthcare: A major way nurses can do this is by joining with the National Academy of Medicine (formerly the Institute of Medicine) to help define required competencies for practice. Included in each chapter are multiple-choice questions based on the Quality and Safety Education for Nurses (QSEN) competencies, so students can better envision how these competencies can be applied to practice.
- The importance of basing nursing care on evidence-based practice: The variety of new care settings, as well as the diversity of roles in which nurses practice, is reflected both in the proliferation of community-based nursing facilities and also in the increase in the numbers of nurse-midwives, women's health, pediatric, and neonatal nurse practitioners. This new edition places emphasis on the need for nurses to read and apply research to practice by demonstrating how recent research applies directly to a patient scenario woven throughout each chapter. In addition, boxes on Nursing Care Planning Using Assessment, Nursing Care Planning Based on Responsibility for Pharmacology, and Nursing Care Planning Using Procedures illustrate how medical science is applied to care.
- The need to coordinate care: With a growing ambulatory population, nurses assume the increasingly important role as coordinators for healthcare teams. Interprofessional Care Maps in each chapter demonstrate how the nursing process works for a specific patient throughout the care cycle.
- The responsibility of health teaching with families as a cornerstone of nursing: The teaching role of the nurse has greater significance in the new healthcare milieu as the emphasis on preventive care and short stays in acute care settings create the need for families to be better educated in their own care. Nursing Care Planning Based on Family Teaching displays present detailed health information for the family, emphasizing the importance of a partnership between nurses and patients in the management of health and illness. Nursing Care Planning to Empower a Family boxes provide students with the type of information families need to learn how to participate in and improve both family and individual health.
- The obligation to individualize care according to sociocultural uniqueness: This is a reflection of both greater cultural sensitivity and an increasingly diverse population of caregivers and care recipients. Greater emphasis is being placed on the implications of multiple sociocultural factors in how they affect responses to health and illness. Nursing Care Planning Tips for Effective Communication boxes give examples of ways to improve nurse–patient communication. Nursing Care Planning to Respect Cultural Diversity displays demonstrate solutions in areas of caregiving that differs among patients of various cultures.

Organization of the Text

Maternal & Child Health Nursing follows the family from prepregnancy through pregnancy, labor, birth, and the postpartum period; it then follows the child and the family from birth through adolescence. Coverage includes ambulatory and inpatient care and focuses on primary as well as secondary and tertiary care.

The book is organized into eight units:

Unit 1 provides an introduction to maternal and child health nursing. A framework for practice is presented as well as current trends and the importance of considering childbearing and childrearing within a diverse sociodemographic and family/community context. This focus includes attention to health disparities and the provision of care in the home as well as the hospital setting.

Unit 2 examines the nursing role in preparing families for childbearing and childrearing and discusses reproductive and sexual health, the role of the nurse in genetic counseling, reproductive life planning, and the concerns of the subfertile family.

Unit 3 presents the nursing role in caring for a pregnant family during pregnancy, birth, and the postpartum period and serving as a fetal advocate. A separate chapter details the role of the nurse in providing comfort during labor and birth.

Unit 4 addresses the nursing role when a woman develops a complication of pregnancy, labor, or birth or has a complication during the postpartum period. Separate chapters address the role of the nurse when a woman has a preexisting illness, develops a complication during pregnancy or the postpartum period, has a unique concern, or chooses or needs a cesarean birth. A final chapter details care of the high-risk newborn or a child born with a physical or a developmental challenge.

Unit 5 discusses the nursing role in health promotion during childhood. The chapters in this unit cover principles of growth and development and care of the child from infancy through adolescence, including child health assessment and communication and health teaching with children and families.

Unit 6 presents the nursing role in supporting the health of children and their families. The effects of illness on children and their families, diagnostic and therapeutic

procedures, medication administration, and pain management are addressed, with respect to care of the child and family in the hospital, home, and ambulatory settings.

Unit 7 examines the nursing role in restoring and maintaining the health of children and families when illness occurs. Disorders are presented according to body systems so that students have a ready orientation for locating content.

Unit 8 discusses the nursing role in restoring and maintaining the mental health of children and families. Separate chapters discuss the role of the nurse when intimate partner violence or child maltreatment or mental, long-term, or fatal illness is present.

Pedagogic Features

Each chapter in the text is organized to provide a complete learning experience for the student. Numerous pedagogic features are included to help a student understand and increase retention. Important elements include:

- **Chapter Objectives:** Learning objectives are included at the beginning of each chapter to identify outcomes expected after the material in the chapter has been mastered.
- **Key Terms:** Terms that would be new to a student are listed at the beginning of each chapter in a ready reference list. Terms are shown in boldface type where they are defined in the text. Definitions also appear online in the Glossary.
- **Chapter-Opening Scenarios:** Short scenarios appear at the beginning of each chapter. These vignettes are designed to help students appreciate that nursing care is always individualized and provide a taste of what is to come in the chapter. Throughout the chapter, open-ended and multiple-choice questions related to the scenario connect learning with patient care.
- **Nursing Process Overview:** Each chapter begins with a review of nursing process in which specific suggestions, such as examples of nursing diagnoses and outcome criteria helpful to modifying care in the area under discussion, are presented. These reviews are designed to improve students' preparation in clinical areas, so they can focus their care planning and apply principles to practice.
- **Nursing Diagnoses and Related Interventions:** A consistent format highlights the Nursing Diagnoses and Related Interventions throughout the text. A special heading draws the students' attention to these sections where individual nursing diagnoses and outcome evaluation are detailed for the major conditions and disorders discussed.
- **QSEN Checkpoint Questions:** Throughout the text, NCLEX-style multiple-choice QSEN Checkpoint Questions appear to help students check their progress and reward them for their comprehension. They relate the chapter-opening scenario to the six QSEN competencies: safety, quality improvement, evidence-based practice, team work and collaboration, informatics, and patient-centered care. Students can check their work by reading the answers provided in the Appendix.
- **What If... Questions:** These critical thinking questions, formatted to reflect NCLEX style, also appear throughout each chapter in the text. They ask readers to apply the information just acquired in the patient scenario presented in the chapter opening, thus maximizing learning and emphasizing critical thinking. Suggested solutions are supplied on thePoint.
- **Tables and Displays:** Numerous tables and displays summarize important information or provide extra detail on topics so that a student has ready references to this information.
  - **Nursing Care Planning Based on *Healthy People 2030* Goals:** To emphasize the nursing role in accomplishing the healthcare goals of our nation, these displays state specific ways in which maternal and child health nursing can provide better outcomes for families. They help the student to appreciate the importance of national healthcare planning and the influence that nurses can have in creating a healthier nation.
  - **Nursing Care Planning Tips for Effective Communication:** This feature presents tips to apply communication skills in practice and provides case examples of effective communication, illustrating for the student how an awareness of communication can improve the patient's understanding and positively impact outcomes.
  - **Nursing Care Planning Based on Family Teaching:** These boxes present detailed health teaching information for the family, emphasizing the importance of a partnership between nurses and patients in the management of health and illness.
  - **Nursing Care Planning Based on Responsibility for Pharmacology:** These boxes provide quick reference for medications that are commonly used for the health problems described in the text. They give the drug name (brand and generic, if applicable), dosage, pregnancy category, side effects, and nursing implications.
  - **Nursing Care Planning Using Procedures:** Techniques of procedures specific to maternal and child healthcare are boxed in an easy-to-follow two-column format, often enhanced with color figures.
  - **Nursing Care Planning Using Assessment:** These visual guides provide head-to-toe assessment information for overall health status or specific disorders or conditions.
  - **Nursing Care Planning: Interprofessional Care Maps:** Because nurses rarely work in isolation but rather as a member of a healthcare team or unit, Interprofessional Care Maps written for specific patients are included in each chapter to demonstrate the use of the nursing process, provide examples of critical thinking, and clarify nursing care for specific patient needs. These Interprofessional Care Maps not only demonstrate nursing process but also accentuate the increasingly important role of the nurse as a coordinator of patient care.
  - **Nursing Care Planning to Respect Cultural Diversity:** These boxes help students appreciate how care delivery should alter to meet the needs of each patient in a country that continually attracts immigrants from throughout the world.

- **Nursing Care Planning to Empower a Family:** Because patient education is an important nursing responsibility, these boxes provide students with the type of information families need to learn how to participate in improving their health.
- **Unfolding Patient Stories:** Written by the National League for Nursing, these Unfolding Patient Stories are an engaging way to begin meaningful conversations in the classroom. These vignettes, which appear in relevant chapters, feature patients from Wolters Kluwer's *vSim for Nursing: Maternity and Pediatric* (codeveloped with Laerdal Medical) and DocuCare products; however, each Unfolding Patient Story in the book stands alone, not requiring purchase of these products.
- **Concept Mastery Alerts:** These Concept Mastery Alerts clarify common misconceptions as identified by Lippincott's Adaptive Learning Powered by PrepU.
- **Key Points:** A review of important points is highlighted at the end of each chapter to help students monitor their own comprehension.
- **Critical Thinking Care Studies:** To involve a student in the decision-making realities of the clinical setting, each chapter ends with an additional case scenario, followed by several thought-provoking questions. These could also serve as a basis for conference or class discussion. Suggested answers are supplied on thePoint.

Teaching and Learning Package

RESOURCES FOR INSTRUCTORS

Tools to assist you with teaching your course are available upon adoption of this text at http://thepoint.lww.com/SilbertFlagg9e.

- **Prelecture Quizzes:** These exercises ask students to recall information. Based on the main points of the chapter, each of the five true/false statements and five fill-in-the-blank questions will help you determine whether students have read the chapters. Answers are provided.
- **Assignments:** Grouped into Written Assignments, Group Assignments, Clinical Assignments, and Web Assignments, the Assignments package will give you a means to gauge students' understanding of the textbook material. The Assignments give students many chances to test their own knowledge of the chapter concepts as well as their developing critical thinking skills. Suggested Answers are provided.
- **Discussion Topics:** With these topics, you can initiate and foster classroom discussion or assign them for use outside the classroom. Each Discussion Topic is designed to help students make a connection between the textbook and application. Suggested Answers are provided.
- **E-Book:** Online access to the book's full text and images gives you an easy-to-transport format.
- **PowerPoint Presentations with Guided Lecture Notes:** The PowerPoint presentations provide you with visual aids to support your lectures or classroom lessons. The accompanying Guided Lecture Notes offer brief talking points you can use along with the presentations.
- **Test Generator:** The Test Generator lets you put together exclusive new tests from a bank containing hundreds of questions to help you in assessing your students' understanding of the material. Test questions link to chapter learning objectives. This test generator comes with a bank of more than 1,100 questions.
- **Image Bank:** Access to downloadable photographs and illustrations from this textbook offers you the ability to use them in your PowerPoint slides or as you see fit throughout your course.

Resources for Students

Students can access all these learning tools using the code printed in the front of their textbooks by visiting http://thepoint.lww.com/SilbertFlagg9e.

- **NCLEX-Style Review Questions:** These *application-level* questions provide students the opportunity to test themselves on their ability to apply specific nursing actions based on what a nurse should know and what a nurse should do in a specific situation related to the chapter content. They also give students experience in answering questions of the type that will appear on the NCLEX.
- **Suggested Readings:** This list of journal articles provides students with the information needed to do more in-depth reading relevant to the topics included in the chapter.
- **Answers and Rationales:** Suggested Answers to the each chapter's What If… and Critical Thinking Care Study questions allow students to gauge whether they are on the right track by providing the main points that they are expected to address in answering these questions.
- **Patient Scenarios:** A patient care scenario details a full health history and examination findings pertinent to each chapter's content. Each scenario includes 25 related NCLEX-style questions to help students sharpen their skills and grow more familiar with NCLEX-type questions. Completing these exercises serves as an excellent review of the chapter content.
- **Journal Articles:** Updated for the new edition, online articles offer students the opportunity to read current research related to each chapter's material as available in Wolters Kluwer journals.
- **Watch & Learn Video Clips:** These audiovisual aids cover both maternal and childcare topics.

A Fully Integrated Course Experience

We are pleased to offer an expanded suite of digital solutions and ancillaries to support instructors and students using *Maternal & Child Health Nursing*, Ninth Edition. To learn more about any solution, please contact your local Wolters Kluwer representative.

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Lippincott CoursePoint+ is an integrated digital learning solution designed for the way students learn. It is the only nursing education solution that integrates:

- **Leading content in context:** Content provided in the context of the student learning path engages students and encourages interaction and learning on a deeper level.

- **Powerful tools to maximize class performance:** Course-specific tools, such as adaptive learning powered by PrepU, provide a personalized learning experience for every student.
- **Real-time data to measure students' progress:** Student performance data provided in an intuitive display let you quickly spot which students are having difficulty or which concepts the class as a whole is struggling to grasp.
- **Preparation for practice:** Integrated virtual simulation and evidence-based resources improve student competence, confidence, and success in transitioning to practice.
  - ***vSim for Nursing*:** Codeveloped by Laerdal Medical and Wolters Kluwer, vSim for Nursing simulates real nursing scenarios and allows students to interact with virtual patients in a safe, online environment.
  - ***Lippincott Advisor for Education*:** With over 8,500 entries covering the latest evidence-based content and drug information, Lippincott Advisor for Education provides students with the most up-to-date information possible while giving them valuable experience with the same point-of-care content they will encounter in practice.
- **Training services and personalized support:** To ensure your success, our dedicated educational consultants and training coaches will provide expert guidance every step of the way.

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KEY TERMS

evidence-based practice
fertility rate
infant mortality rate
maternal and child health nursing
nursing research
patient advocacy
Quality and Safety Education for Nurses (QSEN)
scope of practice

OBJECTIVES

After mastering the contents of this chapter, you should be able to:

1. View the areas of maternal and child health as a continuum with a seamless flow between the two areas.
2. Identify the specific goals and philosophies of maternal and child health nursing and apply these to nursing practice.
3. Identify the *Healthy People 2030* goals as an important guide to understanding the health of the nation and goals that nurses can help the nation achieve.
4. Integrate knowledge of maternal and child health nursing with the interplay of the nursing process, the six competencies of QSEN, and family nursing to achieve quality maternal and child health nursing care.
5. Identify health trends in maternal and child health nursing and define and use common statistical terms used in the field, such as infant and maternal mortality.
6. Describe family-centered care and ways maternal and child health nursing could be made both more family-centered and respectful of diversity.
7. Describe the evolution, scope, competencies, and professional roles of nurses in maternal and child health nursing.
8. Identify ethical issues related to maternal and child health nursing and consider ways to provide factual information to patients facing tough healthcare decisions.

A.C. is an early premature neonate who will be transported to a regional center for care about 30 miles from the community where she was born. Her parents, M.C. and R.C., tell you they are worried about their tiny daughter being cared for by strangers so many miles away. They're also concerned how they will be able to pay for or give informed consent for this special level of care. M.C., 42 years old, feels too exhausted to leave the hospital only 2 days after having a cesarean birth. She wonders how she and her husband will be able to visit the new baby because of her exhaustion and because their first child, B.C., 6 years old, is on home care for pneumonia. R.C. wonders how B.C. will react to having an ill rather than a healthy sister.

This chapter discusses competencies, philosophies, challenges, and new roles for nurses in maternal–child healthcare and how these challenges and changes mold and affect care.

What are some healthcare issues evident in the previous scenario? What would be your nursing role with M.C.? With her two children?

Goals and Philosophies of Maternal and Child Health Nursing

The area of childbearing and childrearing families is a major focus of nursing practice in promoting health for the next generation. Comprehensive preconception and prenatal care is essential in ensuring healthy outcomes for mother and child. Although childbearing and childrearing are often viewed as two separate entities, they are interrelated, and a deeper understanding is achieved when they are viewed as a continuum (Fig. 1.1) (Lincetto et al., n.d.).

The primary goal of both maternal and child health nursing is the promotion and maintenance of optimal family health. Major philosophical assumptions about combined maternal and child health nursing are listed in Box 1.1. **Maternal and child health nursing** extends from preconception to menopause with an expansive array of health issues and healthcare providers. Examples of the scope of practice include:

- Preconception healthcare
- Care of women during three trimesters of pregnancy and the puerperium (the 6 weeks after childbirth, sometimes termed the fourth trimester of pregnancy)

A

B

Figure 1.1 Maternal and child health nursing includes care of the pregnant person, child, and family. **A.** During a prenatal visit, a nurse assesses that a pregnant patient's uterus is expanding normally. **B.** During a health maintenance visit, a nurse assesses a child's growth and development. (© Barbara Proud.)

BOX 1.1

A Philosophy of Maternal and Child Health Nursing

Maternal and child health nursing is:

- Family-centered; assessment should always include the family as well as an individual.
- Community-centered; the health of families is both affected by and influences the health of communities.
- Evidence-based; this is the means whereby critical knowledge increases.
- A challenging role for nurses and a major factor in keeping families well and optimally functioning

A maternal and child health nurse:

- Considers the family as a whole and as a partner in care when planning or implementing or evaluating the effectiveness of care.
- Serves as an advocate to protect the rights of all family members, including the fetus.
- Demonstrates a high degree of independent nursing functions because teaching and counseling are major interventions.
- Promotes health and disease prevention because these protect the health of the next generation.
- Serves as an important resource for families during childbearing and childrearing as these can be extremely stressful times in a life cycle.
- Respects personal, cultural, and spiritual attitudes and beliefs as these so strongly influence the meaning and impact of childbearing and childrearing.
- Encourages developmental stimulation during both health and illness so children can reach their ultimate capacity in adult life.
- Assesses families for strengths as well as specific needs or challenges.
- Encourages family bonding through rooming-in and family visiting in maternal and child healthcare settings.
- Encourages early hospital discharge options to reunite families as soon as possible in order to create a seamless, helpful transition process.
- Encourages families to reach out to their community so the family can develop a wealth of support people they can call on in a time of family crisis.

- Care of infants during the perinatal period (the time span beginning at 20 weeks of pregnancy to 4 weeks [28 days] after birth)
- Care of children from birth through late adolescence
- Care in a variety of hospital and home care settings

Regardless of the setting, a family-centered approach is the preferred focus of nursing care (Browne et al., 2020). The health of an individual and their ability to function as a member of a family can strongly influence and improve overall family functioning.

Family-centered care enables nurses to better understand individuals and their effects on others and, in turn, to provide more holistic care (Browne et al., 2020). It includes encouraging rooming-in with the birthing parent by their partner or support person and with the child by their caregiver. Family members are encouraged to provide physical and emotional

Figure 1.2 A nurse involves the mother in a physical exam to promote family-centered care.

care based on the individual situation and their comfort level. Nurses provide guidance and monitor the interactions between family members to promote the health and well-being of the family unit (Fig. 1.2).

Box 1.2 provides guidance on how to assist a family with choosing a healthcare setting that is family-centered. Family teaching boxes of this kind are found in all chapters as examples of the type of health teaching important in maternal and child healthcare.

BOX 1.2

Nursing Care Planning Based on Family Teaching

TIPS FOR SELECTING A FAMILY-CENTERED HEALTHCARE SETTING

Q. M.C. asks you, "With so many healthcare settings available, how do we know which one to choose?"

A. When selecting a setting, asking the following questions can help you decide what is best for your family:

- If the setting is for childcare, are personnel interested in you as well as your child? If the setting is a maternal care site, do they ask about family concerns as well as individual ones?
- Can the setting be reached easily? Going for preventive care when well or for continuing care when ill should not be a chore.
- Will the staff provide continuity of care so you'll always see the same primary care provider if possible?
- Does the physical setup of the facility provide a sense of privacy yet a sense that healthcare providers share pertinent information so you do not have to repeat your history at each visit?
- Is the cost of care and the number of referrals to specialists explained clearly?
- Are preventive care and health education stressed? Maintaining wellness is as important as recovering from illness.
- Is health education done at your learning level?
- Do healthcare providers respect your opinion and ask for your input on healthcare decisions?
- Will the facility still be accessible if a family member becomes disabled?

Maternal and Child Health Goals and Standards

Healthcare technology has contributed to a number of important advances in maternal and child healthcare. Through immunization, childhood diseases such as measles and poliomyelitis have almost been eradicated. New fertility drugs and fertility techniques allow more families to conceive. The ability to prevent preterm birth and improve the quality of life for both preterm and late preterm infants has increased dramatically. As specific genes responsible for children's health disorders are identified, stem cell therapy may make it possible to replace diseased cells with new growth cells and cure these illnesses. In addition, a growing trend toward shared decision making (SDM) has made childbearing and childrearing families active participants in their own health monitoring.

Access to healthcare and social determinants of health impact the role of the nurse and the health of the patient. These factors have expanded the roles of nurses in maternal and child health and, at the same time, have made the delivery of quality maternal and child health nursing care a challenge.

NATIONAL *HEALTHY PEOPLE 2030* GOALS

The importance a society assigns to human life can best be measured by the concern a nation places on its most vulnerable members—those who are the youngest and the oldest as well as those who are disadvantaged. In light of this, in 1979, the U.S. Public Health Service first formulated healthcare objectives for the nation. Healthcare goals are reviewed every 10 years. In 2020, the government set new goals to be achieved by 2030, the *Healthy People 2030* goals (U.S. Department of Health and Human Services, 2020). Many of these objectives directly involve maternal and child healthcare because improving the health of these age groups will have long-term effects on the population. The three overall health and well-being measures include:

- Well-being, including overall life satisfaction
- Life expectancy in good health, free of activity limitations and of disability
- Summary mortality and health measures

The *Healthy People 2030* goals are intended to help Americans more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. It is important for maternal and child health nurses to be familiar with these goals because nurses play such a vital role in helping the nation achieve these objectives through both practice and research. The goals also serve as the basis for grant funding and financing of evidence-based practice. Visit www.healthypeople.gov for additional information.

GLOBAL HEALTH GOALS

The United Nations (UN) and the World Health Organization (WHO) established millennium health goals in 2000 in an effort to improve health worldwide. In an effort to continue the work of the millennium goals, 169 sustainable development goals (SDGs) with 17 targets were established. All UN members have agreed to work toward these health goals

by 2030 (World Health Organization, 2020). Healthcare issues are addressed in SDG 3, to ensure healthy lives and promote well-being for all at all ages. Central to this goal are the targets that relate to maternal and child health:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- By 2030, end preventable deaths of newborns and children under 5 years of age.
- By 2030, ensure universal access to sexual and reproductive healthcare services.
- Achieve universal health coverage.
- Strengthen the prevention and treatment of substance abuse.
- By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases (World Health Organization, 2020).

HEALTH SETTING MAGNET STATUS

Magnet status is a credential furnished by the American Nurses Credentialing Center (ANCC), an affiliate of the American Nurses Association (ANA), to hospitals that meet a rigorous set of criteria designed to improve the strength and quality of nursing care. Hospitals that achieve Magnet status meet criteria in five major categories:

- *Transformational leadership.* This is the ability of nurses in the designated organization to convert their organization's values, beliefs, and behaviors in order to create a high professional level of nursing care.
- *Structural empowerment.* This refers to the ability to provide an innovative environment where strong professional practice can flourish with regard to the hospital's mission, vision, and values.
- *Exemplary professional practice.* The setting demonstrates a comprehensive understanding of the role of nursing; the application of that role with patients, families, communities; and the interdisciplinary team is clear, so new knowledge and evidence can be applied to nursing care.
- *New knowledge, innovation, and improvements.* The organization demonstrates strong nursing leadership, empowered professionals, and exemplary practice while contributing to patient care.
- *Empirical quality results.* The hospital demonstrates solid structure and processes where strong professional practice can flourish and where the mission, vision, and values come to life as the organization achieves the outcomes believed to be important for the organization (Haller et al., 2018).

Magnet hospitals typically demonstrate a high level of nursing job satisfaction and a low staff nurse turnover rate and have policies in place that include nurses in data collection and decision making about patient care. These hospitals demonstrate they value staff nurses, involve them in research-based practice, and encourage and reward them for obtaining additional degrees in nursing. All nurse managers and nurse leaders in Magnet-designated hospitals must have either a baccalaureate or master's degree in nursing.

Not all hospitals can qualify for Magnet status; the desirability of being named a Magnet hospital, however, has encouraged all hospitals to examine their nursing environment and bring about changes that improve working conditions, stress evidence-based practice, and improve the education level of their nurses (Haller et al., 2018). According to the ANCC, Magnet hospitals "attract and maintain top talent; improve patient care, safety and satisfaction; foster a collaborative culture; advance nursing standards and practice; and grow business and financial success" (ANCC, n.d.).

A Framework for Maternal and Child Health Nursing Care

Maternal and child health nursing can be visualized within a framework in which nurses use the nursing process, nursing theory, and **Quality and Safety Education for Nurses (QSEN)** competencies to care for families during childbearing and childrearing years and through the four phases of healthcare:

- Health promotion
- Health maintenance
- Health restoration
- Health rehabilitation

Examples of these phases of healthcare as they relate to maternal and child health are shown in Table 1.1.

TABLE 1.1 DEFINITIONS AND EXAMPLES OF PHASES OF HEALTHCARE

Term	Definition	Examples
Health promotion	Educating parents and children to follow sound health practices through teaching and role modeling	Teaching people the importance of rubella immunization before pregnancy; providing preteens with information about safer sex practices well before they are likely to become sexually active
Health maintenance	Intervening to maintain health when risk of illness is present	Encouraging patients to be partners in prenatal care; teaching parents the importance of safeguarding their homes by childproofing against poisoning
Health restoration	Using conscientious assessment to be certain that symptoms of illness are identified and interventions are begun to return patient to wellness most rapidly	Caring for a patient during a complication of pregnancy such as gestational diabetes or a child during an acute illness such as pneumonia
Health rehabilitation	Helping prevent complications from illness; helping a patient with residual effects achieve an optimal state of wellness and independence; helping a patient accept inevitable death	Encouraging a patient with gestational trophoblastic disease (abnormal placenta growth) to continue therapy or a child with a renal transplant to continue to take necessary medications

NURSING PROCESS

At its best, nursing care is designed and implemented in a thorough manner using an organized series of steps to ensure quality and consistency of care (Carpenito, 2016). The nursing process, a scientific form of problem solving, serves as the basis for assessing, making a nursing diagnosis, planning, implementing, and evaluating care. It is a process broad enough to serve as the basis for modern nursing care because it is applicable to all healthcare settings from the home to ambulatory clinics to intensive care units.

Because nurses rarely work in isolation but rather as members of interprofessional teams, interprofessional care maps and checkpoint questions on teamwork and collaboration are included throughout the text to demonstrate the use of the nursing process as well as to provide examples of critical thinking, clarify nursing care for specific patient needs, and accentuate the increasingly important role of nurses as coordinators of care for a collaborative team.

NURSING THEORY

One of the requirements of a profession (together with other critical determinants, such as members who set their own standards, self-monitor their practice quality, and participate in research) is that a discipline's knowledge flows from a base of established theory.

Concept Mastery Alert

Health Maintenance and Health Promotion

Make note of the differences between health *maintenance* and health *promotion*. Health maintenance involves intervening to maintain health *when risk of disease is present*, for example, teaching a group of sexually active adolescents about contraception and prevention of sexually transmitted infections. Health promotion involves education when no specific risk is present.

Nursing theories are designed to offer helpful ways to view patients so nursing activities can be created to best meet patient needs. For example, Callista Roy's theory stresses that an important role of the nurse is to help patients adapt to change caused by illness or other stressors (Roy, 2011); Dorothea Orem's theory concentrates on examining patients' ability to perform self-care (Younas, 2017); and Patricia Benner's theory describes the way nurses move from novice to expert as they become more experienced and prepared to give interprofessional care (Menard & Maas, 2019). Using theoretical bases such as these can help you appreciate the significant effect of a child's illness or the introduction of a new member on the total family, for instance.

Other issues most nursing theorists address include how nurses should be viewed or what the goals of nursing care should be. Extensive changes in the scope of maternal and child health nursing have occurred as health promotion (teaching, counseling, supporting, and advocacy, or keeping parents and children well) and SDM have become greater priorities in care (Baijens et al., 2018). As promoting healthy pregnancies and keeping children well protects not only patients at present but also the health of the next generation, maternal–child health nurses fill these expanded roles to a unique and special degree. SDM, or involving the patient as a partner in their own care, can result in increased patient understanding of their health condition, lower anxiety, and greater compliance to treatment plans (Baijens et al., 2018).

QUALITY AND SAFETY EDUCATION FOR NURSES

In 2007, the Robert Wood Johnson Foundation challenged nursing leaders to improve the quality of nursing care and build the knowledge, skills, and attitudes necessary to help achieve that level of care with prelicensure and graduate programs (Craft-Blacksheare, 2018).

Because of this challenge, the QSEN Learning Collaborative created six competencies deemed necessary for quality care (Cronenwett et al., 2009). These competencies included five competencies that originated from a study by the Institute of Medicine: patient-centered care, teamwork and collaboration, quality improvement, informatics, and evidence-based practice. The QSEN Learning Collaborative added safety as the sixth competency.

Throughout all domains of QSEN, the overall goal is to address the challenge of preparing future nurses with the abilities necessary to continuously improve the quality and safety of the healthcare systems in which they work. Definitions for each of the six competencies along with examples of the knowledge, skills, and attitudes necessary to achieve quality maternal and child healthcare are shown in Box 1.3.

EVIDENCE-BASED PRACTICE

Evidence-based practice existed as an important element of nursing practice prior to the development of QSEN; it has since been incorporated into QSEN as one of its competencies. **Evidence-based practice** is the conscientious, explicit, and judicious use of current best evidence to make decisions about the care of patients (Falk et al., 2012). Evidence can be a combination of research, clinical expertise, and patient preferences or values.

Use of evidence such as that obtained from randomized controlled trials helps move healthcare actions from "just tradition" to a more solid and therefore safer, scientific basis. The Cochrane Database (listed in PubMed, Ovid, and MEDLINE) is a good source for discovering evidence-based practices as the organization consistently reviews, evaluates, and reports the strength of health-related research (Horntvedt et al., 2018).

"QSEN Checkpoint Questions: Evidence-Based Practice" boxes are included throughout the text and contain summaries of current maternal and child health research followed by questions to assist you in developing a questioning attitude regarding current nursing practice or in thinking of ways to incorporate research findings into care.

NURSING RESEARCH

Nursing research (the systematic investigation of problems that have implications for nursing practice usually carried out by nurses) plays an important role in evidence-based practice as bodies of professional knowledge only grow and expand to the extent people in that profession are able to carry out research (Melnyk et al., 2018). Examining nursing care in this way results in improved, cost-effective patient care as it

BOX 1.3

QSEN Competencies in Relation to the Family of A.C.

Competency	Knowledge	Skills	Attitudes
Patient-Centered Care			
The patient or designee is thought of as the source of control and full partner in the provision of compassionate and coordinated care based on respect for the patient's preferences, values, and needs.	Take an admission history detailing the composition of the family of A.C. Document the roles of family members and who will be the chief childcare provider.	Encourage A.C.'s family to spend as much time as possible with her while she is hospitalized; assess family support on transition to home.	Don't think of admitting A.C. to the neonatal care nursery as a single patient but rather as admitting her family to the setting.
Teamwork and Collaboration			
Nurses function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making as they achieve quality patient care.	Familiarize yourself with how many other healthcare providers will be interacting with A.C. (e.g., neonatologist, nurse practitioner, nutritionist) to help appreciate how frightening having to meet so many people could be to a family.	Discuss with A.C.'s parents what problems, if any, they will have visiting so other team members can help reassure and support them when they visit.	Consider and respect A.C.'s parents as integrative members of her healthcare team.
Evidence-Based Practice			
Nurses integrate the best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal healthcare.	Read journal articles related to new evidence about healthy families or neonatal care to be better prepared to help A.C. seamlessly transition from one setting to the next.	Implement evidence-based practice so A.C.'s family are confident that care is based on credible research.	Value the need for change based on new evidence so you can explain to A.C.'s family with confidence any need for change in care.
Quality Improvement			
Nurses use data to monitor the outcomes of care and use improvement methods to design and test changes to continuously improve the quality and safety of healthcare systems.	View quality improvement as an important role for all healthcare professionals beginning with prelicensure students.	Use whatever aids, such as checklists, flow sheets, or patient information forms, necessary in order to provide seamless nursing care from nursery admission to home.	Appreciate that continuous quality improvement is an essential part of successful working with and respecting families.
Safety			
Nurses minimize the risk of harm to patients and providers through both system effectiveness and individual performance.	Learn the requirements for a safe healthcare setting for a vulnerable preterm infant.	Be certain A.C. receives developmental stimuli as well as is cared for in an environment that promotes a sense of security and is as free from pain as possible.	Recognize families under stress do not "hear" instructions well and so may need these repeated or provided in a written form as well as orally.
Informatics			
Nurses use information and technology to communicate, manage knowledge, mitigate error, and support decision making.	Keep records and documentation current so various healthcare providers can keep informed in order to provide seamless care shifts and setting shifts in care.	Document care in an electronic health record so it can be available to various healthcare providers.	Recognize that documentation must be complete to be valuable (in audit reviews, what wasn't documented as being done is considered as not done).

provides evidence for action and justification for implementing activities.

A classic example of how the results of nursing research can influence nursing practice is the application of research carried out by Rubin (1963) concerning mothers' initial approaches to their newborns. Before the publication of this study, nurses assumed a birthing parent who did not immediately hold and cuddle the infant at birth was a cold or unfeeling parent (Rubin, 1963). After observing a multitude of new mothers, Rubin concluded attachment is not a spontaneous procedure; rather, it more commonly begins with only fingertip touching, then over the next few days moves to "motherly" actions such as hugging and kissing. Armed with Rubin's findings, nurses today are better able to differentiate healthy from unhealthy bonding behaviors in new parents. Additional nursing research in this area (see Chapter 17) has provided further substantiation regarding the importance of this original investigation.

Some examples of current questions that warrant nursing investigation in the area of maternal and child health nursing include:

- What is the most effective stimulus to encourage patients to come for prenatal care or parents to bring children for health maintenance visits?
- How can nurses be instrumental in fostering diversity and inclusion in care?
- How much self-care should young children be expected (or encouraged) to provide during an illness?
- What is the effect of market-driven healthcare on the quality of maternal–child nursing care?
- What active measures can nurses take to reduce the incidence of child or intimate partner violence?
- How can nurses best help families cope with the stress of a complication of pregnancy or a child's long-term illness?
- How can nurses help prevent violence such as homicide in communities and modify the effects of violence on families?
- What information do maternal and child health nurses need to know about alternative therapies, such as herbal remedies, so their practices remain current?

QSEN Checkpoint Question 1.1

TEAMWORK AND COLLABORATION

A nursing assistant informed the nurse that R.C. asked why the hospital where his baby is being cared for is termed a "Magnet hospital." The nurse would want team members to know which rationale?

a. Magnet hospitals are those that care for the most acutely ill patients.
b. The designation is one assigned by the American Medical Association.
c. The hospital has met high standards for nursing competency.
d. The term refers to hospitals that only admit a limited number of patients.

Look in Appendix A for the best answer and rationale.

A Changing Discipline

Maternal and child health is an ever-changing area of nursing. For example, childhood infections, such as pertussis (whooping cough) and measles (rubeola), can now be prevented so children do not usually require care for these conditions. At the same time, illnesses that could not be treated before, such as cystic fibrosis or hypertension of pregnancy, can now be treated, so the number of settings and critical aspects of care increases and the nature of nursing evolves.

TRENDS IN THE MATERNAL AND CHILD HEALTH NURSING POPULATION

Not only patterns of illness but also variations in social structure, family lifestyles (a way of living in which families cope with social, physical, psychological, and economic variables in their life), and responsibilities continue to constantly change. Table 1.2 summarizes some of these changes that have directly altered assessment and planning care for maternal and child health nurses.

MEASURING MATERNAL AND CHILD HEALTH

Measurements of maternal and child health are not as simple as defining whether patients are ill or well because individual patients and healthcare practitioners can maintain different perspectives on illness and wellness. A more objective view of health can be provided with national or regional health statistics to describe degrees of illness (Box 1.4).

Birth Rate

The birth rate in the United States has continued to gradually decrease in recent years to 11.6 per 1,000 population in 2018 (Fig. 1.3). It has substantially decreased from a high of 30.2 per 1,000 population in 1909 (Martin et al., 2019).

Early last century, births to teenage mothers were steadily increasing; however, due to additional counseling and increased availability of contraception, particularly long-acting, reversible contraception such as intrauterine devices and subdermal implants, this rate is now steadily declining (presently at 17.4/1,000 from a high of 618/1,000 in 1961) (Martin et al., 2019).

The birth rate for women 20 to 24 years of age (68.0/1,000) is gradually declining as well, as people choose to postpone having children until past college age. In contrast, the number of children born to mothers older than 40 years of age is steadily increasing (presently at 11.8/1,000 from a low of almost no births in this age group in 1901) (Martin et al., 2019).

Fertility Rate

The **fertility rate** tends to be low in countries where there are fewer nutritional resources because poor nutrition makes conceiving difficult, as well as in countries where the proportion of young adult men is low because of war or disease. This rate tends to be high in countries where the average person has access to good nutrition and feels safe to begin a family. The U.S. fertility rate is currently at 59.1%, a rate typical of a healthy, high-resource country (Martin et al., 2019).

TABLE 1.2 TRENDS IN MATERNAL AND CHILD HEALTHCARE AND IMPLICATIONS FOR NURSING

Trend	Implications for Nursing
Families are not as extended as in previous generations, so they contain fewer members.	Fewer family members are available as support people in times of crisis. Nurses are called on to fulfill this role more than ever before.
The number of single-parent families is increasing so rapidly it now equals the number of nuclear families in the United States.	A single parent may have fewer financial resources than dually employed parents. Nurses need to be aware of alternative care options and available to provide a backup opinion as needed.
Ninety percent of people who identify as women in the United States work outside their home at least part-time; many are the main wage earners for their families.	Healthcare must be scheduled at times a working parent can come for care or can bring a child for care. Problems of children left home alone and the number and safety of childcare centers need to be addressed.
Families are more mobile than previously; there is an increase in the number of people and families without homes.	Good interviewing and health monitoring are necessary with mobile families so a health database can be established and there can be continuity of care.
Both child abuse and intimate partner violence are increasing in incidence.	Screening for child abuse or intimate partner violence should be included in all family assessments. Nurses must be aware of the legal responsibilities for reporting violence.
Families are more health-conscious than ever before; the use of websites to monitor their health or ask health questions is rapidly increasing.	Families are ripe for health education; providing evidence-based information can be a major nursing role.
Healthcare must respect cost containment by creating "healthcare homes" or "medical homes."	Comprehensive care is necessary in primary care settings because referral to specialists may not be an option depending on a family's type or lack of health insurance.
Patient advocacy is necessary as it is easy for families to feel lost in the healthcare system.	**Patient advocacy** is safeguarding and advancing the interests of patients and their families. Familiarity with the healthcare services available in a community, establishing and maintaining a relationship with families, as well as helping them make informed choices about what course of action to take or what services would be best to use are important nursing roles.

BOX 1.4

Common Statistical Terms Used to Report Maternal and Child Health

Birth rate: The ratio of the number of total live births to the total population; expressed as births per 1,000 population

Fertility rate: The number of pregnancies per 1,000 biologic women of childbearing age

Fetal death rate: The number of fetal deaths (over 500 g) per 1,000 live births

Neonatal death rate: The number of deaths per 1,000 live births occurring at birth or in the first 28 days of life

Perinatal death rate: The number of deaths during the perinatal time period (beginning when a fetus reaches 500 g, about week 20 of pregnancy, and ending about 4 to 6 weeks after birth); the sum of the fetal and neonatal rates

Maternal mortality rate: The number of maternal deaths per 100,000 live births that occur as a direct result of the reproductive process

Infant mortality rate: The number of deaths per 1,000 live births occurring at birth or in the first 12 months of life

Childhood mortality rate: The number of deaths per 1,000 population in children aged 1 to 14 years

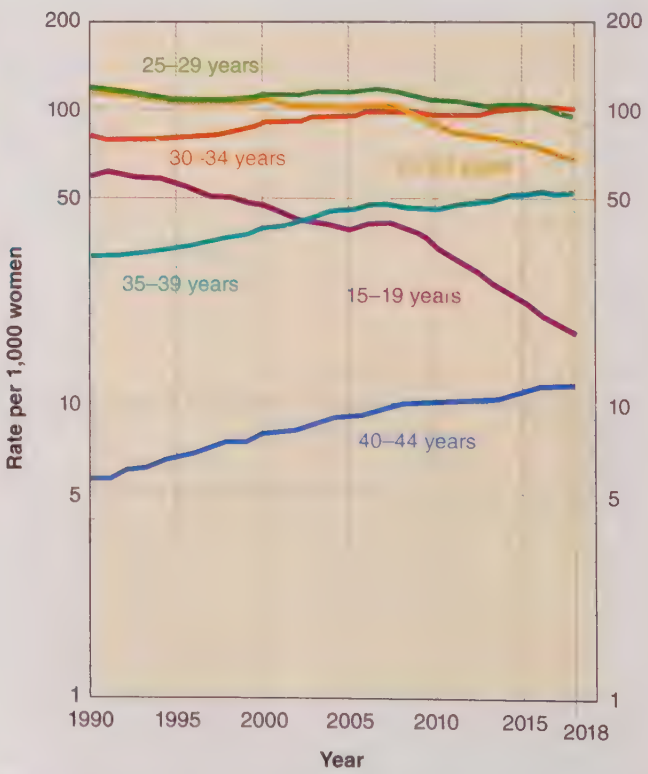

Figure 1.3 Birth rates by age of birthing parent: United States, 1990–2018. (Martin, J. A., Hamilton, B. E., Osterman, M. J. K., & Driscoll, A. K. [2019]. *Births: Final data for 2018.* National Vital Statistics Reports [Vol. 68, No. 13]. National Center for Health Statistics.)

Fetal Death Rate

Fetal deaths before birth but after 20 weeks gestation occur because of maternal factors (such as premature cervical dilatation and maternal hypertension) and also because of fetal factors (such as chromosomal abnormalities or poor placental attachment). The cause of many fetal deaths cannot be documented or occur for unknown reasons. Fetal death rate is important in evaluating the health of a nation because it reflects the overall quality of maternal health and whether common services such as prenatal care are available. A renewed emphasis on both preconception and prenatal care has helped reduce the U.S. rate from a number as high as 18% in 1950 to 5.87% in 2017 (Hoyert & Gregory, 2020).

Neonatal Death Rate

The neonatal death rate reflects not only the quality of care available to patients during pregnancy and childbirth but also the quality of care available to infants during the first month of life. According to the Centers for Disease Control and Prevention's (CDC) most recent data, the number of infant deaths per 100,000 live births in 2018 was 566.2. The leading causes of death during the first month of life are prematurity with associated low birth weight or congenital malformations, maternal complications of pregnancy, sudden infant death syndrome (SIDS), and injuries (Xu et al., 2018).

The proportion of infants born with low birth weight was about 8.28% of all births in 2018. The number of low-birth-weight infants has declined after steadily increasing since 2006. Infants born to birthing parents under the age of 20 years and between the ages of 40 and 54 years had the highest rate of neonatal and infant deaths (Xu et al., 2018).

Infant Mortality Rate

The **infant mortality rate** of a country is a good index of its general health because it measures the quality of pregnancy care, overall nutrition and sanitation, and infant health and available care. This rate is the traditional standard used to compare the health of a nation to previous years or to other countries.

Thanks to the introduction of prenatal care and other community health measures (such as efforts to encourage breastfeeding, require immunizations, initiate better unintentional injury prevention measures [e.g., requiring car seats], and reduce SIDS or the sudden death of an infant younger than 1 year that cannot be explained after a thorough investigation of the cause of death), in combination with the many technologic advances available for care, the U.S. infant mortality rate has decreased from 47.0 in 1940 to 5.87 per 1,000 live births in 2018 (Ely & Driscoll, 2020; Xu et al., 2018).

Infant mortality is not equal among all demographic groups of Americans. For example, the rate is higher among Native Alaskan, Native American, and Black infants than it is for White, Asian or Pacific Islander, and non-Hispanic newborns (Fig. 1.4). These differences are thought to be related to a combination of factors, including those related to social determinants of health, like an unequal provision of and access to healthcare in different communities (Xu et al., 2018).

The infant mortality rate also varies greatly from state to state within the United States (Table 1.3). For example, in Mississippi, the area with the highest infant mortality (8.3%), the rate is over twice that of New Hampshire, the state with the lowest rate (3.6%) (CDC, n.d.-a).

The United States belongs to the Organisation for Economic Co-operation and Development (OECD), which includes countries working to "promote economic development and social well-being of people worldwide" (America's Health Rankings, 2018). One might expect the United States, which

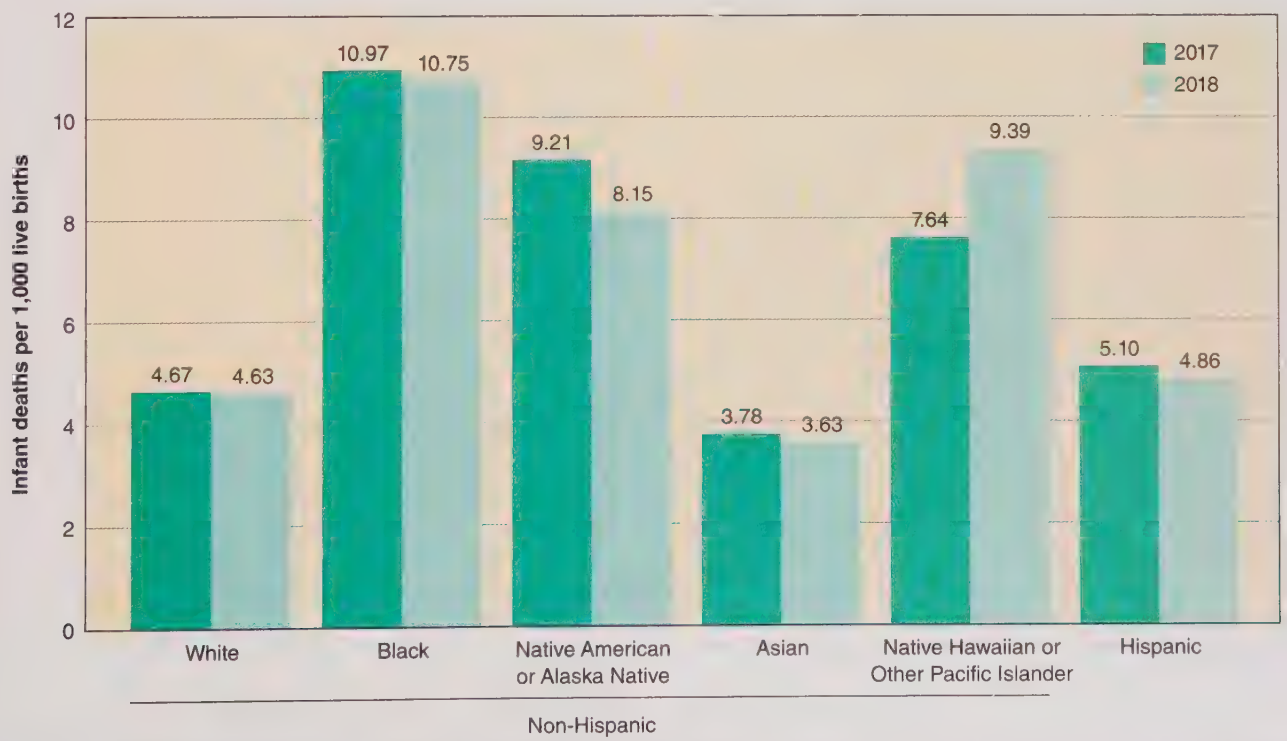

Figure 1.4 Infant mortality rates by race and Hispanic origin: United States, 2017–2018. (Ely, D. M., & Driscoll, A. K. [2020]. *Infant mortality in the United States, 2018: Data from the period linked birth/infant death file.* National Vital Statistics Reports [Vol. 69, No. 7]. National Center for Health Statistics.)

TABLE 1.3 INFANT MORTALITY RATES BY STATE, 2013–2018

State	2013	2018
Alabama	8.60	6.94
Alaska	5.77	6.25
Arizona	5.25	5.71
Arkansas	7.85	7.51
California	4.76	4.21
Colorado	5.12	4.75
Connecticut	4.79	4.20
Delaware	6.37	5.93
District of Columbia	6.68	7.38
Florida	6.14	6.04
Georgia	6.98	7.05
Hawaii	6.37	6.78
Idaho	5.63	5.05
Illinois	5.97	6.55
Indiana	7.24	6.72
Iowa	4.25	4.98
Kansas	6.49	6.37
Kentucky	6.39	6.05
Louisiana	8.69	7.65
Maine	7.12	5.52
Maryland	6.63	6.02
Massachusetts	4.18	4.18
Michigan	7.05	6.22
Minnesota	5.09	5.06
Mississippi	9.60	8.41
Missouri	6.52	6.35
Montana	5.57	4.78
Nebraska	5.21	5.77
Nevada	5.31	6.14
New Hampshire	5.57	3.50
New Jersey	4.50	3.80
New Mexico	5.27	5.69
New York	4.93	4.33
North Carolina	6.99	6.75
North Dakota	6.04	5.64
Ohio	7.33	6.94
Oklahoma	6.73	7.09
Oregon	4.94	4.22
Pennsylvania	6.65	5.94
Rhode Island	6.48	4.95
South Carolina	6.87	7.11
South Dakota	6.45	5.89
Tennessee	6.80	6.89
Texas	5.82	5.48
Utah	5.18	5.49
Vermont	4.35	6.44
Virginia	6.18	5.61
Washington	4.53	4.69
West Virginia	7.64	6.96
Wisconsin	6.26	6.12
Wyoming	4.84	5.33
Puerto Rico	7.10	6.53
Guam	9.07	11.69

Matthews, T. J., MacDorman, M. F., & Thomas, M. E. (2015). *Infant mortality statistics from the 2013 period linked birth/infant death data set. National Vital Statistics Report, 64*(9), 5.

Ely, D. M., & Driscoll, A. K. (2020). *Infant mortality in the United States, 2018: Data from the period linked birth/infant death file.* National Vital Statistics Reports (Vol. 69, No. 7). National Center for Health Statistics.

has one of the highest gross national products in the world and is known for its advanced technologic capabilities, to have the lowest infant mortality rate among these countries. However, the United States has one of the highest infant mortality rates in this group (America's Health Rankings, 2018). See Table 1.4 to compare the U.S. infant mortality rate to those of other countries.

TABLE 1.4 INFANT MORTALITY RATES BY COUNTRY

Country	Latest Year Data Available	Infant Mortality Rate
Australia	2018	3.1
Austria	2018	2.7
Belgium	2018	3.1
Brazil	2018	12.8
Canada	2018	4.7
Chile	2018	6.6
China	2018	7.4
Colombia	2016	16.8
Costa Rica	2017	7.9
Czech Republic	2018	2.6
Denmark	2018	3.7
Estonia	2018	1.6
Finland	2018	2.1
France	2019	3.8
Germany	2018	3.2
Greece	2018	3.5
Hungary	2018	3.3
Iceland	2018	1.7
India	2018	29.9
Indonesia	2018	21.1
Ireland	2018	2.9
Israel	2018	3.0
Italy	2018	2.8
Japan	2018	1.9
Korea	2018	2.8
Latvia	2018	3.2
Lithuania	2018	3.4
Luxembourg	2018	4.3
Mexico	2018	12.9
Netherlands	2018	3.5
New Zealand	2016	4.2
Norway	2018	2.3
Poland	2018	3.8
Portugal	2018	3.3
Russia	2018	5.1
Slovak Republic	2019	5.1
Slovenia	2018	1.7
South Africa	2018	28.5
Spain	2018	2.7
Sweden	2018	2.0
Switzerland	2018	3.3
Turkey	2018	9.2
United Kingdom	2018	3.9
United States	2017	5.8

Data from OECD. (2021). Infant mortality rates (indicator). *OECD iLibrary*. Retrieved May 3, 2021, from https://doi.org/10.1787/83dea506-en

Factors that may contribute to national variances in infant mortality are differences in reporting capability as well as the type of health insurance and care available. In Sweden, for example, a comprehensive healthcare program provides state-sponsored maternal and child healthcare to all residents. People who attend prenatal clinics early in pregnancy receive a monetary award, a practice that almost guarantees pregnant individuals will come for prenatal care. This type of healthcare policy contrasts sharply with the availability of healthcare in an occupation-linked insurance system such as the one in the United States.

Fortunately, the proportion of pregnant people who receive prenatal care, which has the potential to identify risks and allow preventive strategies against complications of pregnancy, is increasing; about 76% of people receive early prenatal care in the United States (U.S. Department of Health and Human Services, 2020).

The main causes of infant mortality in the United States are problems that occur at birth or shortly thereafter, such as prematurity, low birth weight, congenital malformations, and SIDS. Although other factors that contribute to SIDS are yet to be identified, the recommendations made by the American Academy of Pediatrics (AAP) to place infants on their backs to sleep, use room sharing but not bed sharing, and avoid exposure to overheating or cigarette smoke have led to an almost 50% decrease in its incidence (Moon et al., 2016). Nurses have been instrumental in reducing the number of these deaths, as they are the healthcare professionals who most often discuss newborn care and make recommendations for new parents.

Maternal Mortality Rate

Early in the 20th century, the maternal mortality rate in the United States reached levels as high as 600 per 100,000 live births. As of 2017, the U.S. maternal mortality rate was 17.3 per 100,000 live births (Fig. 1.5) (Davis et al., 2019). General improvements in the rates of maternal mortality can be attributed to improved preconception, prenatal, labor and birth, and postnatal care such as:

- Increased participation of individuals in prenatal care
- Greater detection of disorders such as ectopic pregnancy or placenta previa and prevention of related complications through the use of ultrasound
- Increased control of complications associated with hypertension of pregnancy
- Decreased use of anesthesia with childbirth
- Ability to better prevent or control hemorrhage and infection

This dramatic overall decrease is not a cause for celebration, however. Although the rates of maternal mortality had begun to increase again in 2011 to 17.8% and in some areas to as high as 24 per 100,000 live births, it showed a decline in 2012 to 15.8%. Since 2012, there has been an increase in 2017 to 17.3%. Although some of the causes for maternal mortality remain unclear, known causes include:

- Noncardiovascular disease
- Cardiovascular disease
- Infection or sepsis
- Hemorrhage
- Cardiomyopathy
- Pulmonary embolism
- Hypertensive disorders of pregnancy
- Cerebral vascular accidents
- Amniotic fluid embolism
- Anesthesia complications (Davis et al., 2019)

Child Mortality Rate

Similar to the maternal mortality rate, the United States compares poorly with other similarly resourced areas. A 2018 study indicates the United States ranks 19th out of 20 nations

Figure 1.5 Trends in pregnancy-related mortality in the United States, 1987–2017. (Centers for Disease Control and Prevention. [2020]. *Pregnancy mortality surveillance system*. Author.)

QSEN Checkpoint Question 1.2

INFORMATICS

M.C.'s doctor has told her that her baby's most dangerous time will be until the perinatal period ends. When does the perinatal period take place?

a. From the day of birth until 1 month afterward
b. During the time the infant will be on ventilator support
c. From the 20th week of pregnancy to 4 to 6 weeks after birth
d. Until the infant's body temperature stabilizes following birth

Look in Appendix A for the best answer and rationale.

reporting (Thakrar et al., 2018). In 1980, for example, the mortality rate was about 6,400 per 100,000 for children aged 1 to 4 years. In 2017, it was 23.3 per 100,000. Children in the prepubescent period (age 5 to 14 years) have the lowest mortality rate of any child age group at 13.4 per 100,000. Between 15 and 24 years of age, the rate increases to 69.7 per 100,000 (Xu et al., 2018).

The most frequent causes of childhood death are listed in Box 1.5. Notice unintentional injuries are the leading cause of death in children, though many of these accidents are largely preventable through education about the value of car seats and seat belt use, the dangers of drinking/drug abuse and driving, and the importance of pedestrian safety.

A particularly disturbing mortality statistic is the high incidence of homicide and suicide in the 10- to 19-year-old age group (more girls than boys attempt suicide, but boys are more successful). Although school-aged children and adolescents may not voice feelings of depression or anger during a healthcare visit, such underlying feelings may still be a primary concern (CDC, n.d.-b). Nurses who are alert to cues of depression or anger can be instrumental in detecting these emotions and lowering the risk of self-injury.

Childhood Morbidity Rate

Health problems commonly occurring in large proportions of children today include respiratory disorders (including asthma and tuberculosis), gastrointestinal disturbances, and consequences of injuries. Obesity rates for children aged 12 to 19 years now average 26% (National Center for Health Statistics, 2018). Obesity in school-aged children can lead to cardiovascular disorders, self-esteem issues, and type 2 diabetes, so counseling children about maintaining a healthy weight is an important nursing responsibility. Morbid obesity in pregnant people can lead to complications during pregnancy, at birth, and following birth (Carlson et al., 2018).

As more immunizations for childhood diseases become available, fewer children in the United States are affected by common childhood communicable diseases. Continued education about the benefits of immunization against rubella (German measles) is still needed because if a person contracts this form of measles during pregnancy, the infant can be born with severe congenital malformations.

Overall vaccination rates in the United States remain encouraging. *Healthy People 2030* goals include maintaining the 1.3% baseline of those children who receive no vaccinations by age 2 and also maintaining the baseline of 90.8% who receive two doses of the measles, mumps, and rubella vaccines (U.S. Department of Health and Human Services, 2020). Although the decline in the overall incidence of preventable childhood diseases is encouraging and most regions of the country report strong adherence to recommended vaccination schedules, many children are still not fully immunized. Vaccine hesitancy persists nationally. In 2019, a total of 1,282 cases of measles were reported in 31 states (CDC, 2021). Reasons cited include religious, philosophical, and medical exemptions; limited access to care; and increasing rates of vaccine misinformation (Danielson et al., 2019; Gardner et al., 2020).

HIV has also changed care in all areas of nursing but has particular implications for maternal and child health nursing. Sexually active teenagers are at risk for becoming infected

BOX 1.5

Major Causes of Death in Childhood

UNDER 1 YEAR

1. Congenital malformations and chromosomal abnormalities
2. Disorders related to short gestation age and low birth weight
3. Maternal complications of pregnancy
4. Sudden infant death syndrome
5. Unintentional injuries (accidents)

1 TO 4 YEARS

1. Unintentional injuries (accidents)
2. Congenital malformations and chromosomal abnormalities
3. Malignant neoplasms
4. Homicide
5. Diseases of the heart

5 TO 9 YEARS

1. Unintentional injuries (accidents)
2. Malignant neoplasms
3. Congenital anomalies
4. Homicide
5. Diseases of the heart

10 TO 14 YEARS

1. Unintentional injuries (accidents)
2. Suicide
3. Malignant neoplasms
4. Homicide
5. Congenital anomalies

15 TO 24 YEARS

1. Unintentional injuries (accidents)
2. Suicide
3. Homicide
4. Malignant neoplasms
5. Diseases of the heart

Data from the Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). *Underlying cause of death 1999-2019.* CDC WONDER Online Database.

with HIV through sexual contact. Infected pregnant people may transmit the virus to a fetus during pregnancy through placental exchange or at birth through body secretions (FitzHarris et al., 2017).

Nurses play a vital role in helping prevent the spread of HIV by educating adolescents and teenagers about safer sexual practices (Simone et al., 2021) (see Chapter 5). Follow standard infectious precautions in all areas of nursing practice to safeguard yourself, other healthcare providers, and patients from the spread of this and other infections.

A number of infectious diseases that are increasing in incidence include syphilis; genital herpes; hepatitis A, B, and C; and tuberculosis. The rise in syphilis, hepatitis C, and genital herpes probably stems from an increase in nonmonogamous sexual relationships and lack of safer sex practices. The increase in hepatitis B is due largely to drug abuse and the use of infected injection equipment. One reason for the increase in hepatitis A is shared diaper-changing facilities in day care centers. Tuberculosis, once considered close to eradication, has experienced such a resurgence that one form occurs as an opportunistic disease in HIV-positive persons and is particularly resistant to usual therapy (Barr et al., 2020). Methicillin-resistant *Staphylococcus aureus* is an infection that often occurs in hospitals, causes skin infections or pneumonia, and is also growing in incidence (Kusbaryanto, 2020).

The incidence of social concerns, such as intimate partner violence and child maltreatment, remains high. Twelve million adults report experiencing intimate partner violence and 10 million children under the age of 18 years experience maltreatment at the hands of a caregiver ranging from neglect to sexual abuse (Scoglio et al., 2021). Pregnant people are at increased risk for adverse maternal and fetal outcomes as a result of intimate partner violence. Despite the increased risks of maternal, fetal, and neonatal morbidity and mortality, fewer than half of pregnant people in the United States are screened prenatally for intimate partner violence (Halpern-Meekin et al., 2019).

Also increasing in incidence is autism spectrum disorder (ASD), a range of complex neurodevelopment disorders characterized by social impairment, communication difficulty, and repetitive stereotyped patterns of behavior. Most recently available data indicate that 18.5 per 1,000 children (one in 54) are diagnosed with ASD. ASD is 4.3 times more common among children born male. Black children are less frequently and later diagnosed than White children. This is in alignment with other healthcare disparities based on social determinants of health (Maenner et al., 2020).

TRENDS IN THE HEALTHCARE ENVIRONMENT

The settings for healthcare as well as nursing roles are changing, with the goal of being able to better meet the needs of increasingly well-informed and vocal consumers.

Initiating Cost Containment

Cost containment refers to reducing the cost of healthcare by closely monitoring the costs of personnel, use and brands of supplies, length of hospital stays, inpatient-to-outpatient ratios as is clinically appropriate, number of procedures performed, and number of referrals requested while maintaining quality care (Stadhouders et al., 2019). Examples of delegation responsibility or teamwork to make care more cost-effective or family-centered are highlighted in "Interprofessional Care Maps" throughout this text. Examples of effective communication are shown in "Effective Communication" boxes throughout chapters.

Changes in Health Insurance Coverage

Prior to the Affordable Care Act (ACA) in 2010, the United States was unique among developed countries in that its healthcare system was privately financed or controlled by work sites. This contrasts with other countries where national health insurance has been available to everyone without connection to a person's employment. Because of this unique system, the United States spent about 17.7% of its gross national product on healthcare in 2019, whereas other countries, for example, Switzerland, spent less yet had healthier citizens (Martin et al., 2021). The increase in expenditure is partially related to the increase in numbers of individuals who have health insurance and obtain healthcare services as a result of the ACA. Other increasing costs are related to hospital care, clinician services, and prescription drugs. These costs were generally offset by health insurance (Martin et al., 2021).

Increasing Alternative Settings and Styles for Healthcare

The past 100 years have seen several major shifts in settings for maternity and childcare. At the turn of the 20th century, for example, most births took place in the home, with only poor or ill people giving birth in "lying-in" hospitals. By 1940, about 40% of live births occurred in hospitals. By 2017, the figure had risen to 98.4%. Out-of-hospital births account for a total of 1.6% of births, with 0.99% occurring in the home and 0.52% occurring in freestanding birth centers (MacDorman & Declercq, 2019).

Increasing numbers of people are choosing home births or birthing in freestanding alternative birth centers. People who give birth in these alternative settings feel they have a greater control of their birth experience and their family can be more involved in the birth. Additional concerns regarding infection exposures during the COVID-19 pandemic are predicted to increase the use of non-hospital birth settings (Garsd, 2020). Alternative settings also allow more practice opportunities for nurses in advanced practice roles, such as nurse-midwives (Martin et al., 2019).

An important outcome of this movement is that hospitals have responded to consumers' demands for more natural childbirth environments by refitting labor and delivery suites as homelike birthing rooms, often called labor-delivery-recovery (LDR) or labor-delivery-recovery-postpartum (LDRP) rooms (Fig. 1.6). Partners, family members, and other support people can stay with the person in labor as if they were home and so can feel a part of the childbirth. Couplet care—care for both the birthing parent and newborn by a primary nurse—is encouraged after the birth. Whether childbirth takes place at home, in a birthing center, or in a hospital, the goal is to keep it in line with the family's wishes as much as possible while ensuring the protection experienced healthcare providers offer.

Healthcare settings for children are also changing. Patients' homes, community centers, or school-based or retail

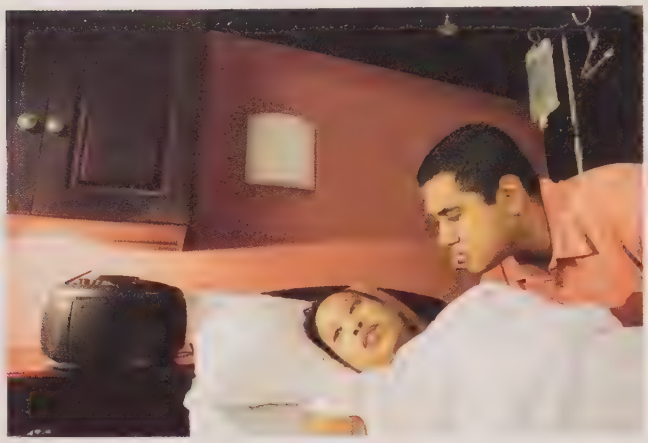

Figure 1.6 Soon-to-be parents share a close moment in a birthing room.

setting emergent care clinics are examples of places in which comprehensive healthcare may be administered. Retail clinics or emergent care clinics located in shopping malls are often staffed by nurse practitioners, so nurses play a vital role in seeing such healthcare settings do not limit continuity of care (Akobirshoev et al., 2019).

In ambulatory settings of this nature, a nurse practitioner may provide immunizations, screenings, health and safety education, counseling, crisis intervention, or parenting classes. This form of community-based care has the potential to provide cost-effective health promotion, disease prevention, and patient care to large numbers of children and families in an environment familiar to them.

More and more, children and people experiencing a pregnancy complication or an acute illness who might otherwise have been admitted to a hospital are now being cared for in ambulatory clinics or at home. Separating a child from their family during a long hospitalization has been shown to be potentially harmful to the child's development, so any effort to reduce the incidence of separation has a positive effect (see Chapter 36). Avoiding long hospital stays for people during pregnancy is also a preferable method of care because it helps maintain family integrity.

Ambulatory or non-hospital-based care requires intensive health teaching by the nursing staff and follow-up by home care or community health nurses to ensure a smooth transition to and from this setting. Teaching parents of an ill child or a person with a pregnancy complication what danger signs to watch for that will warrant immediate attention includes not only imparting self-care information but also providing support and reassurance that the patient or parents are capable of accomplishing this level of care.

Increasing Use of Technology

The use of technology is increasing in all healthcare settings. The field of assisted reproduction technology such as in vitro fertilization and the possibilities of stem cell research are forging new pathways, specifically with regard to embryo transfer (Heitmann et al., 2017). Charting by computer into electronic health records and monitoring fetal heart rates by Doppler ultrasonography are other examples (Cypher, 2018). Using an electronic charting system has the ability to allow different healthcare providers to share information (e.g., an X-ray taken at one site can be reviewed at another, a caregiver can be alerted to all the medicines a pregnant patient has been prescribed). As long as privacy is maintained, the system allows for a coordination of care never before possible.

To protect patient privacy, the Health Insurance Portability and Accountability Act, commonly referred to as HIPAA, creates national standards to protect individuals' medical records and other personal health information and applies to healthcare providers who conduct healthcare transactions electronically. The rule requires appropriate safeguards be put into place to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients rights over their health information, including the rights to examine and obtain a copy of their health records and to request corrections (U.S. Department of Health and Human Services & O. of C. R., 2007).

In addition to learning these technologies and rules, maternal and child health nurses must be able to explain their uses and their advantages to patients. Otherwise, patients may find new technologies more frightening than helpful to them.

QSEN Checkpoint Question 1.3

QUALITY IMPROVEMENT

Nurses must always be aware of quality improvement because as society changes, nursing care must make responding adjustments. Which is a trend that will influence the care that A.C. is likely to receive?

a. More and more children are treated in ambulatory settings rather than hospital settings, so nurses will be less significant in the future.
b. Immunizations are available for all childhood infectious diseases so the A.C. will never need treatment for these.
c. The use of multiple technologies can make parents feel overwhelmed unless they receive nursing support.
d. Prematurely born infants, assuming the birthing parent received prenatal care, rarely need long-term or follow-up care.

Look in Appendix A for the best answer and rationale.

Meeting Work Needs of Pregnant and Breastfeeding Individuals

As many as 57% of people who identify as women work at least part-time outside the home, and many pregnant people want to continue to work during a pregnancy. Although most women make less than their male counterparts, many are the sole or primary wage earner for their families and need to continue to work during pregnancy or postpartum to meet their family's needs (U.S. Bureau of Labor Statistics, 2019). Following the birth of a child, however, people may want or need a leave from work to care for their newborn.

The Family Medical Leave Act of 1993 is a federal law that requires employers with 50 or more employees to provide a

minimum of 12 weeks of unpaid, job-protected leave to employees under four circumstances crucial to family life:

- Birth of the employee's child
- Adoption or foster placement of a child with the employee
- Need for the employee to care for a parent, spouse, or child with a serious health condition
- Inability of the employee to perform their functions because of a serious health condition

A serious health condition is defined as "an illness, injury, impairment, or physical or mental condition involving such circumstances as inpatient care or incapacity requiring 3 workdays' absence" (U.S. Department of Labor, 1995). Specifically mentioned in the law is any period of incapacity due to pregnancy or for prenatal care with or without treatment. Illness must be documented by a healthcare provider. Nurse practitioners and nurse-midwives are specifically listed as those who can document health conditions, so they have an equal role with physicians in alerting people to this benefit. Although not as generous a program as many other developed countries, protected leave can help with the care of an ill child or a person who is ill during pregnancy.

In 2010, President Barack Obama signed the ACA into law, mandating that work settings with more than 50 employees provide "reasonable break time for a woman to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express milk." Employers are also required to provide "a place, other than a bathroom, that is shielded from view and free from intrusion for a setting to express breast milk."

This law has had a major impact on allowing people to continue breastfeeding while working full-time. However, issues persist with the provision of breast pumps and dedicated lactation room availability (McCardel & Padilla, 2020).

Regionalizing Intensive Care

To avoid duplication of care sites, communities are establishing centralized maternal or pediatric health services. Such planning creates single sites that are properly staffed and equipped for potential problems rather than multiple lesser equipped sites. When a newborn, older child, or parent is hospitalized in a regional center, the family members who have been left behind need a great deal of support. They may feel they have "lost" their infant, child, or parent unless healthcare personnel can keep them abreast of the ill family member's progress by means of phone calls or snapshots and by encouraging the family to visit as soon as possible.

When regionalization concepts of newborn care were first introduced, transporting the ill or premature newborn to the regional care facility was the method of choice (Fig. 1.7). Today, if it is known in advance that a child may be born with a life-threatening condition, it may be safer to transport the mother to the regional center at the time of birth because the uterus has advantages as a transport incubator that far exceed those of any commercial incubator yet designed.

Important arguments against regionalization for pediatric care include that children may feel homesick in strange settings, become overwhelmed by the number of sick children they see around them, and grow frightened because they are miles from home. An important argument against regionalization of maternal care is that being away from the community and support network places a great deal of stress on the pregnant patient and their family and limits the primary care provider's participation in care. These are important considerations. Because nurses, more than any other healthcare group, set the tone for hospitals, they are responsible for ensuring patients and families feel as welcome in a regional center as they would have been in a small hospital. Staffing should be adequate to allow sufficient time for nurses to comfort frightened children and prepare them for new experiences or to support a frightened pregnant patient and family. Documenting the importance of such actions allows them to be incorporated in critical pathways and preserves the importance of the nurse's role (Follett et al., 2017).

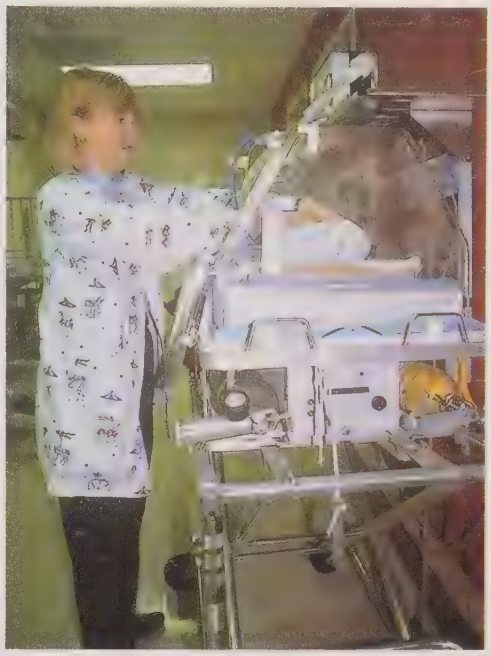

Figure 1.7 A nurse prepares an infant transport incubator to move a premature infant to a regional hospital. Helping with the safe movement of pregnant people and ill newborns to regional centers is an important nursing responsibility. (© Caroline Brown, RNC, MS, DEd.)

What If... 1.1

M.C. has to remain in her local hospital after the birth of her new baby for an extended time while her baby is cared for at a regional center. How could the nurse at the regional center help her keep in touch with her new baby?

Increasing Use of Alternative Treatment Modalities

There is a growing tendency for families to use alternative forms of therapy, such as acupuncture or therapeutic touch, in addition to or instead of traditional healthcare measures. Nurses have an increasing obligation to be aware of complementary or alternative therapies as they have the potential to either enhance or detract from the effectiveness of traditional therapy (Kim, 2017). However, many nurses, particularly in the pediatric setting, do not feel comfortable discussing these therapies with their patients (Lartey et al., 2019).

Healthcare providers who are unaware of the existence of some alternative forms of therapy may lose an important opportunity to capitalize on the positive features of that particular therapy. For instance, it would be important to know that an adolescent who is about to undergo a painful procedure is experienced at meditation because asking the adolescent if they want to meditate before the procedure could help them relax. Not only could this increase comfort, but it could also foster a feeling of control over a difficult situation. People are using an increasing number of herbal remedies, such as drinking herbal teas during pregnancy to relieve morning sickness. Asking about these at a health assessment is important to prevent drug interactions (Judson et al., 2017). Boxes that highlight the importance of both nursing responsibility for pharmacology and respecting cultural diversity are present in chapters throughout the text to provide more information about these areas of care (Box 1.6).

QSEN Checkpoint Question 1.4

EVIDENCE-BASED PRACTICE

A growing body of evidence suggests skin-to-skin contact between the birthing parent and baby immediately after birth provides numerous benefits, including regulating heartbeat and temperature for the baby and promoting feelings of calm and well-being in both the birthing parent and baby. To see if nonbirthing parents were interested in participating in this form of care (often called kangaroo care), researchers interviewed seven new fathers who had spent time in skin-to-skin interaction with their newborn. Findings showed kangaroo care allowed fathers to feel more in control and also that they were doing something good for their infant (Srinath et al., 2016). Based on this information, what action would the nurse take?

a. Assess whether R.C. is willing to try skin-to-skin care.
b. Suggest neither parent use skin-to-skin care to prevent infection.
c. Encourage R.C. to praise his partner when she provides skin-to-skin care.
d. Apologize to M.C. because men do skin-to-skin care more effectively than women.

Look in Appendix A for the best answer and rationale.

Increasing Reliance on Home Care

Shortened hospital stays have resulted in a transition from hospital to home for many people before they are optimally ready to care for themselves. In some instances, ill children and people with pregnancy complications may choose to remain at home for care rather than be hospitalized. Outcomes for those remaining in home care as opposed to in-office antenatal care have shown similar outcomes for birthing parents and neonates (Kalafat et al., 2019).

Nurses can be instrumental in assessing patients at hospital discharge and help them plan the best type of continuing care, devise and modify procedures for home care, and sustain patients' morale so a transition to home is seamless. Home care as a unique and expanding area in maternal and child health nursing is discussed in Chapter 4.

BOX 1.6

Nursing Care Planning to Respect Cultural Diversity

The term *alternative healthcare practices* refers to therapy such as acupuncture, homeopathy, therapeutic touch, herbalism, and chiropractic care or nonmainstream sources of care such as tribal medicine or Hispanic herbalists such as *yerberos* or *curanderos*. Some people seek out these types of therapy or alternative providers before consulting a mainstream healthcare provider; others consult with them after they perceive they have received inadequate care by a mainstream provider. Still others rely on these methods as their major form of healthcare and therapy.

Respect for these forms of care can be instrumental in showing families their sociocultural traditions are important in their plan of care. Assessing what alternative measures are being used is also important because the action of an herb can interfere with prescribed medications. For example, the consumption of traditional ethnic remedies such as *Jin Bu Huan*, a Chinese herbal medicine to relieve pain, can cause adverse effects such as life-threatening bradycardia and respiratory depression. Lead poisoning has resulted from ingestion of *greta*, a traditional Hispanic remedy used as a laxative.

What If... 1.2

M.C. demands her 6-year-old, diagnosed with pneumonia, be hospitalized even though it is the clinic's policy to have such children cared for at home by their parents. Would the nurse advocate for hospitalization?

HEALTHCARE CONCERNS AND ATTITUDES

As we progress through the 21st century, there will be even more changes as the United States actively works toward health goals and improved healthcare for all citizens. These steps can create new concerns.

Increasing Concern for Quality of Life

In the past, healthcare was focused on maintaining physical health. Today, many patients view quality of life to be as important as physical health, so the scope of healthcare has expanded to include the assessment of psychosocial facets of life in such areas as self-esteem and independence. Good interviewing skills are necessary to elicit this information at healthcare visits. Nurses can not only help obtain such information but also plan ways to improve quality of life in the areas the patient considers most important.

One way in which quality of life is being improved for children with chronic illnesses is the national mandate to allow them to attend regular schools, guaranteeing entrance despite severe illness or use of medical equipment such as a ventilator (Public Law 99-452, U.S. 99th Congress, 1986). Under this same law, adolescents who are pregnant cannot

be excluded from school. School nurses or nurses asked to be consultants to schools play important roles in honoring these children's rights and making these changes possible.

Increasing Awareness of the Individuality and Diversity of Patients

Maternal and child patients do not fit easily into any set mold. Varying family structures, cultural backgrounds, socioeconomic levels, and individual circumstances lead to unique and diverse patients. People having children may range in age from 12 or 13 years to a first pregnancy after the age of 40 (Martin et al., 2019).

Family structure varies; LGBTQ+ families raise children, conceiving children through reproductive endocrinology means or adoption. As a result of advances in research and therapy, people who were once unable to have children, such as those with cystic fibrosis, are now able to manage full-term pregnancies. Individuals with cognitive and physical challenges who once would have been isolated from childbearing are now able to establish families and rear children.

Many families who have emigrated from other countries enter the U.S. healthcare system for the first time during a pregnancy or with a sick child. This requires sensitivity to sociocultural aspects of care on the part of healthcare providers, as people not used to non–government-sponsored healthcare can easily be lost in the U.S. system. They may have different cultural beliefs about health and illness than their healthcare providers. Some families may live in unsafe neighborhoods and so may not feel safe with home care. All of these concerns require increased nursing attention (see Chapter 2).

What If... 1.3

M.C. is concerned because she is 42 years old and wants to have a third child in a few years. Are many women delaying childbirth until their 40s? Does the nurse anticipate this trend will continue into the future?

Empowerment of Healthcare Consumers

In part because of the influence of market-driven care and a strengthened focus on health promotion and disease prevention, individuals and families have recently begun to take increased responsibility for their own health. For some families, this means learning preventive measures such as following more nutritious diets and planning regular exercise; for other families, this means adopting entirely new lifestyles. When a family member is ill, learning more about the illness, participating in the treatment plan, and preventing the illness from returning can offer a sense of empowerment. Parents want to stay with their ill child in the hospital and are eager for information about their child's health and ways they can contribute to the decision-making process. They may question a treatment or care plan if they believe it is not in their child's best interest. If healthcare providers do not provide answers to a patient's or family's questions or are insensitive to their needs, many healthcare consumers are willing to take their business to another healthcare setting or rely totally on therapies or information they find from social media and other websites (Wright et al., 2019).

Nurses can promote empowerment of parents and children by respecting their views and concerns, regarding parents as important participants in their own or their child's health, keeping them informed, and helping and supporting them in making decisions about care. Although a nurse may have seen 25 patients already in a particular day, they can make each patient feel as important as the first by adopting a warm manner and keen interest. Boxes on ways to help empower families at home or at healthcare facilities are included throughout the text.

QSEN Checkpoint Question 1.5

SAFETY

M.C. waited until she was 42 years old to have her second baby. She asks the nurse if that is the reason her baby was born prematurely. Which statement would be the most reassuring for her?

a. "It's hard to say because so few women over 40 years are having babies today."
b. "No one can say for certain. You did all you could to ensure a healthy pregnancy."
c. "It's good to see you taking responsibility for your child's prematurity."
d. "You should ideally have had your children as a teenager as that's the safest time."

Look in Appendix A for the best answer and rationale.

Legal Considerations of Maternal–Child Practice

Legal concerns arise in all areas of healthcare. Maternal and child health nursing carries some legal concerns above and beyond other areas of nursing because care is often given to patients who are not of legal age for giving consent. Additionally, reproductive healthcare rights and laws are complex and vary from state to state. These issues require specific attention when caring for expectant families. New technologies (e.g., assisted reproduction, surrogate motherhood, umbilical cord sampling, safety of new medicines with children, and end-of-life decisions) can lead to potential legal action, especially if patients are uninformed about the reason or medical necessity for these procedures.

Nurses are legally responsible for protecting the rights of their patients, including confidentiality, and are accountable for the quality of their individual nursing care and that of other healthcare team members. New regulations on patient confidentiality guarantee patients can see their medical records if they choose, but health information must be kept confidential from others. Although nurses recognize the need for patient privacy, it can be easy to make mistakes, like giving report at a nurse's station and a visitor overhearing (Gierke, 2019). Patients are also not aware of the importance of their own medical record privacy.

Understanding the **scope of practice** (the range of services and care that may be provided by a nurse based on state requirements) and standards of care can help nurses practice within appropriate legal parameters.

Documentation is essential for justifying actions. The implications are long-lasting because children who feel they