LEARNING OBJECTIVES

- Describe the scope of maternity nursing.
- Evaluate contemporary issues and trends in maternity nursing.
- Describe sociopolitical issues affecting the care of women and infants.
- Compare selected biostatistical data among races and countries.
- Examine social concerns in maternity nursing.
- Explain quality management and standards of practice in the delivery of nursing care.
- Debate ethical issues in perinatal nursing.
- Examine the Healthy People 2010 goals related to maternal and infant care.

KEY TERMS AND DEFINITIONS

- **best practice** A program or service that has been recognized for excellence.
- **clinical benchmarking** Standards based on results achieved by others.
- **Cochrane Pregnancy and Childbirth Database** Database of up-to-date systematic reviews and dissemination of reviews of randomized controlled trials of health care.
- **evidence-based practice** Practice based on knowledge that has been gained through research and clinical trials.
- **failure to rescue** Concept that the quality and quantity of nursing care can be measured by comparing the number of surgical patients who develop common complications who survive versus those who do not survive.
- **integrated health care** Complementary and alternative therapies in combination with conventional Western modalities of treatment.
- **low-birth-weight (LBW) infants** Babies born weighing less than 2500 g.
- **outcomes-oriented care** Measures effectiveness of care against benchmarks or standards.
- **preterm infants** Infants born before 38 weeks of gestation.
- **standard of care** Level of practice that a reasonable, prudent nurse would provide.
- **telemedicine** Use of communication technologies and electronic information to provide or support health care when participants are separated by distance.

ELECTRONIC RESOURCES

Additional information related to the content in Chapter 1 can be found on the companion website at [http://evolve.elsevier.com/Lowdermilk/Maternity/](http://evolve.elsevier.com/Lowdermilk/Maternity/) or on the interactive companion CD.

- NCLEX Review Questions
- WebLinks
Maternity nursing focuses on the care of childbearing women and their families throughout all stages of pregnancy and childbirth, as well as the first 4 weeks after birth. Throughout the prenatal period, nurses, nurse practitioners, and nurse-midwives provide care for women in clinics and physicians’ offices and teach classes to help families prepare for childbirth. Nurses care for childbearing families during labor and birth in hospitals, birthing centers, and in the home. Nurses with special training may provide intensive care for high risk neonates in special care units and for high risk mothers in antepartum units, in critical care obstetric units, or in the home. Maternity nurses teach about pregnancy, the process of labor, birth, and recovery; and parenting skills; and provide continuity of care throughout the childbearing cycle. The Vision for Women and Their Health of the International Confederation of Midwives provides an excellent model for nurses who care for women and children (Box 1-1).

Tremendous advances in the care of mothers and their infants have taken place during the past 150 years (Box 1-2). However, in the United States serious problems exist related to the health and health care of mothers and infants. Lack of access to pre pregnancy and pregnancy-related care for all women and lack of reproductive health services for adolescents are major concerns. Sexually transmitted infections, including acquired immunodeficiency syndrome (AIDS), continue to adversely affect reproduction. One fifth of all people in the United States, 58 million people, lack health insurance for a year or more sometime during their life (Marwick, 2002). Racial and ethnic diversity are increasing within North America. It is estimated that by the year 2050, 50% of the U.S. population will be European-American, 15% will be African-American, 24% will be Hispanic, and 8% will be Asian-American (U.S. Census Bureau, 2004). Health care providers will be challenged to provide culturally sensitive health care.

Although the United States has made great strides in public health, significant disparities exist in health outcomes among people of various racial and ethnic groups. In addition, people may have lifestyles, health needs, and health care preferences related to their ethnic or cultural backgrounds. They may have dietary preferences and health practices that are not understood by caregivers. To meet the health care needs of a culturally diverse society, the nursing workforce must reflect the diversity of its patient population.

This chapter presents a general overview of issues and trends related to the health and health care of women and infants during the maternity cycle.

**BOX 1-1**

The Vision for Women and Their Health

The International Confederation of Midwives envisions a world where

- Women are respected and treated as persons in their own right in all societies.
- Women stand as equal partners with men in the world order.
- Women are recognized as crucial to the health of any nation.
- Women and their families are part of a health care system with high-quality care and easy access when needed.
- Women have the right to choose from among safe options for care throughout their lives, including high-quality, state-of-the-art care from competent providers who truly care about the woman and her health.
- Women are educated and empowered to delight in a strong sense of self, to trust their bodies, to plan their pregnancies, and to make wise choices in their health care.
- Women experience a reasonable standard of living, including a clean and safe environment, healthy food, and a reasonable place to live.
- Women need no fear for their lives or the lives of their babies when they are pregnant.
- Women believe that birth is normal and prefer to avoid unnecessary intervention.

*From The International Confederation of Midwives Internet document available at www.internationalmidwives.org/vision.htm (accessed June 15, 2002).*

**CONTEMPORARY ISSUES AND TRENDS**

**Structure of Health Care Delivery**

The changing health care delivery system offers opportunities for nurses to alter nursing practice and improve the way care is delivered through managed care, integrated delivery systems (IDSs), and redefined roles. Nurses have been critically important in developing strategies to improve the well-being of women and their infants and have led the efforts to implement clinical practice guidelines and to practice using an evidence-based approach. Through professional associations, nurses can have a voice in setting standards and in influencing health policy by actively participating in the education of the public and of state and federal legislators.

Changes in the health care market are influencing the way health care providers can care for their patients. Health spending varies considerably among nations (Table 1-1). In the United States during 2001 health spending accounted for 13.9% of the gross domestic product (GDP); in Canada 9.7% of the GDP was spent on health care (Reinhardt, Hussey, & Anderson, 2004). A national nursing shortage exists, and nurses are working longer hours. The longer hours jeopardize patient safety (Rogers, Huang, Scott, Asken, & Dings, 2004). A minimum nurse-patient ratio has been legislated.

The role of the nurse is evolving from primary caregiver to the leader of an interdisciplinary care team. Documentation of patient outcomes has become essential (see later discussion). Advanced practice roles will increase as nurses assume more responsibility for patient care.
Integrative Health Care

Integrative health care encompasses complementary and alternative therapies in combination with conventional Western modalities of treatment. Many popular alternative healing modalities offer human-centered care based on philosophies that recognize the value of the patient’s input and honor the individual’s beliefs, values, and desires (Fig. 1-1). The focus of these modalities is on the whole person, not just on a disease complex (Box 1-3). Patients often find that alternative modalities are more consistent with their own belief systems and also allow for more patient autonomy in health care decisions. Complementary and alternative therapies are identified throughout the text with an icon.

Increasing numbers of U.S. adults are seeking alternative and complementary health care, which exceeds visits paid

### Historic Milestones in the Care of Mothers and Infants

- **1847**—James Young Simpson in Edinburgh, Scotland, used ether for an internal podalic version and birth; the first reported use of obstetric anesthesia
- **1861**—Ignaz Semmelwies wrote *The Cause, Concept, and Prophylaxis of Childbed Fever*
- **1908**—Childbirth classes started by the American Red Cross
- **1909**—First White House Conference on Children convened
- **1911**—First milk bank in the United States established in Boston
- **1912**—U.S. Children’s Bureau established
- **1916**—Margaret Sanger established first U.S. birth control clinic in Brooklyn, New York
- **1923**—First U.S. hospital center for premature infant care established at Sarah Morris Hospital in Chicago
- **1933**—Natural Childbirth published by Grantly Dick-Read
- **1939**—Virginia Apgar, anesthesiologist, published Apgar scoring system of neonatal assessment
- **1955**—Jonas Salk’s injected polio vaccine was found to be safe and effective
- **1960**—International Childbirth Education Association formed
- **1960**—Birth control pill introduced in the United States
- **1962**—Thalidomide found to cause birth defects
- **1962**—Albert Sabin’s oral polio vaccine replaced the Salk vaccine
- **1963**—Title V of the Social Security Act amended to include comprehensive maternity and infant care for women who were low income and high risk
- **1966**—Supreme Court ruled that married people have the right to use birth control
- **1967**—Rh(D) immune globulin produced
- **1967**—Nancy Rubini published article on Maternal Role Attainment
- **1968**—Rivka vaccine became available
- **1969**—Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG) founded; renamed Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) and incorporated as a 501(c)3 organization in 1993
- **1972**—Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) started
- **1973**—Abortion legalized
- **1974**—First standards for obstetric, gynecologic, and neonatal nursing published by NAACOG
- **1975**—The Pregnant Patient’s Bill of Rights published by the International Childbirth Education Association
- **1978**—Louise Brown, first test-tube baby, born
- **1989**—Gene for cystic fibrosis identified
- **1991**—Society for Advancement of Women’s Health Research founded
- **1992**—Office of Research on Women’s Health authorized by U.S. Congress
- **1993**—Human embryos cloned at George Washington University
- **1993**—Family and Medical Leave Act enacted
- **1999**—Newborns’ and Mothers’ Health Act put into effect

### Integrative Health Care

Integrative health care encompasses complementary and alternative therapies in combination with conventional Western modalities of treatment. Many popular alternative healing modalities offer human-centered care based on philosophies that recognize the value of the patient’s input and honor the individual’s beliefs, values, and desires (Fig. 1-1). The focus of these modalities is on the whole person, not just on a disease complex (Box 1-3). Patients often find that alternative modalities are more consistent with their own belief systems and also allow for more patient autonomy in health care decisions. Complementary and alternative therapies are identified throughout the text with an icon.

Increasing numbers of U.S. adults are seeking alternative and complementary health care, which exceeds visits paid
to U.S. primary care physicians. Use of complementary and alternative therapies is increasing rapidly in Canada (Verhoef & Findlay, 2003). Approximately 40% of the general population uses complementary and alternative therapies (Barrett, 2003), and most of these users do not tell their physicians. Annual expenditures related to alternative therapies are estimated at $27 billion, over half of which consists of out-of-pocket expenses not covered by medical insurance (Eisenberg et al., 1998). Throughout the world the use of traditional medicine presents unique challenges in terms of policy, efficacy, accessibility, and utilization (World Health Organization, 2002).

In 1992 the National Institutes of Health (NIH) developed the Office of Alternative Medicine (OAM). Mandated by Congress, the OAM was designed to support research and evaluation of various alternative and complementary modalities and to provide information to health care consumers about such modalities. In 1998 Congress instituted the National Center for Complementary and Alternative Medicine (NCCAM), which incorporates the work of the OAM in its mission and function.

Childbirth Practices

Prenatal care may promote better pregnancy outcomes by providing early risk assessment and promoting healthy behaviors such as improved nutrition and smoking cessation. In 2003 84.1% of all women received care in the first trimester and 3.5% had late or no prenatal care. There is disparity in use of prenatal care in the first trimester by race and ethnicity: non-Hispanic whites (89%), non-Hispanic blacks (76%), and Hispanic (77.4%) (Martin, Kochanek, Strobino, Guyer, & MacDorman, 2005).

Women can choose physicians or nurse-midwives as primary care providers. In 2002, physicians attended 91% and nurse-midwives attended 8% of all births (Martin et al., 2003). Hospital births accounted for 99% of births. Of the out-of-hospital births, 65% were in the home, 27% in free-standing birth centers, and 2% in clinics or doctors’ offices (Martin et al., 2003). Cesarean births increased to 27.6% of live births in the United States in 2003, the highest rate ever in the United States, whereas the rate of vaginal births after cesarean (VBACs) declined to 10.6% (Martin et al., 2005). Women who choose nurse-midwives as their primary providers actively participate in childbirth decisions and receive fewer interventions such as epidural analgesia for labor (Jackson et al., 2003) (Table 1-2).

Changes are occurring in the conduct of the second stage of labor (from 10 cm dilation to birth of the baby); positions are varied, with more emphasis on upright posture. The arbitrary limit of 2 hours for the second stage is less rigid, as delayed pushing (waiting until the forces of labor propel the fetus down in the birth canal instead of encouraging pushing as soon as the cervix is 10 cm dilated) is instituted. Delayed pushing conserves the energy of the mother, results in fewer instrumental deliveries, and is less costly. The rates of episiotomy are declining, resulting in fewer severe perineal lacerations. Midwives perform fewer episiotomies than do physicians.

The method of analgesia varies, depending on the condition and choice of the mother and the preferences of the providers. Mothers typically are awake and aware during labor and birth. Contrasting philosophies exist regarding analgesia during labor. Some women prefer to experience the sensations of birth with little or no analgesia; others opt for...
epidural analgesia to provide comfort and control over their behavior during the experience.

With family-centered care, fathers, partners, grandparents, siblings, and friends may be present for labor and birth. Fathers or partners may be present for cesarean births. Father participation may include cutting the umbilical cord (Fig. 1-2). Doulas—trained and experienced female labor attendants—provide a continuous, one-on-one, caring presence throughout the labor and birth. Newborn infants remain with the mother and are encouraged to breastfeed immediately after birth. Parents participate in the care of their infants in nurseries and neonatal intensive care units. Kangaroo care, parent holding an infant skin-to-skin, is supported for preterm infants.

Childbirth education and parenting classes encourage the participation of a support person, teach breathing and relaxation techniques, and give general information about birth, infant development, and parenting. Other classes or parent support groups may be organized for the weeks and months after birth.

In some cases a woman labors, gives birth, and recovers in the same room (labor-delivery-recovery), she may stay in the same room for the entire birth experience (labor-delivery-recovery-postpartum). Instead of having one nurse care for the baby and another nurse care for the mother, some hospitals have one nurse care for both the mother and baby (couplet or mother-baby care). In some hospitals, central nurseries have been eliminated, and babies “room-in” with their mothers. Many hospitals use lactation consultants to assist mothers with breastfeeding.

Discharge of a mother and baby within 24 hours of birth has created a growing need for follow-up or home care. In some settings, discharge may occur as early as 6 hours after birth. Legislation has been enacted to ensure that mothers and babies are permitted to stay in the hospital at least 48 hours after vaginal birth and 96 hours after cesarean birth. Focused and efficient teaching is necessary to enable the parents and infant to make a safe transition from hospital to home. Nurses may use follow-up telephone calls or home visits to assist families needing information and reassurance.

Neonatal security in the hospital setting is of concern. Cases of “baby-napping” and of sending parents home with the wrong baby have been reported. Security systems are common in nurseries and mother-baby units (Fig. 1-3), and nurses are required to wear photo identification or some other security badge.

**Certified Nurse-Midwives**

Certified nurse-midwives (CNMs) are registered nurses with education in the two disciplines of nursing and midwifery. Certified midwives (direct-entry midwives) are educated only in the discipline of midwifery. In the United States, certification of midwives is through the American College of Nurse-Midwives, the professional association for midwives in the United States. The Royal College of Midwives is the professional association, and the College of Midwives of Ontario is the regulatory body for midwives in Ontario; the other provinces of Canada have similar regulatory bodies. Many national associations belong to the International Confederation of Midwives, which is composed of 83 member associations from 70 countries in the Americas and Europe, Africa, and the Asia-Pacific region.

**Views of Women**

Women must be viewed holistically and in the context in which they live. Their physical, mental, and social factors must be considered because these interdependent components influence health and illness. Even the language health care professionals use to describe women and their problems needs to be examined (Freda, 1995). For example, practitioners describe women who have an “incompetent cervix,” who “fail to progress,” or who have an “arrest” of labor. They may describe a fetus as having intrauterine growth “retardation.” They also “allow” women a “trial” of labor. Freda suggests that practitioners use phrases such as “women who
have recurrent premature dilation of the cervix’ or ‘fetuses whose intrauterine growth has been restricted.’ There is a movement to refer to spontaneous pregnancy loss as a ‘miscarriage’ instead of the more politically charged ‘abortion,’ especially when talking to patients (Freda, 1999).

Breastfeeding in the Workplace
Women are a significant proportion of the workforce. Companies are recognizing that it is good business to retain good employees and are making provisions for women returning to work after childbirth. Lactation rooms that provide space and privacy for pumping are available at many work sites and on college campuses (Fig. 1-4). In some instances, breastfeeding women bring their babies to work. Since 1999, by law, women may breastfeed in federal buildings and on federal property. Some states have enacted legislation to ensure that mothers can breastfeed their babies in public places. These efforts may help mothers breastfeed longer and meet the recommendation of the American Academy of Pediatrics that breastfeeding continue for at least 1 year.

Family Leave
The Family and Medical Leave Act of 1993 provides for up to 12 weeks of unpaid leave to eligible employees for birth, adoption, or foster placement; for care of a child, spouse, or parent who is seriously ill; or for the employee’s own illness. This is of great benefit to women because they are usually the primary caretakers of family members.

Violence
Violence is a major factor affecting pregnant women. This includes battering (which may increase during pregnancy), rape or other sexual assaults, and attacks with various weapons. Approximately 8% of pregnant women are battered. Violence is associated with complications of pregnancy such as bleeding, miscarriage, and preterm labor and birth.

HIV and AIDS in Pregnancy and the Newborn
Cases of perinatally acquired human immunodeficiency virus (HIV) infection and AIDS peaked in 1992; since then the rate of AIDS among infants has continued to decline. Treatment with zidovudine of mothers who tested positive for HIV before giving birth has resulted in a dramatic decrease in the number of infants infected with the virus; highly active antiretroviral therapy (HAART) and elective cesarean birth reduce the rate of mother-to-child transmission of HIV (European Collaborative Study, 2005). Universal HIV testing and access to quality prenatal care will contribute to reducing the transmission of HIV and prolonging survival. For women in labor who have had no prenatal care, rapid HIV testing is available (European Collaborative Study, 2005).

International Concerns
Female genital mutilation, infibulation, and circumcision are terms used to describe procedures in which part or all of the female external genitalia are removed for cultural reasons (Ahmed & Abushama, 2005; Momoh, 2004). Worldwide, many women undergo such procedures. With the growing number of immigrants from African and other countries in which female genital mutilation is practiced, nurses will increasingly encounter women who have undergone the procedure. Ethical dilemmas arise when the woman requests that after birth the perineum be repaired as it was after infibulation and the health care provider believes that such repair is unethical. The International Council of Nurses and other health professionals have spoken out against the procedures as harmful to women’s health.

Healthy People 2010 Goals
Healthy People 2010 is the nation’s agenda for improving health. It has two overarching goals: to increase the quality and years of healthy life and to eliminate health disparities. Within Healthy People 2010 are 467 objectives to improve health, which are organized into 28 specific focus areas including one related to maternal, infant, and child health (Box 1-4). Current information about the goals of Healthy People 2010 is available on the Internet at www.health.gov/healthypeople.

Trends in Fertility and Birthrate
Fertility trends and birthrates reflect women’s needs for health care. Box 1-5 defines biostatistical terminology useful in analyzing maternity health care. In 2003 the fertility rate—the number of births per 1000 women from 15 to 44 years of age—was 66.1 (Martin et al., 2005). This is a slight increase from the 64.8 live births per 1000 women reported in 2002. The highest birthrates (number of births per 1000 women) were for women between ages 25 and 29 (115.7 per...
1000, but the birthrate for women 40 to 44 years old (8.7 per 1000) continues to increase (Martin et al., 2003). One third (34.6%) of all births in the United States in 2003 were to unmarried women, with much variation in proportion among racial groups (African-American 68.5%, Hispanic 45%, non-Hispanic white 23.9%) (Martin et al., 2005). Births to unmarried women are often related to less favorable outcomes, such as low birth weight or preterm birth, because there are typically a large number of teenagers in the unmarried group. The rates of pregnancy and abortion among adolescents have declined (Martin et al., 2005) but are still higher in the United States than in any other industrialized country.

**Incidence of Low Birth Weight**

Babies born weighing less than 2500 g are classified as low-birth-weight (LBW) infants, and their risks for morbidity and mortality increase. In 2002 the incidence of LBW was 7.8%, and the incidence of very low birth weight (VLBW; less than 1500 g) was 1.4% (Martin et al., 2005). There is racial disparity in the incidence of LBW. African-American babies are twice as likely as Caucasian babies to be LBW and to die within the first year of life. By race, the incidence of LBW in 2002 for African-American births was 13.3%; for Hispanic births, 6.5%; and for Caucasian births, 6.8%. Cigarette smoking is associated with LBW, prematurity, and intrauterine growth restriction. In 2003, 11% of pregnant women smoked, a proportion that has declined from 19.5% since 1989 (Martin et al., 2005). The proportion of preterm infants (i.e., those born before 38 weeks of gestation) in 2002 was 17.8% for non-Hispanic black births, 11.9% for Hispanic births, and 11.3% for non-Hispanic white births (Martin et al., 2005). Multiple births accounted for 3.3% of births in 2002, with most of the increase associated with increased use of fertility drugs and older age at childbearing (Martin et al., 2005).

**Infant Mortality in the United States**

A common indicator of the adequacy of prenatal care and the health of a nation as a whole is the infant mortality rate, the number of deaths of infants younger than 1 year of age per 1000 live births. The infant mortality rate in the U.S. for 2002 was 7.0, the first increase in this rate in over 40 years (Martin et al., 2005). The infant mortality rate continues to be higher for non-Hispanic black babies (13.9 per 1000) than for non-Hispanic whites (9.8 per 1000) and Hispanic (5.6 per 1000) babies (Martin et al., 2005). Limited maternal education, young maternal age, unmarried status, poverty, and lack of prenatal care appear to be associated with higher infant mortality rates. Poor nutrition, smoking and alcohol use, and maternal conditions such as poor health or hypertension are also important contributors to infant mortality. A shift from the current emphasis on high-technology medical interventions to a focus on improving access to preventive care for low-income families is necessary to reduce the disparity. Research on racial disparities must increase.

**International Trends in Infant Mortality**

The infant mortality rate of Canada (5.2 per 1000 in 2001) ranks nineteenth and that of the United States ranks twenty-seventh when compared with other industrialized nations (Martin et al., 2005). One reason for this is the high rate of LBW infants in the United States compared with other countries.

**Maternal Mortality Trends**

Worldwide, approximately 1600 women die each day of problems related to pregnancy or childbirth; many of these deaths are preventable. In the United States in 2002, the...
Evidence—Is there sufficient evidence to draw conclusions about Yu Mei’s comprehension of the oral and written instructions?

Assumptions—What assumptions can be made about patient understanding of the information and instructions?

Critical Thinking Exercise

Health Literacy

Yu Mei speaks English as her second language; she speaks Cantonese at home. She has been diagnosed with a urinary tract infection. While giving Yu Mei instructions about perineal hygiene and medication administration, the nurse notes that Yu Mei listens intently to her instructions, nods affirmatively, and looks at the patient in formation handout.

1. Evidence—Is there sufficient evidence to draw conclusions about Yu Mei’s comprehension of the oral and written instructions?
2. Assumptions—What assumptions can be made about patient understanding of the information and instructions?
3. What implications and priorities for nursing care can be drawn at this time?
4. Does the evidence objectively support your conclusion?
5. Are there alternative perspectives to your conclusion?
U.S. population, there is a more urgent need to address health literacy as a component of culturally and linguistically 
competent care. Health care providers contribute to health 
literacy by using simple common words, avoiding jargon, 
and assessing whether the patient is understanding the dis-
cussion. Speaking slowly and clearly and focusing on what 
is important will increase understanding (Roberts, 2004).

High-Technology Care
Advances in scientific knowledge and the large number of 
high risk pregnancies have contributed to a health care sys-
tem that emphasizes high-technology care. Maternity care 
has been extended to preconception counseling, more and 
better scientific techniques to monitor the mother and fe-
tus, more definitive tests for hypoxia and acidosis, and 
neonatal intensive care units. Point-of-care testing is avail-
able. Personal data assistants are used to enhance compre-
hensive care (Lewis & Sommers, 2003); the electronic med-
ical record is being used. Virtually all women are monitored 
electronically during labor despite the lack of evidence of ef-
ficacy of such monitoring.

Telemedicine is an umbrella term for the use of com-
munication technologies and electronic information to pro-
vide or support health care when the participants are sepa-
rated by distance. Telemedicine permits specialists, including 
nurses, to provide health care and consultation when dis-
tance separates them from those needing care. For example, 
Baby CareLink (Gray et al., 2000) is an Internet-based pro-
gram that incorporates teleconferencing and the World Wide 
Web to enhance interactions among health care providers, 
families, and community providers. It includes distance 
learning, virtual home visits, and remote monitoring of the 
infant after discharge. This technology has the potential to 
save billions of dollars annually spent on health care.

Strides are being made in identifying genetic codes, 
and genetic engineering is taking place. In general, high-
technology care has flourished while “health” care has been 
relatively neglected. These technologic advances have also 
contributes to higher health care costs. Nurses must use 
cautions and prospective planning and assess the effect of 
the emerging technology.

Community-Based Care
A shift in settings, from acute care institutions to the home, 
happens being. Even childbearing women at high risk 
are cared for in the home. Technology previously available 
only in the hospital is now found in the home. This has af-
fected the organizational structure of care, the skills required 
to provide such care, and the cost to consumers.

Home health care also has a community focus. Nurses are 
involved in caring for women and infants in homeless shel-
ters, in caring for adolescents in school-based clinics, and in 
promoting health at community sites, churches, and shop-
ing malls. Nursing education curricula are increasingly com-
unity based.

Increase in High Risk
Pregnancies
The number of high risk pregnancies has increased, which 
means that a greater number of women are at risk for poor 
pregnancy outcomes. Escalating drug use (ranging from 11% 
to 27% of pregnant women, depending on geographic lo-
cation) has contributed to higher incidences of prematurity, 
LBW, congenital defects, learning disabilities, and withdrawal 
symptoms in infants. Alcohol use in pregnancy has been as-
associated with miscarriages, mental retardation, LBW, and fe-
tal alcohol syndrome.

The two most frequently reported maternal medical risk 
actors are hypertension associated with pregnancy and 
diabetes. The birthrate of higher-order multiples (triplet, 
quadruplet, and greater) rose 2% from 2000 to 2001 
(Martin et al., 2005). Multiple births now account for 3.2% 
of all births (Martin et al., 2003). The cesarean birthrate in-
creased to 27.6% of all births in 2003, with primary ce-
sareans rising to 19.1% and VBACs dropping to 10.6% 
(Martin et al., 2005). This cesarean rate is significantly 
higher than the Healthy People 2010 goal of 15%. Births of 
babies born vaginally assisted with forceps or with vacuum 
extraction decreased to 5.9% (Arias, MacDorman, Strobino, 
& Goyer, 2003).

High Cost of Health Care
Health care is one of the fastest-growing sectors of the U.S. 
economy. The United States spends proportionately more 
than any of the other 190 countries that make up the World Health Organization (Reinhardt, Hussey, & 
Anderson, 2004). A shift in demographics, an increased em-
phasis on high-cost technology, and the liability costs of a 
litigious society contribute to the high cost of care. Most re-
searchers agree that the cost of caring for the increased num-
ner of LBW infants in neonatal intensive care units con-
tributes significantly to the overall health care costs.

Midwifery care has helped contain some health care 
costs. However, not all insurance carriers reimburse nurse 
practitioners and clinical nurse specialists as direct care pro-
viders. Nor do they reimburse for all services provided by 
nurse-midwives, a situation that continues to be a problem.

Nurses must be involved in the politics of cost con-
tainment because they, as knowledgeable experts, can pro-
vide solutions to many of the health care problems at a rel-
avely low cost.

Early postpartum discharge programs also are used to re-
duce costs. The American Academy of Pediatrics has pub-
lished minimal criteria for early discharge of a newborn 
(American Academy of Pediatrics Committee on Fetus and 
Newborn, 2004) (see Box 16-2.)

Limited Access to Care
Barriers to access must be removed so pregnancy outcomes 
can be improved. The most significant barrier to access is the 
ability to pay. Lack of transportation and dependent child
care are other barriers. In addition to a lack of insurance and high costs, a lack of providers for low-income women exists. Many physicians either refuse to take Medicaid patients or take only a few such patients. This presents a serious problem because a significant proportion of births are to mothers who receive Medicaid.

**TRENDS IN NURSING PRACTICE**

The increasing complexity of care for maternity and women’s health patients has contributed to specialization of nurses working with these patients. This specialized knowledge is gained through experience, advanced degrees, and certification programs. Nurses in advanced practice (e.g., nurse practitioners and nurse-midwives) may provide primary care throughout a woman’s life, including during the pregnancy cycle. In some settings, the clinical nurse specialist and nurse practitioner roles are blended, and nurses deliver high-quality, comprehensive, and cost-effective care in a variety of settings. Lactation consultants provide services in the postpartum unit or on an outpatient basis, including home visits.

**Nursing Interventions Classification**

When the National Institute of Medicine proposed that all patient records be computerized by the year 2000, a need for a common language to describe the contributions of nurses to patient care became evident. Nurses from the University of Iowa developed a comprehensive standardized language that describes interventions that are performed by generalist or specialist nurses. This language is included in the Nursing Interventions Classification (NIC) (Dochterman & Bulachek, 2004). Interventions commonly used by maternal-child nurses include those in Box 1.6.

**Evidence-Based Practice**

Evidence-based practice—providing care based on evidence gained through research and clinical trials—is being increasingly emphasized. Although not all practice can be evidence based, practitioners must use the best available information on which to base their interventions. The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) Standards and Guidelines for Professional Nursing Practice in the Care of Women and Newborns (1998) and the Standards for Professional Perinatal Nursing Practice and Certification in Canada (2002) include an evidence-based approach to practice. Discussion of nursing care and evidence-based nursing boxes throughout this text provide examples of evidence-based practice in perinatal nursing.

AWHONN has conducted six research-based practice projects (Box 1–7). These projects were conducted in several states, and staff nurses were involved in their implementation and in data collection. The AWHONN practice guidelines incorporate evidence-based practices for second-stage labor management, continence for women, breastfeeding

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**BOX 1.6 Childbearing Care Interventions**

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<thead>
<tr>
<th>LEVEL 1 DOMAIN: FAMILY</th>
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<tr>
<td>* Care that supports the family</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 2 CLASS: CHILDBEARING CARE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>* Interventions to assist in the preparation for childbirth and management of the psychologic and physiologic changes before, during, and immediately after childbirth</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 3: INTERVENTIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>* Amnioinfusion</td>
<td></td>
</tr>
<tr>
<td>* Birthing</td>
<td></td>
</tr>
<tr>
<td>* Bleeding reduction: antepartum uterus</td>
<td></td>
</tr>
<tr>
<td>* Bleeding reduction: postpartum uterus</td>
<td></td>
</tr>
<tr>
<td>* Breastfeeding assistance</td>
<td></td>
</tr>
<tr>
<td>* Cesarean section care</td>
<td></td>
</tr>
<tr>
<td>* Childbirth preparation</td>
<td></td>
</tr>
<tr>
<td>* Circumcision care</td>
<td></td>
</tr>
<tr>
<td>* Electronic fetal monitoring: antepartum</td>
<td></td>
</tr>
<tr>
<td>* Electronic fetal monitoring: intrapartum</td>
<td></td>
</tr>
<tr>
<td>* Environmental management: attachment process</td>
<td></td>
</tr>
<tr>
<td>* Family integrity promotion: childbearing family</td>
<td></td>
</tr>
<tr>
<td>* Family planning: infertility</td>
<td></td>
</tr>
<tr>
<td>* Family planning: unplanned pregnancy</td>
<td></td>
</tr>
<tr>
<td>* Fertility preservation</td>
<td></td>
</tr>
<tr>
<td>* Genetic counseling</td>
<td></td>
</tr>
<tr>
<td>* Grief work facilitation: perinatal death</td>
<td></td>
</tr>
<tr>
<td>* High risk pregnancy care</td>
<td></td>
</tr>
<tr>
<td>* Intrapartal care</td>
<td></td>
</tr>
<tr>
<td>* Intrapartal care: high risk delivery</td>
<td></td>
</tr>
<tr>
<td>* Kangaroo care</td>
<td></td>
</tr>
<tr>
<td>* Labor induction</td>
<td></td>
</tr>
<tr>
<td>* Labor suppression</td>
<td></td>
</tr>
<tr>
<td>* Lactation suppression</td>
<td></td>
</tr>
<tr>
<td>* Newborn care</td>
<td></td>
</tr>
<tr>
<td>* Newborn monitoring</td>
<td></td>
</tr>
<tr>
<td>* Nonnutritive sucking</td>
<td></td>
</tr>
<tr>
<td>* Phototherapy: neonate</td>
<td></td>
</tr>
<tr>
<td>* Postpartal care</td>
<td></td>
</tr>
<tr>
<td>* Preconception counseling</td>
<td></td>
</tr>
<tr>
<td>* Pregnancy termination care</td>
<td></td>
</tr>
<tr>
<td>* Prenatal care</td>
<td></td>
</tr>
<tr>
<td>* Reproductive technology management</td>
<td></td>
</tr>
<tr>
<td>* Reasssessment: fetus</td>
<td></td>
</tr>
<tr>
<td>* Reassuication: neonate</td>
<td></td>
</tr>
<tr>
<td>* Risk identification: childbearing family</td>
<td></td>
</tr>
<tr>
<td>* Surveillance: late pregnancy</td>
<td></td>
</tr>
<tr>
<td>* Tube care: umbilical line</td>
<td></td>
</tr>
<tr>
<td>* Ultrasonography: limited obstetric</td>
<td></td>
</tr>
</tbody>
</table>

support, midlife well-being, perianesthesia care, neonatal skin care, and cardiac health. By using such guidelines and published reports, nurses can develop protocols and procedures based on published research and incorporate an evidence base into their practice. AWHONN research priorities include the aforementioned topics, as well as family violence, fetal surveillance, genetics, infertility, and early parenting (Box 1-8). The incorporation of research findings into practice is essential in developing a science-based practice.

Introduction to Evidence-Based Practice Reviews

Evidence-based practice review groups systematically examine all relevant research studies on a certain topic and efficiently communicate their findings to the professionals who make clinical decisions and write protocols for clinical practice. Many studies are too small to be generalizable to the general population. With the studies combined, several smaller studies together achieve more “power,” or predictive value. The review by Brown, Small, Faber, Krastev, and Davis (2002), for example, combined eight smaller trials with a total of 3600 women (Evidence-Based Practice box). A review group may choose to review only randomized trials, because these are the most generalizable to the larger population. In addition, they may choose only controlled trials (one group gets the intervention and one group, the control, does not), which makes a stronger case that any difference between the groups is actually a result of the intervention rather than to some other influence. In the study in the Evidence-Based Practice box, the studies ranged from 1962 to 2000 and were from North America, Sweden, the United Kingdom, and Australia. The standard length of stay after normal birth ranged from 2 to 5 days, and early discharge ranged from 6 hours to 4 days, so considerable overlap prevented some calculations from all the studies together. In this case the reviewers combined studies with similar definitions.

Conclusions are the review committee’s best recommendations for clinical practice, based on the best available evidence. Reviewers may find that some of our long-standing assumptions about clinical care are not beneficial, or may even be harmful for mother or baby. In the Brown and colleagues (2002) review, the trend was toward improvement in most outcome measures with early discharge, but there were no statistically significant differences. Therefore the conclusion is that early discharge appears to do no harm, but adverse outcomes cannot be ruled out because of limitations in the studies.

Box 1-7

Association of Women’s Health, Obstetric and Neonatal Nurses Research-Based Practice Programs

Transition of the Preterm Infant to an Open Crib Management of Women in Second-Stage Labor Continence for Women Neonatal Skin Care Cyclic Pelvic Pain and Discomfort Management Setting Universal Cessation Counseling, Education, and Screening Standards: Nursing Care for Pregnant Women Who Smoke (SUCCESS)

Box 1-8

Association of Women’s Health, Obstetric and Neonatal Nurses Research Priorities for Women’s and Neonatal Health

STRATEGIES TO PROMOTE HEALTHY BEHAVIORS IN WOMEN ACROSS THE LIFESPAN
- Prevention of unintended pregnancy
- Cardiovascular health, including smoking cessation
- Weight management and nutrition
- Menstrual and menopausal adjustment and symptom management
- Cancer screening and risk reduction
- Chronic illness self-care (e.g., diabetes)
- Social risks (poverty, addiction, sexual risks, violence)
- Promotion of women’s mental health and stress management

REDUCING HEALTH DISPARITIES
- Delivering culturally competent care
- Enhancing access to and use of health care
- Reducing disparities in rates of low birth weight
- Improving breastfeeding rates among low-income and minority women

MODELS OF NURSING CARE DELIVERY
- Strategies to increase diversity of the nursing workforce
- Effect of workforce diversity on patient outcomes
- Comparative studies of quality, patient outcomes, and cost across the following:
  - Providers (physicians, nurses, advanced practice nurses)
  - Delivery settings (medical centers, birth centers, primary care, home care)
  - Practice decisions and decision making (levels and types of clinical decision making and interventions)
  - Staff development and support models
  - Models of care delivery in prenatal and antepartum care

EVIDENCE-BASED PRACTICE
Early Postnatal Discharge of Healthy Mothers and Babies

BACKGROUND
• Since the 1970s the trend has been toward shorter postpartum length of stay. Current average stays in the United States are typically 12 to 24 hours for uncomplicated vaginal births. Many have debated the consequences to mothers and babies of this change in practice. Risks include delay in detecting maternal and infant mortality, readmission of mothers and babies, breastfeeding problems, decreased maternal satisfaction in care, and decreased confidence in infant care. Advantages included family-centered bonding, better sleep for the mother in her own home, decreased exposure to nosocomial infections for mother and baby, increased maternal satisfaction in care, and decreased cost.

OBJECTIVES
• Specific research questions include identifying whether early postnatal discharge leads to any of the following:
  1. Increased maternal or infant readmissions or physical problems
  2. Increased maternal fatigue, depression, or anxiety
  3. Breastfeeding problems
  4. Change in maternal satisfaction levels with health care
  5. Increased paternal anxiety
  6. Increased costs, including any prenatal teaching and support after discharge

METHODS
Search Strategy
• The search strategy included searching in the Cochrane, Medline, CINAHL, and EMBASE databases. Search keywords were postnatal care, postpartum, puerpera, childbirth, length of stay, discharge, hospitalization, and readmission.
• The reviewers selected eight randomized, controlled studies, involving a total of 3600 women and their babies. The studies were published from 1962 to 2000 and involved Australia, Canada, the United States, the United Kingdom, and Sweden. All studies had some cointervention to accompany early discharge, such as antenatal education and postdischarge midwife or nurse visits or calls.

Statistical Analysis
• Reviewers independently analyzed the studies and then met to resolve disagreements. "Early" and "standard" time frames overlapped, so the reviewers agreed to accept the "standard" of the setting of each study. Statistical analysis enabled comparison of outcomes, such as readmissions or breastfeeding problems, of early versus standard discharge groups (using the standards of that particular study).

FINDINGS
• The reviewers found no significant differences between early versus standard discharge groups in numbers of readmissions of infants or mothers. One study found significantly increased depression scores (indicating more depression) in the standard discharge group at 1 month. There was no significant difference in maternal fatigue. Both groups were the most exhausted the day after discharge. Early discharge mothers were more confident at 1 week, but there was no difference between the groups by 1 month.
• Trends were mixed for breastfeeding, which may reflect the cultural differences of the time frame (1960s to present) and countries. The reviewers identified no significant differences.
• There was a trend toward higher maternal satisfaction with care in the early discharge group that was not statistically significant.
• Fathers spent significantly more time with the baby who was discharged early. No data about paternal anxiety were found.
• One study showed that early discharge cost was considerably less than standard care, even with the costs of multiple home visits and acute care visits factored in.

LIMITATIONS
• Many studies had low recruitment rates (only 24% to 44%) and high exclusion rates after randomization and withdrawals for reasons such as not following the assigned protocol. Some women changed their minds about their length of stay or developed problems and stayed longer. Cointerventions included some combination of prenatal education and from one to seven postnatal visits by midwives or nurses. Available postnatal primary and specialist medical support varied. Definitions of "standard" versus "early" discharge overlapped. The three studies that measured depression scores did not use validated depression screening tools. The studies were too heterogeneous to assess breastfeeding success or maternal satisfaction with care. Few studies reported costs.

CONCLUSIONS
• The review committee finds no evidence of adverse outcomes from early discharge. However, methodologic limitations may obscure adverse outcomes.

IMPLICATIONS FOR PRACTICE
• Health care providers can include in their prenatal education information that all women feel the most exhausted on the first day after discharge. Maternal confidence seems to increase with time after discharge. Early discharge may allow more time for paternal bonding before the father must return to work.

IMPLICATIONS FOR FURTHER RESEARCH
• The authors call for large, well-designed trials, using standardized approaches, factoring in the likely attrition rates. Much remains to be clarified in further research regarding the importance of postdischarge nursing and midwifery care.

have been successful in addressing specific needs and select institutions. Staff members then identify solutions that determine best practices, information is collected from similar perspectives. To provide a better or a new way to achieve goals and be sound is considered to be a best practice.

A program or service that has been recognized for excellence and quality of care are receiving increased emphasis. Outcomes-oriented care measures effectiveness of care against benchmarks or standards. It is a measure of the value of nursing using quality indicators and answers the question, “Did the patient benefit or not benefit from the care provided?” (Moorhead, Johnson, & Maas, 2004). The Outcome Assessment Information Set (OASIS) is an example of an outcome system important for nursing. Its use is required by the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration (HCFA), in all home health organizations that are Medicare accredited. The Nursing Outcomes Classification (NOC) is an effort to identify outcomes and related measures that can be used for evaluation of care of individuals, families, and communities across the care continuum (Moorhead, Johnson, & Maas, 2004). An example of outcomes classification is provided in Table 1-3.

### Best Practices as Goal of Care

A program or service that has been recognized for excellence is considered to be a best practice. A best practice must provide a better or a new way to achieve goals and be sound from operational, clinical, and financial perspectives. To determine best practices, information is collected from similar institutions. Staff members then identify solutions that have been successful in addressing specific needs and select one that incorporates the best resolutions of the problem that fit the agency’s unique population and mission characteristics. The agency continually compares its performance against the best in the industry and the best of a specific function.

### Clinical Benchmarking

Clinical benchmarking is a process used to compare one’s own performance against the performance of the best in an area of service. Benchmarking supports and promotes continual quality improvement and helps the organization remain competitive in the health care market. Collaborative benchmarking involves sharing strategies and outcomes that are common to the development of new best practices (Clinical Benchmarking, 2005). Collaborative benchmarking is a tool used to compare one’s own performance with the performance of the best in the industry and the best of a specific function.

### A Global Perspective

Advances in medicine and nursing have resulted in increased knowledge and understanding in the care of mothers and infants and reduced perinatal morbidity and mortality rates. However, these advances have affected predominantly the industrialized nations. For example, the majority of the 3.2 million children living with HIV or AIDS acquired the infection through perinatal transmission and live in sub-Saharan Africa. This illustrates the inequities that exist between industrialized and resource-poor parts of the world (Cohan, 2003).

As the world becomes smaller because of travel and communication technologies, nurses and other health care providers are gaining a global perspective and participating in activities to improve the health and health care of people worldwide (Kutz & Hirsch, 2003). Nurses participate in medical outreach, providing obstetric, surgical, ophthalmologic, orthopedic, or other services; attend international meetings; conduct research; and provide international consultation. International student and faculty exchanges occur (Perry & Mander, 2005) (Fig. 1-5). More articles about health and health care in various countries are appearing in nursing journals. Several schools of nursing in the United States are World Health Organization Collaborating Centers.

### Millennium Development Goals

The member states of the United Nations adopted the Millennium Development Goals in September 2000. The Millennium Development Goals are a guide to implementing the Millennium Declaration in 2000. The Millennium Development Goals are to (1) eradicate extreme poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empower women, (4) reduce child mortality, (5) improve maternal health, (6) combat HIV and AIDS, malaria, and other diseases, (7) ensure environmental sustainability, and (8) develop a global partnership for development. The target date for achievement of the goals is 2015. The goals help to define a yardstick with which...
TABLE 1-3

Nursing Outcomes Classification

**TAXONOMY**

**Level 1: Domain IV—Health Knowledge and Behavior**
Outcomes that describe attitudes, comprehension, and actions with respect to health and illness

**Level 2: Q—Health Behavior**
Outcomes that describe an individual's actions to promote, maintain, or restore health

**Level 3: 1607—Prenatal Health Behavior**
Care Recipient: Data Source: Scale(s)—Never demonstrated to Consistently demonstrated
Definition: Personal actions to promote a healthy pregnancy and a healthy newborn

<table>
<thead>
<tr>
<th>Outcome Target Rating:</th>
<th>Maintain at</th>
<th>Increase to</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Prenatal Health Behavior</th>
<th>Never demonstrated</th>
<th>Rarely demonstrated</th>
<th>Sometimes demonstrated</th>
<th>Often demonstrated</th>
<th>Consistently demonstrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>160701 Maintains healthy preconceptual state</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160702 Uses proper body mechanics</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160703 Keeps appointments for prenatal care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160704 Maintains healthy weight gain pattern</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160705 Receives proper dental care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160706 Uses seat belt appropriately</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160707 Attends childbirth education classes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160709 Participates in regular exercise</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160710 Maintains adequate nutrient intake for pregnancy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160711 Practices safe sex</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160712 Uses medications as prescribed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160713 Consults health care professional concerning use of nonprescription drugs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160714 Avoids environmental hazards</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160715 Avoids exposure to infectious diseases</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160716 Avoids recreational drugs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160717 Abstains from alcohol</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160718 Abstains from tobacco use</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160719 Avoids teratogenic agents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>160719 Avoids abusive situations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>


to measure results. With the rich resources of many developed countries, poorer countries can be provided with additional resources and assistance (Millennium Development Goals, 2004).

Nursing standards of practice in perinatal nursing have been described by several organizations, including the American Nurses Association (ANA), which publishes standards for maternal-child health nursing; AWHONN, which publishes standards of practice and education for perinatal nurses and women’s health (Box 1-9); the American College of Nurse Midwives (ACNM), which publishes standards of practice for midwives; and the National Association of Neonatal Nurses (NANN), which publishes standards of practice for neonatal nurses. These standards reflect current knowledge, represent levels of practice agreed on by leaders in the specialty, and can be used for clinical benchmarking.

In addition to these more formalized standards, agencies have their own policy and procedure books that outline standards to be followed in that setting. In legal terms, the standard of care is that level of practice that a reasonably prudent nurse would provide. In determining legal negligence, the care given is compared with the standard of care. If the

![Fig. 1-5](image)

**Fig. 1-5** U.S. nursing students and faculty posing with head nurses in a pediatric hospital in China as part of an international perspectives in nursing course. (Courtesy Shannon Perry, Phoenix, AZ.)
standard was not met and harm resulted, negligence occurred. The number of legal suits in the perinatal area has typically been high. As a consequence, malpractice insurance costs are high for physicians, nurse-midwives, and nurses who work in labor and delivery.

**LEGAL TIP Standard of Care**

When you are uncertain about how to perform a procedure, consult the agency procedure book and follow the guidelines printed therein. These guidelines are the standard of care for that agency.

**Risk Management**

Risk management is an evolving process that identifies risks, establishes preventive practices, develops reporting mechanisms, and delineates procedures for managing lawsuits. Nurses should be familiar with concepts of risk management and their implications for nursing practice. These concepts can be viewed as systems of checks and balances that ensure high-quality patient care from preconception until after birth. Effective risk management minimizes the risk of injury to patients and the number of lawsuits against nurses. Each facility or site develops site-specific risk management procedures based on accepted standards and guidelines. The procedures and guidelines must be reviewed periodically.

To decrease risk of errors in the administration of medications, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed a list of abbreviations, acronyms, and symbols not to use (Table 1-4). In addition, each agency must develop its own list.

**Sentinel Events**

JCAHO describes a sentinel event as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.” These events are called “sentinel” because they signal a need for an immediate investigation and response (JCAHO, 2002).

**ETHICAL ISSUES IN PERINATAL NURSING**

Ethical concerns and debates have multiplied with the increased use of technology and with scientific advances. For example, with reproductive technology, pregnancy is now possible in women who thought they would never bear children, including some who are menopausal or postmenopausal. Should scarce resources be devoted to achieving pregnancies in older women? Is giving birth to a child at an older age worth the risks involved? Should older

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**TABLE 1-4**

**JCAHO “Do Not Use” List**

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>POTENTIAL PROBLEM</th>
<th>PREFERRED TERM</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero, four, or cc.</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten).</td>
<td>Write “International unit.”</td>
</tr>
<tr>
<td>Q.D., Q.O.D. (Latin abbreviations for once daily and every other day)</td>
<td>The period after the Q can be mistaken for an “I.” If the “O” can be mistaken for “I.” The decimal point is missed.</td>
<td>Write “daily” and “every other day.”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg); lack of leading zero (1.X mg)</td>
<td>Decimal point is missed.</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg).</td>
</tr>
<tr>
<td>MS</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write “morphine sulfate” or “magnesium sulfate.”</td>
</tr>
<tr>
<td>MSO4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MgSO4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

parents be encouraged to conceive a baby when they may not live to see the child reach adulthood? Should a woman who is HIV positive have access to assisted reproduction services? Should third-party payers assume the costs of reproductive technology? With induced ovulation and in vitro fertilization, multiple pregnancies occur, and multifetal pregnancy reduction (selectively terminating one or more fetuses) may be considered. Innovations such as intraterine fetal surgery, fetoscopy, therapeutic insemionation, genetic engineering, stem cell research, surrogate childbearing, surgery for infertility, “test tube” babies, fetal research, and treatment of VLBW babies have resulted in questions about informed consent and allocation of resources. The introduction of long-acting contraceptives has created moral choices and policy dilemmas for health care providers and legislators; that is, should some women (substance abusers, women with low incomes, or women who are HIV positive) be required to take the contraceptives? With the potential for great good that can come from fetal tissue transplantation, what research is ethical? What are the rights of the embryo? Should cloning of humans be permitted? Discussion and debate about these issues will continue for many years. Nurses and patients, as well as scientists, physicians, attorneys, lawmakers, ethicists, and clergy, must be involved in the discussions.

Research plays a vital role in the establishment of a maternity nursing science. Nurses should promote research funding and conduct research on maternity and women's health, especially concerning the effectiveness of nursing strategies for these patients. Research can validate that nursing care makes a difference. For example, although prenatal care is clearly associated with healthier infants, no one knows exactly which nursing interventions produce this outcome. Many possible areas of research exist in maternity and women’s health care. The clinician can identify problems in the health and health care of women and infants. Through research, nurses can make a difference for these patients.

Ethical Guidelines for Nursing Research
Nurses must protect the rights of human subjects (that is, patients) in all of their research. For example, nurses may collect data on or care for patients who are participating in clinical trials. The nurse ensures that the participants are fully informed and aware of their rights as subjects. Research with perinatal patients may create ethical dilemmas for the nurse. For example, participating in research may cause additional stress to a woman concerned about outcomes of genetic testing or one who is waiting for an invasive procedure. Obtaining amniotic fluid samples or performing cordocentesis poses risks to the fetus. The nurse may be involved in determining whether the benefits of research outweigh the risks to the mother and the fetus. Following the ANA ethical guidelines in the conduct, dissemination, and implementation of nursing research helps nurses ensure that research is conducted ethically.

<table>
<thead>
<tr>
<th>Community Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examine a daily newspaper for 7 days. Identify articles reporting topics related to maternity or reproductive health.</td>
</tr>
<tr>
<td>■ How many articles did you identify? What are the topics? Are they local or national issues?</td>
</tr>
<tr>
<td>■ Is the reporter a health reporter? A local or national columnist? Male or female?</td>
</tr>
<tr>
<td>■ What is the “slant” of the articles? Are the reports favorable to women and reproductive health? Does the viewpoint of the articles limit reproductive freedom or infringe on women’s rights?</td>
</tr>
<tr>
<td>■ What conclusions can you draw related to the treatment of women’s issues and reproductive health in your community?</td>
</tr>
</tbody>
</table>

**Key Points**

- Maternity nursing focuses on women and their infants and families during the childbearing cycle.
- Nurses caring for women can play an active role in shaping health care systems to be responsive to the needs of contemporary women.
- Childbirth practices have changed to become more family focused and to allow alternatives in care.
- Canada ranks nineteenth and the United States ranks twenty-seventh among industrialized nations in infant mortality.
- Integrative medicine combines modern technology with ancient healing practices and encompasses the whole of body, mind, and spirit.
- Evidence-based practice, outcomes orientation, best practices, and clinical benchmarking are emphasized in current practice.
- Risk management and learning from sentinel events can improve quality of care.
- Healthy People 2010 provides goals for maternal and infant health.
- Research plays a vital role in improving the health of women and infants.
- Ethical concerns have multiplied with increasing use of technology and scientific advances.
Answer Guidelines to Critical Thinking Exercise

Health Literacy

1. No. The nurse should assess Yu Mei's understanding of the instructions—for example, by asking Yu Mei to tell the nurse how she will practice perineal hygiene and take her medications.

2. a. Patients must be able to read and understand written information if the nurse is relying on that mode of patient education.
   b. Looking at the written instructions does not indicate that Yu Mei can read or understand English or can comprehend the information that is in the material.
   c. Patients of different cultures may process information differently.
   d. Patients' nonverbal language may vary based on their culture.
   e. Patients are more likely to understand information if it is given clearly and slowly, while using simple and common words.
   f. Interpreters (unless professional) may not translate completely and accurately.

3. Yu Mei must receive information about perineal hygiene and taking her prescribed medications. She must have information about contraindications and side effects of the medication. She needs to know when to call her health care provider.


5. Nodding may mean that Yu Mei is listening, not that she understands the nurse's instructions. Respect for authority dictates that she not question the nurse. Sensitivity to diversity and culture is necessary in a setting where patients are from a variety of cultures and speak other languages. Interpreters who are not family members should be available; patients have the right to an interpreter. Nurses in this type of setting should increase their language capabilities and work with other staff members to prepare patient education materials in a variety of languages to meet the needs of the patients they see.

Resources

Alternative Health News Online
www.altmedicine.com

Alternative Medicine Foundation
www.amfoundation.org

Alternative Medicine: Health Care Information Resources
http://hsl.mcmaster.ca/sonfilm/almmed.html

American College of Nurse Midwives
www.acnm.org

American Massage Therapy Association
www.amtamassage.org

Ask NOAH: Complementary and Alternative Medicine
www.noah-health.org

Association of Nurse Advocates for Childbirth Solutions
www.anacs.org

Benchnet, the Benchmarking Exchange
Benchmarking and Best practices Network
www.benchnet.com

Birth from Within
www.birthpower.com

CAM on PubMed

Childbirth.org
www.childbirth.org

Clinical Benchmarking
P.O. Box 63
Glen Ellyn, IL 60138
600-696-3076
630-690-7086 (fax)
http://clinmarking.com

Doula of North America
P.O. Box 626
Jasper, IN 47547
888-788-DONA (3682)
812-644-1494 (fax)
www.dona.org

Emerging Infectious Diseases
Centers for Disease Control and Prevention
www.cdc.gov/ncidod/cid/index.htm

Global Health Council
www.globalhealth.org

HerbMed
www.herbmed.org

Homebirth Information
www.changesurfer.com/Whis/homebirth.html

International Council of Nurses
3, Place Jean Martnaus
1201 Geneva
Switzerland
41-22-908-01-00
41-22-908-01-01 (fax)
www.icn.ch

Internet Health Library
www.internethealthlibrary.com

MEDLINEplus: Alternative Medicine
www.nlm.nih.gov/medlineplus

Midwives Alliance of North America
P.O. Box 6310
Charlottesville, VA 22906
800-808-3076
630-690-7086 (fax)
www.mana.org

National Association of Childbirth Centers
www.birthcenters.org

National Center for Complementary and Alternative Medicine
National Institutes of Health
P.O. Box 7923
Gaithersburg, MD 20898-7923
888-644-6226
866-464-3616 (fax)
http://nccam.nih.gov/

National Institutes of Health
Office of Dietary Supplements
http://dietary-supplements.info.nih.gov/
References


Maternal Child Nursing, 25(1), 221-223.


