Maternal-Newborn Nursing: Thirteen Challenges That Influence Excellence in Practice

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Abstract

The purpose of this paper is to review the research and discuss 13 challenges that currently influence excellence in maternal-newborn nursing practice. Nurses working in the maternal-newborn arena are encouraged to evaluate their own practices in relation to the identified areas. The 13 identified challenges are the following: integration and expansion of midwifery and family-centered models of care, reduction in the use of unnecessary or questionable-benefit technology, patient and family teaching, the questionable need for a normal newborn nursery, integration of research into practice, further development of genetic technology and counseling, computer technology as an adjunct to prenatal care and birth, the need for comprehensive breastfeeding education and support, prenatal care on a continuum beginning as women's health promotion, health promotion beyond the postpartum period, culturally competent care, health insurance coverage for all women and children, and an undereducated work environment.

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Introduction

During a review of the literature, 13 challenge areas were identified as important to achieving excellence in maternal-newborn nursing practice. These challenges point out priority areas on which to focus improvement efforts to achieve the highest level of patient care in maternity settings. Many of the identified challenges overlap and, thus, affect one another. Acknowledging the significance of these issues can be useful for clinicians and administrators in evaluating their own practices and

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facilities. Improvement in any or all of these issues of care would increase the quality of patient care for mothers and their newborns. As the literature on each of the 13 issues is presented below, a discussion of the implications for maternal-newborn care is integrated into the presentation.

Challenges Related to Models of Maternity Care

1. Integration and Expansion of Midwifery and Family-Centered Models of Care

Gagnon and Waghorn (1999) conducted a secondary analysis to compare the benefits of one-to-one nurse labor support with usual intrapartum nursing care in women stimulated with oxytocin. One hundred nulliparous women with a singleton gestation participated in the study. All fetuses were vertex and women had a cervical dilation of less than 5 centimeters at the time of entry into the study. The authors describe one-to-one nursing care as the presence of a nurse during labor and birth who attends to the physical and emotional needs of the laboring woman and her family. Such a nurse also provides instruction on relaxation and coping techniques. Usual care in this study consisted of one nurse caring for 2 to 3 laboring patients, with supportive interventions varying according to nurse preference. Results of the secondary analysis indicate a beneficial trend to having one-to-one nursing care. In this sample, a 56% reduction in the risk of total cesarean deliveries existed in the group receiving one-to-one nursing care. The results of this study warrant careful consideration by nurses and nurse managers of labor and delivery units to ensure excellence in maternal newborn care.

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Certified Nurse Midwives are an essential part of delivering family-centered care. The expansion and integration of nurse-midwives into all areas of maternity practice are essential to improving maternity care throughout the world. Nurse-midwifery care has been

documented in repeated studies to be equal to or better than care provided by physicians. Nurse-midwives tend to focus on health promotion and patient teaching, which further assist the patient to have favorable birth outcomes. Nurse-midwives traditionally are less invasive than their physician colleagues, which can lower costs, increase patient satisfaction, and contribute to improved outcomes by avoiding unnecessary interventions.

2. Reduction in the Use of Unnecessary or Questionable-Benefit Technology

The following is a review of evidence related to overuse of technology in childbirth. Curtin and Mathews (2000) provide an in-depth discussion of current obstetric procedures for 1998. They note that electronic fetal monitoring, ultrasound, and stimulation and induction of labor continued to rise in 1998. Both the total numbers of cesarean sections and primary cesarean sections increased. The rate of vaginal births following cesarean delivery (VBAC) declined for the second year in a row. While the number of births assisted by vacuum extraction has continued to rise, a slight decrease was reported for 1997-1998 (Ventura, Martin, Curtin, & Mathews, 2000).

Sleutel and Golden (1999) conducted an in-depth review of the literature regarding food and fluid restrictions during labor. They reviewed MEDLINE, CINAHL, and historical texts. The authors concluded that research does not support the restriction of food or oral fluids during routine labor for the prevention of gastric aspiration. They also note that restricted oral intake can have adverse effects.

Another controversial practice in maternal-newborn nursing is the use of routine continuous electronic fetal monitoring. Haggerty (1999) notes that several professional organizations have endorsed the use of intermittent auscultation for low-risk pregnant women, yet the majority of U.S. women continue to receive continuous electronic fetal monitoring during labor. Routine electronic fetal monitoring was quickly implemented into practice without appropriate research to test the effectiveness, reliability, or efficiency of its use. Haggerty notes that, while a reassuring fetal heart rate pattern is a good predictor of fetal well-being, a nonreassuring fetal heart rate pattern is not a good predictor of fetal problems or demise.

Lundquist, Olsson, Nissen, and Norman (2000) con-

ducted a study to determine if any differences existed in the healing or discomfort associated with vaginal lacerations that were or were not sutured following childbirth. Eighty women with first- or second-degree tears were randomized to either group. The perineum was examined and the women were questioned about their experiences at 2 to 3 days, 8 weeks, and 6 months after delivery. No differences were found in healing or amount of pain. However, women in the sutured group reported more visits to their health care provider for care related to the sutures. Sixteen percent of the women in the sutured group also reported that the sutures had a negative impact on breastfeeding.

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Creedy, Shochet, and Horsfall (2000) conducted a study to determine the incidence of acute trauma symptoms in women that resulted from their labor and delivery experiences. In this prospective study, women were recruited during their last trimester of pregnancy. Telephone interviews were conducted with 499 women 4 to 6 weeks after delivery. In this sample of urban Australian women, 33% (or 1 in 3 women) reported a traumatic birthing event and at least three symptoms they believed were related to the experience. Slightly more than 5% of women met DSM-IV criteria for acute post-traumatic stress disorder. A high level of intervention and the perception of inadequate intrapartum care were associated with the development of symptoms in this group of women. Prenatal variables did not contribute to the development of symptoms in this sample. When high levels of support are available, this high level of trauma should not occur.

3. Patient and Family Teaching

Chapman (2000) conducted a qualitative study to describe expectant fathers' labor and delivery experiences when their partners received epidural anesthesia. Fathers identified two main concepts: "losing her" and "she's back." The theme "losing her" referred to women turning

inward as a way to cope with labor prior to epidural administration. "She's back" referred to the transition women went through after they received an epidural and their pain was controlled. Expectant fathers who are aware of what to expect during labor and delivery and from the use of epidural anesthesia will be better able to support their partners and have a positive birthing experience. Nurses and childbirth educators are in a key role to educate the father (and significant others) regarding labor and delivery.

Ruchala (2000) conducted a study to identify what nurses and postpartum women believed to be the most important areas for postpartum teaching. Nurses were invited to participate via mailed surveys and new mothers were interviewed in the hospital within 24 hours of delivery. Statistically significant differences were found between the mothers' and nurses' prioritizations. New mothers identified issues related to their own care as most important, while nurses rated newborn care issues as most important. This information has implications for nurses who work with postpartum mothers. New mothers may need to learn how to appropriately care for themselves before being able to care for another. Birth is an intimate process and women have significant fears related to their healing and adaptation. If their energy is focused here, they may not be able to learn effectively about newborn care. The nurse must first assess what the learner knows and what the learner believes she needs to know before teaching occurs. Focusing first on what a mother needs to know will allow her to absorb that information and then move on to what the nurse believes to be important. Facilitating learning in such a manner will provide the best opportunity for the new mother to learn as much as possible before being discharged. It is likely that facilitated teaching would reduce the risk of unnecessary rehospitalizations and complications.

Karl (1999) described the use of an interactive newborn bath as a method both for teaching the family about the newborn and as a way to help parents learn to interact with the newborn. During the bath, the nurse is able to point out infant reflexes, states of alertness, and newborn skills such as eye contact and listening. The nurse can also encourage the parents to touch and hold their newborns and help the parents to interpret the newborn's responses. This type of interaction accomplishes several goals: It cleans the newborn; the parents

learn how to give a bath, interpret behavior, and understand newborn emotions and reflexes; and it allows the nurse to assess family cohesion, readiness to learn, and previous experience.

Sampsel, Seng, Yeo, Killion, and Oakley (1999) conducted a study to describe patterns of postpartum physical activity and to identify any specific risks or benefits from such activity. The authors interviewed 1,003 women at their 6-week postpartum checkup. Almost 35% of these women reported participating in vigorous exercise. In this sample, women who were more active retained less pregnancy weight, scored better on measures of postpartum adaptation, and participated in more social activities and hobbies. These initial exploratory results warrant discussion of the benefits of exercise with new mothers before hospital discharge.

4. The Questionable Need for a Normal Newborn Nursery

Those who are truly devoted to excellence in maternal-newborn nursing and family-centered care have to question the necessity of the normal newborn nursery, which has disappeared in some progressive hospitals. Many mothers desire to have their infants in the nursery so that they have a chance to rest. However, mothers and infants tend to rest more completely if they room-in together (Keefe, 1987). Other mothers state they want to shower. Sending a newborn back to the nursery is generally not necessary, as the new mother will likely have to shower at home too. Staying in or near the bathroom with the mother during her shower will not harm the newborn. Nursing staff may challenge that they prefer to have the newborn in the nursery for procedures. Routine procedures such as vital signs and drawing blood can be effectively accomplished in the mother's room. Less disruption to the mother's routine occurs and the procedures offer the nurse an opportunity to observe family interaction and to teach the mother about her new infant. Additionally, the nurse's presence in the room may generate questions from the mother. One must also acknowledge that assisting personnel, not the nurse, may perform such skills. These are still good opportunities for interaction with the mother. Simply having another individual in the mother's room can be helpful; nursing assistants can report a problem to the nurse or may, themselves, be able to answer a simple question, such as when dinner is served.

Challenges Related to Keeping Maternity Practice Current

5. Integration of Research into Practice

The following are examples of practice-ready research of which clinicians should be aware. Mayberry, Gennaro, Strange, Williams, and De (1999) found that the reduction in maternal fatigue related to second stage labor needs to be addressed. Fatigue can be minimized by shortened periods of strong pushing or bearing down and by open-glottis breathing. Women who have received epidural anesthesia may be particularly at-risk for fatigue. Excessive fatigue may interfere with the woman's ability to manage care activities following discharge (Tulman, Fawcett, Groblewski, & Silverman, 1990). Lee and Zaffke (1999) found that fatigue during the postpartum period was related more to the new mother's receiving adequate amounts of uninterrupted sleep and adequate nutrition (especially in terms of iron, folic acid, and ferritin) than to the number of other children, amount of household responsibilities, and whether or not the mother was employed outside the home. Nurses who work with pregnant and postpartum women need to implement these types of research findings into their current practice; new mothers need to be made aware of the likelihood of fatigue during the first postpartum months and how best to resolve such fatigue. Lee and Zaffke (1999) also found that younger women were more likely to experience fatigue than their older counterparts, even after controlling for parity.

D'Apolito (1999) conducted a repeated-measures experimental design to determine if the use of a mechanical rocking bed with maternal intrauterine sounds would decrease symptoms of withdrawal and promote neurobehavioral adaptation in drug-exposed infants. She found that infants who experienced the intervention had a significantly greater incidence of symptoms and sleep withdrawal. The author concluded that the infants who received the intervention might have been overstimulated. Therefore, it is imperative that nurses integrate such findings into their own practice, to ensure that these delicate newborns are not overstimulated but calmed and helped to recover from addiction.

Dowling (1999) conducted a study to describe and compare short-term physiologic responses of preterm infants during breastfeeding and bottle-feeding with an

orthodontic nipple. She found statistically significant differences in physiologic parameters between feeding methods. In this research project, infants served as their own controls. Infants were able to breathe better and experienced fewer oxygen desaturations during breastfeeding when compared to bottle-feeding. This research has implications for nurses who work in neonatal intensive care units in terms of the safety and appropriateness of breastfeeding for preterm newborns.

Pridham et al. (1999) conducted a study to determine if caloric and protein intake and weight change of fully nipple-fed infants differed by feeding regimen (scheduled vs. ad-lib) and the caloric density of the formula (20 or 24 kcalories per ounce). Seventy-eight infants were randomized by feeding method and calorie groups. In this group of infants, the ad-lib feeding regime had a negative impact on the amount of formula the infants consumed and the overall total caloric intake. Caloric intake, not feeding regime or the caloric density of the assigned formula, influenced infant weight gain.

Ludington-Hoe et al. (1999) conducted a study to assess preterm neonates' (34-36 weeks) physiological and behavioral responses during "Kangaroo Care"* for the first 6 hours after birth. Data were collected in Columbia, South America. Six neonates with 5-minute Apgar scores of 6 or more were enrolled in the study. Heart rate, respirations, oxygen saturation, temperature, and behavioral state were recorded every minute. Heart rate, respiratory rate, temperature, and oxygen saturation remained stable. All babies were fully breastfed and able to be discharged within 48 hours, suggesting that Kangaroo Care is an environment that assists the infant to recover from birth-related fatigue and adapt to his or her extrauterine environment.

There are implications for nurses who work neonatal intensive care units and delivery suites. Labor and delivery nurses can facilitate a preterm neonate's adaptation to extrauterine life by beginning Kangaroo Care immediately after birth for infants who are not in severe distress. Neonatal intensive care nurses can assist by remaining patient and keeping the infant with his or her mother, rather than rushing an infant to the neonatal intensive care unit or to a nearby warmer.

Nick (1999) conducted a study to identify the presence

*"Kangaroo Care" involves placing the infant on the mother's chest, skin to skin.

of residual blood and organic matter on "clean" infant stethoscopes in maternal-newborn units. This study was a retrospective, nonexperimental study in which 97 stethoscopes were collected from 11 acute care hospitals. A special lens was used to assess for visual evidence of buildup, and a phenolphthalein test was used to detect residual blood. Eighty percent of stethoscopes from labor and delivery units and 72% of stethoscopes from nurseries had organic buildup present. Seventy-six percent of stethoscopes from labor and delivery and 46% of nursery stethoscopes tested positive for blood. Nurses need to examine stethoscopes in their own units and carefully monitor their cleanliness. Consultation with the hospital biomedical or housekeeping services may be a first step to rectify the problem.

6. Further Development of Genetic Technology and Counseling

With the recent advances in genetic technology and the mapping of the human genome, nurses will have an instrumental role in the future care of families affected by this new genetic technology. While some initial successes have occurred, nurses will need to continually monitor new advances in genetic technology to ensure excellence in maternal-newborn nursing practice. For example, many advances can be anticipated in providing information regarding genetic testing for expectant parents and couples considering pregnancy. It will be crucial that families' rights are protected. The discovery of genetic information must be protected and used to the benefit of the patient and family, not to their disadvantage, as might be threatened by some insurance companies who are struggling for financial gain. Nurses must advocate for patients and families to ensure that they receive appropriate follow-up care and counseling for new genetic therapies. Genetic decision-making can be some of the most difficult decisions a person may face in a lifetime. Nurses are in a key role to ensure that families are supported.

7. Computer Technology as an Adjunct to Prenatal Care and Birth

The Internet is an enormous source of information that can assist nurses in providing safe, effective care. Huyhn et al. (2000) describe the development of an Internet web site to promote healthy behaviors among teens. The

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authors note that the teen years are a time when healthy behaviors are learned and when teens often have difficulty seeking out such information from parents and other adults. A survey recently conducted in Seattle, WA, found that students wanted to know information that was not being presented in their current health classes. The authors report that personnel were positive about the use and development of the Internet site described in the article.

While the project discussed by these authors did not specifically address prenatal care, some reproductive information likely was included in such a web site or will be included in the near future. Additionally, the authors present a solid foundation to further build on their ideas and experiences. The information provided can be used as a stepping stone for the further development of Internet technology that can be used during the perinatal period.

Corrarino, Walsh, and Anselmo (1999) describe the use of a slide program to be viewed by the mother and her nurse during a home visit. The topic of the presentation is hepatitis B. The slide presentation is used as an adjunct to one-on-one teaching. It is easy to see how such an intervention could be adopted to a variety of topics to improve perinatal nursing care.

Challenges Related to Competency and Scope of Maternity Care

8. The Need for Comprehensive Breastfeeding Education and Support

A number of authors have documented the problems that arise when breastfeeding education and support for mothers is inconsistent or is not comprehensive. For example, Mozingo, Davis, Droppleman, and Merideth (2000) conducted a phenomenological study of the experience of women who initiate breastfeeding but wean within the first 2 weeks postpartum. The women who

participated in this study (n = 9) described incongruence between their expectations and the reality of the first weeks of breastfeeding. The incongruence these women felt slowly led to the cessation of breastfeeding. The women also described guilt, a sense of failure, shame, and self-doubt about discontinuing breastfeeding. While this study was exploratory in nature and attempted to understand the experience in-depth with a few participants, the results should be examined carefully. Women who wish to breastfeed benefit from having realistic expectations about the first weeks of breastfeeding. Further, once they are fully informed regarding their options, women need to be supported in whatever decision they choose, whether it is to wean or to continue breastfeeding. In order to increase their readily available sources of support and, hence, their ability to prevent or resolve problems, women can be assisted to identify supportive family members, contacts, and informational resources prenatally for the postpartum period. Additionally, women can be referred to support groups and professional lactation consultants for further assistance.

In another recent example, Riordan, Gross, Angeron, Krumwiede, and Melin (2000) conducted a study to examine the relationship of labor pain relief medications with neonatal suckling and breastfeeding duration. One hundred twenty-nine mothers who delivered vaginally participated in the study. The authors controlled for infant gestational age, birth weight, and gender, and found that infants born to unmedicated mothers had greater sucking abilities. Breastfeeding duration did not differ between unmedicated and medicated groups (measured up to 6 weeks postpartum); however, infants with a lower suckling score tended to wean earlier than cohorts with higher suckling scores. The results of this study provide important considerations for clinicians working with breastfeeding mothers. This recent study supports previous assertions that unmedicated births and/or early assessment and correction of neonatal suckling abilities can be instrumental in breastfeeding success. Additionally, the above information needs to be communicated to mothers during the prenatal period so that they can make informed choices about preparation, support, and pain relief options during labor. Mothers aware of such information can be assisted to exert the effort to ensure that breastfeeding efforts are more successful even when the level of medication used during labor is not ideal. In summary, comprehensive breastfeeding support is

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broader than assisting the mother with the techniques of breastfeeding. Her ongoing support system and preparation for labor are examples of items to be included in comprehensive support.

9. Prenatal Care on a Continuum Beginning as Women's Health Promotion

A number of health behaviors of preconceptual women will influence their childbearing experiences. Thus, providers of preconceptual health care or health education have the opportunity to link general health behavior to prenatal health behavior. In a preconceptual example, Leffler (2000) conducted a study to evaluate the knowledge and attitudes of U.S. high school girls regarding infant feeding. One hundred teenagers from two suburban high schools participated in the study. The author reported that 79% of girls expected to have children, and 52% of them planned to breastfeed. Girls who were breastfed or had exposure to breastfeeding were more likely to report that they would breastfeed their own children. The author concludes that teens may be receptive to health promotion activities that relate to breastfeeding. Breastfeeding health promotion is an excellent place for preconception health promotion activities to begin. Many adolescent girls have thought about childbirth and becoming a mother; however, many of them have not had breastfeeding experiences. Introducing them to the health benefits for both mothers and infants would help to provide a solid foundation for preconceptual health promotion.

In a prenatal example, Bungum, Peaslee, Jackson, and Perez (2000) conducted a nonexperimental retrospective study to assess for an association between participation in aerobic exercise during the first two trimesters of pregnancy and delivery type in nulliparous women. One hundred thirty-seven women participated in the study. The authors found that sedentary women ($n = 93$) were 2 times more likely to deliver via cesarean section. When mother's prepregnancy exercise program, age, use of epi-

dural anesthesia, change in prepregnancy to delivery body mass index, labor length, whether labor was induced, and the hospital of birth were controlled, the risk of cesarean delivery increased for sedentary women to greater than 4 times. This presents another prime area for health promotion. The cesarean delivery rate in the U.S. is rather high, and a simple nursing intervention such as teaching women about prenatal exercise may prove useful in helping women to avoid an unnecessary cesarean delivery.

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Nutrition promotion is an example of health behavior with both preconceptual and prenatal implications for pregnancy. Reifsnider and Gill (2000) conducted an in-depth review of the literature to provide state-of-the-science recommendations for preconceptual and pregnancy nutrition. They concluded that maternal nutrition directly relates to neonatal health, size, and growth, both during pregnancy and lactation. Prenatal weight gain may also contribute to a woman's future risk of obesity. Therefore, nutritional teaching and monitoring are an essential part of the continuum of prenatal care from preconception through postpartum and lactation. A more specific nutritional example pertains to folic acid. Montgomery and Mayne (2000) describe a program to increase awareness of the need for folic acid during the preconception period and during pregnancy. Folic acid awareness is a crucial component of prenatal care that must be emphasized across the perinatal continuum to adequately protect against birth defects. An example is the need to advise women to obtain adequate amounts of folic acid to prevent spina bifida.

10. Health Promotion beyond the Postpartum Period

Walker and Wilging (2000) note that most mothers have physical, mental, and social concerns that continue beyond 6 weeks postpartum. The authors advocate for

increased services for women beyond the initial 6 weeks postpartum. They identify that key areas for health promotion include lifestyle changes in exercise, nutrition, and smoking, and services that address psychosocial well-being, including mood and body image. The authors describe a dichotomy that includes maternal-child health (MCH) and women's health. MCH traditionally has dealt with reproductive health issues, while women's health has dealt more with health issues not related to reproductive function. However, beyond 6 weeks postpartum (or the cessation of reproductive function) little effort has been devoted to health promotion activities for mothers. Walker and Wilging (2000) advocate for redefining "postpartum" to include the first year following delivery. They note that this is consistent with published research that confirms women do not return to normal activities of daily living, lose weight, or regain their previous level of energy until one year or more after delivery.

Parks, Lenz, Milligan, and Han (1999) conducted a secondary analysis to understand the consequences of mothers experiencing fatigue throughout the first 18 months following delivery. Their sample included 229 women, half of whom reported that they were persistently fatigued. Mothers identified that their fatigue contributed to more physical and mental problems. There were no differences in infant health. However, infant performance development (e.g., eye-hand coordination) was lower for infants whose mothers had either persistent mental or physical fatigue.

Bottorff, Johnson, Irwin, and Ratner (2000) found that, while many women stop smoking during pregnancy, many resume during the postpartum period. The authors interviewed women about their experiences with smoking relapse and found that five general story lines could be identified: controlling one's smoking, being vulnerable to smoking, nostalgia for one's former self, smoking for relief, and never really having quit smoking. Findings from this exploratory study provide some initial evidence that smoking resumption among postpartum women may have unique characteristics and, therefore, require different interventions than other populations who experience smoking relapse. This is an important area in which health promotion can begin.

11. Culturally Competent Care

Sinclair (2000) quotes the 1990 U.S. Census Bureau in that 1 in 4 persons who responded to the census was of

color, and the numbers are expected to increase with the collection of data for Census 2000. Sinclair also notes that the increasing diversity of America's culture demands that health care providers become more culturally aware. Gichia (2000) conducted an ethnographic study to describe motherhood, maternal role requirements, and family life as perceived by poor, urban, African-American women. She interviewed 15 new mothers between the ages of 14 and 44. In addition to interviewing the mothers, Gichia collected information through home and community observation and conducted interviews with significant others. Initial interviews with the new mothers occurred within 24 hours of the birth of a normal, full-term infant. Participants described motherhood as a significant event in their lives, with both positive and negative aspects. In this sample, maternal role attainment behaviors were learned from extended family and seemed to follow a sequential pattern. Nurses caring for African-American mothers during the postpartum period must consider family and cultural influences if they are to provide the best care to new mothers and their infants.

Mattson (2000) notes that culturally competent care is especially essential in perinatal care, because individuals who immigrate tend to be young and often initially enter the health care system for maternity care. According to Heilemann, Lee, Stinson, Koshar, and Goss (2000), health outcomes for urban women who are of Mexican descent are related to acculturation. The authors compared perinatal outcomes for 773 women who gave birth in three counties in California. They measured acculturation by place of birth and language spoken, and by combining the two factors to form an acculturation index (AI). They found that the language spoken by the Mexican women who participated in this study had less of an impact on acculturation associated with perinatal outcomes when compared to either place of birth or the AI measure.

Challenges Related to the General Health Care System

12. Health Insurance Coverage for All Women and Children

Another essential component of providing excellent nursing care to mothers and newborns is advocating

for health insurance for all women and children. Low-income families and probably many middle-income families are not able to receive routine health maintenance visits without health insurance. Health promotion check-ups are directly related to overall health and well-being and are a crucial component of global health for all persons. Routine visits often include immunizations, which benefit every individual worldwide by preventing the spread of devastating, preventable diseases. Health promotion visits are often used for routine screening such as cholesterol, cancer risk, and other lifestyle factors. Potential problems that are identified and managed early are much less likely to become serious problems, and are much more likely to be able to be treated affordably.

Health insurance coverage during the preconception and prenatal period helps to ensure that women receive early and regular prenatal care. Early and regular prenatal care has been associated with improved outcomes and healthier general lifestyles for mothers and babies. Similar to general health promotion, care during the prenatal period can help to identify problems early to prevent further complications or dysfunction.

13. An Undereducated Work Environment

Anderson (2000) notes that nurses, when compared to other health care professionals, are severely undereducated. She quotes the 1997 U.S. Department of Health and Human Services figures that indicate only 31% of RNs in the workforce hold a college degree. Without a higher level of education, many nurses will find it difficult to effectively participate in discussions regarding appropriate patient care and health care at interdisciplinary or policy levels. If most nurses are unable to participate in these types of discussions, nursing cannot hope to advance. It is crucial that nurses be able to participate in such discussions so that they can help guide practice and health care policy for the benefit of the profession and patient care. Taking positive action will allow nurses to have a say in what happens to them, rather than letting someone else decide.

Conclusion

Excellence in the delivery of health care services to new mothers and their infants is a realistic goal that can be achieved in nursing today. This paper identifies some

specific challenges toward achieving this goal. Nurses who are concerned about achieving excellence in maternal-newborn practice can examine their beliefs and attitudes and act not only as individuals but also as a group to take responsibility for ensuring quality nursing care in maternal newborn nursing.

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Get Up and Go!

You can't build a reputation on what you're going to do.

—Henry Ford

It is in vain to say human beings ought to be satisfied with tranquility; they must have action; and they will make it if they cannot find it.

—Charlotte Bronte (*Jane Eyre*, 1847)