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AAP

American Academy of Pediatrics

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AAP: Preventative Care & Periodicity Schedule

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

2025 Recommendations for Preventive Pediatric Health Care: Policy Statement

Committee on Practice and Ambulatory Medicine

The 2025 Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) has been approved by the American Academy of Pediatrics (AAP). Each child and family is unique; therefore, these recommendations are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.[1]

To ensure that health care professionals have the most current recommendations, the Periodicity Schedule is not published in *Pediatrics* but is posted on the American Academy of Pediatrics website (www.aap.org/periodicityschedule). This webpage includes the most recent version of the Periodicity Schedule and the full set of footnotes. The Periodicity Schedule is reviewed and revised annually to reflect current evidence and recommendations. This review process did not identify sufficient evidence to support updates to the 2025 Periodicity Schedule. The approved 2025 Periodicity Schedule remains unchanged from the 2024 Periodicity Schedule.

COMMITTEE ON PRACTICE AND AMBULATORY MEDICINE, 2024–2025
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Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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PEDIATRICS Volume 155, Issue 5, May 2025:e2025071066

FROM THE AMERICAN ACADEMY OF PEDIATRICS 1

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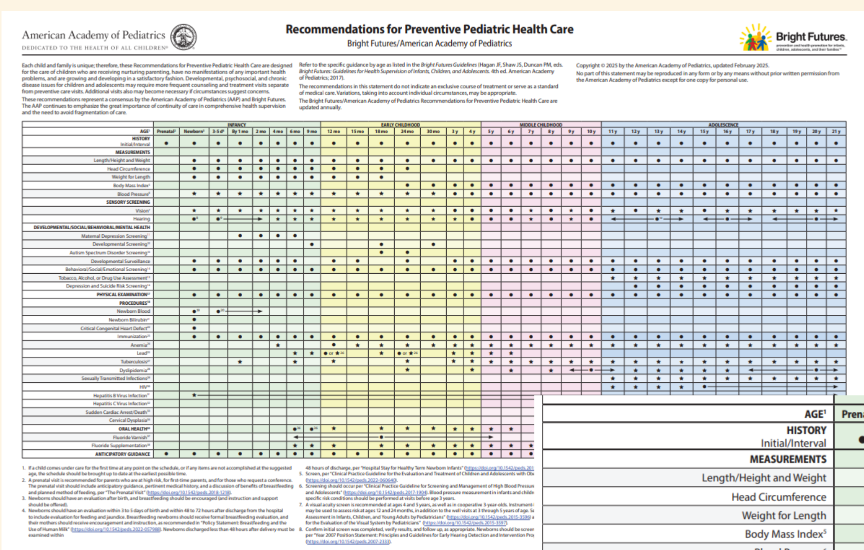

AAP: Preventative Care & Periodicity Schedule

AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo
				INFANCY				
HISTORY Initial/Interval	●	●	●	●	●	●	●	●
MEASUREMENTS								
Length/Height and Weight		●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●
Weight for Length		●	●	●	●	●	●	●
Body Mass Index[5]								
Blood Pressure[6]		★	★	★	★	★	★	★
SENSORY SCREENING								
Vision[7]		★	★	★	★	★	★	★
Hearing		●[8]	●[9] →	→	→	★	★	★
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH								
Maternal Depression Screening[11]				●	●	●	●	

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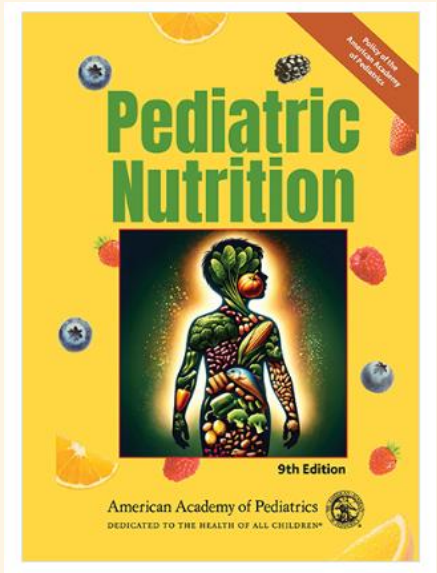
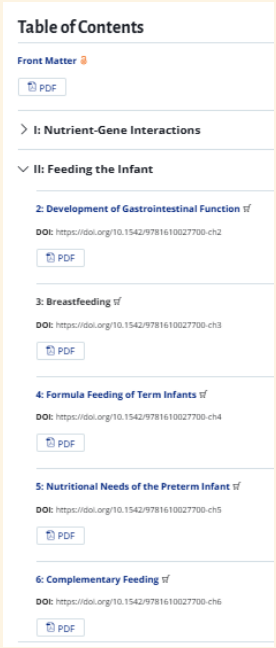
AAP - Policy Statement Series





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AWHONN

Association of Women's Health, Obstetric and Neonatal Nurses

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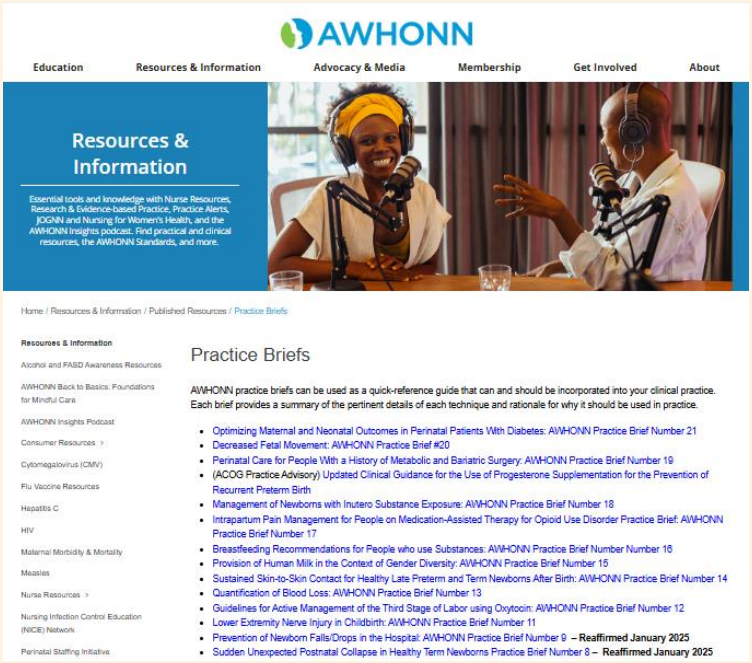

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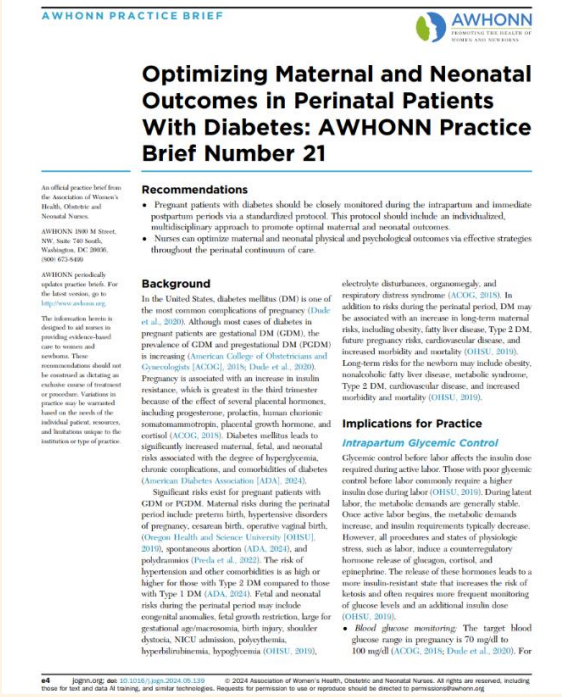
AWHONN Practice Brief #21

"Although diabetes is a common condition in the perinatal period, appropriate management and support can lead to positive maternal and neonatal outcomes. Multidisciplinary obstetric teams should establish standardized protocols for diabetic management to reduce unnecessary variation while individualizing patient needs to ensure safe, high-quality care."


AWHONN PRACTICE BRIEF

AWHONN

Optimizing Maternal and Neonatal Outcomes in Perinatal Patients With Diabetes: AWHONN Practice Brief Number 21

An official practice brief from the Association of Women's Health, Obstetric and Neonatal Nurses.

AWHONN, 1800 M Street, NW, Suite 740 South, Washington, DC 20036. (800) 673-8400

AWHONN periodically updates practice briefs. For the latest version, go to http://www.awhonn.org.

The information herein is designed to aid nurses in providing evidence-based care to women and newborns. These recommendations should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Recommendations

- Pregnant patients with diabetes should be closely monitored during the intrapartum and immediate postpartum periods via a standardized protocol. This protocol should include an individualized, multidisciplinary approach to promote optimal maternal and neonatal outcomes.
- Nurses can optimize maternal and neonatal physical and psychological outcomes via effective strategies throughout the perinatal continuum of care.

Background

In the United States, diabetes mellitus (DM) is one of the most common complications of pregnancy (Dude et al., 2020). Although most cases of diabetes in pregnant patients are gestational DM (GDM), the prevalence of GDM and pregestational DM (PGDM) is increasing (American College of Obstetricians and Gynecologists [ACOG], 2018; Dude et al., 2020). Pregnancy is associated with an increase in insulin resistance, which is greatest in the third trimester because of the effect of several placental hormones, including progesterone, prolactin, human chorionic somatomammotropin, placental growth hormone, and cortisol (ACOG, 2018). Diabetes mellitus leads to significantly increased maternal, fetal, and neonatal risks associated with the degree of hyperglycemia, chronic complications, and comorbidities of diabetes (American Diabetes Association [ADA], 2024).

Significant risks exist for pregnant patients with GDM or PGDM. Maternal risks during the perinatal period include preterm birth, hypertensive disorders of pregnancy, cesarean birth, operative vaginal birth, (Oregon Health and Science University [OHSU], 2019), spontaneous abortion (ADA, 2024), and polyhydramnios (Perela et al., 2022). The risk of hypertension and other comorbidities is as high or higher for those with Type 2 DM compared to those with Type 1 DM (ADA, 2024). Fetal and neonatal risks during the perinatal period may include congenital anomalies, fetal growth restriction, large for gestational age/macrosomia, birth injury, shoulder dystocia, NICU admission, polycythemia, hyperbilirubinemia, hypoglycemia (OHSU, 2019), electrolyte disturbances, organomegaly, and respiratory distress syndrome (ACOG, 2018). In addition to risks during the perinatal period, DM may be associated with an increase in long-term maternal risks, including obesity, fatty liver disease, Type 2 DM, future pregnancy risks, cardiovascular disease, and increased morbidity and mortality (OHSU, 2019). Long-term risks for the newborn may include obesity, nonalcoholic fatty liver disease, metabolic syndrome, Type 2 DM, cardiovascular disease, and increased morbidity and mortality (OHSU, 2019).

Implications for Practice

Intrapartum Glycemic Control

Glycemic control before labor affects the insulin dose required during active labor. Those with poor glycemic control before labor commonly require a higher insulin dose during labor (OHSU, 2019). During latent labor, the metabolic demands are generally stable. Once active labor begins, the metabolic demands increase, and insulin requirements typically decrease. However, all procedures and states of physiologic stress, such as labor, induce a counterregulatory hormone release of glucagon, cortisol, and epinephrine. The release of these hormones leads to a more insulin-resistant state that increases the risk of ketosis and often requires more frequent monitoring of glucose levels and an additional insulin dose (OHSU, 2019).

- *Blood glucose monitoring:* The target blood glucose range in pregnancy is 70 mg/dl to 100 mg/dl (ACOG, 2018; Dude et al., 2020). For

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AWHONN Practice Brief #21

Optimizing Maternal & Neonatal Outcomes in Perinatal Patients with Diabetes

Intrapartum Glycemic Control

- *Blood glucose monitoring:* The target blood glucose range in pregnancy is 70 mg/dl to 100 mg/dl (ACOG, 2018; Dude et al., 2020). For blood glucose levels less than 70 mg/dl or greater than 100 mg/dl, follow the institution's protocol. Regardless of the type of diabetes, blood glucose
  - should be monitored every 2 hours when the patient is in early labor and not on an insulin drip.
  - should be monitored every hour when the patient is in active labor and on an insulin drip.
  - may be monitored less frequently for a patient with diet-controlled GDM, whose glucose values are within the normal range.
  - may be monitored more frequently when medications such as ephedrine, epinephrine, terbutaline, or betamethasone are administered, or in the case of intrauterine inflammation, or infection or both.

Personal continuous glucose monitors are not approved by the U.S. Food and Drug Administration for inpatient use and should not be substituted for point of care testing or to guide management.

- *Insulin protocols:* Although agreement exists that maternal euglycemia should be maintained during the intrapartum period, standardized, universal protocols for the management of blood glucose levels for this time period have not been established. A standard insulin protocol for blood glucose results should be developed by the institution's obstetric service line.
- *Fetal monitoring:* Continuous fetal heart monitoring during labor for patients at risk of uteroplacental insufficiency or fetal acidemia, that is, those with uncontrolled diabetes, vascular disease, or hyperglycemia, is recommended. Limited evidence suggests that patients with GDM without other risk factors may be candidates for intermittent auscultation; however, more research is needed (Jabak & Hameed, 2022).

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AWHONN Practice Brief #21

Optimizing Maternal & Neonatal Outcomes in Perinatal Patients with Diabetes

Postpartum Glycemic Control

During the postpartum period, insulin requirements vary widely; close monitoring and dosing adjustments may be needed.

- In obstetric patients with Type 1 DM, insulin resistance dramatically decreases after childbirth because of the loss of placental hormone influence. The required insulin dose is 30% to 50% less during the immediate postpartum period in comparison to the prepregnancy dose (Ringholm et al., 2020).
  - Stop insulin after the delivery of the placenta for patients with Type 2 DM (OHSU, 2019).
  - Individualize continuation of prepregnancy oral antihyperglycemic medications or insulin administration and include frequent glucose monitoring.
- Encourage breastfeeding and/or feeding expressed human milk to optimize short- and long-term maternal and neonatal outcomes (Ringholm et al., 2020).
  - Consider adjusting insulin for patients with Type 1 DM because of the increased risk of nocturnal hypoglycemia.

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AWHONN Practice Brief #21

Optimizing Maternal & Neonatal Outcomes in Perinatal Patients with Diabetes

Special Considerations

- Glucocorticosteroid administration:
  - Assess for hyperglycemic effects that peak at 4 hours to 10 hours after injection. The effects may continue for 24 hours to 48 hours but may last as long as 3 days to 5 days after injection.
  - Monitor for higher rates of neonatal hypoglycemia and hyperbilirubinemia.
  - Consider that most patients may need significantly more than their current insulin requirements for adequate control because of the varying physiologic responses to corticosteroids.
- Avoid betamimetic tocolytics in patients with DM.
- Diabetic ketoacidosis (DKA):
  - Be aware that pregnant patients are at increased risk of developing DKA at lower blood glucose levels than nonpregnant patients.
  - Manage the plan of care via a collaborative and multidisciplinary approach.
  - Transfer patients to a critical care setting with co-management by obstetrics and critical care personnel.

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Optimizing Maternal & Neonatal Outcomes in Perinatal Patients with Diabetes

Insulin Safety

- Ensure all oral antihyperglycemics are stopped before initiation of insulin.
- Initiate and maintain dedicated intravenous (IV) lines for the prescribed mainline fluid and IV insulin.
  - Use 20 ml of the prescribed insulin solution to prime the IV tubing so the patient receives the full insulin dose (Dude et al., 2018).
- Discard the IV insulin after 48 hours or if exposed to temperatures that exceed 98.6 °F (37 °C; U.S. Food and Drug Administration, 2017).
- Obtain a second registered nurse-independent validation, because insulin is a high-alert medication, in the following scenarios:
  - starting insulin drip,
  - hanging a new insulin bag,
  - giving an IV insulin bolus (push),
  - changing shifts or handing off to another nurse, and
  - using downtime processes when electronic verification is not available.
- Monitor for signs and symptoms of hypoglycemia (e.g., pallor, diaphoresis, tachycardia, tremors, irritability, weakness, confusion, lethargy).
- Monitor for signs and symptoms of hyperglycemia (e.g., abdominal pain, nausea and vomiting, altered sensorium). Continuous fetal heart monitoring may show abnormal fetal heart rate patterns and should be managed with intrauterine resuscitation techniques.

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Optimizing Maternal & Neonatal Outcomes in Perinatal Patients with Diabetes

Education for Nurses and Other Health Care Professionals

- Screen all patients for mood and anxiety disorders during the prenatal period. Pregnant patients with diabetes are at higher risk of depression and anxiety because of the stressors of DM management (OHSU, 2019); therefore, increased psychosocial care may be needed during the perinatal continuum of care.
- Continue point-of-care testing glucose monitoring in the immediate postpartum period for patients with GDM because of the potential for continued glucose abnormalities (OHSU, 2019).
- Individualize continuation of prepregnancy oral antihyperglycemic medications or insulin administration and include frequent glucose monitoring in the postpartum period.
  - Consider reducing the insulin dosage during the first 1 month to 4 months after birth because insulin requirements remain approximately 21% lower than before pregnancy (Ringholm et al., 2020).
- Expect a physiologic decrease in hemoglobin A_{1C} during pregnancy. Because of blood loss at birth and during the postpartum period, hemoglobin A_{1C} may be low in the first 1 month to 2 months after birth (Ringholm et al., 2020) and should not be used to determine adequate glucose control.
- Assist in a seamless transition to follow-up care. Follow-up care should be a multidisciplinary collaboration in which the patient's risk factors and access to resources are taken into consideration (Choi et al., 2022).

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Optimizing Maternal & Neonatal Outcomes in Perinatal Patients with Diabetes

Postpartum Patient Education

In the postpartum period, educate patients with Type 1 DM and their families about the following:

- To maintain enough glucose for adequate milk production, maintain appropriate blood glucose levels, and avoid DKA, patients who breastfeed should consume a daily minimum of 210 g of carbohydrates (Ringholm et al., 2020).
  - Aim for glucose values of 72 mg/dl to 126 mg/dl before afternoon and evening meals and 72 mg/dl to 180 mg/dl at all other times (Ringholm et al., 2020)
- Aim to achieve prepregnancy weight within 3 months to 6 months after childbirth (Ringholm et al., 2020).

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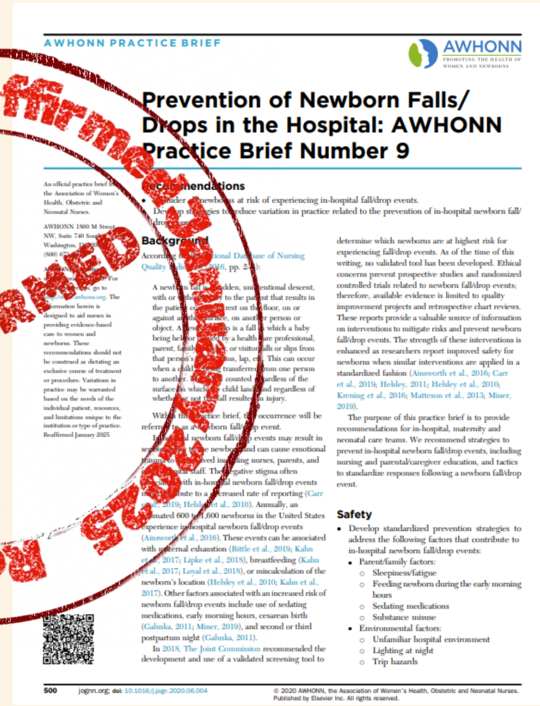
AWHONN Practice Brief #9

Prevention of Newborn Falls/Drops in the Hospital


AWHONN PRACTICE BRIEF

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Prevention of Newborn Falls/Drops in the Hospital: AWHONN Practice Brief Number 9

Recommendations

Background

Safety

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AWHONN Practice Brief #8

Prevention of Newborn Falls/Drops in the Hospital


AWHONN PRACTICE BRIEF

AWHONN

Sudden Unexpected Postnatal Collapse in Healthy Term Newborns: AWHONN Practice Brief Number 8

Recommendations

Background

Outcomes Related to SUPC

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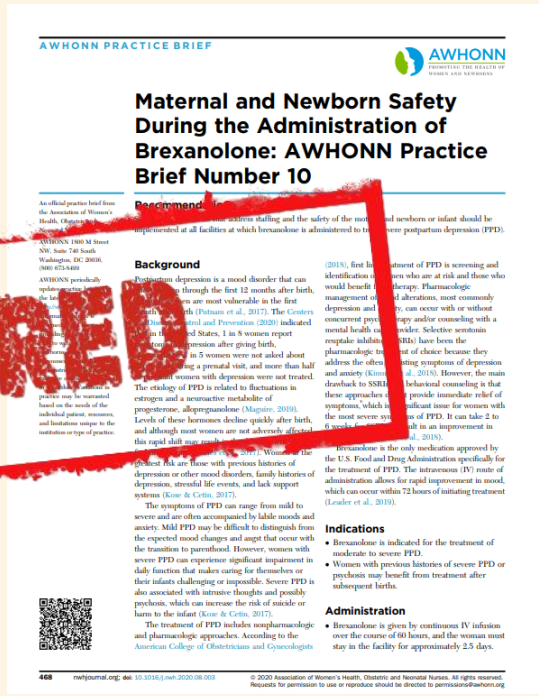
AWHONN Practice Brief #10

Mater & Newborn Safety During the Admin stration of Brexan lone

RETIRED



AWHONN PRACTICE BRIEF

AWHONN

Maternal and Newborn Safety During the Administration of Brexanolone: AWHONN Practice Brief Number 10

Background

Postpartum depression is a mood disorder that can through the first 12 months after birth, en are most vulnerable in the first th (Putnam et al., 2017). The Centers Control and Prevention (2020) indicated in ed States, 1 in 8 women report pression after giving birth, in 5 women were not asked about g a prenatal visit, and more than half women with depression were not treated. The etiology of PPD is related to fluctuations in estrogen and a neuroactive metabolite of progesterone, allopregnanolone (Maguire, 2019). Levels of these hormones decline quickly after birth, and although most women are not adversely affected this rapid shift may result in , 2017). Women at the greatest risk are those with previous histories of depression or other mood disorders, family histories of depression, stressful life events, and lack support systems (Kose & Cetin, 2017).

The symptoms of PPD can range from mild to severe and are often accompanied by labile moods and anxiety. Mild PPD may be difficult to distinguish from the expected mood changes and angst that occur with the transition to parenthood. However, women with severe PPD can experience significant impairment in daily function that makes caring for themselves or their infants challenging or impossible. Severe PPD is also associated with intrusive thoughts and possibly psychosis, which can increase the risk of suicide or harm to the infant (Kose & Cetin, 2017).

The treatment of PPD includes nonpharmacologic and pharmacologic approaches. According to the American College of Obstetricians and Gynecologists (2018), first li atment of PPD is screening and identification o en who are at risk and those who would benefit f therapy. Pharmacologic management o d alterations, most commonly depression and y, can occur with or without concurrent psyc apy and/or counseling with a mental health ca vider. Selective serotonin reuptake inhibito SRIs) have been the pharmacologic tre t of choice because they address the often sting symptoms of depression and anxiety (Kinsr al., 2018). However, the main drawback to SSRI behavioral counseling is that these approaches provide immediate relief of symptoms, which is ificant issue for women with the most severe sy s of PPD. It can take 2 to 6 weeks sult in an improvement in al., 2018).

Brexanolone is the only medication approved by the U.S. Food and Drug Administration specifically for the treatment of PPD. The intravenous (IV) route of administration allows for rapid improvement in mood, which can occur within 72 hours of initiating treatment (Leader et al., 2019).

Indications

- Brexanolone is indicated for the treatment of moderate to severe PPD.
- Women with previous histories of severe PPD or psychosis may benefit from treatment after subsequent births.

Administration

- Brexanolone is given by continuous IV infusion over the course of 60 hours, and the woman must stay in the facility for approximately 2.5 days.

468 nwhjournal.org; doi: 10.1016/j.nwh.2020.08.003

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AWHONN

Position Statements

POSITION STATEMENTS

Academic Preparation of Registered Nurses

Access to Health Care

Adoption *(New)*

Advanced Cardiac Life Support in Obstetric Settings

Advanced Practice Registered Nurse Position *(New)*

Breast Cancer Screening

Breastfeeding and the Use of Human Milk

Confidentiality in Adolescent Health Care

Continuous Labor Support for Every Woman

Contraception and Abortion **NEW**

Elective Induction of Labor

Expert Witnesses in Women's Health, Obstetric, and Neonatal Nursing **NEW**

Fetal Heart Monitoring **Revised April 2024**

Health Information Technology for the Perinatal Setting

Human Trafficking

Infertility Treatment and Fertility Preservation

Intimate Partner Violence

Marijuana Use During Pregnancy

Newborn Screening

Nursing Care of Incarcerated Women During Pregnancy and the Postpartum Period **(Reaffirmed, June 2024)**

Nursing Safety on the Job: Workplace Violence and Personal Protection **(NEW)**

Nursing Workforce Diversity Position Statement **(NEW)**

Optimizing Outcomes for Women with Substance Use Disorders in Pregnancy and the Postpartum Period

Orientation of the Registered Nurse to the Perinatal Setting

Perinatal Mood and Anxiety Disorders

Perinatal Palliative Care **(NEW)**

Prevention of Fetal Alcohol Spectrum Disorders **(NEW)**

Racism and Bias in Maternity Care Settings

Role of the Registered Nurse in the Care of the Pregnant Woman Receiving Analgesia/Anesthesia by Catheter Techniques

Tobacco Use and Women's Health

The Role of Assistive Personnel

The Use of Chaperones during Sensitive Examinations and Treatment

The Use of Licensed Practical/Vocational Nurses in Clinical Settings **(NEW)**

RETIRED

AWHONN, NANN, NPA: Essential Care in the NICU during the COVID-19 Pandemic RETIRED

Emergency Contraception RETIRED

Health Care Decision Making for Reproductive Care RETIRED

Insurance Coverage for Contraceptives RETIRED

Midwifery RETIRED

Rights and Responsibilities of Nurses Related to Reproductive Health Care RETIRED

Women's Cardiovascular Health RETIRED

AWHONN CONSENSUS STATEMENTS

Joint Statement from Leaders in Women's Health on Arkansas Executive Order

Obstetric Care Professionals Recommend RSV Vaccine for Pregnant Individuals

Commitment to Action: Eliminating Preventable Maternal Mortality

AWHONN Joins Nine Other Maternal Health Specialty Organizations in Joint Statement on Roe v. Wade Decision

AWHONN, NPWH and ACNM Release Joint Statement on Roe v. Wade Decision

AMCHP, AWHONN, CityMatCH, NHSA, and NICHQ: Joint Organizational Commitment to Anti-Racism and Racial Equity

International Council of Nurses and European Nursing organizations condemn invasion of Ukraine

COVID-19 Vaccination if You Are Pregnant or Breastfeeding

ACNM, ACOG, ASRM, AWHONN, NPWH, SMFM, SOGH: Leaders in Women's Health Encourage Health Workers to Receive the COVID-19 Vaccine

ENA and AWHONN Consensus Statement: Emergency Care for Patients During Pregnancy and the Postpartum Period

AWHONN CO-PUBLICATIONS

Improving Maternal Immunization Status White Paper

AWHONN RESPONSE STATEMENTS

AWHONN's Response to the Supreme Court Opinion on Access to Mifepristone

AWHONN's Commitment to Inclusivity in Healthcare

AWHONN Response to Philly Pregnancy Center Patient Maltreatment and Abuse

AWHONN Response to ACOG's Practice Advisory on Oxygen Supplementation in the Setting of Category II or III Fetal Heart Rate Tracings

Policy questions, contact Government Affairs

Clinical questions, contact Practice Reference

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AWHONN POSITION STATEMENT

Advanced Practice Registered Nurses

Official Position Statement of the Association of Women's Health, Obstetric and Neonatal Nurses

AWHONN 1800 M Street NW, Suite 740 S, Washington, DC 20036

Approved by the AWHONN Board of Directors, 1990; revised and reaffirmed, June 2005. Revised, retitled, and approved June 2015. Revised, retitled, and approved November 2022.

Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) supports full practice authority for advanced practice registered nurses (APRNs) as independent providers of health care services for women and newborns. AWHONN supports a woman's right to choose and have access to a full range of providers and settings for pregnancy, birth, and women's health care. Women have a right to fair, reliable, and unbiased information about care options so they can make well-informed choices best suited to their individual and family needs. A woman's choice may be influenced by several factors, such as health status; personal circumstances and preferences; and family, religious, or cultural values. Clinicians should respect a woman's health care provider choices.

Background

The Role of APRNs

The APRN designation includes the following roles: certified nurse-midwife (CNM)/certified midwife, certified nurse practitioner (NP), certified registered nurse anesthetist (CRNA), and clinical nurse specialist (CNS). APRNs serve as patient care clinicians, in nursing leadership roles in health care delivery organizations, and as faculty in academic settings.

The APRN consensus model core elements include licensure, accreditation, certification, and education to ensure uniformity across the United States. However, boards of nursing regulations can vary regarding licensure, practice authority, and prescriptive authority (APRN Consensus Work Group & National Council of State Boards of Nursing [NCSBN], 2008).

Throughout the COVID-19 pandemic, APRNs established themselves as critical health care team members, filling gaps regarding access to care and shortages of health care clinicians. However, the lack of certification examinations for specific designated APRN populations, the lack of standardization of licensure requirements, and differences in scope of practice and prescriptive authority made it difficult for APRNs to practice to their fullest capabilities and address the community's health care needs during the pandemic.

The Role of CNMs

Midwifery practice includes health care for women from adolescence through menopause. Midwives partner with women to provide evidence-based, individualized care that consists of the following (American College of Nurse-Midwives [ACNM], 2021):

- primary care and gynecologic care
- family planning
- preconception care
- pregnancy, childbirth, and postpartum period care
- normal newborn care during the first 28 days of life
- treatment of partners for sexually transmitted infections

Midwifery practice facilitates natural processes with an emphasis on the holistic care of women for their families and communities. The midwife collaborates with and refers women and their newborns to qualified specialists, as needed, if complications arise beyond the midwife's scope of practice.

AWHONN supports the Essential Competencies for Midwifery Practice and Global Standards for Midwifery Education as defined by the International Confederation of Midwives (ICM, 2010, 2021), which have been endorsed by the ACNM (2014) and American College of Obstetricians and Gynecologists (2020) as the minimum requirements that should be recognized for practicing in the United States. The ICM defines a midwife as a person who has successfully completed a nationally recognized midwifery educational program that is consistent with the Essential Competencies and the Global Standards framework. Individuals must pass a nationally recognized midwifery certification examination offered by the American Midwifery Certification Board and the North American Registry of Midwives (NARM). Upon certification, individuals must be registered and legally licensed to practice midwifery, demonstrate competency in the practice of midwifery (ICM, 2017), and meet all requisite qualifications for the jurisdiction in which the midwife practices (ACNM, 2014).

It is important to distinguish the differences between a CNM/certified midwife and a certified

AWHONN POSITION STATEMENT

Expert Witnesses in Women's Health, Obstetric, and Neonatal Nursing

Official Position Statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 1800 M Street NW, Suite 740 S, Washington, DC 20036

Approved by the AWHONN Board of Directors November 2024.

Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) asserts that a nurse expert witness should be selected based on skills, knowledge, and experience in the relevant nursing specialty for which the nurse will offer an opinion or testimony. Nurses are not hired based on their affiliation with a specific facility or nursing profesional organization unless the relationship is material to a witness's expertise. Expert opinions may differ between clinicians, but testimony should be based on recognized scientific evidence and best practice recommendations from peer-reviewed sources. Although nurses who are members of AWHONN may provide expert witness testimony, this does not represent AWHONN's endorsement. This position statement offers guidance for nurses providing expert testimony in legal proceedings involving women's health, obstetric, and neonatal nursing to comply with AWHONN's *Standards for Professional Nursing Practice in the Care of Women, Newborns, and People Across the Life Span* (2023) and the American Nurses Association's (2015) code of ethics for nurses.

Background

A nurse expert witness may be hired for various reasons and play an integral role in medical–legal case review and litigation. Women's health, obstetric, and neonatal nursing are the subject of litigation due to the inherently high levels of risk and dynamic nature of these specialties. It is necessary to make a clear distinction between medical malocccurrence and malpractice (American College of Obstetricians and Gynecologists, 2007). Medical malocccurrence encompasses undesirable outcomes unrelated to the quality of care provided, whereas malpractice requires a demonstration of negligence. Nurses may also be called upon to offer opinions in criminal prosecutions regarding the necessity or impact of care.

Nurses who serve as expert witnesses review case facts and identify applicable standards of care based on the clinical circumstances. A medical record review should involve a comprehensive, impartial, and unbiased analysis of data elements and not exclude relevant information to create a view favoring either the plaintiff or the defendant. Once facts are determined, a nurse expert decides if the case has merit and provides an opinion within the scope of nursing practice on whether nurses involved with a patient's care acted within the standard of care.

Opinions and testimony shall reflect the state of nursing knowledge at the time of the event, not what a nurse expert would have done in their clinical practice. These views should be consistent with nationally accepted nomenclature and practice recommendation. Knowledge of community standards may also be required. It is recognized that opinion may change over time based on evolving evidence or best practice recommendations. For example, terms such as "fetal distress" or "reassuring/nonreassuring fetal status" are not supported by the standardized, descriptive terms set forth in the National Institute of Child Health and Human Development consensus statement (Macones et al., 2008).

With some nuances based on state law, the standard of care generally is defined as reasonable care that a nurse would provide in the same or similar circumstances. This is supported by the nursing process, professional guidelines, literature, knowledge, training, and experience. Opinions are based on facts and supported by literature. These opinions shall neither criticize performance that falls within generally accepted practice standards nor legitimize care that falls outside of these standards (Markowitz, 2023). The nurse should not knowingly provide false oral or written testimony. Nurses should only offer causation testimony in jurisdictions where allowed based on their licensure.

The nurse expert assists the court in understanding complex, technical, or scientific issues. However, for purposes of court testimony, only a judge may determine whether a witness is qualified to provide expert testimony in accordance with applicable law. Qualifications of an expert witness are outlined by state or federal rules of civil procedure and

AWHONN POSITION STATEMENT

Nursing Safety on the Job: Workplace Violence and Personal Protection

Official Position Statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 1800 M Street NW, Suite 740 S, Washington, DC 20036

Approved by the AWHONN Board of Directors, September 16, 2024

Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) maintains that nurses have the right to work in safe and respectful environments free from workplace violence, including physical or verbal abuse, harassment, intimidation, bullying, or other disruptive behavior that occurs at the worksite. Furthermore, AWHONN strongly supports and encourages policy initiatives, safe staffing levels, training, and equipment needed to protect nurses on the job and their patients.

Background

Workplace violence prevalence in health care settings is a significant public health issue (International Association of Healthcare Security and Safety, n.d.). According to the Occupational Safety and Health Administration (OSHA), approximately 75% of nearly 25,000 workplace assaults reported annually occurred in health care and social service settings, and workers in health care settings are four times more likely to be victimized than workers in private industry (The Joint Commission [TJC], 2018). Workplace violence is any act or threat of physical violence; harassment; intimidation; bullying; or other threatening, disruptive behavior from patients, patients' family members, external individuals, and hospital personnel occurring in the work setting that creates an explicit or implicit challenge to safety, well-being, or health (American Nurses Association, n.d., 2015b; National Institute for Occupational Safety and Health [NIOSH], 2020). The most common type of violence in the health care setting is a physical or verbal assault against a health care worker by a patient or visitor (Phillips, 2016; TJC, 2018).

The acts of workplace violence against a nurse may exact a heavy physical and emotional toll. The consequences can range in intensity from minor to serious bodily injuries, from temporary to permanent disability, and from psychological trauma to death (NIOSH, 2020). The consequences for organizations and health care systems include harm to staff, loss of team cohesiveness, decreased staff morale, lost productivity, absenteeism, job dissatisfaction, professional burnout, and increased employee turnover (Gates et al., 2011). Furthermore, workplace violence fosters medical errors and contributes to poor patient satisfaction and otherwise preventable adverse outcomes (NIOSH, 2020; TJC, 2008).

Health care settings and underlying health conditions can create an extreme level of stress for patients and their families, friends, and employees. Illness, fear, loneliness, and seclusion are significant contributors to agitation and aggression from patients. Evidence suggests that the implementation of national and local workplace violence prevention policies, situational awareness, environmental assessment training, and building organizational trust reduces the incidence and effect of workplace violence.

The OSHA Act of 1970 requires that, in addition to compliance with hazard-specific standards, all employers provide a work environment for employees that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm" (OSHA, n.d.). Employers have the responsibility, stated in the OSHA Act of 1970, to lessen the hazard. OSHA's five elements of an effective workplace violence prevention program are the following:

1. management commitment and employee involvement
2. worksite analysis
3. hazard prevention and control
4. safety and health training
5. recordkeeping and program evaluation

It is important to note that these guidelines are not enforceable regulations. The guidelines are intended to help organizations implement effective workplace violence prevention programs.

Training and education ensure that employees are aware of potential security hazards and behavioral triggers and how to protect themselves and their coworkers through established policies and procedures. Frequent, evidence-based training also can reduce the likelihood of being assaulted (NIOSH, 2020; Rodrigues

AWHONN POSITION STATEMENT

Nursing Workforce Diversity

Official Position Statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 1800 M Street NW, Suite 740 S, Washington, DC 20036

Approved by the Executive Board, June 1969. Reaffirmed, 1997, 2000, 2005. Revised and reaffirmed by the Board of Directors, November 2010 and March 2016. Retitled, revised, and affirmed by the AWHONN Board of Directors, February 2023.

Position

Diversification of the health care workforce aligns with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) strategic goals. In the 21st century, research supports the continuous efforts to attract, develop, and foster a diverse workforce. AWHONN maintains that developing a diverse nursing workforce is an essential component to attracting the largest possible pool of talent and achieving health equity for childbearing people, newborns, and individuals throughout their life span by increasing concordance in patient–nurse relationships. AWHONN opposes discrimination in the nursing workforce based on ability, age, generation, ethnicity, gender identity, national origin, race, religion, and sexual orientation. AWHONN acknowledges that as our knowledge of diversity continues to evolve, so will our definition of workforce diversity.

Background

The U.S. maternal mortality rates remain high. Adverse birth outcomes for Black women remain disproportionately high, with a rate that is 3 to 7 times that of White women (Howell, 2018; Hoyert, 2022). This disparity is second to women in the American Indian/Alaska Native community. Additionally, the disparate care provided in the care of Black and American Indian/Alaska Native individuals and other people of color (BIPOC) is well documented (Martino, 2022).

According to the Institute of Medicine, the demographic characteristics of the nursing workforce should more closely match the population at large to enhance interactions and communication (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016). Therefore, an increase in the diverse nursing workforce is an essential component to achieving concordance in patient–nurse relationships (Hoyert, 2022).

Race and Ethnicity

Although the U.S. population is becoming increasingly diverse, the current nursing workforce does not reflect the nation's population. The U.S. Census Bureau (2021) indicated that 57% of the population identified as White in 2020; however, the population that identified as multiracial has increased by 276% over the past decade. It is predicted that the U.S. population may be majority non-White by 2050 (Vespa et al., 2020). The nursing workforce, though, is not keeping pace with the U.S. population diversity trends, as only 19% to 24% of registered nurses (RNs) self-reported as being non–White/Caucasian (National Council of State Boards of Nursing [NCSBN], 2021; U.S. Bureau of Labor Statistics, 2020).

While diversity in nursing has improved for the Asian community, which represents 6.1% of the total population and 9.1% of the total body of nurses, other ethnic groups, such as African American and Hispanic populations, have room for improvement. African Americans make up 12% of the population and represent only 4% of the nursing workforce. The disparity between the Hispanic population and the number of Hispanic nurses is even greater: Hispanic individuals represent 18.3% of the population; however, they represent only 7.4% of the nursing workforce (NASEM, 2016).

Schools of nursing and colleges of health sciences have an integral role in contributing to diversity in nursing. A prerequisite for diversification of the workforce begins with strategic recruitment and access to enter the field. Student recruitment strategies require purposeful efforts to be more representative of the population. Between 2010 and 2019, Black student enrollment remained virtually unchanged, advancing from 5.3% to 5.8% (Hampton et al., 2022). Black students are more likely to experience racism and other structural barriers such as attending schools with out-of-date resources and competing financial obligations that impact academic performance. Modifications to admission criteria that include a more holistic approach, considering life experiences and the evaluation of written essays over interviews, can help eliminate this barrier for prospective students.

Changing admission criteria will increase the diversity in enrollment, but work is also needed to support students through the program until graduation. Black students have expressed a lack of belonging as well as feelings of discrimination, difficulty in keeping pace with the curriculum, and financial challenges (National Commission to Address Racism in Nursing, 2022). Mentorship programs that focus on the development of basic skills such as math and writing inclusive of financial incentives have improved