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Enhancing Quality in Perinatal Care: Thirteen Key Barriers to Optimal Maternal-Newborn Nursing Practice

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Abstract
Maternal-newborn nursing has a central role in guaranteeing secure and caring treatment accessible to the mother and her infant. Nonetheless, there are various issues that are still hindering the provision of quality in this field on a regular basis. This paper discusses these thirteen issues, which are important in shaping high-quality maternal-newborn nursing practice: workforce shortages, care disparities, communication barriers, inadequate nursing training, and changing family dynamics. The barriers are discussed within the context of the contemporary clinical settings and best-evidence practices, which can give us an idea of how nurses and health systems may be able to adjust to enhance the final outcomes. It is stated that systemic reforms, cultural competence, and interprofessional collaboration are all important to meet these challenges.

Keywords: ***Maternal-newborn nursing, perinatal care, nursing challenges, clinical excellence, healthcare disparities, patient safety, workforce issues, neonatal outcomes, evidence-based practice, interprofessional collaboration, quality improvement, nursing education, maternal health equity.***

1.Introduction
Maternal-newborn nursing is a professional discipline that takes center stage in health equity, safety and satisfaction during one of the most fragile and changing stages in a human life childbirth and NICU care. Although the world has witnessed significant improvement in medical care and better perinatal outcomes, the quest to achieve excellence in practice is an ever-adapting factor and continues to rely on changing health systems, the social determinant, or clinical model. Research on maternity care in modern practice shows that the framework and the philosophy of the maternity care delivery model play a great role in forming the results among those giving birth and their babies. One of the greatest needs is to extend and incorporate midwifery led and family centered maternity into the mainstream maternity systems. These frameworks that are based on holistic, person-centered care have succeeded in producing positive results in low-risk and some high-risk pregnancies. Nevertheless, there is still a barrier to their full adoption and sustainability in most healthcare frameworks because of systemic and institutional barriers.

The emergence of the midwifery care models can be seen as a paradigm shift of the quite interventionist, traditional obstetrics towards supportive and empowerment oriented maternity care. Certified Nurse-Midwives (CNMs) and direct-entry midwives focus on health promotion education and the provision of uninterrupted labor support, as well as individual care planning, especially in the case of normally pregnant women. The efficiency of midwife-led care in decreasing rates of cesareans, reducing the level of intervention, raising the satisfaction among mothers and raising the results in breast-feeding initiation has been confirmed by various international studies. A landmark comparative study by Sandall et al. (2016) released in The Cochrane Database of Systematic Reviews found that those women who received midwife-led continuity models were less prone to preterm births and more inclined to describe a positive experience in their births(1). This was in line with other countries like the Netherlands, Sweden and the United Kingdom where midwives are the ones who carry out most of the births as the main maternity care providers. Maternal and neonatal mortality rates are also lower in these countries, which, in part, the World Health Organization (2022) could attribute to their investment in a midwifery system.

In the UK, midwifery care has found its place in the general maternal care, however, it has not been embraced fully even though it has shown its effectiveness. The proportion of midwife-attended births in the country is small, with less than 10%, and nearly 60% in countries with developed midwifery (ACNM, 2020). This misrepresentation is usually based on structural reasons, such as issue of limited scope-of-practice acts, lack of institutional supervision, irregular reimbursement systems and interprofessional strains. In addition, access to midwifery services is further undermined by racial and socioeconomic disparities including underserved populations in rural or urban communities where disparities in maternal health are most severe. The process of introducing midwifery

into these areas is both a social justice requirement and an in-depth approach to care. When applied in a non-discriminatory capacity, midwifery models have been demonstrated to help decrease disproportionality in maternal morbidity and mortality among black, indigenous, and other women of color (Vedam et al., 2019).

At the same time, the use of philosophies governing family-centered care should be accompanied by the expansion of the midwifery structure(2). Family-centered care is a change in which the decision-making process shifts to a collaborative approach of involving birthing people, and their supportive environment in the process of care planning without compromising their rights, values, and preferences. It is a method that welcomes the partners, relatives, and support individuals to the process by enabling them to be directly involved in birth preparations, assisting with labor, as well as the recovery following the delivery. The data indicate that this model leads to greater satisfaction with care, better mental health outcomes, and greater attachment and breastfeeding outcomes of infants (Sakala & Declercq, 2018). A report published in 2019 by the National Partnership for Women & Families showed that females who felt fully engaged in their care felt more positive about this experience, more likely to describe their experience as positive and say they trusted their healthcare professionals.

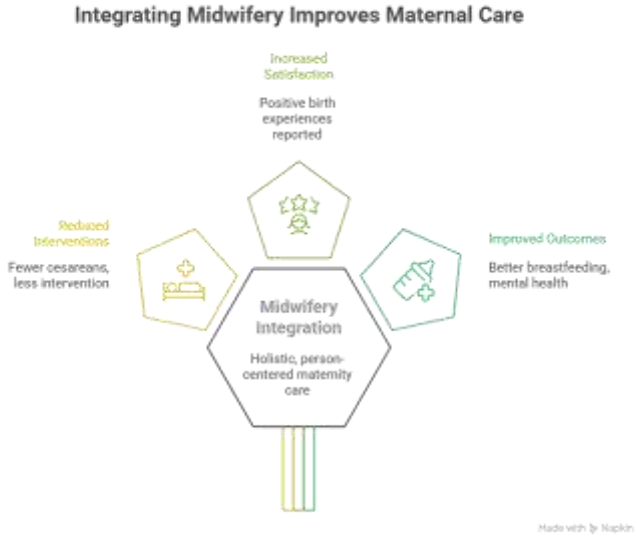

FIGURE 1 Integrating Midwifery Improves Maternal Care

However, to bring about the viability of midwifery and family-centric models on the ground, there is need of concerted effort in many fronts. The education training programs have to be redesigned to ensure the promotion of interprofessional collaboration and mutual respect among midwives, physicians, nurses, and other allied professionals. Hospital regulations and unit cultures should adapt shared model governance, in which the voice of midwifery rises to the leadership and care planning positions. Insurance companies are supposed to provide fair reimbursement of midwifery care comprising births outside the hospital, prenatal care and an extended postnatal contact. Finally, the state and national health policy should eliminate laws that are a barrier to midwives to practice at the highest levels of their licenses.

A possible direction of integration is in the field of collaborative care teams whereby midwives and obstetricians team up in the management of patients according to risk stratification. These models where the care is provided by a team maintain the autonomy of midwives but guarantee that in high-risk situations that a patient requires care that needs a specialist. Such integrated models are successfully provided in birth centers, federally qualified health centers (FQHCs), and large academic medical centers that subsidize midwifery-led units. The programs are regularly linked with less expensive care since there are fewer cesarean births and days in the hospital (Renfrew et al., 2014). Also, the collaborative models boost the morale among the works and decrease the problem of burnouts since the workload is more evenly distributed and the feeling of common cause is strengthened(3).

In the final analysis, the growth trajectory of scope of midwifery and family-centered care in maternal-newborn nursing is not and can never be a policy fancy, but rather an ethical and evidence-based approach to the demands of delivering families in the 21 st century. Technology and protocols alone fail to achieve excellence in practice, and that excellence can be achieved with relationship-based, culturally competent, and compassionate care. Nurse leaders, educators and policymakers should take advantage of the situation and invest in those models using data and fueled by the desire to have equitable, dignified and respectful births.

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2.Rethinking Technology Use in Maternal-Newborn Nursing Practice

Since the technological innovation has no doubt altered contemporary care of obstetrics and young ones, presenting potent equipment of diagnosis, monitoring, and intervention. There is however an increasing amount of evidence pointing to the fact that most of the routine practice in maternal-newborn materials nursing adopt technology use that is either unnecessary, not supported by target-oriented research findings, or even detrimental in cases where they become overused without discretion. This perinatal dilemma poses a serious setback to excelling in the care of perinatal subjects. Curbing the unnecessary use of medical technology, especially in cases of low-edge births would be possible after a review of clinical practices, compliance with evidence-based practice and a paradigm shift towards physiological birth and personalized care(4). The nurses can be in the frontline in promoting safer, more suitable technology use, in line with the patient-centered and family-centered values.

2.1 Unnecessary use of Intrapartum Technologies

Probably one of the most widespread instances of technology abuse in maternity care, the continuous electronic fetal monitoring (EFM) during childbirth is now performed regularly, when, in fact, such practice is highly advised. EFM was introduced initially as a potential way of lowering fetal mortality and morbidity, but nowadays there is hardly a hospital in the U.S. where EFM is not used even in low-risk pregnancies. Nevertheless, even though the prevalence is high, various major professional organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the Association of Women Health, obstetric, and neonatal nurses (AWHONN) have recommended the utilization of intermittent auscultation in low-risk situations due to its equal effectiveness and minimize the actual cesarean sections (Alfirevic et al., 2017). Overuse of EFM has also been associated with higher prevalences of false-positive outcomes of fetal distress, which in turn have led to unnecessary births via cesareans and other procedures, which in turn have exposed both birthing people and infants to unnecessary harms.

The prevalence of the use of the oxytocin in the process of the labor induction or augmentation, at least, in the cases where it is not reflected by the positive effect of the clinical benefit, also contributes to the problem. The trend of induction of labor based on minor changes in fetal electronic monitor heart patterns or maternal status represents part of a larger pattern of defensive medicine generally based on risk aversion, and sometimes at the expense of the normal birth process(5). In cases of low-risk pregnancies, spontaneous labor is demonstrated to be relevant to improved mother and newborn survival rates (Caughey et al., 2009), but there is still high predominance of interventionist treatment in most centers.

2.2 Rates of Cesarean Delivery and Technology

The issue of excessive monitoring, augmentation of labor, is closely interlinked to another phenomenon repeatedly increasing the rate of cesarean delivery, which is opposite to health guidelines in the international arena. World Health Organization (2015) insists that maternal and neonatal mortality is not associated with rates of cesarean delivery higher than 10-15 percent at population level. However, in the United States, c-section rates hover about 32 percent and some attributes to this is overdependence on technology, fear of being sued and institutional bias.

Constant cesarean births particularly, a primary cesarean may result in elevated danger in later pregnancies such as placenta accreta and uterine rupture and surgical issues. Nurses can make a significant difference in reducing those risks by advancing non-interventionist policies, encouraging mobility during labor, and assisting in the communication between the patient and the provider on both the risks and advantages of cesarean and vaginal birth. Moreover, nurses may promote trial of labor following cesarean type (TOLAC) in suitable candidates and encourage development of institutional cultures that give emphasis on vaginal birth following cesarean section (VBAC) which is clinically merited.

2.3 Unjustified Denying Food and Fluids during Labor

Preventing oral intake in labor, yet another result of outdated thinking centered on technology in the care of maternal patients, is yet another example of a technology-oriented thinking. This policy has a long history of being rooted in fears of aspiration under general anesthesia; and regardless of improved anesthesia methods and general use of epidurals, this policy continues to creep along in many institutions. Studies both old and recent continue to demonstrate that food and fluid limitation in otherwise healthy, low-risk women in the labor room is not beneficial and it can only add to their maternal distress and feelings of exhaustion and nervousness (Singata et al., 2013).

Light eating and unlimited access to clear fluid to most women during labor are evidence-based guidelines. Nurses should spearhead the change to contemporary labor policies by attending to educational needs of the employees

and management bodies, updating clinical instructions, and discussing dietary plans with patients. This is a valid justification to this problem and agrees with the international standards of maternity care about a humanising and evidence-based approach to birth.

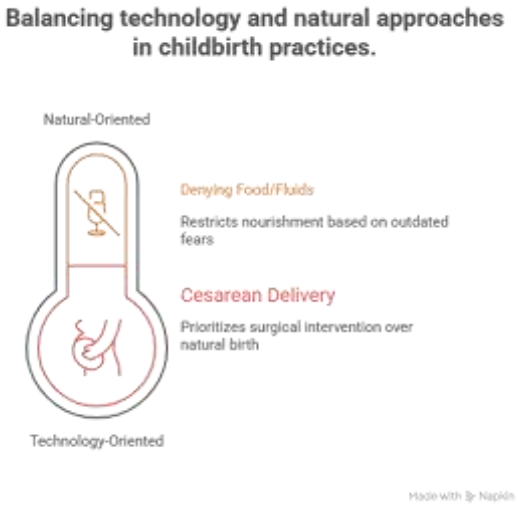

FIGURE 2 Balancing technology and natural approaches in childbirth practices

2.4 Practices on Episiotomy and Vaginal Suturing

Overuse of technology does not go hand in hand only with machines but also procedure interventions that continue without evidence of its significance. As a case in point, lacerations of the perineum that are relatively minor may be sutured routinely, but such practice does not result in any measurable benefits (related to the process of healing or reducing pain), and nevertheless, the routine procedure is largely used by many professionals. Lundquist and other researchers found out that the healing outcome was the same with minor tears did not have stitches done on them as they experienced fewer follow up appointments and fewer disruptions in employing the breast to breastfeed their babies as those who had the stitches. The problem with over-medicalization of the perineal region during childbirth and post parturition is that this phenomenon simply leads to enhancement of the postpartum pain thereby complicating the bonding of the parent and infant at early stages(6).

Nurses are recommended to promote the selective practice of suturing with references to the available evidence and assist midwives and physicians in making clinical decisions with the best interests of mothers in mind rather than focusing on healing and maternal comfort. It is also a huge chance of shared decision-making because women are not to be excluded in the discussion of whether a tear should be stitched or not, at least when the case is of first-degree or second-degree lacerations.

2.5 Advocacy of Physiologic Birth and Informed Choice

One major aspect of decreasing inappropriate technology means educating and encouraging normal physiologic labor and birth whenever safe to do so. Nurses must be the prime supporters of ensuring that labor is not just monitored but active. This can be seen through the promotion of constant support during the labor, movement, role of change of position and alternative pain management techniques such as hydrotherapy, massage, and breathing. Evidence has always established that when labor support is made one-to-one, it shortens the duration of labor, decreases intervention rates, enhances satisfaction (Hodnett et al., 2013).

Promoting physiologic birth also translates into empowering the people who undertake the process of birth via informed consent and decision-making ability. Nurses are able to assist patients by helping them (including evidence-based information on proposed interventions and alternatives). The patient-provider bond becomes stronger when a provider respects the decision of a patient and can refuse or delay the implementation of such measure as EFM, IV fluids, or artificial rupture of membranes, which is an ethical practice of nursing.

In conclusion, the discussion may be summed up as striking a balance between technology and compassionate care.

Maternal-newborn nursing should not be automatic when dealing with technology. In all cases, high-quality care does not equal high-tech care. Improper or overuse of technology in child birth may disrupt normal delivery process, diminish maternal choice and cause complications. Nurses should learn to critically assess technology,

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promote evidence-based clinical decision-making and be involved in supporting the decrease in unnecessary interventions that are not in the best interests of the health or well-being of the birthing person.

Nurses can transform maternity systems toward a more humane, efficient, and equitable future, by advocating low-intervention birth, personalized care planning, and institute transformation(7).

3.Enhancing Patient and Family Teaching in Maternal-Newborn Nursing

Teaching of patients and their families is at the center of maternal-newborn nursing. Perinatal education influences both short-term outcomes to maternal and neonatal health, and they build longer-term family relationships, parental reassurance, and preventive health practices. In the changing and fast paced healthcare sector, the maternal-newborn nurses at the frontline should provide teaching that is personalized, culturally sensitive and developmentally mature to ensure that the families are empowered. However, the essential role is frequently undermined through systemic limitations, variability of priorities and disparity of patient needs and institutional educational principles. The issue is with how healthcare institutions can turn patient education into the dynamic patient-controlled activity, which will allow understanding, skills development, and engagement among highly different populations and family models.

3.1 Improving Your Teaching Gap: Missing Priorities Between Nurses and Patients

Studies repeatedly show that there is a gap between the priorities of nurses in the process of educating patients and those of the patients themselves in terms of what they immediately need or find useful. As shown by Ruchala (2000), nurses usually focus on the newborns: how to feed, soak, sleep, but postpartum mothers are more interested in self-care: how to take care of pain, healing of perineum, fatigue, and mental condition. This discrepancy has the effect of overwhelming, misunderstanding, or not supporting the mothers, particularly when the emotions and physical conditions are at their weakest.

The way out is the needs-based teaching, which is informed by the practice of active listening and open-ended questions. The first thing to be done by the nurses is to determine the gaps that exist in the knowledge the mother and the family already possess, and which topics they consider vital, as well as the preferences in terms of how the family or mother wants to be instructed. At that point, it is possible to customize education in such a way that the most pertinent issues of the patient could be addressed. Creating patients-only educational content enhances memorization, self-certainty, and satiety, which are vital after-effects of family-centered care.

3.2 Engaging Fathers and Support Persons in Labor and Birth Education

The learning process during the child birthing experience need not be applied on the birthing individual only. Family and significant others are important sources of support, but they are usually not well prepared or active participants in the medical system. According to Chapman (2000), the perception of fathers was investigated when being present in the delivery room due to epidural assistance, and most of them were disengaged and powerless stating that the time of their woman partner labour as a confusing stage of their emotional view. Such categories of concept as losing her shows how strong perceived exclusion or loss of control is(8).

This demonstrates why it is necessary to do active education of fathers and birth partners. Prenatal sessions given by nurses and childbirth educators can focus on the partner and incorporate information on labor stages, how best to offer emotional and physical support, expectations upon medications or any issue, and how to be an advocate through decision-making. SWAH videos and virtual reality simulation videos, review or a birth plan and tutorials involving a tangible experience of coaching in labor, can promote confidence and collaboration among patients and their support systems.

3.3 Engaging instruction on a day-to-day basis in the care activities

The use of daily routine care events, as real-time teaching opportunities, is one of the most efficient teaching strategies in maternal-newborn nursing. The newborn bath by Karl (1999), as it is known, is an ideal model. Explaining to parents about newborn reflexes, sensory indicators, skin care and safe handling, by shifting a routine task into a platform of learning, nurses are able to do both: teach parents about newborns; and emphasize the parent-infant bonding.

Such teaching moments in the bedside produce greater effect than lectures or pamphlets, especially in times where the family is sleepless or overwhelmed. As an example, in a situation when a nurse gives a heel prick or vital signs by the bed, they would be able to tell every action, the normal values, and alarming indicators. It makes medical care less mysterious and prepares parents to see the danger home-based signs.

3.4 Teaching Strategies in Trauma Informed Care

The instruction that takes place in the perinatal period should also be responsive to the psychological state and the emotion of the mother. Traumatic labor or delivery experience is reported in a considerable number of birthing people. According to Creedy et al. (2000) results showed that trauma symptoms occurred after delivery in one-third of the women and 5 percent of women met the acute stress disorder criteria.

Here, learning should be presented in a traumatized frame of perspective. This includes creating an emotional safe place, seeking permission before instruction, avoiding judgemental terms, and keep a watchful eye on signs of discomfort. Data about the recovery of the emotional state (including postpartum mood disorders, alterations of the body image, and the time when one should address a specialist) can also be provided by nurses. Laboring with the birthing person through quiet tones, validation and incorporating teaching adjustments into natural moments of care helps to build trust, and mitigate a risk of re-traumatization(9).

3.5 Personalising Health Literacy Education and Cultural Relevance

Not every patient comes with equal a chance to assimilate, comprehend, or reproduce health information. Health literacy continues to be a significant source of determining maternal and new-born outcomes. Education should be modified according to the cerebral capacity of the learner, language and format liked by the learner. In order to serve patients with poor literacy skills, nurses can utilise visualisation, demonstrating, teach-back and translated information that enables patients to access the information.

It is also equally important that cultural competence be included in the teaching of patients. The cultural beliefs influence the view in regard to pain, breast feeding the newborns, postpartum practices and even the use of drugs. As soon as nurses create dominant cultural expectations, they should turn them around and use open-ended questions like, what in your family are the customs regarding the care of newborns? or How do you plan to feed your child? This will help the nurse not to slip past the medical knowledge and patient beliefs, instead, reconcile them.

4.Re-Evaluating the Role of the Normal Newborn Nursery in Family-Centered Maternity Care

With the shift of healthcare to more patient-centered, and whole-body care, the old care provision role of the normal newborn nursery is reconsidered. Historically newborn nurseries were part of the hospital maternity units and provided a specified area where the babies could be observed, evaluated, treated independent of the mother. Recent in evidence and the emerging philosophies of family-centered care have, however, challenged the need and the usefulness of infant and mother separation at birth and in times when there is no poor health among them both. This problem suggests that maternity care providers rethink the automatic implementation of newborn nursery and measure its compliance with the current requirements of bonding, breastfeeding, and parental education.

4.1 Newborn nursery historical Purpose and Institutional logic

The first newborn nursery was initiated in the mid 20 th century, when birth in the hospital became a cultural standard. It was based on infection control, maternal rest and routine monitoring. When paternal participation was minor, rooming-in was unheard of, and nurses could feed, evaluate, and clean effectively and without parental obstruction in the nurse, it maximized the effectiveness of the nursery. The facility was also in line with medicalized model of birth or a model where childbirth was perceived as a medical event and the care disintegrated between mother and infant.

The truth is that these assumptions have over time been questioned by research as well as the changing expectations of families. The modern mothers have a greater chance of being well informed, participating actively in the decisions, and interested in shared care. Such clinical and cultural changes have led institutions to question whether it is actually the most effective (and most responsible) practice to support the separation of well mothers and newborns at all in the way they have always.

4.2 The Rooming-In Advantages: growling and Breastfeeding

The advantages of rooming-in are made by an increasing body of literature regarding keeping the mother with the newborn in a 24/7 basis in the hospital. Rooming-in is greatly linked with enhanced maternal-infant attachment, greater initiation and longer periods of breastfeeding, greater maternal assurance and diminished infant anxiety. The World Health Organization and UNICEF recommend it as part of the program of the Baby-Friendly Hospital Initiative (BFHI), one of ten steps to successful breastfeeding.

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Breastfeeding on demand is possible when infants stay with mothers and this provides a natural rhythm or time when milk is needed and when the infants are hungry. Researchers have indicated that rooming-in results in a decreased duration of time before successful latch and fewer cases of formula supplement (Jaafar et al., 2016). Its continuous physical proximity allows and enables the skin to skin contact which helps to predetermine the temperature of the baby, its heart rate, as well as the blood glucose without any observation in the nursery.

4.3 The Fable of the Repose of the Mother when the baby is not Present

Having a newborn nursery will be one of the major arguments that would encourage others to keep them because they give the mothers relaxation time. Although it is important to have rest during the postpartum recovery process, evidence has shown that it might be easier to find the real rest when the baby is not out there. When the mothers room-in, they get to rest easier having their baby close to them, and they do not have to feel the fear of losing their baby or waiting to get them back after their scheduled visit to the nursery.

More so, in their home, which is where the mothers get to recover eventually, there are no nurseries. Consequently, the rehabilitation during the hospital stay provides a golden chance to recreate the experience that would take place at home and make the mothers learn how to rest along with getting to know more about the needs of the baby. Nurses can facilitate such a balance providing mothers with a coaching on cluster feeding schedules, warning signs of overstimulation, and the necessity to rest together (e.g. when the baby sleeps, you sleep).

4.4 Education Opportunity Between Room-Inning

Rooming-in also enables what is known as real-time teaching which is a must when a mother is only staying in hospital a short period of time as most mothers do nowadays. By keeping the baby in the presence of the mother, the nurses will be able to notice the manner in which the mother administers feeds, putting on and taking off the diapers, swaddling, and calming(10). The face-to-face coaching time is used in order to develop parental competence, as well as recognise any potential signs of trouble, like latch or maternal reluctance.

Also, when the tests are carried out in the bed like the newborn examining, blood taking and vaccinations are taken at the bedside this, it forms a teaching moment to the family. Nurses have the opportunity to tell how every procedure works, how to read the reaction of the child and how to maintain some practices at home. This also provides the nurse with an understanding of the cultural preferences as well as the learning needs of the family making care even more personal.

4.5 Restructuring the Work of the Nursery to the Medical Need

Although the case is very strong in favor of rooming-in, there are still chief instances where newborn nursery would be very useful. By way of example, the babies requiring phototherapy, surveillance of hypoglycemia or surveillance after the usage of medicine by the mother may want momentary isolation into a special nursery. Equally, in case of a mother recovering following surgerized birth or when she is facing vaginal complications, like bleedings or infections, phase treatment in newborn nursery could become requisite.

It is however imperative that in these instances, the nursery does not become a default option but a clinical tool that is threatened when there is clear indication. Besides, when separation is unavoidable, hospitals need to ensure that separation takes the shortest time possible and contact allowed by early reuniting, bedside procedures or even mobile bassinets and partner presence.

4.6 Institutional Issues and Staffing Models

Transformation of a nursery-based into a rooming-in approach requires not the adoption of new policies, but transformation of staffing models and alteration of the culture within the unit. Nurses who are mainly trained in infant care might refer to coaching parents on the bedside reluctantly or be too unprepared to engage in the coaching. In the meantime, not all facilities might have the facilities as needed (e.g., sufficient area of rooms, adjustable bassinets, reclining chairs) to provide comfortable maintenance of continuous rooming-in.

Other institutions that pursue this transition need to buy interprofessional training, such as family-centered communication training, lactation education and cultural sensitivity. Other types of support personnel, such as nursing assistants and postpartum doulas can support the mother through the night and rooming-in is a possibility even when the mothers are too tired or in need of recuperation.

4.7 Family-Based Reproductive Autonomy and Informed Choice

It is also necessary to accept that not every mother will be able or want to room-in all the time. Body and mental fatigue, previous traumatic experience, mental illness, the absence of support among the spouse, and other reasons might be the factors leading to the need or desire to temporarily visit the nursery. In these incidences, nurses are required to respect the ideology of an informed choice by making sure that families are aware of the advantages

of rooming-in and leave it to their own will giving them a chance to do it without conscience or any form of pressure.

Empowerment also includes respecting the decision of a mother that wants to put her baby in the nursery, so she receives a couple of hours of rest, and it also implies the opposite, not interfering with a decision to breastfeed, cosleep, or in case she wants to refuse some intervention.

5.Conclusion and Future work

Technical competence is insufficient to provide maternal-newborn nursing care of high quality: a patient-centered, interdisciplinary, and holistic approach to delivering maternal-newborn nursing care must have clinical evidence, cultural sensitivity, emerging technologies, and patient and family lived experiences in mind. Having reviewed it with respect to thirteen different but interrelated issues, excellence in this specialty is affected by systemic structures and professional preparation, policy frameworks, and practical everyday bedside protocol. Whether a resource or not, every challenge is also an opportunity to reexamine existing models of care and envision nursing practice in a different light in which safety, equity, and dignity are put center stage to every birthing person and their newborns.

The development of recognition in evidence-based, cost-effective, and person-centered alternatives to conventional obstetric practice of midwifery and family-centered models is one of the most fundamental changes which has occurred over the past few decades. A combination of midwives and the encouragement of collaborative care teams results not only in better results but also in the expanded range of options that the families will have. Similarly the use of family-centered practices, i.e., the use of continuous labor support, the involvement of partners, and birth planning on an individual basis allow building a basis of trust and shared decision-making, empowering the patients. Rapid growth of such models, however, presupposes the institutional commitment, innovative regulatory systems and a workforce, trained to interprofessional collaboration and communication.

The high level of tech dependence in the everyday maternity care is another burning issue. Although their selective application may save a life, the failure to apply them selectively, especially in low-risk pregnancy, may result in unwarranted and invasive forces, such as cesarean delivery. It has been showed that non-invasive, assistive measures, i.e. intermittent auscultation, mobility in labor and comfort measures, are shown to produce improved results with reduced complications. Nurses are in the front lines to advocate and need to have confidence to question the routine practices as well as to insist on physiologic birth as much as possible.

The area of excellence that became very important yet had not been considered before was patient and family education. A teaching process cannot be limited to giving discharge instructions or some standardized pamphlets. Rather, education should be dynamic, venerable and based on principles of adult learning. This lack of alignment between what nurses should prioritize (which is the newborn) and what mothers see as a priority (they should take care of themselves) demonstrates that people should be assessed individually and taught taking into consideration their needs and priorities. Furthermore, the greater postpartum adaptation, equal distribution of caregiving is guaranteed by the inclusion of fathers, partners, and extended family in the educational process. Nurse also needs to adopt interactive teaching concepts like demonstrations using their hands and teach-back to instill understanding, particularly among low-health-literacy patients.

The reconsideration of the role of the traditional newborn nursery also indicates the trends of the changing complexion in maternal-newborn care. Even though it was created before to enable observation and efficiency, research findings have revealed that continuous rooming-in facilitates the bonding between the mother and the infant, successful breastfeeding, and early parenting skills acquisition. The concept that mothers and babies are separated to get a good rest proved wrong in most situations when the mother develops anxiety, i.e., they do not notice when one needs to feed, then a lack of empowerment. The focus needs changing towards the establishment of rest-supportive settings in rooming-in models and training nursing personnel so that they may support mothers recuperating physically or emotionally in a sufficient manner.

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Conflicts of interest

The authors have no conflicts of interest to declare

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