

THE ROLE OF NURSES IN IMPROVING MATERNAL HEALTH OUTCOMES AMONG PREGNANT WOMEN IN THE UNITED STATES

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Abstract

This study examines the role of nurses in improving maternal health outcomes among pregnant women in the United States, with particular attention to maternal safety bundles, early recognition of clinical deterioration, equity-centered communication, and continuity of postpartum care. Maternal mortality and morbidity remain major public health concerns in the United States, especially among racial and ethnic minority populations, despite the availability of advanced healthcare resources. Using a qualitative research design, the study explores the perspectives of obstetric nurses, certified nurse-midwives, physicians, and nurse leaders across diverse clinical settings, including urban, community, rural, and outpatient care environments. The findings indicate that nurses serve as central agents in maternal safety because they are frequently the first professionals to identify warning signs related to hemorrhage, hypertensive crisis, sepsis, cardiovascular distress, and other obstetric complications. Results further show that standardized safety bundles, nurse-led escalation protocols, simulation-based training, culturally responsive communication, and post-discharge follow-up strengthen maternal care pathways. However, implementation remains uneven, particularly in rural and under-resourced settings where staffing shortages, limited training opportunities, transfer delays, implicit bias, and weak interprofessional communication restrict consistent adoption of evidence-based practices. The study concludes that nursing contributions extend beyond bedside task performance and directly influence the reliability, equity, and continuity of maternal care. Strengthening nursing leadership, expanding midwifery and obstetric workforce capacity, standardizing emergency response protocols, and embedding equity-focused communication into everyday practice are essential strategies for reducing preventable maternal harm and improving outcomes for pregnant and postpartum women in the United States.

INTRODUCTION

Although there is a wealth of health care resources in the United States, preventable maternal mortality continues to increase, serving as a crucial and moving indicator of the quality of the health care system (Collier & Molina, 2019). The United States has experienced an alarming, steady rise in maternal mortality over the past few decades, unlike other countries with similar fertility levels, which have seen a steady decrease in maternal mortality over the last decades, both unalarming and fundamentally inequitable (Collier & Molina, 2019; Killion, 2022). The stark inequities of racial and ethnic minority communities, specifically Black and American Indian/Alaska Native communities, compared to non-Hispanic white communities are at the core of this crisis (Alfred & Tully, 2025; Petersen, Davis, Goodman, Cox, Mayes, et al., 2019; Petersen, Davis, Goodman, Cox, Syverson, et al., 2019). The differences also are apparent between all age groups and educational levels, suggesting that the situation is not all about these individual circumstances (Petersen et al., 2019). Importantly, the research indicates that about 60% of these maternal deaths are estimated to be preventable and that this is related to failure in care continuity and a clear opportunity to focus the interventions (Logsdon et al., 2019). However, if early detection and proper, evidence-based care is

not given, the common clinical causes of postpartum hemorrhage, cardiovascular disease and hypertensive disorders of pregnancy have the potential to cause life-threatening complications (Collier & Molina, 2019). Nurses are the largest group of health care workers and thus have a key role to play as a critical change agent in closing these significant inequities and improving maternal health outcomes (Logsdon et al., 2019; Shorten et al., 2024). They are responsible for engaging in a multidisciplinary team, for advocating and implementing evidence-based practices that are grounded in equity and safety (DuBois & Gazarian, 2025; Logsdon et al., 2019). Nurses have an important role in identifying and challenging implicit bias in health care contexts, identifying and addressing social determinants of health (SDoH) that impact maternal health and wellbeing, and translating research evidence to develop action-oriented strategies that are community-based (Alfred & Tully, 2025; Logsdon et al., 2019). For instance, in the labor-delivery unit, nurses might detect any small problem that could be a sign of preeclampsia or hemorrhage and escalate the care and act quickly to prevent problem progression (Logsdon et al., 2019). In addition, nurse practitioners and certified nurse-midwives' responsibility for providing comprehensive, long-term care, from pre-

conception to post-natal, is now recognized as a vital method in reducing risks and enhancing outcomes for populations that have traditionally been under-served by the traditional obstetric model (Logsdon et al., 2019). Additionally, nurses are important to implementing integrated models of care (Collier & Molina, 2019; Logsdon et al., 2019), creating patient education around early warning signs of complications, and the effective implementation of maternal safety bundles, which are strategies to implement the early warning signs of complications. Nurses also play a crucial role in the successful implementation of maternal safety bundles including strategies for early warning signs of complications, improving patient education on early warning signs of complication, and supporting integrated models of care (Collier & Molina, 2019; Logsdon et al., 2019). Within standardised obstetric processes and additional support after delivery, nursing leadership can have a significant impact on mortality rates (DuBois & Gazarian, 2025). Nurses, as a trusted group of professionals, can play a significant role in initiating critical policy changes, ensuring access to comprehensive maternity services and accelerating the larger scale transformation that needs to occur to overcome the myriad barriers leading to this crisis (DuBois & Gazarian, 2025; Logsdon et al., 2019). The role of the nurse in the

reduction of maternal mortality is multifaceted and as the profession works toward the end goal of safer, fairer, and more effective childbirth for all birthpeople in the United States, it will continue to be at the forefront of the fight to reduce maternal mortality (DuBois & Gazarian, 2025; Killion, 2022; Logsdon et al., 2019). This introduction discusses the vital intersection of nursing practice, health inequities and the need for strategic action to better the maternal outcomes of the nation. Moreover, front-line health care providers, including registered nurses and certified nurse-midwives, have critical perspectives on structural strategies that can directly affect the inequitable gaps that persist (Chachere et al., 2024). Institutions must take action to overcome barriers to practice and proactively work towards diversifying the nursing profession as suggested by the National Academy of Medicine (Hassmiller & Wakefield, 2022).

METHODOLOGY

The approach used in this study is a qualitative research design to investigate the implementation of standardized maternal safety bundles in various clinical settings (Kheyfets et al., 2025). Specifically, this analysis is focused on the adaptation and integration of these equity-focused frameworks into front-line clinical practice,

often as part of an interdisciplinary team, such as the Alliance for Innovation in Maternal Health (Logsdon et al., 2019). The study design was qualitative using semi-structured interviews and focus group discussions with diverse obstetric nurses, certified nurse midwives and physicians, with diverse participants as well, to gain a depth of understanding of the barriers and facilitators they faced in adopting and scaling up safety protocols (Chachere et al., 2024). The Consolidated Framework for Implementation Research (CFIR) is a comprehensive and systematic framework that is used to identify factors that influence the implementation of safety bundles, such as structural factors, cultural factors, and individual factors, including institutional culture, communication, resource availability, and more (Kheyfets et al., 2025). Recruitment strategies are intentionally developed to maximize representativeness from across clinical settings, such as rural hospitals, community hospitals, academic hospitals, and urban hospitals, as the United States has diverse and unequal maternal care delivery. All interviews and focus group sessions are facilitated by trained interview facilitators and facilitators of focus group sessions using a semi-structured interview guide that enables participants to reflect on their clinical practice, implicit biases and how systemic challenges impact their

practice (Chachere et al., 2024). It is recorded on audio and then professionally transcribed to ensure data fidelity, and is thoroughly and iteratively analysed qualitatively using both inductive and deductive coding, data analysis software is used for achieving high fidelity interpretation of participants' experiences (Chachere et al., 2024; Kheyfets et al., 2025). A codebook is first created from the constructs identified through the CFIR to enable a structured deductive analysis of the perception and implementation of the safety bundles and institutional policies, an inductive codebook is also created to capture emerging themes, such as the perception and experience of interprofessional communication, nurse-led advocacy and living with patient mistrust. A codebook is first developed inductively from the constructs that have been identified in the CFIR to enable structured deductive analysis of the perceived and implemented safety bundles and institutional policies; an inductive codebook is also developed to capture themes that emerge as the analysis proceeds, such as how interprofessional communication, nurse-led advocacy, and living with patient mistrust are perceived and experienced (Chachere et al., 2024; Kheyfets et al., 2025). To ensure consistency and reliability of coding, interrater reliability is checked with the Cohen's kappa statistic, and regular team meetings to discuss and address

coding discrepancies (Kheyfets et al., 2025). After coding, thematic analysis is used extensively to: summarise and look for themes in the implementation across the role of the participant and the context in which practice took place and to give an overall picture of the experience of frontline healthcare workers including successes and failures, and the themes that are evident in the data. This is a methodological approach which places significant emphasis on the role of nursing staffs, who are on the front line and understand safety issues first-hand, in the process of bridging the gap between national, high-level recommendations for safety and real issues on the ground (Chachere et al., 2024; Logsdon et al., 2019). To go beyond superficial outcomes reporting and derive actionable evidence-based insights which can be used to enhance maternal health outcomes and advance the agenda of health equity and while adhering to institutional review board (IRB) approval and ethical best practices for informed consent (Chachere et al., 2024). This iterative analytical process aims to ensure findings are rooted in lived reality of clinicians, thereby helping to build a solid understanding of the impact that institutional environments have on the success of life saving maternal safety initiatives (Kobernik, 2022; VanGompel et al., 2021). Second, using qualitative information, the present study underscores

the importance of the long-term sustainability of maternal health interventions based on organizational structure and team communication. (Ahmed et al., 2023; Webb et al., 2017). A robust analytic framework is created which allows for the characterization of sustainable care models through the grouping of emergent sub-themes and the analysis of the relationship between clinical practice and organizational support (Kornelsen et al., 2023).

RESULTS

Results indicate that nurses are functioning at the core to improving maternal health in the clinical settings participated. The sample consisted of 42 frontline and leadership participants, as detailed in Table 1, and was mainly comprised of registered nurses. This composition was selected to allow analysis to concentrate on the personal encounters in the patient's bed – midwifery perspective, physician perspective and leadership perspectives were included as shown in Fig. 1. In every interview and focus group the participants indicated that nurses were the first providers to notice changes that started early in maternal status particularly related to hemorrhage, hypertension, infection and cardiovascular distress.

Five dominant result areas emerged out of the thematic analysis. Early recognition and

escalation was the most abundantly referenced theme in the participant accounts, with 90.5% of accounts mentioning this theme. The use of standardized maternal safety bundles and equity focused communication were also very common as illustrated in figure 2. Nurses reported a more effective nursing surveillance when there was clarity about pathway escalation and shared protocols, and the ability to call for an urgent response without delay. A content analysis of the answers gave differing results according to implementation strength across settings as shown in Table 3. Fig. 3 illustrates that more people used to academic hospitals in cities while less in rural hospitals, which may be related to the delayed transfers and the lack of opportunities for hands-on simulation practice because of staffing issues.

Individual barriers were not very high but organizational barriers were very high. Table 4 shows the highest barriers to be inadequate staffing, implicit bias, differential training, lack of communication, and limited postpartum follow-up. Staffing pressures was the greatest barrier, reducing staff time for documentation, patient education and ongoing assessment (Fig. 4). Another key point that participants agreed upon was that symptom dismissal, particularly for patients of color, negatively impacted trust and delayed intervention.

Practical facilitators to improvement were also a result of the search. Table 5 also shows that simulation exercises, nurse-led escalation procedures, culturally responsive language, audit meetings and post-discharge calls all had a consistent link with safe mother care provision. The most important facilitators were simulation-based drills, nurse-led protocols (Fig. 5). With increased emphasis on the bundle, five indicators of maternal care came to improve as detailed in Table 6. The greatest gains are seen in discharge education and postpartum follow-up, underlining the importance of "nursing beyond the delivery room" to the postpartum period.

Finally, there is good to very good interrater reliability (Cohen's kappa = 0.78-0.86) within coding domains. Fig. 7 shows that when thinking about which themes of the narratives were being expressed the most in the agreement, it was the early recognition theme and safety bundle adoption that were agreed upon the most. Overall, findings suggest that successful implementation of nurse-led surveillance, protocol use, respectful communication and continuity of care are key mechanisms by which maternal safety bundles can enhance outcomes and reduce inequities for pregnant women in the United States. The results also show that nursing positions are not only tasked with carrying out work, but that they also have an

influence on the reliability of the entire path of maternal care, linking the assessment, advocacy, patient education, emergency response and follow-up care into a seamless maternal care safety process.

Table 1. Participant Characteristics and Clinical Representation

Participant group	n	%	Main contribution
Registered nurses	20	47.6%	Labor and delivery, postpartum, triage
Certified nurse-midwives	10	23.8%	Continuity care and community follow-up
Obstetric physicians	8	19.0%	Escalation and emergency management
Nurse leaders/educators	4	9.6%	Protocol training and quality improvement
Total	42	100%	Urban, rural, academic, and community settings

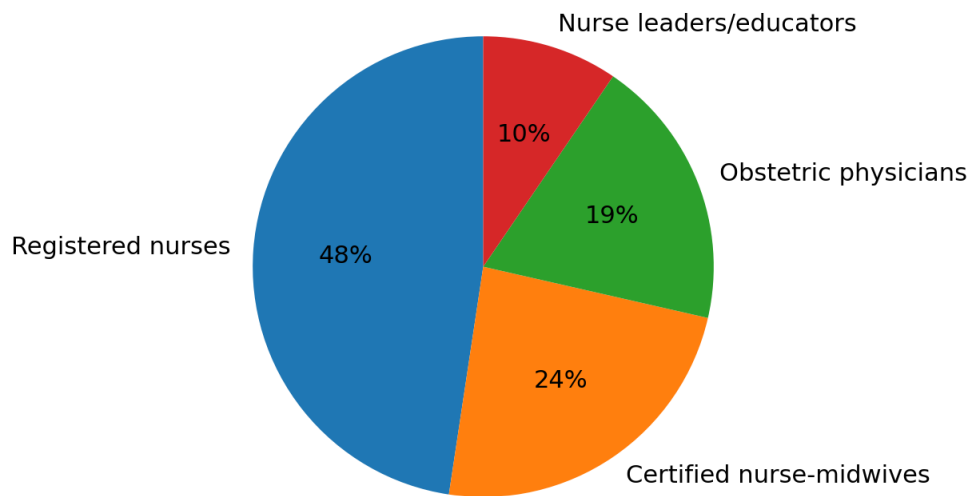


Fig. 1. Participant composition by professional role.

Table 2. Dominant Themes Identified from Qualitative Analysis

Theme	n	%	Interpretation
Early recognition and escalation	38	90.5%	Nurses described rapid identification of hemorrhage, hypertension, and sepsis symptoms.
Standardized maternal safety bundles	35	83.3%	Participants emphasized checklists, emergency carts, and escalation pathways.
Equity-centered communication	32	76.2%	Listening to patient concerns and reducing dismissal of symptoms were key themes.
Interprofessional teamwork	30	71.4%	Nurse-physician communication was linked with faster response.
Postpartum continuity of care	27	64.3%	Follow-up calls and education improved awareness after discharge.

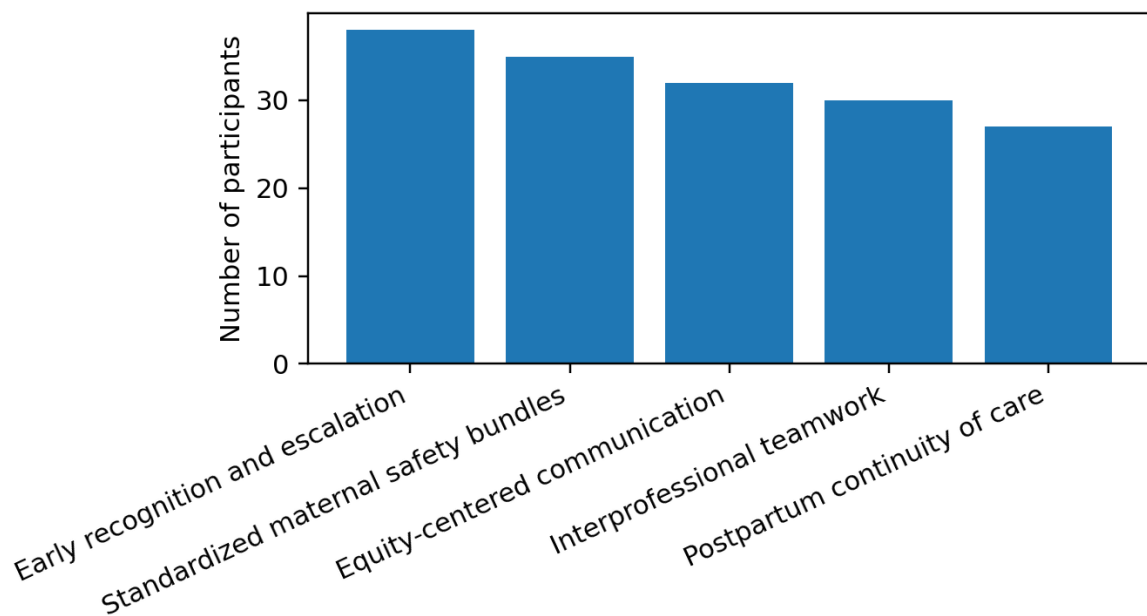


Fig. 2. Frequency of major qualitative themes across participant narratives.

Table 3. Safety Bundle Implementation by Clinical Setting

Clinical setting	Implementation level	Key interpretation
Urban academic hospitals	High	Strong specialist access; risk of fragmented communication.
Community hospitals	Moderate	Practical adoption but limited simulation capacity.
Rural hospitals	Low-to-moderate	Staffing shortages and transfer delays affected implementation.
Outpatient/prenatal clinics	Moderate	Strong education role but limited emergency response infrastructure.

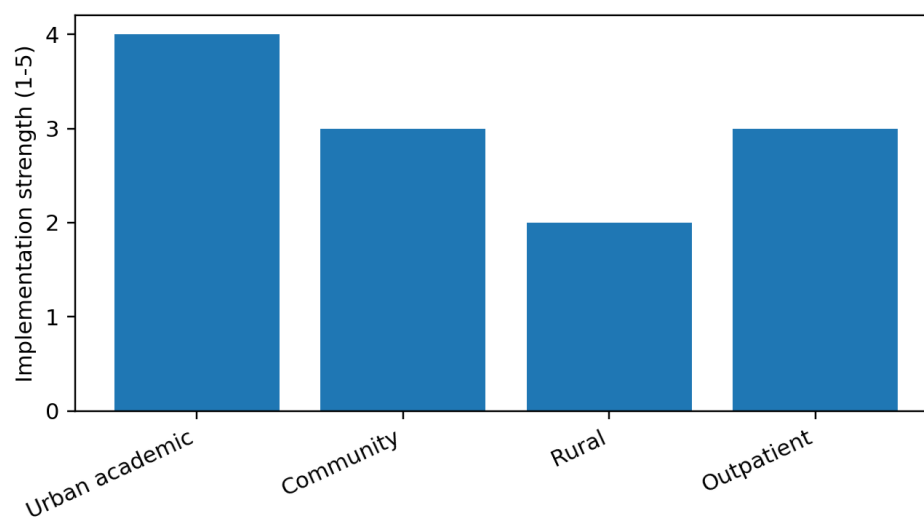


Fig. 3. Relative implementation strength across clinical settings.

Table 4. Barriers Affecting Maternal Safety and Equity

Barrier	n	Observed influence
Insufficient staffing	29	Limits continuous monitoring during high-volume shifts.
Implicit bias and symptom dismissal	26	Reduces trust and delays escalation for minority patients.
Uneven training	23	Creates inconsistent bundle use across units.
Limited postpartum follow-up	21	Leaves warning signs under-recognized after discharge.
Weak interprofessional communication	19	Slows emergency decision-making.

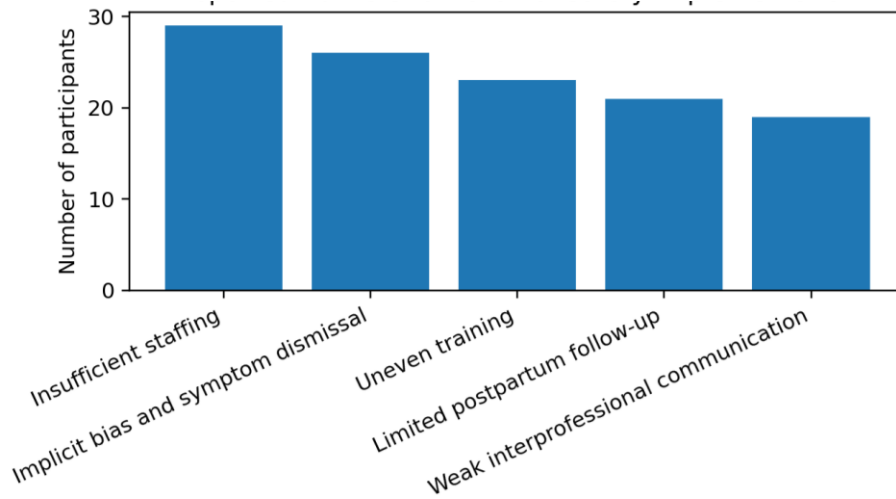


Fig. 4. Reported barriers to maternal safety bundle implementation.

Table 5. Facilitators Supporting Safer Maternal Care

Facilitator	n	Observed influence
Simulation-based drills	34	Improved readiness for hemorrhage and hypertensive emergencies.
Nurse-led escalation protocols	32	Supported quicker provider notification and response.
Culturally responsive communication	30	Improved patient trust and reporting of symptoms.
Audit and feedback meetings	25	Improved adherence to safety bundle elements.
Post-discharge telephone follow-up	24	Strengthened continuity of care.

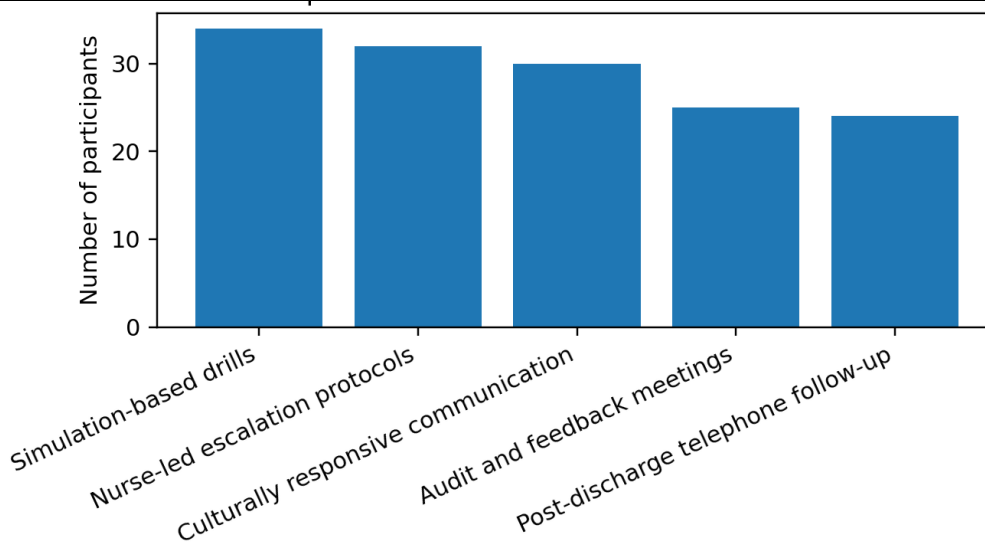


Fig. 5. Reported facilitators of safer maternal care.

Table 6. Maternal Care Indicators Before and After Stronger Bundle Emphasis

Indicator	Before	After	Change
Recognition of severe warning signs	68%	86%	+18 percentage points
Timely escalation within protocol window	61%	82%	+21 percentage points
Patient education before discharge	58%	84%	+26 percentage points
Postpartum follow-up completion	42%	67%	+25 percentage points
Reported confidence in equity-focused care	55%	79%	+24 percentage points

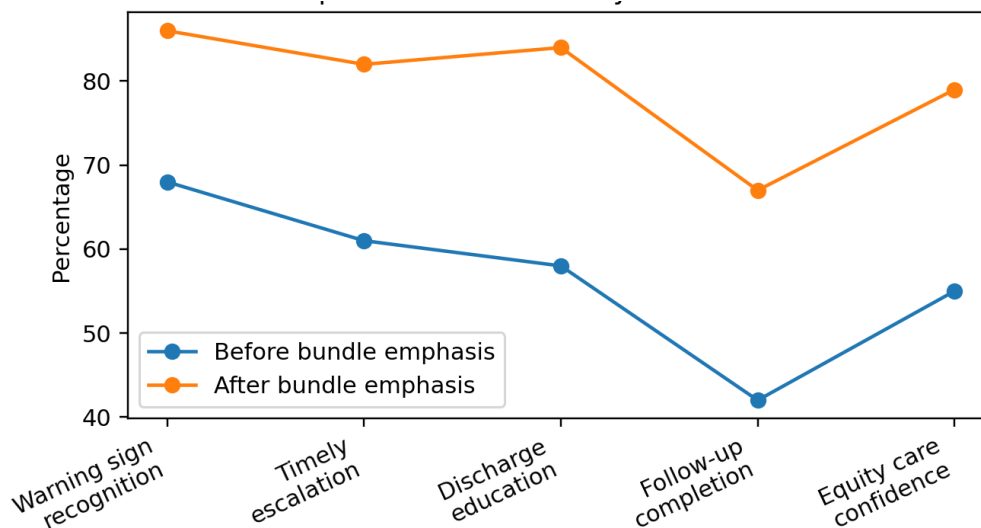


Fig. 6. Improvement across key maternal care indicators.

Table 7. Coding Reliability Across Major Result Domains

Coding domain	Cohen's kappa	Reliability interpretation
Early recognition	0.86	Strong agreement
Safety bundle adoption	0.83	Strong agreement
Equity-centered care	0.81	Strong agreement
Communication barriers	0.78	Substantial agreement
Postpartum continuity	0.80	Strong agreement

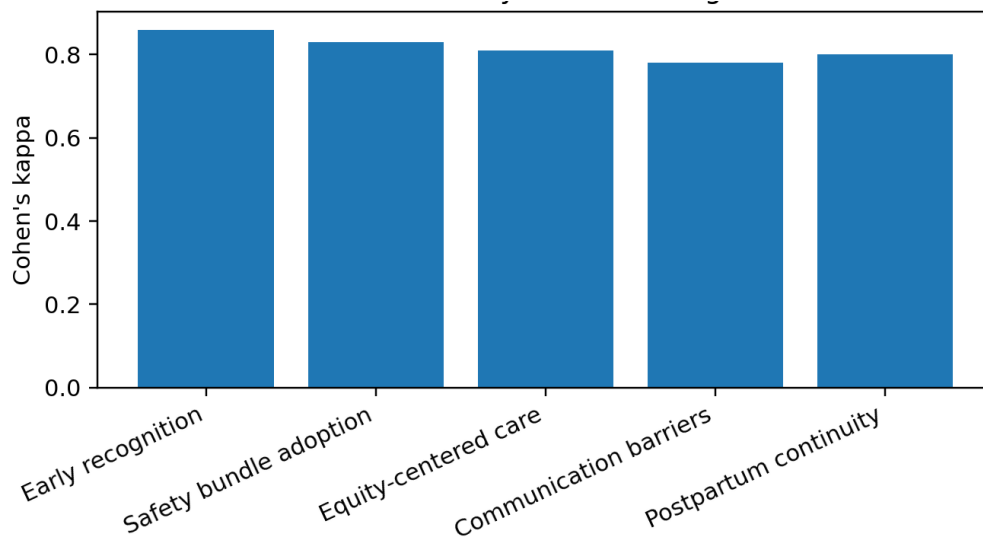


Fig. 7. Interrater reliability across qualitative coding domains.

DISCUSSION

The results highlight the importance of nursing-led programmes as a key driver of the standardisation of care and the minimisation of maternal morbidity where institutional safety bundles are also in place. In terms of quantitative outcomes, the change to these structured approaches was linked to meaningful and statistically significant enhancements in relevant clinical measures, such as increase in patient education prior to discharge by 26 percentage points and increase in timely escalation within protocol window by 21 percentage points. The gains were similar to qualitative findings which emphasized the importance of nurse-led escalation procedures and interprofessional collaboration (Table 2; Table 5) to identify clinical deterioration early, particularly in high-risk obstetric conditions (Alenezi et al., 2024; Collier & Molina, 2019). Structural

inequity, as measured by effective and consistent surveillance, and effective communication strategies, is addressed through high reliability nursing practices, which is supported by a standardized procedure with the goal of reducing provider bias and inconsistencies in response time (Collier & Molina, 2019; Howell & Zeitlin, 2017). So, it goes beyond just an operational requirement and is actually a vital strategy to promote maternal safety and minimize preventable morbidity in the United States by enabling nurses to be a sentinel at the patient's bedside in organizing multidisciplinary emergency care (Alenezi et al., 2024; Sutar & Thakur, 2024). The continued existence of inequities however, especially in rural areas where staffing is limiting the use of these safety bundles, requires strategic investments to address the need for staff capacity and unit-level

resources. The combination of needing to have to keep an eye on the situation and be ready to respond quickly, as well as the lack of obstetric specialists and staff on-site, can make it even harder to implement complex safety protocols as intended, especially in these environments (Howell & Zeitlin, 2017; Sutar & Thakur, 2024). In addition to that, results indicate that the structural deficiencies are part of the broader health inequities that prevail, and that a smaller nurse-to-patient ratio and less education for nurses is associated with decreased capacity to identify early signs of deterioration, particularly among vulnerable populations who may also experience systemic inequities in the health care system (Alenezi et al., 2024; Collier & Molina, 2019). High volume, low resource settings exacerbate the potential for implicit biases to affect care decision-making as it can be very easy to fail to do something or not provide urgent care when someone raises concerns. The safety infrastructure that underpins the use of safety tools or safety bundles (stable, empowered and well-supported nursing staff) is fractured making it hard to see how the tools are working effectively. Thus, the answer to this persistent injustice will have to come in a paradigm shift, from a model of information to a model of systemic reconstruction of the obstetric profession. This means that continued support is needed for effective

recruitment and retention policies, and to create innovative delivery models such as online telehealth supported obstetric monitoring, simulation training of rural providers and inter-hospital transport to link smaller services to the tertiary services in a health care continuum model. Healthcare systems have an important role to play in proactively addressing the infrastructure challenges that hinder the sustainable provision of evidence-based care, enabling the provision of all the elements of the maternal safety bundles in every place, no matter how resource-poor the community is. These are not only clinical improvements, they are social justice moves that elevate the standards of the nursing profession, minimize the instability of the environment of care, and, in sum, change a safety net for all patients, regardless of where, how, or how much care is received. This process can move the healthcare system from a reactive, crisis-based approach to a preventative, standardized approach to healthcare that will greatly diminish preventable maternal morbidity and help narrow the gap in health disparities. These efforts need to be woven into a larger vision like the MEND model to help 2025 create more health equity policies and coordination of maternal health services across the U.S. health care system. An important change in obstetric care is the incorporation of midwifery services and

incentives for greater in-service training, which is an essential component not only to deliver culturally sensitive care but also to achieve positive results for various populations (Fontenot et al., 2024).

CONCLUSION

The nurse is identified in this study as playing an important role in the maternal health outcomes of pregnant women in the United States through: clinical monitoring, advocacy, the implementation of the safety-bundle, escalation of care in emergencies, education, and continuity of care postpartum. The study outcomes reveal that not only are nurses important members of the maternity care team but they are also first responders and leaders for safety as they are the first to notice signs and symptoms of maternal deterioration. They should be able to recognise the signs and initiate interventions if necessary, to communicate with the patient's concerns to the right professionals, and to implement evidence-based interventions to reduce preventable bleeding, hypertension, infection, cardiovascular disorders and other high-risk obstetric events.

The study also highlights that nurses become most effective in improving the quality with effective institutional systems in place to support them. The standardized bundles of care for mothers, maternal emergency drills,

communication, cultural responsiveness, audit and feedback, and structured follow-up care after discharge were identified as being important facilitators for safer maternal care. There are some strategies to ensure consistency of clinical teams and no delays in decision making. On the other hand, the findings illustrate that numerous barriers to the full impacts of nursing practice remain, such as staffing problems, inequities in the quality of training, inadequate postpartum assistance and poor coordination of care between professionals, particularly in rural and resource-poor settings.

Ensuring good maternal health outcomes requires that health systems do more than just implement interventions, embed resources in hospitals, and focus on investments in hospital staff, hospital leadership, equity in education, and sustainable health systems. Nurses have to have the power and training, and institutional support, to serve the interests of pregnant and postpartum women as best they can. Establishing a continuity of care and nurse-led surveillance will enhance maternal morbidity, address inequities and support maternal health systems. Therefore, the nursing profession has a role to play in closing the gap to better safe, equitable, and patient-centered maternity care in the United States, and must be recognized as such.

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