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СОДЕРЖАНИЕ

МЕДИЦИНСКИЕ НАУКИ

МЕДИЦИНСКИЕ НАУКИ

APPLICATION OF OASIS-E PROTOCOLS FOR ASSESSING THE QUALITY OF HOME ENDOCRINOLOGICAL CARE

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ABSTRACT

The article examines the characteristics of applying the unified OASIS-E (Outcome and Assessment Information Set-E) toolkit for assessing the quality of outpatient care for patients with endocrinopathies, predominantly those suffering from diabetes mellitus. The aim of the article is to evaluate the suitability of the basic OASIS-E protocols and to propose adaptations that enhance the accuracy of monitoring the quality of home endocrine care. The methodology includes an analysis of CMS (Centers for Medicare & Medicaid Services) regulatory and legal documentation and a review of specialized publications from recent years. The results demonstrate that although individual elements of OASIS-E partially reflect the status of patients with endocrine disorders, they do not encompass fundamentally important disease management indicators — glycemic control parameters, insulin self-administration technique and the level of patient awareness of their own condition. In this regard, an enhanced assessment model is proposed, supplementing the standard protocol with specialized indicators. The findings confirm the necessity of implementing revised protocols for a more objective evaluation and optimization of clinical outcomes. The presented materials will be useful to home care organization managers, practicing clinicians, quality assurance specialists and researchers in the field of health services organization.

Keywords: OASIS-E, endocrinology, home care, quality of medical care, diabetes mellitus, QAPI, outcomes assessment, compliance, disease management, telemedicine

Introduction

The increase in the prevalence of chronic endocrine diseases, primarily diabetes mellitus, against the backdrop of a global demographic trend of population aging dictates the necessity to expand home healthcare delivery systems. In 2021, diabetes entered the top ten leading causes of death worldwide. In lower-middle-income countries, it became an increasingly serious threat, rising from the fourteenth to the eighth position among leading causes of death. In 2024, diabetes remains a global public health challenge, with the number of individuals affected by this disease projected to continue increasing. Diabetes is widely prevalent in the United States, affecting 8.9% of the population, which corresponds to over 29 million individuals [1]. The shift in emphasis from inpatient treatment to outpatient and home-based care models underscores the need for process standardization and the development of objective criteria for evaluating the quality of such services. In the United States, the principal instrument for this purpose is the Outcome and Assessment Information Set (OASIS), mandatory for all home health agencies accredited by the Medicare program. The OASIS-E edition, implemented on January 1, 2023, provides for expanded data collection on social determinants of health and patients' cognitive functions, representing a significant advancement in the assessment of healthcare outcomes [2]. Nevertheless, despite its multifaceted nature, this instrument remains universal and does not always offer sufficient sensitivity when evaluating the quality of care for patients with highly specialized nosologies, such as endocrine pathologies. The scientific literature notes a lack of studies dedicated to the adaptation and validation of OASIS-E protocols with respect to specific nosological groups.

The aim of this article is to evaluate the suitability of the basic OASIS-E protocols and to propose adaptations that contribute to enhancing the accuracy of monitoring the quality of home-based endocrine care.

The novelty of this study lies in the development of a conceptual foundation for the inclusion of disease-specific endocrine biomarkers within the unified OASIS-E model. To the best of the author's knowledge, the proposed methodology is the first to integrate differentiated parameters specific to endocrine disorders into the OASIS-E system, which is designed to support home health care for this patient population. The study's hypothesis is based on the premise that integrating targeted metrics reflecting the management nuances of patients with endocrinopathies into the core clinical protocol will enhance the validity of quality-of-care assessments and establish a solid basis for the development of effective Quality Assurance and Performance Improvement (QAPI) programs.

The author's hypothesis is based on the premise that supplementing the standard protocol with targeted indicators reflecting the specifics of managing patients with endocrinopathies will improve the precision of care quality assessment and serve as the basis for the development of effective Quality Assessment and Performance Improvement (QAPI) programs.

Materials and methods

With the growing global prevalence of diabetes mellitus and the increased burden on healthcare systems, the issue of improving the quality of endocrine care in home settings becomes increasingly relevant. According to Global Diabetes Statistics 2024, at the beginning of 2024 the number of patients with diabetes worldwide exceeded 537 million people [1], which is corroborated by the rising trend in hospitalizations due to diabetes complications in the United States (Rubens M., et al. [8], Aloke C., et al. [9]). These data underscore the need to implement unified protocols for assessing the quality of home visits and remote monitoring capable of ensuring timely therapy adjustments and reducing the risk of hospitalizations.

The primary body of work on the direct application of telemedicine technologies in the care of patients with diabetes consists of reviews and meta-analyses of the effectiveness of remote monitoring. Mad Robson N., Hosseinzadeh H. [3] conducted a meta-analysis of randomized controlled trials in primary care for type 2 diabetes and demonstrated a statistically significant improvement in HbA1c levels among patients receiving telehealth interventions compared with conventional outpatient care. Udsen F. W., et al. [4] demonstrated that telemedicine solutions facilitate more frequent patient–provider interactions, which correlates with improved glycemic control and a reduction in the number of hypo-/hyperglycaemic episodes. The authors emphasize the necessity of unifying evaluation criteria and standardizing monitoring protocols, a requirement that directly resonates with the objectives set forth in the Oasis e guidance manual [2] – a detailed guide for implementing the OASIS-E protocol aimed at systematizing the assessment of patients' status in home environments.

A comprehensive approach to assessing patients' needs in home settings, extending beyond a single disease, is presented in the work of Kamei T., et al. [5], in which multifactorial assessment tools were tested in elderly individuals with chronic diseases. The use of these tools enabled improved adherence to recommendations, enhanced quality of life, and better overall treatment outcomes through the early identification of risks associated with the accumulation of comorbid conditions. It is important to note that the methodologies proposed by Kamei T. and colleagues can be adapted for endocrine practice, but they have not yet been sufficiently validated in this field, highlighting a gap between system-wide assessment instruments and specialized protocols.

Educational programs for self-management constitute another theme in the literature Yu X., et al. [6] investigated the impact of a structured, nurse-led educational program based on integrative medicine and identified a statistically significant increase in patient adherence to the therapeutic regimen and self-monitoring of blood glucose among newly diagnosed type 2 diabetes patients. Kumah E., et al. [7] focused on cognitive-behavioral strategies to reduce the risk of inadequate glycaemic control, resulting in a significant decrease in HbA1c levels after six months of follow-up.

Broad systemic approaches to evaluating and enhancing the value of medical care are represented in studies by Kokko P. [12], in a review on the application of the Triple Aim framework, demonstrates that simultaneously focusing on population health improvement, service quality enhancement, and cost reduction requires comprehensive metrics that should include indicators of patient-centered home care. Carcella T., et al. [11] illustrate how the implementation of a comprehensive quality assurance and continuous improvement process can improve outcomes without increasing costs.

The review by Kruse F. M., et al. [10] underscores the importance of organizational and managerial factors in the quality of long-term care.

Thus, two primary directions emerge in the literature: the assessment of clinical outcomes and educational interventions at the patient level, and systemic methodologies for quality and management. Contradictions are observed in evaluating the true clinical effect of telemedicine protocols: some studies demonstrate a significant positive effect [3, 4], while others point to heterogeneity of results and dependence on specific tools and context [2, 5]. Issues such as integrating educational programs into home monitoring and long-term support for self-management skills, as well as the impact of organizational factors and financial models on the effectiveness of OASIS-E implementation, are insufficiently explored. Furthermore, little attention has been paid to adapting the protocol to the characteristics of different cultural and socioeconomic groups, assessing the influence of social determinants of health, and performing cost-effectiveness analyses of home endocrine care programs.

Results and Discussion

The analysis of the standard OASIS-E dataset reveals that individual components of this toolset can serve as indirect markers of the condition of patients with endocrine pathology. Thus, assessment of skin integrity directly correlates with the risk of developing diabetic foot syndrome. The self-care and mobility parameters, as well as the section dedicated to ambulation, reflect overall functional status, which inevitably declines with decompensation of diabetes mellitus. The Management of Oral Medications section enables determination of the extent to which a patient is capable of independently adhering to the medication regimen, a component critically important for antidiabetic therapy.

Nevertheless, these indicators are overly generic and fail to encompass fundamental aspects of glycemic control. The existing protocol does not record the dynamics of glycated hemoglobin level (HbA1c), the frequency and severity of hypo- and hyperglycemic episodes, the correctness of subcutaneous insulin administration technique, the degree of patient knowledge regarding dietary principles, or the algorithms for action in cases of acute glycemic disturbances. This omission precludes a comprehensive analysis of the quality of endocrinological care based on the available data, rendering the evaluation of its effectiveness superficial and incomplete.

The absence of specialized indicators complicates the identification of bottlenecks and the development of targeted corrective interventions within quality assurance and performance improvement programs (QAPI). As a result, many organizations, experiencing difficulties in passing inspections and maintaining regulatory compliance, are forced to make managerial decisions based on empirical conjecture, which does not always ensure optimal patient care [2, 4].

To address this gap, it is proposed to implement a modified assessment module integrating industry-specific endocrinological metrics into the existing OASIS-E framework. The proposed overlay does not require amendments to the officially approved protocol and can be applied internally within the institution for in-depth monitoring and planning of therapeutic and rehabilitative measures. The conceptual scheme of this model is presented in Figure 1.

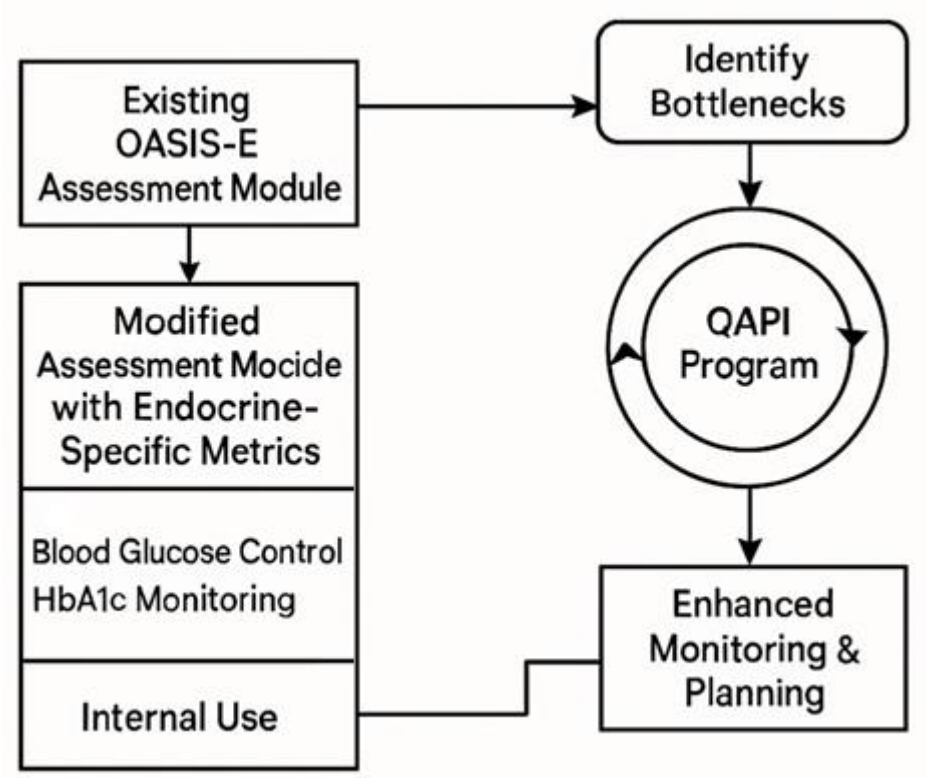

Fig.1. Conceptual model of an integrated process for assessing the quality of endocrinological care at home [2, 6, 7].

This approach allows for preservation of the standard data collection procedure for CMS reporting while simultaneously enriching it with clinically meaningful information. Based on this information, more precise care plans can be formulated. The specific additional metrics proposed for monitoring are presented in Table 1.

Table 1

Comparison of standard OASIS-E elements and proposed additional endocrinological indicators [2, 8].

Assessment category	Standard OASIS-E element	Proposed additional indicator	Rationale
Clinical condition	Presence/status of wounds	Dynamics of HbA1c levels; Average blood glucose level based on self-monitoring	Direct indicator of carbohydrate metabolism compensation
Treatment management	Management of oral medications	Evaluation of insulin/GLP-1 agonist injection technique; Assessment of dietary adherence	Critically important skills for preventing complications
Patient knowledge	Patient/family ability to learn	Assessment of knowledge of hypo-/hyperglycemia symptoms and management measures	Key factor for patient safety and timely response
Functional status	Transfer from bed to chair	Assessment of frequency of falls related to hypoglycemia or peripheral neuropathy	Specific risk for patients with diabetes
Technology utilization	No direct analogue	Use of CGM (continuous glucose monitoring) or flash monitoring by patient	Contemporary standard of diabetes management influencing outcomes

Incorporation of the expanded suite of assessment metrics serves as the cornerstone of the authorial methodology for quality enhancement and compliance assurance in home care agencies. The system is founded on the QAPI continuous improvement cycle, the focus and effectiveness of which are enhanced through the use of in-depth clinical data (Figure 2).

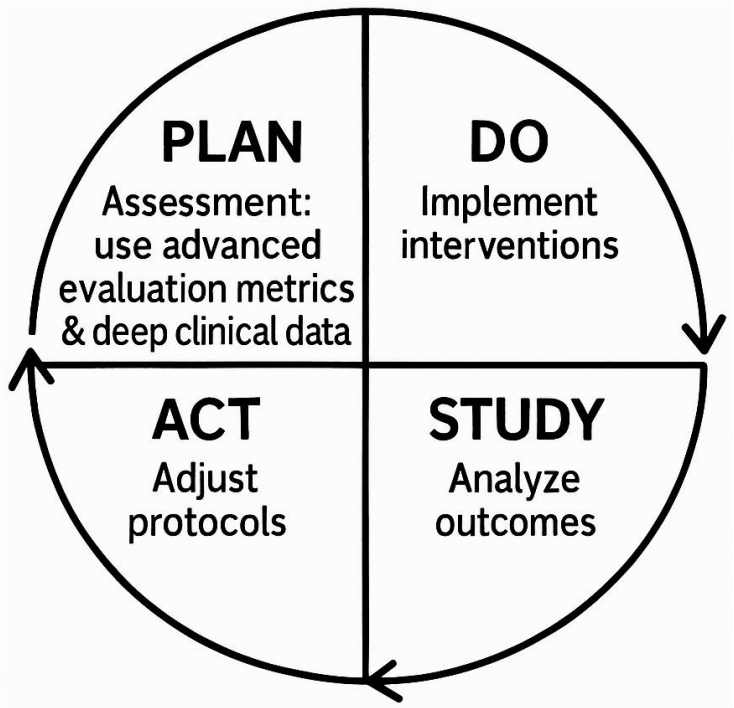

Fig. 2. QAPI cycle adapted for endocrinology care at home [2, 5, 11, 12].

Use of concise yet comprehensive checklists based on additional clinical indicators enables nurses and other care personnel to systematically monitor critical care parameters in a targeted manner, promptly identifying deviations from the norm. Thus, when planning a visit to a patient with diabetes, the proposed algorithm may include review of the glycemic self-monitoring diary, careful foot inspection for lesions and cracks, analysis of insulin injection technique and discussion of characteristic signs of hypoglycaemia. Such a structure transforms a complex regulatory task into a clear and reproducible set of actions accessible to specialists with varying levels of training. To assess the effectiveness of this methodology, modelling was performed based on aggregated data from two hypothetical agencies, which demonstrated its potential under real organisational conditions [2, 10]. When interpreting the results, it is important to underline that the developed model neither replaces nor contradicts OASIS-E, but rather harmoniously complements it by establishing a two-level evaluation framework: a regulatory level for external reporting and a clinical level for internal quality management.

When interpreting the results, it is important to emphasise that the developed model neither replaces nor contradicts OASIS-E but harmoniously complements it by forming a two-tier evaluation system: regulatory level – for external reporting, and clinical level – for internal quality management. This approach resolves the conflict between the drive for strict standardisation and the necessity to adapt care to the individual characteristics of the patient. A logical development is the integration of telemedicine solutions, in particular continuous glucose monitoring (CGM), data from which can be automatically transmitted to the agency information system and serve as an objective source for calculation of the indicators presented in Table 1. This corresponds to contemporary directions described in works [3, 8] and allows transition from episodic assessment of the patient's condition during a visit to continuous monitoring of physiological parameters. The practical significance of the proposed model consists in reducing the number of preventable hospitalisations associated with diabetes complications, which is one of the priority tasks of healthcare [5, 9]. The precise definition of the sequence of actions for each team member reduces the likelihood of errors and increases patient safety. For managers, this yields not only improved clinical outcomes but also enhanced competitiveness and strengthened positions during external audits. At the same time, it is necessary to acknowledge a number of limitations: the proposed model is conceptual in nature and requires prospective validation in real clinical settings on a representative patient cohort. Furthermore, introduction of additional assessment procedures may increase staff workload, necessitating further planning and optimisation of work processes.

Conclusion

The conducted study demonstrates that despite the key role of the standardized OASIS-E dataset in providing a unified approach to assessing the quality of home care, its sensitivity is insufficient for a comprehensive analysis of the condition of patients with endocrine pathology. A scientific gap was identified related to the absence of protocols adapted to

the specifics of this nosological group. In response to this problem, a two-level evaluation model was developed, expanding the basic protocol with specialized clinical indicators, including glycemic monitoring, improvement of insulin injection techniques and analysis of patient knowledge level. The authorial compliance enhancement methodology underlying the proposed model not only increases assessment accuracy but also forms a foundational platform for the implementation of targeted QAPI programs. The implementation of this approach in home care agencies is capable of improving clinical outcomes, reducing the number of hospitalizations and increasing the overall effectiveness of endocrine home care. Given the universal nature of diabetes treatment challenges and the widespread adoption of the OASIS tool among certified Medicare agencies, this model possesses scalable potential for nationwide adaptation.

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PROFESSIONAL OBSTETRIC RESPONSIBILITY - CRITICAL ANALYSIS OF THE PROFESSION

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SUMMARY

There are a number of career opportunities in healthcare, each with a different set of responsibilities and responsibilities. Midwives care for pregnant women and women during every stage of the pregnancy monitoring process, from sharing advice on prenatal care to assisting mothers in childbirth and providing postnatal care.

Understanding and studying the responsibilities of midwifery care can help professionals to be better prepared, to increase their alertness when performing routine or urgent, often life-saving activities. In this article, we bring out the responsibilities of Midwives, detail their general duties, present important skills needed to perform specific activities and explore their typical work environment. The analysis of the regulatory framework shows that a number of legislative mechanisms are missing, such as: standard of health care, methodology for costing the work done, adequate pay, opportunity for scientific work and participation in clinical studies, opportunity for upgrading and continuing training. The mechanisms for maintaining the qualification are internal training courses, trainings from professional organizations or different partner structures.

Conclusions: the lack of rules and methodologies are demotivating factors for young professionals who leave the profession or choose realization abroad. This leads to difficulties in ensuring continuity of care, an increase in the age limit of working specialists, who have difficulty with the new guidelines of the control institutions for work. Motivation and attestation as mechanisms do not have the desired effect to ensure quality of care. Urgent regulatory reforms are needed to create security in the workplace, the work process and the provision of specialists.

Keywords: responsibility, obstetric activities, professional skills, obstetric competence, communication.

Introduction

Institutional education in the specialty of midwifery is acquired in the medical universities [10,19,20], recognized by the state and the training in it corresponds to the state requirements for training of the Educational-Qualification Degree „Bachelor“ in health care with professional qualification „midwife“ [19]. As the profession is regulated, all higher education schools that train midwives are obliged to comply with the uniform state requirements for the specialty. Training is only regular and takes place within 4 years [19]. Students are taught a curriculum that includes general medical, clinical, special and humanities subjects. The main task of the training is the formation of knowledge, habits and skills in the field of primary prophylaxis, general and special obstetric care for pregnant, birthing, parturition and newborns and for women with gynecological diseases, family planning, etc. The practical training has a minimum duration distributed in academic (clinical) practice – from the first to the sixth semester inclusive, and pre –Graduate Internship- in the seventh and eighth semester.

Graduates of Midwives acquire the Educational-Qualification Degree „Bachelor“ and can work in state, municipal and private medical institutions. They may have independent practice in accordance with the provisions of the Medical Institutions Act [13].

The ongoing reforms in the health sector require reforming the methods and modes of education in universities so that they can adequately prepare new professionals according to the requirements of the environment [6,7], with the new trends in the provision of health care [12,18] and adequately meet the expectations of health service users (by defining trends, the services sought and the quality of the care provided).

In the implementation of certain activities, leading normative guidelines are the medical standards by Profile Specialties, The Protocols of professional companies [8,27] and the guidelines of the regulations on the implementation of activities on clinical pathways under the national framework contract for medical activities [15]. All this is determined and documented by the doctor –medical specialist, who reports The performed medical activity of the Regional Health Insurance Fund, as a local authorizing officer of the National Health Insurance Fund [13,15]. The care after the medical service rendered to the patient is not defined and is not taken into account in the full extent of its provision [15]. This has a negative effect on the motivation to attract qualified healthcare professionals, to ensure the state of the healing structure and to ensure continuity of care.

In order to be able to speak and provide adequate obstetric care to women, childbirth and newborns, it is necessary to have a standard of health care, on the basis of which the responsibilities and contributions of the relevant specialists are defined. This requires the recognition of the midwifery profession as independent of its responsibilities, duties and importance in the exercise of the profession of midwifery [25,26,27].

I. Responsibilities of the midwife

The responsibilities of the midwife cover every aspect of the birth process, from patient examinations and prenatal care to competent maternity care and postnatal care. Midwives specialise in providing care for both mothers and babies, ensuring they are safe and as comfortable as possible before, during and after birth [3,12]. Some midwives can be implemented in clinics where highly specialized medical activities of expectant mothers are carried out to ensure that their pregnancy progresses safely. Others are implemented in maternity, nonantological or gynecological structures in hospitals and indicate the necessary care for patients after performing a medical service (according to BG legislation under the clinical

pathways of the Regional Health Insurance Fund - support the process of childbirth, monitoring of patients and providing support during childbirth) [13,15].

II. Duties of the midwife

Midwives can have several duties depending on their place of work and realization (fig.1). Here are some common duties of Midwives [14]:

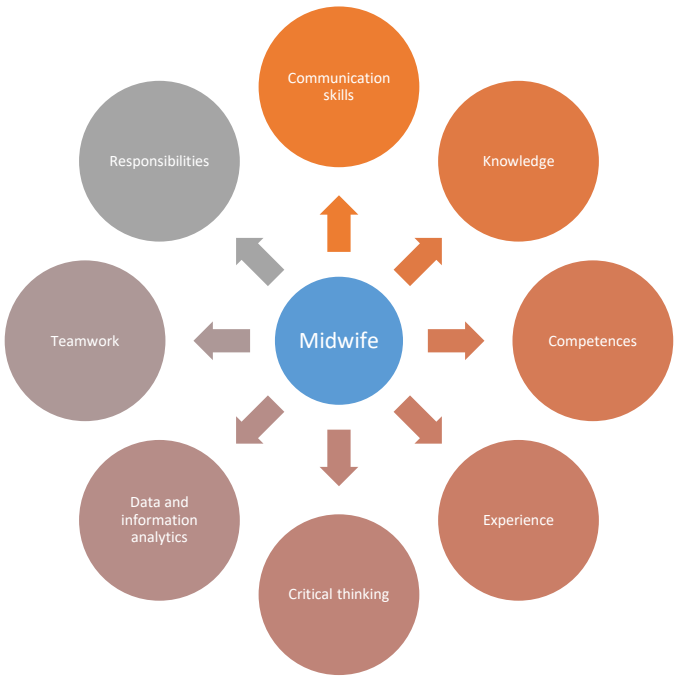

Fig. 1. Midwifery skills and competences

1. Prenatal care

Midwives help patients both before and after birth by performing a number of activities during pregnancy monitoring (monitoring of vital signs, auscultation, beveling, anthropometry, sampling of blood, secretions, etc. materials, if necessary, giving advice on nutrition and exercise regime). Their competences are related to the establishment of primary obstetric diagnosis and monitoring of the general condition of the pregnant woman, monitoring of DST, giving instructions on rational nutrition, through which they assess the health of the pregnant woman and the expected outcome of pregnancy. These activities assist the specialist doctor in the follow-up and sharpen, if necessary, attention to the appearance of certain deviations. Midwives work in a team of specialists (doctors, laboratory specialists, clinicians, etc.), which interpret the information collected and the documented obstetric activities and outcomes [16,17].

In order to conduct an adequate obstetric consultation, it is necessary to have legislative changes, by the ministry, and recognition of the role and competence of the midwife.

2. Provision of prenatal education

Midwives help teach expectant mothers how to properly care for themselves and developing children. They can provide tips on nutrition, exercise, and methods to relieve the discomfort that comes from pregnancy. Midwives help pregnant women understand the changes they are experiencing, recognize symptoms for signs of problems. They can provide advice on different approaches to childbirth and guide mothers to further information on the birthing process [21].

The Midwife does not take into account the extra-curricular activities in prenatal care. Assists in documenting the activities performed and reported by the specialist doctor.

3. Assistance in childbirth

During childbirth, midwives stay by the mother's side and provide support, empathy, assistance and assistance. The midwife performs monitoring of the vital signs of the fetus and the mother, makes a primary assessment of the needs of the birthing, carries out Coordination activities with the obstetrician-gynecologist to implement the delivery plan and actively monitors the mother during childbirth. Prepares the workplace for work, monitors the processes of sterilization, sepsis and asepsis. Performs manipulations, assists in carrying out various diagnostic and treatment procedures aimed at relieving and assisting the woman in labor. The midwife prepares the expectant mother for surgery, provides support and assistance to the operating room, assists the mother in the process of recovery, in building the relationship with the newborn, provides support in breastfeeding [24].

For the implementation of all these activities, the Midwife does not have statutory protocols and instructions for implementation, there is no obstetric specific documentation, and does not take into account the activities performed by the control body.

III. Basic tasks are defined:

1. Care after childbirth. Immediately after birth, midwives stay with the mother and baby to monitor and provide support. They support both mother and child in the first days, provide assistance in adaptation, monitor for any complications and perform tests and screening

to ensure good health and development. They can give instructions to the mother on how to hold and feed the baby safely without any tension. Midwives continue to monitor the mother and baby as they recover and coordinate with doctors while resolving any complications [4,5].

2. Postpartum care. Midwives monitor the mother and baby, prepare them for sleeping in an outpatient environment. Midwives monitor the development of the mother and baby according to the days during the simple stay in the maternity home and ensure a regime of feeding, sleep and wakefulness. They share tips on caring for the baby and ensure that the mother is ready to handle the new responsibilities on her own. They can take blood samples from the baby or administer the necessary vaccines according to the vaccination calendar [23].

If necessary, they provide emotional support and psychological assistance in registered deviations from the norm in the baby and the mothers themselves. Midwives are involved in communicating unwanted news to the relatives and family of the mother or newborn.

All activities in postpartum care are not documented in obstetric protocols and are not reported to the controlling body.

3. Administrative responsibilities. Midwives perform many administrative tasks in the course of their daily activities. They can record information about patients in diagrams so that doctors can immediately understand the current situation. Nurses add information to medical records and update them as needed. They consult patient records to develop a care plan and note any important issues. Midwives often take responsibility for the condition of the delivery room, sterilize the instruments, ensure that everything is in the right place and follow individual hospital procedures.

4. Coordination of care. Midwives work with doctors, other nurses and patient staff to coordinate care and ensure patient safety. They take instructions from doctors and make sure they have all the tools they need to help mothers during childbirth. Midwives coordinate with other midwives – senior midwives-to provide care for all patients in the structure, allocating their time appropriately [25,27]. Midwives can instruct other hospital staff to transport patients or clean the hall after childbirth.

5. Important skills for midwives. Midwives work in a dynamic, challenging environment, so they require several skills to be successful. Here are some of the most important skills for nurses.:

A) communication/ the art of communicating with a patient. Midwives use communication skills as they connect with patients and monitor their symptoms. They ask appropriate questions to determine the condition of each patient and check for problems. They use active listening skills as they pay special attention to patients ' problems and respond to their requests. Midwives require strong communication skills to be able to explain baby care techniques to new mothers and educate them on how to keep their child healthy [4,27]. Communication skills help nurses build strong relationships with colleagues and work together to provide excellent patient care.

B) Empathy. Empathy helps midwives work with patients as they go through the challenging process of childbirth. Entering a hospital can be a frightening experience for new mothers, and midwives take responsibility for accompanying patients as they undergo tests, go through Labor and deliver a baby. Patients can become frightened and unpredictable, so midwives use empathy to help calm them down and guide them to a successful birth. Empathy helps nurses provide quality care and stay focused on the comfort of each patient they encounter [4,27].

(C) Professional Identity. Very little attention is paid to professional identity. It identifies the independence of the profession, knowledge, acquired and upgraded skills, qualifications. Rarely, the profession of midwife has the opportunity to declare its independence, according to the nomenclature of the professions, except for the independent practices, which are entirely in the field of paid services and do not have the right and legal regulation to conclude a contract with a health insurance source. With regard to pre-hospital and hospital obstetrics, midwives are executors of orders of Doctors, Without being able to make independent decisions, due to the need to verify all appointments, decurs in the National Health Information System at the National Health Insurance Fund [15,22]. The work of the doctor is institutionalized, but not the midwife. But when seeking responsibility and traceability from control bodies, doctors have defined their activity in the patient's documentation, while the healthcare professional – a midwife-cannot verify their care and monitoring in the system.

D) critical thinking. Midwives use critical thinking skills to make decisions in stressful medical situations. When unexpected problems arise during the birth process, midwives use their learning and decision-making skills to accurately diagnose problems and determine the best course of action. They monitor symptoms and make changes to the patient's care plan according to the circumstances. The hospital environment is dynamic, so midwives demonstrate critical thinking skills to make important medical decisions in an environment of uncertainty, risk, or stress [9].

(E) attention to detail. Attention to detail helps midwives focus on their patients and monitor any change in their condition. They define and manage the patient's risk by providing health care. Midwives remain vigilant while performing medical procedures such as drawing blood or administering medication to ensure they follow best practices. They strive to administer care while minimizing the patient's discomfort. Midwives connect patients to the monitoring equipment and record the results, carefully noting all anomalies. Attention to detail allows them to notice problems and take steps to solve them before they become serious [1,9].

5) teamwork. Midwives often work as part of a team in a hospital setting. They receive instructions from a doctor and assist during operations or other

procedures. They listen carefully to all instructions and help doctors in their work. Midwives can work as part of a team with other healthcare professionals and hospital staff, so they focus on building strong relationships and sharing responsibilities while working to make sure each patient receives quality care [11].

6) The Midwife at the centre of care and the working environment. Some midwives work in a pre-hospital or hospital environment and, depending on the subject of work, perform a number of activities, combine different skills, continuous communication with patients, staff, superiors, supervisors, non-medical personnel, relatives of patients, suppliers and others. clinical setting, providing care for Obstetric and gynecological patients. This requires strict coordination of the executed activities, precision of the tasks, grading in importance, analytical and critical thinking, opportunity for corrective actions and, if necessary, training in new responsibilities (continuous change of the regulatory framework, new requirements of the National Health Insurance Fund, National Health Information System, etc. [9.15]) (fig.2).

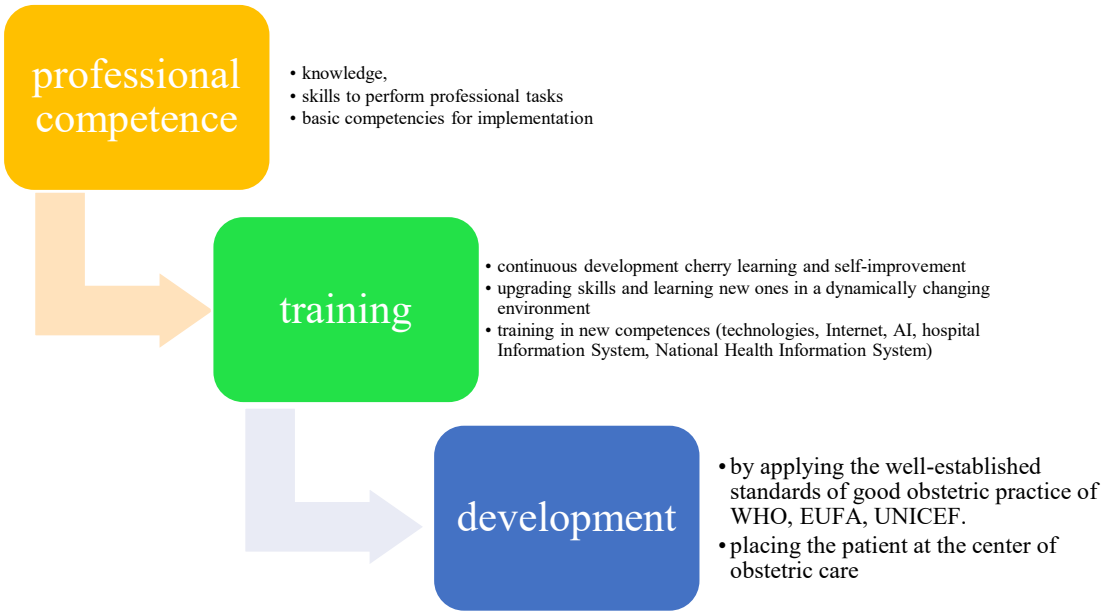

Fig. 2. Development of obstetric skills

IV. Discussion

Institutions (at national and local level) have an obligation to provide security and protection to professionals in connection with the performance of their work tasks, to provide a favorable environment for interaction with patients, trainees, providers and controllers of Health Services. Institutions (institutions) must maintain a well-established process of protection and reporting, conduct timely control and audit of proscenium, structure and resources, in order to achieve optimal quality of medical care by developing their staff, providing the facilities and maintaining the working environment. Access to such a process can protect patients and facilitate fair relationships between subjects and objects, ensuring stability and safety over time [11,16,27].

It is the responsibility of each health professional and structure to develop and train [2,13,16] to meet the competitive requirements of the environment (fig.3).

Fig. 3. Obstetric responsibility

Conclusion

The problem of the provision of midwives in hospital structures is brewing, because in medical standards there is no determination of the number of healthcare professionals to serve patients and there is no ratio of doctor: midwife to number of patients. The number of doctors is legally defined in the standard but the relevant clinical specialty and in the requirements of the clinical path for the performance of the activity of the given structures. This has opened up a number of managers to undertake activities to limit the cost of staff, training and qualification.

As a result of this negative trend, education may become a low priority for young professionals regarding their realization. The process of medical education can reduce the effectiveness of patient care and increase costs.

It is the responsibility of all doctors and institutions involved in the training of healthcare professionals to ensure, to recognize the importance of the profession and its responsible position, because teamwork requires different qualified specialists with different competences, which will increase the efficiency of the work process, guarantee quality of activities and continuity of care. Efforts to reduce the cost of human capital do not reduce the opportunities for training in professional skills and the acquisition of new knowledge and good practices. Institutions have an ethical responsibility to develop their own rules and practices that ensure process stability, process safety and resource security, and guidelines for involving healthcare providers in patient care in ways that provide good education and high-quality medical care.

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