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Question

1. USE OF PARTOGRAPH IN THE MANAGEMENT OF FIRST STAGE OF LABOUR

2. MANAGEMENT OF 2ND AND 3RD STAGES OF LABOUR

Answer

1. Partography is a method of graphically recording the progress of labour. It may be used purely to record observations but management guidelines to indicate the appropriate timing of certain interventions can be incorporated.

The condition of the mother, the condition of the fetus, and the progress of labour are recorded on the partogram.

Recording the condition of the mother

A. Recording the blood pressure, pulse and temperature

The maternal blood pressure, pulse and temperature should be recorded on the partogram.

B. Recording the urinary data

Volume is recorded in ml.

Protein is recorded as 0 to 4+.

Ketones are recorded as 0 to 4+ (see figure 8C-2).

Recording the condition of the fetus

C. Recording the fetal heart rate pattern

The following two observations must be recorded on the partogram:

The baseline heart rate.

The presence or absence of decelerations. If decelerations are present, you must record whether they are early or late decelerations

D. Recording the liquor findings

Three symbols are used:

I = Intact membranes.

C = Clear liquor draining.

M = Meconium-stained liquor draining.

E. How often should you record the liquor findings?

The recordings should be made:

At each vaginal examination.

Whenever a change in the liquor is noted, e.g. when the membranes rupture or if the patient starts to drain meconium-stained liquor after having had clear liquor before.

Recording the progress of labour

F. Recording the cervical dilatation

Cervical dilatation is measured in cm and then recorded by marking an ‘X’ on the partogram.

G. Recording the length of the cervix (effacement)

The length of the cervix is recorded by drawing a thick, vertical line on the same part of the chart that is used for the cervical dilatation. The length of the line drawn indicates the length of the endocervical canal in cm. It is drawn on the chart whenever the cervical dilatation is recorded. Alternatively, the length of the endocervical canal, measured in cm or mm, can be noted in the space provided.

H. Recording the amount of the head palpable above the brim of the pelvis (descent and engagement)

The findings are recorded by marking an ‘O’ on the partogram

I. Recording the position of the fetal head

The position of the fetal head is recorded by marking the ‘O’ with fontanelles and the sagittal suture. Alternatively, the position can be noted (e.g. ROA) in the space provided (see figure 8C-4). This is recorded at every vaginal examination.

J. Recording moulding of the fetal head

The degree of moulding (i.e. 0 to 3+) is also recorded on the partogram.

K. Recording the duration of contractions

The duration of contractions is also recorded on the partogram. The block is stippled if the contractions last less than 20 seconds (i.e. weak contractions), the block is striped if the contractions last between 20 and 40 seconds (i.e. moderate contractions) and the block is coloured in completely if the contractions last 40 seconds or longer (i.e. strong contractions).

L. Recording the frequency of contractions

The number of contractions occurring within 10 minutes is recorded by marking off 1 block for each contraction, e.g. 2 blocks marked off equals 2 contractions in 10 minutes, 4 blocks marked off equals 4 contractions in 10 minutes, and 5 blocks if 5 or more contractions in 10 minutes

M. Recording drugs and intravenous fluid given during labour

In the space provided on the partogram you should record:

The name of the drug.

The dose of the drug given.

The time the drug was given.

The type of intravenous fluid.

The time the intravenous fluid was started.

The rate of administration.

The amount of intravenous fluid given (after completion).

N. Assessment and management

After each examination an assessment must be made and recorded on the partogram. All management in labour must also be recorded on the partogram.

O. Recording the time on the partogram

The time, to the nearest half hour, should also be entered on the partogram whenever an observation is recorded, medication is given, an assessment is made or management is altered.

1. Third Stage of Labour

Delivery of the placenta

Conservative method:

Put the ulnar border of the left hand just above the fundus at the level of the umbilicus to detect any bleeding inside the uterus known by rising level of the atonic uterus.

Wait for signs of placental separation and descent but do not massage the uterus.

As soon as they are detected massage the uterus to induce its contraction, ask the patient to bear down and push the uterus downwards to deliver the placenta.

Hold the placenta between the two hands and roll it to make the membranes like a rope in order not to miss a part of it.

Give ergometrine 0.5 mg or oxytocin 5 units IM after delivery of the placenta to help uterine contraction and minimise blood loss. These may be given before delivery of the placenta.

Signs of placental separation and descent:

The body of the uterus becomes smaller, harder and globular.

The fundal level rises as the upper segment overrides the lower uterine segment which is now distended with the placenta.

Suprapubic bulge due to presence of the placenta in the lower uterine segment.

Elongation of the cord particularly on pressing on the uterine fundus and it does not recede back into the vagina on relieving the pressure.

Gush of blood from the vagina.

The active method (Brandt- Andrews method):

With delivery of the anterior shoulder, 0.5 mg ergometrine or syntometrine (0.5 mg ergometrine + 5 units oxytocin) is given IM.

When the uterus contracts, put the left hand suprapubic and push the uterus upwards while gentle downward and backward traction is applied on the cord by the right hand when the placenta is delivered it is rolled as in the conservative method.

Advantage: reduction of the blood loss.

Disadvantages:

Constriction ring may occur with retention of the placenta.

Avulsion of the cord if undue pressure is applied.

Inversion of the uterus if fundus is pressed while the uterus is lax.

Routine examinations

Examination of the placenta and membranes:

by exploring it on a plain surface to be sure that it is complete. If there is missed part, exploration of the uterus is done under general anaesthesia.

Explore the genital tract:

For any lacerations that should be immediately repaired.

Repair of episiotomy

Fourth Stage of Labour

Observation for the patient particularly atony of the uterus and vaginal bleeding.

Care of The Newborn

Clearance of the air passages

The newborn is placed in supine position with the head lower down. A metal, rubber or better disposable plastic catheter is used to aspirate the mucus from the pharynx and mouth directly by the physician’s mouth or by attach it to an electric suction pump.

Crying of the baby is usually occurs within seconds, if delayed slapping its soles, flexion and extension of the legs and rubbing the back usually stimulate breathing.

Apgar score

Is calculated at 1 and 5 minutes and further steps of resuscitation are arranged according to it (see later).

The umbilical cord

A disposable plastic umbilical clamp is applied about 5 cm from the umbilicus to avoid the possibility of tying an umbilical hernia then cut about 1.5 cm distal to the clamp. Inspect for bleeding and paint it with alcohol.

If the plastic umbilical clamp is not available, 2 ligatures of silk are applied instead of it.

The umbilical stump is painted daily with an antiseptic till its fall within 10 days.

Congenital anomalies

The newborn is examined for injuries or congenital anomalies as imperforate anus, hypospadias (not to be circumcised as the cut skin will be used in the repair later on), cyanotic heart diseases.... etc.

Weight:

the newborn and record it.

Dressing

Dressing as well as all previous procedures should be done in a warm place better under radiant warmer to prevent heat loss which occurs rapidly after delivery increasing the metabolism and acidosis.

Care of the eyes

An antibiotic eye drops as chloramphenicol are instilled into the eyes as a prophylaxis against ophthalmia neonatorum.

Identification:

of the baby by a plastic bracelet on which its mother’s name is written.