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Assignment: 1)use of partograph in the management of first stage of labor

2)management of 2nd and 3rd stage of labor

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.t is intended to provide an accurate record of the progress in labour, so that any delay or deviation from normal may be detected quickly and treated accordingly. However, a [Cochrane review](/wiki/Cochrane_review" \o "Cochrane review) came to the conclusion that there is insufficient evidence to recommend partographs in standard labour management and care.

The **use** of the **partograph** is recommended as an important indicator for monitoring intrapartum care. **Partograph**includes several **labour** vitals including cervix dilatation of the mother. Plotting the cervix dilatation against time can help in predicting deviation from the **normal**progress of **labour**.

USE OF PARTOGRAPH IN FIRST STAGE OF LABOUR

The partograph with associated management guidelines is designed to improve the timing of critical management decisions in labour. These are:

a. Transfer of a woman in labour from a peripheral unit (health centre) to a central unit (hospital with facilities for caesarean section delivery).

b. Augmentation of labour with oxytocin infusion.

c. Termination of labour by operative delivery (usually caesarean section).

Poor timing of, or failure to perform, these actions may lead to problems of iatrogenesis or neglect. Without management guidelines, these decisions may be made on the basis of intuition or experience which probably contributes to the widely varying rate of, for example, caesarean section delivery.

Based on the experiences WHO considered that the actions appropriate different points on the partograph should be as follows:

- If cervical dilation remains on or to left of the alert line in the active phase – no action is indicated

-If cervical dilation moves between the alert and action lines ( but not to action line)

- If a peripheral unit, transfer to a central unit

- If in a central unit, no specific action indicated

- If cervical dilation reaches or crosses the action line;

- Review by medical staff with a view to augmentation, termination of labour or supportive therapy

-Prolonged latent phase( 8hrs of observed latent phase)

- Review by medical staff

Second stage of labor:

from full dilatation of the cervix up to the birth of the singleton baby or the last baby in a multiple pregnancy. At the start of the second stage, the fetal presenting part may or may not be fully engaged (meaning that the widest diameter has passed through the pelvic brim), and the woman may or may not have the urge to push.

MANAGEMENT OF SECOND STAGE OF LABOUR

-Continuously provide information, support, and encouragement to the woman and her companion.

-Encourage active pushing once the urge to bear down is present, with encouragement to adopt any position for pushing preferred by the woman, except lying supine which risks aortocaval compression and reduced uteroplacental perfusion.

-Listen frequently (every 5 minutes) to the fetal heart in between contractions to detect bradycardia.

-Check the maternal pulse and blood pressure, especially where there is a pre‐ existing problem of hypertension, severe anemia, or cardiac disease.

-Observe progressive descent and rotation of the presenting part. This includes observing progressive distension of the perineum and visibility of the presenting part, and vaginal examination especially where progress appears to be slow.

-Conduct the delivery with support for the perineum to avoid tears, and use of episiotomy only where a tear is very likely.

-Be ready to augment contractions with an intravenous oxytocin infusion during the second stage where contractions have become infrequent and where the fetal heart rate remains normal, to avoid the need for instrumental vaginal delivery or transfer.

-Be ready to undertake instrumental vaginal delivery (vacuum or forceps) where indicated for fetal bradycardia or nonadvance of the presenting part.

-Close monitoring and the skills and capacity to offer timely intervention are required for all births to prevent adverse outcomes. High‐quality care in the second stage of labor is necessary to prevent stillbirth and newborn complications arising from undetected hypoxia and acidemia, as well as maternal mortality and morbidity from complications such as vesicovaginal fistula, genital tract lacerations, infection, hemorrhage, as well as worsening of hypertensive disease.

The third stage of labor refers to the period following the completed delivery of the newborn until the completed delivery of the placenta. Relatively little thought or teaching seems to be devoted to the third stage of labor compared with that given to the first and second stages.

There are two ways of managing the third stage of labour:

1. The active method.
2. The passive method.

Whenever possible, the active method should be used. However, a midwife working on her own may need to use the passive method.

### **What is the active management of the third stage of labour?**

1. Immediately after the delivery of the infant, an abdominal examination is done to exclude a second twin.
2. An oxytocic drug is given if no second twin is present.
3. When the uterus contracts, controlled cord traction must be applied:
   * Keep steady tension on the umbilical cord with one hand.
   * Place the other hand just above the symphysis pubis and push the uterus upwards.

4. Placental separation will take place when the uterus contracts. When controlled cord traction is applied the placenta will be delivered from the upper segment of the uterus.

5. Once this occurs, continuous light traction on the umbilical cord will now deliver the placenta from the lower uterine segment or vagina.

6. If placental separation does not take place during the first uterine contraction after giving the oxytocic drug, wait until the next contraction occurs and then repeat the manoeuvre.

### **What is the passive method of managing the third stage of labour?**

1. After delivery of the infant the signs of placental separation are waited for.
2. When the signs of placental separation appear, the patient is asked to bear down and the placenta is delivered spontaneously, by maternal effort only.
3. Only after the placenta has been delivered is an oxytocic drug given.

### **What are the advantages and disadvantages of the active method of managing the third stage of labour?**

Advantages:

1. Blood loss is less than when the passive method is used.
2. There is less possibility that additional oxytocin will be needed to contract the uterus following the third stage of labour.

Disadvantages:

1. The person actively managing the third stage of labour must not leave the patient. Therefore, an assistant is needed to give the oxytocic drug and examine the newborn infant, while the person conducting the delivery continues with the management of the third stage of labour.
2. The risk of a retained placenta is increased if the active method is not carried out correctly, especially if the first two contractions after the delivery of the infant are not used to deliver the placenta.
3. Excessive traction on the umbilical cord can result in inversion of the uterus, especially if the fundus of the uterus is not supported by placing a hand above the bladder on the abdomen.

### **What are the advantages and disadvantages of the passive method of managing the third stage of labour?**

Advantages:

1. No assistant is needed.
2. A retained placenta is less common than with the active method.

Disadvantages:

1. Blood loss is greater than with the active method.
2. The active method may be needed anyway, if:
   * there is excessive bleeding before delivery of the placenta.
   * the placenta does not separate spontaneously.