MATRIC NUMBER: 16/MHS01/214

NAME: OSE FAVOUR UFUOMAVEFE

COURSE CODE: NSC404

DATE: 14/04/2020

ASSIGNMENT

1.Use of partograph in the management of labour

2. Management of second and third stage of labour

PARTOGRAPH

 This is a composite graphical record of key data during labour entered against time on a single sheet of paper. Relevant measurements might include statistics such as cervical dilation, fetal heart rate, duration of labour and vital signs.

It 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.

A partograph is contained in the Perinatal Institute's "Birth notes".

COMPONENTS

-Patient identification

-Time: It is recorded at an interval of one hour. Zero time for spontaneous labour is time of admission in the labour ward and for induced labour is time of induction.

-Fetal heart rate: It is recorded at an interval of thirty minutes.

-State of membranes and color of liquor: "I" designates intact membranes, "C" designates clear and "M" designates meconium stained liquor.

-Cervical dilatation and descent of head

Uterine contractions: Squares in vertical columns are shaded according to duration and intensity.

-Drugs and fluids

-Blood pressure: It is recorded in vertical lines at an interval of 2 hours.

-Pulse rate: It is also recorded in vertical lines at an interval of 30 minutes.

-Oxytocin: Concentration is noted down in upper box; while dose is noted in lower box.

Urine analysis

-Temperature record

ADVANTAGES OF PARTOGRAPH

-Provides information on single sheet of paper at a glance

-Early prediction of deviation from normal progress of labour

-Improvement in maternal morbidity, perinatal morbidity and mortality

DISADVANTAGES OF PARTOGRAPH

-It requires a skilled healthcare worker who can fill and interpret the partograph.

-Recent studies have shown there is no evidence that partograph use is detrimental to outcomes.

-Often paper-partograph and the equipment required to complete it are unavailable in low resource settings.

-Despite decades of training and investment, implementation rates and capacity to correctly use the partograph are very low.

-cervical dilatation over time is a poor predictor of severe adverse birth outcomes. This raises questions around the validity of a partograph alert line.

USE OF PARTOGRAPH IN FIRST STAGE OF LABOUR

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

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

- Augumentin of a labour with oxytocin infusion

- Termination of labour by operative delivery (usually caesarean section)

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

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.

MANAGEMENT OF THIRD STAGE OF LABOUR

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

The active method.

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.

Midwives who choose to use the passive method of managing the third stage of labour must also be able to confidently use the active method, as this method may have to be used in some patients.

ACTIVE METHOD

-Immediately after the delivery of the infant, an abdominal examination is done to exclude a second twin.

-An oxytocic drug is given if no second twin is present.

-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.

-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.

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

-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.

PASSIVE METHOD

-After delivery of the infant the signs of placental separation are waited for.

-When the signs of placental separation appear, the patient is asked to bear down and the placenta is delivered spontaneously, by maternal effort only.

-Only after the placenta has been delivered is an oxytocic drug given.