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LEVEL: 400

COURSE TITLE: MATERNAL HEALTH AND NORMAL MIDEWIFERYII

Question

1. Use of partograph In the management of first stage of labour
2. Management of 2nd and 3rd stages of labour.

A partogram is a chart on which the progress of labour over time can be presented. You will notice that provision has been made on the chart to record all the important observations regarding the condition of the mother, the condition of the fetus, and the progress of labour

A patient is in labour when she has both of the following:

1. Regular uterine contractions with at least 1 contraction every 10 minutes.
2. Cervical changes (i.e. cervical effacement and/or dilatation) or rupture of the membranes.

The first stage of labour can be divided into two phase.

1.The latent phase

2. active phase

The latent phase starts with the onset of labour and ends when the patient’s cervix is 3 cm dilated. With primigravidas the cervix should also be fully effaced to indicate that the latent phase has ended. However, in a multigravida the cervix need not be fully effaced. this phase does not normally last longer than 8 hours.

**Monitoring of the first stage of labour**

1. The routine observations (usually done hourly or half-hourly) of the condition of the mother, the condition of the fetus, and the contractions.
2. A careful abdominal examination.
3. A careful vaginal examination.

This examination is only complete when the findings have been charted on the partogram. If the findings are abnormal, a plan must be made regarding the further management of the patient

**Management of a patient in the latent phase of the first stage of labour**

When a patient is admitted in early labour, and on examination everything is found to be normal, only routine observations are done. The next complete examination is done 4 hours later, or sooner if the patient starts to experience more regular and painful contractions. The patient should should be encouraged to walk around.

**Management of a patient in the active phase of the first stage of labour**

When a patient is admitted in the active phase of labour, she will probably be in normal labour. However, the possibility of cephalopelvic disproportion must be considered, especially if the patient is unbooked.

When the condition of the mother and the condition of the fetus are normal, and there are no signs of cephalopelvic disproportion, the next complete examination must be done 4 hours later. The cervical dilatation, in centimetres, is recorded on the alert line of the partogram.

The graph sections of the partograph

The graph sections of the partograph are where you record key features of the fetus or the mother in different areas of the chart.

* Immediately below the patient’s identification details, you record the Fetal Heart Rateinitially and then every 30 minutes. The scale for fetal heart rate covers the range from 80 to 200 beats per minute.
* Below the fetal heart rate, there are two rows close together. The first of these is labelled Liquor  which is the medical term for the amniotic fluid; if the fetal membranes have ruptured, you should record the colour of the fluid initially and every 4 hours.
* The row below ‘Liquor’ is labelled Moulding this is the extent to which the bones of the fetal skull are overlapping each other as the baby’s head is forced down the birth canal; you should assess the degree of moulding initially and every 4 hours.
* Below ‘Moulding’ there is an area of the partograph labelled **Cervix (cm) (Plot X)** for recording **cervical dilatation**, meaning the diameter of the mother’s cervix in centimetres. This area of the partograph is also where you record**Descent of Head (Plot O)**, which is how far down the birth canal the baby’s head has progressed. You record these measurements as either X or O, initially and every 4 hours. There are two rows at the bottom of this section of the partograph to write the number of hours since you began monitoring the labour and the time on the clock.
* The next section of the partograph is for recording **Contractions per 10 minutes** initially and every 30 minutes.
* Below that are two rows for recording administration of **Oxytocin** during labour and the amount given.
* The next area is labelled**Drugs given and IV fluids** given to the mother.
* Near the bottom of the partograph is where you record the mother’s vital signs; the chart is labelled **Pulse and BP**(blood pressure) with a possible range from 60 to 180. Below that you record the mother’s **Temperature**.
* At the very bottom you record the characteristics of the mother’s **Urine: protein, acetone, volume**.

In the section for cervical dilatation and fetal head descent, there are two diagonal lines labelled**Alert**and **Action**. The Alert line starts at 4 cm of cervical dilatation and it travels diagonally upwards to the point of expected full dilatation (10 cm) at the rate of 1 cm per hour. The Action line is parallel to the Alert line, and 4 hours to the right of the Alert line. These two lines are designed to warn you to take action quickly if the labour is not progressing normally.

2.a.MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labor is defined as the time from complete dilation to delivery of the infant. Modifiers that affect the second stage length include factors such as parity, epidural anesthesia, delayed pushing, fetal station at complete dilation, maternal body mass index, fetal weight and occiput posterior (OP) position. Optimization of the second stage of labor is essential to ensure safe maternal and fetal outcomes.

TYPES OF SECOND STAGE OF LABOUR

• Passive second stage of labour : a period of time, not necessarily continuous, when The finding of full dilatation of the cervix before or in the absence of involuntary expulsive contractions.

• Active second stage of labour when: Presenting part is visible or Expulsive contractions with a finding of full dilation of the cervix or other signs of clinical descent.

Care in second stage

* Do not perform manual stretching of perineum or perineal massage in the second
* stage of labour.
* Encourage and help the woman to move and adopt whatever positions she finds
* most comfortable.
* Ensure perineum is visualised by primary accoucheur.
* If pushing is ineffective or if requested by the woman, offer strategies to assist

birth such as change in maternal position, emptying bladder and encouragement.

Observations of the following

Maternal

1. Temperature 4 hourly

2. Respiratory rate 4 hourly

3. Heart rate 15 minutely and when assessing FHR

4. Blood pressure (BP) 1 hourly

5. Contractions 30 minutely

6. Vaginal examination 1 hourly

7. Abdominal palpation prior to vaginal examination

8. Vaginal loss ongoing. If meconium present with CMP at home

consultation and transfer to the supporting hospital must occur.

9. Bladder document frequency of void

**Fetal**

FHR after each contraction or at least 5 minutely, for at least 1 minute.

The maternal heart rate should be palpated and documented to differentiate

between maternal and fetal heart rates.Preparation for birth of the baby

1. PPE wears:

* protective full face visor
* plastic apron
* sterile gloves

2. Assemble equipment for birth, placing it within easy reach of the accoucheur

3. you should do the follow to prepare the birth canal

* Swabbing downward from urethral orifice to anal area
* Placing drape under woman’s buttocks
* Clean pad over anal area

Birth of the baby

1. Encourage the woman to minimise active pushing using gentle verbal guidance.

The use of controlled slowed or shallow maternal breathing should be used to

birth the baby slowly.

2. Support the perineum with the dominant hand.

3. Apply gentle counter pressure to the fetal head with the non-dominant hand to

control the fetal head, allowing progress whilst preventing uncontrolled

expulsion.

4. Once the head has birthed, wait for restitution to occur.

2.b.MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labour starts immediately after the delivery of the infant and ends with the delivery of the placenta and membrane. The normal duration of the third stage of labour depends on the method used to deliver the placenta. It usually lasts less than 30 minutes, and mostly only 2 to 5 minutes.

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

The active method.

The passive method

ACTIVE MANAGEMENT OF THID 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.

Controlled cord traction is also called the Brandt-Andrews method (manoeuvre).

1. 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.
2. Once this occurs, continuous light traction on the umbilical cord will now deliver the placenta from the lower uterine segment or vagina.
3. 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 OF MANAGEMENT OF 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.

ADVANTAGES AND DISADVANTAGES OF ACTIVE METHOD

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.

ADVANTAGES AND DISADVANTAGES OF PASSIVE METHOD

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.