MATRIC NUMBER: 16/MHS02/043

NAME: OLUNLADE OLOLADE ESTHER

COURSE CODE: NSC404

DATE: 11/04/2020

MATERNAL HEALTH AND NORMAL MIDWIFERY

Use of pathograph in the management of first stage of labour

Management of second and third stages of labour

ANSWER

INTRODUCTION

A partograph is a tool used in assessing the progress of labour to detect early complications such as fetal distress, prolonged or obstructed labour.

Partograph is a basic tool or a chart where all labour observations are recorded in a clear way and these observations are interpreted to detect abnormality at a glance.

THJNGS TO NOTE

* Use problem solving skills.
* Ask and listen.
* Look and feel.
* Identify needs or problem.
* Take appropriate actions.

CONTRAINDICATIONS OF PARTOGRAPH

* Ante partum hemorrhage.
* Cervical dilation at 9-10cm.
* Elective Caesarean Section .
* Emergency Caesarean Section on emergency.
* Malpresentation and abnormal lie e.g face or brow
* Gestational age less than 30weeks
* Confirmed cephalo pelvic disproportion.
* Severe pregnancy induced hypertension.

CHARTING ON THE PARTOGRAPH

* Patients information including the name, gravida, parity, and hospital number is written on top of the partograph.
* The date and time of admission is recorded in the space provided.
* The maternal condition which includes the temperature, respiration, blood pressure, and pulse rate is also recorded. The blood pressure is represented with a (+) sign and the pulse rate is represented with a (.) sign.
* Urine: Instruct the patient to empty the bladder every 2 hours. Observe the urine for the concentration and determine the amount. A concentrated urine indicate dehydration. The urine is observed for the presence of glucose, acetone, and protein. Presence of protein indicates pregnancy induced hypertension while presence of acetone indicates dehydration or diabetes.
* Drugs or rehydration fluids administered must be recorded.
* Oxytocin administered must be recorded in the space provided.
* The foetal condition is also monitored. foetal heart rate is counted every half hour and plotted at the top of the partograph with a dot (.) The lines for 120 and 160 beats per minutes are darker to remind the nurse that these are the normal limits of the foetal rate. Colur of amniotic fluid is observed at every vagina examination and recorded as:
* I: membranes are intact OR A: liquor is absent.
* R: membranes ruptured
* C: membranes ruptured; clear fluid/ liquor
* M: meconium-stained fluid/ liquor
* B: blood-stained fluid/ liquor

ADVANTAGES

* 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

LIMITATIONS

* It requires a skilled health care worker who can fill and interpret the paragraph.
* Often paper-partograph and the equipment required to complete it are unavailable in low resource settings
* Implementation rates and capacity to correctly use the partograph are very low
* The validity of a partograph is questioned because cervical dilatation over time is a poor predictor of severe adverse birth outcomes.

MANAGEMENT OF LABOUR USING PARTOGRAPH

The partograph with associated management guidelines 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
* The WHO manuals for use with the partograph give little details on the suggested management. The manuals advice the development of local protocols.

THE MANAGEMENT OF SECOND AND THIRD STAGE OF LABOUR

MANAGEMENT OF SECOND STAGE LABOR

Management includes the principle, the measures, preparation for delivery and the conduction of delivery.

* The principles include:
* To assist in the natural expulsion of the fetus slowly and steadily.
* To prevent perineal injuries.
* Measures include:
* The patient should be in bed
* Constant supervision
* To administer analgesics
* Vaginal examination.
* Preparation for delivery include
* The patient is wheeled to the delivery room.
* Positioning.
* The lower abdomen upper parts of the thighs, vulva and perineum are swabbed with antiseptic lotion.
* Sterile legs and towels are applied.
* Ask patients to bear down during contractions and relax in between.
* Conduction of delivery include
* Delivery of the head
* Delivery of the shoulders
* Delivery of the trunk.
* Nursing care of patients in second stage of labor
* Never leave the patients alone once she has been transferred to the delivery room.
* Encourage the patient to rest between contractions and push with contractions.
* Position the patients’ legs in the stirrups for the lithotomy position.
* Prepare the patients perineum
* Monitor the patients’ blood pressure and the fetal heartbeat every 5 minutes and each after contractions.
* Immediate care of the newborn
* Baby should be placed on a tray covered with clean dry linen with the head slightly downwards soon after delivery.
* Maintaining thermoregulation
* Suctioning to clear air passage
* Maintaining cardio respiratory function
* Oxygen maybe given as needed until the infant cries vigorously
* APGAR scoring
* Clamping and ligature of the cord: the cord is divided between 2 clamps to avoid bleeding from a possible second uniovular twin.
* Documenting urination or passage of meconium
* Administering vitamin k
* Prophylactic eye care
* Promoting parent newborn bonding
* Quick check is made to detect any gross abnormality.

MANAGEMENT OF THIRD STAGE OF LABOUR

* There are two ways of managing the third stage of labour:
* 1.The active method.
* 2.The passive method.

ACTIVE 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.
* Everybody conducting a delivery must be able to use the active method of managing the third stage of labour.
* 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.
* NOTE:Controlled cord traction is also called the Brandt-Andrews method (manoeuvre).
* 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.
* Advantages:
* Blood loss is less than when the passive method is used.
* There is less possibility that additional oxytocin will be needed to contract the uterus following the third stage of labour.

DISADVANTAGES:

* 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.
* 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.
* 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.

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. Midwives working in a peripheral clinic or level 1 hospital may find this method useful, when they do not have an assistant while conducting a delivery.
* This method is safe in most low-risk patients managed in clinics and hospitals.

ADVANTAGES:

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

DISADVANTAGES:

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

THE MANMANAGEME OF A RETAINED PLACENTA?

* Continue with the intravenous infusion of oxytocin and make sure that the uterus is well contracted. This will reduce the risk of postpartum haemorrhage.
* While waiting for the theatre to be ready for transfer of the patient, check continuously whether the uterus remains well contracted and for excessive vaginal bleeding. The blood pressure and pulse must be measured and recorded every 30 minutes.
* If the patient is at a clinic or a level 1 hospital without an operating theatre, she must be transferred to a level 2 or 3 hospital, for manual removal of the placenta under general anaesthesia.
* Keep the patient nil per mouth.