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

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

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

The **partograph** is a graphical presentation of the progress of labour, and of fetal and maternal condition during labour. It is the best tool to help you detect whether labour is progressing normally or abnormally, and to warn you as soon as possible if there are signs of fetal distress or if the mother’s vital signs deviate from the normal range.

### 1 & 2). Recording and interpreting the progress of labour

A normally progressing labour is characterised by at least 1 cm per hour cervical dilatation, once the labour has entered the active first stage of labour. Another important point is that (unless you detect any maternal or fetal problems), every 30 minutes you will be counting fetal heart beats for one full minute, and uterine contractions for 10 minutes.

You should do a digital vaginal examination initially to assess:

* The extent of cervical effacement and cervical dilatation
* The presenting part of the foetus
* The status of the fetal membranes (intact or ruptured) and amniotic fluid
* The relative size of the mother’s pelvis to check if the brim is wide enough for the baby to pass through.

Thereafter, in every 4 hours you should check the change in:

* Cervical dilatation
* Development of cervical oedema (an initially thin cervix may become thicker if the woman starts to push too early, or if the labour is too prolonged with minimal change in cervical dilatation)
* Position (of the foetus, if you are able to identify it)
* Fetal head descent
* Development of moulding and caput (Study Session 2 in this Module)
* Amniotic fluid colour (if the fetal membranes have already ruptured).

You should record each of your findings on the partograph at the stated time intervals as labour, progresses. The graphs you plot will show you whether everything is going well or one or more of the measurements is a cause for concern. When you record the findings on the partograph, make sure that:

* You use one partograph form per each labouring mother. (Occasionally, you may make a diagnosis of true labour and start recording on the partograph, but then you realise later that it was actually a false labour. You may decide to send the woman home or advise her to continue her normal daily activities. When true labour is finally established, use a new partograph and not the previously started one).
* You start recording on the partograph when the labour is in active first stage (cervical dilation of 4 cm and above).
* Your recordings should be clearly visible so that anybody who knows about the partograph can understand and interpret the marks you have made.

If you have to refer the mother to a higher level health facility, you should send the partograph with your referral note and record your interpretation of the partograph in the note.

* Without looking back over the previous sections, quickly write down the partograph measurements that you must make in order to monitor the progress of labour:

**I) cervical dilatation**

The first stage of labour is divided into the latent and the active phases. The **latent phase** at the onset of labour lasts until cervical dilatation is 4 cm and is accompanied by effacement of the cervix. The latent phase may last up to 8 hours, although it is usually completed more quickly than this. Although regular assessments of maternal and fetal wellbeing and a record of all findings should be made, these are not plotted on the partograph until labour enters the active phase.

Vaginal examinations are carried out approximately every 4 hours from this point until the baby is born. The **active phase** of the first stage of labour starts when the cervix is 4 cm dilated and it is completed at full dilatation, i.e. 10 cm. Progress in cervical dilatation during the active phase is at least 1 cm per hour (often quicker in multigravida mothers).

In the cervical dilatation section of the partograph, down the left side, are the numbers 0–10. Each number/square represents 1 cm dilatation. Along the bottom of this section are 24 squares, each representing 1 hour. The dilatation of the cervix is estimated by vaginal examination and recorded on the partograph with an X mark every 4 hours. Cervical dilatation in multipara women may need to be checked more frequently than every 4 hours in advanced labour, because their progress is likely to be faster than that of women who are giving birth for the first time. If progress of labour is satisfactory, the recording of cervical dilatation will remain on, or to the left, of the alert line.

If the membranes have ruptured and the woman has no contractions, do not perform a digital vaginal examination, as it does not help to establish the diagnosis and there is a risk of introducing infection. (PROM, premature rupture of membranes)

**II)  Descent of the fetal head**

For labour to progress well, dilatation of the cervix should be accompanied by descent of the fetal head, which is plotted on the same section of the partograph, but using O as the symbol. But before you can do that, you must learn to estimate the progress of fetal descent by measuring the **station** of the fetal head. The station can only be determined by examination of the woman’s vagina with your gloved fingers, and by reference to the position of the presenting part of the fetal skull relative to the Ischia spines in the mother’s pelvic brim.

When the fetal head is at the same level as the Ischia spines, this is called station 0. If the head is higher up the birth canal than the Ischia spines, the station is given a negative number. At station –4 or –3 the fetal head is still ‘floating’ and not yet engaged; at station –2 or –1 it is descending closer to the Ischia spines.

If the fetal head is lower down the birth canal than the Ischia spines, the station is given a positive number. At station +1 and even more at station +2, you will be able to see the presenting part of baby’s head bulging forward during labour contractions. At station +3 the baby’s head is **crowning**, i.e. visible at the vaginal opening even between contractions. The cervix should be fully dilated at this point. When the baby’s head starts crowning (station +3), you may not have time to record the O mark on the partograph.

**III)  Assessing moulding and caput formation**

The five separate bones of the fetal skull are joined together by sutures, which are quite flexible during the birth, and there are also two larger soft areas called fontanels. Movement in the sutures and fontanels allows the skull bones to overlap each other to some extent as the head is forced down the birth canal by the contractions of the uterus. The extent of overlapping of fetal skull bones is called **molding**, and it can produce a pointed or flattened shape to the baby’s head when it is born

**IV)  Recording moulding on the partograph**

To identify molding, first palpate the suture lines on the fetal head, the skull bones that are most likely to overlap are the parietal bones, which are joined by the sagittal suture, and have the anterior and posterior fontanels to the front and back.

* **Sutures apposed:** This is when adjacent skull bones are touching each other, but are not overlapping. This is called degree 1 molding (+1).
* **Sutures overlapped but reducible:** This is when you feel that one skull bone is overlapping another, but when you gently push the overlapped bone it goes back easily. This is called degree 2 molding (+2).

**Sutures overlapped and not reducible**: This is when you feel that one skull bone is overlapping another, but when you try to push the overlapped bone, it does not go back. This is called degree 3 molding (+3). If you find +3 molding with poor progress of labor, this may indicate that the labor is at increased risk of becoming obstructed. When you document the degree of molding on the partograph, use a scale from 0 (no molding) to +3, and write them in the row of boxes provided:

* 0 Bones are separated and the sutures can be felt easily.
* +1 bone is just touching each other.
* +2 Bones are overlapping but can be separated easily with pressure by your finger.
* +3 Bones are overlapping but cannot be separated easily with pressure by your finger.

In the partograph, there is no specific space to document caput formation. However, caput detection should be part of your assessment during each vaginal examination. Like molding, you grade the degree of caput as 0, +1, +2 or +3. Because of its subjective nature, grading the caput as +1 or +3 simply indicates a ‘small’ and a ‘large’ caput respectively. You can document the degree of caput either on the back of the partograph or on the mother’s health record (if you have it).

**V) Uterine contractions**

You already know that good uterine contractions are necessary for good progress of labour. Normally, contractions become more frequent and last longer as labour progresses. Contractions are recorded every 30 minutes on the partograph in their own section, which is below the hour/time rows. At the left hand side is written ‘Contractions per 10 minutes and the scale is numbered from 1–5. Each square represents one contraction, so that if two contractions are felt in 10 minutes, you should shade two squares.

On each shaded square, you will also indicate the duration of each contraction by using the symbols shown in Figure below:

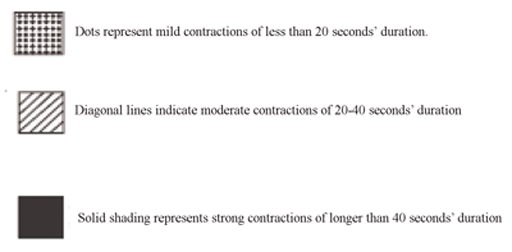


Figure above showing Different shading on the squares you draw on the partograph indicates the strength and duration of contractions.

**VI)  Assessment and recording of fetal wellbeing**

To know if the foetus is in good health during labour and delivery, the methods open to you are limited, but you can assess fetal condition:

* By counting the fetal heart beat every 30 minutes;
* If the fetal membranes have ruptured, by checking the colour of the amniotic fluid.