MATRIC NO: 16/MHS02/027

COURSE TITLE: MATERNAL HEALTH AND NORMAL MIDWIFERY

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The patograph

A graphic recording and an effective means of recording the progress of labour that serves as a tool that can be used by midwives to assess the progress of labour and to identify when intervention is necessary. The principles of using the graph during the active phase of labour are that labour must be confirmed, recording on the graph should commence at 3 cm cervical dilatation, timelines should be followed with each block indicating an hour in time, that the partograph should reflect the fetal wellbeing, maternal wellbeing and the progress of labour.

Midwifery record

Midwifery record is a legal document that must be kept meticulously by midwives. They may go before midwifery council conduct committee and usually examined in the audit process of statutory supervision in relation to clinical negligence (Fraser et al., 2009).

Labour management

This is the reflections on interventions and timing of care in order to optimize the wellbeing of the woman and her baby during the course of labour.

MANAGEMENT OF 3RD AND 4TH STAGE OF LABOUR

THIRED STAGE

The third stage of labour may be managed expectantly or actively. In expectant (physiological) management, uterotonic drugs are not given prophylactically, the cord may or may not be clamped early, and the placenta is delivered by maternal effort. In active management, uterotonic drugs are given before delivery of the placenta, the cord is usually cut 2–3 minutes after birth, and the placenta is delivered by controlled cord traction (CCT

1. ASSESSMENT: Place the baby in skin-to-skin contact on the abdomen of the mother, dry the baby, assess the baby’s breathing and perform resuscitation if needed. Cover the baby’s head with a cloth or, preferably a hat/bonnet. Cover the woman and baby.
2. UTEROTONIC: Administer an uterotonic (oxytocin or misoprostol) within 1 minute after the baby’s birth and after ruling out the presence of another baby (the uterotonic of choice is oxytocin 10 IU IM). Give 600 µg of misoprostol by mouth within 1 minute after the baby’s birth and after ruling out the presence of another baby. Give 600 µg of misoprostol by mouth within 1 minute after the baby’s birth and after ruling out the presence of another baby.
3. CORD CUTTING: Clamp and cut the cord after cord pulsations have ceased or approximately 2–3 minutes after birth of the baby, whichever comes first. Cover the cord with a piece of gauze when cutting the cord to avoid splashing blood.
4. CONTROLLED CORD TRACTION: When there is a contraction, apply external pressure on the uterus in an upward direction (toward the woman’s head) with the hand just above the pubic bone. At the same time with your other hand, pull with firm and steady tension on the cord in a downward direction (follow the direction of the birth canal). Avoid jerky or forceful pulling. Do not release support on the uterus until the placenta is visible at the vulva. Deliver the placenta slowly and support it with both hands. Only release support of the uterus when the placenta is visible at the vulva.
5. DELIVERY OF THE PLACENTA: As the placenta is delivered, hold and gently turn it with both hands until the membranes are twisted. Slowly pull to complete the delivery. Gently move membranes up and down until delivered.
6. MASSAGE: Massage the uterus immediately after delivery of the placenta and membranes until it is firm. During recovery, assist the woman to breastfeed if this is her choice, monitor the newborn and woman closely, palpate the uterus through the abdomen every 15 minutes for 2 hours to make sure it is firm and monitor the amount of vaginal bleeding. Provide prevention of mother-to-child transmission care as needed.

 FOURTH STAGE

The recovery phase immediately after delivery of the placenta is often referred to as the fourth stage of labour. This is misnomer because labour and delivery are completed with the expulsion of the placenta. This stage begins after delivery of the placenta and ends when the mother’s system is stabilized, usually 1-4 hours later.

MANAGEMENT

EVALUATION AND INSPECTION

1. Assess for pain the type, location and intensity. Look for signs of discomfort
2. Evaluate the uterus: after delivery of the placenta, the uterus is normally found in the midline of the abdomen approximately two thirds to three fourths of the way up between the symphysis pubis and umbilicus.

A uterus found above the umbilicus is indicative o blood clots inside, which needs to be expressed and expelled. A uterus found above the umbilicus and to the side usually the right side indicates a full bladder. The uterus is assessed every 15 minutes for the first hour.

 The woman is positioned with knees flexed and head flat.

The nurse uses one hand to stabilize the uterus just above the symphysis pubis and the pouter edge of the other hand to locate the fundus. Position of the fundus is noted in relation to the umbilicus and recorded as centimetres above or below the umbilicus. During this stage, fundal height is usually at the level of the umbilicus. Placement of uterus is also noted in relation to midline. Consistency is noted. If the uterus id not firm, it is referred to as a boggy, and the fundus is massaged gently in a circular motion until the uterus contracts and becomes firm.

1. Inspection of the cervix and upper vaginal vault: the uterus is contracted but there continues to be steady trickle or flow of blood from the vagina. The mother was pushing prior to complete dilatation of the cervix. The labour and delivery were rapid and precipitous. Traumatic second stage of delivery such as prolonged shoulder dystocia or large baby.
2. Inspection and evaluation of the placenta membranes and umbilical cord: these are done before repairing any laceration or episiotomy. This is because if during the placenta. The midwife determines that the uterus needs to exposed manually because of a retained placental fragment, it needs to be done as soon as possible since it has the potential for causing haemorrhage.
3. Repairs: the repair of any laceration or an episiotomy is done after the examination of the placenta and membranes. If a uterine exploration for retained placental fragments is necessary it is done prior to the repair. The uterus is checked again for consistency and repair is begun.
4. Perineal cleansing and positioning of legs: the next nursing action is to wash off the mother’s entire perineal area including the perineum, vulva, inner thighs, buttocks and the rectal area. A perineal pad is then placed against the perineum and mother assisted to put her legs together.
5. Continuing care and monitoring: vital signs check. Palpation of the fundus of the uterus for contractility. Massage of the fundus, and expression of the clots and free bloom from the uterus. Measurement of the fundus in relation to the umbilicus. Inspection of the perineum for discolouration and swelling. Inspection of the perineal pad and change, if necessary. Offering food and fluids if allowed and comfort and safety measures.