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.

The partograph is actually your record chart for the labouring mother. It has an identification section at the top where you write the name and age of the mother, her ‘gravida’ and ‘para’ status, her Health Post or hospital registration number, the date and time when you first attended her for the delivery, and the time the fetal membranes ruptured (her ‘waters broke’).

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 Rate initially 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, i.e. 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 mins (minutes) initially and every 30 minutes.

\* Below that are two rows for recording administration of Oxytocin during labour and the amount given. (You are NOT supposed to do this – it is for a doctor to decide! However, you will be trained to give oxytocin after the baby has been born if there is a risk of postpartum haemorrhage.)

\* 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 Temp °C (temperature).

\* At the very bottom you record the characteristics of the mother’s Urine: protein, acetone, volume. You learned how to use urine dipsticks to test for the presence of a protein (albumin) during antenatal care.

MANAGEMENT OF 2ND STAGE OF LABOUR

The second stage of labor is defined as that time from the completion of dilitation of the cervix to the delivery of the infant. Considerable controversy exists in the current obstetric and midwifery literature concerning the appropriate management of this stage of labor.

Management

 With increased use of regional anesthesia, electronic fetal monitoring and the shift in favor of active management of labor, the second stage is often accompanied by forceful bearing-down efforts, repeated Valsalva maneuvers and an increase in the use of forceps, vacuum extraction and episiotomies. Probably the single strongest point resulting in active intervention in the second stage of labor is the rigid use of the Friedman Curve. This approach tends to insist upon a predetermined time interval and promotes early intervention.

MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labor commences with the completed delivery of the fetus and ends with the completed delivery of the placenta and its attached membranes. The clinician immediately recognizes that from a practical perspective, the risk of complications continues for some period after delivery of the placenta. For this reason, many authorities have advocated a so-called fourth stage of labor, which begins with the delivery of the placenta and lasts for an arbitrary period afterward. The most commonly chosen duration is 1 hour; however, periods as long as 4 hours have been suggested. The length of the third stage itself is usually 5-15 minutes. The absolute time limit for delivery of the placenta, without evidence of significant bleeding, remains unclear. Periods ranging from 30-60 minutes have been suggested.

Management

Commence preparations for the third stage of labor well before delivery of the baby. In the antepartum period, discuss with the patient and her partner their preferences for the delivery process with an open dialogue regarding any risk factors present and what implications they might have for the woman. Thoroughly discuss any concerns or variations from accepted practice. It is important that the patient understand the implications and potential risks involved if management options are limited.