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QUALIFIED CARE TO LABOR: A DESCRIPTIVE STUDY

ATENÇÃO QUALIFICADA AO TRABALHO DE PARTO: UM ESTUDO DESCRITIVO

ATENCIÓN CUALIFICADA AL TRABAJO DE PARTO: UN ESTUDIO DESCRIPTIVO

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ABSTRACT

Objective: to know the care during labor based on the essential obstetrics skills recommended by the International Confederation of Midwives. ***Method:*** this is a descriptive and prospective study with data collection through non-participatory systematic observation of nursing actions. Eighteen labors were observed and data were systematically organized by simple statistics with frequency and percentage presented in a table, enabling to describe and summarize all data collected. The research project was approved by the Research Ethics Committee, Opinion No. 0824/2007. ***Results:*** the model of care prioritized the professional qualification however, many of the essential skills in obstetrics no longer developed or were incomplete. ***Conclusion:*** it was necessary to rethink about education and professional practice. The knowledge and skills recommended to a qualified professional to provide quality care and reduce maternal and neonatal mortality were not present during the study. ***Descriptors:*** Professional Ability; Skill; Nursing; Obstetrics.

RESUMO

***Objetivo*:** conhecer a atenção ao trabalho de parto tendo por base as competências essenciais em obstetrícia preconizadas pela Confederação Internacional de Parteiras. ***Método*:** estudo descritivo e prospectivo, com coleta de dados por meio da observação sistemática não participativa das ações de enfermagem. Foram observados 18 trabalhos de parto e os dados foram sistematicamente organizados pela estatística simples, com frequência e percentual apresentados em uma tabela, possibilitando descrever e sintetizar todas as informações coletadas. O projeto de pesquisa teve a aprovação do Comitê de Ética em Pesquisa, parecer nº 0824/2007. ***Resultados*:** o modelo de atenção priorizava a qualificação profissional, no entanto, muitas das habilidades essenciais em obstetrícia deixaram de ser desenvolvidas ou as foram de maneira incompleta. ***Conclusão*:** foi evidente a necessidade de repensar formação e prática profissional. Os conhecimentos e as habilidades preconizados ao profissional qualificado para proporcionar atenção de qualidade e reduzir a mortalidade materna e neonatal não estiverem presentes durante o estudo. ***Descritores*:** Competência Profissional; Habilidade; Enfermagem; Obstetrícia.

RESUMEN

***Objetivo*:** conocer la atención al trabajo de parto teniendo por base las competencias esenciales en obstetricia preconizadas por la Confederación Internacional de Parteras. ***Método*:** estudio descriptivo y prospectivo, con recolección de datos por medio de la observación sistemática no participativa de las acciones de enfermería. Fueron observados 18 trabajos de parto y los datos fueron sistemáticamente organizados por la estadística simple, con frecuencia y porcentaje presentados en una tabla, posibilitando describir y sintetizar todas las informaciones recogidas. El proyecto de investigación tuvo la aprobación del Comité de Ética en Investigación, parecer nº 0824/2007. ***Resultados*:** el modelo de atención priorizaba la calificación profesional, sin embargo, muchas de las habilidades esenciales en obstetricia dejaron de ser desarrolladas o fueron de manera incompleta. ***Conclusión*:** fue evidente la necesidad de repensar formación y práctica profesional. Los conocimientos y las habilidades preconizadas al profesional calificado para proporcionar atención de calidad y reducir la mortalidad materna y neonatal no estuvieron presentes durante el estudio. ***Descriptores*:** Competencia Profesional; Habilidad; Enfermería; Obstetricia.

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INTRODUCTION

Maternal mortality reduction was ratified by the United Nations and its members as one of the eight goals of the Millennium Development with an increase in the proportion of births attended by skilled staff. This initiative is endorsed by historical and epidemiological evidence indicating the qualified care with significant effect in reducing maternal deaths.[1-2]

The skilled care is the process that a pregnant woman and her baby receive adequate care during pregnancy, labor, birth and the postpartum period and immediate neonatal with the childbirth at home, in the health center or hospital. For this to occur, the provider of this care besides having the necessary skills should have the support of a facilitator at different levels of the health system context. This includes a framework of policies, standards, medicines, materials, equipment and adequate infrastructure and an efficient and effective system of communication, referral and transportation.

A qualified person should be able to handle labor and vaginal delivery, recognizing complications, performing essential interventions, starting the appropriate treatment immediately and promoting timely referral of mother and baby to interventions beyond their ability or not possible in the particular context.[2]

The staff or qualified provider term refers only those people with skill in professional delivery care (doctors, midwives and nurses) trained to achieve expertise in the needed skills offering competent care during pregnancy and childbirth.[3] The World Health Organization (WHO), the United Nations, the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) established a consensus about indicators that guide the expected professional profile with essential skills to give care to the woman in puerperal cycle.[1]

The document on the Essential Competencies for Basic Exercise of Obstetrics recommends what knowledge and skills that qualified professional must have to give the woman a quality care in all phases of the reproductive cycle, seeking to answer: What does a midwife do? And what she does, is it based on evidence? This document lists six broad skills that professionals should have. Each of these skills provides a list of basic knowledge and skills required for safe a practice in any situation, as well as additional knowledge and skills being adopted according to the reality of each country.[1]

In Brazil, one of the mechanisms adopted by the government was the creation of the program "National Pact for the Reduction of Maternal and Neonatal Mortality" consisted in the execution of a set of coordinated actions by the different spheres of government to qualify obstetric and neonatal care, with priority actions for training and continuing education. Although some progress has been achieved, as a result of these strategies, there is still much to be done around the world, requiring commitment and contributions of different partners, including governments, non-governmental organizations, international organizations and donor systems, among others.[1]

Studies that investigated the coverage of qualified care revealed that especially in the last decade, significant differences persisted within each world region.[2-1] In developing countries, for example, only a little bit more than half of women (53%) were attended by qualified staff.[4] In Brazil, the most alarming situation today is the poor quality of care, including access to the service.[4] Maternal deaths are still a problem to be struggled and qualified care at birth is a key strategy to make pregnancy and childbirth safer, reducing maternal deaths.

When considering the importance of this topic and the contribution of nursing professionals in this scenario, the objective of this study was to characterize the actions developed by this professional in labor asistance in the city of Araraquara, interior of São Paulo, with reference of the essential abilities for the practice of obstetrics of ICM/WHO/Figo and the proposed and recommended actions by the Ministry of Health of Brazil.

OBJETIVE

- To know the care during labor based on the essential abilities in obstetric preconized by the International Confederation of Midwives.

METHOD

This is an article elaborated from the research project **<<Nursing care to women during pregnancy and puerperium cycle: the reality of Araraquara/SP>>** developed by the School of Nursing of Ribeirão Preto, University of São Paulo/EERP/USP, with support of the Collaborating Center of the World Health Organization to develop Nursing Research. This research was during the period of

January-July 2008 with the approval of the Ethics Committee in Research from the University of São Paulo/CEP/USP, under protocol No. 0824/2007.

Descriptive, cross-sectional study with a quantitative approach, centered on the actions performed by nursing professionals during care to labor in the city of Araraquara, interior of São Paulo/SP. The study was performed in the public maternity linked to the Unified Health System - SUS, assisted most of the vaginal deliveries (99%).

All nursing professional (nursing assistants, technical nursing and midwives nurses) who worked in the obstetric center and providing care to women in labor at the time of the study were considered eligible. The exclusion criteria was: not acting in obstetric center and not providing care to women in labor at the time of the study, and also if they explicitly refuse to participate in the study.

The sample consisted of 11 nurses in the obstetric center, after agreeing to participate in the study and signed an Informed Consent Form. The care observed were to those women who were in the condition of parturient and after being informed about the purpose of the study, they agreed with the observation and signed the consent form. The choice of women to be observed was made by lot with those who were in attendance at the time of the study.

Data collection was performed prospectively by non-participatory, structured and systematic direct observation of the actions of nurses, directed by checklist instrument and guided by the essential midwifery skills.

Eighteen births were observed for a total period of 31 hours of observation, divided between work shifts (morning, afternoon and evening). The smallest observation time of labor was 15 minutes and the maximum time 5 hours and 45 minutes, with an average time of 1 hour and 45 minutes.

The observation period for each labor was ending with the resolution vaginal or cesarean. The closure of the data collection phase of the research was at the time the actions became repetitive and routine, revealing the practices were not necessary any more, not giving extra scientific values.

Data were systematically organized by the simple statistics, frequency and percentage presented in a table, describing and synthesizing all the information collected, based on the documents that support the qualified care at birth: The essential competencies published by ICM/WHO/PAHO, the practical Guide of care in normal birth (WHO) guidelines of the Integrated Management of Pregnancy and Childbirth (IMPAC) published by WHO and childbirth, abortion and postpartum manual - Humanized Healthcare for women of the Ministry of Health

RESULTS

The nursing staff was composed of six midwives nurses, two nursing assistants and three technical nurses, totaling 11 professionals. In all shifts was a midwife and a professional nursing assistant integrating the team, beyond the obstetrician who works in that shift.

All professionals developed some action, some of them exclusively determined by particular category, showing the division of work according to ability. Those conducted only by the midwife were cardio-fetal monitor installation and administration of intra-vaginal medication (misoprostol) as medical prescription.

The midwife does the peculiar actions to review the progress of labor, although this function was also attributed to the obstetrician. Among the 18 labors observed, the midwife evaluated 17 and 12 by the obstetrician; six women were evaluated only by the midwife, however, one patient was not evaluated even once by the midwife.

Although all nurses were specialists in obstetrics and practice vaginal deliveries, all procedures were recorded in the addendum of hospitalization - AIH as a medical procedure.

The nursing assistant performed the activities of lesser technical complexity as intravenous medicine administration, blood pressure measurement and installation of serotherapy. The professional held the role of "obstetric center´s auxiliary." During the practice, no difference in the execution of actions among nursing assistants and technicians was observed, as in the Brazilian legislation.

Among the activities observed, there were those the most frequently performed during labor performing the vaginal examination, auscultation of the cardio-fetal rate and uterine contractility. Table 1 shows the frequency distribution of actions held by women in labor in the public hospital in Araraquara-SP, São Paulo, 2008.

Tabela 1. Frequency of the actions held during eighteen labors observed in the public maternity of Araraquara-SP, 2008.

Action Descrption	Assistant nursee		Tech. Nurese.		Midwives		Total	
	n	%	n	%	n	%	n	%
Forward to hygiene	3	1.67	-	-	-	-	3	1.67
Offer nightdress	3	1.67	2	1.11	3	1.67	8	4.46
To do enema	-	-	-	-	-	-	-	-
To do perineal shaving	2	1.11	-	-	2	1.11	4	2.23
Encourage fluid intake	-	-	2	1.11	5	2.79	7	3.91
Indicate amniotomy	-	-	-	-	4	2.23	4	2.23
Perform amniotomy	-	-	-	-	5	2.79	5	2.79
Auscultation cardio-fetal beat	-	-	-	-	29	16.20	29	16.20
Conduct cardiofetal monitoring	-	-	-	-	3	1.67	3	1.67
Perform abdominall palpation	-	-	-	-	12	6.70	12	6.70
Evaluate uterine activity	-	-	-	-	25	13.96	25	13.96
Perform vaginal examination	-	-	-	-	43	24.02	43	24.02
Request installation of oxytocin	-	-	-	-	2	1.11	2	1.11
Install serotherapy with oxytocin	2	1.11	3	1.67	1	0.55	6	3.35
Control oxytocin infusion	-	-	-	-	8	4.46	8	4.46
Guide labor	-	-	-	-	7	3.91	7	3.91
Guide left lateral decubitus	-	-	1	0.55	6	3.35	7	3.91
Guide breathing exercise	-	-	1	0.55	4	2.23	5	2.79
Guide to pull	-	-	-	-	1	0.55	1	0.55
Total	10	5.58	9	5.02	160	89.38	179	100.00

No action was performed for all 18 women observed. The digital vaginal examination, for example, stopped being performed in one pregnant woman (subsequently referred to the surgical delivery), fetal heartbeats were not auscultated in two pregnant women, the conference of uterine activity stopped being performed in three pregnant women, there was not monitoring of intravenous oxytocin infusion in 11 pregnant women and blood pressure measurement was performed only in seven pregnant women (once in every woman). We highlight that once the blood pressure measurement by the midwife was observed, revealing that in the institution studied this action was up to the assistant nursing professional. However, the midwife primarily competed performing vaginal examination, action to evaluate cervical and fetal presentation parameters. The evaluation of cervical effacement, descent of the presentation and integrity of membranes stopped being performed in all the patients. Only on three cases the variety of position was observed and on any case the characteristics of the basin were observed.

Some actions were not performed to any woman in labor as the measurement of uterine height and abdominal circumference, the referral of the parturient to ambulate, the use of the Bobath ball, labor analgesia and amnioscopia. The temperature measurement was performed in two women only.

Este estudo revelou que o uso de procedimentos não farmacológicos para o alívio da dor foi uma prática pouco utilizada, sendo o encaminhamento ao banho de relaxamento a ação realizada com seis ocasiões indicados pela enfermeira obstetra e em duas ocasiões, por profissional de nível médio. A realização de massagem foi observada em dois momentos, ocasião em que a enfermeira e a profissional de enfermagem de nível médio a executaram. O uso do cavalinho ocorreu uma única vez, a partir da iniciativa do profissional de enfermagem de nível médio.

This study revealed that the use of non-pharmacological procedures for the relief of pain was almost not used and a referral to the bath relaxation was the more frequently performed (for eight women) by the nursing professionals: in six times indicated by the obstetrician and twice by the assistant nursing professional. Massage was observed on two cases, where the nurse and assistants nursing professional performed it. The use of a birthing bar occurred only once by the assistant nursing professional.

The use of pharmacological methods of pain relief was only through intravenous medication - procedure adopted for six of eighteen women - in four of them, the nurse midwife requested this action. Nobody offered labor analgesia to women, although this action is from the protocol of the service.

The use of the partograph was a practice adopted for all women. However, the annotation on the chart occurred in only six labors, and in all cases performed by the midwife. The annotations were performed mostly under observation; the assistant nursing professional was noting only the blood pressure values.

The presence of a companion occurred only once during the entire period of observation, through verbal authorization by the obstetrician because the right of a companion was not guaranteed in the service.

DISCUSSION

The constitution of the essential midwifery skills was based on a care model including pregnancy and birth as normal events. It also includes centered care in women with monitoring the physical, psychological, spiritual and social wellbeing of the woman/family throughout the reproductive cycle, education and individualized care for women and continuing care with minimum technological interventions.[1]

The study reveals that the assistance to labor in the city of Araraquara-SP prioritized qualification execution of actions, identifying the demarcation of limits of performance based on professional skills and concern with skilled attendance at delivery and birth. The midwives developed actions governed by Brazilian law, as Decree No. 94406 of 08 June 1987, providing the professional practice of the nurse with diploma or certificates professional midwife or Nurse Midwife, which differs from findings of a study in institutions of Rio Branco - AC.[5]

The analysis of observed actions revealed that in this institution the midwife has to give care to the labor. However, there was no difference in the performance of assistants nursing professional, according to the degree of activation (nurse and nurse technician), as determined by Decree No. 94,406, of June 8, 1987, which regulates law No. 7,498, of June 25, 1986.

It was not observed the Systematization of Nursing Care -. SAE as COREN-SP/DIR/008/1999 decision, approved by the Federal Council of Nursing COFEN by Decision No 001/2000 of January 4, 2000. The Nursing Consultation was not performed as recommended by professional legislation of the country. For obstetric evaluation is followed the medical model and this action is not part of the clinical protocol of the institution.

The doctor was responsible for outpatient care record (FAA) and the addendum of hospitalization (AIH), and in this circumstance the role of midwife was omitted. Although the approach of this study was limited to the period of labor, we considered valid to reveal that 75% of vaginal births were assisted by midwives. Midwives appropriated this space for their professional practice, different from the reality found in the maternity in Rio Branco/AC where only 28% of births are performed by trained people and in Londrina/PR, where the delivery by the midwife occurs in a simple way.[5-6]

The findings make us see that despite the care model to labor prioritize the qualification, many of the basic skills are no longer performed, or were incomplete and additional skills, when executed, also were incomplete. Similar results were found in a maternity hospital in the state of Paraná, where most of the guidelines proposed by the Ministry of Health for safe delivery was not met effectively, and in fact found in the maternity of Rio Branco in Acre.[5-7]

In the analyzed institution, there were not behavior established in care protocols, leaving the decision to the obstetrician on call. There was no consensus on the practices adopted for the woman in labor, despite the recommendations of the World Health Organization - WHO, for example, in relation to the trichotomy, enema, food and water intake. On many cases the women were subjected to these actions.

Many of the basic skills are no longer performed or were incomplete, as the conference of uterine activity, auscultation of fetal heartbeats - BCF and performing vaginal examination, vital actions to skilled attendance at birth and maternal and fetal risk reduction. In the evaluation of uterine activity were not considered essential parameters such as frequency and intensity of contractions for a period of ten minutes. Auscultation was performed for less than a minute, was not followed by the minimum 30 minute interval between assessments of BCF, were not described the pace and location of the fetal back, and these reviews did not occur during uterine contractions. On vaginal examination the characteristics of the basin, the variety of maternal-fetal position and De Lee Plan were not evaluated. The observations about not performing auscultation of BCF and vaginal examination were also found in the maternity in Rio Branco (AC).[5]

Some useful practices to normal delivery were little used, while other harmful or

ineffective routinely used. Reversing this picture is essential to reduce maternal and neonatal mortality and provide humane care and quality. Although the practice of humanization in the normal birth process is rising, it is still quite common to identify this process linked to the biomedical and intervention model that fragments humans contributes to the medicalization and unnecessary interventions, subjecting the woman and the fetus to risk.[8]

Trichotomy, although performed in a minority of women during the observation period, it was a routine practice in the institution, since all women have already done this procedure. The Ministry of Health recommends that as the enema, this practice is carried out only if requested by women.[9] In the maternity hospitals in Rio Branco (AC) trichotomy and enema are not routinely performed; however, 98.2% of women with normal vaginal delivery shaved at home or in the hospital and the enema was used in 18% of births in a maternity and 38% in another maternity.[5]

The water intake was free and food stopped in the active phase of labor - however, only eight of the eighteen mothers were encouraged to drink fluids. In the maternity of Rio Branco (AC) food and hydration are released and stimulated during labor.[5] The World Health Organization recommends to encourage women about hydration and nutrition that is offered to mothers in labor.[9]

The use of non-pharmacological methods of pain relief was not part of the study practice. Only eight of 18 pregnant women were referred to the bath for relaxation, ambulation and the use of the ball were not encouraged and the use of the birthing bar and massage occurred eventually. Encouraging walking differs from the reality of Rio Branco (AC) where women are encouraged by midwives to ambulate during labor.[5] The assistants nursing professionals encouraged the use of non-pharmacological methods of pain relief as much as the midwives.

The WHO recommends that pregnant women are encouraged to walk and considers this practice as beneficial for pain relief as well as non-pharmacological techniques such as breathing exercises, muscle relaxation, massage and lumbosacral shower.[9] These strategies shown to be effective and well accepted by the women. Non-invasive, non-pharmacological pain relief methods are rarely used in the maternity of Rio Branco (AC) and when they occur, were performed by the midwives.[5] Non-pharmacological methods of pain relief in childbirth are gaining strength through the motions in favor of humanization practices. Studies include methods such as hydrotherapy, ambulation, position changes, relaxation exercises, breathing techniques, massage therapy, using the birthing ball, transcutaneous electrical stimulation and cryotherapy.[8]

The use of pharmacological methods of pain relief during labor occurred mainly in the institution studied by the intravenous medication - buscopam compound, PLAMET and glucose 25% (33.3%); labor analgesia was not part of obstetric practice.

Intravenous administration of oxytocin was a routine practice: 15 of 18 pregnant women were observed with oxytocin infusion during labor. We note that the systematic control of infusion or drip of oxytocin was not part of the routine. The request for installation of oxytocic was also performed by midwife subsequently prescribed by the doctor. A study of the welfare characteristics of births attended by midwives found that oxytocin was used in half of women.[10] The World Health Organization guidance is not clear that the liberal use of oxytocin for the correction of uterine activity offers benefits for women and their newborns.[11]

The orientation of the pregnant women regarding the evolution of labor, breathing technique and benefits of pull and position in the left lateral decubitus were performed predominantly by midwives, although not all women had received such instructions. The educational activity should be viewed not just as another activity, but as a practice that underpins and reorients the entire health care,one of the tasks that arises is to build a profile of competencies for nursing education activities in the process of providing care.[12]

The use of the partograph, and in particular the chart, it was not a practice in the institution, although this form is annexed to find records of all the patients, because in less than 35% of cases occurred the record in this chart. Studies have identified that as the bladder evaluation and abdominal palpation, the use of the partograph was not part of the professional practice in the hospitals of Rio Branco - AC.[5] According to the Ministry of Health/ MH, partograph is a graphical representation used to monitor the progress of labor, because with its use can make early diagnoses and their respective interventions.[9]

The presence of a companion was not understood as part of the care provided, revealing not part of obstetric practice. A study of pregnant women in early labor, attended in the interior of Ceará/ CE,

identified feelings of fear, insecurity and lack of knowledge about the birth process expressed by mothers and they converged on the need for inclusion of a companion in childbirth and an environment of privacy.[13]

CONCLUSION

This research revealed that reality studied in the midwife found openness to their professional practice through monitoring of labor, developing actions together with a multidisciplinary team responsible for the care and birth.

The study provided support for reflection on the quality of nursing care provided to women in labor. We found that many of the essential skills in obstetrics for quality care, recommended by the International Confederation of Midwives have been developed, but some are no longer performed or when executed were incomplete. Some additional skills, although not backed by professional Brazilian legislation, were executed and most often incompletely.

We argue that it is necessary to rethink the training and professional practice as a measure to improve the quality of care for women and newborns. The role of the professional with the skills necessary for qualified care is essential for reducing maternal and neonatal morbidity and mortality and the indiscriminate cesarean section. The teaching-learning process should prioritize the most active and innovative pedagogical practices, incorporating cultural, anthropological and technological approach as part of critical and reflective thinking, empower professionals to qualified care and make them aware regarding the current state of reproductive health in Brazil. Public policies and proposals of humanization have valued the training of midwives, strategies that contribute effectively to the achievement of safe motherhood.

It is important the reorganization of care involving labor including the incorporation of guidelines and care protocols improving the quality of services and the offering of a non-interventionist, humane and safe care. The actors involved in the process of labor and birth - such as healthcare professionals, managers, women, non-governmental organizations, activists, the whole community - must work together to promote a process of sensitization in favor of qualified care to delivery and birth, fostered by assertive political articulations and government investment in all instances.

Conducting studies like this, in other realities of the country, will assist the actual participation of nursing and establishing training policies to meet the maternal and neonatal demands, since this has limitations because it is a clipping from a reality in particular.

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