



PROFILE OF ATTENTION TO THE DELIVERY IN A PUBLIC HOSPITAL: NURSING ASSISTANCE

PERFIL DE ATENÇÃO AO PARTO EM UM HOSPITAL PÚBLICO: CONTRIBUIÇÕES DA ENFERMAGEM

PERFIL DE ATENCIÓN AL PARTO EN UN HOSPITAL PÚBLICO: CONTRIBUCIONES DE LA ENFERMERÍA

Dielly Natannara Chagas Fernandes¹, Jane Baptista Quitete², Jéssika Andrade de Melo Braga Monteiro³, Suellen Gonçalves Maia⁴, Thainá Pinheiro das Neves e Silva⁵, Daniela Matos Oliveira⁶

ABSTRACT

Objective: to perform situational diagnosis of delivery care at a public maternity of the coast of the State of Rio de Janeiro. **Method:** descriptive study with a quantitative approach, applying two instruments for data collection, checklist type in the first half of 2014 with time cutting of nine years running of a a maternity hospital. For data analysis the theoretical reference of the National Survey on Labor and Delivery/Childbirth in Brazil, Ministry of Health and the Recommendations of the World Health Organization. **Results:** zero diet was prescribed for 69.4% of pregnant women throughout labor. The continuous infusion of oxytocin was prescribed at admission to 38.9% pregnant women. **Conclusion:** it was found a high rate of surgical deliveries than vaginal births. It was also observed the performance of obstetric interventions such as fasting, oxytocin, lithotomy and episiotomy carried out routinely and without proper indication. **Descriptors:** Attention to Childbirth; Women's Health; Professional Qualification; Nursing.

RESUMO

Objetivo: realizar diagnóstico situacional da atenção ao parto em uma maternidade pública da baixada litorânea do Estado do Rio de Janeiro. **Método:** estudo descritivo com abordagem quantitativa. Foram aplicados dois instrumentos para coleta de dados, do tipo *checklist*, no primeiro semestre de 2014, tendo como recorte temporal os 9 anos de funcionamento de uma maternidade. Para a análise dos dados, foram utilizados os referenciais teóricos do Inquérito Nacional sobre Parto e Nascimento/Nacer no Brasil, Ministério da Saúde e as Recomendações da Organização Mundial de Saúde. **Resultados:** foi prescrita dieta zero para 69,4% das parturientes durante todo trabalho de parto. A infusão de ocitocina contínua foi prescrita na admissão para 38,9% parturientes. **Conclusão:** constatou-se alto índice de partos cirúrgicos em detrimento dos partos via vaginal. Evidenciando também a realização de intervenções obstétricas, tais como jejum, ocitocina, litotomia e episiotomia sendo efetuadas de modo rotineiro e sem indicação adequada. **Descritores:** Atenção ao Parto; Saúde da Mulher; Formação Profissional; Enfermagem.

RESUMEN

Objetivo: realizar diagnóstico situacional de la atención al parto en una maternidad pública del litoral del Estado de Rio de Janeiro. **Método:** estudio descriptivo con enfoque cuantitativo, habiendo aplicado dos instrumentos para recolección de datos, del tipo *checklist*, en el primer semestre de 2014 con recorte temporal de 9 años de funcionamiento de una maternidad. Para el análisis de los datos, los referenciales teóricos de la Encuesta Nacional sobre Parto y Nacimiento/Nacer en Brasil, Ministerio de la Salud y las Recomendaciones de la Organización Mundial de la Salud. **Resultados:** fue prescrita dieta cero para 69,4% de las parturientes durante todo trabajo de parto. La infusión de oxitocina continua fue prescrita en la admisión para 38,9% parturientes. **Conclusión:** se constató alto índice de partos quirúrgicos en comparación con los partos vaginales. Se evidenció también la realización de intervenciones obstétricas, tales como ayuno, oxitocina, litotomía y episiotomía siendo realizadas de modo rutinario y sin indicación adecuada. **Descriptores:** Atención al Parto; Salud de la Mujer; Formación Profesional; Enfermería.

¹Student, Nursing course, Fluminense Federal University/UFF - Campus Rio das Ostras (RJ). Rio das Ostras (RJ), Brazil. E-mail: dynatannara@hotmail.com; ²Obstetric Nurse, Ph.d. Professor in Nursing, Nursing Course, Fluminense Federal University/UFF - Campus Rio das Ostras (RJ). Rio das Ostras (RJ), Brazil. E-mail: janebq@oi.com.br; ³Student, Nursing Course, Fluminense Federal University/UFF - Campus Rio das Ostras (RJ). Rio das Ostras (RJ), Brazil. E-mail: jessikaamelo@gmail.com; ⁴Student, Nursing Course, Fluminense Federal University/UFF - Campus Rio das Ostras (RJ). Rio das Ostras (RJ), Brazil. E-mail: suellengmaia@yahoo.com.br; ⁵Student, Nursing Course, Fluminense Federal University/UFF - Campus Rio das Ostras (RJ). Rio das Ostras (RJ), Brazil. E-mail: thaina_pns@hotmail.com; ⁶Student, Nursing Course, Fluminense Federal University/UFF - Campus Rio das Ostras (RJ). Rio das Ostras (RJ), Brazil. E-mail: daniellaoliver@hotmail.com

INTRODUCTION

The institution being studied is a theoretical and practical teaching field of the Nursing Subjects Course in Women's Health Care I and II and supervised training of the Nursing Course/REN/Campus Rio das Ostras/UFF. The students about the contradictions of the theoretical content taught with their experience in a practical teaching field who still use obsolete and harmful obstetric practices to maternal and fetal health have raised numerous questions.

This study is the first monitoring percentage of types of deliveries of the institution in its ten years of operation. There is no other institute for this purpose, aiming at improving in care.

The scenario studied is a public hospital health institution, located in a municipality of the coast of the State of Rio de Janeiro. It has a maternity department with fifteen (15) rooming-in beds, one pre-natal, 4 (four) no individual beds, and 04 (four) beds for pregnant women under observation, and 1 (one) vaginal delivery room located inside the operating room.

It is noteworthy that obstetric procedures adopted by the maternity are based on that giving birth and birth are eminently processes of risk and away from the family and the presence of a companion to mothers during labor and delivery are not allowed, except for adolescents.

This study aims at assisting interventions qualifying care to delivery and childbirth based on them as physiological and family events.

OBJECTIVE

- To conduct a situational diagnosis of delivery care at a public maternity of the coast area.

METHOD

Descriptive study with a quantitative approach, using the retrospective documentary technique. Data collection was carried out between May and December 2014. The study consisted of two stages; the first stage used a form filled out by the researchers, who collected data recorded in the institution's delivery book, with the frame period of 2005-2013.

The variables selected for carrying out the first stage of this study were the type of birth (vaginal and abdominal), place of birth (antepartum bed, delivery room, home and public roads). One of the variables excluded

from the survey was the episiotomy because we found that this data is not registered in the institution's delivery book.

The second stage of the study collected information from medical records of 36 women admitted in labor, with a temporal random sample, of the period from May 8 to June 6, 2013. In this second stage, a form was also used, type checklist filled by the researchers.

The variables selected to carry out the second stage of the study were kind of diet prescribed on admission, oxytocin prescription at admission, delivery position, episiotomy achievement, locoregional anesthesia accomplishment and pudendal partograph filling.

For data analysis, the theoretical frameworks of the National Survey of Labor and Delivery/Childbirth in Brazil⁵, Ministry of Health² and Recommendations of the World Health Organization were used.⁶

This study was not submitted to the Ethics Committee in Research of the Fluminense Federal University because we chose to preserve the identity of the institution studied and used available data on birth records and medical records without identifying the population researched.²

RESULTS

This study had 25 (69.4%) women subjected to total fast throughout labor and delivery, from the time of admission. The continuous infusion of oxytocin was prescribed on admission to 14 (38.9%) women and 20 (55.5%) women in the immediate postpartum period.

The mothers were placed in lithotomy in 26 (75%) of vaginal births in the delivery room, and the supine position adopted by 09 (25%) women who had their births in antepartum bed. The partograph was filled, even partially, only in 24 (66.7%) of records.

A local and regional anesthesia was performed, respectively, in only 20 (55.5%) and 05 (13.4%) of the patients, although episiotomy was performed in 27 (75%) of vaginal deliveries, as described in records by the medical professional who attended the childbirth.

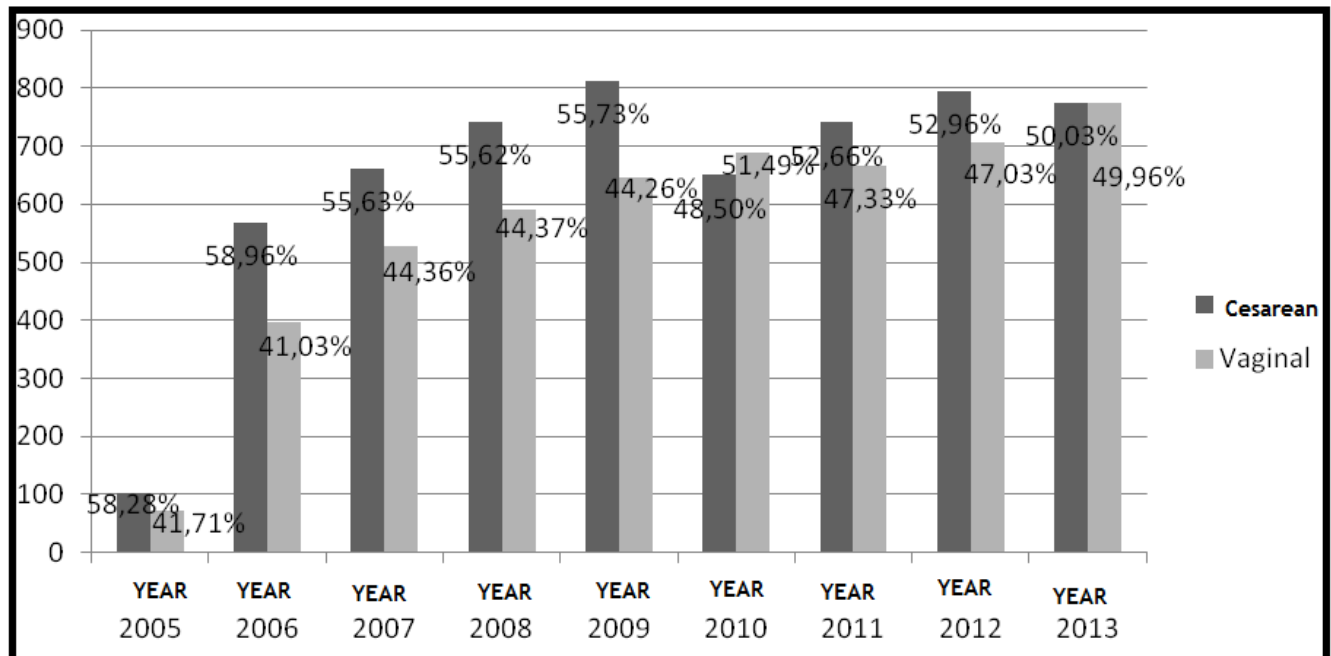


Figure 1. Distribution of the absolute number of births by type of birth. Source: Book of delivery records of the institution studied, 2014.

Of total births in the research institution, 53.5% were a cesarean section, while vaginal deliveries were 46.4% of births.

DISCUSSION

Concerning to fasting, this study showed that for 69.4% of pregnant women, a diet zero throughout labor was prescribed. Compared to other studies, the index is high. In another similar study was zero diet prescribed for 40% of mothers.¹⁶ The Brazilian rate of zero diets for pregnant women is 74%.⁵ The offer of oral liquid or liquid diet is part of the recommendations of the Ministry of Health^{6,1} throughout the delivery process and is characterized as humanized childbirth practice and should prescribe by the medical team and stimulated by the nursing staff.

Multicenter studies conclude that there is no justification for restricting liquids in cases of low risk for cesarean sections and use of general anesthesia, so the offer should be encouraged.^{6,1,10}

Concerning the behavior and/or practices considered harmful to be eliminated⁶, there was that the venous access for fluid infusion occurred in 38.9%, from admission and concomitant infusion of oxytocin. Regarding the use of oxytocin, the results were similar to other studies, occurring around 30.0 to 37.7%.^{16 8} Oxytocin infusion rate in women in labor is 40% of the Brazilian population.⁵

According to the Ministry of Health⁶, the administration of oxytocics is detrimental at any time before delivery, because the effect cannot be controlled, and should be avoided.^{13,10} The indiscriminate use of oxytocin is clearly harmful or ineffective practice that should be eliminated from the health services who attend births, and may

even lead to an increase in uterine activity with consequent fetal hypoxia.¹¹

It is noteworthy that, the routine parenteral infusion alone is also considered an ineffective practice and should be eliminated. Therefore, it reduces mobility, "holding" the mother to bed and increases the discomfort of women. Also, the glucose solution may increase the chance of neonatal hypoglycemia.¹¹ In Brazil, venipuncture routine of women in labor is 70%.⁵

The vertical position reduces labor time and is not associated with increased intervention or negative effects. It should be also considered that the benefits of the upright position for woman and fetus during the delivery period are well described.¹⁰⁻¹ However, we found that the lithotomy position is considered usual for all vaginal births in the study institution, not offering any other possibility of position to give birth. This fact is confirmed because 25% of vaginal birth occurs in dorsal position when the place of birth is in the prepartum bed not assisted mode. This finding is supported by national data that shows 92% of vaginal births occurring in lithotomy position.⁵

The partograph is the instrument that shows the graphical representation of the progression of labor. Therefore, it is essential for monitoring the evolution of labor, cervical dilatation and descent of the presentation and fetal position. The partograph, above all, allows the diagnosis of possible dystocia and guides the professional as the necessary and appropriate behavior for recovery.¹ However, there has been little support for the use of this technology in the studied institution, which was also found in another study and only 2.4% coverage by medical personnel.¹⁶

Studies show that the benefits of this technology are not limited only to the monitoring of the development of labor, but also reflects the control of the use of pharmacological methods aimed at relieving pain and accelerating the uterine contraction in hospitals, such as analgesia and oxytocin, respectively. Also, the partograph interferes with the high cesarean rate without statement, assists in duty exchanges and systematically based on learning of the new active in Obstetrics.^{1,13}

Therefore, the Ministry of Health has its practice for more than three decades as mandatory in all hospitals. Opposite to what this body advocated, the National Survey of Labor and Delivery held in all regions of Brazil, in February 2011 to October 2012, pointed out that the incidence of good obstetric practices in women with low and high risk was low. The partograph was applied in only 41.4% of all deliveries in this period.⁵

Thus, being careful about filling the partograph in health facilities should be viewed as a legal document and essential to the health professional regarding the visibility of all aspects involved during the labor and birth. This shows the consolidation of the security of a well-assisted delivery and commitment of nurses and doctors before the humanized actions along the delivery.

Among the most frequently performed procedures in assisting childbirths, there is the episiotomy highlighted, which was established to assist the complicated vaginal deliveries. It is currently considered nationally as a routine practice, second only to cutting and clamping the umbilical cord.¹¹

The episiotomy is done through the surgical incision with scissors or scalpel in the perineal region, at the end of the second stage of vaginal labor.¹⁵ It is classified according to its location: lateral, medial-lateral and median. The lateral episiotomy is abandoned because of this region is highly vascularized, and having risks to damage the vagina, vulva, anus and of the perineum.¹⁵

To this practice performance, it is necessary that the patient is anesthetized by the anesthetic block - pudendal nerve block and infiltration of the superficial perineal region. Bilateral pudendal anesthesia aims to stop the sensitivity in the vagina, vulva, anus and part of the perineum.^{15,1}

It is noteworthy also that often episiotomy is performed without indication, guidance and consent of the woman, also without local anesthesia and/or locoregional. It is also stand out in this practice, the minimum registration

and/or missing in medical records, as evidenced in this study, however, episiotomy sets up an important indicator of obstetric practices, requiring accurate record in the medical record. It is considered a distinctly harmful practice or ineffective and must be discarded.⁶⁻¹³ Therefore, it increases the risk of perineal laceration third and fourth degrees of infection and bleeding complications without reducing long-term pain and urinary incontinence and fecal.¹¹ The incidence of episiotomy in Brazil is 56%,⁵ therefore, lack of proper registration in the records reveals a flaw that compromises the quality of the health service.

By analyzing Figure 1, the number of vaginal deliveries increased gradually over the ten years of the maternity, although the number of surgical deliveries always remained above the vaginal delivery percentage, except for 2013 when there was a match in the two delivery routes. Perhaps this finding can be explained by all social movements, empowerment of the female population, public policy incentives and other movements for the vaginal delivery.

The data found in this study confirm national data on the percentage of births by cesarean section, being higher over the years and remaining higher, in a percentile of 53.5% of all births, and 40% in services public and 85% in private hospitals.⁵ This predominance of the delivery is justified by the care model still focused on delivery as surgery and imminent risk, bringing maternal and neonatal health risks and is strongly associated with maternal mortality.

During data collection, it was found the lack of description in the records analyzed on the obstetric indication birth by cesarean section. In the study recently conducted throughout Brazil, indicate that cesarean surgeries are performed without proper medical indication and discrimination on the records. In the same study, this can lead to repercussions on the intra-uterine development of the newborn and the future health of the children.^{5,13,11}

Concerning the percentage found of 1% of childbirths vaginally occurred in antepartum bed, it is noteworthy that these should be considered unassisted births, as the place of birth did not happen by the choice of the mother but because she was not monitored by health staff during the second period and gave birth alone. This data reflects the care provided to the mother without guaranteeing the right to the presence of a companion of his chose⁸, lack of obstetric nurses for 24 hours, as recommended by the DRC 36^{19,13},

and lack the 4th individual PPP model (pre-labor/delivery/postpartum).⁶

The organization of care directly affects cesarean rates, which tend to be lower in countries with maternity care less medicalized, with most activities of midwives, equivalent to that played by midwives in the United States, the Netherlands, New Zealand and Scandinavian countries.¹¹ According to the Ministry of Health⁶, delivery care performed by trained professionals is the most important factor in reducing maternal mortality. In Brazil, doctors and their associations show great concern for the usual risk of birth attended by midwives, usually claiming that births attended by these professionals would have a greater risk for the mother and the fetus. This is not verified in the literature, and is refuted by it.¹¹

CONCLUSION

The study reveals the high rate of surgical deliveries at the expense of vaginal births. It is also noted the performing of obstetric interventions such as fasting, oxytocin, a lithotomy and episiotomy being held in a generalized way and often without proper indication.

These interventions, unfortunately, cause the time of delivery not being a pleasant process for women. We found that the assistance is dehumanized, away from the family, not valuing autonomy, femininity and women's intuition at the time of giving birth.

This study reinforces the need for a partnership between the University and the health facility to develop and evaluate strategies to modify the determinants of excess cesareans, and excessive use of unnecessary and harmful interventions to women's health during labor and delivery.

REFERENCES

1. Ministério da Saúde(BR). Secretaria de Políticas de Saúde. Área Técnica de Saúde da Mulher. Parto, aborto e puerpério: assistência humanizada à mulher. [Internet]. 2001 [cited 2015 Mar 10]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/cd04_13.pdf
2. Ministério da Saúde (BR). Portaria 1.459, de 24 de junho de 2011 e Portaria 2.351, de 05 de outubro de 2011. Dispõe sobre a Rede Cegonha. [cited 2013 Dec 05]. Available from: http://portal.saude.gov/portal/arquivos/pdf/portaria_consolidada_cegonha.pdf
3. Ministério das Relações Exteriores(BR). Objetivos de Desenvolvimento do Milênio. [cited 2013 dez 03]. Available from: <http://www.itamaraty.gov.br/temas/temas-multilaterais/direitos-humanos-e-temas-sociais/metas-do-milenio/objetivos-de-desenvolvimento-do-milenio>
4. Conselho Federal de Enfermagem (COFEN). Resolução 477, de 14 de abril de 2015. Dispõe sobre a atuação de Enfermeiros na assistência às gestantes, parturientes e puérperas. Diário Oficial da União, 20 de abril 2015 [cited 2015 July 01]. Available from: http://www.cofen.gov.br/resolucao-cofen-no-04772015_30967.html
5. Gama SGN, Leal MC. Inquérito Nacional sobre Parto e Nascimento. Parir no Brasil. Sumário Executivo Temático da Pesquisa [Internet]. 2014 [cited 2014 Sept 27]. Available from: www.ensp.fiocruz.br/portal-ensp/informe/site/arquivos/anexos/mascerweb.pdf
6. Organização Mundial de Saúde (OMS). Maternidade Segura. Assistência ao Parto Normal: um guia prático. Genebra: Organização Mundial de Saúde; 1996.
7. Quitete JB, Mouta RJO, Progiante JM, Vargens OMC. Aplicando a Teoria das Revoluções Científicas na construção de um novo campo da enfermagem obstétrica. Rev enferm UFPE [Internet]. 2013 [cited 2014 June 11];7(12):6913-20. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2950/DOI:105205/01122013>
8. Dodou HD, Rodrigues DP, Guerreiro EM, Guedes MVC, Lago PN, Mesquita NS. A contribuição do acompanhante para a humanização do parto e nascimento: percepções de puérperas. Escola Anna Nery Revista de Enfermagem [Internet]. 2014 [cited 2014 June 12];18(2):262-269. Available from: http://revistaenfermagem.eean.edu.br/detalhe_artigo.asp?id=1077
9. Reis CSC, Souza DOM, Progiante JMP, Vargens OMC. As práticas utilizadas nos partos hospitalares assistidos por enfermeiras obstétricas. Enfermagem Obstétrica [Internet]. 2014 [cited 2014 Oct 12];1(1):7-11. Available from: <http://www.enfo.com.br>
10. International Federation of Gynecology and Obstetrics (FIGO) et al. Mother-baby friendly birthing facilities. International Journal of Gynecology and Obstetrics [Internet]. 2014 [cited 2015

Fernandes DNC, Quitete JB, Oliveira JAMB et al.

Profile of attention to the delivery in a...

- July 18];128:95-99. Available from: <http://dx.doi.org/10.1016/j.ijgo.2014.10.013>
11. Tesser CD, Knobel R, Andrezzo HFA, Diniz SD. Violência obstétrica e prevenção quaternária: o que é e o que fazer. Rev Bras Med Fam Comunidade [Internet]. 2015 [cited 2015 July 01];10(35):1-12. Available from: [http://dx.doi.org/10.5712/rbmfc10\(35\)1013](http://dx.doi.org/10.5712/rbmfc10(35)1013)
12. Ribeiro, EDLM. Hospital Regional Materno Infantil de Imperatriz, Maranhão: via de parto predominante em outubro e novembro de 2013. J Manag Prim Health Care [Internet]. 2014 [cited 2015 May 15];5(2):195-201. Available from: <http://www.jmphc.com/ojs/index.php/01/article/view/187/140>
13. World health organization (WHO). Recommendations for Argumentation of Labour. WHO Library Cataloguing in Publication [Internet]. 2014 [cited 2014 Dec 28]; Available from: http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363_eng.pdf
14. Secretaria Municipal de Saúde do Rio de Janeiro (SMS/RJ). Protocolo Assistencial da Enfermagem Obstétrica da Secretaria Municipal. SMS/RJ. Rio de Janeiro [Internet]. 2013 [cited 2014 Oct 12]. Available from: <http://www.abenforedesindical.com.br>
15. Neme, B. Obstetrícia Básica. 2ª ed. São Paulo: Sarvier, 2000.
16. Lucas MTB, Rocha MJF, Costa KMM, Oliveira GG, Melo JO. Nursing care during labor in a model maternity unit: cross-sectional study. Online braz j nurs [Internet]. 2015 [cited 2015 July 18];14(1):32-40. Available from: <http://www.objnursing.uff.br/index.php/nursing/article/view/5067>
17. Giglio MR, Franca E, Lamounier JA. Avaliação da qualidade da assistência ao parto normal. Rev Bras Ginecol Obstet [Internet]. 2011 [cited 2015 July 21];33(10):97-304. Available from: www.scielo.br/pdf/rbgo/v33n10/05.pdf
18. Silva FMB, Paixao TCR, Oliveira SMJV, Leite JS, Riesco MLG, Osava RH. Care in a birth Center according to the recommendations of the World Health Organization. Rev Esc Enferm USP [Internet]. 2013 [cited July 21];47(5):1031-8. Available from:

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342013000501031_pdf

19. Pereira ALF.(org.) Legislação Profissional e Marcos Regulatórios da Prática Assistencial da Enfermeira Obstétrica no Sistema Único de Saúde. Rio de Janeiro: Centro de Estudos da Faculdade de Enfermagem da UERJ [Internet]. 2010 [cited Sept 20]. Available from: abenfo.resindical.com.br/arqs/manuais/039.

Submission: 2015/09/28

Accepted: 2015/11/20

Publishing: 2016/01/01

Corresponding Address

Daniela Matos de Oliveira
Rua Recife, Lotes 1-7
Jardim Bela Vista

CEP 28895-532 – Rio das Ostras (RJ), Brazil