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Original Article

Implementation of good practice in assistance to labor at a reference maternity

Implementação das boas práticas na atenção ao parto em maternidade de referência

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Objective: to describe the implementation of good practices of attention to labor at a reference maternity. **Methods**: descriptive, documentary study, with 300 Forms for Monitoring Assistance to Labor and Birth. The data were gathered on tables and submitted to descriptive and numerical inferential analysis. **Results**: in category A we observed that 48.3% of the births filled the partogram; 84.0% of women did not use pharmacological methods for pain relief; 67.0% remained at zero diet during labor; 84.7% had no companion during labor, delivery and after giving birth; 57.0% had skin-to-skin contact; and 65.3% breast-fed in the delivery room. In category B it was found that 54.0% of women remained in venoclysis; 60.7% remained in semi-sit position in the expulsive period; and 14.7% women were shaved. **Conclusion**: some practices proved useful in childbirth are still not implemented in many cases, while others that are harmful or ineffective are still being carried out.
Descriptors: Obstetric Nursing; Natural Childbirth. Humanization of Assistance.

Objetivo: descrever a implementação das boas práticas de atenção ao parto em uma maternidade de referência. **Métodos:** estudo documental, descritivo, com 300 Fichas de Monitoramento da Atenção ao Parto e Nascimento. Os dados foram reunidos em tabelas e submetidos à análise descritiva e numérica inferencial. **Resultados:** na categoria A observou-se que, 48,3% dos partos tiveram o preenchimento do partograma; 84,0% das parturientes não utilizou métodos não farmacológicos para alívio da dor; 67,0% permaneceu em dieta zero durante o trabalho de parto; 84,7% não teve acompanhante no pré-parto, parto e pós parto; 57,0% realizou contato pele a pele; e 65,3% amamentou em sala de parto. Na categoria B encontrou-se que 54,0% das parturientes permaneceu em venóclise; 60,7% permaneceu na posição semi-sentada no período expulsivo; e foi realizada tricotomia em 14,7% das mulheres. **Conclusão:** algumas práticas demonstradamente úteis no parto ainda são pouco implementadas, enquanto outras prejudiciais ou ineficazes continuam sendo executadas.
Descritores: Enfermagem Obstétrica; Parto Normal; Humanização da Assistência.

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Introduction

Traditionally, labor was a family event, centered on the woman and her role, in which the midwives provided the necessary assistance to both mother and child in the home environment. However, due to the hospital-centered influences on the 19th century, labor went on to be considered pathological, causing the medicalization of this moment and depersonalizing women[1].

Along with the changes in the history of childbirth assistance, rates of maternal and neonatal morbidity and mortality have increased. In Brazil, Maternal Mortality Ratio corrected was 70 deaths out of 100,000 in 2010. In Ceará, the average Maternal Mortality Ratio was 78.1 maternal deaths per 100,000 live births in the same period, well above the numbers recommended by the World Health Organization[2].

Aiming at the reduction of these indices and a quality obstetric care, were developed strategies for a humanized attention through good practices in attention to labor and birth.

The insertion of good practices was one of the strategies implemented by the Stork Network (Rede Cegonha) to ensure the quality of care at delivery and childbirth[3]. These practices were introduced in 1985 by the World Health Organization that in 1996 produced a classification of frequent practices in the conduct of normal childbirth, driving for what should and what should not be done in the process of childbirth[4].

This classification was distributed in four categories: category A- useful practices that should be stimulated; category B-clearly harmful or ineffective practices that should be eliminated; category C-practices without sufficient evidence to support a clear recommendation that should be used with caution until more research to clarify the issue; category D-practices often used improperly[4].

This context highlights the need to conduct studies to assess the implementation of good practices in labor and birth assistance so that it can be discerned what is being implemented in a positive way as well as check for gaps and weaknesses in this implementation, making it viable to collaborate with the reality of Brazil's obstetric care and the promotion of the health of mother and child.

Before those problems the following question arose: How is the implementation of good practices in assistance to labor and birth at a State reference maternity? The study aimed to describe the implementation of good practices of attention to labor at a reference maternity.

Methods

The present study was document type, carried out with medical records, descriptive, with a cross-sectional design and a quantitative approach. It occurred in the delivery room of a high technological density hospital dedicated to education and health care. It is an institution of high complexity, reference in the State of Ceará in the areas of internal medicine, surgery, gynecology, obstetrics and neonatology, as well as Internship in Obstetric Nursing.

Data were extracted from the Forms of Monitoring of the Attention to Labor and Birth of women who had vaginal birth in that maternity from January to December 2014.

According to the data of the assistance production of the institution available in its website, in this period 3517 deliveries were carried out, being 1359 by normal childbirth and 2158 by cesarean section. So that the population of this study consisted of 1359 Forms of Monitoring of the Attention to Labor and Birth.

For sample calculation and size definition we established a confidence interval of 95.0%, a significance level of 0.05 (sampling error) and a prevalence of 50.0%. We obtained, after calculations, a sample of 300 forms.

In this study, we included forms of women who gave birth vaginally, which include indicators relating to good practices of labor and childbirth of the users. And we excluded the forms with no signature of the

professional who filled it, forms of women in labor with dead concept and of who gave birth in the way to the hospital or at home because they did not contain information relevant to the study.

First, the forms were separated into two groups, vaginal delivery and cesarean delivery, later, the vaginal delivery forms were placed in ascending order of date and listed to finally sort them through a table of random numbers, so that all of them had the same chance to participate in the study. After numbering the forms, we had a total amount of 1165 women who had natural childbirth. 46 forms of women in labor with dead concept, 8 forms of women who gave birth on the way to the hospital and 140 forms that have not been signed by the professional who filled them were excluded. From the amount, 300 were sorted.

Only the categories A and B of practices were discussed for presenting measures that must be adopted and abolished in obstetric practice, respectively.

The data collection instrument was a form prepared by the researcher containing the characterization of the sample and the data relating to the implementation of good practices in assistance to labor and birth as proposed by the World Health Organization and referred to in the monitoring schedule of the institution.

The layout of the data followed the quantitative technique. To this end, the information was compiled in Microsoft Excel 2007. The data were gathered in tables, submitted to descriptive and inferential numerical analysis and analyzed in the light of the literature.

The study complied with the formal requirements contained in the national and international regulatory standards for research involving human beings.

Results

The number of investigated monitoring forms in this study was 300, however in some variables we found high amounts of blank information which demonstrate error in filling them.

The implementation of good practices to the labor and birth, categories A and B, are presented in tables 1 and 2 respectively.

Table 1 - Implementation of good practices to the labor and birth according to category A of the World Health Organization recommendations

Variables	n(%)	Confidence interval
Partogram filling		
Yes	145(48.3)	42.6 -54.1
No	50(16.7)	12.6- 21.3
Not informed	105(35.0)	29.6 – 40.6
Type of diet		
Liquid	80(26.7)	21.7- 32.0
Zero	201(67.0)	61.3 – 72.2
Not informed	19(6.3)	3.8- 9.7
Non-pharmacological methods for pain relief		
Yes	34(11.3)	7.9 -15.4
No	252(84.0)	79.3 – 87.9
Não informado	14(4.6)	40.2 – 51.8
Types of non-pharmacological methods for pain relief (n=65)		
Swiss Ball	5(7.7)	4.9 – 11.2
Shower	6(9.2)	6.2 – 13.2
Massage	25(38.5)	33.1- 44.4
Sitting	12(18.5)	14.4 – 23.5
Exercises	3(4.6)	2.5 – 7.7
Not informed	14(21.5)	17.1 – 26.7
Free choice companion		
Yes	43(14.3)	10.5 -18.8
No	254(84.7)	80.0- 88.5
Not informed	3(1.0)	0.2- 2.8
Freedom of movement and position		
Yes	164(54.7)	48.8 -60.3
No	70(23.3)	18.6 – 28.5
Not informed	66(22.0)	17.4 – 27.1
Uninterrupted skin-to-skin contact of the mother and newborn		
Yes	171(57.0)	51.1- 62.6
No	72(24.0)	19.2 – 29.2
Not informed	57(19.0)	14.7 – 23.9
Breastfeeding in the delivery room		
Yes	196(65.3)	59.6-70.7
No	93(31.0)	25.8 – 36.5
Not informed	11(3.7)	18.4 – 64.6
Total	300(100.0)	

With respect to the group A of good practices it was possible to verify that some important points were assessed positively, as the use of partogram, freedom of movement and movement during labor, uninterrupted skin-to-skin contact between mother and newborn and breastfeeding in the delivery room.

However, some important points had unfavorable evaluation, as maintaining zero diet, use of non-pharmacological methods of pain relief in childbirth and the impossibility for the mother to have a companion of her choice.

It should be noted that some items of the forms were ignored by professionals, making it impossible to evaluate whether they are in accordance with good practice.

Table 2 - Implementation of good practices to labor and birth according to Category B of the World Health Organization recommendations

Variables	n(%)	Confidence interval
Venoclysis		
Yes	162(54.0)	48.2 – 59.7
No	118(39.3)	33.7- 45.1
Not informed	20(6.7)	4.1 – 10.1
Enema		
No	285(95.0)	91.8 – 97.1
Not informed	15(5.0)	2.8 – 8.1
Trichotomy		
Yes	44(14.7)	10.8 – 19.2
No	239(79.9)	75.0 – 84.3
Not informed	17(5.6)	3.3 – 8.9
Position in the expulsive period		
Squatting	1(0.3)	0.0 – 1.8
Semi-sitting	182(60.7)	54.8 – 66.2
Lateral decubitus	2(0.7)	0.0 – 2.3
Lithotomy position	9(19.7)	15.3 – 24.6
Others	1(0.3)	0.0 - 1.8
Not informed	5(18.3)	14.1 – 23.1
Total	300(100.0)	

About category B best practices, it was found that some practices proven not recommended are still being conducted routinely, for example: venoclysis, trichotomy and lithotomy position during the expulsion stage.

On the other hand, the enema is a procedure rarely done and most women adopted an active, semi-sitting during the expulsion stage.

Discussion

The limitation found in this study was the high amount of blank information on monitoring forms, which demonstrate error in filling by professionals what undermines the adequate data collection and the development of qualified studies aimed at improving the health care of mother and child.

With regard to category A, the use of partogram is a recommendation from the Ministry of health and the research has shown the importance of this instrument in the diagnosis of the changes in the evolution of labor, enabling to realize interventions in a timely manner, ensuring mother and baby well-being[5]. However, in this study we found only 48.3% of patient records had the partogram filled.

It is worth mentioning that monitoring the evolution of labor should be made through the partogram to diagnose the possible changes and take the decision suitable for their resolution[6].

A study that aimed to evaluate the quality of hospital care to normal delivery found the presence of partogram in the records in only 28.5% cases, and 13.0% did not present any note, reflecting the low importance given to that instrument[7].

In relation to the common practice to repress food or liquids intake during labor is due to a fear of aspiration of stomach contents during anesthesia. However, the risk is associated with general anesthesia in women at risk. Based on the need to maintain hydration and a suitable caloric intake for women during childbirth, as well as offer comfort and well-being, the intake of light food or liquid during labor does not increase the incidence of complications[5].

A research conducted with 10 women in labor, in Minas Gerais University Hospital, pointed out that only 25.2% of them were fed during labor and only 26.7% received the application of non-pharmacological methods for pain relief, demonstrating that these practices still suffer resistance of professionals who provide assistance to women in labor, despite the recommendations and studies that stimulate them[8].

Regarding pain in childbirth, for most, some form of relief may be necessary. Body massages, baths (shower or immersion), breathing and relaxation techniques, active ambulation, comforting touch, use of balls and wheelies, exercises and other physical and emotional support measures should be used for pain relief[5].

Not all non-pharmacological strategies are effective, but they can decrease the use of pain-killers and the administration of oxytocin in women in labor which can cause adverse effects that are harmful to the mother and the fetus[9].

Several studies show the importance of companion during labor process. One of them, held in a secondary hospital in Fortaleza, concluded that the care provided by companions not only contributed to the humanization of labor and birth but also brought comfort, calm and security, relieving women's tension[8].

A research that evaluated the quality of care at childbirth made in Goiânia, showed that only 19.5% of women had free choice companion at the time of labor[7]. This fact corroborates the findings of the present study, in which the majority (84.7%) of women did not have a companion of their choice at the time of delivery.

In most maternity hospitals, the woman is still asked to remain lying down, in left lateral decubitus, during labor. Although this position can allow better fetal oxygenation compared with the right lateral decubitus and the supine position, allow her to choose the position that suits her best, wandering or other vertical positions, does not offer great risk, as well as providing shorter duration of labor and decrease the need for analgesia[10].

For postnatal breastfeeding and skin-to-skin contact, it is recommended to help mothers initiate breastfeeding within the first half an hour after birth, put babies in skin-to-skin contact with their mothers immediately after birth for at least 1 hour, encouraging them to recognize when their babies are ready to be fed. Therefore, it is important that these practices are carried out still in the delivery room in the first hour of birth[11].

This early contact means putting the baby naked in prone position on the mothers to favor adaptation in the transition from intra uterine space to extra uterine space, encouraging breastfeeding immediately after birth[12].

In a study conducted in a tertiary maternity in João Pessoa to identify the prevalence of the completion of the fourth step of the Baby Friendly Hospital Initiative (Iniciativa Hospital Amigo da Criança) that is, to put the babies in skin-to-skin contact with their mothers immediately after birth for at least half an hour, it was found that in just over 50.0% of cases skin-to-skin contact between the mother and the baby was conducted[13].

On the above, we can see that these practices should have a larger adhesion of professionals, since there are scientific evidence showing how they are beneficial for both mother and child.

As regards category B, it is scientifically known that the practices listed in this category are clearly harmful or ineffective and should be eliminated, among them: routine use of Trichotomy, routine intravenous infusion in labor and routine use of the lithotomy position[4].

The routine use of venoclysis limits the freedom to position and ambulation of women in labor. It is known that the supine position must be encouraged to facilitate the process and provide greater comfort for pregnant women[5].

Other studies have brought recommendations for avoiding techniques considered harmful as the enema, trichotomy, amniotomy, routine episiotomy and induction of childbirth[13-14].

A study carried out in a public maternity in Teresina found that the use of trichotomy was not prescribed for any mother, venoclysis was only for of 7.7%, and delivery in gynecological position for 95.6%[15].

According to the World Health Organization, corroborating with findings of other studies, there are still unnecessary interventions and without criteria in

childbirth assistance, which coincides with high rates of maternal mortality in the national and international panorama[4].

Based on the exposed, it becomes apparent the need for change in the panorama of normal childbirth assistance; evident harmful practices and practices with no evident efficiency should be replaced for practices recommended by the World Health Organization, aiming at the promotion of a healthy birth and environment with all the appropriate apparatus for maternal and fetal well-being during the process of delivery.

Conclusion

With respect to category A that consists of clearly useful practices and should be stimulated, we noted that most of the practices are not yet implemented. More than 80.0% of women had no companion during childbirth and did not receive the application of non-pharmacological methods for pain relief. About the category B formed by clearly harmful or ineffective practices which should be removed, it was found that the rates of trichotomy (14.7%) are low, demonstrating that there is no routine use of this practice, but there is also a high percentage of women who are kept in venoclysis (54.0%) and deliver in semi-sitting (60.7%).

Collaborations

Melo BM contributed with the project design, analysis, interpretation of data and writing the article. Henrique ACPT and Lima SKM contributed with the critical review of the intellectual content. Gomes LFS and Damasceno AKC contributed for the approval of the final version to be published.

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