Reproductive Care Program of Nova Scotia
RCP
SPRING/SUMMER 2010
NEWSLETTER

THE REVISED NOVA SCOTIA LABOUR PARTOGRAM

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Introduction

The Nova Scotia Labour Partogram (RCP 03) has been revised. The main purpose of the Labour Partogram is to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and to provide a guide for evidence-based intrapartum care. Secondly, as with all RCP forms, information documented in specific fields on the Partogram is collected as part of the Nova Scotia Atlee Perinatal Database (NSAPD). These data are used to inform the monitoring of provincial perinatal outcomes and to improve health care planning and provision in the province.

Although minor modifications have been made over the last several years, the last major revision to the Nova Scotia Labour Partogram was in 2000. In the fall of 2008, RCP staff partnered with health care facilities across the province to develop and trial the new form. As part of the process, we obtained extensive feedback from nurses, midwives and other perinatal health professionals across the province, consulted with content experts, and collaborated with perinatal programs in other parts of the country.

This article will highlight the principles that guided the design and development of the new partogram as well as two areas of intrapartum care that are supported by the revised Nova Scotia Labour Partogram: supportive care in labour and fetal health surveillance.

Guiding Principles

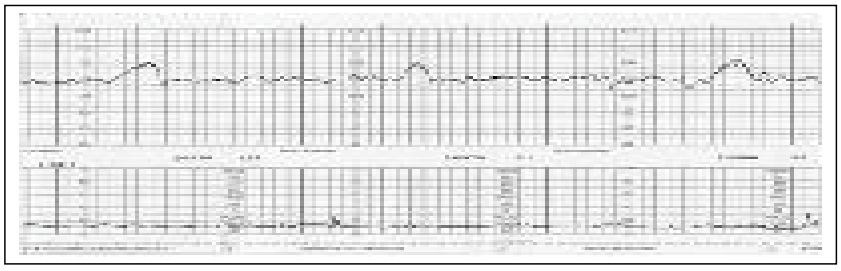
Several key principles guided the design and development of the partogram. The partogram must:

- Be applicable for all maternity sites offering different levels of perinatal care
- Provide a complete record of labour from admission through birth to the beginning of 4th stage
- Incorporate relevant intrapartum assessment and interventions
- Utilize standard terminology and abbreviations

- Be adaptable to charting by exception or variance charting and eliminate the need for excessive, repetitive narrative charting. This allows for more time to provide supportive care in labour
- Utilize standard terminology and abbreviations
- Support normal labour and birth
- Facilitate early recognition, timely communication and intervention for changes in labour progress
- Support use by all members of the multidisciplinary team
- Facilitate data collection for NSAPD
- Enable electronic archiving or formatting

Fetal Health Surveillance

The Society of Obstetricians and Gynecologists of Canada (SOGC) released new fetal health surveillance (FHS) guidelines in September 2007 (www.sogc.org). **The Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline** includes standardized definitions from the National Institute of Child Health and Human Development (NICHD) for fetal heart rate assessment and electronic fetal monitoring Included in the guideline is a new classification of fetal monitoring tracings and a decision guide for auscultation that promote consistent interpretation and appropriate response. The NS Labour Partogram has incorporated this new information.



Supportive Care in Labour

An important component of a woman's labour and birth experience is the support she receives from her partner, friends and family as well as the professional support she receives from a midwife or nurse. The NS Labour Partogram is designed to capture key elements of professional support. Supportive care is defined by Simkin (2002) as "non-medical care that is intended to ease a woman's anxiety, discomfort, loneliness, or exhaustion, to help her draw on her own strengths and to ensure that her needs and wishes are known and respected. It includes physical comforting measures, emotional support, information and instruction, advocacy, and support for the partner." (p.721)

REVISED NS LABOUR PARTOGRAM

A central component of supportive care is the continuous physical presence of a caregiver whose aim is to build a genuine, meaningful relationship with the birthing woman and her family (Goldberg, 2005; Koloroutis, 2004). Therefore, one-to-one nursing care once the woman is in active labour is recommended.

The overall effect of one-to-one supportive care for a woman in labour has been well researched and documented in the literature (Health Canada, Canadian Institute of Child Health, 1995), and is a key component of active management of labour (O'Driscoll et al., 1980). In a number of studies, women who received supportive care in labour experienced a decrease in cesarean section rates, oxytocin use, use of pain medications, length of labour, use of forceps, requests for epidural analgesia, and an increase in vaginal delivery for those women who received supportive care (Sauls, 2002; Scott, Berkowitz & Klaus, 1999; Hodnett, 2002).

In addition to using the NS Labour Partogram to prompt, document and communicate the supportive care provided, we will now have the opportunity to capture supportive care data elements, to be added to the Nova Scotia Atlee Perinatal Database. This not only renders supportive care visible but also provides key information that can be used in perinatal research and care planning.

RCP prints and distributes chart forms free-of-charge in an effort to make them readily available and accessible to perinatal care providers in Nova Scotia. For information and/or toobtain copies please contact RCP at (902) 470-6798, or see the chart forms link on our website: http://rcp.nshealth.ca

* A complete list of references is available on the RCP website at: http://rcp.nshealth.ca

IMPORTANT WINRHO®SDF IV ADMINISTRATION INFORMATION

It has come to the attention of the Rh Program of Nova Scotia that WinRho®SDF is only compatible with normal saline. When this product is administered by intravenous bolus route into an already existing intravenous line, it is necessary to clear the line prior to and post medication administration with 0.9% saline. This will ensure that the dose of WinRho®SDF has been completely administered to the patient. For futher information please contact the Rh Program of Nova Scotia at:

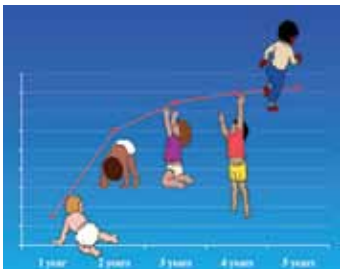
5850/5980 University Avenue
PO Box 9700
Halifax, Nova Scotia
B3K 6R8
Tel: (902) 470-6458,Fax: (902) 470-7468.

Survey for Health Care Providers on Growth Monitoring Practices

Beth Currie, BSc. HNU
Health Promotion Intern
NS Health Promotion & Protection

Laura Brennan, MHSc., PDt.
A/Coordinator, Early Childhood Nutrition
NS Health Promotion & Protection

Consistent and regular growth monitoring is essential for assessing the health and nutritional status of infants and children at both the individual and population levels. Growth charts are a useful tool for health care providers and parents to understand patterns of growth and identify potential growth problems.



The World Health Organization (WHO) released new growth charts that reflect optimal growth. These include the 2006 WHO Child Growth Standards (birth-five years) and the 2007 WHO Growth Reference for children and adolescents (5-19 years). They differ from the 2000 CDC growth charts in that they focus on a multi-ethnic population of children living in optimal conditions for growth and development, are based on a breastfed population, and are adjusted to take into account the emerging childhood obesity epidemic.

The Canadian Pediatric Society, College of Family Physicians of Canada, Community Health Nurses and Dietitians of Canada are recommending the adoption of the WHO growth charts in Canada.

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The Nova Scotia Departments of Health, Health Promotion & Protection and RCP conducted a short online survey to gain an understanding of current practices and barriers to growth monitoring of infants and children. Survey results will be used to inform discussions on how to support the adoption of the WHO growth charts in Nova Scotia.

For additional information on the WHO growth charts, please visit: www.dietitians.ca/growthcharts

Upcoming RCP Event

ALSO

Advanced Life Support in Obstetrics (ALSO)
November 27TH & 28TH, 2010
Parker Reception Room
IWK Health Centre, Halifax, Nova Scotia
Registration Information: http://rcp.nshealth.ca

FIRST6WEEKS.CA

Local breastfeeding support

Moms across Nova Scotia have identified the importance of both professional and peer support while they are learning to breastfeed. There are many programs, clinics, and groups across the province that provide breastfeeding support for women and families. To find information on breastfeeding support services in your area go to www.first6weeks.ca and click on ***Support***.

Breastfeeding: Learning Makes it Natural.

SKIN-TO-SKIN CONTACT

DARLENE INGLIS
CLINICAL NURSE SPECIALIST – IWK NICU, AND LACTATION CONSULTANT

Step 4 of the Ten Steps to Successful Breastfeeding: Help mothers initiate breastfeeding within the first half hour of life.

All mothers should be given the opportunity to hold their baby in skin-to-skin contact in an unhurried environment as soon as possible after delivery. They should be given support and encouragement to give the first breastfeed as soon as the baby is receptive. If skin contact has to be delayed or interrupted because the health of either mother or baby demands it, it should be started or resumed as soon as possible (WHO).

The first hour or so after birth are very important for mother and baby in terms of their physical and emotional wellbeing and the opportunity to begin a life long relationship with one another. Skin-to-skin contact can help to enhance this very special time between mom, dad/partner and baby. Skin-to-skin contact has been found to calm the baby, regulate heart rate, breathing and temperature, and stimulate breastfeeding. Provided the medical condition of both mother and baby allows, then an unhurried, unlimited, and uninterrupted period of skin contact should be facilitated for all healthy mothers and babies beginning immediately following birth.

SKIN-TO-SKIN CONTACT

The baby should be dried quickly and placed directly skin-to-skin on the mother's abdomen/chest. Evidence has shown that a newborn baby's temperature is more effectively maintained through skin contact with his mother than by any other means. 'Skin-to-skin contact' means that the baby's skin is touching the mother's skin over the greater ventral part of his/her body. A warm blanket may be placed over both of them to prevent heat loss and to maintain the mother's privacy.

Care providers may choose to carry out most routine newborn assessments and procedures while the baby is in skin contact with his/her mother. Separation of mother and baby in the immediate post-birth period should be minimized. If the health of either demands that they be separated, they should be reunited, skin to skin, as soon as possible.

A mother and her baby may be transferred to the postnatal room while maintaining skin-to-skin contact, whether this occurs via wheelchair or on a stretcher. The father/partner may be encouraged to experience skin-to-skin contact with baby when the mother is unable or unavailable.

Attention to the baby's wellbeing is a fundamental part of postnatal care in the first few hours after birth. Proper positioning will ensure that the baby remains safe. This includes ensuring the mother is able to support the baby on her chest and that the baby has an open airway, has easy respirations and is pink in color. The ability to find the breast and self-attach is known to be strongest within the first hour or so after birth. Thus, skin-to-skin contact facilitates early breastfeeding initiation which significantly impacts later progress and duration of breastfeeding. However, there is no need to hurry either the baby or the mother or to try to force the baby on to the breast – as this may prove counter-productive and hinder the baby's ability to attach effectively later on. Healthy, term babies are known to instinctively move towards the breast for feeding.

Photos shown are part of the IWK's campaign to increase awareness of the benefits of skin-to-skin

Over the last year, the IWK has implemented strategies to promote awareness and support for early, extended skin-to-skin contact of moms and babies. For more information, please contact Darlene Inglis, clinical nurse specialist and lactation consultant at darlene.inglis@iwk.nshealth.ca

BREASTFEEDING: MAKING A DIFFERENCE

In September 2009, 30 health professionals from all DHA's, the IWK Health Centre, and First Nations attended a workshop in Oak Island, NS to become trainers of the 20-hour Breastfeeding: Making a Difference (MaD) course. The workshop was organized by RCP and sponsored by the NS Department of Health Promotion and Protection. It was a major initiative to promote implementation of the NS Provincial Breastfeeding Policy, and to achieve the standard for our population of exclusive breastfeeding for six months and continued breastfeeding with complementary foods for a year or more. The course was recommended by the Provincial Breastfeeding Steering Committee and the Breastfeeding Education Working Group, in good part because of the enthusiastic endorsement from many who had taken it in other parts of the country. We were assured that this course would change practice, attitudes and beliefs about infant feeding. In particular, the course was designed for health professionals to work together to effectively support breastfeeding families.

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The expert facilitators of the workshop were course developers Marianne Brophy and Kathy Venter - educators, Baby Friendly Initiative (BFI) assessors and internationally renowned breastfeeding advocates. They shared their knowledge, many tools and strategies for trainers to utilize as they, in turn, provide the 20-hour course in their own districts and communities. Trainers have stayed connected as they prepare and provide these courses. Even with the slides and other materials supplied by Kathy and Marianne, the additional workload for trainers has been significant.

Twenty-one, twenty hour courses have been offered to date and more than 300 people have participated in this education. Courses are generally held on three consecutive days and although this sometimes presents challenges around scheduling, trainers have noted that the momentum builds and commitment to a new approach becomes apparent over the three days. Participants have included hospital and public health nurses, dietitians, nutritionists, home visitors, outreach workers, nursing students, and nurse practitioners. The feedback has been overwhelmingly positive.

Reports of improvements in breastfeeding support received from participants, mothers, and members of the community have been inspiring! Many of those who have taken this course have changed their own practice and have influenced others to change as well. For example, skin-to-skin contact for moms and babies over extended periods of time has now become the norm in many hospital units where there had previously been resistance to this practice. People have come to recognize the benefits of skin-to-skin and the effect on early, successful initiation of breastfeeding. One provincial trainer shared a story in which a nursing student and a labour and birth nurse were awed by their first baby-led experience. Skin-to-skin contact was promoted until 'baby was ready'. The baby self-attached and nursed beautifully while everyone watched in wonder.

BREASTFEEDING: MAKING A DIFFERENCE

Our Provincial MaD trainers – September 2009

If you would like more information about the 20-hour Breastfeeding: Making a Difference Course, please contact your local Public Health or Mother/Baby unit, or the RCP office.

CONGRATULATIONS!

Dr. Krista Jangaard is the New Head of the Division of Neonatal-Perinatal Medicine at the IWK Health Centre as of July 1, 2010.

Dr. Linda Dodds is the new Director of the Perinatal Epidemiology Research Unit (PERU) as of July 1, 2010.

Melissa Walker-Nauss, office clerk with RCP and her husband, Michael welcomed their first baby, Rylan Kenneth into the world on June 24, 2010.

Annette Elliott Rose (nee Ryan), perinatal nurse consultant with RCP and her husband, Chris were married July 8, 2009 and are expecting their first baby in September.