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EXCHANGE OF PROFESSIONAL KNOWLEDGE BETWEEN RESIDENCIES IN OBSTETRIC NURSING

INTERCÂMBIO DE SABERES PROFISSIONAIS ENTRE RESIDÊNCIAS EM ENFERMAGEM OBSTÉTRICA

INTERCAMBIO DE SABERES PROFESIONALES ENTRE RESIDENCIAS DE ENFERMERÍA OBSTÉTRICA

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Objective: to describe the experience of residents in obstetric nursing in professional exchange. Method: report of experience lived through a partnership between the Residency Programs in Obstetric Nursing of the Franciscan University Center, Santa Maria/Rio Grande do Sul and the Faculty of Nursing of the Rio de Janeiro State University, between August and September 2015. Results: the residents were offered the follow-up and assistance to prenatal care, labor, delivery and immediate puerperium, at usual risk, which were fully and exclusively attended by obstetrical nurses, as well as the accompaniment and assistance shared with the medical team and medical residents, of high-risk parturients and in the process of abortion. Conclusion: nursing residents were offered important reflections on the care provided in Rio de Janeiro and Santa Maria.

Descriptors: Obstetric Nursing; Humanized Delivery; Humanization of Assistance.

Objetivo: descrever a experiência de residentes em enfermagem obstétrica em intercâmbio profissional. Método: relato de experiência vivenciado por meio de convênio entre os Programas de Residência em Enfermagem Obstétrica do Centro Universitário Franciscano, Santa Maria, Rio Grande do Sul, e a Faculdade de Enfermagem da Universidade Estadual do Rio de Janeiro, entre agosto e setembro de 2015. Resultados: foi oportunizado às residentes o acompanhamento e a assistência ao pré-natal, trabalho de parto, parto e puerpério imediato, de risco habitual, os quais eram assistidos integral e exclusivamente por enfermeiras obstetras, assim como o acompanhamento e a assistência compartilhada com a equipe médica e residentes de medicina, de parturientes de alto risco e em processo de abortamento. Conclusão: foram possibilitadas às residentes em enfermagem obstétrica reflexões importantes sobre a assistência prestada no Rio de Janeiro e em Santa Maria.

Descritores: Enfermagem Obstétrica; Parto Humanizado; Humanização da Assistência.

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Objetivo: describir la experiencia de residentes de enfermería obstétrica en un intercambio profesional. Método: relato de experiencia experimentado por medio de la convivencia entre los Programas de Residencia de Enfermería Obstétrica del Centro Universitario Franciscano, Santa María/Rio Grande del Sur y la Facultad de Enfermería de la Universidad Estadual de Rio de Janeiro, entre agosto y septiembre de 2015. Resultados: fue oportunizado el acompañamiento y la asistencia al cuidado prenatal, trabajo de parto, parto y puerperio inmediato, de riesgo habitual, a las residentes, asistidos integral y exclusivamente por enfermeras obstetras, y también el acompañamiento y una asistencia compartida con el equipo médico y residentes de medicina, de parturientes de alto riesgo y en proceso de aborto. Conclusión: les fue posibilitado a las residentes de enfermería obstétrica reflexiones importantes sobre el cuidado prestado en Rio de Janeiro y en Santa María.

Descriptores: Enfermería Obstétrica; Parto Humanizado; Humanización del Cuidado.

Introduction

Obstetric and neonatal care is part of a changing Brazilian care model. Delivery and birth are still considered a disease, and parturients are submitted to routine interventions[1]. National and international institutions emphasize the need for changes in this area, and they support a model based on humanized and quality care that respects the philosophy, subjectivity and rights of women regarding their bodies[2].

To follow the trend for changes in obstetric practices, Brazil has adopted neoliberal conceptions and, at the end of the 20th century, the country began to rely on obstetric nursing in care delivery. Despite the increased autonomy of obstetric nurses, these professionals continue to seek confirmation and recognition of their practice in Brazil[3].

In the city of Rio de Janeiro, movements favoring changes in obstetrics and neonatal care were based on documents issued by the World Health Organization (WHO), such as "Safe Motherhood" and "Best Practices of Delivery and Childbirth Care", both based on scientific evidence. In 1985, the managers of public birth centers in the state of Rio de Janeiro were pioneers in their inclusion of public employee obstetric nurses in delivery and childbirth care. In 1987, the Municipality Institute for Women "Fernando Magalhães" was founded as a referral center for high-risk pregnancy. In 1988, obstetric nurses were hired to improve care and, mainly, to reduce cases of perinatal asphyxia[4].

In 1994, the Municipality Health Office of Rio de Janeiro launched the Implantation of Nursing Care Project for Pregnant Women and Parturient to guarantee humanization of delivery and childbirth. The Leila Diniz Birth Center is highlighted as the first public birth center to implement adaptations for humanized care in terms of environment, physical structure, provision of technologies for relief of pain during labor and delivery and employment of obstetric nurses[5-6].

This municipality of Rio de Janeiro became the reference standard for the inclusion of obstetric nurses and for implementation of good practices. In the city of Santa Maria (Rio Grande do Sul, Brazil) this movement is still incipient, although gradual changes have been proposed after inclusion of the Nurse-Midwifery Residency Program in care services provided by the Brazilian Unified Health System (SUS [acronym in Portuguese]).

The first class of obstetric nurses in the state of Rio Grande do Sul begun in 2013 at the Nurse-Midwifery Residency Program at Centro Universitário Franciscano. At first, difficulties were experienced because of the lack of obstetric nurses working in the state who could help run the program. In addition, several obstacles occurred with the inclusion of residents in practical settings because delivery care was still performed by the physician. In general, the physician preferred cesarean delivery instead of

vaginal delivery and favors the use of routine interventions and active management of labor and delivery. Concomitantly, the medical authority of the doctors was explicit; it superseded nurse activities, and doctors sometimes ignoring nurses' knowledge and their desire for change. The changes in care also caused feelings of inadequacy even within the nurse team; these feeling led to uncertainty and even conflicts, which were overcome by persistence, courage and determination.

In 2014, the second class of nurse-midwifery residents was enrolled. We observed gradual improvements in the quality of care delivered, as well as important changes toward humanization. However, residents are interested in knowing a different reality, one in which humanization and good practices are already consolidated and obstetric nurses work directly in delivery care. This demand gave the opportunity for the second class of students to experience, in 2015, the professional exchange in the birth center of the state of Rio de Janeiro, the Maternity Hospital "Fernando Magalhães".

This paper describes the experience of nurse-midwifery residents in this professional exchange.

Methods

This is a descriptive study of the experience with the professional exchange through cooperation between the Nurse-Midwifery Residency Program at Centro Universitário Franciscano, Santa Maria (RS), and the Nursing School at Universidade Estadual do Rio de Janeiro (UERJ), Brazil.

Four residents participated in the professional exchange. They were divided into pairs and spent 30 days in an internship in different sectors: ambulatory (a setting in which they participated in prenatal and puerperium care, planned parenthood consultation, and assistance with victims of sexual violence), reception and risk classification, urgent care and emergency, hospitalization of pregnant women and women having an abortion, hospital ward, and delivery room. Our report describes only the experience in the delivery room.

Residents were supervised by a preceptor nurse, who was responsible for the nurse-midwifery residents of UERJ. Residency duration was 40 hours (8 hours a day, Monday to Friday). In addition, for part of the workload, a visit was organized at a primary care service, "Casa de Parto Davi Capistrano Filho", which is a family care clinic.

The hospital maternity ward is located in a central region of the Rio de Janeiro in the São Cristovan neighborhood. This is a referral hospital for high-risk pregnancy (mainly for pregnant women with sickle cell anemia, hypertension, and diabetes), women who were victims of sexual violence (the hospital is a site for legal abortion) and gynecological emergencies. The hospital is also part of Cegonha Carioca, which is a pioneer program implemented in 2011 with the aim of humanizing and guaranteeing care for mothers and newborns, from prenatal care through delivery, in order to reduce maternal-fetal mortality. The program was implemented at Rocinha, Santa Cruz, Paciência and Sepetiba, but in 2012 it extended to the entire city of Rio de Janeiro; pregnant women from all health units are enrolled in the program[7].

Results and Discussion

The professional exchange allowed good opportunities to follow up on the provision of prenatal care, as well as to engage in other activities, such as labor, delivery, immediate care after delivery and during the puerperium; usual risk; all these activities were performed exclusively by obstetric nurses. Other areas of patient management included shared care with medical team and medical residency, care for high-risk parturients, and abortion.

Especially in the delivery room of the maternity hospital, residents deliver care to high-risk parturients under the supervision of

obstetric nurse with practical experience. Among the responsibilities highlighted by the residents were the reception of pregnant women in the delivery room, identification and classification of risk performed in an emergency setting, and entrance point for maternity; patient interview that consisted of verifying gestational age and questioning the patient (about parity, history of previous pregnancy, preexisting disease and any pregnancy-related complications, use of medications, treatments and clinical conditions, number of prenatal consultations, examination results, including rapid test for HIV and syphilis performed in the emergency unit); checking pregnant women's identification documents and asking them about their main complaints; and a general physical examination, including a vital sign check and obstetric examination (measurement of uterine height, Leopold maneuver [uterine palpation to evaluate fetal status and position], auscultation of fetal heartbeat, evaluation of uterine dynamic and pelvic examination, if necessary). Vaginal examination is to be avoided if the patient had already recently undergone such an exam with another professional.

After verification of active labor, the patient is admitted and a partogram opened. In cases of patients of usual risk, fetal heartbeats are auscultated every hour; in this same interval, the uterine dynamic is also assessed. Vaginal examination are done every 2 hours or on the basis of parturient evolution. No consistent evidence has shown the best method for assessment of labor progression. Only one international study compared vaginal examination in the active phase of labor every 2 hours versus every 4 hours; there was no benefit of performing more frequent examinations[8].

In relation to the rights of pregnant women, in SUS patients can continue using the follow-up of their choice throughout the labor process, both during immediate labor and after labor, according to state in law 11.108/2005[9].

During labor, parturients and their accompanying person received guidance on ambulation and use of nonpharmacologic methods for pain relief, which could be done in a "relaxing room". This room provides musical therapy, lumbar region massage, exercise with a birthing ball, squatting on fixed bars, aromatherapy, use of special chairs, and warm showers. These methods are the so-called good practices for labor and birth care established by the World Health Organization since 1996. This is a classification of what should be done or not done during labor, delivery, and birth, and these guidelines are based on scientific evidence and meticulous studies carried out in the field worldwide[10].

Parturients also received information concerning their freedom to move during labor and the possibility of choosing their position at the time of delivery: squatting, sitting, semi-reclining or side-lying position. Freedom of movement is associated with proven benefits, such as pain relief, because it changes the focus of the feeling and can lead to the rapid progression of delivery; it also allows patients to engage in other pain relief techniques, such as showers. Provision of these options is related to respect for women's autonomy and their right to choose the position that would be more comfortable to them[11].

We emphasize that in usual risk labor, because obstetric nurse are responsible for care, women have more freedom regarding their position; this freedom, however, does not occur in deliveries assisted by physicians. The WHO advocates that freedom of position and stimulation to vertical positions are practices that should be encouraged[10]. In medical care, the lithotomy position is still standard; however, evidence suggests that this position increases the risk of lacerations and need for episiotomy[12].

The structure of the delivery room at HMFM includes eight cubicles separated by curtains (each cubicle contains a retractable bed with leg bed frames), relaxing room, nursing ward, multidisciplinary room, canteen and bathroom. The delivery room is separated from the obstetric center, where cesarean deliveries take place. The pregnancy planning program "Rede Cegonha,"

as well as the best practice guide, emphasizes the environment at birth clinics and hospital maternity; guidance includes the offering of a welcoming, embracing environment for the woman and her accompanying person, similar to the house of the parturient[1,10].

We observed different obstetric approaches in relation to the expulsive period between obstetric nurses and physicians. Professionals who have recently finished their education suggest hand-off of the perineum in labor, therefore leaving the fetus to perform movements by himself; in this way there will the need only to grab the baby. Such practice is widely used by obstetricians and midwives, who advocate its use; an exception is given in cases of obstetric intercurrences[13]. In medical care, there is predominance of deliveries with active management and interventions during labor and delivery.

During internships, episiotomies were still observed but more restricted, according to what is recommended. Once obstetric nurses assumed care of the parturient, a small proportion of episiotomies have been done by obstetric nurses, who justify this procedure because of the concern for severe perineal laceration. The WHO preconizes the restrictive practice of episiotomy and report a rate of 10%-15% in vaginal deliveries[10]. Recent studies suggest that routine practice of these procedures does not show benefits, and a restrictive practice is advised in certain cases to reduce risk of severe perineal lacerations, infections and suture-related complications[14-15].

Primary care of newborns is performed by a professional who provides assistance during labor. The newborn is cleaned and dried using sterilized pads and then delivered to the mother; umbilical cord clamping is then done. Such actions are more common in births assisted by obstetric nurses; in medical care these practices are more restrictive. Finally, the newborn is evaluated by a pediatrician, is assigned Apgar and Capurro scores, and is placed over a warmed cradle. At this point nursing care is also provided, such as placement of wrist-band identification, administration of vitamin K, and application of prophylactic eye drops to prevent eye infections.

The clamping of umbilical cord in newborns with good vitality at birth is advised to improve levels of ferritin and reduce the childhood anemia indexes[16], as well as help thermoregulation of the body in full-term newborns[17]. During opportune clamping, the newborn should be delivered to his/her mother in order to promote skin-to-skin contact. The mother's body is used as source of heat, which has proven beneficial to reduce risk of neonatal hypothermia. We highlight that for regulation of newborn temperature, the baby should be covered with heated fields[18]. In addition, the main long-term benefit of skin-to-skin contact is to create affective bonding[19].

Immediately after birth, the baby should be stimulated for breastfeeding (first hour of life), which usually occurs in the care provided by obstetric nurses. Breastfeeding in the first hour of life increases the duration of exclusive breastfeeding[19]. According to data from a literature search among 67 countries available in National Demographic and Health Survey (NDHS) on health and nutrition of mothers and infants, breastfeeding has immunologic protective effect against neonatal mortality and has many components that guarantee this effect, mainly in relation to the first milk produced upon delivery (colostrum). For this reason, breastfeeding in the first hour of life must be a routine practice in birth centers and hospital maternity wards; these centers should adhere to and support programs designed to help the mother and child, such as the Brazilian program "Friend of the Children's Hospital"[20].

In the immediate puerperium, the mother's breasts are evaluated concerning type, nipple format and presence of colostrum. Breastfeeding is stimulated, and there is need for support regarding correct holding and positioning for suction. Uterine involution and tone and transvaginal bleeding are evaluated. In relation to the perineum, we observed the occurrence of laceration; in addition the degree and need for

correction are evaluated. After these procedures, the baby is sent to nursery.

In this brief report on care, we highlight the importance of obstetric nurses to provide care during delivery and birth with respect for and understanding the process as natural and physiologic, for which there is no need for routine obstetric interventions. This understanding enables these professionals to promote the empowerment of parturients and helps combat the obstetric violence practiced at many health institutions[21].

This experience led to many reflections among the residents who participated in the professional exchange. They perceived that implementation of good practices is present in the hospital and that the service promotes humanization based on national and international guidelines and local projects, such as "Cegonha Carioca", according to the national strategy for the hospital maternity network, called "Rede Cegonha" and launched in 2011.

By establishing a parallel between hospital maternity centers in Rio de Janeiro and hospital maternity centers at Rio Grande do Sul, we observed that the second state is advancing in terms of inclusion of humanizing practices in obstetric care and that the state is not far from the reality experienced in Rio de Janeiro in this regard.

Conclusion

A professional exchange enabled nurse-midwifery residents to (re) think their practices and broaden their critical reflection concerning models and professional behaviors imposed by traditional knowledge.

This experience helped improve knowledge regarding humanized practices of delivery and birth care and enabled the follow-up of obstetric nurses with practical experience in application of pain relief methods in labor and during the expulsive period. In Rio Grande do Sul, an important highlight was that residents did not have contact with obstetric nurses. This made it difficult to apply good practice hours in the hospital maternity and in the obstetric center. The experience of a service that has already been working with the new model of care was, therefore, characterized as a great learning opportunity that will be brought to the South of the country.

Advances in obstetric nursing can already be observed. An important achievement for hospital maternity Santa Maria after the internship was the hiring, in 2015, of obstetric nurses and the stimulation for general nurses to become specialists. Such action promoted reduction of unnecessary interventions and even more constant action of resident nurses.

Collaborations:

1. conception, project, analysis and interpretation of data: Bruna Dedavid da Rocha and Juliana Silveira Bordignon;

2. drafting the manuscript, critical review relevant for intelectual contente: Bruna Dedavid da Rocha, Cláudia Zamberlan, Dirce Stein Backes, Hilda Maria Barbosa de Freitas, Regina Gema Santini Costenaro and Juliana Silveira Bordignon;

3. approval of final version to be published: Cláudia Zamberlan, Dirce Stein Backes, Hilda Maria Barbosa de Freitas and Regina Gema Santini Costenaro.

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