

Action ETD-It is a time-4 hours after the 'Alert ETD' and it dictates that, if she has not delivered spontaneously even by the end of this extra time, **action should be taken** to deliver her soon by the suitable means.

The strategic purpose of writing these pivotal time figures in big bold letters is – so that everyone concerned (both nurses and doctors) –

- Compulsorily notice it
- Remain acutely and constantly aware about it and
- Manage labor so as to *deliver her by these two time stages or targets*

As can be seen, by this simple 20 sec action the care giver precisely knows:

- ▶ where to go
- ▶ in how many hours and
- ▶ when the labor must be terminated

i.e. in other words the *labor gets programmed*

So, this way, the occurrence of prolonged and obstructed 'active phase of labor' which is the root cause of most of maternal, fetal and neonatal morbidity and also mortality is effortlessly eliminated.

Analgesic, IV drip, FHR, T/P/BP monitoring etc-as usual (see the Smart LABOR CHART attached).

" PAPERLESS PARTOGRAM "
Single Sheet - 'at a glance' Graphpaperless Partogram

Reg No. 362/10 Date 17.3.2010
Name Usha Devi Age 25 Para 0+0 Wk of gest. 37+
 PELVIS Adequate / Not Adequate RISK FACTOR (if any) Nil

ALERT ETD **8 PM** ACTION ETD (4 Hrs.) **12 MN**
(Write in RED)

(For use in 'Active phase' of labour - from 4 cm dilatation of cervix onwards)

Nursing Observations										Doctor's			
TIME (Check Hourly)	T/P	BP	I Vs	Urine output	FHR	Mec/ Liquor Thin-1 Thick-2	No. of Contrn per 10 min.	Oxytocin/ Miso dose	Analgesic given Time/Dose	Dilatation (in cm)	Expected	Actual	LAG
2-05 PM	98-2 78	120/ 70	X	260	152	clear PRM acute	2/10	X	X	-	4	0	
4-15 PM		120/ 70	X		144	clear	2/10						
5-20 PM	98-2 80	120/ 70	Sym. disp. 2 units R.B.	170	148	clear	2/10	Sym. 2 units 30/min	Droclin 40 mg	7	5	2	
6-15 PM	98 84	120/ 70	"		150	clear	3/10	"					
7 PM	98 84	116/ 70	"	200	148	clear	3/10	"	Sym. 50 mg Droclin 40 mg	9	7+	2	
8 PM	98 88		"		140	clear	3/10	"					
9-30 PM	99-2 92	120/ 70	"	250	146	clear	3-4/10	"		10	10	0	

RULE OF SEVEN (7) FOR SLOW DILATORS

I - Slow dilatation between 4-7cm dilatation range
(Primary dysfunctional labor)
Probable cause - Inadequate contraction
Management - Oxytocin after excluding mechanical hindrance

II - Slow dilatation between 7-10cm dilatation phase
(Secondary dysfunctional labor)
Probable cause - Mechanical hindrance
Plan for management - According to cause found in:
• Power • Passage • Passenger

Time of Rupture of Membranes - $\frac{2}{3}$ 05

d-3 Chart - For Secondary dysfunctional Labor

Time	Descent	Depth of Caput (cm)	Degree of moulding

REMARKS: Delivered normally at 11.44 PM
Male, 2865 gm, Apgar 10/5 min

II- 3 Subsequent PVs at roughly 3 hourly interval

The main purpose of these PVs is to assess *whether the dilatation is occurring at the standard rate of 1 cm/hour or not*. The PV findings are to be recorded in a simple little chart as exemplified below with in-built loud RED warning about any lack of progress (see the Smart LABOR CHART attached). (No unnecessary jugglery of plotting, graphing and then trying to interpret the graph).

PROGRESS in DI L ATATION

Time of PV	Expected dilatation (cm)	Actual dilatation (cm)	LAG in Dil Circle in RED (hrs)

The RED warning, permanently shines *-from shift to shift-* from one doctor to the next-from one nurse to the next (ensuring AUTOMATIC ‘Visual’ HANDOVER)– and would prompt the care giver to carefully check the cause of the slowness which has to lie – either in the ■power or ■passage or ■passenger or ■in combination of these and to plan necessary corrective action.

The logic of 3 PVs :

The distance from 4 cm (the starting point of the 1 cm/hour dilatation formula) – to 10 cm is only 6 cm or **6 hours**, so even if one plans to do 2 hourly PV-one cannot do more than 3 PVS.

Anyway, the recommended frequency of PV is three hourly (Studd et al, 1982). Only the slow dilators (according to literature they constitute only 20% of laboring Women, Philpott and Castle, 1972) will need more PVs.

The logic of laying such high importance to cervical dilatation “cervical dilatation is the only **exact** arbiter of progress in labor” (Friedman, 1955; Philpott, 1972; Studd, 1973; Studd, Cardozo and Gibb, 1982).

About ARM - According to WHO-ARM may be done at any dilatation in active phase of labor i e from 4 cm onwards (WHO, 1994).

III –To follow the following simple rule of SEVEN (7) for the lack of progress of dilatation

This rule serves as a simple but quite effective guide for the ♦diagnosis and ♦management of the ‘primary’ and ‘secondary’ *dysfunctional labor* without any - complexity, mental skill requirement, time investment and trouble of making, studying and interpreting some emerging graph as is required in conventional partogram.

I - *Slow dilatation between 4-7cm dilatation range*
(= ‘Primary’ Dysfunctional Labor)

Probable cause-Inadequate contraction

Logical treatment-Oxytocic after excluding mechanical obstruction

II - *Slow dilatation or no dilatation between 7-10 cm dilatation phase*

(= 'Secondary' Dysfunctional Labor)

Probable cause-Mechanical hindrance.

Plan of management-

- a) True mechanical obstruction present (CPD, Brow, Shoulder etc) – arrange to deliver by caesarean section
 - b) Mechanical obstruction absent (Deflexion, Malrotation, Poor contraction, ? borderline CPD etc - Give Oxytocin drip in the standard regime to stimulate uterine contraction which has multiple mode of action as follows –
 - i) Corrects deflexion
 - ii) Brings about rotation
 - iii) Negotiates borderline clinical-impression CPD
- (Dewhurst, 1981; Studd et al, 1984)

*****Multipara-a special category for Secondary Dysfunctional Labor***

Slow or no dilatation in a multipara at this advanced dilatation range is very Ominous !

The watch dog here is the *rate of 'descent'* which has to be carefully assessed by frequent vaginal examination and timed. Multis are expected to dilate and descend very fast at this stage.

IV-Maintenance of an usual 'Nursing observation chart' on a long foolscap paper

Please see the single page *Smart LABOR CHART* attached. Nothing new to learn. Nothing else is required. No dotting, no graphing, no creation of art unlike the conventional partogram.

REFERENCES

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856 results (0.03 seconds)

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