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THE ROLE OF OBSTETRIC NURSING IN THE CARE OF THE NEWBORN IN A NORMAL DELIVERY CENTER IN THE CITY OF CASTANHAL-PARA

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ABSTRACT

The aim of the study was to describe the performance of the obstetric nurse in the immediate care of the newborn in a Normal Delivery Center (NDC).This study is of the descriptive type with qualitative approach, developed in the municipality of Castanhal-PA.At the Center, 12 obstetrical nurses worked, where only 09 were participants and 03 were excluded because of the selection criteria.The analysis was performed using Bardin's methodology, using the software IRaMuTeQ for the treatment of the results. It was concluded that the performance of the obstetrical nurses at the study site, surpasses positively all the care recommended by the World Health Organization, according to scientific evidence currently proposed, rescuing the natural childbirth and respecting the process of adaptation of the newborn after the birth.

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INTRODUCTION

Nurses currently play an essential role in childbirth and birth care, where they have been requested in care settings involving prenatal, childbirth and puerperium actions, due to the quality of the care provided and the contributions in reducing maternal morbidity and mortality neonatal. It is a professional that uses a differentiated approach, giving greater emphasis to the physiological, emotional and socio-cultural aspects, offering a singular, continuous and healthy assistance in which the woman and the newborn (NB) are the main focus (SOUZA *et al*., 2015).

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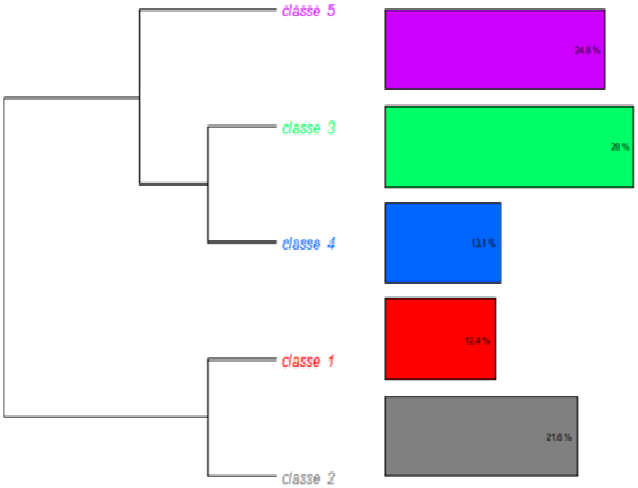
The first care offered to the newborn in its first hours of adaptation to the extrauterine environment, directly implies its survival and its development. The act of clamping the umbilical cord soon after birth, aspirating airways, administering medications, bathing and anthropometry early, as well as excessive manipulations, are considered the main unnecessary interventions for the newborn, as well as interfering in the first contact with can cause harm to their health (MULLER; ZAMPIERI, 2014). Reis (2015) observed that the delivery rooms of traditional hospitals provide a tumultuous, noisy, cold and high light environment. Many of these traditional hospitals still practice conducts such as securing the child through the feet after expulsion with the justification of faster elimination of the lung fluid, aspiration

of the airways of the NB even in the absence of secretion, sectioning the umbilical cord early and other care performed by nursing, are often performed away from the mother's and / or companion's visualization. All these behaviors are performed in neonates classified as low risk who are born without presenting any complications that justify so many interventions. Over the last few years, a number of changes have emerged with regard to the care provided to healthy newborns, and the main objective of these changes is to decrease the number of interventions performed, since such attitudes influence the relationship mother-child and altering the physiology and behavior of both. Such changes have been discussed in several situations, with different impacts on the health of the newborn. Several studies report an enormous difference between current scientific evidence and clinical practice (MOREIRA *et al*., 2014). Considering the good practices established in recommendations of the World Health Organization (WHO) and reinforced by the Ministry of Health, on August 05, 1999, through Administrative Rule 985 / GM and through the policy of the Stork Network, Normal Delivery Centers (NDC) in Health Unic System, to provide exclusive care for normal birth without distortion, offering a more adequate, private environment and a service centered on the binomial and its family, with the objective of improving the quality of obstetric and neonatal care , encouraging the humanization of this assistance in order to reduce rates of cesarean section and neonatal mortality and strengthening the link between the binomial through good health practices (BRAZIL, 2017). The Ministry of Health, to encourage the creation of these centers, drew on positive experiences in countries that offer nurses autonomy in the normal birth scenario and adopting WHO guidelines. In addition, Normal Delivery Centers are institutions in which obstetrical nurses can collaborate more strongly in the qualification of care, characterized, among other things, by the active participation of those involved in the process during the parturition period and by physiological aspects (SILVA, NASCIMENTO, COELHO, 2015). Reflecting on these aspects, the question of research emerged: How does obstetric nurse work in the care of the newborn in a Normal DeliveryCenter?

In this context, the objective of the study was to describe the performance of the obstetric nurse in the immediate care of the newborn in a Normal Delivery Center located in the municipality of Castanhal in the state of Para.

MATERIALS AND METHODS

This is a descriptive study, with a qualitative approach, developed in a Peri-hospital Normal Delivery Center. During the research period, 12 obstetrical nurses worked, being a coordinator of the Center. Due to the selection criteria, only 09 obstetrical nurses were participants, since 03 were excluded because they did not fit into the performance time of at least 06 months. The collection took place during the months of October and November of 2018 at the Haydêe Pereira de Sena Normal Delivery Center, located in the municipality of Castanhal in the state of Para, an institution that provides health care services for women with low-risk pregnancies time of delivery and to the newborn. The study was sent to the Ethics Committee UNIFAMAZ, where it obtained the legal consent to carry out the research through ethical principles, through CAAE 04433218.8.0000.5701 and was approved under opinion No. 3,131,446. After approval, the authors prepared a Free and Informed Consent Term (FICT), in order to guarantee the anonymity and confidentiality of the information acquired and a Voice Recording Term, to analyze the information collected. During the collection of the information the participants were asked to sign the Free and Informed Consent Term and the Voice Recording Term. As a research tool, a semi-structured interview script was drawn up containing two parts, the first one related to the professional profile and the second one with open-ended questions related to the participation of the participants in the care of the newborn. All the interviews were recorded, using a smartphone type cellphone device, lasting approximately 30 minutes each interview. After the collection phase, the records were transcribed in full, and treated using the methodology proposed by Bardin (2016), which consists of three stages: pre-analysis, material exploration and treatment of results. During the pre-analysis, the material was organized in order to systematize and organize the first ideas in a plan of analysis, by means of a general reading, separation of the documents and preparation of the corpus to be analyzed. In the second stage, material exploration was carried out using the software IRaMuTeQ, (Interface of Analytical Multidimensionnelles of Texteset de Questionnaires) 0.6 alpha 3, developed by Pierre Ratinaud, which allowed to make statistical analyzes on the textual and about the words. The corpus generated consisted of 9 ICUs with 331 analyzed segments, that is, 85.20% of the total corpus. From the intersection of text segments and words, applying the descending hierarchical classification (DHC) method, 5 thematic categories appeared, evidenced in the Dendogram according to Figure 1.



Source: Authors, 2018. Reinert method (IRaMuTeQ 0.6)

Figure 1. Dendogramaof Hierarchical Rating Descending (CHD)

At the stage of treatment of results and interpretations, the results were treated, highlighting the information provided by the analysis, proposing inferences and interpretations to the expected objectives. It was observed that of the 05 classes generated, only 03 contemplated the objective of this study.

The organization and discussion of each category allowed the articulation between the practices performed in the daily life with the scientific evidence used as the basis, giving rise to the following thematic axes: First care provided by the obstetric nurse and the benefits of the golden hour for the newborn ; Major intercurrences with the NB and the behaviors performed by the Obstetric Nurse; Difficulties faced by the obstetrician at the Normal Delivery Center.

RESULTS AND DISCUSSION

At present, 12 obstetrician nurses work in the Normal Delivery Center. Of this amount, only 9 were participants of the study, after applying the inclusion exclusion criteria predetermined in the study design; were between 23 and 39 years of age, all of them female. Regarding training time, it was identified that 6 professionals were less than 5 years old, while 3 were over 6 years old. Among the 9 participants, all had post-graduation in obstetrics and one beyond this, also has specialization in neonatology. Regarding the time of performance in the ANC, the participants reported being active between 6 months to 2 years and 6 months. According to the participants, all of them work through the practices recommended by the Ministry of Health, based on the scientific evidence of the World Health Organization (WHO), characterizing humanized care aimed at holistic care of the binomial. Thus, from the analysis of the material collected, the sense nuclei appeared: "First care provided by the obstetric nurse and the benefits of the golden hour for the newborn", "Major intercurrences with the newborn and the behaviors performed by the Obstetric Nurse" and "Difficulties faced by the obstetric nurse at the Normal Delivery Center".

Early care provided by the obstetric nurse and the benefits of the golden hour for the newborn: The NB needs to adapt to the environment more smoothly. What is lacking to a child is compensated and provided by the mother, who favors the satisfaction of all her needs, through the affective bond soon after giving birth. This bond shortly after birth significantly reflects on their survival and healthy development (FONSECA, 2016).

Participants describe the way NDC works during NB care in the first postpartum hour:

> *"The first thing I do is to dry a little to prevent heat loss and it goes to the lap of the mother where it has the golden hour [...] This first hour is theirs, all the rest of the care can be done after this first hour "(Nurse 03).*
> *"It's Golden Hour, the first hour of life, golden hour and nothing can be lost, you cannot miss this" iron "that will still guarantee 6 months that this baby does not have anemia, ensure timely clamping, this skin-to-skin contact, to ensure that contact with his first diaper, a diaper that came from his house to get in touch with the bacteria, the bacterial flora of his house ... but for me, the first hour is the fundamental. It's the time that has all the other factors to be able to guarantee for this newborn, so that he can absorb what is rightfully his, a truly humanized delivery "(Nurse 02).*
> *"In fact, in the first cares with the baby, we take into account the golden hour. The baby stays in skin-to-skin contact and then we do the physical examination [...] we wait for each stage of labor and after the golden hour [...] we take care of the newborn "(nurse 05).*

For Arruda *et al*., (2018), the first 60 minutes of life of the newborn after birth is called golden hour, which represents the moment at which measures are taken to reduce neonatal complications. Among these interventions we have skin-to-skin contact and breastfeeding in the first hour of life, which promote bonding between mother and child and stimulate the baby's sucking reflex. Thus, these measures are essential for the higher survival rates of newborns and lower rates of early weaning. According to Matão *et al*., (2016), the particularities of the bond between mother and child, regardless of their place of birth, are expressive and must be respected, since the transition period from the intrauterine to the extrauterine environment of a newborn, is very delicate, especially in the first hour of life, since it is at that moment that the mother sensitizes herself to her child and allows the establishment of the affective bond between both. According Fernandes; Rudek and Souto (2015) late clamping of the umbilical cord ensures greater blood transfer from the mother to the newborn in order to increase the child's serum iron levels up to 6 months of age.

> *"We do all this care with the baby on the cord. We do not clamber immediately, because the cord is a source of oxygen, if we cut, we are already cutting off a source of oxygen that it is missing. We do all the assistance with it connected in the cord, if it has to ventilate, if it has to reanimate, it is everything with the cord connected "(nurse 06).*

> *"We also respect timely clamping, where scientific evidence suggests that this clamping should be wait at least 3 to 5 minutes or until the cord stops pulsing. Most of the time we do the clamping after the cord stops pulsating or after placental discharge. Therefore, all newborns, with a few exceptions, those who present some serious complications, the timing of cord clamping is respected here "(Nurse 09).*

According to Oliveira (2017), the scientific evidence is adept at the late clamping of the umbilical cord, due to the benefits presented in the short and long term. Among the long-term benefits of delayed clamping is the increase in blood volume and, consequently, iron reserve rates, that is, it acts to prevent iron deficiency and anemia during childhood and is a positive practice in developing countries. Estimates show a higher percentage of 50% in infants who will be anemic at the end of the first year of life. Cuvello *et al*., (2017), complement that the obstetric nurse has effectively proved to be an important agent in reducing interventions during labor, delivery and birth.

> *"Not only calms the baby, but also provides a better fit. We avoid noise, visual stimulation, strong light and even tactile, we do not stimulate this baby in the first hour of life because it has the period of adaptation. So, it's babies you notice that are calmer, calmer, less stressed, less difficult to breastfeed "(Nurse 04).*
> *"We see that some babies accept the birth in a very quiet way, you can light the light, you can talk and it is there happy life. There is a baby that does not, you turn on the light and he starts to cry, when someone raises his voice, he starts to get agitated, nervous, because everything bothers him, he is very new to him. So sometimes, just the fact that you grab a cloth and try to dry it, it gets desperate "(nurse 01).*
> *"This baby will always be born in the twilight. Those who are born with me are in darkness, exceptionally if it is during the day, but when they are born at night, they are born in the gloom, without air conditioning. The team may be sweating, but the priority is to be without the air conditioning "(nurse 07).*

According to Sanfelice and Shimo (2014), excessive environmental sound exposure violates the concept of humanization of delivery care for the newborn. According to

these authors, humanized delivery should provide the newborn with a comfortable, quiet and quiet environment, capable of transmitting security and acceptance, while the presence of excessive stressors is an invasive factor at birth and can cause physiological changes, such as neurological disorganization, apnea, bradycardia, abrupt heart rate, respiratory oscillation, oxygen saturation, and blood pressure. For Santos *et al*., (2014), at the time immediately after birth, the mother-baby contact should be promoted and encouraged, since the newborn will have a warning period, which will serve to both recognize each other, occurring exploitation of the mother's body by the newborn. In this period, immediate and immediate care, such as airway aspiration, the use of the Credé method with 1% silver nitrate, and administration of intramuscular vitamin K should not be performed, as these will be stressor stimuli for the newborn. Ministry of Health recommends postponing postpartum for at least the first hour of life and avoid any routine care of the newborn that separates the mother from her baby.

> *"We always prioritize here that the physical examinations be done on her or that anything, be done on her side. This baby will never go to another room even if it is with a chaperone, with the father[...] The bath here in the newborn is made only after 24 hours, if she wishes to do only at home, she can. It is not mandatory that the bath be done, as after three, four hours, if born at dawn, will do the physical examination on the next team of the day. Weigh, measure, do some tests, evaluate it right "(nurse 07).*
> *"Care: vitamin K, argirol, regret, is somewhat different from what we are accustomed elsewhere, regret, anthropometric measures and the physical examination of the newborn can be left for after about 4 hours after childbirth" (nurse 03).*

According to Fucks *et al*., (2015), in the process of birth, the immediate assistance given to newborns aims to provide conditions that aim to assist them in their adaptation to extrauterine life. During care of the newborn from a normal birth without distortion, procedures such as applying Vitamin K at the time of gold hour, use of 1% silver nitrate unnecessarily in newborns without infection and low birth weight risk, hygiene of the newborn before 24 hours, and others, should not be performed in order to promote a lighter and healthier adaptation to the external environment to the newborn.

Major intercurrences with the newborn and the behaviors performed by Obstetric Nurse: The process of childbirth and birth is understood by an adaptation phase, both for the mother and the newborn, and that can result in unpredictable risks to the health of both, this requires more attention and preparation by the professionals. Even if this service is provided in an environment of habitual risk, and that offers all possible support, the professional must be able to attend to any complications that may arise (CAVALCANTE *et al*., 2016).
"We can only meet up a first line of conduct, from this, persistent discomforts, baby with a persistent tachycardia, it is necessary to transfer to the Magalhães hospital, because whether or not it already flees our standard, but the emergency care we get (Nurse 02).

> *"If he has respiratory discomfort, sometimes I use the ambu on her or her side, there is always a table that we put very close and we are doing these guidelines and if I need a transfer, a pediatric evaluation, we take with the companion "(Nurse 07).*

Mendonça *et al*., (2015) report that from 10 to 20% of pregnancies, it is possible to observe the presence of meconium in the amniotic fluid, and that 1 to 2% may evolve the Meconial Aspiration Syndrome. In this way, the team should be able to recognize, early on, possible factors that influence the release of this intrauterine meconium, adopting interventionist measures more appropriate for each case.

> *"You have to be very skilled with meconium, there are people who see and are soon agonized, depends on the thickness, the fluid meconium gives you to wait a little longer, the thick meconium is the most dangerous. So meconium is a "Russian roulette", it can give problem and nothing can happen. It does not mean that there is meconium present in childbirth that will suffer "(Nurse 06).*

In Brazil, the recommendation of the Brazilian Society of Pediatrics for newborns with meconium-based amniotic fluid who are vigorous at birth consists of the immediate clamping of the umbilical cord and initiating the first resuscitation procedures: bringing the newborn to the table of resuscitation under a heat source, positioning it in a slight extension of the neck, suctioning excess secretion from the mouth and nose, drying it and removing the moist fields. The meconium aspiration is reserved for newborns with meconium-containing amniotic fluid who present at birth with irregular breathing or apnea and / or heart rate below 100 bpm and / or flaccid muscle tone (FERNANDES; RUDEK; SOUTO, 2015).

Difficulties faced by the obstetrician at the Normal Delivery Center: Regarding the physical structure and components of NDCVico (2017, p.38) states that "the conception of NDC in Brazilian legislation can be considered as an innovation of obstetric care spaces, but not yet as developed as in others countries. " It is notorious in the participants' speech that the other difficulties they refer to are related to material and service issues that are independent of the NDC and its performance, as shown below:

> *"I believe that the only difficulty would be just the lack of exams or the lack of a single place of the NDC that will do our exams coverage, but other than that I do not see. In those 8 months here, I have not had anything that can be seen as a failure, because when an intercurrence or distortion occurs ... The baby is not responding well and is crying, I do a postural drainage and a tactile stimulation. Improved?Cool! Not improved? Are you still uncomfortable? Make a positive pressure ventilation PPV. Intercurrences are basically this, the baby stabilizes soon "(Nurse 02).*

> *"The greatest care we have to have, for example, is every day when we arrive, to check for oxygen, but if you do not have it, we'll send for the oxygen bullet. Test whenever the ambusis used, because we need a pediatric ambu. We have some, but after a while they get soft. If we have one that is not legal, we have to report it. These are the biggest difficulties, and what we do not yet have is the cradle for transportation. If need be, we do not even have, unfortunately. We made the request but it still has not arrived (Nurse 01).*

"At the moment it does not have the transport isolete so it ends up transporting this newborn baby in a common crib and this makes transportation difficult, so I believe that our greatest difficulty is this" (Nurse 09).

Dulfe *et al*. (2015) considers ensuring access to adequate and timely neonatal transport, when necessary, may be critical to the survival of the newborn under the best possible conditions. Neonatal mortality is lower when the birth of a child occurs in well-equipped childbirth centers in terms of material and human resources. However, in some situations, the birth of a diseased concept may occur and such patients should be transferred to a specialized unit. The responsibility for the indication of this type of transport is of the team that provides assistance to the NB. In order for transport to be carried out safely, it is essential, in addition to a well-trained transport team, the adequate clinical stabilization of the newborn before transport (SANTOS, 2016).

Conclusion

Building this study provided in addition to the deepening of the thematic humanized assistance to the newborn, the unveiling of the practices performed by obstetric nurses in a Normal Delivery Center in the city of Castanhal in the state of Para. It was also verified that, in line with the evidence-based guidelines proposed by the Ministry of Health, such obstetrical nurses act to meet the criteria of humanization to the mother and newborn binomial. It was noticed that the performance of the nurses within the Normal Delivery Center, surpasses positively all the care recommended by the World Health Organization. Following, according to their discourses, the scientific evidences currently proposed, rescuing the natural childbirth and respecting the process of adaptation of the newborn after birth. It was also observed that nurses have full mastery of their actions and always seek to improve them through researches, lectures and congresses, and cherish the sharing of new ideas with other professionals. It also demonstrates that the nurse in her praxis can act autonomously and interdependently, demystifying the idea of submission between categories, but as evidenced by the practice of the participants, it is necessary to understand that nurses should act based on scientific knowledge aimed at their object order that is the nursing care. It is hoped that the results of this study contribute to the importance of the promotion and implantation of new units of the Normal Delivery Center in the state of Pará, adding value to the care provided to the newborn in the State, valuing the humanization of the care provided by the nurse.

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