

Reflection on antenatal care in a low risk pregnancy



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TRADITIONAL SKILLS IN MIDWIFERY: ABDOMINAL PALPATION

The purpose of this assignment is to reflect on the learning gained from a clinical experience regarding an aspect of antenatal care in a low risk pregnancy.

The reflection per se will follow the structure of Gibbs reflective Cycle and the topic chosen is abdominal palpation. The Nursing and Midwifery Council (NMC) Code 2018 and the National Institute for Health and Clinical Excellence (NICE) 2008 guidelines will be referenced and followed when appropriate. All the names mentioned will be pseudonyms, following the University of Hertfordshire Confidentiality Policy and the NMC Code 2018 confidentiality guidelines.

Abdominal palpation is a traditional skill in Midwifery that, together with the symphysis-fundal height and auscultation of the fetal heart, conforms the examination of the abdomen in pregnant women that midwives, obstetricians or GPs perform during the antenatal care, when the woman is in established labour, and prior to any invasive procedure. It is very relevant as it gives a knowledge of the presentation, lie and position of the fetus and, therefore, this can make an impact in the woman's plan birth.

During one of my recent practice placements in the Maternity Led Unit of Hospital A I had the opportunity to perform my first Abdominal palpation under the supervision of one of the experienced midwives within the team. The woman (Anne) aged 27 years old, was a primigravid in low risk, singleton and term pregnancy (39 weeks and 5 days) presenting symptoms that resulted to be false labour.

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After the introductions took place, Anne was habilitated in one of the rooms. The midwife then invited her to lie on the bed and asked general questions regarding her wellbeing and if she had been feeling fetal movements and in which part of her abdomen. There was an initial explanation about the abdominal examination we would be performing next and the midwife asked for consent. Oral consent was given and Anne then lied in semi-recumbent position (I would know later that this is the right position to avoid aortocaval compression and she exposed part of her abdomen while we washed and dried our hands.

The communication with both Anne and her partner, was fluent all the time until the palpation took place, when the midwife kept silence and concentrated on the procedure, which she completed with confidence. I could see Anne feeling some discomfort during the pelvic palpation, and the rest of the time she gave the impression of feeling comfortable.

After the midwife finished, I asked Anne for consent and once she gave it, I started the palpation, following the same procedure as the midwife did before.

Therefore, I started with the fundal palpation using both hands firmly on the sides of the fundus, below the xiphisternum, and moving them using the palmar surfaces of the fingers trying to find the breech in the fundus. Therefore, I could confirm that the fetus was in cephalic presentation. Despite I could not find the fetal lower limbs, I could feel the breech (less ballotable and defined that the head).

Secondly, I carried on with the lateral palpation in order to determine the position of the fetus, using both hands on each side of the uterus at the level of the umbilicus and 'walking' the fingers alongside the abdomen. After inspecting for a while, I found the back of the fetus on the left.

Finally, I practiced the pelvic palpation to identify the pole of the fetus in the pelvis using my fingers directed inwards and downwards. The head was presenting, so I easily felt it as a hard mass, although it was not possible for me to determine how much was palpable above the pelvic brim.

When the palpation was ended, the Midwife asked for consent to Auscultated the fetus heartbeat. After this last step, the examination was completely finished. She gave Anne the outcome of the examination while I took the observations and afterwards I recorded all the findings in the maternity notes.

Despite not being an experienced practitioner and not being able to find all the outcomes, the general feeling during the first two stages of the examination was positive. Unfortunately, I was completely concentrated in the procedure and could not confirm whether Anne had felt discomfort.

On the other hand, I felt quite glad to have detected the position and lie of the fetus relatively easy. It resulted to be in a longitudinal lie, cephalic presentation. And was in a Left Occipitoanterior position (LOA). Although despite this positive feeling I had, I was able to figure out that it might not be easy to detect this position in a woman for instance with a higher BMI range, or other positions, lies, and presentations (such as left or right occipitolateral or occipitoposterior).

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Curiously, a few days after the clinical experience had taken place, I happened to be in another clinical placement in the Maternity Led Unit when one of the midwives on duty found during a vaginal examination in a woman in established labour that the fetus was in a breech position. This was an issue of celebration within the midwifery team. To me, it added even more interest in the topic since I questioned myself the effectiveness of abdominal palpation as a method of screening.

Looking in retrospective, the first element I could confirm is the application of the NMC Code 2018 professional standards. This was reflected in the way the woman was treated, with kind and respect, and preserving her dignity and privacy during all the length of the visit. Furthermore, before starting the abdominal examination we asked for consent and after the procedure I recorded all the findings in the Maternity notes, following the NMC Code 2018 and the NICE 2008 Documentation of care guidelines.

In relation to the Midwife that was sharing the experience with me, I would like to add that she also followed The NMC Code and the NICE 2008 guidelines and therefore she informed clearly to Anne and her partner about the procedure and after it the findings. Furthermore, her behaviour was an example of professionalism with respect to me as a student.

Regarding the palpation 'per se', the order can vary depending on the practitioner. Both the midwife and I started with the fundus and carried out with the lateral palpation finishing with the pelvic. But other midwives can start palpating the fundus, then the pelvic palpation and leaving the lateral palpation at the end. Johnson and Taylor (2016) suggest that rather than the

order, what is important is the technique. However, further research suggests that, due to the tightening of the uterine and abdominal muscles that the palpation of the uterus may cause in some women, in order to determine the fetal presentation more easily, pelvic palpation should be performed first (Macdonald and Johnson, 2017).

According to the NICE guidelines (2008), in the UK although the fetal growth is assessed by measuring the symphysis-fundal height during the antenatal appointments from 24 weeks, the presentation does not need to be assessed until 36 weeks' gestation or late. The reason is that the results are not accurate enough and can create discomfort in the woman.

One of the aspects perhaps I did not check enough was the examination of the abdomen prior to the palpation, as this inspection can give very relevant information. about the position and presentation of the fetus as the midwife may observe fetal movements, or the mother may feel them. Let's remember in our clinical experience that the midwife asked this question prior to the examination, although not a deep inspection of the visual appearance of the abdomen was noticed and neither during my examination.

Skin changes can also be detected and any signs of previous abdominal surgery and presence of rashes or itching can be relevant, and even signs of potential domestic abuse (Johnson and Taylor, 2016).

Regarding the technique followed in the palpation, in general the main indications were followed and the palpation was carried out gently, using the pads of the fingers and inspecting the abdomen smoothly to avoid discomfort. As Macdonald and Johnson (2017) maintain, undue pressure may <https://assignbuster.com/reflection-on-antenatal-care-in-a-low-risk-pregnancy/>

make the palpation more difficult as the discomfort can stimulate uterine contractions.

However, in further research I discovered some relevant aspects that should have been included in the procedure. One of these aspects is that woman should be asked to empty her bladder before starting the examination, in order to facilitate the procedure and avoid discomfort especially in the pelvic palpation. Possibly, this could have been one of the reasons why Anne showed some signs of discomfort during the palpation. In addition, in some cases it could also distort the palpation and other aspects like the measurement of symphysis-fundal height when it takes place.

It is also suggested to ask the woman to bend her knees as it helps to relax the abdomen and, therefore, it facilitates the palpation and avoids discomfort. For the same purpose, the woman can facilitate the procedure if she breathes steadily to help her feel more comfortable (Marshall and Raynor, 2014). All these details were omitted during the course of the procedure.

I also found that there are two techniques that can be performed. We performed the two handed one, and literature suggests that this is the most comfortable for the woman and gives the most information. There is another technique that appears in the research quite frequently, that is, the Pawlik's manoeuvre, where the lower pole of the uterus is grasped between the fingers and thumb, and can be used to assess the mobility, flexion and size of the head and should be used only in cases where it is really needed due to the discomfort that may cause to the woman (Marshall and Raynor, 2014).

Furthermore, I found that another aspect which was quite relevant is to reassure that the nails are short, and the hands are not only clean, but also warm. I did not confirm this aspect and although I did not feel my hands were cold as the room temperature was warm, I found that this is quite important as cold hands do not have the necessary acute sense of touch, they tend to induce contraction of the abdominal and uterine muscles and the woman may find palpation uncomfortable.

Moreover, although the woman during the clinical experience looked quite comfortable (leaving aside that discomfort during the pelvic palpation we have already mentioned), it is easy to figure out that for some women the nature of this examination can be found intimate and embarrassing. As NMC Code 2018 establishes, we need to be sure that as professionals we prioritize people, and one of the ways is recognising when they are anxious or in distress, responding compassionately and politely.

For this purpose, literature suggests that the midwife has to be facing the woman during all the procedure of palpation to detect signs of discomfort, like for instance grimacing (Macdonald and Johnson, 2017). In general, during the visit I had a fluent communication with Anne and her partner, but I later realised that I did not face her during all the palpation. This is something that needs to be improved in future clinical experiences. It is interesting to add here that the same attention should be given to multiparous women, not only primigravid, as apparently there are occasions where we tend to assume that women who had previous pregnancies have more knowledge and therefore, reduce the feedback during the maternity care.

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Finally, I would like to mention my findings regarding the effectiveness of the abdominal palpation as a method of screening. Although many agree that is a relevant skill in the Midwifery practice, its accuracy is not totally confirmed. Therefore, according to the Royal College of Obstetricians and Gynaecologists, there is a percentage of 3 to 4% of fetus in breech position, 10% of which are not detected until the onset of labour (one of which I witnessed during one of my placements).

Furthermore, The Norfolk and Norwich University Hospital has carried out a study about implementing a presentation scan in women as part of the routine antenatal screening to improve the effectiveness in detecting breech positions.

Interestingly, many midwives disagree with the use of additional hand-held scans, as they felt it was a way to lose traditional skills in midwifery.

In conclusion, this clinical experience has permitted me to enhance my knowledge in abdominal palpation as part of the relevant skills that conform the spectrum of Midwifery practice. Taking into consideration that this skill requires a lot of practice and experience, following the NMC Code 2018 guidelines of practise effectively I will keep on building further knowledge and experience in this skill. It will also be essential to work cooperatively with my colleagues, asking for a second opinion when needed and referring for a scan if malposition of the fetus is suspected.

Other essential aspects will also be maintained as an essential part of my spectrum of practice, like asking for consent and record-keeping efficiently.

And finally, I will keep my practice as a midwife to a high standard, with effort and commitment, while supporting the woman in her journey to motherhood.

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