Assessment of Nurse – Midwives Practices concerning perinatal care throughout stages of labor

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Abstract

Objective: To assess the Nurse – Midwives practices concerning the management during stages of labor. To find out the association between the Nurse – Midwives practices and certain variables.
Methodology: A questionnaire was prepared for the purpose of this study which was consisted of (2) parts, including: sociodemograghic characteristic concerning Nurse – Midwives, second part consists of (60) items show practices of Nurse – Midwives throughout 1st, 2nd, and 3rd stage of labor. The sample of the study consisted of (75) Nurse – Midwives who they working at delivery room in Baghdad hospitals. A suitable statistically means were used to analyze the findings of the study.
Results: The results revealed that there was statistical significant between nurse – midwives practices concerning first stage of labor and working shifts & birth / average, and significant between nurse – midwives practices concerning second stage of labor and educational level, birth / average, and significant between nurse – midwives practices concerning third stage of labor and age of nurse – midwives.
Recommendation: The investigators recommend that installing inservice educational program for Nurse – Midwives to upgrade the techniques necessary to assess, evaluate and improve the quality of care rendered to laboring women, and conduct training course for the Nurse – Midwives periodicly in order to change their malpractices to good practices.
Keyword: Assessment of Nurse- Midwives practices perinatal care.

الخلاصة

الهدف : تقييم ممارسات الممرضات – القابلات فيما يتعلق بالعناية خلال ادوار الولادة.
و لايجاد العلاقة بين ممارسات الممرضات - القابلات و بعض المتغيرات (العمر ، المستوى الثقافي ، الحالة الاجتماعي ، و جبات العمل ، سنوات الخبرة)
المنهجية : اعدت استمارة استبيان خاصة بهذا البحث و تكونت من جزئين الاستمارة الاولى شملت على المعلومات الديموغرافية المتعلقة بالممرضة- القابلة ، و الجزء الثاني يتكون من ٢٤ فقرة تصف ممارسات الممرضة - القابلة خلال الدور الاول ، و الثاني ، والثالث من الولادة ، تكونت عينة البحث من (٧٥) ممرضة - قابلة و اللواتي يعملن في صالات الولادة في مستشفيات بغداد و قد استخدمت الوسائل الاحصائية الملائمة لتحليل النتائج .
النتائج : اشارت نتائج الدراسة وجود علاقة ذات دلالة احصائية بين ممارسات الممرضة - القابلة المتعلقة بالدور الاول للولادة ووجبة العمل و معدل الولادات ، و كذالك بين ممارسات الممرضة – القابلة للدور الثاني للولادة و المستوى التعليمي، معدل الولادات خلال وجبة العمل ، وبين ممارسات الممرضة القابلة للدور الثالث للولادة و عمر القابلة .
التوصيات : اوصت الباحثة بضرورة انشاء او بناء برنامج تعليمي للممرضات – القابلات لرفع تقنياتهن الضرورية لتقييم و تقويم و تحسين نوعية العناية المقدمة للماخض ، و اقامة دورات تدريبية دورية لغرض تغيير الممارسات السيئة بممارسات صحيحة .

Introduction

Every year more than 200 million women become pregnant. Most pregnancies end with birth of a live baby to a healthy mother. For some, however, childbirth is not the joyous event; it is a time of pain, fear, suffering and even death. Because of difficulties associated with human birth, women often require assistance during delivery. Childbirth may be surrounded by traditions, many of which are beneficial but others may be harmful. All too often, the needs of the woman in labor are neither recognized nor acknowledged as a result, childbirth may end in disability or death for the mother, infant or both [1].

Birth is a risky event for babies too. The complications that cause the deaths and disabilities of mothers also damage the infants they are carrying. These perinatal and neonatal deaths are largely the result of the same factors that cause the deaths and disabilities of Mothers. newborns die or become disabled because of poor maternal health, inadequate care during pregnancy, inappropriate management and poor hygiene during delivery, during the first critical hours after birth, lack of newborn care and discriminatory care [2].

Human birth is a normal physiological process and as such should not be life threatening to the women who experience it. However, in developing countries where pregnancy is complicated by the harsh realities of malnutrition, poverty and the disease associated with them, giving birth dire consequences for mother and child. As a result of child birth half a million women world wide die annually. In 1998, deaths during pregnancy, childbirth and the puerperium were made notifiable events in South Africa [3].

WHO is deeply committed to help member states adapt these midwifery standards for their use, within their own unique health systems and socio- cultural environments. It is certain that their application will contribute very substantially to reducing maternal mortality and to improving the health of mothers and infants throughout the region. They firmly believe that the joint efforts can and will make all difference to herald a healthier 21st century [4].

There are four main components to prenatal care in developing countries: risk screening to identify those women most likely to have poor outcomes of pregnancy and childbirth, the detection and management of associated diseases, the maintenance of maternal nutrition and health, and health education about safe delivery and the early recognition and management of complications [5].

The risks of adverse out-come in mother and baby are usually highest during the intra-partum period. Even though health experts have long appreciated this fact, prioritization of this element of safe motherhood is comparatively recent. Much has been written both on this shift in emphasis and on the underlying rational, as well as on what skilled attendance at delivery should comprise [6].

The health of mothers and babies is a human right needs to be underpinned by policies and laws that increase access to information and good- quality; affordable health services [7]. A positive policy environment is crucial for promoting maternal health and reducing the burden of maternal and perinatal conditions [8].

Importance of the Study:

During labor and Delivery, the nurse – midwives should administer sensitive and appropriate care based on the particular needs of the client and her family. They require a fold effort to assess labor progress and using personal skills to assess the client and family's needs during this physically and emotionally stressful time.

The aim of the care in normal birth is to achieve a healthy mother and Fetus with least possible level of interventions that is compatible with the safety [9].

The investigator tries to highlight the Nurse- Midwives role in the delivery room toward using proper and healthy practices compatible with good knowledge throughout stages of labor.

Human labor is surprisingly hazardous. Evolution ought to favour those mothers who deliver without problems and yet, for those without access to good medical care, the lifetime risk of dying from labor may be 10% or more [10].

Nurses can help the nation achieve these goals by closely monitoring women during labor and birth and by teaching women as much as possible about labor, so that they are able to use as little analgesia and anesthesia as possible [11].

Objectives of the Study were:

To assess the Nurse –Midwives Practices regarding the management throughout stages of labor.

To find out the relationship between the Nurses –midwives Practices and certain variables:

Age, educational level, marital status, Experience in delivery room, attending midwifery courses.

Methodology:

A descriptive study was conducted which was using assessment as an approach for identification of the nurse – midwives practices concerning perinatal care throughout stages of labor. The study was carried out for the period of March 22nd 2008 through June 30th 2008.Non-probability (purposive) sample consist of (75) Nurse – Midwives who where working at the delivery room in Baghdad city.

For the purpose of data collection, an assessment of nurse – midwives practices concerning the management of 1st, 2nd, and 3rd stage of labor. A pilot study was conducted for the determination of the reliability and the content validity of the assessment tool. The data were collected through the utilization of the observational assessment tool and the interview techniques. The data were analyzed through the use of descriptive data analysis approach that included frequency, percentage, mean of score, standard deviation and inferential statistical data analysis approach that included chi- square, Guttman Split half for illustrating reliability coefficient.

Results

Table 1 Illustrates that the highest percentage (33.3%) of the Nurse-Midwives age were (43) years & more, (49.4%) of them were midwifery school graduate, (74.7%) of them were, married, & (16%) of them were inherited the midwifery from their mothers.

Table 2 presented that the highest percentage (28 %) of nurse – midwives having experience in maternity hospitals between (6 – 10) years, (32 %) of them having (1 – 5) years in delivery rooms, (30.7 %) of them not having any training courses during their experiences, & (38.7 %) of them having at least one week duration course.

Table 3 reveals that there was low mean score with negative trends in all items regarding the Nurse – Midwives practices in first stage of labor in monitoring and recording vital signs, checking uterine contractions, monitoring fetal heart rate, conducting vaginal examination, and rupture of membranes.

Table 4 shows that there was low mean of score in most of the items with negative trends regarding Nurse –Midwives practices regarding second stage of labor, while there were high mean of scores with positive trends in Nurse –Midwives practices in delivering the head between contraction, avoid perineal stretching, encourage woman bearing down, using sharp scissor for cutting the cord, and replace clean pad on incision.

Table 5 reveals that there was high mean of scores with positive trends in Nurse-Midwives Practice regarding the third stage of labor, in waiting for placental separation, placental delivery, manual

removal of placenta and membranes, examine the perineum and episiotomy degree of extension, while other items tends toward negative trends with low mean of scores.

Table 6 reveals that regarding Nurse-Midwives practices there were high significant difference between working shifts and birth average and their practices.

Table 8 indicates that there are significant differences between Nurse- Midwives practices regarding 3rd stage of labor and the age while no significant differences between other variables.

Table 7 shows that there is high significant difference between Nurse- Midwives practices regarding 2nd stage of labor and their educational level and birth average.

Table ١. Distribution of Nurse- Midwives regarding Socio-Demographic Characteristics.

	Variables	F (N= 75)	%
1-	Age / years		
	18 -22	2	2.7
	23 - 27	4	5.3
	28 - 32	9	12.0
	33 - 37	17	22.7
	38 - 42	18	24.0
	43 +	25	33.3
	($\bar{X}$ 38.9 ± 9.4)		
2-	Educational Level		
	Nursing Course graduate	1	1.3
	Nursing school graduate	25	33.3
	Secondary Nursing school graduate	12	16
	Midwifery school graduate	37	49.4
3-	Marital status		
	Married	57	74.7
	Single	12	17.3
	Widow	4	5.3
	Divorced	2	2.7
4-	Inheritance of Midwifery		
	Yes	12	16
	No	63	84
	Total	75	100%

Discussion

It was revealed from table 1 that Analysis of the Nurse- Midwives demographic characteristic indicated that the higher percentage (32%) of the Nurse- Midwives age were (43 years) and over and the lowest percentage (2 .7%) of them were in age group (18-22) years, with mean of (38.9 ± 9.4).

Regarding the level of education, the highest percentage (49.4%) of the study sample was Midwifery school graduate.

World Health Organization (WHO)[12] stated that the Nurse- Midwife Secondary is a person who is qualified to practice Midwifery, attending normal delivery, and having a lot of training to conduct normal deliveries on their responsibilities and caring for newborn, and fulfill the requirements of the newly delivered mother and her fetus and monitoring the progress of their health after delivery.

Regarding marital status, the majority (74.7%) of the Nurse- Midwives were married. This is something that can be expected with such population due to the nature of their profession as female oriented.

Table 2. Distribution of Nursing – Midwives Regarding their Experience & Attendance of Midwifery Courses.

	Variables	F. (n= 75)	%
1-	**Duration of Nursing experience in Maternity hospital**		
	< 1 year	1	1.3
	1 - 5 years	13	17.3
	Variables	**F. (n= 75)**	**%**
	6 – 10 years	21	28
	11 – 15 years	16	21.3
	16 – 20 years	14	18.7
	21 – 25 years	5	6.7
	26 +	5	6.7
	X (13.1 ± 9.4)		
2-	**Duration of experience in delivery rooms:**		
	< 1 year	4	5.3
	1 - 5 years	24	32
	6 – 10 years	19	25.3
	11- 15 years	14	18.7
	16 – 20 years	8	10.7
	21 – 25 years	2	2.7
	26 +	4	5.3
	X (10.3 ± 8.9)		
3-	**Training course in Midwifery.**		
	None	23	30.7
	1	20	26.7
	2	19	25.3
	3	9	12
	4	2	2.7
	5	2	2.7
4-	**Duration of training course**		
	None	23	30.7
	One week	29	38.7
	Two weeks	13	17.3
	One month	9	12
	More than One month	1	1.3
	Total	75	100%

The study demonstrated that (16%) of the study sample inherited the midwifery from their mothers. That means they have the desire in the profession, and the tendency to practice it, and having their experience from their relative mother, sister and others.

It was revealed from table (2) that Nurse-Midwives experience and training courses: Regarding their experience the highest percentage (28%) of them were employed for (6-10) years, while (32%) of them spent between (1-5) years of employment in midwifery. This study was in agreement with the study employed by (13), on assessment of Nurse- Midwives practices regarding prolonged labor in Babylon city, reported that (22.8%) of them having between 6 to 10 years experience in nursing, while (40.4%) having spent less than 5 years of their employment in midwifery.

Regarding training course in midwifery, the highest percentage (69.4%) of them, has the opportunity to be enrolled or participated in training courses ranging between 1 to 5 courses, with duration ranging from one week to more than one month. While one third of them not having any training courses.

Table 3. Distribution of Nurse – Midwives practice items score regarding first stage of labor. n= 75

	Items related to 1st stage of labor	Always	Some times	Never	MS
1-	**Monitoring & record B/ P.& vital signs**	10	20	45	1.53
2-	**Checking Uterine contraction**				
	1- monitor Ut. Cont. regularity	12	20	43	1.59
	2- Encourage the women relaxes between Contraction	10	12	53	1.34
3-	**Monitoring of fetal heart rate (FHR)**				
	1- Monitor fetal heart every 15/m. in first stages of labor	10	20	45	1.53
	2- Monitor fetal heart between Uterine Contraction	20	11	44	1.68
4-	**Vaginal examination**				
	1- Using aseptic techniques to perform vaginal exam.	2	26	47	1.76
	2- Cleaning the vulva & introitus	1	36	38	1.50
	3- Using sterile gloves & aseptic creams.	9	33	33	1.68
	4- Assess & Record effacement & dilatation, fetal head desent on partograph	0	0	75	1
5-	**ARM spontaneous**				
	Items related to 1st stage of labor	**Always**	**Some times**	**Never**	**MS**
	1-Inform the pregnant woman, the membrane have ruptured.	0	4	71	1.05
	2- Record, color, a mount & smell of liquor.	0	0	75	1
	3- If membrane ruptured place sterile /clean gauze pad	0	0	75	1
	4- Recordings	0	0	75	1

Table 4. Distribution of Nurse – Midwives Practice Items Score Regarding the Second Stage of Labor n= 75

	Items related to 2nd stage of labor	Always	Some times	Never	MS
1-	**Episiotomy**				
	1- Prepare sterile equipment necessary for this procedure	18	14	43	1.67
	2- Inform the woman the need for an episiotomy & what she feels.	1	6	68	1.10
	3- Using local anesthesia if available.	2	34	39	1.50
	4- Insert two fingers of the left hand in the vagina to protect the fetal head.	10	17	48	1.49
	5- Make sure & check the needle that inserted to blood vessels	21	14	40	1.74
	6- Wait for 1/ m. to allow the anesthetic to make effect & check if it has worked	20	18	37	1.77
2-	**Cleanliness and sterilization**				
	1- Ensure what the place for delivery is clean	0	14	61	1.18
	2- Cleaning the perineum with safe water	1	28	46	1.4
	3- Clean hands using soap & safe water & dry them thoroughly	8	44	23	1.8
	4- Once the baby is born, cover incision with sterile pad, until baby resuscitated	43	18	14	2.39
	5- Using sterile sharp scissor cutting the cord.	43	6	26	2.22
3-	**Conduct of actual delivery**				
	1- Encourage women in 2nd stage to bear down as she desire when fetal head is visible	68	5	2	2.88
	2- Avoid manually stretching the perineum	72	1	2	2.93
	3- Allow delivery of the head slowly, preferably between contractions	72	0	3	2.92
	4- Once the head is delivered, allow the shoulders to rotate spontaneously	0	0	75	1

Table 5. Distribution of Nurse – Midwives Practice Items scores Regarding Third Stage of Labor n= 75

	Items related to 3rd stage of labor	Always	Some times	Never	MS
1-	**Waiting for placental separation signs**	26	34	15	2.14
2-	**Placental delivery**				
	1- Place the left hand above the symphsis pubic to hold the body of uterus	37	27	11	2.34
	2- Keep the cord tight but do not pull on the cord.	27	43	14	2.17
	3- Do not apply pressure to the fundus	16	39	20	1.94
	4- Deliver the placenta slowly & carefully	48	21	6	2.65
	5- As the placenta is visible at vulva, gradually move up word. The placenta flows the same direction as fetus & delivers placenta into left hand	0	0	75	1
3-	**Checking placental & membrane completeness**	9	43	23	1.81
4-	**Manual removal for placenta & membranes**	33	20	22	2.14
5-	**Cleaning perineum with clean water & dry use sterile pads**	8	28	39	1.58
6-	**once check the placenta & membranes are delivered that the uterus is well contracted**	11	21	43	1.57
7-	**Estimate blood loss as accurately as possible**	0	0	75	1
8-	**Give the uterotonics drugs immediately after birth**	17	28	30	1.82
9-	**Put the newborn on breast feed**	0	0	75	1
10-	**Monitoring the vital signs & Blood pressure**	0	0	75	1
11-	**Repairing of Episiotomy**				
	1- Gentle massage for uterine fundus if not well contracted	16	31	28	1.84
	2- Examine the perineum to determine the extent of the incision as soon as possible	58	6	11	2.62
	3- Episiotomy & degree of extension	67	3	5	2.82
12-	**Check for bleeding incision area**	6	14	55	1.34
13-	**Ensure the woman informed for need to keep the perineum dry & clean**	0	1	74	1.14

This study supported by the study conducted by [14], who found that inservice training, is essential to make sure that Midwives skills and their understanding quality of care have been updated. To maintain high quality in their nursing and midwifery practices and give them the opportunity for high quality of performance.

It was revealed from table (3) the results show that there are low mean of scores with negative trends in all items regarding the Nurse- Midwives practices in first stage of labor, such as, monitoring and recording vital Signs, checking uterine contractions monitoring fetal heart rate, conducting vaginal examination and rupturing the membranes. the nurse – midwives practices mostly tend to be poor due to the shortage in the nursing staff in delivery room and poor job satisfaction, and also due to the over load work in delivery room, in addition to shortage in facilities required for conducting their job in the delivery room.

Miltner RS (2002) [15] stated that to describe the type and quantity of interventions provided to women in the first stage of labor, observed surveillance, direct care, and supportive care interventions recorded during the episode of care during. The first stage of labor, nurses provided supportive care more frequently, this supportive care was frequently done in conjunction with other, more technical nursing care with other direct and indirect care interventions may offer the best model for providing high-quality intrapartum nursing care. Continuing assessment is an important part of nursing care for the laboring women during 1st stage of labor, monitoring fetal heart, and uterine contraction [16].

Cunningham- F et. Al. (1997) [17] & Charles- R. W (1995) [18] stated that the performance of vaginal exam obtain the amount of information & to compare each result with previous one.

In addition, Charles- R. W (1995) [18] stated that artificial rupture of membrane was not favored due to increased intrauterine infection on prolonged labor.

Table 6. Association between Nurse- Midwives characteristic and practices regarding first stage of labor.

Variables		Practice		X^2	Sig.	p<
		Inadequate	Adequate			
Age	18-22	2	0	3.20	NS	>0.05
	23-27	4	0			
	28-32	8	1			
	33-37	16	1			
	38-42	14	4			
	43+	22	3			
Total =75		66	9	Df=5		
Educational level	Ng. course	1	0	0.369	NS	>0.05
	Ng. school graduate	22	3			
	Sec. Ng. Sch	11	1			
	Mid. School	32	5			
Total =75		66	9	Df=3		
Marital status	Married	49	8	1.195	NS	>0.05
	Single	11	1			
	Widow	4	0			
	Divorced	2	0			
Total =75		66	9	Df=3		
Working shifts	Day shifts	30	2	7.62	HS	0.02
	Night shifts	21	1			
	Day & Night	15	6			
Total =75		66	9	Df=2		
Birth average / shift	1-5	10	1	10.397	HS	0.015
	6-10	32	1			
	11-15	13	6			
	16+	5	1			
Total =75		66	9	Df=3		
Ng experience in maternity hospital	< 1 year	1	0	6.327	NS	>0.05
	1-5 years	11	2			
	6-10 years	16	5			
	11-15 years	14	2			
	16-20 years	14	0			
	21-25	5	0			
	26+	5	0			
Total =75		66	9	Df=6		
Ng experience in delivery room	< 1 year	2	2	7.956	NS	>0.05
	1-5 years	21	3			
	6-10 years	16	3			
	11-15 years	13	1			
	16-20 years	8	0			
	21-25 years	2	0			
	26+ years	4	0			
Total =75		66	9	Df =6		

Table 7. Association between Nurse- Midwives characteristics and practices regarding second stage of labor

Variables		Practice		X^2	Sig.	p<
		Inadequate	Adequate			
Age	18-22 years	2	0	7.423	NS	>0.05
	23-27 years	3	1			
	28-32 years	9	0			
	33-37 years	10	7			
	38-42 years	11	7			
	43+ years	14	11			
Total =75		49	26	Df=5		
Educational level	Ng. course	0	1	10.21	HS	0.017
	Ng. school graduate	13	12			
	Sec. Ng. Sch	12	0			
	Mid. School	24	13			
Total =75		49	26	Df=3		
Marital status	Married	35	22	2.110	NS	>0.05
	Single	9	3			
	Widow	3	1			
	Divorced	2	0			
Total =75		49	26	Df=3		
Birth average / shift	1-5	1	10	18.495	HS	0.000
	6-10	28	11			
	11-15	15	4			
	16+	15	1			
Total =75		49	26	Df=3		
Ng experience in delivery room	< 1 year	2	2	7.523	NS	>0.05
	1-5 years	18	6			
	6-10 years	15	4			
	11-15 years	7	7			
	16-20 years	5	3			
	21-25	1	1			
	26+	1	3			
Total =75		49	26	Df=6		

It was revealed from table (4) the results presented low mean of score in most of the items with negative trends regarding Nurse- Midwives practices regarding second stage of labor, while there were high mean of score with positive trends in Nurse- Midwives practices in delivery of the head between contractions, avoid perineal stretching, encourage women bearing down, using sharp scissor for cutting the cord, and replace clean pad on incision.

This study was in agreement with study conducted by [13] regarding Nurse-Midwives practices in nursing interventions in stage of labor, concerning their performance in perineal preparation and cleanliness and sterilization during actual conduct of delivery.

Maher- J and Souter- KT (2002)[19] in their study found that one of the key tasks midwives described was assisting birthing women to develop and negotiate satisfactory birth narratives that could encompass the intense and sometimes difficult experience of birth. Midwife informants offered Strategies for the development of such narratives as part of their professional and personal labor in the birth room.

Sawls- DJM (2000)[20] in a study conducted to measure perception labor support found that the labor support is an important part of this experience since it influences the woman's classification of the birth experience as positive or negative. By understanding professional labor support, intrapartum nursing

knowledge can be advanced and help quid professional labor support interventions which can enhance the birthing process for all women.

Table 8. Association between Nurse- Midwives characteristics and practices regarding third stage of labor .

Variables		Practice		X^2	Sig.	p<
		Inadequate	Adequate			
Age	18-22 years	1	1	10.672	S	>0.05
	23-27 years	4	0			
	28-32 years	9	0			
	33-37 years	10	7			
	38-42 years	9	9			
	43+ years	19	6			
Total =75		52	23	DF=5		
Educational level	Ng. course	1	0	0.699	NS	>0.05
	Ng. school graduate	17	8			
	Sec. Ng. Sch	9	3			
	Mid. School	25	12			
Total =75		52	23	DF=3		
Marital status	Married	41	16	4.803	NS	>0.05
	Single	8	4			
	Widow	3	1			
	Divorced	0	2			
Total =75		52	23	DF=3		
Working shifts	Day shifts	18	14	5.346	NS	>0.05
	Night shifts	16	6			
	Day & Night	18	3			
Total =75		52	23		DF=2	
Birth average / shift	1-5	7	4	2.668	NS	>0.05
	6-10	25	14			
	11-15	16	3			
	16+	4	2			
Total=75		52	23	DF=3		
Ng experience in delivery room	< 1 year	4	0	8.625	NS	>0.05
	1-5 years	18	6			
	6-10 years	14	5			
	11-15 years	6	8			
	16-20 years	6	2			
	21-25	2	0			
	26+	2	2			
Total =75		52	23	DF=6		

It was revealed from table (5) the results reveal that there are high mean of score, with positive trend in Nurse- Midwives practices regarding the 3rd stage of labor in waiting for placental separation, placental delivery, manual removed of placenta and membranes, examine the perineum and episiotomy degree of extension, while other items tends toward negative trends with low mean of score in checking placenta and membranes after delivery cleaning the perineum with clean water and drying use sterile pads, checking uterine contraction after placental delivery, estimating blood loss, putting newborn on breast feed, monitoring vital signs, check the bleeding from the incision area, and ensure that the woman informed to keep perineum dry and clean .

Expect management of the third stage of labor involves allowing the placenta to deliver spontaneously or aiding by gravity or nipple Stimulation. Active management involves administration of a prophylactic oxytocic before delivery of placenta, and usually early cord Clamping and cutting,

and controlled cord traction of the umbilical cord. [21-22] conducted a study to assess the effects of active versus expectant management on blood loss, postpartum hemorrhage (PPH), and other maternal perinatal complications of the third stage of labor. They found that routine (active) management is superior to (expectant) management in term of blood loss, PPH, and other serious complications of 3rd stage of labor.

Many maternal deaths across the world results from complications of the third stage of labor (when the placenta is delivered). [23] that found oxytocin showed benefits in reduced blood loss compared to no uterotonics.

Also, [24] found that the use of the combination preparation (syntometrine) as a part of the routine active management of the 3rd stage of labor appears to be associated with statistically significant reduction in the risk of PPH when compared to oxytocin.

It was revealed from table (6) that there is high significant association between Nurse- Midwives practices regarding 1st stage of labor and working shifts ($X^2 = 7.62$, $p = 0.02$) and birth average ($X^2 = 10.397$, $p = 0.015$).

United Kingdom central council for nursing, midwifery and health visiting (1992) initiative for extending the scope of professional practice allow for prospecte that nurses can adopt additional clinical tasks or alter the nature of service provision provided that they acquire the appropriate education or training, level of competence and are prepared to be accountable for their new practices [25].

Kirkhan M (2002)[26] stated that in equalities in the delivery of maternity care are examined and example of midwifery practices which support, rather than challenge, service related inequity are described. Time and the organizational constraints on their practice hindered the development of trusting relationships with those of women most in need of strong midwifery support.

Walsh- D (2002) [27] stated that it is possible to change midwives birthing practice, so that it is more evidence- based rigorous attention to all phases of the audit cycle is required, together with application of appropriate educational strategies. These strategies must address the specific barriers to change.

It was revealed from table (7) that there is high significant association between Nurse- Midwives practices and their educational level ($X^2 = 10.21$, $p = 0.01$), Birth average ($X^2 = 18.495$, $p = 0.000$).

A study in Jamica by [28] found that the birth attendance in all educational levels needs educational and training courses for providing high quality of care at delivery units to prevent maternal and fetal mortality rate.

WHO (1996) [29] stated that nurse's competence differs according to the educational preparation they are given for nursing practice. This nursing practice has a wide range of functions that lack a clear definition of the Nurses role which may lead to overlap with the roles of others.

It was revealed from table (8) there is a significant association between their practices and their age ($X^2 = 10.672$, $p >$ o.o5).

Regarding Nurse- Midwives age, the study was not in agreement with the results of the study conducted [13], which stated that, the younger Nurse- Midwives have more practices than the older ones. And was consistent with [30] who stated that older nurses had better performance than younger probably due to their orientation and the benefits that may gain out of their employment for long period of experience.

Conclusion

1- The majority of 2nd stage practices items tend to low mean of scores with negative trend expect in covering the episiotomy incision, using sterile sharp scissor cutting the cord, encourage women to bear down, avoid manually straching the perineum

and delivering the head slowly between contraction tend toward positive trend with high mean scores.
2- Most of 3rd stage practices items tends towards low mean scores except in waiting placental separation signs, placing hand over symphsis pubic & keep the cord tight, manual removal of placenta, examine the perineum and checking the degree of episiotomy extension.
3- In immediate Newborn care Nurse-Midwives practices the majority of items tend to low mean scores with negative trend in all items except in drying and warming baby and making quick assessment for breathing.

Recommendations

1- Installing inservice education programmes with efficient training courses to upgrade the techniques necessary to assess, evaluate, and improve the quality of care rendered to laboring woman throughout stages of labor.
2- Revising clinical practice guidline regarding management in each area.
3- Implementation of the partograph in delivery room after conducting an educational program for the Nurse-Midwives for how to use it.
4- Providing the Nurse- Midwives with efficient training courses, regarding the proper practices to be hold in delivery room. To take care of the laboring woman and updating their knowledge.
5- Ensuring of the qualification of the Nurse- Midwives who conduct the care in delivery room.

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