CARE AND OUTCOMES OF RELAXATION ROOM ASSISTANCE AT A PUBLIC MATERNITY HOSPITAL, RIO DE JANEIRO, BRAZIL

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ABSTRACT: This descriptive and retrospective study analyzed 648 healthcare records of from the relaxation room for women in labor, in 2007. The participants were low risk pregnant women, nuliparae, and in the active phase of labor. The most frequent care interventions were: warm bath (76.4%), walking (56.2%) and massage (52.8%). Most (86.3%) women had a vaginal delivery, and cesareans accounted for 11.1% of the deliveries. Nurse midwives assisted 56.5% of the vaginal deliveries, while physicians assisted the others (44.5%). Regarding the Apgar score, 1.4% of the live births achieved a score below seven at the fifth minute. The other newborns showed good vital signs at birth. The relaxation room is a care environment that promotes the humanization of care in labor and encourages vaginal childbirth.

DESCRIPTORS: Obstetric labor. Parturition. Humanization of assistance.

CUIDADOS E RESULTADOS DA ASSISTÊNCIA NA SALA DE RELAXAMENTO DE UMA MATERNIDADE PÚBLICA, RIO DE JANEIRO, BRASIL

RESUMO: Trata-se de estudo descritivo e retrospectivo que analisou 648 registros dos atendimentos na sala de relaxamento para gestantes em trabalho de parto no ano de 2007. O perfil obstétrico foi de gestantes de baixo risco, nulíparas, e em fase ativa do trabalho de parto. Os cuidados mais realizados foram: banho morno (76,4%), deambulação (56,2%) e massagem (52,8%). A maioria (86,3%) das parturientes teve parto normal e as cesarianas representaram 11,1% dos partos. As enfermeiras obstétricas assistiram 56,5% dos partos normais e os demais foram atendidos pelos médicos (44,5%). O índice de Apgar abaixo de sete no quinto minuto foi atribuído em 1,4% dos nascidos vivos. Os demais apresentaram boas condições de vitalidade no nascimento. A sala de relaxamento é um ambiente de cuidado que promove a humanização da assistência ao trabalho de parto e favorece o parto normal.

DESCRITORES: Trabalho de parto. Parto. Humanização da assistência.

CUIDADOS Y RESULTADOS DE LA ASISTENCIA EN LA SALA DE RELAJACIÓN DE UNA MATERNIDAD PÚBLICA, RIO DE JANEIRO, BRASIL

RESUMEN: Estudio descriptivo-retrospectivo que examinó 648 registros de atendimientos en la sala de relajación para las embarazadas en trabajo de parto, en el año 2007. El perfil obstétrico fue de embarazadas de bajo riesgo, nulíparas y en la fase activa del trabajo de parto. Los cuidados más realizados fueron: baño con agua caliente (76,4%), deambulación (56,2%) y masaje (52,8%). La mayoría (86,3%) tuvo parto vaginal y las cesáreas representaron el 11,1% de los partos. Las enfermeras obstétricas asistieron 56,5% de los partos vaginales y los demás fueron atendidos por los médicos (44,5%). El índice de Apgar menor que siete en el quinto minuto fue atribuido en 1,4% de los nacidos vivos, los demás presentaron buenas condiciones de vitalidad al nacer. La sala de relajación es un ambiente de cuidado que promueve la humanización del trabajo de parto y favorece el parto normal.

DESCRIPTORES: Trabajo de parto. Parto. Humanización de la atención.

INTRODUCTION

The theme of humanization in childbirth care has guided the agenda of discussions in social, academic and public health policy groups in recent decades. Humanized care practices add new value to childcare and delivery assistance, including the recovery of subjectivity, affection, pleasure, freedom and a return to nature, opening the door to other care practices, such as relaxing massage, the use of aromatic oils, chromotherapy and music therapy, among others.[1]

Humanization is associated with values and principles related to respect, dignity and appreciation of the human being. It requires a reflexive process of professional practice, and ethical behavior in professional activities and institutional work processes, ensuring decent, supportive and welcoming care on the part of health professionals. Therefore, humanization is a process of transformation of organizational culture towards the acknowledgment of subjectivity and the social context of clients and professionals and improvement in the quality of care and working conditions in healthcare.[2]

Care is much more than a technique. What differentiates care from a procedure is concern, interest and motivation, as well as the attitudes incorporated such as kindness, respect and consideration for others. Moreover, there is the intention to promote well-being and to keep people safe and comfortable, offering support, minimizing risks and reducing their vulnerability.[3]

Under government policies, humanization in childbirth means receiving the woman, her family and the newborn with dignity, and it involves ethical and sympathetic attitudes on the part of health professionals and the organization of the institution. Thus, care should be provided in a welcoming environment, and hospital practices should be adopted that are beneficial to the woman and the baby, avoiding the isolation imposed on women and the interventions that are unnecessary and harmful to both.[4]

Since 1998, obstetric nurses have been participating in normal childbirth scenarios in the five major public maternity hospitals of the Municipal Health Secretary and Civil Defense (*Secretaria Municipal de Saúde e Defesa Civil* - SMSDC) in the city of Rio de Janeiro, Brazil. Their participation seeks to improve prenatal care and to offer women the chance to experience labor and birth of their babies in a more humanized way.

Towards these goals, obstetric nurses from a municipal public maternity unit created an environment of individualized labor care attached to the obstetric service, which aims to provide women with an experience of parturition which affords privacy, safety and comfort. This specialized environment has been operating since December 2000 and was named the "Relaxation Room".

Because of this local initiative towards care quality during labor this study was proposed, which aimed to characterize the obstetric profile of pregnant women admitted to the relaxation room, identify the care provided in this room and examine the maternal and neonatal characteristics of births resulting from these services.

METHODS

This study utilized a quantitative, exploratory, descriptive and retrospective approach, using the technique of documentary research. The sources of information were the records of the relaxation room, complemented by the records of normal deliveries and caesarean sections of the obstetric unit from the year 2007. The investigation was approved by the Research Ethics Committee of SMSDC, under protocol 206A/10.

The area of data collection was a large public maternity unit located in the city of Rio de Janeiro. This institution has a large obstetric unit with twelve prenatal beds and serves more than five thousand parturients each year, including pregnancies of both low and high risk.

The physical area of the obstetric ward underwent renovation but the labor and delivery rooms remained separated. In the labor care setting, there are no individual rooms as in some other municipal public maternity hospitals. However, the beds have curtains to protect the privacy of the pregnant women.

The relaxation room was designed as an individualized environment and was differentiated from the labor room. It was created to feel home-like. This room measures about 9m^2, intended for the care of one patient at a time, and includes the presence of a companion. Inside, the decor is in pastel colors. The room enables staff/patients to alter the brightness of the lights and to use ambient music and oils for body massage and incense, as per the need and desire of each woman.

In this room there is also a padded platform, the dimensions of which are of a large

double bed. The room also contains parallel bars and a *bobath* ball to provide freedom of movement and the ability to assume different body positions, such as squatting, so that women can indulge in swaying of the pelvis and/or a squatting posture during the active phase of labor. There is a bathroom attached, where a warm spray bath can be taken.

The admittance and residency of the mother in this room depends on her obstetric profile, her current condition and the condition of her baby. This profile is evaluated according to the institutional protocol regarding obstetric nursing care during normal birth. The medical team is informed of all referrals to this room. If there are changes in maternal condition, fetal condition, or in the course of labor, the procedure calls for the routing of the mother to pre-delivery and medical evaluation.

The variables investigated were the obstetric data of the pregnant women cared for during childbirth (age, parity, gestational age, amniotic membrane integrity, use of oxytocin, cervical dilation and the presence of a companion), the specific care provided in the room and the outcome of the delivery (delivery type, performance of episiotomy, weight at birth and Apgar score at the 5-minute mark).

A structured instrument utilizing closed questions and the data generated were tabulated. During this tabulation, we were faced with a wide variety of records regarding the care provided to pregnant women, which required thematic grouping according to their purpose or therapeutic effect, such as comfort and relaxation to facilitate the delivery process.

The grouping of the care records as an educational and relational tool contain descriptions of guidelines and dialogues established between nurses and the women they cared for. The guidelines and the dialogues were already listed as sections in the record book of the relaxation room, which were summary descriptions of recommendations, explanations and statements of the support provided to women in labor.

Data were submitted to descriptive statistics and are presented through tables with their absolute and relative frequencies. The analyses of these data were based on their distribution and dispersion measures and are compared to the findings of research published in national and international journals on the subject.

RESULTS

In 2007, 5,671 births occurred at the maternity ward. Of this total, 3,383 were born via vaginal delivery (59.7%) and were live births (LB), while 1,854 (54.8%) births were assisted by obstetric nurses; and physicians assisted the others.

That same year, 648 (100%) parturients were cared for in the relaxation room. These were young women in a reproductive age, with most aged between 19 to 32 years (70.4%). The pregnant women who were under 19 years of age accounted for 22.1% of all visits, and the age of 13 was the lowest in this age group. Regarding obstetric characteristics, more than half (63.9%) of the pregnant women were nulliparous and between 39 and 41 weeks in gestation (70.5%). On admission to this room, most women were in the active phase of labor, with 45.1% of cases dilated between four and six cm and 27% with a cervical dilation greater than 6 cm. This distribution can be seen in Table 1.

Table 1 - Distribution of pregnant women (n=648) according to age and obstetric characteristics at admission to the relaxation room of a municipal public maternity hospital. Rio de Janeiro, 2007

Admission data	n	%
Age (years)		
Less than 19	143	22.1
19 – 32	456	70.4
Over 32	40	6.1
No record	9	1.4
Parity (previous births)		
None	414	63.9
1 to 3	209	32.2
Over 3	18	2.8
No record	7	1.1
Gestational age (weeks)		
Less than 36	16	2.5
36 to 38	118	18.2
39 to 41	457	70.5
Over 41	15	2.3
No record	42	6.5
Cervical dilatation (cm)		
Less than 4	165	25.5
4 to 6	292	45.1
Over 6	175	27.0
No record	16	2.4

Source: Relaxation room records - Obstetric Center.

On admission to the relaxation room, the majority of pregnant women had intact amniotic membranes (71.7%), did not require an oxytocin infusion (58%) and relied on the presence of a companion (45.2%) With regard to companions, there were a significant number of cases where this information could not be found (23.6%), as observed in Table 2.

Table 2 - Distribution of pregnant women (n=648) according to the integrity of the amniotic membrane, the use of oxytocin and the presence of a companion on admission to the relaxation room of a municipal public maternity hospital. Rio de Janeiro, 2007

Admission data	n	%
Amniotic membrane		
Intact	465	71.7
Ruptured	147	22.7
No record	36	5.6
Use of oxytocin		
Yes	213	32.9
No	376	58.0
No record	59	9.1
Presence of a companion		
Yes	293	45.2
No	202	31.2
No record	153	23.6

Source: Relaxation room records - Obstetric Center.

Nursing care performed during the stay in the room was grouped into two categories, "comfort and relaxation" and "educational and relational." Among the types of care provided related to comfort and relaxation, there was a predominance of warm baths, massage, and walking, corresponding to 76.4%, 56.2% and 52.8% of all pregnant women seen, respectively. The guidelines were recorded in 317 (48.9%) consultations and the dialogue was used for 34.7% women in labor. These data are displayed in Table 3.

The vast majority (n=559, 86.3%) of pregnant women who were admitted in the relaxation room had a vaginal birth. Those who required cesarean section accounted for only 11.1% (n= 72) of the pregnant women. In 2.6% (n=17) of the visits, data were not found in the logbook of normal deliveries and caesarean sections.

Table 3 - Distribution of pregnant women (n=648) according to type of care performed at the relaxation room of a municipal public maternity hospital. Rio de Janeiro, 2007

Type of care	n	%
Comfort and relaxation		
Warm bath	495	76.4
Walking	364	56.2
Massage	342	52.8
Pelvic exercises	67	10.3
Breathing exercises	43	6.6
Other	35	5.4
Educational and relational		
Guidance	317	48.9
Dialogue	225	34.7

Source: Relaxation room records - Obstetric Center.

Of all the vaginal deliveries, the obstetric nurses assisted in 56.5% (n=310) of the deliveries; the other births were assisted by physicians (n=249, 43.5%).

In terms of the women with a vaginal birth, there was a significant difference regarding the care of the perineum, depending on the professional who attended the birth. In the group assisted by nurses, the episiotomy rate was 19%, while among the group assisted by physicians the rate was 63.9%, as described in Table 4.

Table 4 - Distribution of pregnant women seen in the relaxation room who gave birth by vaginal delivery according to the professional who assisted the delivery and performance of episiotomy in a municipal public maternity hospital. Rio de Janeiro, 2007

Episiotomy	Nurse		Physician	
	n	%	N	%
Yes	59	19.0	159	63.9
No	225	72.6	56	22.5
No record	26	8.4	34	13.6
Total	**310**	**100**	**249**	**100**

Source: Records of vaginal deliveries and caesarean sections. Obstetric Center.

The survey of the degree of perineal laceration among the pregnant women who did not undergo episiotomy was impaired due to the high

number of cases lacking records. The absence of records accounted for 33.8% (n=76) of normal deliveries without episiotomy attended by nurses, whose frequency was lower only in regards to the quantity of first-degree lacerations (n=135, 60%).

Among the group of women giving birth who were assisted by doctors, information was lacking in 58.9% of normal deliveries without episiotomy. Therefore, the survey of the data regarding the type of perineal trauma was impaired in this study.

There were 649 (100%) LB resulting from care in the relaxation room. There was a case of twin pregnancy among these patients. Considering all the births, nine neonates achieved an Apgar score below 7 at the fifth minute. There were no cases of severe neonatal asphyxia, neonates who had Apgar scores less than 4. The expressive majority (93.4%) of the LB achieved a score between 7 and 10 at the fifth minute. Considering the birth weight there were 7.1% LB that weighed less than 2.500 g, classified as low birth weight. The others were within the normal range on that criterion. This distribution is observed in Table 5.

Table 5 - Distribution of characteristics of newborns whose mothers were assisted in the relaxation room according to birth weight and Apgar score at five minutes in a municipal public maternity hospital. Rio de Janeiro, 2007

Neonatal Characteristics	n	%
Apgar score at five minutes		
Below 7.	9	1.4
7 to 10	606	93.4
No record	34	5.2
Weight		
Below 2.500g.	46	7.1
2.500 g or more.	534	82.3
No record	69	10.6

Source: Records of normal deliveries and caesarean sections. Obstetric Center.

DISCUSSION

The representation of natural birth as a painful and suffering experience outweighs the positive images associated with life and joy of the birth as a result of the hegemonic culture of care in birth hospitals.[5] The birth scenario became a unknown and frightening place for women, working as a "locus" of the performance of the professionals and not of the woman.[6]

Overcoming this problem in obstetric care requires a perspective of a humanized, comprehensive and individualized care, where the expectations, needs and rights of pregnant women are considered. In this sense, the presence of the companion must be guaranteed as a legal right defended by Federal law 11.108/2005 and as a beneficial factor for women in the process of childbirth.[7]

It was shown that about one-third (31.2%) of pregnant women assisted in the relaxation room did not have the presence of a companion, signaling the need for advances in the research institution in relation to the guarantee of this right. Despite this challenge, there was an expansion of the percentage of pregnant women with companions in childbirth compared with the proportion of 21.4% found in the maternity wards of Rio de Janeiro, from 1999 to 2001.[8]

Studies[9-10] show that nursing has played an active role in the establishment of humanistic care at maternity wards, encouraging labor physiology and implementing technologies for care and comfort. This experience of care has promoted relational care practices that promote dialogue among subjects, users and professionals, promoting dignity, solidarity and a welcoming posture.

This research identified that nurses deliver services that promote comfort and relaxation, causing women to experience labor with freedom of movement and position. These precautions are classified by the World Health Organization as a non-pharmacological method for pain relief, which aim at reducing a painful perception by means of noninvasive methods that reduce the need for analgesic medication and improve the experience of childbirth.[11]

The empathetic support of the professional and of the companion to the woman is considered the most important factor for this non-pharmacological approach, which means to give information and explanations according to the desires and needs of women and respect their privacy in the childbirth environment.[11]

Research showed that the free movement reduces the duration of the first stage of labor and that immersion in water reduces maternal pain levels request for pharmacological analgesia.[12-13]

The relational dimension of care was also identified in the nursing activities in the relaxation room. Studies have identified that the relationship with health professionals have an important influence on women's perception about the as-

sistance.[14-15] The assistance is perceived positively to the extent that women feel being taken care of by the professionals. Satisfaction with care is related to the professional interest in addressing the needs and placing yourself available to help, which means to be involved, be present and establish a dialogue.

Regarding the use of oxytocin, the routine care of the institution under research provides for the prescription of this drug during labor is the responsibility of the medical team. The nurse only performs this prescription postpartum and intramuscularly, as recommended in childbirth assistance programs of the Ministry of Health.

The research methodological design does not establish the relationship between the use of oxytocin and the type of care provided by nurses. However, the use of this drug is associated with increased pain sensation, and may cause a more confined posture to bed, greater susceptibility to the occurrence of uterine hyperstimulation and alterations in fetal heart rate.[3]

In a given type of delivery it was found a proportion of Cesarean Sections of only 11.1% among pregnant women cared for in the relaxation room. Although the obstetric profile predominant within these services is within the parameters of the classification of low-risk pregnancy, this rate of Cesarean Section was much lower than that found in epidemiological studies.

In the analysis of 347,255 births in 93 hospitals in the city of Rio de Janeiro in 2004, a proportion of a 49.5% (165,905) births was found by caesarean section. Of the births occurring in the network funded by the Unified Health System (*Sistema Único de Saúde* - SUS), it was found that 67.9% corresponded to vaginal delivery, and in those of the private network, 83.2% corresponded to Cesarean Section[16]. In São Leopoldo, Rio Grande do Sul, it was identified that 52.8% women who had their children per Cesarean Section in 2003, whose childbirth funding occurred in 68.6% of the cases by SUS.[17]

In São Paulo there was variation in Cesarean Section rates in hospitals in the city of São Paulo, according to the type of assistance in the period 2003 to 2008. In the hospitals funded by SUS, which service low risk pregnancies, the percentage of Cesarean Section was of 28.1% while those that serve risk pregnancies, this proportion increased to 33.3%. The largest percentage of this surgery was observed in university and private hospitals, representing 57.1% and 87% of births, respectively.[18]

SUS data relating to births in the period 1994 to 2006 show that there was a significant increase of Cesarean Sections in Brazil, while in 1970 the rate was 14.6%; 2006 records the proportion of 45% of live births. Considering this percentage and taking as a basis the recommendation of the World Health Organization, which believes there is no medical justification for rates above 15% by Cesarean Section, the amount of unnecessary Cesareans sections is significant in the country, implying in increased costs ranging from US$139.00 and US$2,294.00, when compared to the cost of a vaginal delivery versus to elective Cesarean Section. In addition to this economic consequence, there are social repercussions that impact on maternal and neonatal health when surgical intervention is performed unnecessarily.[18]

The results of this research show that careful and individualized care, sensitive to the needs of each woman during labor may favorably influence the outcome of labor, reducing the incidence of Caesarean section delivery among low risk pregnant women in hospitals.

This positive effect was also observed in childbirth behavior, such as episiotomy. This procedure has been criticized for not having evidence about its benefits. Actions are recommended to reduce rates and about 15% should be reached.[19] On the other hand, it is estimated that the country would no longer spend around 15 to 30 million dollars if it stopped performing unnecessary episiotomies.[20]

Despite this evidence, this practice is still widespread in routine care, especially among primiparae. Research[21] performed on 416,852 hospital births performed in 16 Latin American countries over the period 1995 to 1998, found the proportion of episiotomy in 9 and of 10 primiparous women whose children were born spontaneously. In Brazil, the rate of this procedure was 94.2%, with similar proportion to public and private hospitals. A study conducted in the city of Rio de Janeiro found the frequency of episiotomies in 77.7% of births in a public maternity.[22] In the present study, the frequency of episiotomy was 15% in vaginal births assisted by obstetric nurses, indicating that these professionals perform less unnecessary interventions in relation to the perineum, in compliance with scientific evidence.

While recommending the restricted use of this procedure, the Ministry of Health does not establish an adequate or maximum rate of episiotomy in childbirth. Evidence shows that the

routine use of episiotomy does not reduce the risk of severe perineal trauma - lacerations of 3 and 4 degrees - and does not prevent injuries in the head and does not improve Apgar scores. On the other hand, episiotomy is one of the single surgical procedures performed without any previous consent from the patient.[23]

Indications for performing episiotomy were investigated in a study developed in a university hospital in the city of São Paulo.[24] Perineal rigidity, primiparity and fetal macrosomia were the most frequent indications The prevailing episiotomy technique was the middle-right side, the choice had as main justifications the academic learning, to be adopted routinely, less chance of damaging the anal sphincter and lower risk of complications.

These results show the importance of aligning academic references with others such as gender, care paradigms, human rights, sexual and reproductive rights and the scientific evidence, based on critical pedagogy so that tradition does not overlap the possibilities of transformation of knowledge and in their resulting practices.

In relation to perinatal conditions, the percentage (7.1%) of low birth weight among newborns whose mothers were treated in the relaxation room was close to that found in research[25] on newborns in the municipality of Rio de Janeiro. In 2001, we identified 6,820 (8.7%) live births with low birth weight among the 78,582 live births. It is noteworthy that the sample size and limitations of this study do not allow for comparison between these percentages.

A study[16] on the conditions of the vitality of live births in the municipality of Rio de Janeiro found that 4.6% of newborns obtained the Apgar score at five minutes less than seven in 2004. Regarding this datum, the research found the percentage of 1.4% of the live births of the pregnant women who were cared for in the relaxation room.

The research[27] showed that births of low-risk pregnant women assisted by obstetric nurses have good maternal and neonatal outcomes, as well as births attended thin the collaborative model between obstetric nurses and doctors.

CONCLUSIONS

The relaxation room is a care environment of obstetric nursing that promotes the humanization of labor, favors normal childbirth and presents good indicators of vitality among newborns whose mothers were treated in this room.

According to data found, the obstetric profile was predominantly of low risk pregnant women in active phase of labor and who were experiencing their first delivery. The types of care that were most performed during the stay in that room were the warm bath, walking and massage.

The quantity of pregnant women undergoing Cesarean Section was within the limit recommended by the World Health Organization, suggesting that individualized, humane, care and continuous professional presence during labor can favorably influence the results of care.

On the other hand, the relaxation room was a strategy established by the nurses so that the principles and values of human care could be delivered within the hospital environment. This fact reveals the need for architectural change in the Brazilian maternity obstetric centers. The organization and functionality of the care environment are directly related to the paradigm of health care and its work process in resulting health.

Other challenges were identified in relation to care practices during labor such as the rate of episiotomy between doctors and the presence of a companion, who may represent the persistence of the hegemonic assistance model and the need for advances in institutional and governmental actions for the humanization of labor and birth.

The attendance records of the relaxation room also need to be improved in order to reduce the lack of important information to assess the quality of care to pregnant women in the institution under research. The results found may support similar initiatives in other maternity hospitals, to achieve sensible and humane care to women and their babies.

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