Brighton and Sussex University Hospitals NHS Trust

Latent Phase of Labour

Maternity Protocol: MP030

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Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgment may be used in the application of a protocol.

Scope

This protocol applies to:

- All those in latent phase in all care settings.

Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure the protocol is available to service users on request

Objective Standards

Respect for women's/person's wishes and their involvement in decision making is essential to their care in pregnancy and labour. All healthcare professionals should recognise this and ensure that the person is in control, listened to, cared for with compassion and that appropriate informed consent is sought (NICE 2014). The birth plan should be discussed in full with the midwife looking after the person in labour.
Those in early labour may be better assessed away from the delivery unit, as this results in fewer interventions during the active phase of labour.

1 Latent phase of labour / Early labour

1.1 Latent first stage of labour
A period of time, not necessarily continuous, when there are strong contractions and there is some cervical change, including cervical effacement and dilatation up to 4 cm. Some people have pain without cervical change. Although these people are described as not being in established labour, they may well consider themselves 'in labour' by their own definition and it may help someone to be acknowledged that they are in early labour

2 Care in Latent phase

2.1 Consider an early assessment of labour by telephone triage

2.2 Consider a face-to-face early assessment of labour for all low-risk nulliparous either: **1.** At home (regardless of planned place of birth) **2.** In their planned place of birth with one-to-one midwifery care for at least an hour

2.3 Those who seek advice or attend hospital with painful contractions but who are not in established labour should be offered individualised support and occasionally analgesia, and encouraged to remain or return home (unless doing so leads to a significant risk that they could give birth without a midwife, or become distressed).

2.4 The triage midwife should document the guidance that they give including safety net advice.

3 Telephone advice

3.1 People should be advised that they can call the telephone triage line at any time. They should be given sufficient time to explain their symptoms during each call so the midwife can make an assessment of their needs. Telephone advice should only be given by a qualified midwife. If a MCA takes a call they should take the persons details and reassure them a midwife will contact them ASAP. If a midwife is unable to call back within 20 minutes this should be escalated. This information and the advice given should be recorded within the triage book. Midwives should exercise professional judgement when advising women by telephone and only where appropriate encourage people to stay at home following discussion of possible coping strategies.

3.2 They should be offered an assessment if they have made more than three telephone calls for advice.

3.3 During the latent phase of labour, people should be encouraged to stay at home and carry on with normal activities for as long as they can. Staying at home in their own environment will encourage the production of oxytocin as well as endorphins and therefore allow the natural labour process to progress.

3.4 The midwife should give advice that breathing exercises, immersion in water and massage may reduce pain during the latent phase of labour.

3.5 Whilst at home they should be encouraged to:

3.5.1 Perform normal activities as much as possible

3.5.2 Go for a walk and be as mobile as possible when not resting

3.5.3 Use of water (warm shower/baths)

3.5.4 Distractions though listening to music, watching television/ DVD

3.5.5 TENS machine when they become uncomfortable

3.5.6 Self-medication of Paracetamol - Midwives must ensure they are aware of dosage and frequency of administration and determine allergies

3.5.7 Focus on breathing techniques and relaxation

3.5.8 Utilise hypnobirthing techniques if attended course

3.5.9 Provide support and guidance to the birth partners

3.6 Advise them and birth partners that breathing exercises, immersion in water and massage may reduce pain during the latent 1st stage of labour.

3.7 Trying different positions and use of birthing ball

3.8 Use of hot water bottle

3.9 Low back massage: Women with babies in the occipito-posterior position often experience increased back pain; massage and back rubbing may help this.

3.10 Trying to sleep/ rest/ nap

3.11 Keep well hydrated

3.12 Eat well at this stage, in order to maintain energy levels throughout labour

3.13 Monitor fetal movements

3.14 To be aware of signs of spontaneous rupture of membranes (SROM)

4 Care of Women on Admission to Unit /Initial Assessment at Home

4.1 Risk assessment should be carried out regularly through all stages of labour and clearly documented in the maternal notes:

4.1.1 On admission to unit/initial assessment at home using CHAPS form (*see Appendix A*)

4.1.2 If there are any changes to the environmental, social, clinical situation

4.1.3 If maternal or fetal observations deviate from the norm

4.1.4 If progress in labour is not as expected

4.1.5 When interventions are required or requested (including vaginal examination and pain relief)

4.1.6 It is a continuous process and any risks identified, or changes to the management plan should be clearly documented in the notes along with actions taken in response to the identified risks.

4.2 **Assessment criteria** (See protocol MP035 Care of women in labour)

4.2.1 A clinical risk assessment should be carried out and documented in the maternal notes and an individual management plan agreed and documented. The assessment should include:

4.2.2 Medical history - see *Appendix B* for conditions to be considered / referred

4.2.3 Anaesthetic history - see *Appendix B* for conditions to be considered / referred

4.2.4 Obstetric history (current and previous) - see *Appendix B* for conditions to be considered / referred

4.2.5 Social / lifestyle history - see *Appendix B* for conditions to be considered / referred

4.2.6 Appropriateness of place of birth (based on risk assessment)

4.2.7 Listen to the women/person, consider their birth plan and wishes

4.2.8 Observe maternal behaviour and ask mother about contractions, fetal movements and PV loss

4.2.9 Maternal observations (ideally within 1 hour of admission or arrival) with maternal informed consent:

4.2.9.1 Temperature

4.2.9.2 Pulse

4.2.9.3 Blood pressure

4.2.9.4 Urine analysis (when next void occurs)

4.2.9.5 Abdominal palpation including symphysis height measurements which need to be plotted on the SFH graph

4.2.9.6 Consider and offer vaginal examination

4.2.9.7 Fetal assessment: IA or CTG dependant on risk factors identified

4.2.9.8 Any decision to admit someone to the unit should be discussed with the labour ward coordinator

5 Prolonged latent phase

5.1 There is no definition for a prolonged latent phase within the literature and anecdotally it can last for 2-3 days.

5.2 Recent research shows that women admitted with a prolonged latent phase are more likely to receive obstetric interventions. With increased rates of instrumental deliveries for nulliparous women, and increase rates of emergency caesareans in both parity's. (Angeby et al 2018)

5.3 Mal -positions especially the occipital position (OP) may lead to a prolonged latent phase. If OP position is suspected, early support and advise from the midwife on how to cope and for promoting optimal fetal positioning.

5.4 A prolonged latent phase of labour can be a discouraging and exhausting experience for people. If a person attends the unit for a third time and remains in latent phase of labour after clinical assessment of maternal and fetal wellbeing (consider CTG) a review by a senior midwife is recommended where an individualised plan of care incorporating the person's preferences can be created.

5.5 If any of the following signs or symptoms are present at any assessment, referral to the obstetric team is recommended including:

5.5.1 Maternal exhaustion, pyrexia, tachycardia or dehydration

5.5.2 Fetal distress

5.5.3 Failure of descent of the presenting part or failure of cervical dilation despite, regular uterine contractions

6 Fetal heart monitoring

6.1 For those who are admitted to the ward during latent phase of labour, especially those who require analgesia, to regularly monitor fetal movements and FHR. For consistency of care, it is advisable to review every **4 hourly** or sooner depending on clinical judgement to include auscultation and assessment of uterine activity and wellbeing.

6.2 Once active first stage of labour is suspected, a full re-assessment is recommended and if confirmed, to follow active labour guidelines.

6.3 If someone receives opiate analgesia, FHR auscultation is required 2 hourly for 4 hours post administration.

6.4 The frequency of fetal monitoring with intermittent auscultation varies according to the labour phase and yet the transitions from the latent to the active phase and from the active to the second stage may occur unnoticed. There needs to be a careful balance between too frequent, intrusive assessments of progressive cervical dilatation and the risks associated with inadequate fetal monitoring (RCOG, 2017).

6.5 BSUH offer the use of aromatherapy for the latent phase of labour for those who fit the inclusion criteria. (*see protocol MP062 Complementary therapies: Aromatherapy*).

7 Pharmalogical analgesia options

7.1 Paracetamol 1g 4 hourly with no more than 4 doses within 24 hours

7.2 Dihydrocodeine 30 -60mg 4-6 hourly maximum dose 240mg within 24 hours

7.3 Morphine sulphate 10mg/5mL (Oramorph) PO, each dose should be prescribed as a once-only medication and a maximum of two doses four hours apart

7.4 Pethidine 50 - 100mg IM, then 50- 100mg after 1-3 hours if required maximum dose 400mg . The women/person may go home 4 hours following pethidine after the completion of an antenatal assessment, if pain has settled and they wish to.

7.5 Please note that Entonox is not appropriate for use in latent phase.

7.6 Consider use of sedatives (oxazepam 10-30 mg) if lack of sleep main factor for woman's perception of not coping with early labour, in liaison with (and prescription from) an obstetrician.

8 Indications for Morphine sulphate 10mg/5mL (Oramorph) use

8.1 Those in the latent phase of labour, experiencing painful contractions and who have exhausted all non pharmalogical coping methods and feel they need further analgesia.

8.2 Morphine sulphate 10mg/5mL (Oramorph) should only be used during the latent phase of labour.

8.3 Morphine sulphate 10mg/5mL (Oramorph) should only be administered following routine maternal and fetal observations and are suitable for discharge home.

8.4 Subsequent doses of Morphine sulphate 10mg/5mL (Oramorph) should only be considered after assessment of maternal and fetal wellbeing

9 Administration

9.1 There is no need to give an anti-emetic unless the mother is nauseous.

9.2 Women who are having a second dose of Morphine sulphate 10mg/5mL (Oramorph) must have a full Antenatal assessment and the dose prescribed by a doctor before going home.

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9.4 Women who have had 2 doses of Morphine sulphate 10mg/5mL (Oramorph) and remain in latent labour can be offered Pethidine, if further analgesia is required

9.5 Pethidine can be administered 2 hours after Morphine sulphate 10mg/5mL (Oramorph)

10 Side effects of Opiate Use

Women/People must be informed of potential side-effects including nausea, vomiting and drowsiness. In rare occasions fetal side effects can include drowsiness, respiratory depression and delayed breastfeeding.
If in the unlikely event that the person experiences a reaction i.e. anaphylaxis this must be responded to appropriately, documented in the notes, and family informed and an incident form completed.

11 Contraindications of Morphine sulphate 10mg/5mL (Oramorph) Administration

11.1 If the woman has had any opioids this needs to be taken account of and documented accordingly.

11.2 Intramuscular versus oral opiates should be considered based

upon professional judgement – consult an obstetrician as required. Morphine sulphate 10mg/5mL (Oramorph) should be the option of choice as much as possible.

11.3 Morphine sulphate 10mg/5mL (Oramorph) must not be used for women with Opiate or Morphine allergies or sensitivities.

11.4 Morphine sulphate 10mg/5mL (Oramorph) must not be used on women whose babies have IUGR (intra-uterine growth restriction).

12 References

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