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Care during the Latent Phase of Labour Guideline

Summary statement: How does the document support patient care?	The purpose of this guideline is to provide good practice for care of women/people in the early stages of labour.
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Division:	Women & Children's
Department:	Maternity
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For use by:	Midwifery staff and Obstetricians
Purpose:	To provide clear guidance for staff caring for women/people in the latent phase of labour.
This document supports:	NICE (2017) Intrapartum Care for Healthy Women and Babies
Key related documents:	UH Sussex (SRH&WH) maternity guidelines: Care in Labour Guidance for the use of Aromatherapy
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1.0	October 2019	Gail Addison Stacie Davies	Archived	New Trust guideline Approved in August – finalised in November 2019 following pharmacy approval.
2.0	April 2022	K. Henton, Community TL J. Collard, Clinical Effectiveness Support Midwife	Live	3-yearly review. Criteria for obstetric review expanded in line with NICE 2021

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician.
If in doubt contact a senior colleague or expert.

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1.0 Introduction

Clinically the latent phase of labour is poorly understood and can be hard to define. The concept of the latent phase has significance in understanding normal childbirth because labour is considerably longer when a latent phase is included (Mcdonald, 2010).

The management of a woman/person's care during this phase of labour has implications for their entire labour experience. Moreover the latent phase of labour is considered to be more sensitive to external influences than the active phase of labour; especially with regard to its duration. Accordingly, the care provided to women/people in the latent phase of labour should focus on allaying their fears, giving them information, and providing reassurance, emotional and physical support (Munro & Jokinen, 2009).

2.0 Aim

The aim of this guideline is to provide clear guidance for midwives to ensure improved consistency of support for women/people who experience a difficult and or long latent phase of labour.

3.0 Scope

This guideline applies to:

- Midwives
- Obstetricians
- Maternity assistants

4.0 Responsibilities

Midwives & Obstetricians:

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

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

5.0 Abbreviations used within this guideline

OP - Occipital position	CBC - Central Birthing Centre
FH - Fetal heart rate	CTG - Cardiotocograph
SROM - Spontaneous rupture of membranes	

6.0 Definitions of the latent and established first stages of labour

- The latent phase or early stage of labour is defined a period of time, not necessarily continuous, when women/people experience painful contractions **and** there is some cervical change, including cervical effacement and dilatation up to 4 cm (NICE, 2007).
- There is no definition for a prolonged latent phase within the literature and anecdotally it can last for 2-3 days.
- Malpositions especially the occipital position (OP) may lead to a prolonged latent phase. If OP position is suspected, early support and advice to women/people from the midwife on how to cope and for promoting optimal fetal positioning.
- Established first stage of labour is defined as the presence of regular painful contraction and progressive cervical dilatation from 4cm (NICE, 2007).

7.0 Inclusion criteria

This guideline is applicable to all low risk women/people between 37 – 42 weeks gestation. This guideline should be considered in conjunction with CG1196 Care in labour.

8.0 Antenatal education of the latent phase of labour

It is good practice for the midwife to discuss with all pregnant women/people and ideally their birth partners what to expect during the latent phase of labour at the 28 week appointment when the woman/person's birth preferences are considered (following an initial discussion of birth preferences at 16-17 weeks). Information should include:

- Management of pain and pain relief options.
- Coping strategies (such as use of water, mobilisation and maternal positioning) and nutrition and hydration advice.
- How and when to contact the maternity unit.
- How to differentiate between Braxton Hicks contractions and active labour contractions.
- The expected frequency of contractions and how long they last.
- Recognition of amniotic fluid ('waters breaking').
- Description of normal vaginal loss.
- What signs and symptoms to report to us and what to do in an emergency.

The latent phase of labour will be discussed during all parent education classes including hypnobirthing and parent education classes.

Pregnant women/people should be signposted to online maternity information on tips to help you during early labour.

9.0 Telephone advice

Women/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. This information and the advice given should be recorded within the telephone triage workflow within the maternity information system.

Information should be provided about:

- What to expect in the latent first stage of labour and how to work with any pain experienced.
- What to expect when they accesses care.
- Agree a plan of care with the woman/person, including guidance about who they should contact next and when.
- Provide guidance and support to the woman/person's birth companion(s).

Midwives should exercise professional judgement when advising women/people by telephone and only where appropriate encourage women/people to stay at home following discussion of possible coping strategies.

The woman/person should be offered an assessment if they have made more than two telephone calls for advice. Should face to face assessment be required, home assessment could be considered especially for women/people in their first pregnancy.

If home assessment is not possible, low risk women/people should be assessed on the Central Birthing Centre (CBC) at SRH, or on Delivery Suite at Worthing.

10.0 Clinical assessment of the latent phase

The criterion for this assessment is discussed in the Trust clinical guideline CG1196 Care in labour.

Review maternal and pregnancy history and listen to the woman/person’s story. Record the following in maternal notes and electronic records:

- Assess and document confirmation that the woman/person is suitable for low risk care.

- Perform maternal observations to assess wellbeing - record blood pressure, temperature, pulse rate and urinalysis.
- Abdominal palpation - fundal height measurement, fetal lie, presentation, position and engagement.
- Length, strength and frequency of contractions.
- Vaginal loss - show, liquor, absence of blood
- Assessment of the woman/person's pain, including their wishes for coping with labour and the options available for pain relief.
- Assess fetal wellbeing - the fetal heart rate (FHR) should be auscultated for a minimum of 1 minute following a contraction. The maternal pulse should be noted to differentiate between maternal pulse and FHR. Enquire about fetal movements within the past 24 hours. If there are any concerns regarding fetal movements or FHR, a CTG should be performed to confirm fetal wellbeing.

This assessment should form the basis of a risk assessment and therefore clinical judgement for a woman/person to continue on the low risk care pathway. If an obstetric opinion is required, consult an obstetrician to assess the woman/person and document a plan of care.

NICE (2007) recommends that this assessment of one-to-one midwifery care should take approximately one hour. If it is deemed appropriate for the woman/person to go home, they **must** stay in the unit for at least one hour following a vaginal examination in the event that this stimulates labour progress. If a vaginal assessment is undertaken by a midwife at home, clinical judgement should be used as to suitability to remain at home based upon findings, parity and previous birth history.

A prolonged latent phase can be a disheartening and exhausting experience for women/people. If a woman/person attends the unit for a **third** time or having a third assessment and is still considered to be in the latent phase she **must** have a review by a senior clinical midwifery manager or obstetrician for a plan. Assessment and confirmation of both maternal and fetal wellbeing is essential for all attendances.

If any of the following signs or symptoms are present during this third (or any other) assessment then referral to an obstetrician is required:

Maternal/birthing parent:

- Maternal/birthing parent exhaustion.
- Pyrexia over 38^{o}C or above on a single reading or 37.5^{o}C or above taken on two consecutive readings 1 hour apart.
- Tachycardia over 120bpm on two occasions 30 minutes apart.
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more.
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart.

- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more).
- Any vaginal loss other than a show.
- Rupture of membranes more than 24 hours before the onset of labour.
- Pain reported by the woman/person that differs from the pain normally associated with contractions.
- Dehydration, presence of ketones in urine.

Fetal:

- Any abnormal presentation, including cord presentation
- Transverse or oblique lie
- High (4/5 to 5/5 palpable) or free-floating head in a nulliparous woman
- Suspected fetal growth restriction or macrosomia
- Suspected anhydramnios or polyhydramnios
- Fetal heart rate below 110 or above 160 beats/minute
- A deceleration in fetal heart rate heard on intermittent auscultation
- Reduced fetal movements in the last 24 hours reported by the woman.
- The presence of significant meconium.
- Failure of descent of the presenting part or failure of cervical dilatation despite regular uterine contractions.
- Maternal request for review.

If any of these arise, perform a cardiotocograph (CTG) to determine fetal wellbeing and perform a full set of maternal observations and document accordingly.

The midwife is responsible for referring any woman/person for obstetric review where there is a deviation from low risk care.

11.0 Fetal heart rate auscultation

Be aware that for women/people at low risk of complications there is insufficient evidence about whether cardiotocograph (CTG) as part of the initial assessment either improves outcomes or results in harm for women and their babies, compared with intermittent auscultation alone (NICE, 2017). The fetal heart rate (FHR) should be assessed and recorded at each face-face assessment. For low risk women/people, it is best practice to first use a pinnards stethoscope to hear the FHR and then use a handheld Doppler for the benefit of the parents. Maternal pulse should always be taken and recorded at each FHR assessment.

For women/people 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 do so every **4 hourly** or sooner depending on clinical judgement.

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

If a woman/person receives opiate analgesia, FHR auscultation is required 2 hourly for 4 hours post administration.

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).

12.0 Considerations

- Recognise that a woman/people may experience painful contractions without cervical change, and although they are described as not being in labour, they may well think of themselves as being 'in labour' by their own definition. It is important staff listen and respond sensitively to women/people and take seriously anything a woman/person is concerned about.
- The midwife assessing the woman/person in latent stage of labour should consider the risk of birthing without a midwife present if advising the woman/person to stay at home or to return home following assessment.

13.0 Pain management during the latent phase

During the latent phase of labour, women/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.

The midwife should advise the woman/person and their birth partner that breathing exercises, immersion in water and massage may reduce pain during the latent phase of labour.

Should the woman/person choose to use aromatherapy, yoga or acupressure for pain relief during the latent phase of labour then their wishes should be respected.

Whilst women are at home they should be encouraged to:

- Perform normal activities as much as possible.
- Go for a walk and be as mobile as possible when not resting.
- Use of water (warm shower/baths).
- Distractions though listening to music, watching television/ DVD.
- TENS machine when they become uncomfortable.

- Self-medication of Paracetamol - Midwives must ensure women/people are aware of dosage and frequency of administration and determine allergies.
- Focus on breathing techniques and relaxation.
- Utilise hypnobirthing techniques if attended course.
- Aromatherapy if advised by a qualified professional.
- Trying different positions and use of birthing ball.
- Use of hot water bottle/ heatpad.
- Try massage. Women/people with babies in the occipito-posterior position often experience increased back pain; massage and back rubbing may help this.
- Trying to sleep/ rest/ nap.
- Keep well hydrated.
- Eat well at this stage, in order to maintain energy levels throughout labour.
- Monitor fetal movements.
- To be aware of signs of spontaneous rupture of membranes (SROM).

Women/people who stay in hospital during the latent phase may be offered further analgesia if options above have been tried and are unsuccessful.

This may include:

- Paracetamol – check if woman/person has already self-medicated at home.
- Codeine based tablets (check self-medication).
- Opiates – as per Trust Medicines Management policy.
- Before use, staff should counsel women/people about the potential side-effects of opioids, including maternal drowsiness, nausea and vomiting, and neonatal respiratory depression, and about the alternative pain relief options available (WHO, 2018).
- Oramorph can be offered if all other options listed above have been exhausted and the woman/person is requesting further analgesia.
- Oramorph 10-20mg (depending on maternal BMI, repeated after 2-4 hours if needed, a maximum of 2 doses (40mg max) can be given (Patient Group Direction or prescription). If after 2 doses the woman/person is still not in active labour and is not coping with the pain, request a midwifery co-ordinator/obstetrician review depending on circumstances and risk assessment.
- If the woman/person has had codeine before moving on to Oramorph (60mg of Codeine is equivalent to 6mg Oramorph) – this needs to be taken account of and documented accordingly.
- Intramuscular versus oral opiates should be considered based upon professional judgement – consult an obstetrician as required. Oramorph should be the option of choice as much as possible.
- Women/people who have received opiates in the latent phase are able to use the birthing pool once in established labour, 2-4 hours post administration. Professional judgment should be applied following risk assessment if less than 2 hours post administration of opiates.

- Suitability to return home following Oramorph should be assessed and documented in the maternity care records.

Consider use of sedatives (Temazepam) if lack of sleep main factor for woman/person's perception of not coping with early labour, in liaison with (and prescription from) an obstetrician.

14.0 Patient Information

All women/people should be advised of the telephone triage contact number and the symptoms that would require them to contact us immediately, such as:

- Reduced fetal movements
- Vaginal bleeding
- Spontaneous rupture of membranes
- Meconium liquor

References

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Appendix 1 Care during the latent phase of labour pathway

Low risk women (37-42 weeks) in latent phase of labour

Triage call assessment(s)

1st and 2nd call
Reassure, advise and assess suitability to remain at home until regular contractions

On 3rd call
Advise and arrange face-face assessment either at home, Birth Centre (SRH) or Labour Ward (WH)

Face-face assessment(s) - outpatient attendance or inpatient

1st and 2nd face-face assessment
Assess maternal and fetal wellbeing
Determine suitability and maternal preferences to return home.
Advise coping strategies.

At 3rd face-face assessment

- Assess maternal and fetal wellbeing.
- Request senior midwifery review (co-ordinator/ward manager).
- Request obstetrician review if presenting risk factors.
- Advise coping strategies and discuss analgesia options.

Subsequent reviews (if low risk)

- Assess maternal and fetal wellbeing.
- Request senior midwifery review of care plan.
- Request obstetrician review if presenting risk factors.
- Advise coping strategies and discuss analgesia options.
- Discuss option to be admitted to ward for monitoring and support.

After two doses (up to 40mg) of Oramorph/IM opiates

- Assess maternal and fetal wellbeing.
- Assess whether labour established.
- Request midwifery co-ordinator /obstetrician review.
- Advise coping strategies and discuss analgesia options.
- Plan of care by obstetrician if labour not established and further dosages required.