Care in the Latent Phase of Labour Guideline

University Hospitals of Leicester NHS Trust

Trust ref: C7/2023

"Currently UHL utilises the terms 'woman' and 'women' within their obstetric and maternity guidelines but these recommendations will also apply to people who do not identify as women but are pregnant or have given birth."

Contents

1. Introduction and Who Guideline applies to

The latent phase or early labour is a period of time, not necessarily continuous, when women experience painful contractions which may be associated with cervical changes including effacement and dilatation up to 4cm (NICE 2021).

However it is difficult to objectively tell when the change from the latent to the active phase of labour occurs, leading to some dilemmas in the management of women. One especially difficult issue is how to define a prolonged latent phase. Studies have used figures from 12 to 24hrs and beyond at the point where a prolonged latent phase is diagnosed.

There is evidence that prolongation of the latent phase is associated with:

- Subsequent labour abnormalities and need for caesarean section.
- Significantly prolonged labour.
- High levels of pain / anxiety in latent phase which were linked to an increase level of medical intervention in the active phase.
- There have also been adverse outcomes for mothers and babies when the prolonged latent phase has not been adequately managed.

A leaflet is available for the woman which contains coping strategies for the latent phase of labour and this should be given. Before labour begins

The aim of this guideline is to support midwives who provide care for women in the latent phase of labour. The guideline is applicable to women planning a vaginal birth at term (37-42 weeks gestation).

Related documents:

Induction and Augmentation of Labour UHL Obstetric Guideline; Trust ref: C131/2005

Pre Labour Rupture of the Membraines UHL Obstetric Guideline; Trust ref: C25/2022

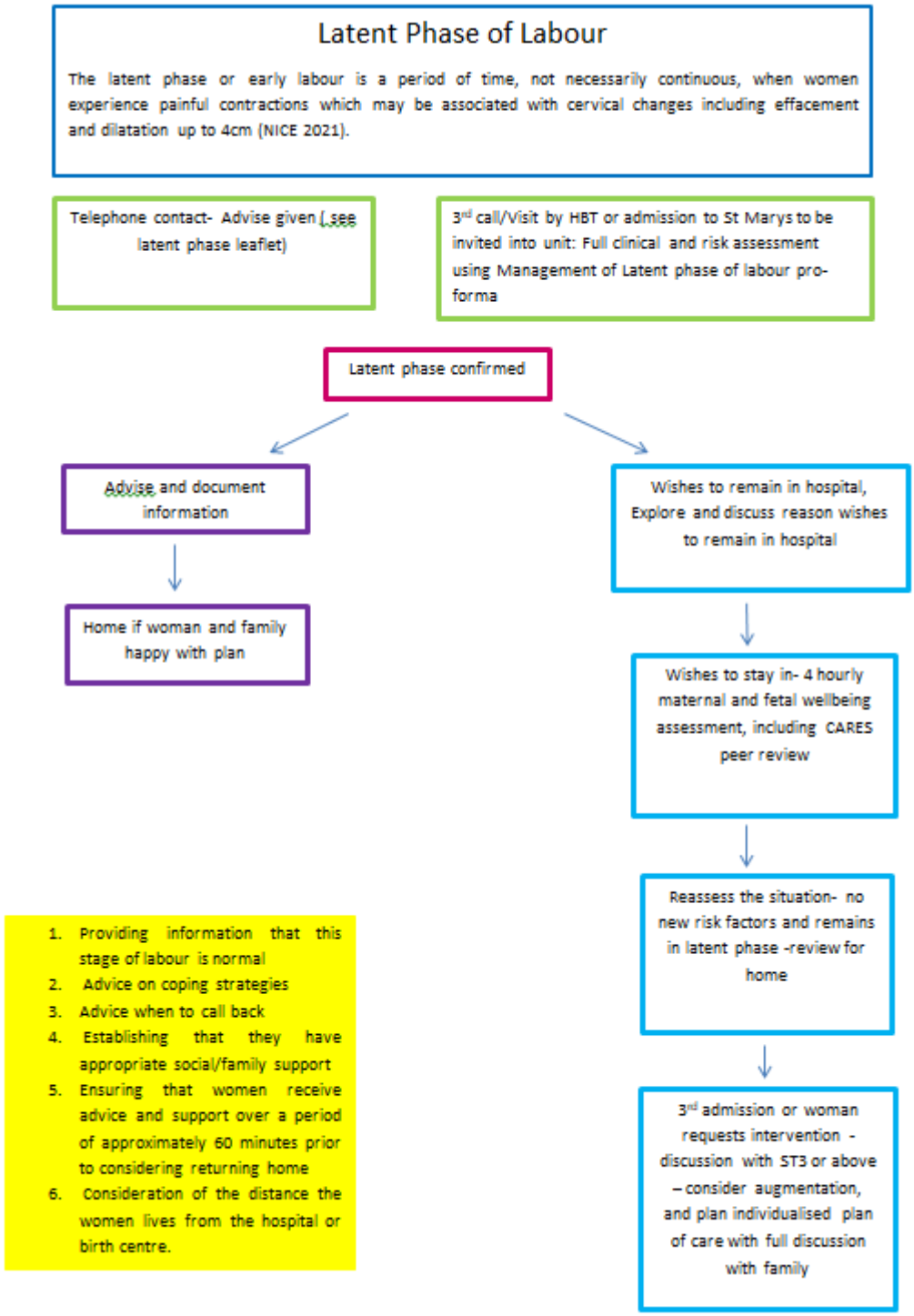
Intrapartum Care UHL Obstetric Guideline; Trust ref: C60/2019

Fetal Monitoring in Labour UHL Obstetric Guideline; Trust ref: C23/2021

Intermittent Auscultation in Labour UHL Obstetric Guideline; Trust ref: C22/2021

Group B Streptococcus in Pregnancy and the Newborn UHL Obstetric Guideline; Trust ref: C97/2008

Latent phase of labour algorithm



2. Guideline Standards and Procedures

2.1 Antenatal period

As part of the planning birth discussion, which should be undertaken around 36 week's gestation, all women and their birth partners should discuss what to expect during this phase of labour. Information should include:

- Optimum environments for birth - including coping in the latent phase of labour
- Working with pain and discomfort at this time
- How to contact midwifery advice and support

2.2 Telephone support

All women should be given sufficient time to explain their clinical picture so the midwife can make a reasonable assessment of their needs. Women may be uncertain about their labour having started and their ability to cope and evidence based compassionate verbal advice can be very supportive.

Include the following in any early or triage assessment of labour:

• Ask the woman how she is, and about her wishes, expectations and any concerns she has.

• Ask the woman about the baby's movements, including any changes.

• Give information about what the woman can expect in the latent first stage of labour and how to work with any pain she experiences.

• Give information about what to expect when she accesses care.

• Agree a plan of care with the woman, including guidance about who she should contact next and when.

• Provide guidance and support to the woman's birth companion(s). (NICE 2021).

• Provide individualised advice and only encourage the woman to stay at home if appropriate to do so. This advice should include a discussion about nutrition/hydration/rest and other strategies that may help the woman to cope.

When women are advised to stay at home at the present time this needs to be supplemented with advice regarding coping strategies. All telephone advice must be documented carefully using the assessment questions on E3.

2.3 Clinical assessment in early labour

Women will be assessed in their chosen birth setting (home/MLU/MAU or DS). Consideration should be given about the optimum environment for the women to have her assessment in; this can depend on acuity, time of day and other factors. If, after this assessment, the woman is found to be in the latent phase and all clinical findings are within normal limits, she should be advised that the evidence supports returning home for optimum health and safety for mum and baby. Key factors in supporting women in returning/remaining at home include:

1. Providing information that this stage of labour is normal

2. Advice on coping strategies

3. Advice when to call back

4. Establishing that they have appropriate social/family support

5. Ensuring that women receive advice and support over a period of approximately 60 minutes prior to considering returning home.

6. Consideration of the distance the women lives from the hospital or birth centre.

Women should be invited in for assessment if they have telephoned 3 times to discuss whether they are in labour – even if their contractions are not yet regular and established.

At every attendance a full set of observations and fetal monitoring should be carried out prior to sending the woman home. A vaginal assessment should be offered if the woman is experiencing regular contractions.

The assessment form in Appendix 1 should be completed at each attendance.

If a woman asks for analgesia or reports concerns about strength/frequency of contractions in the latent phase of labour, please consider the full clinical picture, including review of risk factors risk factors, and ensure an assessment is completed and documented which includes:

- Antenatal or intrapartum risk factors – including HIE score.
- Strength, length and frequency of contractions including abdominal palpation
- Is the baby moving?
- Is there any vaginal loss?
- Auscultation of the fetal heart rate

2.4 Requesting admission during the uncomplicated latent phase

If women prefer not to be at home at this stage, they can be offered the option of staying on an antenatal ward or within the MLU for a few hours. Staff should explore the reasons why the woman does not wish to go home. During this time clinical observations including maternal blood pressure, pulse, respiratory rate, temperature, fetal heart rate, monitoring of fetal movements and assessment of uterine contractions should be carried out at least 4 hourly with completion of CARES review/review of risk assessment.

Low risk women should be checked on at least 4 hourly to ensure she is coping and assess if established labour may have started; if the woman is awake, this review should include a full assessment of maternal and fetal wellbeing, full maternal observations and fetal heart rate auscultation or CTG (dependent on risk factors). If the woman raises concerns or is very anxious, it may be appropriate to check on her more frequently. High risk women may need checking on more often, the frequency of which should be based on clinical judgement and existing risk factors.

After a period of time, women may feel confident to return home if still in the latent phase of labour. All clinical advice must be documented in the maternity notes. If the woman remains in hospital, maternal satisfaction and probability of Spontaneous Vaginal Delivery is likely to increase if:

- The environment is free from medical equipment and facilitates self-comforting behaviour

- Maternal positions are encouraged that promote fetal head rotations and relieve pain; such as standing and leaning forward, sitting upright, leaning forward with support, kneeling on all fours, side lying positions. This may include positions and methods used by midwives trained in biomechanics for birth techniques.
- Promote strategies to cope with pain such as water immersion, showering, TENS machine, simple analgesia, aromatherapy. Other strategies could include breathing and relaxation techniques, massage
- Use interventions to reduce emotional distress such as reframing negative thoughts to positive ones, discussing the importance of relaxation, rhythm and visualisation techniques. Avoid the use of negative language such as “you are not in labour”
- Encourage support from birth partners. If all other options have been exhausted, opiate analgesia may be considered after discussion with the woman. Analgesia in the latent phase of labour requires a doctor’s review and prescription, as it does not fall within the remit of midwifery exemptions.
- If, after 4 hours, the woman remains in the latent phase, with no new risk factors and with normal clinical observations and able to cope, another conversation should be held (and documented) to explore the advantages of returning home.

2.5 Prolonged latent phase

There is no standard definition for a prolonged latent phase of labour. It is not unusual for women to be in the latent phase of labour for 2-3 days.
A prolonged latent phase of labour can be a discouraging and exhausting experience for women. If a woman attends one of our units for a THIRD time and remains in the latent phase of labour after a clinical assessment of maternal and fetal wellbeing, it is recommended to discuss with a senior midwifery colleague (co-ordinator) to gain support from a second opinion and to request a medical review.

If any of the following signs or symptoms are present at any assessment, referral for obstetric advice is recommended:

1. Maternal exhaustion, pyrexia, tachycardia or dehydration

2. Suspected fetal distress (rises in baseline, decelerations, and/or overshoots in FHR following contractions).

3. Failure of descent of the presenting part or failure of cervical dilation despite regular, strong uterine contractions.

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There is evidence that prolongation of the latent phase is associated with:

- Subsequent labour abnormalities and need for caesarean section.
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- There have also been adverse outcomes for mothers and babies when the prolonged latent phase has not been adequately managed.

2.6 When to refer for medical review during the latent phase of labour

- Women should have a medical review on their 3rd admission with regular painful contractions and not yet in established labour. Some women may need medical review on their 1st and / or 2nd admission if there are any concerns about the clinical history and / or examination, or following review of the antenatal and intrapartum risk factors.
- Women should have a medical review if they have had 3 vaginal examinations and are not yet established in labour. (This may be during a single admission).
- Women choosing to birth at home should be referred in to hospital for medical review on their 3rd visit by the community midwife. This should ideally be to the delivery suite if a room is available.
- A CTG and full maternal assessment should be carried out prior to medical review and referral should be made using the SBAR tool.
- As per the induction of labour guideline, women who have three admissions in the latent phase of labour, or where the woman requests intervention, should be discussed with the Obstetric ST3 or above. It is reasonable to offer augmentation of labour under these circumstances after discussion with the woman about her preferences.
- Following the review a plan must be made, and fully documented in the maternity records, with consideration to the woman's wishes. These may include:
    - Returning to midwifery led care. Midwives should use their clinical judgement to determine if the woman remains suitable for a midwife-led birth setting; to include how she is coping, normal maternal and fetal observations and good fetal movements.
    - Augmentation with appropriate analgesia as above.
    - Transfer to antenatal ward

Once labour establishes, staff should follow the UHL Intrapartum Care guideline.

3. Education and Training

None

4. Monitoring Compliance

None

5. Supporting References

NICE (2021) Intrapartum care for healthy women and babies, clinical guideline CG190. https://www.nice.org.uk/guidance/cg190

6. Key Words

Latent Phase, Labour, Early Labour

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Helen Fakoya - Consultant Midwife			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
January 2023	**1**		**New document**

Appendix 1: Latent phase assessment form

Addressograph label here

Managing prolonged latent phase of labour
A vaginal examination should be offered in the presence of ***regular*** painful contractions to confirm the active phase of labour. A full explanation and rationale for the procedure should be provided as part of verbal consent.

Primigravida: active labour should be confirmed where there is cervical dilatation and full effacement with ***regular*** painful contractions, increasing in length, strength and frequency.

Multigravida: Date and time of 1st assessment; active labour should be confirmed where there is cervical dilatation with ***regular*** painful contractions, increasing in length, strength and frequency. Dilation should only be used as a guide. The assessment should always take in the whole clinical picture.

		Date	Date	Date
		Time	Time	Time
		1st Assessment This should include a medical review if there are any concerns about the clinical picture	2nd Assessment This should include a medical review if there are any concerns about the clinical picture	3rd Assessment **This should include a medical review**
Contractions	Regular/Irreg	:10	:10	:10
Pain score	Requiring analgesia	/10	/10	/10
Cervix	Position			
	Effacement			
	Application			
	Dilatation			
Presenting part:	Cephalic			
	Station			
	Caput			
	Moulding			
Position				
Membranes	Intact/Absent			
	Liquor colour			
Fetal heart	Normal			
Fetal movements	Normal			
Urinalysis				
MEOWS Score				
HIE Score				
Signature				

Woman not in active labour refer to algorithm.
If following a third vaginal examination the woman is not in active labour, a full assessment including continuous electronic fetal monitoring should be carried out and referral for medical review using **SBAR**.

Discussed with:
Plan: