

Policy, Procedures and other Written Control Documents Template



Aneurin Bevan University Health Board

Latent Phase of Labour Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1. Introduction/Overview

Guidance to support the provision of consistent care in the latent phase of labour for women and birthing people who are >37 weeks' gestation and planning a vaginal birth.

The terms woman/women have been used throughout this guideline as this is the way the majority of those who are pregnant and having a baby will identify. However, it also includes those whose gender identity does not correspond with their birth sex or who may have a non-binary identity. All professionals should be respectful and responsive to individual needs and individuals should be asked how they wish to be addressed throughout their care.

2. Policy Statement

What is the commitment of the Health Board?

What is the statement of intent?

Cross reference to relevant Health and Care Standards Wales.

3. Aims/Purpose

The aim of this guideline is to provide information on providing care and support to women or birthing people in the latent phase of labour and is applicable to women planning a vaginal birth between 37 – 42 weeks' gestation.

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 dilation up to 4cm.

4. Objectives

The aim of this guideline will be achieved by ensuring that all healthcare professionals who have a professional responsibility to provide care to women and birthing people have access to this guideline to support a consistent approach towards care in the latent phase of labour.

The latent phase of labour is the very early part of the first stage of labour. It is a normal part of labour, but its duration is difficult both to measure and predict as women may experience the onset of labour in a variety of different ways.

It is vital that health care professionals caring for women in the latent phase of labour understand this physical process and the psychological impact it may have.

The management of a woman's care during this phase of labour has implications for her entire labour experience. Furthermore, the latent phase of labour is considered to be more sensitive to external influences than the active phase of labour; especially regarding its duration.

As a result, the care provided to women and birthing people in the latent phase of labour should focus on relieving their fears and anxieties, educating them and providing reassurance, emotional and physical support.

5. Scope

The guideline is relevant to all staff who provide care to women who are more than 37 weeks and under 42 weeks gestation and are planning a vaginal birth.

6. Roles and Responsibilities

The maternity management team are responsible for ensuring that the Guidelines are adhered to.

It is the responsibility of individual health care providers to make sure they are aware of and follow the most recent guidance included in this publication.

7. Main Body

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 dilation up to 4cm.

Antenatal period

It is good practice for the midwife to discuss with all women and, preferably, her birthing partner what to expect during this phase of labour at the birth planning visit.

Information should include how to work with any pain they experience, how to contact midwifery care and what to do in an emergency. This topic should also be included in birth preparation classes.

Early labour support via telephone

There is limited research into women's views of this stage of labour. A theme commonly highlighted is that nulliparous women, in particular, maybe uncertain about their labour having started and their ability to cope; therefore, all women who call the service for advice should be given sufficient time to explain their symptoms during each telephone call so that the midwife assessing the woman/birthing person can make an accurate assessment of their needs.

If a woman phones for advice more than three times in the latent phase, then she should be asked to attend for assessment.

Using the telephone SBAR proforma/Part 1 of NLP (Normal Labour Pathway) the Midwife must obtain and document the information in order to carry out a thorough assessment.

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

If women/birthing people require a face-to-face assessment, expert opinion in this area of care suggests that women find it helpful if they have continuity of care with a named midwife during this stage of labour.

Where possible the 'triage' midwife should, ideally, take this role.

Also consider for low-risk nulliparous women, labour assessment at home (regardless of planned place of birth).

NICE recommend 1:1 midwifery care for at least one hour for nulliparous women during this assessment.

Clinical assessment in early labour

The criteria for this assessment are outlined in the All-Wales Normal labour pathway (see appendices). The midwife is responsible for ensuring that this minimum level of care is carried out.

Professional discretion dictates whether or not a vaginal examination is required. If, after this assessment, the woman is found to be in the latent phase and all clinical findings are within normal limits, advise her to return home. Studies have shown that women admitted to hospital in the latent phase of labour, subsequently have higher rates of obstetric intervention.

Key factors in supporting women in returning home include:

- Providing information that this stage of labour is normal
- Advice on coping strategies,
- Advice when to call back
- Establishing that they have appropriate social support.

In a small study, some women felt unsupported and experienced more anxiety when sent home during this phase of labour. Accordingly, some women may reject this advice. It is good practice to offer women choice with the option of staying on the ward for a few hours, and it is important that women are informed that it is their choice and are asked where they feel safest.

During this time clinical observations including maternal pulse, fetal heart rate and assessment of uterine contractions should be carried out hourly and this should be clearly documented in the woman's digital antenatal record. After a period of time, women may feel confident to return home if still in the latent phase of labour.

If the woman remains in hospital, maternal satisfaction and probability of SVD is likely to increase if the environment is free from medical equipment and facilitates a safe calming environment.

Maternal positions are encouraged that promote fetal head rotation and relieve pain; such as standing and leaning forward, sitting upright, leaning forward with support, kneeling on all fours, side lying positions.

Promote strategies to cope with pain such as immersion in water, showering, TENS machine, simple analgesia. Other strategies could include breathing and relaxation techniques, massage and aromatherapy. Use interventions to reduce emotional distress such as reframing negative thoughts to positive ones, discussing the importance of relaxation, rhythm and visualisation techniques. Avoid use of negative language such as "you are not in labour" and encourage support from a birth partner/s.

If all other options have been exhausted, opiate analgesia may be considered after discussion with the woman. Continue with hourly clinical observations, all observations should be clearly documented.

If after 4-6 hours the woman remains in the latent phase of labour and able to cope, she can return home if all clinical observations are normal.

Prolonged latent phase

Opinions are polarised about the management of a prolonged latent phase of labour. For some, it is considered benign and not clinically significant whereas others consider it to be associated with subsequent development of labour abnormalities and a higher risk of caesarean section.

There is no standard definition for a prolonged latent phase of labour. The teaching literature for midwives, states that early labour can take up to 6-8 hours. However, The Royal College of Obstetrics and Gynaecology state that it is common for the latent phase of labour to last between 18 and 24 hours.

Mal positions may lead to prolonged latent phase. Between 10 – 30% of all foetuses in early labour present in the occipital posterior (OP) position but most subsequently rotate spontaneously. On suspicion of OP position early support and advice to women from the midwife on how to cope may be of benefit. Strategies such as optimal fetal positioning/biomechanics and pharmacological pain relief can be used.

A prolonged latent phase of labour can be a discouraging and exhausting experience for women.

If a woman attends the unit for a THIRD time and remains in latent phase of labour after clinical assessment of maternal and fetal wellbeing, an obstetric review is needed (and a CTG considered) where an individualised plan of care incorporating the woman's preferences can be created. If a CTG is required, women should exit the MLC pathway and transfer to an obstetric setting (regardless of the outcome of the CTG).

If any of the following signs or symptoms are present at any assessment, referral to the obstetrician on duty is recommended:

- Maternal exhaustion, pyrexia, tachycardia or dehydration
- Fetal distress
- Failure of descent of the presenting part or failure of cervical dilation despite, regular uterine contractions

Auditable standards

- Telephone proforma is completed for every woman calling for advice in labour
- The clinical criteria outlined in Part 1 of NCP is completed for admission in suspected labour
- Advice and information on coping strategies is given to all women returning home in the latent phase of labour
- All women who stay in hospital in the latent phase of labour are offered advice and support to enable them to cope

8. Resources

Are there any resource issues for the document to be implemented?

Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.

9. Training

Staff are expected to access appropriate training where provided.
Physiological birth training forms part of the mandatory training for midwives. Training needs will be identified through appraisal and clinical supervision.

11. Further Information Clinical Documents

References:

Akmal S. and Paterson-Brown S. Malposition's and malpresentations of the fetal head. *Obstetrics, Gynaecology and Reproductive Medicine* 2009 Vol19 (9): 240 -246

Austin D.A & Calderon L. Triaging patients in the latent phase of labour. *Journal of Nurse Midwifery* 1999 Vol 44 (6): 585-591.

Barnett C. et al 'Not in labour': impact of sending women home in the latent phase. *BJM* 2008 Vol 16 (3): 144-153

Baxter J. Care during the latest phase of labour: supporting normal birth. *BJM* 2007 Vol 15 (12): 765-767

Cheyne H. et al 'Should I come in now?': a study of women's early labour experiences. *BJM* 2007: Vol 15 (10): 604 – 609

Fogarty V Intradermal sterile water for injections for the relief of low back pain in labour – A systematic review of the literature. *Women and Birth, Journal of the Australian College of Midwives* 2008: Vol 21 (4): 157-163

Hodnett E.D. et al Effect of birth outcomes of a formalised approach to care in hospital labour assessment units: international randomised controlled trial. *BMJ* 2008 Vol 337: 618 –622

Hutton EK et al Sterile water injection for labour pain: a systematic review and metaanalysis of randomised controlled trials. *BJOG* 2009: Vol 116 (9): 1158-1166

Munro J. and Jokinen M. Latent Phase Midwifery Practice Guideline in RCM Evidence based guidelines for midwifery – led care in labour 4th edition. 2008. Available online at: www.rcm.org.uk

National Collaborating centre for Women's and Children's health Intrapartum Care. Clinical Guideline 190. 2014 RCOG Press: London

Spiby H., Green J.M. et al Labouring to better effect: studies of services for women in early labour. 2007 Final report to the NIHR Service Delivery and Organisation Programme. SDO/64/2003. London:NCCSDO

16. Review

Generally, 3 years unless legislation requires differently – check with Policy Process Manager (Corporate Services Manager – Policy and Procedures).

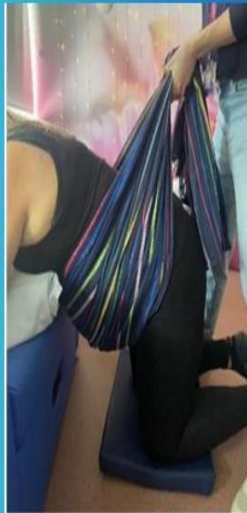
18. Appendices

All Wales Midwifery Led Care guidelines
wisdom.nhs.wales/all-wales-guidelines/all-wales-guidelines/all-wales-midwifery-led-care-guideline-2022/

BIOMECHANICS IN PREGNANCY AND BIRTH

Biomechanics is the study of biology and the mechanics of movement.

In childbirth, biomechanics and positional changes can help babies to rotate and turn to navigate the pelvis.



Side lying release

How does it work?

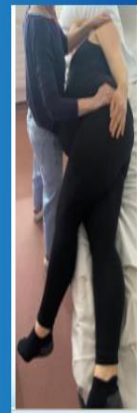
This technique uses a 'static stretch' to temporarily enlarge and soften the pelvis. It can be done weekly to maintain balance and stability, help baby to rotate into an optimal position and encourage regular contractions. It can also ease back and labour discomfort.

How to do side-lying release

- Begin by laying on a side of your choice. Your hips, shoulders, neck and head should be in-line.
- Your birth partner should stand in front of you for support.
- Move towards the edge of the bed until your bump extends over the edge. Flex your toes up towards your knees and allow your top leg to hang over the bed. Remain in this position for 3 contractions or 10 minutes. Repeat on the other side.

Avoid if you suffer from

- Hypermobility
- Ehlers-Danlos Syndrome
- Severe pelvic or back pain



Forward-leaning inversion

How does it work?

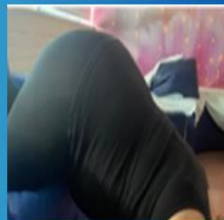
This technique increases room within the lower uterus for baby to move into an optimal position. It can be done in early labour, or when labour stalls. It can temporarily lengthen ligaments to aid alignment of the uterus with the pelvis. It may reduce back and hip pain and can help a breech or transverse baby to turn head down.

How to do forward-leaning inversion

- Kneel on the edge of a couch, bed or chair
- With the help of your partner, carefully lower yourself to your hands on the floor and then lower further to rest your forearms. Keep your elbows out and hands close.
- Let your head hang freely. Your knees should be close to the edge, and your bottom up high. Take three breaths.
- With the support of your partner, come back up on to your hands, then up to a high kneeling position. Take two breaths here, then sit on your heels.

Avoid if you suffer from

- High blood pressure
- Polyhydramnios (increased amniotic fluid)
- Recent laser eye surgery
- Any condition related to an increased risk of stroke



Shake the apple tree

How does it work?

Jiggling activities stretch sensors in muscles, helping them to relax. Relaxed muscles create more space for babies to move. This can comfort in labour and encourage baby's head to descend into the pelvis in a good position. This can also help prevent a delay in labour.

How to do shake the apple tree

- Adopt an all-fours position or lean over a counter.
- Using a rebozo, scarf or blanket, a birthing partner places the material, so it is hugging both buttocks.
- Holding the edges of the material at the hips, gently jiggle from left to right. Jiggle for up to 20 minutes, depending on comfort. Always check whether it is comfortable with the birthing person.

Be cautious to never shake the hips vigorously



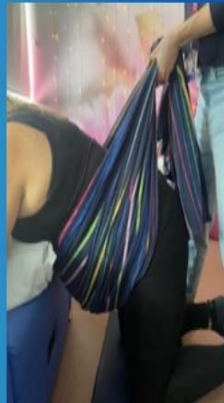
Sifting

How does it work?

The sifting movement helps to relax abdominal muscles to encourage optimal fetal position. It can provide comfort in labour and encourage baby's head to descend into the pelvis,

How to do sifting

- Adopt an all-fours position
- Using a robozo, scarf or blanket, a birthing partner places the material, so it is hugging the tummy comfortably, top to bottom.
- Standing close to the birthing person's hips (to protect the partner's back), lift gently upwards and cycle the hands to create a rocking sensation: Cycle up for 20 minutes, depending on comfort. Always check whether it is comfortable for the birthing person



Be cautious to never shake the hips vigorously

Lunge

How does it work?

This technique aids rotation and descent of baby's head by opening the mid-pelvis. Lifting one leg can help create more room for baby to rotate into a good position. Can be used when labour has slowed and is a useful upright position to adopt in labour.

How to do a lunge

- Whilst facing forwards, place one foot on a chair or stool to your side, toes pointing away from your body (90 degree angle).
- During a contraction, gently rock towards your bent knee beyond your foot.
- A birth partner can stand close or in front for support if needed.
- You can rest your foot on the floor between contractions if required.
- Try 5 contractions, then change to the other leg.



Avoid if you suffer from:

- You are struggling to stand on one leg
- In the presence of severe knee pain.

Alternative methods

There are many other things which can help you to stay relaxed and comfortable in pregnancy and labour.

These include:

- Massage
- TENs (electrical nerve stimulation), TENs machines can be hired or bought privately.
- Changing position
- Warm or cool compress
- Paracetamol 1g every 4-5 hours (not exceeding 4g in 24 hours)
- Peanut ball
- Aromatherapy (please ask your midwife about this when in hospital or provide your own essential oils)
- Bath or shower
- Low lighting
- Music

Useful resources



We value your feedback
Please tell us about your experience of maternity care by completing our short survey

