Latent Phase of Labour Guideline

Guideline information

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Summary of document:
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.

Scope:
The guideline is relevant to all staff who provide care to women or birthing people who are more than 37 weeks gestation and are planning a vaginal birth.

To be read in conjunction with:
991 - Maternity Triage Admission Guideline – opens in new tab

Patient information:
Include links to Patient Information Library

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Reviews and updates:
1.0 – New Guideline
2.0 - Updated

Keywords
Latent Phase, Early Labour, Care in Labour

Glossary of terms
NCP - Normal Care Pathway
Telephone SBAR - Record of contact available to reflect the Situation Background Assessment and Recommendation (SBAR)

Key points:
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.

Contents

Scope

The guideline is relevant to all staff who provide care to women or birthing people who are more than 37 weeks gestation and are planning a vaginal birth. The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

Aim

The aim of this document 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.

Objectives

The aim of this document will be achieved by the following objectives:

- Definitions of latent phase of labour/ long latent phase of labour
- Advise and support that can be given antenatally and during latent phase given
- Clarifying that the woman is “happy”/in agreement with any plan made and understand that that they have the option to attend for assessment regardless of how many times they have rung.
- When to advise women to attend for assessment

General Principles

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. 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 in the latent phase of labour should focus on allaying their fears, giving them information, and providing reassurance, emotional and physical support.

Definition

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 nulliparous 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 be included in the Birth Preference appointment which occurs around 36 weeks gestation.

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, may be 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 triage midwife can make an assessment of their needs.

Every time a woman phones it must be confirmed that the woman is "happy"/in agreement with any plan made and understand that that they do have the option to attend for assessment regardless of how many times they may have phoned. It is important to reflect different people's circumstances in advice, and ensure that all advice is centred on evidence and women's needs and preferences.

If a woman phones for advice on two occasions or more then she should be invited to attend for assessment.

Using the telephone SBAR proforma / Part 1of NCP the Midwife must elicit 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 require or request 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.

Women who are low risk Midwifery Led Care should attend the Midwifery Led Unit (MLU) for assessment. Women at low risk of complications in birth have a lower rate of intervention and a decreased use of pain relief when cared for in a midwifery unit (Safebirth Study 2015 Consideration of whether appropriate to request assessment in the home setting by the Community Team should be done on an individual basis.

NICE[10] 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 labour pathway. 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:

- That the women is happy/ in agreement with plan to return home and understand that they can return for assessment when they feel they want or need to.
- Providing information that this stage of labour is normal
- Advice on coping strategies,
- Advice when to call back and understands can phone again at any time should they feel they need OR want to.
- 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. HSIB report (2020) found that some mothers may not have known when to come back to hospital if asked to return 'when labour is established' as they thought they were in labour already. 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 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 spontaneous vaginal birth 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 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, hot and cold compresses, 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 use of negative language such as "you are not in labour"
- 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 and is happy to do so, 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 fetuses in early labour present in the occipito posterior (OP) position but most subsequently rotate spontaneously[1.] 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, pharmacological pain relief can be used.

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

If a woman re- attends the unit for a second or any subsequent assessment and remains in the latent phase of labour any previous record of admissions should be reviewed including the Telephone Triage Forms as these may be relevant in the formulation of a management. After clinical assessment of maternal and fetal wellbeing (consider CTG) consider review by a senior Midwife/ Registrar or Consultant Obstetrician where the woman's risk status will be reviewed and an individualised plan of care incorporating the woman's preferences can be created.

If any of the following signs or symptoms are present at **any** assessment, referral to the duty obstetrician is recommended 1:

- 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

References

Akmal S. and Paterson-Brown S. Malpositions 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

HSIB (2020) Investigation report: Summary of themes arising from the Healthcare Safety Investigation Branch maternity programme. Available from https://www.hssib.org.uk/patient-safety-investigations/summary-of-themesarising-from-the-hsib-maternity-programme/investigation-report/

Hutton EK et al Sterile water injection for labour pain: a systematic review and meta-analysis 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

National Institute for Health and Clinical Excellence.2023. *Intrapartum Care -NICE clinical guideline 235.* Manchester: NICE.

The birthplace in England study, NPEU 2007, www.npeu.ox.ac.uk/birthplace/component-studies

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.