Latent Phase of Labour Guideline

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Brief 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:	National Institute of Health and Care Excellence (NICE) Intrapartum care for healthy women and babies [NG190]

Owning group	Obstetric Written Documentation Review Group

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	18/6/2021

Glossary of terms

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

Keywords	Latent phase, early labour, care in labour.

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1. Aim

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.

2. 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.

3. 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. 9

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. 9

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. 9

4. 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.*10

5. 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 birth preparation classes.

6. 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; 2, 3, 4, 5 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. 2

If a woman phones for advice ≥ three times or more then she should be asked 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 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.[11] 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[10] recommend 1:1 midwifery care for at least one hour for nulliparous women during this assessment.

7. 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.10 Studies have shown that women admitted to hospital in the latent phase of labour, subsequently have higher rates of obstetric intervention. 9,11

Key factors in supporting women in returning home 9,11 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 3. 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 cleary 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 SVD is likely to increase 7 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, she can return home if all clinical observations are normal.

8. 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. [9,11].

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 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 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

9. 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

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ANTENATAL WARD & TRIAGE GUIDELINES: MANAGEMENT OF THE LATENT/ EARLY PHASE OF LABOUR

Signs of Early Labour

- Pain-like breathing
- Excited, anxious, slightly agitated mood
- Grasps lower abdomen; bends forward with contractions
- Contractions seem to last between 20-40 seconds; occur irregularly

Advice & Support

- Give& discuss ***Latent Phase Information Leaflet***
- **Home is the optimal place***
- Positive support at home from partner, family
- Encourage breathing exercises, massage
- Mobilise, upright, 'all fours' position, use birthing ball
- Have a long bath/ shower
- Contact community midwife, maternity unit for advice when required
- Try TENS machine
- Ensure hydration and nutrition.

Signs of Early Active

- Deeper controlled breathing
- Less mobile; stops for contractions & holds onto something
- Becomes still; inward focus on self; speaks less
- Contractions last for 50 seconds or more; occur at least 4 mins apart

Advice & Support

- Hourly midwifery review when awake
- Document discussion communication and review of care plan
- Continue to encourage upright position using birthing ball; 'all fours ', position
- Try TENS machine
- Try simple analgesics such as Paracetamol
- Consider use of bath / shower
- Ensure hydration and nutrition.
- **Avoid Pethidine/ opioids as first line management**

Signs of Active Labour

- Withdrawn, focussed on breathing
- Quiet; conversation stops during contraction
- Stays in one position with or without contraction; sways hips
- Contractions last over 50 seconds and occur

Advice & Support

- Discuss and agree care at this stage. Consider vaginal examination to assess labour progress
- Review plan of care & decide on the most appropriate environment for continued support
- Emphasise the benefits of upright position using birthing ball; 'all fours ', position
- TENS machine
- Try simple analgesics such as Paracetamol
- Ensure hydration and nutrition.
- **If all other options have been exhausted consider opiates**

*discussions should take place to identify where women feel most secure to experience the latent phase