

Latent Phase of Labour Guideline

Speciality: Maternity
Approval body: Intrapartum Forum
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Owner: Intrapartum forum

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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.

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 as well as ongoing clinical assessment and recognition of possible pathology in 'prolonged latent phase'.

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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

Latent first stage of labour is a period of time, not necessarily continuous, when:

- there are contractions **and**
- there is some cervical change, including cervical position, consistency, effacement and dilatation up to 4 cm (NICE 2023)

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 and when to contact maternity 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 on a second occasion in the latent phase, then she should be asked to attend for face-to-face assessment.

Using the telephone triage proforma/Part 1 of All Wales Clinical Pathway for Normal Labour (Normal Labour Pathway) the Midwife must obtain and document all information to carry out a thorough telephone assessment. All telephone triage should be documented on WPAS antenatal SBAR.

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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 this is not possible midwives should aim to provide continuity in telephone assessment and face to face assessment where possible.

For women with uncomplicated pregnancies (under a midwifery led pathway), labour assessment at home (regardless of planned place of birth) OR in the woman's planned place of birth should be supported. The antenatal assessment unit is not an appropriate clinical area for this cohort.

NICE (2023) recommends 1:1 midwifery care for at least one hour for all women during any initial labour assessment, regardless of care pathway or place of assessment.

Clinical assessment in early labour

The criteria for this assessment are outlined in the All-Wales Clinical Pathway for Normal labour (part 2) and or BSOTS documentation. The midwife is responsible for ensuring that this minimum level of care is carried out.

Professional discretion dictates whether a vaginal examination is required as part of the holistic assessment of onset of labour.

If, after this assessment, the woman is found to be in the latent phase and all clinical findings are within normal limits, the recommendation would be for her to return home where it is safe for her to do so.

Studies have shown that women admitted to hospital in the latent phase of labour, subsequently have higher rates of obstetric intervention this information should be discussed and documented.

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
- Womens confidence to return home

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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.

Where women remain in the clinical area observations including maternal pulse, fetal heart auscultation and assessment of uterine contractions should be carried out hourly, and this should be clearly documented in the woman's records.

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 the clinical area, maternal satisfaction and probability of spontaneous vaginal birth 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.

Advise women that breathing exercises, having a shower or bath, and massage may reduce pain during the latent first stage of labour (NICE 2023) along with simple analgesia.

If a woman seeks advice or attends a midwifery-led unit or obstetric unit with painful contractions, but is not in established labour:

- Recognise that a woman may experience painful contractions without cervical change and offer her individualised support and analgesia if needed
- Encourage her to remain at or return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed.
- Avoid the use of negative language such as “you are not in labour” “you are only 2cm’s”.

If all other options have been exhausted, and pain of the latent phase is considered excessive by the woman, midwives can support with biomechanical techniques and/or opiate analgesia may be considered after discussion with the woman. Continue with hourly clinical observations, all observations and interventions should be clearly documented.

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If after 4-6 hours after opioid administration the woman remains in the latent phase of labour and is 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 chance of caesarean birth.

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 68 hours.

Mal positions/or biomechanical issues may lead to prolonged latent phase. Strategies such as biomechanical techniques and pharmacological pain relief can be used to restore the physiology.

A 'prolonged latent phase of labour' can be a discouraging and exhausting experience for women and thorough holistic assessment is vital to recognise physiology versus pathology and individualised care planning.

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, a professional discussion is needed with a senior midwife or obstetrician depending on the care pathway so that an individualised assessment and plan of care, incorporating the woman's preferences, can be created. For women with uterine scarring obstetric review and individualised care planning should occur after the 2nd admission where the woman remains in the latent phase.

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

- Maternal exhaustion, pyrexia, tachycardia or dehydration
- Fetal heart changes, including an increase of fetal heart baseline by 20 bpm since the last assessment.
- Failure of descent of the presenting part or failure of cervical dilation despite, strong, regular uterine contractions

Auditable standards

- Telephone SBAR is completed for every woman calling for advice about labour
 - The clinical criteria outlined in Part 1 of the All Wales Clinical Pathway for Normal Labour is completed for every 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 and have relevant observations recorded.
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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.

10. Further Information Clinical Documents

[All Wales Midwifery Led Care Guideline \(WMNN 2022\)](#)

NICE [Intrapartum care](#) 2023

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Checklist for Clinical Guidelines being submitted for Approval

Title of Guideline:	Latent Phase of Labour Guideline
Name(s) of Author:	Intrapartum forum
Chair of Group or Committee approving submission:	Intrapartum forum
Brief outline giving reasons for document being submitted for ratification	Update
Details of persons included in consultation process:	Intrapartum forum, Q&S
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File Name: Used to locate where file is stores on hard drive	