Guideline for the Management of the Latent Phase of Labour	Barnsley Hospital NHS NHS Foundation Trust
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Rationale

To provide guidance and a structured assessment tool to be used in the recognition and management of the latent phase of labour in order to reduce the possibility of:

- Misdiagnosis of established labour leading to unnecessary admission and increased levels of intervention

- Failure to recognise a prolonged latent phase or labour dystocia

To ensure the woman's individual circumstances and perception of her labour experience are an integral part of the assessment process

Background Information

Care in labour should be aimed towards achieving the best possible physical, emotional and psychological outcome for the woman and her baby.

Labour is a complex physiological process which can be defined by cervical changes and uterine contractions. However the changes and processes which lead to the expulsion of the fetus are variable and subject to many other influences. As such the onset of labour as a single quantifiable event is difficult to diagnose and the process could be viewed as a continuum of the pregnancy rather than a separate structured event.

There is, however a requirement for parameters for the management of labour in order to facilitate and promote the safe management of the labour process and minimise risk to the woman and her baby.

NICE recommend that labour is divided into stages to ensure that women and staff involved in care have an accurate and shared understanding of the concepts involved in the delivery process:

First stage - which is further divided into:

Latent first stage of labour – a period of time, not necessarily continuous when there are painful contractions and **some cervical changes** including effacement and dilatation up to 4cm

Established first stage of labour – when there are regular painful contractions and progressive dilatation of the cervix from 4cm

Second stage – which is further divided into:
Passive second stage – full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions

Active second stage – full dilatation of the cervix with expulsive contractions, visible presenting part, active maternal effort

Third stage – the expulsion of the placenta and membranes following delivery of the baby

NICE guidance has adapted the World Health Organisation recommendations and set clear parameters for the measurement of the progression of labour, once established, using cervical dilatation in association with regular uterine activity and decent of the presenting part

The management of the latent phase of labour requires careful assessment as it impacts upon the prospective management of established labour, the health and wellbeing of the mother and baby and cannot be viewed in isolation.

The latent stage of labour is difficult to diagnose and quantify as uterine activity and contractions will vary between individual women and the duration can be several hours, days or even weeks.

Management of this stage, is complex and should include an assessment of risk, parity, uterine contractions, cervical changes, the woman's perception of pain, and the woman's social circumstances

The main issues are establishing:

- The best place for the woman to be during this stage
- The recognition of the transition to established first stage of labour
- Best management of pain and the woman's psychological wellbeing
- When latent phase is no longer a normal phenomenon but a labour dystocia requiring intervention
- When the woman or fetuses condition requires intervention due to the development of risk factors or a deterioration in their condition

Guideline Outline

Inclusion criteria

This guidance applies to low risk women experiencing a normal labour (where normal labour is defined as: spontaneous in onset, with the baby in a vertex position between 37 and 42 completed weeks of pregnancy.

Women with the following risk factors are excluded:

- Malpresentation
- Previous LSCS
- SROM

- Maternal/fetal conditions where a specific intrapartum management plan is in place

- Clinical signs of maternal sepsis

Please note an individual management plan will be required for the above cases

Telephone triage

Women are encouraged to contact the Birthing Centre for help, advice and support if they believe they are in labour.

- A telephone triage is performed and the woman is advised to either remain at home or come to Maternity Assessment Unit for assessment.

Initial admission and assessment

The woman will be admitted to the Maternity Assessment Unit (MAU) where a comprehensive assessment will be performed in accordance with the guideline for Admission to the Maternity Assessment Unit.

It is important to recognise that the woman may be experiencing painful contractions without cervical change, and although she is not technically in labour she may feel she is experiencing labour by her own definition

The woman's risk status will be assessed taking into account pre-disposing factors, current history and results of clinical observations and assessment of maternal and fetal wellbeing.

Low risk women will be assessed to determine whether they are in the latent phase of labour and a management plan decided using the assessment tool (see appendix 1)

Please note that the woman's parity is a factor to be considered when using the assessment tool and agreeing upon a management plan

Pain management during the latent Phase of labour

Discuss coping strategies and pain management:

- Encourage the use of breathing techniques and relaxation

- Encourage the use of water for pain relief and relaxation (warm shower/bath)

- Use distraction (e.g) listening to music or watching TV

- Use a hot water bottle

- Adopt different positions and use a birthing ball
- Try massage, especially for back pain
- Commence hypnobirthing techniques if planning to use them
- Consider using a TENS machine

Pharmacological pain relief can be used in the form of:

- Paracetamol – women can self medicate at home but must be made aware of safe dosage and frequency of medication
- Codeine phosphate – prescribed maedication prior to discharge
- Oramorph 10mgs – Can be offered as a once only dose to primigravidas at term with no evidence of fetal or maternal compromise. The woman should remain in hospital for I hour after administration. Maternal and fetal observations and assessment of contractions should be completed prior to discharge.

NB – the midwive must identify any drug allergies and ensure drugs are prescribed unless they are governed by a PGD. All drugs must be recodred on the drug chart. A record of the drugs administered should also be recorded in the woman's hand held records

Management of women who go home

Where possible women should be encouraged to go home once the latent phase of labour is diagnosed. Being at home in her normal enviroment will encouage the production of oxytocin and endorphins. .

Women should be encouraged to carry on with normal daily activities as much as possible:

- Remain mobile – go for a walk
- Try to sleep/rest/nap
- Keep well hydrated
- Eat well in order to maintain energy levels during in labour
- Monitor fetal movements

Discuss:

- Braxton hicks contractions and the latent phase of labour in relation to the diagnosis of active first stage

- Help and support at home and the woman's ability to return to the Birthing Centre when established in labour

Give advice regarding the circumstances in which the woman should re-contact the Birthing Centre:

- Feels unable to cope with contractions irrespective of strength and frequency
- Constant abdominal pain
- SROM
- Bleeding PV
- Diminished fetal movements
- General malaise
- Signs of maternal fever
- Headaches, visual disturbances

It is important to offer positive reinforcement of the normality of the latent phase and ensure the woman is aware of coping mechanisms.

Advise the woman that breathing exercises, immersion in water and massage may reduce pain in the latent phase. Do not advise on the use of aromatherapy, yoga or acupressure during the latent phase but respect the wishes of any women who wish to use theses methods

The woman should be offered the following leaflets:

- Latent Phase of Labour leaflet
- Preparing for birth leaflet number 3: Relaxation
- Preparing for birth leaflet number 4: Giving birth

The woman will be informed prior to discharge that she can telephone the Birthing Centre for advice and support at any time

A management plan will be recorded in the woman's hospital and handheld records

Management if the woman remains in hospital

One to One Care

Women who score >12 for primigravida's or >13 for multigravida's on the latent phase assessment tool will require one to one care and be commenced on a partogram

Transfer to the Antenatal/Postnatal Ward (ANPN)

Although the woman is clinically low risk she is an inpatient in the latent phase of labour and the following minimal observations are recommended:

- Maternal observations – 12 hourly
- Assessment of contractions and general wellbeing – 4 hourly
- Pain management – 4 hourly
- Fetal auscultation – 4 hourly

A comprehensive assessment of the woman and the management plan should be undertaken by the midwife after 4 hours and documented in the woman's hospital records

A medical review of the management plan by a Registrar should be undertaken after 8 hours. At this stage acceleration of labour should be considered if progression has not occurred

The Latent phase assessment tool (Appendix 1) can be used to determine a plan of care

Please note – it is **not** always necessary to perform a vaginal examination prior to using the assessment tool. If a vaginal examination is **not** clinically indicated please use the score from the last vaginal examination performed

The above timescales are minimum requirements with the understanding that midwifery care and/or medical intervention will be given more frequently should the woman's condition suggest intervention is required.

Whilst it is recognised that the duration of the latent phase of labour is variable and difficult to quantify, during assessments consideration must be given to the possibility of labour dystocia.

Management of Subsequent admissions

It is feasible that a woman in the latent phase of labour may be discharged from the MAU or the ANPN

The woman will advised to contact the Birthing Centre if she needs advice and support and where applicable, re-admission will be arranged

If re-admission is required the woman will be admitted to the MAU. Any previous record of admissions will be reviewed including the Telephone Triage Forms as these may be relevant in the formulation of a management plan

A comprehensive assessment will be made (as above) and the management plan reviewed. The woman's risk status will be reviewed and the management plan adapted accordingly

Transfer home, transfer to the ANPN/Birthing center will be determined as before

Advice from a consultant should be sought if labour dystocia is suspected

Staff roles and responsibilities

Midwives/Support staff
To work collaboratively with the woman and the obstetric team to ensure the timely recognition and effective management of the latent phase of labour; promoting the normality of birth whilst minimising the risk to the woman and her baby

Obstetricians
To work collaboratively with the woman and midwifery staff to provide timely intervention and management plan if deviations from normal progression in the latent phase are suspected or there is evidence of maternal or fetal malaise

Documentation

Documentation of the management of the latent phase of labour including plans and discussions with the woman will be recorded in the woman's maternity records and where applicable the handheld notes

Storage of guidelines

The intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments

Audit/Monitoring

Any adverse incidents relating to the management of the latent phase of labour will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the management of the latent phase of labour will be audited in line with the annual audit programme, as agreed by the CBU. The results will be reviewed and presented to the multidisciplinary audit meeting. Any deficiencies will be actioned via the audit action plan to try and improve safety and learn from previous mistakes. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Equality Impact Assessment

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others are central to what we believe and central to all care provided.

Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Review

This guideline will be reviewed in three years of authorisation. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required

References

British Journal of Midwifery. Diagnosing the latent phase of labour: use of the partogram, October 2010, Vol 18, No 10, pages 603 – 637

British Journal of Midwifery. Effects of algorithm for diagnosis of active labour: cluster randomised trial [online] http://www.bmj.com/content/337/bmj.a2396 accessed 23/05/2013

National Institute for Health and Care Excellence. Clinical guideline 190: Intrapartum care: care of healthy women and their babies during childbirth. (2014) [online] www.guidance.nice.org.uk/cg190

Royal College of Midwives. Midwifery Practice Guideline: Latent Phase (2012)

Royal College of Midwives. Evidence Based Guidelines for Midwifery-led Care in Labour: Latent phase (2012)

Glossary of terms

ANPN – Antenatal/Postnatal ward
CTG – Cardiotocograph
LSCS – Lower Segment Caesarean Section
MAU – Maternity Assessment Unit
NICE – National Institute for Health and Clinical Excellence
PV – Per vagina
SROM – Spontaneous Rupture of Membranes

Appendix 1

Latent phase assessment tool

To be used as a tool to help determine the care offered to women in the latent phase of labour. The tool is not prescriptive; women's individual circumstances will vary. The woman's choice and the midwives clinical judgement remain key elements when determining care

The tool is to be used for **low risk** women following a comprehensive assessment of maternal and fetal wellbeing (as per guideline for admission to triage).
The women must fulfil the following criteria:

- Spontaneous labour between 37 and 42 weeks
- Cephalic presentation
- No evidence of SROM
- Maternal and fetal observations within normal parameters

Criteria		**Score Primip**	**Woman's score**	**Score Multip**	**Woman's score**
Number of admissions	First admission in latent phase	0		0	
	Second admission in latent phase	1		1	
	Third admission in latent phase	2		2	
Overall demeanour	Calm/Controlled	0		0	
	Some anxiety/ withdrawn/ inwardly focused	1		2	
	Distressed/anxious/out of control	2		3	
Analgesia	None/non pharmacological	0		0	
	Oral analgesia	1		1	
	Entonox/Opiates	3		3	
Social issues/ support	Well supported/no social issues	0		0	
	Some support/some social concerns/ problems with transport	1		1	
	No support/social concerns/ transport difficulties	3		3	
Contractions	Irregular/mild	0		1	
	Moderate/regular	1		4	
	Strong/regular/frequent	2		5	
Vaginal assessment	Closed <2cms	0		0	
	>2cms but <3cms	2		1	
	>3cms but <4cms	5		2	
			Total:		**Total:**

Assessment of scores and suggested management

	Advice/Home	**Offer admission for observation**	**One to one care**
Primip	0 - 6	7 - 12	>12
Multip	0 - 6	7 - 11	>13

Obstetric Guideline Checklist

Guideline for the Management of the Latent Phase of Labour	**Lead Professional** B Godwin, S Stables, G Dunning,

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