Humber, Coast and Vale
Local Maternity System

Latent Phase of Labour
Guideline

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Approval by:	Uma Rajesh and Aparna Manou, LMS Clinical Leads
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1. INTRODUCTION

This guideline, that was written by HUTH Maternity Services, has been adopted with thanks for use across HCV.

The aim of this guideline is to provide clear guidance when assessing and caring for women in labour both by telephone and in person.

It is intended that this guideline is used for women deemed to be at low risk of developing problems in the intrapartum period. Normal labour is a physiological process characterised by an uncomplicated pregnancy with a spontaneous onset of labour between 37 and 42 weeks gestation. The aim is to encourage a positive and flexible approach which facilitates choice for women.

This guideline encourages a consistent approach whilst not forgetting the uniqueness of each woman's experience and the importance of evidence-based practice, team approach and good communication. It also aims to facilitate a safe birth with the minimum amount of intervention and maximum amount of support and control for the woman.

2. PURPOSE

To support, inform and empower women and the midwives caring for them, during the latent phase of labour, thereby enabling the midwives to provide the best possible care

To provide a framework for midwives in recognising the latent phase of labour and when intervention may be necessary

The latent phase of labour can be defined as the period of time, not necessarily continuous, when there are painful uterine tightenings and there is some cervical change, including cervical effacement and dilatation up to 4 cm (NICE 2007). There is little evidence to suggest how long the latent phase of labour may last but if the labour is spontaneous in a normal, term, healthy pregnancy this could be up to 20 hours in a first pregnancy and up to 6 hours in subsequent pregnancies (Chelmow, 1993).

3. GUIDELINE DETAILS

3.1 Scope of practice

This guideline is applicable to women with an uneventful, term, healthy pregnancy with a singleton cephalic fetus between 37+0 and 40+13 weeks gestation.

3.2 Core assumptions

This guideline has been developed around the set of core assumptions that underpin the physiology that care remains woman centred, is informed by international standards and is evidence-based best practice.

These assumptions are:

- labour and birth are considered to be a natural physiological process until identified otherwise
- there should be a valid medical reason before intervening with the process of normal labour and birth
- the woman will be kept informed of the progress throughout labour

- the clinician, in partnership with the woman, is responsible for informed decision- making
- collaboration and co-operation between the multidisciplinary professional groups underpins optimal care for all women
- there will be appropriate and timely escalation processes to expedite decision- making and any necessary actions.

3.3 Rationale

In 2000 Walsh concluded that the Labour Ward is not an appropriate environment for women who are in the latent phase of labour. Barnett et al (2008) stated the reasons given by women for wanting to be in hospital during the latent phase include:

- the influence of others
- reassurance
- coping
- sleep deprivation.

Managing these emotional issues is key in reducing women's levels of anxiety. Women feel vulnerable and need reassurance that what they are experiencing is normal and midwives should acknowledge their important role in providing this reassurance.

3.4 Antenatal Period

Women who are prepared for and understand the latent phase of labour are more likely to be in active labour on their first admission to hospital (Maimburg et al, 2010). This is linked to a shorter labour, reduced epidural uptake, reduced use of synthetic oxytocics and a more positive birthing experience (McNiven et al, 1998).

It is good practice for the facilitator of any birth preparation classes to discuss with all women and preferably their birthing partners what to expect during the latent phase of labour.

This should include:

- How to cope with uterine tightenings
- Frequency and duration of tightenings and how they differ from Braxton Hicks
- The potential length of the latent phase
- Advise that the first stage of labour is defined as progressive cervical dilation from 4cm onwards with painful, regular uterine contractions (NICE, 2007)
- Recognition of a spontaneous rupture of membranes and other PV loss
- Encouragement to eat and drink as normal
- Recognition of altered/reduced fetal movements even during the latent phase of labour
- What would require a telephone call to a midwife (and which telephone number to call dependent upon planned place of birth)
- It is not always necessary to be admitted in the latent phase of labour if there are no complications
- Being informed that if all parameters remain normal the woman may be advised to return home following an admission if they are found not to be in established labour.

3.5 Early support using telephone triage sheet

The midwife should speak to the woman directly and take time to listen to the woman's story with empathy and concern. The telephone triage proforma (see appendix A) must be fully completed by the midwife who receives the call and gives advice.

The discussion will include the following:

- Discuss the woman's pregnancy and general health (identifying risk factors including any previous admissions)
- Discuss any previous pregnancies and births
- Ask about vaginal loss (including spontaneous rupture of membranes- assessment must include colour, amount and if any offensive odour)
- Discuss with the woman about fetal movements, including an altered/reduced pattern
- Give information about what to expect and coping strategies for uterine tightenings using all of the information on the telephone triage sheet
- The midwife can make a full assessment of the woman's needs and ask about any concerns she may have
- The discussion is to be of sufficient length to assess the frequency and duration of tightenings/contractions and how the woman appears to be coping
- Encourage support from birth partners (Cheyne et al, 2007)
- Explain staying at home is safe (if appropriate) which encourages the production of oxytocins as well as endorphins (her own natural pain relievers). Reassure this is a normal physiological process that may last up to 20hours in a first pregnancy and up to 6 hours in subsequent pregnancies
- Advise to continue normal activity, eat a light diet, ensure adequate hydration, take a warm bath and be advised to rest (Greulich and Tarrant, 2007)
- Midwives to use their professional judgment if recommending the woman should remain at home or attend the hospital
- Assess the woman's willingness to stay at home, method of transport and distance from the hospital
- Agree an individualised plan of care (RCM, 2012)
- Advise they can ring back at any time, especially if their condition changes.

3.6 Home management during latent phase of labour

The woman should be encouraged to:

- Perform normal activities
- Go for a walk and use of water (warm shower/baths)
- Distraction through listening to music, watching television, etc.
- Use of a TENs machine
- Focus on breathing techniques
- Relaxation and/or hypno-birthing
- Trying different positions and use of the birthing ball
- Use of hot water bottle/heat packs
- Use of massage
- Trying to rest/sleep
- Paracetamol 1g every six hours up to a maximum of eight tablets in 24 hours, if required.

3.7 When to invite the woman into the unit for a maternal and fetal assessment

Studies have shown women who are admitted to hospital in the latent phase of labour have higher rates of intervention (Holmes et al 2001, Bailit et al, 2005). Depending on the woman's preferences and personal circumstances, the woman can be invited to attend for assessment at any time but should be encouraged to attend:-

- If a third telephone call is received
- The midwife deems it necessary

- Where the latent phase has exceeded 20hours with almost continuous, painful contractions (considered prolonged)

This criteria also applies to women booked for a homebirth.

3.8 Clinical assessment on admission/attending planned homebirth

- Clinical observations to include MEOWS score (this should be repeated 4 hourly during the inpatient episode or earlier if clinically indicated)
- Abdominal palpation including fetal descent, presentation, rotation
- Contraction strength, frequency and duration
- Length of time in the latent phase
- Vaginal assessment – assessing for cervical changes
- Urinalysis
- Assessment of rest periods during the latent phase of labour
- Ability of the woman to cope
- Assessment of fetal wellbeing (an admission CTG is not recommended in a low risk pregnancy-NICE, 2007)

The fetal heart should be auscultated and the woman asked about fetal movements at a minimum every four hours whilst an inpatient.

3.9 In hospital analgesic management of the latent phase of labour

- Co-codamol 8/500mg, maximum 8 tablets within 24hours, if required
- After all other analgesia options (see the listed criteria above) have been exhausted opiate analgesia may be considered after discussion with the woman. Pethidine 100mgs IM can be given twice in the latent phase of labour, following prescription by an obstetric doctor. If further doses are required a full clinical assessment by a senior midwife is indicated, this may also trigger escalation to the obstetric medical team.

3.10 Discharge in the latent phase of labour

It is important to complete a full ongoing clinical review prior to the woman being considered for discharge during the latent phase of labour. This should include the woman's ability to cope and they must feel confident with the decision. Ensure the woman and her family are made to feel welcome and are able to return to the hospital if she feels her condition has changed. A repeat vaginal examination can be considered as this will identify clinical situations where discharge may not be appropriate for example a woman who began contracting only one hour ago and has a cervix which is 2cms dilated and fully effaced.

3.11 Prolonged latent phase

If there are no cervical changes despite ongoing regular painful tightenings, a diagnosis of prolonged latent phase of labour can be made. It is recommended that in this instance a risk assessment is made and if necessary referral is made to a senior obstetrician to assist in care planning. In some cases, particularly if the gestation is post mature it may be appropriate to induce labour.

If any of the following signs or symptoms are present, referral to a senior obstetrician-

- **Fetal Distress**
- **Maternal exhaustion**

- **MEOWS assessment 2 or above**
- **Dehydration/Ketosis**
- **Prolonged latent phase of labour (of more than 20 hours)**

If the woman is admitted to the hospital for observation, it is vitally important an ongoing continual risk assessment is undertaken by the midwife to ensure any deviations from normal are actioned and escalated for appropriate senior obstetrician medical review. There must be a documented plan of care regarding the type of and frequency of fetal monitoring and maternal observations required, dependent upon the full clinical picture.

4. PROCESS FOR MONITORING COMPLIANCE

This guideline will have a full review every three years to ensure compliance with current best evidence based practice. Any interim amendments to reflect practice changes will be made in a timely manner.

5. REFERENCES

1. Bailit JL, Dierker L, Blanchard et al. (2005) Outcomes of women presenting in active versus latent phases of spontaneous labour. British Journal of Obstetrics and Gynaecology 105(1): 77-79
2. Barnett C, Hundley V, Cheyne H, et al. (2008) 'Not in labour': impact of sending women home in the latent phase. British Journal of Midwifery. 16(3): 144-153
3. Chelmow, D., Kilpatrick, S.J., Largos, R.K., Jr. , Maternal and neonatal outcomes after prolonged latent phase. Obstetrics and Gynecology 1993. 81(4): p. 486-91
4. Cheyne H , Terry R, Niven C, et al. (2007) "Should I come in now ?" a study of women's early labour experiences. British Journal of Midwifery (15) 10:604-609.
5. Greulich, B. and B. Tarrant, The latent phase of labor: diagnosis and management. Journal of Midwifery & Women's Health, 2007. 52(3): p. 190-198
6. Holmes P, Oppenheimer L, Wen S, (2001) The relationship between cervical dilation at initial presentation in labour and subsequent intervention. British Journal of Obstetrics and Gynaecology 108: 1120-1124
7. Maimburg RD, et al (2010) Randomised trial of structured antenatal training sessions to improve the birth process. British Journal of Obstetrics and Gynaecology 117:921- 928.
8. McNiven P, Williams J, Hodnett E, et al (1998) An early assessment programme: A randomised control trial. Birth 25:5-10
9. Mercer, J.S., et al., Delayed cord clamping in very preterm infants reduces the incidence of intraventricular hemorrhage and late-onset sepsis: a randomized, controlled trial. Pediatrics, 2006. 117(4): p. 1235-1242
10. Munro J. and Jokinen M. Latent Phase Midwifery Practice Guideline in RCM Evidence based guidelines for midwifery – led care in labour 4th edition. 2008
11. National Institute for Health and Clinical Excellence, Intrapartum Care; care of healthy women and their babies during childbirth., in London: RCOG.2007
12. Royal College of Midwives (2012) Evidenced based Guidelines for Midwifery Led Care in Labour. 5th edition. London RCM.
13. Walsh, D., Part three: assessing women's progress in labour. British Journal of Midwifery, 2000. 8(7): p. 449-57

APPENDIX A – Telephone Triage template

Speak to the woman directly. Telephone call to be of sufficient length to assess frquency & duration of contractions and how the woman is coping					**Name:** (Speak to the woman directly)
REASON FOR CALL:					**HEY number:**
Medical History					**Address:**
Obstetric History / Previous admissions					**EDD:____/____/____ G____P ____ Gestation:_____+____**
Current Pregnancy	**(Must circle) CLC or MLC**				
		1st Call	**2nd Call**	**3rd Call**	
Normal FM / NO	YES				
SROM / NO If Yes: Descent of pp ≥ 3/5, admit) Presentation Any signs of infection Colour of liquor GBS?	YES (If				
PV loss YES/NO					
Abdominal pain YES/NO					
Contractions YES/NO					
Please tick the advice you have given					
Mobilise to enable gravity to aid labour & continue normal activity					
Consider the use of massage/TENS					
Soak in warm bath & advise rest					
Paracetamol 2 tablets every 6 hours max 8/24					
Wear a pad to observe vaginal loss					
Encourage light diet & adequate hydration					
Latent phase of labour can last upto 20 hours					
Staying at home is safe & aids endorphins					
Ask woman how she is feeling following discussion & agree a plan of care					**If the woman is remaining at home, reassure she can ring back at any time**
Date & Time					**Advise admission if 3rd telephone call, the midwife deems it necessary or the latent phase of labour is prolonged**
Print & Signature					