1. **Aim/Purpose of this Guideline**

1.1 To provide a framework for the best possible care, including self-management, for women during the latent phase of labour.

1.2 This guideline applies to all midwives assessing women in the latent phase of labour who are planning an expectant birth between 37-42 weeks gestation.

2. **The Guidance**

2.1 **Definition of latent and established first stages of labour**

The timely diagnosis of active labour is acknowledged as problematic both for women and their caregivers (RCM 2012). For the purposes of care provision use the following definitions of labour:

**Latent phase of labour** is defined as a period of time, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilation up to 4cm.

**Established first stage of labour** - when: there are regular painful contractions and there is progressive cervical dilatation from 4cm (NICE 2007)

2.2 **Education**

Women should be given information antenatally about:

- What to expect in the latent phase of labour
- Coping strategies for any pain they may experience.
- How to contact their midwife (09:00-17:00) or Maternity Triage Service (01872 25 2788 between 17:00 – 09:00)

An in-depth discussion should include:

- How to differentiate between Braxton-Hicks contractions and active labour contractions
- The expected frequency of contractions and how long they last
- Recognition of amniotic fluid (“waters breaking”)
- Description of normal vaginal loss including after a membrane sweep (NICE 2014)
- The RCHT patient information leaflet: *The latent phase of labour: what it is and how to cope* should be given to women at 36 weeks gestation in addition to verbal information
- Women should receive a clear message that they will be advised to return home if they are found not to be in established labour.

2.3 **Telephone Triage**

Speak to the woman directly. If English is not her first language and there is difficulty with communication, then a face to face assessment is recommended.
During the telephone conversation, as a minimum, the clinician should establish:

- The woman’s account of her pregnancy (including any risk factors) and possible signs of labour she is experiencing
- The strength, frequency and duration of any contractions and how well the woman appears to be coping with these contractions
- Any vaginal loss the woman may have experienced (including SROM)
- Ask the woman about the baby’s movements, including any changes
- Ask the woman how she is, and about her wishes, expectations and any concerns she may have
- Give information about what to expect in the latent phase of labour and coping strategies for any pain they may experience
- Agree a plan of care including who she should contact next and when.
- The telephone call should be of sufficient length to assess how the woman copes during a contraction.
- If a third telephone contact is made the midwife should invite the woman for assessment in the community, the birth centre or maternity unit
- The triage midwife should document the guidance that she gives to the woman (NICE 2014). Use the RCHT Labour Triage assessment proforma document advice given to the woman and guide questions.

2.4 If the woman seeking advice/ attends for assessment reports painful contractions, but is not in established labour:

- Reassure her that some women experience pain without cervical change, and although these women are described as not being in labour, they may think of themselves as “being in labour”
- 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 (NICE 2014)
- Advise the woman to eat and drink normally and to ensure that as well as periods of activity, she should rest from time to time (particularly at night when she would normally be asleep) to conserve her strength and energy
- Offer her individualised support and analgesia if needed
- Acknowledge that a longer latent phase can be distressing, demoralising and exhausting: treat every woman as an individual and consider her own particular needs and wishes when discussing and agreeing a plan of care.
Before suggesting that a woman returns to or remains at home, ensure that an holistic assessment is carried out and all relevant considerations (how she appears to be coping, degree of support, the nature of contractions, any comorbidities) **not just the assessment of the woman`s cervix** have been considered.

For those women who are distressed and do not wish to return home **do not insist that they returns home against their wishes**.

### 2.5 Pain relief

- Advise the woman and her birth companions that breathing exercises, immersion in water, TENS and massage may reduce pain during the latent phase.
- Advise that Paracetamol 1g may be taken every six hours up to a maximum of eight tablets in 24 hours.
- Do not advise aromatherapy, yoga or acupressure for pain relief. If the woman wishes to use any of these, respect her wishes *(NICE 2014)*.
- If the woman is finding it difficult to cope with a longer latent first phase of labour in-patient administration of opiate analgesia may be considered.

### 2.6 Face to Face Triage Assessment

Following telephone triage the midwife may decide to invite the woman to attend the birth centre or maternity unit for further assessment. Labour assessment should comprise of one to one midwifery for at least 1 hour *(NICE 2014)*. When performing an assessment, listen to the woman`s story and take into account her preferences and emotional and psychological needs *(NICE 2014)*. Guidance and support should also be provided to the woman`s birth companions *(NICE 2014) (new 2016)*.

#### 2.6.1 Observations of the woman:

- Review the antenatal notes and discuss these with the woman
- Ask her about the length, strength and frequency of her contractions
- Ask her about any pain she is experiencing and discuss her options for pain relief
- Record her pulse, blood pressure, respiration rate, temperature and urinalysis
- Record if she has had any vaginal loss *(new 2016)*

#### 2.6.2 Observations of the woman indicating obstetric review or transfer to Delivery Suite

- Maternal pulse .120 bpm on 2 occasions 30 minutes apart
- A single reading of either diastolic BP of 110 mmHg or more or systolic BP of 160 mmHg
- Either raised diastolic BP of 90 mmHg or more or raised systolic BP of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart
- A reading of 2+ protein on urinalysis and a single reading of either raised diastolic BP (90 mmHg or more) or raised systolic BP (140 mmHg or more)
• Temperature of 38 °C or above on a single reading or 37.5° or above on two consecutive readings two hour apart
• Any vaginal blood loss other than a “show”
• The presence of significant meconium
• Pain reported by the woman that differs from the pain normally associated with contractions
• Any risk factors recorded in the woman’s notes that indicate the need for obstetric – led care (unless there is a documented “outwith guidelines” care plan in the woman`s notes and no new risk factors or concerns developed since the plan was made) (new 2016)

2.6.3 Observations of the unborn baby:
• Ask the woman about the baby`s fetal movements in the last 24 hours (new 2016)
• Palpate the woman`s abdomen to determine fundal height (and document on GROW chart), the baby`s lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions
• Auscultate the fetal heart rate for a minimum of one minute immediately after a contraction and record as a single rate (NICE 2014) Use a Pinard stethoscope initially.
• Do not preform CTG for women with a low-risk pregnancy (NICE 2014)
• Offer CTG if any risk factors and explain why it is necessary (NICE 2014) (new 2016)

2.6.4 Observations of the unborn baby indicating obstetric review or transfer to D/S
• Any abnormal presentation including cord presentation
• High (4/5 -5/5 palpable) or free head in a nulliparous woman
• Suspected SGA or macrosomia
• Suspected anhydramnios or polyhydramnios
• Fetal heart rate baseline below 110 bpm or above 160 bpm
• Reduced fetal movements in the last 24 hours reported by the woman (new 2016)

2.6.3 Vaginal Examination
• Offer vaginal examination if it will add important information to the decision-making process, it may not always be necessary if it is thought that the woman is not in labour and she does not wish it.
• All multiparous women must be encouraged to remain in a midwife led or hospital setting for 1 hour post vaginal assessment, even if in latent phase, prior to discharging home (NEW 2016)
• Explain the reason for the examination and what will be involved.
• Ensure the woman’s informed consent, privacy dignity and comfort
• Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth partner (NICE 2014) (new 2016)

If established labour is not diagnosed then encourage the woman to return home and inform her that that fear and anxiety often inhibit labour which can result in additional interventions when in hospital. For these reasons the best place for her to be during the latent phase of labour is at home where she can feel more comfortable and relaxed.

• Ensure the woman has a copy of the latent phase of labour patient information leaflet
• The triage midwife should document the guidance that she gives to the woman (NICE 2014)
• If there is a delay in performing the labour assessment of more than one hour from admission (or before if clinically appropriate) escalate to the Delivery Suite Co-ordinator using SBARD.
• If the birth is imminent, assess whether birth in the current location is preferable to transferring the woman to Delivery Suite. Discuss with the D/S Co-ordinator (NICE 2014) (new 2016)

2.7 Practices which may have a negative impact on woman’s experience
• Avoid referring to women as “only” being in latent phase or “not in labour” as this can devalue the woman’s experience
• Focussing on only objective measures such as frequency of contractions. By the midwife focussing on the woman’s experience, the woman may be less anxious and consequently not require early admission

2.8 Management of Prolonged latent phase of labour
Prolonged latent phase lasting > 8 hours may be seen a small percentage of women.
• If the cervix is < 4cm dilated but the woman is obviously distressed and needing additional analgesia consider offering TENS and/or an injection of opiate analgesia as opposed to Entonox
• Reassess in 4 hours
• If there is no cervical change and contractions are less frequent, irregular or less painful discharge home with a clear plan for return or review
• If there is no cervical change and still <4cm but contractions are still painful consider further analgesia
• Reassess after 4 hours. If there is still no cervical change despite regular painful contractions then diagnosis of prolonged latent phase is made. Discuss with Co-ordinating Midwife and senior obstetrician regarding management and consider augmentation with artificial rupture of membranes (ARM) (new 2016)

References
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance</th>
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</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Maternity Forum</td>
</tr>
<tr>
<td>Tool</td>
<td>1. On the Maternity Telephone Triage Assessment Record is there documentation of:  2. Assessment of the woman  3. Advice for early labour  4. Is the plan of care complete  5. Are labour assessments during the hours of 9am to 5pm 7 days per week were carried out by community midwives  6. Was a vaginal examination performed when the patient was considered to be in the latent phase of labour?  7. Did the woman stay for a period of time of no less than an hour?</td>
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<tr>
<td>Frequency</td>
<td>Once in the lifetime of the guideline or earlier is identified through risk management</td>
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<tr>
<td>Reporting arrangements</td>
<td>• Maternity Forum and the Clinical Audit Forum  • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Maternity Risk Forum and Clinical Audit Forum and an action plan agreed</td>
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<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>• Maternity Risk Management Forum and Clinical Audit Forum will develop an action plan  • Action plan leads will be identified and a time frame for completed actions</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>• Required Changes to practice will be identified and actioned within a time frame agreed on the action plan  • A lead member of the forum will be identified to take each change forward where appropriate  • The results of the audits will be distributed to all staff through the Risk Management Newsletter as per the action plan</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.
4.2. *Equality Impact Assessment*

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>CLINICAL GUIDELINE FOR MANAGEMENT OF LATENT STAGE OF LABOUR</th>
</tr>
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<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>3rd November 2016</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>3rd November 2016</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>3rd November 2019</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Karen Stoyles, Bereavement Specialist midwife</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872252149</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>This guideline applies to all midwives assessing women on the telephone and face to face in the latent phase of labour who are planning an expectant birth between 37 – 42 weeks gestation.</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Latent Labour Stage Management Pregnancy Phase</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>3rd November 2016</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Latent Phase of Labour – Clinical Guideline</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>Maternity Guidelines Group Obs and Gynae Directorate</td>
</tr>
<tr>
<td><strong>Divisional Manager confirming approval processes:</strong></td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories:</strong></td>
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</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
<tr>
<td><strong>Document Library Folder/Sub Folder</strong></td>
<td>Clinical / Midwifery and Obstetrics</td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
<td></td>
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<tr>
<td><strong>Related Documents:</strong></td>
<td>• NICE (2007) Intrapartum care: management and delivery of care to</td>
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Training Need Identified?

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>2 Apr 2015</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Karen Stoyles Antenatal Ward &amp; DAU Lead Midwife</td>
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| 4th August 2016 | V1.2       | • Amendments to information surrounding assessment face to face and telephone  
              |                         | • Addition of minimum time required to conduct assessment  
              |                         | • Addition of Appendix 1 to list risk factors                    | Rob Holmes Obs and Gynae Consultant  
              |                         |                                                                                     | Sarah Harvey-Hurst Antenatal Ward and DAU Deputy Ward Sister |
| 4th August 2016 | V1.2       | Amended to include the recommendation of one hour minimum stay post VE in hospital | Sarah-Jane Pedler Practice Development Midwife |
| 3rd November 2016 | V1.3     | Updated post SI                                                                    | Karen Stoyles, Bereavement Specialist Midwife |

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

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Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th>Name of individual completing assessment: Karen Stoyles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Obs and Gynae Directorate</td>
<td>Telephone: 01872 255149</td>
</tr>
<tr>
<td>Is this a new or existing Policy? Existing</td>
<td></td>
</tr>
</tbody>
</table>

1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?

To provide a framework for the best possible care, including consistency of advice and self –management for women during the latent phase of labour.

2. Policy Objectives*

Appropriate and timely management of women presenting or contacting midwives for advice when in the latent phase of labour.

3. Policy – intended Outcomes*

Reduction in unnecessary hospital attendances and improve patient experience for pregnant women.

4. *How will you measure the outcome?

Compliance Monitoring Tool.

5. Who is intended to benefit from the policy?

All pregnant women.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

No.

b) If yes, have these groups been consulted?

N/A

C). Please list any groups who have been consulted about this procedure.

N/A

7. The Impact

Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
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</tbody>
</table>

Draft Clinical Guideline for Management of the latent phase of labour

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| Sex (male, female, trans-gender / gender reassignment) |  |
| Race / Ethnic communities /groups |  |
| Disability - learning disability, physical disability, sensory impairment and mental health problems |  |
| Religion / other beliefs |  |
| Marriage and civil partnership |  |
| Pregnancy and maternity |  |
| Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian |  |

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No

9. If you are not recommending a Full Impact assessment please explain why.

| Signature of policy developer / lead manager / director | Date of completion and submission |
| Names and signatures of members carrying out the Screening Assessment | 1. Karen Stoyles 2. |

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler

Date 3rd November 2016