Latent Phase of Labour Management
Clinical Guideline

V2.2

July 2020
1. **Aim/Purpose of this Guideline**

1.1. To provide guidance to Midwives and Obstetricians on the management of latent phase of labour.

1.2. This version supersedes any previous versions of this document.

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the Information Use Framework Policy or contact the Information Governance Team rch-tr.infogov@nhs.net

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals (NEW 2020).

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:

2.1.1. **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 (NICE 2017).

2.1.2. **Established first stage of labour** when there are regular painful contractions and there is progressive cervical dilatation from 4cm (NICE 2017)

2.2. **Education**

2.2.1. 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 8000 between 17:00 – 09:00)

2.2.2. 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)

• Discuss fetal movements and encourage the woman to report any changes. Explain that a reduction in fetal movements is not normal in either the latent phase or established labour (New 2019)

• 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:

2.3.1. 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. Use the trust translation telephone service via the intranet. (New 2019)

2.3.2. 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

• If a woman requires analgesia see section 2.7 (New 2019)

• 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.

• Following telephone triage the midwife may decide the woman needs a face to face assessment. When performing an assessment, listen to the woman’s story and take into account her preferences and emotional and psychological needs (NICE 2017). Guidance and support should also be provided to the woman’s birth companions (NICE 2017)

• 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 2017). Use the RCHT Labour Triage assessment proforma and document the advice given to the woman. See Appendix 3 (New 2019)

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”

   • 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 2017)

   • 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, please see section 2.7 (New 2019)

- 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 a holistic assessment is carried out. If this is a face to face assessment then auscultate the fetal heart. (New 2019)

- Ensure all relevant considerations (how she appears to be coping, degree of support, the nature of contractions, any comorbidities or risk factors not just the assessment of the woman’s cervix have been considered. (New 2019)

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

2.5. Face to Face Triage Assessment
2.5.1. Observations of the woman:
2.5.1.1. Review the antenatal notes, identify any risk factors (New 2019) and discuss these with the woman

2.5.1.2. Ask her about the length, strength and frequency of her contractions

2.5.1.3. Ask her about any pain she is experiencing and discuss her options for pain relief (See section 2.7)

2.5.1.4. Record her pulse, blood pressure, respiration rate, temperature (MEOWS) urinalysis and fetal heart for every admission (New 2019).

2.5.1.5. Record if she has had any vaginal loss

2.5.1.6. 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.

2.5.1.7. 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 2017)

2.5.1.8. Women should not be discharged home until they have been assessed for at least one hour after admission. (New 2019)
2.5.2. **Observations of the woman indicating obstetric review or transfer to Delivery Suite:**

- Maternal pulse 120 bpm on 2 occasions 30 at least minutes apart

- A single reading of either diastolic BP of 110 mmHg or more or systolic BP of 160 mmHg or more.

- Either raised diastolic BP of 90 mmHg or more or raised systolic BP of 140 mmHg or more on 2 consecutive readings taken at least 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 at least two hours apart

- Any vaginal blood loss other than a bloody “show” (*New 2019*).

- The presence of 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 “outside guidelines” care plan in the woman’s notes and no new risk factors or concerns developed since the plan was made).

2.5.3. **Observations of the unborn baby:**

2.5.3.1. Ask the woman about the baby’s fetal movements in the last 24 hours

2.5.3.2. Palpate the woman’s abdomen to determine fundal height and document on GROW chart (This is not necessary if the patient is having serial growth USS) the baby’s lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions.

2.5.3.3. Auscultate the fetal heart:

- Initial assessment should be performed by using a pinard stethoscope or handheld Doppler
• The baseline of the fetal heart (FH) should be assessed when the fetus is at rest and between contractions.

• The fetal heart must be auscultated and counted for a full minute and the value recorded as a single figure (i.e. not as a range)

• The normal rate is 110 – 160 bpm but consideration must be given to what is expected for each individual fetus.

• Following palpation of a contraction, the FH must be auscultated for a full minute. This will enable identification of decelerations and overshoots.

• Intermittent Auscultation cannot establish the type of deceleration, therefore any deceleration heard will warrant further investigation.

• Fetal activity is a positive feature of fetal well-being. Fetal movement (FM) must be discussed. Auscultation of the fetal heart at the time of FM should reveal acceleration, demonstrating a non-hypoxic fetus.

2.5.3.4. Do not perform CTG for women with a low-risk pregnancy (NICE 2017)

2.5.3.5. Risk assess the need for a CTG if any risk factors and explain why it is necessary (NICE 2017) (New 2019)

2.5.3.6. Do not use Dawes Redman criteria as it is not valid during the Latent Phase of labour (Redman statement 2019) (New 2019). Use traditional CTG and perform a structured review of all the features; document the classification on the preformatted antenatal CTG sticker at the end of the trace.

2.5.4. Observations of the unborn baby indicating obstetric review or transfer to D/S:
• Any abnormal presentation including cord presentation

• Suspected SGA or macrosomia

• Suspected anhydramnios or polyhydramnios

• Abnormality of FH detected: Abnormal baseline, rising baseline, presence of decelerations, repetitive overshoots. (New 2019)
Reduced fetal movements in the last 24 hours reported by the woman

2.5.5. Vaginal Examination:

2.5.5.1. 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.

2.5.5.2. All multiparous women must be encouraged to remain in a midwife led or hospital setting for 1 hour post vaginal assessment, if in latent phase, and auscultate the fetal heart prior to discharging home (New 2019)

2.5.5.3. Explain the reason for the examination and what will be involved.

2.5.5.4. Ensure the woman has given informed consent and ensure her privacy dignity and comfort

2.5.5.5. Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth partner (NICE 2017)

2.5.5.6. Do not perform a stretch and sweep unless consent has been gained by the woman prior to the examination. (New 2019)

2.5.5.7. 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.

2.5.5.8. Ensure the woman has a copy of the latent phase of labour patient information leaflet

2.5.5.9. The triage midwife should document the guidance that she gives to the woman (NICE 2017)

2.5.5.10. If the woman is reluctant to go home in the latent phase of labour it would be acceptable to advise her to mobilise for 2 hours and then offer a 2 hourly review +/- a vaginal examination. (New 2019)
2.6. Practices which may have a negative impact on woman’s experience:
   2.6.1. Avoid referring to women as “only” being in latent phase or “not in labour” as this can devalue the woman’s experience
   2.6.2. 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

2.7. Pain relief
   2.7.1. Advise the woman and her birth companions that breathing exercises, immersion in water, TENs and massage may reduce pain during the latent phase
   2.7.2. Advise that Paracetamol 1g may be taken every six hours up to a maximum of eight tablets in 24 hours
   2.7.3. Women who receive Dihydrocodeine should be observed in hospital for at least one hour following administration and the fetal heart auscultated prior to discharge (New 2019).
   2.7.4. Pethidine should only be prescribed as a STAT dose by the obstetric team. Following this the woman should stay in the hospital for at least 4 hours and the fetal heart should be auscultated prior to her discharge if she goes home (New 2019).
   2.7.5. Any subsequent doses require review by a member of the obstetric team and further STAT prescription (New 2019)
   2.7.6. Any patient who receives two doses of pethidine in the latent phase should not be discharged home and should remain an inpatient. The woman should have an obstetric review if she does not establish labour and a CTG performed if deemed necessary by the Obstetrician (New 2019).
   2.7.7. It is important for clinicians to be aware that heavy sedation may occur following opiates including Dihydrocodeine and pethidine. This can present as a woman who appears to have stopped contracting whilst continuing to labour and is unware and relaxed due to the effects of analgesia (New 2019).
   2.7.8. If the woman wishes to use aromatherapy for relaxation purposes and if you are appropriately trained you can offer this as per the Aromatherapy and Massage Clinical Guideline (New 2019).

2.8. Management of Prolonged latent phase of labour
   There is no standard definition for prolonged latent phase of labour. The teaching literature for midwives states that early labour can take up to 6-8hrs.
However in reality it often lasts much longer and it is not unusual for women to be in the latent phase of labour for 2-3 days. (New 2019)

If a woman remains an inpatient during the latent phase contact should be made with the woman a minimum of 4 hourly or more frequently according to clinical need (New 2019).

These contacts should include:
- 4 hourly MEOWs (New 2019)
- 4 hourly assessment of fetal wellbeing by enquiry regarding fetal movements and auscultation of the fetal heart (New 2019)
- 4 hourly assessment of the length strength and frequency of contractions (New 2019)
- 4 hourly enquiry regarding general wellbeing including how she is coping and check that she passes urine regularly (New 2019)

### 3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>1. Are labour assessments during the hours of 9am to 5pm 7 days per week were carried out by community midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Was a vaginal examination performed when the patient was considered to be in the latent phase of labour?</td>
</tr>
<tr>
<td></td>
<td>3. Did the woman stay for no less than an hour?</td>
</tr>
<tr>
<td></td>
<td>4. Were women advised to remain inpatients appropriately if receiving analgesia not available over the counter (pethidine, Oramorph or Dihydrocodeine)</td>
</tr>
<tr>
<td></td>
<td>5. Were multiparous women advised to stay for a minimum of 1 hour post VE?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lead</th>
<th>Audit midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool</td>
<td>Excel spread sheet used to analyse data</td>
</tr>
<tr>
<td>Frequency</td>
<td>Once in the lifetime of the guideline. Earlier if identified by patient safety</td>
</tr>
</tbody>
</table>
| Reporting arrangements | • 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 Forum and Clinical Audit meeting and an action plan agreed |
| Acting on recommendations and Lead(s) | • Maternity Forum and Clinical Audit meeting will develop an action plan  
• Action plan leads will be identified and a time frame for completed actions |
| Change in practice and lessons to be shared | • 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 Patient Safety Newsletter as per the action plan |
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, Inclusion & 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>Document Title</th>
<th>Latent Phase of Labour Management Clinical Guideline V2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Latent Phase of Labour Management Clinical Guideline V2.1</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>2nd July 2020</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>July 2020</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>September 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Sarah Harvey-Hurst, Antenatal Ward Manager</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252 149</td>
</tr>
<tr>
<td>Brief summary of contents</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>
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<tr>
<td>Suggested Keywords:</td>
<td>Latent Labour Stage Management Pregnancy Phase</td>
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<tr>
<td>Target Audience</td>
<td></td>
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<tr>
<td></td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✓</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Maternity Guidelines Group Obstetrics and Gynaecology Directorate</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Debra Shields</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>Not required</td>
</tr>
</tbody>
</table>

**References:**
- Redman C. Statement on the use of Dawes
### Training Need Identified?
No

### Publication Location (refer to Policy on Policies – Approvals and Ratification):
Internet & Intranet  ✓  Intranet Only

### Document Library Folder/Sub Folder
Clinical/Midwifery and Obstetrics

### 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>
</tr>
</thead>
<tbody>
<tr>
<td>2 Apr 2015</td>
<td>V1.0</td>
<td>Initial version</td>
<td>Karen Stoyles, Antenatal Ward &amp; DAU Lead Midwife</td>
</tr>
<tr>
<td>4th August 2016</td>
<td>V1.1</td>
<td>• Amendments to information surrounding assessment face to face and telephone&lt;br&gt;• Addition of minimum time required to conduct assessment&lt;br&gt;• Addition of Appendix 1 to list risk factors</td>
<td>Rob Holmes, Obs and Gynae Consultant, Sarah Harvey-Hurst, Antenatal Ward and DAU Deputy Ward Sister</td>
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<tr>
<td>4th August 2016</td>
<td>V1.2</td>
<td>Amended to include the recommendation of one hour minimum stay post VE in hospital</td>
<td>Sarah-Jane Pedler, Practice Development, Midwife</td>
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<tr>
<td>3rd November 2016</td>
<td>V1.3</td>
<td>Updated post SI</td>
<td>Karen Stoyles, Bereavement Specialist Midwife</td>
</tr>
<tr>
<td>July 2019</td>
<td>V2.0</td>
<td>Full review to incorporate NICE recommendations 2017.</td>
<td>Sarah Harvey-Hurst, Truro Birth Centre Lead Midwife</td>
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<tr>
<td>December 2019</td>
<td>V2.1</td>
<td>2.5.3.6 Following a statement by Professor Redman. Dawes Redman analysis is not valid for Latent phase or early labour</td>
<td>Sally Budgen, Fetal Monitoring Lead midwife</td>
</tr>
<tr>
<td>July 2020</td>
<td>V2.2</td>
<td>GDPR updated template&lt;br&gt;1.3. Inclusion statement&lt;br&gt;2.5.5.2. the word ‘even’ removed&lt;br&gt;Appendix 1 updated Governance template&lt;br&gt;Appendix 2 updated EIA template</td>
<td>Sophie Haynes, Consultant Obstetrician</td>
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## Appendix 2. Initial Equality Impact Assessment

### Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Latent Phase of Labour Management Clinical Guideline V2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Obs and Gynae Directorate</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual/group completing EIA</td>
<td>Sarah Harvey-Hurst, Antenatal Ward Manager</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 25 2025</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). Who did you consult with?

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td></td>
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</tbody>
</table>

Please record specific names of groups:
Maternity Guidelines Group
Obstetrics and Gynaecology Directorate

### 6b). Please list any groups who have been consulted about this procedure.

### 6c). What was the outcome of the consultation?

Guideline approved
### 7. The Impact

Please complete the following table. If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have a positive/negative impact on:

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female non-binary, asexual etc.)</td>
<td></td>
<td>x</td>
<td></td>
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<tr>
<td>Gender reassignment</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Race/ethnic communities /groups</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)</td>
<td></td>
<td>x</td>
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<tr>
<td>Religion/other beliefs</td>
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<td>x</td>
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<tr>
<td>Marriage and civil partnership</td>
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<tr>
<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual orientation (bisexual, gay, heterosexual, lesbian)</td>
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<td>x</td>
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</tbody>
</table>

**If all characteristics are ticked ‘no’, and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.**

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

**Name of person confirming result of initial impact assessment:** Sarah Harvey-Hurst

**If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here:**

[Section 2. Full Equality Analysis](#)

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead [debby.lewis@nhs.net](mailto:debby.lewis@nhs.net)
# Appendix 3
## Maternity Telephone Triage Assessment Record

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date</th>
<th>Call start time</th>
<th>Call finish time</th>
<th>1st call today</th>
<th>Person calling if not patient</th>
<th>Contact No</th>
<th>Lead Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR Number</td>
<td></td>
<td></td>
<td></td>
<td>Yes / No</td>
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<td>DOB</td>
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<td>Address</td>
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</tr>
</tbody>
</table>

**Date** / / 201

**Call start time** .......................  **Call finish time** ..............

**1st call today**  Yes / No  (If 'No' turn page over)

**Person calling if not patient**

**Contact No**

**Lead Professional**

---

**Domestic violence may be a reason for contacting maternity services, consider this in your assessment**

<table>
<thead>
<tr>
<th>Parity:</th>
<th>EDD:</th>
<th>Gestation:</th>
<th>Blood Group:</th>
</tr>
</thead>
</table>

## SITUATION

**Reason for Call**

---

## BACKGROUND

**Previous pregnancies**

**Medical History**

**Previous LSCS? Yes / No**

**Current pregnancy (inc. previous admissions / DAU**

---

## ASSESSMENT

**Fetal Movements:** Normal / None / Reduced / Excessive

**First episode of reduced movements?** Y / N

**If fetal movements reduced - for how long?** ………………...hours

**PV Loss:** None / Mucoid / Clear / Green

**Blood** Old / fresh

**Amount** ………………..mls

**Contractions:**

**Date & time of onset**

**Frequency** ………………..

**Duration** ………………..

**Strength** ………………..

**Abdominal pain:** Y / N

**If yes location of pain**

**Headache** Y / N

**Blurred vision** Y / N

**Increasing oedema** Y / N

**Epigastric pain** Y / N

**Nausea** Y / N

---

Other professionals contacted before triage?

---

## RECOMMENDATION

**Advice for Early Labour**

**Paracetamol**

**Warm bath**

**TENS**

**Regular Snacks**

**Regular Fluids**

**Rest**

**Mobilise**

**Observe FMs**

---

**Plan**

**Stay at home / Ring back at** ……………….. / **Community Midwife / Penrice**

**TCL to D/S / Triage / Antenatal Ward / DAU appointment booked for** …………………………………………..(Date & time)

---

*All women who are thought to be in advanced labour are to be admitted directly to Delivery Suite*

---

**Call taken by**

**Signature**

**Print name**

**Designation**

---

---
### RECORD OF 2<sup>nd</sup> TELEPHONE CALL WITHIN 24 HOURS

**SITUATION - Reason for Call**

<table>
<thead>
<tr>
<th>Date:</th>
<th>/</th>
<th>201</th>
<th>Call Start Time</th>
<th>Call End Time</th>
</tr>
</thead>
</table>

**ASSESSMENT**

<table>
<thead>
<tr>
<th>Fetal Movements:</th>
<th>Normal</th>
<th>None</th>
<th>Reduced</th>
<th>Excessive</th>
<th>(please circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If fetal movements reduced - for how long?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PV Loss:</th>
<th>None</th>
<th>Mucoid</th>
<th>Clear</th>
<th>Green</th>
<th>(please circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>Old / fresh</td>
<td>Amount</td>
<td></td>
<td></td>
<td>mls</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contraction:</th>
<th>Date &amp; time of onset</th>
<th>Frequency</th>
<th>Duration</th>
<th>Strength</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Abdominal pain:</th>
<th>Y / N</th>
<th>If yes location of pain</th>
<th>Epigastric pain Y / N</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache Y / N</td>
<td></td>
<td>Blurred vision Y / N</td>
<td>Increasing oedema Y / N</td>
<td>Nausea Y / N</td>
</tr>
</tbody>
</table>

**RECOMMENDATION - Further Advice Given and Plan**

**Advice for Early Labour**

- Paracetamol
- Warm bath
- TENS
- Regular Socks
- Rest
- Mobilise

**Plan**

Stay at home / Ring back at ……………… / Community Midwife / Penrice
TCI to / D/S /Triage / DAU appointment booked for …………………..(Date & time)

*All women who are thought to be in advanced labour are to be admitted directly to Delivery Suite*

**Call taken by:**

Signature: 
Print name: 
Designation: 

---

### RECORD OF 3<sup>rd</sup> TELEPHONE CALL WITHIN 24 HOURS - INVITE IN IF 3<sup>rd</sup> CALL

**SITUATION - Reason for Call**

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<thead>
<tr>
<th>Date:</th>
<th>/</th>
<th>201</th>
<th>Call Start Time</th>
<th>Call End Time</th>
</tr>
</thead>
</table>

**ASSESSMENT**

<table>
<thead>
<tr>
<th>Fetal Movements:</th>
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<th>None</th>
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<th>Excessive</th>
<th>(please circle)</th>
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<tr>
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<td></td>
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</tbody>
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<table>
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<tr>
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<td></td>
<td>Blurred vision Y / N</td>
<td>Increasing oedema Y / N</td>
<td>Nausea Y / N</td>
</tr>
</tbody>
</table>

**RECOMMENDATION**

Revised plan - 3<sup>rd</sup> call - invite in

**Call taken by:**

Signature: 
Print name: 
Designation: 

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Latent Phase of Labour Management Clinical Guideline V2.2
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