Guideline for the Management of Early Latent Phase of Labour

Specialty: Maternity Services
Date Approved: May 2011
Approved by: W&CH Quality & Safety Group
Date for Review: April 2013
Definition

According to McNiven et al (1998) the Latent Phase of Labour is poorly understood and can be hard to define.

There is a lack of guidance for midwives on the significance of this phase and how best to care for women at this time (McDonald 2010)

The initial phase of labour is termed the latent phase. It begins at the point at which a woman perceives regular uterine contractions. These contractions gradually soften, efface and begin to dilate the cervix.

The end of the latent phase occurs when the active phase begins. Precise determination of the time that the latent phase ends is also problematic. The active phase is defined as the period when changes in the cervical dilation accelerate to at least 1 – 2 centimetres per hour and the fetus descends into the birth canal. A study of the transition from latent to active phase in uncomplicated pregnancies observed that 60% of women reached the latent active phase by 4 centimetres dilatation and 90% by 5 centimetres dilatation. (Peisner et al 1986)

Rationale

Barnett et al (2008) explored the themes which make women want to be in hospital in early labour. The results included:-

The influence of others
Reassurance
Coping
Sleep deprivation

All these themes affected women’s emotions and were key elements in the women’s levels of anxiety.

Care Bundle

Care bundles were first described by the Royal College Physicians in 2007. Care bundle theory says that there should be six ‘must do’ clinical interventions which will benefit and improve the outcomes for patients.

The latent phase care bundle aims to structure care by midwives when caring for women during the latent phase of labour and therefore ensuring better outcomes for both women and the babies.

Using the principles from the SELAN trial (Hodinett 2008) and the theory regarding care bundles the word LATENT has been used to structure care given to women by midwives. The latent phase care bundle is ‘Women Centred’ and ‘Women led’, enabling and encouraging women to tell their stories to their care givers.
Guideline

The following guideline has been developed to help midwives when caring for nulliparous women regardless of any risk factors. When nulliparous women are at least 28 weeks pregnant midwives should take every opportunity to discuss the latent phase at every contact.

The discussion should include:
Optimal fetal positioning
Signs of latent phase
Coping strategies and how the women can work with the pain they are experiencing to include:
• Mobilisation
• Water therapy
• TENS
• Massage
• Isotonic drink therapy and nutrient
• Birthing partners
• Home assessment and the importance of remaining out of hospital

According to Janneson (2004) the single predictor of an increasing caesarean rate is a woman’s perception that she has been in labour for more than 24 hours. The aim within ABMU Health Board is that during the antenatal period nulliparous women will be given information regarding the latent phase. This information will include coping strategies that women can adopt to help them cope with this phase of labour. Women need to know that the Latent Phase of Labour may last up to 48 hours before the commencement of the active phase of labour.

The latent phase discussion should take place in all the parent education sessions including:

• Traditional parent education
• One to one parent education with teenage women
• Aqua natal
• Active birth sessions
• Yoga in pregnancy
• A discussion regarding the latent phase should also take place at 36 weeks home visit

Contact with a midwife in the early latent phase of labour

When a midwife makes contact with a nulliparous woman in the latent phase, the care bundle should be used. The latent phase care bundle is ‘a woman’ led approach.

L is for looking at the woman and to listen to her story

The midwife should look at the woman, assess her body language, watch her during contractions and observe how well she is coping with the pain.

The midwife should listen to the woman’s story and document what she is saying in the latent phase booklet. (appendix 2)
A is for assessing maternal and fetal wellbeing

For a woman with an uncomplicated pregnancy the midwife should use part two of All Wales Clinical Pathway for normal labour (2003) to ensure that the pregnancy remains normal and is still low risk.

For a woman with risk factors, the midwife should document the risk factors and any agreed management plan for labour.

Assessment of maternal wellbeing:-

The following observations should be taken and recorded in the care bundle booklet,
- Maternal temperature, pulse, blood pressure
- Urinalysis
- Uterine contractions, frequency, strength and duration

Assessment of fetal wellbeing:-

The following should be undertaken and recorded in the booklet-
- Abdominal palpation to determine that the fetal lie is still longitudinal and remains in the cephalic position. The midwife should avoid discussing the position of the fetus but inform the woman on what positions she needs to adopt.
- A woman does not need an external cardiotocograph tracing to assess fetal wellbeing unless there is a clear indication to do so.
- The midwife needs to ask the woman about the pattern of her fetal movements and if possible listen to the fetal heart for 60 seconds after a contraction.

There are no recommendations on how often maternal and fetal observations need to be taken during the latent phase. This should be at the discretion of the midwife.

T is for time. Assessing the woman for at least 60 minutes

A woman in the latent phase of labour will have at least 60 minutes of a midwife’s time for the first assessment to take place. Whenever possible, the woman should be taken to a quiet area. The midwife doesn't have to remain with the woman constantly. However, the midwife needs to inform the woman that she is caring for her and observing her closely to determine what is happening at this stage of the labour.

E is for giving the woman encouragement

During the assessment the midwife needs to explore the woman’s thoughts and feelings regarding her labour and turn any negative thoughts into positive actions. The midwife should try to avoid statements such as ‘you are not in labour’ ‘you are not dilating’ ‘you have a long way to go yet’.

Any woman in the early latent phase of labour is at the beginning of her labour process. All comments and actions by the midwife should confirm this situation.
The midwife should also refrain from commenting about the size of the fetus. When terms such as ‘you are having a large baby are used’ some women become anxious and again the language that is used by health professionals can undermind women’s ability to birth normally. Always leave any woman with positive comments, such as ‘everything is fine and the baby is perfect for you’.

The midwife should re-emphasis the coping strategies for this period and concentrate on;

- Optimal fetal positioning
- Hydration including isotonic drink therapy
- Nutritional needs
- Mobilisation and rest periods
- The woman should be encouraged to mobilise during the daytime and sleep during the night.

**N is for Non pharmacological pain relief**

The concept of working with pain (Walsh 2009) as opposed to pain relief should be adopted with the woman.

To work with their pain, the woman should be encouraged to use;

- water
- paracetamol
- TENS
- when appropriate the woman’s birthing partner should be encouraged to and shown how to massage her back

**Only as the last resort and when every other coping strategy has been exhausted, should the woman be offered opioid injection and/or inhalation analgesia in the latent phase.**

**T is for telephone**

At the end of the assessment if the woman is thought to be in the early latent phase of labour and not yet in active labour she should be encouraged to go home. If she goes home during daylight hours the midwife should telephone her to enquire how she is coping with the latent phase. If possible the community midwife should be asked to make a visit to the woman’s home to determine how she is coping with the latent phase.

**Ongoing management plan**

At the end of the assessment together with the woman the midwife should write an on going management plan for the latent phase. This should include, coping strategies, analgesia for the woman and how her birthing partner can assist.

A diagnosis that the woman is in the latent phase should be documented in the notes.
Pain Score

The midwife should assess the woman’s level of pain using the pain scoring grid (appendix 3).

Only as the last resort and when every other coping strategy has been exhausted, should a woman be offered opioid injection and/or inhalation analgesia in the latent phase.

Evaluation and audit

The care bundle approach and a structured assessment and care by midwives in the latent phase will continue to be evaluated. Audit on the care bundle will be performed on annual basis whilst funding will be sought to undertake research to evaluate if the latent phase care bundle makes a difference to women’s care.

References


McDonald Ginny (2010) Diagnosing the latent phase of labour: use of the partogram British Journal of Midwifery October 630 - 637


Welsh Assembly Government (2003), All Wales Clinical pathway for Normal labour.
Appendix 1 Additional information

There is a lack of guidance for midwives on the significance of this phase and how best to care for women at this time (McDonald 2010)

Walsh’s observation in 2004 which was supported by Winter and Cameron in 2006 explored the myth that surrounded the different stages of labour. They stated that labour does not have a discrete beginning, thus determining the time of onset is a source of frustration for clinicians. The phenomenon of the latent phase of labour is questioned in theory but in clinical practice it appears to be an observable fact.

The initial phase of labour is termed the latent phase. It begins at the point at which a woman perceives regular uterine contractions. These contractions gradually soften, efface and begin to dilate the cervix.

This simple definition begins a complex process not completely understood by modern science. Women have irregular contractile activity beginning in the second trimester, with gradual alterations in the size, shape and consistency of the cervix occurring over the remaining months of the pregnancy. (Gronstrom et al 1989)

Cheyne et al (2007) explored the reasons why despite advice to stay at home in early labour, women insisted on going into hospital. Similar results showed the emotion of uncertainty regarding the women’s ability to cope with anticipated pain. On this study many women were found to be able to cope on admission, but they also reported that they wanted to be there ‘just in case’. Women’s experiences of being sent home was varied, some felt that they needed more support but some women were satisfied and felt that they had received the reassurance they needed to go home and continue labour alone.

The SELAN (Structured early labour assessment by nurses) trial results were published in the British Medical Journal in August 2008.

Hodnett et al (2008) undertook a randomised controlled trial in Canada and the United Kingdom. Women having their first babies in the latent phase of labour were either randomised into the intervention group or the control group. Women in the intervention group were seen by a ‘trained’ midwife. The ‘trained’ midwife
  • Assessed the woman for at least 60 minutes,
  • Encouraged the woman to have positive thoughts regarding her labour
  • Discussed the benefits of optimal fetal positioning
  • Talked about coping mechanisms and non pharmacological pain relief.

Women in the controlled group received the normal care.

The normal birth rate increased by 3% in the intervention group but this wasn’t statistically significant. However, women in the intervention group reported that they were more satisfied with their care.
# Appendix 2  Care Bundle – Latent Phase Documentation

**Care Bundle - Latent Phase**

<table>
<thead>
<tr>
<th>Initials</th>
<th>Name (print)</th>
<th>Designation</th>
<th>Care commenced (Date &amp;Time)</th>
<th>Care ceased (Date &amp;Time)</th>
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**Specialty:** Maternity Services  
**Date Approved:** 10th February 2010  
**Approved by:** W&CH Clinical Governance Committee  
**Date for Review:** January 2013
The latent phase of labour, especially for women expecting their first babies, will always be a challenge for midwives. If the latent phase is managed appropriately then many women will probably have a normal birth, if mismanaged many may experience a Caesarean Section. Although many factors may contribute to a prolonged latent phase, two problems consistently associated are high maternal anxiety and a mal-positioned fetal head.

Offering a structured approach may offer women the opportunity to prevent complications during a woman’s labour. The following Care Bundle for the Latent Phase has been based on the Structure Early Labour Assessment and Care by Nurses (SELAN Trial, Hodnett et al 2008).

Women that were randomised into the Structures Care Group were 3% more likely to have a normal birth even though this wasn’t statistically significant, women were also more satisfied with their care.

Midwives should adopt the following when assessing women either in hospital or at home in the **Latent** Phase:

**L Look and listen** - Observe the woman and take a history of her pregnancy and recent events.

**A Assess maternal observations** - Fetal heart, contractions - frequency / strength. Assess the pain using a pain score. Palpate the uterus to determine fetal position, if necessary, a vaginal examination.

**T Time** - Take the woman to a quiet area and give her time – approximately one hour. Watch and listen.

**E Encouragement** - Give her encouragement, ask her to describe her feelings. Talk to her to turn negative thoughts into positive thoughts. Discuss optimal fetal positioning.
**N** Non-pharmacological pain relief - Talk to the woman about coping mechanisms, breathing and relaxation techniques. Offer TENS, birthing balls. Discuss the use of heat and old, massage, showers and baths. Carry on every day activities, mobilising, eating and drinking as normal.

Pain Score Chart*:

<table>
<thead>
<tr>
<th>Pain score</th>
<th>Description</th>
<th>Action</th>
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<tbody>
<tr>
<td>3</td>
<td>Severe pain / agony; Pain causes extreme distress; Not smiling.</td>
<td>Vaginal examination; Consider water before opioids.</td>
</tr>
<tr>
<td>2</td>
<td>Moderate/bothersome pain; Pain causes distress but is able to perform activities; Still smiling.</td>
<td>Offer TENS, water, paracetemol before opioids; Consider vaginal examination.</td>
</tr>
<tr>
<td>1</td>
<td>Mild pain or discomfort.</td>
<td>Offer TENS, mobilisation, paracetemol, normal food and drink.</td>
</tr>
<tr>
<td>0</td>
<td>No pain; Comfortable.</td>
<td>No action required.</td>
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**T** Telephone - After you have left the woman, telephone to establish what is going on. If going off duty, give the woman the name of the midwife who will take over her care.
### Look and listen
- Observe the woman and take a history of her pregnancy and recent events

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### Assess maternal observations
- Fetal heart, contractions – frequency / strength. Assess the pain using a pain score. Palpate the uterus to determine fetal position, if necessary, a vaginal examination.

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Non-pharmacological pain relief - Talk to the woman about coping mechanisms, breathing and relaxation techniques. Offer TENS, birthing balls. Discuss the use of heat and old, massage, showers and baths. Carry on every day activities, mobilising, eating and drinking as normal. Use pain score 0-3 (see chart*)

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On going management plan agreed with the woman:
### Appendix 3

#### Pain Scoring Grid

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