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Guideline – Latent phase of Labour

Document History

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Approvals

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Distribution

This document is to be distributed to:

Name	Title
All All All	Midwives & Obstetric Medical Staff Operational Managers Service Managers General Manager

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1. Introduction

The management of the latent phase of labour, especially for women expecting their first babies, can be challenging. The evidence base would indicate that admission to hospital in latent phase of labour increases the likelihood of a cascade of intervention. The challenge for midwives lies in assisting the woman to stay at home until labour becomes established. This may be achieved by increasing the woman's confidence in her inherent ability to cope and work with her body.

Nolan (2005) states that some women expressed feelings of fear at home whilst in the latent phase of labour. Worrying leads to increased adrenalin levels thereby causing decreased oxytocin levels. A possible consequence of this is a woman presenting in an exhausted, tense and miserable state with irregular and inco-ordinate uterine activity.

Studies report that midwives attitudes can impact on women, a dismissive or critical attitude can have a negative impact on labour by further increasing adrenalin levels. During initial telephone conversations and face to face contact it is essential for the health care professional to be caring and compassionate (Draft Framework for Maternity Services 2010). Although many factors contribute to a prolonged latent phase, two problems consistently associated are high maternal anxiety and a mal-positioned fetal head. It is useful to consider both of these factors when offering advice and support to women

2. Aims of the guideline

This guideline aims to provide a structured approach for midwives to assist them in helping women manage the latent phase of labour.

The guideline is divided into three sections 1) telephone contact 2) face- to- face contact 3) admission to hospital in the latent phase of labour.

3.Telephone Contact

L Listen – Listen to what the woman has to say, take a history of her pregnancy and recent events and document on telephone triage form.

A Assess - Talk to the woman, assess contractions - frequency / strength. Note reaction to contractions during conversation. How does she feel she is coping? Enquire about fetal movements.

T Time – Give the woman time to tell her story, show interest and that you value her experience.

E Encouragement - Give her encouragement. Talk to her to turn negative thoughts into positive thoughts. Discuss positions for comfort. Has she a companion to offer support?

N Non-pharmacological pain relief - Talk to the woman about coping mechanisms such as the use of breathing and relaxation techniques, TENS and birthing balls. Discuss the use of heat and cold, massage, showers and baths. Encourage her to carry on every day activities, mobilising, eating and drinking as normal, advise to rest if appropriate.

T Telephone – during the conversation advise that staff are available for further consultation and inform her that she is welcome to call back for further advice or reassurance, or if she has any concerns.

During each telephone discussion the woman should be offered the option of a face to face assessment if she wishes. After the 3rd phone call the midwife will recommend that the woman comes in for assessment.

4.Face to Face Contact

NB. The NICE (National Institute for Clinical Excellence) definition of established labour is when there are regular painful uterine contractions and there is progressive cervical dilatation from 4cms.
The clinician 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 and fetal condition - Fetal heart , contractions - frequency / strength. Assess her pain and document in notes. Palpate the uterus to determine fetal position. Undertake a vaginal examination if indicated. Obtain urine sample.–correct ketosis by fluids and diet if appropriate. First set of observations should be in the format of a full MEWS score.
T Time - Take the woman to a quiet area and give her time – *one hour if at all possible* as the stress of change in environment can often make contractions decrease in frequency and strength. 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 positions for comfort.
N Non-pharmacological pain relief - Talk to the woman about coping mechanisms, breathing and relaxation techniques. Advise use of TENS, birthing balls. Discuss the use of heat and cold, massage, showers and baths. Carry on every day activities, mobilising, eating and drinking as normal.
If the woman is still distressed in latent labour, despite non-pharmacological methods of coping, initially try Paracetamol 1 gram. If no effect from this, 30mgs Dihydrocodiene may be prescribed by medical staff or a Non-medical prescriber (tablet to be given in maternity unit, women may be sent home following administration if discomfort settles).
T Telephone – if not in active labour advise that she is welcome to call back for further advice or reassurance or if any change in circumstances

Midwifery Led Care Pathway

After clinical assessment: Follow LATENT mnemonic
Ausculation of FH on admission and again prior to discharge
If not in established labour offer-

1. Home with advice
2. Offer Paracetamol 1 gram. Consider 30mgs oral Dihydrocodiene if necessary.
3. If admission required (i.e for anxiety/pain control/ geography) refer to section 5.

Consultant or Shared care pathway

After clinical assessment:
Follow LATENT mnemonic
Ausculation of fetal heart on admission, or CTG if clinically indicated.
If not in established labour -
Inform obstetric registrar, plan of care may include

1. Home with advice
2. Offer Paracetamol 1 gram.Consider 30mgs oral Dihydrocodiene.
3. Admission to hospital (i.e for anxiety/pain control/ geography)

Women should be admitted to hospital following the 3rd presentation in latent labour

5.Women who require admission to hospital

A woman who has had a prolonged latent phase of labour may have high levels of anxiety and be exhausted which may be exacerbated by negative or dismissive attitudes. Remember the importance of reassuring the woman in order that her hormonal feedback loop is not compromised.

<u>On admission to antenatal ward – Midwifery Led Care – Low Risk Women</u>

- Document plan of care
- Document FH and uterine activity 2 hourly unless patient off ward or asleep
- Full reassessment to include abdominal palpation, maternal and fetal observation (intermittent auscultation of the fetal heart) +/- VE to be repeated 6 hourly or earlier if clinical condition indicates.
- Analgesia – consider use of emotional support, TENS, water therapy. Pharmacological analgesia: Paracetamol 1g, Dihyracodiene 30 mg or Diamorphine if indicated.
- If a patient remains on the antenatal ward > 24 hours in the latent phase a medical review is indicated.

<u>On admission to antenatal ward – Shared/consultant led care women</u>

- Document plan of care
- Document FH and uterine activity 2 hourly unless patient off ward or asleep
- Perform CTG 12 hourly or earlier if clinical condition indicates {if patient is asleep wait until she awakens}
- Full reassessment to include abdominal palpation, maternal and fetal observation, +/- VE to be repeated 6 hourly or earlier if clinical condition indicates.
- Analgesia – consider use of emotional support, TENS, water therapy. Pharmacological analgesia: Paracetamol 1g, Dihyracodiene 30 mg or Diamorphine if indicated.

- If a patient remains on the antenatal ward > 24 hours in the latent phase a medical review is indicated.

- Medical re-assessment at each shift change/ward round. Care options include further assessment of fetal condition with scan, discharge home with follow up plan, induction of labour – particularly if in latent labour for over 24 hours.

The 'Latent Phase Care Bundle' included in this guideline was developed by Maggie E. Davies, Consultant Midwife, Abertawe Bro Morgannwg University Health Board, and is used with permission

6.References

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