Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

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EXECUTIVE SPONSOR	Medical Co-director of Maternity
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SUMMARY	This Clinical Business Rule is developed to guide clinical practice at the Royal Hospital for Women when caring for a woman in the first stage of labour. It provides guidance for monitoring of maternal and fetal wellbeing and escalation during the latent, active, and delayed first stage of labour.

Royal Hospital for Women (RHW)
BUSINESS RULE

First Stage of Labour – Latent, Active, Recognition and management of Delay

RHW CLIN032

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First Stage of Labour – Latent, Active, Recognition and management of Delay

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1. BACKGROUND

First stage of Labour is the time from onset of labour to complete cervical dilatation. It consists of a latent and active phase[8]

Latent phase of labour is defined as a period of time, not necessarily continuous, when there are painful contractions and there is some gradual cervical change, including cervical effacement and dilatation up to 4cm[3]

Active phase of labour is defined as when there are regular painful contractions and there is more progressive cervical dilatation from 4cm until full dilatation[3]

The aim of this CBR is to guide:

- management of a low risk woman in the latent and active first stage of labour
- recognition of normal progress of the active stage, and
- recognition of delay in the active stage and appropriate escalation

2. RESPONSIBILITIES

- Midwifery staff – assessment and management of the latent and active first stage of labour. Recognition of delay in progress and escalation of care when necessary
- Medical staff – assessment and management of the first stage of labour when there is delay in progress

3. PROCEDURE

3.1 Clinical Practice

3.1.1 Latent stage of Labour, assessment and management

Telephone assessment

- Obtain labour information from woman, using maternity telephone enquiry record form (see appendix 1) and document (see Maternity - Clinical Advice Provision and Completion of Telephone Enquiry Record for more details)
- Ascertain from the woman if she is in the active or latent phase of labour by speaking with and listening3 to her. Assess the length, strength and frequency of contractions and take into consideration how she is coping and any previous obstetric history
- Provide woman with option of staying at home (if no concerns or risk factors), or coming to hospital for individualised assessment if she wishes
- Reassure woman that she will not have to return home if she does not feel comfortable or have appropriate supports or transport
- Give woman option of home visit for labour assessment if appropriate model of care e.g Midwifery Group Practice
- Provide woman with information regarding the latent stage of labour and strategies she may use at home (e.g. mild analgesia, bath, shower, hot packs, transcutaneous electrical nerve stimulation (TENS), mobilisation, relaxation techniques)3
- Recommend review in Birthing Services if a woman calls a third time for the same indication

Physical Assessment

- Perform maternal and fetal assessment as per RHW Midwifery Assessment and/or admission CBR. This may include a vaginal examination if indicated or if the woman requests, but not always necessary3
- Discuss and personalise ongoing options with woman in latent stage of labour (see educational note for more details on latent phase):
    - discharge home to await active labour
    - admit for pain relief if required e.g., morphine or panadeine forte ®
        - do not discharge home in latent labour after administration of opioid analgesia unless; contractions have ceased, and a further comprehensive maternal and fetal assessment (medical and midwifery) has been undertaken
    - Medical review if woman is not reassured by either of the above options, or has individual clinical circumstances that warrant this
    - Labour augmentation/induction after assessment and counselling the woman of the benefits and risks. The timing of augmentation/induction will be subject to activity in birthing services
- Perform A to I assessment and observations fourth hourly as per standard maternity observation chart (SMOC)
- Auscultate fetal heart rate as per Fetal Heart Rate Monitoring – Maternity (GL2018/025)
- hourly if contractions are ≥ 1 in 10 minutes but not in active labour (as per definition)
- fourth hourly if contracting irregularly and < 1 in 10 minutes

3.1.2 **Active first stage of labour care**

- Discuss and respect woman's birth preferences and include woman, her birthing partner and/or support people actively in all decisions around labour care
- Perform A to I assessment as per Midwifery Assessment and/or admission
- Palpate abdomen on admission, and prior to vaginal examinations, or as required in labour to determine fetal:
    - lie
    - position
    - presentation
    - engagement of presenting part
    - volume of amniotic fluid
- Document any vaginal loss e.g. show, blood, amniotic fluid and monitor colour of liquor half hourly
- Auscultate fetal heart rate (FHR) with Pinard or doppler every 15 minutes immediately after a contraction for at least one minute. If there are any fetal heart rate concerns commence a Cardiotocograph (CTG) and escalate as per Fetal Heart Rate Monitoring – Maternity (GL2018/025). Check maternal pulse simultaneously with FHR auscultation
- Palpate contractions for ten minutes every half hour to monitor frequency, strength and duration

- Monitor and document maternal temperature and blood pressure (BP) two hourly
- Encourage woman to drink to thirst and avoid excessive intake during labour, record fluid input and output on a fluid balance chart
- Advise two hourly emptying of bladder. If the woman is unable to void and the bladder is palpable recommend insertion of an indwelling catheter (IDC)
- Encourage woman to mobilise and adopt a position of her choice e.g birth ball, floor mats
- Advise vaginal examination four hourly or earlier if clinically indicated
- Document maternal and fetal assessment in medical record
- Document all discussions with woman as part of the Comprehensive Care Plan (i.e., be with woman)

3.2 **Recognition of active normal labour progress, and management of delay**

3.2.1 **Active normal first stage of labour progress**

- Inform woman that there is a wide variation in the average duration of the active first stage of labour:
  - A nulliparous woman labours on average for 8 hours and is unlikely to labour beyond 18 hours3
  - A parous woman labours on average for 5 hours and is unlikely to labour beyond 12 hours3
- Inform woman that the rate of dilatation in active first stage is similar in both spontaneous and induced labours9
  - dilatation of 0.5 - 1 cm/hour in active first stage is normal for both the nulliparous and parous woman
  - a slower rate of cervical change can be normal for a woman providing there is some progress, and maternal and fetal condition is reassuring9
- Perform A to I assessment upon admission (as per midwifery assessment and/or admission CBR), and offer a vaginal examination with consent
- Assess the criteria for the active phase of labour according to the following:
  - observation of labouring woman
  - frequency of contractions (3-4 in 10 minutes)
  - duration of contractions (40-60 seconds)
  - cervical dilatation (4 to 10cm)
- Commence partogram assessments once active first stage has been confirmed
- Offer a repeat abdominal and vaginal examination (with consent) every four hours (and recommend one every six hours if declined earlier)1
- Update midwifery team leader regularly with progress of active labour and maternal/fetal wellbeing

3.2.2 **Recognition of delay in active first stage of labour**

- Consider the following when recognition of delay in labour occurs:
  - Parity and previous labour history

- Nutrition and hydration
- Bladder status
- Maternal position, mobility and behaviour
- Support and birth environment
- Continuity of carer
- Woman's expectations and wishes
- Pain and exhaustion
- Fetal heart rate assessment
- Contraction length, strength and frequency
- Position and descent of presenting part
- Induced or spontaneous labour
- Cervical change and dilatation

- Ensure increase in frequency of maternal observations when maternal condition changes3
- Refer to and consult with medical staff according to Australian College of Midwifery (ACM) guidelines
- Discuss situation with the woman and her birthing partner/s
- Arrange review by medical team when delay in progress is recognised
- Determine management according to the woman's parity, preferences, and her consent to recommendations, as well as the suspected cause of delay

3.2.3 **Management of delay in active first stage of labour**

- Refer and consult with medical staff according to the ACM guidelines
- Assess the following prior to commencement augmentation:
  - Fetal compromise and malpresentation
  - Any signs of obstructed labour e.g. haematuria or maternal pyrexia
  - Uterine scar
  - Contraction frequency and duration
- Recommend CTG prior to augmentation
- Recommend artificial rupture of membranes (ARM) (see CBR) if forewaters present and no contraindications and inform obstetric medical team and midwifery team leader
- Recommend oxytocin infusion if no forewaters present and no contraindications, after review by obstetric registrar or consultant
- Recommend repeat abdominal and vaginal examination, at 2- 4 hours depending on the clinical situation after:
  - **two hours** if:
    - ARM only
    - ≥ 8cm

- or if augmentation has been declined by the woman
  - **four hours** if oxytocin commenced
- Inform obstetric medical team and midwifery team leader of ongoing progress. See Table 1

Table 1

Nulliparous woman	Parous Woman
• Continue with active labour care if: ○ cervical dilatation is **≥0.5cm per hour,** ○ +/- descent and rotation of the presenting part, ○ reassuring maternal/fetal status • Review by obstetric registrar if delay in active labour continues	• Recommend management as per nulliparous woman (see above), except in the situation of **grand multiparity** (≥ 5 births). Individualised plan to be made • Continue with active labour care if: ○ cervical dilatation is **0.5 - 1cm per hour,** ○ +/- descent and rotation of the head, ○ reassuring maternal-fetal status • Review by obstetric registrar if delay in active labour continues

3.3 **Documentation**

- Medical Record
- Antenatal Card
- Telephone Enquiry Record SESLHDPR/295

4. EDUCATIONAL NOTES

- The World Health Organisation (WHO) acknowledges that the “latent first stage” (or the “latent phase”) is sometimes described as the “early” or “passive” first stage. This is the oldest and most familiar terminology. Likewise, the use of “active first stage” (or the “active phase”) to describe the period of accelerative labour during the first stage is preferred to other terms such as “established” labour8
- There is no standard duration of latent phase. The duration varies between women and is not simply based on parity. A systematic review involving over 100,000 women found that it can take 4 hours to progress from 3-4 cm and a further 4 hours to progress from 4-5 cm9
- The Friedman curve for labour progression (1 cm/hour from 3cm dilation) has traditionally been used for diagnosis of delay in the active first stage of labour. However, a more contemporary description of labour progress has been developed by Zhang and colleagues10 that takes into consideration the effects of increased epidural use and higher average BMIs etc. First stage dilatation is described as

non-linear / hyperbolic, with no abrupt change in rate of dilation to indicate transition into active first stage around 5-6 cm. Slower rates of dilatation are now largely accepted8

- The use of medical interventions to accelerate labour before 5 cm dilation is not recommended providing maternal and fetal assessment is reassuring8
- Delaying admission to the Birth unit until active first stage may result in reduced medical intervention (e.g. pharmacological pain relief, augmentation of labour, caesarean section). A decision to admit the woman to hospital for increased support should be made in consultation with the woman to ensure her emotional, psychological and medical needs are being met (e.g. need for continuous labour support, pain relief)8
- Women who have had panadeine forte or morphine are recommended not to be discharged from the facility until contractions have ceased and the medical team have reviewed (as per NSW
- It is important that all Healthcare professionals giving care to women should think about how their own values and beliefs inform their attitude and ensure their care supports the woman's choice 3
- Continuous 1:1 support in labour is associated with improved labour and birth outcomes and increased satisfaction with care5
- It is important to monitor fluid intake during labour as excessive oral fluid intake can cause hyponatremia3

4.1 **Related Policies/procedures**

- Midwifery Admission and/or assessment
- Morphine – subcutaneous (Maternity)
- Second Stage of Labour Care – Recognition of Normal Progress and Management of Delay
- Hyponatremia (Adult) – Management of including hypertonic saline – administration and precautions
- Fetal Heart Rate Monitoring – Maternity (GL2018/025)

4. IMPLEMENTATION, COMMUNICATION AND EDUCATIONAL PLAN

This revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

6. REFERENCES

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7. CULTURAL SUPPORTS

- When clinical risks are identified for an Aboriginal woman, she may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services.
- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service:
- NSW Ministry of Health Policy Directive PD2017_044 – Interpreters Standard Procedures for Working with Health Care Interpreters.

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
5/03/2024	1 – combination of all below	Maternity CBR Committee
History	*Early labour assessment and management in a low risk pregnancy* Maternity Services LOPs group 4/12/17	
	First stage labour care for a woman with a low risk pregnancy Reviewed and endorsed Maternity Services LOPs 24/1/17 Approved Quality Council 19/6/06 Maternity Services Clinical Committee 11/4/06	
	First stage labour – Recognition of normal progress and management of delay Reviewed and endorsed Maternity Services LOPs group 14/8/18 – incorporated previous title Vaginal Examinations in Labour, approved Quality & Patient Safety Committee 17/7/14 now deleted) Approved Quality & Patient Safety Committee 20/9/12 Endorsed Maternity Services LOPs group 11/9/12	
21 March 2024	1	Endorsed at RHW Safety and Quality Committee

Health
NSW GOVERNMENT South Eastern Sydney Local Health District

Facility:

ANTENATAL/INTRAPARTUM MATERNITY TELEPHONE ENQUIRY RECORD

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CALL NO 1: **DATE:** / / **TIME:** **Midwife Taking Call:**

IS ENGLISH YOUR FIRST LANGUAGE: ☐ YES ☐ NO

ARE YOU ABLE TO UNDERSTAND ME OR DO YOU NEED AN INTERPRETER?

IS THERE SOMEONE ELSE WITH YOU WHO COULD SPEAK FOR YOU: ☐ YES ☐ NO

PERSON SPOKEN TO (eg husband / sister):

Model of Care:

BEST TELEPHONE CONTACT NO: | EDD | Gravida | Parity

PREGNANCY AND OR MEDICAL CONDITIONS?

Gestation: | Presentation:

Fetal movement pattern/changes in last 24hrs:

Reason for call

Clinician's Advice

Plan discussed and agreed with woman: ☐ YES ☐ NO

If no provide details:

Signature of Midwife: Print Name:

Further calls received from this woman should be documented on the reverse side of this form.

NO WRITING

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BINDING MARGIN - NO WRITING

DO NOT PRINT

ANTENATAL/INTRAPARTUM MATERNITY TELEPHONE ENQUIRY RECORD

SES060.402

S0608 080118

HOSPITAL FOR WOMEN

Health
South Eastern Sydney
Local Health District

Facility:

ANTENATAL/INTRAPARTUM MATERNITY TELEPHONE ENQUIRY RECORD

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CALL NO 2: **DATE: / /** **TIME:** **Midwife Taking Call:**

Fetal movement pattern/changes in last 24hrs:

Reason for call

Clinician's Advice

Plan discussed and agreed with woman: ☐ YES ☐ NO

If no provide details:

Signature of Midwife: Print Name:

***At Call No.2 with similar issues or symptoms consider an invitation to come in for assessment.**

CALL NO 3: **DATE: / /** **TIME:** **Midwife Taking Call:**

Fetal movement pattern/changes in last 24hrs:

Reason for call

Clinician's Advice

Plan discussed and agreed with woman: ☐ YES ☐ NO

If no provide details:

Signature of Midwife: Print Name:

***At Call No.3 with similar issues or symptoms an invitation to come in for assessment is recommended.**

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