Ashford and St. Peter's Hospitals
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS MATERNITY UNIT

MANAGEMENT OF LATENT PHASE IN LOW RISK WOMEN

Amendments			
Date	Page	Comments	Approved by

Complied by: Marta Galan - Midwife

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Review date: October 2026

Contents

SECTION **Page**

Appendices

See also:

Abbey Birth Centre Clinical guideline
Intrapartum fetal heart rate monitoring clinical guideline
Labour care of women clinical guideline
Triage telephone standardised advice Clinical guideline

1. Introduction

1.1 The latent phase of labour can vary widely from woman to woman; it is hard to measure and predict as factors such as parity and obstetric history can play an important role in the length of a woman's latent phase.

The latent phase of labour is more sensitive to external factors compared to the active phase of labour, i.e. lighting, language used, and emotional support given (2). It is therefore vital that healthcare professionals understand the physiology behind this stage and the psychological impact that care in the latent phase can have on women and the length of their overall labour.

For the purpose of this guideline the terms "latent phase" and "early labour" will be used interchangeably, and both refer to the definition provided below.

2. Definition

2.1 *"A period of time, not necessarily continuous when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4cm." (1)*
There is little evidence to suggest how long the latent phase of labour may last but if the labour is spontaneous in a normal, term, healthy pregnancy this could be up to 20 hours in a first pregnancy and up to 6 hours in subsequent pregnancies (4).

3. Aim

3.1 The aim of this guideline is to support midwives caring for low-risk women planning a vaginal birth in the early stage of labour by providing a standardised approach specific to the latent phase. This guideline is not relevant for women with high risk pregnancies who should have an individualised care plan on admission.

4. Exclusion criteria

- Gestation <37 weeks or >42 weeks
- Breech presentation
- Previous caesarean
- Growth restricted fetus
- Presence of abnormal features (reduced fetal movements, meconium stained liquor, PVB, anmormal MEOWS or concerns with fetal heart monitoring.)

This list is not exhaustive and any clinical concerns should be reviewed by the obstetric team prior to discharging the woman home.

5. Telephone advice in early labour

5.1 The latent phase can vary widely from woman to woman; therefore midwives are expected to exercise their professional judgement to determine whether the woman should remain at home or be invited in for assessment. When carrying out a telephone assessment for a woman in early labour, it is vital that the midwife asks about:

- Duration and frequency of contractions,
- Vaginal loss/ colour of liquor if SROM
- Fetal movements
- How the woman is coping at home

Women are encouraged to wearing a sanitary pad and observe PV loss as well as monitor fetal movements and their own wellbeing, they should be reassured they can come in at any time if concerns arise.

5.2 In the absence of any clinical concerns following telephone assessment and if coping well at home, women should be advised to remain at home for as long as possible or until contractions are 3-4:10, strong and lasting up to 1 minute indicating active labour. Generally, women may experience higher levels of anxiety during the latent phase of labour, due to the uncertainty in length; therefore, midwives should explain the physiological process of the latent phase to women, and offer recommendations for coping techniques at home.

These may include:

- 1g Paracetamol 4-6 hours
- Warm bath
- Mobilising
- TENS machine
- Biomechanics
- Breathing techniques

5.3 Ensure every contact is clearly documented under the “communication” section on the woman’s Badger Notes. If a woman has called 3 or more times with the same complaint, this should trigger an invitation to maternity triage to carry out a wellbeing assessment and obstetric review. *Please refer to Triage telephone standardised advice Clinical guideline.*

6 Face to face assessment in early labour

6.1 When carrying out an early labour assessment, midwives should be mindful of the environment in which the woman will be assessed and try to make it welcoming and relaxing environment, using dimmed lights and reducing noise levels. Avoid use of negative language such as “you are not in labour”, instead reassure women that the latent phase is a physiological process and use encouraging language such as “every contraction is making a difference”. Studies suggest maternal satisfaction and probability of SVD is likely to increase if the environment is free from medical equipment and facilitates self-comforting behaviour (5).

As a minimum, the midwife assessing a woman in early labour should carry out:

- Full set of observations
- Urinalysis
- Symphysis fundal height measurement
- Fetal heart auscultation with Pinnard or Doppler, preferably following a contraction
- Assessment of frequency, duration, and strength of contractions as well as resting tone in between
- Vaginal loss/liquor observation (if any)
- Fetal movements

Vaginal examinations should not be routinely carried out unless the woman requests one, particularly if it is evident labour has not yet started. If the woman requests a vaginal examination, risks and benefits such as increased risk of infection should be discussed.

6.2 If following assessment, it is apparent active labour has not yet started, women should be strongly advised to return home and it should be discussed that admission may bring with it increased chance of intervention including induction, epidural and caesarean section (3).

Women should be advised to return if:

- SROM
- PV bleeding
- Reduced fetal movements
- Unable to pass urine
- Abdominal pain/no space between contractions
- Not coping at home
- Change in colour of liquor

Prior to discharging home, it is vital the midwife discusses coping techniques with the woman and her birthing partner, to aid coping with contractions at home. See point 5.2 for list.

6.3 If a woman presents contracting strongly every 2-3 minutes, lasting 50-60 seconds, is unable to breathe through and/or she is displaying any other obvious signs of established labour, she should be admitted and 1:1 labour care commenced, as per Burvill Score (Appendix 4).

In the case of multiparous women, it is important to note latent phase length can be significantly shorter. Midwives assessing multiparous women in early labour should therefore be cautious when advising women to go home if contracting regularly, regardless of vaginal examination findings.

7 Inpatient latent phase care (see Appendix 5 for flowchart)

7.1

- Fetal heart auscultation and PAUSES review (Appendix 1) to be performed hourly for primiparous women and every half hour for multiparous women. If at any point the woman's behaviour changes or contraction frequency increases, 15 minutely auscultation and partogram should be commenced, assuming established labour has commenced.
- Maternal observations every 4 hours
- In the case of multiparous women, fetal heart auscultation is performed every half an hour, to assess contraction strength and frequency more regularly, to ensure the start of established labour is not missed.

Note a vaginal examination may be offered but should not be routinely used as a way of determining whether labour is established.

If 4-6 hours following admission the woman remains in the latent phase of labour and is coping well with contractions, she should be encouraged to return home assuming there are no clinical concerns.

8 Prolonged latent phase and escalation

8.1 There is no standard definition for a prolonged latent phase of labour. The teaching literature for midwives' states that early labour can last for up to 6-8 hours. However, in reality, it often lasts much longer and it is not unusual for women to be in the latent phase for 2-3 days (Spiby et al 2007).

8.2 Prolonged latent phase can be as a result of malposition with between 10-30% of fetuses in early labour presenting in the occipito posterior position. Most will subsequently rotate spontaneously (Akmal and Paterson-Brown 2009). Refer to the Biomechanics patient leaflet for further information on how to help resolve malpositioned fetuses in early labour.

8.3 If any of the following signs/symptoms arise at presentation or during admission, immediate escalation to the shift leader and obstetric registrar and continuous CTG monitoring on labour ward is required.

- Fetal distress identified on IA (baseline not appropriate for gestation/decelerations heard)
- Pyrexia, tachycardia, hypertension or MEWS of >2
- Any woman requesting a CTG or to be seen by a doctor

If a woman **calls for advice** in early labour 3 times, she must be invited in for a full antenatal assessment.
If a woman **is seen** 3 or more times in early labour, an obstetric review and CTG monitoring are recommended. (Appendix 3)

Please note if following obstetric review and CTG, if no clinical concerns, discharge home may be considered if admission for latent phase care is declined.

9 Approval and Ratification

9.1 Guideline has been circulated with relevant clinical groups for up to three weeks, allowing for comments and changes to be made. Guideline has been presented by the author to the committee and finally been submitted to the board for ratification and approval.

10 Dissemination and Implementation

10.1 Guideline will be published on Ashford and St. Peter's TrustNet, where it will be widely available for all clinical staff, as well as shared via mailing list to all relevant clinical groups.

11 Review and Revision Arrangements

11.1 This guideline is to be reviewed every three years. In the event of national guidance changing, gaps in information being identified by the committee or staff, or any serious incident occurring because of the information or lack thereof in this guideline, this will trigger an immediate review.

12 Supporting References / Evidence Base

1. NICE Guidelines- Latent Phase of labour. 2022. https://www.nice.org.uk/guidance/cg190/chapter/recommendations#latent-first-stage-of-labour

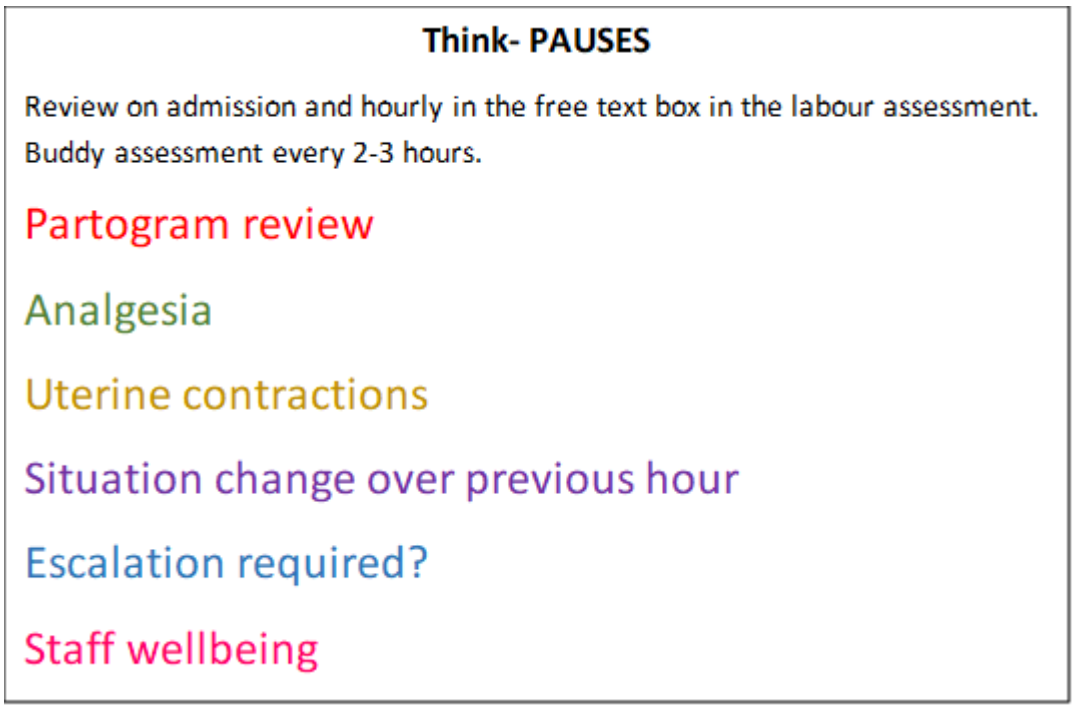
2. Munro J. and Jokinen M. Latent Phase Midwifery Practice Guideline in RCM Evidence based guidelines for midwifery – led care in labour 4th edition. 2008. Available online at: www.rcm.org.uk

3. Barnett C et al (2008) 'Not in labour': impact of sending women in the latent phase BJM 2008 Vol 16 (3): 144-153

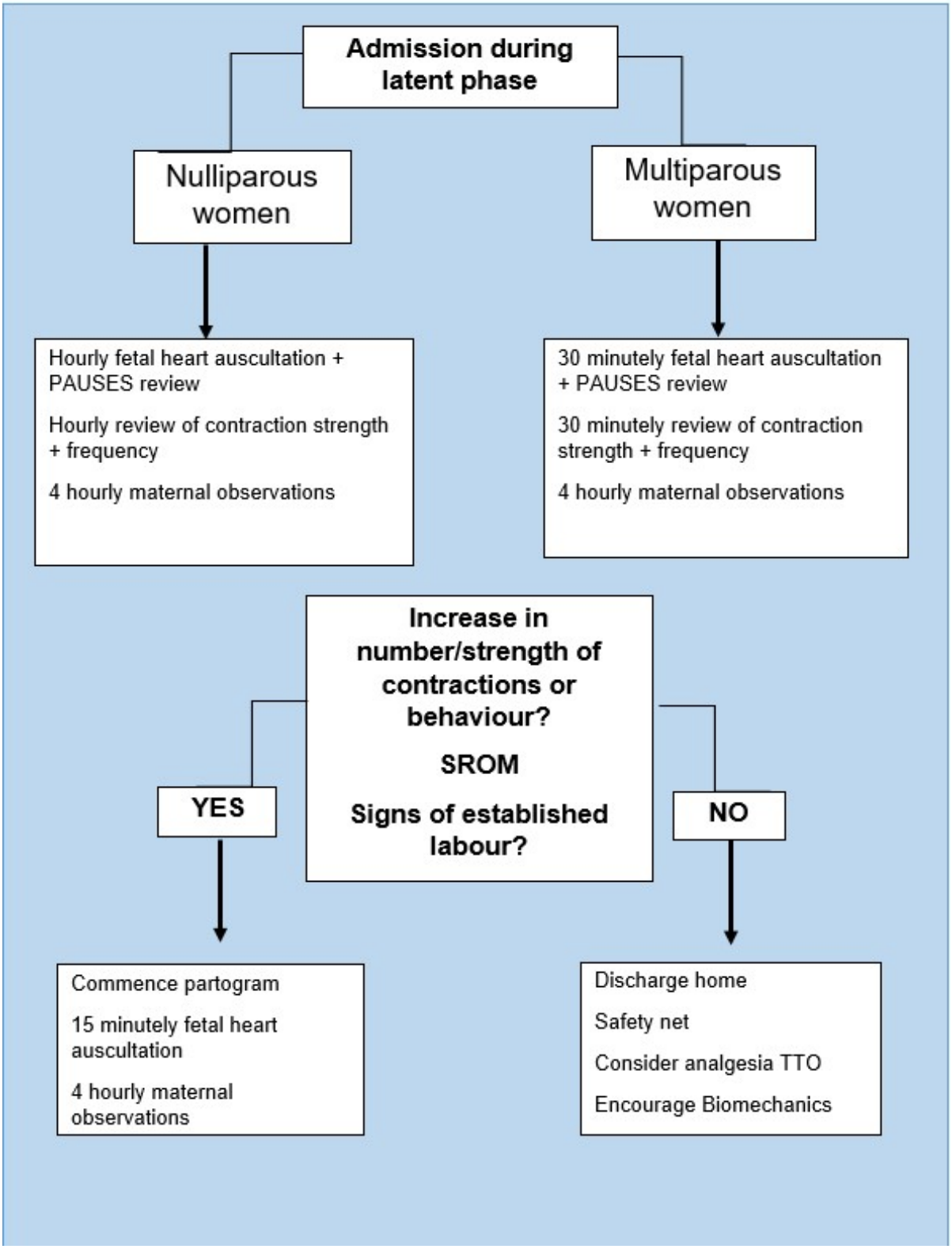
4. Chelmow, D., Kilpatrick, S.J., Largos, R.K., Jr. , Maternal and neonatal outcomes after prolonged latent phase. Obstetrics and Gynaecology 1993. 81(4): p. 486-91

5. Hodnett E.D. et al Effect of birth outcomes of a formalised approach to care in hospital labour assessment units: international randomised controlled trial. BMJ 2008 Vol 337: 618 – 622

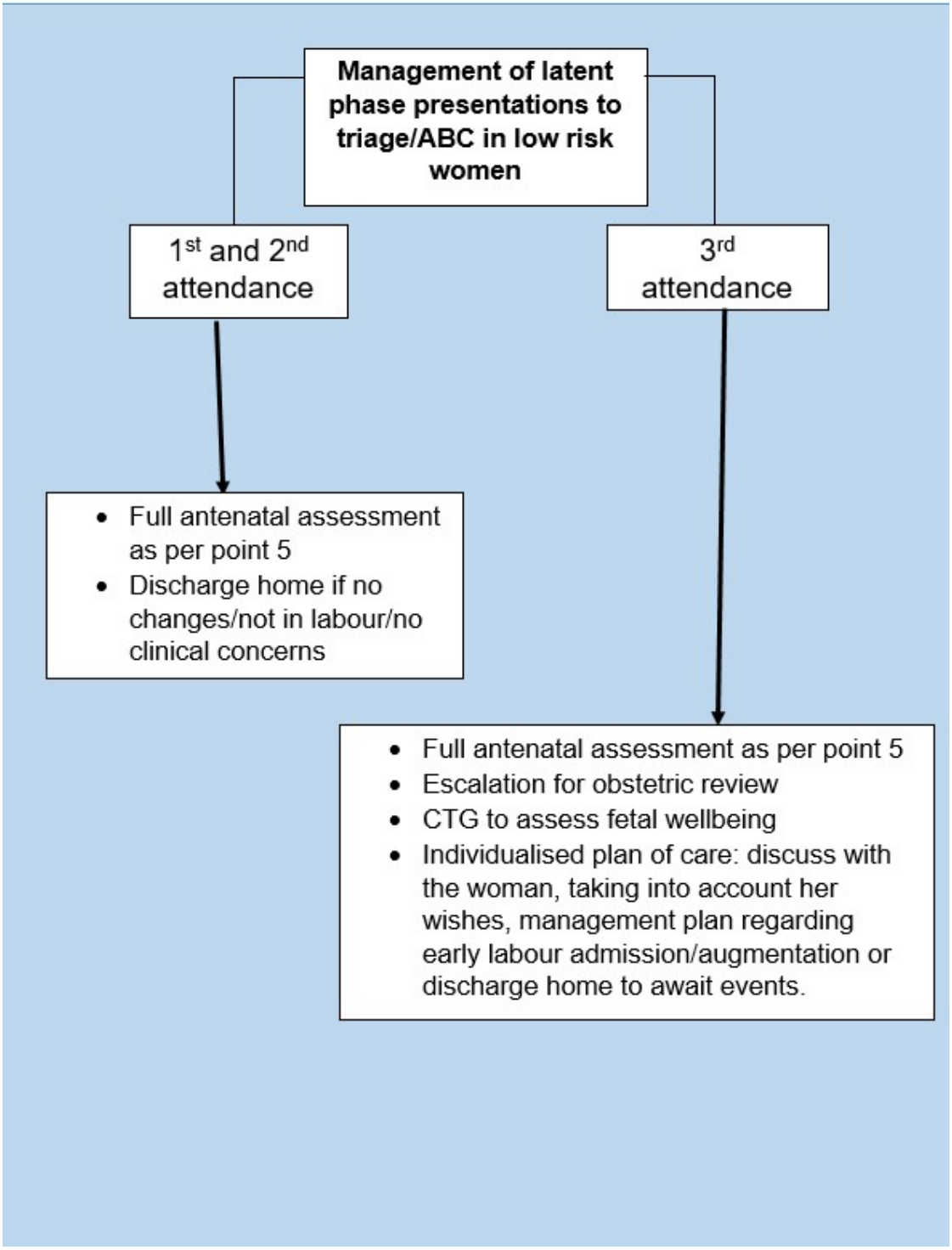
APPENDIX 1: PAUSES review tool



APPENDIX 2: INPATIENT LATENT PHASE FLOWCHART



APPENDIX 3: ESCALATION IN THE LATENT PHASE



APPENDIX 4: MODIFIED BURVILL SCORE

	0	1	2
Themes	**Signs may indicate Early Labour**	**Signs may indicate Early Active Labour**	**Signs may indicate Active Labour**
Breathing	Exaggerated, pain like breathing	Deeper breathing, controlled, pronounced, like a sigh	Not shallow, cannot talk, focused on breathing slow with contractions; grunting sounds, cries out with expiration
Conversation	Chatty, excitable, speaks quickly	Speaks less	Becomes quiet, conversation stops with each contraction, takes 20 seconds or more to resume talking; focus goes inward
Mood	Excitement/anxiety, happy, slightly agitated	Ceases to worry about external concerns	Withdraws, focus is on self
Energy	Wants to sort out practicalities	Becoming still. Inward focus on self	Still. Withdrawn into self
Movement & Posture	Grasps abdomen and bends forward with contractions	Less mobile. Stops for contractions and holds onto something/one	Stays in one position with or without contraction. Sways hips during contraction
Contractions without palpation	20 - 40 seconds	50 seconds or more - at least 4 minutes apart	50 seconds or more, 2-3 minutes apart