



*The Royal College of*  
**Midwives**

# Evidence Based Guidelines *for* *Midwifery-Led Care in Labour*

## Latent Phase



## Practice Points

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Women and their chosen birth companions should be offered good education about the latent phase antenatally. Antenatal preparation can increase women's likelihood of arriving in hospital in established labour (Maimburg et al. 2010).

Women's need for reassurance that what they are experiencing is normal is cited as a main reason for contacting the hospital in early labour (Carlsson et al. 2011; Eri et al. 2010; Barnett et al. 2008; Cheyne et al. 2007). Midwives should acknowledge their important role in providing this reassurance.

Labour wards may not be the appropriate environment for women in the latent phase (Bailit et al. 2005; Klein et al. 2004; Holmes et al. 2001; McNiven 1998).

Women value home assessment in the latent phase and this can reduce the number of visits to hospital (Spiby et al. 2008; Janssen et al. 2006)

Midwives should allow time to enable women to 'tell their story' before offering advice (Eri et al. 2010; Spiby et al. 2006).

The duration of the latent phase is particularly difficult to measure, as women experience the onset of labour in a variety of different ways (Gross et al. 2006; Albers 2001; Enkin et al. 2000).

A long latent phase can often be a discouraging and exhausting experience, and women need good consistent psychological support (Simkin and Ancheta 2000).

NICE (2007) recommend the following definitions of stages of labour:

Latent phase:

- 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.

Active phase:

- There are regular painful contractions; and

There is progressive cervical dilatation from 4cm.

Women experience onset of labour in a variety of different ways (Gross et al. 2006; Albers 2001; Enkin et al. 2000). Gross et al.'s (2003) study suggested that for many women the onset of regular contractions does not coincide with what they perceive to be their onset of labour. Cervical anatomy at labour onset is also highly variable from woman to woman (Albers 2001). The way in which women experience the onset of labour has not been found to be associated with the duration of labour following admission to hospital (Gross et al. 2010). The latent phase of labour and its impact on labour as a whole is poorly understood (Greulich and Tarrant 2007; Enkin et al. 2000), and the duration of this phase is particularly difficult to measure (Albers 2001; Enkin et al. 2000).

Freidman (1954) coined the terms "latent" and "active" phases of labour, and developed statistical norms from retrospective graphic analysis of large datasets (Freidman and Kroll 1971). Albers et al. (1999) have commented on the methodological problems in this study data, which included women who had received oxytocin augmentation, or who had been administered excessive doses of opiates, and women with breech presentations or twins, all of which are now acknowledged as partial determinants of the duration of labour. More recent studies by Albers et al. (1996) and Zhang et al. (2002) suggest that the pattern of labour progress in contemporary populations differs significantly from that which was observed in the 1950s.

The timely diagnosis of active labour is problematic both for women and for their caregivers (Cheyne and Hundley 2009; Lauzon and Hodnett 2004). In their qualitative study of Norwegian women's experiences of contact with labour ward midwives in the latent phase of labour, Eri et al. (2010) found that women considered subjective factors, such as pain level, were not useful tools for self diagnosing established labour. These findings confirm those of Cheyne et al. (2007) whose qualitative study of British women's experiences in early labour reported that women felt their labour onset was 'vague' and difficult to define. Women prefer to use objective, 'textbook' definitions to recognise the onset of established labour, such as contractions 5 minutes apart and lasting 60 seconds; often feeling hesitant and unsure if their experiences do not match up to these expectations (Eri et al. 2010, Cheyne et al. 2007). The findings from Gross et al.'s (2003) qualitative study suggest that the right question to ask is not, "When did your contractions start?" but, "When did your labour start?" and, "How did you know?". Gross et al.'s (2009) observational, multicentre cohort study found that women and midwives often disagree about the timing of the onset of labour; there was agreement for only 28.5% of primiparous and 39.4% of multiparous women. Despite the difficulty, accurate diagnosis is important as a mistaken one can lead to a subsequent diagnosis of labour dystocia and a consequent cascade of interventions. Women's confidence in themselves and in their carers may be undermined and the whole birth experience negatively affected (Simkin 1996).

Peisner and Rosen's (1986) observational study of 1699 women, investigating the transition from latent to active labour, reported that 60% of labours had moved into the active phase by the time the cervix was 4 cm dilated and 89% by 5cm. There was no difference between the nulliparous and multiparous women.

NICE (2007) recommend the following definition of latent phase – 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 and the onset of active labour when there are regular painful contractions and there is progressive cervical dilatation from 4cm.

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A prolonged latent phase is widely considered to be benign and not clinically significant (Freidman 1983). Chelmlow et al.'s (1993) study challenged this premise, finding an association between a prolonged latent phase and subsequent labour abnormalities and the need for caesarean section. However, this was a retrospective study that did not use a standardised definition of labour onset on arrival at hospital (Walsh 2000). In their prospective observational study of 2,072 Swedish primiparous women with an uncomplicated pregnancy, Dencker et al. (2010) found that a prolonged latent phase of over 12 hours was associated with a significantly longer duration of active labour. A limitation of this study is that it required women to identify the onset of their latent phase of labour, which is difficult to define. The extent to which "prolonged latent phase" means anything in terms of adverse outcomes remains a subject of disagreement (Austin and Calderon 1999).

Antenatal education about the latent phase of labour for women and their birth companions is important. A Danish randomised controlled trial of a structured antenatal education programme about birth and parenthood compared to standard care (Maimburg et al. 2010) found that women who attended the programme were statistically more likely to arrive in hospital in established labour compared to women who did not. This indicates that women who were prepared for their latent phase were better able to cope at home. This may go some way to explaining the findings of Nolan et al.'s (2009a) quantitative survey of 2,433 women who use a popular peer reviewed parenting website. They found that women whose experience of early labour was as they expected were more likely to have a spontaneous vaginal birth than women whose experience differed from their expectations.

Studies have shown that women admitted to hospital in the latent phase have higher rates of obstetric intervention (Bailit et al. 2005; Klein et al. 2004; Holmes et al. 2001; McNiven et al. 1998). McNiven et al.'s study (1998) found that women who were reviewed in a specifically designated early labour assessment area away from the central delivery suite had shorter labours, fewer epidurals, less syntocinon augmentation and more positive birth experiences. As Walsh (2000) commented, this study confirmed what midwifery experience had been saying, that labour wards may not be the appropriate environment for women in the latent phase. Cheyne et al. (2008) compared the use of an algorithm with midwives' judgement alone to diagnose the onset of established labour, in a randomised cluster trial. The algorithm was designed to assist midwives in the timely diagnosis of labour, in order to avoid unnecessary intervention. This study found that the intervention did not significantly affect the rate of oxytocin usage to augment labour or other labour interventions. The only significant difference was that women in the algorithm group were more likely to be discharged from the delivery suite following their first labour assessment. These findings differ from the McNiven et al.'s study (1998), suggesting that the location of assessment may have more impact than the method. However, Janssen et al.'s (2006) randomised controlled trial of early labour assessment and support at home versus telephone triage found that support at home reduced the number of visits to hospital but did not impact on the use of analgesia, augmentation of labour or caesarean section. These findings were confirmed by Spiby et al.'s (2008) large multicentre trial, comparing home assessment and standard hospital care for low-risk primiparous women. No differences were found in rates of operative and instrumental birth or early labour admissions; but women were discharged from hospital in early labour on fewer occasions and were more likely to evaluate their care more positively if they were visited at home.

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A number of studies have provided an insight into women's experiences in the latent phase of labour, which can help midwives understand the role they play in caring for women during this phase. Cheyne et al. (2007) found that women knew they should remain at home for as long as possible during the latent phase of labour, but that they sometimes found this difficult. Carlsson et al. (2009) interviewed Swedish women who had requested admission to the delivery suite in early labour. The reasons that they gave for this included the relative distance of their homes from the hospital, the fear of not reaching the hospital in time and the comfort they found in handing over control to the midwives. The reassurance that midwives can provide in early labour is a common theme in the literature. Women's vulnerability and their need for reassurance that what they are experiencing is normal is cited as a main reason for contacting the hospital in early labour (Carlsson et al. 2011; Barnett et al. 2008; Eri et al. 2010; Cheyne et al. 2007). Midwives should acknowledge their important role in providing this reassurance. Women also cite pain or the fear of impending pain as a reason for attending the delivery suite in the latent phase of labour (Barnett et al. 2008; Cheyne et al. 2007).

Another significant theme in the literature is the role and influence of women's partners and birth companions during the latent phase of labour. Carlsson et al.'s (2011) qualitative study of women who remained at home throughout their latent phase discovered that the involvement of their partners was very important to them. There was substantial agreement in qualitative studies from Britain and northern Europe that partners and birth companions influenced the decision to go into hospital (Barnett et al. 2008; Carlsson et al. 2009; Eri et al. 2010). Women reported that their anxiety was heightened by that of their partners who often encouraged them to attend hospital even when the women felt they were coping at home (Nolan et al. 2009b; Cheyne et al. 2007). This strengthens the recommendation that partners and birth companions are involved in antenatal education.

A prolonged latent phase can often be a discouraging and exhausting experience and women clearly need good psychological support (Simkin and Ancheta 2000). This principle is reinforced by Nolan et al. (2009a) who found that women who felt 'happy' and 'excited' during the latent phase of labour were more likely to have a spontaneous vaginal delivery than an assisted vaginal delivery. Whilst this does not prove causation, the association between positive feelings during the latent phase and improved birth outcomes is important for midwives to consider when caring for women. This theory was previously tested by Hodnett et al. (2008) in their international randomised controlled trial of a formalised approach to care in the latent phase of labour, which included interventions to help women stay positive. Whilst it did not reach statistical significance, use of the intervention did suggest a modest increase in the spontaneous vaginal birth rate, compared to standard care.

A careful individualised plan of care incorporating the woman's preferences is vital when the distinction between latent and active labour is so difficult. Koontz and Bishop (1982) warn against the simplistic "cookbook" approach, which can lead to an inappropriate response. Based on their findings, from their qualitative study of 17 primiparous women, Eri et al. (2010) advise that midwives should allow women the opportunity to 'tell their story' rather than focussing on objective questions, such as enquiring about contraction frequency, before offering advice to women about when to attend hospital. Spiby et al. (2006) agree, suggesting that midwives take their time on telephone assessments. Whilst this may seem difficult in a busy delivery suite, the extra time spent at this stage can pay dividends if women are appropriately reassured to remain at home during the latent phase of labour. Communication, reassurance and education are vital, and anxiety needs to be alleviated before any other techniques of relaxation can become effective (Austin and Calderon 1999). High levels of pain and anxiety in the latent phase are linked with more labour interventions in active labour (Wuitchik et al. 1989).

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The findings of the research into the latent phase of labour have identified some practices that may improve women's experience and outcomes:

- Good education about the latent phase antenatally, which involves the birth companion;
- In-depth discussion about the latent phase when completing the birth plan at 36 weeks;
- Home assessment in early labour;
- Good access to verbal support and encouragement;
- Encouraging staying at home and normal everyday activity;
- Practical advice, such as use of TENS, birthing ball, shower, bath, massage;
- Continuity of advice from a named midwife;
- Midwives taking their time during telephone labour assessments and enabling women to tell their story before offering advice;
- Receiving clear messages about local care arrangements; for example, women will be advised to return home if they are found not to be in established labour;
- Maintain usual food and fluid intake and amount of sleep and rest;

Practices that may have a negative impact on women's experience and outcomes may include:

- The use of opiates instead of exploring more natural methods of coping;
- Continuous fetal monitoring;
- Repeated vaginal examinations;
- Augmentation;
- Reference to women "only" being in early labour or 'not in labour', which can devalue women's experience;
- Focussing only on objective measures, such as the frequency of contractions; focussing on the women's experiences can make them less anxious to negotiate admission to hospital too early.

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The guidelines have been developed under the auspices of the RCM Guideline Advisory Group with final approval by the Director of Learning Research and Practice Development, Professional Midwifery Lead.

The guideline review process will commence in 2016 unless evidence requires earlier review.

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## Appendix A

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### Sources

The following electronic databases were searched: The Cochrane Database of Systematic Reviews, MEDLINE, Embase and MIDIRS. As this document is an update of research previously carried out, the publication time period was restricted to 2008 to March 2011. The search was undertaken by Mary Dharmachandran, Project Librarian (RCM Collection), The Royal College of Obstetricians and Gynaecologists.

### Search Terms

Separate search strategies were developed for each section of the review. Initial search terms for each discrete area were identified by the authors. For each search, a combination of MeSH and keyword (free text) terms was used.

### Journals hand-searched by the authors were as follows:

- Birth
- British Journal of Midwifery
- Midwifery
- Practising Midwife
- Evidence-based Midwifery