

FIRST STAGE OF LABOUR - RECOGNITION OF NORMAL PROGRESS AND MANAGEMENT OF DELAY

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- To recognise and support normal first stage of labour
- To make a timely diagnosis of delay in the first stage of labour and recommend management that will increase the likelihood of a safe birth

2. PATIENT

- A woman who has been diagnosed as being in the active first stage of labour

3. STAFF

- Medical and midwifery staff

4. EQUIPMENT

- Sterile gloves
- Lubricant
- Doppler
- Pinard stethoscope
- Amnihook/Amnicot
- Intravenous (IV) cannula
- Fetal monitoring equipment

5. CLINICAL PRACTICE

- Perform full and holistic assessment of labour progress upon admission, and offer a vaginal assessment where there are no contraindications
- Ensure the woman is in the active phase of labour by assessing the following:
 - behaviour
 - frequency of contractions (3-4 in 10 minutes)
 - duration of contractions (40-60 seconds)
 - cervical dilatation (at least 3-4 cm dilated and effacing)
- Recommend woman return or remain at home during latent phase, if there are no contraindications and no clinical concerns about maternal or fetal welfare
- Commence partogram once active first stage has been confirmed
- Offer a repeat abdominal and vaginal examination every four hours (and recommend one every six hours if declined earlier)
- Do not offer clinical intervention when labour is progressing normally and woman and fetus are well
- Consider the following when reviewing labour history and considering the possible need for intervention for labour delay:
 - 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
 - Cervical dilatation and change
 - Position and descent of presenting part
 - Induced or spontaneous labour

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- Delay is diagnosed when the woman in established labour, has progressed less than 0.5cm per hour over a four-hour period, however, delay may be diagnosed earlier if the history and clinical picture warrants earlier examination
- Arrange review by obstetric team and midwifery team leader when delay in progress is diagnosed and discuss situation with woman and her supporters. Referral and consultation with medical staff should be according to Australian College of Midwifery (ACM) guidelines
- Determine management according to the woman's parity, preferences, and her consent to recommendations, as well as the suspected cause of delay
- Manage as below:

6. DOCUMENTATION

- Partogram
- Medical record
- Obstetric database

Management of diagnosed delay for nulliparous women

- Referral and consultation with medical staff should be according to ACM guidelines
- Recommend artificial rupture of membranes (ARM) if forewaters present and no contraindications, and inform obstetric medical team and midwifery team leader
- Assess for the following prior to commencement of Syntocinon:
 - Fetal compromise and malpresentation
 - Any signs of obstructed labour
 - Uterine scar
 - Contraction frequency and duration
- Recommend IV Syntocinon if no forewaters present and no contraindications, after review by obstetric registrar
- Commence continuous electronic fetal monitoring once Syntocinon infusion begins
- Recommend repeat abdominal and vaginal examination:
 - After two hours if ARM only, if cervix is ≥ 8 cms, or if ARM +/- Syntocinon is declined
 - After four hours if Syntocinon commenced
- Inform obstetric medical team and midwifery team leader of ongoing progress
- Continue with the labour if cervical dilatation is ≥ 0.5 cm per hour, +/- descent and rotation of the presenting part, and reassuring maternal-fetal status, otherwise arrange medical review

Management of diagnosed delay for primiparous/multiparous woman

- Referral and consultation with medical staff should be according to ACM guidelines
- Recommend artificial rupture of membranes (ARM) if forewaters present and no contraindications, and inform obstetric medical team and midwifery team leader
- Assess for the following prior to commencement of Syntocinon:
 - Fetal compromise and malpresentation
 - Any signs of obstructed labour
 - Previous caesarean section/other uterine scar
 - Grand multiparity
 - Contraction frequency and duration
- Recommend IV Syntocinon if no forewaters present and no contraindications after review by obstetric registrar, and discussion with senior obstetric registrar or obstetric consultant
- Commence continuous electronic fetal monitoring once Syntocinon infusion begins
- Recommend repeat abdominal and vaginal examination after two hours
- Inform obstetric medical team and midwifery team leader of ongoing progress
- Continue with the labour if cervical dilatation is ≥ 1 cm per hour, +/- descent and rotation of the head, and reassuring maternal-fetal status, otherwise arrange medical review

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7. EDUCATIONAL NOTES

- There are variations in the definition of labour and the definition above was reached by consensus by a multidisciplinary consensus at the Royal Hospital for Women.
- There is also a wide range of “normal” when observing progress in labour and the following factors have been shown to promote physiological labour:
 - Staying at home (if no contra-indications) until woman is in established labour
 - Encouraging an atmosphere of calm, privacy and safety
 - Offering continuity of midwifery care whenever possible
 - Encouraging continuous non-professional support persons and/or doulas
 - Listening to the woman and acknowledging her preferences and birth plan
- Offering timely intervention is aimed at reducing the risk of further interventions and complications. Studies have shown that appropriate timely interventions can decrease labour times and increase maternal satisfaction.
- Contemporary literature suggests the active first stage to commence at 6cm cervical dilation, although this is still not universal practice.

8. RELATED POLICIES/PROCEDURES CLINICAL PRACTICE LOP

- First stage labour care for women with a low risk pregnancy
- Delivery Suite responsibility for review and management of public patients
- Syntocinon induction or augmentation of labour
- Vaginal examinations in labour
- Intrapartum Fetal Heart Rate monitoring
- ACM guidelines for consultation and referral
- Postpartum haemorrhage – Prevention and Management
- Epidural Analgesia Programmed Intermittent Epidural Bolus (PIEB) and Patient Controlled Epidural Analgesia (PCEA) – Delivery Suite
- Early Labour Assessment and Management in a Low Risk Pregnancy

9. RISK RATING

- Low

10. NATIONAL STANDARD

- CC – Comprehensive Care

11. REFERENCES

- 1 National Institute of Clinical Excellence United Kingdom Clinical Guideline 2007. Guidelines for intrapartum care
- 2 Royal Women's Hospital, Melbourne 2010. Clinical Practice Guideline. Care during first stage of labour
- 3 King Edward Memorial Hospital, Perth. Clinical Guidelines. 2009. Management of delay in first stage of labour
- 4 Frigoletto, FD, Jr., Lieberman E, Lang JM et al. 1995 A clinical trial of active management of labor New England Journal of Medicine **333**(12): 745-750

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- 5 Lavender T, Hart A, Smyth R. 2013 Effect of partogram use on outcomes for women in spontaneous labour at term. The Cochrane Library
- 6 Zhang J et al 2010 Contemporary Patterns of Spontaneous Labour with Normal Neonatal Outcomes Obstetrics and Gynecology 116(6): 1281-7
- 7 Spong CY, Berghella V, Wenstrom KD, et al. Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists workshop. Obstet Gynecol 2012; 120(5):1181–93.
- 8 Zhang J., Landy H.J., Branch D.W., et al: Contemporary patterns of spontaneous labor with normal neonatal outcomes. Obstet Gynecol 2010; 116: pp. 1281-1287
- 9 Harper L.M., Caughey A.B., Odibo A.O., et al: Normal progress of induced labor. Obstet Gynecol 2012; 119: pp. 1113-1118

REVISION & APPROVAL HISTORY

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