CLINICAL PRACTICE GUIDELINE

Labour: First stage

This document should be read in conjunction with this Disclaimer

This guideline is for the care of healthy women and babies.

If the woman has a known medical and/or pregnancy complication, staff are to refer to the appropriate guideline.

Contents

Key points

1. Determine the woman's preferences for birth and support these preferences within the scope of the setting (home, birth centre, hospital).
2. Ask the woman's consent before all procedures and observations. Document consent for procedures.
3. Document escalation of care as clinically indicated.

Definitions [1]

First stage of labour: From commencement of contractions causing cervical effacement and dilation to 10cm and/or head on view.

Latent first stage of labour – a period of time, not necessarily continuous, when:

- there are painful contractions and
- there is cervical change, including cervical effacement and dilatation up to 4cm.

Established first stage of labour, when:

- there are regular painful contractions and
- there is progressive cervical dilatation from 4cm.

Normal ranges [1]

- First labours last on average 8 hours and are unlikely to last over 18 hours.
- Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours.

Note: no upper limit to the latent phase of labour can be defined. It is not uncommon for labour to stop and start multiple times before labour is finally established. Recurrent or prolonged episodes of this may contribute to a clinical decision to induce labour in some women. [3]

Initial labour assessment

*See also CMP & FBC additional notes

1. Greet the woman with a personal welcome, establish her language needs, introduce yourself and explain your role in her care.
   - If in the hospital setting place an ID band on the woman, and confirm the absence or presence of:
     - Allergies
     - Micro alerts

- Identify the model of care and/or midwifery student continuity of care experience (CCE) allocation

2. Confirm gravity and parity, gestational age, maternal weight, past history, medications, pregnancy complications, investigation results including:
   - MRSA and VRE
   - Hepatitis B
   - Hepatitis C
   - HIV
   - Rubella immunity
   - Group B streptococcal. See also O&G guideline: Infections: GBS.
   - Blood group and rhesus
   - Haemoglobin
   - Recent ultrasound reports
   - Risk factors – refer to Labour: Women with risk factors guideline.
3. Check MR004 Obstetric Special Instruction Sheet.
4. Record maternal vital signs: respiratory rate, oxygen sat, heart rate, blood pressure and temperature.
5. Confirm presence of fetal movements (FM) and fetal heart rate (FHR). Auscultate FHR for 1 minute after a contraction and document it as a single rate.
   - See Clinical Guideline, O&G: Fetal Surveillance: Fetal Heart Rate Monitoring to determine whether a CTG is indicated.
6. Document the strength, frequency and duration of contractions, including the woman's discomfort.
7. Document vaginal loss.
8. Perform urinalysis.
9. Perform an abdominal palpation, document:
   - symphysis fundal height
   - lie
   - presentation
   - level of the presenting part above the pelvic brim
10. If the woman appears to be in established labour, and there are no contraindications offer a vaginal examination. Document:
    - Cervical dilatation and effacement
    - Application
    - Presentation and position
    - Station of presenting part

- Caput and/or moulding
- Presence of AF, colour and volume
- Adequacy of pelvis

11. Perform:
    - Skin integrity - see WNHS Policy Pressure Injury Prevention and Management
    - Risk of falls – see O&G Guideline: Falls: Risks, Prevention & Management

Note: If the woman is not in labour, advise her to return to hospital/call her health provider if:

- The frequency or duration of contractions increase
- pain relief is required
- membranes rupture
- changes in vaginal loss – bright vaginal bleeding, green/yellow discharge
- reduced FMs
- she has any concerns

Document care and advice on MR 225 Maternal Fetal Assessment Unit Admission

Care in labour

1. The birth plan should be read and discussed with the woman, and include numbers of support people.
2. Ask the woman how she is feeling and if there is anything in particular she is worried about.
3. Encourage the woman to adapt the environment to meet her individual needs.
4. Encourage and help the woman to move and adopt whatever positions she finds most comfortable throughout labour. [1, 3]
5. Encourage the woman to have support from birth companions(s) of her choice.
6. Provide women in established labour with one-to-one care.
7. Inform the woman that she may:[1]
    - drink during established labour and that isotonic drinks may be more beneficial than water
    - eat a light diet in established labour unless she has received opioids or develops risk factors that make a general anaesthetic more likely.
8. Escalate any delay in 1st stage and/or deviations from the normal progress of labour to medical team. See also O&G guideline: Labour (First stage): Management of delay

Observations [1, 3]

Maternal

1. Temperature – 4 hourly
2. Respiratory rate – 4 hourly
3. Heart rate – with auscultation of FHR
4. Blood pressure (BP) – 4 hourly
5. Contractions – 30 minutely
6. Vaginal examination (VE) – 4 hourly
7. Abdominal palpation – prior to vaginal examination
8. Bladder – document frequency of void, encourage woman to void 2 hourly.

Fetal

FHR – intermittent auscultation 15 – 30 minutely. [4]

- The maternal pulse should be palpated and documented to differentiate between maternal and fetal heart rates.
- Intermittent auscultation (IA) is an appropriate method of intrapartum fetal monitoring in women with no indications for continuous FHR monitoring. Each auscultation episode should commence toward the end of contraction and be continued for at least 30-60 seconds after the contractions has finished.

If an intrapartum CTG has been started because of concerns arising from IA, but the trace is normal after 20 minutes, you may after consultation with medical team, return to IA unless the woman asks to stay on continuous CTG.[4]

Documentation

1. Document alert and action lines on Partogram once woman's cervix has been assessed as greater than or equal to 4cm dilated.
2. Document all maternal and fetal observations on Partogram contemporaneously.
3. Document in progress notes (if CMP use MR08) 30 minutely.
4. If documenting in retrospect date and time entry.
5. Document all VE findings on Partogram.
6. Document woman's consent to procedures.

Note: all documentation must have date, time, legible signature and staff position.

CMP and FBC additional notes

CMP

- Home birthing women assess the home situation as per the WA Health Policy for Publicly Funded Home Births, noting date and time of arrival in birth record. If transfer is required at any stage, refer to the following guideline, Obstetrics & Gynaecology: Transfer from Home to Hospital (VMS / MGP / CMP)
- If in the home: Obtain a verbal history of events leading up to hospital presentation or midwife's arrival at the home.
- In the community, transfer to LBS or the supporting hospital must occur if an intrapartum CTG is required
- Escalate any delay in first stage and/or deviations from normal labour progress to Obstetric Registrar or above at supporting hospital.

CMP & FBC

- **FBC & CMP**: If meconium present, transfer from the FBC or home must occur as per guideline, O&G: Labour: Meconium Stained Amniotic Fluid.
- **FBC & CMP**: Confirm whether the chosen place of birth remains appropriate for the woman's clinical needs.

References

1. National Institute for Clinical Excellence. Intrapartum care forhealthy women and babies. **NICE Clinical Guidelines,**. 2014
2. The Cochrane Library. Continuous support for women during childbirth. Bohren, M.A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R.K. and Cuthbert, A. 2017.
3. Provision of routine intrapartum care in the absence of pregnancy complications. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. July 2017.
4. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Intrapartum Fetal Surveillance Clinical Guideline – Third Edition (2014). Melbourne, Victoria: RANZCOG
5. Government of Western Australia, Department of Health, CTG Monitoring Standard. 2017.

Related legislation and policies

Legislation*: Poisons Act 1965*

NMHS Policy: Falls Risk Management Policy

Related WNHS policies, procedures and guidelines

WNHS Policies (available to WA Health employees through Healthpoint)

- Falls Prevention and Falls Management
- Pressure Injury Prevention and Management
- Visiting Hours and Accommodation for Parent/ Partner/ Support Person

KEMH Clinical Guidelines:

Anaesthetics

- Labour Analgesia & Post-operative Analgesia: Assessment of Motor Function and Testing of Dermatomes

Obstetrics & Gynaecology

- Caesarean Birth: Gastric Aspiration Prevention in Obstetrics
- Infections in Pregnancy: Group B Streptococcal Disease (GBS)
- Falls: Risks, Prevention & Management
- Fetal Surveillance: Fetal Heart Rate Monitoring
- **Labour and Birth**: First Stage Delay; Born Before Arrival; Second Stage and Birth; Partogram, Birth Notification; Birth Photographs/Video During; Perineum Episiotomy & Infiltration; Intrauterine Pressure Transducer Catheter (IUPT); Syntometrine; Third Stage; Moderate & High Risk Women Admitted to MFAU/LBS- Medical Review & Care Planning; Management of Pregnancy Beyond 41 weeks; Meconium Stained Amniotic Fluid; Neonatal Team Attendance at Births; Prelabour Rupture of Membranes at Term

- Pain Management in Adults (includes labour pain management)
- Placenta: Placenta: Being Taken Home; Placenta Indications for Histopathological and Microbiological Examination; Retained Placenta;
- Shoulder Dystocia
- Postnatal: Immediate Maternal Care in Labour and Birth Suite
- Transfer from Home to Hospital (VMS/ MGP / CMP)
- Waterbirth and Immersion In Water for Pain Management During Labour and/or Birth

Useful resources (including related forms)

Forms:

- Maternal Fetal Assessment Unit Admission (MR 225)
- Partogram
- Progress notes (MR 250)
- CMP MR08

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