



**INTRAPARTUM CARE**

**FIRST STAGE OF LABOUR**

**LABOUR (FIRST STAGE): MANAGEMENT OF DELAY**

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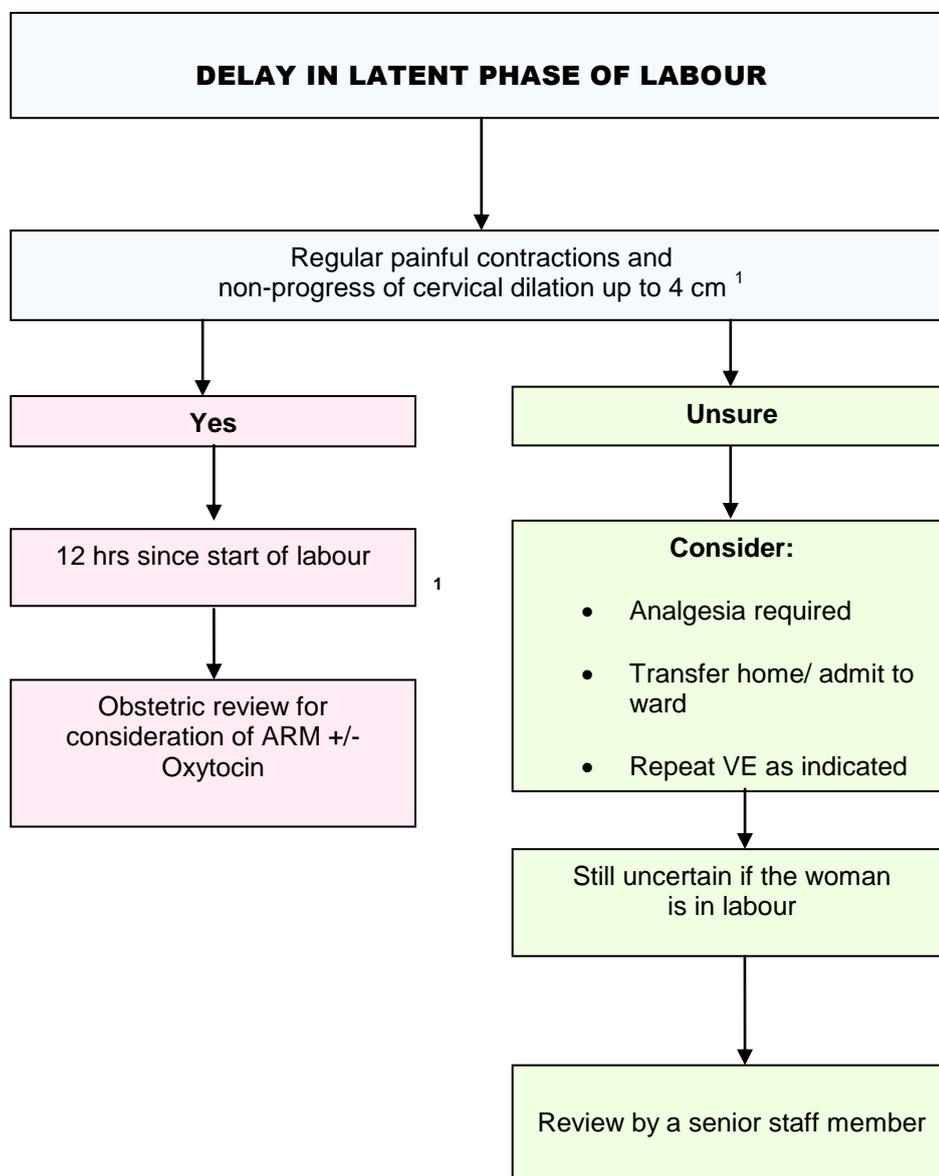
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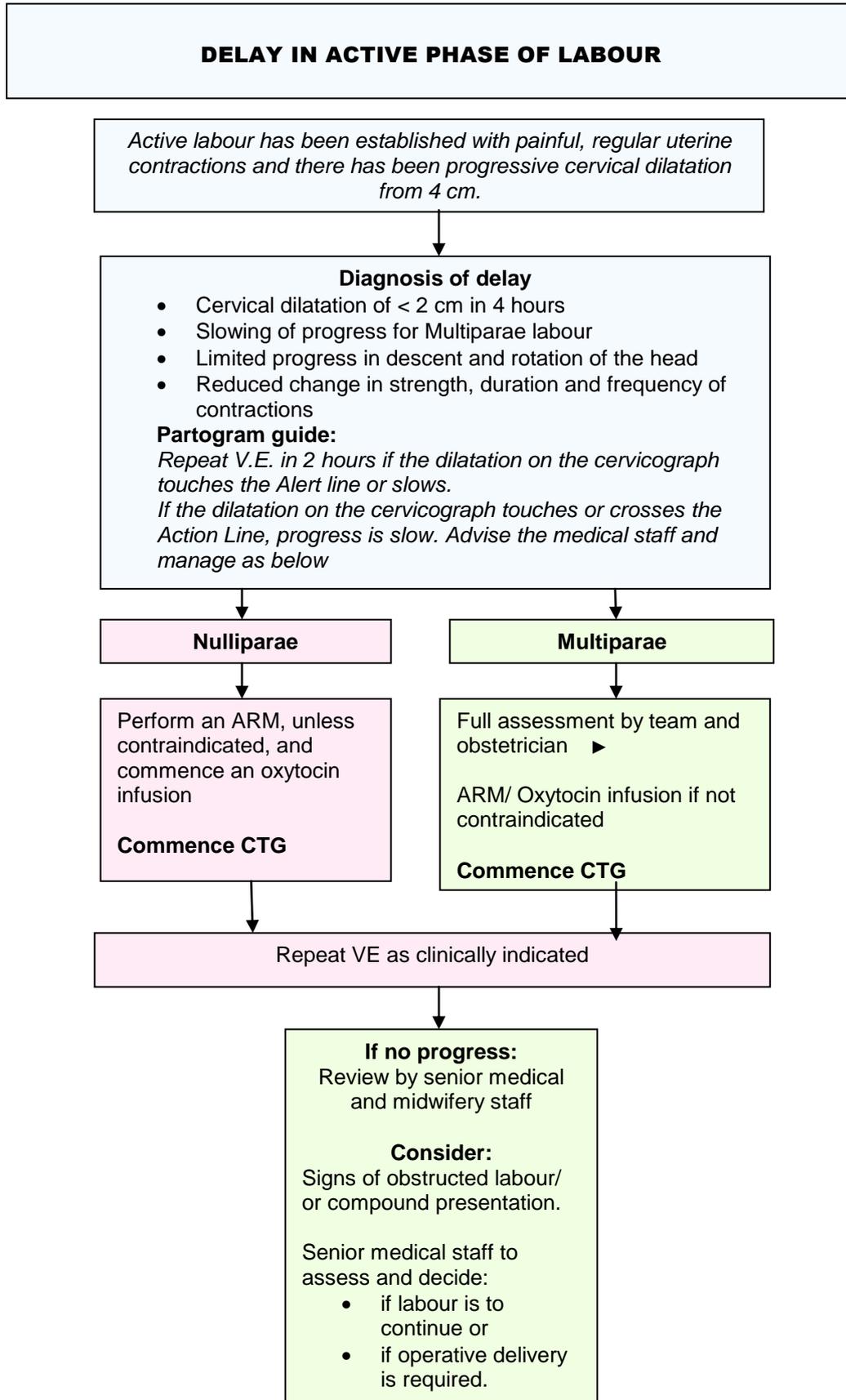
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**FLOW CHARTS FOR DELAY IN SPONTANEOUS LABOUR**





## AIM

- To make a timely diagnosis of delay in the first stage of labour, and to initiate care that will increase the likelihood of the spontaneous vaginal birth of a healthy infant.

## KEY POINTS

- Encourage delayed admission to the labour and birth suite for normal labouring women (before 3cm dilated) unless maternal fatigue or need for support requires early admission. This policy avoids unnecessary intervention<sup>1</sup>.
- All women with delay in the latent phase of labour, or when they reach the active phase of labour should be commenced on a partogram, and their labour progress plotted on the cervicograph.
- The medical obstetric team should be advised of suspected or diagnosed delay in the latent or active phase of labour.
- Continuous fetal heart monitoring should be commenced when the diagnosis of a delay in the active phase of labour is confirmed<sup>2</sup>.

## MANAGEMENT OF DELAY IN THE FIRST STAGE OF LABOUR

The construction of a cervicograph and the drawing of Alert and Action Lines are described in the Clinical Guidelines, O&M, Intrapartum Care: Labour (First Stage): [Partogram](#)

### DELAY IN THE LATENT PHASE

Uncertainty remains over the definition of latent phase of labor, but agreement indicates the active phase of labor is when cervical dilatation is between 3 and 4 cm dilatation<sup>3</sup>. The latent phase of labour can be described when the woman perceives she has regular contractions and clinical assessment by vaginal examination shows progressive cervical effacement and dilatation<sup>2</sup>.

There remains no consensus regarding what constitutes a normal latent phase with definitions varying from 6-8 hours until up to 24-36 hours<sup>4</sup>.

**At KEMH diagnosis of delay in the latent phase of labour is made when the woman's cervix is less than 4cm dilated 12 hours after commencement of labour. A partogram should be commenced at this time.**

### ACTION IF DELAY IN LATENT PHASE

- Advise the medical team when diagnosis of delay of the latent phase of labour is established.
- Reassess labour history – is the woman in labour?
- If diagnosis of labour is confirmed consider artificial rupture of membranes (ARM) and commencement of an oxytocic infusion. Amniotomy together with oxytocin has been associated with a modest reduction in caesarean section when delay in spontaneous labour occurs<sup>5</sup>.

Family Birth Centre women should be transferred to Labour and Birth Suite at this stage.

- If diagnosis of labour is not confirmed; and there is no indication to induce labour, the woman should be discharged home from the Labour and Birth Suite or the Family Birth Centre.
- If diagnosis is unsure:
  - Consider administering analgesia.
  - Consider transfer to an antenatal ward or discharge home.
  - Repeat the vaginal examination 4 hours after **diagnosis of delay** in the latent phase of labour and commencement of the partogram (note – the partogram is commenced 12 hours after diagnosis of labour).

## **DELAY IN THE ACTIVE PHASE**

The active phase of labour is described as when there are painful, regular contractions and progressive cervical dilatation from 4cm<sup>6</sup>.

Diagnosis of delay in the active phase should consider all aspects of labour progress and include<sup>6</sup>:

- Cervical dilatation of less than 2cm in 4 hours for first labours
- Cervical dilatation of less than 2cm in 4 hours or slowing of progress for second or subsequent labours
- Descent and rotation of the fetal head
- Reduced changes in the strength, duration and frequency of uterine contractions

## **CERVICOGRAPH – ALERT AND ACTION LINE MANAGEMENT**

### **Alert Line crossed**

If the cervicograph touches or crosses the Alert Line, this denotes that progress is slower than average. In this instance, a VE should be repeated in two hours to ensure early detection of delay in the active phase of labour. Delay in the active phase of labour is indicated when the cervicograph crosses the Action Line. The medical team should be advised.

### **Action Line crossed**

If the cervicograph touches or crosses the Action Line, progress is abnormally slow and the medical team should be advised immediately, and appropriate management should be taken as follows:

## **NULLIPARAE – MANAGEMENT FOR PERCEIVED DELAY IN THE ACTIVE PHASE OF LABOUR**

1. Perform an artificial rupture of membranes (ARM) unless contraindicated – has been shown to shorten labour by about one hour. Advise the women that the ARM may increase the strength and frequency of her contractions<sup>6</sup>.
2. Repeat the VE in 2 hours after ARM. The VE should be repeated in 2 hours even if the woman has declined an ARM.
3. If no progress:
  - Advise the Registrar and Midwifery Co-ordinator
  - Transfer the Family Birth Centre woman to Labour and Birth Suite.
4. Commence an oxytocin infusion provided none of the following contraindications are present:
  - Malpresentation
  - Severe moulding (+++) or any other sign of obstructed labour
  - Any sign of significant fetal compromise

The woman should be informed that ARM may bring forward her time of birth, but will not influence the mode of birth or other outcomes<sup>6</sup>. The combination of amniotomy and an oxytocin infusion has been found to reduce labour duration by up to 2.5 hr<sup>7</sup>. If not already in progress, continuous external fetal monitoring should be commenced when the oxytocic infusion begins<sup>6</sup>.

5. Continue reassessment for pain relief.
6. A vaginal examination should be performed 4 hours after commencing an oxytocic infusion in active labour. If there is less than 2cm progress after the 4 hours, notify the obstetric team and Midwifery Co-ordinator immediately for review to consider delivery by caesarean section<sup>8</sup>. If there is more than 2cm dilatation, vaginal examination should be done 4 hourly<sup>6</sup>.

## **MULTIPARAE – MANAGEMENT FOR PERCEIVED DELAY IN THE ACTIVE PHASE OF LABOUR**

1. Perform an artificial rupture of membranes unless contraindicated – this has been shown to shorten labour by about one hour. Advise the women that the ARM may increase the strength and frequency of her contractions<sup>6</sup>.
2. Repeat the VE in 2 hours after ARM. The VE should be repeated in 2 hours even if the woman has declined an ARM.
3. If no progress:
  - Advise the Registrar and Midwifery Co-ordinator
  - Transfer the Family Birth Centre woman to Labour and Birth Suite.



4. Multiparous women with confirmed delay in the first stage should be reviewed by the team Obstetrician. A full assessment, including abdominal palpation and VE, should be done prior to a decision being made about oxytocic infusion use<sup>6</sup>.
5. If an oxytocic infusion is used, consider the use of an intra-uterine pressure transducer if external cardiotocograph monitoring is ineffective<sup>1</sup>.

An oxytocic infusion should not be used in multiparous women unless the clinician is convinced there is no cephalopelvic disproportion, and then only if all of the following additional pre-requisites are present:

- Parity of less than 5
  - Unscarred uterus
  - Cephalic presentation
  - No evidence of uterine hyperstimulation or tachysystole
  - Contractions less frequent than 3-4 in 10 minutes, lasting no more than 60 seconds
  - Uterus well-relaxed between contractions
6. Repeat the VE 2 hours after commencement of the infusion.
  7. If the cervical dilatation has not increased by 2cm or if the cervix is fully dilated, allow labour to continue provided there are no signs of obstructed labour or fetal compromise. Otherwise prepare for immediate operative delivery.
  8. If an oxytocic infusion is contraindicated, and immediate delivery is not indicated, repeat the VE in 2 hours. Proceed as described in number 7 above.

### **SPECIAL CASE**

#### **Cervix is $\geq 8$ cm but $< 10$ cm on admission or at first vaginal examination**

1. Draw the Alert Line but not the Action Line. The Alert Line in this case is used as the Action Line.
2. Repeat the VE after one hour if the cervix is 9cm dilated or two hours if the cervix is 8cm dilated.
3. Take appropriate action, as previously described above, if the repeat VE shows that the cervix is not fully dilated.

## REFERENCES / STANDARDS

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National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice  
 Legislation -  
 Related Policies -  
 Other related documents – KEMH Clinical Guidelines: O&M: Intrapartum Care: [Partogram](#)

## RESPONSIBILITY

<b>Policy Sponsor</b>	<b>Nursing &amp; Midwifery Director OGCCU</b>
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