



**OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE**

Labour (first stage): Management of delay

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Community Midwifery Program)

This document should be read in conjunction with this [Disclaimer](#)

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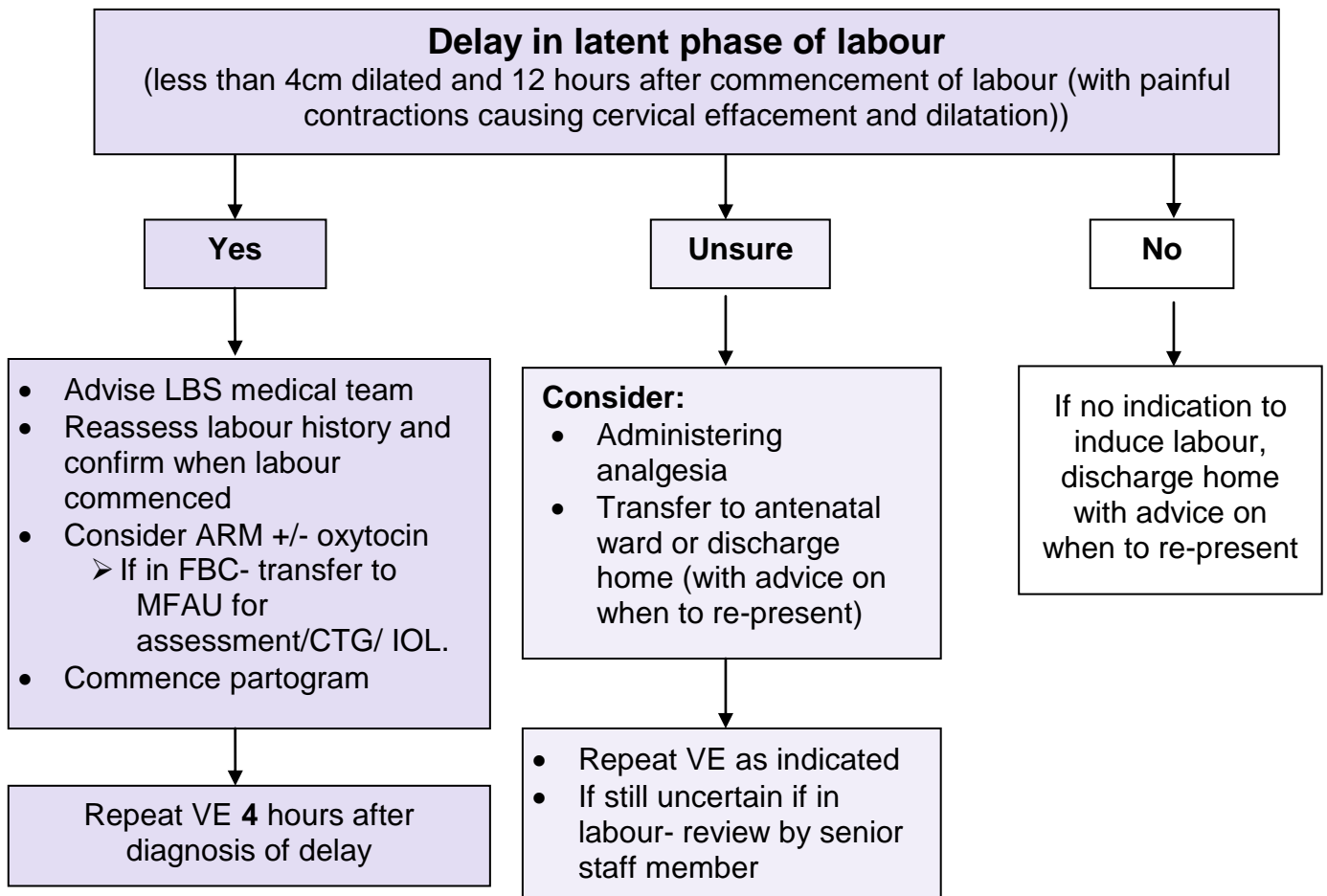
Aim

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.

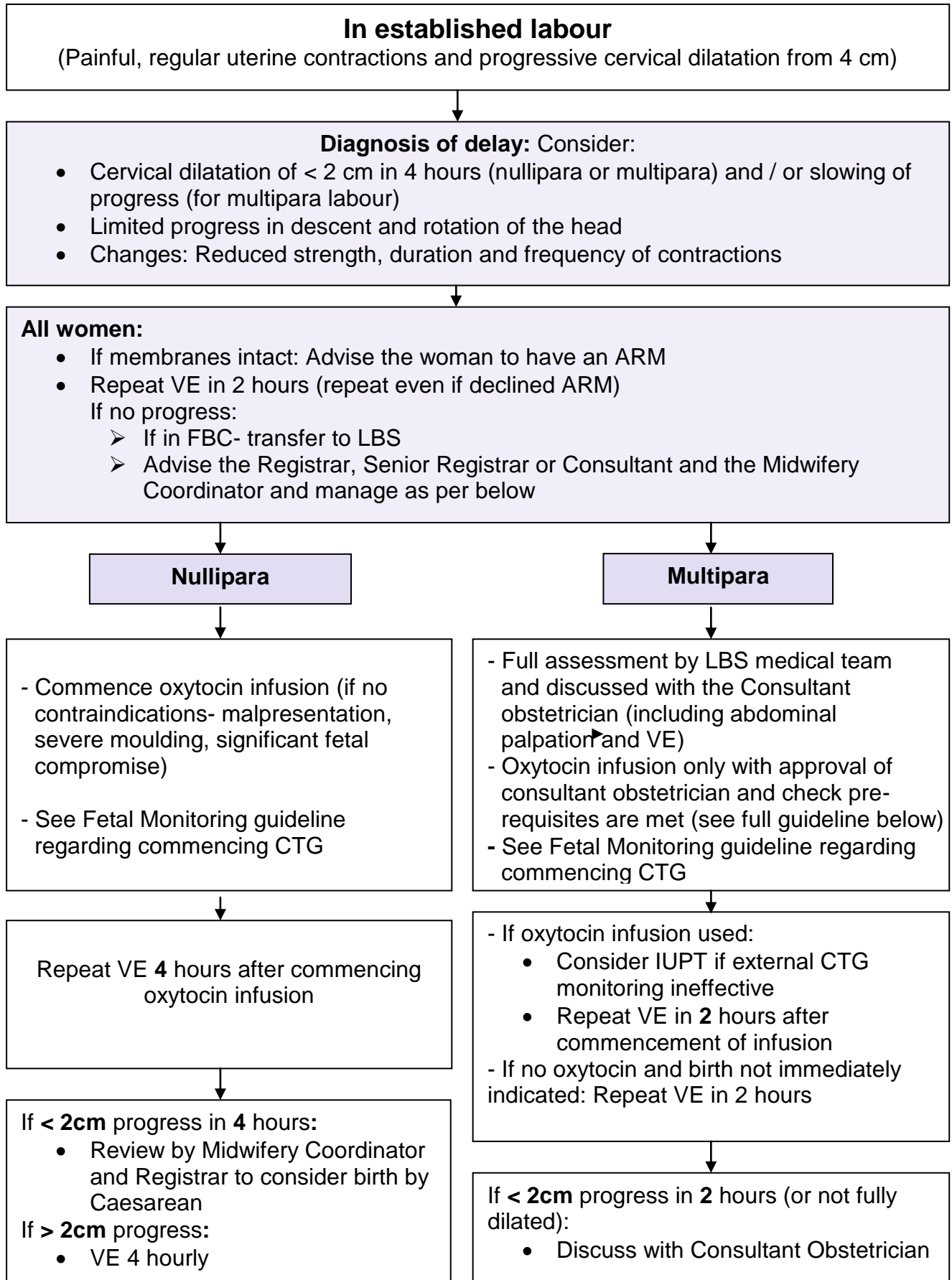


Flow charts

Delay in latent phase



Delay in active phase



Note: For definitions of labour stages refer to KEMH Clinical Guideline, Obstetrics & Gynaecology: [Labour: First Stage](#).

Key points

1. Encourage delayed admission to the labour and birth suite for healthy labouring women (before 4cm dilated) unless maternal fatigue or need for support requires early admission. This avoids unnecessary intervention ¹.
2. 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.
3. The medical obstetric team should be advised of suspected or diagnosed delay in the latent or active phase of labour.
4. Fetal heart monitoring as per [FHR Monitoring guideline](#).
5. An Alert and Action line should be drawn on the Partogram. Refer to KEMH Clinical Guideline, Obstetrics & Gynaecology: [Labour: Partogram](#)

Partogram 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. The Midwifery Coordinator and Obstetric Registrar should be informed.

'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 outlined in this guideline.

Latent phase: Management of delay

At WNHS **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

1. Advise the LBS medical team when diagnosis of delay of the latent phase of labour.
2. Reassess labour history and confirm when labour commenced.
3. 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 occurs².

4. Family Birth Centre (FBC) women should be transferred to MFAU for assessment, CTG and/or analgesia.
5. If diagnosis of **labour is not confirmed**: and there is no indication to induce labour, the woman should be discharged home, with advice on when to re-present.
6. If diagnosis is unsure:
 - Consider administering analgesia
 - Consider transfer to an antenatal ward or discharge home (with advice on when to re-present)
 - Repeat VE as indicated, that is in the evidence or regular contractions.
 - If still uncertain if in labour- review by senior staff member
7. Repeat the vaginal examination (VE) 4 hours after **diagnosis of delay** in the latent phase of labour (and commencement of the partogram as per above).

Active / established phase: Management of delay

The active phase of labour is described as when there are painful, regular contractions and progressive cervical dilatation from 4cm.³

Diagnosis of delay in the active phase should consider all aspects of labour progress and include³:

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

All women

1. Women with intact membranes: Advise the woman to have an ARM– shown to shorten labour by about one hour. Advise the women that the ARM may increase the strength and frequency of her contractions.³
2. Repeat the VE in 2 hours. The VE should be repeated even if the woman has declined an ARM.³
3. If no progress:
 - Advise the Registrar (or higher) and Midwifery Co-ordinator
 - Transfer the FBC woman to LBS if no progress post ARM.
4. Continue support and assessment for pain relief.³

Nullipara

In **addition** to care for '[all women](#)' above:

1. Commence an oxytocin infusion if none of the following contraindications are present:
 - Malpresentation
 - Severe moulding (+++) or any other sign of obstructed labour
 - 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.³ The combination of amniotomy and an oxytocin infusion has been found to reduce labour duration by approximately 2 hours⁴.

2. If not already in progress, continuous external fetal monitoring should be commenced when the oxytocic infusion begins.³
3. A VE should be performed 4 hours after commencing an oxytocic infusion in active / established labour.³ If there is less than 2cm progress after the 4 hours, notify the Registrar and Midwifery Co-ordinator immediately for review to consider birth by caesarean section.³ If there is more than 2cm dilatation, VE should be done 4 hourly.³

Multipara

In **addition** to care for '[all women](#)' above:

1. Multiparous women with confirmed delay in the first stage should be reviewed by the LBS medical team and discussed with the Consultant Obstetrician. A full assessment, including abdominal palpation and VE, should be done prior to a decision being made about oxytocic infusion use.³
2. An oxytocic infusion should not be used in multiparous women unless the clinician is convinced there is no cephalopelvic disproportion, and then only with approval of Consultant Obstetrician and 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

3. If an **oxytocic infusion is used**:

- Consider the use of an intra-uterine pressure transducer if external cardiotocograph monitoring is ineffective¹.
- Repeat the VE 2 hours after commencement of the infusion. If the cervical dilatation has not increased by 2cm or if the cervix is not fully dilated, discuss with consultant obstetrician.

4. If an **oxytocic infusion is not used**:

- If an oxytocic infusion is contraindicated, and immediate delivery is not indicated, repeat the VE in 2 hours. If the cervical dilatation has not increased by 2cm or if the cervix is not fully dilated, discuss with consultant obstetrician.

References

1. Ness A, Goldberg J, Berghella V. Abnormalities of the First and Second Stages of Labor. **Obstetric and Gynaecological Clinics of North America**. 2005;32:201-20.
2. Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, et al. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care (Review). **The Cochrane Colloboration**. 2012 (9).
3. National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies: CG190UK: NICE. 2017. Available from: <https://www.nice.org.uk/guidance/cg190>
4. Bugg GJ, Siddiqui F, Thornton JG. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. **Cochrane Database Syst Rev**. 2013 (6):Cd007123.

Related WNHS policies, guidelines and procedures









WNHS Obstetrics and Gynaecology Clinical Guidelines:

- [Caesarean Birth](#)
- [Fetal Heart Rate Monitoring](#)
- [Labour: First Stage](#)
- [Labour: Intrauterine Pressure Transducer](#)
- [Labour: Moderate and High Risk Women Presenting at MFAU and Birth Suite](#)
- [Labour: Partogram](#)
- [Maternal Fetal Assessment Unit \(MFAU\)](#)

Restricted Area Guideline: [Induction of Labour](#)

Useful resources and related forms

Forms: Partogram

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