LABOUR (FIRST STAGE): CARE OF THE WOMAN

Keywords: first stage of labour, care in labour, intrapartum care, latent stage, active first stage, assessment in labour, first stage, labour, abdominal palpation, vaginal examination in labour, VE, contractions, labour pain management, bladder management

AIMS

- To assess maternal and fetal wellbeing throughout the first stage of labour.
- To facilitate the progress of labour.
- To identify factors that may influence the ongoing management of the woman and her infant.

DEFINITIONS OF THE FIRST STAGE OF LABOUR

LATENT STAGE
A period of time (not necessarily continuous) when the woman has painful contractions with some cervical change, including cervical effacement and dilatation up to 4cm.

ACTIVE OR ESTABLISHED FIRST STAGE
There are regular, painful contractions associated with progressive cervical dilatation from 4cm.

PROCEDURE

<table>
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<th>PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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<tbody>
<tr>
<td>Admission assessment</td>
<td>Obtain a verbal history and perform an assessment of the woman including: Relevant medical/obstetric history, Frequency and duration of contractions, Pain intensity of the contractions, Assessing if the membranes are ruptured. Allows prioritising, preparation, and planning of care.</td>
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<tr>
<td>Planning management according to obstetric and medical history</td>
<td>Ensure an appropriate wrist identification bracelet is in place, and allergy stickers are placed on relevant documents.</td>
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<tr>
<td>Check for allergies</td>
<td>See Clinical Guideline, O&amp;M, Intrapartum Care: Labour: Moderate and High Risk Women Admitted to MFAU and Labour and Birth Suite-Medical Review and Care Planning</td>
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<tr>
<td>Check for an obstetric plan on the Obstetric Special Instruction Sheet (MR004)</td>
<td>Notify medical staff when any moderate or high risk women present in labour.</td>
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<td>Check antenatal screening tests/ blood results.</td>
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<td>Check the Group B Streptococcus (GBS) status</td>
<td>If GBS positive, refer to: Clinical Guidelines, O&amp;M Antenatal Care: Infection in Pregnancy: Group B Streptococcal Disease: Intrapartum Quick Reference Guide.</td>
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<td>If the woman has a birth plan - discuss and implement management as appropriate.</td>
<td>Allows the woman to feel in control and active in the management of her care.</td>
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### PROCEDURE

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<th>3</th>
<th>Maternal observations</th>
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<tr>
<td>Consider the woman’s medical and obstetric history and present condition when determining the frequency of assessments.</td>
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#### 3.1 Temperature

Monitor the maternal temperature:
- on admission
- *Intact membranes* – 4 hourly
- *Ruptured membranes* – 2 hourly
- 1 hourly if the woman is febrile.

Pyrexia may be caused by infection or ketosis, and can be associated with epidural analgesia.²⁻⁵

#### 3.2 Pulse

Monitor the maternal pulse:
- On admission
- During the *Latent phase of labour* – 4 hourly
- During the *Active phase of labour* – every 30 minutes

Tachycardia may indicate anxiety, pain, infection, ketosis and haemorrhage.⁶

#### 3.3 Blood Pressure (BP)

Measure the BP:
- On admission
- During the *latent phase of labour* – 4 hourly
- During the *active phase of labour* – 2 hourly

Labour may cause further elevation of the BP if a woman has essential hypertension or pre-eclampsia. If the BP is abnormal or if the woman has had a neuraxial block (epidural analgesia), measurements will be required to be done more frequently according to guidelines, or in consultation with the medical team.

#### 3.4 Respiration and oxygen saturation

Assess on admission

Provides a baseline observation

Refer also to Clinical Guidelines, Obstetrics & Midwifery: Pain Management. The frequency of monitoring respirations may need to be individualised according to analgesic use.

### ADDITIONAL INFORMATION

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<tr>
<th>4</th>
<th>Additional maternal management</th>
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<tbody>
<tr>
<td>Weigh the woman on admission if there is no recent record of measurement. Provides beneficial information for analgesia and anaesthetic calculations.</td>
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### 4.1 Weigh the woman on admission if there is no recent record of measurement. |

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<thead>
<tr>
<th>5</th>
<th>Fetal well-being assessment</th>
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<tbody>
<tr>
<td>Auscultate the fetal heart rate (FHR) during normal labour:</td>
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<tr>
<td>- On admission</td>
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<tr>
<td>- <em>Latent phase of labour</em> – 2 hourly¹⁻⁶</td>
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<tr>
<td>- <em>Active phase of labour</em> – 30 minutey ⁴⁻⁵</td>
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<tr>
<td>- The maternal pulse should be palpated to differentiate between maternal &amp; fetal heart rates ¹⁻⁵</td>
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During labour, auscultation of the FHR with a Doppler ultrasound on speaker mode should occur before and during a contraction and continue for at least 1 minute after the contraction has ceased.¹
5.2 Refer to the Clinical Guideline, Obstetrics & Midwifery, Intrapartum: Fetal Heart Rate Monitoring; Intrapartum

5.3 **Amniotic Fluid**

Women with ruptured membranes should have the amniotic fluid loss checked for colour, consistency and odour:
- On admission
- In Early labour - 2 hourly
- In Active labour – every 30 minutes

Fetal stress and maturity may contribute to increased gastrointestinal motility resulting in meconium being passed into the amniotic fluid. The presence of meconium may not lead to Meconium Aspiration Syndrome (MAS), but the fetus will require continuous heart rate monitoring during labour. "Offensive" smelling amniotic fluid may indicate chorioamnionitis.

6 **Bladder management**

6.1 Conduct an urinalysis:
- when a woman is admitted
- if her medical or obstetric condition necessitates increased frequency of testing

May detect ketosis, pre-eclampsia and other abnormalities.

6.2 Encourage the woman to empty her bladder prior to abdominal or vaginal assessment. See Clinical Guidelines, Obstetrics & Midwifery, Postnatal Care: Bladder Care for further information

A full bladder may prevent descent of the presenting part, or reduce the contractibility of the uterus.

6.3 Measure urine output if a woman:
- has an intravenous infusion in situ
- has an epidural in situ
- has a medical condition requiring monitoring of fluid balance

6.4 In the *latent* phase of labour:
- Encourage the woman to void 2 hourly

In the *active* phase of labour:
- Encourage the woman to void 2 hourly &
- Measure the volume of the voids

6.5 Women in labour who have an epidural block shall have an indwelling catheter.

If a voiding dysfunction is undetected then bladder over distension can lead to denervation, detrusor atony and prolonged voiding difficulties. Minimal urinary amounts may indicate retention of urine with overflow. Undetected urinary retention leading to an over distended bladder can lead to serious long term morbidity for the woman.

Women who have an operative birth with a spinal or epidural topped up must have an indwelling catheter inserted. It should remain in situ for at least 12 hours following birth.
**PROCEDURE** | **ADDITIONAL INFORMATION**
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6.6 Prior to the removal of an IDC, assess the woman’s motor function to ensure sensation has returned to normal. Perform a Bromage Score and check her Dermatomes if the epidural top-up contained local anaesthetic. Refer to Clinical Guidelines, Anaesthetics: Assessment of Motor Function and Testing of Dermatomes. & Epidural analgesia impedes sensory impulses in the bladder increasing the risk of urinary retention.\(^8\) It has been reported that it may take up to 8 hours after epidural analgesia for bladder sensation to return.\(^9\)

### 7 Mobility

7.1 Allow low risk women without epidural analgesia to ambulate as they desire. & Studies have shown no adverse effects with mobilisation. Benefits, such as greater uterine contractility, shorter labours, less oxytocic use, less operative deliveries, and a reduced amount of fetal distress has been demonstrated.\(^5\)

### 8 Fluids and Nutrition

8.1 In the latent phase of labour allow diet as desired and encourage oral hydration & Uterine muscle contraction requires glucose and, if depleted, muscle inertia may occur.\(^4\). Eating and drinking in early labour has not been shown to significantly affect labour progress, or cause adverse maternal or infant outcomes.\(^5\).

- Allow a light, low fat, low roughage diet in labour for women at low risk for anaesthesia.\(^8\).

- Women at risk for having a general anaesthetic should have sips of clear fluid only. See Clinical Guideline, O&M, Caesarean: Gastric Aspiration Prevention in Obstetrics & Hunger and thirst can lead to ketonuria, which may increase the length of labour and need for interventions.\(^10\).

- Women are at greater risk of morbidity and mortality from aspiration pneumonia if a general anaesthetic is used.\(^10\).

8.4 Consider intravenous fluids for:
- Women at risk of dehydration
- Fasting women & Prevents ketosis.

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- Fasting women & Prevents ketosis.

9.1 Provide continuous midwifery support during labour. & Continuous support during labour reduces a woman’s likelihood of pain medication and results in her having an increased level of satisfaction with labour and the chance of a spontaneous birth.\(^11\).

### 9 Comfort and emotional well-being

9.1 Provide continuous midwifery support during labour. & Continuous support during labour reduces a woman’s likelihood of pain medication and results in her having an increased level of satisfaction with labour and the chance of a spontaneous birth.\(^11\).

9.2 Offer support to birth companions by:
- Involving them in birth options discussions
- Involving them in practical support tasks & Link to WNHS visiting policy
### PROCEDURE

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<td><strong>9.3</strong></td>
<td>Encourage the woman to select comfortable positions during her labour, and ambulate as desired. Advise the woman to avoid the supine position in labour.</td>
</tr>
</tbody>
</table>
| **9.4** | Provide props to facilitate positioning and posture:  
- Birth balls  
- Bean bags  
- Birth stools  
- Comfortable chairs |

### ADDITIONAL INFORMATION

Studies have shown no negative effects connected with ambulation. Varying benefits have been associated with ambulation such as increased uterine contractility, less analgesia, fewer operative deliveries, shorter labours, less requirements for augmentation and less fetal distress.  

### 9.3

Provide props to facilitate positioning and posture:  

- Birth balls  
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### 10 Pain Management

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<td><strong>10.1</strong></td>
<td>Refer to the Clinical Guidelines, Section B4 Pain Management for options available to women.</td>
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Women should be encouraged to assess and communicate their analgesic needs throughout labour.

### 11 Assessing progress of labour

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| **11.1** | Monitor the progress of labour by:  
- Assessing the contractions  
- Abdominal palpation  
- Vaginal examination  
- Drawing the alert and action lines on the partogram  

Notify the medical staff of any deviations from the normal progress of labour. |

A diagnosis of delay in progress in the active phase of first labours should include:

- Cervical dilatation of less than 2cm in 4 hours during first labours  
- Cervical dilatation of less than 2cm in 4 hours, or slowing in the progress of labour for second and subsequent labours.  
- If a patient has crossed the alert line (slower rate than 1cm per hour) the patient should be assessed by an experienced midwife to determine the cause. A VE should be performed 2 hours later to assess progress.  
- Abnormalities for descent and rotation of the fetal head.  
- Changes in the strength, duration and frequency of contractions. |

**Assessment of contractions**

Assess the strength, duration and frequency of contractions:

- On admission  
- *Latent phase of labour* – 2 hourly  
- *Active phase of labour* – 30 minutely

**Vaginal examination (VE)**

The frequency of VEs should be individualised and performed regularly enough to:

- Confirm labour  
- Confirm the fetal presentation

There is a lack of consensus in the literature regarding the frequency of vaginal examinations. Progress of labour is determined by the effacement and dilatation of the cervix, descent, flexion and rotation of
PROCEDURE | ADDITIONAL INFORMATION
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• Assess progress of labour | the fetal head³.
• Identify problems early
• If in doubt, to confirm full dilatation prior to the woman commencing pushing.

Offer the woman a VE:
• 4 hourly in active labour
• if she requests examination and it is appropriate¹.

A VE should be performed if there is concern about the progress of labour¹, or fetal well-being.

Consider performing a VE prior to an intramuscular analgesic injection or an epidural antú. If delivery is imminent analgesia management may need to be reassessed.

11.4 Abdominal Palpation

Perform an abdominal palpation:
• On admission if there are no contraindications
• 2 hourly during the first stage of labour
• Prior to any vaginal examination
• To check the progress of labour as required

Abdominal palpation provides information of lie, presentation, position and engagement of the fetus⁵. This allows monitoring of the descent of the presenting part as labour progresses⁶.

12 Reporting of abnormalities of labour

12.1 Notify any deviations from normal labour as soon as possible to the:
• Medical personnel
• Midwifery Co-ordinator


13 Documentation


13.2 Detailed documentation of progress, deviations from normal labour and management plans are written on the MR250 Integrated Progress Notes.
REFERENCES (STANDARDS)