OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Labour: First stage and management of delay

Scope (Staff):	All clinical staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH, Community Midwifery Program and Midwifery Group Practice

This document should be read in conjunction with the Disclaimer.

This guideline is for the care of healthy women and babies.
If a woman has a known medical and/or pregnancy complication, staff should refer to the more appropriate clinical guideline.

Contents

Introduction

Key points

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

Definitions[1]

- **Latent first stage/early labour:** is a period characterized by painful uterine contractions and variable changes to the cervix, including some degree of effacement and slower progression of dilatation up to 5cm.
- **~~A~~ctive first stage:** a period characterized by regular, painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation.
- **Slow labour:** <2cm change in cervical dilatation during the preceding 4-hours, from 5cm dilatation (active first stage). Other features of the examination such as descent, rotation and application may inform the diagnosis.

Normal ranges[1]

- Women should be informed that a standard duration of the latent first stage of labour has not been established and can vary widely from one woman to another.
- Duration of active first stage usually does not extend beyond 18 hours for a woman's first labour and typically no greater than 12 hours for subsequent labours.

Initial labour assessment

- Greet the woman with a personal welcome, establish her language and cultural needs, introduce yourself and explain your role in her care. Listen to her story and support her preferences and her emotional and psychological needs. Consider her Goals of Care, Sensitive Care Plan and declining Recommended Care.
- Identify the woman's model of care and/or student allocation (continuity of care or rostered student)
- Confirm gravida and parity, gestational age, maternal weight, history, medications, pregnancy complications, investigation results and any risk factors.
- Check Obstetric Special Instruction Sheet MR004 (KEMH) / MR1.1 (OPH).

- Carry out a face-to-face labour assessment, and midwifery monitoring for at least one hour[2]:
    - maternal vital signs: respiratory rate, oxygen saturation, heart rate, blood pressure and temperature
    - fetal movements
    - determine most appropriate method of FHR assessment – refer to Obstetrics and Gynaecology Directorate (OGD) Clinical Practice Guideline (CPG) Fetal Heart Rate Monitoring
    - Ascertain strength, frequency and duration of contractions
    - Perform an abdominal palpation (fetal presentation, lie, position, engagement of the presenting part)
    - Review and document the colour and presence of vaginal loss
    - Perform a urinalysis
- If the woman appears to be in established labour and there are no contraindications, offer a vaginal examination (VE) in the presence of a chaperone.
- Advise the woman the VE can be stopped at any point throughout.
- Document VE findings:
    - Cervical dilatation and effacement
    - Presentation and position
    - Station of presenting part
    - Application of presenting part
    - Presence or absence of Caput and/or moulding
    - presence or absence of membranes and colour of liquor if membranes ruptured
    - Auscultation of FH after VE
- Sensitively explain findings of the examination in the context of the clinical picture and history and discuss any potential impact on the birth plan to the woman and her birth companion/s[2].
- Complete risk assessments:
    - Skin integrity - see WNHS Policy Pressure Injury Prevention and Management
    - Risk of falls – see WNHS Procedure: Falls: Risk Assessment and Management of Patient Falls (WNHS)
    - VTE risk assessment- see OGD Clinical Guideline: Venous thromboembolism (VTE): Prevention and management

Management of early labour

- When after performing an initial labour assessment the woman is found to in early labour / latent phase of labour, offer individualised support regarding:
    - Rest
    - Hydration
    - Nutrition
    - Comfort strategies (risks and benefits)
    - Recommend returning home
- Provide the woman with education regarding when to call/reattend:
    - Increased frequency, strength or duration of contractions
    - Requesting analgesia
    - Spontaneous rupture of membranes
    - Changes in vaginal loss (frank blood loss, green/yellow discharge)
    - Any perceived changes in fetal movements
    - The woman has concerns
- Plan and document the agreed upon time for reassessment.
- Document care and advice on Maternal Assessment KEMH MR225 / OPH MR8A or DMR
- Encourage healthy labouring women to return home (before 5cm dilated) unless maternal fatigue or need for support requires early admission. This avoids unnecessary intervention [1].

Latent phase

- Women should be informed that a standard duration of the latent first stage of labour has not been established and can vary widely from one woman to another. Women having their first baby who are in the latent phase of the first stage of labour and assessed in a primary birthing unit/hospital may be offered discharge home or to remain in the birthing unit/hospital according to their preference[1].The woman should be offered support, encouragement, advice, and analgesia if requested.
- Labour may not naturally accelerate until a cervical dilatation threshold of 5cm is reached. Therefore, for women admitted to the primary birthing unit / hospital during latent first stage, the use of medical interventions to accelerate labour and birth before this threshold is not recommended, provided maternal and fetal conditions are reassuring[4].
- Women in the latent phase of labour are generally supported to be discharged and continue early labour at home. Some women may benefit from opiate analgesia and a chance to rest. When the latent phase is prolonged and/or the woman is distressed augmentation of labour may be appropriate.

Labour care

- All women in established labour will be admitted and provided with one-to-one midwifery care.
- Upon admission, discuss the woman's Goals of Care. Refer to birth plan and/or Sensitive Care Plan, where available.
- Enquire about maternal wellbeing, ensuring the woman and support persons are aware of Aishwarya's Care Call (external website).
- Encourage the woman to adapt the birth environment to her needs.
- Encourage and assist the woman to move into and adopt positions in labour as they choose. [1, 4]
- Ensure the woman is aware she may:[1]
    - drink fluids. Isotonic drinks may be more beneficial than water.
    - eat a light diet. Where risk factors develop that make a general anaesthetic more likely, explain to the woman the recommendation of restricting food intake.
- Escalate any delay in 1st stage and/or deviations from the normal progress of labour to medical team. In all stages of labour, women who have left the normal care pathway because of the development of complications can return to it if or when the complication is resolved[2].

Observations

Maternal

30-minutely	○ Maternal pulse – 30-minutely at a minimum and with every auscultation of the FHR ○ Assessment of contractions
2-hourly	○ Bladder care, encourage voiding. Review and document frequency of passing urine and bladder sensation. Offer to insert a catheter if there are any ongoing concerns over the woman's ability to pass urine. (See Bladder Management guideline)
4-hourly	○ Blood pressure (BP) ○ Temperature ○ Respiratory rate ○ VE's - Offer 4 hourly or more frequently if there are concerns about the wellbeing of the mother or the baby or in response to a women's wishes ○ Abdominal palpation – as required to monitor progress and prior to VE.

Fetal

• Intermittent auscultation (IA) of the FHR is recommended 15 - 30 minutely[6] , in accordance with the OGD Guideline: Fetal Heart Rate Monitoring
• The decision to use IA or continuous CTG monitoring requires a risk assessment per the CTG Monitoring Standard Section 4.3 CTG monitoring in clinical practice[5] and the OGD Guideline: Fetal Heart Rate Monitoring.

Documentation

1. Use a pictorial (partograph) record of labour once labour is established
2. Document all fetal observations as per OGD Guideline: Fetal Heart Rate Monitoring.
3. Document all maternal observations on the Observation and Response Chart incorporating a track and trigger system – in accordance with the WNHS Policy Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health).

Specialist departments: Community Midwifery Program (CMP) and Family Birth Centre (FBC)

- Women should have an initial labour assessment conducted upon arrival of the midwife to the woman's home / arrival of woman to FBC, per above.
- Transfer to a maternity labour ward must occur if use of an intrapartum CTG is indicated.

Management of delay

Key points

1. The medical obstetric team should be advised of diagnosed delay in the active phase of labour [2,3].
2. The decision to use IA or continuous CTG monitoring requires a risk assessment as per the WA Health CTG Monitoring Standard Section 4.3 CTG monitoring in clinical practice - refer to OGD Guideline: Fetal Heart Rate Monitoring.
3. Informed consent must be obtained prior to commencement of any intervention. This should be documented within the woman's medical record.
4. For pregnant women with spontaneous labour onset, the cervical dilatation rate threshold of 1 cm/hour during active first stage (as depicted by the partograph alert line) is inaccurate to identify women at risk of adverse birth outcomes and is therefore not recommended for this purpose.[4]

   Health care professionals should continue to plot cervical dilatation versus time on the cervicograph as well as other partograph parameters to monitor the well-being of the woman and her baby and identify risks for adverse birth outcomes.

Active phase of labour and management of suspected delay

The active first stage is a period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours [1,4].

In active labour, cervical dilatation of 0.5cm per hour (2cm in 4 hours) is considered normal[1,2,4]

If delay in the active first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:

- 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[1].

If delay in the active first stage of labour is suspected, discuss the findings and the options available with the woman (including effective pain relief), and support her decisions.

Offer all women with a suspected delay in the active first stage of labour a VE 2-hours later, and diagnose delay if progress is less than 1cm in 2-hours.

Active phase of labour and management of diagnosed delay

- If delay in the active first stage of labour is diagnosed, recommend artificial rupture of membranes for all women with intact membranes and discuss the use of oxytocin infusion with the woman and her birth partner, in consultation with the obstetric team.
- Primiparous women require an obstetric review and consideration of artificial rupture of membranes (ARM) +/- oxytocin infusion.
- Multiparous women require a full obstetric review including abdominal and VE and the decision for oxytocin should be made by a senior registrar or consultant.
- If the woman chooses to have an ARM only, or declines an ARM, transfer to obstetric-led care is not necessary, but a repeat VE should be advised 2-hours later.
- If there is no progress 2-hours later, diagnose delay and transfer the woman to obstetric-led care. The obstetric review should include abdominal palpation and VE and consideration of ARM +/- oxytocin infusion.
- Assess for the following prior to the commencement of oxytocin infusion:
    - Fetal compromise and malpresentation
    - Any signs of obstructed labour
    - Previous caesarean section/ other uterine scar
    - Grand multiparity
    - Contraction frequency and duration
- Discuss the use of oxytocin with the woman. The woman must be advised that her choice to start, stop or restart the oxytocin infusion will be supported; that

continuous electronic fetal monitoring is needed; and that oxytocin can cause hyperstimulation, which may increase the chance of transient fetal hypoxia, and if hyperstimulation occurs the dose will be reduced or stopped[1].

- Advise the woman to have a VE 4-hours following the commencement of oxytocin infusion and/or regular contractions in active labour, and if:
    - cervical dilatation <2cm in 4-hours, seek additional obstetric review. Collaborative discussion with the woman regarding plans for mode of birth should be discussed.
    - cervical dilatation ≥2cm recommend ongoing 4-hourly VE's.

Specialist departments: Community Midwifery Program (CMP) and Family Birth Centre (FBC)

- Midwives will escalate delay in first stage and/or deviations from normal labour progress to an Obstetric Registrar or Consultant at the woman's booking/treating hospital.

Partogram

All maternal and fetal observations and assessments in labour should be documented on PIP, including VE's, or on equivalent or relevant documentation format. Use a pictorial (partograph) record of labour once labour is established.

Downtime procedures would necessitate use of a paper Partogram and documentation in the medical record.

References

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6. Cardiotocography (CTG) Monitoring Standard. Western Australian Department of Health, August 2024. Located at: www.health.wa.gov.au - www.health.wa.gov.au/~/media/Corp/Policy-

Frameworks/Clinical-Governance-Safety-and-Quality/Cardiotocography-Monitoring-Policy/Supporting/Cardiotocography-Monitoring-Standard.pdf

7. WHO Labour Care Guide: User's Manual. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. ISBN 978-92-4-001756-6 (electronic version)
   REF: https://iris.who.int/bitstream/handle/10665/337693/9789240017566-eng.pdf

Related legislation and policies

NMHS Policies:

- Falls Risk Management Policy
- Photography, Filming and Recording by Patients, Carers, Relatives or Visitors

Related WNHS policies, procedures and guidelines

WNHS Policies (available to WA Health employees through Healthpoint)

- Falls: Risk Assessment and Management of Patient Falls
- Pressure Injury Prevention and Management
- Visitors and Accommodation for Parent/ Partner/ Support Person

WNHS Clinical Guidelines:

Anaesthetics

- Neuraxial Analgesia (including epidural, intrathecal morphine): Assessment of Motor Function and Testing of Dermatomes

Obstetrics and Gynaecology

- Caesarean Birth: Gastric Aspiration Prevention in Obstetrics
- Infections in Pregnancy: Group B Streptococcal Disease (GBS)
- Fetal Surveillance: Fetal Heart Rate Monitoring
- **Labour and Birth guidelines**: Born Before Arrival; Second Stage Management and Second Stage (Management of Delay); Birth Notification; Perineal Care and Repair; Intrauterine Pressure Catheter; Third Stage; Moderate and High Risk Women Presenting at MFAU/LBS- Medical Review and Care Planning; Prolonged Pregnancy; Meconium Stained Amniotic Fluid; Neonatal Team Attendance at Births; Rupture of Membranes - Spontaneous
- Pain Management in Adults (includes labour pain management)
- Placenta: Placenta: Being Taken Home; Placenta Indications for Histopathological and Microbiological Examination; Retained Placenta (see also Third stage);
- Shoulder Dystocia
- Postnatal Care: Immediate Maternal Care in Labour and Birth Suite
- Transfer from Home to Hospital (VMS/ MGP / CMP)
- Water Immersion During Labour and/or Birth

Useful resources (including related forms)

- World Health Organisation (WHO) Labour Care Guide (link).

Forms:

- Maternal Fetal Assessment Unit Admission (KEMH MR 225) or Maternity Assessment (OPH MR8A)
- Partogram (KEMH MR270 / OPH MR72)
- CMP Birth Record MR08

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Version history

Number	Date	Summary
1	June 2019	**History**: Amalgamated and superseded five individual guidelines on assessment and care in the first stage of labour dating from Sept 2001. **Superseded**: 1. Labour (First stage): Care of a Woman (date last amended Nov 2014) 2. Labour (Possible / Early) at Term: MFAU QRG (dated Jan 2016) 3. Labour: Assessment (date last amended Feb 2015) 4. Labour: Admission to Labour & Birth Suite (Booked) (dated Sept 2014)

		5. CMP: Care During the First Stage of Labour in CMP (dated May 2015) See OGD Guideline Updates for changes. Contact OGD Guideline Coordinator for archived versions.
2	April 2025	• Three clinical guidelines contemporised and amalgamated into one. **Supersedes**: 1. Labour: First Stage 2. Labour: First stage: Management of Delay 3. Labour: Partogram • Review and streamline of content • Definition of latent first phase of labour clarified, with consideration for the impact on low-risk settings, such as the family birth unit for increased medical intervention, to ensuring consistency of definitions across clinical practice guidelines to improve clarity of direction to staff. **[RCA recommendation]** • Partogram practice updated- now using electronic PIP alongside contemporised World Health Organisation Labour Care Guide and recommendations.