**First stage of labour**

**Characteristics of latent stage**

NICE (2007) describes this as: ‘a period of time, not necessarily continuous, when:

\_ there are painful contractions, and

\_ there is some cervical change, including cervical effacement and dilatation up to

4 cm’.

**Midwifery care in latent phase**

Women may be excited and/or anxious. They will need a warm response and explicit

information about what is happening to them. In very early labour they may need just

verbal reassurance; they may make several phone calls.

Ideally, home assessment is preferable to hospital; it reduces analgesia use, labour

augmentation and CS and appears cost-effective. Women report greater feelings of

control and an improved birth experience. If women do come to hospital, evidence supports an assessment unit separate from the labour ward, reducing labour ward stay, increasing perceived sense of control and reducing analgesia use.

Some women experience a prolonged latent phase, which may be tiring and demoralising,

requiring more support. Women may undergo repeated visits/assessments and feel something is goingwrong. Most women however cope well.

The first midwife contact is important and it will establish trust:

\_ Greet the woman warmly and make her feel special.

\_ Observe, listen and acknowledge her excitement.

\_ Be positive but realistic: many women, especially primigravidae, can be overoptimistic

about progress.

\_ Women whose first language is not English may need extra reassurance, careful

explanations and sensitivity to personal and cultural preferences. CMACE (2011)

highlights the importance of accessing translation services. A translator that the

woman is comfortable with should have been arranged prior to labour, but this is

sometimes not the case. Some hospitals have local arrangements. In reality many women go through labour with little or no adequate translator.

\_ Physical checks include:

◦ **Baseline observations**.

◦ **Urinalysis.**  testing for protein at labour onset, although this is debatable for normotensive women since vaginal secretions, e.g. liquor,commonly contaminate the sample so protein is often ignored.

◦ **Abdominal palpation.** Ascertain fundal height, lie, presentation, position and

engagement. Ask about fetal movements (FMs): more/less than usual?

◦ **Fetal heart (FH) auscultation.**  Offer intermittent auscultation

(IA) not a ‘routine admission trace’ for low-risk women. (follow partograph)

\_ **Vaginal examination** (VE) is not usually warranted if contractions are *<*5min apart

and lasting *<*60 seconds unless the woman really wants one. (follow partograph)

\_ **Ruptured membranes** are usually obvious. If the woman is contracting, there is no need for a speculum examination.

|  |  |  |
| --- | --- | --- |
| OBSERVATION  | FREQUENCY | SIGNIFICANCE |
| **Blood pressure**Normal range:Systolic: 100–140 mmHgDiastolic: 60–90 mmHg(NICE, 2011) | Tested at labour onsetthen hourly (NICE,2007) | **Hypertension** can be caused by◦ Anxiety and pain◦ General anaesthesia◦ Essential hypertension or pre-eclampsia(See Chapter 20 for definitions of pre-eclampsia)**Hypotension** can be caused by◦ An epidural/top-up◦ Aortocaval occlusion secondary to lying supine◦ Haemorrhage and hypovolaemic shock |
| **Pulse rate**Normal range: 55–90Bpm | Tested at labour onsetthen hourly whenchecking the fetal heart(NICE, 2007) | **Tachycardia** ≥**100 bpm** can be caused by◦ Anxiety, pain, hyperventilation◦ Dehydration◦ Pyrexia, infection◦ Obstructed labour◦ Haemorrhage, anaemia and shock**Bradycardia** ≤**55 bpm** can be caused by◦ Rest and relaxation◦ Drugs, e.g. opiates, magnesium sulphate◦ Cardiac problems |
| **Temperature**Normally 36–37◦C(97–98.4◦F) | Tested at labour onsetthen 4-hourly (NICE,2007) or hourly if inbirthing pool | **Pyrexia >37.5**◦**C** can be caused by◦ Infection◦ Epidural – usually low-grade pyrexia but rises withtime◦ Dehydration◦ Overheated birth pool |

Established first stage of labour

Characteristics of established first stage

**In early labour:**

\_ The woman may eat, laugh and talk between/during contractions.

\_ Contractions become stronger, increasingly painful, 2–5 minutes apart lasting ≤60

seconds.

\_ The cervix is mid to anterior, soft, effaced (not always fully effaced in multiparous

women) and *<*4 cm dilated.

**As labour advances:**

\_ She usually becomes quieter, behaves more instinctively, withdrawing as the primitive

parts of the brain take over

\_ During contractions she may become less mobile, holding someone/something

during a contraction or stand legs astride and rock her hips. She may close her eyes

and breathe heavily and rhythmically, moaning or calling out during

the most painful contractions.

\_ Talking may be brief, e.g. ‘water’ or ‘back’. This is not the time for others to chat.

 The most important thing is *do not disturb the birthing woman*’. Midwives are usually adept at reading cues.

Others unfamiliar with labour behaviour, including her partner and students, may

need guidance to avoid disturbing her, particularly during a contraction. Before FH

auscultation, first speak in a quiet voice or touch the woman’s arm; do not always

expect an answer.

**Midwifery care in established first stage**

**Make sure your manner is warm.** Involve her partner. Clarify how they prefer to be

addressed. Ideally, the woman will have already met her midwife antenatally. A good

midwife, familiar or not, will quickly establish a good rapport. Kind words, a constant

presence and appropriate touch are proven powerful analgesics.

\_ **Take a clear history:**

◦ Discuss previous pregnancies, labours and births

◦ Look for relevant risk factors.

◦ Ask about vaginal loss, ‘show’ and time of onset of tightenings.

\_ **Review the notes:**

◦ Ultrasound scan (USS) for dates and placental location

◦ Blood results: group, rhesus factor, antibodies, recent haemoglobin

◦ Any allergies.

\_ **Offer continuous support**. Evidence found that continuous

female support in labour:

◦ reduces use of pharmacological analgesia including epidural

◦ makes spontaneous birth more likely (fewer instrumental/CS births)

◦ shortens labour

◦ increases women’s satisfaction with labour.

**Supporting male birth partner.** Some men don’t cope well in hospitals, or when

their partner is in pain.

Encourage them to take frequent breaks, eat and drink.

Some men are clumsy when offering support, annoying the woman. Men may also

worry about the birth noises women make.

Communicating quietly, and giving

gentle guidance on anticipating his partner’s needs will help both partners.

Supporting a woman and her partner in labour is an intense relationship, hour after

hour, and can be physically and mentally demanding.

Providing emotional support,

monitoring labour and documenting care maymean that the midwife can hardly leave

the woman’s side.

Involving the birth partner(s) or a doula can both support the midwife and enhance the quality of support the woman receives. There should be no restriction on the number of birth partners present, although be very sure that they are the people the mother really wants. Sometimes women accede to the desires of sisters

or friends to be at the birth. Birth however is not a spectator sport: if they are chatting

amongst themselves and not supporting the woman then the midwife may need to

offer them some direction or tactfully suggest they leave the room.

\_ **’Listen to her’ .** Talk through any birth plans early, while the woman is

still able to concentrate. As labour progresses, observe her verbal and body language

and tell her how well she is coping, offering simple clear information. Try not to

leave her alone unless she wishes this. Many women report that they and/or their

birth partner were ‘left alone and worried at some time during labour’ .

\_ **‘Build her a nest’.** Make the birth environment welcoming: prepare

the room before she arrives.

◦ Mammals like warm dark places to nest, so keep it relaxed with low lighting.

◦ Remove unnecessary monitors/equipment.

◦ Noise, particularly other women giving birth, can be distressing; low music may

help cut out such noise. Avoid placing a woman arriving in labour near someone

who is noisy.

◦ Keep interruptions to a minimum; always knock before entering a room and do

not accept anyone else failing to do this.

◦ If there is a bed, consider pushing it to the side so that it is not the centre-piece

\_ **Eating and drinking.** Women often want to eat in early (rarely later) labour.

Drinking well will prevent dehydration, and a light diet is appropriate unless the woman

has recently had opioids or is at higher risk of a general anaesthetic. Ensure her birth supporters eat too.

\_ **Basic observations** supports many routine labour observations, evidence recommends

hourly pulse (checked simultaneously with the1/2 hourly fetal heart rate (FHR)) BP, and

4-hourly temperature. Consider hourly temperature if water birth.

\_ **Frequent micturition** should be encouraged, but urinalysis in labour is probably

pointless.

\_ **Observe vaginal loss**, e.g. liquor, meconium, blood and offensive smell.

\_ **Do not offer a shave or enema!** Fortunately, the days of routine enemas

and pubic shaves have long gone, since they are at best ineffective and at worst

embarrassing, painful and harmful; leading paradoxically to increased infection

rates . Very occasionally a loaded rectum\can be felt, on VE or the woman may report she is constipated. A couple of glycerine suppositories may bring relief.

\_ **FH auscultation.** recommends every 30 minutes for following a contraction.

**Assessing progress in labour**

‘Justify intervention’.

Unless birth is imminent, most midwives undertake *abdominal palpation* when taking

on a woman’s care and, periodically thereafter, to ascertain the lie, position and

presentation of the baby. Engagement is particularly helpful to monitor descent of the

presenting part and thus labour progress (see Figure 1.1). However, some women may

find this examination painful, particularly in advanced labour.

Labour progress can also be judged *observationally*: by the woman’s contractions and

her verbal and non-verbal response to them (see Table 1.2).

Some midwives also observe the ‘purple line’, present in 76% women, which may

gradually extend from the anal margin up to the nape of the buttocks by full dilatation

**Vaginal examination, artificial rupture of the membranes and partograms**

VEs in labour are an invasive, subjective intervention of unproven benefit but are the ‘accepted’method for assessing labour progress.

It can be difficult for woman to decline a VE or for the midwife to perform one only

when she/he feels it is best indicated. Even in low-risk births, midwives often feel pressured to adhere to medicalised guidelines which lack good evidence.

NICE (2007) recommends:

\_ Four-hourly VEs in the first stage of labour.

\_ Cervical dilatation of 0.5 cm/hour as reasonable progress

\_ Artificial rupture of the membranes (ARM) should not be performed routinely and

may not significantly improve normal labour duration.

\_ *Document* care on partogram and in notes, including any problems, interventions

or referrals.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CERVICAL DILATATION | 0 – 3 CM | 3 – 4 CM | 4 – 7 CM | 7 – 8 CM | 8 – 10 CM |
| Frequency ofcontractions | May beirregular andsometimesstopGraduallyincreasing in frequency | 2:10 minutesIncreasinglyregular,lasting 20–40 seconds | 3:10 minutesRegular,lasting ≤60 seconds | 3–4:10minutesRegular,lasting ≤60seconds | 4–5:10 minutesSometimes almostcontinuous, althoughcan ‘fade away’ for awhile in transition |
| Pain ofcontractions | Varying frompainless/mild/stronger | Becoming morepainful but usually bearable | Becoming morepainful but usually bearable | Increasinglypainful | Often almost(sometimescompletely)unbearable painalthough if intransitional stage mayhave some respite |
| Behaviour | Chatty, nervous, excited, ableto make jokes and laugh.Often able to talk throughcontractionsMay use learned breathingtechniques too early, andneed reminding to paceherself | WithdrawingmoreDeeper‘sighing’breathingSense ofhumourfading | WithdrawingmoreDeeper‘sighing’breathingSense ofhumourfading | Becomingvocal: cryingout withsomecontractionsMay expressirritationwhentouched | Appears withdrawn, inanother worldMay not reply, oranswer sharplyConcentrating onbreathing which slowsand deepens with acontractionThroaty gruntingnoises, crying outwith expiration: maypanic and expressdesperate ideas: ‘Ican’t do this!’ |
| Movementand posture | Mobile during contractions. | Mobile during contractions | Needing tostop andconcentrateduringcontractions | Graspsabdomen andleansforward.May rock, curltoes | Less mobile, holdingon to somethingduring acontraction; ofteneyes closed, but mayopen wide in surprise with pushing urge |

**Midwifery care in transition**

**Support birth partners.** They can become tired, be stressed and want something done

to help the woman. This common reaction sometimes leads to inappropriately timed analgesia, e.g. epidural, with subsequent discovery of a fully dilated cervix. It can be a difficult judgement call for the midwife.

**Keep it calm.** Change the dynamics if the women panics; e.g. suggest a walk to the

toilet, a position change or focus on her breathing.

**Avoid the temptation of VE.** Unless the woman really wants it, VE is likely to yield

disappointment: at this stage it is painful and the cervix is often 8–9 cm dilated

**To push or not to push?** Telling women that they must not push when they cannot

stop themselves at the end of the first stage is unnecessary and distressing for the

woman. The belief that pushing on an undilated cervix will cause an oedematous cervix is based on very limited evidence. 20% of women, irrespective of parity experience an early pushing urge. Downe *et al.* (2008) found that those with the urge had a better chance of a spontaneous normal birth than those who didn’t.