The diagnosis of labour and improving the safety of the latent phase of labour

A framework to support best practice

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Introduction

The failure to diagnose labour and subsequent presentation in late labour with a problem or born before arrival (BBA) feature frequently among adverse events, complaints, HSIB/MNSI investigations and legal cases. Enhancing the Safety of Midwifery - Led Births (ESMiE 2020); MBRRACE reports; Each Baby Counts (RCOG 2015) and HSIB/MNSI all report this as contributory to adverse outcomes (such as stillbirth, hypoxic ischaemic encephalopathy (HIE) or neonatal death).

Aims of this document

1. To create a framework to aid the diagnosis of labour and prevent adverse outcomes associated with presentation in late labour
2. Improve the birth experience
3. Minimise unnecessary maternal intervention
4. Allow most appropriate use of resource/ midwifery workload

History of this document

In response to HSIB/MNSI investigations, adverse events and women's experiences, Health Innovation Oxford & Thames Valley Maternity Network formed a task and finish group in 2021 to try to unify best practice regarding the diagnosis of labour and the management of the latent phase of labour (particularly where prolonged).

Despite the agreed need, the network members and unit representatives agreed in 2022 that despite updates and changes in response to comments, such changes in practice were simply not possible given the constraints within their services.

In response to this and following further communications with representatives from HSIB/MNSI, the network clinical lead contracted the aim to cover the diagnosis of labour only, as 1) this was felt to be the situation relevant to most adverse events, and 2) was less controversial among clinicians.

Where does this document sit?

Guidelines for diagnosis of labour, and latent and active phase differ widely between different trusts in the region and nationally. It is suggested that this document forms a framework to support best practice, and forms part of the teaching of midwifery and medical staff.

Key stakeholders

A wide group of midwives, obstetricians and clinical risk leads from across five maternity units in the Thames Valley collaborated on the original versions of this document.

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Representatives from HSIB/MNSI have contributed to and supported this work based on findings from their investigations within England, which have identified safety factors related to the diagnosis of labour and the definition of active labour.

Principles in making the diagnosis of labour

1. Listen to the woman. This is particularly so for multiparous women.
2. The diagnosis of labour in multiparous women should not be based on cervical dilatation alone.
3. In nulliparous women, regular painful contractions, at >1 in 5, in the presence of cervical effacement should be considered in labour.
4. Women with regular painful contractions at >1 in 5, and spontaneous rupture of membranes (SROM) are likely to be in labour.
5. A low station of the fetal head is a sign that progress in labour may be very quick, whatever the parity.
6. The diagnosis of 'active phase' of labour according to cervical dilatation should be abandoned.
7. Intrapartum care, indeed, 1:1 midwifery care, is intended to support both the woman and her unborn baby at a time of need. These needs differ.

Other issues to consider

1. Take into account her social circumstances, her access to healthcare (e.g., language barriers), the time of day, and the distance that she will travel when deciding whether admission is appropriate.
2. In higher risk women, including where there is a uterine scar, the threshold for advising admission should be lower, and electronic fetal monitoring (EFM) should be offered.
3. In women in preterm or threatened preterm labour, the course of labour may be very variable. Point of care tests to guide rather than dictate management are advised.

Implementation

Agreement of the above principles could lead to their embedding in a local management of labour guideline, emphasising particularly the importance of cervical effacement in nulliparous women and the limited use of cervical dilatation in multiparous ones. These measures alone could have considerable benefit.