Latent Labor Management

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We start in latent labor

- We approach the issue of labor progress by identifying the start of labor.
- We need to use revised expectations for it’s progress based on current evidence.
- No longer using Friedman’s curve!
Evidence supporting this approach

- New parameters for active labor
- Shared decision making
- Admission in active labor
- Continuous support
- Movement in labor
- Water immersion
The “4 P’s” of Labor Progress

- Permission
- Physical Environment
- People
- Practices

Slide courtesy of Amy Romano
Hospitals/obstetric units wishing to change the culture in all 4 of these areas can implement this Quality Improvement action bundle. The bundle and supporting tools can be found at www.birthtools.com
Permission
Promoting autonomy and mobility
“Integrative power”

- Movement/position changes
- Eat and drink
- Control lighting and ambient sound
- Wear or shed clothing
- Informed consent and refusal
Physical Environment

“Sanctum” vs. “Surveillance Room”

• Promotes privacy and sense of safety
• Options for comfort and mobility
• Supports partner / family involvement

Slide courtesy of Amy Romano
People
“Guardianship” vs. “Domination”

• Trust and connectedness
• Attending to woman
• Attending to environment
• Keeping a watchful eye

Slide courtesy of Amy Romano
Practices
“Physiologic care” vs. “Medical Management”

- Promote, protect, and support physiologic birth
- Minimize routine interference
- Standards for diagnosing active labor and admitting
Definitions

**Labor:** Uterine contractions resulting in cervical change (dilation and/or effacement)

**Phases:**

- **Latent phase** – from the onset of labor to the onset of the active phase
- **Active phase** – accelerated cervical dilation typically beginning at 6 cm
Evidence to support our activities

New parameters for active labor
Zhang- Low risk women meeting NTSV criteria
N= >62,000
Method: A repeated-measures analysis was used to construct average labor curves by parity.
Results: Labor may take over 6 hours to progress from 4 to 5 cm and Over 3 hours to progress from 5 to 6 cm of dilation.
Nulliparas and multiparas appeared to progress at a similar pace before 6 cm. However, after 6 cm labor accelerated much faster in multiparas than in nulliparas.
Zhang, 2010: **Figure 2.** Average labor curves by parity in singleton, term pregnancies with spontaneous onset of labor, vaginal delivery and normal neonatal outcomes. P0: nulliparas; P1: women of parity 1; P2+: women of parity 2 or higher.

“Acceleration phase” - but no longer the marked increase in rate of dilation found by Friedman.
Zhang 201 Figure 3. The 95th percentiles of cumulative duration of labor from admission among singleton, term nulliparas with spontaneous onset of labor, vaginal delivery, and normal neonatal outcomes.

The graph illustrates the cumulative duration of labor for women admitted at different cervical dilations. The graph shows that admission at or after 5 cm has a lower chance of routine or non-evidence based interventions.
Since “Active” labor does not start until 6 cm, this is an example of a partogram that starts at 6cm.
Active Labor Dx

3 or more painful ctx in 10 min
AND

More than 75% effacement
AND

4-5 cm immediately preceded by more than 1 cm cervical change in less than 2 hours
OR

6 or more cm dilation

Evidence to support our activities

Shared decision making
Definition

Shared decision making (SDM) has been defined as a process in which decisions are shared by patients and health care providers, informed by the best evidence available and weighted according to the specific characteristics and values of the patient.

Kimal, Anjali J. et al. Decision Making for Primary Cesarean Delivery: The Role of Patient and Provider Preferences. Seminars in Perinatology, Volume 36, Issue 5, 384 – 389. A review of the literature on patient and provider preferences and obstetrical decision making in the context of primary cesarean delivery, and offer recommendations for future research directions, including potential interventions that may impact the patient and provider factors affecting the primary cesarean rate.
Why use shared decision making?

“SDM recognizes the need to support autonomy by building good relationships, respecting both individual competence and interdependence on others¹.

“SDM is supported by evidence from 86 randomized trials showing knowledge gain by patients, more confidence in decisions, more active patient involvement, and, in many situations, informed patients elect for more conservative treatment options.²”

It is an active process that results in decisions where both providers and patients are confident about the decision made.


SDM addresses components of 2 of the “4 P’s”

People and Permission
People
“Guardianship” vs. “Domination”

Permission
Promoting autonomy and mobility
“Integrative power”

- Trust and connectedness
- Attending to woman
- Informed consent and refusal

Slide courtesy of Amy Romano
How do we facilitate this process of decision making?

3 step process

1. **Choice talk**
   - Step back
   - Offer choice
   - Justify choice - preferences matter
   - Check reaction
   - Defer closure

2. **Option talk**
   - Check knowledge
   - List options
   - Describe options – explore preferences harms and benefits
   - Provide patient decision support
   - Summarize

3. **Decision talk**
   - Focus on preferences
   - Elicit preferences
   - Move to a decision
   - Offer review

Elwyn, et al 2012
Components of the choice talk include:

- **Step back.** Summarize and say: “Now that we have identified your concerns, it’s time to think what to do next”

- **Offer choice.** “There is good information about how these treatments differ that I’d like to discuss with you.”

- **Justify choice.** Emphasize:
  1) the importance of respecting individual preferences
  2) the role of uncertainty

- **Check reaction.** Choice of options may be disconcerting: some patients may express concern about going home. Suggested phrase: “Shall I tell you about the options?”

- **Defer closure.** Some patients react by asking clinicians to “tell me what to do …” We suggest that deferring closure if this occurs, reassuring that you are willing to support the process. Say: “I’m happy to share my views and help you get to a good decision. But before I do so, may I describe the options in more detail so that you understand what is at stake?”

Elwyn, et al 2012
Options talk

Components of the options talk include:

- **Check knowledge.** “What do you know about early vs active labor?”

- **List options.** Home with support, medication before going home, walking and returning

- **Describe options.** Point out differences between options

- **Harm and benefits.**

- **Provide patient decision support.** May need more than one encounter

- **Summarize.** Teach back

Elwyn, et al 2012
Components of the decision talk include:

- **Focus on preferences.** Guide the patient to form preferences. Suggested phrases: “What, from your point of view, matters most to you?”
- **Elicit a preference.** Be ready with a back-up plan by offering more time or being willing to guide the patient, if they indicate that this is their wish.
- **Moving to a decision.** Try checking for the need to either defer a decision or make a decision. Suggested phrases: “Are you ready to decide?” or “Do you want more time? Do you have more questions?” “Are there more things we should discuss?”
- **Offer review.** Reviewing decisions is a good way to arrive at closure.

Elwyn, et al 2012
Evidence to support our activities

Admission in active labor
Practices

“Physiologic care” AND/OR

“Medical Management”

• Promote, protect, and support physiologic birth
• Minimize routine interference
• Standards for diagnosing active labor and admitting
Admission Before Active Labor

- Is associated with increased cesarean
- Creates potential for over-diagnosis and over-treatment
- Impacts all 4 Preventive P’s
- Costs more
- May improve patient satisfaction?

Ballilt et al., 2005
Outcomes of Women Presenting in Active Versus Latent Phase of Spontaneous Labor

- 6,121 women in latent phase labor
- More latent phase women were nulliparous
- Latent phase women had more active phase arrest
Neal et al., 2012
Outcomes of Nulliparous Women With Spontaneous Labor Onset Admitted to Hospitals in Preactive vs Active Labor

- Prospective study, 216 women
- Nulliparous, absence of major complications, 37–42 weeks gestation
- Singleton, cephalic presentation
- Dilated at least 1–5 cm, intact or SROM for less than 6 hours
- Cervical exam on admission and 4 hours later
Results:

- Preactive – Didn’t progress more than 0.5 cm in 4 hours
- Active – Progressed more than 0.5 cm in 4 hours
Neal et al., 2012

Preactive Group:

- Less effaced and had higher BMIs
  - Risk of increase for cesarean birth 5% for each unit increase in BMI (e.g., 1 kg/m²)
- Had higher temperatures after amniotomy
- More likely to be augmented with oxytocin
- Average 4 hours longer labor
- More likely to give birth by cesarean
  - Same indications for cesarean
Clinical Implications: Assessment

Women admitted <4 cm dilatation are approximately twice as likely to have their labors augmented with oxytocin (high alert drug), more interventions

## Bishop Score

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Appendix M

Spontaneous Labor Algorithm

If Maternal or Fetal Medical Indication for Admission: DO NOT USE THIS ALGORITHM

**TRIAGE**

- Spontaneous Labor
- Intact membranes
- Stable Mother and Baby
- Term, Singleton, Vertex (TSV)

Cervix less than 4 cm

Home

(if still less than 4 cm) → Walk and Reassess

For Induction of Labor: See Induction Algorithm (if enters active phase, follow arrow)

Cervix ≥ 4 cm & in Labor.

*Note: special circumstances such as severe fatigue, multiple triage visits, prolonged latent phase, and difficulty coping may warrant admission before 4 cm.

Admit to L&D
Therapeutic Rest

Include therapeutic rest in latent labor policies

- Administration of medication is a safe alternative to admission (CMQCC Supporting Vaginal Birth and Reduce Primary Cesareans)
Role of the Nurse in the OB Evaluation Unit

- The nursing interaction in the OB evaluation unit is a critical component of a woman’s ability to successfully manage latent labor in the home setting.
- Fear and anxiety will be reduced only if the woman feels supported and cared for.
- Evaluate staffing and productivity.
Other possibilities

Creating space and permission for activity

BEFORE ADMISSION:

• Create a walking map with of the hospital, hospital grounds or unit with “resting stations” and activity stations
• Create a labor lounge
• Create a latent labor policy/guideline
Permission
Promoting autonomy and mobility
“Integrative power”

- Movement/position changes
- Eat and drink
- Control lighting and ambient sound
- Wear or shed clothing
- Informed consent and refusal
At home strategies

- Assess home environment
- Movement
- Continuous support
  - Partner support,
  - Doula support
- Interventions to help women stay positive and conserve energy
  - Breathing and relaxation
  - Touch techniques and massage
  - Positions to promote comfort
  - Heat and cold therapy
  - Hydrotherapy
  - Eating and Drinking
Keep Calm and Labor On!

Know what to expect in early labor

Oh baby! You just had your first contraction. Is this it? Should you grab your birthing bag and head out?

You may be in early labor – the phase that comes before active labor.

WHAT HAPPENS IN EARLY LABOR? 1

- Normal changes continue to prepare mom and baby for birth and breastfeeding
- Pre-labor (early labor and early contractions that occur during the last weeks of pregnancy) gradually get a way to start labor
- Contractions may last short times, but as it gets closer to labor, contractions get longer and more intense
- Contractions usually start off mild, may last 30–60 seconds, and occur every 20 minutes or so, then become longer, stronger, and closer together
- cervix dilates to 6 cm to prepare for labor, as the baby moves down into your pelvis
- Every labor is unique, one that may last half of the total labor time

DID YOU KNOW?
The average length of early labor is 6–12 hours for first-time moms. Early labor is equal to or longer than second labor. In some cases, early labor may last 24 hours or more, which can be perfectly normal

THERE ARE BENEFITS TO STAYING HOME DURING LABOR AS LONG AS POSSIBLE:

- Gives you more flexibility to move freely—what can reduce the risk of medical interventions
- Help increase the hormone oxytocin—which allows the cervix to thin and open

HOW CAN YOUR PARTNER OR DOULA SUPPORT YOU?

- Offering comfort, physical care, and assistance
- Encouraging contractions—”just a normal part of labor, continue walking”
- Helping you relax, breathe deeply, and focus on your breathing

STAY COMFORTABLE BY:

- Resting and relaxing
- Drinking plenty of fluids and eating what appeals to you
- Going for a short walk
- Moving around in different positions
- Focusing on breathing
- Using a warm washcloth on your lower back
- Reading an informative book
- Listening to music

STAY COMFORTABLE BY:

How do I know when to go?
Active labor begins when contractions are every 3–5 minutes apart, last 1 minute and have been that way for 1–2 hours.
However, listen to your body. If you feel it’s time to go to your birthing facility, follow that instinct and/or call your care provider first especially if you have breaks.

Learn more about early labor in a Lamaze class, in-person or online, so you can be prepared!

Lamaze.org/push
hforyourbaby

Evidence to support our activities

Movement in labor
Why don’t more women move in labor?

Benefits of Movement in Labor

“There is clear and important evidence that walking and upright positions in the first stage of labor:
■ reduces the duration of labor
■ the risk of caesarean birth
■ the need for epidural
■ does not seem to be associated with increased intervention or negative effects on mothers’ and babies’ well being.”

What we know about movement in labor

- Women who are **free to move** in labor will move
- Women who are **encouraged** to move will move even more
- Most women don’t move as much **once** they are admitted to the hospital

"MOVING FREELY IN LABOR IMPROVES A WOMAN’S SENSE OF CONTROL, DECREASES HER NEED FOR PAIN MEDICATION, AND MAY REDUCE THE LENGTH OF HER LABOR."
Evidence to support our activities

Continuous support
The term "continuous labor support" refers to non-medical care of the laboring woman throughout labor and birth by a trained person.

Supportive care during labor may involve physical support, emotional support, comfort measures, information and advocacy.

*Caring activities should focus on support and comfort measures to assist a woman to cope with labor, e.g., freedom of movement, hydrotherapy, nutrition and hydration in labor, and use of non-pharmacologic pain management techniques.
Continuous labor support

↑ spontaneous vaginal birth
↓ length of labor
↓ intrapartum analgesia
↓ dissatisfaction
↓ low 5-minute Apgar

Conceptual model for continuous labor support

Continuous labor support

- Increased mobility
- Increased self-esteem
- Decreased pain
- Decreased anxiety

Decreased use of epidurals

- No need for extra interventions (Pitocin)

Better infant outcomes

- Higher satisfaction
- Spontaneous vaginal birth
- Decreased C-section rates

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Slide courtesy of Lisa Kane Low
Evidence to support our activities

Comfort from shower or tub
Hydrotherapy

The safety and efficacy of immersion hydrotherapy are well established for the first stage of labor. While pain relief is the only certain effect of immersion hydrotherapy in labor at this time, immersion may also hasten cervical dilation, resolve labor dystocia, and contribute to postpartum maternal satisfaction with childbirth.


Patient Education

- It is OK to come in
- When to return to L&D
- Latent labor can last 20 hours
- Strategies to support delayed admission until active labor
Give adequate anticipatory guidance during the prenatal period about early labor expectations and the safety of completing early labor at home.

Educate women and families on supportive care practices and comfort measures to facilitate completion of early labor at home.
Conclusion

- Supporting the progress of physiologic labor is an evidence based practice
- Nurses provide essential components of assisting women to make care decisions, provide information, facilitate physical activities that support progress of labor
Thank You!

Recorded webinar will be available on the website at cmqcc.org

Slides will be available for CMQCC members on the SHARE site.