PROGRESS IN LABOUR

INTRODUCTION

This guideline provides information for midwives and obstetric staff on how to identify and manage suspected delay in progress of first and second stages of labour in a low risk woman[1].

Labour is monitored by observing:

- The woman's demeanour, response to contractions including breathing/vocalising, positions she adopts, interactions with others, how she relates her labour experience (Thorpe & Anderson 2019).
- Uterine activity: duration, strength and frequency of contractions
- Abdominal palpation: position, descent and rotation
- Cervical assessment: progressive effacement and dilatation of the cervix, and descent of the presenting part.
- Vaginal discharge: show, any bleeding, amniotic fluid (presence, colour).

CARE IN LABOUR AND PREVENTION OF DYSTOCIA/DELAY

Most women with uncomplicated pregnancies in spontaneous labour will have discussed their wishes and plans for birth with their midwife antenatally. This guideline recognises that continuity of care from a known midwife reduces the likelihood of women needing interventions including epidural and instrumental birth (Sandall et al. 2016). When women are under the care of core midwives, establishing a rapport, asking about the woman's wants and expectations of labour, and reading and discussing her written birth plan (if she has one) are important elements of supportive care (NICE 2017, p. 17). One-to-one midwifery care in active labour and informed decision-making are essential requirements for all women.

The birthing environment is known to have an effect on the progress of physiological labour and birth for many women. Organise the room according to the woman's wishes. Factors that support normal labour progress for many women include open spaces to move around (rearrange furniture if necessary), low or adjustable lighting, support people, privacy, quiet and a feeling of 'safe' space, as well as the use of warm water immersion in labour. Some women want distraction and company - take into account individual and cultural preferences in all situations (Thorpe & Anderson 2019).

DEFINITIONS

ACTIVE LABOUR

- A period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation until full dilatation for first and subsequent labours[2].

DELAY IN FIRST STAGE

- Cervical dilatation of less than 2 cm in four hours for first labours
- Cervical dilatation of less than 2 cm in four hours or a slowing in the progress of labour for second or subsequent labours[1]

DELAY IN SECOND STAGE

- Birth would be expected to take place within three hours of the start of the active second stage in most nulliparous women, or within two hours for multiparous women.
- If epidural analgesia is present and there is no urge to push then an hour of passive descent is included in the total time[1].

NOTE

Delay should be suspected if progress (in terms of rotation and descent of presenting part) is not evident after one hour of active 2nd stage in a nulliparous woman, or 30 mins in a multiparous woman.

BACKGROUND

Delay in progress of labour is common, and it is now one of the leading indications for caesarean section worldwide. Historic criteria for normal progress in labour (as outlined by Friedman in 1950s) are increasingly being challenged in contemporary practice[3]. Some evidence suggests that up to one third of first labours experience a delay in progress in the first stage of labour.

A recent local audit[4] showed that 45% of non-elective caesarean sections had failure to progress listed as an indication for operative delivery, this represented 13.4% of all births in that period. In the same audit instrumental birth for failure to progress in the second stage accounted for 44% of all instrumental births, which represented 12.3% all births in that period.

Slow progress in labour may arise due to:

- Inefficient uterine contractions
- Fetal malpresentation or malposition
- Inadequate bony pelvis
- Pelvic soft tissue abnormalities

Where a delay in labour has been recognized interventions such as amniotomy and/or oxytocin infusion are offered with the aim to progress labour to prevent complications and to avert caesarean section[1].

As long as there is evident progress of labour in terms of cervical dilatation, with descent and/or rotation of the presenting part and reassuring fetal status, there is no maximum length of time for either first or second stage of labour. RANZCOG guidelines state that instrumental birth is not indicated for delay in second stage alone[5]. However, the WHO recommendations for augmentation of labour[5] discuss the correlation between increasing length of second stage with increased maternal and fetal morbidity[5].

MANAGEMENT

SUSPECTED DELAY IN FIRST STAGE OF LABOUR

Consider:

- Parity
- Dilatation and rate of change < 2 cms in 4 hours, or slowing of rate in a multigravida
- Contractions – strength, duration and frequency
- Station, descent and rotation
- Emotional status

Offer:

- Support – give consideration to birth plan
- Hydration – oral and/or intravenous
- Bladder care
- Appropriate and effective pain relief – non-pharmacological, for example, use of bath/pool; IM opioids (IV/PCA, but not likely in low risk); epidural – medical consultation[6].

Consider:

- Complete partogram as a visual representation of progress
- ARM (consider descent of presenting part and contraindications)

Make a full assessment of labour progress in 2 hours.

CONFIRMED DELAY IN FIRST STAGE LABOUR

- Refer for medical consultation as per the MOH, Guidelines for consultation with obstetric and related medical services [7] by phone if in a primary unit/home.
- Consider transfer if women is labouring in a community unit and then oxytocin (for continuous Electronic Fetal Monitoring (EFM) if oxytocin and/or epidural) following assessment when at the obstetric unit.
- Make a full assessment of labour progress in 4 hours if there are concerns about progress being stalled as above.
- If dilatation > 2 cms in 4 hours, continue and reassess in 4 hours and then if no further progress request a further medical consultation.
- If dilatation < 2 cms in 4 hours, request a further medical consultation.

SECOND STAGE LABOUR

If all else is well, allow a minimum of 1 hour for passive descent if the woman is fully dilated without involuntary expulsive contractions (with or without epidural). Assess contractions at the start of second stage.

Women in spontaneous, normally progressing labour are sometimes observed to have a reduction in frequency and intensity of contractions for up to an hour when full dilation is reached, after the period of intense contractions that characterise the transition phase. In the absence of maternal or fetal concerns, this 'latent' phase of the second stage should be respected and the woman reassured and supported to rest before the work of pushing begins (Lee & Tracy 2019; Thorpe & Anderson 2019). As

the presenting part descends further, contractions typically increase to become expulsive, indicating the start of active second stage.

Primiparous women – in the event of concerns about maternal or fetal wellbeing at diagnosis of full dilation or if the period of latent/passive second stage exceeds one hour, medical consultation and consideration of the use of oxytocin is advised if contractions are insufficient (for continuous EFM if oxytocin and/or epidural).

Ongoing assessment of:

- Maternal position
- Hydration
- Pain relief needs
- Contractions
- Fetal wellbeing
- Advancement of presenting part

SUSPECTED DELAY IN SECOND STAGE OF LABOUR

No signs of descent after active pushing efforts 30 minutes – multiparous
60 minutes – primiparous

Consider/Do:

- Offer vaginal examination and ARM if the membranes are intact
- Bladder care
- Position change

CONFIRMED DELAY IN SECOND STAGE

Primiparous after 2 hours active pushing, and multiparous 1 hour active pushing - confirm delay in second stage and refer for medical consultation.[2]

Continue:

- Bladder care
- Fetal heart monitoring - commence continuous fetal monitoring if not already in place.

Consider/Do:

- Consider oxytocin with 15-30 minute medical reviews and then decision regarding birth if no progress, ie. operative or instrumental.

DOCUMENTATION

Partogram (Ref.2400266)

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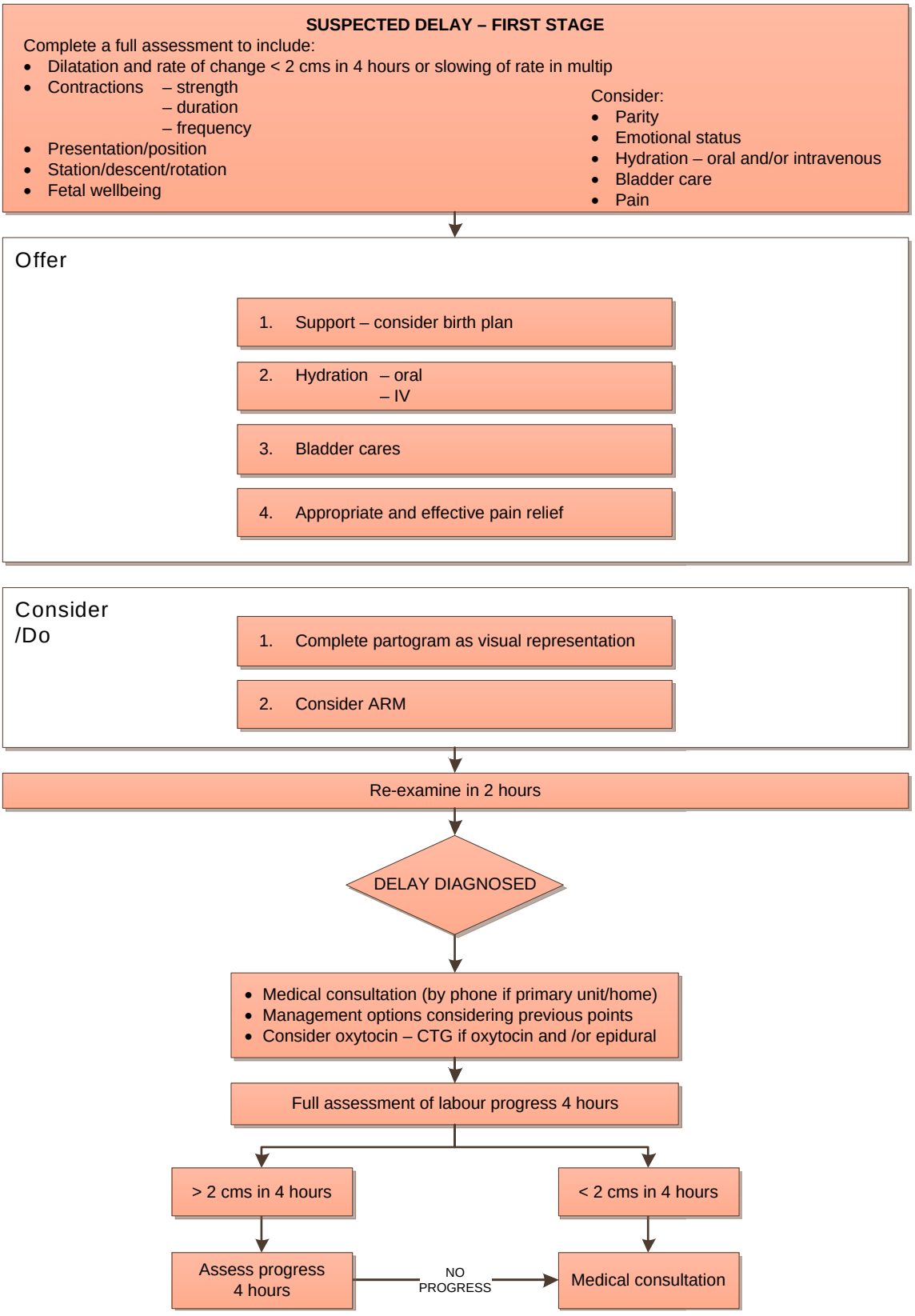
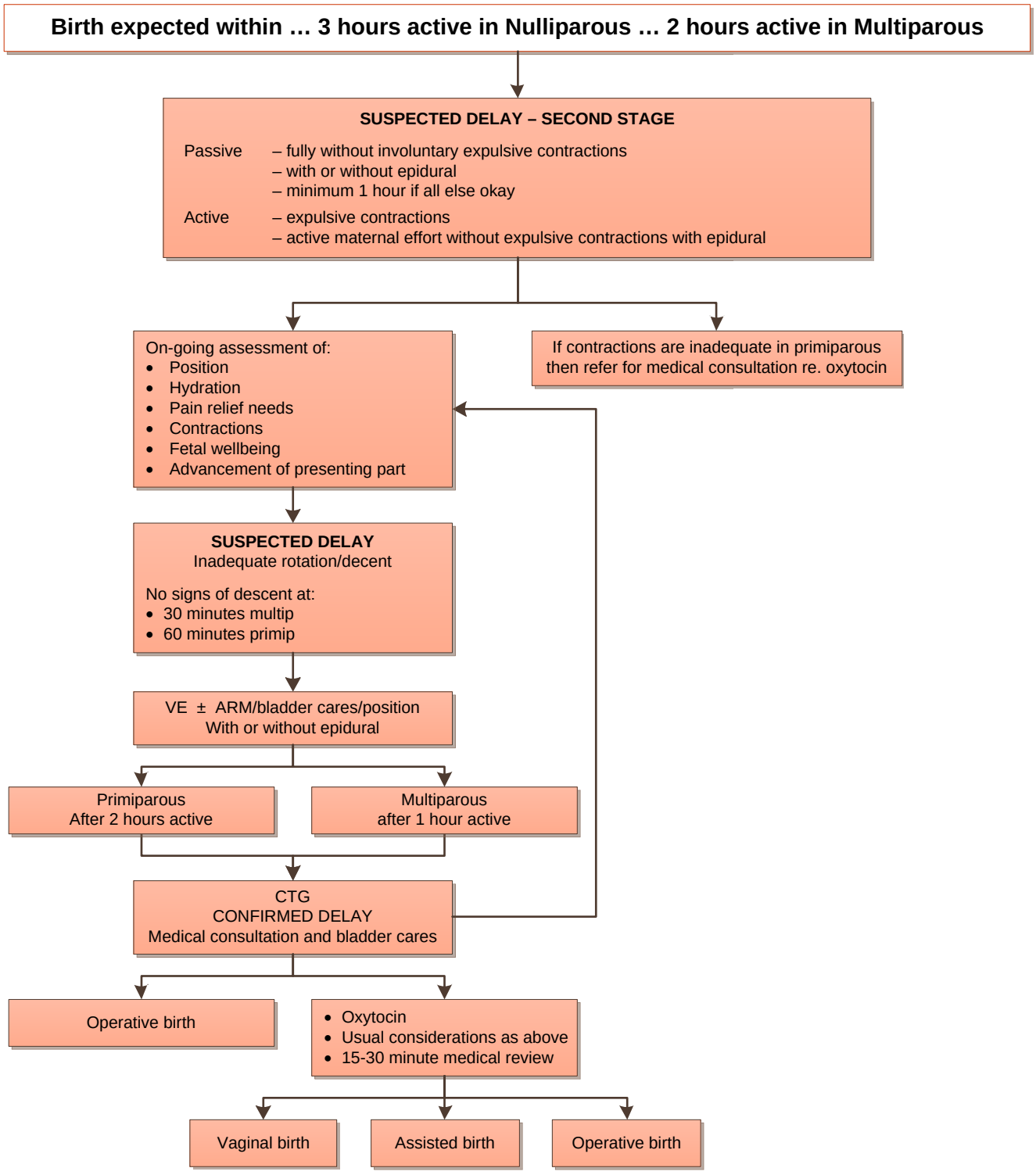
APPENDIX 1 MANAGEMENT OF LABOUR FOR SUSPECTED AND CONFIRMED DELAY IN LABOUR





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