

# LABOR Stage I—Latent Phase

The latent phase, or the first phase of stage I labor, begins with the onset of true labor and ends with the cervix dilated 4 cm. The phase averages approximately 8–10 hr, up to 20 hr for nulliparas and 3–6 hr, up to 14 hr for multiparas. It usually occurs with client at home, unless specific concerns necessitate inpatient care, e.g., spontaneous rupture of membranes (SROM), history of rapid labor, unsafe weather conditions/distance from facility.

## CLIENT ASSESSMENT DATA BASE

### Ego Integrity

May be excited or anxious

### Pain/Discomfort

Regular contractions, increasing in frequency, duration, and severity.  
Contractions are mild to moderate, 10–20 min apart, progressing to 5–7 min apart, lasting 15–20 sec, progressing to 30–40 sec.

### Safety

Fetal heart tones best heard below level of umbilicus (dependent on fetal position)

### Sexuality

Membranes may or may not have ruptured.  
Cervix dilates from 0 to 4cm.  
Fetus may be at station 1 to 0 (primigravida) or from 0 to +2 cm (multigravida).  
Scant vaginal discharge, may be pink or brownish mucus (“show”), or may consist of mucous plug.

## NURSING PRIORITIES

1. Enhance client’s/couple’s/other involved family members’ emotional and physical preparedness for labor.
2. Promote and facilitate normal labor progress.
3. Support client’s/couple’s/involved family members’ coping abilities.
4. Prevent maternal/fetal complications.

## DISCHARGE GOALS

(Inpatient care is not required in early labor, unless complications develop necessitating hospitalization.)

1. Displays only early, or no, signs of active progression of labor.
2. Demonstrates appropriate coping behaviors.
3. Understands self-care needs and signs of labor progression requiring re-evaluation.

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**NURSING DIAGNOSIS:****Anxiety, risk for****Risk Factors May Include:**

Situational crisis, interpersonal transmission, unmet needs

**Possibly Evidenced By:**[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

## DESIRED OUTCOMES/EVALUATION

### CRITERIA—CLIENT WILL

Report anxiety is at a manageable level.

Use breathing and relaxation techniques proficiently.

Appear relaxed appropriate to the labor situation.

Remain normotensive.

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## ACTIONS/INTERVENTIONS

## RATIONALE

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### Independent

Provide primary nurse or continuous intrapartum professional support as indicated.

Continuity of care and assessment may decrease stress. Research studies suggest that these clients require less pain medication, which may result in shorter labor.

Orient client to environment, staff, and procedures. Provide information about psychological and physiological changes in labor, as needed.

Education may reduce stress and anxiety and promote labor progress.

Assess level and causes of anxiety, preparedness for childbirth, cultural background, and role of significant other/partner.

Provides baseline information. Anxiety magnifies pain perception, interferes with use of coping techniques, and stimulates the release of aldosterone, which may increase sodium and water resorption.

Monitor BP and pulse as indicated. (If BP is elevated on admission, repeat procedure in 30 min to obtain true reading once client is relaxed.)

Stress activates the hypothalamic-pituitary-adrenocortical system, which increases retention and resorption of sodium and water and increases excretion of potassium. Sodium and water resorption may contribute to development of intrapartum toxemia/hypertension. Loss of potassium may contribute to reduction of myometrial activity.

Monitor uterine contractile pattern; report dysfunctional labor. (Refer to CP: Dysfunctional Labor/Dystocia.)

A hypertonic or hypotonic contractile pattern may develop if stress persists and causes prolonged catecholamine release.

Encourage client to verbalize feelings, concerns, and fears.

Stress, fear, and anxiety have a profound effect on the labor process, often prolonging the first phase because of utilization of glucose reserves; causing excess epinephrine release from adrenal stimulation, which inhibits myometrial activity; and increasing norepinephrine levels, which tends to increase uterine activity. Such an imbalance of epinephrine and norepinephrine can create a dysfunctional labor pattern.

Demonstrate breathing and relaxation methods. Provide comfort measures. (Refer to CP: Labor: Stage I—Active Phase; ND: Pain [acute].)

Reduces stressors that might contribute to anxiety; provides coping strategies.

Promote privacy and respect for modesty; reduce unnecessary exposure. Use draping during vaginal examination.

Modesty is a concern in most cultures. Support person may or may not desire to be present while client is examined or care provided.

Be aware of client's need or preference for female caregivers/support persons.

Cultural practices may prohibit presence of men (even father of the child) during labor and/or delivery.

Provide opportunity for conversation to include choice of infant names, expectations of labor, and perceptions/fears during pregnancy.

Determine diversional needs; encourage variety of activities (e.g., television, books, cards, walking, rocking, showering, massage, music, aroma therapy).

Prepare for, and/or assist with, discharge from hospital setting, as indicated.

Presents opportunity for client to verbalize excitement about herself, the pregnancy, and her baby. Serves as a diversion to help pass time during what is commonly the longest phase of labor.

Helps divert attention away from labor, making time pass more quickly. If condition permits, walking usually promotes cervical dilatation, shortens labor, and lowers the incidence of fetal heart rate (FHR) abnormalities.

During very early latent phase with no apparent progress of labor, the comfort and familiarity of the home environment may decrease anxiety and allow opportunity for a variety of acceptable diversional activities, thereby hastening the labor process.

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**NURSING DIAGNOSIS:**

**May Be Related To:**

**Possibly Evidenced By:**

**DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:**

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**Knowledge deficit [Learning Need], regarding progression of labor, available options**

Lack of exposure/recall, information misinterpretation

Questions, statements of misconception, inaccurate follow-through of instruction

Verbalize understanding of psychological and physiological changes.

Participate in decision-making process.

Demonstrate appropriate breathing and relaxation techniques.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Assess client's preparation, knowledge level, and expectations/birth plan.

Provide information about procedures (especially fetal monitor and telemetry) and normal progression of labor.

Discuss options for care during the labor/delivery process. Provide information about birthing alternatives, if available and appropriate.

Review roles of staff members.

Demonstrate breathing/relaxation techniques appropriate to each phase of labor; teach and review pushing positions for stage II.

Helps establish information/learning needs and set priorities.

Antepartal education can facilitate the labor and delivery process, assist the client in maintaining control during labor, help promote a positive attitude and/or sense of control, and may decrease reliance on medication.

Necessary for the client/couple to participate actively in the decision-making process.

Identifies resources for specific needs/situations.

Unprepared couples need to learn coping mechanisms on admission to help reduce stress and anxiety. Couples with prior preparation can benefit from review and reinforcement.

Review appropriate activity levels and safety precautions, whether client remains in hospital/clinic or returns home.

Obtain informed consent for procedures, e.g., invasive monitoring, episiotomy. Explain usual procedures and the possible risks associated with labor and delivery.

Provides guidelines for client to make appropriate self-care choices; allows client to engage in safe diversional activities to refocus attention/pass time.

When procedures involve client's body, it is necessary for client to have appropriate information to make informed choices.

(Refer to ND: Coping, Individual, risk for ineffective, for further discussion of coping techniques.)

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**NURSING DIAGNOSIS:****Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—CLIENT WILL:****Fluid Volume risk for deficit**

Decreased intake, increased losses (e.g., nausea/vomiting, mouth breathing, hormonal shifts)

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Maintain fluid intake as able.

Demonstrate adequate hydration (e.g., moist mucous membranes, yellow/amber urine of appropriate amount, absence of thirst, afebrile, stable vital signs/FHR).

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Monitor intake/output. Note urine specific gravity. Encourage client to empty bladder at least once every 1 1/2–2 hr.

Intake and output should be approximately equal, dependent on degree of hydration. Concentration of urine increases as urine output decreases and may warn of dehydration. Fetal descent may be impaired if bladder is distended.

Monitor temperature every 4 hr, more frequently if elevated. Monitor vital signs/FHR as indicated.

Increases in temperature, BP, pulse, respirations, and FHR may reflect presence of dehydration.

Assess production of mucus, amount of tearing within eyes, and skin turgor.

Additional signs of adequacy of hydration or development of dehydration.

Provide clear fluids (e.g., juice, broth, popsicles, jello) and ice chips, as permitted.

Helps promote hydration and may provide some calories for energy production.

Determine cultural practices regarding intake.

Some cultures (e.g., some African immigrants, residents of the southern region of the United States) drink special teas, believing they stimulate continued progression of labor, or avoid certain foods believed to inhibit labor.

Provide mouth care and hard candy, as appropriate.

Reduces discomfort of a dry mouth.

**Collaborative**

Administer bolus of parenteral fluids, as indicated.

May be needed if oral intake is inadequate or restricted. Acts as a safeguard in the event of dehydration or hemorrhage; counteracts some negative effects of anesthesia/analgesia.

Monitor Hct level.

Hct increases as the plasma component decreases in the presence of severe dehydration.

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**NURSING DIAGNOSIS:**

**Coping, Individual, risk for ineffective**

**Risk Factors May Include:**

Situational crisis, personal vulnerability, inadequate support systems and/or coping methods

**Possibly Evidenced By:**

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

**DESIRED OUTCOMES/EVALUATION**

Verbalize awareness of own coping abilities.

**CRITERIA—CLIENT WILL:**

Identify individually appropriate behaviors to maintain control.

Use medication appropriately.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Determine client's cultural background, coping abilities, and verbal and nonverbal responses to pain. Determine past experiences and antepartal preparation.

Each client responds in a unique manner to the stresses of labor and associated discomfort based on these factors. The appearance of appropriate or inappropriate coping may actually be a manifestation of one's culture; e.g., Asian or Native American women may be stoic because of fear of shaming self or family, whereas Hispanic and Middle Eastern cultures typically encourage verbal expression of suffering. For this reason, it is important to compare both verbal and nonverbal responses when assessing coping ability.

Note age of client and presence of partner/support person(s).

Negative coping may result in increased anxiety, in which case the client may request medication too early in the labor process. Younger clients and those unattended may exhibit more vulnerability to stress/discomfort and have difficulty maintaining composure/control.

Stay with/provide companion (e.g., doula [woman's servant]) for client who is alone.

At a time of increased dependence, unmet needs and fear of being abandoned may interfere with ability to focus on the task at hand. Note: Doula describes an individual who provides emotional, physical, and informational support to the pregnant woman but does not perform clinical tasks. These childbirth companions may be volunteers or may be paid for their services. Research suggests that using doulas during labor and delivery results in shorter labors, decreased use of forceps and epidural anesthesia, reduced oxytocin use, fewer cesarean births, better infant outcomes, and enhanced client/partner satisfaction.

Reinforcing breathing and relaxation techniques during contractions.

Establish rapport and accept behavior without judgment. Make verbal contract about expected behaviors of client and nurse.

Assess uterine contraction/relaxation pattern, fetal status, vaginal bleeding, and cervical dilatation.

### Collaborative

Discuss types of systemic/regional analgesics or anesthetics when available in birth setting.

Discuss administration of sedatives such as secobarbital (Seconal), pentobarbital (Nembutal), or hydroxyzine (Vistaril).

Provides support for client/couple. Reduces anxiety and provides distraction, which may block perception of pain impulses within the cerebral cortex.

Facilitates cooperation; provides an opportunity for the client to leave the experience with positive feelings and enhanced self-esteem. Nurse may need to assist the client in maintaining/regaining control of breathing and relaxation, or set limits if inappropriate (unsafe) behavior occurs.

Rule out possible complications that could be causing or contributing to the discomfort/reduced coping ability.

Helps client make informed choice about methods to relieve pain/promote comfort and maintain control.

Occasionally, a barbiturate or ataractic may be administered during early labor to promote rest/sleep, so that the client enters the active phase more relaxed and rested and better able to cope. Note: Because barbiturates can have a prolonged depressant effect on the newborn, Vistaril may be the drug of choice.

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#### NURSING DIAGNOSIS:

##### Risk Factors May Include:

##### Possibly Evidenced By:

#### DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

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#### Infection, risk for maternal

Invasive procedures, repeat vaginal examinations, fecal contamination, rupture of amniotic membranes

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Identify/use techniques to minimize risk of infection.

Be free of signs of infection (e.g., afebrile; amniotic fluid clear, nearly colorless and odorless).

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### ACTIONS/INTERVENTIONS

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### RATIONALE

#### Independent

Emphasize importance of/demonstrate good hand washing.

Use aseptic technique during vaginal examination.

Reduces risk of acquiring/spreading infective agents.

Helps prevent growth of bacteria; limits contaminants from reaching the vagina.

Perform initial vaginal examination; repeat only when contractile pattern or client's behavior indicates significant progress of labor.

Provide/encourage perineal care after elimination and prn as indicated; change underpad/linen when wet.

Assess vaginal secretions using phenolphthalein (nitrazine paper). Perform microscopic examination for positive ferning.

Monitor and describe character of amniotic fluid.

Monitor temperature, pulse, respirations, and white blood cell (WBC) count, as indicated.

## Collaborative

Provide oral and parenteral fluids, as indicated.

Carry out perineal preparation, as appropriate.

Administer cleansing enema, if indicated.

Administer prophylactic antibiotic IV, if indicated.

Administer oxytocin infusion, as ordered. (Refer to CP: Labor: Induced/Augmented.)

Obtain blood cultures if symptoms of sepsis are present.

Repeated vaginal examinations contribute to the incidence of ascending tract infections.

Reduces risk of ascending tract infection.

Spontaneous rupture of membranes 1 hr or more before onset of labor increases risk of chorioamnionitis during the intrapartal period. Color changes of nitrazine paper from yellow to dark blue indicate presence of alkaline amniotic fluid; ferning indicates rupture of membranes. Note: Excess bloody show, which is more alkaline than vaginal secretions, may cause similar changes on nitrazine paper.

With infection, amniotic fluid becomes thicker and yellow-tinged and has a strong, detectable odor.

Within 4 hr after rupture of membranes, the incidence of chorioamnionitis increases progressively with the passage of time, reflected by elevations of vital signs and WBC count.

Maintains hydration and general sense of well-being.

Some providers believe it may facilitate perineal repair at delivery and cleaning of perineum in the postpartal period, thereby reducing risk of infection.

Although not often done, bowel evacuation may promote progression of labor and prevent or reduce risk of infection caused by contamination of the sterile field during delivery.

Although antibiotic administration in the intrapartal period is controversial because of antibiotic load for the fetus, it may help protect against development of chorioamnionitis in the client at risk.

If labor does not ensue within 24 hr after rupture of membranes, infection may occur. If client is at 36 weeks' gestation, onset of labor reduces risk of negative effects on client/fetus.

Detects and identifies causative organism(s).

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### NURSING DIAGNOSIS:

**Risk Factors May Include:**

**Possibly Evidenced By:**

### DESIRED OUTCOMES/EVALUATION

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### Injury, risk for fetal

Tissue hypoxia/hypercapnia or infection

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Display FHR and beat-to-beat variability within

**CRITERIA—CLIENT WILL:**

normal limits, with no ominous periodic changes in response to uterine contractions.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Perform Leopold’s maneuvers to determine fetal position, lie, and presentation.

A transverse lie or breech presentation may necessitate cesarean birth. Other abnormalities, such as face, chin, and posterior presentations, may also require special interventions to prevent prolongation of labor/fetal harm.

Obtain baseline FHR manually and/or electronically. Evaluate frequently per protocol. Note FHR variability and periodic changes in response to uterine contractions.

FHR should range from 120–160 bpm with average variability, accelerating in response to maternal activity, fetal movement, and uterine contractions.

Note progress of labor.

Prolonged/dysfunctional labor with an extended latent phase can contribute to problems of maternal exhaustion, severe stress, infection, and hemorrhage caused by uterine atony/rupture, placing the fetus at greater risk for hypoxia and injury.

Inspect maternal perineum for vaginal warts, herpetic lesions, or chlamydial discharges.

STDs can be acquired by the fetus during the delivery process; therefore, cesarean birth may be **to** indicated, especially for clients with active herpes simplex virus type II. (Refer to CP: Prenatal Infection.)

Administer perineal care to mother according to protocol; change underpad when wet.

Helps prevent growth of bacteria; eliminates contaminants that might contribute to maternal chorioamnionitis or fetal sepsis.

Note FHR when membranes rupture, reassess per protocol, obtain 30-min EFM strip for record. Evaluate periodic changes in FHR.

Changes in amniotic fluid pressure with rupture, and/or variable decelerations of FHR after rupture, may reflect compression of the umbilical cord, which reduces oxygen transfer to the fetus.

Assess for visible cord prolapse at vaginal introitus. If present:

Calm client/partner, explain the prolapse and its implications;

Helps couple understand the significance of prolapse, and promotes cooperation with emergency measures.

Elevate client’s hips (elevated Sims’ position), or assume knee-chest position, push presenting part off of cord and hold off while summoning help;

Relieves pressure of presenting part on cord. This help client to is an emergency situation requiring surgical intervention.

Check cord for pulsations; wrap cord in sterile gauze soaked in saline solution.

Keeps cord moist and helps decrease chance of uterine infection.

Monitor FHR and periodic changes if a problem is detected with fetoscopy or external monitor. Note presence of bradycardia/tachycardia or sinusoidal pattern.

Position client in lateral recumbent position.

## Collaborative

Prepare for transfer to a level 2 or 3 hospital setting as indicated, if client is at home, or in free-standing birth setting.

Rule out maternal problems or medications that could effect an increase in FHR;

Turn off oxytocin if infusing, and increase plain IV solution;

Administer oxygen via face mask;

Assist as needed with obtaining fetal scalp blood sample when indicated.

Prepare for surgical intervention, as indicated. (Refer to CP: Cesarean Birth.)

Any decrease in baseline FHR variability—severe and untreatable variable decelerations, recurrent late decelerations, or persistent bradycardia—indicates fetal decompensation, hypoxia, or acidosis resulting from anaerobic metabolism. Sinusoidal pattern is often associated with fetal anemia or severe fetal hypoxia just prior to fetal demise.

Increases placental perfusion; prevents supine hypotensive syndrome.

Compromised fetal status or identification of maternal conditions such as STD requires closer observation and may indicate need for therapeutic interventions such as cesarean birth.

Factors such as fever, anxiety, anemia, or use of beta-sympathomimetic drugs can increase maternal and fetal heart rate.

Promotes greater periods of uterine relaxation and increases uteroplacental blood flow; increases circulating blood volume available for oxygen transfer within maternal circulation of the placenta.

Increases maternal oxygen available for fetal uptake.

Direct measurement of fetal pH is occasionally indicated to determine fetal metabolic reserve and to differentiate fetal respiratory acidosis from metabolic or mixed acidosis. Fetal pH between 7.20 and 7.25 may reflect intermittent umbilical cord compression, necessitating constant monitoring and/or possibly immediate surgical intervention.

CNS damage occurs if fetal hypoxia/acidosis persists for more than 30 min. To avoid fetal compromise/demise, cesarean birth is treatment of choice for prolapsed cord prior to full cervical dilatation.