

FIRST-TIME MOTHERS' EXPERIENCES OF EARLY LABOUR WITHIN ITALIAN MATERNITY CARE SERVICES

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ABSTRACT

Objective. To explore first-time mothers' experiences of early labour within Italian maternity care services in the event that women are admitted to hospital or advised to return home after maternity triage assessment.

Setting. One second-level Maternity Hospital in northern Italy with an obstetric unit for both low and high-risk women.

Participants. Fifteen first-time mothers in good general health with spontaneous labour at term of a low-risk pregnancy that accessed the maternity triage during the latent phase of labour, and were either admitted at the hospital or advised to return home.

Design. Qualitative interpretive phenomenological study. One face-to-face recorded semi-structured interview was conducted with each participant 48-72 hours after birth.

Findings. Four key themes emerged from the interviews: **a)** recognising early labour signs; **b)** coping with pain at home; **c)** seeking reassurance from healthcare professionals; **d)** being admitted to hospital versus returning home. Uncertainty about the labour progress and the need for reassurance was referred by women as the main reasons for going to hospital in early labour. An ambivalent feeling was reported by the participants when being admitted to hospital in early labour. In fact, while in the first instance the women felt reassured, some felt dissatisfied later on due to the absence of one-to-one dedicated care during the latent phase of labour. When advised to go back home, a number of women manifested feelings of disappointment, anger, fear, discouragement and anxiety for not having been admitted to hospital; however, some participants reported a subsequent feeling of comfort with being at their own home and putting in place the suggestions provided by the midwives at the moment of maternity triage assessment. The guidance provided by midwives during triage assessment seemed to be the key factor influencing women's satisfaction when advised either to return home or to stay at the hospital during the latent phase of labour.

Conclusions and implications for practice. During antenatal classes and clinics, midwives should provide clear information and advice on early labour to increase women's confidence, self-efficacy and decrease their anxiety and fear. During early labour, appropriate maternity care services should be offered according to individual needs. When home visits are not provided by midwives, a telephone triage run by midwives should be considered as a routine service for the first point of contact with women during the latent phase of labour.

KEY WORDS: early labour; latent phase; women's experiences; Italy; maternity services.

INTRODUCTION

The latent phase of labour, also known as early labour, is a not necessarily continuous period of time characterised by painful uterine contractions. During this stage an initial slow progression of cervical changes occurs, including cervical effacement and dilatation of up to 4 centimeters (NICE, 2014). The uterine contractions become progressively regular, polarised and coordinated, in view of the next active phase of labour (Marshall and Raynor, 2014). The extremely variable duration of the latent phase makes it difficult to delineate a normal time range for this stage of labour (McNiven et al., 1998; McDonald, 2010).

The latent phase of labour is frequently an area of conflict between women and healthcare professionals. In fact, while women in early labour usually manifest the need for support from maternity care providers, the latter often delay hospitalisation in an attempt to protect the normalcy of childbirth in consideration of the existing scientific evidence (Janssen and Desmarais, 2013; Iannuzzi and Borrelli, 2014). Several authors stated that being admitted in the latent phase would lead to higher rates of intrapartum intervention such as oxytocin augmentation, instrumental delivery or caesarean section, when compared to women admitted to hospital in active labour (McNiven et al., 1998; Holmes et al., 2001; Klein et al., 2003; Bohra et al., 2003; Bailit et al., 2005; Cheyne et al., 2006). Moreover, Lauzon and Hodnett (2009) found that early labour assessment programmes to defer the admission of women who are not in established labour may bring benefits to women at term of pregnancy. Similarly, Jackson et al. (2003) and Scotland et al. (2011) suggested the introduction of guidelines designed to discourage early admissions and unnecessary procedures during labour. However, this may lead to a gap between women's expectations and their actual experience of maternity services during early labour. Furthermore, women admitted to hospital may have a greater sense of control when compared to women being sent home in the latent stage of labour (Barnett et al., 2008). Janssen et al. (2003) argued that women

supported by midwives during the latent phase at home showed an association with admission to the health facility in the active phase of labour, a reduction of the use of analgesia, and a lower rate of neonatal morbidity. Moreover, there appeared to be greater satisfaction with the care received in terms of reassurance, trust and respect for maternal choices.

Exploring how to provide the best advice to women in early labour about when they should go to hospital, Spiby et al. (2008), suggested that the introduction of a telephone triage for early labour may have a positive impact on the clients' perception of quality of care. In fact, their findings highlighted that women sought prolonged contact with midwives during the latent phase of labour and were unhappy when their concerns were not resolved during telephone conversations. Midwives often reported difficulty in trying to encourage women to stay at home in early labour (Spiby et al., 2008).

The importance of women's experiences of early labour is often underestimated, in part because they are often thought not to require care at this time (Greulich and Tarrant, 2007; Barnett et al., 2008). However, uncertainty seems to be a central issue for women in early labour, accompanied by anxiety and lack of confidence in the ability to cope with pain. These seem to be the main factors that drive mothers to go to the hospital (Barnett et al., 2008; Nolan et al., 2009; Nolan and Smith, 2010). Eri et al. (2010) found that first-time mothers try to negotiate their credibility with the midwives, emphasising the regularity of uterine contractions as an objective 'proof' of labour and showing their vulnerability in an attempt to avoid being sent home. The reassurance from midwives about the normality of the slow progression of early labour seems to be a key factor in encouraging women to stay at home (Beebe and Humphreys, 2006; Cheyne et al., 2007). Greulich and Tarrant (2007) suggest that midwives should provide pregnant women with information about different stages of labour, including when to go to hospital for birth; consequences related to early

hospitalisation; and the inclination of professionals to admit women to hospital when they are in the active phase of labour.

Although there is a growing body of literature and ongoing international debates around the importance of addressing women's needs during early labour, there is a lack of research and information about the provision of early labour care and women's perceptions of maternity services during early labour in Italy. In light of the evidence gaps identified, the aim of the study was to explore first-time mothers' experiences of early labour within Italian maternity care services whether they were admitted to hospital or advised to return home after maternity triage assessment in an Italian Maternity Hospital.

METHODS

Study design

A qualitative methodology with an interpretive phenomenological approach using semi-structured interviews was undertaken in order to describe the phenomenon of early labour on the basis of how it was experienced and perceived by first-time mothers after birth (Smith et al., 2009). The principal investigator and co-investigators were all midwives. Based on a phenomenological approach, the researchers interpreted the phenomenon under study by listening to the participants' personal stories. As argued by Willis (2007: 53), 'phenomenology is focused on the subjectivity of reality, continually pointing out the need to understand how humans view themselves and the world around them'. According to the interpretivist approach, the researchers held an exploratory orientation during the phases of data collection and analysis, with the intent to understand what was going on in each particular case and to comprehend the distinctive participants' perspectives. In regard to this, interpretivists argue that 'there is no absolutely objective scientific analysis of culture of social phenomena independent from special and one-sided viewpoints' (Weber, 2003: 111).

Furthermore, human values and beliefs cannot be identified through an instrumental way but through meaning (Weber, 2003). Therefore, the researchers adopted a multifocal view of the participants' insights of the reality under investigation. The substance of the interviews was given particular attention and underlining meanings were shared during the conversation (Oliver et al., 2005).

Setting

In Italy, intra-partum maternity care is mostly provided by the National Health System (Sistema Sanitario Nazionale - SSN). It is free at the point-of-service and funded by taxation. Births take place mainly in obstetric units with no option of home visiting from SSN midwives in early labour. The organisation of Italian maternity services is geographically heterogeneous and may vary in different areas. The research site was a second-level Maternity Hospital in northern Italy with an obstetric unit for both low and high-risk women (approximately 3,000 births/year), where one-to-one midwifery care is usually provided to all women during labour and birth. Women in the latent phase of labour are usually accompanied by their birth partner(s) at the maternity triage. There is also a telephone line run by the triage midwife to which women can refer for advice and information, but this is not a specific service aimed at supporting women in early labour. After the assessment of maternal and fetal wellbeing, nulliparous women in early labour are often advised to return home. In this case, the midwife usually provides the woman with information on the latent and active phases of labour, advice on how to deal with pain at home and clarifications about signs that indicate the need to return to hospital. If the woman wishes to stay at the hospital, she could be admitted in the antenatal ward until the onset of the active phase of labour if there are available beds. In regard to information provided on early labour in the Italian context, pregnant women usually attend obstetric-led antenatal clinics and midwives are not the primary care givers during pregnancy (Lauria et al., 2012). Therefore, they often miss

the opportunity to have their questions and uncertainties addressed by a midwife who might have a different approach to normal childbirth when compared to the more medicalised ideologies of obstetricians.

Participants

A non-probability purposive sampling strategy was used to identify potential participants. Women were considered to be eligible for participation if they: a) accessed the maternity triage in early labour; b) had a good general health (WHO, 1946); c) had a singleton low-risk pregnancy; d) completed 37 or more weeks of gestation; e) were nulliparous; f) spoke the Italian language. Exclusion criteria included pre-existing or pregnancy-related conditions that would not allow women to stay at home during early labour. According to the inclusion and exclusion criteria, the sample included 15 first-time mothers in good general health with spontaneous labour at term of a low-risk pregnancy that accessed the maternity triage during the latent phase of labour, and were either admitted into the hospital or advised to return home. The participants were typical of those in the region, with various ethnic backgrounds; thirteen women were Italian and the other two participants were from North Africa and East Europe. The average age was 30, with a range from 24 to 36 years. The average gestational week at delivery was 40⁺¹ weeks, with a range from 39 to 41⁺⁵ weeks. Antenatal care was mainly provided by an obstetrician for thirteen women; only two participants were cared for by a hospital midwife during pregnancy. Fourteen women attended antenatal classes.

Recruitment

The midwives of the research site were fully informed about the study and were asked to identify eligible women, inform them about the ongoing research and recruit participants.

The recruitment stage lasted four months (August 2013-November 2013). The study was presented to the women who met the inclusion criteria by the clinical midwife involved in their care during the first access to the maternity triage. Each woman was given time to read the information sheet and to decide whether to take part in the study or not. If the person was willing to participate, the midwife proceeded to gain written informed consent. The researcher's contact details were available in case there was the need for clarification from both midwives and women. Mothers were then approached by the researcher 48-72 hours after birth in the maternity ward (in Italy, women are usually admitted to hospital for approximately three days after a normal birth) to agree on a suitable moment for them to participate in a semi-structured interview.

Data collection

One semi-structured face-to-face recorded interview was conducted by one investigator (midwife) with each participant 48-72 hours after birth in a reserved room located in the maternity ward. Semi-structured interviews encouraged participants to share their stories; however, they also facilitated the balance between maintaining an open interview and focusing on significant aspects (Rees, 2011; Rose, 1994). The interviews were characterised by the following initial open-ended question to put the participants at ease and to allow them to decide on what to focus on initially: 'Could you please tell me about your experience of the initial phase of labour?'. The researcher then referred to an interview guide with the following key topics: information about early labour received during pregnancy; sources of information; signs of onset of labour; management of onset of labour; reasons for going to hospital in early labour; experience of maternity triage access; experience of being hospitalised or being sent home in early labour; influence of the experience of early labour on the later stages of labour and delivery. The interview was not given a time limit and the participants were free to speak about their childbearing experience and to express

their feelings. When the responses were not very detailed, the researcher investigated the key aspects by asking more targeted questions.

Data analysis

All interviews were audio-recorded, listened and re-listened to and fully transcribed. A thematic line-by-line data analysis was undertaken using an interpretive phenomenological approach. Reading repeatedly through the transcripts helped the researchers to understand what was being said by the participants, identifying the core elements of each text. The main question that guided and facilitated the analysis of the interviews was: 'What is this participant talking about?'. The use of analytic memos guided the process of identifying emerging themes. The development of the main themes was discussed by all members of the research team. Data analysis was conducted in Italian in order to maintain language nuances and only relevant quotes were translated in English by the authors for data dissemination.

Ethics

The research started after ethical approval was obtained from the local Ethics Committee. Each participant was given an information sheet explaining the study. Informed consent was gained from each woman before the interview. Confidentiality and anonymity of the data collected were guaranteed. Women were free to withdraw at any time. Participants were given the opportunity to receive the research findings on conclusion of the study.

FINDINGS

Four key themes emerged from the interviews: **a)** recognising early labour signs; **b)** coping with pain at home; **c)** seeking reassurance from healthcare professionals; **d)** being admitted to hospital versus returning home.

Recognising early labour signs

The participants seemed to be aware of the presence of the latent phase of labour, with the main sources of information during pregnancy being antenatal classes, books, the Internet and family and friends' experiences. The majority of the women interviewed found the information about the latent stage received during antenatal classes as really helpful and accurate, especially when compared with the less reliable information available on the Internet:

"The Internet is useful, but I think it's misleading because you find a lot of negative experiences. On the other hand, the antenatal course gives you information about what happens in reality"
(W7)

Only one woman said she did not receive any information about the latent phase of labour, despite the attendance of antenatal education classes. Another woman reported that some inaccurate information was received on the topic:

"We knew that it was like a transitional phase that didn't last long and wasn't very painful. So I wasn't expecting it to be so long and painful. There isn't enough information about this stage. Maybe it's because only few women experience a long initial phase, but it would be better if someone told you that it may occur eventually" (W12)

Despite the majority of interviewees having reported receiving information on the early labour phase in the course of their pregnancy, they had some difficulties in recognising the main characteristics of this stage. During the latent phase of labour, the interviewed women experienced an emotional state that varied from joy of the imminent birth, to the fear of not being able to cope with this sensitive stage, and uncertainties over labour progression due to the little physical modifications which were not as tangible as those of active labour. Early labour was considered by women as very exhausting, both physically and mentally, characterised by an unexpected intensity that they believed belonged to more advanced stages of labour:

"I had a latent phase that lasted for 72 hours. That's why I was scared... because I thought that it had no purpose" (W12)

"The latent phase is hard because I didn't believe it... I thought there were few contractions, but it's just part of the whole process" (W1)

The participants reported the signs of early labour related to the physical sphere, such as pelvic pain similar to the one perceived during the premenstrual phase, with initial tolerable intensity. Some interviewees reported they were alerted by the fact that they never had such symptoms during pregnancy. Another characteristic sign of early labour identified by women was the gradual intensification and rhythmicity of contractions:

"Throughout the pregnancy I have never had that kind of contractions" (W5)

"Premenstrual pain which then became worse with each passing hour... then irregular contractions came... but then it became stronger and more regular... every two or three minutes I had one of the same intensity and length" (W7)

Coping with pain at home

Before going to hospital, women dealt with the onset of labour at home. The use of water in terms of having a warm shower or bath was preponderant among women. The advice received during pregnancy on breathing techniques during uterine contractions also helped them:

"I had a warm bath, as I'd been advised, and actually it was really helpful. I was very relaxed. If I had not been told at the antenatal course, I would have never thought about it, but it helped me a lot" (W7)

"The thing that helped me the most was probably breathing" (W15)

The participants mentioned that they tried to listen to their bodily needs during early labour, alternating phases of movement, rest and choosing various positions that would give them greater comfort. More than half of the women interviewed described a sense of relief given by mobilisation, both in terms of adopting alternative maternal positions and carrying out a variety of activities that helped distract them from pain, such as cooking or walking:

"Initially, when I didn't feel much pain, I tried to find something to do, so I cooked. Then I walked" (D4)

"I walked, and when the contraction came, I put my hands against the wall while my partner massaged my back" (W9)

In the following statement, the importance for this woman to follow a proper dietary regime during early labour appeared very clear. She was aware that it was important to maintain a good caloric intake to provide the right amount of energy required during active labour and at the moment of birth:

"I continued to eat, not so much, but I was told that it was very important at that stage... and then I ate pasta, grains, those things that give you energy but that are quickly digested" (W4)

All the women reported the presence of their birth partners during the latent phase. They acted as a supportive presence providing emotional support and sometimes participating actively to promote the woman's relaxation by massaging her back, making her to walk and holding her:

"When I had strong contractions, it was very helpful when he massaged my back, he held me, he encouraged me to walk "(W4)

"Luckily my husband was able to stay home with me. I don't know what I would have done alone" (W1)

Quite a few participants referred to the use of electronic devices to monitor the frequency and duration of uterine contractions at home. In some cases, Smartphone Apps especially designed to monitor uterine contractile activity were used by women and their partners:

"I downloaded a program on my phone, because they tell you to score the contractions when they arrive, how long they last, etc. I downloaded a program called 'Contraziometro' [Contractiometer]. It calculates the duration, then makes a graph based on the duration of the contractions" (W11)

Seeking reassurance from healthcare professionals

The participants' number of accesses to maternity triage was one to four. Three women were admitted to hospital after the first access to the maternity triage. Six participants accessed the maternity triage twice before admission, four women three times and two mothers four times. This means that the majority of women made at least two trips to the

maternity triage to seek reassurance and guidance from healthcare professionals at the hospital. The main reasons for accessing maternity triage for the first time during early labour were uncertainty about physical changes (e.g. cervical dilatation) and a need for reassurance about labour progression:

"I came to hospital because I wanted to understand what was happening, because I didn't know how dilated I was. I just thought I'll go, I'll see, at least they'll examine me and tell me how dilated I am" (W9)

"I was in pain and then I maybe needed to be reassured, with it being the first baby... at least we see how the situation is progressing" (W2)

At subsequent accesses, the most frequently reported reasons involved intensification of contractile activity, stronger pain and an increasing regularity of contractions, suggesting the likelihood of being in established labour. A woman said that it was not possible to manage pain at home anymore because she did not know what to do and was concerned about not being able to arrive at the hospital 'on time':

"I was told that it was normal but the pain was stronger, so we came here. It was my first experience of birth!" (W15)

"I didn't know what to do. I couldn't stay at home any longer. I was afraid of not being able to come on time" (W1)

A number of women perceived a sense of calm and security when they accessed the maternity triage. The feeling that mostly emerged from participants was reassurance deriving from the midwives' compassionate and competent care. The interviewees stressed the importance of the role of the midwives on duty at the maternity triage, from whom they received useful and appropriate information on the phase of labour they were going through:

"I felt taken care of. The people who welcomed me were nice and competent, and above all they made me feel at ease" (W7)

Although the meeting with healthcare professionals was seen as a moment of reassurance, the maternity triage setting was sometimes not perceived in the same way because it lacked the necessary quiet and calm environment:

"I noticed that the maternity triage was full of women and they were all busy. I knew I would have been asked to wait in some place" (W14)

Moreover, some participants reported the frustration associated with their perception of regularity of contractions and the contrasting midwife's diagnosis of irregular uterine activity:

"It's difficult to understand it from the outside. Those contractions seemed already regular to me" (W1)

Being admitted to hospital versus returning home

After triage assessment, several women reported to be pleased with hospital admission in early labour because they said this was what they needed in order to feel safer and more in control of the situation:

"There is an irrational part of you that wants to go to the safe place [hospital]" (W1)

"I would have committed suicide if they had discharged me because I was already feeling really bad [...]. When admitted, you're already in the place you need to be. You feel cared for" (W8)

"I was reassured because I was close to health professionals. I was reassured by this" (W11)

However, an ambivalent feeling was reported by some of them. In fact, while in the first instance these women felt reassured, they felt abandoned and remained dissatisfied later on due to the absence of one-to-one dedicated care during the latent phase of labour:

"I came to hospital thinking that I would find a safe place where I could be reassured. Instead it wasn't like that. [...] I didn't feel helped, it's more like I was abandoned" (W12)

Almost all of the women returned home in the latent phase of labour as they were not in established labour. When advised to go back home, a number of participants mentioned feelings of disappointment, anger, fear, discouragement and anxiety for not having been admitted to hospital:

"From a psychological point of view, you go through very difficult times when you are sent home twice in one night. People don't understand that women, although they attend antenatal classes, are still unprepared for their first baby... the first experience. It's difficult to be sent home" (W1)

"At first I would have preferred to stay in hospital, to see if the pain would have continued. So I went home with the fear of not recognising the symptoms of the real contractions and not arriving in time to the hospital ... so I was discouraged "(W7)

However, some participants reported a subsequent feeling of comfort at being home and putting in place the suggestions provided by the midwives at the moment of the maternity triage assessment (e.g. use of water, mobilisation and maternal positions):

"I managed the pain at home by following the advice that the midwives had given me in maternity triage" (W15)

These two participants, who respectively accessed maternity triage four times (W4) and once (W11), were convinced from the beginning that home was the best place to stay during early labour, identifying the lack of intimacy of a hospital room and the importance

of being in a familiar place with their partner to be able to relax and prepare for the birth of their baby:

"It's better to wait at home so at least you have your space, your bathroom, your stuff to relax [...]. I always went back to my home, even when I was told that I would be hospitalised, I preferred to go home. Especially because otherwise my partner wouldn't have been able to stay with me. I preferred to do it in this way instead of being alone in a hospital room" (W4)

"After I had been told what was going on, I thought that going back home was the right thing to do. Even if I had been admitted, I would not have been allowed to go straight to the delivery room. So it was useless to stay monitored in a hospital bed" (W11)

Following their birth experience, some women argued that home was probably the best place for early labour. It emerged that it was advantageous to stay at home in their own environment with their birth partner, being free to behave as they wished. Therefore, returning home in the latent phase of labour seemed to be retrospectively considered as positive by the women interviewed:

"At home you have all your stuff, you're a little more calm. You have your shower, your things, your bed. And at home we managed to stay together" (W10)

"In the end I was glad [to go back home] because it was the moment in which I did all my things calmly at home and I prepared myself for the delivery" (W14)

The guidance provided by midwives during triage assessment seemed to be the key factor influencing women's satisfaction when advised either to return home or to stay at the hospital during the latent phase of labour.

DISCUSSION

This study explored first-time mothers' experiences of early labour within Italian maternity care services when admitted to hospital or advised to return home after maternity triage assessment.

An ambivalence between women's perspectives and medical definitions of early and active labour emerged from the findings of this research, recalling contemporary debates on the latent phase of labour as an area of conflict between clients and healthcare professionals (Iannuzzi and Borrelli, 2014; Janssen and Desmarais, 2013). Some examples were observed regarding the women's 'subjective' perception of the regularity of contractions as opposed to the midwife's assessment of contractile activity; the unexpected intensity that women believed belonged only to the more advanced stages of labour; the early labour stage seen as 'part of the whole' and not as a separate period of time coming before the first stage of active labour. According to this, Iannuzzi and Borrelli (2014: 134) claimed that 'the Italian traditional classification of labour stages seems to reinforce the view of early labour as a distinctive step, in a step-like pathway rather than an early phase of a continuous process of labour/childbirth'.

With regard to the onset of labour at home, our findings seem to support the results of the study of Carlsson et al. (2012), which identified that the women tried to listen to the rhythms of their body. In line with existing evidence, the physical and instinctive reaction of women was associated with the need for a more rational understanding of the labour progress, resulting initially in the attentive monitoring and recording of uterine contractions and, subsequently, in the access to the hospital maternity triage in order to seek confirmation and reassurance from healthcare professionals (Barnett et al., 2008; Carlsson et al., 2009; Cheyne et al., 2007). Supporting the findings of the present study, other authors highlighted uncertainty, the need for reassurance, anxiety and lack of confidence as central issues for

women in early labour and are the main factors that drive them to access the hospital triage (Barnett et al., 2008; Nolan et al., 2009; Nolan and Smith, 2010). The reassurance from midwives about the normality of the slow evolution of this phase seems to be a key factor in encouraging women to stay home during early labour (Cheyne et al., 2007). It is evident that midwives often advise women in the latent phase to remain or return home in order to avoid unnecessary interventions (Bailit et al., 2005; Holmes, 2001; Rahnama et al., 2006). In most cases, women are encouraged to spend the latent phase at home with their birth partners when midwifery care at home is absent. It is therefore central to provide advice on how to cope with pain during this sensitive stage of labour. This might give women a greater perception of being in control of their birth experience (Jackson et al., 2003; Greulich and Tarrant, 2007). Dixon et al. (2013) found that women in early labour were reassured by contacting a midwife they knew, felt comforted by talking to her and consequently confident to stay at home during the latent phase. When continuity of carer and home visiting cannot be provided, the introduction of a telephone triage dedicated to early labour may be a good alternative for childbearing women and their birth partners (Spiby et al., 2008; Weavers and Nash, 2012).

Regarding the ambivalent feeling reported by the participants when being admitted to hospital or sent home after triage assessment, previous research highlighted feelings such as disappointment, anger, fear, discouragement and anxiety when women were advised to return home in early labour (Barnett et al., 2008; Cheyne et al., 2007; Janssen and Desmarais, 2013). Conversely, women admitted to hospital may have a greater sense of control when compared to women being sent home (Barnett et al., 2008). However, the home setting is often advised as the best place to stay in the latent stage of labour (Jackson et al., 2003; Lauzon and Hodnett, 2009; Scotland et al., 2011) since this is a familiar and tranquil place, where women are able to exercise full control over space and time, and where

they are free to follow their own 'schedule' and needs. Regardless of the healthcare professionals' advice to either return home or be admitted after triage assessment, the information and guidance provided by midwives during pregnancy and at maternity triage should be considered as a key factor in caring for women in early labour.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

This paper focused on women's experience of early labour care in the context of Italian maternity care services. Although the sample size was relatively small, the number of participants was appropriate for understanding the phenomenon and highlighted interesting aspects. Despite the fact that the study was conducted in a local setting, the authors offer recommendations for practice that are relevant within international debates on early labour services in both cases of hospitalisation and returning home after maternity triage assessment.

In light of the findings presented in this paper and literature on early labour, it is clear that maternity care systems in Italy, as elsewhere, should put in place strategies to inform, empower and support women during the latent phase of labour. As suggested by Cheyne et al. (2007: 604), 'the value of midwifery support and reassurance in the latent and early stages of labour should not be underestimated'. Suggestions for practice include a focus on the need for communication with women in early labour to better understand their individual needs, providing support to reduce anxiety and fear and increasing confidence, self-efficacy and empowerment.

In the presence of physiological signs, the home should be promoted as the ideal place for early labour. When women are advised to stay/return home, they should receive information on how to cope with this stage of labour at home and when to go back to hospital. It is

advised that additional time should be dedicated during antenatal classes and clinics to provide pregnant women with reliable and consistent information on early labour signs and characteristics. When domiciliary midwifery care is not available, a dedicated telephone triage run by midwives should be considered in Italy and other countries as a routine service for first contact with women during the latent phase of labour. In this way, women in early labour could find answers to their needs and reassurance from healthcare professionals without accessing the hospital maternity triage repeatedly. When women in early labour are admitted to hospital, one-to-one care in a dedicated space should be provided, offering to the birth partner the opportunity to be present.

As part of the research agenda, mapping early labour maternity services in Italy, as in other countries, is certainly a priority. A survey of women's experiences of the available services during the latent phase of labour at local, national and international levels would allow for the establishment of general and specific guidelines on early labour care. Other ideas for future research concern the exploration of birth partners' experiences of supporting labouring women during early labour. Further investigation is needed to understand midwives' experiences of caring for women in early labour and the decision-making processes that underlie hospital admission, or the advice given to women about returning home.

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