Aneurin Bevan University Health Board

Intrapartum Fetal Surveillance Guideline

N.B. *Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.*

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Contents:

Background

Auscultation of the fetal heart forms part of fetal surveillance. Its aim antenatally and in labour is to detect those babies who may be compromised or potentially compromised by a shortage of oxygen (fetal hypoxia), or by non-hypoxic causes. If the shortage of oxygen is both prolonged or severe, babies are at risk of being born with a disability or of dying either during labour or shortly after (ACOG, 2021).

As identified in The 4th Confidential Enquiry into Stillbirths and Deaths in Infancy Report (CESDI, 1997), the misinterpretation of cardiotocography, failure to integrate clinical picture, incoherent team functions and delay in action and appropriate action once a decision to deliver is made, were all identified as common themes in cases of poor fetal outcome (NHS Resolution, 2023).

For a woman who is healthy and has had an uncomplicated pregnancy, intelligent intermittent auscultation (IIA) should be offered and recommended in labour to monitor fetal wellbeing, regardless of birth setting (Wales Maternity Network, 2022).

However, cardiotocography - continuous electronic fetal monitoring (EFM) is recommended where there are risk factors identified during the initial assessment or arise during labour and for high-risk pregnancies. ST Analysis (STAN) can be used in labour as an aid/adjunct to interpretation of CTG and clinical management but does not replace the clinical judgement of an appropriately qualified professional. Both the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) codes of conduct, require that registrants take part in continued professional development to maintain their competence to ensure the safety of those receiving care.

Please see antenatal fetal surveillance guideline for antenatal CTG, computerised CTG and Dawes Redman analysis.

This guideline applies to all people who are pregnant and may use the term woman but recognises that not all people having babies within Aneurin Bevan University Health Board, identify as women.

Abbreviations

ABUHB – Aneurin Bevan University Health Board
ANC – Antenatal Clinic
APH – Antepartum Haemorrhage
AWCPNL – All Wales Care Pathway for Normal Labour
cCTG – Computerised Cardiotocography
CEFM – Computerised Electronic Fetal Monitoring
CESDI – Confidential Enquiries into Stillbirths and Deaths in Infancy
CS – Caesarean Section
DAU – Day Assessment Unit
DHR – Digital Health Record
DR – Dawes Redman
ECTG – Electronic Cardiotocography
EFM – Electronic Fetal Monitoring
FGR – Fetal Growth Restriction
FSE – Fetal Scalp Electrode
GDM – Gestational Diabetes Mellitus
GMC – General Medical Council
IIA – Intelligent Intermittent Auscultation
IUGR – Intrauterine Growth Restriction
MSAF – Meconium-Stained Amniotic Fluid
NMC – Nursing and Midwifery Council
OH – Online House
OLC – Obstetric Led Care
PET – Pre-eclampsia
PIH – Pregnancy Induced Hypertension
SGA – Small for Gestational Age
STAN – ST Analysis
SOP – Standard Operating Procedure

Aims

- ABUHB demonstrates a standardised approach to the use and interpretation of intermittent auscultation of the fetal heart, computerised and electronic fetal monitoring.

Compliance with the All-Wales Fetal Surveillance Standards through annual training and appraisals.

Intelligent Intermittent Auscultation (IIA) - Intrapartum

Offer intelligent intermittent auscultation of the fetal heart rate to women at low risk of complications in established labour, as set out in the NICE (2022) NG229 Practice recommendations.

- A full risk assessment of the woman should be undertaken in the first instance to assess the suitability of using IIA.

- To monitor the fetal heart either use a Pinard Stethoscope or Doppler ultrasound, (documenting which device used). CTG transducers are not licenced for IIA.

- Enquire and record the presence of fetal movements

- Auscultate the fetal heart for a minimum of 1 minute between contractions when the fetus is at rest to establish a baseline and then subsequently immediately after a contraction, every 15 minutes in the first stage of labour and record it as a single rate. This should be increased to every 5 minutes or with each contraction during the second stage of labour.

- ABUHB promotes use of the 15 second counting method when performing IIA.

Plot the baseline on the partogram as a single figure

- If fetal movement was felt, the fetal heart accelerated between contractions with fetal movement and there was no deceleration with or after the contraction, this indicates good fetal health and the mother can be reassured. Record this.

- Palpate the maternal pulse hourly, or more frequently if there are concerns to differentiate between maternal and fetal heart rate.

- Record any acceleration and/or deceleration if heard, in the variation section of the All-Wales Care Pathway for Normal Labour (AWCPNL).

- Attention should be given to identification of a rising baseline and the presence of decelerations. Where there is suspicion that the baseline has risen this would warrant increased auscultation of the fetal heart. If confirmed transfer to MDU for continuous monitoring.

- If a CTG is needed to confirm fetal wellbeing, the woman must leave the midwifery-led pathway and be transferred to the obstetric-led unit. A CTG should be commenced once transferred.

- In exceptional cases, such as an acute concern for fetal wellbeing and no available room or staff in the consultant-led unit, clinical judgement should be used to decide on CTG use on the midwifery-led unit. However, regardless of the CTG interpretation, the woman must exit the ANCPNL pathway and continue care on the obstetric-led unit.

- If a CTG has been commenced due to suspected fetal heart rate abnormalities this can be discontinued if the recording shows no evidence of hypoxia or any other form of fetal compromise and has been in situ for no less than 20 minutes. At this time the health professional can resume IIA on the obstetric-led unit, if the woman wishes.

Transferring from intermittent auscultation to continuous CTG

As per Wales Maternity and Neonatal Network, 2022. If any of the below risk factors are present at the initial assessment of labour or arise during labour then the woman should be advised to transfer to obstetric led care and receive continuous CTG:

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more.
- Either raised diastolic blood pressure of 90 mmHg or more, or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart.
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90mmHg or more) or raised systolic blood pressure (140 mmHg or more)
- A temperature of 38'c or above on a single reading or 37.5'c or above on 2 consecutive readings 1 hour apart.
- Fresh vaginal bleeding
- Rupture of membranes more than 24 hours before the onset of established labour
- The presence of significant meconium or a change in liquor state i.e., insignificant to significant or clear to insignificant
- Pain reported by the woman that differs from pain of contractions.
- Suspected chorioamnionitis or sepsis
- Risk factors that indicate the need for obstetric led care for fetal reasons i.e., SGA, PET, PIH
- Abnormal presentation
- Fetal complications of pregnancy such as small for gestational age foetus, macrosomia, oligohydramnios/polyhydramnios.
- Fetal heart rate above 160 bpm or below 110 bpm or baseline deemed abnormal for gestational age.
- A rising baseline rate or audible decelerations following contractions.
- Reduced fetal movements in the last 24 hours reported by the woman.

- Confirmed delay in the first or second stage of labour. Do not regard amniotomy alone for suspected delay in established first stage of labour as an indication to commence continuous CTG

Address any concerns that the woman has about continuous CTG and give them the following information: -

- Explain that using continuous monitoring may restrict her mobility, however if not contraindicated FSE can be offered to reduce this risk.
- See appendix 1.

Intrapartum Electronic Fetal Monitoring

EFM should be used in the following situation;

- Women assessed as being high risk and booked for Obstetric led care (OLC) will require an appropriate risk assessment at the start of labour to determine the appropriate form of fetal monitoring.

- Continuous EFM is recommended once in established labour where there is a risk factor for fetal compromise or per maternal choice.

- Women transferred from midwife led to obstetric led care in labour.

The professional undertaking EFM:

- Performs a risk assessment and documents the indication for undertaking EFM and maternal pulse on Badgernet using the 'CTG review' form.

- Discusses the need for EFM with the woman and gains her verbal consent. Explains to the woman, the process of obtaining an EFM recording.

- Women should be informed that EFM will restrict their mobility in labour (NICE 2022). However, women should be encouraged to adopt various positions such as sitting on a chair, standing, using the birth ball or any other positions per biomechanics in labour.

All members of the multidisciplinary team should encourage and promote this practice. An FSE may be required to achieve this.

STAN fetal monitoring in labour

STAN is designed for use in the intrapartum stage and its use should be considered from ≥36weeks for women with ruptured membranes. Use of a fetal scalp electrode (FSE) is required when using STAN monitoring. All contra-indications for FSE apply to STAN monitoring.

What is STAN?

- STAN monitoring analyses ST segment changes in fetal ECG which occur as a result of changes in fetal myocardial oxygenation. It calculates T/QRS ratio and identifies changes in the ratio.

- The STAN concept is based on the unique ability of the ST interval to reflect the function of fetal heart muscle during stress/hypoxia. The fetal heart and brain are equally sensitive to oxygen deficiency.

Indications/ Contraindications

Indications – any high-risk pregnancy over 36 weeks with no contra-indications after discussion and consent.

Contraindications
- Under 36 weeks gestation- Abnormal fetal baseline and/ or variability.
- Pre-terminal CTG
- Known fetal heart conditions or congenital defects
- Woman's choice
- Use of TENS machine (TENS can cause interruption to the ECG Signal)
- Maternal HIV/HepB (Unless there is an undetectable viral load in cases of HIV carriers)
- Active herpes or gonorrhoea
- Suspected/confirmed fetal coagulopathy.

Clinical Use

- STAN should be considered and offered in all high-risk women in labour, other than those suitable for IIA.

- STAN is an adjunct to Physiological CTG interpretation, if an ST deviation occurs it must be classified in relation to the CTG. If the CTG is classified as normal, there is no need to act on ST event/deviation. See appendix (4) for decision tree guide.

- A pre-terminal CTG should always result in delivery of the baby regardless of the ST segment analysis.

- A full holistic assessment should be undertaken hourly, or more frequently if there are concerns and documented on Badgernet under the 'Labour assessment' form. (See appendix 3)

- Do not make any decision about a woman's care in labour on the basis of cardiotocography (CTG) findings alone.

- Take into account any antenatal and intrapartum risk factors, the current wellbeing of the woman and unborn baby, and the progress of labour when interpreting the CTG trace.

- It is crucial that STAN is commenced on a compensated fetus, ideally in the first stage of labour. (See appendix 2)

- STAN Monitoring can be commenced where there is a stable baseline and 'normal' fetal heart variability between 5-25bpm.

- On commencement STAN requires up 20 minutes before it is able to identify a control baseline from which subsequent changes may be identified.

Systematic CTG assessment

All women requiring continuous electronic fetal monitoring must undergo a regular assessment with additional fresh eyes and clear documentation of findings. This review will be performed by the midwife responsible for care and fresh eyes undertaken by another midwife or obstetrician (ST3 or above) within a maximum period of two hours. The fresh eyes can be documented on Badgernet under the 'CTG Review' form under 'peer review'. The assessment of maternal and fetal risk factors must include documentation on:

Maternal: Contractions, Maternal Pulse, Cervical Dilatation, and Reason for CTG

Fetal: Liquor Colour (if known), Gestation, CTG Baseline, Variability, Accelerations, Decelerations

Decision: Date and Time of Fresh Eyes, E-Signature, and Status of Assessor, Classification of CTG and Action Taken

Review: Date and Time of Fresh Eyes, E-Signature and Status of Assessor and if agreements with Review and Action

A review of previous CTG is an important factor to identify any changes including that of the baseline rate.

Principles for intrapartum CTG trace interpretation

When reviewing the CTG trace, assess and document all 4 features (baseline fetal heart rate, variability, presence or absence of decelerations, presence or absence of accelerations)

It is not possible to categorise or interpret every CTG trace. **Senior obstetric input is important in these cases**.

In instances of loss of contact or inability to monitor FH abdominally consider use of alternative forms or monitoring as soon as possible i.e FSE where appropriate and not contra-indicated.

Accelerations

- The presence of fetal heart rate accelerations is generally a sign that the unborn baby is healthy

- If there is a stable baseline fetal heart rate appropriate for gestational age and normal variability, continue usual care as the risk of fetal acidosis is low.

- Accelerations in conjunction with contractions should not be documented as true accelerations, they are cord compression (umbilical vein compression), in the presence of a stable baseline and normal variability a sign of fetal compensation.

Documentation

At the commencement of EFM the patient details should be input into the STAN monitor, if this is not done the recording is not identifiable and cannot be linked to the rest of the patient notes.

The following details should be documented on the monitor;

- Full name
- Hospital Number
- Gestation

Once the EFM is commenced a CTG can be 'commenced' on Badgernet and the STAN monitor number should be documented alongside the reason for EFM, maternal pulse and the time and date of commencement.

Any event that may affect the FHR should be noted contemporaneously on the EFM trace and case notes. (E.g., vaginal examination, siting of epidural, drugs). These events must be recorded electronically on Badgernet under the relevant form. Notes concerning the CTG directly can be added to the CTG on Badgernet using the 'CTG Comment' tab or onto the STAN monitor digitally.

ALL CTG recordings should be documented in the woman notes using the 'CTG Review' tab on Badgernet. This method should always be used by all obstetricians and midwives.

During labour, formal assessment of the fetal heart rate should be undertaken hourly and the assessment clearly documented in the notes using the 'CTG Review' tab. The Fetal heart rate can be recorded on Badgernet every 15 minutes in the first stage and every 5 minutes in the second stage using the 'quick labour assessment' form.

In addition, during labour, a continuous CTG recording should be reviewed by another midwife or obstetrician on an hourly basis. This is referred to as the "fresh eyes" approach. It can be undertaken by an appropriately trained professional. It is not a referral to a more senior midwife or obstetrician but an opportunity for a colleague to provide a fresh assessment to the CTG. This should be regarded as an opportunity for effective team working and the promotion of continuous CTG assessment skills.

It is essential that the CTG assessment is digitally signed. This applies to the professional caring for the woman and the professional providing the fresh eyes assessment.

A clear action plan must be documented upon review. This can be a good opportunity to use tools such as 'Teach or Treat' (Appendix 6).

All findings should be explained to the woman. Where appropriate, consider the use of interpretation services.

On completion of an intrapartum CTG trace (non-STAN), the professional should note the date, time and mode of delivery on digitally on monitor or on Badgernet using the 'CTG Comment' tab.

Physiological Interpretation Guidance

Hypoxia	Features	Management
No Hypoxia	• Baseline appropriate for gestational age • Normal variability and cycling • No repetitive decelerations	• Consider whether the CTG needs to continue • If continuing CTG complete routine hourly review (Using CTG Review Tab on Badgernet)
Evidence of Hypoxia		
Chronic Hypoxia	• Higher baseline than expected for gestational age • Reduced variability and/or absence of cycling • Absence of accelerations • Shallow decelerations • Consider the clinical indicators; Reduced fetal movement, meconium, bleeding, evidence of chorioamnionitis, post maturity, IUGR	• Avoid further stress • Expedite delivery, if delivery is not imminent
Gradually Evolving Hypoxia	**Compensated** Rise in baseline (with normal variability and stable baseline) preceded by decelerations and loss of accelerations	• Likely to respond to conservative intervention • Regular review every 30-60 minutes to assess for signs of further hypoxic change, and that the intervention resulted in an improvement. • Other causes such as reduced placental reserve MUST be considered and addressed accordingly.
	Decompensated	

	• Reduced or increased variability • Unstable/ progressive decline in the baseline (step ladder pattern to death)	• Needs urgent intervention to reverse the hypoxic insult (Remove prostaglandin pessary, stop oxytocin infusion, tocolysis). • Delivery should be expedited if no signs of delivery are seen.
Subacute Hypoxia	• More time spent decelerating than at the baseline • May be associated with saltatory pattern (Increased variability)	**First Stage**
		• Remove prostaglandins/ stop oxytocin infusions • If no improvement needs urgent tocolysis • If still no evidence of improvement within 10-15 minutes, review situation and expedite delivery
		Second Stage
		• Stop maternal active pushing during contractions until improvement is noted • If no improvement is noted, consider tocolysis if delivery is not imminent or expedite delivery by operative vaginal delivery
Acute Hypoxia	Prolonged deceleration (>3 minutes)	**Preceded by reduced variability and lack of cycling or reduced variability within the first 3 minutes**
		Immediate delivery via the safest and quickest route
		Preceded by normal variability and cycling and normal variability within the first three minutes of deceleration
		• Exclude the three accidents (cord prolapse, placental abruption, uterine rupture – if an accident is suspected prepare for immediate delivery) • Correct reversible causes • If no improvement by 9 minutes or any of the accidents diagnosed, immediate delivery via the safest and quickest route

Unable to Ascertain fetal wellbeing (Poor signal quality, uncertain baseline, possible recording of the maternal heart rate)	• Escalate to senior Obstetrician • Consider adjunctive techniques, if appropriate • Consider the application of FSE to improve signal quality

Assessing the WHOLE clinical picture

In addition to interpreting the CTG and categorising it using the Physiological CTG interpretation guideline (2018), it is also essential to consider the whole clinical picture.
Maternal observations should be noted; maternal pulse, blood pressure, respiratory rate and temperature. Any deviation from the norm and in particular maternal Pyrexia (38.0C or above on one occasion or 37.5C or above on two or more occasions two hours apart) should be noted and communicated to the obstetric team.

Omniview Monitoring System

Omniview is an electronic 'Central Fetal Monitoring and Archiving System' that provides central monitoring surveillance of live and archived antenatal and intrapartum CTG's performed using STAN monitors.
The Central monitoring system provides a unique opportunity for CTG teaching discussions and monitoring evolving changes without worrying the woman.
It is important to note that a review of the CTG on central monitoring does not replace a bedside assessment of a woman when required or requested by the labour ward co-ordinator or midwife caring for the woman.
All women on STAN monitoring, as previously highlighted, must;

- have their name and hospital number electronically input at the commencement of their CTG.
- The date and time of each monitor must be correct.

The central monitoring is a supportive aid and not a substitute for midwifery care. The midwife providing 1:1 care is responsible for escalating concerns and seeking appropriate support in a timely manner. However, if concerns are identified by a senior member or

staff observing the central monitoring screen, they also have a responsibility to escalate appropriately.
When used appropriately, the central monitoring system acts as a 'fail safe mechanism'.

Education and Training Standards

All Midwives and Obstetric Doctors should meet the All-Wales Fetal Surveillance Standards (Welsh Risk Pool, 2023).

Audit

- Compliance with the guideline will be audited on an annual basis by the Fetal Surveillance Lead Midwife. (See Appendix 5)

- Audit of study day attendance, compliance with IIA online package and case reviews/ discussions on an annual basis by Fetal Surveillance Lead Midwife.

References

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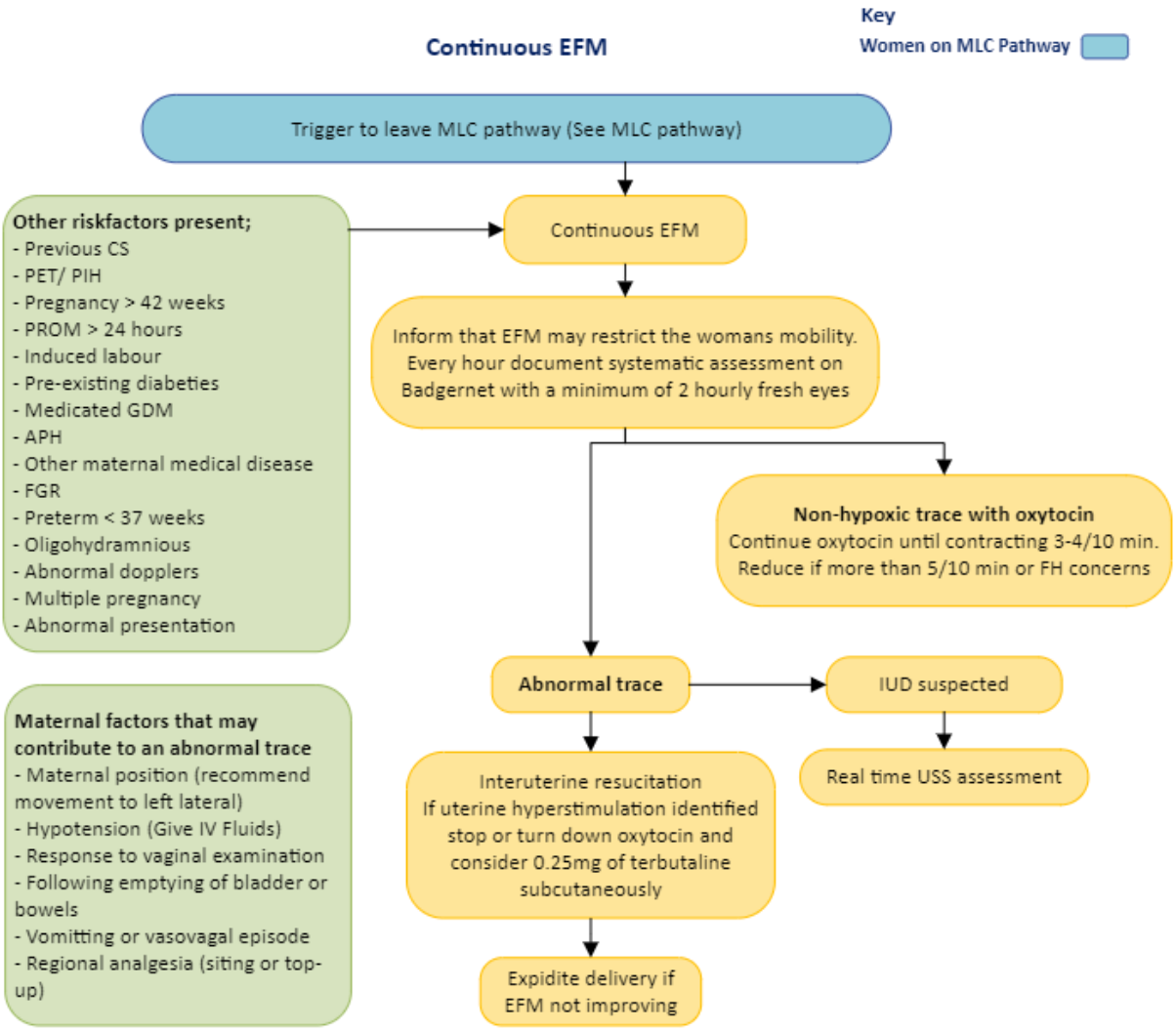
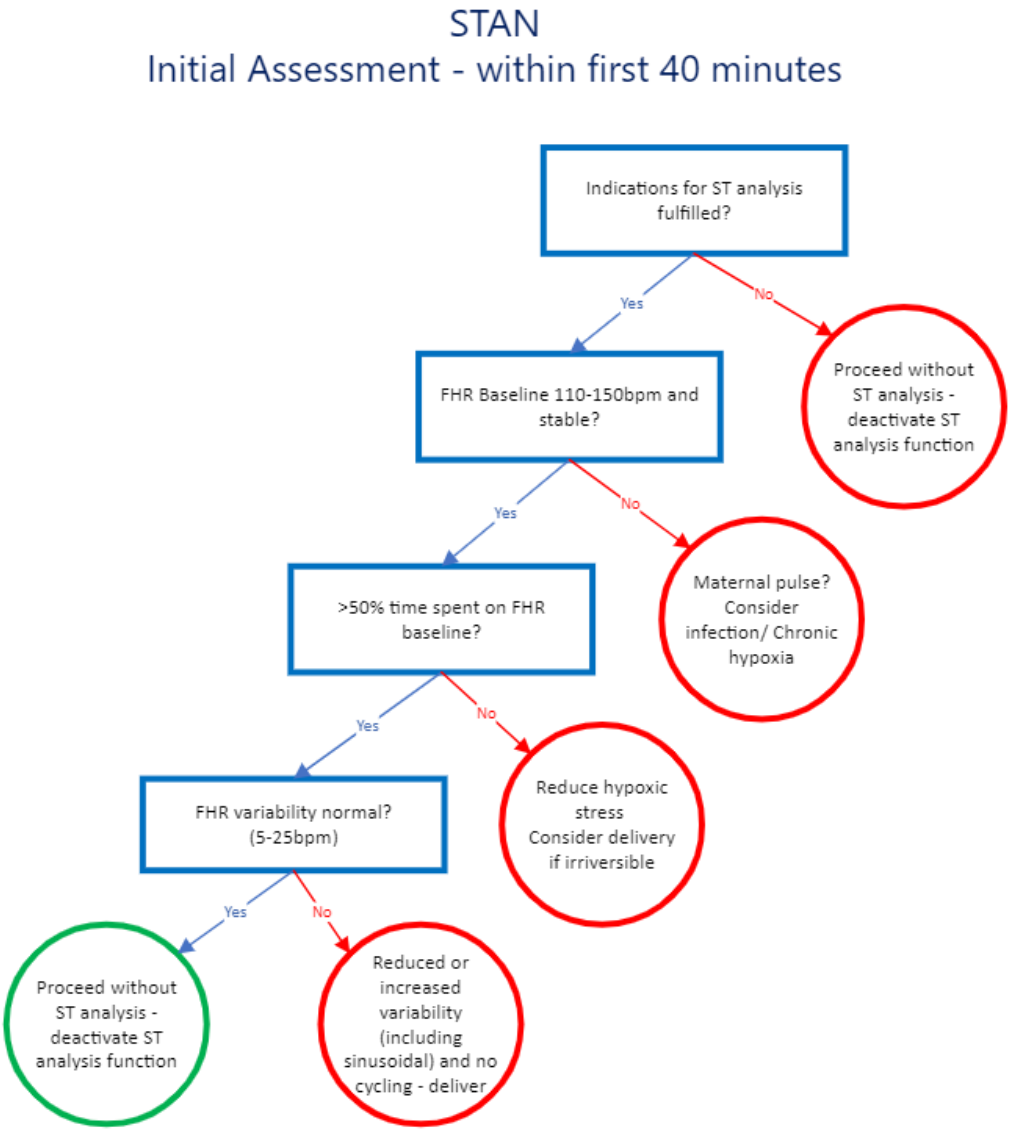
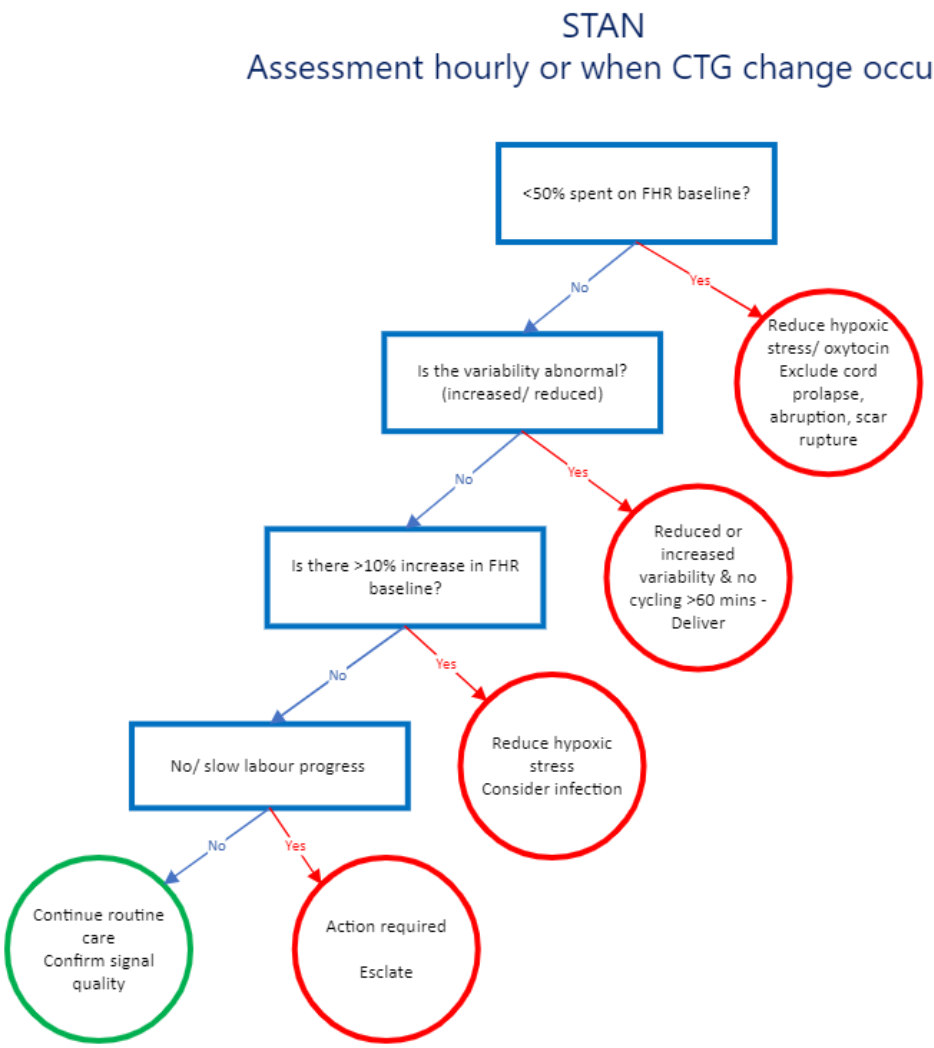
Appendix 1


Continuous EFM
Key
Women on MLC Pathway
Trigger to leave MLC pathway (See MLC pathway)
Other riskfactors present;
- Previous CS
- PET/ PIH
- Pregnancy > 42 weeks
- PROM > 24 hours
- Induced labour
- Pre-existing diabeties
- Medicated GDM
- APH
- Other maternal medical disease
- FGR
- Preterm < 37 weeks
- Oligohydramnious
- Abnormal dopplers
- Multiple pregnancy
- Abnormal presentation
Continuous EFM
Inform that EFM may restrict the womans mobility. Every hour document systematic assessment on Badgernet with a minimum of 2 hourly fresh eyes
Non-hypoxic trace with oxytocin
Continue oxytocin until contracting 3-4/10 min. Reduce if more than 5/10 min or FH concerns
Abnormal trace
IUD suspected
Real time USS assessment
Maternal factors that may contribute to an abnormal trace
- Maternal position (recommend movement to left lateral)
- Hypotension (Give IV Fluids)
- Response to vaginal examination
- Following emptying of bladder or bowels
- Vomitting or vasovagal episode
- Regional analgesia (siting or top-up)
Interuterine resucitation
If uterine hyperstimulation identified stop or turn down oxytocin and consider 0.25mg of terbutaline subcutaneously
Expidite delivery if EFM not improving

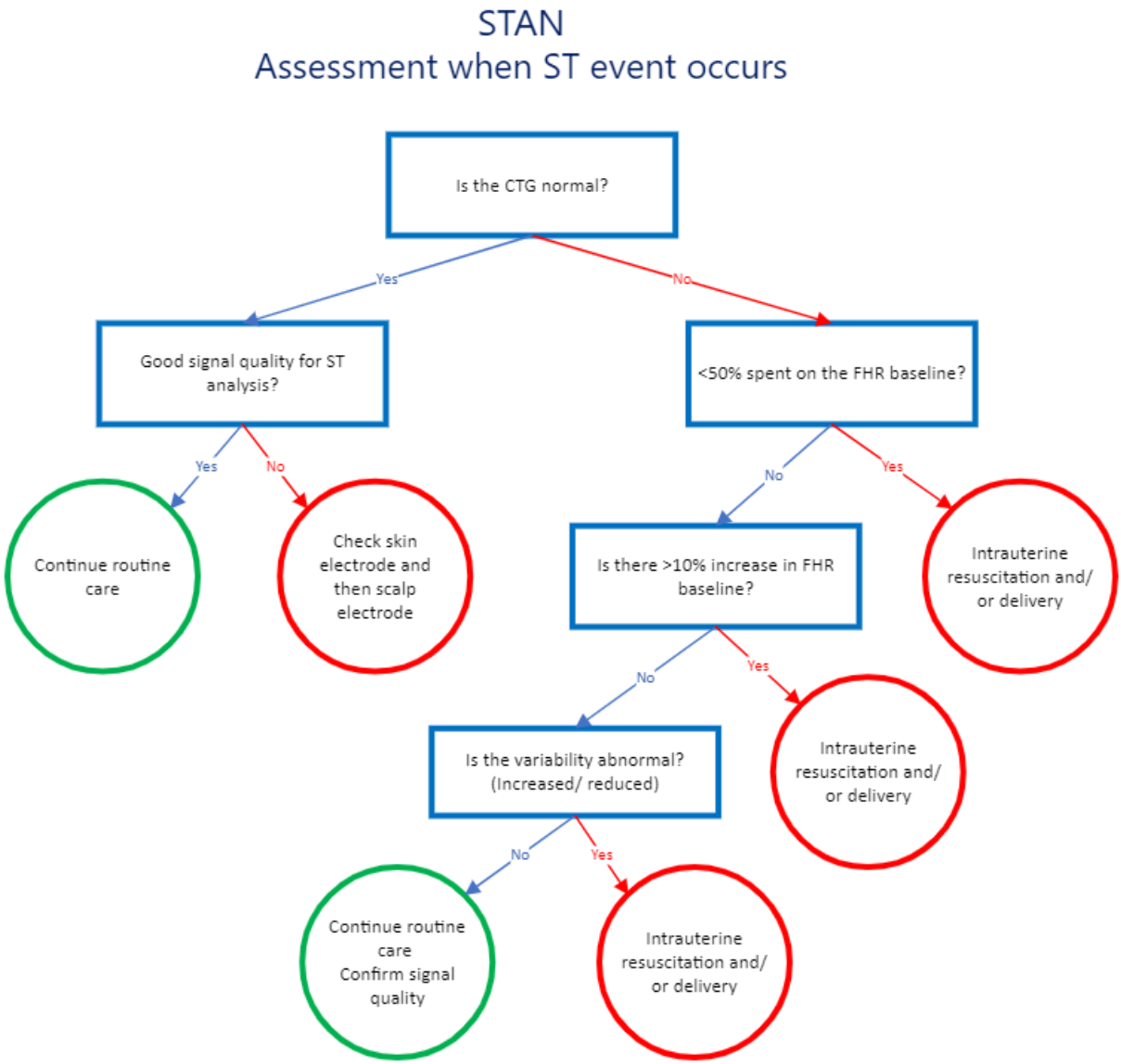
Appendix 2


STAN
Initial Assessment - within first 40 minutes
Indications for ST analysis fulfilled?
Yes
No
Proceed without ST analysis - deactivate ST analysis function
FHR Baseline 110-150bpm and stable?
Yes
No
Maternal pulse? Consider infection/ Chronic hypoxia
>50% time spent on FHR baseline?
Yes
No
Reduce hypoxic stress Consider delivery if irriversible
FHR variability normal? (5-25bpm)
Yes
No
Proceed without ST analysis - deactivate ST analysis function
Reduced or increased variability (including sinusoidal) and no cycling - deliver

Appendix 3


STAN
Assessment hourly or when CTG change occurs
<50% spent on FHR baseline?
No
Yes
Reduce hypoxic stress/ oxytocin Exclude cord prolapse, abruption, scar rupture
Is the variability abnormal? (increased/ reduced)
No
Yes
Reduced or increased variability & no cycling >60 mins - Deliver
Is there >10% increase in FHR baseline?
No
Yes
Reduce hypoxic stress Consider infection
No/ slow labour progress
No
Yes
Continue routine care Confirm signal quality
Action required Esclate

Appendix 4


STAN
Assessment when ST event occurs
Is the CTG normal?
Yes
No
Good signal quality for ST analysis?
<50% spent on the FHR baseline?
Yes
No
No
Yes
Continue routine care
Check skin electrode and then scalp electrode
Is there >10% increase in FHR baseline?
Intrauterine resuscitation and/ or delivery
No
Yes
Is the variability abnormal? (Increased/ reduced)
Intrauterine resuscitation and/ or delivery
No
Yes
Continue routine care
Confirm signal quality
Intrauterine resuscitation and/ or delivery

Appendix 5 – Annual Audit Tool

Antenatal CTG Audit

CTG review completed
Correct terminology
Classification of CTG
Staff name/ digital signature
Date and time of CTG
Maternal Pulse recorded
Auscultation with pinard/ handheld doppler pre CTG
EDD/ Gestation recorded
Reason for CTG documented
Documentation of intervention
CTG linked to Badgernet
Appropriate action for abnormal CTG
Performed in appropriate setting
Location of CTG identified
DR used
DR used appropriately
DR Criteria Met/Not met
CTG 'completed' on Badgernet

Intrapartum CTG Audit

STAN no. documented
Use of ST analysis
Use of decision tree in response to ST events
Room number noted
Patient details on omniview
Appropriate action for abnormal CTG
Correct terminology
Staff name/ digital signature
Date and time of CTG
Maternal Pulse recorded
Auscultation with pinard pre CTG
EDD/ Gestation recorded
Reason for CTG documented
Hourly CTG review in 1st stage
Minimum 2 hourly fresh eyes
Documentation of intervention

IIA Audit

Accelerations noted in latent phase
FHR documented every 15 minutes in 1st stage of labour
FHR documented every 5 minutes in 2nd stage of labour
Pathway excited appropriately
CTG performed on HBC
Correct plotting of FHR on partogram
Documented use of IIA

Appendix 6 – 'Teach or Treat' Tool