

# Intermittent Auscultation of the Fetal Heart During Labour Guideline

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Brief Summary of Document:	To provide safe care and management of low risk women during labour using intermittent auscultation of the fetal heart
Scope	Low risk women who are confirmed to be in active labour under the care of midwives in Midwifery-led units and in the mother's home in Hywel Dda University Health Board. 'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.'

To be read in conjunction with:	813- Intrapartum Continuous Fetal Monitoring Guideline 2019
Patient Information:	<a href="#">Include links to Patient Information Library</a>

Owning group	Obstetric Guideline and Audit Group
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Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline Reuploaded 22.1.2020 as incorrect review date showing	12.3.2019

## Glossary of terms

Term	Definition
AWNCPfNL	All Wales Normal Care Pathway for Normal Labour
CTG	Cardiotocograph
CU	Consultant Unit
EFM	Electronic fetal monitoring
FHR	Fetal heart rate
IA	Intermittent Auscultation
MLC	Midwife-led care

Keywords	Intermittent auscultation, cardiotocograph, intrapartum, low risk
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## 1. AIM OF GUIDELINE

The aim of this guideline is to provide guidance and standardise practice in relation to intermittent auscultation of the fetal heart rate during in low risk women.

## 2. OBJECTIVES

The objective of intermittent auscultation of the fetal heart during labour is to reduce fetal mortality/morbidity by ensuring that any fetal hypoxic insult is identified in time to allow either:

- Removal/amelioration of the hypoxic insult
- Delivery of the fetus from the uterus before irreversible asphyxial damage occurs

## 3. SCOPE

Women assessed as being low risk and booked for Midwifery-led care (MLC) will require intermittent auscultation of the fetal heart rate once in established labour.

## 4. INTRODUCTION

Intermittent auscultation (IA) of the fetal heart (FH) in labour with a sonicaid or Pinnard should be recommended for all women who are healthy and have uncomplicated pregnancies. In low risk women routine continuous electronic fetal monitoring (CEFM) is associated with more caesarean sections and assisted vaginal births.

This guideline aims to highlight best practice and minimum standards when carrying out intermittent auscultation of the fetal heart in labour. Increased fetal surveillance through prolonged auscultation (i.e. >one minute) with a sonicaid (or Pinnard) may be indicated in certain situations. Women who are apparently at low risk should have a formal fetal risk assessment on admission in labour irrespective of the place of birth to determine the most appropriate fetal monitoring method.

## 5. MANAGEMENT

### Technique for performing intermittent auscultation of the fetal heart (Appendix 1)

- Use either a Pinard stethoscope and Doppler ultrasound
- During the initial assessment of the woman:
- Auscultate the fetal heart between contractions to obtain a baseline rate
- Auscultate the fetal heart immediately after a contraction, to identify any concerning decelerations
- Auscultate the fetal heart during fetal movements to confirm presence of accelerations to enable scrutiny for a rising baseline HR and/or tachycardia which may indicate fetal hypoxia
- Record the fetal heart on the partogram of the AWNCPfNL as a single rate during labour
- If at any time you are unable to listen to the fetal heart as frequently as required assistance must be summoned in order to continue to do so
- The routine use of an admission CTG is not recommended in low risk women with otherwise normal observations
- Record accelerations and decelerations if heard.

### 5.1 FIRST STAGE OF LABOUR

- Carry out intermittent auscultation immediately after a contraction for **at least** 1 minute and **at least** every 15 minutes
- Palpate the maternal pulse **at least once** every 30 minutes concurrently with the fetal heart to ensure two separate rates and that they are within normal limits

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## 5.2 SECOND STAGE OF LABOUR

- Carry out intermittent auscultation immediately after a contraction for **at least** 1 minute and **at least** every 5 minutes
- Palpate the maternal pulse **at least once** every 15 minutes concurrently with the fetal heart to ensure two separate rates and that they are within normal limits

## 6. CONCERNS ABOUT THE FETAL HEART (APPENDIX 1)

- If a rising baseline or decelerations are confirmed, further actions should include:
- Summoning help
- Palpating the maternal pulse to enable comparison
- Advising continuous cardiotocography
- Explaining to the woman and her birth companion(s) why it is needed
- Initiating transfer to an obstetric-led unit

## 6.1 REASONS FOR TRANSFER TO CONTINUOUS ELECTRONIC FETAL MONITORING

- Advise transfer to CU for continuous cardiotocography if any of the following risk factors are present at initial assessment or arise during labour (Appendix 1)
- If CEFM is normal the trace can be discontinued after 20 minutes, providing all clinical/risk assessments are within normal parameters.
- A full systematic assessment must be undertaken prior to discontinuing the CTG using the **Intrapartum CTG Sticker and Fresh Eyes** approach.

## 7. RECORD KEEPING

- All documentation must be recorded in line with the guidance in the AWNCPfNL
- Any deviations must be documented using the variation codes in the AWNCPfNL
- In the event of transfer to an obstetric unit AWNCPfNL has to be exited and the appropriate yellow Exit Audit form completed.
- All clinicians must continue to document the fetal heart, maternal and assessment findings in the AWNCPfNL partogram.

## 8. COMMUNICATION

- **Maternal wishes and concerns should be discussed and documented**
- The benefits, risks and limitations of intermittent auscultation of the fetal heart in labour should be explained.
- Consent should be sought prior to any interventions.
- The woman should be included in the decision making process regarding her care.

## 9. EDUCATION AND TRAINING

Health professionals performing, interpreting and managing CTGs and performing intermittent auscultation of the fetal heart during labour should update their skills regularly.

The updates should be multidisciplinary to ensure use of common terminology and shared understanding. Midwives and obstetricians will be allocated:

- Two hours on the PROMPT Mandatory day.
- Two hours on the Maternity Update Day.
- Two hours to be accessed via weekly CTG and Intrapartum Case Reflection.

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## 10. AUDITABLE STANDARDS

- All women will have the fetal heart rate (FHR) monitored and documented in the maternal health record as a minimum every 15 minutes during the first stage of labour and every 5 minutes or after every contraction during the second stage of labour. When using intermittent auscultation the FHR will be auscultated for at least a minute after a contraction, and the rate will be recorded as an average.
- The equipment used for intermittent auscultation of the FHR will be in line with guideline. This will be documented in the maternal health care record.
- In all cases when a transfer from intermittent auscultation to continuous electronic fetal monitoring occurs, the timing and reason for transfer will be documented in the AWCNCPfNL. The indication for transfer will be in accordance with the listed indications for continuous electronic fetal monitoring stated in the guideline.
- The yellow Exit Audit form to be completed for all transfers to an obstetric unit.
- The maternal pulse will be palpated and documented at the beginning of the intrapartum auscultation in line with the AWCNCPfNL.
- The maternal pulse will be palpated and documented in the maternal health record to differentiate between the two heart rates in all cases when a FHR abnormality is detected.

## 11. REFERENCES

- <https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/ebc-2015-report/fetal-monitoring/intermittent-auscultation/recommendations-intermittent-auscultation/>
  - All Wales Midwife-led Care Guidelines (5<sup>th</sup> Edition)
  - <https://www.nice.org.uk/guidance/cg190/chapter/Recommendations>
  - All Wales Midwife-led Care Guidelines (5<sup>th</sup> Edition)
  - All Wales Normal Care Pathway for Normal Labour
- <https://www.nice.org.uk/guidance/cg190/chapter/Recommendations>

## 12. APPENDIX 1 - IA ALGORITHM



### First Stage of Labour

Listen & count the heart rate immediately after a contraction **for a minimum** of 60 seconds **at least** every 15 mins.

### Active Second Stage of Labour

*(in the presence of expulsive contractions)*

Listen & count the heart rate immediately after a contraction **for a minimum** of 60 seconds **at least** every 5 minutes or after every contraction

- Record the baseline rate as *an average* to enable scrutiny for a rising baseline HR and/or tachycardia which may indicate fetal hypoxia.
- Document presence/absence of accelerations/ decelerations/ FMs

**As a minimum**, palpate and document maternal pulse hourly or on detection of FH anomalies to enable comparison between the 2 rates.

For any FH anomaly palpate the maternal pulse for comparison



If the CEFM is normal, the trace can be discontinued after 20 minutes, providing all other clinical/risk assessments are within normal parameters

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## 13. APPENDIX 2 – REASONS FOR TRANSFER TO CONSULTANT UNIT FOR CONTINUOUS ELECTRONIC FETAL MONITORING

<b>Reasons for Transfer to Consultant Unit for Continuous Electronic Fetal Monitoring</b>			
<i>Refer to All Wales Midwife-led Guidelines</i>			
<b>MATERNAL ASSESSMENT</b>		<b>FETAL ASSESSMENT</b>	
Fresh vaginal bleeding that develops in labour other than a show		Suspected late decelerations	
Pain reported by the woman that differs from pain normally associated with contractions		An increasing fetal heart baseline	
Contractions that last longer than 60 seconds (hypertonus)	Contractions occurring more than 5 contractions in 10 minutes (tachysystole)	Fetal heart rate below 110bpm	Fetal heart rate above 160bpm
Confirmed delay in the first or second stage of labour		The presence of meconium	
Maternal pulse over 120 beats/minute on 2 occasions 20 minutes apart		Any abnormal presentation including cord presentation	
Suspected chorioamnionitis or sepsis			
<b>Maternal Pyrexia</b>			
Temperature of 38°C or above on a single reading	37.5°C or above on 2 consecutive occasions 1 hour apart	Suspected macrosomia or fetal growth restriction	
<b>Severe Hypertension</b>		Suspected polyhydramnios or anhydramnios	
A single reading of either systolic blood pressure of 160 mmHg measured between contractions	Diastolic blood pressure of 110 mmHg or more measured between contractions	High (4/5–5/5 palpable) or free-floating head in a nulliparous woman	
<b>Hypertension</b>		Persistent accelerations heard immediately after a contraction - this could be an overshoot from a deceleration of the FH	
Either systolic blood pressure of 140 mmHg or more measured between contractions	Diastolic blood pressure of 90 mmHg or more on 2 consecutive readings taken 30 minutes apart measured between contractions	<b>If in doubt always ask for a second opinion</b>	
Urinalysis = 2+ of protein and a single reading of either	Raised diastolic blood pressure (90 mmHg or more)		



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raised systolic blood pressure (140 mmHg or more)

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