

Intermittent Auscultation (IA)

Clinical Guideline

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Intermittent Auscultation

1. Introduction

Intermittent auscultation (IA) of the fetal heart (FH) in active labour with a handheld doppler or Pinard stethoscope is recommended as the standard of care for all women who are healthy with uncomplicated pregnancies (RCM, 2018; FIGO, 2018; NICE, 2017; WHO, 2018).

1.1 Aim/Purpose of this Guideline

- 1.1.1 To give guidance to all midwives and obstetricians on the process of intrapartum IA of the FH in labour.
- 1.1.2 This guideline follows national guidelines and seeks to prevent variation. In the absence of any additional evidence base, the frequency and method of auscultation will follow guidance from NICE (2017) and RCM (2018).
- 1.1.3 This guideline should be read in conjunction with the All Wales Clinical Pathway for Normal Labour (AWCPNL).
 - 1.3.1.1 The aim of IA is the timely identification of babies with hypoxia/acidosis to enable appropriate action before the occurrence of injury.
 - 1.3.1.2 In the absence of risk factors for fetal hypoxia or acidosis IA is the recommended method of fetal monitoring; regardless of birth setting.
 - 1.3.1.3 IA facilitates the normal physiology of labour by enabling freedom of movement.
 - 1.3.1.4 Effective IA enables the detection of potential fetal decompensation; timely intervention can prevent perinatal & neonatal morbidity and mortality. IA is not reliable for assessing fetal wellbeing if the fetus is already compromised.
- 1.1.4 There is currently no high quality evidence to recommend any particular frequency and duration of IA. IA in accordance with RCM & NICE guidelines is generally accepted as the gold standard within the UK, this is reflected within the AWCPNL.

2. Inclusion Criteria

2.1 Women suitable for midwifery led care (NICE, 2017a).

- 2.1.1 The AWCPNL must be used in all settings for all women suitable for midwifery led care and on individual assessment for women under consultant led care. This includes the initial assessment of labour, as well as care in active labour.
- 2.1.2 Continuous electronic fetal monitoring (CEFM) in low risk women is associated with an increased rate of caesarean sections and assisted vaginal birth without any improvement in outcome (Maude et al., 2014). Women must be fully informed of the risks and benefits of IA and CEFM. If she chooses not to be monitored by the recommended method a full discussion of the potential impact on her and the fetus should be undertaken, and the labour ward coordinator and senior obstetrician informed. This discussion must be clearly documented in the woman's records.

2.2 Women under consultant led care.

- 2.2.1 All women with medical or obstetric conditions should be offered an obstetric review during pregnancy with a full plan of care formulated for labour and birth. At 36 weeks this should include a discussion with the lead professional regarding suitability for different birth settings and the method of fetal monitoring recommended when in labour (NICE, 2017a). This discussion should be documented on page 29 of the All Wales hand held record.
- 2.2.2 Some women under consultant led care (CLC) may be eligible for IA. Individual care plans should be discussed and agreed between the woman and her care giver antenatally, or in labour.
- 2.2.3 Women who are CLC and planning to birth on the labour ward may be eligible for IA. Please use the Intermittent Auscultation Assessment Tool (appendix 2) where deemed appropriate.

3. Method of IA

3.1 Initial Assessment

3.1.1 An initial assessment using the AWCPNL should be made in conjunction with any antenatal risk factors, birth plans and history as well as the current presenting history & physical assessment. Where there are maternal or neonatal complexities but IA is a suitable form of fetal monitoring during labour, please use the IA Initial Assessment Tool (appendix 2).

3.1.2 Irrespective of any previous plan, this assessment will determine:

- The appropriate birth setting
- The appropriate lead professional
- The appropriate fetal monitoring method

3.1.3 The method

- Ask about fetal movements (FM) in the last 24 hours.
- An abdominal palpation will determine the optimal position for auscultation. Assess the strength and frequency of contractions; tachysystole (more than 5 contractions in 10 minutes) requires further evaluation (NICE, 2017b).
- IA should be performed using a handheld Doppler or Pinard stethoscope.
- On first auscultation listen for at least one full minute in between contractions, when the baby is at rest, to establish a baseline FH rate. The normal range is 110-160bpm (but, consideration must be given to what is expected for each individual fetus).
- Auscultate IMMEDIATELY after the end of a contraction for one minute. This will enable identification of decelerations and overshoots if present. The end of the contraction is determined by palpating the uterus.
- Auscultate during FM or following stimulation of the baby by vaginal examination. An acceleration should be noted, and chronic hypoxia can then be excluded. This can be more difficult to demonstrate in the later stage of labour. The absence of accelerations in established labour is of unknown significance, but should be considered as part of the whole clinical picture and on its own is not a reason to exit the AWCPNL but should be noted as a variation.
- Fetal activity is a positive feature of fetal wellbeing. FM must be discussed. Auscultation of the FH at the time of FM should reveal acceleration, demonstrating a non-hypoxic fetus.
- Variability cannot be assessed using IA (Munro & Jokinen, 2012).

3.1.4 The maternal pulse should be palpated simultaneously while auscultating the FH to differentiate between the two heart rates, as it is possible to

inadvertently pick up the maternal heart rate from surrounding vessels. This should be done in accordance with the AWCPNL and if a FH abnormality is suspected.

3.1.5 Recommend IA as the method of fetal monitoring during labour where no abnormalities are detected.

3.1.6 3.1.6 Routine CTG on admission to hospital is not recommended and can increase the risk of caesarean section (NICE, 2017a).

3.2 The 1st stage of labour

3.2.1 The Method

- After the initial assessment outlined above, the FH should be auscultated IMMEDIATELY after a contraction for at least 1 minute every 15 minutes throughout the first stage and recorded as a single figure on the partogram. In the absence of decelerations and accelerations, this will be your baseline rate.
- Fetal movements and accelerations are reassuring signs of fetal wellbeing.
- If FH abnormalities are heard i.e. a rise in baseline rate, decelerations or persistent accelerations after a contraction (overshoots), increase surveillance and auscultate immediately AFTER the next 3 contractions. Consider the clinical picture and identify a possible cause, such as maternal position, fetal movements, vaginal examination/fetal scalp stimulation, hydration or pool temperature (>37.5) which may be affecting maternal & FH rates.

3.2.2 Confirmation of an abnormality warrants CEFM and transfer to obstetric-led care (see table 1) (NICE, 2017a; RCM, 2018; FIGO, 2015).

3.3 The 2nd stage of labour

3.3.2 The second stage of labour has increased demand on oxygen supply to the fetus for this reason the identification of this stage is important, so that the appropriate level of fetal monitoring can be performed (RCOG, 'Each Baby Counts', 2015).

3.3.3 The Method

- Auscultation of the FH should occur IMMEDIATELY after a contraction for at least 1 minute, every 5 minutes, or more frequently where an abnormality is suspected.

- Ensure it is the FH being auscultated; descent of the fetal head, with increased maternal heart rate increases the likelihood of hearing the maternal pulse.
- Confirmation of an abnormality (as outlined above) warrants CEFM in an obstetric setting.

3.4 If at any time you are unable to listen to the FH as frequently as required, you must seek help in order to do so.

3.5 The assessment of fetal wellbeing is made in conjunction with the overall clinical picture.

N.B. *Although a CTG machine utilizes the same technology as the handheld doppler, it **should not** be used for intermittent auscultation, as this is an inappropriate use of resources. The handheld doppler has a narrow beam and is unlikely to easily pick up the maternal sound. It gives a swishing noise when tracked to a blood vessel compared with the electronic heartbeat sounds of the US transducer of a CTG machine.*

N.B. *If using a handheld doppler do not rely on the range shown on the screen, as there have been instances where the machine has miscalculated the FH rate (NICE, 2014; MHRA, 2010).*

4. Conversion Criteria for Changing from IA to CEFM (see table 1)

4.1 During the course of pregnancy or labour the clinical circumstances may change. Recommend CEFM if FH abnormalities are identified or further risk factors develop (see appendix 1) this may be in addition to those risk factors already identified (NICE, 2014; Physiological-CTG, 2018) where routine CEFM would be advised. See Fetal Monitoring Guideline (ABMU, 2018)

4.2 FH abnormalities identified by IA include an abnormal baseline rate, a rising baseline, presence of decelerations, repetitive overshoots.

4.2.1 Initial action should be to listen more frequently to confirm your suspicion. Auscultate the FH immediately after the following three consecutive contractions in order to review. In the case of a prolonged deceleration and/or identified bradycardia then CEFM should be recommended along with transfer to the obstetric unit, ongoing assessment via IA is not recommended.

4.2.2 Review the whole clinical situation including maternal observations, strength and frequency of contractions, maternal position, hydration, FM or vaginal examination and take action for correctable causes.

- 4.3 If CEFM is advised the rationale should be discussed with the woman, her consent obtained and all actions documented in the notes. If CEFM is declined, the potential risks should be explained, and the midwife in charge and obstetric team informed. All discussions must be clearly documented and the woman supported in her choice.
- 4.4 Provided it is safe and appropriate, transfer the women to the obstetric unit for obstetric review.
- 4.5 If CEFM has been commenced due to concerns arising during IA but the CTG is classified as normal after a minimum of 20 minutes, it is appropriate to return to IA (RCM, 2018; NICE, 2017a). Continue care within the obstetric setting. A full systematic assessment must be undertaken prior to discontinuing the CTG using the Intrapartum CTG Sticker and Fresh Eyes approach.

5. 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.

6. 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:

- Four hours on the Maternity professional Update Day.
- Two hours to be accessed via professional debate and discussion with a CTG champion, CTG workshops, OCRIM or Midwifery led reflections.

7. 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 IA the FHR will be auscultated for at least a minute after a contraction, and the rate will be recorded as a single figure.
- The equipment used for IA of the FHR will be in line with guidance. This will be documented in the maternal health care record.

- In all cases when a transfer from IA to CEFM occurs, the timing and reason for transfer will be documented in the AWCPNL. The indication for transfer will be in accordance with the listed indications for CEFM as stated in the guideline.
- The yellow Transfer SBAR form to be completed for all transfers to an obstetric unit (Pg. 23 of AWCPNL).
- The maternal pulse will be palpated and documented at the beginning of the intrapartum auscultation in line with the AWCPNL.
- 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.
- In all cases where IA is considered appropriate, the Part 2 of the AWCPNL or the Intermittent Auscultation Assessment Tool will be used.

Appendix 1

Maternal	Fetal
*Pulse over 120bpm on 2 occasions 30 minutes apart	Undiagnosed breech presentation; transverse or oblique lie (review mode of delivery)
*A single reading of diastolic blood pressure ≥ 110 mmHg or systolic blood pressure ≥ 160 mmHg	The presence of significant meconium (NICE, 2017a)
*Diastolic blood pressure 90 to 109 mmHg or systolic blood pressure of 140 to 159 mmHg on 2 consecutive readings taken 30 minutes apart	Recurrent accelerations (immediately following a contraction i.e. overshoot)
Maternal pyrexia (defined as ≥ 38.0 °C once or ≥ 37.5 °C on two occasions 1 hour apart)	Fetal heart rate below 110bpm or above 160 bpm, or if it is perceived as inappropriate for gestational age
Any vaginal blood loss other than a show	Evidence of a rising baseline on the partogram
Persistent pain in between contractions	3 x decelerations in fetal heart rate heard on intermittent auscultation after 3 successive contractions
Epidural or Remifentanyl analgesia	Reduced fetal movements in the last 24 hours
	Suspected fetal growth restriction (by USS or symphysis fundal measurement)
	Free-floating head in a nulliparous woman
Table 1 – Risk factors indicating conversion from Intermittent Auscultation to Continuous Electronic Fetal Monitoring	

Intermittent Auscultation Assessment Tool

Affix label

In the absence of risk factors for fetal hypoxia IA is the recommended method of fetal monitoring regardless of birth setting.

Use this **assessment tool** for women on labour ward for complexity with no risk factors for fetal hypoxia in labour.
E.g. Raised BMI, GBS, large for gestational age, hypothyroid, previous PPH, previous shoulder dystocia.

	YES	NO
Singleton pregnancy		
Cephalic presentation		
No concerns with fetal growth		
Pre-labour rupture of membranes for < 24 hours?		
Significant meconium absent?		
No concern with maternal wellbeing		
Intelligent Auscultation of the Fetal Heart (exclude hypoxia)		
Has there been a normal pattern of fetal movements over the past 24 hours?		
Fetal movements present		
<i>Accelerations heard (Use opportunity with fetal movements, abdominal palpation or vaginal examination)</i>		
Normal <i>baseline rate</i> obtained in between contractions when fetus is at rest <i>(listen for at least 1 minute)</i>	Rate:	
Exclude decelerations & overshoots <i>(Auscultate IMMEDIATELY after a contraction)</i>		
Is there a clear difference between fetal & maternal pulse? Fetal heart <input style="width: 50px; height: 20px;" type="text"/> Maternal pulse <input style="width: 50px; height: 20px;" type="text"/>		
Woman accepts IA as method of fetal monitoring		

If 'YES' to all the above IA is suitable as per IA Guideline

Ongoing assessment of fetal & maternal wellbeing should be performed & documented as per the IA Guideline on the Birth Record (not the NLCP)

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Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Intermittent Auscultation (IA)
Name(s) of Author:	Catrin Elis/Victoria Owens
Chair of Group or Committee approving submission:	Labour ward Forum
Brief outline giving reasons for document being submitted for ratification	To provide best practice guidance around fetal monitoring using intermittent auscultation
Details of persons included in consultation process:	Labour ward forum members.
Name of Pharmacist (mandatory if drugs involved):	N/A
Issue / Version No:	01
Please list any policies/guidelines this document will supercede:	New guideline
Date approved by Group:	11/03/2020
Next Review / Guideline Expiry:	20/2023
Please indicate key words you wish to be linked to document	Fetal monitoring, intermittent auscultation, intrapartum, Labour
File Name: Used to locate where file is stores on hard drive	