Fetal Surveillance Policy

Document Type	Policy
Function	Clinical Practice, Patient Care
Directorate(s)	Auckland District Health Board (Auckland DHB) National Women's Health
Department(s) affected	Auckland DHB Maternity
Applicable for which patients, clients or residents?	All Auckland DHB maternity patients
Applicable for which staff members?	Clinicians in maternity including access holder lead maternity carers (LMCs)
Key words (not part of title)	CTG fetal heart monitoring
Author – role only	Midwifery Educator
Owner (see ownership structure)	Owner: Service Clinical Director - Secondary Maternity Issuer: Charge Midwives - DU and WAU
Edited by	Clinical Policy Facilitator
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Contents

1. Purpose of policy

To ensure certain elements of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Intrapartum Fetal Surveillance Clinical Guidelines are followed within Auckland DHB by all practitioners employed or with an access agreement.

2. Recognition of risk factors

If antenatal or intrapartum risk factors (listed in RANZCOG Clinical Guideline) are present, continuous Cardiotocography (CTG) in labour is recommended.

Fetal surveillance in labour, whether by intermittent auscultation or by electronic fetal monitoring, should be discussed with and recommended to all women. Any practitioner performing intermittent auscultation must be trained in the correct method of as per the RANZCOG guidelines (Recommendation 6)

3. Documentation of continuous CTG

A CTG sticker should be completed at least **every 60 minutes** and placed in the patient's clinical notes. The CTG should be reviewed by another midwife or doctor every two hours and the CTG sticker should be co-signed and placed in the patient's clinical notes, ("fresh eyes"). Doctor's reviewing the patient/CTG need to complete a CTG sticker as part of their documentation, regardless of the timing of when a sticker was last used.

4. Management of abnormal CTG

Identify any reversible cause and **initiate intrauterine resuscitation** by:

- Positioning the patient on her left side
- Stopping the oxytocin and/or starting tocolysis as needed
- Correcting low blood pressure
- Rehydrating with intravenous fluids

Escalate to a more experienced midwife or clinical charge midwife or consult with the Labour and Birthing Suite team on call.

Consider further fetal evaluation with scalp stimulation or scalp lactate.

Document the above actions in the patient's clinical notes.

5. Further fetal evaluation

If fetal scalp stimulation leads to acceleration in the fetal heart rate, regard this as a reassuring feature. Take this into account when reviewing the whole clinical picture. If fetal scalp lactate is undertaken, patient should be in a position that avoids inferior vena cava compression (eg left lateral position).

Contraindications to fetal scalp lactate are listed in the RANZCOG Clinical Guideline (Recommendation 13).

6. Management of fetal scalp lactate results

Lactate results	CTG	Action
Less than or equal to 4.0	CTG improves	No need to repeat
Less than or equal to 4.0	CTG remains abnormal	Repeat in 1-2 hours
4.1 – 4.7		Repeat in 30 minutes
4.8 – 5.7		Expedite birth
Over 5.7		Category 1 Caesarean Section

7. Umbilical cord lactates

Umbilical cord lactates should be taken where any of the following are present:

- Any labour where there has been concerns about fetal wellbeing
- Fetal scalp lactate performed during labour
- Assisted vaginal birth (ventouse and forceps)
- Emergency caesarean section
- Apgar < 4 at one minute
- Apgar < 7 at five minutes
- Small for gestational age babies
- Preterm babies
- Babies with fetal abnormalities

Cord lactates should be taken and processed within 10 minutes of cord clamping.

Results must be documented and signed for on the Newborn Record, the Lactate Record Sheet (whilst this is in use) and the clinical notes.

8. Management of umbilical cord lactate results

Lactate results	Action
Less than 6.0	Document results
6.0 or above	Send paired umbilical cord gases

9. Management of umbilical cord gas results

Umbilical cord gases can be analysed within one hour of birth if clamped immediately after delivery. Both umbilical cord arterial and venous gases should be analysed.

Umbilical cord gas result	Action
pH less than 7.0 OR base excess less than or equal to -12 mmol/L	**Call paediatric registrar 2nd on call for review**
pH 7.0 – 7.15 OR base excess -11 to -7 mmol/L OR umbilical cord gas result not available and cord lactate greater than or equal to 6.0 mmol/L	**Monitor baby for signs of neonatal encephalopathy (hypotonia, poor feeding, lethargy, weak or absent suck/gag or moro reflex, seizures)** **Call paediatrician if any concerns**
pH above 7.15 AND base excess above -7 mmol/L	**Document results**

10. Associated Auckland DHB documents

- Intrapartum Care – Normal Labour and Birth
- Oxytocin (Syntocinon) for Induction & Augmentation of Labour
- Caesarean Section (CS) - Pre, Peri & Post-Op Care

11. Supporting Evidence

- RANZCOG. (2014). Intrapartum Fetal Surveillance Clinical Guideline – Third Edition.

12. Disclaimer

No policy can cover all the variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it immediately, when an individual patient falls outside of the boundaries of this policy.

13. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed before the scheduled date, they should contact the owner or email the Clinical Policy Facilitator without delay.