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<tr>
<th>NAME OF DOCUMENT</th>
<th>Intrapartum Intermittent Auscultation (IA)</th>
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<tr>
<td>TYPE OF DOCUMENT</td>
<td>Procedure</td>
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<td>SESLHDPR/580</td>
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<tr>
<td>DATE OF PUBLICATION</td>
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<tr>
<td>RISK RATING</td>
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National Safety and Quality Health Service Standards:  
1 – Governance for Safety and Quality in Health Service Standards  
1.2.2 – Action is taken to improve the safety and quality of patient care  
1.5.2 – Actions are taken to minimise risks to patient safety and quality of care  
1.7.1 – Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce  
9 – Recognising and Responding to Clinical Deterioration in Acute Health Care |
| REVIEW DATE               | May 2020                                  |
| FORMER REFERENCE(S)       | New LHD procedure. NSW Health Maternity – Fetal Heart Rate Monitoring GL 2016_ 001 |
| EXECUTIVE SPONSOR or     | A/Professor Andrew Bisits                 |
| EXECUTIVE CLINICAL SPONSOR| A/Director Women and Children’s Clinical Stream |
| AUTHOR                    | Dee Sinclair and LHD expert working party |
| POSITION RESPONSIBLE FOR   | A/Professor Andrew Bisits                 |
| THE DOCUMENT              | A/Director Women and Children’s Clinical Stream |
| KEY TERMS                 | Intermittent Auscultation, Intrapartum, abdominal palpation, risk assessment, fetal heart rate. |
| SUMMARY                   | Providing current evidence based guidance on methodology for Intermittent Auscultation of fetal rates in labour and the need for on-going risk assessments. |
1. **POLICY STATEMENT**

   This procedure will support midwives to perform safe appropriate intermittent auscultation (IA) using evidence based methodology. A flow chart is provided in Appendix 1.

2. **BACKGROUND**

   Effective structured intrapartum IA is the method of choice for fetal surveillance for women labouring in water and on land with no identified risk factors. Application of unnecessary continuous electronic fetal heart rate monitoring (CEFM) using cardiotocograph machines (CTGs) should be avoided as this restricts maternal mobility and may contribute to unnecessary interventions.

   Rigorous on-going risk assessments should be undertaken for each individual woman throughout labour to assess suitability for IA. There are varying documented opinions from professional bodies regarding frequency of IA which are based on expert opinion.

3. **RESPONSIBILITIES**

   **Employees and Visiting Medical Officers will:**
   - Ensure familiarity with the procedure and any related local business rules.

   **Network Managers/Service Managers and Line Managers will:**
   - Ensure that staff are familiar with the Local Health District policies and procedures and the requirement for adherence.
   - Conduct periodic review of compliance, and appropriate action if identified breaches with procedure.

4. **PROCEDURE**

   **Established First Stage of Labour**

   - **Assess risk factors:** Assess if IA is appropriate or if CEFM required. Discuss and agree with the woman the planned methodology for fetal surveillance, document the discussion and rationale in the medical record.
   - **Perform a comprehensive abdominal palpation:** fundal height, fetal lie, presentation, descent as a fifth palpable (/5) position of presenting part.
   - **Enquire if fetal movements (FM) are normal for this baby?**
   - **Assess fetal heart rate (FH) with Doppler/pinards over approximately 10 minutes between contractions to identify a baseline rate, document findings in the contemporaneous record.**
   - **Assess FH rhythm:**
     - Normal baseline rate is 110-160 bpm
     - Recommend CEFM if there are any FH abnormalities i.e. decelerations or an abrupt decrease of 20 beats or more in a previously identified FH baseline rate
     - Commence CEFM and escalate to midwifery team leader
     - If CEFM is normal discuss with midwifery team leader and consider returning to IA
   - **Auscultation should occur** in established first stage of labour after a contraction for one minute every 15 minutes. If unable to provide, discuss with the midwifery team leader and document the set of circumstances.
Intrapartum Intermittent Auscultation (IA)

- Document a single FH rate on the partogram.
- Auscultate FH and maternal pulse simultaneously to differentiate between fetal and maternal heart rates.
- Remain vigilant and identify changes in maternal or fetal status throughout first stage labour.

**Second Stage of Labour**

- Auscultate and document FH rate every five minutes in passive second stage of labour.
- Auscultate and document FH rate for one minute after every contraction in active second stage of labour.
- Ensure the FH rate is between 110-160bpm, identify abrupt or gradual decreases from the previously identified baseline rate.
- Remain vigilant and identify changes in maternal or fetal status throughout second stage.
- Following one hour of active pushing in second stage of labour:
  - undertake a risk assessment
  - escalate to midwifery team leader, discuss clinical management on a case to case basis
  - Re-evaluate the need for commencement of CEFM.

6. **AUDIT**

Medical Record audit every six months or as required by Midwife Unit Manager.

7. **REFERENCES**

- NSW Ministry of Health Guideline - GL2016_001 Maternity - Fetal Heart Rate Monitoring
- NSW Ministry of Health Policy - PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating
- National Institute of Clinical Excellence (NICE), Clinical Guideline 90 Intrapartum care for Healthy Women and Babies, February 2017

8. **REVISION AND APPROVAL HISTORY**

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<td>11.11.2016</td>
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<td>May 2017</td>
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Appendix 1 - STRUCTURED INTERMITTENT AUSCULTATION FLOW CHART

**COMMENCE STRUCTURED INTRAPARTUM INTERMITTENT AUSCULTATION (IA)**

- NO IDENTIFIED RISK FACTORS
- NO PRIOR NON-REASSURING CEFM PATTERNS
- FMS AND CONTRACTIONS NORMAL

**IN FIRST STAGE OF LABOUR**
AUSCULTATE EVERY 15 MINUTES FOR ONE MINUTE AFTER A CONTRACTION
DOCUMENT AS A SINGLE RATE ON PARTOGRAM

**IN ACTIVE SECOND STAGE OF LABOUR**
AUSCULTATE AFTER EVERY CONTRACTION FOR ONE MINUTE AND DOCUMENT
LISTEN FOR ABRUPT, GRADUAL DECREASES OR SIGNIFICANT CHANGES IN FHR
AFTER ONE HOUR OF ACTIVE PUSHING ESCALATE TO TEAM LEADER, RISK ASSESS AND RE-EVALUATE THE NEED FOR CEFM

**RISK ASSESSMENT**

- UNDERTAKE AN INITIAL COMPREHENSIVE RISK ASSESSMENT THEN REPEAT 2-4HRLY OR AS REQUIRED THROUGHOUT LABOUR
- REVIEW AND ASSESS MEDICAL AND OBSTETRIC HISTORY
- REVIEW PRIOR CEFM PATTERNS
- ARE FETAL MOVEMENTS AND UTERINE ACTIVITY NORMAL?
- IDENTIFY A BASELINE RATE WITH A DOPPLER / PINARDS OVER 10 MINUTES, DOCUMENT FINDINGS
- TAKE MATERNAL PULSE SIMULTANEOUSLY TO DIFFERENTIATE BETWEEN RATES

- IF SUSPECTED FETAL HEART RATE ABNORMALITIES WITH NO OTHER RISK FACTORS, CONVERT TO CEFM
- ESCALATE TO MIDWIFERY TEAM LEADER AND DISCUSS THE RETURN TO IA IF CEFM MEETS NORMAL CRITERIA

**REQUIRES CONTINUOUS FETAL MONITORING**
REFER TO LOCAL PROTOCOLS + NSW HEALTH GUIDELINE 2016_001

- RISK FACTORS IDENTIFIED
- PRIOR NON-REASSURING CEFM PATTERNS NOTED
- FMS REDUCED / ABSENT
- TACHYSYSTOLE
- ABNORMAL BASELINE RATE + / OR DECELERATIONS

**REVIEW AND ASSESS MEDICAL AND OBSTETRIC HISTORY**

**REVIEW PRIOR CEFM PATTERNS**

**AUSCULTATION IN LABOUR**