

ADVANCING MATERNITY SAFETY: THE 2024 INTRAPARTUM FETAL MONITORING AUDIT

AUTHORS:

- ❖ Miss Vibha Giri – O&G Consultant & Fetal Surveillance Lead Consultant
- ❖ Kritika Vats – JSD Higher
- ❖ Sarra Merzougui – ST7
- ❖ Arooj Fatimah Khosa – ITF
- ❖ Van Idoracaera Calisa Binti Ikhwan – ST4
- ❖ Tammy Martin – Fetal Surveillance Lead Midwife
- ❖ Sarah Bishop – Fetal Surveillance Champion
- ❖ Toni Caines – Fetal Surveillance Champion

Affiliations:



OBJECTIVE:

This audit evaluates staff compliance with the Trust Fetal monitoring in labour guideline as a whole in accordance with the benchmarks outlined in the monitoring and suggested quality standards and any links to adverse outcomes.

Audit data will be used as a benchmark for specific elements within the QI fetal monitoring workstream

AUDITING STANDARDS

- Accurate risk assessment for method of fetal monitoring at the onset of labour inclusive of ongoing risk assessment
- Documentation of hourly holistic review and peer review to check if standards are in accordance with SBLv3 with both intermittent auscultation and continuous fetal monitoring
- Documentation of both the FHR and classification of the CTG trace
- Management of any identified FHR/CTG concerns
- Use of fetal blood sampling
- Outcome
- Actual CTG trace review

Aims of CTG trace review

- Review availability of paper trace
- Details documented on trace upon commencement
- Intrapartum events documented on trace
- Classification comparison within the hour prior to delivery – auditors' opinion

RESULTS

Primary Midwife Ongoing Holistic Hourly Assessment completion encompassing all the standards

- Her reports of the frequency, length and strength of her contractions
 - Any antenatal and intrapartum maternal or fetal risk factors for fetal compromise
 - Any new or developing intrapartum risk factors (See table 1)
 - The current wellbeing of the woman and the unborn baby
 - How labour is progressing
 - Partogram review of the fetal heart rate baseline
- *A baseline rise of 20bpm or more from commencement of the Partogram is highly suggestive of evolving hypoxia and warrants CEFM even if below 180bpm

IA 100%

CEFM 85%

Peer Reviews/Fresh Eyes completion in accordance with standards

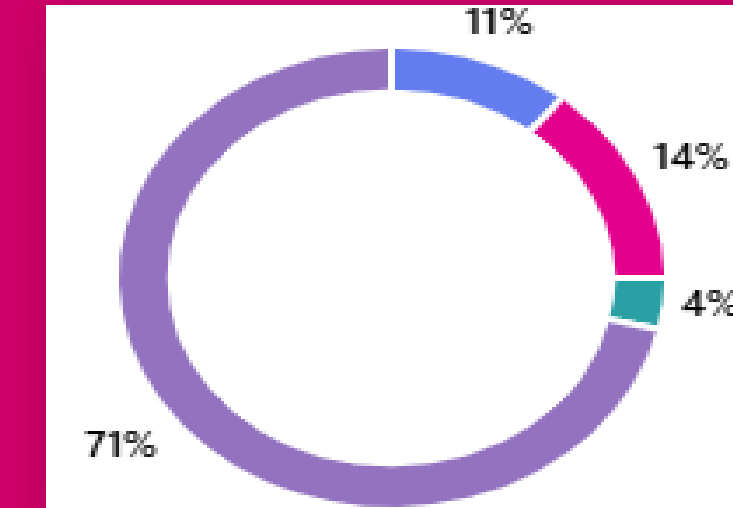
- Holistic review encompassing all of the above
- First stage of labour – minimum hourly
- Second stage of labour – minimum hourly
- Performed by Band 7 coordinator or S... above
- *A non-preceptorship midwife can perform the F... in the following circumstances;
- During handover of shift
- Delegation from the Labour Ward coordinator
- Absence of the coordinator(s) or obstetrician due to ward activity which may potentially cause a delay in peer review

IA 47%

CEFM 49%

Documentation by primary midwife when fresh eyes delayed or not completed

- Fresh eyes requested
- Delay due to LW being busy
- Unable to find a band 7
- Nothing additional documented



Forms used to document Fresh Eyes/Peer Reviews on Badgernet

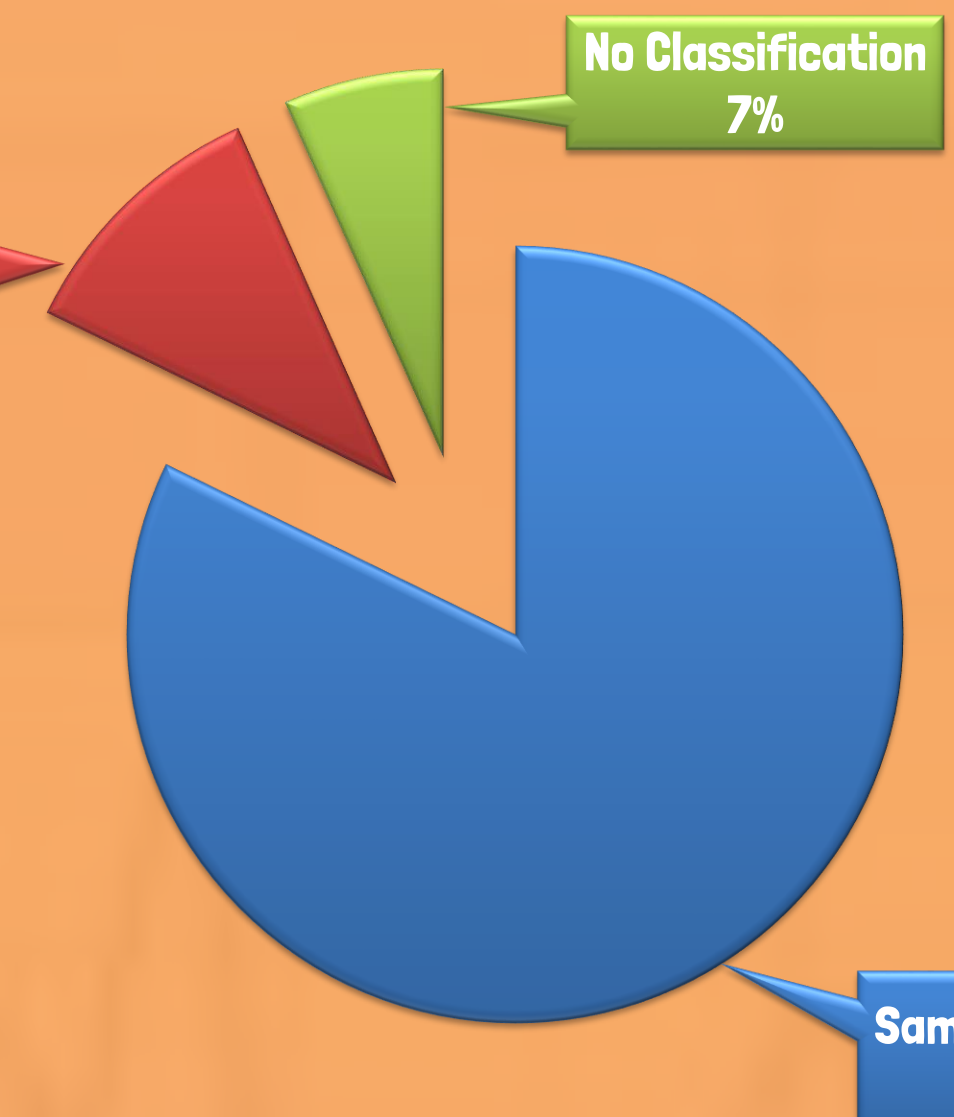
Fetal monitoring labour review form only 26%
Specialist review form only 2%
Peer CTG review form only 11%

Combination of all 3 forms 61%

Use of free text forms without the CTG review mnemonic within often resulted in lack of documentation of some CTG parameters and/or classification

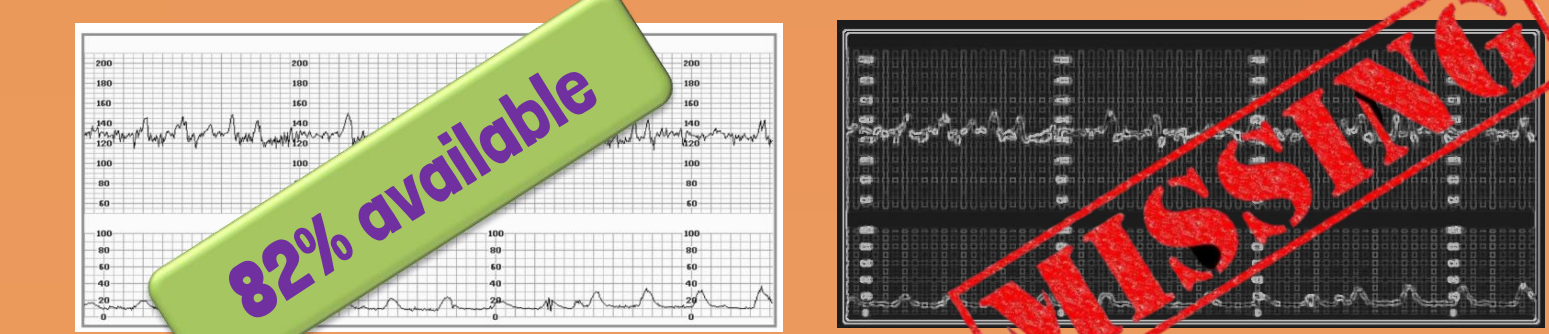
- 11% classifications differed
- Traces will be jointly reviewed by the FS Leads

Auditors' opinion – CTG classification (last 30–60mins prior to delivery)



- 7% CTG's not classified on Badgernet
- Due to loss of contact and poor-quality recording.
- Parameters were outlined but CTG wasn't classified. However, birth was expedited accordingly

Auditors' opinion – Actual CTG trace paper review



FSE applied in 1 case with poor quality second stage recording
FSE offered in poor quality recording throughout – declined by pt – Cat 1 c/s – no adverse outcome

Quality of recording

- Good quality throughout the whole trace 58%
- Mostly – some periods of lost contact – would not impact on the ability to interpret 31%
- Good quality in 1st stage but poor quality in 2nd stage 9%
- Poor quality recording throughout whole trace – impacting on the ability to interpret 2%

CTG Classification, Escalation & Management

Was the CTG classified as suspicious at any time? (Denominator 45)

Once – 35%
Numerous times – 47%
Never – 18%

ESCALATED

Every time – 82%
Sometimes – 7%
Never – 11%

MANAGEMENT

Conservative measures utilised in most cases
61% of total suspicious CTG's normalised
20% became pathological
19% remained suspicious – half of which were expedited

Was the CTG classified as pathological at any time? (Denominator 18)

Once – 24%
Numerous times – 9%
Never – 67%

ESCALATED

Every time – 100%
Sometimes – 0%
Never – 0%

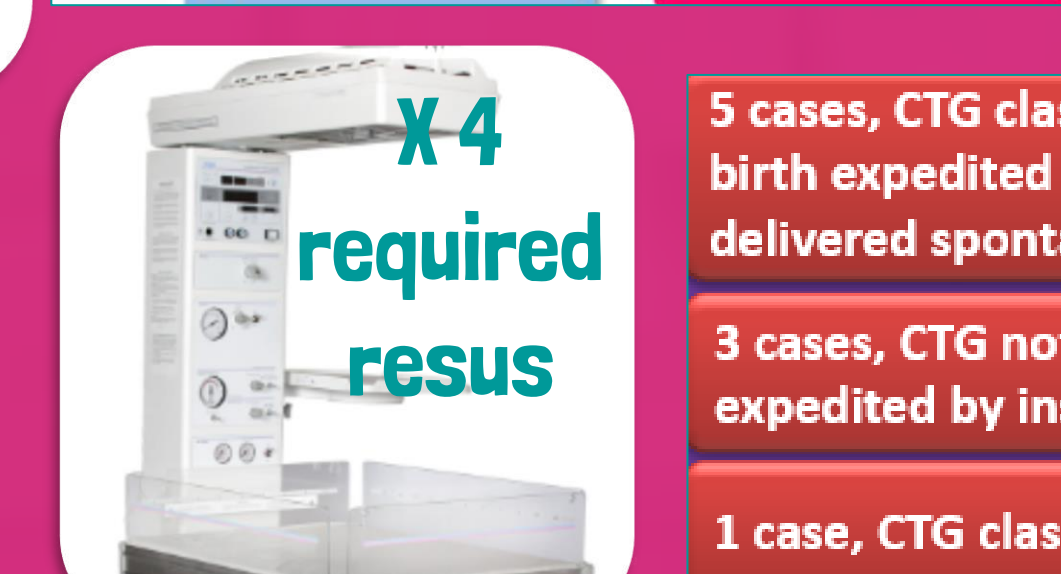
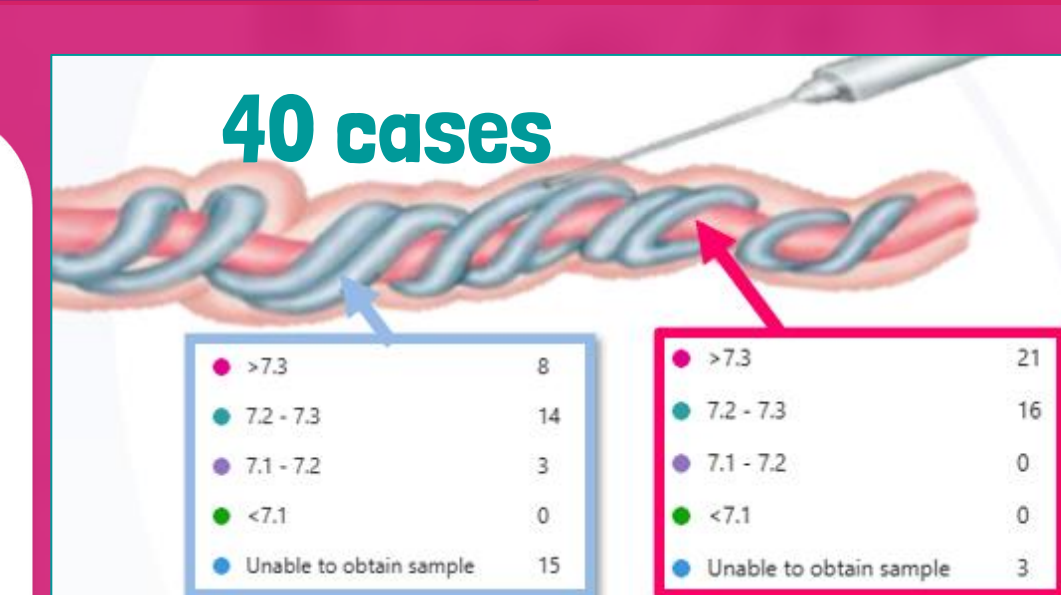
MANAGEMENT

78% delivery expedited
17% CTG improved with conservative measures
6% delivery imminent – no intervention needed

OUTCOMES

	GHH	BHH
● Spontaneous vaginal delivery	35	17
● Instrumental (Kiwi/Forceps)	9	5
● Cat 1 following failed trial	2	1
● Cat 1 EMCS	8	4
● Cat 2 EMCS	6	3
● Cat 3 C/S	0	3

APGAR's



5 cases, CTG classified as Pathological prior to delivery and birth expedited in all but 1 case. Reg present but pt delivered spontaneously
3 cases, CTG not classified prior to birth but birth expedited by instrumental
1 case, CTG classified as Suspicious prior to birth – SVD

	2 days/ 3 days/ 16 hrs
3 babies requiring Oxygen	10 day stay
1 baby with low blood glucose – mum GDM	<24 hrs
1 baby required septic screen	3 day stay
1 baby transferred from PN ward 2 days later-? Reason	1 day stay
1 baby born in poor condition at birth	2 day stay
1 baby requiring NG tube passed due to vomiting feeds	
1 baby grunting with RDS, required phototherapy	

No adverse outcomes in any of the 60 cases

Scan the QR code for details of the following:

- Methodology & rationale
- Full proforma
- Key findings and recommendations
- Overall summary

