TITLE: FETAL MONITORING

PURPOSE:

To provide standardized interpretation and communication regarding fetal heart rate (FHR) and uterine contraction (UC) data based on criteria set forth by the National Institute of Child Health and Human Development (NICHD) during fetal monitoring.

POLICY:

At all hospital encounters, pregnant patients will be assessed for spontaneous labor and fetal heart rate by appropriate methods based on gestational age and risk-status.

1. All pregnant patients are assessed upon ER triage, OB triage, and/or admission for spontaneous labor and fetal heart rate data. Interpretation and communication of uterine contraction and fetal heart rate data is based on NICHD criteria. This criteria is endorsed by all of the following:
   - *American College of Obstetrics and Gynecology (ACOG)*
   - *Society of Maternal Fetal Medicine (SMFM)*
   - *Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN)*
   - *American College of Nurse Midwives (ACNM)*

2. Interpretation and communication of FHR and UC data requires advanced assessment and clinical judgment skills in electronic fetal monitoring (EFM) regardless of the setting in which it is used. Therefore, each aspect of EFM should be performed by licensed, experienced health care professionals consistent with their state or provincial scope of practice. Physicians, registered nurses, advanced practice nurses (Nurse practitioner or Clinical Nurse Specialist), certified nurse midwives, physician assistants, and residents are nationally recognized practitioners who may be skilled in EFM. Proficiency and competency is validated at a frequency relative to the patient population served at the facility. On-going multidisciplinary continuing education is necessary to maintain skill and competency in EFM.

3. AWHONN staffing guidelines are required for the duration of fetal monitoring. Please refer to the AWHONN (2010) reference in this document for specific requirements as criteria varies according to risk-status, pain relief, and stage of labor.
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PROCEDURE:

1. FHR and UC data may be interpreted and communicated based on the following:

   a. METHODS: Determine the appropriate method of interpretation based on gestational age, risk-status, and physician order. It is important that a woman’s preference be taken into account whenever possible when deciding on FHM techniques:

      1) Auscultation: intermittent assessment of the FHR with either a-
         a. Doppler Ultrasound
         b. Fetoscope


      3) Electronic Fetal Monitoring (EFM): intermittent or continuous assessment of the FHR and UC data with an electronic medical device. Both FHR and UC data may be interpreted with external or internal devices:

         a. External:
            i. Ultrasound transducer-uses Doppler technology to assess FHR data
            ii. Tocodynamometer- uses pressure technology to estimate UC data

         b. Internal:
            i. Fetal Scalp Electrode (FSE) or Fetal ECG (FECG)- applied to fetal presenting part for direct assessment of FHR
            ii. Intrauterine pressure catheter (IUPC)- permits direct assessment of UC data from within the uterine compartment. Montevideo units (MVUs) may be calculated with this device.

   b. ASSESSMENT PARAMETERS: Assessment is based on the method used. Frequency of assessments are based on risk-status and are outlined in the AWHONN Position Statement (2008).

      1) Auscultation:
         o FHR Baseline rate
         o Presence or absence of audible decelerations

      2) Manual Palpation:
(Customize this form by using your logo if desired and inserting your policy header)

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Responsible Dept./Committee: 

- Frequency, duration, intensity, & resting tone

3) EFM
  - FHR: baseline rate, variability, periodic or episodic patterns (accelerations or decelerations)
  - UC: Frequency, duration, intensity, & resting tone

c. FHR/UC INTERPRETATION & COMMUNICATION: Both FHR and UC data are interpreted and communicated based on criteria set forth by NICHD terms and guidelines outlined in the EFM Dictionary Tool (2014) (located also in this section of the toolkit).

d. FHR/UC INTERVENTION MANAGEMENT: Management of FHR and UC patterns is based on the ACOG 3 Tier FHR Category (ACOG, 2009) System, and ACOG intrapartum management algorithms (ACOG, 2010). The EFM Dictionary Tool also contains evidence-base, peer-reviewed guidelines and recommendations for specific FHR and UA patterns that may be observed during EFM.

e. EFM COMMUNICATION: All forms of communication, both written and verbal, will include NICHD terminology. Perinatal practitioners will document all communication within the electronic medical record to include: name, credentials, time of notification, response time, clinical data, actions/interventions, and patient response. Forms of communication may include:
  - Phone calls
  - Hospital electronic medical record (EMR)
  - EFM EMR
  - Change of Shift Reports: RN-RN
  - Hand-off Reports: MD-MD, MD-CNM, CNM-CNM
  - Hospital documentation of any nature that may include EFM data

Documentation should contain streamlined, factual and objective information and should include, but may not be limited to:
- a systematic admission triage and/or assessment of the woman and fetus;
- periodic assessments of the woman and fetus;
- interventions provided and evaluation of responses;
- communication with the patient and their families or primary support persons;
- communication with providers
- communication within the chain of authority

f. CHAIN of AUTHORITY: A formal line of communication among perinatal staff members to discuss concerns regarding patient care. Both the hospital and medical staff will use open and clear communication skills that optimize a
mutually acceptable resolution with a focus on patient safety. The focus of resolution should be between the two primary care providers. If this is not possible, additional individuals may become involved at the request of any involved party:

i. Additional staff RN
ii. Charge Nurse
iii. Nurse Manager
iv. Physician partner/colleague
v. Director of OB/Women’s Health
vi. Medical Director
vii. OB Director
viii. Chief of Staff
ix. CEO/Administrator on-call

g. PATIENT EDUCATION: Patient education regarding fetal monitoring should include: indications, contraindications (if any), and findings. Questions are addressed and answered periodically during the procedure as indicated by patient request.

REFERENCES: