NSW HEALTH

Safety Alert 004/07

4 October 2007

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Directors of Clinical Operations

Action required by:

- Directors of Maternity Services
- Directors of Clinical Governance

For response by:

- Directors of Clinical Governance

We recommend you also inform:

- Directors of Nursing and Midwifery
- Directors of Maternity Services
- Midwives and Student Midwives
- Obstetric Medical Staff

Deadline for completion of action

Provide the implementation plan to address the six actions by 30 October 2007

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Electronic Fetal Heart Rate Monitoring

Supersedes Safety Notice 008/07 – Electronic Fetal Heart Rate Monitoring

Background

During the period 2004 to July 2006, 31 percent of maternal and perinatal Reportable Incident Briefs (RIBs) received by the NSW Department of Health related to inadequate fetal welfare surveillance, inadequate or untimely obstetric or neonatal emergency response, and poor communication between teams.

Between 2005 and 2006, there has been a six-fold increase in reported incidents related to fetal welfare surveillance. The RIBs identified some of the following situations:

- Inability of maternity care providers to recognise risk factors that require continuous electronic Fetal Heart Rate (FHR) monitoring during labour.
- Failure to recognise, react and manage FHR patterns that should cause concern.
- Removal of the FHR monitoring in the presence of an abnormal FHR pattern.
- Inadvertent monitoring of maternal heart rate in the presence of a deceased fetus.

Issue

Since the issue of the Safety Notice SN:008/07 *Electronic Fetal Heart Rate Monitoring* a significant number of critical incidents had continued to occur in relation to this issue. Since June 2007, of the Maternal and Perinatal reported SAC 1 incidents, approximately 58% could be attributed to inadequate fetal welfare assessment.

The NSW Department of Health is developing an education, policy directive and guidelines strategy to improve fetal welfare surveillance, neonatal resuscitation and obstetric emergency management, and to reduce poor outcomes for mothers and babies in NSW.

Actions required by AHS

1. Ensure all maternity care providers performing and interpreting FHR patterns are clinicians privileged or appointed by the AHS to practise obstetrics or midwifery or be student midwives under the supervision of a Registered Midwife. **(Action required by 30 November 2007)**
2. Ensure all facilities providing maternity services function in accordance with their official role delineation. **(Action required by 14 December 2007)**
3. Ensure all hospitals not delineated to perform an emergency caesarean section undertake antenatal electronic FHR monitoring **only if** clear referral arrangements to a designated higher level centre for advice, and/or consultation are in place. **(Action required by 28 February 2008)**
4. Ensure all hospitals not delineated to perform an immediate emergency caesarean section **do not** undertake continuous electronic FHR monitoring during the intrapartum period. The need for continuous electronic FHR monitoring implies a higher level of risk and, in such cases, women should be referred as soon as possible to an appropriately delineated facility for advice and/or consultation. **(Action required by 28 February 2008)**
5. Develop evidence-based guidelines on the practice, interpretation and documentation of electronic FHR monitoring and a plan to audit compliance with these guidelines. **(Action required by 31 March 2008)**
6. Ensure all maternity care providers performing and interpreting FHR patterns undertake education in regard to fetal welfare assessment on a three-yearly basis. **(Action required by 31 March 2008)**

Action required by Area Health Services

1. Develop an **implementation plan** to address the six issues set out above.
2. Advise of the **status** of each of the six issues by the designated dates.

Made Obsoleted October 2021
Supersedes SN008/07. In current policy: Maternity - Fetal heart rate monitoring (GL2018_025).