

Plan:

- Upon introduction to the market, continuous electronic fetal monitoring (CEFM) quickly became the standard of care for all laboring women despite any evidence to support improved outcomes.
 - Although CEFM may decrease the risk of neonatal seizures (a very rare outcome), it is known to increase risk of cesarean section, operative vaginal delivery and needing pain medication in labor without decreasing risk of cerebral palsy.¹
 - Intermittent Auscultation (IA) is the standard of care for low risk women in out of hospital settings.
 - More than 90% of women report having continuous fetal monitoring during labor.
 - ACNM², ACOG³ and AWHONN⁴ all have statements indicating that IA is an appropriate option for low risk laboring women, yet few women actually receive this option.
- “Given that available data do not clearly support EFM over IA, either option is acceptable in a patient without complications.” ACOG 2009

Do:

- The purpose of our quality improvement was to improve the awareness, availability and create a standard implementation of intermittent auscultation for low risk laboring women at Tampa General Hospital.
- An Intermittent Auscultation of the Fetal Heart Rate Policy was created in accordance to ACNM, ACOG and AWHONN guidelines.
- 93 Labor and Delivery RNs attended a 2 hour education session on labor support and IA training. Audio clips of fetal heart rates were used for instructional purposes.
- Copies of the policy were included in the Labor and Delivery resource book found in each patient room.
- IA was incorporated in the New Nurse Transitional Program.

Identified Barriers:

- Resistance to change
- Staffing ratios
- Delay in formal authorization of the policy.

Overcoming Barriers:

- Many new nurses voiced discomfort with this method of fetal monitoring.

- Champion nurses would share stories with the staff to discuss the benefits to the patient and nurse.

- During periods of high volume, experienced nurses would be needed to advocate for extra support to more novice nurses.

- Many of the physician providers continued to order CEFM (mostly out of habit) and several of the Nurse Midwives were requesting periods of CEFM (or intermittent NSTs) that were not indicated. Youtube video link was used to train the physicians and midwives on how to order IA, appropriate candidates and appropriate use of the policy.

- Reminder signs were posted in work areas.

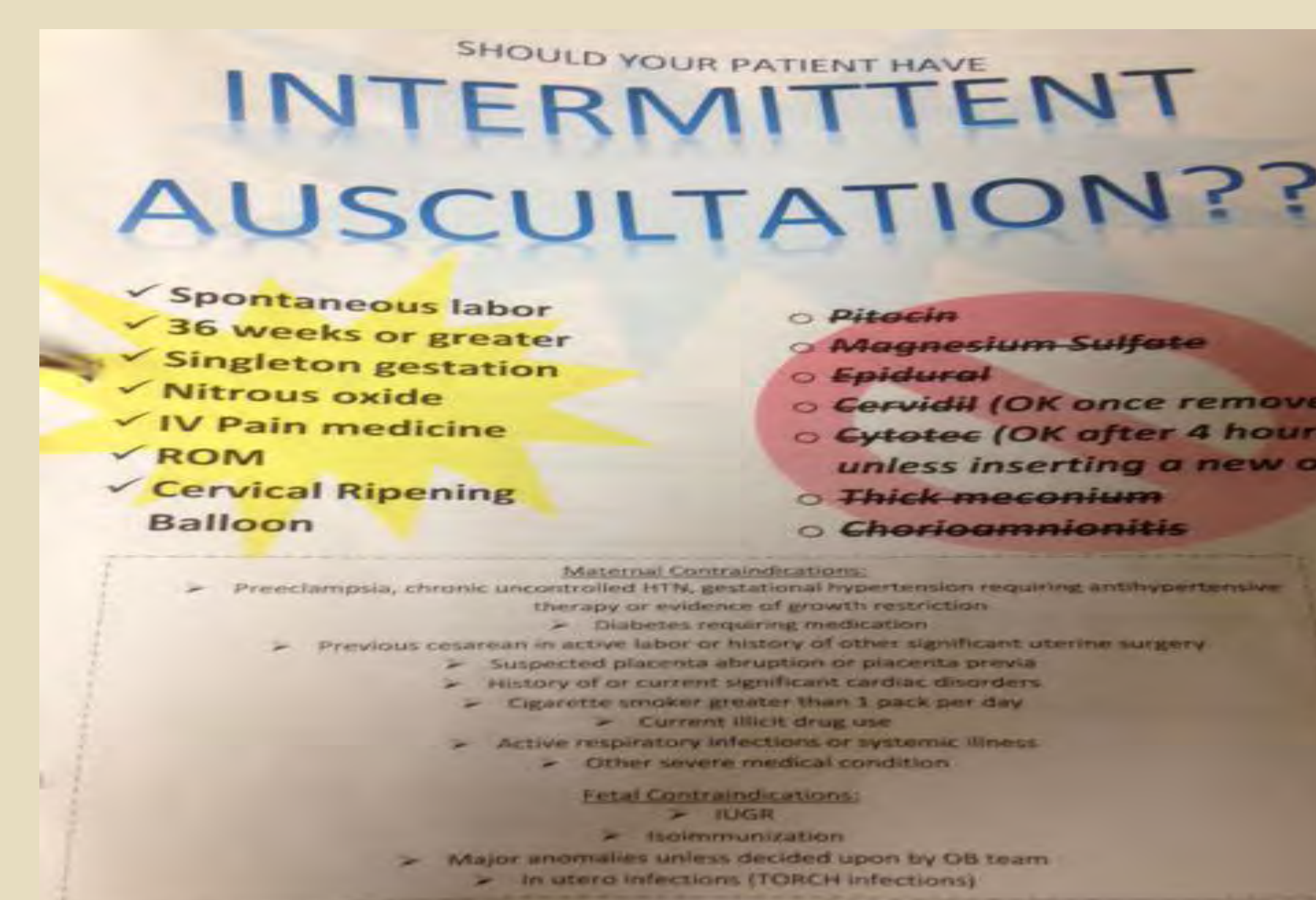
Interpretation Auscultation Findings
Category I—Normal Auscultation Findings Predictive of Fetal Well-being Includes ALL of the following: <ul style="list-style-type: none"> Normal FHR baseline between 110-160 bpm Regular rhythm Presence of FHR increases or accelerations from the baseline Absence of FHR decreases or decelerations from the baseline
Category II—Indeterminate Auscultation Findings Includes ANY of the following: <ul style="list-style-type: none"> Irregular rhythm Presence of FHR decreases or deceleration from the baseline Tachycardia (baseline >160bpm >10 minutes in duration) Bradycardia (baseline < 110 <10 minutes in duration)

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Suggested Auscultation Frequency			
	Latent Phase	Active First Stage	Active Second Stage
ACNM		Every 15-30 Minutes	Every 5 minutes
AWHONN		Every 15-30 Minutes	Every 5-15 minutes
ACOG,AAP		Every 15-30 Minutes	Every 5 minutes
RCOG		Every 15	Every 5 minutes
SOGC	At the time of assessment and approximately every 1 hour	Every 15-30 Minutes	Every 15 minutes then every 5 minutes after pushing initiated

(AAP & ACOG, 2007; ACNM, 2007; ACOG 2005;AWHONN, 2009; Feinstein, Sprague & Trepanier, 2008; RCOG; SOGC, 2007)

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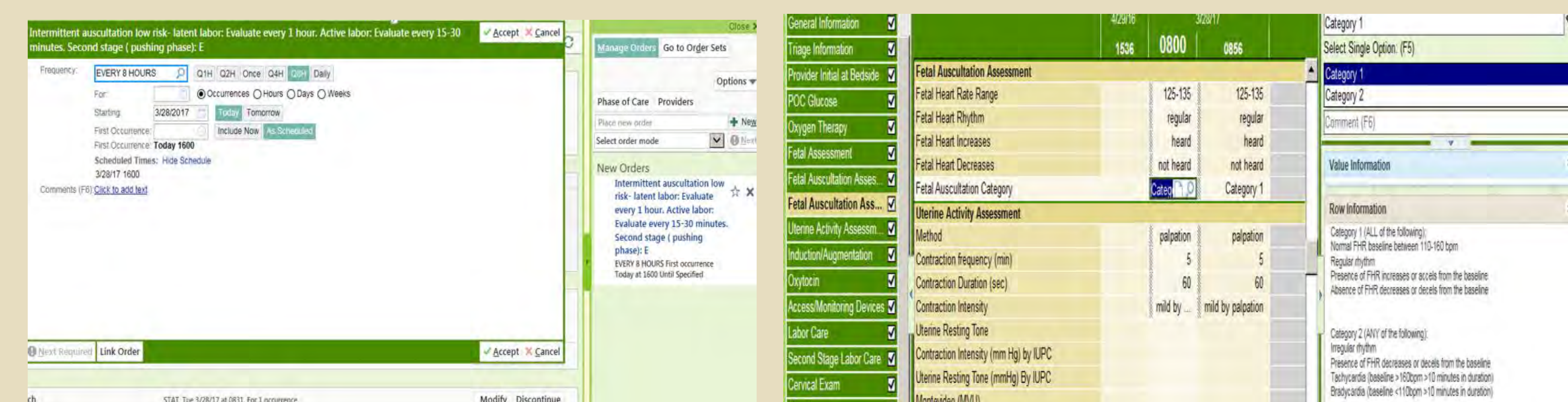
Check:

Periodic audits have demonstrated that about 50% of eligible women consistently receive IA throughout labor. This is a vast improvement over nearly 0% prior to implementation. Women desiring unmedicated childbirth now have the freedom of movement to better achieve this goal in a safe environment. Nurses, midwives and physicians now have a safe evidence based standard of care to follow for fetal monitoring in low risk laboring woman.



ACT:

After six months of utilizing the IA Policy in draft form, the policy was approved and made available on the Tampa General Portal. The changes to the admission order set were added to the electronic medical record. All staff received additional education which included: a short video and flyers posted throughout the nursing unit. Nurses were required to attend a mandatory IA lecture provided by nurse champions. Data was collected by the Perinatal Safety Nurse on eligible patients versus actual application of IA. If the patient was a candidate for IA and was on continuous fetal monitoring the Perinatal Safety Nurse reminded the nurse to obtain an order for IA.



CONCLUSIONS

Periodic audits have demonstrated that about 50% of eligible women consistently receive IA throughout labor. This is a vast improvement over nearly 0% prior to implementation. Women desiring unmedicated childbirth now have improved freedom of movement to better achieve this goal in a safe environment. Nurses, midwives and physicians now have a safe evidenced based standard to follow for fetal monitoring in the low risk laboring woman.