Aneurin Bevan Health Board

Fetal Monitoring Guideline

Intermittent Auscultation and Electronic Fetal Monitoring

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.
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Executive Summary

The aim of monitoring the fetal heart rate in labour is to detect those babies who may be compromised or potentially compromised by a shortage of oxygen (fetal hypoxia). If the shortage of oxygen is both prolonged or severe, babies are at risk of being born with a disability or of dying either during labour or shortly after (Alfirevic et al 2007)

For a woman who is healthy and has had an otherwise uncomplicated pregnancy, intermittent auscultation (IA) should be offered and recommended in labour to monitor fetal wellbeing (NICE 2007). ABHB does not support the use of “admission CTG” in those women who are receiving Midwifery Led care as supported by Nice (2007):

1.6.9. "The use of admission cardiotocography (CTG) in low risk pregnancy is not recommended in any birth setting” (NICE 2007)

However, continuous electronic fetal monitoring (EFM) is recommended for high risk pregnancies (NICE, 2007). The basic principle of intra partum monitoring is to detect developing fetal hypoxia. However, NICE, 2007 also notes that reports from the Confidential Enquiry into Maternal and Child Health (CEMACH) have highlighted problems related to the use and interpretation of electronic fetal monitoring.

Aims
Aneurin Bevan Health Board demonstrates a standardised approach to the use and interpretation of intermittent auscultation of the fetal heart and electronic fetal monitoring.

Objectives

- Define the indications for use
- Give definitions of normal and abnormal parameters
- Provide clarity and consistency of terminology used to describe

Defining the Indications for use. (Appendix 1)

a) Intermittant Auscultation

- Intermittant auscultation of the fetal heart should be undertaken at routine antenatal assessments after 24 weeks gestation.
Intermittent auscultation should be the preferred method of monitoring the fetal heart rate during labour for women who are booked for MLC and labour in low risk settings. These women should be cared for using the All Wales Normal labour Pathway. The fetal heart should be listened to every 15 minutes immediately following a contraction (for a full minute) during the first stage of labour. This should be increased to every 5 minutes during the second stage of labour.

Women must be included in the decisions around the method of fetal monitoring. The principles of informed choice must be employed and the woman’s decision respected.

b) Electronic Fetal Monitoring

Any woman after 26 weeks gestation requiring an assessment at DAU or Triage (see DAU and Triage guidelines)

Any woman after 26 weeks gestation requiring admission to an antenatal ward.

Women assessed as being high risk and booked for Obstetric led care (OLC) will require continuous EFM once in established labour and where there is a risk factor for fetal compromise.

Low risk women booked for Midwifery Led Care (MLC) in labour who require changing from intermittent auscultation to continuous EFM for any of the reasons below:

1. Meconium stained liquor

   EFM is advised for women with liquor that is either dark green or black amniotic fluid that is thick or tenacious, or any meconium stained liquor that contains lumps of meconium.

   EFM should be considered for women with light meconium stained liquor depending on a risk assessment which should include as a minimum their stage of labour, volume of liquor, parity, the FHR and transfer pathway (NICE 2007)

   Light meconium stained liquor alone does not indicate a requirement for continuous electronic fetal monitoring or transfer to a obstetric led unit (ABHB Guideline for MLC: meconium stained liquor)

2. Abnormal fetal heart rate heard by intermittent auscultation
3. Maternal Pyrexia (38.0°C or above on one occasion or 37.5°C or above on two or more occasions two hours apart)
4. Fresh bleeding developing in labour
5. Oxytocin use for augmentation
6. Maternal choice (NICE 2007)
   - Women must be included in the decisions around the method of fetal monitoring. The principles of informed choice must be employed and the woman’s decision respected.

**Procedure**

a) Intermittant Auscultation (IA)

The principle of “Intelligent” intermittent fetal heart auscultation should be applied.

Gibb and Arulkumaran (2008) suggest that “intelligent auscultation” (IA) is a better way of assessing fetal well being and should be used for all women who are following midwifery-led models of care or where continuous electronic fetal monitoring is not indicated.

IA involves a complete and thorough assessment and clear documentation of that assessment in the records. This means writing it on the All Wales Normal Labour Pathway documents as opposed to simply recording a number for the fetal heart (which must be documented on the partogram).

- A full risk assessment of the woman should be undertaken in the first instance to assess the suitability of using IA to monitor the fetal heart.
- Assessment of current situation including fetal movements, maternal observations, liquor colour. This assessment should be clearly documented on the All Wales Normal Labour Pathway

**On Admission: (always with consent for examination)**

1. Ask the mother when she last felt her baby move and note the time.
2. Use a Pinard stethoscope to locate the fetal heart and then use a doppler so that the mother and partner can hear also
3. Record a baseline fetal heart by listening for at least a minute
4. Keep hands on the mother’s abdomen and ask her to notify when she feels the baby moving.
5. Note this time and whether you feel the movement also.
6. Auscultate the fetal heart again when the heart rate should be expected to be 15 beats more than the baseline, indicating acceleration with the fetal movement. Record this.
7. If contractions are palpated, auscultate the fetal heart during and for at least a minute after the contraction.
8. Presence or absence of obvious decelerations should be noted and recorded.
9. If fetal movement was felt, the fetal heart accelerated with fetal movement and there was no deceleration with or after the contraction, this indicates good fetal health and the mother can be reassured. Record this.

Subsequent auscultation of the fetal heart:

1. Listen every 15 minutes for at least a minute after a contraction in the first stage of labour and record on the partogram.
2. Listen every 5 minutes after a contraction in the second stage of labour and record on the partogram.
3. Note any fetal movements at regular intervals, listen for accelerations with movement and record.

- Maternal pulse should be taken at least hourly and done either immediately before or after auscultation to confirm the difference in heart rates.
- Attention should be given to identification of a rising baseline, presence of decelerations and absence of accelerations.
- The fetal heart rate should be documented clearly on the partogram and documentation should also evidence awareness of intelligent auscultation.

b) Electronic Fetal Monitoring

The professional undertaking EFM:

- Performs a risk assessment and documents the indication for undertaking EFM on the CTG sticker placed on the start of the CTG paper and on the CTG interpretation sticker to be used in the notes.
Discusses the need for EFM with the woman and gains her verbal consent. Explains to the woman, the process of obtaining an EFM recording.

Women should be informed that EFM will restrict their mobility in labour (NICE 2007). However, women should be encouraged to adopt various positions such as sitting on a chair, standing or using a birth ball. All members of the multi-disciplinary team should encourage and promote this practice.

Ensures EFM monitor is clean, fully equipped and correct EFM tracing paper is used.

EFM monitor must be checked to ensure the date and time clocks are correctly set. Any inaccuracies must be rectified or the machine taken out of use.

Performs an abdominal palpation.

Auscultates the fetal heart rate using a Pinard stethoscope in the first instance, however in certain circumstances e.g. raised BMI, use of a sonicaid is acceptable. The maternal pulse is palpated simultaneously with the fetal heart rate in order to differentiate between the two. Maternal pulse must be documented.

Affix CTG/EFM label to beginning of trace, containing the following information:
- Woman’s name
- Case note number
- Date of trace
- Time commenced
- Maternal pulse
- Pinard auscultation
- Indication for EFM
- Name of midwife
- Clear, legible signature of Midwife
- Estimated date of delivery

Ensure the mother’s comfort, avoiding aorto-caval compression. Enquire as to latex allergy, it is preferable to use single use non latex straps. The toco transducer needs to sit on top of the fundus for optimal tracing. Straps should be correctly secured.

**Once EFM commenced:**
Ensure the CTG machine is operating correctly i.e. paper moving freely and sitting correctly on rollers, tracing clear and readable.

Settings on CTG machines should be standardised so that

- Paper speed is set to 1 centimetre per minute
- Sensitivity displays are set to 20 beats per minute (bpm/cm)
- FHR range displays of 50-210 bpm are used

Ensure toco pressure is correctly set to 10 to 15 (Some CTG monitors automatically reset this at 20)

All staff changeover of care should be noted on the trace with a clear legible signature.

Who does the document relate to:
- All Staff?
- Locality/Directorate/Clinical Department specific?

**Interpretation of EFM (definitions of normal and abnormal parameters)**

In order to ensure that there is a consistent approach taken to the interpretation of EFM, ABHB promotes the use of the NICE (2007) definitions and classifications of fetal heart rate trace/cardiotocograph (CTG). Midwives and obstetricians should all use the same language when referring to CTG interpretation and therefore should use the terms in the below tables.

**Nice Classification of FHR trace features. (appendix 2)**

NICE (2007) classifies FHR trace features as reassuring, non-reassuring and abnormal. This terminology relates to the specific feature of the CTG and should not be used to categorise the overall CTG. The **four** features that should be classified are:

- Baseline
- Variability (bpm)
- Accelerations
- Decelerations
The following table demonstrates the parameters of reassuring, non-reassuring and abnormal classifications of the four features:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Baseline</th>
<th>Variability (bpm)</th>
<th>Decelerations</th>
<th>Accelerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reassuring</strong></td>
<td>110-160</td>
<td>&gt;5</td>
<td>None</td>
<td>Present</td>
</tr>
<tr>
<td><strong>Non-Reassuring</strong></td>
<td>100-109 161-180</td>
<td>&lt; 5 for 40-90 mins</td>
<td>Typical variable decelerations with over 50% of contractions, occurring for over 90 minutes</td>
<td>The absence of accelerations with otherwise normal trace is of uncertain Significance.</td>
</tr>
<tr>
<td><strong>ABNORMAL</strong></td>
<td>&lt;100  &gt;180</td>
<td>&lt;5 for &gt;90 minutes</td>
<td>Either atypical variable decelerations with over 50% of contractions, or late decelerations, both for over 30 minutes.</td>
<td>Single prolonged Deceleration for more than 3 minutes.</td>
</tr>
</tbody>
</table>

It is important to note here that the terms “reassuring” and “non-reassuring” should **NOT** be used to categorise a CTG trace. Remember, they only refer to the individual feature.

Once each feature has been assessed, the **category** of the CTG can be determined.
There are three categories of CTG as described by NICE (2007). These are normal, suspicious and pathological. The following table illustrates the definition of each:

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>An FHR trace in which all four features are classified as reassuring.</td>
</tr>
<tr>
<td>Suspicious</td>
<td>An FHR trace with one feature classified as non-reassuring and the remaining features classified as reassuring.</td>
</tr>
<tr>
<td>Pathological</td>
<td>An FHR trace with two or more features classified as non-reassuring or one or more classified as abnormal.</td>
</tr>
</tbody>
</table>

It is essential that ALL CTG traces are interpreted and categorised as either normal, suspicious or pathological. It is also important that ONLY these terms are used. Universal adoption of this language will avoid confusion and subsequently reduce clinical risks and will provide clarity and consistency of terminology used to describe and document findings.

A suspicious CTG should be reviewed by an obstetrician and a clear plan documented in the notes.

In the case of a pathological CTG, fetal blood sampling should be undertaken to assess the condition of the fetus unless there is clear evidence of acute compromise, in which case consideration should be given to delivering the baby.

**Documentation**

Any event that may affect the FHR should be noted contemporaneously on the EFM trace and case notes. (e.g. vaginal examination, siting of epidural, drugs) Care must be taken to avoid obscuring the recorded features. Where there is the facility to record these events electronically on the CTG paper this should be used instead of writing on the paper (newer CTG machines have this facility).

ALL CTG recordings should be documented in the woman’s notes using the appropriate interpretation sticker. This method should always be used by all obstetricians and midwives.
During labour, formal assessment of the fetal heart rate should be undertaken hourly and the assessment clearly documented in the notes using the CTG sticker.

In addition, during labour, a continuous CTG recording should be reviewed by another midwife or obstetrician on an hourly basis. This is referred to as the “fresh eyes” approach. It can be undertaken by any grade of midwife or doctor. It is not a referral to a more senior midwife or obstetrician but an opportunity for a colleague to provide a fresh assessment to the CTG. This should be regarded as an opportunity for effective team working and the promotion of continuous CTG assessment skills.

It is essential that the CTG sticker is signed and the name of the professional printed legibly. This applies to the professional caring for the woman and the professional providing the fresh eyes assessment.

A clear action plan must be documented.

All findings should be explained to the woman. Where appropriate, consider the use of interpretation services.

On completion of an antenatal CTG trace, it should be signed and reason for discontinuation documented. A portion of blank paper should be left at the end of the trace before tearing it off. The trace should then be stored in a CTG wallet and securely stored within the notes.

On completion of an intrapartum CTG trace, the professional should note the date, time and mode of delivery on trace. It should then be signed with a clear legible signature. The traces are then securely stored within the case notes in a CTG wallet. The wallet should be identified with the mother’s name, case note number and delivery outcome.

**Assessing the WHOLE clinical picture**

In addition to interpreting the CTG and categorising it using the NICE (2007) definitions, it is also essential to consider the whole clinical picture.

Maternal observations should be noted; maternal pulse, blood pressure, respiratory rate and temperature. Any deviation from the norm and in particular maternal Pyrexia (38.0C or above on one
occasion or 37.5°C or above on two or more occasions two hours apart) should be noted and communicated to the obstetric team.

When assessing the CTG, the pneumonic Dr MCQ BRAVADO is helpful to assist the assessment of the WHOLE situation. It can used in conjunction with the NICE classification by enabling us to assess both the trace and the clinical picture as a whole.

**However, writing DR MCQ BRAVADO should NOT replace the CTG interpretation sticker in the notes.**

**DR Define Risk**  
Consider the whole clinical picture. (gestation, medical and obstetric history. Maternal observations: tachycardia, pyrexia)

**M Movements**  
Are there any? significant for an antenatal trace.

**C Contractions**  
Are there any and how often? These should be documented as the number occurring in 10 minutes  
Is there Hyperstimulation? Hyperstimulation is described as 5 or more contractions in 10 minutes. Consider the use of a tocolytic

**Q Quality**  
How good is the trace, is there lots of loss of contact? can you read it? Do you need to consider putting on an FSE?

**BR Baseline rate** as per NICE

**V Variability** as per NICE

**A Accelerations** as per NICE

**D Decelerations** as per NICE

**O Overall assessment and plan**  
What is the category of the CTG according to NICE?  
*Normal?*  
*Suspicious?*  
*Pathological?*  
What is your overall assessment of the WHOLE clinical picture? What is your plan of care? Be clear about who you are referring to and why.

**Fetal Blood sampling (appendix 3)**

Where there are concerns that a CTG is pathological, a fetal blood sample (FBS) should be obtained to assess fetal acidosis. Undertaking an FBS enables professionals to make an informed decision about the plan of care and avoids unnecessary over-intervention.

Unless there is clear evidence of acute compromise, for example in the case of a prolonged fetal bradycardia, FBS should be attempted.
A fetal blood sample should be obtained from the fetus with the woman in left lateral position. The procedure and the rationale for undertaking it must be explained to the woman and her family.

The following table illustrates the classification of fetal blood sampling results (NICE 2007):

<table>
<thead>
<tr>
<th>FBS result (ph)</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;7.25</td>
<td>Normal FBS result</td>
</tr>
<tr>
<td>7.21-7.24</td>
<td>Borderline FBS result</td>
</tr>
<tr>
<td>&lt;7.20</td>
<td>Abnormal FBS result</td>
</tr>
</tbody>
</table>

If the FBS result is normal but the CTG remains pathological, the FBS sample should be repeated no later than 1 hour (or sooner if further abnormalities occur).

If the FBS result is borderline, but the CTG remains pathological, the FBS sample should be repeated no later than 30 minutes (or sooner if further abnormalities occur).

If the FBS result is abnormal, expedite delivery of the baby and contact the consultant obstetrician.

If a third FBS is required, consultant obstetrician should be informed.

The time required to obtain a FBS should be considered when planning repeat samples.

Where there is clear evidence of acute fetal compromise (for example, prolonged deceleration greater than 3 minutes), FBS should NOT be undertaken and urgent preparations to expedite birth should be made.

FBS should not be done in the case of maternal infection (HIV, hepatitis viruses and herpes simplex virus), fetal blood disorders (e.g., hemophilia) and if the gestation is less than 34 weeks.

**Audit**

Compliance with the guideline will be audited on an annual basis by supervisors of Midwives.
Education and training

All midwives and obstetricians working in ABHB must undertake two CTG training updates each year (preferably one in each 6 month period). This is a Welsh Risk Pool requirement.

At present, this requirement is:

1. Completion of the K2 CTG/Acidbase chapters, including the completion of 10 simulated cases.
2. Undertaking either a CTG teaching session (obstetricians) or attending the mandatory study day for midwives.

(Please note that this is in the process of review and plans are in place to provide a multi-disciplinary half day update for both midwives and obstetricians)

References


Standards for Health Services Wales

This guidelines complies with standard 7 and 8
Appendix 1

Continuous EFM

- Meconium-stained liquor (see page 15)
- FHR less than 110 or greater than 160 bpm; decelerations after a contraction
- Maternal pyrexia (38.0°C once or 37.5°C twice 2 hours apart)
- Fresh bleeding in labour
- Oxytocin for augmentation

Key:
- low-risk women

Other risk factors present:
- Previous C5
- Pre-eclampsia
- Pregnancy > 42 weeks
- PROM > 24 hours
- Induced labour
- Diabetes
- Antepartum haemorrhage
- Other maternal medical disease
- Fetal growth restriction
- Prematurity
- Oligohydramnios
- Abnormal Doppler artery velocimetry
- Multiple pregnancies
- breech presentation

Maternal factors that may contribute to an abnormal trace:
- Woman's position: advise her to adopt left-lateral position
- Woman is hypotensive
- Woman has just had a vaginal exam
- Woman has just emptied her bladder or bowel
- Woman has been vomiting or had a vasovagal episode
- Woman has just had regional analgesia sited or topped up

With oxytocin:
- Suspicious trace: ODI review; continue to increase oxytocin till 4 or 5 contractions every 10 min
- Pathological trace: stop oxytocin; full assessment by obstetrician before recommencing

Abnormal trace

- Pathological trace
- Fetal death suspected with recordable trace
- Real-time ultrasound assessment

- Acute compromise (deceleration > 3 min)

Normal trace with oxytocin
- Continue oxytocin until 4 or 5 contractions every 10 min.
- Reduce if more than 5 in 10 min

Inform that EFM will restrict woman's mobility.
Every hour take documented systematic assessment based on tables 1 and 2, page 18

3 These factors (risk factors for women outside the scope of this guideline and maternal factors that may contribute to an abnormal trace) are from 'Electronic fetal monitoring' (NICE Inherited guideline C) which this guideline updates and replaces.
4 At the time of publication (September 2007), terbutaline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.
Appendix 2

EFM: definitions and classifications

Table 1 Definition of normal, suspicious and pathological FHR traces

<table>
<thead>
<tr>
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</table>

Table 2 Classification of FHR trace features

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<th>Variability (bpm)</th>
<th>Decelerations</th>
<th>Accelerations</th>
</tr>
</thead>
<tbody>
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<td>≥ 5</td>
<td>None</td>
<td>Present</td>
</tr>
<tr>
<td>Non-reassuring</td>
<td>100–109</td>
<td>&lt; 5 for 40–90 min</td>
<td>Typical variable decelerations with over 50% of contractions, for over 90 min</td>
<td>The absence of accelerations with otherwise normal trace is of uncertain significance</td>
</tr>
<tr>
<td></td>
<td>161–180</td>
<td></td>
<td>Single prolonged deceleration for up to 3 min</td>
<td></td>
</tr>
<tr>
<td>Abnormal</td>
<td>&lt; 100</td>
<td>&lt; 5 for 90 min</td>
<td>Either atypical variable decelerations with over 50% of contractions or late decelerations, both for over 30 min</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 180 Sinusoidal pattern</td>
<td>≥ 10 min</td>
<td>Single prolonged deceleration for more than 3 min</td>
<td></td>
</tr>
</tbody>
</table>

Record-keeping

- Check date/time clock on EFM machine.
- Label FHR traces with mother’s name, date and hospital number.
- Sign trace and record date, time and mode of birth.
- Note events, e.g. vaginal exam, FBS, epidural siting on trace.
- Store traces securely.

Risk management

- Consider the time taken for instrumental vaginal birth and CS when making decisions about fetal wellbeing.
- Keep FHR traces for 25 years; where possible store electronically.
- If the baby may suffer developmental delay, photocopy and store FHR traces indefinitely.
- Use tracer systems if FHR traces stored separately from women's records.
- Take paired cord blood gases only when concerned about the baby either in labour or immediately following birth.
- Ensure an additional clamp for double-clamping is available at all birth settings.
Appendix 3

Fetal blood sampling (FBS)

FBS

Woman in left-lateral position

Normal pH ≥ 7.25

Borderline pH 7.21–7.24

Abnormal pH ≤ 7.20

Repeat FBS within 1 hour if FHR trace remains pathological

Repeat FBS within 30 min if FHR trace remains pathological

Urgent birth

FBS

Normal pH ≥ 7.25

Borderline pH 7.21–7.24

Abnormal pH ≤ 7.20

FHR trace unchanged and FBS result stable: defer third/further FBS unless additional abnormalities develop on the trace

Third FBS necessary

Urgent birth

Key:

GB seek obstetrician advice (transfer to obstetric unit if appropriate)

HF healthcare professional trained in operative vaginal birth

Neonatal resuscitation

- Start basic resuscitation of newborn babies with air.
- Use oxygen for babies who do not respond.
- Attend a neonatal resuscitation course at least once a year6.

6 Consistent with the algorithm adopted in the “Newborn life support course” developed by the Resuscitation Council (UK), available from www.resus.org.uk/stationx.htm
APPENDIX 4

EQUALITY IMPACT ASSESSMENT GUIDANCE
Aneurin Bevan Health Board

Flowchart for the Completion of the EqIA Paperwork

1. Complete FORM 1 ‘Preparation and Assessment of Relevance & Priority’

2. Complete FORM 2 ‘Evidence Gathering’

3. Complete FORM 3 ‘Action Plan’

4. Complete FORM 4 ‘Assessment of Relevance and Priority Scoring Chart’
   To be scored following consideration of relevant action to be taken

5. Complete FORM 5 ‘Outcome Report’
Equality Impact Assessment (EqIA)

Form 1

Part A: Preparation and Assessment of Relevance and Priority
Step1: Preparation

1. What are you equality impact assessing?

Fetal Monitoring guideline

2. Policy Aims and Brief Description - What are its aims, give brief description.

Aneurin Bevan Health Board demonstrates a standardised approach to the use and interpretation of intermittent auscultation of the fetal heart and electronic fetal monitoring.

Objectives

- Define the indications for use
- Give definitions of normal and abnormal parameters
  Provide clarity and consistency of terminology used to describe

3. Who Owns the Policy? - Who is responsible for the policy/work?

Guideline owned by the Maternity clinical Effectiveness forum
Guideline updated by Mrs C Roche – Senior Midwifery Manager

4. Who is involved in undertaking this EqIA? - Who are the key contributors to the EqIA and what are their roles in the process?

Debbie Pimbley
Family & Therapy Quality & Safety Lead
5. **Other Policies** - Describe where this policy/work fits in a wider context.

- Labour ward guidelines

6. **Stakeholders** – Who is involved with or affected by this policy?

- Midwives, obstetricians and junior medical staff working within ABHB maternity services. Women utilising the service

7. **What factors may contribute to the outcomes of the policy? What factors may detract from the outcomes? These could be internal or external factors.**

- Distribution and availability of guideline

**Next Steps**
For the next stage of the EqIA process please see form:
Part A, Step 2 - Evidence Gathering.
<table>
<thead>
<tr>
<th>Equality Strand</th>
<th>Evidence Gathered</th>
<th>Does the evidence apply to the following with regard to this policy/work?</th>
<th>Taking account of difference even if it involves treating some individuals more favourably</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>There is no evidence that a persons race will affect the monitoring of the fetal heart rate</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>There is no evidence identified to demonstrate that a persons disability will affect operation of this guideline</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>There is no evidence identified to demonstrate that a persons gender will affect operation of this guideline as this guideline is specifically for pregnant women</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>There is no evidence identified to demonstrate that a persons sexual orientation will affect operation of this guideline</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>There is no evidence identified to demonstrate that a persons age will affect operation of this guideline</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Religion/Belief</td>
<td>There is no evidence identified to demonstrate that a persons religion/belief will affect operation of this guideline</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Welsh Language</td>
<td>There are facilities for translation if required</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Human Rights</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This column relates only to disability due to the DDA 2005 specific duty*
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Expected Outcome</th>
<th>Divisional/Department Response</th>
<th>Responsible person</th>
<th>Progress to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No additional actions required</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Aneurin Bevan Health Board: Equality Impact Assessment

**Assessment of Relevance and Priority – Scoring Chart**

**Name of Policy:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
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</tr>
<tr>
<td>Disability</td>
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<tr>
<td>Gender</td>
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</tr>
<tr>
<td>Sexual Orientation</td>
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<td>3</td>
<td>3</td>
</tr>
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<td>Age</td>
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<td>3</td>
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<tr>
<td>Religion/Belief</td>
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<td>3</td>
</tr>
<tr>
<td>Welsh Language</td>
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<td>3</td>
</tr>
<tr>
<td>Human Rights</td>
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</table>

**Evidence Available**

<table>
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<tr>
<th>Evidence Available</th>
<th>Potential Impact</th>
<th>Impact Decision</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>-3 High negative</td>
<td>-6 to -9 High Impact (H)</td>
</tr>
<tr>
<td>2</td>
<td>-2 Medium negative</td>
<td>-3 to -5 Medium Impact (M)</td>
</tr>
<tr>
<td>1</td>
<td>-1 Low negative</td>
<td>-1 to -2 Low Impact (L)</td>
</tr>
<tr>
<td></td>
<td>0 No impact</td>
<td>0 No Impact (N)</td>
</tr>
<tr>
<td></td>
<td>+1 Low positive</td>
<td>1 to 9 Positive Impact (P)</td>
</tr>
<tr>
<td></td>
<td>+2 Medium positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+3 High positive</td>
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</table>

* Rule: Multiplication of a negative number by a positive number yields a negative result. Multiplication of two positive numbers yields a positive result. Multiplication of two negative numbers yields a positive result.
**Equality Impact Assessment (EqIA) Outcome Report**

<table>
<thead>
<tr>
<th><strong>Policy Title:</strong></th>
<th>Fetal Monitoring Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisation:</strong></td>
<td>Aneurin Bevan Health Board</td>
</tr>
<tr>
<td><strong>Name of policy Assessors:</strong></td>
<td>Debbie Pimbley</td>
</tr>
<tr>
<td><strong>Division/ Department:</strong></td>
<td>Family &amp; Therapies Division  Maternity Services</td>
</tr>
<tr>
<td><strong>Proceed to Full EqIA:</strong></td>
<td>The assessors are satisfied that as there are no negative impacts identified in this assessment a full EqIA is not required.</td>
</tr>
<tr>
<td><strong>Summary of the EqIA process and key points to be actioned:</strong></td>
<td>This EqIA has been undertaken using the tool kit designed by the NHS Wales Centre for Equality &amp; Human Rights. The tool kit gives due consideration to each statutory limb of the Equality Act (2010) and in keeping with an inclusive equality agenda also includes consideration of the Welsh Language Act and the Human Rights Act. This report is not intended to provide a definitive account of the content and outcome of the EqIA screening process but offers a summary of the findings. In this instance no negative differential is identified</td>
</tr>
<tr>
<td><strong>Responsibility for validation of the EqIA:</strong></td>
<td>Maternity Service Clinical Effectiveness forum</td>
</tr>
<tr>
<td><strong>Date:</strong></td>
<td>31st January 2013</td>
</tr>
<tr>
<td><strong>Monitoring Arrangements:</strong></td>
<td>This Guideline will be monitored via the Maternity Services Clinical Effectiveness forum</td>
</tr>
<tr>
<td><strong>Policy expiry date:</strong></td>
<td>31st January 2016</td>
</tr>
</tbody>
</table>

This information is available on request in a range of accessible formats, Welsh and other community languages as required.
For more information please contact:
Aneurin Bevan Health Board Policy Process Manager on 01495 765460
APPENDIX 5

CHECKLIST FOR THE APPROVAL AND RATIFICATION OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

Please note that no policies or other written control documents should be taken to the [enter sub committee name] for ratification unless they have been seen and approved by the [enter the name of the sub group or forum].

Name of Policy or written control document:

...............Fetal Monitoring Guideline.

Owner(s): Maternity Clinical effectiveness forum
review Date: 31st January 2016.................................

1. Please specify the date and name of person who carried out the policy or other written control document Equality Impact Assessment
   Date: ...6/3/2013......
   Name : Debbie Pimbley

2. Have you taken into consideration the relevant legislation that may be applicable to this policy or other written control document?
   Yes ☑ No   
   Comments : .

3. Has a patient information leaflet been developed to assist this policy or written control document?
   Yes ☐ No   
   Not Applicable ☑
   If yes, is the information available in the variety of accessible formats and languages? (including welsh and other community languages as appropriate)
Comments:

4. Where appropriate, have you consulted with the relevant services/personnel throughout the Aneurin Bevan Health Board when completing the policy or other written control document?
   (e.g. Voluntary, Legal, Pharmacy, IT, Finance, personnel, etc.)
   
   Comments:

5. If applicable, please state what training has been identified as a result of this policy or other written control document, and what has been taken:
   (Has the training department been informed of any training needs?)
   Training will be undertaken as part of the All Wales CTG training and assessment recommendations

6. Have the necessary users been consulted in the development of this policy or written control document?
   (e.g. Aneurin Bevan Health Board, Division/Locality wide, Third Sector, etc.)
   
   Yes ☑ No ☐ Not Applicable ☐
   Please provide details: sent for comment to all senior midwifery and obstetric staff…………………………………………………………………………………………………………………………

7. Has the necessary Equality Impact Assessment documentation been completed?
   
   Yes ☑ No ☐
   If no, give reason(s):

8. Has the necessary Environment Impact Assessment been completed?
   
   Yes ☑ No ☐ Not Applicable ☐
Ratification

The [enter name of committee, group or forum] has considered the information and agrees/ratifies on [insert date].

Chair signature ......................Mrs J Singh Obstetric Consultant ratified 31st January 2013......