Frequently Asked Questions

Q: Why is there no intrapartum algorithm and label for the fetus <32 weeks gestation?
A: During labour, the FHR features of a fetus <32 weeks may develop more 'mature' characteristics, due to the administration of steroids and / or the stress of labour. Although it is possible to develop an intrapartum algorithm and label for the fetus <32 weeks, in the sake of simplicity, this has not been done.

Q: In the fetal welfare teaching tools, we are informed two FHR accelerations of 10bpm for more than 10 seconds is acceptable in an 'immature' fetus at gestation <32 weeks. Why does the antenatal algorithm <32 weeks require two FHR accelerations of more than 15bpm for more than 15 seconds in a twenty minute period?
A: For consistency, to minimise confusion. Accelerations are a most important indicator of fetal wellbeing. In a preterm fetus, accelerations and reactivity may have altered characteristics from a term fetus. Carefully look at the CTG features to establish what may be characteristic for that particular fetus, and seek experienced clinical opinions and advice when interpreting all preterm CTGs.

Q: On the algorithm, what does the instruction "Escalate to the midwife in charge and determine need for clinical review. Continue to monitor with ongoing assessment. Clinical review by a medical officer within 30 minutes, as per local CERS."
A: Section 2.3.3 of the fetal heart rate monitoring guideline states: "A CTG feature which falls within the Yellow Zone is abnormal and requires a clinical review within 30 minutes." This means if a yellow zone feature is identified, the woman must have a clinical review within 30 minutes of the yellow zone feature occurring, as per the local CERS policy. Usually, in most facilities, clinical review will be performed by a medical officer. In facilities with no on-site medical officers, local CERS protocols will identify the appropriate lead clinician to perform the clinical review.

Q: In the EMR, where do I put my label?
A: This will be determined by local business rules. E.g. adhered to the printed copy of the CTG and scanned into EMR.

Q: Altered Calling Criteria
A: Altered Calling Criteria are generally established in the antenatal period and should be documented in the management plan/medical record. It is very rare for altered calling criteria to be identified during labour. One example is during the loading dose of Magnesium Sulphate. Local CERS /business rules should identify appropriate protocols to Alter Calling Criteria.
Q: When using the pre admission Antenatal Assessment in Cerner eMR where do I document if there is an ‘altered calling criteria’?
A: There is a specific generic Cerner form called Altered Calling Criteria and this is used with Fetal Monitoring tools to document if there is an Altered Calling Criteria for Fetal Monitoring (antenatal and intra-partum).

Q: The Maternity Emergency Program does not fill a full 8 hour day, how do we manage this?
A: The Maternity Emergency program can be delivered according to the local LHD’s needs. The afternoon may be used for practical adult and neonatal resuscitation training sessions.

Q: Please clarify the documentation of cycling and variability in antenatal and intrapartum CTGs.
A. In an antenatal CTG, the presence of a baseline rate appropriate for gestational age, normal variability (6-25) reactivity (2 accelerations in 20 minutes) with no decelerations is considered normal.

In an intrapartum trace, within each hour period, there should be evidence of cycling. There is no minimum time frame a fetus should remain in any particular fetal state, but there should be evidence that the fetus is able to transition between the different states.