Failure to Monitor Fetal Status

Sector: Acute Care (Maternal/Newborn)

Fetal heart rate (FHR) monitoring during labour assists practitioners detect changes in normal heart rate over time. In civil actions involving compromised infant cases (where it is alleged that the management of labour, delivery and/or resuscitation processes contributed to long term harm), the health record is considered the most reliable source of evidence of the care provided to the labouring woman (i.e. the records are frequently regarded as proof of the facts). It is often the lack of documentation of fetal assessments that makes defending claims challenging.

**COMMON CLAIM THEMES**

- Lack of a formal contingency plan to respond to resource challenges (staffing shortage, lack of equipment, lack of access to operating room, etc.).
- Inexperienced nurses, including agency nurses, assigned to patients without adequate support.
- Patients unattended for significant periods of time during the first stage and active stage of labour.
- Practicing under the assumption that another practitioner is monitoring ('double checking') at a centralized/remote fetal surveillance monitoring station.
- Fetal assessments not/infrequently performed:
  - Once an urgent or emergent C-Section is called, including patients being prepped for and/or in the OR awaiting team arrival;
  - Following transfer of care from midwife to a physician.
- The misidentification of the maternal heart rate as the FHR.
- Challenges monitoring fetal status when caring for large body mass index obstetrical patients.
- Immediate action not taken in response to unreadable or non-interpretable tracings.
- Poor understanding and/or compliance with hospital/health region fetal surveillance policies.
- Poor charting-by-exception practices (i.e. normal findings are not recorded).
- Partogram/flowsheets not completed in full.
- Patients choosing to decline some/all fetal assessments during labour.
- Lack of documentation of:
  - Intermittent auscultation (IA) and electronic fetal monitoring (EFM) (episodic and continuous) during the first, early second and active stages of labour at triage and once admitted;
  - IA performed where the woman is temporarily removed from (EFM) (unable to pick up a good tracing, walk breaks, preparing the woman for C-Section, etc.);
  - Uterine contractions;
  - Presence or absence of accelerations;
  - Fetal station and position;
  - Justification for discontinuing continuous EFM;
  - Intrauterine resuscitation measures performed in response to atypical or abnormal fetal status.

**CASE STUDY 1**

A G1P0 patient was admitted to hospital for monitoring related to reduced fetal movement. Following an abnormal stress test, care was transferred from the midwife to the consulting obstetrician. A nurse was also assigned to support the patient’s care. The abnormal fetal status continued over three hours and an emergent C-Section was performed. The infant sustained significant asphyxia in utero and was ultimately diagnosed with a permanent brain injury. Expert review was not supportive of the nurse’s care and management. The review noted significant concerns related to the substandard quality and inadequate frequency of the nurse’s fetal monitoring, as well as the inconsistent documentation in the partogram and ineffective communication with the obstetrician. The health record also lacked evidence of the evolving concerns of the nurse in the hours leading up to the C-Section.

**CASE STUDY 2**

A G3P1 patient was admitted to hospital with pre-labour rupture of membranes. Meconium stained amniotic fluid was noted several hours later. Three hours into labour, the fetal heart rate dropped to 90 and then 60 beats per minute (BPM) with slow recovery to baseline. Fetal bradycardia was encountered shortly after epidural catheter insertion and a decision was made to proceed to a vacuum and forceps assisted vaginal delivery. While the Apgar scores and cord gases were initially reassuring, the infant manifested seizure activity within 24 hours and required transfer to a tertiary pediatric facility. Long term neurological sequelae were not ruled out. Expert review was not supportive of the nurse’s care and management, with noted concerns in regard to the nurse’s decision to switch from continuous EFM to IA in the presence of ongoing abnormal tracings. The review also questioned the nurse’s engagement in infrequent IA fetal assessments (and documentation) post-epidural and during the active stage of labour.

**Canadian Case Examples**
REFERENCES

- HIROC claims files.
- Salus Global Corporation. (2014). MOREOB program – Management of labor decision tree (part 1, 2 and 3).

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Failure to Monitor Fetal Status: Maternal/Newborn

MITIGATION STRATEGIES

Note: The Mitigation Strategies are general risk management strategies, not a mandatory checklist. Please also refer to the following Risk Reference Sheets: 1) Failure to Interpret/Respond to Abnormal Fetal Status; 2) Failure to Communicate Fetal Status; 3) Mismanagement of Induction/Augmentation Medications.

Reliable Care Processes

☐ Adopt a standardized decision tree/algorithm to guide decision making for monitoring fetal status including:
  - Specific clinical situations that require use of continuous EFM;
  - Who can terminate continuous EFM and under what circumstances;
  - Ensuring fetal monitoring takes place in the OR while awaiting arrival of the team and/or during preparation of the patient for C-Section;
  - Prohibiting practitioners from switching from continuous EFM to IA in the presence of abnormal FHR pattern, uterine tachysystole and/or meconium stained amniotic fluid;
  - For patients attempting a trial of labour following a prior C-Section delivery (e.g. method for monitoring, potential need to expedite C-Section; induction/augmentation protocol, access to cultural/language translator for informed consent discussions);
  - For patients with a large body mass index (e.g. duration of second stage of labour, method of fetal monitoring, impact on uterine monitoring/ contractility, pain relief/ anaesthesia, macrosomia and shoulder dystocia, thromboembolism, potential IV in early labour).

☐ Adopt best practice/methodology for performing IA, such as starting the listening and counting immediately after the contraction and listening to the FHR for a full minute (i.e. not assessing for 10 or 15 seconds then multiplying by 6 or 4, respectively).

☐ Adopt the current Canadian recommendations for the frequency of fetal assessment during labour (first stage-active phase: q15-30 minutes; second stage – pushing phase: q5 minutes).

☐ Ensure one-to-one nursing (or midwifery) care is available for all labouring patients.

☐ Ensure alerts and alarms within electronic perinatal surveillance systems are set appropriately to prevent alarm fatigue.

☐ Adopt formal program-specific contingency plan(s) to respond to short-term and long-term staffing and resource challenges (e.g. redirect for emergency medical transport, temporary closure of the unit and accompanying notification to the media, public and community care providers).

Documentation

☐ Where electronic health records are utilized:
  - Prohibit staff from using the system’s “cut and paste” function; consider electronically disabling this feature;
  - Ensure free text/narrative boxes are available in addition to templates/flowsheets.

☐ Ensure complete and timely documentation of all fetal and maternal assessments performed, regardless of whether the findings are considered normal, atypical or abnormal including:
  - IA assessments (i.e. uterine activity [frequency, duration, intensity and relaxation between contractions], FHR [baseline, rhythm and gradual/abrupt decelerations or accelerations] and practitioner interpretation);
  - IA performed when the patient is discontinued from continuous EFM (e.g. ambulation, shower, labouring in water, preparation for and/or transport to OR);
  - EFM assessments (i.e. uterine activity [frequency, duration, intensity and relaxation between contractions], FHR [baseline, variability, presence/absence of accelerations, presence and type of decelerations, changes in trends over time] and practitioner interpretation);
  - Fetal assessments performed by nurses when managing patients of midwives with epidurals and/ or IV oxytocin inductions/augmentations (where this practice is in place).

☐ Ensure complete and timely documentation of the reasons for:
  - Not performing scheduled fetal and maternal assessments;
  - Not utilizing and/or switching to continuous EFM where suggested by professional and/or hospital/health region guidelines;
  - Not immediately requesting physician attendance/ consult in the presence of a non-responsive abnormal fetal status;
  - Disagreement with perinatal surveillance software alerts, alarms, interpretation and/or recommendations (including overrides/bypasses);
  - Discontinuing continuous EFM where utilized;
  - Care-related differences with the MRP and implementation of chain of command/escalation protocol.