Intelligent Intermittent Auscultation Masterclass (13 & 20 January 2020)

FAQ and comments received during the webinars

1. Are you recommending auscultation for 90 seconds rather than 60 seconds?

   Not necessarily. You need to auscultate for at least 60 seconds however if you can't identify a stable baseline during this time we recommend you listen for longer. If there isn't time to listen for longer than 60 seconds because the next contraction starts, then we would recommend listening again after that contraction. You must keep listening until you can identify your baseline and if you cannot then you need to convert to EFM.

2. Is there any evidence that counting in this way (multiple counts of 15 seconds) alters outcomes?

   This has not been formally evaluated yet however we have been using this method for approximately 3 years and have not had any cases of adverse outcomes in low risk women due to fetal heart rate concerns during this time. This package has been designed to incorporate a pre and post assessment which we are hoping will provide us with an evaluation of the training package. We hope to publish these results this year.

3. Baseline rate and fetal heart are all same. FHR is only use when performing IA.

   We appreciate this may be a new concept for some however using a physiological approach means that the baseline fetal heart rate is significant in identifying the baby at risk of developing hypoxia or sepsis. Therefore, we strongly recommend educating midwives about the importance of baseline rate.

4. Edwin Chandrahan clearly states in the Midwifery Network IA package he has developed that variability cannot and should not be assessed with IA. Only change in trend of rate decelerations and accelerations should be assessed

   We agree. In this teaching package we talk about variation which should not be confused with variability

5. Auscultation during second stage is a point of discussion in our unit, can I confirm what this group recommends for passive/inactive second stage (do we continue with 15 min auscultation until pushing commences??)

   Physiologically the fetus is not at greater risk until active second stage begins however we need to be very accurate in assessing when this starts and not missing the transition phase when a woman may begin involuntary pushing without a confirmation of second stage.

6. We don't have CTG on the birth unit, would it be appropriate to use them on MLC units?

We do not advocate using CTGs on the midwife led care unit, we recommend transferring to an obstetric led unit once you have made a thorough assessment with your IIA skills and therefore identified a problem which warrants continuous monitoring.

7. Have you seen an increase in the transfer rate from MLU for Continuous CTG?

   No, we have not seen an increase in transfer rates.

8. Rising rate and relevant decelerations are very important and relate to our knowledge of fetal physiology. These can be heard I believe without the counting method you specify. Can these elements not be retained in the training package without prescribing counting technique?

   We are not advocating one method over another. What the training package aims to do is to help you understand whether the method you are using is working. If it is working that is great and we don't advocate changing this however if you are not able to interpret the sound accurately we then suggest another method for you to consider which we believe will allow you to be accurate.

9. Do you advocate a buddy system as per SBL Bundle? / Do you practice Fresh ears in your unit?

   We, along with Consultant Midwives UK are strongly opposed to the practice of fresh ears in relation to simply having a second person to listen to the fetal heart periodically. We like many units have adopted a care review / supportive review process which is a more holistic method of ensuring maternal and fetal wellbeing. The consensus statement from Consultant Midwives UK will be available within the resources folder.

10. Why don't you listen INBETWEEN contractions at a time the baby is quiet to get the baseline rate - instead of the counting for 4x15 secs method you advocate???

    Identifying the baseline by listening in-between contractions is an important part of the initial assessment however you must listen immediately after a contraction during labour to identify the features of evolving hypoxia such as the slow to recover deceleration or tachycardic overshoot. Please remember if your method is working for you then you don't have to use the 15 second count method

11. Does this method recommend auscultating THROUGHOUT a contraction? Knowing that decelerations can be a normal physiological response to labour, if there is no rise in baseline rate or other abnormal features?

    We don't advocate listening throughout a contraction unless you are suspicious that you are hearing a tachycardic overshoot following a contraction. Listening during a contraction may be part of your assessment.

12. I didn't get the same figures for my count, but the overall impression was the same

    We allow for a slight variance (5 bpm either way) in the baseline rate however if your count is outside of these parameters you will not be identifying the baseline and therefore this

makes observing the trend during the labour challenging. This package is designed to help you to be more accurate in your assessment of the baseline rate.

13. How can you not include an acceleration when you are counting for a minute?

    This is the reason we advocate counting for at least 60 seconds. If you hear (or count by using the 15 second method) an acceleration you must exclude this from your calculation of the baseline. This will mean you will need to listen for longer to hear the fetal heart return to the baseline.

14. Is there a cost for the e-lfh module and is it available for students?

    No there is no cost and yes, it is available to students. You need to have an Open Athens account. See the information within the resources for further information.

15. Why can a CTG not be used for IA?

    This is because of the licensing agreement from the manufactures of your CTG machines. You will need to check with the manufactures of the machines you use. We were told when we did this some years ago that they are not licensed for IA. We strongly recommend that you remember this is a listening skill and for use in a low risk environment where CTGs aren't present.

16. Listening with a sonicaid that displays the fetal heart helps me to identify where the baseline is / any accels or decels due to seeing the FH continually within that minute, rather than intermittent counts.

    Intermittent auscultation is a listening skill and we need to develop our skills rather than become dependent on technology which may not always be available. We believe your count will be more accurate than the Doppler. For example, we all know of situations in which electronic devices have doubled the sound.

17. Is this only for labour or should this be used antenatally as well?

    The program is focussed on labour, but the skills can be used antenatally and we have benefitted from this as it has helped us identify a high risk woman that we may otherwise have missed. It also consolidates practice.

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