Questions and comments from IIA Updates to E-Learning package Monday 12 October 2020
With Wendy Randall, Christine Harding and Eileen Dudley

Notes taken directly from Teams meeting chat box

Is this the nationally recommended technique that we should be teaching?

The programme links physiology to the assessment of the fetal heart in low risk labours, it highlights that there are more than one method to assessing the fetal baseline however if a practitioner is not accurate with their method it encourages them to consider using the block counting method. This is described in detail. We feel that teaching should help to increase the accuracy of assessing the fetal heart and therefore if this method encourages midwives to be more accurate it should be recommended.
We have developed it because we identified that there is a lack of robust training using a physiological approach to IA and we have rolled it out on a national platform so that it can be used widely. We have been approached by organisations both nationally and internationally and therefore feel it is very important that it is available on a national scale.

From a governance point of view, are NICE onboard?

NICE do not have any detail on how to undertake IA in their guidance and therefore nothing within our programme contradicts their recommendations. We are very hopeful in the fullness of time that NICE will recognise our training however we appreciate that we need to evaluate it first. NICE published a best practice paper in 2014 in which we describe the importance of assessing the baseline and moving to a physiological approach which suggests they are supportive of the work we are doing.

https://www.nice.org.uk/sharedlearning/intelligent-auscultation-listen-for-fetal-wellbeing

You said a rise in baseline >20bpm is worrying, where did you get that figure from?

A fundamental feature of FIGO physiology is a rising baseline rate. None of the publications quantify this rise however when pressed for a figure this was the figure recommended by Edwin Chandraharan, one of the leading authors of the physiological approach to monitoring fetal wellbeing.

NICE refer to differences in baseline rate in their fetal monitoring guideline and focus on specific rates but FIGO apply more rigour to it asking for consideration regarding differences with baseline rates, for example, post-dates pregnancies where you may have a baseline of 110bpm so a rise in that baseline to 130-140 bpm is significant but will not trigger under NICE. In this situation midwives need to understand that you are already starting off at a lower baseline and a rise in baseline heart rate can be significant and midwives should think about it in terms of evolving hypoxia.

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In FIGO, it states that you should be listening during and for at least 30 seconds after a contraction. While I understand that a rising baseline is a sign of evolving hypoxia, the appearance of decelerations precedes this, and by listening towards the end of a contraction you will detect this earlier rather than a stable risen baseline where you are in a compensated response to stress status. Listening immediately after a contraction the midwife may still miss variable decelerations which if repetitive will flag a fetus who may be in the early stages of evolving hypoxia. I wonder if we will ever bring back in listening towards the end of a contraction just so we start to pick up those variable decelerations especially as they are getting wider in that evolving hypoxia?

The wording in Sue Downs at al publication (2015) alludes to listening during and at least 30 seconds after a contraction. However they do not explain this in terms of physiology but in terms of expert opinion. We believe that purely from a physiological point of view the practitioner listening immediately after a contraction will gather enough information to be able to identify a baby who is not coping in labour without routinely disturbing the mother coping with her contractions. Listening during a contraction will alert the midwife to early decelerations which do not indicate fetal hypoxia and may lead to unnecessary intervention. If the deceleration has ended by the end of the contraction there is no need for intervention based solely on this finding, however if it has not, there is.
Commenting on interrupting a woman for the purpose of auscultation: It is important for women to understand why the midwife is doing those things? You need to explain what the value is of what you are doing and why it makes a difference, the amount of information given to the woman about the impact of stress on her baby should be tailored to the woman's needs but it is important that the woman understands why the midwife needs to have a hand on her abdomen and to explain that it will allow the midwife to be able to feel when that contraction is going off and she will be poised and ready to listen immediately then you can pick up on those subtleties without having to disrupt her for the rest of the contraction .

FIGO states we should be listening during and for at least 30 seconds after a contraction and if we are following the FIGO guideline I am wondering why we are not following that part of the recommendation of the guideline?

Answered above

Responding to ED on 'share your top tips for helping midwives in education roles to roll out this programme in their organisations'

Midwives realise that now we are putting a bit more emphasis on IA and also adding in a new technique or counting skill so there may well be some anxiety. We would advise you to encourage them to have a go, to practice it, see if the way they are counting means they are accurate in assessing their baseline and if so they do not need to change anything. However if they are not accurate then we are giving them more help and a different method to use. It does take practice but that is what the training package can be used for.

Our personal experience is from midwives who have had the training and come back saying they have had a light bulb moment and are much more accurate.

We have seen a reduction in the number of babies born in poor condition in our birth centres because we have been using this programme for some time now.

In terms of % and the suggestion that less people come through the birth centres, specifically in Oxford, births in our MLUs and home births have increased considerably especially during COVID and over the last 6-12 months and we are not seeing an increase in the number of babies born with low apgars.

From our (HSIB) investigations we observe what the challenges are and where it is likely that inaccuracies in IA occurred because of timing, equipment failure and external factors. During your preliminary gathering of evidence and initial phase of implementation did you look at what the different variables were for improving accuracy with this method alongside the standard IA practice rather than implementing a different model? For example did you compare if midwives were doing IA with accurate timing and accurate counting rather than looking at their sonicaids and consider you would have improved the accuracy without implementing a different model?

My experience from investigating poor outcomes in Oxford where IA was a contributary factor meant that I was meeting with the women and talking with them about what the midwives were doing. The common thing was that the midwife listens for 6 secs and multiplies by 10, or 15 secs and multiplies by 4. Women told me that midwives did not listen for a minute, so they were not listening for that period to make that assessment of baseline rate. Hence the concern about the arbitrary number that has been identified during the last number of years because that does not tell you anything. The other thing was that the midwives were not listening immediately after a contraction, they were listening in between, and we know from years of CTG interpretation that babies can recover in between contractions.

We felt there was no application of physiology behind IA so that is why we are very driven getting people to understand the physiology of what is happening, how the baby is responding and sharing techniques we have used that have worked for us. I am aware that there is so much anxiety for some midwives about caring for women in birth centres and at home because they are anxious about having a poor outcome so anything that helps to build the midwife's confidence in her IA skill is beneficial. The key thing when you introduce this training is about providing the support to midwives who realise that there have been inaccuracies with her listening skills.

Personal reflection from a PDM who has struggled with listening and counting, she found she was concentrating so much on the counting that she stopped 'listening' so for her the problem was remembering four numbers and adding them up when her maths skills are terrible. She felt that for some people it will work incredibly well and recognised that in her trust there are poor outcomes related to IA skills and nationally there are errors in IA evidenced by the CTGs on women who are transferred to labour ward from a low risk setting and the condition the baby is born in. Recognises there is a massive need for this but that she finds it difficult to teach something that she struggles with personally.

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One of the things we emphasise in this programme is that if you have a skill in IA that is working for you, you do not need to change your technique, it is a suggestion for people who find that their skill is not working for them . Recalling the evidence discussed earlier and accepting that it is limited due to the pandemic we noted that almost 50% of midwives were using an IA technique that was working for them. We would not want them to change and we are not saying that you have to change. Again it is the midwives whose technique is not working for them that we would recommend they try this method.