ANTENATAL ≥ 32 WEEKS EFM ALGORITHM

Always consider the full clinical picture				
Maternal indicators for EFM	Any obstetric risk factors or change/s in maternal condition which may compromise fetal welfare e.g. administration of mechanical or chemical cervical ripening agents			
Fetal indicators for EFM	Any condition/s that suggest or increase the risk of fetal compromise e.g. FGR, absent or decreased fetal movements			
Review whether any altered calling criteria is in place and when this requires review				
Uterine activity	**Baseline rate (bpm)**	**Baseline Variability (bpm)**	**Reactivity** > 15 bpm rise from baseline for > 15 seconds (2 in 20 minutes)	**Decelerations** > 15 bpm amplitude for > 15 seconds Recurrent (more than one per hour)
Document the presence of any uterine activity If there are any concerns refer to NSW Health Management of Threatened Preterm Labour Guideline	< 100 > 180	≤ 5 for > 90 minutes Sinusoidal/Sawtooth > 15 minutes	Absent > 90 minutes	Prolonged > 3 minutes Recurrent without reactivity
	100 - 109 > 160 - 180	≤ 5 for > 45 minutes > 25 for > 15 minutes	Absent > 45 minutes	Single for > 90 seconds and ≤ 3 minutes Recurrent with reactivity
	110 - 160	6 - 25	Present	Nil Single for < 90 seconds with reactivity
Clinical Escalation Response (as per local fetal CERS)				**Ask: Could there be fetal hypoxia?**
NORMAL	Review full clinical picture If there is continued risk to the woman and/or fetus continue EFM Cease EFM when all normal criteria is met after consultation with a second clinician			
ABNORMAL 2 or more YELLOW ZONE features = **a Rapid Response**	Inform midwife in charge **Clinical Review** by a medical officer within 30 minutes Initiate appropriate clinical care, identify and treat any reversible causes Continue to monitor, conduct an A-G assessment and review collaborative care plan			
ABNORMAL	Call a **Rapid Response** Notify a medical officer for immediate review Initiate appropriate clinical care, identify and treat any reversible causes Consider further fetal welfare assessment and/or expediting birth. NOTE: *Do not give food or oral fluids*			
A second clinician is required to ensure that every CTG trace is interpreted, co-signed and escalated appropriately **If the two clinicians are not in agreement with the assessment, then escalation for a Clinical Review is required as a minimum**				

This resource is to be used in conjunction with the NSW Health Fetal Heart Rate Monitoring Guideline.

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