Patient Safety Alert [02/18]

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Confusion of maternal heart rate with that of fetal heart rate with continuous electronic fetal monitoring.

Date of Alert: 9th January 2018

Background

This alert is being issued because it is recognised that confusing the maternal heart with the foetal heart has been a factor in adverse outcomes in the Irish maternity service. This limitation of cardiotocography has been recognised for a long time and in many different health services[1]. This alert is being circulated now because a number of concerns have recently been raised about this issue.

The NWIHP wishes to emphasise the need for all staff involved in CTG usage to have on-going and documented training.

Actions required

By Whom: Hospital Group CEOs/ Hospital CEOs and Managers, Clinical Directors, Lead Clinicians in each Directorate/ Unit and Directors of Nursing and Midwifery.

By When: For **IMMEDIATE ACTION** in Maternity Hospitals and Acute Hospitals with Maternity Units/Services. Implementation must be kept under **CONTINUOUS REVIEW** as part of the Hospital/ maternity service's quality and safety structures.

Clinical Departments must ensure:

- All staff are aware of the possibility of the clinical risk described in this Notice when interpreting CTG tracings.
- If any question or doubt arises, auscultation of the fetal heart rate should be undertaken and the mother's pulse rate should be manually counted.
- That if there is any clinical concern in relation to the interpretation of the CTG occurs, an opinion should be sought ***immediately*** from a second individual, qualified in CTG interpretation.
- That this Notice forms part of onsite mandatory CTG training programmes.
- This Patient Safety Alert is circulated to all relevant staff and that lead professionals (Consultants, nurses and midwives) are aware of their responsibility in the implementation of the Alert.

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[1]Bhogal, B, 2010. Maternal and fetal heart rate confusion during labour. *British Journal of Midwifery*, 18/7, 424-428

Emereuwaonu, I, 2012. Case Report - Fetal Heart Misrepresented by Maternal Heart Rate: A Case of Signal Ambiguity. *American Journal of Clinical Medicine*, 9/1, 52 -57.

Murray, M.L., 2004. Maternal or Fetal Heart Rate? Avoiding Intrapartum Misidentification. *JOGNN*, 33/1, 93 - 104.

Contact Person for queries in relation to this alert Aideen Quigley, National Women and Infants Health Programme smi.nwihp@hse.ie