

GUIDELINE FOR: External Fetal Heart Rate / Uterine Activity Monitor Tracings: Charting and Documentation

INTRODUCTION: A fetal monitor tracing is a permanent and legal part of the patient record. The actions to be taken to properly document information on monitor tracing, progress notes, and flow sheet as well as Non-stress Test stamp are listed below. Non-stress tests have specific criteria by which the tracing is evaluated.

PROCEDURE:

ACTION

POINTS OF EMPHASIS

For use of monitor tracing label:

- | | |
|---|--|
| <ol style="list-style-type: none">1. The monitor tracing will be labeled with a monitor sticker with the patient's addressograph.2. Fill in all areas on label. See attached example.3. Explain meaning of symbols used; i.e.:
↓ = arrow for fetal movement, contraction, etc.
_ = calibration and recalibration of monitor4. Record position of patient at start of tracing, e.g., semi-Fowlers, left side-lying.5. Document explanations of attempts at improvement in recording of FHR or uterine recording.6. Identify fetus with the related FHR tracing when monitoring multiple gestations.7. Document fetal heart rate patterns based on ACOG Practice Bulletin No. 62 and University of Connecticut Guideline.8. Document if applicable to patient:
a. Vaginal exams. | <ol style="list-style-type: none">1. Provide space at the beginning of tracing to place label. Do not cover any part of tracing or written information with label.2. Not on monitor sticker reason why tracing is being done, e.g., NST, labor, contraction strip, unscheduled monitoring. All documentation must be done in ink.3. Ensures a more accurate interpretation by the physician or nurse.5. Circling or initialing any part of tracing is not acceptable.6. When more than one monitor is being used simultaneously to monitor multiple gestations, note that the date and time on the tracings are in agreement.7. Refer to attached addendum (pg.5-6) for pattern definitions.8. Suggested list of items to chart on electronic fetal monitor tracing. |
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- b. Anesthesia/medication administration (beginning and end times).
 - c. Vital signs.
 - d. Patient movement: out of bed, on bedpan, to bathroom.
 - e. O₂ use and amount.
 - f. Emesis.
 - g. Pushing.
 - h. Adjustments of equipment such as relocation of transducers, flushing IUPC, placement of new electrode, intrauterine catheter.
 - i. Mode of monitoring and changes in mode of monitoring for, e.g., ultrasound, spiral electrode are noted by monitor automatically.
 - j. Fetal movement.
 - k. Patient's awareness of contractions and/or fetal movement.
 - l. Physician's interventions.
9. Chart all observations, interventions and evaluations in Nurses' Notes.
- FOR USE OF NST STAMP:
- 10. Place NST stamp on Progress Note in Progress Note section of patient's chart.
 - 10. See attached NST stamp (p.4).
 - 11. Record all information as requested on stamp. See attached example.
 - 12. Call physician to notify of monitor tracing finish and document by name physician notified and information given to patient.

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APPROVAL: Nursing Standards Committee

CREDENTIALS: RN

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NST STAMP:

TIME ON MONITOR: _____
BASELINE RATE: _____
LTV: _____
FA: _____
2-3/10 MIN. _____
LESS _____
MORE _____
ACCEL TO _____ BPM
LASTING _____ SECS
DECCEL: YES _____ NO _____
COMMENTS _____
US'S: YES _____ NO _____
FREQ. _____
DURATION _____
STRENGTH _____
M.D. NOTIFIED: YES _____ NO _____
M.D. NOTIFIED: YES _____ NO _____
R.N. SIGNATURE _____

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Definitions of Fetal Heart Rate Patterns

<i>Pattern</i>	From ACOG Practice Bulletin No. 62	<i>Definition</i>	University of Connecticut Health Center
Baseline		<ul style="list-style-type: none"> The mean FHR rounded to increments of 5 beats per min during a 10 min segment, excluding: - -Periodic or episodic changes -Periods of marked FHR variability -Segments of baseline that differ by more than 25 beats per min <p>The baseline must be for a minimum of 2 min in any 10-min segment</p>	
Baseline variability		<ul style="list-style-type: none"> Fluctuations in the FHR of two cycles per min or greater (<i>LTV implied</i>) Variability is visually quantitated as the amplitude of peak-to-trough in beats per min -Absent-amplitude range undetectable -Minimal-amplitude range detectable but 5 beats per min or fewer -Moderate (normal)-amplitude range 6-25 beats per min -Marked-amplitude range greater than 25 beats per min 	<p><i>Short term Variability (STV, beat-to-beat)</i> <i>Present, absent, intermittent</i> ***Sinusoidal <i>Amplitude usually 5-15 BPM, absence of reassuring variability or accelerations</i> <i>Pseudosinusoidal</i> <i>Reassuring FHR variability and accelerations may be present</i></p>
Acceleration		<ul style="list-style-type: none"> A visually apparent increase (onset to peak in less than 30 sec) in the FHR from the most recently calculated baseline The duration of an acceleration is defined as the time from the initial change in FHR from the baseline to the return of the FHR to the baseline At 32 weeks of gestation and beyond, an acceleration has an acme of 15 beats per min or more above baseline, with a duration of 15 sec or more but less than 2 min Before 32 weeks of gestation, an acceleration has an acme of 10 beats per min or more above baseline, with a duration of 10 sec or more but less than 2 min Prolonged acceleration lasts 2 min or more but less than 10 min <p>If an acceleration lasts 10 min or longer, it is a baseline change</p>	
Bradycardia		Baseline FHR less than 110 beats per min	
Early Deceleration		<ul style="list-style-type: none"> In association with a uterine contraction, a visually apparent, gradual (onset to nadir 30 sec or more) decrease in FHR with return to baseline <p>Nadir of the deceleration occurs at the same time as the peak of the contraction</p>	<p>**Uniform in shape ***Rarely falls more than 20 - BPM below baseline</p>

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Late deceleration	<ul style="list-style-type: none"> In association with a uterine contraction, a visually apparent, gradual (onset to nadir 30 sec or more) decrease in FHR with return to baseline Onset, nadir, and recovery of the deceleration occur after the beginning, peak, and end of the contraction, respectively 	<p><i>** Uniform specific FHR pattern whose shape reflects the shape of the associated uterine contraction</i></p> <p><i>*** Rarely falls more than 30 BPM below baseline and usually not more than 10 to 20 BPM</i></p> <p><i>**** Duration proportional to duration of contraction</i></p>
Tachycardia	<ul style="list-style-type: none"> Baseline FHR greater than 160 beats per min 	
Variable deceleration	<ul style="list-style-type: none"> An abrupt (onset to nadir less than 30 sec), visually apparent decrease in the FHR below the baseline. The decrease in FHR is 15 beats per min or more, with a duration of 15 sec or more but less than 2 min 	<p><i>** Varies markedly in shape from contraction to contraction</i></p> <p><i>** Onset bears a variable time relationship to the beginning of the associated uterine contraction</i></p> <p><i>** It usually falls below 100 BPM</i></p> <p><i>*** Variable in duration, intensity and timing relative to uterine contractions</i></p>
Prolonged deceleration	<ul style="list-style-type: none"> Visually apparent decrease in the FHR below the baseline Deceleration is 15 beats per min or more, lasting 2 min or more but less than 10 min from onset to return to baseline 	

** From an Atlas of Fetal Heart Rate Patterns; Edward. H. Hon

*** Fetal Heart Rate Monitoring; Roger K Freeman, Thomas J. Garite, Michael P. Nageotte

**** Exercises in Fetal Monitoring; Barry S. Schifrin