Royal Cornwall Hospitals
NHS Trust

Intermittent Auscultation (IA) Clinical Guideline

V4.0

July 2025

1. Aim/Purpose of this Guideline

1.1. To give guidance to all Midwives on the process of intrapartum intermittent auscultation of the fetal heart in labour and when to transfer to continuous electronic fetal monitoring (CEFM).

1.2. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

1.3. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. This guideline should be read in conjunction with current RCHT Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline and the Intrapartum Continuous Electronic Fetal Monitoring (CEFM) and ST Analysis Clinical Guideline.

- Intermittent auscultation can be undertaken using either a Pinard stethoscope or a Sonicaid (doppler ultrasound).

- For women with no risk factors for fetal hypoxia or acidosis, IA is the recommended method for intrapartum fetal monitoring; this is regardless of the birth setting. IA allows the women to move more freely and facilitates the normal physiology of labour.

- Effective, Intelligent Intermittent auscultation enables detection of potential fetal decompensation; timely intervention can prevent perinatal/ neonatal morbidity and mortality. IA is not reliable for assessing fetal wellbeing if the fetus is already compromised.

2.2. Initial Assessment

2.2.1. A detailed, systematic, assessment should be made which includes immediate and existing risk factors. This will include antenatal risk factors, care plans, birth plans and history and the current presenting history and physical assessment.

2.2.2. Irrespective of any previous plan, this assessment will determine:

- The appropriate birth setting.
- The appropriate lead professional.
- The appropriate fetal monitoring method.
- An abdominal examination will ascertain the optimal position for auscultation. The strength and frequency of uterine contractions must be assessed; tachysystole (contractions 5 or more in 10 minutes) requires further evaluation.
- Initial assessment should be performed by using a pinard stethoscope or handheld Doppler.
- The baseline of the fetal heart (FH) should be assessed when the fetus is at rest and between contractions. The FH must be auscultated and counted for a full minute and the value recorded as a single figure (i.e., NOT as a range). The normal rate is 110 to 160 (but consideration must be given to what is expected for each individual fetus).
- Following palpation of a contraction, the FH must be auscultated for a full minute. This will enable identification of decelerations or overshoots.
- IA cannot establish the type of deceleration, therefore any deceleration heard will warrant further investigation.
- Fetal activity is a positive feature of fetal wellbeing. Fetal movement (FM) must be discussed. Auscultation of the FH at the time of FM should reveal accelerations in the fetal heart rate, demonstrating a non-hypoxic fetus.

2.2.3. The maternal pulse should be palpated whilst simultaneously auscultating the fetal heart to differentiate between maternal and fetal heart rate.

2.2.4. The initial assessment and resulting recommendation are documented on the labour assessment/admission page in the maternal handheld notes/electronic records.

2.2.5. The recommendations should be discussed with the woman and details of this discussion documented in the maternal notes. **Women should have the opportunity to discuss the evidence supporting IA for low-risk women (see references).**

2.2.6. If no fetal heartbeat is detected, offer urgent real-time ultrasound assessment to check fetal viability.

2.3. 1st Stage of Labour

2.3.1. Intermittent auscultation of the FH should occur for at least 1 minute, at least every 15 minutes, **immediately** after a palpated contraction and the single figure documented on the partogram. This should be commenced if the 1st stage of labour is suspected until you confirm with a vaginal examination.

2.3.2. Maternal pulse must be recorded hourly and simultaneously with auscultation, to confirm two different rates.

2.3.3. Continued vigilance is required to ensure that situations needing further investigation are not overlooked.

2.3.4. Every 4 hours a “Stop and Share” risk assessment should be undertaken. This is a two-person systematic review of the full clinical picture including the fetal heart. This should be undertaken with another midwife or appropriate trained clinician using the “Stop and Share” documentation tool (Appendix 5) (SBLv3, 2025).

2.4. 2nd Stage of Labour

2.4.1. If you suspect transition from first stage to second stage, commence auscultation at least every five minutes. This must continue until the birth of the baby or until full dilation is not confirmed on vaginal examination.

2.4.2. When full dilatation is diagnosed auscultate the fetal heart at least every 5 minutes, even with no urge to push.

2.4.3. Perform Intermittent auscultation immediately after a palpated contraction for at least 1 minute, repeated at least every 5 minutes and record it as a single rate on a partogram.

2.4.4. Descent of the fetal head, with increased maternal heart rate (due to exertion of pushing) increases the likelihood of recording maternal pulse. Palpate the women’s pulse simultaneously to differentiate between the maternal and fetal heart rates and record on the partogram at least every 15 minutes (NEW 2025).

2.4.5. If there are concerns about differentiating between the 2 heart rates, seek help and consider changing the method of fetal heart rate monitoring.

2.4.6. Every hour a “Stop and Share” risk assessment should be undertaken. This is a two-person systematic review of the full clinical picture including the fetal heart. This should be undertaken with another midwife or appropriate trained clinician using the “Stop and Share” documentation tool (Appendix 5) (SBLv3, 2025).

2.5. When to Transfer from IA to Continuous Electronic Fetal Monitoring (CEFM)

2.5.1. Abnormality of fetal heart rate:

- Abnormal baseline for gestation.
- Rising baseline - if, on intermittent auscultation there is an increase in the fetal heart rate (as plotted on the partogram) of 20 beats a minute or more from the start of labour.
- Presence of decelerations.
- Repetitive overshoots.

2.5.2. Action to be taken if there are any concerns with the fetal heart rate:

2.5.2.1. Keep women and their birthing companion(s) informed about what is happening if additional advice or review is being sought by the care team, for example from a senior midwife or obstetrician.

2.5.2.2. Carry out intermittent auscultation more frequently. The fetal heart must be auscultated immediately after the following three consecutive contractions.

2.5.2.3. Carry out a full review, taking into account the whole clinical picture including antenatal and existing or new intrapartum risk factors, maternal position, hydration, maternal observations, contraction frequency (including hypertonus) and the progress of labour. Identify and take action for correctable causes.

2.5.2.4. If there is difficulty auscultating the fetal heart, or if audible fetal heart abnormalities persist despite taking appropriate action, help should be summoned and continuous CTG monitoring should be advised. Care must be escalated to the Delivery Suite coordinator and the obstetrician.

2.5.2.5. If a prolonged deceleration (3 minutes or more) is auscultated and is not recovering, immediate action and escalation is required.

2.5.2.6. Advise continuous CTG monitoring and explain to the woman and her birth companion(s) why it is recommended, and the implications for her choices of type and place of care.

2.5.2.7. Return to intermittent auscultation if continuous CTG monitoring has been started because of concerns arising from intermittent auscultation but the CTG trace is normal after 20 minutes, unless the woman decides to remain on continuous CTG monitoring (New 2025).

2.5.2.8. SBARD processes will aid clear communication for escalation.

2.5.2.9. When a decision is made to convert from intermittent to continuous fetal monitoring, the reason must be documented in the maternal notes on the fetal risk assessment page within the intrapartum booklet. Explain the reason for this recommendation to the woman and her birth companion.

2.5.2.10. Provided it is safe and appropriate to do so, transfer the woman from midwifery-led care to Delivery Suite for obstetric review. This review should occur within 30 minutes of arrival (New 2025).

2.5.3. Intrapartum risk factors

Be aware that intrapartum risk factors may increase the risk of fetal compromise, and that intrapartum risk factors that develop as labour progresses are particularly concerning.

2.5.3.1. **M**econium-Stained Liquor: if transferring in from a community setting via ambulance, evaluation for safe transfer should be undertaken. Consider; the full clinical picture including the woman's parity and stage of labour, the fetal heart rate, and transfer time.

2.5.3.2. **O**xytocin used to augment labour.

2.5.3.3. **T**emperature: A maternal pyrexia of 38° centigrade, once, or 37.5° centigrade on 2 occasions, 1 hour apart. Transfer should also be recommended for suspected chorioamnionitis or sepsis.

2.5.3.4. **T**achycardia – maternal heart rate greater than 120bpm on 2 occasions 30 minutes apart.

2.5.3.5. **H**aemorrhage: Fresh vaginal bleeding developing in labour.

2.5.3.6. **H**ypertension: either systolic blood pressure of 140 mmHg or more or diastolic blood pressure of 90 mmHg or more on 2 consecutive readings taken 30 minutes apart, measured between contractions.

Severe hypertension: a single reading of either systolic blood pressure of 160 mmHg or more or diastolic blood pressure of 110 mmHg or more, measured between contractions).

2.5.3.7. **E**pidural analgesia requested.

2.5.3.8. **R**equested by woman.
Women should have the opportunity to discuss the evidence, and the implications of their choices of type and place of care.

2.5.3.9. Contractions that last longer than two minutes, or five or more contractions in ten minutes.

2.5.3.10. Pain reported by the woman that appears, based on her description or her previous experience, to differ from the pain normally associated with contractions.

2.5.3.11. A reading of 2+ of protein on urinalysis and a single reading of either raised systolic blood pressure (140 mmHg or more) or raised diastolic blood pressure (90 mmHg or more).

2.5.3.12. Confirmed delay in the first or second stage of labour.

2.5.3.13. Insertion of regional analgesia (for example, an epidural).

2.5.3.14. Consider continuous CTG monitoring if, based on clinical assessment and multidisciplinary review, there are concerns about other intrapartum factors not listed above that may lead to fetal compromise.

2.6. **Documentation:**

2.6.1. The initial assessment should be documented in the clinical notes. This will include the discussion with the woman, the rationale for the choice of monitoring, the frequency and equipment used for IA.

2.6.2. All fetal heart rate and maternal pulse recordings should be documented in the woman's notes until labour has established.

2.6.3. All fetal heart rate and maternal pulse recordings should be documented on the partogram during the first and second stage of labour.

2.6.4. Discussions relating to fetal heart monitoring and plans made in the event of the detection of an abnormality should be documented in the woman's notes.

3. Monitoring compliance and effectiveness

Information Category	**Detail of process and methodology for monitoring compliance**
Element to be monitored	Compliance.
Lead	Fetal Wellbeing Midwives.
Tool	1. Maternal pulse palpated when a FH rate abnormality was detected.

Information Category	Detail of process and methodology for monitoring compliance
	2. FH auscultated every 15 minutes during the 1st stage of labour. 3. FH auscultated every 5 minutes during the 2nd stage of labour. 4. Appropriate transfer from intermittent auscultation to continuous EFM. 5. Has the fetal heart been documented as a single figure? 6. Is there documented evidence of an initial assessment of risk of the development of fetal hypoxia/ acidosis for that individual fetus? 7. Is the rationale for intermittent auscultation included in the initial management plan? 8. Is there documented evidence that the risk of developing fetal hypoxia/ acidosis, for that individual fetus, has been reviewed throughout the woman's labour? 9. Is the rationale for continuing Intermittent auscultation verses reverting to Continuous Fetal Monitoring included in subsequent intrapartum management plans?
Frequency	This will be audited once during the 3 years of the life of this guideline or earlier if indicated following an incident.
Reporting arrangements	• A formal report of the results will be received at the Maternity Forum or Clinical Audit Forum. • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted, and an action plan agreed.
Acting on recommendations and Lead(s)	• Action leads will be identified and a time frame for the action to be completed. • The action plan will be monitored by the Patient Safety.
Change in practice and lessons to be shared	• A lead member of the Patient safety team will be identified to take each change forward where appropriate. • Patient Safety Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Intermittent Auscultation (IA) Clinical Guideline V4.0
This document replaces (exact title of previous version):	Intermittent Auscultation (IA) Clinical Guideline V3.2
Date Issued/Approved:	July 2025
Date Valid From:	July 2025
Date Valid To:	July 2028
Directorate / Department responsible (author/owner):	Holly Connolly and Charlotte Boswell, Fetal Monitoring Lead Midwives.
Contact details:	01872 255019
Brief summary of contents:	To give guidance to all midwives on the process of intermittent auscultation of the fetal heart in labour and when to transfer to continuous electronic fetal monitoring (CEFM).
Suggested Keywords:	Intermittent, auscultation, EFM, electronic, fetal, FH, stage, pinard, Sonicaid.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guideline Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	CNST 2.2
Related Documents:	• National Institute for Health and Clinical Excellence (NICE) (2014) CG190 Intrapartum care: Care of healthy women and their babies during childbirth.

Information Category	Detailed Information
	• RCHT (2023) Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline V3.0. • RCHT (2023) Epidural Analgesia for Labour Pain - Clinical Guideline. • RCHT (2022) Intrapartum Continuous Electronic Fetal Monitoring (CEFM) and ST Analysis Clinical Guideline. • The Royal College of Midwives (RCM) (2012) Evidence Based Guidelines for Midwifery-Led Care in Labour: Intermittent Auscultation. • RCOG (2017) Each Baby Counts Full Report. • NHS England (2019) Saving Babies' Lives Version Three A care bundle for reducing perinatal mortality.
Training Need Identified?	Yes. All staff providing intrapartum care must have Intermittent auscultation training as part of annual intrapartum fetal monitoring training.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
2006	V1.0	Initial Issue.	Jan Clarkson, Supervisor of Midwives.
October 2009	V1.1	Updated in line with NICE guidance.	Jan Clarkson, Maternity Risk Manager.
October 2010	V1.2	Updated to include compliance monitoring.	Jan Clarkson, Maternity Risk Manager.
August 2012	V1.3	Changes to compliance monitoring only.	Jan Clarkson, Maternity Risk Manager.

Date	Version Number	Summary of Changes	Changes Made by
18 September 2015	V1.4	Reviewed and benchmarked against new NICE (2014) guidance. No changes required.	Kate Putman, Maternity Risk Manager.
6 April 2017	V1.5	Updates by Lead Fetal Monitoring Midwife.	Sally Budgen, Fetal Monitoring Midwife.
14 March 2018	V1.6	Addition to 2.4: 2nd stage of labour. See new 2018 in body of text. Addition to 2.5: when to transfer from IA to CEFM.	Sarah-Jane Pedler, Practice Development Midwife.
10 August 2018	V1.7	Intermittent Auscultation Sticker added as Appendix.	Sally Budgen, Fetal Monitoring Midwife.
June 2019	V2.0	2.2 Initial Risk assessment. 2.3. Ongoing Risk Assessment. 2.5. Escalation of Care. Response to Saving Babies' Lives Bundle V2.	Sally Budgen, Fetal Monitoring Lead Midwife.
August 2022	V3.0	Document reviewed for timely update, addition of 2.5.1.5 If a prolonged deceleration is auscultated and is not recovering immediate action and escalation is required.	Jane Pascoe, Fetal Monitoring Lead Midwife.
October 2023	V3.1	Partial update in relation to new NICE guidance.	Jane Pascoe, Fetal Monitoring Lead Midwife.
November 2023	V3.2	Removal of 2.4.6.	Catherine Wills Maternity Guidelines Midwife.
July 2025	V4.0	Full update with small additions noted throughout	Holly Connolly and Charlotte Boswell, Fetal Monitoring Lead Midwives.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Intermittent Auscultation (IA) Clinical Guideline V4.0
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Catherine Wills, Maternity Guidelines Midwife
Contact details:	01872 255019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To give guidance to all Midwives on the process of intermittent auscultation of the fetal heart in labour and when to transfer to continuous electronic fetal monitoring (EFM).
2. Policy Objectives	To ensure evidence-based auscultation of the fetal heart.
3. Policy Intended Outcomes	Safe care in labour for women and their babies.
4. How will you measure each outcome?	Compliance Monitoring Tool.
5. Who is intended to benefit from the policy?	All women in labour and their babies.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guideline Group.
6c. What was the outcome of the consultation?	Guideline agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, Maternity Guidelines Midwife.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Intermittent Auscultation – Stop and Share

Intermittent Auscultation Stop and Share

Affix Patient Sticker here	Date & Time:	Birth Location:
	No risks for fetal hypoxia identified and suitable for IA? **Yes** ☐ **No – recommend transfer for CTG** ☐ **Birth Outside of Guidance- refer to individualised care plan** ☐	

Clinical details:

Initial Fetal Heart Rate:		Is the baseline suitable for gestation?	Y	Current Maternal Pulse:	
Current Fetal Heart Rate:			N	Meows Score:	

First stage: Auscultate the FH at least every 15 minutes immediately following a palpated contraction – **plot on partogram**

Second stage: Auscultate the FH at least every 5 minutes immediately following a palpated contraction – **plot on partogram**

Please Review and Confirm all the following in your Stop and Share. Review Partogram

Baseline Fetal Heart Stable - FH 110-160 bpm and not rising >20bpm	**No audible decelerations or overshoots**	**Normal maternal observations**	**Adequate Analgesia**	**No vaginal bleeding**	**No meconium-stained liquor**
No delay in first stage **-Primips: Cervical dilatation of <2cm in 4 hours** **-Multips: <2cm in 4 hours or a slowing in the progress of labour**	**No delay in second stage** **-Primip: birth within 2 hours of active 2nd stage** **-Multip: birth within 1 hour of active 2nd stage**		**Frequency of contractions not >4:10**	**Adequate Nutrition and Hydration**	**Bladder care**
Also consider Descent & Rotation of Fetal Head & Changes in Strength, Duration & Frequency of Contractions					

Escalation: If you cannot confirm the above immediate escalation is required alongside a clinical management plan and/or transfer plan

Consider transfer time, for a timely obstetric review.

Is further escalation required?

Yes ☐ **No** ☐

Escalated to (Name & Role):

Clinical management and Action plan: (Consider Maternal choice and informed decision making)

Primary Midwife Print: **Sign:**	**Reviewer Print:** **Sign:**