HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology		
Document:	Multidisciplinary Policy and Procedure		
Title:	Management of Fetal Distress		
Applies To:	All Obstetrics and Gynecology Staff		
Preparation Date:	January 08, 2025	**Index No:**	L&D–MPP–007
Approval Date:	January 22, 2025	**Version :**	2
Effective Date:	February 22, 2025	**Replacement No.:**	L&D–MPP–007(1)
Review Date:	February 22, 2028	**No. of Pages:**	3

1. PURPOSE:

1.1 To ensure prompt and efficient action during fetal distress in labor.

2. DEFINITIONS:

2.1 **Fetal Distress**– refers to signs before and during childbirth indicating that the fetus is not well. Fetal distress is an uncommon complication of labor. It typically occurs when thefetus has not been receiving enough oxygen.

3. POLICY:

3.1 All patients with viable fetus should have a cardiotocography (CTG) as soon as possible on arrival to L&D as baseline for 30 minutes.
3.2 Repeated/ continuous CTG monitoring is performed according to the clinical needs decided by physician on call.
3.3 Any deviations from normal should be reported immediately to resident on call.

4. PROCEDURE:

4.1 Problems of fetal distress in labor:
- 4.1.1 Pathological CTG.
- 4.1.2 Thick meconium– stained amniotic fluid.

4.2 General management:
- 4.2.1 Place women on her left side.
- 4.2.2 Stop oxytocin if it is being administered.
- 4.2.3 Hydration (1L fluid).
- 4.2.4 Oxygen mask (intermittent).
- 4.2.5 Vaginal examination to assess the progress/ may use FSE for direct monitoring.

4.3 Abnormal fetal heart rate:
- 4.3.1 Refer to the cardiotocogram.
- 4.3.2 Perform vaginal examination to check for explanatory signs of distress.
- 4.3.3 If there is bleeding with intermittent or constant pain, suspect abruption placenta.
- 4.3.4 If there are signs of infection (fever, foul smelling vaginal discharge) give antibiotics as for amnionitis.
- 4.3.5 If the cord is below the presenting part or in the vagina, manage as prolapsed cord.
- 4.3.6 If fetal heart rate abnormalities persist or there are additional signs of distress (thick meconium stained fluid), plan for FBS to check for fetal pH / Lactate/ Acid base excess.
- 4.3.7 Any member of staff who is asked to provide an opinion on a trace should note their findings on both the trace and the woman's medical records along with the date, time and signature.

4.3.8 Any intrapartum events that may affect the FHR should be noted at the time on the FHR trace, which should be signed and the date and time noted (foe e.g. vaginal examination, FBS or sitting of an epidural).

4.3.9 If the cervix is fully dilated and the fetal head is not more than 1/5 above the symphysis pubis or the leading bony edge of the head is at +1 station, deliver by vacuum extraction or forceps.

4.3.10 If the cervix is not fully dilated or the fetal head is more than 1/5 above the symphysis pubis or the leading bony edge of the head is station or above deliver by caesarean section.

4.4 Meconium :

4.4.1 Meconium is associated with postmaturity, long labor and fetal distress and by itself is not an indicator of fetal distress.

4.4.2 Continuous EFM should be advised for women with significant meconium stained liquor, which is defined as either dark green or black amniotic fluid that is thick or tenacious or any meconium stained amniotic fluid containing lumps of meconium.

4.4.3 Continuous EFM should be considered for woman with light meconium stained liquor depending on a risk assessment which should include as a minimum their stage of labor, volume of liquor, parity, the FHR and where applicable, transfer pathway.

4.4.4 If significant meconium stained liquor is identified, healthcare professionals trained in advanced neonatal life support should be readily available for the birth.

4.4.5 Suctioning of the nasopharynx and oropharynx prior to birth of the shoulders and trunk should not be carried out.

4.4.6 In breech presentation, meconium is passed in labor because of compression of the fetal abdomen during delivery. This is not a sign of distress until it occurs in early labor.

4.5 Cord pH measurement: (after delivery of the baby) Cord blood pH measurements must always be obtained following:

4.5.1 Delivery for fetal distress.

4.5.2 Low Apgar (< 7 at 5 minutes).

4.5.3 All emergency caesarean sections and instrumental deliveries.

4.5.4 Shoulder dystocia: Blood sample must be taken from the umbilical artery or vein by the midwife. The results must be recorded in the mother's and newborn's notes. The actual pH measurements can be taken at any time in the following 15–20 minutes, allowing birth attendants the opportunity to deal with the immediate needs of mother and newborn.

5. MATERIAL AND EQUIPMENT:

5.1 CTG.

5.2 Partogram.

6. RESPONSIBILITIES:

6.1 Physician

6.2 Nurse

6.3 Midwife

7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 MOH, Guidelines for Obstetrics and Gynecology, Clinical Policies and Procedures.

8.2 National Institute for Clinical Excellence, The Use of Electronic Fetal Monitoring, London, May 2007.

8.3 CBAHI Standard 3rd Edition 2016.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Dr. Abdalla Mohamed Albasha	Obstetrician and Gynecologist		January 06, 2022
Reviewed by:	Dr. Mohannad Yaghmour	Head of the Department		January 13, 2022
Reviewed by:	Ms. Awatif Hamoud Al - Harbi	IPCD Director		January 13, 2022
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 13, 2022
Reviewed by:	Mr. Abdulelah Ayed Al - Mutairi	QM&PS Director		January 13, 2022
Reviewed by:	Dr. Thamer Naguib	Medical Director		January 13, 2022
Approved by:	Mr. Fahad Hezam Al - Shammari	Hospital Director		January 20, 2022