Timely interventions are critical to prevent problems during delivery

By Chris Rokosh

Litigation surrounding "bad baby" cases often involves a claim that damage to the unborn infant occurred during labour and delivery. Specific allegations include failure to recognize nonreassuring changes to the fetal heart rate (FHR) and inappropriate or untimely nursing and medical intervention. As the mechanisms of labour and delivery can place tremendous stress on a fetus – even during a relatively low risk birth – timely interventions to nonreassuring changes in the FHR are critical in an effort to optimize fetal outcomes.

Briefly, the key elements of a nonreassuring FHR include: a baseline rate below 110 or above 160 beats per minute, a persistent decrease in or absent variability of the fetal heart, and prolonged variable or late decelerations. A nonreassuring FHR may be indicative of decreasing oxygen reserves of the fetus and has been associated with poor fetal outcomes.

In the medical record, evidence that a nonreassuring FHR has been recognized may be documented in the doctors' or nurses' progress notes or on the labour partogram as: tachycardia, bradycardia, decreased variability (indicated by a downward arrow) or variability less than six, decelerations (commonly written as "decels"), severe decels, variable decels, late decels, sinusoidal pattern or the words nonreassuring or nonreactive (often abbreviated as "non R").

In Canada, clinical practice guidelines for physicians are established by the Society of Obstetricians and Gynaecologists of Canada (SOGC) while nursing practice is guided by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Both organizations concur that, in the presence of nonreassuring fetal heart rate patterns, specific interventions, referred to as intrauterine fetal resuscitation measures, are warranted to optimize fetal outcomes. These measures include maternal repositioning, intravenous fluid administration, oxygen therapy and discontinuation of uterine stimulating drugs.

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"Maternal repositioning" refers to moving the labouring woman from one position to another and is often the first intrauterine fetal resuscitation measure put into place.

Repositioning the labouring woman to a supported side lying position allows the uterus to move away from the large blood vessels of the mother's back and can relieve fetal umbilical cord compression which occurs due to contractions, fetal position or decreased amniotic fluid.

Common abbreviations used in the medical record to indicate repositioning include: "Pos'n change" ("change" may be indicated by a triangle), "LL or Lt. Lat." (indicating left side lying), "RL" or "Rt. Lat" (indicating right side lying), "wedged" right or left (meaning supported with a pillow), "tilted" (if on an Operating Room table) or "hands and knees". Documented evidence of position change may be found in the progress notes, the labour partogram or on the fetal monitor tracing.

"Intravenous fluid administration" refers to rapid infusion of 400 milliliters or more of an intravenous solution. Providing a fluid bolus to the mother can increase maternal cardiac output, maximizing blood flow to the placenta and the fetus. Intravenous fluids may also decrease the frequency of uterine contractions, providing temporary relief to a compromised fetus.

Common notations used to indicate increased intravenous infusion include; "bolus", "I.V. w.o." (wide open), "I.V. increased" (indicated by an upward arrow) or

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