

AUDIT REPORT:

Intrapartum CTGs

Welcome to the first of a new series entitled 'Audit Report'. In each issue of *O&G* we plan to bring you new and interesting ideas for performing audits by interviewing Fellows who have developed audits in their practice. Audits are a great way of identifying areas for improvement in your practice. They can be as simple or as extensive as you like, ongoing or retrospective, and enable you to earn points in the all-important, mandatory PR&CRM category.

AN INTERVIEW WITH



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Our topic for this issue is the management of intrapartum cardiotocographs (CTGs). This issue was raised by Dr Bruce Warton, Director of Medical Services at the Western District Health Service (WDHS) in Hamilton, Victoria for the last eight years. WDHS is a public base hospital, servicing an area with a population of approximately 25,000 people, and assisting 200 deliveries per year. In his role of Director of Medical Services, Dr Warton had a number of responsibilities including Chairman of the obstetrics specific Limited Adverse Occurrence Screening (LAOS) committee. It was during his time with this committee, screening patient records and histories, that he noticed frequent problems with intrapartum cardiotocographs (CTGs). There was a high level of use, lack of information regarding who ordered the CTG and particularly, little or no impact made on the management of labour following the CTG results. With looming potential legal implications, the situation was found to be a significant risk for the hospital requiring further investigation.

Development & conduct of the audit

Dr Warton instigated the development of the CTG audit in 2003 along with two colleagues, the Quality Manager of the hospital and a consultant in obstetrics and gynaecology. The first task was to complete a risk management assessment of the situation, identifying the risks and determining what criteria should be included in the audit.

The retrospective audit was conducted, examining 50 consecutive records in which a total of 186 CTGs were taken. This was performed by the Quality Manager

and consultant in obstetrics and gynaecology, taking around two full days to complete. One of the main difficulties encountered was the lack of identification on many CTG traces in the records, a problem easily rectified for future traces.

Audit criteria

- Patient identification
- Date/time of CTG
- Indication for ordering the CTG
- Record of who ordered and who initiated the CTG
- Quality and duration of record
- Impact of CTG results on the management of labour

Outcomes & follow-up

As initially suspected, the main outcomes of the audit revealed that in many instances it was unclear why the CTG was taken, unknown who ordered the CTG (if any order at all), and unknown who actually performed the CTG. Furthermore, they identified a surprisingly high index of CTGs for a relatively low level unit (Level 1 nursery). Audit results were also compared with the RANZCOG Clinical Guidelines on Intrapartum Fetal Surveillance. This assisted in the follow-up stage of the quality cycle: developing an action plan.

Essentially, the action plan was to 'increase compliance with CTG ordering and reporting'. This was implemented by educating the staff involved through WDHS participating in RANZCOG's pilot Fetal Surveillance Education (FSE) Program run by Mark Beaves.

The first visit by Mark in July 2004 was a great success. All of the doctors and midwives involved



in CTG use at WDHS attended the day-long session together. A marked improvement in mean questionnaire scores was revealed when comparing pre- and post-education results, highlighting the effectiveness of the program. In addition, the use and discussion of CTGs amongst staff was more co-operative with better liaison between doctors and midwives following Mark's visit.

A repeat audit in 12 months time confirmed the success of the education program and completed the quality cycle. This time the audit results revealed vast improvements in: identification and documentation of records, quality of the traces, compliance with RANZCOG indications and also a significant reduction in the number of CTGs taken.

Comments on the audit process

Dr Warton found the audit to be a very useful tool, the most valuable result being 'the identification of where the CTG process had gone wrong'. He recommends other Fellows perform CTG audits, with a practice audit based on Dr Warton's work now available on the RANZCOG website (at www.ranzcog.edu.au/fellows/prcrmacactivities) or by contacting staff at College House. He admits that audits can be very time consuming, but if clinically directed and done accordingly, can be very straightforward. Plus, in addition to improving your practice you also have the opportunity to earn points in the PR&CRM category.

Revised Intrapartum Fetal Surveillance Clinical Guidelines

The revised RANZCOG Clinical Guidelines on Intrapartum Fetal Surveillance were approved at the July meeting of Council. This second edition (the first was published in December 2002) will soon be available both on the RANZCOG website and in hard-copy.

For more information, please contact the College:

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Fetal Surveillance Education Program

The Fetal Surveillance Education Program (FSEP) is a highly regarded CTG program run through the RANZCOG, with ongoing support from the Department of Human Services Victoria and the Victorian Managed Insurance Authority.

FSEP workshops comprehensively address the physiology of fetal heart rate control, the CTG, interpretation and management.

A one day workshop will be held at College House (RANZCOG) on **Friday 7 October 2005**.

All Obstetricians are invited to participate in this session, which will be the final workshop held at College House in 2005. FSEP workshops attract RANZCOG PR&CRM points.

Due to the program's success, further workshops will be held in 2006 on the following dates:

24 February 2006
23 June 2006
6 October 2006

Numbers are strictly limited. For more information or registration please contact

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