Actions following CTG categorisation

Assess fetal wellbeing every hour, taking into account antenatal and intrapartum risk factors, in conjunction with interpretation of the CTG trace (NICE, 2022).

Take the whole clinical picture into account when making decisions on how to manage the labour, including maternal observations, contraction frequency and labour progress (NICE, 2022).

Discuss with the woman or birthing person and their birth companion(s) what is happening, taking into account her individual circumstances and preferences, and support her decisions (NICE, 2022).

Classification	Plan
Normal	• Continue CTG (unless it was started because of concerns arising from intermittent auscultation and there are no ongoing antenatal or intrapartum risk factors) and usual care. • Continue to perform a holistic review and Peer review at least hourly and document the findings.
Suspicious and no other concerning risk factors	• Perform a full risk assessment, including a full set of maternal observations, taking into account the whole clinical picture, and document the findings. • Note that if accelerations are present then fetal acidosis is unlikely. If the CTG trace was previously normal, consider possible underlying reasons for the change. • Undertake conservative measures as indicated (see the section on underlying causes and conservative measures).
Suspicious and additional intrapartum risk factors such as slow progress, sepsis or meconium	• Perform a full risk assessment, including a full set of maternal observations, taking into account the whole clinical picture, and document the findings. • Consider possible underlying causes, and undertake conservative measures as indicated (see section 8.2.2). • Obtain an urgent review by an obstetrician or a senior midwife. • Consider fetal scalp stimulation (see the section on fetal scalp stimulation) or expediting birth.
Pathological	• Obtain an urgent review by an obstetrician and a senior midwife. • Exclude acute events (for example, cord prolapse, suspected placental abruption or suspected uterine rupture) that need immediate intervention. • Perform a full risk assessment, including a full set of maternal observations, taking into account the whole clinical picture, and document the findings. • Consider possible underlying causes and undertake conservative measures as indicated (see section 8.2.2).
Pathological after implementing conservative measures	• Obtain a further urgent review by an obstetrician and a senior midwife. • Evaluate the whole clinical picture and consider expediting birth • if there are evolving intrapartum risk factors for fetal compromise, have a very low threshold for expediting birth.

Acute bradycardia, or a single prolonged deceleration for 3 minutes or more	• Urgently seek obstetric review. • If there has been an acute event (for example, cord prolapse, suspected placental abruption or suspected uterine rupture), expedite the birth. • Consider possible underlying causes and undertake conservative measures as indicated (see section 8.2.2). • Make preparations for an urgent birth, including a request for paediatric or neonatal support. • Expedite the birth if the acute bradycardia persists for 9 minutes, or less if there are significant antenatal or intrapartum risk factors for fetal compromise. • If the fetal heart rate recovers at any time up to 9 minutes, reassess any decision to expedite the birth, but take into account other antenatal and intrapartum risk factors and discuss this with the woman or birthing person.

Table 1: Recommended actions following CTG categorisation (NICE, 2022)

If a decision is made to expedite birth, ensure the time at which urgent review was sought, and the time the decision was made, are documented (NICE, 2022).