

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

The New Zealand College of Midwives provides and promotes quality standards for New Zealand midwives. Their role is a midwifery voice for midwives and women.

1. Fetal monitoring in labour: Don't automatically initiate continuous electronic fetal heart rate monitoring during labour for women without risk factors: undertake intermittent auscultation (IA) first.

Continuous electronic FHR monitoring for healthy women during labour, is a routine procedure in many hospitals, yet is associated with an increase in caesarean and instrumental births without improving Apgar score, NICU admission or intrapartum fetal death rates. IA allows women more freedom of movement during labour, enhancing their ability to cope with labour pain and utilize gravity to promote labour progress. Upright positions and walking have been associated with shorter duration of first stage labour, fewer caesareans and reduced epidural use.

The routine use of CTG for intrapartum fetal surveillance has become entrenched in practice without robust randomised controlled trial (RCT) evidence to support it. The RCTs of continuous CTG which have been undertaken have identified that its use is not associated with statistically significant improvements in long-term neonatal outcomes such as cerebral palsy, but that it is associated with significantly increased rates of (unnecessary) operative delivery.

CTG is the visual interpretation of continuously generated signals from the fetal heart and is subject to shortcomings in interpretation. Review of cases with poor outcomes repeatedly demonstrate that abnormal CTGs were misinterpreted and the resulting management inappropriate. Admission CTG increases the rate of continuous electronic fetal monitoring use, may increase the rate of caesarean section but may identify a small number of previously unidentified at-risk fetuses.

Women should receive one to one continuous midwifery support during intrapartum care. Cardiotocography should not be used as a substitute for adequate intrapartum midwifery care. Intermittent auscultation is an appropriate method of intrapartum fetal monitoring in women without recognised risk factors.

Regardless of the method of intrapartum monitoring, it is essential that an accurate record of fetal wellbeing is obtained. Fetal and maternal heart rates should be differentiated whatever the mode of monitoring used.

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2. Early pregnancy ultrasound for dating: Don't offer women with uncomplicated pregnancies a routine early first trimester ultrasound for dating purposes alone.

Accurate knowledge of gestational age is valuable for pregnancy care. Pregnancies can be dated based on LMP or ultrasound, with numerous research papers demonstrating that ultrasound is superior. First trimester gestational ultrasound prediction is more accurate than second trimester prediction, but the difference is small. However, a late first trimester scan can give reliable dating information while providing a more detailed fetal assessment.

A routine early first trimester scan is not justified if pregnancy dating is the sole reason for the scan, other clinical indications are

required to justify its use. Nearly 80% of all New Zealand women have a nuchal translucency scan (between 11 weeks and 13+6 gestation as part of the first trimester fetal anomaly screening process). This scan can be used for dating purposes if LMP is uncertain. If women choose not to have fetal anomaly screening, a late first trimester ultrasound may be clinically useful to determine chronicity in twin pregnancies and to exclude major fetal abnormality.

Routine ultrasound use before 24 weeks improves detection of undiagnosed twins, reduces postdates inductions, and allows detection of fetal anomalies before birth. If a woman declines all pregnancy ultrasounds, estimation of gestational age is calculated by LMP and clinical assessments.

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3. **Ultrasound for large babies: Unless the mother has diabetes, in the absence of other clinical concerns ultrasound scans should not be routinely offered to check if a baby is bigger than normal for its gestational age.**

The term fetal macrosomia implies fetal growth beyond a specific weight, regardless of the fetal gestational age. Results from large cohort studies support the use of 4,500g as the weight at which a fetus should be considered macrosomic. Large for Gestational Age (LGA) is defined as birth weight above the 90th percentile for population and sex-specific growth curves. There has been a rise in the prevalence of LGA babies over the past few decades in many countries. As birth weight increases, the likelihood of labour abnormalities, shoulder dystocia, birth trauma, and permanent injury to the neonate increases. However, the diagnosis of fetal macrosomia is imprecise. For suspected fetal macrosomia, the accuracy of estimated fetal weight using ultrasound biometry is no better than that obtained with clinical palpation.

Ultrasonography significantly overestimates the prevalence of LGA in women with gestational diabetes mellitus, and an ultrasound diagnosis of LGA is associated with an increased risk for caesarean delivery independent of birth weight. Caesarean section is associated with increased morbidity for women, and risk of stillbirth in subsequent pregnancy.

It can be difficult to estimate fetal growth in women with a raised BMI using abdominal palpation alone. In the presence of clinical concerns or factors (such as raised BMI) practitioners decision making regarding ultrasound use to assess fetal growth should be individualised based on clinical assessments.

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4. Timing of umbilical cord clamping: In term and pre-term infants who do not require resuscitation at birth, delay umbilical cord clamping for at least 3 minutes or until the cord has stopped pulsating (whichever is longer).

Delayed cord clamping increases neonatal haemoglobin levels at birth and improves iron stores in the first several months of life, which may have a favourable effect on developmental outcomes. Delayed umbilical cord clamping is associated with significant neonatal benefits in preterm infants, including improved transitional circulation, better establishment of red blood cell volume, decreased need for blood transfusion, and lower incidence of necrotizing enterocolitis and intraventricular haemorrhage. There is a small increase in the incidence of jaundice that requires phototherapy in term infants undergoing delayed umbilical cord clamping but the benefits of delayed clamping outweigh this risk. Delayed umbilical cord clamping does not increase the risk of postpartum haemorrhage.

The third stage of labour may be completed by either physiological means or active management. If active management or uterotonic drugs are being used, the optimal timing for administration of the uterotonic is currently unknown and the effect of the administration of a uterotonic on neonatal health when given in relation to clamping of the cord is unknown. Until further evidence to support practice is collated, it is advised that the uterotonic drug of choice be administered after the cord has been clamped and cut if possible.

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How was this list created?

The New Zealand College of Midwives represents approximately 90% of the practising midwifery workforce in New Zealand. There are ten regional committees, and five sub committees in the smaller provincial centres. Consultation with members is imperative for consensus and position statements. The Choosing Wisely work was discussed on a national basis with committees and members to inform the finished statements.