

Document Code:	DPOTMH-NSD-DR-SOP008
Revision Number:	0
Effective Date:	10-30-2020
Document Type:	Standard Operating Procedure
Page Number:	1
Department/Section:	Delivery Room
Document Title:	FETAL HEART RATE ASSESSMENT

PURPOSE:

To assess the fetal heart rate of the baby.

OBJECTIVE:

To standardize the process of assessing fetal heart rate

RESPONSIBLE PERSON:

Attending Physician, OB Gyne resident, Registered Nurse, Registered Midwife

GENERAL GUIDELINES:

- 1. Monitoring fetal well-being of the baby in the form of fetal heart rate assessment should be an essential part of the care during labor.
- 2. Universal precaution and hand washing before and after the procedure should be applied.
- FHR should be checked every hour while the patient is in the labor room unless otherwise ordered and should be referred immediately to Resident on duty when abnormal rate and rhythm is detected
- 4. FHR should be checked immediately after rupture of membranes
- 5. FHR should be checked upon patient's arrival at the triage unit (for 12 weeks AOG and above)

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APPROVAL:

	Name/Title	Signature	Date
Prepared by:	MAANE GERALDINE U. SUN, RN Delivery Room Staff Nurse	July	10-20-2020
Verified:	MA. CARMELA O. HECHANOVA, RN Delivery Room Head Nurse	Nu	10 - 20 - 20W
Reviewed:	GEORGE ANTHONY S. ANG, RN Accreditation Standard Internal Auditor for Patient Care	1/48	10/20/2020
	DENNIS C. ESCALONA, MN, FPSQua Quality Assurance Supervisor	Va	10/20/2020
Recommending Approval:	MA. ANTONIA S. GENSOLI, MD, FPPS Medical Director	marginiel	10-21-20n
	HENRY F. ALAVAREN, MD, FPSMID Total Quality Division Officer	A Munes	10/25/2020
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO	#	12/20/2020

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EQUIPMENT NEEDED:

- 1. Doppler
- 2. Lubricating Jelly

PROCEDURE:

- 1. Nurse on duty places the pregnant woman comfortably in bed in a supine position.
- 2. Nurse on duty provides privacy and maintains good lighting and should explain procedure to the patient.
- 3. Nurse on duty does hand washing before performing the procedure.
- 4. Nurse on duty does Leopold's maneuver and finds the fetal back.
- 5. Nurse on duty counts the fetal heart rate in one full minute when using fetoscope or doppler and notes for irregularities in the rate and rhythm:

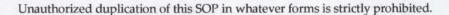
Tachycardia – heart rate above 160/minute

Bradycardia – unusually slow heart rate below 110 bpm

- 6. Nurse on duty informs the Resident on duty of the result.
- 7. Nurse on duty does after care and hand washing should be done after the procedure.
- 8. Document the rate and rhythm correctly and properly.

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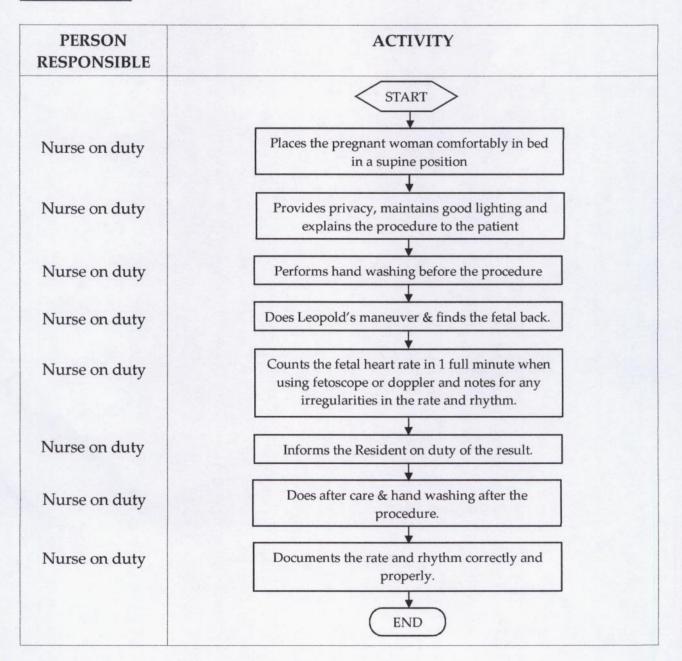






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FLOWCHART:



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