



Aneurin Bevan University Health Board

Integrated Care Pathway

ABUHB Pathway for stillbirths, Intra Uterine Deaths (IUD's), Late Miscarriage over 20 weeks

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1. ICP Definition

This ICP is intended as a guide in providing care for the service user and their family. It is a multidisciplinary document.

2. Evidence Based

Royal College of Obstetricians and Gynaecologists (2010)
Late Intrauterine Fetal Death and Stillbirth Green Top Guidelines No 55

SANDS Stillbirth and Neonatal Death Charity (2007)
Pregnancy Loss and Death of a baby Guidelines for professionals

The use of Mifepristone and Misoprostol in the management of late intrauterine fetal death. Nzewi C, Araklitis G, Narvekar N. Journal of Obstetrics and Gynaecology 2014; 16(4):233-237

3. Objective of the ICP

To provide standard evidence-based guideline for patients following diagnosis of a stillbirth / IUD over 24 weeks, late miscarriage over 20 weeks.

To ensure appropriate bereavement care is delivered.

4. Criteria for Use – Eligibility Criteria

All women following diagnosis of a stillbirth, IUD >24 weeks and late miscarriage.

5. Instructions for Use

When using this document please ensure that you date, time and initial against each activity where indicated. If an activity in the ICP has not, for whatever reason been completed, then this must be documented in the case notes.

6. Signature Key Box

NAME	SIGNATURE	DESIGNATION	INITIALS

7. Demographics

Patient Addressograph	Consultant		
	Gravida		
	Parity		
	EDD		
	Obstetric History		
	Medical History		
Tel Number	First Language Spoken		
Mobile Number	Interpreter/signer required (Contact Switchboard)	Y	N
Next of Kin Name	Faith		
Address	Community Midwife		
	GP		
Post Code	GP Address GP Tel Number		
Tel Number	GP Tel Number		

8. Diagnosis of Still Birth/IUD, Late Miscarriage

Event	Date	Time	Signature
Death confirmed by real time USS and second observer (see Appendix 1)			
Patient informed of findings			
Family / support contacted			
Plan of care discussed and documented in notes			
Obtain Bloods – (discuss with Obstetrician as may not all be necessary) (see Appendix 2)			
FBC/HBA1C	Purple/EDTA x1		
Group and Save	Pink x 1		
U+E's LFT, CRP, TFT, Bile Acids	Yellow x 1		
Kleihaur for all mothers to rule out Feto-Maternal Haemorrhage	Pink x1		
Clotting Screen	Blue x1		
Parvo virus, Toxoplasma, Rubella, CMV, Varicella zoster virus (VZV) and syphilis	Yellow x1		
Random Glucose	Grey x 1		
Commence MEOWS Chart			
Thromboprophylaxis Risk Assessment			
Drugs Prescribed in line with plan of care on in-patient medication chart (See Appendix 3)			

Event	Date	Time	Signature
If >20 weeks Mifepristone 200mgs ORALLY see (Appendix 1)			
Patient to remain in the clinical area 1-2 hours in case of vomiting. Monitor BP every 30 minutes and record on the MEOWS chart.			
Home if requests and return in 48 hours			
Retain the All Wales Maternity Hand Held Records			
Provide delivery suite telephone number & SANDS leaflet: <i>'When a baby dies before labour begins'</i>			

9. Induction and Intrapartum

Event	Date	Time	Signature
Explain Plan of Care/facilitate questions			
Review by Obstetric Team documented in the notes			
Anaesthetist informed of admission (and review patient if appropriate to discuss options)			
Drugs prescribed in line with plan of care (see Appendix 3)			
Cannulate and commence PVC Bundle (ABUHB/Clinical 0603 Peripheral Intravenous Cannulation Policy)			
Continue MEOWS chart and observations			
Confirm patient's wishes regarding seeing baby following delivery.			
Commence a partogram when in established labour			
Discuss post-mortem, examination and answer any questions			
Monitor and document PV loss			
Thromboprophylaxis risk assessment			

10. Post Delivery

Event				Date	Time	Signature
Complete examination of the baby						
Date of Birth						
Time						
Any Signs of Life?		Y	N			
Time of Death						
Sex (tick)	Male	Female	Indeterminate			
Gestation _____ /40						
Birth Weight _____ kg						
Head Circumference _____ cm						
Length _____ cm						
Abnormalities						

Memory making

Given opportunity to see and hold the baby	Y	N
Photographs offered either on their own phone or on our camera	Y	N
If photographs taken by staff give the SD card to parents.	Y	N
Lock of Hair (if possible)	Y	N
Baby bath offered or top and tail if appropriate	Y	N
Hand and Footprints offered and taken	Y	N
Clay impression kit offered (can be used after 24 weeks)	Y	N
Memory Box	Y	N
Offer support/blessing from chaplaincy departemtn or relevant faith leader		
Inform of Local Groups SANDS / BERESFORD Email: cardiffsands@hotmail.co.uk www.beresfordcentre.org.uk	Y	N
Cuddle Cot utilised (instructions in information folder)	Y	N
Given opportunity to take the baby home	Y	N
Inform them that, when they are ready, the baby will be taken to the mortuary and collected from there by the funeral directors or hospital transport to UHW	Y	N

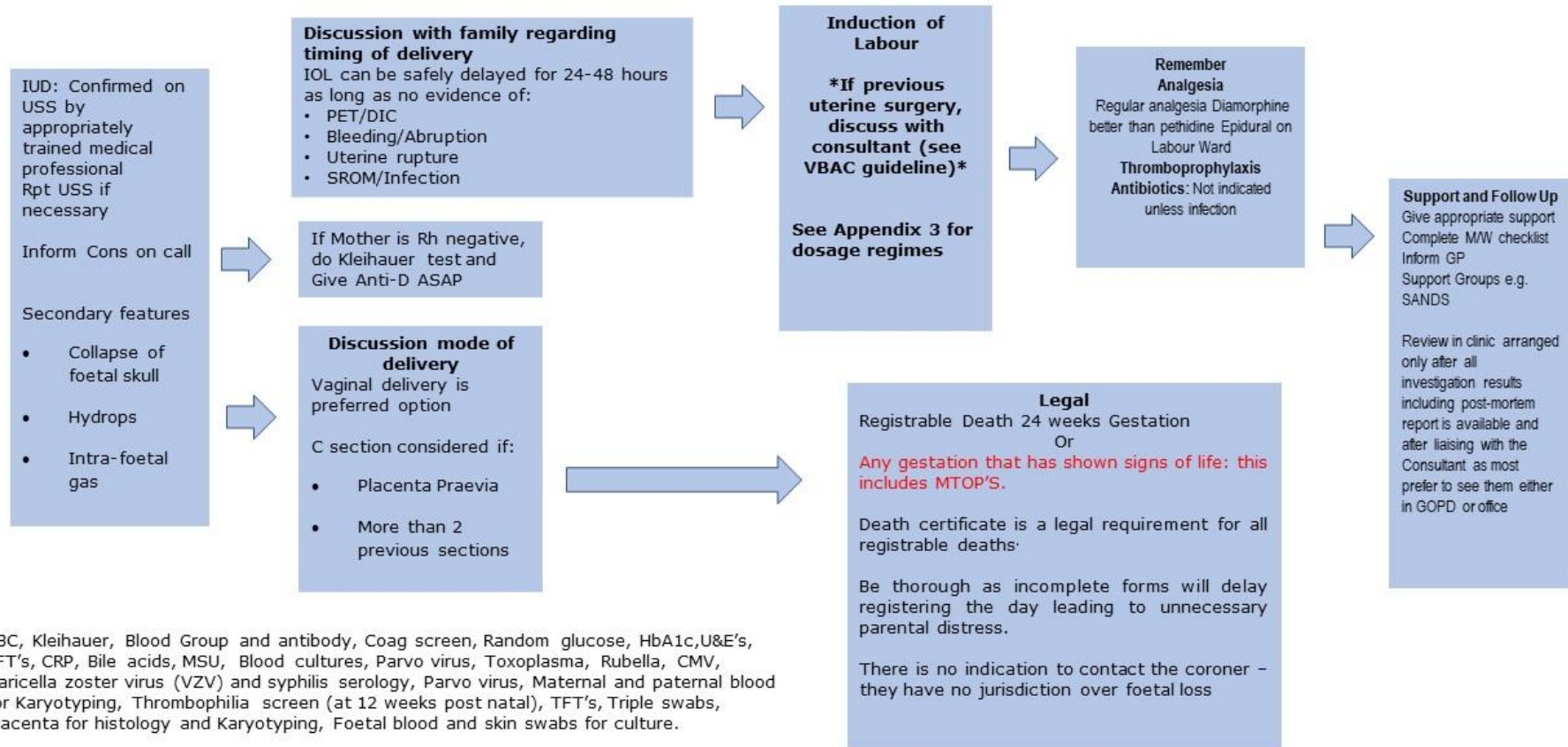
11. Postnatal Documentation

	Date	Time	Signature				
Complete CSC for all deliveries							
Take Kleihauer if Rh Neg							
Administer Anti D if applicable							
Encourage families to arrange own funeral							
NAME AND NUMBER OF FUNERAL DIRECTOR CHOSEN BY FAMILY							
STILLBIRTH CERTIFICATE OR MEDICAL CERTIFICATE (if signs of life) (Appendix 4)							
<u>Placenta</u> – if not for PM, send the placenta in formalin for histology.							
Post-mortem / Cytogenetics see (Appendix 5)							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">Cremation</td> <td style="width: 25%;"></td> <td style="width: 25%; text-align: center;">Burial</td> <td style="width: 25%;"></td> </tr> </table>	Cremation		Burial				
Cremation		Burial					
Complete YELLOW cremation form for under 24 weeks Complete GREEN cremation form for over 24 weeks							
Stillbirth Certificate Issued > 24 WEEKS							
Certificate of birth (in file) for under 24 weeks							
Complete appropriate documentation for any babies born with signs of life (see flow chart)							

12. Discharge

Event	Date	Time	Signature
Complete a Datix for ALL IUD'S. Only complete a Datix for an MTOP if there was an issue with the care or other trigger			
Request discharge medication if appropriate			
Medication explained to mother			
Discuss pv loss, expected duration, volume, action to take			
Ask Mother if she would like a visit from the community Midwife	Y	N	
Inform mother that community midwife will be in contact within 24hrs			
Discuss and Advise re breast Discomfort/lactation			
Advise if any concerns in the interim to contact hospital and provide telephone numbers			
Discharge with All Wales Postnatal Notes for Mother			
Inform GP / HV (via Phone) IS THIS DONE BY THE CMW OR THE CLERKS?			
Formal CSC Letter to GP			
Inform Community Midwife (Via Phone)			
Give information regarding support organisations – refer to healthier together website 'coping with loss' page https://abbhealthiertogether.cymru.nhs.uk/pregnant-women/coping-loss			
Explain how OPD will be arranged (following PM report or around 12 weeks) <i>i.e. re PM results, postnatal examination, Family Planning/ Genetic Counselling if appropriate</i>			
Ask ward clerk to cancel all antenatal follow up appointments			
Complete Bounty Form – available online Registration (dma.org.uk) https://secure.dma.org.uk/bmcsr/			
CARIS form completed if abnormality			
Put notes in drawer for Bereavement midwife or Sharon Deacon			

Appendix 1 - Process Flowchart



FBC, Kleihauer, Blood Group and antibody, Coag screen, Random glucose, HbA1c, U&E's, LFT's, CRP, Bile acids, MSU, Blood cultures, Parvo virus, Toxoplasma, Rubella, CMV, Varicella zoster virus (VZV) and syphilis serology, Parvo virus, Maternal and paternal blood for Karyotyping, Thrombophilia screen (at 12 weeks post natal), TFT's, Triple swabs, Placenta for histology and Karyotyping, Foetal blood and skin swabs for culture.


Inform patient of the reason for these tests and implications of the potential findings

²Informed consent should only be obtained by a trained and registered clinician

³Don't forget - date and sign, no abbreviations, do not guess at cause of death (difficult to change at a later date), write clearly, write GMC number and qualifications.

Appendix 2 - Blood Investigations for stillbirths, Intra Uterine Deaths (IUD's), Late Miscarriage over 20 weeks

With the patient and her partner discuss the reason for the blood investigations, the implications of the potential findings and obtain informed consent.




Obtain bloods for:

Please use the Hyperlink to blood request form


<http://howis.wales.nhs.uk/sitesplus/866/page/40107>

- FBC/HBA1C
- Blood Group and antibodies
- U+E's LFT, CRP, TFT, Bile Acids
- Kleihauer for Rhesus negative mothers
- Coagulation Screen
- Parvo virus, Toxoplasma, Rubella, CMV, Varicella zoster virus (VZV) and syphilis.
- Random Glucose
- Blood cultures
- Other investigations for infection as clinically relevant (eg. maternal illness in pregnancy, contact with chickenpox in non-immune patient visible abnormality of fetus/placenta at delivery – specify type of abnormality on request form).

(Discuss with Obstetrician as not all bloods maybe necessary)



The lead consultant obstetrician and antenatal screening co-ordinator will be informed of positive syphilis results which are confirmed by reference Laboratory to facilitate appropriate follow up and treatment if required.



If any other additional tests are performed by the Laboratory Services and abnormalities are identified, the Laboratory Services will inform the lead consultant obstetrician as per Laboratory Standard Operating Procedure.

Appendix 3 - Drugs Prescribed in-line with plan of care

20 - 24 weeks Gestation

- 1) **Mifepristone 200mcg po**
- 2) **36-48 hours later Misoprostol 100mcg p.v. 6 hourly to maximum of 5 doses**

If previous Caesarean Section or uterine scar then dose of Misoprostol can be halved.

Once the baby has been delivered wait a minimum of 4 hours after last dose of Misoprostol before surgical removal of placenta is considered (unless bleeding or infection)

Over 24 weeks Gestation

Induction of Labour

If previous uterine surgery, discuss with consultant (see VBAC guideline)

Standard Regimen

- 1) **200mcg Mifepristone orally**
- 2) **36-48 hours later return for misoprostol regime in line with gestation**

24-27 weeks: 100mcg Misoprostol 4 hourly p.v. (4 doses max)

>27 weeks: 50mcg 6 hourly pv (5 doses max)

Total misoprostol dose not to exceed 1000 microgram for gestation 24-27 weeks, and not to exceed 500 microgram for gestation >28 weeks (i.e. maximum of 2 full courses)

Retained placenta Complete full course of misoprostol as prescribed, unless significant bleeding

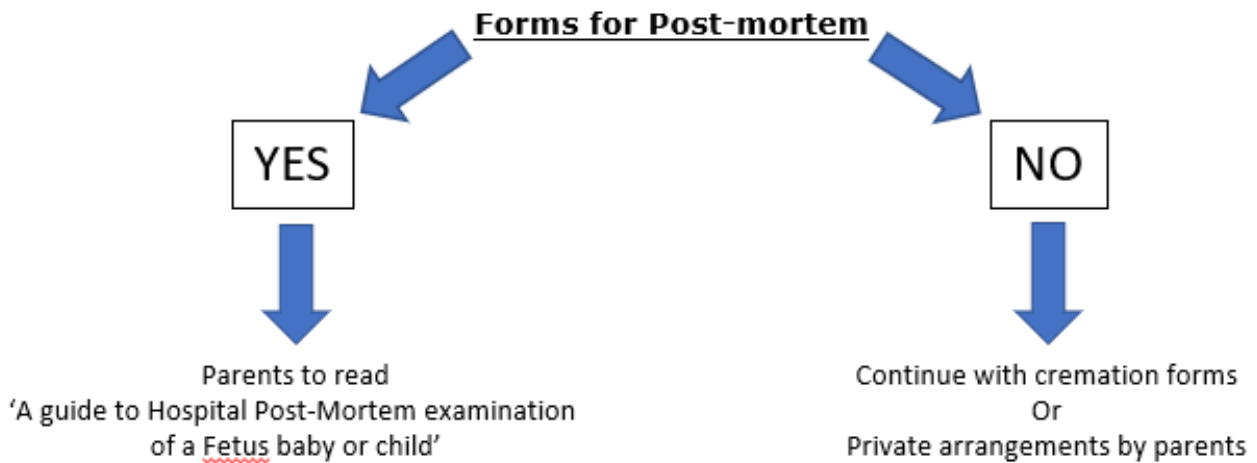
Prev LSCS: Mifepristone 200mcg tds for 2 days, then misoprostol 25 mcg PV 4th hourly maximum 5 doses

In event of infection or patient too distressed to wait, Misoprostol can be given after the first dose of Mifepristone

Vaginal route helps to reduce the side effects and should be the first choice.

In the event of bleeding sublingual or oral tablets can be given.

Appendix 4 - Post-mortem or Tissue sampling for Cytogenetics



Forms required

1) Request for Fetal perinatal Or infant PM examination

2) Fetal Pathology Unit Tissue Transfer Chain of Custody form

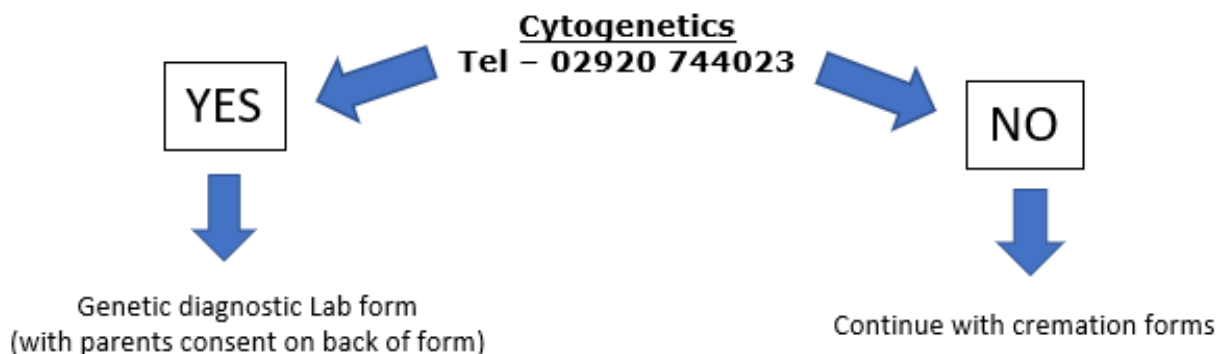
3) Consent for PM

4) Any copies of scans or blood reports if high risk

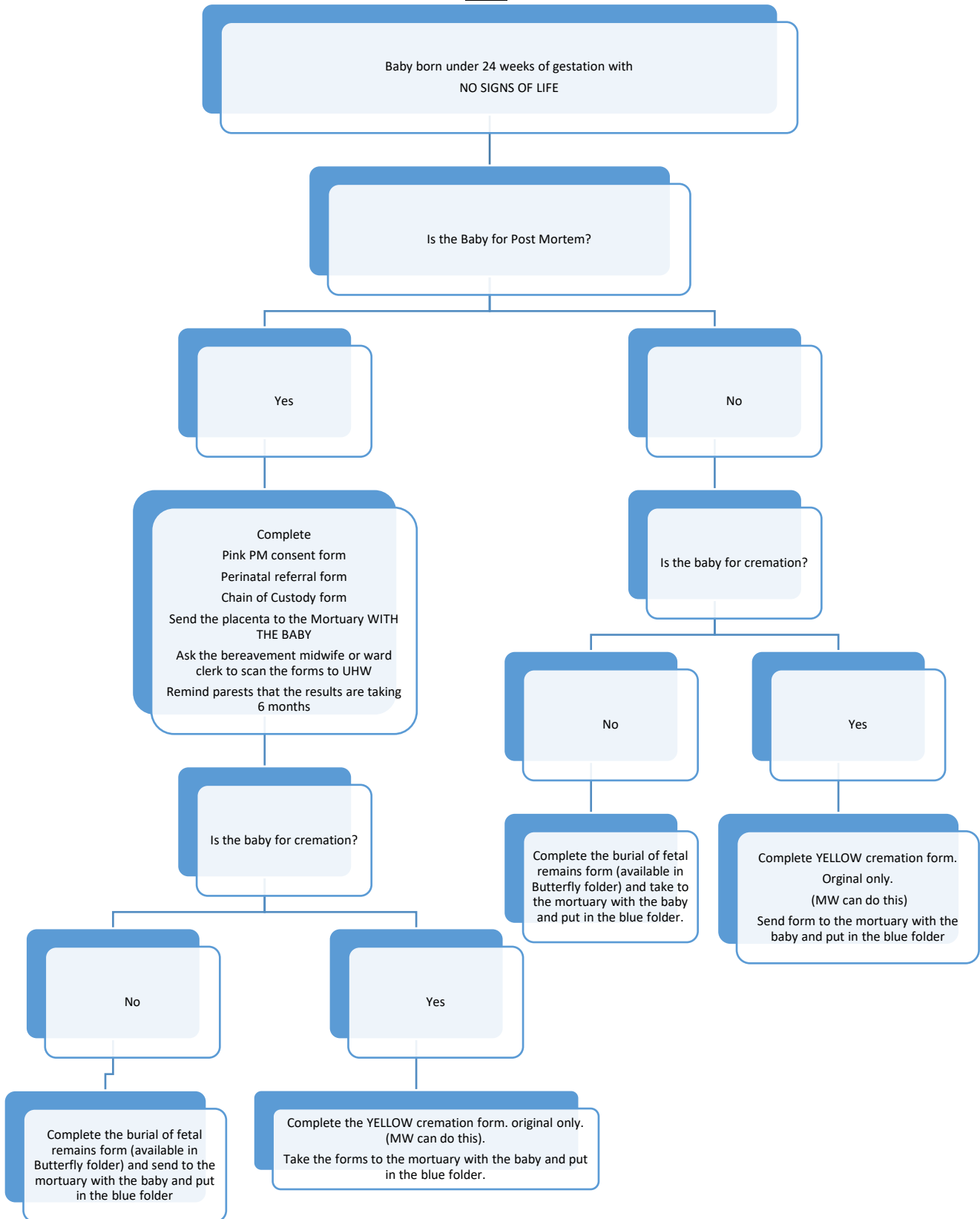
<24 weeks contact Fetal Pathology at UHW on 02920 744025

>24 weeks contact mortuary at UHW on 02920 744269

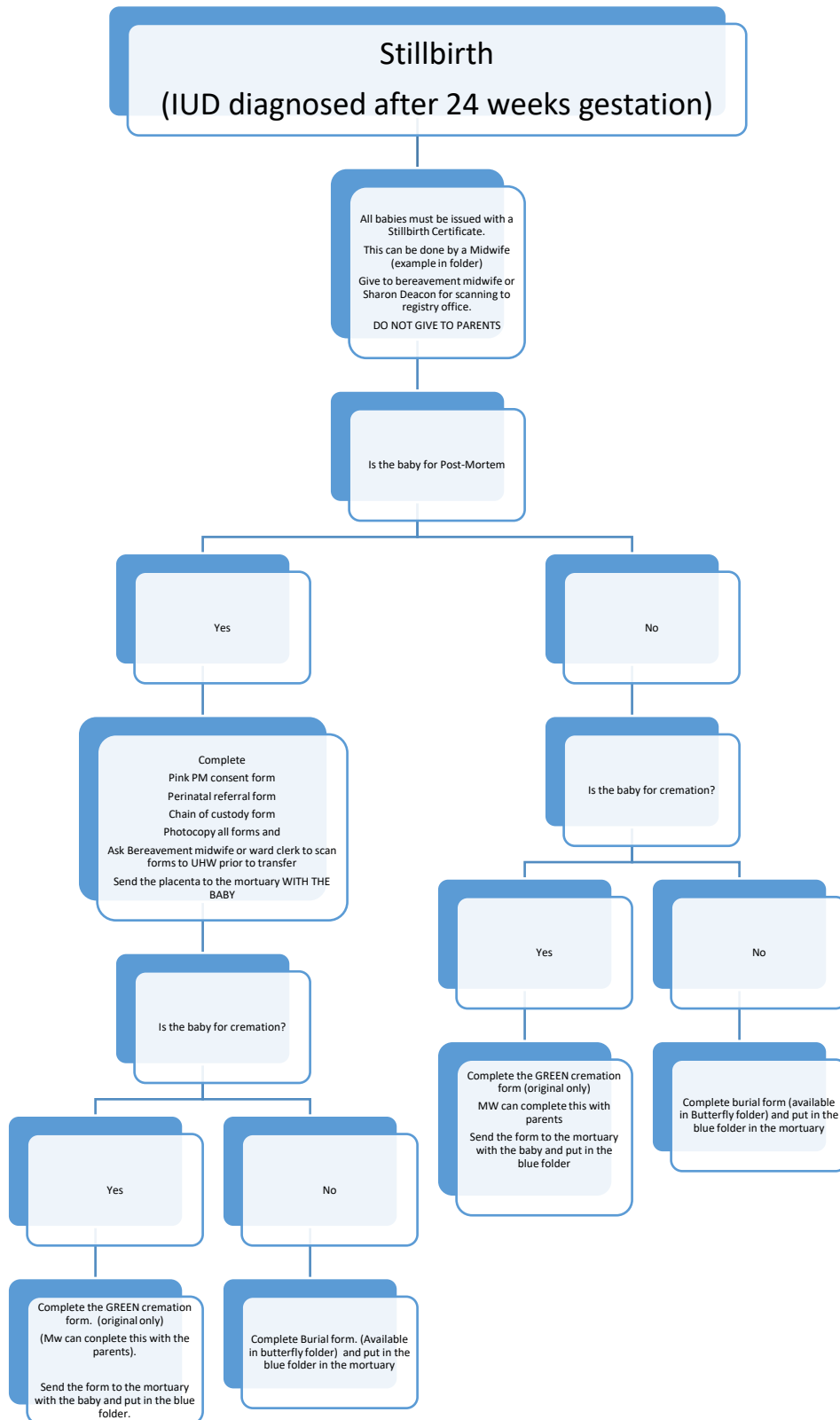
If PM placenta (in Saline) to accompany baby.



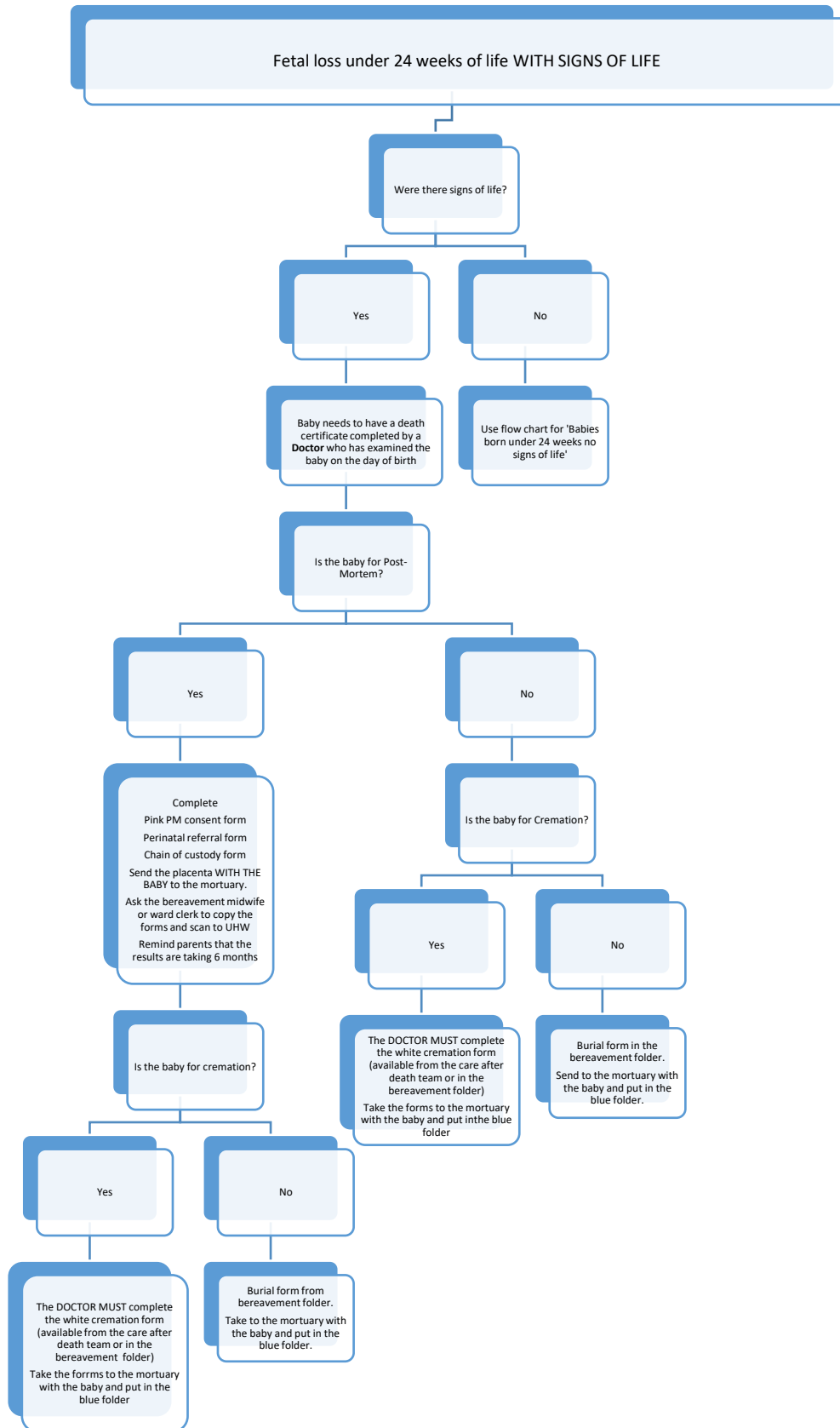
Appendix 5 Flow chart for babies under 24 weeks born with no signs of life



Appendix 6 Flow chart for babies born over 24 weeks with no signs of life



Appendix 7 Flow chart for babies born with signs of life



Appendix 8 - Thromboprophylaxis Risk Assessment for Pregnant Women

Patient addressograph	 Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	COMPLETE AND FILE IN PATIENT'S NOTES PRESCRIBE PROPHYLAXIS ON DRUG CHART
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THROMBOPROPHYLAXIS RISK ASSESSMENT FOR PREGNANT WOMEN

Assess all Women at their first Hospital visit and at each antenatal admission

Indications for outpatient antenatal thromboprophylaxis (continue through any inpatient admission)

Tick if no risk factors identified Date/...../..... Signature

	Tick if Present		Tick if Present
Previous DVT/PE Refer to joint Haem Clinic		Antithrombin deficiency Refer to joint Haem Clinic	
Systemic Lupus Erythematosus Refer to joint Haem Clinic		Sickle cell disease Refer to joint Haem Clinic	
Anthiphospholipid Syndrome Refer to joint Haem Clinic		Myeloproliferative disorder Refer to joint Haem Clinic	
BMI > 46 kg/m² Consider AN thromboprophylaxis and refer to anaesthetic clinic at 32/40		Assessed by	Date

Consider postnatal thromboprophylaxis for 6 weeks if there is a strong family history of venous thromboembolism, particularly related to pregnancy

Indications for thromboprophylaxis whilst antenatal inpatient
 (IF one criteria is ticked - Patient requires thromboprophylaxis)

Date				
Indication	Tick if present	Tick if present	Tick if present	Tick if present
Hyperemesis				
BMI ≥35				
Dehydration haematocrit >45				
Sepsis				
Immobility - >3 days bed rest				
Acute/Chronic disease -Rh Arthritis				
Nephrotic syndrome				
Varicose veins with phlebitis				
Active cancer/cancer treatment				
Ongoing antenatal thromboprophylaxis				
Signature				

Booking Weight	Dose of Dalteparin
< 50 Kg	2500 units once daily
50 - 100 Kg	5000 units once daily
>100 Kg (BMI >40)	7500 units once daily

Contraindications to pharmacological thromboprophylaxis?	
Birth anticipated within 12 hrs	Spinal or epidural anaesthesia is to be performed within 12 hrs of administration
Platelet count < 70 x 10 ⁹ /l	Epidural Catheter has been removed within 4 hrs
Active bleeding	DIC
Already having therapeutic anticoagulation	Sever Liver disease
Renal Impairment - if e GFR <30 min l/min or evidence of acute renal failure please use unfractionated heparin 5000 u bd	Previous heparin induced thrombocytopenia (discuss with haematologist)
Consider TED stockings if LMWH is contraindicated	
Avoid stockings if pedal pulses are impalpable, peripheral vascular disease, sever dermatitis, peripheral neuropathy, recent skin graft	

Postnatal Thromboprophylaxis

Indications for 10 days of thromboprophylaxis following birth	Tick if present
PPH > 1500 mls	
Red cell transfusion or transfusion of coagulation factors (FFP)	
Caesarean section (elective or emergency)	
Stillbirth	
BMI > 40 Kg/m ²	
Sepsis	
Complex vaginal delivery	
Antenatal thromboprophylaxis for recurrent miscarriage in absence of personal history of VTE	
SIGNED	

If any indication ticked, then please prescribe Dalteparin on the drug chart and TTH

Indications for 6 weeks of thromboprophylaxis following birth	Tick if present
Previous antenatal thromboprophylaxis for VTE prevention	
Family history of VTE particularly pregnancy or hormone related VTE	
All inherited thrombophilia's - including Factor V Leiden, Protein C and S deficiency, Antithrombin deficiency	
SIGNED	

If any indication ticked then please prescribe Dalteparin on the drug chart and TTH

Booking Weight	Dose of Dalteparin
< 50 Kg	2500 units once daily
50 – 90 Kg	5000 units once daily
91 – 130 Kg	7500 units once daily
> 130 Kg	10,000 units once daily

Delay starting Dalteparin:

- Until 12 hrs post epidural catheter withdrawal
- If DIC present
- If there is a need for spiral anaesthesia

Encourage early mobilisation, hydration and awareness of symptoms of VTE in all women

Appendix 9 Intrauterine death/late miscarriage/stillbirth Request Form



Dated: / /20

Dear:

Re: Understanding what happened – Hospital review

We are sorry that your baby has died. We understand that this is a difficult time to be reading new information.

It is important to understand as much as we can about what happened and why your baby died. In order to do this, in the coming weeks a multi-disciplinary team at Aneurin Bevan University Health Board will hold a meeting and review your and your baby's care.

The review will:

- look at medical records, tests and results, including post mortem results if you have consented to one
- answer any questions you may have and address any concerns
- talk to staff involved
- look at guidance and policies to ensure the care you received was appropriate

The review may tell us that we need to change the way we do things or that good and appropriate care was given to your family.

Involving you

Your views are important, and it would be helpful if you could share your feelings and thoughts about your care, or any questions you have with us before we carry out the review. To support you in doing this, we have provided you with a key contacts available Monday to Friday 08:00am to 16:00hrs

Senior Midwifery Manager Sian Bailey Email sian.bailey@wales.nhs.uk	Bereavement Midwives Email: abb_bereavementmidwives@wales.nhs.uk
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Your key contact will:

- call you to talk to you about the review process
- ask if you would like to ask any questions or give your perspective of your care to the review team
- give you choices about how you might do this

Keeping you informed

It may take up to 6 months to gather all the information required for a review meeting especially if you have had a post mortem.

We understand that this is a long time to wait and if you would like to meet with a consultant before the review takes place, you can arrange this through your key contact.

We may, however, not have any further information about what happened and why your baby died by then.

Once the review report is completed, a consultant will discuss its findings with you. We can also send you the review report by post or email if you prefer.

If you have any questions about this information, please ask a member of staff before you leave hospital. Once you are home one of our bereavement midwives will be in touch with you within 10 days.

With sympathy

Aneurin Bevan University Health Board

Maternity Team

