Extreme Preterm Pathway (document 2)

Perinatal Management & Parental Discussion Proforma

(see supporting information before completing this proforma)

Date:	**Time:**
Previous counselling: yes / no	

Mother's name:	**Gestational age today:** _____ weeks __ days
Hospital number:	**Based on LMP / ultrasound at:** _____ weeks
NHS number:	**Single / Multiple pregnancy**

Maternal History:

Maternal past medical history:	
Maternal drug history:	
Antenatal scans:	

Sex *(if known):* Male / Female

Estimated weight / centile:

Additional risk factors to consider	
Restricted growth:	Yes / No
Prolonged pre-labour rupture of membranes:	Yes / No
Clinical evidence of chorioamnionitis:	Yes / No
Antenatal steroids:	complete course / incomplete course / none
Setting for birth:	Hospital with NICU / transfer pending / local hospital

Decision making around management of delivery, following risk assessment and consultation with parents

Extremely High Risk	22+0 to 22+6 with unfavourable risk factors Some 23+0 to 23+6 with unfavourable risk factors Rarely babies >24 weeks (severe FGR, PPROM)	**PALLIATIVE CARE***	
High Risk	22 + 0 to 23+6 weeks with favourable risk factors	***Informed by parental wishes –*** **PALLIATIVE CARE***	
High Risk	22 + 0 to 23+6 weeks with favourable risk factors	***Informed by parental wishes –*** **ACTIVE CARE**	
Moderate risk	Most babies > 24 weeks Some babies 23+0 to 23+6 with favourable risk features	**ACTIVE CARE**	

- ** Palliative care – see appropriate guideline for advice*

Documentation of Parental wishes

Obstetric care:	
Neonatal care:	

Obstetric counselling:

Antenatal steroids:	
Tocolysis:	
Magnesium sulphate:	
Transfer to centre co-located with NICU:	
Mode of delivery:	

Other discussion:	

Obstetric counselling led by: *(sign, print, designation, GMC)* _____

Date: _____ **Time:** _____

Neonatal counselling: *Highlight salient points of discussion*

(resuscitation / stabilisation; respiratory; neurological; gastrointestinal / feeding; metabolic; infection; outcome and prognosis)

Neonatal counselling led by: *(sign, print, designation, GMC*) _____

Discussion with tertiary referral unit *(if appropriate):*

Who:	
Accept referral:	Yes / No
Recommendations:	

Further episode of discussion with mother and partner:

Date / time:	
Mothers name:	
Birth partner / family members present:	
Clinical team present:	
Summary of further discussions:	
Conclusions and management plan:	

Signature: _____

Name / GMC: _____

Further episode of discussion with mother and partner:

Date / time:	
Mothers name:	
Birth partner / family members present:	
Clinical team present:	
Summary of further discussions:	
Conclusions and management plan:	

Signature: _____

Name / GMC: _____

Supporting information and guidance for completion of document.

Management of labour, birth and immediate neonatal period should reflect the wishes and values of the mother and her partner, informed and supported by consultation and in partnership with obstetric, midwifery and neonatal professionals.

Decision making for babies born before 27 weeks of gestation should not be based on gestational age alone, but on assessment of the babies' prognosis taking into account multiple factors (page 1). Neonatal stabilisation may be considered for babies born from 22+0 weeks of gestation.

Risk assessment should be performed with the aim of stratifying the risk of outcome into 3 groups: extremely high risk, high risk and moderate risk. Examples of risk groups are given in the table.

Decisions should be made with input from obstetric and neonatal teams in the relevant tertiary centre (if possible), if transfer is being contemplated.

It is not appropriate to attempt to resuscitate babies born before 22+0 weeks of gestation.

If life sustaining treatment for the baby is anticipated, pregnancy and delivery should be managed with the aim of optimising the baby's condition at birth.

This proforma records the situation at a particular point in time in order to determine the best course of action for the mother and fetus/baby.

Decisions relate to that particular time-point and are not binding at a different time or place.

Subsequent decisions and plans should always be reviewed in the light of current clinical circumstances. Awareness of previous decisions about the same case may be useful and help further decision making. Plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change.

Antenatal assessments and judgements are not binding on the professionals attending the infant after delivery. The infant may be born in much poorer condition than expected, and it may be appropriate to reconsider the planned provision of active management and move to palliative care.

Not all aspects in this form need to be completed. It is advisable to complete the document after counselling the parents.

Reference:

1. BAPM Framework for Practice, October 2019
2. Mactier, Bates etal, BAPM Working Group. Perinatal management of extreme preterm birth before 27 weeks of gestation: a framework for practice. *Arch Dis Child Fetal Neonatal Ed* May 2020 Vol 105 No 3 F232-9.