Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Ref: CTMobs107

POLICY for THE MANAGEMENT LATE MISCARRIAGE (>13 weeks) STILLBIRTH and NEONATAL DEATH

Initiated By	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
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Version	Date	Author Job Title	Reasoning
1	Sept 22	Myscha-Dene Bates Bereavement specialist midwife	New CTMU HB Guideline (replaces previous CT UHB and ABMU HB guidance)

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Author	Myscha-Dene Bates	Ratification Date	September 2022
Job Title	Bereavement Specialist Midwife	Review Date	September 2025

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1. INTRODUCTION

Cwm Taf Morgannwg University Health Board is committed to ensuring that pregnancy remains are treated with respect regardless of the circumstances of the loss or termination, and that women* are aware that there are disposal options available to them.

It is the intention of the health board that personal, religious or cultural needs relating to the disposal of the pregnancy remains are met wherever possible. Women should be given verbal or written information about the options, given the opportunity to discuss them, and supported in an individual and sensitive manner to ensure that she can make a decision that is right for her.

The disposal of pregnancy remains should take place in line with the woman's wishes as soon as practicable after she has communicated her decision.

Staff who may be asked, or expected, to provide information about disposal should be aware of this policy and prepared to discuss it. They should have detailed knowledge of, and understand the practical aspects of, each form of disposal to be able to properly communicate this information to women.

Staff will be receiving training to equip them to best support the woman in a sensitive and caring manner. Any staff member who feels they require additional training should advise their line manager in order that appropriate training can be arranged.

Staff should also be made aware that access to counselling services can be arranged should they feel the need for support themselves.

*Throughout the policy, we refer to 'woman/women'. Consideration should be made to the fact that a woman may wish to include, or delegate the decision to, her partner, a family member or friend.

2. PURPOSE

This policy is intended to inform staff of the correct procedures, advise and documentation required to guide to provide appropriate care for the woman and their families from diagnosis of the pregnancy loss to delivery and beyond. This will include the care of fetal remains, stillborn babies and infants who die neonatally (up to 28 days of age).

This policy should be read in conjunction with the Human Tissue Act 2004 which makes no distinction between the disposal of pregnancy remains and the disposal of other tissue from a living person; pregnancy remains are regarded as the tissue of the woman. Although under the Act, consent is not required for the disposal of pregnancy remains, the particularly sensitive nature of this tissue means that the wishes of the woman, and her understanding of the disposal options open to her, are of paramount importance and should be respected and acted upon.

3. ROLES AND RESPONSIBILITIES

3.1 Clinical Director of Women & Child Health and Director of Pathology

The Directorate Clinical Directors are responsible for ensuring the implementation of this policy. In particular, they are responsible for ensuring that:

- All Staff involved in the management of pregnancy loss are aware of, and are competent in respect to procedures within the policy.
- Adequate arrangements are implemented for the safe and respectful disposal, of non-viable fetal material, and products of conception, and for arrangements for stillbirths and neonates.
- Incidents relating to inappropriate disposal are correctly and promptly reported and investigated.
- Adequate resources are available to operate the policy.
- Systems are in place for staff training.

3.2 Consultant Obstetricians, Gynaecologists and Paediatricians

All relevant Consultants are responsible for ensuring:

- That all relevant junior medical staff are aware of and adhere to the policy.
- That appropriate documented evidence of patient consent is obtained as required within the policy.
- Completion of required documentation.

NB: Some medication in this guideline are "off label" this is acknowledged by CTMUHB Guideline Group

3.3 Midwives and Nurses

Midwives and Nurses are responsible for ensuring:

- Parents/families are provided with adequate information in order to empower them through the entire decision making process.
- They provide support and privacy to parents and enable them to spend time with the baby if they so choose.
- Provision of information regarding bereavement / counselling services.
- Completion of all appropriate documentation.
- Provision of advice and support for other nurses encountering fetal loss, still birth or neonatal death.

3.4 Specialist Midwife for Bereavement

The health board recognises the sensitive nature of the disposal of pregnancy remains and has an employed specialist midwife to support and sign post women who have experienced a late miscarriage, stillbirth or neonatal death. It is acknowledged that some women may not wish to know about the disposal of the pregnancy remains or be involved in decisions about disposal, and may decline the offer of information of possible options or support from a specialist midwife.

The Specialist Bereavement Midwife for bereavement is responsible for:

- Provision of support and sign posting for this patient group, following stillbirth, neonatal death second trimester medical termination and late miscarriage.
- Providing support and training to staff to assist in caring for women and their families
- The person designated for The Human Tissue Authority for Obs & Gynae.
- An active role within Perinatal mortality review (PMRT) meetings and liaising with families around their reviews.

3.5 Ultrasonographers and Radiographers

Radiology staff are responsible for ensuring:

- Provision of support, early counselling, information and privacy to parents during and following ultrasound, which detects fetal loss or fetal anomalies.
- Appropriate arrangements are in place when scans are undertaken following stillbirth or neonatal death.
- Completion of all appropriate documentation

3.6 Senior Nurse (Theatres)

The Senior Nurse (Theatres) is responsible for ensuring:

- That theatre staff are aware of and adhere to the policy.
- That theatre staff are able to provide support and privacy to parents.
- That theatre staff handle and transfer tissue safely and respectfully at all times to the appropriate department.

3.7 Consultant Pathologists

Consultant Pathologists are responsible for:

- Provision of advice on histopathology
- Ensuring that histology procedures are only carried out as stated within the documented consent process.
- Ensuring adequate arrangements are implemented within Histopathology and the Mortuary for the safe handling and respectful disposal of non-viable foetal material, products of conception, stillbirths and neonates and related issues as required.

3.8 Laboratory Staff

Laboratory staff are responsible for:

• Working within departmental standard operating procedures.

• Ensuring that histology procedures are only carried out as stated within the documented consent process.

• Ensuring the safe handling and respectful disposal of non-viable fetal material and products of conception as stated within the documented consent process.

3.9 Mortuary Staff

Mortuary staff are responsible for:

• Working within departmental standard operating procedures.

• Ensuring the safe and respectful arrangements for miscarriages, stillbirths and neonatal deaths as stated within the documented consent process.

4. MEDICAL MANAGEMENT

Miscarriage is a pregnancy loss prior to the 24th week of pregnancy with the majority occurring within the first 13 weeks of pregnancy. Although miscarriages are a frequent gynaecological event, it is a very distressing time for the woman and her family. It is essential that information is given to women regarding treatment options, where appropriate post mortem examination and sensitive disposal of the fetal remains. Follow up treatment should also be discussed and arranged.

Intrauterine fetal death (IUD) refers to babies with no signs of life in utero. Stillbirth is defined as a baby delivered with no signs of life known to have died at or after 24 weeks of pregnancy. In addition to any physical effects, stillbirth often has profound emotional and social effects on parents, their relatives and friends. The purpose of section 4 of the guideline is to outline the medical management of miscarriage, intrauterine death or stillbirth. Suspected Intrauterine death (IUD) should be confirmed by ultrasound imaging of the fetal heart by a practitioner experienced in Ultrasonography (senior obstetrician or radiographer). A second opinion is recommended where possible, with women and their families made aware of the need for a second opinion at the earliest opportunity.

4.1 Medical Management of Miscarriage, Stillbirth or fetal demise.

13 to 17+6 weeks gestation

- Mifepristone 200mg administered orally as a single dose 36-48 hours before misoprostol.
- Misoprostol 200micrograms can be administered vaginally or orally 6 hourly for 4 doses until products passed.
- Speculum examination should be performed if no products passed after 3 doses.
- If the first dose of misoprostol is not effective, dose should be doubled to 400 micrograms unless the woman has had a previous caesarean section (do not double dose).
- Maximum dose of misoprostol 1600 micrograms in 24 hours.
- Monitor at least 4 hourly- pulse, temperature, BP and symptoms

18 to 26+6 weeks gestation

- Mifepristone 200 mg administered orally 36-48 hours before misoprostol.
- Misoprostol 100 micrograms can be administered vaginally, sublingually or buccally 6 hourly for 4 doses until products passed.
- If 1st dose misoprostol not effective double dose of misoprostol to 200 micrograms unless the woman has undergone prior uterine surgery, in which case do not double dose.
- Maximum dose of misoprostol 800micrograms in 24 hours.
- Monitor hourly- uterine contractions, pulse, temperature, BP and symptoms

27 weeks gestation and above

- Misoprostol: 50 micrograms administered orally or vaginally every 4 hours up to 6 doses (Decision on route of administration to be made following discussion with the woman)
- If the first dose misoprostol does not lead to effective contractions then the subsequent dose can be increased to 100 micrograms, unless she has had a previous caesarean section, do not double dose. The maximum dose should not exceed 600 micrograms in 24hrs.
- If unsuccessful, repeat the cycle with misoprostol after 24 hours after discussion with the consultant obstetrician
- Monitor hourly- uterine contractions, pulse, temperature, BP and symptoms

Note: Misoprostol is only available as 200 micrograms tablets. Therefore:

- 100 micrograms misoprostol: break the tablet in half down the score line with the tablet cutter and give orally or vaginally
- 50 micrograms misoprostol: Either dissolve the 200 micrograms misoprostol tablet in 20ml of water and give 5ml (drawn up in an oral syringe) to be taken orally by the patient. Alternatively this can be carefully divided into 4 with the tablet cutter if to be given vaginally.
- Discard any leftover tablet or solution.

Caution: Clinicians who are or may become pregnant should not handle the crushed or broken mifepristone or misoprostol. Gloves should be worn by all staff when handling misoprostol.

For women with previous uterine surgery

- A discussion of the safety and benefits of induction of labour should be undertaken by Consultant Obstetrician.
- Mifepristone can be used alone to increase the chance of labour significantly within 72 hours (avoiding the use of prostaglandin) – 600 mg daily for 2 consecutive days (RCOG).
- Consider Propess (dinoprostone) 10mg vaginally or Dilapan-S®for second part of induction of labour.
- Misoprostol can be used for induction of labour in women with a single previous LSCS after discussion with Consultant Obstetrician.
- Avoid doubling dose of misoprostol.

All women should be prescribed anti-emetics and analgesia. Inform women of the potential side effects of treatment including pain, diarrhoea and vomiting. A thorough discussion around pain relief options should take place in advance to treatment.

- Give 6 hourly paracetamol 1gram orally (to control maternal temperature)
- Analgesia – Morphine sulfate 10 mg 4hrly / Patient controlled analgesia / epidural if required
- Do not rupture membranes unless deemed essential (risk of chorioamnionitis)

Drug monographs and contraindications can be accessed via;

BNF (https://bnf.nice.org.uk/) or eMC (https://www.medicines.org.uk/emc

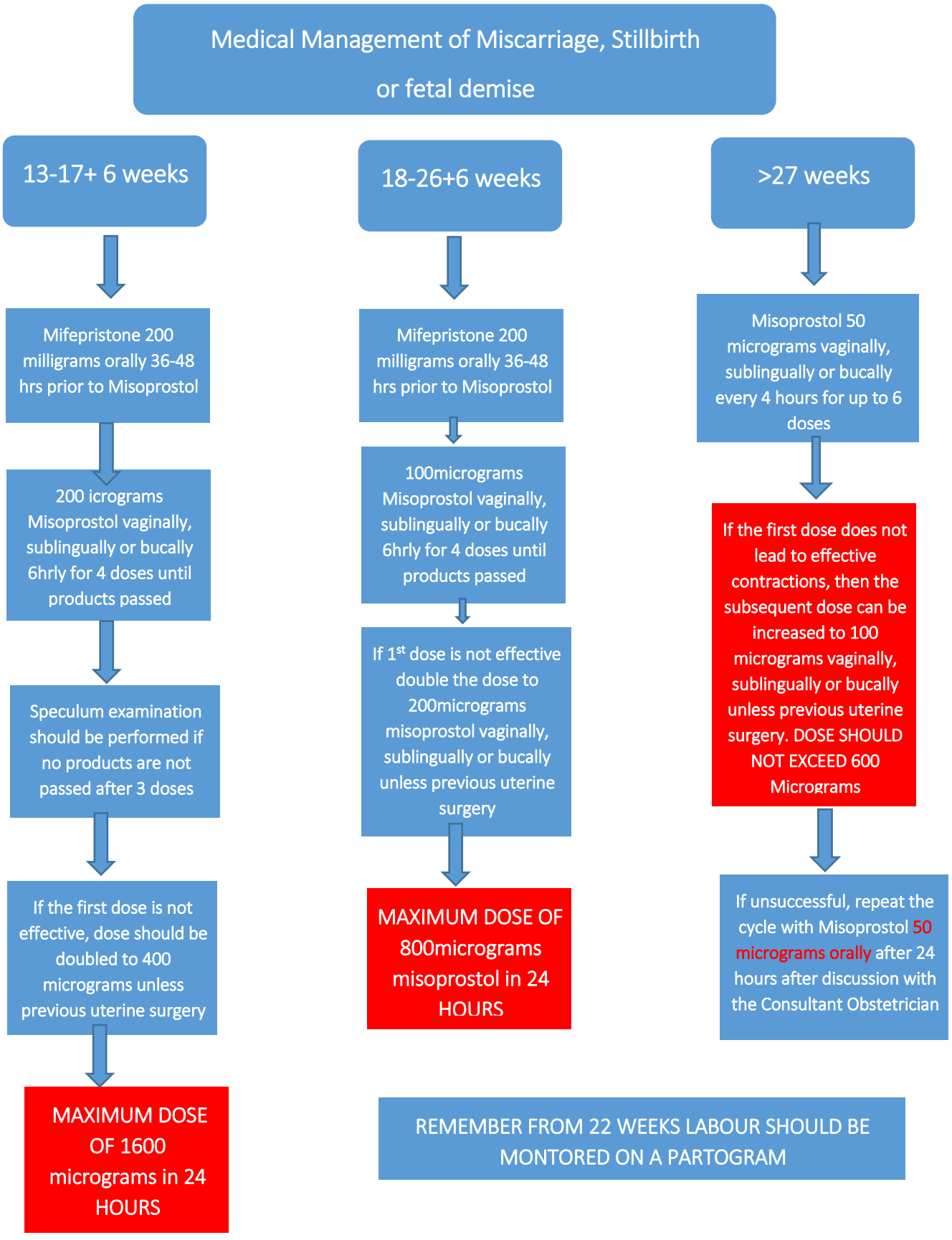
4.2 Points for Best Practice

- In high risk cases e.g. 2 or more caesarean sections, low lying placenta/ placenta praevia, transverse lie, the Consultant on call will need to formulate an individualised delivery plan depending on the gestation.
- If the membranes have ruptured, then prolonged retention of the fetus may lead to intrauterine infection and Induction of labour should be commenced as soon as possible, with antibiotic cover if necessary https://viewer.microguide.global/CWMTAF/Abx#content,a03bde51-3191-4035-95f4-21968c9d0120 – in such cases IOL with oxytocin can be considered.
- If there is heavy vaginal bleeding or pyrexia, then early delivery should be advised.

4.3 Prevention of Rhesus - D Isoimmunisation

Feto-maternal haemorrhage may have occurred days before clinical presentation. A Kleihauer should be taken at diagnosis and Anti-D given immediately to Rh negative women, as delivery may not occur until 72 hours later. A further dose of Anti-D may be required depending on Kleihauer result.

Flowchart for Medical Management of Miscarriage, Stillbirth or fetal demise.



N.B. These are guidelines, and any variation in care which deviate from the guidance must be undertaken at a senior obstetric level.

5.0 Management- Postpartum

Offer single dose of cabergoline or prevention of lactation (see page 26 for dosage) as one third of women experience severe discomfort with non-pharmacologic measures. Dopamine agonists such as cabergoline, should not be given to women with hypertension or pre-eclampsia.

- All key staff responsible for care of the woman during pregnancy and afterwards should be informed as per the bereavement care checklist of the events. This includes the woman's consultant, community midwife, G.P. and health visitor.
- All existing appointments for the woman should be cancelled as per bereavement care checklist.
- A community midwife call should be offered and a call made to the patient within 24hrs if declined.
- Women should be routinely assessed for thromboprophylaxis.
- Refer to the specialist bereavement midwife via email.
- Obstetric follow up will be arranged by the bereavement midwife when results are available.

5.1 Checklist for Investigations

All cases	Unexplained IUD	Specific to cause
FBC, G&S; Coagulation screen including fibrinogen; Kleihauer; Fetal post-mortem (full / limited); Cytogenetic analysis in relevant cases; Person who delivers the baby should document: • degree of maceration of skin • any obvious external abnormality of features or limbs • baby's weight and overall impression - IUGR/normal/macrosomia □ gender and name given by parents, if known; Fetal anomaly CARIS form to be completed.	CRP; TORCH, Parvo virus, Rubella, Syphilis (particularly in presence of polyhydramnios and/or fetal hydrops); Thyroid Function Tests; Placental swab for microbiology; Placental Histology; HbA1c; MSSU, HVS or LVS. *** Blood for antiplatelet antibodies only required if alloimmune thrombocytopenia suspected ***	Placental abruption – Placental histology, thrombophilia screen. Chorioamnionitis Infection screen including blood cultures, placental swab, swabs from baby. If IUGR suspected Lupus-anticoagulant; Anticardiolipin antibodies; Factor V Leiden Prothrombin gene mutation; *Repeat thrombophilia and APLA screen 6 weeks post delivery; Placental Histology; If h/o itching or jaundice LFT and bile acid. Parental karyotyping Indicated if: - fetal unbalanced translocation; - other fetal aneuploidy, e.g. 45X; - fetal genetic testing fails and history; - suggestive of aneuploidy (fetal abnormality on postmorterm, previous unexplained IUFD, recurrent miscarriage).

-An abnormal result might not be linked to the intra uterine fetal death but rather be simply an incidental finding

-Comprehensive investigation can be important even though one cause is particularly suspected

-Parents should be advised that no specific cause is found in almost half of stillbirths

-Parents should be advised that when a cause is found it can crucially influence care in a future pregnancy

NB: An abnormal test result is not necessarily related to the intra uterine fetal death, correlation between blood tests and post-mortem examination should be sought. Further tests might be indicated following the results of the postmortem examination.

6. Death of a fetus before 24 weeks of pregnancy but delivery occurred after 24 weeks.

When it is known that one or more fetuses have died in utero, either naturally or through medical intervention such as selective reduction, it can be said that the pregnancy of that fetus (or fetuses) has ended. It may be that there are other continuing pregnancies in the same womb but the pregnancy of the dead fetus is no longer continuing.

This means that in a number of situations where it is known that one or more fetuses has died prior to 24 the week of pregnancy (for example where there has been a delay between a diagnosed intrauterine death and delivery, vanishing twins or selective multi-fetal pregnancy reduction in multiple pregnancies), those fetuses known to have died prior to the 24th week of pregnancy would not be registered as stillbirths. In all of these cases, there would have to be evidence that it was known that the fetus (fetuses) had died prior to the 24th week of pregnancy and this evidence, usually based on ultrasound, would need to be clearly detailed in the mothers notes in case of any queries arising later. In cases of medical termination of pregnancy where Mifepristone is administered, unless there is a ultrasound to confirm passing prior to birth, gestation should be recorded as the day of birth where conformation of no signs of life are made.

In cases where one or more fetuses has been born dead after 24 weeks of pregnancy but it was not known prior to its birth that it had died and it is not know precisely when it died it may be appropriate to use the stage of development of the fetus as an indicator of when death occurred and used as a basis for determining when that particular pregnancy ended relative to the 24 week limit. This would need to be agreed by the medical professionals involved on a case by case basis.

6.1 Fetus Papyraceous

In the case of a fetus papyraceous it is known that the fetus must have died before the 24th week of pregnancy and thus it would be incorrect to register it as a still birth.

7.0 The Care of Babies Born Alive on the Threshold of Viability

The threshold of viability is defined as 22-24 weeks gestation (BAPM 2000). **Once a baby has been born showing signs of life in keeping with MBRACE 2021 guidance, it is to be recorded as a live birth regardless of gestation. The infant then acquires legal rights and therefore the right to a live birth and subsequent death registration regardless of the infants gestational age.** Advice on the correct procedures to follow should be sought from the Directorates resuscitation of the newborn policy, or see the flowchart within the <24 week bereavement care checklist.

Women and their families should be made aware of potential signs of life prior to delivery and thorough counselling delivered by the relevant team. Please ensure that the paediatric team are in attendance for the birth where active survival focused care ***is being considered or an assessment for active care is being made.***

- If resuscitation/active survival focused care is <u>not</u> taking place, comfort measures should be provided to baby; ***wrap baby for warmth, a hat, skin to skin with parents (if parents wish).*** In the case of comfort measures only, there is no need to disturb the woman's environment and baby/babies may remain with their mother/parent/s throughout this time if the woman so wishes.
- An obstetrician or paediatrician (any grade with a GMC) should attend to assess/witness signs of life. Only a medical practitioner may certify a neonatal death, and therefore a doctor must witness the signs of life to certify them in keeping with the documentations request for a statement of truth to confirm the witnessing of these signs.
- The doctor can re-attend to confirm the baby has passed when the midwife or mother notes signs of life to have <u>ceased</u>. Please see the flowchart for signs of life in the appendices checklist.
- and this can only take place by witnessing signs of life. In cases where due to the location or rapid timing of delivery attendance was not possible, escalate to bereavement lead midwife.
- In cases where due to the location (i:e home) or rapid timing of delivery, doctor attendance was not possible, escalate to bereavement lead midwife.
- Ongoing arrangements and paperwork for babies at this gestation, in these situations, should be in line with the neonatal death procedure on passing.

8.0 Management of Disposal of Fetal Remains (under 24weeks gestation)

It is essential to ensure that consent is sought to enable the health board to provide disposal of fetal remains. Parents must be informed of all options available to them and that staff are able to consider any personal wishes expressed by the parents. Parents must be given guidance and support whilst making the decisions as to whether they wish the hospital to make arrangements or they wish to make their own arrangements.

In order that all relevant forms are present the bereavement care checklist for the appropriate gestation should be followed.

Documentation relating to disposal includes the following forms:

- Consent for arrangements for sensitive disposal of fetal remains **PATH02** to be completed for all pregnancy loss under 24 weeks gestation with NO SIGNS OF LIFE. (Appendix 2)
- "Practical arrangements following a pregnancy loss" information booklet should be provided. (Appendix 5)

All pregnancy losses < 24 weeks with no signs of life must be documented in the Pregnancy loss remains register at ward level and on arrival at the mortuary. Details must include mothers details, date of delivery, disposal arrangements, and the time/date booked into the mortuary. The baby should be recorded as PLR 'A' and the placenta of the baby recorded as PLR 'B'.

8.1 Hospital Management

If parents wish the hospital to take responsibility for disposal this will be by communal cremation and will be in line with the agreement between the Health Board and crematorium/funeral director in question. Fetal remains are safely stored in the hospital mortuary until the date of cremation is reached. Communal cremations take place bi-monthly, parents should be made aware of this. It is important that when discussing the arrangements that parents understand that the disposal arrangements will be by what is known as a "communal cremation" which means there will be other fetal remains with their baby, cremated at the same time therefore it is not possible to identify any individual cremated remains after cremation or to allow any other option for disposal. Parents are not permitted to attend the cremation itself or the scattering of ashes.

A council register of all cremations of fetal remains, using the unique case number, will be undertaken by the crematorium in order to provide traceability thereafter. Parents must be made aware that they will not be involved in the communal cremation or be informed routinely when it is going to take place. However they will be able to make contact with the mortuary or bereavement midwife if they wish to know of the dates.

8.2 Private arrangements

If parents decide that they wish to make their own arrangements you must advise them to contact a funeral director of their choice who will make all necessary arrangements for them. The decision, and the date of collection, should be reflected on the the paperwork, and recorded in the woman's medical notes and she should be given written confirmation that she is entitled to take the remains to make her own arrangements.

- **Cremation**: Any remains can be scattered in the crematorium or parents may wish to follow their own arrangements.
- **Burial**: Late miscarriages above 18/40 may wish to use Laleston/Margam Children's Garden of Remembrance however, neither are able to accept scattering of ashes but do have an area where ashes can be buried. Cefn Y Parc, or Lwydcoed baby remembrance garden may also be used however each site should be contacted in advance to discuss the patient's requests. Councils should be contacted to confirm availability of services in each individual cemetery in the first instance. Advice and information to ensure an appropriate choice would be given by the funeral directors.
- **Burial at home:** If the parents request to bury the fetal remains themselves at home they must be advised that they need to own the land and they will also need to inform the local council. Please see ***"Practical arrangements following a pregnancy loss"*** leaflet **(Appendix 5)**

8.3 Sensitive Incineration option

Fetal remains will be respectfully prepared for incineration. They will be transferred to a clinical waste facility following preparation and will be disposed of with clinical waste incineration. Parents should be aware that there is no committal process or ashes returnable or scattered for this option.

8.4 Undecided option

This is a difficult period for parents where they may need time to make this often-difficult decision. If parents feel that they need time, ask them to complete the PATH02 form indicating they are undecided and ensure the parents are fully informed on who and where to contact once they have made their decision. The nurse /midwife present at the delivery should be aware of this undecided option and the mortuary staff made aware.

After 4 weeks mortuary staff or the bereavement midwife will ring the woman in question and prompt her that we are awaiting a decision. If the woman is unable to be contacted a letter will be sent on behalf of pathology, advising the woman of the health boards position in relation to disposal of fetal remains.

All these actions MUST be documented in the case notes.

9.0 MANAGEMENT OF STILLBIRTHS (24+ weeks gestation)

A stillbirth refers to the death of a baby born after 24/40 gestation showing no signs of life.

Stillbirths during pregnancy are classed as an antenatal intrauterine death. Those occurring during labour are classified as intrapartum death. The diagnosis and care parents receive from those looking after them and their baby has a huge impact on their perception of the experience and how they cope and deal with their loss in the long term. In order to provide this care, the following should be observed:

9.1 Diagnosis

- When an intrauterine death is suspected mothers should be seen in a private area.
- At every stage parents need accurate information communicated sensitively and promptly.
- Contact consultant/registrar.

Initial confirmation of an intrauterine death by a suitably qualified person can be undertaken at ward level by use of a portable ultrasound scanner. These findings must be confirmed with a second ultrasound scan by a suitably qualified person, with accompanying clear documentation to reflect the findings. Its is good practice in day time ours for the conformation scan to be undertaken by the ultrasonography department. However this is not essential. Should the second ultrasound scan be undertaken departmentally, a qualified midwife will accompany the mother when a scan is to be performed in the ultrasound department.

9.2 Breaking Bad News

- It is important for staff to take into consideration the significance and extent of the information being given to parents. The importance of the news should be acknowledged.
- The news should be given in a private place, never in public.
- What is said should be stated clearly but sensitively and parent's questions answered. Always express your sympathy & concern and offer what support you can
- Ensure parents are given adequate time to talk over the implications of the news with staff or they may need time alone. Parents always remember the way that information is given and the attitude of the people involved.
- When a woman's partner is with her discussion should always include both partners.
- A professional interpreter should be involved if necessary.
- Parents may need a lot of detailed information. This maybe overwhelming if it is given all at once and sometimes it helps to give information at stages. But parents should not have to wait for information or for answers to their questions without knowing when they will have the opportunity to talk with the professional concerned.
- Some continuing support from either hospital or community professionals should be offered although not all women will wish to take up the offer.
- No one wants to break bad news and it is always a distressing task. It is important that professional are supported by their colleagues.

- All those involved in breaking bad news to parents should have received some training in the relevant communication skills.

9.3 Plan of Care

- The Consultant on duty must be informed once confirmation of a stillbirth has been received
- The Consultant or Registrar should discuss options of care and a clear management plan documented in woman's notes.
- Parents should be cared for in a bereavement suite or suitable room according to their immediate physical and emotional needs which includes ensuring there are facilities for the father to stay overnight if required.
- Every effort should be made to fully explain and answer questions ensuring that parents understand.
- Induction of labour to be followed as documented individually for each client. Some parents may wish to delay induction of labour to give them time to prepare themselves. Other parents may wish to proceed with the delivery as soon as possible.
- Relevant bloods should be discussed with the consultant as part of care planning.
- Inform Anaesthetist of patient and ensure that adequate pain relief has been prescribed and options fully discussed with the woman.
- The bereavement care checklist for stillbirth and intra uterine death must be followed.

9.4 Preparation For Labour and Delivery

These guidelines are directed to all professionals who are caring for parents and their baby around the time of death. The care that we give to parents must be sensitive and appropriate. Excellent bereavement care can help families in their grief, whilst poor care can exacerbate and prolong a family's distress.

- Enquire whether there are any religious or cultural aspects of care and ensure every effort is made to meet their requests and documented in patient's notes. Some families may have strong beliefs that require specific procedures to be carried out. Others, even those who do not regularly practice a religion may find time with a chaplain a comfort. Ask sensitively if parents would like a blessing etc. It is important to honour any cultural traditions the family may have.
- Post mortem: If it is felt to be appropriate, the introduction of this subject prior to delivery may give parents more time to understand this difficult decision. The information for parents booklet should be provided.
- Discuss with parents their wishes regarding seeing /holding their baby, giving time for parents to prepare clothes and discuss any needs they may have. This should be re offered at a later time.
- Offer the opportunity to take baby home, a cuddle cot should be provided and the relevant form for this completed with a photocopy made for the maternal records ***''Release form for the deceased infant''*** **(Appendix 4).** If the family wish to take baby home provide a cuddle cot and make the mortuary aware of the parents wishes, ensuring the baby is recorded in the mortuary register prior to

discharge for traceability purposes. The parents can then contact an undertaker themselves to arrange for the baby to go to the local undertakers chapel of rest until the funeral when they are ready for this. If the woman and family have consented to a post mortem baby should be returned to the hospital mortuary, via labour ward ideally within 48 hours. The midwife visiting the parents to offer postnatal care and support must be informed of this also, and the local police in case of an incident when travelling to or from the hospital.

- The use of mementos, memory box, and photographs will help support these memories and should be kept even if parents decline them at the time.
- Always use the babies name if one has been chosen. This will acknowledge that the baby is respected. Referring to "your baby" is much more personal than "the baby". You may also demonstrate your sensitivity in holding and touching the baby. Parents may be afraid to hold their little one and your care will help them to create a relationship.
- It is the responsibility of the parents to arrange a funeral director and meet any cost of the funeral or plots for burial. Please note that generally funeral directors do not charge for their services for those under 18 years of age in Wales however this should be clarified with the chosen funeral director in the first instance. Local authorities may charge for plots, this should be clarified with the local authority.
- Parents can be supported by midwife to advise them of their choices around arrangements, but the hospital cannot take any responsibility for this. The midwife providing care can seek clarity or support from the specialist bereavement midwife if required when advising around arrangements.
- Parents may choose to bathe and/or dress their babies and the midwives can support them in this request.
- It is important to encourage parents to talk about their feelings. Explain to parents that reactions to death can include numbness disbelief sadness and anger. We should provide the SANDS bereavement support booklet to all families, these are included in the bereavement packs.

10.0 Mortuary Transfer

All fetal remains, stillborn infants, neonates and their placenta's are to be taken directly to the mortuary and never to another location such as histology. Please contact the porters out of the hours of 8am-4pm to gain access.

The handling and management of fetal remains, stillborn infants neonates and their placenta's is a sensitive and highly important matter. It is therefore imperative that this policy is adhered to by all health personnel involved in the care, transportation and disposal of these remains.

10.1 Procedure for < 24 week pregnancy loss (PLR)

- The PLR must be placed in an opaque container with a sealed water tight lid. No formalin, saline or fluid of any kind should be added to the container as this may interfere with investigations if required.

- If a discernible fetus AND placenta is present (for post mortem investigation), the placenta should be placed in a separate opaque addressographed container, labelled 'PLR B' and kept with the fetus.

- Paperwork should be complete in full and placed in an addressographed envelope with PLR and placenta. Photocopies of the paperwork should be made for the clinical notes.

- All fetal and placental remains, which are either for transportation to the Paediatric Pathology Unit at University Hospital of Wales or are for disposal, are to be taken directly to the Mortuary. They must not be taken to Histology or elsewhere.

- It is the responsibility of the designated nurse or midwife to record any pregnancy loss under 24 weeks at ward level, in the ward Pregnancy loss remains register, and in the corresponding mortuary pregnancy loss remains register, on arrival at the mortuary. All fields must be complete.

- Pregnancy loss remains should be transported with sensitivity in the PLR purple carry cases available on each ward.

- The placenta should be recorded in the ''Pregnancy loss remains register'' on labour ward with baby/PLR as PLR 'A' for baby and PLR 'B' for placenta, the same should be recorded in the mortuary ''Pregnancy loss remains register'' on arrival to the mortuary.

- The PLR & placenta must be placed in the appropriate fridge in the mortuary; ***PCH blue and white PLR fridges, POWH Bay I infant and child fridge out of hours, in daytime hours you will have access to the PLR fridges in POWH and PLR/placentas should be placed in there.***

- The Mortuary Department will arrange for the delivery of the fetal remains to Cardiff and its return following post mortem. Upon return the Mortuary will arrange for the disposal of the remains in line with the wishes of the parents.

10.2 Procedure for transfer of a stillborn infant of neonate

- When the parents are ready the baby must be transferred to the mortuary by the midwife accompanied by the porter if out of hours.

- The infant should be prepared in accordance with the standard operating procedure for ***''Transfer of the stillborn infant or neonate to the mortuary''***

- Paperwork should be complete in full and placed in an addressographed envelope with infant and their placenta. Photocopies of the paperwork should be made for the clinical notes, and paperwork details should match that of the infants identity bands.

- The birth must be recorded in the labour ward birth register.

- Upon transfer the infant must be recorded in the ''Stillbirth and neonatal death infant transfer register''.

- On arrival at the mortuary the stillborn infant or neonate must be recorded in the main mortuary ledger. If the infant is a stillborn infant record under the mothers details ''stillborn infant of''. If the infant is a neonatal death record with their own sticker/details.

- ***The placenta must be recorded in the ''property'' field*** of the main mortuary register next to the infants details to reflect its arrival in the mortuary.The placenta must be transferred with baby, and this must be evidenced in the clinical documentation, care checklist and ledgers.

- The infant should be placed in the infant and child fridge; ***Fridge H in PCH, Bay I in POWH, , accompanied with his/her paperwork and placenta.***

If there is any uncertainty surrounding relevant documents please speak with the specialist bereavement midwife prior to transfer to the mortuary. Please avoid transferring personal belongings to the mortuary, as these may get misplaced during transfer. Advise parents to give these to their chosen funeral director to put with baby once baby is within their care.

11.0 Ongoing Investigations

11.1 Post Mortem Examination

Patients should be offered the three types of post mortem examination available to their baby- full, limited, or external. The post mortem must be performed by an appropriately qualified Perinatal Pathologist. University Hospital of Wales, Cardiff is the only centre in Wales where there is an appropriately qualified Perinatal Pathologist. Cwm Taf Morgannwg University Health Board has an agreement in place for the transport of baby and placenta to UHW.

The process for obtaining consent for PM should be given over a minimum of 2 separate contacts with the parents.

1) Parents will be given the All Wales information leaflet ***"Deciding about a post mortem: Information for parents"*** as a minimum*. It is recommended that this should be complemented by the booklet produced by SANDS. It is important that parents are given the appropriate time to consider the information provided and given the opportunity to ask questions.
2) Obtaining consent - The person obtaining consent for the post mortem must have undergone the All Wales consent for post mortem training and be registered on the National Database held at the paediatric pathology department at University Hospital of Wales (UHW). If there is uncertainty surrounding whether the practitioner is on the all wales database please clarify with UHW before consent is obtained on 02920748421 OR 02920742706.

The All Wales consent documentation will be completed to a high standard and copies filed as followed:

- ***One copy to the parents***
- ***One copy filed in the medical notes***
- ***Top copy sent to the pathology department with the baby***

Parents have the right to change their mind about any of the decisions they have made. Parents may make contact with the Bereavement Midwife or Labour Ward Coordinator within the time specified in the 'Right to change your mind' section of the Consent Form for a PM Examination of a Fetus, Baby or Child.

The Labour Ward Co-ordinators has overall responsibility to ensure UHW are informed the baby will be transferred for post mortem by telephoning 02920748421/02920742706. The Specialist Bereavement Midwife will be the point of contact for parents should they require information relating to the transport of the baby to UHW.

The Specialist Bereavement Midwife will be the designated named person in place to monitor the progress of the report and communication with the family.

The post mortem report will be shared with families at the earliest opportunity and a copy made available should they wish. Ideally this should be within 12 weeks from the point of post mortem. However time

scales can vary due to consultant availability and workload within the University Hospital Wales. The appointment will take place in an appropriate environment away from the clinical area with the woman's named consultant with an offer of support from the specialist midwife at this appointment made. A minimum time of one hour should be allocated for this appointment. Follow up appointments should be coordinated by the specialist bereavement midwife. The parents should be given details of who to contact should they wish to arrange a follow up appointment with the consultant in the event of them having further questions.

11.2 Placental Examination

As part of every post mortem the placenta will be examined by the perinatal pathologist. If a post mortem examination is declined, verbal consent will be sought from the parents for specialist placental examination with a perinatal pathologist. The placenta must be sent for examination to the Perinatal Pathologist at University Hospital of Wales, Cardiff. The placenta must be placed in the appropriate opaque container, with an addressograph on the side. A placental histology form should be completed with **''FAO Fetal Pathology Department, UHW, Cardiff''** written in black ink along the top of the form, and taken to the mortuary where transport will be arranged by mortuary staff. If specialist histology of the placenta is declined by the woman, offer hospital histology.

11.3 Genetic Counselling

Where a baby has a known abnormality a referral can be made to a geneticist for counselling following delivery. Genetic testing is sometimes part of the post mortem procedure although this additional test is carried out solely at the discretion of the Pathologist. If the woman specifically wants genetic testing this should be discussed at delivery. Cytogenetic sampling can be carried out within the ward area if required and if post mortem is declined. Please refer to the All wales cytogenetic manual for sampling criteria.

12.0 Bereavement Room

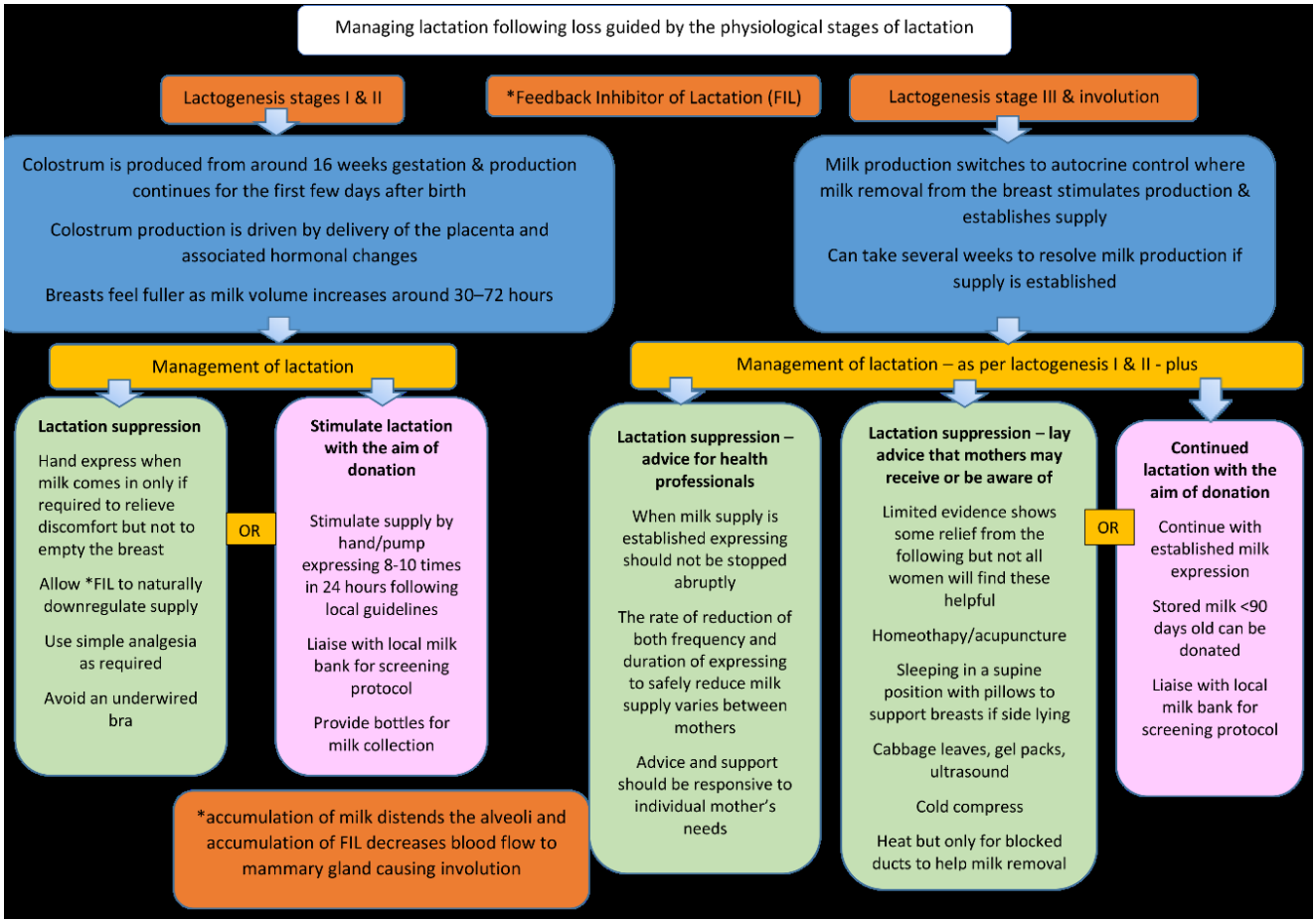
If appropriate and a private family room is available, this should be offered as it gives parents and their families the privacy to spend time with their baby. Some parents may feel more comfortable remaining within the hospital. The use of the cold cot should be offered and explained to the parents in order to support parents spending an extended period of time with their baby before there is deterioration of the body. The family should also be offered the opportunity to have use of a cuddle cot to take baby home, if they so wish. When the parents feel they can finally leave their baby you should contact the porters if in PCH/RGH and carry the baby in the appropriate carrier for that unit to the mortuary with the porter. The baby should be appropriately prepared for the mortuary by wrapping baby in clean cotton sheets, accompanied with the original paperwork and transferred in the appropriate carrier to the mortuary. The baby should not be carried in the arms of the mother or midwife to the mortuary in order to avoid the risk of staff member or the woman tripping with baby. The families own blankets/items can be placed on baby to be transferred with baby if they so wish. As previously mentioned parents should be advised against sending valuable/sentimental items with baby due to the risk of loss during transfer. The parents should always be told who is responsible for transferring their baby. Leaving their baby will be very hard and it is important for the parents to have the correct information if they were to wish to return to see their baby again. Offer to accompany the parents to their car when they leave the hospital, as leaving without their baby is one of the most traumatic experiences for grieving parents.

13.0 Follow-up care and support

We should ensure continuity of care and support in the community is put in place. Parents will be offered visits by their community midwife, if this is declined offer a telephone call from the community midwife. The midwife at discharge will assist in ensuring all appropriate healthcare professionals are notified including the GP, health visitor, antenatal clinic and community midwifery team. A referral to the specialist bereavement midwife should be sent via email by the delivering midwife or midwife providing care prior to discharge. The specialist bereavement midwife will make contact with the family with their consent by telephone. There is no right way to grieve and support needs to be available at any stage. It should be explained that contact with the bereavement counsellors can occur at whatever stage in their grieving they chose. Please ensure the specialist bereavement midwife telephone number is provided so that parents who initially decline input can uptake support at any time should they change their mind.

13.1 Managing lactation after loss (BAPM Framework for practice 2022)

This is dependent upon the route that mothers and families choose to take and is guided by the stage of lactogenesis. Details on the different approaches are discussed below. Lactation suppression is a choice that some mothers make, while others may wish to initiate or continue lactation as part of the narrative around their baby's death. Whatever they choose to do should be discussed openly and supported as appropriate. The chart below helps support professionals in planning management of lactation after loss BAPM (2022).



Lactation Suppression: Pharmacological methods

Cabergoline has two treatment regimes, depending upon whether one is in the first 24 hours after delivery or after this time. Commonly reported side effects of cabergoline are dizziness, headache and nausea. These side effects should be clearly communicated to the woman and the community team made aware upon discharge that the woman has been prescribed this drug. The dosing regimen is as follows;

Prevention of lactation

1mg to be taken as a single dose on the first day post partum

Suppression of established lactation

• 250 micrograms every 12 hours for 2 days

For up to date information please see the most recent version of the British National Formulary- ***BAPM 2022.***

Non Pharmalogical prevention and/or suppression of lactation

In the past, many non-pharmacological approaches to lactation suppression have been recommended that have no beneficial effect, including breast binding, the use of ice, fluid restriction and forced fluids. It's important for professionals to be aware of different practices as mothers and partners may bring up some of these practices.

Lay advice

• There is some weak evidence that homeopathy and acupuncture may have a beneficial effect, however there is not sufficient evidence to justify this as a recommendation.

• A well supporting bra should be worn day and night.

• Use of breast pads within the bra can help with breast leakage.

• Sleeping in a supine position may take pressure off the breasts to aid a more restful sleep; pillows can be used to support the breasts if side lying.

- Some 'traditional' treatments may help, such as cabbage leaves, although this may be due to the gentle massage that is involved rather than the treatment per se. There is some evidence that phytoestrogens in the cabbage leaves may reduce swelling in the tissues.
- Gel packs have shown benefit by the same mechanisms cold cabbage leaves.
- Heat should be avoided. Advise mother to shower with her back to the water.
- Simple analgesia may help with discomfort such as paracetamol or a non steroidal anti inflammatory unless there are contraindications to these medications.

- Breast binding is noted by mothers to be helpful, however if mothers choose this option it is important to note that there is an increased risk of mastitis.

- As breast engorgement and subsequent negative feedback mechanisms work to suppress lactation, it is important to explain this to mothers. The aim when suppressing lactation is to avoid painful engorgement. For mothers with an established milk supply, abrupt withdrawal is not advised as it can lead to severe engorgement and intense pain.

- There are different reported methods of pumping designed to reduce the production of breastmilk. The frequency and duration of pumping will vary from one woman to another, depending upon multiple factors such as how much milk she produces. Mothers should continue to express using a good quality breast pump, unless she is experienced in manual expression, thus one should be supplied. Removing just enough milk to reduce the discomfort, but not emptying the breast will gradually reduce lactation.

BAPM Framework for practice, Lactation after loss (2022)

Whatever options the mother chooses must be carefully documented evidencing she has received adequate support and advice to guide her at this extremely sensitive and emotive time. The options of breastmilk jewellery and breast milk donation can be explored with the woman at an appropriate interval should she wish. Clinicians should ensure this is discussed ***prior to admission of cabergoline or other pharmalogical forms of suppression***, as this may then prevent the mother donating milk or collecting milk for jewellery if she wishes to do so.

Milk bank donation- https://ukamb.org/medication-and-donating-breastmilk-2/

14.0 Documentation

Checklists should not replace professional documentation. Documentation should be completed in the usual way in keeping with The NMC Code, but complimented by the relevant bereavement checklists should be completed. The checklists will support the practitioner in adhering to this policy and best practice principles. Particularly when it is acknowledged that this is a less than common scenario for every day practice.

15.0 Legal Requirements

A stillbirth must be registered within 42 days. It is the responsibility of the parents to register the stillbirth with the registrar. The stillbirth certificate should be scanned and emailed to the registrar and bereavement midwife, with the original copy addressed to the mortuary bereavement officer. A neonatal death must be registered within 5 days, and the certificate must be scanned and emailed to the registrar and bereavement midwife, with the original given to the mortuary bereavement officer.

A fetus born with no signs of life prior to 24 completed week's gestation is legally considered a pregnancy loss or miscarriage and does not require a certificate. There are separate guidelines and checklists available in the bereavement box for this gestation. A ''Certificate of Life'' can be given at this gestation as a memento gesture, these do not have any legal binding, and can be found in the bereavement cupboard.

16.0 Children's Garden of Remembrance

Within the Health board there are Children's Remembrance Gardens in Bridgend and Margam Crematoriums for the Bridgend community which are dedicated to babies. Morriston Crematorium has a communal burial area. For the Prince Charles community there is Lwydcoed Crematorium which has its own baby garden and Cefn Y Parc which also has a dedicated baby garden. The cost of a baby's funeral is usually very minimal or more commonly at no cost at all for the services. However this must be discussed with the chosen funeral director prior to discharge ideally. A list of local funeral directors is available and parents, the bereavement specialist midwife can support with contacting funeral directors on behalf of the family if required.

16.1 Memorial Service

Memorial services are held at both areas within hospital chapels, and these are open to all families' friends and professionals to attend. Dates can be obtained from the chaplaincy department.

A book of remembrance is kept in the chapels in Prince Charles, Royal Glamorgan, and Princess of Wales, where parents are invited to write messages of rememberance. Chaplaincy can be contacted to facilitate this.

Non religious services are held annually in local churches and children's remembrance gardens annually- bereavement leads should be contacted to clarify dates and times.

17.0 MANAGEMENT OF POLICY

17.1 Equal Opportunities Impact Assessment

The EIA has been assessed as low/medium and therefore does not require a fill EIA. For the purpose of this policy where there is a reference to communication the needs of all people in the context of language reading difficulties or disabled groups will need to be considered.

All staff should undertake equality and diversity awareness training.

17.2 Training and Education Plan

All personnel involved in implementation of this policy should undergo an annual training programme as a minimum. This policy will then form part of the directorate internal mandatory programme to alert ongoing training needs or changes.

- PLR management training is available throughout the year on a self-directed basis via files share.
- Post mortem consent training is available throughout the year, no less than bi monthly sessions held.
- An annual bereavement study day will be held and all staff invited to attend.

- As part of the health boards induction programme all staff undertaking an induction with receive bereavement training to include post mortem consent.

17.3 Risk Management

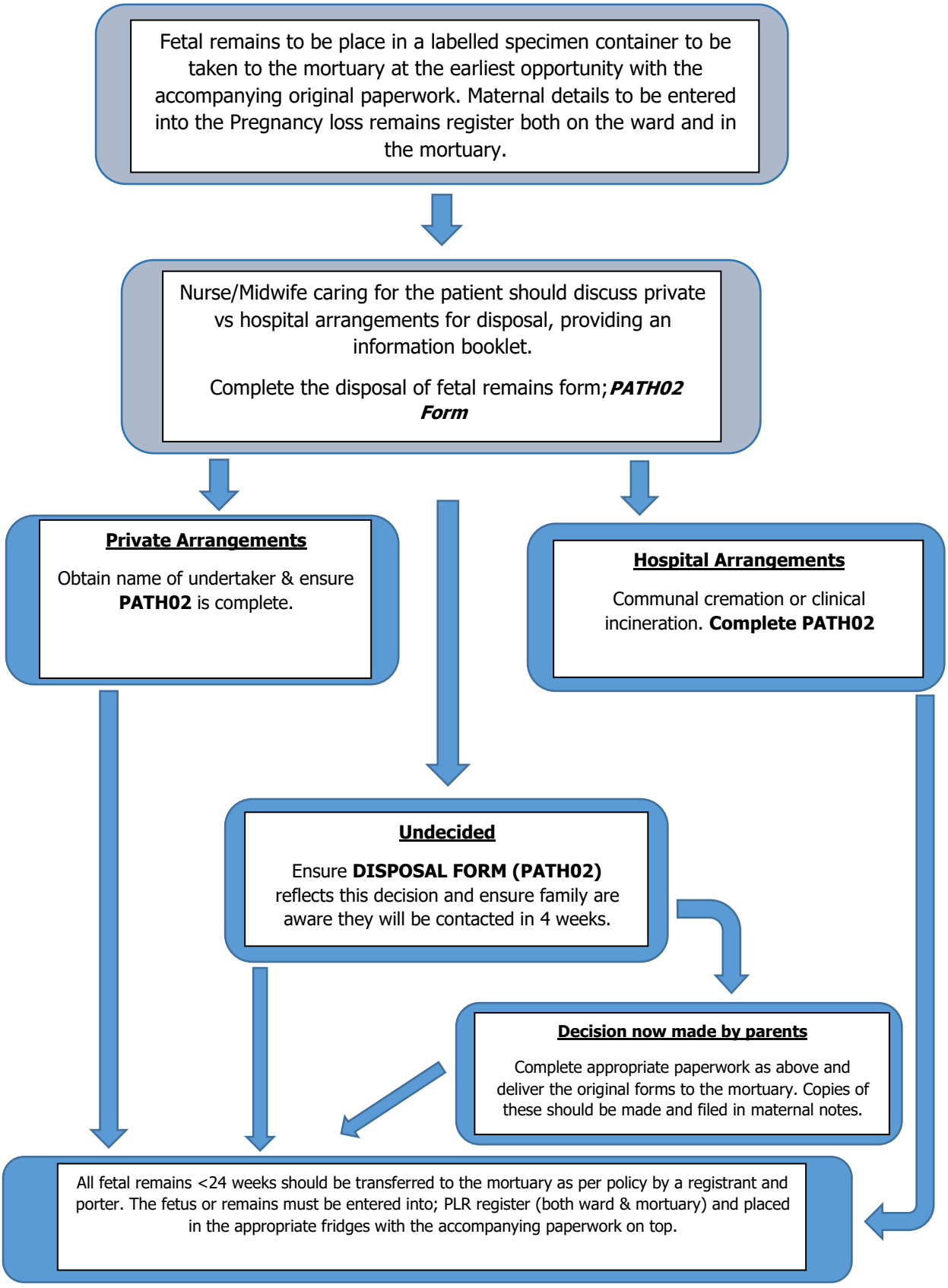
Any incidents occurring as a consequence of non-compliance with the policy will managed in line with the adverse incident policy. This policy will be subject to internal audit requirements and be placed on the Directorate audit business plan.

18.0 REFERENCES

- Human Tissue Act 2004
- Abortion Act 1967
- Lactation and loss: Management of lactation following the death of a baby. A Framework for Practice British Association of Perinatal Medicine (BAPM May 2022)
- NMC Circular 0/3
- Welsh Health Circular (92)
- Human Tissue Authority Code of practice 5
- Late Intrauterine Fetal Death and Stillbirth. RCOG Green top guideline no: 55, Oct 2010.
- Gomez Ponce de León R, Wing D, Fiala C. Misoprostol for Intrauterine fetal death. Int J Gynaecology Obstet 2007(99) S190–S193.
- NICE guideline on Induction of Labour NG207 (Nov 21)
- Misoprostol Clinical guidelines - www.misoprostol.org

APPENDIX ONE - FLOWCHART FOR THE MANAGEMENT OF FETAL REMAINS

FOR ALL MISCARRIAGES UP TO 24 WEEKS, ECTOPIC PREGNANCIES AND TERMINATION OF PREGNANCY



APPENDIX TWO

PART A: Consent for respectful disposal of pregnancy loss remains under 24 weeks gestation

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

MOTHERS INFORMATION	
Hospital No.	D.O.B
Surname:	
First name(s):	
Address:	
Post Code:	NHS No.

This form enables you to consent for the respectful disposal of pregnancy remains delivered before the 24th week of gestation of the person named below. For each section please **INITIAL** the relevant box(s).

Hospital	Ward	Date

- I confirm that I have had the opportunity to read ***'Your choices following pregnancy loss'*** booklet
- I have had an opportunity to ask questions about the disposal options.
- Any questions I have asked have been answered to my satisfaction.

Initial ☐

Consent for disposal: <u>Initial ONE option only</u>

A. Communal Cremation at; **Initial** ☐

☐ Glyntaff Crematorium ☐ Llwydcoed Crematorium ☐ Coychurch Crematorium

B. Sensitive Incineration by Cwm Taf Morgannwg University Health Board **Initial** ☐

C. Private Arrangements **Initial** ☐

Appointed funeral Director_____

D. Undecided **Initial** ☐

Contact telephone number_____

Details of person giving consent

I have discussed the options above with my care team and hereby make an application for the option I have chosen below, in respect of my pregnancy remains. I indicate my consent by signing this application. I acknowledge that it is not possible to recover any individual ashes following communal cremation or sensitive incineration:

I also understand that if I am unable to provide the name of an appointed funeral director to organise my private arrangements or provide my preferred disposal option after 60 calendar days then the health board will proceed with sensitive incineration

NAME:	
SIGNATURE:	DATE:

Details of Health care professional obtaining consent

NAME:	SIGNATURE

POSITION:	DATE:
IDENTIFIER:	EXTENSION:

PART B: Certificate of Midwife/Nurse Practitioner or Medical Practitioner in Respect of Pregnancy Remains

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

TO BE COMPLETED BY A MIDWIFE, NURSE OR MEDICAL PRACTITIONER

This is to certify that I have examined the pregnancy remain of;

Mothers name

on Date at Time was of a gestation up to and

no more than gestation Weeks and that the foetal remain showed no signs of life

Declaration of Health care professional	
NAME:	SIGANTURE
GRADE/POSITION:	DATE:
NMC/GMC No::	BLEEP:
The above signatory must be either the medical practitioner, registered nurse or registered midwife who delivered the baby or the head of the clinical unit.	

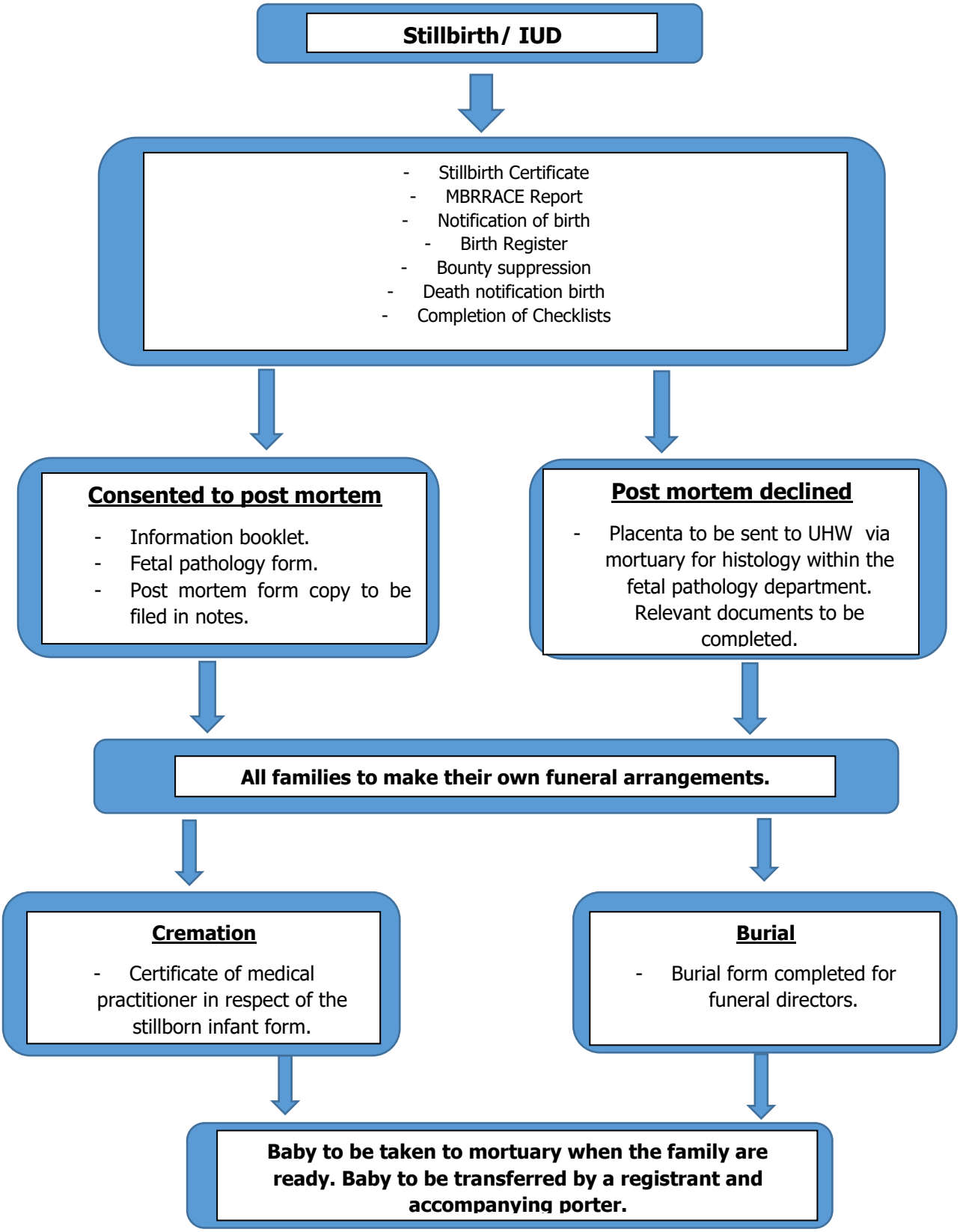
Notification of further investigation

A. Histology	
B. **Cytogenetic Investigation**- NOTE: All Wales Medical Genetics Service general request form http://www.wales.nhs.uk/sites3/Documents/525/Cytogenetics%20From%20UKAS%20LOGO.pdf	
C. **Post Mortem Examination –** NOTE: The Consent for a Post-Mortem Examination of a Fetus, Baby or Child form must be completed with the family **And;** Request for fetal, perinatal or infant post mortem examination form	

Property: Please list all property sent with the pregnancy remains:

APPENDIX THREE FLOW CHART FOR DOCUMENTATION

**** Documentation packs will all relevant paperwork packs are available on all Labour Wards ****



APPENDIX FOUR

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Release form of a deceased infant or fetus

Baby entered into mortuary register ☐

Site: PCH ☐ POWH ☐ RGH ☐ NPTH ☐ Singleton ☐

Name of patient:

Address:

Infant/fetus date of birth:

Confirmation date/time no signs of life:

Hospital site:

Mode of transport to non-hospital location:

Time & Date released from hospital site:

Police informed ☐ **Community Midwife informed** ☐

Bereavement Midwife informed ☐ **Mortuary informed** ☐

Name of registrant: **Signature:**

APPENDIX FIVE

Practical arrangements following a pregnancy loss under 24 weeks

Please click on the link below to access this.

Practical arrangements following a pregnancy loss under 24 weeks

APPENDIX SIX

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Bereavement Checklist Stillbirth

24 weeks and over

Specialist Bereavement Midwife 07918 355 257
Myscha-dene.Bates@wales.nhs.uk

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

IUD/STILLBIRTH CHECKLIST

To be used alongside the Bereavement Guidance Folder

Actions	YES/NO	Signature	Date/Time
IUD confirmed by scan 1st Scan ☐ 2nd Confirmatory Scan ☐			
Parents sensitively informed of their baby's death.			
Consultant on call informed			
Consultant or Registrar consultation (please print name)……..			
Plan of care discussed and documented (including maternal blood tests to be taken post-delivery)			
Discuss appropriate clothing/items parents could consider bringing in for their baby (if they wish).			
Discussion surrounding analgesia options for labour.			
FBC, Coagulation, CRP, U&E's, Group & Save, Keilhauer (in cases of unknown cause of IUD not fetiscide) ***even if patient is not RH negative.***			
Discuss post mortem with parents allowing ***(only if All wales trained within the last 2 years) Results are taking between 12-16 weeks. Baby is returned when the examination is complete this is usually within a week but please DO NOT give specific time scales.***			

Provide parents with the 'Deciding about a post mortem: Information for parents' leaflet to take home and consider prior to making any decisions regarding PM. **Given- YES** ☐ **Given- NO** ☐			
ACTIONS	**YES/NO**	**TIME/DATE**	**SIGNATURE**
Parents informed of the time/place they should arrive at within the hospital (if they have gone home prior to induction). Please state **Time/Date:……** **Unit Aware** ☐ **Bereavement Midwife aware** ☐ **Time/Date:……**			
MIFEPRISTONE AND MISOPROSTOL ***Consider Propess if last trimester*** Prescribed and discussed. ****Consider adjusted dose for previous Caesarean Section or uterine surgery****			
Commence; MEWS ☐ WATERLOW ☐ MEDICATION CHART ☐ PARTOGRAM (22weeks only) in keeping with PMRT ☐			
Orientate woman and family to the surroundings upon arrival including use of call bell. ☐			
Consider early IV access			
Mifepristone Given			

Prescribed dose in keeping with local policy ☐ **Date:** **Time:** **Dose:**			
On Admission **Patient pain assessment NAD ☐** **Patient PV loss assessment NAD ☐** **MEOWS score NAD ☐**			
Misoprostol Given **Prescribed dose in keeping with local policy ☐** **All documentation should be prescribed, given and signed for as per the medication chart**			

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

IUD/STILLBIRTH CHECKLIST 2

TO BE COMPLETED FOLLOWING THE BIRTH OF THE BABY

Actions	YES/NO	Signature	Date

Parent's offered the opportunity to see/hold their baby at birth. -***offer use of cuddle/cold cots***			
Conformation of no signs of life ***TIME/DATE***:……..			
Memory making;) - Offer professional photos - Hand/footprints and/or clay impressions. - Offer parents to take own photos or use of our camera. - Lock of hair if possible. - Offer chaplaincy Blessing - Dressing/Bathing - Weigh/Measure - Memory Box - Offer opportunity to take baby home (cuddle cot available)- ***Complete relevant forms for this if YES.*** **Complete:** - Identity bands - WPAS/MITS/Grow - Birth register/MBRACE book - Relevant SB/IUD paperwork. - Bounty suppression form. - DATIX report ***DATIX number:*** Email Bereavement Midwife with patient details, please inc history/phone number. **INFORM POW COMMUNITY TEAM VIA EMAIL:** **CTM_Brynhyfryd_Community_Midwives@wales.nhs.uk** CTM_Glanymor_Community_Midwives@wales.nhs.uk CTM_Penyfro_Community_Midwives@wales.nhs.uk **INFORM PCH community via notification to the designated team**			

Ongoing Investigations

Action	YES/NO	DATE/TIME	SIGNATURE
If **YES** to PM Individual obtaining consent **STOP** and ensure consent for PM is carried out by a clinician who is up to date trained and registered on ***The All Wales national database. Ring UHW if you are unsure or Bereavement MW.***			
If parents' consent to post mortem ensure the following are complete: - **Pink** copy to parents - **Green** copy in the notes. - **White** copy to go with baby. - Request for examination of fetal/infant/paediatric remains form. - The placenta must be sent with baby ***(does not require a histology form IF yes to PM).*** - UHW to be informed of transfer of baby to them ***02920 748 421***			
Name of person having PM discussion……			

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Ongoing Investigations Continued

Actions	YES/NO	DATE/TIME	SIGNATURE
If YES to Cytogenetics but NO to PM, a fetal skin sample should be obtained by a clinician within the unit. -Obtain sample less than 1ml (5p piece) in size, immersed in saline or culture medium, and contained in a sealed leak-proof, standard sized universal container. -Samples to be transported from mortuary services to the ***All Wales Genetics Laboratory*** at the University Hospital of Wales hospital using using **urgent transport** arrangements- private taxi using our cost code. ***Refer to the trusts SOP for cytogenetic sampling for further guidance, medical staff can assist with obtaining this. Babies should not***			

be sent to UHW solely to have this sample obtained.			
Provide blood forms for the woman's repeat ***thrombophilia and APLA*** screening to be performed 6 weeks post delivery			

Placenta Care Checklist

ACTION	YES/NO	DATE/TIME	SIGNATURE
PLACENTA ***Examine and swab the placenta*** **1.**Ensure placenta is placed in an opaque container, no formalin, fixative or fluid should be added. Affix mothers addressograph to the side of the container. **2.**Placenta to be transferred to the mortuary at the **earliest available opportunity.** The placenta is recorded in the ***'property' field*** in the ***main mortuary ledger*** where you will record the infant details as **STILLBORN INFANT OF: MOTHERS M NUMBER/details.** **3**.If placentas are being **temporarily** stored in the labour ward fridge ***(hours not days)*** whilst parents spend time with baby this **MUST** be			

clearly recorded in the FRIDGE ledger. This should reflect at **what time/date** the placenta was clerked into the fridge, and **who by**. Its **exit** from the fridge for transfer and **where it is being taken MUST** also be recorded to ensure end to end traceability. **4**.Prior to transfer to the **mortuary** the placenta & baby must be recorded in the ***"Stillborn infant or neonate transfer ledger"*** before leaving labour ward for traceability purposes.			

Placenta Care Continued

ACTION	YES/NO	DATE/TIME	SIGNATURE
2nd PLACENTA CARE CHECK POINT! **PLACENTA TRANSFERRED TO MORTUARY SEPARATELY TO BABY. MORTUARY REGISTER COMPLETE TO REFLECT THIS BY:.....** **TIME/DATE:** **PLACENTA STORED TEMPORARILY IN LABOUR WARD FRIDGE, WITH FRIDGE LEDGER COMPLETE, FOR**			

TRANSFER WITH BABY ON…… **TIME/DATE:** **PLACENTA TRANSFERRED WITH BABY TO THE MORTUARY AND RECORDED IN THE RELEVANT 'STILLBIRTH AND NEONATAL DEATH INFANT TRANSFER REGISTER'** **TIME/DATE:**			
On arrival to the mortuary infant details MUST be recorded in the MAIN MORTUARY LEDGER. PLACENTA TO BE RECORDED IN THE ''PROPERTY FIELD'' **Record details as:** **STILLBORN INFANT OF: MOTHERS DETAILS/STICKER.** **NEONATE: BABYS DETAILS/ STICKER**			

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

STILLBIRTH/IUD CHECKLIST 3

TO BE COMPLETED PRIOR TO DISCHARGE

Actions	YES/NO	Signature	Date
Is this a coroner's case?			

If YES has a phone call to the coroner by the obstetrician been made and a referral to coroner sent? Please ***DO NOT*** hand this over, this must be completed in a timely fashion to ensure this is not missed. ***Name of person making referral*** ***……*** ***Job title:***			
If **YES** to coroners referral please inform your senior team in a timely manner.			
Community Midwife informed INFORM COMMUNITY TEAM VIA EMAIL: **CTM_Brynhyfryd_Community_Midwives@wales.nhs.uk** **CTM_Glanymor_Community_Midwives@wales.nhs.uk** **CTM_Penyfro_Community_Midwives@wales.nhs.uk**			
All appointments **cancelled** and ANC informed			
GP informed			
Health Visitor informed			
Newborn Hearing informed			
Bereavement lead informed			
Scan medical certificate of stillbirth to bereavement midwife for the registrar. **The original must be sent to the mortuary with baby in an addressographed envelope ''FAO Bereavement officer''** Writing **MUST** be clear and legible and the individuals NMC or GMC pin clearly written. ***Please see the bereavement folder for an example copy.***			
Memory box and personal belongings given to parents.			
Contact details for Bereavement Midwife given			
Patient in postnatal discharge book for ***CMW & Discharge paperwork complete.***			
Inform family of annual memorial service dates. ***Please note these are not being held during COVID.***			

Inform patient of available support: community MW, bereavement MW, bereavement counsellor, and support groups. ***Please do not inform women that they will receive a specific pattern of visits as their individual plan of care will be discussed with them when contact is made. Reassure women that the specialist midwife and community team will be in touch to provide support.***			
Consider Thromboprophylaxis- refer to VTE chart and policy for correct doses. ***Cons/Reg discussed with:*** **.....**			
Take home prescription given			
Offer ***Cabergoline*** for lactation suppression. BP check must be booked for CMW in the days to follow if uptaken.			
Case notes to risk team- ***please ensure they are tracked.***			
Postnatal check prior to discharge NAD Discuss; Wound care ☐ PV loss ☐ After paints ☐ Signs/Symptoms of infection ☐ Perineal care ☐ Emotional well being ☐ Contraception ☐ Available Support ☐			

PMRT
Supporting high quality local perinatal reviews

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Perintal Mortality Compliance Check list

The actions below can only be completed with a member of the senior team, specialist midwife or risk midwife at an appropriate time.

Please contact the bereavement lead for a nominated team member.

Contact clinician NAME & ROLE:……

Action	YES/NO	Signature of senior team member	Date/Time completed
MBRACE reported **Name of reporter:** **……** **MBRACE Reference:** **……**			
Opportunity for parents to share their perspective.			
PMRT leaflet for parents provided.			
Parents perspective documented on a PMRT parents perspective feedback form appropriate to their loss.			
Added to Bereavement team database.			

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FINAL PAPERWORK CHECKLIST

MUST BE CHECKED WITH THE BAND 7 ON DUTY

Paperwork	Completed? YES/NO	Signature	Date

Post Mortem consent form. ***Original (if having PM).***			
Request for examination of fetal/perinatal/ paediatric remains form (Only if having PM) –***Original with baby, copy in the notes.***			
Histology Form for placental examination ***Note on the form 'for the attention of UHW'*** ***Please <u>DO NOT</u> send these placenta's to Singleton. UHW only VIA MORTUARY.***			
Cremation 9 form-'' Burial arrangements in respect of a Stillborn'' form. ***Original to go with baby, copy in notes.***			
Transport of a stillborn or Neonate to UHW form ***(if baby is going for PM)***			
Release form of the deceased infant- ***for babys going home ONLY. Make a copy for the notes, original to be given to the family.***			
Medical certificate of stillbirth-(large A3 out of book) - scan to the bereavement midwife. **Original must go to the mortuary with baby in an addressographed envelope FAO**			

bereavement officer.			

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Bloods to Consider

If you are uncertain about bottle colours of quantity ring microbiology to confirm.

All cases	ALL Unexplained IUD	Specific to cause

-FBC, G&S **-Coagulation screen including fibrinogen** **-Kleihauer** **-Fetal post-mortem (full / limited)** **-Cytogenetic analysis in relevant cases**	**-CRP** **-TORCH** **-Parvo virus** **-Rubella** **-Syphilis (particularly in presence of polyhydramnios and/or fetal hydrops)** **-Thyroid function** **-Placental swab** **-Placental Histology in UHW** **-HbA1c** **-MSSU, HVS or LVS.** *** Blood for antiplatelet antibodies only required if auto immune thrombocytopenia suspected *** **Lupus-anticoagulant;** **Anticardiolipin antibodies;** **Factor V Leiden Prothrombin gene mutation; *Repeat thrombophilia and APLA screen 6 weeks post-delivery;**	**<u>Placental abruption</u> –** **Placental histology UHW, thrombophilia screen.** **<u>Chorioamnionitis</u>** **Infection screen including blood cultures, placental swab, swabs from baby.** **<u>If IUGR suspected</u>** **Lupus-anticoagulant;** **Anticardiolipin antibodies;** **Factor V Leiden Prothrombin gene mutation; *Repeat thrombophilia and APLA screen 6 weeks post-delivery;** **<u>If h/o itching or jaundice</u> LFT and bile acid.** **<u>Parental karyotyping</u> Indicated if:** **fetal unbalanced translocation;** **other fetal aneuploidy, e.g. 45X; fetal genetic testing fails and history; - suggestive of aneuploidy (fetal abnormality on post mortem, previous unexplained IUFD, recurrent miscarriage).**

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Pattern of Care

1) The bereavement midwife should receive a referral from the clinician. This should include the clinical history, contact details for the woman, name and choices around post mortem and funeral

care.. This support should be offered to all women and their families and their wishes respected to accept or decline. If they decline this does not mean they cannot re-engage for support at a later date if they wish.

2) A call out to be arranged with the community midwife for physical and emotional support. If women decline to have a home visit, please ensure a telephone call is made by community.

3) The woman will (if she accepts) will receive follow up contact from the specialist midwife in the days following discharge. A support and a care plan will be created based on the woman's individual needs, in keeping with the new national standards.

4) The specialist midwife will liaise closely with all agencies to coordinate care, follow up and results, you do not need to arrange follow up or organise the registration of baby.

5) The woman and her family will be offered counselling from our specialist baby loss counsellor at an appropriate time. Counselling is not effective within the first very raw weeks of any pregnancy loss or major trauma.

6) The woman and her family will receive direction and support to the trusts support groups at a time that is appropriate for them (one in Bridgend one in Merthyr)

7) The woman will receive ongoing support when results are available and into subsequent pregnancies in the future.

This checklist is intended for use alongside the Bereavement Guidance folder situated on labour ward. This should not replace professional documentation but acts as a prompt/guide system for provision of care. Please be mindful that during COVID 19 some services and processes may differ, refer to the bereavement guidance folder where changes are noted.

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ADDRESSOGRAPH

Mothers Care Pathway

If you have any concerns, or if your midwife has not visited by 3pm the day after discharge from hospital, please contact:

POW Ward 12 – 01656752309

POW Labour Ward – 01656 752383

PCH ward 21 - 01685 728890

PCH labour ward – 01685 728870

Remember to bring your notes with you to any hospital appointment

Signature Sheet

Initials	Print Name	Designation

Postnatal Appointments

Date	Reason for visit	Location

Postnatal thromboprophylaxis risk assessment and management

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Postnatal assessment and management to be assessed on delivery suite:

Any previous VTE
Anyone requiring antenatal LMWH
High-risk thrombophilia
Low-risk thrombophilia + FHx

→ **HIGH RISK**
At least 6 weeks

C-section in labour
BMI >40
Readmission or prolonged admission (>3 days) in the puerperium
Any surgical procedure in the puerperium except immediate repair of the perineum
Medical comorbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU

→ **INTERMEDIATE RISK**
At least 10 days' postnatal prophylactic LMWH
NB If persisting or >3 risk factors, consider extending thromboprophylaxis with LMWH

Obesity (BMI >30)
Age >35
Parity ≥23
Smoker
Elective C-section
Family history of VTE
Low-risk thrombophilia
Gross varicose veins
Current systemic infection
Current pre-eclampsia
Immobility e.g. Paraplegia, PGP, long-distance travel
Multiple pregnancy
Preterm delivery in this pregnancy (<37 weeks)
Stillbirth in this pregnancy
Mid-cavity rotational or operative delivery
Prolonged labour (>24 hours)
PPH >1 litre or blood transfusion

→ **Two or more risk factors**

→ **Fewer than two risk factors:**
LOWER RISK
Early mobilisation and avoidance of dehydration

Name: ..... Signature: ..... date: ..... time: .....

For prescribing guidance please see over page

Adapted from: Royal College of Obstetricians and Gynaecologists. Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. Green-top Guideline No.37a. April 2015.

Antenatal and postnatal prophylactic dose of LMWH:

Weight	Enoxaparin	Dalteparin	Tinzaparin (75units / kg / day)
<50kg	20mg daily	2500 units daily	3500 units daily
50-90kg	40mg daily	5000 units daily	4500 units daily
91-130kg	60mgdaily*	7500 units daily	7000 units daily*
131-170kg	80mg daily*	10,000 units daily	9000 units daily*
>170kg	0.6mg/kg/day*	75 units/kg/day	75 units/kg/day*
High prophylactic dose for women weighing 50-90kg	40mg twice daily	5000 units twice daily	4500 units twice daily

*may be given in 2 divided doses

Contraindications / cautions to LMWH use:

- Known bleeding disorder (e.g. haemophilia, von Willebrand's disease or acquired coagulopathy)
- Active antenatal or postpartum bleeding
- Women considered at increased risk of major haemorrhage (e.g. placenta praevia)
- Thrombocytopenia (platelet count< 75 x 109/1)
- Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)
- Severe renal disease (glomerular filtration rate [GFR] < 30 ml/minute/1.73m2)
- Severe liver disease (prothrombin time above normal range or known varices)
- Uncontrolled hypertension (blood pressure> 200 mm Hg systolic or> 120 mm Hg diastolic)

Postnatal Handover from Labour Ward to Postnatal Ward / Community

Date: Time:

Intrapartum Midwife:

Postnatal Midwife / Community Team :

Maternal Care Plan

Mode of delivery: EBL:

Obs: Hourly □ Four Hourly □ Twice Daily □ Once Daily □ Other □

Sepsis: Yes □ No □

Antibiotics: IV □ PO □ N/A □

Venflon: Yes (See VIP chart) □ No □

Catheter: Insitu □ N/A □

FBC required: Yes □ No □

MMR: Immune □ Susceptible □

Anti D required: Yes □ No □

Kleihaur Bloods taken: Yes □ No □ N/A □

Daily Postnatal Examination

Date: Time: Postnatal Day:

Examination	✓× or NA	Examination	✓× or NA
Breasts		Temperature	
Uterus		Pulse	
Lochia		Blood Pressure	
Perineum (daily)		Respiratory Rate	
LSCS Wound Site (daily)		Urinary Output: 1st/2nd within 6 hours post SVD	(>250ml x 2)
Wound Drain		Catheter	1st: 2nd:
Venflon/IVI		Bowels Open (within 3 days post delivery)	
Legs (DVT?)		Psychological and emotional well-being	

Time	Comments & Care Plan	Signature

Daily Postnatal Examination

Date: Time: Postnatal Day:

Key: ✓ Normal

× Abnormal – provide comments below

NA Not applicable

Examination	✓× or NA	Sign	Examination	✓× or NA	Sign
Breasts			Temperature		
Uterus			Pulse		
Lochia			Blood Pressure		
Perineum (daily)			Respiratory Rate		
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Time	Comments & Care Plan	Signature

Time	Comments & Care Plan (Continued)	Signature

Daily Postnatal Examination

Date: Time: Postnatal Day:

Key: ✓ Normal

× Abnormal – provide comments below

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Time	Comments & Care Plan (Continued)	Signature

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