GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

Late Intrauterine Fetal Death (Ultrasound)

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	June 2023

Item No.	Contents	Page
1	Introduction	6
2	Objective	6
3	Definitions	6
4	Responsibilities	7
5	Process	8
6	Monitoring Compliance, audit and review	11
7	References / Bibliography	11

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Maternity Policies Group
Radiology Ultrasound Board
Women’s and Children’s policies group

Circulated to the following for Consultation

Date	Role / Designation
07.03.22	DAU Midwife Sonographers / Consultant Midwife /
	Assistant Head of Midwifery / Governance Lead for Ultrasound, Head of Radiology, Powys Midwives,
20.06.22	Safeguarding
20.06.22	W&C Policies & Procedures Oversight Group
11.04.23	Radiology Department

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? RCOG (2010) Late Intrauterine Fetal Death and Stillbirth All Wales Midwife Led Care guidelines SCoR/BMUS Standards for the provision of an ultrasound service (2014) SCoR/ BMUS Guidelines for Professional Ultrasound Practice (2021)

IMPACT ASSESSMENTS

Equality Impact Assessment Summary

	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impacts that may arise from the implementation of this policy***
Age	x				
Disability	x				
Gender reassignment	x				
Pregnancy and Maternity	x				
Race	x				
Religion or Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and Civil Partnership	x				
Welsh Language	x				

Risk Assessment Summary

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No risks identified with the implementation of this policy.
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? No information governance issues identified from the implementation of this policy.
Have you identified any training and / or resource implications as a result of implementing this? No training or resource implications identified from the implementation of thus policy.

1 Introduction

The Perinatal Mortality Surveillance Report (CEMACH) defined stillbirth as 'a baby delivered with no signs of life known to have died after 24 completed weeks of pregnancy'. Intrauterine fetal death refers to babies with no signs of life in utero.

Stillbirth is common, with 1 in 200 babies born dead.3This compares with one sudden infant death per 10 000 live births. There were 4037 stillbirths in the UK and Crown Dependencies in 2007, at a rate of 5.2 per 1000 total births. The overall adjusted stillbirth rate was 3.9 per 1000. Rates ranged from 3.1 in Northern Ireland to 4.6 in Scotland.

Overall, over one third of stillbirths are small-for-gestational-age fetuses with half classified as being unexplained. The 8th Annual Report of the Confidential Enquiries into Stillbirths and Deaths in Infancy (CESDI) identified suboptimal care as being evident in half of the pregnancies. The stillbirth rate has remained generally constant since 2000. It has been speculated that rising obesity rates and average maternal age might be behind the lack of improvement; a systematic review identified these as the more prevalent risk factors for stillbirth.

In addition to any physical effects, stillbirth often has profound emotional, psychiatric and social effects on parents, their relatives and friends.

2 Objective

- To standardize the process when confirming an intrauterine fetal death by ultrasound
- To identify intrauterine fetal death by ultrasound
- To break bad news sensitively when an intrauterine death is confirmed
- To facilitate referral to the District General Hospital to which the woman is booked or wishes to transfer her care
- To accurately document findings

3 Definitions

- **PTHB** Powys Teaching Health Board
- **IUD** Intrauterine Death
- **RCOG** Royal College of Obstetricians and Gynecologists
- **DGH** District General Hospital

4 Responsibilities

4.1 Head of Midwifery and Assistant Head of Midwifery

- Ensure that robust procedures are in place in order that PTHB can discharge its organisational responsibilities in the provision of safe services to the Powys population of pregnant women.
- Ensure the overall implementation of the guidance.
- Ensure all staff read and understand this procedure. Support allocation of resources to ensure compliance with this procedure.
- Chair the Governance oversite meetings

4.2 Training and Governance Lead for Ultrasound

- Audit monthly sets of images for each midwife sonographer
- Provide support and guidance on DATIX investigations
- Support with debriefing midwife sonographer
- Provide training in relation to policy as appropriate

4.3 Midwife Sonographer

- Datix diagnosis of an IUD as per 'Trigger List'
- Assist with DATIX investigations to improve service delivery through learning and recommendations for service improvement
- Assist with training and support of MSW and Community Midwives
- Be responsible for collection of data and audit
- Liaise with the DGH Obstetric Team to provide efficient and timely care
- Communication with the community midwife regarding ultrasound findings and any action taken
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4.4 Community Midwife

- Appropriate referral to the DAU for assessment
- Attend the with the woman if possible and support the woman during or post findings
- Contact the woman following the diagnosis of an IUD to offer support and signpost to relevant organisations

4.5 Maternity Support Worker

- Retrieve medical records for DATIX investigations

- Support midwife sonographer in contacting DGH with referral
- Provide support to the woman and act as a chaperone
- Ensure equipment and environment is maintained and supplies are available
- Assist with data collection and audit
- Act as scribe for times and record keeping
- Assist with ensuring the woman and her attendees are cared for while the midwife sonographer is in communication with the DGH

5 Process

5.1 Referral for Ultrasound Scan

In the event of a suspicion of intrauterine death:
The community midwife should refer to the nearest hospital or hospital of the woman's choosing. Referrals should be undertaken through the hospital triage.

If referring for an ultrasound scan to a Powys Maternity Day Assessment Unit, the community midwife must phone to ensure a midwife sonographer is available and complete a referral form. It is preferred that the community midwife attend for the ultrasound scan with the woman for support and as a chaperone.

In the event of a confirmed intrauterine death:
If an IUD is identified at ultrasound scan or following referral from community midwife into the ultrasound service. The on-call consultant at the respective DGH should be notified and a plan of care agreed.

5.2 Scanning Process

Real-time ultrasound is essential in the accurate diagnosis of an intrauterine fetal death. Fetal heart imaging must be augmented with M mode and colour doppler of the fetal heart and umbilical cord. Consideration should be made for poor image quality maternal obesity, abdominal scar, and/or oligohydramnios.

Growth measurements should be attempted to assist with the post-mortem and delivery management. The measurement accuracy may not be accurate depending on the length of fetal demise and secondary features documented.

Secondary features of fetal death include:

- Overlapping and misalignment of the fetal skull bones (Spalding's sign), and

- Presence of gas in the fetal heart and blood vessels (Robert's sign)

  The Spalding's sign is not usually present until a week after death whereas gas formation may be seen after only 2 days.
- Gross distortion of the fetal anatomy
- Soft tissue oedema skin >5mm
- Echogenic amniotic fluid

An offer should be made to the woman to see on screen the findings but her decision not to must be respected. A second ultrasound scan/opinion for diagnosis should be obtained to confirm findings in accordance with the RCOG (2010) Late Intrauterine Fetal Death and Stillbirth guidance.

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Suspected

- When IUFD is suspected an ultrasound scan will take place as soon as possible and where possible at the closest local hospital.
- For midwife ideally to be present during the scan as a support to the woman
- To be accompanied by person of her choice
- To be given bad news sensitively
- Following confirmation of intrauterine death for referral to the DGH of woman's choice as soon as possible
- A set of observations including blood pressure, maternal pulse, temperature, respirations, and urinalysis should be recorded in the woman's handheld records.

Unexpected

- To give bad news sensitivity
- Following confirmation of intrauterine death for referral to the DGH of woman's choice as soon as possible
- Inform midwife
- A set of observations including blood pressure, maternal pulse, temperature, respirations and urinalysis should be recorded in the woman's handheld records.

Giving Bad news

- Offer to show the parent(s) their baby on the ultrasound monitor
- Take a memorial photo that can be retained in the notes if the parent(s) wish to have it later.
- Offer time alone and where possible escort to a private room
- In unexpected circumstances where the woman is unaccompanied, take to a private room and call a person of their wishes

- Written information should be offered to supplement discussions, either from the hospital the woman wishes to birth at and/or the RCOG leaflet 'Information for You' (2012) downloaded from the internet
- Inform the woman that if she starts to feel unwell, she is advised to contact the hospital immediately to avoid sepsis.
- The woman should be prepared for the possibility of passive fetal movements and will be advised that if they occur, she will be offered a further scan.

5.3 Documentation and Information

If the woman is unaccompanied an immediate offer should be made to call her partner, relatives, or friends.

Written information should be offered to supplement discussions either from the hospital the women wish to birth at and/or the RCOG 'Information for You' (2012) leaflet downloaded from the internet.

Discussions should aim to support maternal/paternal choice and include signposting to organisations for support if required e.g., SANDS.

- Complete RADIS report and send PACS Images
- File report in the woman's handheld records and copy to community midwife
- Complete DATIX
- Inform community midwife team for follow-up

5.4 Referral to DGH

Referral should be made to the hospital at which the woman is booked or wishes her care to be transferred. The referral should be made through the consultant on call and the labour ward coordinator, and an appointment arranged for her to attend for confirmation and diagnosis, and to discuss plan of care within 48 hours due to the risk of disseminated intravascular coagulation and sepsis. Attendance at a hospital should be expedited if severe fetal maceration is noted.

- Refer to the chosen DGH via on-call consultant and labour ward coordinator
- If any blood tests are requested by the DGH, including Kleiheur test these should be taken, and blood forms accurately completed. It is essential to write 'intrauterine death on the request form for Rhesus positive women.

- Contact phone number and contact name for the labour ward the women are being transferred to must be given
- The woman should be reminded to take her handheld records including blood results and scan reports with her.
- The woman should be informed that a repeat scan may be offered on arrival to hospital.
- The designated community midwife or the team members on duty should be informed of the referral as well as the operational team lead.

6 Monitoring Compliance, Audit & Review

It is a requirement that a DATIX is submitted for an incident listed on the 'Incident notification List' and any adverse incident that is of concern and requires further investigation. Feedback of findings and trends should be undertaken at regular intervals through the clinical incident meetings held monthly and in the DAU oversight meeting.

Peer/ consultant review of cases will be arranged periodically to monitor practice.

Auditing will be undertaken as appropriate to ensure clinical standards and governance measures meet clinical professional standards. Image audits are to be completed monthly, for growth, dating and anomaly scans and performed by the training and governance lead Sonographer. A monthly report will be sent to the Head of Midwifery, Assistant Head of Midwifery, Head of Radiography and will be fed into the maternity day assessment unit governance oversight meeting/pathways meeting.

Record keeping audits must be performed to ensure compliance with NMC standards using the template created by the Clinical Supervisor for Midwives. Balanced feedback should be provided to DAU staff for reflection and practice review. Review of the audit should recognize trends for further investigation.

Self-audit of ultrasound images and record-keeping forms part of the audit and review process and time must be allocated for this to occur.

7 References / Bibliography

If you include a PTHB document, please ensure you have the document code and correct title.

Confidential Enquiry into Maternal and Child Health (CEMACH). Perinatal Mortality 2007: United Kingdom. CEMACH: London, 2009 [http://www.cmace.org.uk/getattachment/1d2c0ebc-d2aa-4131-98ed-56bf8269e529/PerinatalMortality-2007.aspx

Confidential Enquiry into Stillbirths and Deaths in Infancy. 8th Annual Report. London: Maternal and Child Health Research Consortium; 2001 [http://www.cmace.org.uk/getattachment/8ce7dc4e-6d7d-47cc-8cee-7c0867941606/8th-annualreport.aspx].

RCOG (2010) Late Intrauterine Fetal Death and Stillbirth

All Wales Midwife Led Care guidelines