National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Stillbirth – Prevention, Investigation, Management and Care

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the prevention, of stillbirth as well as in the investigation, management and care of pregnancies complicated by stillbirth.

Following a comprehensive literature review a number of evidence-based recommendations for the prevention, investigation, management and care of Stillbirth were agreed upon.

Key Recommendations

RISK FACTORS: Preconceptual and antenatal risk factors

1. Healthcare professionals that are involved in the delivery of care to pregnant women should be familiar with the preconceptional and antenatal risk factors that may increase the risk of stillbirth. These risk factors are diverse and can be broadly classified as maternal, fetal or related to pregnancy-specific conditions.
2. It is important for healthcare professionals to recognise that a risk factor may not exist in isolation and that an individual woman's risk for an adverse pregnancy outcome, specifically stillbirth, may depend on the complex interplay of several variables.
3. While some risk factors for stillbirth may be present from the onset of pregnancy, some may emerge as the pregnancy progresses. Healthcare professionals should be vigilant of this in their interactions with pregnant women, regardless of the setting.
4. While the terms modifiable and non-modifiable have traditionally been used when describing risk factors, it should be noted that these terms have limitations and they do not acknowledge the complexity of the risk factor, the environment, resourcing and human behaviour. As such, all risk factors should be considered as potentially modifiable when it comes to devising risk-reduction strategies, both at a local and national level.
5. Risk factors should be identified and clearly communicated to the woman in a sensitive manner, using language that is clear and devoid of ambiguity.
6. While measures to reduce socio-economic disparities are mainly focused at a public health and policy level, it is important for the clinician, and the maternity hospital/unit, to be aware of the potential barriers to accessing care for some women.
7. A woman-centred approach to care is encouraged: women should be involved in the decision-making process to support a positive pregnancy experience and promote engagement with antenatal care.
8. In the presence of one or more risk factors for stillbirth, a plan of care for the pregnancy should be clearly documented. This may evolve as the pregnancy progresses and should be reviewed by a consultant Obstetrician.
9. When a risk factor for stillbirth is identified, healthcare practitioners should refer to the local and national clinical practice guidelines that pertain to that risk factor to optimise management.

RISK FACTORS: The delivery of antenatal care

10. It is recommended that a booking visit should be offered to pregnant women in the first trimester.
11. Women should be screened at the booking visit for risk factors that may alter their recommended pathway of care in order to create a pregnancy plan that is tailored to their needs.
12. All women should be offered a dating ultrasound scan and a detailed anatomy ultrasound that includes screening for placental localisation.

13. Women should have access to, when indicated, ultrasonographic tests of fetal wellbeing including fetal biometry, biophysical profiling and Doppler ultrasound studies.
14. It is recommended that service providers strive to ensure that the minimum schedule of care (eight points of contact), as delineated by the World Health Organisation, is achieved for all pregnant women. Potential barriers to accessing care should be explored and addressed.
15. Women should be at the heart of decision-making processes, and services should strive for maternal autonomy in care. Good communication and well-designed antenatal education programmes can empower women to engage with healthcare professionals and improve pregnancy outcomes.
16. Antenatal care should be delivered with the support of the multidisciplinary team.
17. It is good practice to advise pregnant women to monitor for changes in patterns of fetal movement. If a woman is concerned about the quality or quantity of fetal movement, she should be advised to contact her local maternity service.
18. Individual services and hospital groups should have clear pathways of care for the management of reduced fetal movement and staff should be educated in the implementation of these pathways.
19. Maternity hospitals/units should strive to ensure that infrastructural and educational systems are in place to support the delivery of intrapartum care with the goal of reducing preventable term stillbirth.
20. Women triaged to the specialised care pathway should have consultant-led care. This includes pregnancies complicated by a previous stillbirth.
21. Should an individual unit be unable to meet the care requirements of a pregnancy, care should be transferred to a maternity hospital/unit with the appropriate expertise.
22. In the normal-risk setting, fetal growth should be monitored by serial assessment of symphysio-fundal height (SFH). A growth estimate with ultrasound scanning in the third trimester should not be offered in the absence of a clinical indication.
23. In the presence of risk factors for fetal growth restriction, or where SFH measurement in unreliable, serial growth measurement should be offered. Fetal growth should not be monitored at intervals of less than 2 weeks.

DIAGNOSIS

24. Real-time ultrasound is the gold standard method for the diagnosis of intrauterine fetal death (IUFD).
25. Real-time ultrasound should be readily available in maternity hospitals/units.
26. The use of clinical assessment or fetal heart auscultation with Pinard stethoscope or handheld Doppler is not sufficient to diagnose IUFD.
27. Cardiotocography should not be used to diagnose IUFD.
28. A second opinion should be sought to confirm the diagnosis of IUFD. At least one of the healthcare professionals performing the ultrasound should be a practitioner or sonographer with sufficient expertise in the use of ultrasound.
29. A dedicated room should be available in the admission unit/ultrasound department for the purpose of disclosing bad news.
30. If a woman is unaccompanied, an offer should be made to contact her partner or a close relative/friend.
31. Healthcare providers should ensure, where appropriate, that a pregnant woman is not alone when leaving the hospital after a diagnosis of IUFD. Transport arrangements should be made if required. Women should also be provided with a named contact when leaving the hospital in order to facilitate effective communication.
32. Healthcare providers should use appropriate language using terms that are easily understandable by the woman/parents.
33. Healthcare providers should advocate for maternal choice and autonomy; parents should feel included in the decision-making process.

34. Written information should be provided and should ideally be available in several languages.

INVESTIGATIONS: Maternal investigations

35. If diagnosed with an IUFD, all women should be assessed by a clinician at the time of diagnosis. This is important, not only to assess risk, but to document important features that may contribute to determining the cause of the stillbirth.

36. A Kleihauer-Betke test, full blood count and group and antibody screen should be performed at the time of diagnosis. As postnatal testing can result in false positives and any delay in testing can lead to false negatives, testing for FMH should be performed prior to delivery and at the time of diagnosis of intrauterine death.

37. Prior to discharge, women should be tested for the following:
    - Acquired thrombophilias [lupus anticoagulant (LA), anticardiolipin (aCL) and anti-b2-glycoprotein 1]
    - Haemoglobin A1c (HbA1c)
    - Serum bile acids (SBA)
    - Serology for cytomegalovirus (CMV), toxoplasma, parvovirus B19 (PV B19) and rubella (unless immune)

38. The following maternal tests should be performed if clinically indicated: rubella IgM/IgG, syphilis testing, coagulation studies, C-reactive protein, renal function, uric acid, liver function, thyroid function, inherited thrombophilia testing (including factor V Leiden testing), auto/alloimmune antibodies, toxicology screen, microbiological studies and parental karyotypes.

INVESTIGATIONS: Fetal Investigations

39. Post mortem examination (PME) should be offered in all cases of stillbirth.

40. All cases of stillbirth should be discussed with the local Coroner before the issue of a consented PME is raised with the woman/parents.

41. Informed consent for a PME should be obtained by a senior clinician.

42. All aspects of the consent process should be in line with national and local policy. The most up-to-date national guidance on PME and consent should be consulted.

43. Women/parents should be given clear, honest and accurate information including the potential contribution that PME may have in providing a diagnosis or managing subsequent pregnancies.

44. The consent-taker should be prepared to answer women's/parents' questions and written information should always be provided.

45. For a consented PME, it should be made clear to women/parents that they are under no obligation to provide consent if they do not wish to do so.

46. When a consented PME is declined – whether for personal, religious or cultural beliefs – this decision should be respected. Cultural stereotyping and culture-based assumptions should be avoided as diversity exists in all cultural groups.

47. Consent forms should have a section on organ retention. This should include options regarding consent to organ retention and options surrounding organ disposition once the necessary examinations have been completed.

48. Consent is not required for a Coronial PME; in the event that a post mortem examination is directed by the Coroner, written information relating to the Coronial PME process and parental rights should be provided.

49. Cytogenetic testing should be performed in all cases of stillbirth. Microarray analysis is the preferred method of testing, if available.

50. Care needs to be taken when performing placental biopsy for cytogenetic analysis; the fetal vessels and umbilical cord insertion site should be avoided/preserved for further pathological examination.

51. A complete PME is recommended to optimise the information obtained from the examination.

52. While a limited PME may be of value, it is important that women/parents understand that this may restrict the information obtained, and result in higher rates of unexplained stillbirth. If women/parents wish to proceed with a limited PME, the case should be discussed with the Pathologist involved in order to facilitate informed consent.
53. It is recommended that a Perinatal Pathologist perform the PME and compile the final report. However, the PME may be delegated, where appropriate, to a designated medical scientist who has been deemed competent in the execution of such examinations, and who works under the supervision of the Perinatal Pathologist.
54. Pathological examination of the placenta should be performed in all cases of stillbirth.

MANAGEMENT: Planning labour and birth

55. Expectant management can be offered to women if, following review by an Obstetrician, there is no contra-indication such as ruptured membranes, antepartum haemorrhage or evidence of maternal compromise.
56. If a woman opts for expectant management, routine testing for coagulopathy at regular intervals is not indicated in the absence of risk factors such as suspected abruption, sepsis or prolonged fetal retention. The risk for coagulopathy should be determined on a case-by-case basis; in the first instance at diagnosis, and then again at each encounter.
57. If a woman wishes to initiate the process of delivery as soon as possible, services should be resourced to facilitate birth within a reasonable timeframe. Ideally the process should be initiated within 24 hours from diagnosis.
58. If no contraindication exists to vaginal birth, this is the preferred mode of delivery in the event of an intrauterine fetal death.
59. The recommended medication regimen, for a uterus with no scar, is mifepristone 200mg followed by a course of misoprostol after an interval of 36 to 48 hours. National medication protocols should be followed.
60. Misoprostol should be titrated to gestational age due to the increased sensitivity of the gravid uterus to prostaglandins with advancing gestational age.
61. Intravaginal, buccal and sublingual misoprostol may be more effective than oral misoprostol.
62. For a woman with one uterine scar, the mode of delivery should be reviewed by the consultant overseeing the woman's care with consideration of maternal wishes.
63. Induction regimens to be considered for women with one uterine scar include prostaglandins such as misoprostol at lower doses, mifepristone monotherapy, mechanical methods of cervical priming and the use of oxytocin. National medication protocols should be followed.
64. Decisions on mode of delivery in women with two previous lower segment caesarean sections should be consultant-led.
65. Women with a history of more than two caesarean scars, or atypical uterine scars, should be advised that the risk of uterine rupture likely outweighs the potential benefit of vaginal birth.

MANAGEMENT: Intrapartum care

66. Women who have experienced an intrauterine death should be provided with a birthing space that acknowledges the emotional and practical needs of the woman/parents in addition to the medical needs of the woman.
67. Women should be provided with the same options for analgesia that are offered to women with uncomplicated pregnancies.
68. There is no strong evidence to recommend the use of one parenteral opioid over another.
69. If there is a clinical concern for sepsis or coagulopathy, an FBC and coagulation profile should be obtained prior to proceeding with neuraxial anaesthesia.
70. Intrapartum antibiotic prophylaxis (IAP) should not be routinely employed in cases of intrauterine fetal death.

71. In women with a uterine scar, the birth attendant must rely on maternal evaluation in order to make an assessment of scar integrity. Care must be taken not to miss subtle maternal signs in the absence of fetal monitoring.
72. All intrapartum interventions for a woman who has experienced an IUFD should be approached with sensitivity, whether instigated by the primary birth attendant or the covering Obstetrician.
73. In cases where a difficult birth is anticipated, for example where there is a fetal malposition or a malpresentation such as breech, an appropriately skilled Obstetrician should be available to assist with the delivery.
74. Women/parents should be appropriately counselled, both antenatally and during the birthing process, on the changes that take place within the baby after death, and how these may alter the physical appearance of their baby after birth.
75. Women/parents should be supported in the decision-making process when it comes to labour and interactions with their stillborn baby after birth. Birthing conditions should facilitate open communication and informed consent.

MANAGEMENT: Postnatal care

76. A risk assessment for venous thromboembolism should be carried out according to national and local clinical guidelines.
77. Psychological stressors may impact on the perception of pain. Care should be taken to ensure adequate analgesia for the woman, both acutely and at discharge.
78. A standard approach to wound care should be taken as per national clinical guidelines.
79. An individualised care plan should be made for each woman depending on personal, medical and peripartum risk factors.
80. The need for postnatal anti-D prophylaxis should be determined after birth and should be in keeping with local and national guidance.
81. Healthcare staff allocated to caring for and liaising with the bereaved woman/parents should be kept to the minimum number required. Continuity of care, where possible, should be facilitated.
82. All healthcare professionals (HCPs) that have been involved in the woman's antenatal care, or who are routinely involved in postnatal care [including the woman's General Practitioner, (GP)] should be informed of the stillbirth.
83. All scheduled antenatal visits and appointments should be cancelled before the woman is discharged home.
84. Physiologic lactogenesis, and what to expect, should be discussed with the bereaved woman. This discussion should include options for artificial suppression. Written information should be provided.
85. Women should be advised that non-pharmacologic options for artificial lactation suppression are available, but that the efficacy of these options versus placebo (no treatment) has not been demonstrated.
86. Cabergoline is recommended as a first line treatment for the pharmacologic suppression of lactation.
87. Appropriate follow-up should be arranged for bereaved parents after discharge with their named Obstetrician. The nature and timing of this follow-up may depend on the woman, the clinical context and the degree of the investigations performed. Women and parents should, however, be seen within three months following the birth of a stillborn infant, to discuss the available results and address any queries or concerns.

MANAGEMENT: Comprehensive bereavement care

88. Staff should be familiar with the Irish National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death (The Standards).
89. Providing quality bereavement care is an integral part of every maternity service. It is vital that such bereavement support is integrated within the hospital's clinical care pathways for women/parents.
90. All maternity services should have a dedicated clinical Midwife or Nurse specialist who is experienced in the field of bereavement and loss.

91. Women/parents should be provided with the opportunity to meet with a member of the bereavement team; ideally the first encounter should take place at the time of diagnosis.
92. Women/parents should be provided with the opportunity to meet with a pastoral care team or chaplain/ spiritual leader of their choosing.
93. Women/parents should be provided with the opportunity to see or hold their baby after birth. Mementos of their baby and pregnancy experience should be offered.
94. Women/parents should be supported in making decisions regarding funeral arrangements, including burial and cremation.
95. Women/parents should be offered the appropriate psychological supports antenatally, intrapartum and postnatally with no puerperal time limit on support. Written information should be provided to women/parents on the supports available, at both a community and hospital-based level. Support may come in the form of professional counselling services, support groups and online sites or forums.
96. Clear pathways of care should be available in all maternity units in order to optimise the parental experience. The Standards should be consulted when implementing such pathways.
97. Maternity hospitals/units should regularly audit their service with reference to The National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death.
98. All healthcare professionals who care for bereaved women/parents should have access to regular and appropriately designed training in bereavement care.
99. A formal policy on staff support should be devised and implemented in all maternity hospitals/units.
100. A range of support options should be available to staff including individual debriefing, peer group support and professional counselling.
101. Tailored debriefing sessions should be made available following serious adverse events, such as intrapartum stillbirth, for all staff involved – regardless of whether the involvement is direct or indirect.
102. Consideration should be given to the introduction of Schwartz rounds or Balint group sessions as part of the regular schedule within individual maternity units.
103. Information regarding self-care and the available support services within a unit should be provided to staff at induction training and at regular intervals throughout the working year.

MANAGEMENT: Special circumstances

104. Every effort should be made to support women/parents in the decision-making process when diagnosed with a fetal anomaly that may be fatal or life-limiting. Comprehensive bereavement support is essential regardless of the chosen pathway of care.
105. If a woman elects to proceed with a termination for fatal fetal anomaly and, should the pregnancy exceed 21+6 weeks, options surrounding feticide and intrapartum care should be discussed, with shared decision-making based on pregnancy-related factors and the circumstance of the termination. Intrapartum electronic fetal heart rate monitoring should not form part of the routine care plan for termination of pregnancy.
106. All stillborn infants delivered at ≥ 24+0 weeks or weighing ≥ 500g need to be registered in accordance with the Stillbirths Registration Act, 1994, regardless of whether the birth occurred in the context of a termination of pregnancy.
107. Decisions regarding post mortem examination after termination of pregnancy for fetal anomaly should be discussed and documented in the woman's healthcare record.
108. In the event of selective intrauterine fetal death, a multiple pregnancy should be managed by an Obstetrician with appropriate expertise in the management of complicated twin and multiple pregnancies.
109. Woman/parents should be counselled on the risk to the remaining fetus(es) in the event of selective intrauterine fetal death.
110. While the process of grief in a multiple pregnancy may be complicated by mixed emotions, the grief reaction needs to be recognised, and women/parents should be afforded the appropriate supports in the antenatal, intrapartum and postnatal period.

111. If delivery at the threshold of viability (23 weeks) is anticipated, every effort should be made to provide counselling to the expectant woman/parents in advance of the delivery by a specialist in neonatology.
112. In the event of birth at the threshold of viability, women/parents should receive the appropriate psychological support before, during and after birth.
113. Every effort should be made to ensure that accurate calculations of both birth weight and gestational age at the time of birth are used when documenting a stillbirth.
114. Healthcare providers must ensure that both the physical and psychological needs of the woman are met in the context of an intrapartum stillbirth, particularly as the birth may be complicated by an obstetric emergency that may also compromise the wellbeing of the woman.
115. Detailed documentation is important for all intrapartum deaths so that factors contributing to the death can be delineated and explored.
116. Care following an intrapartum death should be consultant-led with appropriate arrangements made for follow-up post discharge.
117. Staff involved in the care of a woman who has experienced an intrapartum death should be debriefed and provided with the appropriate supports.
118. All cases of intrapartum death should undergo a formal review process, including timely referral to the local Serious Incident Management Team (SIMT).

CLASSIFICATION, AUDIT AND REVIEW: Classification and audit

119. In the event of a stillbirth, two forms must be completed:
    - The Birth Notification Form
    - The Perinatal Death Notification Form
120. In the event of a termination of pregnancy, a Birth Notification Form (BNF/01) must be completed if the gestation or birth weight exceed or are equal to 24+0 or 500g.
121. The National Perinatal Epidemiology Centre (NPEC) classification system (2007) is the current system for classifying stillbirth in Ireland. All stillbirths should be reported to NPEC using their standardised notification form. It is important that accurate information is used when recording information on the details of a stillbirth.
122. Perinatal audit is crucial to maintaining and improving standards. While NPEC collates data for audit at a national level, individual maternity units, and hospital groups, should have structures in place for performing perinatal audit.

CLASSIFICATION, AUDIT AND REVIEW: Legal requirements

123. Registration of a stillborn infant in a civil registration centre is not mandatory. This can be organised by the woman/parents, if they wish to do so, once a certificate with the cause of death has been issued.
124. Women/parents should be informed that the Coroner's role is to inquire into the cause of reportable deaths; the Coroner does not consider civil or criminal liability – they simply establish the "who, when, where and how" of the death.
125. Women/parents should be informed that, in the event of a stillbirth, the Coroner will usually consult with a family member before directing an inquest.
126. Women/parents should be informed that the Coroner will notify the district registrar once they have concluded the inquiry and have established a cause of death. This will permit the parents to register the stillbirth should they so wish.

CLASSIFICATION, AUDIT AND REVIEW: Multidisciplinary care and case review

127. All bereaved women/parents should have access to multidisciplinary bereavement care. While the majority of services will be available within the treating hospital/unit, access to the extended multidisciplinary team should be available within the hospital group.

128. The multidisciplinary team (MDT) should, ideally, comprise the following: Consultant Obstetrician, Neonatologist, Perinatal Pathologist, Anaesthetist, Midwifery and nursing staff, Palliative and bereavement care specialist, Perinatal mental health specialist, Bereavement and loss CMS/CNS, Chaplaincy/pastoral care team and Social work team
129. Support staff, including administrative staff, medical scientists, laboratory technicians and mortuary staff
130. Good communication is important in order to optimise the parental experience. Effective communication should take place at both a bedside level and an interdisciplinary level within the MDT.
131. Multidisciplinary care should be individualised with parental autonomy at the forefront.
132. Every service should have access to a regular perinatal mortality multidisciplinary meeting (PM MDM). This may be arranged locally, at a hospital level, or on a larger scale within a hospital group.
133. Staff should be facilitated in their attendance of the PM MDM in order to optimise the potential for education, learning and peer discussion.
134. The PM MDM should discuss individual cases within a reasonable timeframe in order to provide information to bereaved women/parents, and to explore learning points to be had from review of the case, at both a local and regional level.

FOLLOW UP: Postnatal review

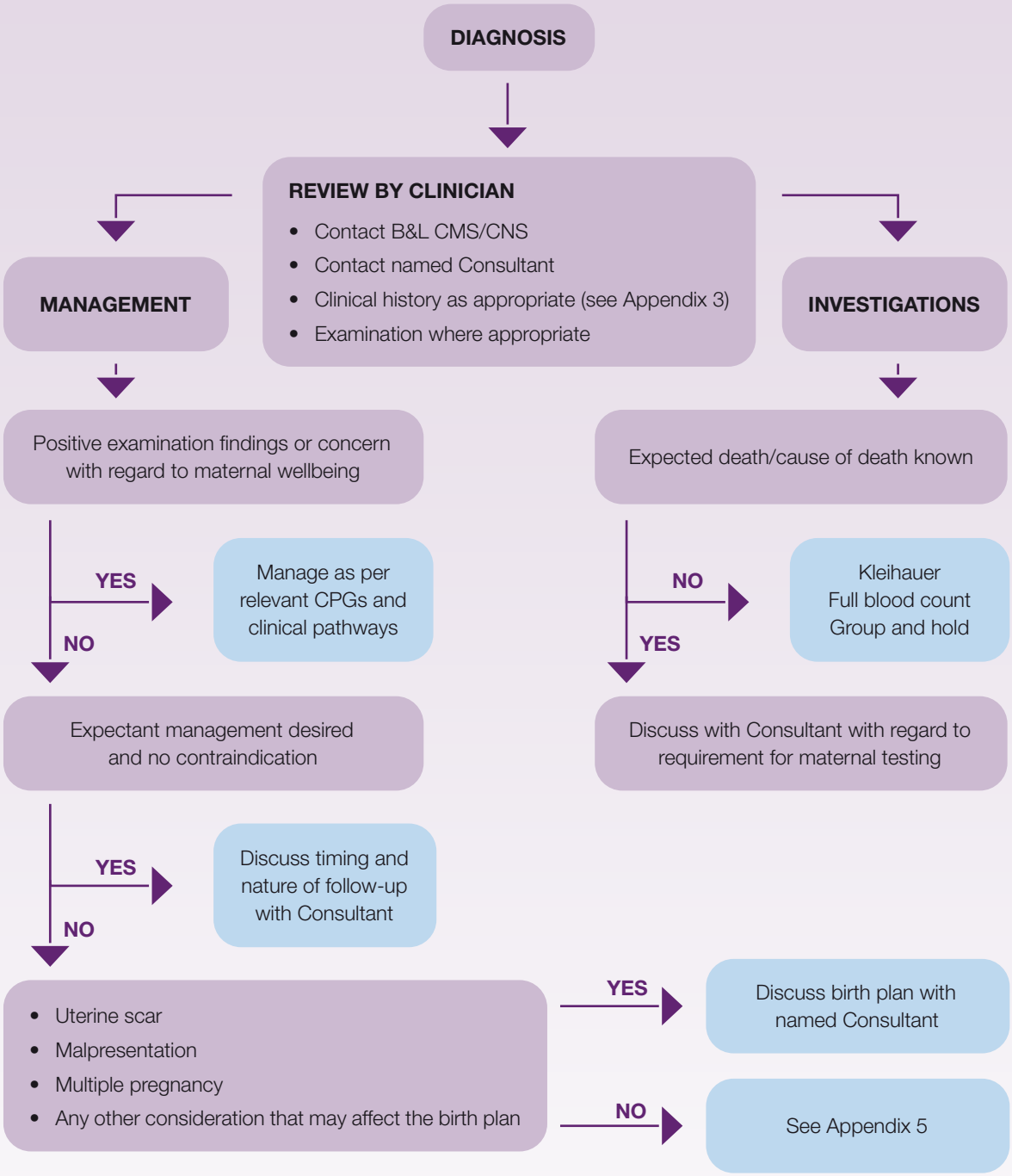
135. Follow-up should be arranged with women/parents who have experienced a stillbirth within an appropriate timeframe.
136. The preferences of women/parents should be considered when organising follow-up.
137. The timing of follow-up may depend on the circumstances surrounding the stillbirth and the nature of the investigations such as PME. Should some results be delayed, women/parents should still be seen within 3 months of birth to discuss any provisional results and to explore the circumstances leading up to and surrounding the birth.
138. The report from a Coronial-directed post mortem examination may take a variable and unpredictable amount of time and it is important that women/parents are made aware of this.

FOLLOW UP: Pregnancy after stillbirth

139. Pregnancies after a stillbirth are at increased risk of a subsequent stillbirth; however, women/parents can be reassured the risk does not appear to be affected by the interpregnancy interval.
140. Clinical recommendations for interpregnancy interval should consider the woman's health status, age, fertility, desired family size and child spacing, past obstetric history including mode of delivery and psychosocial readiness to conceive.
141. Following a stillbirth, discussions surrounding future conception should form part of bereavement care pathways.
142. Women who have experienced a previous stillbirth should be triaged to the specialised care pathway in their subsequent pregnancy and should be managed by an Obstetrician with sufficient experience to manage the pregnancy.
143. Women should be booked early in their next pregnancy in order to create an appropriate care plan for the pregnancy and birth.
144. Fetal growth should be monitored in subsequent pregnancies, if indicated, based on a review of the factors contributory to the previous stillbirth.
145. The timing of birth needs to be considered on an individual basis, in consultation with the woman, her treating consultant, and the multidisciplinary team.
146. Maternity services should be resourced to deliver an appropriate level of psychological support to bereaved women/parents in subsequent pregnancies. All women/parents should have access to a specialised bereavement team. This team should comprise a specialised clinical Midwife or Nurse specialist, a chaplain or spiritual guide, a social worker and a member of the perinatal mental health team if required.

Algorithms

Algorithm 1: Algorithm for initial management following diagnosis of IUFD



Algorithm 2: Algorithm for fetal investigations following stillbirth

Prior to birth

Consider amniocentesis if felt to be contributory to diagnostics (e.g., if electing for expectant management etc.)

↓

BIRTH

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At the time of birth

- Harvest and store placental sample for cytogenetic analysis [1cm3 section (approximately) from a normal appearing segment of umbilical cord (away from the cord insertion site)]
- Harvest and store cord sample for cytogenetic analysis [1cm3 section from the centre of the fetal surface of the placental disc (away from the cord insertion site and any large fetal vessels)]
- Send placenta for histopathological examination

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Inform the Coroner

- Parents to be informed of the role of the Coroner and the intention to discuss the death of their baby with the Coroner
- Senior clinician to contact the Coroner
- All relevant details of the case to be provided

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Coroner's post mortem examination (PME) mandated?

YES

- Pamphlet/written information to be provided
- Consultant/senior registrar to discuss with parents
- Organ retention to be discussed, and wishesdocumented
- Liaise with local/regional Perinatal Pathology Services

Coroners protocol/paperwork should be followed

NO

Consented PME to be discussed/offered*

- Liaise with local/regional Perinatal Pathology Services
- Pamphlet/written information to be provided
- Consultant/senior registrar to take consent
- Organ retention to be discussed and parental consent documented
- Skeletal survey to be ordered

* If parents do not consent to a full PME then a limited PME should be discussed. Options should be clarified with the Pathologist in advance in order to inform consent.

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

1. The proportion of women who attend for a booking visit within the first trimester and who are risk assessed at this visit by a Midwife and Obstetrician.
2. The proportion of women who attend for at least eight scheduled points of contact in the course of their pregnancy.
3. The proportion of women undergoing the appropriate maternal investigations after a stillbirth.
4. The proportion of stillborn infants that undergo post mortem examination.
5. The proportion of post mortem examinations that are directed by the Coroner.
6. The proportion of stillbirth cases where the discussion (and consent) with regard to post mortem examination was undertaken by an appropriately trained senior Obstetrician.
7. The proportion of stillbirth cases that have placental histopathology and cytogenetic analysis performed.
8. The proportion of maternity units/hospitals that have access to perinatal pathology services.
9. In the event of induction of labour, the time from initiation to delivery (first mifepristone to delivery) and from induction to delivery (first misoprostol to delivery).
10. In the event of induction of labour, the number of women that receive both mifepristone and misoprostol and the time interval between the two medications.
11. The proportion of women that receive both verbal (documented) and written information on the physiology of lactation and the methods of suppression.
12. The proportion of women that receive pharmaceutical lactation suppression. In the event of suppression with cabergoline, the number of women that receive the appropriate dose within 24 hours of delivery.
13. The proportion of women who experience a preterm delivery at the threshold of viability (currently 23-24 weeks, however the exact gestation may vary depending on updates to neonatal guidelines) that receive an antenatal neonatology consultation.
14. The proportion of stillbirths that are reported to and discussed at the hospital/unit SIMT.
15. The timeframe from stillbirth to the availability of the post mortem examination report for women/parents and clinicians.
16. The proportion of maternity services who have access to a regular scheduled perinatal mortality multi-disciplinary meeting (PM MDM).
17. The proportion of stillbirths that undergo review at the PM MDM meeting and the interval between the stillbirth and the PM MDM discussion.
18. The proportion of women/parents who attend for a postnatal review with a consultant Obstetrician within three months of delivery.
19. The proportion of women who have experienced a previous stillbirth that are triaged to the specialised pathway of care in a subsequent pregnancy.
20. The planned gestation of elective delivery in pregnancies subsequent to a stillbirth.

Recommended reading:

1. HSE Nomenclature for Clinical Audit – https://www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines at https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/
3. Health Service Executive. National standards for bereavement care following pregnancy loss and perinatal death [Internet]. HSE: Ireland; 2022. Available from: https://www.hse.ie/eng/services/list/3/maternity/bereavement-care/
4. National Health Service. Saving Babies' Lives Version Two: a care bundle for reducing perinatal mortality. [Internet]. NHS: England; 2019 [cited 2022 Jun 12]. Available from: https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
5. Thomson K, Moffat M, Arisa O, Jesurasa A, Richmond C, Odeniyi A, et al. Socioeconomic inequalities and adverse pregnancy outcomes in the UK and Republic of Ireland: a systematic review and meta-analysis. BMJ Open. 2021 Mar 1;11(3): e042753. DOI: 10.1136/bmjopen-2020-042753
6. Flenady V, Koopmans L, Middleton P, Frøen JF, Smith GC, Gibbons K, et al. Major risk factors for stillbirth in high-income countries: a systematic review and meta-analysis. Lancet Lond Engl. 2011 Apr 16;377(9774):1331-40. DOI: 10.1016/S0140-6736(10)62233-7
7. Escañuela Sánchez T, Meaney S, O'Donoghue K. Modifiable risk factors for stillbirth: a literature review. Midwifery. 2019 Dec 1;79:102539. https://doi.org/10.1016/j.midw.2019.102539
8. O'Connell O, Meaney S, O'Donoghue K. Caring for parents at the time of stillbirth: How can we do better? Women Birth. 2016 Aug;29(4):345-9. https://doi.org/10.1016/j.wombi.2016.01.003
9. Stillbirths 2016: ending preventable stillbirths. The Lancet [Internet]. 2016 Jan; Available from: https://www.thelancet.com/series/ending-preventable-stillbirths
10. Flenady V, Oats J, Gardener G, Masson V, McCowan L, Kent A, et al. for the PSANZ Care around the time of stillbirth and neonatal death guidelines group. Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death. Version 3.4. NHMRC Centre of Research Excellence in Stillbirth: Brisbane, Australia; 2020. https://stillbirthcre.org.au/wp-content/uploads/2021/03/Clinical-Practice-Guidelines-for-Care-Around-Stillbirth-and-Neonatal-Death2-2.pdf
11. Hunter A, Schott J, Henley A, Kohner N. Pregnancy loss and the death of a baby: Guidelines for professionals 4th Edition. London: Tantamount on behalf of Sands, the stillbirth & neonatal death charity; 2016. https://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Sands2016-Guidelines-2016th-editionPDF.pdf
12. www.pregnancyandinfantloss.ie

Authors

McDonnell A, Butler M, White J, Escañuela Sánchez T, Cullen S, Cotter R, Murphy M, O'Donoghue K. National Clinical Practice Guideline: Stillbirth: Prevention, Investigation, Management and Care. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. January 2023.

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/