IMPORTANT NOTE – IMPACT OF ELECTRONIC PATIENT RECORD SYSTEM ROLL OUT

From 10th October 2022, the Trust will replace the following systems with Cerner Millennium:

- ECAMIS
- iSOFT
- Nervecentre
- Symphony
- ECDM
- ICM
- EPMA

Policies, procedures and clinical guidelines are being updated over the coming months. In the interim, **any activities taking place on the above systems referenced in this document will now be undertaken using the SOPs and pathways in place for Cerner Millennium.**

SOPS AND PATHWAY DOCUMENTS FOR CERNER MILLENNIUM CAN BE FOUND HERE or http://intranet/sites/ws-EPR/Workflows/Forms/AllItems.aspx

County Durham and Darlington NHS
NHS Foundation Trust

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Ratification

Signature of Chairman of Ratifying Body	
Name / Job Title of Chairman of Ratifying Body:	Anne Holt, Associate Director of Nursing, Family Health
Date Ratified	June 2020
Signed Paper Copy Held at:	Governance Office, Family Health

Contents

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Version control table

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Date	Section	Revision	Author
15/02/12	Full	Merged with bereavement guideline	Jackie Hendy
26.4.12	Full	Updated with drug dosage Amendments made re support and communication Key performance indicators	Joanne Woodward
Jun 2015	Full	Out of date – for review Out of date – for review – Review of drug regime used in other Trusts - No changes to misoprostol regime 5.6 Where to care for families expanded 5.1 Included Anti D for IUD as a sensitizing event as recommended by BCSH	EBPG Sheila Reed E Bouic
2020	Full	Out of date for review Placenta histology guidance updated	Dr A S Johnson Dr J Milne

1. Introduction

Stillbirth is common, with 1 in 200 babies born dead.
Overall, over one third of stillbirths are small-for-gestational-age fetuses with half classified as being unexplained.
The stillbirth rate has remained generally constant since 2000.
In addition to any physical effects, stillbirth often has profound emotional, psychiatric and social effects on parents, their relatives and friends.

Major fetal abnormalities are uncommon. In England and Wales in 2017 there were 3314 terminations for major fetal abnormalities.

2. Purpose

The purpose of this guideline is to support staff in providing care based on best practice and best available evidence when caring for women and their relatives who have a pregnancy loss, stillbirth or who have opted for termination of pregnancy (ToP) after confirmation of major fetal abnormality from 16^{+0} weeks.

3. Scope

This guideline defines the roles and responsibilities of Obstetric and midwifery staff and other disciplines involved in the care and management of women and their relatives who have had a pregnancy loss, stillbirth or who have opted for ToP after confirmation of a major fetal abnormality from 16^{+0} weeks.

4. Duties

This guideline defines the roles and responsibilities of Obstetric and midwifery staff and other disciplines involved in the care and management of women and their relatives who have had a pregnancy loss, stillbirth or who have opted for ToP after confirmation of a major fetal abnormality from 16^{+0} weeks.

Obstetrician will discuss confirmed diagnosis, and subsequent plan of care. Follow up care will be offered to discuss findings of investigations and selected tests.

- Consultant must ensure that the correct legal paperwork is completed for ToP. 2 Doctors to sign.
- Consent forms must be signed for ToP for fetal abnormality.
- Reaffirmation of consent must be taken if consent already obtained in tertiary unit.

5. Management:

5.1 Diagnosis

- **Intrauterine fetal death (IUD)**

  To confirm IUD real-time ultrasound to be performed by trained personnel (sonographer or Obstetric medical staff signed off for confirmation of IUD), allowing direct visualisation of the fetal heart.

  A second scan should be offered if the mother wishes a repeat scan to confirm IUD or the first scan is performed by an Obstetric Trainee.

  Mothers should be prepared for the possibility of passive fetal movement. If the mother reports passive fetal movement after the scan to diagnose IUD a repeat scan can be offered.

- **Fetal anomalies**

  Fetal anomalies are usually diagnosed following ultrasound scan or prenatal invasive tests. Following diagnosis women will be counselled regarding future management of pregnancy and/or offered ToP where appropriate. Women who are offered ToP for major fetal abnormality beyond 21 weeks gestation should be fully counselled and fetocide discussed, this would necessitate referral to the Fetal Medicine Unit (FMU), Royal Victoria Infirmary (RVI), Newcastle.

- **Preterm birth**

  When preterm birth is expected **from 22^{+0} – 26^{+0} weeks** the Obstetric Team should discuss with Senior Paediatrician and tertiary referral centre. Senior Paediatrician should undertake pre delivery discussions with parents. For those babies where active management is considered appropriate in-utero transfer should be arranged.

  When the clinical situation makes it inappropriate to consider in-utero transfer Senior Paediatrician should attend delivery.

  When preterm birth is expected **less than 22^{+0} weeks** the Obstetric Team should fully counsel the parents regarding the implications of birth prior to viability. Ensure parents are aware that when a baby is delivered spontaneously after 16 weeks there may be signs of life, such as breathing, movements and cord pulsation.

  See **Perinatal Management of Extreme Preterm Birth Before 27 Weeks of Gestation (2019) – a BAPM Framework for Practice.**

- **Kleihauer – All Women**

  Take blood for Kleihauer once sensitizing event has occurred (IUD confirmed or pregnancy loss) in **all** women to exclude feto-maternal haemorrhage as cause for loss (fetal cells may only be present in the maternal circulation for a short time so Kleihauer must be done at time of diagnosis).

- **Anti-D**

  In women who are rhesus negative and where analysis of free fetal DNA (ffDNA) is predictive of a rhesus positive baby – Administer Anti-D immediately

following diagnosis of IUD. It is recommended to give Anti-D again following delivery as there may be a significant delay between the diagnosis of IUD and the subsequent delivery.

In rhesus negative women who have not had the ffDNA test or test was inconclusive, administer Anti-D (BCSH Guidelines 2014).

5.2 Discussing the diagnosis - Communication

- Be prepared with relevant information when dispensing bad news.
- Find an appropriate place.
- Ensure all discussions with parents are documented fully in the notes.
- Prepare parents for difficult news and inform parents something may be wrong as soon as it is suspected on ultrasound findings.
- Ask parents if they would like a support person present.
- When a woman has had an invasive test to confirm major fetal abnormality, the result may be given over the phone. The woman will be invited in following this initial telephone call to fully discuss the results, implications and further management. Provide written information where appropriate.
- The diagnosis should be explained clearly using appropriate language without medical jargon. If there are any language or communication support needs, ensure they are addressed e.g. with an interpreter.
- Give parents time to absorb news and answer any questions you are able to. Give the parents information about what happens next. The couple's choice about further management should be supported and they should be offered written information to supplement discussions. These are available in different languages and formats.
- Provide named contact details.
- Check the parents can get home safely.
- If there is one or more surviving sibling from a multiple pregnancy, don't focus solely on them. Acknowledge the baby has died. Recognise the challenge that parents face in welcoming the arrival of one baby with the tragic loss of another.

5.3 Discussing subsequent care

- The mother's preference should be respected however it is important to assess maternal wellbeing and manage any potential problems; sepsis, disseminated intravascular coagulation, pre-eclampsia, placental abruption or membrane rupture are some of the indications for immediate steps towards delivery.
- The options to discuss with the women who have no risk factors are expectant management and medical management / induction of labour. In rare circumstances caesarean birth may need to be considered.

- Discuss birth plan, pain relief, timings and memory making and provide written details.

- Ensure parents are aware that when a baby is delivered spontaneously after 16 weeks but before 24 weeks, there may be signs of life, such as breathing, movements and cord pulsation.

  Parents should be fully counselled by the Obstetric Team regarding the implications of delivery prior to and at the limits of viability.

  When preterm birth is expected **from 22^{+0} – 26^{+0} weeks** the Obstetric Team should discuss with Senior Paediatrician and tertiary referral centre. Senior Paediatrician should undertake pre delivery discussions with parents. For those babies where active management is considered appropriate in-utero transfer should be arranged.

  When the clinical situation makes it inappropriate to consider in-utero transfer Senior Paediatrician should attend delivery.

  When preterm birth is expected **less than 22^{+0} weeks** the Obstetric Team should fully counsel the parents regarding the implications of birth prior to viability.

  If a baby is delivered between **16^{+0} and 22^{+0} weeks** with signs of life the baby should be assessed **immediately** by the Duty Obstetric Registrar.

  See **Perinatal Management of Extreme Preterm Birth Before 27 Weeks of Gestation (2019) – a BAPM Framework for Practice.**

- Ensure good communication between all staff caring for the parents. Ensure communication is sensitive. Continuity of staff is preferable.

- Enable the woman to have a support person present.

- Following confirmation of a major fetal abnormality the women should be counselled regarding all options including continuation of pregnancy and support as well as ToP. If the woman choses to terminate the pregnancy she should be offered medical or surgical management up to 12^{+0} weeks. If the woman wishes surgical management after 12^{+0} weeks contact FMU, RVI. *NB: post-mortem is not possible following surgical ToP.*

- Provide emotional support to the parents and their support person.

- Ensure staff are supported in caring for the parents.

- Ensure all paperwork is completed accurately.

5.4 Expectant management for IUD

- In well women with intact membranes, management can be delayed up to 48 hours without any physical harm. Ensure the woman is given a 24 hour contact number for support and information. If there is delay in management > 48 hours coagulation time and plasma fibrinogen should be done twice weekly and advise that prolonged intervals of delay may reduce the value of post-mortem and alter the appearance of the baby.

5.5 Medical management / Induction of labour: - see appendix 1

5.6 Suitable facilities

- It is important to provide appropriate care and facilities which reflect commitment and respect for the parents and their baby.
- Medical ToP:

  If major fetal abnormality is confirmed < 16^{+0} weeks the woman will be cared for on the gynaecology ward.

  If major fetal abnormality is confirmed ≥ 16^{+0} weeks to 17^{+6} weeks the woman will be offered the options of care on the labour ward or care on the gynaecology ward.

  If major fetal abnormality is confirmed ≥ 18^{+0} weeks the woman will be cared for on the labour ward.

- Surgical ToP:

  If the woman wishes a surgical ToP this will be arranged with the gynaecology ward up to 12^{+0} weeks of pregnancy.

  If the woman is > 12^{+0} weeks and wishes a surgical ToP contact the Fetal Medicine Unit, RVI. Advise the woman she would need to be seen by the RVI Fetal Medicine Team to discuss the procedure and associated risks with advancing gestations. Also advise the woman regarding the delay in management what would naturally be associated with referral and subsequent admission for surgery which could be 2-3 weeks.

- IUD / Pregnancy Loss:

  If IUD / pregnancy loss is confirmed < 16^{+0} weeks the woman will be cared for on the gynaecology ward.

  If IUD / pregnancy loss is confirmed ≥ 16^{+0} weeks to 17^{+6} weeks the woman will be offered the options of care on the labour ward or care on the gynaecology ward.

  If IUD / pregnancy loss is confirmed ≥ 18^{+0} weeks the woman will be cared for on the labour ward.

- Visiting arrangements should be open and flexible according to the family's wishes, to promote individualised care and facilitating the family to support each other as they wish.

5.7 Antibiotic Prophylaxis

Routine antibiotic prophylaxis is not indicated.

Intrapartum antibiotic prophylaxis for women colonised with group B streptococcus is not indicated.

Women at risk of sexually transmitted infections should receive Azithromycin 1g orally with the mifepristone followed by Azithromycin 500mg daily for 2 days.

5.8 Pain relief

- Wherever possible the different options and the advantages, disadvantages and side effects of each, should be discussed carefully beforehand and, where appropriate, during management.
- Women being care for on the labour ward should be offered the opportunity to meet with an obstetric anaesthetist, to discuss analgesia options, where appropriate.

5.9 Following delivery

- A resource / information file is available to all staff involved in the care of bereaved parents.
- Appropriate check list to be used dependant on case specific pregnancy loss – this lists the tasks to be carried out, records all samples that have been sent, ensures paperwork has been completed and that information has been passed to other health professionals.
- See Appendix 2 check lists - pregnancy loss investigations 16 weeks gestation and above; and pregnancy loss investigations termination for fetal anomaly 16 weeks gestation and above, for relevant investigations.
- The parents may have specific views and questions in relation to cytogenetics, which should be fully discussed prior to gaining written consent.

  Ensure staff discussing cytogenetic consent with parents are trained to do so.

  If Prenatal Diagnosis has previously been performed on CVS or Amniocentesis further cytogenetic studies including Parental Bloods are **NOT** indicated unless specifically requested by the Northern Genetics Service.

  If Prenatal Diagnosis has previously been performed on Fetal Blood (Fetocide or Cordocentesis) the Northern Genetics Service advise that further fetal cytogenetic studies should be performed.

  For gestations less than 22 weeks it may be difficult to identify the sex of the fetus. Therefore, care should be taken in discussing the gender with the parents even if they have been informed of the gender on antenatal scan. Offer rapid cytogenetics to women who have not had Prenatal Diagnosis for confirmation sex and contact the Northern Genetics Service.

For those parents who wish cytogenetics for fetal sex only and not full cytogenetics ensure this is clearly documented in the notes, on the request form and contact the Northern Genetics Service.

- The parents may have specific views and questions in relation to the post-mortem examination, which should be fully discussed prior to gaining written consent.

  Ensure staff discussing post-mortem examination consent with parents are trained to do so.

  A copy of the consent form should be offered to the parents and another kept within the maternal Medical Records. Ensure discussion takes place in a quiet and private place.

  Inform the parents that the post-mortem will take place in Newcastle. Transport arrangements will be respectful, and the baby's body will be labelled and tracked. Transport to Newcastle is via the hospital contracted funeral services.
  Inform parents of the likely timescales for the return of the body (within 1 week) and the results of post-mortem (up to 10/12 weeks).
  A named contact should be identified as responsible for following up on results.

- Parents should be offered other tests, including perinatal pathology examination of the placenta if any form of post-mortem is declined (Complete the Newcastle upon Tyne Hospitals NHS Trust Placental Pathology Request Form), as appropriate. See Appendix 2 check lists - pregnancy loss investigations 16 weeks gestation and above; and pregnancy loss investigations termination for fetal anomaly 16 weeks gestation, for relevant investigations.

- Fundamental principles and choices about their situation and plan of care may differ between parents depending upon gestation and type of pregnancy loss.

- Immediate post-delivery care of mother is dependent on her physical condition and wellbeing and type of delivery.

5.10 Creation of memory

- Following full discussion staff may be able to help by offering information and opportunities to create positive memories and physical mementos.

- Offer to describe how the baby may appear prior to delivery. Parents may wish to spend time with and/or hold their baby and staff should respect their wishes to do so, equally others may not wish to see their baby.

- Creation of memories always discussed / offered to parents and **only** done with their full consent. e.g. footprints, handprints, photographs, locks of hair. Parent's wishes must be followed at all times to avoid unnecessary distress and ensure that they are able to remember their baby the way in which **they** want to. Parents must be given time to reflect and decide what they want. Parents should be told they can change their minds and their decisions should be respected.

- When there is a death from a multiple pregnancy, discuss with parents the options around memory making with sibling.

5.11 Psychological / Spiritual Support

- Parents may find it helpful to talk to someone supportive this may be the midwife, obstetrician, GP, chaplain. Pregnancy loss counselling services offer sessions with a qualified counsellor (See bereavement documentation Counselling leaflet - Accessing Counselling after Pregnancy Loss).

- Many parents get valuable support from national charities and local groups such as SANDS, the Miscarriage Association and ARC. Details of how to contact these groups should be offered to the parents.

- Offer support from members of the clergy including the hospital chaplain. Parents may wish to have a blessing – explain this can be arranged for them. Parents may choose to contact their own member of the clergy.

5.12 Suppression of lactation:

- The management of lactation after loss varies – there is no conclusive evidence to show pharmacological methods are more effective than non-pharmacological ones.

- Women who use non pharmacological methods in the first week although they have more pain initially have fewer symptoms in the long term (Sands 2007).

- Women should be given the options of non-pharmacological measures and pharmacological measures for lactation suppression, where appropriate.

- Dopamine agonists successfully suppress lactation and are well tolerated. However, it should be avoided in women with hypertension or pre-eclampsia.

- Cabergoline is superior to bromocriptine. Cabergoline is given 1mg per day for 14 days. Bromocriptine is as 2.5 mg twice daily for 14 days. Oestrogens should not be used to suppress lactation.

5.13 **Legal Aspects**

- Certification and registration will alter dependent upon the gestation.

- A stillbirth certificate should be issued if the baby died at or after 24 weeks.

- If the baby died before 24 weeks and the gestation is known or provable from stage of development or ultrasound, but was delivered after 24 weeks, a stillbirth certificate is not required.

- Where a baby is born under 24 weeks without signs of life, a certificate for medical practitioner in respect of non-viable fetus is completed for the funeral directors. Certification if the parents wish is available on the SANDs website.

- When a baby is delivered spontaneously after 16 weeks and before 24 weeks there may be signs of life such as breathing, movements and cord pulsation.

  The case should be referred to the coroner so that a livebirth and subsequent neonatal death certificate can be completed. Once referred, an interim

certificate may be issued by the coroner. Further arrangements will then be made through the coroner.

- Inform parents that a stillbirth certificate must be registered within 42 days.

- At UHND - midwife to make an appointment with the birth registrar. At DMH - midwife to inform the birth registrar who will attend the hospital before the woman is discharged.

5.14 Choices with regard to baby

- Provide parents with information regarding the options for burial or cremation. Discuss Trust and other local options and costs involved. Be aware of different personal, religious and cultural needs. Assumptions should not be made. Record all discussions in the medical notes.

5.15 Documentation

- Record all discussions with the parents in the notes. This ensures that once a decision has been made it is not raised again unless the parents themselves wish to raise it. Staff should check notes regularly to ensure they know what decisions parents have made.

- Follow checklists including pregnancy loss investigations 16 weeks gestation and above; and pregnancy loss investigations termination for fetal anomaly 16 weeks gestation and above, and ensure relevant documentation is completed.

- Senior Obstetrician to examine baby and document observations.

- When post-mortem examination is arranged the Newcastle upon Tyne NHS Hospitals Trust Perinatal Post Mortem Request and Consent form should be completed (notes should be reviewed and all relevant information inserted on the form **and** copy of all scans sent).

- When any form of post-mortem examination is declined but perinatal pathology examination of the placenta is arranged the Newcastle upon Tyne Hospitals NHS Trust Placental Pathology Request Form should be completed.

- When cytogenetics is arranged obtain written consent using the Northern Genetic Service consent form - cytogenetic analysis after pregnancy loss.

- In cases of "Stillbirth" an experienced senior member of medical staff on duty at time of delivery must ensure that **Stillbirth Certificate** is properly completed. This is a legal document – **should be legible, written in black ink and contain no abbreviations (see above under legal aspects).**

- Confirm that Consultant and GP have been informed.

- Confirm NCARDRS (National Congenital Anomaly and Rare Disease Registration) form completed online where appropriate.

5.16 Discharge home

- There should be provision for close co-ordination and communication between all disciplines of staff, especially between hospital and community to promote increased levels of support for bereaved families**.** The Community Midwives, Health Visitor and General Practitioner should be informed of the events.
- Multi-disciplinary agencies involved in care provision should be informed of the events.
- Appointments for antenatal clinics (hospital and community), ultrasound scans, obstetric anaesthesia clinic and preoperative assessment etc should be cancelled.
- Inform the relevant Consultants secretary, so they are aware if woman rings up for an appointment or results.
- A follow up appointment will be made with the Consultant once all results are available to allow discussion re findings and future plans. The appointment will be after 3-4 months when post-mortem is being performed and after 2-3 months when post-mortem is not being performed.
- Ensure that contact telephone numbers are given to the family prior to discharge to ensure an easy means of communication with those involved with their care and follow up. Advise family they will need to make an appointment with their own GP for Postnatal check where appropriate.
- Enquire as to whether the woman would like a community midwife to visit at home and make arrangements for this – this should be encouraged where there are any issues regarding maternal health. Alternatively, where the woman does not want a community midwife to visit, offer a follow-up phone call.

5.17 Investigations

- See appendix 2 – pregnancy loss investigations 16 weeks gestation and above; and pregnancy loss investigations termination for fetal anomaly 16 weeks gestation and above.

6. Training

In-house pregnancy loss workshops are accessible to all staff that may be part of the multi-disciplinary team involved in caring for bereaved families. This ensures that staff are kept up to date with issues surrounding pregnancy loss and encouraged to develop coping strategies with colleagues.

A staff counselling service should be available within the Trust to provide additional support for staff dealing with bereaved families.

Additional external training is available through external resources such as SANDs, the Miscarriage Association, Bliss, and RCOG.

7. Key Performance Indicators

Monitoring Criterion	**Response**
Who will perform the monitoring?	Maternity services
What are you monitoring?	• Pregnancy loss from 16^{+0} weeks • Provision of postnatal support for parents in cases of pregnancy loss • Provision of support to parents who have communication or language support needs • That all discussions with parents documented in notes • Ensure parents have information about the relevant support group
When will the monitoring be performed	Case by case basis
How are you going to monitor?	Safeguard reporting system
What will happen if any shortfalls are identified?	Obstetric & Gynaecology Operational Group will address shortfalls and implement action plans
Where will the results of the monitoring are reported?	Quarterly Clinical Governance Meeting - Audit results will be presented in conjunction with results from the notes audit
How will the resulting action plan be progressed and monitored?	Obstetric & Gynaecology Operational Group will monitor and formulate plans, amend guidelines
How will learning take place?	Labour Ward Forums, Gynaecology Forums, Mandatory Study Days and Team Meetings

8. References

RCOG Greentop Guideline 55 Late Intrauterine Fetal Death and Stillbirth. October 2010, updated July 2011, December 2014 & February 2017

National Bereavement Care Pathway. Stillbirth. www.nbcpathway.org.uk

National Bereavement Care Pathway Termination of Pregnancy due to Fetal Abnormality (ToPFA). www.nbcpathway.org.uk

Perinatal Management of Extreme Preterm Birth before 27 Weeks of Gestation (2019) – a BAPM Framework for Practice

BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. Qureshi et al. Transfusion Medicine. 2014

SANDS Guidelines for professionals Pregnancy Loss and the Death of a Baby. 4th edition 2016

9. Associated documentation

CDDFT Screening for Down's, Edwards' and Patau's Syndromes Guideline
CDDFT Atypical Screening Test Result in Pregnancy following screening for Down's, Edwards' and Patau's Syndrome Guideline
CDDFT 18^{+0} to 20^{+6} week Fetal Anomaly Ultrasound Scan and Referral when Fetal Abnormality is detected Antenatally Guideline
CDDFT Placental for Histology Guideline
CDDFT Induction of labour Guideline
CDDFT Care of women in labour
CDDFT Operative vaginal delivery
CDDFT Obstetric Haemorrhage

10. Equality Analysis / Impact Assessment

Division/Department:	**Family Health – Maternity Services**
Title of policy, procedure, decision, project, function or service:	**Intra-uterine death, Pregnancy Loss & Termination of Pregnancy for Major Fetal Abnormality from 16^{+0} weeks; and Stillbirth**
Lead person responsible:	**Evidence Base Practice Group – chair**
People involved with completing this:	**Dr Sarah Johnson** **Dr Jane Milne**

Type of policy, procedure, decision, project, function or service:

Existing Yes ☐

New/proposed ☐

Changed ☐

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure women have the safest care that can be given

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Pregnant women

What outcomes do you want to achieve?

No incidents – good outcome – good experience for women and their families

What barriers are there to achieving these outcomes?

Not adhering to guidelines and policies - non-attendance at training and education

How will you put your policy, procedure, project, decision, function or service into practice?

Monitoring incidents and ensuring lessons are learned

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

None

Step 2 – Collecting your information

What existing information / data do you have?

Incident data

Who have you consulted with?

Clinical colleagues

What are the gaps and how do you plan to collect what is missing?

N/A

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010? check

Ethnicity or Race

No

Sex/Gender

No

Age

No

Disability

No

Religion or Belief

No

Sexual Orientation

No

Marriage and Civil Partnership

No

Pregnancy and Maternity

No

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

No

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

No If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 –

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Agreed at Obstetrics and Gynaecology Operational Group and approved at the quality & Health Care Governance Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Case by case reporting, reported at Clinical Governance meetings to discuss actions plans and amendments to guidelines.

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk ?

Appendix 1

IUD MEDICAL MANAGEMENT / INDUCTION OF LABOUR

- **Initial management** – Mifepristone 200mg orally straightaway if woman chooses (at a later agreed time if preferred).

  Women at risk of sexually transmitted infections should receive Azithromycin 1g orally with the mifepristone followed by Azithromycin 500mg daily for 2 days.

- Following diagnosis of IUD / spontaneous loss

  Take blood for Kleihauer to exclude feto-maternal haemorrhage as cause for loss (fetal cells may only be present in the maternal circulation for a short time so Kleihauer must be done at time of diagnosis).

  Administer Anti-D immediately following diagnosis of the IUD in women who are rhesus negative and where analysis of free fetal DNA (ffDNA) is predictive of a rhesus positive baby.

  In rhesus negative women who have not had the ffDNA test or test was inconclusive, administer Anti-D.

  It is recommended to give Anti-D again following delivery as there may be a significant delay between the diagnosis of IUD and the subsequent delivery. BCSH Guidelines 2014.

- Arrange admission to Labour Ward or Gynaecology Ward as appropriate 36 – 48 hrs after Mifepristone.

- Warn woman there is possibility of contractions starting in the 36-48 hrs after Mifepristone. Advise them to contact Labour Ward/Gynaecology Ward if necessary. Ensure has phone number.

- Advise that may have some bleeding and abdominal cramps – if it is severe need to come to hospital.

- As with any sensitising event greater than 20 weeks Repeat Kleihauer to determine if higher than normal dose is required.

Women with unscarred uterus or parity < 5 – see flow chart

16^{+0} to 26^{+6} weeks women with unscarred uterus or parity < 5

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 100 micrograms every 6 hours if required for a maximum of 4 doses

If first dose does not lead to effective contractions **double** subsequent dose to 200 mcg – **Max daily dosage 800mcg**

If delivery has not occurred after 24 hours – review re repeating regime or if cervix favourable consider IV oxytocin as per CDDFT Induction of Labour Guideline.

> 27^{+0} weeks women with unscarred uterus or parity < 5

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 50 micrograms every 4 hours if required for a maximum of 6 doses

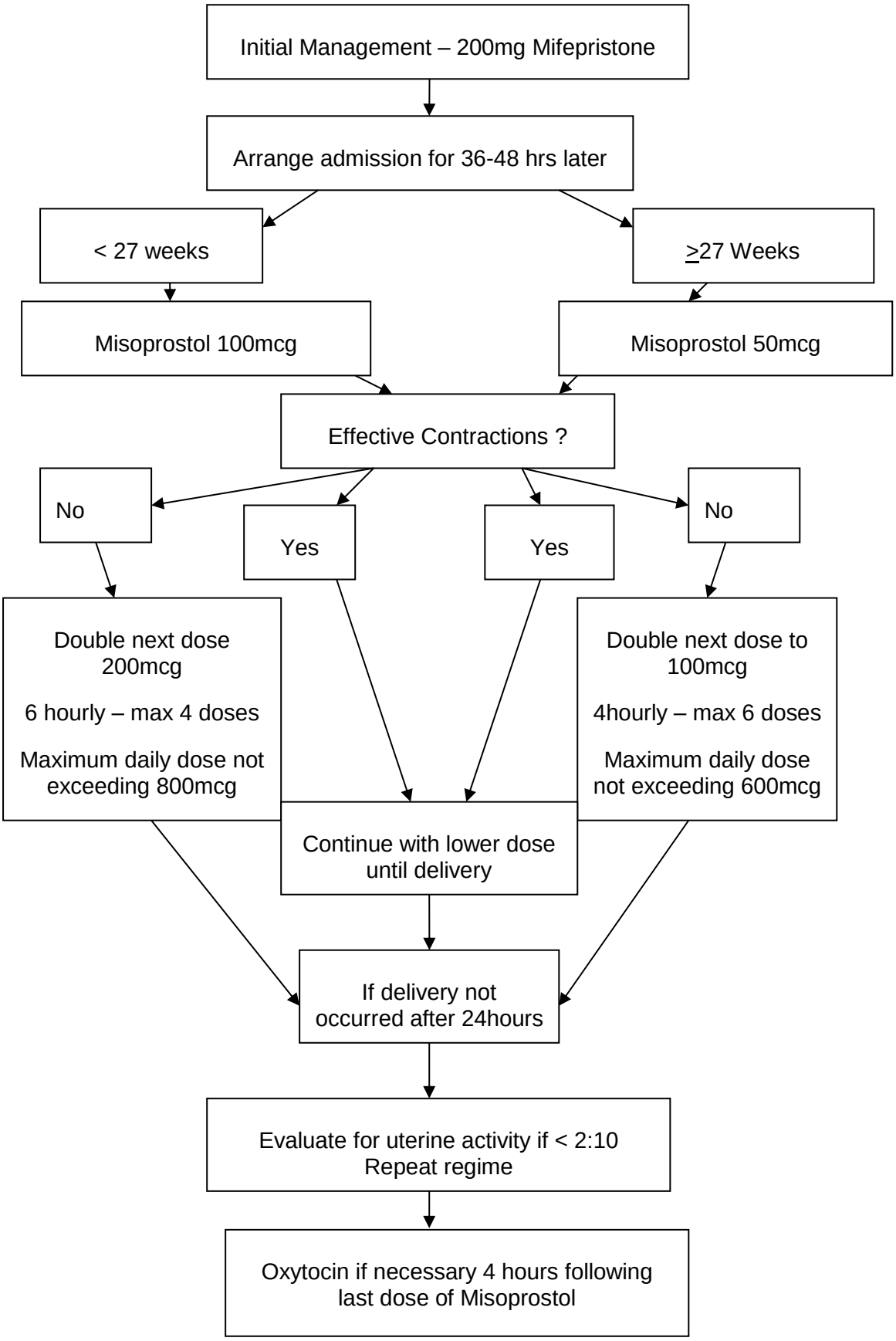
If first dose does not lead to effective contractions **double** subsequent dose to 100 mcg – **Max daily dosage 600mcg**

If delivery has not occurred after 24 hours – review re repeating regime or if cervix favourable consider IV oxytocin as per CDDFT Induction of Labour Guideline.

NB Misoprostol tablets can be quartered to 50mcg with a tablet cutter – remaining dose must be discarded.

Vaginal misoprostol is as effective as oral and has less side effects

Induction of Labour for Intrauterine Fetal Death – unscarred uterus or parity < 5



Women with scarred uterus or parity > 5

16^{+0} to 26^{+6} weeks women with scarred uterus or parity > 5

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 50 micrograms every 6 hours if required for a maximum of 4 doses

≥ 27^{+0} weeks women with scarred uterus or parity > 5

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 25 micrograms every 4 hours if required for a maximum of 6 doses

NB Misoprostol tablets can be quartered to 50mcg with a tablet cutter – remaining dose must be discarded.

Vaginal misoprostol is as effective as oral and has less side effects

- Safety and benefits of IOL should be discussed by a consultant. Induction of labour with prostaglandin is safe but not without risk.
- Women with more than two LSCS deliveries or atypical scars should be advised that the safety of induction of labour is unknown.
- Mechanical methods for induction of labour in women with an IUFD should be used only in the context of a clinical trial.

Retained Placenta

If bleeding remains minimal, observe up to 1 hour. The Registrar should examine the woman and arrange manual removal under anaesthesia if the placenta is still retained.

ToP FOR MAJOR FETAL ABNORMALITY

16^{+0} to 23^{+6} weeks

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 800 micrograms by vagina

Then Misoprostol 400 micrograms every 3 hours if required for a maximum of 4 doses

If termination has not occurred 3 hours after the last dose of misoprostol, a further dose of mifepristone may be given, and misoprostol may be recommenced 12 hours later

24^{+0} to 25^{+0} weeks

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 400 micrograms every 3 hours if required until delivery

25^{+1} to 28^{+0} weeks

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 200 micrograms every 4 hours if required until delivery

> 28^{+0} weeks

Mifepristone 200 milligrams

36-48 hours later

Misoprostol 100 micrograms every 6 hours if required until delivery

NB Misoprostol tablets can be quartered to 50mcg with a tablet cutter – remaining dose must be discarded.

Vaginal misoprostol is as effective as oral and has less side effects

Medication


Medications all.docx


Medications IUD 16 to 27wk unscarred u


Medications IUD after 27wk unscarre


Medications IUD 16 to 27wk scarred utei


Medications IUD after 27wk scarred u


Medications ToP 16 to 24wk.docx


Medications ToP 24 to 25wk.docx


Medications ToP 25 to 28wk.docx


Medications ToP after 28wk.docx

Appendix 2

Checklists **Pregnancy Loss Investigations-16 weeks gestation and above**

Pregnancy Loss Investigations-Termination for Fetal Abnormality 16 weeks gestation and above

Pregnancy Loss Investigations - 16 w

Pregnancy Loss Investigations - Term

Appendix 3

Newcastle upon Tyne Hospitals NHS Trust Placental Pathology Request Form

Perinatal placental examination request

Appendix 4

Flow Chart When Fetal Abnormality is suspected