Developing a standardised pathway for reducing and investigating stillbirths

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Description
Although Scottish stillbirth rates are falling (with the lowest recorded rate of 4.72/1000 live births in 2015) for families, it is a tragedy, with profound emotional and psychological sequelae. Recent national perinatal reports (MBRRACE 2017, Each Baby Counts 2016) highlight the fact that in 80% of reviewed cases, different care might have made a difference.

Methodology
We focused on improvements across the following key areas:

• Movement Matters campaign raising awareness about altered or reduced fetal movement and increased risk of stillbirth
• Implementing a standardised pathway for women reporting altered or reduced fetal movements
• Establishing a multi-professional review group to undertake robust reviews of all stillbirths, including the parent’s perspective of their care
• Sharing learning from reviews with all staff and parents.

Key Learning

• Placental histology is useful in ‘near miss’ cases too.
• Communication between teams is essential (especially in multiple gestation).
• Every case should be assessed individually and delivery planned taking account of the mother’s wishes.
• Parents should be informed of a review.
• Parents may wish to submit questions to be answered during the review.
• Parents should be informed of the outcomes of the review in plain jargon-free English.
• Each case should have identified persons to collate results and communicate with the parents.

Aims/Objectives
The project aligns with local and national aims; reducing stillbirths by 35% by December 2019, alongside key recommendations from national perinatal reports to ensure all cases have a standardised review to which families can contribute and learning is shared.

Results/Outcomes

• Improved awareness amongst women of the importance of reduced or altered fetal movement. 95% compliance with documented discussion about fetal movement.
• Standardised pathway of care for women presenting with concerns regarding fetal movements.
• All stillbirths trigger a standardised review by the Perinatal Mortality and Morbidity Group(PMMRG), including parent’s perspective of their care.
• Perinatal Matters newsletter is published quarterly to feedback learning to the wider staff across maternity and neonatal services and share messages from national reports.
• Local stillbirth rate in 2017 was reduced to 2.5/1000 live births.
• 5 month period in 2017 when no family experienced a stillbirth.

References