IMPLEMENTATION OF THE NHS CARE BUNDLE IN A PRIVATE PRACTICE

Dr. Heather Florescue MD FACOG

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STAR LEGACY FOUNDATION STILLBIRTH SUMMIT 2019

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THE STEPS

1. Reduce maternal smoking:
   (CO monitoring in pregnancy)
2. Educate mothers about importance of fetal movement
3. Identify all fetal growth restricted babies
4. A formal plan for maternal reported decreased fetal movement

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WGCA PLAN - STEP 1: REDUCE MATERNAL SMOKING

1. Identify all mothers who smoke at beginning of pregnancy
2. Ensure smoking status is reassessed regularly during prenatal care
3. Ensure mothers who smoke receive third trimester growth scan

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WGCA PLAN – STEP 2: EDUCATE PATIENTS ABOUT FETAL MOVEMENT

We are using the word "stillbirth"

Signs placed in all our bathrooms talking about fetal movement and kick counts

At 20-24 weeks and our third trimester talk, our RNs are handing out cards about fetal movement

Dispel the myth that babies slow down closer to term

We discuss that decrease, *concerning increase* or *no* fetal movement are risk factors for stillbirth

Make sure patients know to call immediately and trust their instincts!
- (Do not instruct patients to drink juice and lay down)

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WGCA PLAN - STEP 3: IDENTIFY FGR BABIES

Provider is assigned to review the charts of all patients receiving a third trimester talk with the RNs (around 32 weeks), and orders an ultrasound if indicated

Per the UK protocol, we obtain an ultrasound on women with a BMI > 35 and those with large myomas

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WGCA PLAN- STEP 4: PLAN FOR DECREASED FETAL MOVEMENT

Patient reports decreased or changed fetal movement:

- Flowsheet started
- NST performed:
  - If risk factor for stillbirth, US with fluid and growth is done within 24 hours, even if reactive NST
  - If not reactive, plan per protocol
- If NST reactive, ask if mom is reassured. If not, US performed even in absence of risk factors
  - Call next day and continued to assess
- If decreased/no FM is recurrent or persistent – IOL > 39 weeks, twice weekly NST/weekly US until 39 weeks then IOL

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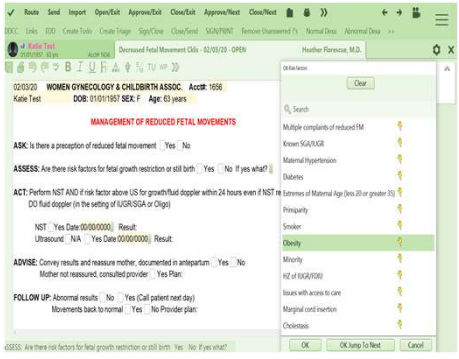

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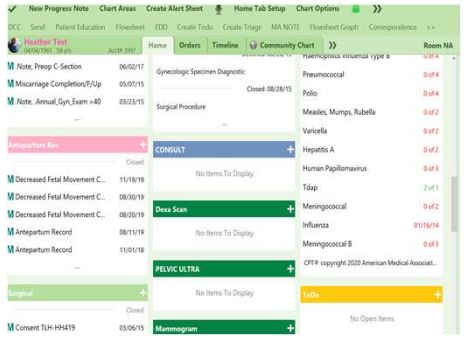

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CASE STUDY 1: PRE-PROTOCOL IMPLEMENTATION

EM presented to the office for a routine visit at 37 4/7 weeks with her first baby. Baby was felt to be breech on exam.

US that day showed EFW 60th %, AFI 12 cm and normal UA dopplers (RIT student was there and wanted to practice).

Patient re-presented to office after 48 hours of no fetal movement at 38 0/7 weeks and FDIU was diagnosed.

Baby Sarah was delivered the following day. Cause of death was placental insufficiency due to maternal floor infarction.

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CASE STUDY 2: POST-PROTOCOL IMPLEMENTATION

AJ presented to the office at 37 1/7 weeks for growth scan due to marginal cord insertion. EFW 45%ile and AFI 12 cm. Breech presentation was noted.

Patient called at 37 2/7 weeks with decreased FM - came in for NST which was reactive. Patient said that she was reassured.

Patient called at 37 4/7 weeks with complaint of pink discharge and no FM. A speculum exam was performed showing no blood or evidence of ROM, reactive NST.

Patient stated she was not reassured, so repeat AFI done and noted to be 3.8 cm. No 2 x 2 cm pocket seen.

C/S performed for healthy baby named Jane. The placenta showed a marginally increased twist index, basal chronic villitis and an intervillous thrombus.

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