

NWT Clinical Practice Information Notice

UPON RECEIPT: (1) PLEASE FOLLOW THE DIRECTIONS BELOW
 (2) FILE THIS NOTICE IN SECTION C, CLINICAL PRACTICE INFORMATION BINDER FOR FUTURE REFERENCE

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

Hospitals
 Community Health Centers
 Public Health Units
 Doctors' Offices
 Social Services Offices
 Other: _____

The information contained in this document is a Departmental:

Policy
 Standard
 Protocol
 Procedure
 Guidelines

Title: Guidelines for Management of a Stillborn

Effective Date: April 30, 2008

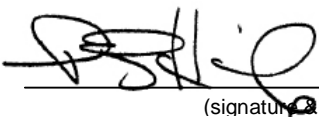
Statement of approved clinical practice:

The attached *NWT Guidelines for Management of a Stillborn*, dated April 2008, is recommended for use by the NWT Maternal-Perinatal Committee in order to streamline the management of stillborns. The *Stillborn Examination Record* (NWT 8795/0408) is approved as the NWT standard for use with stillborns.

- The *NWT Guidelines for Management of a Stillborn* package consists of three (3) components:
 - Flow Sheet
 - Study of Perinatal Deaths
 - Stillborn Examination Record (NWT 8795/0408)
- An electronic copy of these guidelines is also available on the Department of Health and Social Services Public Website at: <http://hlthss.gov.nt.ca> Once you have accessed the site, click on "Manuals". The Clinical Practice Information Notice and the *NWT Guidelines for Management of a Stillborn* will be found in the *NWT Clinical Practice Information* manual.

Attachments:

- NWT Guidelines for Management of a Stillborn

This clinical practice is approved.  01 May 2008
 (signature & date)

Assistant Deputy Minister
 Chief Medical Officer of Health
 Director, Child & Family Services
 Director, Adoptions

GUIDELINES FOR MANAGEMENT OF A STILLBORN

These Guidelines have been developed by the NWT Maternal Perinatal Committee to streamline the management of stillborns.

There are **3 components** to this document:

1. **Flow Sheet:** to be completed on any fetus over 20 weeks gestation or weighing over 500 grams.
2. **Study of Perinatal Deaths:** to be submitted to the NWT Maternal Perinatal Committee for review of this case.
3. **Stillborn Examination Record:** the stillborn should be examined and the findings recorded. Complete parts A through F in the Stillbirth Investigations if possible:

Part A:

- Take cord blood or blood from the heart if possible.
- Unclotted blood is needed.
- One pediatric blood culture bottle should be used.
- Blood tubes required are one purple top, one yellow top, and one light green top.

Part B:

- The placenta should be sent in saline unfixed in a bucket to the lab. (If in a hospital setting, contact Dynacare lab about specimen and formalin).

Part C:

- An autopsy should be requested and arrangements made for this if consent is given.
- If consent is not received, take clinical photos and a babygram (x-ray).

Part D:

- For maternal investigations you will need two purple tops (one 4ml and one 7 ml), one blue top, one yellow top.
- Adult blood culture bottles should be used (aerobic and anaerobic).

Part E:

- Copy of prenatal record and labor & delivery records are sent to the MPC.
- A copy of the Stillborn Examination Record must be kept in the medical chart.
- A copy of all these documents must be sent to the pathologist as indicated.

Part F:

- Follow-up should be arranged to discuss these results with the family about six weeks later. A referral to an obstetrician may be indicated.

FLWSHEET FOR MANAGEMENT OF A STILLBORN
Any Fetus over 20 weeks gestation or weighing over 500 grams

Community Health Centres and Hospitals

- ___ Registration of stillborn (to be completed by appropriate Health Care Provider)
 - ___ Original copy to City Hall/Hamlet Office for burial permit
 - ___ Photocopy to accompany body
 - ___ Photocopy on chart

- ___ Labor and Delivery Record Parts 1 and 2

- ___ Newborn Record Part I

- ___ NWT Study of Perinatal Deaths (to be completed by appropriate Health Care Provider)

- ___ Cord Blood sent for tests as ordered

- ___ Maternal Investigation as ordered

- ___ Post Mortem (autopsy) Consent Form (if ordered by coroner)
 - ___ One copy on chart
 - ___ One original copy to accompany body

- ___ Placenta (refrigerated) sent with body for autopsy

- ___ Pathology requisition for placenta

- ___ Social worker/medical social worker notification, mementos as requested by parents

- ___ Permission for Burial form-RAH and Burial Permit form- NWT (if parents do not want body returned for burial)
 - ___ One copy for Chart
 - ___ One original copy to accompany body

Hospitals:

- ___ Notification of Royal Alexandra Hospital (if autopsy ordered): Pathology:
 - Phone#: (780) 735-4629
 - Fax#: (780) 735-4401Include referring centre number and fax so Pathology may send information.

- ___ Territorial Funeral Home for transportation and/or burial arrangements.

- ___ Burial and/or transportation arrangements made by: (if needed for travel to settlements)
 - Containers available from Territorial Funeral Home or strong cardboard box. (See Dangerous Goods Regulations)
 - Box must be clearly labeled.
 - Parents make arrangements with Air Cargo for transportation (baby may not be carried in passenger compartment).
 - Parents or other delivery to Air Cargo.

- ___ Other (specify): _____

STUDY OF PERINATAL DEATHS

To be completed on: all fetal deaths of 20 weeks of gestation and older and/or weighing 500 grams or more
and infant deaths up to and including seven days of age.

PART A: MOTHER				
SURNAME		GIVEN NAME(S)		
Community				
Date of Birth (D/M/Y)	Age	HCP#	Hospital #	
ATTACH COPIES OF PRENATAL RECORD – Parts 1,2,3,4,5 LABOUR & DELIVERY RECORD – Parts 1 & 2 NEWBORN RECORD – Parts 1 & 2 If NOT attached, health care provider/health facility to contact for information _____				
HOSPITALIZED DURING PREGNANCY		NO or YES	CONSULTATION DURING PREGNANCY	
If “yes”, date(s)			If “yes”, date & name of consultant	
INFORMATION WHICH YOU THINK MIGHT HELP THE COMMITTEE (in retrospect, would you have managed this case differently? In what ways?)				
*PLEASE USE THE BACK OF THIS FORM IF MORE SPACE IS REQUIRED.				
HEALTH CARE PROVIDER’S NAME (Print)			SIGNATURE	
PART B – INFANT				
WEIGHT (grams)	SEX M / F	DATE OF BIRTH (Day/Month/Year)	DATE OF DEATH (Day/Month/Year)	TIME OF DEATH (24 hour clock)
CONSULTATION		NO or YES		
If “yes”, date/ time & name of consultant				
INFORMATION WHICH YOU THINK MIGHT HELP THE COMMITTEE (In retrospect, would you have managed the case differently? In what ways?)				
*PLEASE USE THE BACK OF THIS FORM IF MORE SPACE IS REQUIRED.				
AUTOPSY		NO or YES		
If “Yes”: Attach copy		or Findings not yet available (circle)		
HEALTH CARE PROVIDER’S NAME (print)			SIGNATURE	
DATE COMPLETED (D/M/Y)				

Please return form and attachments in an envelope marked “medical confidential”, Attention of the Chairperson,
Maternal & Perinatal Committee, Box 10, Yellowknife, NT X1A 2N1
April 2008



Stillborn Examination Record

Part 1: Significant Maternal & Obstetrical Examination:		G	P	LB	SA	TA	Dene	Métis	Inuit	Other (please specify):			
Part 2: Physical Examination:		Gestational Age (wks)	Weight (gms)	Circumference: (cm)	Head	Chest	Abdomen	Length: (cm)	Crown-heel	Crown-rump	Foot		
	Normal	Abnormal (Describe)										Stillbirth Investigation	
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/> Recent Stillbirth					<input type="checkbox"/> Macerated + ++ +++					<p align="center">Check <input checked="" type="checkbox"/> as completed</p> <p>A. Fetal Blood: (cord or cardiac) <input type="checkbox"/> Blood Culture <input type="checkbox"/> Cytogenetics <input type="checkbox"/> Syphilis serology, Parvovirus, CMV, Rubella & Toxoplasmosis <input type="checkbox"/> CBC <input type="checkbox"/> Direct antibody test, Blood group, and Rh type</p> <p>B. Placenta and Cord <input type="checkbox"/> Placenta tissue (unfixed) <input type="checkbox"/> Cytogenetics <input type="checkbox"/> Cultures <input type="checkbox"/> Sent to pathology</p> <p>C. Autopsy <input type="checkbox"/> Consent <input type="checkbox"/> full <input type="checkbox"/> limited <input type="checkbox"/> No consent <input type="checkbox"/> Clinical photographs <input type="checkbox"/> Baby gram (x-rays)</p> <p>D. Maternal <input type="checkbox"/> CBC, Platelets count <input type="checkbox"/> PT/PTT <input type="checkbox"/> Blood group & Rh type antibody screen <input type="checkbox"/> Kleihauer-Betke <input type="checkbox"/> HbA1C <input type="checkbox"/> Syphilis serology, Parvovirus, CMV, Rubella & Toxoplasmosis <input type="checkbox"/> Blood culture <input type="checkbox"/> Other: (i.e. Autoimmune serology, Thyroid studies, Hgb electrophoresis, HIV, TB test) list: _____ _____ _____</p> <p>E. Documentation to Pathologist <input type="checkbox"/> Prenatal record <input type="checkbox"/> Labor & delivery record <input type="checkbox"/> Laboratory & ultrasound reports <input type="checkbox"/> Other</p> <p>F. Follow-up arrangements <input type="checkbox"/> Results to be reviewed and discussed with parents by: (Name and Title) _____ _____ _____</p>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/> Mec. Stained	<input type="checkbox"/> Petechiae	<input type="checkbox"/> Hydrops	<input type="checkbox"/> Bruising								
3. Head	<input type="checkbox"/>	<input type="checkbox"/> Peeling	<input type="checkbox"/> Edema	<input type="checkbox"/> Jaundice									
4. Scalp	<input type="checkbox"/>	<input type="checkbox"/> Hydrocephalic <input type="checkbox"/> Collapsed <input type="checkbox"/> Neural Tube Defect (specify)											
5. Eyes	<input type="checkbox"/>	Spacing: <input type="checkbox"/> narrow <input type="checkbox"/> wide <input type="checkbox"/> asymmetric <input type="checkbox"/> Opaque											
6. Nose	<input type="checkbox"/>	Slanting: <input type="checkbox"/> up <input type="checkbox"/> down <input type="checkbox"/> Cataracts											
7. Nostrils	<input type="checkbox"/>	<input type="checkbox"/> Eyelids Fused <input type="checkbox"/> Prominent <input type="checkbox"/> Sunken											
8. Ears	<input type="checkbox"/>	<input type="checkbox"/> Flat Bridge											
9. Mouth	<input type="checkbox"/>	<input type="checkbox"/> Obstructed <input type="checkbox"/> Single Nostril											
10. Mandible	<input type="checkbox"/>	<input type="checkbox"/> Low Set <input type="checkbox"/> Periauricular Tags/Pits <input type="checkbox"/> Abn Form											
11. Neck	<input type="checkbox"/>	<input type="checkbox"/> Posterior Rotation <input type="checkbox"/> Edema											
12. Chest	<input type="checkbox"/>	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Cleft Palate											
13. Abdomen	<input type="checkbox"/>	<input type="checkbox"/> Micrognathia <input type="checkbox"/> Asymmetric											
14. Cord	<input type="checkbox"/>	<input type="checkbox"/> Short <input type="checkbox"/> Excess Skin <input type="checkbox"/> Cystic Mass											
15. Back	<input type="checkbox"/>	<input type="checkbox"/> Asymmetric <input type="checkbox"/> Barreled <input type="checkbox"/> Small											
16. Arms	<input type="checkbox"/>	<input type="checkbox"/> Sternal Defects <input type="checkbox"/> Constricted <input type="checkbox"/> Nipples Wide Spaced											
17. Hands	<input type="checkbox"/>	<input type="checkbox"/> Flattened <input type="checkbox"/> Distended <input type="checkbox"/> Wall Defect											
18. Legs	<input type="checkbox"/>	<input type="checkbox"/> Vessels <input type="checkbox"/> True Knot <input type="checkbox"/> Cord Constriction											
19. Feet	<input type="checkbox"/>	<input type="checkbox"/> Sacral Dimple <input type="checkbox"/> Neural Tube Defect											
20. Genital-Rectal	<input type="checkbox"/>	<input type="checkbox"/> Short <input type="checkbox"/> Abnormal Muscle Development											
21. Other:	<input type="checkbox"/>	<input type="checkbox"/> Long <input type="checkbox"/> Abnormal Positioning											
Name (printed)		Signature				Date - dd/mm/yy		Time (24hrs)					
		X											