AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Stillbirth

Clinical Care Standard

November 2022

This clinical care standard describes clinical care to support the prevention and investigation of stillbirth, and bereavement care for all forms of perinatal loss, including stillbirth, miscarriage, termination of pregnancy and neonatal death. This content may cause discomfort or distress for some people.

The Australian Commission on Safety and Quality in Health Care acknowledges the traditional owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

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The *Stillbirth Clinical Care Standard* has been endorsed by the following organisations:

ASUM
Promoting ultrasound excellence

asa
australasian sonographers association

AUSTRALIAN & NEW ZEALAND NEONATAL NETWORK

acm
Australian College of Midwives

acnp
australian college of nurse practitioners

Australian College of Nursing

Australian College of Rural & Remote Medicine
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COUNCIL OF DEANS OF NURSING AND MIDWIFERY
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CRANA plus
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Maternal Health Matters

NACCHO
National Aboriginal Community Controlled Health Organisation

National Rural Health Alliance

PERINATAL SOCIETY of Australia & New Zealand
PSANZ

PACFA
Psychotherapy and Counselling Federation of Australia

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RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SOMANZ
SOCIETY OF OBSTETRIC MEDICINE OF AUSTRALIA AND NEW ZEALAND

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stillaware.org

Stillbirth
CENTRE OF RESEARCH EXCELLENCE

Stillbirth Foundation
AUSTRALIA

WOMEN'S HEALTHCARE
AUSTRALASIA

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A woman intending pregnancy is offered pre-conception care that supports her to identify and manage stillbirth risks and improve her chance of giving birth to a healthy live-born baby.

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A woman's risk factors for stillbirth are identified early, monitored and managed with evidence-based care throughout her pregnancy. She is offered the most appropriate available model of maternity care for her clinical, personal and cultural needs.

3 **Stillbirth awareness and strategies to reduce risk**
Early in pregnancy, a woman is informed about stillbirth as a potential outcome. Throughout the pregnancy, she is supported to adopt strategies that may reduce her risk of stillbirth, including smoking cessation, using a side going-to-sleep position from 28 weeks gestation and being aware of fetal movements.

4 **Ultrasound during pregnancy**
A woman is offered high-quality ultrasound during pregnancy to assess fetal growth and morphology, and identify stillbirth risks. Ultrasound performance and reporting, and communication of outcomes to the woman, are in line with current best-practice guidelines.

5 **Change in fetal movements**
A woman who contacts her clinician or health service with concerns about a change in the frequency, strength or pattern of her baby's movements is offered timely assessment and care according to the Decreased Fetal Movement Care Pathway developed by the Centre of Research Excellence in Stillbirth and the Perinatal Society of Australia and New Zealand, or a locally approved alternative.

6 **Informed decision-making about timing of birth**
A woman is provided with information that enables her to make informed decisions about timing of birth, in line with her individual risks and preferences. Whenever a planned birth is being considered, including when there are concerns about maternal or fetal health, the potential benefits and harms are discussed with the woman and documented appropriately.

7 **Discussing investigations for stillbirth**
When a stillbirth is diagnosed, the availability, timing and anticipated value of clinical investigations, including autopsy, are discussed with the parents. The parents are supported to share their views about factors they perceive may have contributed to the stillbirth, including aspects of the woman's clinical care. This information is documented and considered alongside the agreed clinical investigations, and as part of local perinatal mortality audit or incident investigation processes.

8 **Reporting, documenting and communicating stillbirth investigation results**
The results of stillbirth investigations are reported in a timely manner, documented appropriately and discussed with the parents, along with any information they have provided about perceived contributing factors. The stillbirth is reviewed as part of a local perinatal mortality audit process, classified according to the Perinatal Society of Australia and New Zealand classification system, and outcomes are used to inform local improvements in care.

9 **Bereavement care and support after perinatal loss**
After a perinatal loss, parents and their support people are provided with compassionate, respectful and culturally safe bereavement care that recognises their specific needs and preferences, and ensures that follow-up support is available after discharge.

10 **Subsequent pregnancy care after perinatal loss**
During a subsequent pregnancy after a perinatal loss, a woman receives antenatal care that recognises factors that may have contributed to the previous loss, and ensures that she has access to appropriate clinical expertise and psychosocial support, as required.

Indicators for local monitoring

The following indicators will support healthcare services to monitor how well they are implementing the care recommended in this clinical care standard. The indicators are intended to support local quality improvement activities.

2

Stillbirth risk assessment during pregnancy

Indicator 2a: Proportion of women assessed for clinical risk factors for fetal growth restriction at their first antenatal appointment at the hospital and the outcomes of the risk assessment documented in their medical record.

3

Stillbirth awareness and strategies to reduce risk

Indicator 3a: Proportion of pregnant women who reported smoking who were provided with advice on smoking cessation, offered a referral to a smoking cessation service (for example, Quitline), and/or nicotine replacement therapy if clinically indicated.

Indicator 3b: Proportion of women who gave birth who demonstrated their understanding of safe maternal going-to-sleep position at an antenatal visit from 28 weeks gestation.

Indicator 3c: Proportion of women who gave birth who reported from 28 weeks gestation that they knew how to monitor their fetal movements and what to do if they were concerned about a change in their fetal movements.

5

Change in fetal movements

Indicator 5a: Evidence of local arrangements to enable timely assessment and appropriate care for women presenting with concerns about changes in fetal movements. The local arrangements should include the:

- Locally approved fetal movement care pathway
- Fetal monitoring and assessment protocol, with timelines and a process to access urgent clinical expertise if fetal heart tone is difficult to determine
- Guidance and communication protocols for clinicians who may identify a fetal death, consistent with the *Parent-centred Communication in Obstetric Ultrasound Guidelines*
- Process to provide appropriate care for women if fetal death has been confirmed, in line with the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*
- Process to ensure clinicians are trained and competent in the fetal movement care pathway
- Governance process to oversee implementation of the local arrangements and evaluate their effectiveness.

Indicator 5b: Median time from when women report that they first noticed a change in fetal movements to when they contacted a clinician or healthcare service.

6 Informed decision-making about timing of birth

Indicator 6a: Proportion of women who had a planned birth who received written and verbal information on the potential benefits and harms of planned birth, including the timing of intervention.

Indicator 6b: Proportion of women who had a planned birth before 39 weeks gestation whose medical record documents the reason(s) for intervention.

Indicator 6c: Proportion of women with singleton pregnancies who had a planned birth before 39 weeks gestation.

7 Discussing investigations for stillbirth

Indicator 7a: Proportion of clinicians who provide bereavement care to parents who have experienced a stillbirth who have completed an evidence-based bereavement care professional development program.

8 Reporting, documenting and communicating stillbirth investigation results

Indicator 8a: Proportion of stillbirths reviewed by the healthcare service for potential contributing factors and classified according to the Perinatal Society of Australia and New Zealand classification system.

9 Bereavement care and support after perinatal loss

Indicator 9a: Evidence of local arrangements to support the provision of bereavement care in line with the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death* and *Sands Australian Principles of Bereavement Care*. The arrangements should include but not be limited to the:

- Process to involve interpreter services, Aboriginal and Torres Strait Islander health workers or liaison officers, or cross-cultural health workers when required
- Discharge protocol to ensure prompt communication with the woman's general practitioner or other primary care provider to advise of the baby's death and recommendations for follow-up care and support
- Details of the designated clinician at the hospital, who can be contacted should the parents require follow-up support after discharge
- Referral processes and pathways for appropriate clinical and psychosocial care and parent support programs following perinatal loss.

The definitions required to collect and calculate indicator data are specified online at meteor.aihw.gov.au/content/766607. More information about indicators and other quality improvement measures is provided in Appendix B.

Clinical care standards

Clinical care standards help support the delivery of evidence-based clinical care and promote shared decision making between patients, carers and clinicians. They aim to ensure that people receive best-practice care for a specific clinical condition or procedure, regardless of where they are treated in Australia.

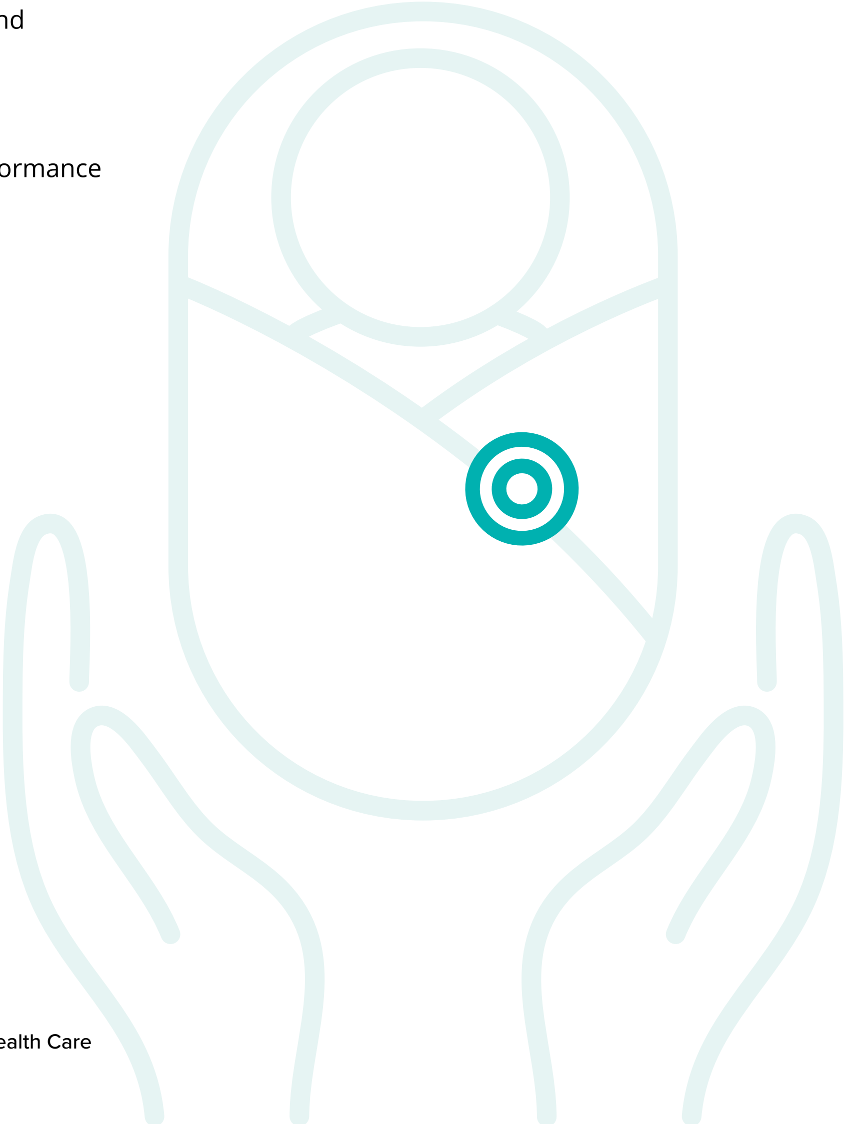
A clinical care standard contains a small number of quality statements that describe the level of clinical care expected for a specific clinical condition or procedure. Indicators are included for some quality statements to help healthcare services monitor how well they are implementing the care recommended in the clinical care standard.

A clinical care standard differs from a clinical practice guideline. Rather than describing all the components of care for a specific clinical condition or procedure, a clinical care standard focuses on key areas of care where the need for quality improvement is greatest.

Clinical care standards aim to improve healthcare outcomes by describing key components of appropriate care, enabling:

- Patients and the community to understand the care that is recommended and their healthcare choices
- Clinicians to provide best-practice care
- Healthcare services to monitor their performance and make improvements in the care they provide.

Clinical care standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission), an Australian Government agency that leads and coordinates national improvements in the safety and quality of health care, based on the best available evidence. By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.



About the Stillbirth Clinical Care Standard

Context

This clinical care standard was developed in response to a recommendation in the *National Stillbirth Action and Implementation Plan*[1] that the Commission develop a clinical care standard to improve national consistency in best-practice care for stillbirth prevention and bereavement care.

This clinical care standard describes the key components of care that pregnant women can expect to help reduce their chance of experiencing a stillbirth. It also addresses the need for appropriate bereavement care for parents (and their support people) who have experienced any form of perinatal loss. It supports the provision of high-quality, evidence-based care that considers the context in which care is provided, local variation and the quality improvement priorities of the individual health service.

Although described in the context of stillbirth prevention, some aspects of care included in this clinical care standard are recommended as part of good antenatal care and may optimise pregnancy outcomes more generally.

Goal

To reduce unwarranted clinical variation in the prevention and investigation of stillbirth, and to reduce the number of women experiencing stillbirth, especially after 28 weeks gestation. This clinical care standard also aims to support best practice in bereavement care for parents (and their families and support people) following any perinatal loss, and in the care provided to women when planning for, and during, subsequent pregnancies.

Scope

This clinical care standard applies to the care provided to women who are pregnant or planning a pregnancy, from pre-conception to after a stillbirth occurs.

Elements of this clinical care standard that address bereavement care and care for future pregnancies apply to women (and their families and support people) who have experienced any form of perinatal loss, regardless of gestational age or the reasons for the loss.

What is not covered

This clinical care standard does not specifically address:

- Prevention or investigation of miscarriage
- Prevention of preterm birth
- Prevention or investigation related to terminations of pregnancy for medical reasons that occur before 20 weeks gestation
- Prevention or investigation of neonatal death.

However, the Commission acknowledges the tragedy of every perinatal loss, regardless of the nature of the loss or the gestational age at which the loss occurs. The Commission anticipates that care for women and families experiencing such losses may also be improved through implementation of the principles outlined in this clinical care standard.

Terminology

Some of the key terms used in this clinical care standard are described below (also see Background: Stillbirth and Glossary).

Term	How it is used in this document
Stillbirth	For the purposes of this clinical care standard, the following Australian Institute of Health and Welfare (AIHW) definition has been used[2]: ▪ A fetal death prior to the birth of a baby of 20 or more completed weeks of gestation or of 400 grams or more birthweight.
Perinatal loss	The term perinatal loss is used in this clinical care standard to describe any form of pregnancy loss[3], including following a miscarriage, stillbirth, ectopic pregnancy, termination of pregnancy or neonatal death. The following AIHW definition has been used for neonatal death[2]: ▪ The death of a live-born baby within 28 days of birth.
Woman	The term 'woman' is used throughout this clinical care standard to refer to the person who becomes pregnant and gives birth. It is recognised that individuals have diverse gender identities, and some people who become pregnant and give birth do not identify as a woman. As described in *Woman-centred Care: Strategic directions for Australian maternity services*, 'maternity care is inclusive of the diverse experiences of women, including their social circumstances (including experience of family violence), cultural and religious background, health, disability, sexual orientation and the gender with which they identify'.[4] The care described in this clinical care standard is intended to include all people who become pregnant and give birth, and the same values of safety, respect, choice and access apply to all. Clinicians should consider the needs of people who do not identify as a woman, have diverse gender identities or have non-heterosexual family structures, and provide care that is respectful of these needs.
Fathers, partners, family members and support people	Women have the right to involve whoever they want in discussions and decisions about their own and their baby's health care and treatment. This includes the baby's father, other parent and/or the woman's partner, family members or other support people of her choosing, such as carers, friends, advocates, or religious or spiritual support people. This clinical care standard primarily refers to the woman as the recipient of care. Content or statements that refer to clinicians' discussions with a woman about her care should be understood to include her partner or other family members and support people, if this is in line with her preferences. For certain quality statements, the term 'parents' is used, in recognition that the care offered and decisions made regarding these aspects of care will most often involve both parents. While using this term, the diversity of family structures and of individual preferences for decision-making is recognised – for example, some women may choose not to involve a second parent in decision-making, or a woman may give birth as a single parent. Use of 'parents' is not intended to exclude such situations.

Term	How it is used in this document
Clinician	In this document, the term 'clinician' refers to all types of healthcare providers who deliver direct clinical care to patients, including: ▪ Aboriginal and Torres Strait Islander health workers and practitioners ▪ Medical practitioners such as general practitioners (GPs), GP obstetricians, obstetricians, gynaecologists, sonologists and radiologists ▪ Midwives ▪ Nurses ▪ Allied health practitioners such as sonographers, psychologists and qualified social workers.

Pathway of care

This standard relates to care provided in the following care settings:

- Public hospital maternity and high-risk maternity care, including midwifery continuity of care
- Rural and remote area maternity care
- Private obstetric care
- Private midwifery care
- General practice, including care provided by GP obstetricians
- Other primary healthcare settings, such as Aboriginal Community Controlled Health Organisations (ACCHOs)
- Community and home-based care.

Evidence that underpins this clinical care standard

Key sources that underpin the *Stillbirth Clinical Care Standard* are current clinical guidelines and evidence from:

- Australian Government Department of Health – *Clinical Practice Guidelines: Pregnancy care*[5]
- Perinatal Society of Australia and New Zealand (PSANZ) and Centre of Research Excellence in Stillbirth – *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6]
- Centre of Research Excellence in Stillbirth – Safer Baby Bundle.[7]

A list of the evidence sources for this clinical care standard is available on the **Commission's website**.

Supporting resources

The following supporting resources for this clinical care standard are available on the **Commission's website**:

- Fact sheets for women and parents
- Clinician fact sheet
- Healthcare services fact sheet.

How to use this clinical care standard

The quality statements in this clinical care standard describe the expected standard for key components of care offered to women and parents. The standard explains what each quality statement means:

- **For women/parents**, so they know what care may be offered by their healthcare system, and can make informed treatment decisions in partnership with their clinician
- **For clinicians**, to support recommendations about appropriate care
- **For healthcare services**, to inform them of the policies, procedures and organisational factors that can enable the delivery of high-quality care.

Specific considerations relating to cultural safety and equity in the provision of care, have also been provided for some quality statements.

General principles of care

This clinical care standard should be implemented as part of an overall approach to safety and quality, incorporating the following key principles that are the foundation for achieving safe and high-quality care:

- Person-centred care and shared decision making
- Informed consent
- Cultural safety for Aboriginal and Torres Strait Islander people and other cultural groups
- Equity of care for people from diverse backgrounds.

When applying the information contained in a clinical care standard, clinicians are advised to use their clinical judgement and to consider the individual woman's circumstances, in consultation with the woman, and her partner or support people if in line with her preferences.

This clinical care standard supports the values and principles in *Woman-centred Care: Strategic directions for Australian maternity services*[4], which aims to ensure that Australian maternity services provide care that is equitable, safe, woman-centred, informed and evidence based.

For more information and additional Commission resources, see **Appendix A**.

Measurement for quality improvement

Measurement is a key component of quality improvement processes. The Commission has developed a set of indicators to support clinicians and healthcare services to monitor how well they are implementing the care recommended in this clinical care standard. The indicators are intended to support local quality improvement activities. No benchmarks are set for these indicators.

The indicators are listed with the relevant quality statements. The definitions required to collect and calculate indicator data are available online **meteor.aihw.gov.au/content/766607**. More information about indicators and other quality improvement measures is provided in **Appendix B**.

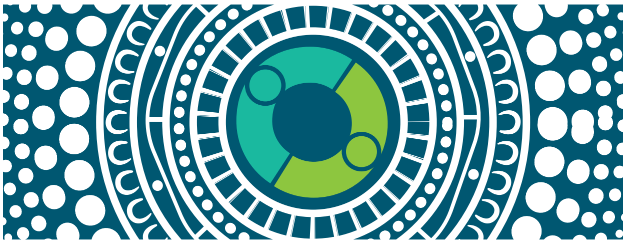
Information on other quality measures, including patient-reported outcome measures and patient experience measures, is provided in **Appendix C**.

Meeting the requirements of national standards and accreditation

Implementing this clinical care standard as part of a quality improvement activity can help health services achieve actions within the National Safety and Quality Health Service (NSQHS) Standards[8] and the National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards.[9]

For more information, see **Appendix D**.

Cultural safety and equity



This clinical care standard highlights specific issues for consideration with regard to cultural safety and equity in the care provided to women and their families.

Social and cultural factors can contribute to adverse health outcomes in several ways that may be complex and interrelated.[10] Cultural factors can affect a woman's participation in health care, whether due to an imbalance in power, differences in language, a lack of cultural awareness, or racism and discrimination. Culturally safe and responsive health care supports equitable access, and delivery of safe and high-quality health care.[11]

This is particularly relevant for Aboriginal and Torres Strait Islander women and their families, given the disparities in stillbirth rates compared with the rest of the Australian population. The reasons for these higher rates are complex and multifaceted, but include a lack of cultural safety when accessing care. Like safety and quality more broadly, the safety and quality of care for Aboriginal and Torres Strait Islander people can only be improved when everyone who works in a healthcare service recognises that they are responsible for providing equitable care – it is not solely the responsibility of Aboriginal and Torres Strait Islander healthcare services and staff.

For more information about cultural safety for Aboriginal and Torres Strait Islander people, see **Appendix A**.

Clinicians should ensure that all women who require an interpreter to support discussions about their care are offered access to such services and, where available, written information in their preferred language. Some women may be more comfortable with a female interpreter – every effort should be made to accommodate such preferences.

Aboriginal and Torres Strait Islander women should also be offered access to Aboriginal and Torres Strait Islander health workers and liaison officers to support their care, where available and in line with the woman's needs and preferences.

Background: Stillbirth

Stillbirth is a tragic and profound experience that affects more than 2,000 families in Australia every year. In Australia, of approximately 820 births, six babies are stillborn every day. Stillbirth is defined as the birth of a baby without signs of life, either after 20 or more completed weeks of gestation or at a weight of 400 grams or more.[2]

Worldwide, stillbirth is recognised as a serious public health problem that is associated with significant and far-reaching impacts on families and societies.[12] Despite this, for many families, the experience of stillbirth is hidden because of stigma, taboo and a culture of silence.[1,13]

Stillbirth is the most common form of perinatal death in Australia.[2] In 2017 and 2018 combined, stillbirths accounted for 7 of every 1,000 births in Australia.[2] This rate has not changed significantly over the past two decades, even though the rate of neonatal deaths (the death of a live-born baby within 28 days of birth) has decreased over the same period.

Of particular concern, the rate of late-gestation stillbirths (after 28 weeks gestation) in Australia is almost 50% higher than in countries with the lowest rates worldwide, including the Netherlands, Finland and Denmark.[14] Although Australia has achieved a small reduction in late-gestation stillbirth rates[2,15], research indicates that there is an ongoing need for improvement.[6,14,16,17]

There are also significant equity gaps in stillbirth rates in Australia. Research shows that stillbirth rates are higher among Aboriginal and Torres Strait Islander women, women from some migrant and refugee groups, and women who live in rural and remote or socially disadvantaged areas.[2,14,18,19] The reasons for these differences are complex and multifaceted, but for some women may include barriers to accessing the care they need due to language differences or remoteness of residence, cumulative effects of low socioeconomic status and historical trauma, and systemic issues including culturally unsafe and discriminatory practices within healthcare services.[19]

Common causes of stillbirth in Australia include congenital anomalies, spontaneous preterm birth and various maternal conditions such as diabetes.[2] Although not every stillbirth is preventable, it is estimated that a lack of appropriate care – such as delayed response to emerging clinical disorders, inadequate attendance for antenatal visits, and poor diabetes management – is a contributing factor in as many as half of all stillbirths. There is evidence that, in 20–30% of cases, the death could have been prevented had the woman received the required high-quality care.[20]

In recent years, several countries have had success in reducing stillbirth rates.[1,21] These include the United Kingdom (UK), where targeted interventions delivered through the Saving Babies' Lives Care Bundle (SBLCB – the UK bundle), contributed to reductions in stillbirth rates.[22,23] Despite these promising outcomes, evaluation of this care bundle identified that some elements of the bundle may have led to unwarranted obstetric intervention – demonstrated by increased rates of preterm births, induction of labour and caesarean section.[22,24,25] A second iteration of the UK bundle (SBLCB version 2) has since been developed to improve the effectiveness of the bundle and minimise the risk of such harms, including a recommendation that planned births before 39 weeks gestation should be based on evidence of fetal compromise or other concerns relating to maternal health.[26]

The lessons learned from international initiatives and the findings of ongoing research about this pressing public health problem have informed strategies to reduce stillbirth rates in Australia, such as the Safer Baby Bundle developed by the Centre of Research Excellence in Stillbirth[7], and this clinical care standard.

Safer Baby Bundle

The Safer Baby Bundle[7] is an Australian quality improvement program that aims to reduce the rates of late-gestation stillbirth (after 28 weeks gestation) (see **Box 1**). The care described in this clinical care standard is consistent with the five elements of the Safer Baby Bundle.

Box 1: Summary of the five elements of the Safer Baby Bundle[7]

Element 1: Supporting women to stop smoking

Stopping smoking in pregnancy by providing support and strategies for women to quit and not resume smoking.

Element 2: Improving detection and management of fetal growth restriction

Risk assessment and surveillance of singleton pregnancies for fetal growth restriction.

Element 3: Raising awareness and improving care for women with decreased fetal movements

Supporting women to be aware of their baby's movements from 28 weeks gestation onwards, and to contact their clinician if they are concerned about a change. Ensuring clinicians follow the best available evidence when caring for women who report decreased fetal movement.

Element 4: Improving awareness of maternal safe going-to-sleep position in late pregnancy

Raising awareness among pregnant women of the importance of going to sleep on their side from 28 weeks of pregnancy.

Element 5: Improving decision-making about timing of birth for women with risk factors for stillbirth

Improving decision-making about the timing of birth for women with singleton pregnancies with risk factors for stillbirth.

Preliminary data on the implementation of the Safer Baby Bundle in Victoria through the Safer Baby Collaborative revealed positive results, including a 21% decrease in stillbirth rates across participating healthcare services.[27] Australian data available to date[27,28] do not indicate that implementation of the Safer Baby Bundle is associated with any increase in unwarranted obstetric intervention, as was observed with the first iteration of the UK bundle.[22,24,25] It is likely that this is due to differences between the Safer Baby Bundle[7] and the first iteration of the UK bundle.[29] These include differences in the management pathway for women with decreased fetal movements, and a standalone element in the Safer Baby Bundle on decision-making about timing of birth, which was not included in the UK bundle.

Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death

The *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6], aims to support best-practice care around the time of perinatal death, including appropriate investigation, audit and classification of perinatal deaths, and the bereavement care offered to women and their families after a loss. The care described in this clinical care standard aligns with the recommendations provided in the guideline relating to stillbirth investigations, and the provision of respectful and culturally safe bereavement care after any perinatal loss. These guidelines are currently being updated.

1

Quality statement 1 – Stillbirth risk assessment before pregnancy

A woman intending pregnancy is offered pre-conception care that supports her to identify and manage stillbirth risks and improve her chance of giving birth to a healthy live-born baby.

Purpose

To identify and manage risk factors for stillbirth before pregnancy, to improve a woman's chance of giving birth to a healthy live-born baby.

What the quality statement means

For women

Although most women who become pregnant give birth to healthy live-born babies, some women will experience a stillbirth. Around 820 babies are born in Australia every day – of these, six babies are stillborn.[2]

Sadly, not every stillbirth can be prevented. But there are some ways to improve the chance of a healthy baby, even before becoming pregnant.

Sometimes pregnancy can happen unexpectedly. However, if you are thinking about becoming pregnant in the near future, it is a good idea to speak with a clinician who can provide you with information and advice, and support you to prepare for a healthy pregnancy. This may be a general practitioner, obstetrician, nurse or midwife.

To help understand factors that may cause problems during your pregnancy or increase the risk of stillbirth, you and your clinician should discuss:

- Your pregnancy and birth history
- Whether you have had complications during a previous pregnancy, or a previous stillbirth (and the results of any investigations undertaken, such as an autopsy)
- Your medical history, including conditions such as diabetes or high blood pressure (hypertension)
- Tests to identify whether your baby could be affected by certain genetic conditions, and whether these tests are appropriate for you and/or your partner
- Whether you, your partner or other household members are currently smoking and, if so, ways to help you, your partner or other household members to quit smoking
- Your current alcohol intake and/or use of recreational drugs
- Your body weight, and ways to support you to achieve a healthy weight, especially if you are currently overweight or obese.

Discussing these issues with your clinician can help you to prepare for your pregnancy, and make decisions about your health and wellbeing. Your clinician will provide you with information about any risks identified through these discussions, and recommendations for how to manage these risks, including what you can do to reduce your risks.

For some women, pregnancy can be a time of change not only for their physical health but also their mental health.[5] Because of this, your clinician may also ask you about your mental health, and discuss ways to support your mental wellbeing before pregnancy. They can also arrange referrals to clinicians with specific training (for example, psychologists or qualified social workers) to support you, if this is something you would prefer.

You should expect that your care before pregnancy will be delivered in line with your personal and cultural needs and preferences. If required, your clinician should offer to arrange access to an interpreter to support your discussions, and/or an Aboriginal and Torres Strait Islander health worker or cross-cultural health worker, if this is something you would prefer.

For clinicians

Many women may not actively seek pre-conception care, even for a planned pregnancy. When providing care for women of reproductive age, consider opportunities to assess intentions about pregnancy. For example, the use of a simple question such as 'Would you like to become pregnant in the next year?' can encourage pre-conception care discussions.[30]

If a woman is intending to become pregnant, discuss the importance of pre-conception health, and provide information and support, to optimise her health in preparation for pregnancy. Discuss with the woman that, although most pregnancies result in the birth of a healthy live-born baby, some women experience unexpected or adverse outcomes, including the small risk of stillbirth.

Assess the woman's risk of adverse pregnancy outcomes by considering recommendations for pre-conception risk assessment provided in relevant clinical guidelines such as the *Guidelines for Preventive Activities in General Practice*[31], developed by the Royal Australian College of General Practitioners.

Discuss risk factors that are best managed before conception, including[1,7,32]:

- Pre-existing maternal conditions such as diabetes or hypertension, especially if these are poorly controlled
- Maternal smoking and the risk of passive smoking through exposure to household or environmental sources
- Maternal alcohol consumption and recreational drug use
- Maternal mental health disorders
- Maternal substance use disorders
- High maternal body mass index
- Experiencing, or being at risk of, family violence.

Also, consider specific risk factors for stillbirth, including if the woman has had a previous stillbirth, complications during a past pregnancy (such as fetal growth restriction or pre-eclampsia), or has a history of congenital anomalies or genetic conditions. Where appropriate, discuss the suitability of genetic carrier screening for the woman and her partner, and offer referral for genetic counselling, if required.[31]

Discuss the outcomes of the risk assessment with the woman and recommendations for the management of identified risks, including lifestyle changes, in a sensitive and supportive way. Provide appropriate referrals to support clinical management and facilitate access to support services, as appropriate. This should include offering the woman and her partner a referral to Quitline to support smoking cessation, if required.

Provide information in a way that meets the woman's health literacy, language and cultural needs. Document the outcome of discussions, including how any identified risks will be monitored and managed, in the woman's healthcare record.

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

Consider social and cultural factors that may limit a woman's access to pre-conception assessment and care, and personal biases that may influence the way you communicate with women about their care.

Discuss any identified risks with women using careful and sensitive language. Offer women access to an Aboriginal and Torres Strait Islander health worker or liaison officer, or a cross-cultural health worker to support discussions about pre-conception risk, in line with the woman's needs and preferences.

For healthcare services

Healthcare services that provide pre-conception care to women should ensure that appropriate policies, procedures and protocols are in place to:

- Encourage clinicians to have opportunistic discussions with women of reproductive age about their intention to become pregnant
- Support assessment and management of risks for adverse pregnancy outcomes, including the risk of stillbirth[8]
- Encourage information provision that is consistent with current guidelines, and meets each woman's health literacy, language and cultural needs
- Support women to make informed decisions about the management of identified risks
- Promote delivery of culturally safe and appropriate care.

In primary care, ensure that clinicians are appropriately trained to provide pre-conception care according to relevant clinical guidelines, such as the Royal Australian College of General Practitioners *Guidelines for Preventive Activities in General Practice*.[31] Ensure that systems are in place to facilitate timely clinician referral to relevant services and specialist care to support management of identified risk factors, as appropriate.

Ensure that systems are in place to record the outcomes of assessments and discussions with women, during both face-to-face and telehealth consultations.[33,34] These systems should enable appropriate communication between clinicians involved in the woman's care, especially at transitions of care, to ensure that information regarding identified risk factors is communicated effectively, as outlined in relevant guidance such as the Communicating for Safety criterion of the NSQPCH Standards.[9]

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

Ensure that systems are in place to support pre-conception risk assessment and care for women that are free from racism, bias and assumptions.

Recognise potential barriers to women accessing care, such as language differences, being from a remote or vulnerable community (for example, women from some migrant and refugee backgrounds) and a lack of cultural safety within healthcare services.

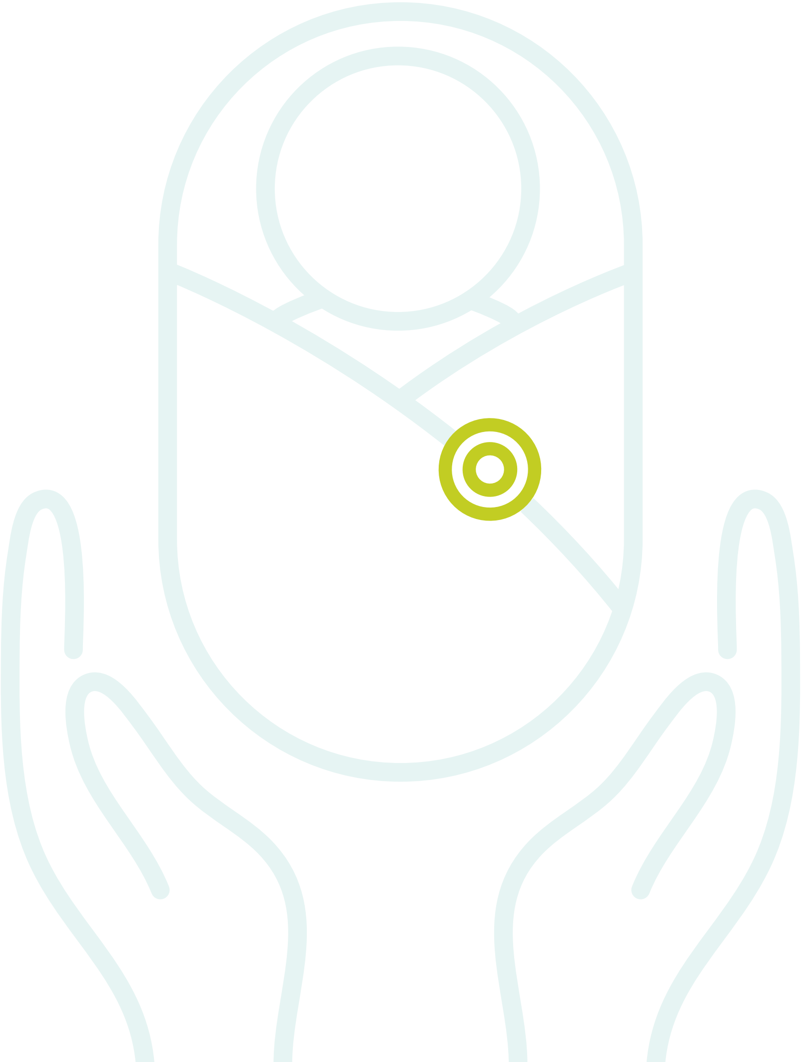
Support clinicians to address potential barriers to care by having systems in place to facilitate access to Aboriginal and Torres Strait Islander health workers and liaison officers, cross-cultural health workers and interpreters, in line with the woman's needs and preferences.

Provide regular education and training for clinicians in cultural safety.

Related resources

Further information for women about preparing for pregnancy is available in the following resources:

- Australian Government Department of Health – **Preparing for your healthy pregnancy**
- New South Wales Health – **Thinking of having a baby**
- Pregnancy, Birth and Baby – **Planning for pregnancy**
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists – **Planning for pregnancy**.



2

Quality statement 2 –
Stillbirth risk assessment during pregnancy

A woman's risk factors for stillbirth are identified early, monitored and managed with evidence-based care throughout her pregnancy. She is offered the most appropriate available model of maternity care for her clinical, personal and cultural needs.

Purpose

To ensure that women receive appropriate assessment and management of stillbirth risks throughout their pregnancy. Discussions about available maternity care models will help ensure that women are aware of their options for care, and that consideration is given to their clinical, personal and cultural needs.

What the quality statement means

For women

Early in pregnancy, your clinician will work with you to identify any factors that may increase your risk of experiencing complications during pregnancy or birth. The possibility of stillbirth is one of the risks they will discuss with you. Although for many women the risk is small, your clinician will discuss any risk factors that may be relevant to you, and ways to reduce your risk.

It is not possible to predict stillbirth, and it cannot always be prevented. However, factors that increase the risk for pregnant women include[35-37]:

- A history of a stillbirth, or complications during a previous pregnancy
- Medical conditions such as diabetes or hypertension
- Being pregnant with more than one baby
- Being under 20 years of age or over 35 years of age
- Smoking, or living with household members who smoke
- Consuming alcohol, or using other drugs
- Being overweight or obese.

Other factors that may increase stillbirth risk include experiencing family violence and having limited access to health care (such as women living in rural or remote areas).

Your clinician will work with you to identify and discuss any risks during your pregnancy, and ways to manage them. They may recommend that you consider further tests or investigations, treatments and supports. They may offer to refer you to other clinicians or services as part of this care.[5,38,39]

Your clinician will discuss how your health can be monitored over the duration of your pregnancy, including things that you can do to support your own health and wellbeing. They will share information with you about any changes that may be needed as part of your care if your risks change during pregnancy. This may include having additional ultrasounds or other tests during your pregnancy.

Having regular check-ups during pregnancy is important for preventing stillbirth. This can be difficult for some women. For example, in rural and remote areas, it may be hard for some women to access the care they need as a result of limited availability of healthcare services, lack of access to transport and lengthy travel times required to access care. Some women may not feel comfortable in healthcare services because of previous experiences, language or cultural differences, or other concerns.

Your clinician will work with you to find a way to have regular check-ups during pregnancy, and to access relevant information to optimise your health and wellbeing, according to your needs and preferences. Where appropriate, your clinician should offer you the option of access to care via telehealth, especially if you live in a rural or remote area and cannot easily access this care.

It is important to let your clinician know if you have any other concerns about your health and wellbeing during your pregnancy.

Types of pregnancy care

In Australia, pregnancy care can be provided in different ways (sometimes called ‘models of care’). The main differences are in:

- Who provides most of your pregnancy care – this may be a GP, a midwife or group of midwives, an obstetrician or GP obstetrician (a GP with specialised training in obstetrics), or in some cases a combination of these clinicians
- Whether you usually see the same clinician or group of clinicians throughout your pregnancy (sometimes called ‘continuity of carer’), or a different person at each visit
- Whether your care is through the public or private healthcare system.

Some GPs have a particular interest in pregnancy care, and provide this care to women in partnership with a local hospital or maternity service – this is called ‘shared care’. You can ask your GP if they offer shared care, and for further information about what this model of care involves.

Some models of care have been developed specifically for Aboriginal and Torres Strait Islander women to ensure that pregnancy care is delivered in a culturally safe environment – this often involves an Aboriginal and Torres Strait Islander clinician, or a clinician who has received training to deliver care that is culturally safe. These models of care may be delivered through an Aboriginal medical service (AMS) or an Aboriginal Community Controlled Health Organisation (ACCHO).

Your clinician should discuss the different models of care that are available to you, and ask you about your preferences, including your cultural and language needs. They may suggest certain models of care if your pregnancy is considered high risk for any reason. The clinician providing most of your pregnancy care should also know when to seek other expert advice that may help you.

For clinicians

Assess the likelihood of risk factors for stillbirth as early as possible in the woman's pregnancy, and at each subsequent antenatal visit.[38,39] Factors that are associated with an increased risk of stillbirth are listed in Table 1.

Fetal growth restriction is a key contributor to stillbirth. Assess the risk of fetal growth restriction as early as possible, and at each subsequent antenatal visit. Provide care as described in the Fetal Growth Restriction (FGR) Care Pathway.[40]

Table 1: Risk factors for stillbirth*

Category	Risk factor[2,14,35-37,41,42]
Demographic	▪ Maternal age under 20 years or over 35 years ▪ Living in a rural or remote area with limited access to health care ▪ Low socioeconomic status ▪ Low educational attainment
Maternal health	▪ Conditions including diabetes or hypertension (pre-existing or onset during pregnancy) ▪ High risk of, or suspected, fetal growth restriction ▪ High risk of, or diagnosed, pre-eclampsia ▪ Overweight and obesity† ▪ History of stillbirth or other complications during a previous pregnancy (for example, pre-eclampsia or fetal growth restriction) ▪ Syphilis infection ▪ Mental health disorders ▪ Substance use disorders
Pregnancy and fetal health	▪ Nulliparity ▪ Multiple pregnancy, with or without monochorionic placentation ▪ Pregnancy through assisted reproductive technology ▪ Prenatal diagnosis of a genetic or structural fetal anomaly ▪ Post-term (prolonged) pregnancy (≥ 42 weeks gestation)
Environmental and lifestyle	▪ Maternal or household smoking ▪ Maternal alcohol consumption or other drug use ▪ Experiencing, or being at risk of, family violence ▪ Poor nutrition and food security

* The relative weight of these risk factors is uncertain.

† Discuss weight management and provide care in accordance with recommendations in the Management of Obesity in Pregnancy statement by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[43]

Discuss identified risk factors with the woman, using careful and sensitive language to minimise anxiety and provide reassurance, and address any questions or concerns that she may have.

Provide information to the woman about any further investigations, monitoring or referrals that may be recommended based on the outcome of the risk assessment.

Where modifiable risks are identified, provide advice to the woman about evidence-based strategies that may reduce her risk and support ongoing management.

Document any identified risks in the woman's healthcare record, including details about any agreed treatments, investigations and referrals. With the woman's permission, communicate information about potential risks and their planned management to other clinicians involved in her care.

Models of care

Provide information to the woman about available maternity care models, and discuss her preferences for care in line with her level of risk, and personal and cultural needs.

The benefits of continuity of maternity carer should be recognised.[44] Several models of care promote continuity, including those delivered by midwives, GPs and obstetricians. Where possible, all women should be offered access to models that allow continuity of carer, and access to an appropriate service for women with known risk factors for stillbirth should be prioritised.[44]

For women who live in rural or remote areas, consider the use of telehealth services to enable access to care, where available and appropriate to the woman's clinical needs.

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

Use sensitive and culturally safe language when discussing potential stillbirth risks and management with women.

There is an increased (population-level) risk of stillbirth among Aboriginal and Torres Strait Islander women, and women from some migrant and refugee backgrounds.[2,14,45-48] The reasons for this are complex and multifaceted, but may include language barriers; a lack of familiarity with, or distrust of, healthcare services; and systemic issues, such as the impacts of colonisation, racism and a lack of cultural safety within healthcare services on the ability of women to access care in line with their needs and preferences.[19]

Offer Aboriginal and Torres Strait Islander women access to culturally safe maternity care models, in line with the woman's preferences.[5] This may include models of care offered through ACCHOs or AMSs, or models that allow continuity of carer with the involvement of an Aboriginal and Torres Strait Islander health worker or liaison officer to support the woman's care.

Midwifery continuity of carer models have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth[49], including Aboriginal and Torres Strait Islander women.[50]

For women from migrant and refugee backgrounds, facilitate access to cross-cultural health workers to support improved access to care, where appropriate and in line with the woman's preferences.

Stillbirth rates are also higher among women who live in rural and remote areas, compared with metropolitan areas.[2] Address potential barriers to care by considering the woman's options for care, including the suitability of accessing care via telehealth services, where appropriate.

For healthcare services

Establish protocols and pathways to facilitate systematic, ongoing assessment of stillbirth risks during pregnancy, and support management of modifiable risks such as maternal smoking, overweight and obesity, and risk of fetal growth restriction (for example, through the Fetal Growth Restriction (FGR) Care Pathway[40]). These protocols and pathways should also address access to appropriate resources and services, specialist referrals and ongoing monitoring.

Ensure that information about stillbirth risks shared with the woman is consistent with current guidelines and meets her health literacy, language and cultural needs.

Ensure that policies, procedures and systems are in place to facilitate access to maternity care models that allow continuity of carer (including GP shared antenatal care and midwifery continuity models) for women at risk of stillbirth, in line with their preferences for care. For women assessed to be at increased risk of stillbirth, prioritise access to models that allow continuity of carer suitable to the woman's individual needs, and taking into account the level of ongoing support she may require for preventive care.

Ensure that clinicians are appropriately trained and skilled to assess and manage stillbirth risk factors during pregnancy, and to communicate with women about identified risks and how to manage them. Offer access to relevant training, such as the Safer Baby Bundle **eLearning module**.[51]

Ensure that GPs providing antenatal care as part of shared care arrangements meet relevant training and credentialing requirements.

Healthcare services in rural and remote locations should consider the use of appropriate communication technology, such as telehealth services, to provide women with access to appropriate care, where available and in line with the woman's needs.

Ensure that systems are in place to record the outcomes of assessments and discussions, and to enable appropriate clinical communication between all clinicians involved in the woman's care – especially as part of shared care arrangements and at transitions of care – in line with the recommendations in the Communicating for Safety Standard of the NSQHS Standards.[8]

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

Consider the increased (population-level) risk of stillbirth among Aboriginal and Torres Strait Islander women, women from some migrant and refugee backgrounds, and women from rural and remote areas, and the relevance of this for the population accessing the healthcare service.[2,14,45-48]

Ensure that systems are in place to support culturally safe maternity care for Aboriginal and Torres Strait Islander women. This may include providing access or referral to maternity care models developed for Aboriginal and Torres Strait Islander women, including models of care offered through ACCHOs or AMSs, or models that allow continuity of carer with support from Aboriginal and Torres Strait Islander health workers. These include midwifery continuity of carer models, which have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth[49], including Aboriginal and Torres Strait Islander women.[50]

Support clinicians to provide culturally safe care to women from migrant and refugee backgrounds, including by facilitating access to cross-cultural health workers, where appropriate and in line with the woman's preferences.

Provide regular education and training for clinicians in cultural safety.

Support clinicians to address potential barriers to accessing care for women in rural and remote areas – for example, by using telehealth services, where available and appropriate.

Related resources

- Australian College of Midwives – ***National Midwifery Guidelines for Consultation and Referral***
- Several programs support culturally safe pregnancy care for Aboriginal and Torres Strait Islander women. Examples are **Birthing on Country** initiatives, the **Australian Nurse-Family Partnership Program** and services offered in different states and territories, such as
  - New South Wales – **Aboriginal and Maternal Infant Health Service**
  - Victoria – **Koori Maternity Services**
  - South Australia – **Aboriginal Family Birthing Program**
- A comprehensive list of ACCHOs across Australia is available from the **National Aboriginal Community Controlled Health Organisation**.

Indicator for local monitoring

Indicator 2a: Proportion of women assessed for clinical risk factors for fetal growth restriction at their first antenatal appointment at the hospital and the outcomes of the risk assessment documented in their medical record.

METEOR link: **meteor.aihw.gov.au/content/766642**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found at the above METEOR link.

3

Quality statement 3 – Stillbirth awareness and strategies to reduce risk

Early in pregnancy, a woman is informed about stillbirth as a potential outcome. Throughout the pregnancy, she is supported to adopt strategies that may reduce her risk of stillbirth, including smoking cessation, using a side going-to-sleep position from 28 weeks gestation and being aware of fetal movements.

Purpose

To ensure that, early in pregnancy, women are provided with information about the potential risk of stillbirth and are supported to adopt strategies that may reduce their risk.

What the quality statement means

For women

Although there is only a very small chance of stillbirth, you should be informed about the possibility. Sadly, not every stillbirth can be prevented and, for approximately 20% of all stillbirths, a reason for the loss is not identified.[13]

However, there are some things you can do that may reduce your risk. Your clinician will discuss these with you, according to your specific risks, needs and preferences. Your clinician should also provide you with written information (including online resources) about these strategies, and how they may support you to have a healthy pregnancy and give birth to a healthy baby.

Quitting smoking

Smoking during pregnancy is a significant contributor to stillbirth.[52]

Quitting smoking at any time during your pregnancy reduces the risk of harm to your baby. However, the earlier you quit smoking during pregnancy, the better for your baby's health.[52]

Your clinician will ask if you, your partner or other members of your household smoke, and provide advice and support to stop smoking. They should offer to refer you or your partner to support services that can help you to quit smoking, such as Quitline. This is a free telephone counselling service staffed by counsellors who are specifically trained in supporting people to quit smoking, including pregnant women.

Going to sleep on your side from 28 weeks of pregnancy

After 28 weeks of pregnancy, going to sleep on your back can increase your risk of stillbirth.[53]

Going to sleep on your side (whether right or left) from 28 weeks of pregnancy can halve your risk of stillbirth compared with going to sleep on your back.[53] Lie on your side any time you go to sleep, including daytime naps, at night or when going back to sleep during the night. If you wake up on your back, don't worry – just settle back to sleep on your side.

Getting to know your baby's movements

Your baby's movements during pregnancy are one sign of their wellbeing.[54] Women often describe these movements as a kick, flutter, swish or roll.

Most women will start to feel their baby move between 16 and 24 weeks of pregnancy, and will continue to feel these movements until the baby is born, including during birth.[55] However, there is no set number or pattern of normal movements – this differs between women and between pregnancies.

Your clinician will encourage you to get to know your baby's movements, and understand what movements are normal and healthy for your baby. They should ask you about your baby's movements at every appointment, and keep a record of what you discuss with them in your healthcare record.

For clinicians

During pregnancy, provide antenatal care in line with the principles outlined in the *Clinical Practice Guidelines: Pregnancy care*.[5]

Using careful and sensitive language, inform the woman about stillbirth as a possible pregnancy outcome. Explain that, although not every stillbirth can be prevented, there are strategies that may reduce the risk of stillbirth, including late-gestation losses (that is, after 28 weeks gestation).

Provide verbal and written information to the woman about the strategies outlined below, and support her to adopt them, in line with her specific risks, and personal and cultural needs and preferences.

Smoking cessation

At the first antenatal visit, ask the woman about her smoking status, including her exposure to passive smoking through household or other environmental sources.

Support women who report that they smoke to stop smoking by using evidence-based approaches, such as the three-step 'Ask, Advise, Help' model, as outlined in Supporting Smoking Cessation: A guide for health professionals[56], and the **Smoking cessation care pathway**.[57] Offer the same advice and support to other smokers in the woman's household, whenever possible.

Explain the importance of smoking cessation and emphasise the benefits of quitting early in the pregnancy, as well as the risks of passive smoking. Discuss any concerns that the woman may have.

Provide information about available services to support the woman, her partner or household members to quit. Offer the woman and/or her partner **a referral to Quitline**. If they decline, provide smoking cessation resources and consider pharmacotherapy, such as nicotine replacement therapy, in line with the *Supporting Smoking Cessation During Pregnancy: Nicotine replacement therapy* guidelines.[58,59]

Monitor the woman's smoking status at each antenatal visit, and offer access to further smoking cessation information or support services, if required.[5]

Side going-to-sleep position from 28 weeks gestation

Provide information to the woman about the importance of going to sleep on her side from 28 weeks gestation. This should include any time the woman goes to sleep, including at night, daytime naps or returning to sleep after waking. Reassure her that it is normal to shift position when sleeping and that, if she wakes up on her back, not to be alarmed, and to settle back to sleep on her side if she is continuing her sleep.

This information should be provided to the woman by week 28 of pregnancy. The importance of going to sleep on her side should be discussed, and the woman's understanding of this information assessed, at every subsequent antenatal visit. The outcomes of these discussions should be documented in the woman's healthcare record.

Awareness of fetal movements

Between 20 and 27 weeks of pregnancy, provide the woman with verbal and written information about normal fetal movements.[5]

Discuss the following points with the woman[5,55,60]:

- Fetal movements are an important sign of fetal wellbeing
- Fetal movements will change as the fetus grows and develops
- Most women can detect fetal movements by 20 weeks gestation, and these movements should continue until the end of the pregnancy
- There is no set number or pattern of fetal movements – movements may differ between women, and between pregnancies
- Several factors, such as wake/sleep cycles, may affect a woman's perception of fetal movements.

Support the woman to become familiar with her fetal movements, and to understand what frequency, strength and pattern of movement is normal for her pregnancy. The use of 'kick charts' is not currently recommended as part of routine antenatal care.[5,61] Encourage the woman to promptly seek advice if she has concerns about a change in her fetal movements.

At every subsequent antenatal visit, ask the woman about her fetal movements and record the information in her healthcare record. Remind the woman at each visit about the importance of fetal movement awareness, and assess and document her understanding of the information provided. Provide further information and support as required.

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

When discussing the risk of stillbirth with women and ways to reduce the risk, use careful and culturally sensitive language to minimise anxiety and provide reassurance. Where appropriate, involve an Aboriginal and Torres Strait Islander health worker or a cross-cultural health worker to support these discussions.

Offer Aboriginal and Torres Strait Islander women access to culturally appropriate smoking cessation services, in line with their needs and preferences.[5]

For healthcare services

Ensure that appropriate policies, procedures and protocols are in place so that:

- Stillbirth is discussed during antenatal visits as a potential pregnancy outcome
- Women are provided with information about strategies that may reduce the risk of stillbirth (such as smoking cessation, side going-to-sleep position from 28 weeks gestation and fetal movement awareness), in line with current evidence, and their health literacy, language and cultural needs
- Clinicians advise women about the benefits of smoking cessation early in pregnancy, side going-to-sleep position from 28 weeks gestation and fetal movement awareness, and assess their understanding at follow-up visits

- Women are supported to make informed decisions about strategies that may reduce stillbirth risk, and are supported to implement these strategies
- Clinician referrals to appropriate services (for example, Quitline) are facilitated to support implementation of strategies that may reduce stillbirth risk.

Provide clinicians with access to relevant training, such as the Safer Baby Bundle **e-learning module**, and the Quit Centre **online training modules**, where appropriate.

Ensure that systems are in place to document the outcomes of discussions with women, including their understanding of advice on side going-to-sleep position and fetal movement awareness, during face-to-face and telehealth antenatal consultations.[33,34] These systems should enable appropriate communication between clinicians involved in the woman's care, especially at transitions of care, in line with the recommendations outlined in the Communicating for Safety Standard of the NSQHS Standards.[8]

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

Support clinicians to address potential cultural and language barriers for women accessing care by having systems in place to facilitate involvement of Aboriginal and Torres Strait Islander health workers, cross-cultural health workers and interpreters, in line with the woman's needs and preferences.

Related resources

Smoking cessation

- Australian Government Department of Health – Quitline
  - National Quitline telephone number – 13 78 48
  - Quitline **referral form**
  - Quit Centre **resources and training** for clinicians
- Centre of Research Excellence in Stillbirth – Safer Baby Bundle **smoking cessation resources** for parents and clinicians.

Side going-to-sleep position

- Centre of Research Excellence in Stillbirth – Safer Baby Bundle **side sleeping resources** for parents and clinicians.

Fetal movements

- Centre of Research Excellence in Stillbirth – Safer Baby Bundle **fetal movement resources** for parents and clinicians.

Indicators for local monitoring

Indicator 3a: Proportion of pregnant women who reported smoking who were provided with advice on smoking cessation, offered a referral to a smoking cessation service (for example, Quitline), and/or nicotine replacement therapy if clinically indicated.

METEOR link: meteor.aihw.gov.au/content/766646

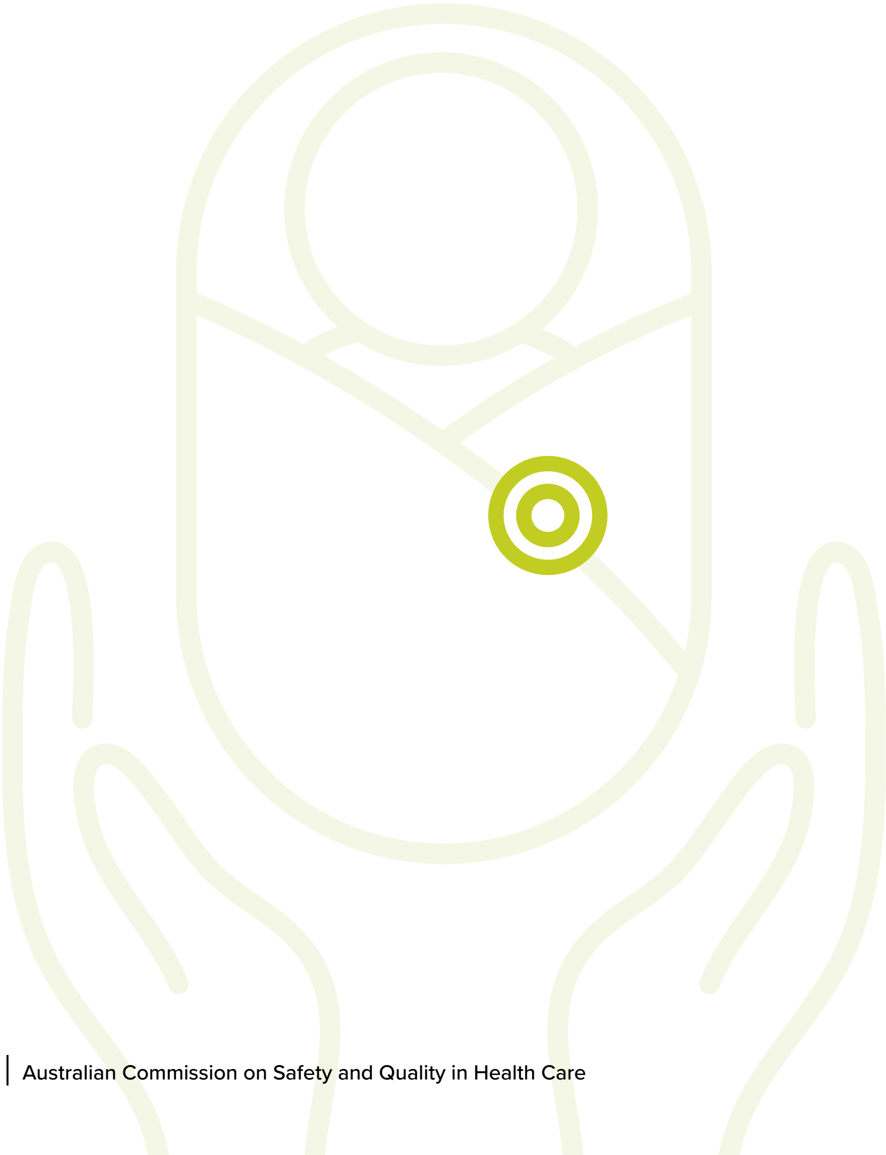
Indicator 3b: Proportion of women who gave birth who demonstrated their understanding of safe maternal going-to-sleep position at an antenatal visit from 28 weeks gestation.

METEOR link: meteor.aihw.gov.au/content/766648

Indicator 3c: Proportion of women who gave birth who reported from 28 weeks gestation that they knew how to monitor their fetal movements and what to do if they were concerned about a change in their fetal movements.

METEOR link: meteor.aihw.gov.au/content/766650

More information about the indicators and the definitions needed to collect and calculate indicator data can be found at the above METEOR links.



4

Quality statement 4 – Ultrasound during pregnancy

A woman is offered high-quality ultrasound during pregnancy to assess fetal growth and morphology, and identify stillbirth risks. Ultrasound performance and reporting, and communication of outcomes to the woman, are in line with current best-practice guidelines.

Purpose

To ensure that women are offered high-quality ultrasound during pregnancy to identify factors increasing stillbirth risk, that ultrasounds are performed and reported on, and that outcomes are communicated to women appropriately, in line with current best-practice guidelines.

What the quality statement means

For women

Ultrasounds can be useful for many reasons during pregnancy, including assessing and managing the risk of stillbirth. They can be used to identify whether you are pregnant with more than one baby, whether your baby may have a genetic condition, and check your baby's growth and development. This information can help your clinician assess whether you have a higher risk of stillbirth, and how to best plan your ongoing care with you.

Ultrasounds should be offered at certain times during pregnancy. Your clinician will explain the reasons for these ultrasounds, what they may reveal about your or your baby's health, and the recommended timing for the scans.

You should be supported to make informed decisions about any ultrasound that is offered to you during pregnancy. Your clinician can give you information about these ultrasounds and answer any questions. Information should be given in a way you can understand it. You can choose to proceed with, or decline, any ultrasounds that are offered to you, depending on your needs and preferences. Your decisions should be respected by those involved in your care.

Your clinician may recommend a number of ultrasounds during pregnancy, as listed in Table 2. These ultrasounds can give you information to help you to make decisions about your pregnancy care and to manage risks wherever possible.

Table 2: Ultrasounds that may be recommended during pregnancy

Name	Description
Dating scan	This ultrasound is recommended for women who are unsure of their conception date. It is usually performed between 8 and 14 weeks of pregnancy.[5] It is used to work out the age of your baby (also called 'gestational age') and approximately when your baby is due (due date). This helps your clinician plan the best timing for other scans and care that may be needed during your pregnancy. It is also used to check whether you may be pregnant with more than one baby, which may increase the risk of stillbirth, especially if the babies are sharing the same placenta.
Nuchal translucency scan	This ultrasound is offered to pregnant women in addition to a blood test to help identify the likelihood of their baby having a genetic condition such as Down syndrome, which may increase the risk of stillbirth. Together, this ultrasound and the blood test are referred to as a 'combined first trimester screen'. The ultrasound is performed between 12 and 14 weeks of pregnancy.[5] It measures the thickness of a fluid layer that is found under the skin of your baby's neck – this is called the nuchal translucency. The blood test is performed between 9 and 14 weeks of pregnancy. It is used to check the levels of hormones found in your blood that may indicate an increased likelihood of your baby having a genetic condition.
Mid trimester fetal morphology scan	This ultrasound is usually performed between 18 and 20 weeks of pregnancy.[5] It is used to check your baby's growth and development, and identify factors that may indicate an increased risk of stillbirth, such as your baby growing more slowly than expected. In some cases, this scan may also identify concerns about your baby's health or development.
Other tests	Your clinician will talk with you about other tests that can be considered to help identify your baby's likelihood of a genetic condition. These include non-invasive prenatal testing (NIPT), which is a blood test that examines small pieces of genetic information (DNA) released from the placenta as your baby grows, and can be performed from 10 weeks of pregnancy. The costs of NIPT are not currently covered by Medicare or private health insurance in Australia. Your clinician will talk with you about the potential benefits and risks of these tests, and answer any questions you may have. If you choose to proceed with NIPT, you may not require the nuchal translucency scan, because NIPT will be carried out earlier and covers some of the same genetic conditions as a combined first trimester screen. Your clinician will discuss the ultrasound options available to you in this case, including the option to have an ultrasound between 11 and 13 weeks of pregnancy to check how your baby is developing.[62]

Your clinician will discuss the results of your ultrasounds with you, and let you know if any further actions are recommended, such as further scans to check on your baby's wellbeing. With your permission, the results of your pregnancy ultrasounds should be shared with other clinicians involved in your care, including any findings that need follow-up.

You should expect that any ultrasound you have during pregnancy is performed by clinicians who are appropriately trained and qualified. Ask your clinician to recommend where you should have your ultrasound.

If you are concerned that you cannot pay for an ultrasound during pregnancy, it is a good idea to let your clinician know, as they may be able to help you access services that provide ultrasounds at a reduced cost.

If you live in a rural or remote area with limited access to ultrasound services, you and your clinician will need to discuss suitable options for your care, and plans to facilitate your access to the care you need.

For clinicians

Early in pregnancy, discuss the importance of obstetric ultrasound with the woman. Optimally timed, high-quality ultrasound can help identify factors that may affect a woman's stillbirth risk, including the presence of a multiple pregnancy, chorionicity, the likelihood of fetal or chromosomal anomalies, and fetal growth restriction.[5]

Discuss recommended obstetric ultrasounds with the woman, including the reasons for the ultrasounds, possible findings, and at what stage of pregnancy they are recommended. Provide verbal and written information about these ultrasounds, in line with the woman's needs and preferences, and answer any questions she has. All women should be offered access to an interpreter, if required to support these discussions, and written information in their preferred language, where available.

Some women may choose to decline some, or all, recommended ultrasounds after considering the information provided, and their right to do so should be respected. Arrange for obstetric ultrasounds that the woman has agreed to, at the appropriate gestation.

Consider the woman's personal circumstances, including her financial situation, and whether she lives in a rural or remote setting and may need additional support to access recommended care.

Recommended obstetric ultrasounds that should be discussed with the woman, and their relevance to ascertaining stillbirth risk, are noted below.

Dating scan

- Primarily recommended for women who are uncertain of their conception date.
- Helps to ascertain gestational age, and the most appropriate time for other scans (for example, a nuchal translucency scan).
- Can identify the presence of a multiple pregnancy or chorionicity, which can affect stillbirth risk.

If undertaken, the dating scan is recommended between 8 weeks 0 days and 13 weeks 6 days of pregnancy.[5]

Nuchal translucency scan

- Assesses the likelihood of aneuploidy, including trisomy 21 (responsible for Down syndrome), which may increase stillbirth risk.
- Should be offered to all women in combination with maternal plasma testing (combined first trimester screening), as this offers increased sensitivity for aneuploidy detection.
- Can ascertain gestational age, identify a multiple pregnancy, and assess chorionicity, for women who have not had a dating scan.
- Provides early anatomical assessment of the fetus, including for anomalies with high lethality (for example, anencephaly), and visualisation of structures including the placenta, amniotic fluid, cervix, uterus and adnexae.

If undertaken, the nuchal translucency scan is recommended between 12 weeks and 13 weeks 6 days of pregnancy.[5] Maternal plasma testing is recommended between 9 weeks and 13 weeks 6 days of pregnancy.[5]

Mid trimester fetal morphology scan

- Assesses fetal development and anatomy, and the position of the placenta.
- Can identify factors that can affect a woman's stillbirth risk, including the presence of fetal structural anomalies, placental length and placenta praevia.[5]

The ultrasound is generally performed between 18 and 20 weeks of pregnancy[5], but may be offered up to 22 weeks in some circumstances.[63] The timing of this ultrasound should ensure that, if structural anomalies are identified, women have time to consider termination within the time frames permitted in their state or territory. In some states and territories, access to termination after 20 weeks of pregnancy is highly restricted.[64]

Screening for chromosomal anomalies

All women should be offered screening for common chromosomal anomalies such as trisomy 21. This can be undertaken through combined first trimester screening, a nuchal translucency scan alone, NIPT or second trimester maternal serum testing.

Women should be provided with information about the potential benefits, risks and costs of these options, and supported to make decisions that are in line with their needs and preferences.

Further obstetric ultrasound, including in the third trimester

Consider the need for increased obstetric ultrasound surveillance on an individual basis and according to clinical need, rather than as routine monitoring.[5] Indications for further obstetric ultrasounds, including third trimester growth and wellbeing scans, may include:

- Clinical concerns about the risk of fetal growth restriction (for example, as outlined in the Fetal Growth Restriction (FGR) Care pathway*) or a small-for-gestational-age fetus
- Women for whom measurement of fundal height may be inaccurate (for example, high body mass index, large fibroids, polyhydramnios)
- A prenatal diagnosis of a genetic or structural anomaly
- Reassurance for women who have had a previous perinatal loss who request further ultrasounds for reassurance about fetal wellbeing.

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* Provide care as described in the **Fetal Growth Restriction (FGR) Care Pathway**, developed by the Centre of Research Excellence in Stillbirth and PSANZ.

Performing and reporting ultrasounds during pregnancy

Obstetric ultrasound should be performed by clinicians who have appropriate training and qualifications, and are working within their scope of practice.[5] All referred obstetric ultrasounds, including dating, nuchal translucency and morphology scans, should be performed, interpreted and reported on by appropriately qualified clinicians, in line with the guidelines for the performance of first[65], second[66] and third[67] trimester ultrasounds developed by the Australasian Society for Ultrasound in Medicine.

If a woman is being referred for an ultrasound examination, refer her to a service that meets these requirements. Consider social factors such as cost, language, remoteness of residence or distrust of mainstream health care that may be barriers to the woman accessing obstetric ultrasound, and facilitate access to an appropriate service.

If a woman has a history of stillbirth or other perinatal loss, ensure that this information is clearly communicated on any referrals for obstetric imaging. Offer all women the opportunity to have a partner or support person attend the ultrasound with them.

The woman should be advised of the results of her obstetric ultrasound. Offer all women access to an interpreter, when required, and to an Aboriginal and Torres Strait Islander health worker or cross-cultural health worker, where available and in line with the woman's preferences, to support these discussions. Note that some women may prefer to receive some, but not all, information about the findings of ultrasounds undertaken (for example, opting out of receiving information about an identified fetal anomaly if it is not life limiting), and care should be taken to respect these wishes.

A copy of the report for every ultrasound should be offered to the woman. At a minimum, key findings should be documented in her healthcare record and, with her permission, shared with other clinicians involved in her care – this includes clinicians providing care for Aboriginal and Torres Strait Islander women through ACCHOs and AMSs. If any concerns about the health or wellbeing of the fetus are identified, refer the woman for further investigation and care, and provide information on how she can access relevant support in the interim.

Use clear and sensitive language to communicate with the woman regarding concerning or unexpected findings. Provide empathic care, in line with the recommendations in the *Parent-centred Communication in Obstetric Ultrasound Guidelines* developed by the Australasian Society for Ultrasound in Medicine.[68]

For healthcare services

Healthcare services providing pregnancy care which refer for obstetric ultrasound should ensure that protocols are in place for appropriate referrals to enable identification and management of stillbirth risks, including for further investigation of adverse findings. This includes for a dating scan for women who are uncertain of their conception date, a nuchal translucency scan as part of combined first trimester screening, a mid trimester fetal morphology scan and further ultrasounds if clinically appropriate (for example, where there are clinical concerns about fetal growth restriction).

When a woman is referred for obstetric ultrasound as part of her maternity care, the healthcare service should take steps to assess the quality of the service that she is referred to. The service should also consider whether the woman's financial situation and geographic location may be barriers to her accessing high-quality obstetric ultrasound, and make arrangements to mitigate this risk.

Healthcare services providing obstetric ultrasound for dating, nuchal translucency, mid trimester fetal morphology, and (where appropriate) third trimester growth and wellbeing scans should have clinical systems in place to ensure that referred obstetric ultrasounds are performed, interpreted and reported on by appropriately qualified clinicians, in line with the guidelines for the performance of first[65], second[66] and third[67] trimester ultrasound developed by the Australasian Society for Ultrasound in Medicine.

Clinicians performing obstetric ultrasound should have relevant qualifications and training, including ongoing professional development relating to stillbirth risks, and work within their scope of practice.[5]

Systems should support clinicians to communicate sensitively with women regarding any concerning or unexpected findings, in line with the recommendations provided in the *Parent-centred Communication in Obstetric Ultrasound Guidelines* developed by the Australasian Society for Ultrasound in Medicine.[68]

Ensure that systems are in place to document the ultrasound findings, and for this information to be discussed with the woman and, with her permission, shared with other clinicians involved in her care.

Within a maternity network, arrangements should be made for larger centres to support smaller and remote locations with the performance and interpretation of obstetric ultrasound.

Related resources

Further information for women about ultrasounds and other tests during pregnancy is available through the Pregnancy, Birth and Baby website:

- Ultrasound scans during pregnancy
- Dating scan
- Nuchal translucency scan
- Morphology scan
- Non-invasive prenatal testing (NIPT).

5

Quality statement 5 –
Change in fetal movements

A woman who contacts her clinician or health service with concerns about a change in the frequency, strength or pattern of her baby's movements is offered timely assessment and care according to the Decreased Fetal Movement Care Pathway developed by the Centre of Research Excellence in Stillbirth and the Perinatal Society of Australia and New Zealand, or a locally approved alternative.

Purpose

To ensure that women who have concerns about their baby's movements are able to access timely assessment and management.

What the quality statement means

For women

During pregnancy, your clinician will encourage you to get to know your baby's movements, and understand what movements are normal for your baby.

If you notice a change in your baby's normal pattern of movement, this could be a sign that they are unwell. This may include a change in the strength of your baby's movements, how often they are moving (such as a decrease in movement) or their usual pattern of movement (such as being active at bedtime).

If you are concerned about a change in your baby's movements, contact your clinician immediately – you are not wasting their time. Your clinician will take your concerns seriously and may ask you to visit them, or your nearest hospital or maternity health service, as soon as possible for assessment.

You should not delay visiting your clinician, nearest hospital or maternity health service if advised to do so, or if you cannot contact them by phone. You should not wait until the next day to seek assistance if you have concerns about changes in your baby's movements, even if these changes have occurred at night-time. Often, there is no problem, but you are doing the right thing by checking.

Advice to stimulate your baby's movements by having something to eat or drink is not correct – it is best to check with your clinician about any concerns.

When you arrive at the health service, your clinician will ask you questions about what is concerning you, and will check your baby's heartbeat. Depending on your individual circumstances (such as stage of pregnancy), they may perform extra tests to check on your baby's wellbeing, such as[55]:

- Asking about your baby's normal movements
- Completing a fetal heart trace (sometimes called cardiotocography or CTG)
- Measuring your baby's growth
- Performing an ultrasound scan on your baby (on the same day or the next day)
- Performing other tests, such as taking a blood sample from you.

Your clinician will discuss the findings of these tests with you. If they have concerns about your baby's wellbeing, they will provide you with advice about any further actions that are needed.

With your permission, your clinician will share this information with other clinicians involved in your care. This will help to ensure that they can develop a follow-up care plan according to your needs.

You should not hesitate to contact your clinician again if you have further concerns about your baby's movements another time, even if this is on the same day.

For clinicians

During pregnancy, support the woman to become familiar with her fetal movements. Let her know that she should seek clinical advice immediately if she notices any changes in the frequency, strength or pattern of fetal movements, particularly decreases in movement.[5,69]

Explain that advice to attempt to stimulate the baby's movements (for example, by having something to eat or drink) is not correct. Emphasise that she should seek assistance without delay and that it is best to contact a clinician about any concerns, even if subsequent assessment confirms the baby's health and wellbeing.

Provide her with clear advice on how and where to present for further evaluation if required, including contact phone numbers. Consider options that will allow appropriate and timely assessment, especially for women in rural and remote areas who may have limited access to care. Discuss these options with the woman in advance, so that she is aware of how and when to seek assistance, if required.

When a woman presents with concerns about fetal movements, discuss her concerns and immediately assess the presence of fetal heart tones. All women should be offered access to professional interpreting services, when required, to support discussions about their assessment and care.

Note that a woman's concern about fetal movements is an important indicator, and should always be taken seriously.

Provide assessment and care according to the **Decreased Fetal Movement (DFM) Care Pathway**[60], or a locally approved alternative. Provide or arrange urgent clinical review if fetal heart tones are difficult to determine.

If fetal heart tones are confirmed, consider further investigations to assess fetal wellbeing. These may include[60]:

- CTG
- Taking a detailed history of fetal movements
- Using ultrasound to assess fetal growth and development
- Testing for fetomaternal haemorrhage, if indicated.

Discuss the findings of any investigations with the woman, and provide advice on further actions that may be needed. If induction of labour or caesarean section is being considered, careful consideration should be given to the potential risks and benefits of intervention. This information should be discussed with the woman to enable her to make informed decisions about timing of birth. Unless clinically indicated, birth should not be planned before 39 weeks gestation – for further information, see **Quality statement 6**.

With the woman's permission, share the findings of these investigations with other clinicians involved in her care to ensure that any plans for ongoing care and support can be updated as appropriate.

If fetal heart tones are absent and fetal death is confirmed, communicate this to the woman promptly and sensitively, and provide appropriate care, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6] and the *Parent-centred Communication in Obstetric Ultrasound Guidelines* developed by the Australasian Society for Ultrasound in Medicine.[68]

For healthcare services

Ensure that discussions about fetal movements are routinely included in antenatal visits, including advice on promptly seeking care if the woman has concerns about fetal movements, and that the outcomes of these discussions are recorded in the woman's healthcare record.

Establish appropriate policies, procedures and protocols to enable timely assessment of women presenting with concerns about changes in fetal movements, according to the **Decreased Fetal Movement (DFM) Care Pathway**[60], or a locally approved alternative. Every effort should be made to ensure that the woman is assessed as soon as possible after arrival.

Policies, procedures and protocols should:

- Ensure that women are provided with contact details for, and are encouraged to promptly contact, a clinician if they have concerns about a change in fetal movements
- Recognise that a woman's concerns about a change in fetal movements override any set definitions of normal fetal movements[5]
- Encourage attendance at the healthcare service as soon as possible for assessment when a woman makes contact about changed fetal movements
- Ensure assessment of fetal heart tone as soon as possible after a woman presents to the healthcare service with concerns about a change in fetal movements
- Address how clinical assessment and access to urgent clinical review will be provided if fetal heart rate is difficult to determine, including for women accessing care after hours or in rural and remote settings
- Enable access to interpreters, Aboriginal and Torres Strait Islander health workers or liaison officers, and cross-cultural health workers, where appropriate
- Enable prompt communication with the woman and appropriate care if fetal death is confirmed, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6] and the *Parent-centred Communication in Obstetric Ultrasound Guidelines*[68]
- Provide guidance and appropriate communication protocols for any clinician who may identify a fetal death, including sonographers, consistent with the *Parent-centred Communication in Obstetric Ultrasound Guidelines*[68]
- Ensure that systems are in place to record the outcomes of assessments, provide appropriate follow-up care and, with the woman's permission, enable information to be shared with other clinicians involved in her care, including her GP and/or clinicians providing care for the woman through an ACCHO or AMS.

Ensure that clinical governance processes are in place to oversee the implementation of the Decreased Fetal Movement (DFM) Care Pathway[60] or a locally approved alternative, monitor its use and evaluate outcomes, including potential impacts on rates of early planned births.

Related resources

- Centre of Research Excellence in Stillbirth – Safer Baby Bundle **fetal movement resources** for parents and clinicians.

Indicators for local monitoring

Indicator 5a: Evidence of local arrangements to enable timely assessment and appropriate care for women presenting with concerns about changes in fetal movements. The local arrangements should include the:

- Locally approved fetal movement care pathway
- Fetal monitoring and assessment protocol, with timelines and a process to access urgent clinical expertise if fetal heart tone is difficult to determine
- Guidance and communication protocols for clinicians who may identify a fetal death, consistent with the *Parent-centred Communication in Obstetric Ultrasound Guidelines*
- Process to provide appropriate care for women if fetal death has been confirmed, in line with the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*
- Process to ensure clinicians are trained and competent in the fetal movement care pathway
- Governance process to oversee implementation of the local arrangements and evaluate their effectiveness.

METEOR link: **meteor.aihw.gov.au/content/766719**

Indicator 5b: Median time from when women report that they first noticed a change in fetal movements to when they contacted a clinician or healthcare service.

METEOR link: **meteor.aihw.gov.au/content/766722**

More information about the indicators and the definitions needed to collect and calculate indicator data can be found at the above METEOR links.

6

Quality statement 6 –
Informed decision-making about timing of birth

A woman is provided with information that enables her to make informed decisions about timing of birth, in line with her individual risks and preferences. Whenever a planned birth is being considered, including when there are concerns about maternal or fetal health, the potential benefits and harms are discussed with the woman and documented appropriately.

Purpose

To ensure that women can make informed decisions about timing of birth, depending on their specific risks, needs and preferences.

What the quality statement means

For women

The ideal time for most babies to be born is as close to 40 weeks of pregnancy as possible. For most women, this means waiting for labour to begin on its own. However, if there are concerns about the health of a woman or her baby, including the risk of stillbirth, a planned birth is sometimes considered. This means timing the birth on a specific date, through induction of labour or caesarean section.

Even when a planned birth is recommended, there are benefits in continuing the pregnancy for as long as it is safe and possible to do so. Unless there is a clinical reason to do so, birth should not be planned before 39 weeks of pregnancy – this is called an early planned birth.[70] This is because research shows that every week that a baby can remain safely inside their mother's womb towards 40 weeks of pregnancy improves the health and developmental outcomes for the baby, in the short and long term.[71]

Early in pregnancy, your clinician will have a discussion with you about timing of birth. They will explain the benefits of your pregnancy continuing for as long as it is safe for you and your baby, and they will discuss your preferred preliminary birth plan with you. You should expect that any information discussed with you about timing of birth will meet your language needs. Your clinician will offer to arrange access to an interpreter to support these discussions, if required.

Towards the end of your pregnancy (close to 36 weeks of pregnancy), your clinician will have another discussion with you about timing of birth. This discussion may happen sooner if your clinician has any concerns about your or your baby's wellbeing. The discussion should consider any changes to your level of risk during the pregnancy, and your personal preferences about timing of birth.

For some women, the risk of stillbirth may be greater than the risks associated with an early planned birth. Your clinician should support you to understand any risks for your pregnancy, and provide you with verbal and written information about the potential benefits and harms for you and your baby.

The risk of stillbirth also increases for pregnancies that continue for 42 weeks or more – this is called a prolonged or post-term pregnancy. If labour has not started on its own by 41 weeks of pregnancy, a planned birth may be recommended to help reduce the risk of stillbirth.

Whenever a planned birth is suggested, you should expect to receive verbal and written information about the potential benefits and harms for you and your baby. Your clinician should support you, your partner and other support people to make informed decisions about timing of birth, and include information about any changes to your agreed timing of birth in your healthcare record.

If you live in a rural or remote area with limited access to health care, your clinician will discuss how this may affect your timing of birth plans, and any particular considerations or arrangements that may be required to support your decisions.

For clinicians

While spontaneous onset of labour is generally preferred, a planned birth through induction or caesarean section may be considered if there are concerns about maternal or fetal health, including the risk of stillbirth.

Unless clinically indicated (that is, there is an identified increased risk to the health or wellbeing of the mother or fetus), birth should not be planned before 39 weeks gestation.[70] A growing body of evidence supports the importance of the last few weeks leading up to 40 weeks of pregnancy for the health and developmental outcomes of babies, in the short and long term.[71-73]

For some women, the risk of experiencing an adverse pregnancy outcome, such as stillbirth, may outweigh the potential adverse consequences of a planned birth before 39 weeks gestation.

The decision to have a planned birth to reduce the risk of stillbirth should be made according to the woman's individual risks and preferences. If a planned birth before 39 weeks gestation is being considered, provide verbal and written information to the woman about the possible benefits and harms for her and her baby. All women should be offered access to an interpreter, if required, or to an Aboriginal and Torres Strait Islander health worker or liaison officer, to support any discussions about timing of birth.

When risk factors for stillbirth are identified early in pregnancy, discuss with the woman how these may affect decisions around timing of birth. Discuss the recommended timing of birth with the woman, and agree on a provisional timing of birth plan in line with her individual risks and preferences.[38] Document the outcomes of the discussion in the woman's healthcare record, including any identified risk factors, how risk factors will be monitored, and the provisional timing of birth plan.

If the woman lives in a rural or remote area, consider and discuss how distance from health care may influence her needs and preferences regarding timing of birth.

Reassess every woman's stillbirth risk regularly, and again towards the end of pregnancy (at approximately 36 weeks gestation). Discuss with the woman any changes to her level of risk. If appropriate, consider the need for increased surveillance – this may include[38]:

- Weekly antenatal visits, with careful inquiry about fetal movements
- Fetal heart rate assessment by CTG, weekly or every second week
- Serial ultrasound assessment.

If further monitoring is recommended, discuss with the woman how this may help inform decisions about timing of birth and guide revisions to the provisional birth plan.

The risk of stillbirth increases for prolonged or post-term pregnancies (that is, ≥ 42 weeks gestation)[5,74], and measures to assess fetal wellbeing in the preterm period (for example, fetal biometry, blood flow, heart rate) may not be predictive of stillbirth risk. Where appropriate towards 39 to 40 weeks of pregnancy, discuss these risks with the woman, and considerations for a planned birth to reduce her risk. Provide verbal and written information to the woman about the potential benefits and risks of a planned birth in this context.

Document the outcomes of discussions in the woman's healthcare record, including changes to her level of risk, any further monitoring that is recommended, and any revisions the woman chooses to make to her provisional birth plan. Ensure that the reasons for a planned birth at any stage of pregnancy are clearly documented in the woman's healthcare record.

For healthcare services

Ensure that women are provided with information about timing of birth that is consistent with current evidence, and appropriate to their health literacy, language and cultural needs.

Policies, procedures and protocols should be in place to:

- Support discussions between clinicians and women about timing of birth during antenatal visits, and enable women to make informed and shared decisions
- Ensure that clinicians are appropriately trained and skilled to discuss with women stillbirth risks, how identified risks may affect considerations about timing of birth, and the potential benefits and harms of planned birth
- Ensure that the outcomes of discussions about timing of birth and the woman's preferences are documented in the woman's healthcare record; this includes stillbirth risks identified during pregnancy, recommendations for investigations or monitoring, and details of the agreed birth plan
- Ensure that birth is not planned before 39 weeks gestation, unless clinically indicated, and enable pregnancy to continue for as long as it is safe and possible to do so
- Support information provision and informed decision-making any time a planned birth is being considered, including because of concerns about maternal or fetal health; this includes providing verbal and written information to the woman about the possible benefits and harms of a planned birth to reduce the risk of stillbirth
- Minimise the likelihood that operational factors such as the availability of beds will limit a woman's options for timing of birth.

Healthcare services should have systems in place to monitor rates of planned births before 39 weeks gestation, and to ensure that reasons for early birth are appropriately documented and reviewed by clinicians and management. This includes monitoring when operational factors, such as the availability of staff or beds, have contributed to timing of birth.

Provide clinicians with access to resources and training on timing of birth, such as those developed as part of the **Every Week Counts** initiative[71] and the **Safer Baby Bundle educational program** on timing of birth for maternity care providers.[51]

Related resources

- Centre of Research Excellence in Stillbirth – Safer Baby Bundle **timing of birth resources** for parents and clinicians
- Red Nose – **Timing of birth**
- Women and Babies Research – Every Week Counts information for **parents** and **clinicians**.

Indicators for local monitoring

Indicator 6a: Proportion of women who had a planned birth who received written and verbal information on the potential benefits and harms of planned birth, including the timing of intervention.

METEOR link: **meteor.aihw.gov.au/content/766724**

Indicator 6b: Proportion of women who had a planned birth before 39 weeks gestation whose medical record documents the reason(s) for intervention.

METEOR link: **meteor.aihw.gov.au/content/766726**

Indicator 6c: Proportion of women with singleton pregnancies who had a planned birth before 39 weeks gestation.

METEOR link: **meteor.aihw.gov.au/content/766728**

More information about the indicators and the definitions needed to collect and calculate indicator data can be found at the above METEOR links.

7

Quality statement 7 –

Discussing investigations for stillbirth

When a stillbirth is diagnosed, the availability, timing and anticipated value of clinical investigations, including autopsy, are discussed with the parents. The parents are supported to share their views about factors they perceive may have contributed to the stillbirth, including aspects of the woman's clinical care. This information is documented and considered alongside the agreed clinical investigations, and as part of local perinatal mortality audit or incident investigation processes.

Purpose

To ensure that parents and their support people are provided with information about the availability and potential benefits of clinical investigations after stillbirth, including to help identify potential causes and assist with decisions about future pregnancies. To ensure that their perspective on potential contributing factors to the stillbirth is sought, documented and used to complement the agreed clinical investigations, local perinatal mortality audits, and, where appropriate, incident investigation and management processes.

What the quality statement means

For parents

After a stillbirth, several clinical investigations can be performed to help identify what may have contributed to the death of your baby. For many parents, this information can be an important and helpful part of living with the loss of their baby. It may also help you, your support people and clinicians with decisions about your care if you want to become pregnant again in the future.

Your clinician will speak with you and your support people about the clinical investigations that can be considered. As this can be a challenging subject to discuss, your clinician will try to have this discussion at a time that suits you, taking into account your emotional and personal needs during this difficult time. Your clinician will also explain that this discussion can take place through more than one conversation, to provide you and your support people with time to consider the options offered to you, and allow your clinician to address any questions you might have.

You should be offered the opportunity to have an Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker and/or interpreter to support this discussion if needed.

Your clinician will also ask you about any personal, cultural or religious preferences or needs that may affect your decisions about the clinical investigations they recommend, and about any concerns you might have. You can involve your family members or other support people, including those who can provide spiritual or religious support, in these discussions if you want to.

Your clinician will only perform clinical investigations – for you or your baby – with your permission. For some investigations (such as autopsy), written permission is required; for other investigations (such as blood tests), your clinician will seek your verbal permission. You should be given the time you need to consider, and make decisions about, any investigations that are discussed with you.

Your clinician should explain:

- What contact you can have with your baby before and after the investigations
- What the investigations may identify
- What the investigations involve and where they will take place
- How long the results will take
- How you will be informed about the progress and results of the investigations
- Who you should contact if you have any questions
- That you can change your mind about proceeding with any investigation you have agreed to, up until the time it takes place.

Clinical investigations for mother and baby

After a stillbirth, your clinician may recommend some clinical investigations for the mother, such as taking a detailed history of the pregnancy and blood samples. They will also recommend examining the placenta and umbilical cord. Some women may have particular preferences about what happens to the placenta – for example, some women may wish to bury the placenta. Your clinician should ask you about your preferences and support your decisions.

Your clinician will also discuss clinical investigations for your baby. They will explain that your baby will always be treated with care and respect during any investigations. You will also be able to spend time with your baby before and after any investigations are completed, if you would like to do so.

Investigations for your baby may include[6]:

- Completing an external examination, and taking photographs of your baby
- Performing an autopsy (also known as a ‘post-mortem examination’), where a pathologist who specialises in babies and children will complete an external and internal examination of your baby’s body
- Examining or taking small samples from only certain parts of your baby’s body (also known as a ‘limited’ or ‘minimally invasive’ autopsy)
- Taking scans of your baby using imaging such as X-ray, ultrasound or magnetic resonance imaging (MRI, which gives a detailed internal image of your baby).

Your clinician will provide further information about these investigations and support you to make decisions that you feel are best for you and your baby. This is regardless of whether you choose to proceed with all of the recommended investigations; some investigations, but not others; or no investigations at all.

Sharing your perspective

You should also be offered an opportunity to discuss anything that you think may have contributed to the stillbirth of your baby, including any aspects of your pregnancy care. Your clinician will explain that this discussion can occur whenever you feel ready, and that the information you provide will be discussed with sensitivity and respect at all times. You can choose to have this conversation with another clinician if you do not feel comfortable sharing this information with the clinicians who were directly involved in your care. The support people of your choosing can also be involved in these discussions.

The information you provide should be taken into account, along with the results of any clinical investigations you choose to have. Your perspective should also be considered as part of standard review processes conducted within the hospital to identify factors that may have contributed to the death of your baby (sometimes called mortality audits or incident investigations).

For clinicians

Discuss with the parents the availability of clinical investigations to help identify factors that may have contributed to the stillbirth. Recognise that this discussion is likely to occur at an acute time of loss and emotional distress for the parents and their support people.

Decisions about the timing of this discussion should take into consideration when the stillbirth was diagnosed, and the parents' emotional and personal needs and preferences, while acknowledging the time-sensitive nature of some investigations.

The discussion should be led by a senior clinician who has established rapport with the parents, and care should be taken to ensure that information is conveyed in a clear, respectful and empathic way. Many parents value having more than one conversation about stillbirth investigations, allowing sufficient time between discussions for them to adequately consider the options offered – every effort should be made to accommodate these preferences.

Discuss with the parents and their support people[6]:

- That investigations will only be performed with their consent
- What the investigations involve
- What information is expected from the investigations
- Where the investigations will take place and arrangements for transporting their baby if required
- How long until the results are likely to become available
- Who to contact if they have any questions or concerns
- That they can change their mind about proceeding with any investigation they have agreed to, up until the time it takes place.

Explain that the results from the investigations may help with the woman's future care, by either identifying factors that caused or contributed to the stillbirth, or ruling factors out. Advise that results of investigations may be inconclusive, and that sometimes a cause for the baby's death is not found. Some families might find it helpful to know that investigation results may help with further research about stillbirth, and potentially help reduce stillbirth rates in Australia.

Recognise the diverse beliefs and practices that may be important to women and their families after a stillbirth. Ask the parents about their personal, cultural or religious needs and preferences relating to any clinical investigations, and seek further guidance, where appropriate.[6] Where remoteness of residence and travel distance may be a limiting factor for parents, discuss this in the context of the parents' preferences.

Provide written or electronic information to supplement and support discussions about clinical investigations, and to encourage shared decision making. Ensure that parents are given the time they need to consider and make decisions about the clinical investigations discussed with them.

Ensure that the parents and their support people are given the opportunity to share their views on factors they perceive may have contributed to the stillbirth, including any aspects of the woman's pregnancy care, and document the outcomes of this discussion. This information should complement the clinical investigations agreed to by the parents and inform discussions that occur as part of local perinatal mortality audit, and, where appropriate, incident investigation and management processes.

Care should be taken to ensure that parents are able to discuss their views in an environment that is safe, respectful and judgement-free, and that clinicians engage in these discussions sensitively to prevent any perception that the parents are to blame for the death of their baby. Advise the parents that the discussion does not need to occur immediately, and can take place at a later time when they feel ready and comfortable to share their views. Parents should also be offered the opportunity to have this discussion with another clinician, if they do not feel comfortable sharing this information with the clinicians who were directly involved in their care. Parents should also be offered to involve the support people of their choosing in these discussions.

Clinical investigations

Clinical investigations after stillbirth should be performed in line with recommendations from the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6], and the **Stillbirth Investigations Flowchart**.[75]

Assure the parents that their baby will always be treated with care and respect, regardless of the investigations performed. Explain to them that they will have the opportunity to see and spend time with their baby before and after investigations are completed, if they would like to do so.

The following core investigations should be recommended for all stillbirths[6]:

- Comprehensive maternal and pregnancy history
- Kleihauer–Betke test or flow cytometry
- External examination of the baby by an appropriately trained clinician
- Clinical photographs of the baby
- Autopsy (unless a definitive cause of death has been established, for example through antenatal genetic testing)
- Full body X-ray imaging of the baby (also known as a 'babygram')
- Examination of the placenta and cord at birth by the attending clinician
- Histopathology of the umbilical cord and placenta
- Cytogenetic testing (chromosomal microarray (CMA) or karyotype if CMA is not available).

Address any questions that the parents may have about these investigations. Explain that they can choose to proceed with all, some or none of the recommended investigations, depending on their preferences.

If the parents choose not to proceed with a full autopsy, discuss other appropriate options. These may include a partial autopsy; a minimally invasive autopsy; examination of the placenta and umbilical cord alone; or other suitable investigations such as X-ray, ultrasound or MRI, where available.[6]

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

Recognise the diverse personal, cultural and religious beliefs and practices that are important to women and their families following stillbirth, which may influence their decisions about the clinical investigations offered.

Ensure that discussions about stillbirth investigations are carried out in a sensitive and culturally safe manner that recognises these diverse perspectives, to help address parents' needs and support informed decision making. Where appropriate, offer access to an Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker, and relevant spiritual or religious support people, to help facilitate these discussions.

Assumptions should not be made about the woman's preferences on the basis of her culture, religion or ethnicity – rather, discussions about stillbirth investigations should seek to identify the woman's individual perspectives, and support informed decision-making in line with her needs and preferences.

For healthcare services

Ensure that information about clinical investigations after stillbirth is available to parents and their support people. Ensure that this information is consistent with current evidence and meets the parents' needs.

Healthcare services should have policies, procedures and protocols in place to:

- Enable timely investigations after stillbirth and ensure appropriate follow-up of results
- Ensure that consistent information is provided to, and discussed with, parents and their support people about available clinical investigations for stillbirth and their potential value (including autopsy)
- Ensure that clinicians providing care to parents after stillbirth understand the processes and arrangements required to facilitate access to a perinatal autopsy, and are appropriately trained to discuss the procedure and its potential benefits, while acknowledging that a cause of death may not be found in all cases
- Provide clinicians with access to relevant training, such as the **Improving Perinatal Mortality Review and Outcomes Via Education (IMPROVE)** educational program[76]
- Ensure that parents and their support people are given an opportunity to share their views on factors they perceive may have contributed to the loss, including aspects of the woman's pregnancy care, in a safe, respectful and judgement-free environment; this information should be documented and used to complement the results of agreed clinical investigations, and inform discussions that occur as part of local perinatal mortality audit, and, where appropriate, incident investigation and management processes
- Recognise personal, cultural and religious needs and preferences relating to birth and death, and ensure that discussions relating to clinical investigations after stillbirth respect the needs of the parents and their support people
- Involve relevant support people, including Aboriginal and Torres Strait Islander health workers or liaison officers, cross-cultural health workers and interpreters, in line with the parents' needs and preferences
- Ensure that all clinicians who provide care for parents who have experienced a stillbirth are supported to provide this care, through opportunities for formal and informal debriefing, clinical supervision and access to relevant mental health services, when required.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

Ensure that systems are in place to support clinicians to discuss stillbirth investigations with parents sensitively, and in a culturally safe manner. These systems should enable clinicians to access support from an Aboriginal and Torres Strait Islander health worker, cross-cultural health worker, and relevant spiritual or religious support people, in line with parents' needs and preferences, to help facilitate these discussions.

Related resources

- Centre of Research Excellence in Stillbirth:
  - Autopsy: Trying to find answers when your baby has died
  - *Guiding Conversations with Your Health Care Team When Your Baby Dies*[77], a resource developed in partnership with Stillbirth Foundation Australia to support conversations between parents and clinicians after the death of a baby
- Red Nose Grief and Loss – information for parents who have experienced stillbirth:
  - Born still or died soon after birth
  - Finding out a cause of a stillbirth or neonatal death
  - After the autopsy.

Indicator for local monitoring

Indicator 7a: Proportion of clinicians who provide bereavement care to parents who have experienced a stillbirth who have completed an evidence-based bereavement care professional development program.

METEOR link: **meteor.aihw.gov.au/content/766750**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found at the above METEOR link.

8

Quality statement 8 –

Reporting, documenting and communicating stillbirth investigation results

The results of stillbirth investigations are reported in a timely manner, documented appropriately and discussed with the parents, along with any information they have provided about perceived contributing factors. The stillbirth is reviewed as part of a local perinatal mortality audit process, classified according to the Perinatal Society of Australia and New Zealand classification system, and outcomes are used to inform local improvements in care.

Purpose

To ensure that parents can access results of investigations after stillbirth in a timely manner, and that information on potential causes and contributory factors for the death is discussed and documented appropriately to support ongoing care for the woman, including future pregnancy planning.

What the quality statement means

For parents

Clinical investigations that you have agreed to following the death of your baby will be carried out by specialist clinicians. These clinicians will also review and interpret the results. In most cases, a pathologist who specialises in causes of death for babies and children will write a detailed report on the results.

Discussing clinical investigation results

When the results are available, a clinician who understands your case will arrange a follow-up meeting with you and your support people to discuss the results. You should be offered the option of participating in this meeting via telehealth, especially if you live in a rural or remote area, or cannot easily meet in person. Because the results of some clinical investigations can take longer than others, your clinician may not have all the results available at this first meeting, and further meetings may be required.

You should expect that your clinician will discuss clinical investigation results with you in a caring, sensitive and culturally safe way. You should also be offered the opportunity to have an Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker and/or interpreter to support this discussion, if needed.

During this discussion, your clinician will consider any information that you and your support people have shared about factors you think may have contributed to the death of your baby. Your clinician will discuss the information you have provided, with sensitivity and respect at all times.

If more specialist clinical expertise is needed to explain what the results mean, or if more tests are needed, your clinician will discuss this with you and arrange relevant referrals. Where appropriate, this should include the option of discussing the results via telehealth, especially if you live in a rural or remote area, or cannot easily access the necessary clinical expertise.

Information you should expect to receive

Your clinician will provide you with a summary of information about your pregnancy and the death of your baby. This should include a record of the results of the investigations (including whether a cause for your baby's death was found), and any recommendations about how this might affect your plans to become pregnant again. They should also let you know how this information has been documented in your healthcare record.

It is important to be aware that, although investigations can sometimes provide information about what may have contributed to the stillbirth, reasons for the baby's death cannot always be found.

Hospital review processes – perinatal mortality audits and reviews

After a stillbirth occurs, many hospitals will complete a formal review of the care provided to the mother and baby, to help understand the events leading up to the death of the baby. This process is called a 'perinatal mortality audit' or 'perinatal mortality and morbidity review'. As part of this process, the results of any clinical investigations you have agreed to, and any information you have provided about potential contributors to the loss, are carefully considered by the clinicians involved in your care. Because the results of investigations will not be available straight away, it may take some time for this process to be fully completed.

Your clinician should let you know if there were any aspects of your pregnancy care that may have contributed to the death of your baby. Although stillbirth cannot always be prevented, if aspects of your care that may have contributed to your stillbirth are identified, you should expect to receive an apology, be offered an opportunity to share your views on what happened, and be provided with an explanation of how the incident happened and the steps being taken to prevent it from happening again. This process is known as 'open disclosure' and may involve more than one meeting.[78]

Sharing investigation results

With your permission, your clinician should share information about the death of your baby with other clinicians involved in your care, including your GP and/or your Aboriginal Community Controlled Health Organisation or Aboriginal Medical Service. This should include information about your pregnancy, the findings of the autopsy or any other investigations completed, and recommendations for your future care.

For clinicians

Arrange a time with the parents to discuss clinical investigation results as soon as these are available. Inform the parents that the results of some investigations may become available before others, and that more than one meeting may be required to discuss all results. The discussion should be led by a senior clinician who has an established rapport with the family. It should consider the parents' views on factors they perceive may have contributed to the baby's death.

Care should be taken to discuss results with parents in an empathic, sensitive and culturally safe manner. The parents should be offered access to an Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker and/or interpreter to support the discussion, where appropriate.

Discuss with the parents the results of any investigations undertaken, including whether any causes for the baby's death were identified and relevant recommendations for future pregnancy planning. If further consultation or investigation is needed, discuss this with the parents and arrange referrals as required. Where appropriate, this should include the option of accessing care via telehealth, especially for parents who live in rural or remote areas that may have limited access to the required clinical expertise.

Provide the parents with a copy of the results of any investigations, and a plain-language summary that outlines any recommendations for future care. Document this information, including the outcomes of the discussion with the parents, in the woman's healthcare record.

Every stillbirth should be reviewed as part of a formal perinatal mortality audit process. The PSANZ Classification System for Stillbirths and Neonatal Deaths[6] should be used to assign a cause of death and any associated conditions for the stillbirth. As part of the audit meeting, the circumstances surrounding the stillbirth, including aspects of the woman's clinical care that may have contributed to the death and their significance, and information provided by the parents about potential contributors to the loss, should be considered to identify areas for practice improvement. These factors should be assessed using the Australian Perinatal Mortality Audit Tool[79] or equivalent local tool. Outcomes should be documented, including recommendations for actions to address identified problems, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*.[6]

If any aspects of the woman's clinical care were identified as potential contributors to the baby's death, engage in open disclosure with the family. This should include issuing the parents with an apology, providing them with an opportunity to share their views on what happened, and explaining to them how the incident happened and what preventive measures are being taken.[78]

With the parents' permission, ensure that a comprehensive clinical summary, including the results of any investigations and relevant recommendations, including implications for future pregnancy planning, are shared promptly with other clinicians involved in the woman's care, including her GP and/or clinicians providing care for the woman through an ACCHO or AMS.

For healthcare services

Ensure that policies, procedures and protocols are in place to enable timely access to investigation results after stillbirth. This includes supporting clinicians to make referrals for specialist clinical expertise, if required for interpretation of results, including access via telehealth, where appropriate.

Healthcare services where births occur should have a formal perinatal mortality auditing process in place to ensure that all perinatal deaths are reviewed, and any contributing factors are assessed, appropriately documented and used to inform improvements in quality of care to prevent recurrence. Care should be taken to ensure that this auditing process is systems focused and blame-free. All clinicians involved in providing maternity care to the woman (obstetricians, midwives and, where possible, her GP – for shared care arrangements) should be supported to actively participate in these processes to develop their practice and encourage quality improvement. As part of these processes, clinicians should consider the results of any investigations, as well as information provided by the parents and their support people about factors they perceive may have contributed to their baby's death.

The process should be carried out in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*.[6] The process should include:

- Using the PSANZ Classification System for Stillbirths and Neonatal Deaths[6] to assign a cause of death, and any associated conditions and contributing factors related to care for all stillbirths
- An assessment of factors, including aspects of the woman's clinical care, that may have contributed to the baby's death using relevant auditing tools such as the Australian Perinatal Mortality Clinical Audit Tool[79]
- Development of clear recommendations to address identified problems, accompanied by an implementation plan to be completed within a nominated time frame
- Ensuring that a process of feedback to clinicians is in place to support improvements in clinical practice as a result of the review process
- Reporting recommendations from the audit process at the appropriate level of clinical governance within the healthcare service, and to a jurisdictional perinatal mortality council or respective body, to support identification of areas for service improvement and national reporting.

If any aspects of the woman's clinical care are identified as potential contributors to the baby's death, engage in open disclosure with the family, in line with the recommendations in the Australian Open Disclosure Framework.[78]

Policies, procedures and protocols should be in place to:

- Support clinician discussions with parents about the results of investigations, including any implications for future pregnancy planning
- Ensure that clinicians document the outcomes of these discussions in the woman's healthcare record
- Facilitate participation of the clinicians involved in providing care for the woman during pregnancy in formal perinatal mortality auditing processes (including obstetricians, midwives and, where possible, GPs)
- Ensure that information about the woman's pregnancy and the baby's death, including the results of investigations and any recommendations for her future care, are shared with the woman's GP and other clinicians involved in her care.

Related resources

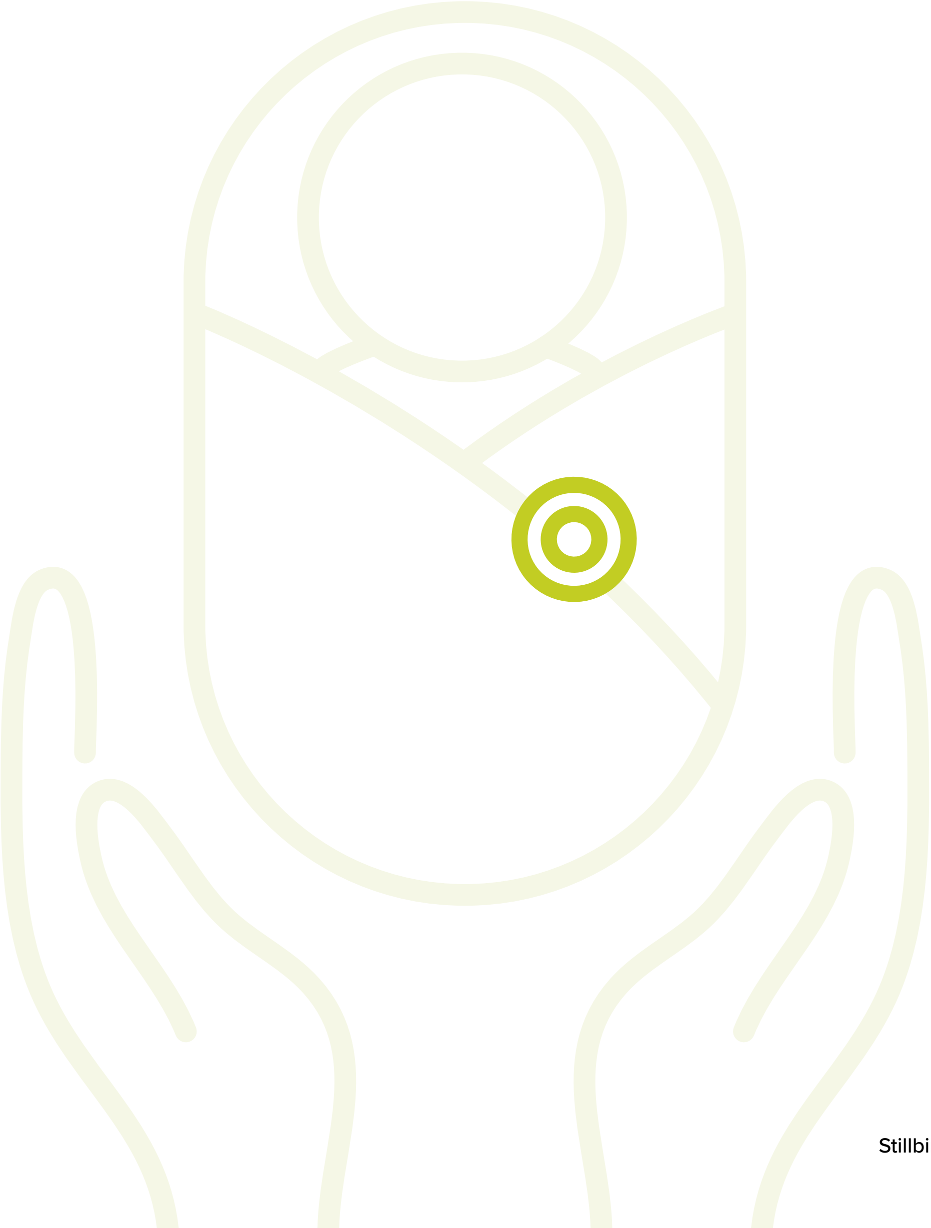
- Australian Commission on Safety and Quality in Health Care
  - Open disclosure resources for consumers
  - Incident management guide for clinicians and healthcare services
- Centre of Research Excellence in Stillbirth – *Guiding Conversations with Your Health Care Team When Your Baby Dies*[77], a resource developed in partnership with Stillbirth Foundation Australia to support conversations between parents and clinicians after stillbirth.

Indicator for local monitoring

Indicator 8a: Proportion of stillbirths reviewed by the healthcare service for potential contributing factors and classified according to the Perinatal Society of Australia and New Zealand classification system.

METEOR link: **meteor.aihw.gov.au/content/766752**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found at the above METEOR link.



9

Quality statement 9 –
Bereavement care and support after perinatal loss

After a perinatal loss, parents and their support people are provided with compassionate, respectful and culturally safe bereavement care that recognises their specific needs and preferences, and ensures that follow-up support is available after discharge.

Purpose

To ensure that parents and their support people receive appropriate bereavement care and follow-up after a perinatal loss, to support their physical, emotional and psychological wellbeing. To ensure that appropriate referral pathways and supports are in place after discharge from the hospital.

What the quality statement means

For parents

The death of a baby is a devastating and difficult experience for parents, their families and support people. This is regardless of when the death has occurred, or the reasons for the death.

When you experience the death of a baby, or are told that your baby will not live long because of a life-limiting condition, you will be offered care to support your physical, emotional, psychological and spiritual wellbeing. Your clinician should ask you about your personal, cultural and religious or spiritual needs and preferences during this time, and support your decisions about the care you receive.

You should expect that any information your clinician shares with you (verbal or written) is provided in a way that meets your language and literacy needs. If needed, your clinician will offer to arrange an interpreter to support your discussions.

If your baby has died before birth

When it is recognised that your baby has died before you give birth, your clinician will have a discussion with you about next steps. This may include arranging for you to give birth through induction of labour or caesarean section, if you are not already in labour. All pain relief options for labour and birth will be discussed with you, and you will be given time to make up your mind. Your clinicians will also understand that you may change your mind, and will provide care that best supports you and your individual situation.

After the birth of your baby

The care that is provided to you after your baby is born should be sensitive to your needs. This may include your clinician:

- Arranging to have discussions with you in a private, quiet area that is separate from other mothers and newborn babies
- Letting other staff members who are caring for you know that your baby has died
- Involving family members or other support people of your choice in helping you to make decisions about your care
- Ensuring that you are given time to spend with your baby following the birth, in a private space.

Your clinician should also offer you access to an interpreter, Aboriginal and Torres Strait Islander health worker or liaison officer, or cross-cultural health worker, depending on your needs.

You should also be given a chance to organise mementos of your baby, if this is something you would like to do. This may include things such as:

- Taking photos with your baby
- Keeping a lock of your baby's hair
- Having your baby's handprints and footprints taken
- Creating cot cards or name tags for your baby
- Arranging meaningful rituals such as a memorial service or other mourning rituals with the assistance of spiritual support people.

If you would like to take your baby home, or to another place that is important to you, your clinician will discuss the options that are available with you.

You can also receive practical support with any arrangements to do with the death of your baby. This may include making or cancelling appointments; completing documentation, including birth registration paperwork; and receiving suitable supports after you leave the hospital. Your clinician should provide you with information about arranging a commemorative service, funeral or other mourning rituals for your baby if you wish, and support you to make an unhurried decision. They can also provide you with information about your eligibility for financial support, where available.

The clinicians involved in your care should answer any questions that you may have about your care, and give you and your support people the time that you need to make decisions.

Your physical and mental wellbeing after perinatal loss

Your clinician will also discuss ways to support physical recovery after giving birth. This may include providing information and advice relating to breast milk production (lactation), vaginal bleeding, wound care and physical activity. Some women may prefer to stop their body from making breast milk by using medication, while others may choose to continue lactating and/or donate their breast milk through a milk bank (where available) to help another family.[77] A postnatal check with a GP or obstetrician within six weeks of birth will be recommended. You should let your clinician know if you have any questions, and expect to be supported to make decisions about your care that are right for you.

Before leaving the hospital, you should expect to be given the details of someone you can contact if you have any questions or concerns after discharge.

Your clinician may also discuss the impact the death of a baby can have on your mental health and wellbeing. It is normal to feel grief and sadness after the loss. For some parents, these feelings can become worse over time, or mental health issues may arise. Your clinician should give you information about support services that are available outside the hospital, including bereavement care, other parent support organisations or psychological support services. Your clinician can arrange formal referrals to these services, with your consent.

Your clinician should also acknowledge the grief that other members of your family or support people may be experiencing, including the baby's grandparents and siblings. They will explain that it is important for them to speak to someone if they require support, and discuss what support services are available for them.

Support after leaving the hospital

Your clinician will offer you a follow-up meeting within 12 weeks of leaving the hospital to check on your physical and emotional wellbeing. This will include discussing the results of clinical investigations, if available, including anything that may affect your decisions about future pregnancies. As some parents may require support beyond this time, your clinician will discuss available options for ongoing support, depending on your needs and preferences.

Your clinician will also refer you to your GP for follow-up care and support. With your permission, your clinician will share information about your baby's death with your GP promptly, including the circumstances surrounding the death, and recommendations to support your physical, emotional and psychological wellbeing. They can also arrange referrals to clinicians with specific training and expertise in bereavement care for pregnancy loss, such as a psychologist or qualified social worker, if this is something you would prefer.

For clinicians

The death of a baby is a traumatic experience for parents, their families and support people, and the clinicians involved in their care. This is regardless of when the death occurs or the reasons for the loss.

Following diagnosis of an intrauterine fetal death or when a perinatal loss occurs, provide respectful, culturally safe and evidence-based bereavement care, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6] and *Sands Australian Principles of Bereavement Care*.[80] Parents should also be provided with bereavement care and support during pregnancy and birth when the fetus has been diagnosed with a life-limiting condition.

If a fetal death has been diagnosed in utero and the woman is not already in labour, provide information to the woman about her options for giving birth, and their potential risks and benefits – this should include a discussion about available options for pain relief during labour and birth.

Recognise the diverse beliefs and practices that may be important to women after a perinatal loss. Ask the woman about her personal, cultural, religious or spiritual needs and preferences during this time, and seek further guidance, where appropriate.

After giving birth

The following should be offered to parents who have experienced a perinatal loss:

- Verbal and written information about care that meets their health literacy, language and cultural needs
- The involvement of an interpreter, Aboriginal and Torres Strait Islander health worker or liaison officer, or cross-cultural health worker, where appropriate
- A location for care that is private, quiet, and separate from other mothers and newborn babies, if possible
- Strategies to enable members of the workforce (both clinical and non-clinical) who are interacting with the family in the hospital to recognise that the parents have experienced a perinatal loss, such as using a discreet symbol on the woman's room and in her healthcare record
- The chance for them and their family or support people to spend as much time as possible with their baby in private, and consideration of available options to facilitate taking their baby home
- Opportunities to make mementos, such as taking photos, keeping a lock of the baby's hair, or making impressions of the baby's handprints and footprints.

Support the woman to make shared decisions about the care she receives, and encourage the involvement of her partner or other support people in decision-making, if she prefers.

Physical and mental wellbeing after perinatal loss

Provide information to the woman about, and discuss ways to support, her physical recovery after giving birth, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*.[6] This may include offering advice and support relating to lactation, vaginal bleeding, wound care and physical activity.

Discuss with the parents the potential mental health impacts of experiencing a perinatal loss. Explain that, although it is normal to feel grief and sadness after the loss, for some parents, these feelings can become worse over time, and mental health issues such as anxiety and depression may arise. Acknowledge that the experience of perinatal loss can be equally challenging for the parents' other family members (for example, grandparents, siblings) and support people. Where appropriate, discuss the availability of relevant support services for the parents and their family, including the option of referral to clinicians with specific training in perinatal bereavement care (for example, psychologists, qualified social workers).

Support for parents after discharge

Provide the parents with the details of a contact person at the hospital, such as a bereavement care coordinator, who can be contacted should the parents require follow-up support after discharge, especially within the first 24 hours. Also provide written information about ongoing support services, including telephone, online and face-to-face services.

Offer the woman a follow-up review meeting within 12 weeks of the baby's death. Give her clear verbal and written details of the appointment time and what the meeting is expected to involve. Discuss other opportunities for ongoing support, depending on the parents' needs and preferences.

GPs and other primary care clinicians will provide health care to the woman after discharge. With the woman's agreement, promptly inform these clinicians of the baby's death so that appropriate follow-up can be arranged. Ensure that relevant information about the nature of the loss and the woman's ongoing care needs is recorded in the woman's discharge summary.

Offer and arrange for post-discharge care appropriate to the woman's needs and preferences, such as referral to:

- The GP or other primary care clinician who will provide ongoing care
- Parent support organisations and programs
- A counsellor or qualified social worker with expertise or experience in perinatal bereavement care
- A psychologist or psychiatrist, especially if the woman is assessed as having pre-existing mental health risk factors.

For parents who live in rural and remote areas, consider the use of telehealth services to enable access to appropriate clinical and psychosocial expertise following a perinatal loss, where available and in line with the parents' needs.

Support for clinicians

The death of a baby can be a devastating and difficult experience, not only for the parents and their support people, but also for the clinicians involved in their care. Your healthcare service should support you to deliver this care, by providing opportunities for bereavement care training, formal and informal debriefing, clinical supervision and access to mental health services, when required.

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

Women may have diverse belief systems and important religious or cultural rituals or practices that need to be performed after perinatal loss. Many women may prefer to involve other family members or support people when making decisions about her care during this time. It is important to always ask women about their needs and preferences during this time and not make assumptions about the care they require.

Some Aboriginal and Torres Strait Islander women will participate in a range of cultural practices and protocols associated with the passing away of a family member – this is called 'sorry business'. During this time, it may be important for women to have the support of their extended family, who may or may not be blood relatives, as they grieve the loss of their baby. If a woman has given birth away from her community or Country, she may prioritise early discharge to return to her home so that she can access this support.

Recognise that some aspects of care offered after perinatal loss that are acceptable in one culture may be considered offensive in other cultures. This may include use of the term 'death', referring to the baby using his or her name, creating mementos (for example, cot cards, photographs with the baby) or making eye contact with the woman and asking her questions directly.

Offer access to an Aboriginal and Torres Strait Islander health worker or liaison officer, a cross-cultural health worker and an interpreter, if required, to facilitate discussions with women and their families after perinatal loss, and support the provision of respectful and culturally safe bereavement care. Note that some women may be more comfortable with a female interpreter – every effort should be made to accommodate such preferences.

ACCHOs and AMSs play an important role in providing Aboriginal and Torres Strait Islander women with access to relevant support after discharge, especially in rural and remote areas. If the woman's usual care provider is based in an ACCHO or AMS, offer to contact them to advise that the woman is being discharged and discuss suitable support arrangements. Alternatively, facilitate referral to a relevant service to support ongoing care, in line with the woman's needs and preferences.

For healthcare services

Healthcare services should establish and foster a commitment to delivering best-practice bereavement care following perinatal loss.[6] This care should recognise that the death of a baby is an emotionally traumatic event, regardless of when the death occurs or the reasons for the loss. Care should also address the experiences of a woman going through pregnancy and birth after the fetus has been diagnosed with a life-limiting condition.

Ensure that policies, procedures and protocols are in place to support clinicians in providing respectful, comprehensive and culturally safe bereavement care, in line with the recommendations in the *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death*[6] and *Sands Australian Principles of Bereavement Care*.[80] These should address[6]:

- Providing the parents and their support people with access to appropriate spaces and surroundings following the perinatal loss (for example, rooms that are away from other mothers and newborn babies)
- Adopting a universal, discreet symbol to help all staff who interact with the parents and their support people to recognise the loss
- Offering opportunities for creating and managing mementos (for example, photographs of the baby, locks of hair, handprints and footprints)
- Providing verbal and written information to parents that is consistent, unbiased, and in line with their health literacy, language and cultural needs
- Enabling access to religious or spiritual care and support, in line with the parents' needs and preferences
- Enabling access to Aboriginal and Torres Strait Islander health workers or liaison officers, and cross-cultural health workers, where appropriate
- Facilitating prompt communication with the woman's GP or other primary care provider, with the woman's consent, to advise of the baby's death
- Providing the parents, their support people and the woman's GP with the contact details of a designated clinician at the hospital who can be contacted for further information or support, including after discharge
- Establishing links and partnerships with relevant local services for post-hospital bereavement care and support, including parent support organisations
- Having appropriate referral pathways in place to ensure that parents can access bereavement care and psychosocial support services after discharge.

Ensure that discharge policies support appropriate follow-up after discharge. A discharge summary should be provided to the woman and forwarded to her GP or other primary care provider. This summary should detail the nature of the loss, and any follow-up care or referrals that may be needed.

Healthcare services should give all clinicians who provide bereavement care to parents who have experienced perinatal loss access to relevant training, such as the **Improving Perinatal Mortality Review and Outcomes Via Education (IMPROVE)** educational program.[76] Healthcare services should also ensure that clinicians are supported to provide bereavement care, through opportunities for formal and informal debriefing, clinical supervision and access to relevant mental health services, when required.

Healthcare services located in rural and remote locations should consider the use of appropriate communication technology, such as telehealth services, to provide parents and their support people with access to appropriate clinical and psychosocial expertise following a perinatal loss, where available and in line with their needs.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

Ensure that systems are in place to respectfully manage protocol and provide culturally safe bereavement care for all women and their families after perinatal loss, including Aboriginal and Torres Strait Islander women going through sorry business.

Aboriginal and Torres Strait Islander women who have given birth away from their community or Country may require structured support to ensure safe return to their place of residence, especially in rural or remote areas. Establish appropriate networks – for example, with local AMSs – to facilitate the woman's transfer and care.

Ensure that systems are in place to support women to access culturally safe avenues of support after discharge, such as support offered through ACCHOs and AMSs.

Support clinicians to provide respectful and culturally safe care by having systems in place to facilitate involvement of Aboriginal and Torres Strait Islander health workers, cross-cultural health workers and interpreters, in line with the parents' needs and preferences.

Provide regular education and training for clinicians in cultural safety.

Related resources

- Australian Breastfeeding Association – further information about **lactation after infant death**
- Centre of Research Excellence in Stillbirth – ***Guiding Conversations with Your Health Care Team When Your Baby Dies***[77], a resource developed in partnership with Stillbirth Foundation Australia to support conversations between parents and clinicians after the death of a baby
- Pregnancy, Birth and Baby – information for parents about **experiencing a pregnancy loss**
- Red Nose Grief and Loss – bereavement care information for **parents** and **clinicians**
- Stillbirth and Neonatal Death Support (Sands) Australia – **fact sheets for parents**.

Indicator for local monitoring

Indicator 9a: Evidence of local arrangements to support the provision of bereavement care in line with *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death* and *Sands Australian Principles of Bereavement Care*.
The arrangements should include but not be limited to the:

- Process to involve interpreter services, Aboriginal and Torres Strait Islander health workers or liaison officers, or cross-cultural health workers when required
- Discharge protocol to ensure prompt communication with the woman's general practitioner or other primary care provider to advise of the baby's death and recommendations for follow-up care and support
- Details of the designated clinician at the hospital, who can be contacted should the parents require follow-up support after discharge
- Referral processes and pathways for appropriate clinical and psychosocial care and parent support programs following perinatal loss.

METEOR link: **meteor.aihw.gov.au/content/766754**

More information about the indicator and the definitions needed to collect and calculate indicator data can be found at the above METEOR link.

10

Quality statement 10 – Subsequent pregnancy care after perinatal loss

During a subsequent pregnancy after a perinatal loss, a woman receives antenatal care that recognises factors that may have contributed to the previous loss, and ensures that she has access to appropriate clinical expertise and psychosocial support, as required.

Purpose

To ensure that pregnant women who have previously had a perinatal loss receive antenatal care that recognises the need for appropriate clinical expertise and the importance of psychosocial support.

What the quality statement means

For women

Pregnancy or planning for pregnancy can be very stressful if you have experienced the death of a baby before. It is important that you speak to your clinician before you become pregnant or early in pregnancy to discuss any concerns you may have. Your clinician can then work with you to discuss and develop a plan for your pregnancy care and birth.

Your clinician may recommend more frequent appointments, or extra obstetric ultrasounds and other investigations, to monitor your and your baby's health and wellbeing during pregnancy. This is because studies show that women who have experienced a perinatal loss, such as a stillbirth, have a higher risk of another loss during a subsequent pregnancy.[81] This risk may depend on what caused the previous perinatal loss, if this is known.

Some studies have shown that women benefit from regularly seeing the same clinician or group of clinicians (sometimes called 'continuity of carer') for pregnancy care, especially women who have had a perinatal loss.[82-84] In Australia, continuity of carer can be provided by GPs, a midwife or group of midwives, obstetricians or Aboriginal and Torres Strait Islander health workers. When you become pregnant, your GP (or other regular care provider) should talk with you about the different types of pregnancy care available to you, and ask you what you would prefer.

The clinician providing your pregnancy care will consider the results of any investigations completed after your previous loss. If a cause for your previous loss was found, this may affect your subsequent pregnancy care, and in some cases can help you and your clinician reduce your risk. For example, depending on the cause, your clinician may recommend that you take certain medications or have extra monitoring during your pregnancy.

It is common for parents and their support people to feel anxious or worried during a pregnancy after a perinatal loss. Your clinician will ask you about any concerns that you have and offer you access to psychosocial and other support services, in line with your needs and preferences. You can also ask your clinician for a referral to these support services at any point during your pregnancy, if your needs change.

Where appropriate, your clinician should offer you the option of accessing the clinical or psychosocial care you need via telehealth, especially if you live in a rural or remote area, or cannot easily access this care.

It is important to get in touch with your clinician if you have any questions or concerns about your physical, emotional or psychological wellbeing during pregnancy.

For clinicians

Women who have experienced a perinatal loss may be at increased risk of adverse outcomes during a subsequent pregnancy.

For women planning a pregnancy after a perinatal loss, provide pre-conception care as described in **Quality statement 1**. During a subsequent pregnancy, provide sensitive and informed antenatal care, delivered by an experienced clinician or multidisciplinary team.[81, 85]

The benefits of continuity of carer should be considered and discussed with the parents. Studies show that, in a subsequent pregnancy following perinatal loss, access to models that offer continuity of carer allows women to develop supportive and trusting relationships with their clinicians, and may assist them to feel more involved in planning their care.[82,84] Ask the parents about their preferences for care; where possible and appropriate, prioritise offering access to a suitable model that offers continuity of carer, in line with the woman's personal and cultural needs.[83] This should include facilitating access to culturally safe models of care for Aboriginal and Torres Strait Islander women, and enlisting the support of an Aboriginal and Torres Strait Islander health worker or liaison officer, or cross-cultural health worker, if required.

The clinician providing maternity care should work in partnership with parents to create an individualised care plan that considers the causes and circumstances of their previous loss, and their personal needs and preferences. Obtain a complete history of the previous loss and seek access to the medical records if care was provided elsewhere and specialised advice if required. Consider any extra tests or monitoring that may be needed and discuss these with the woman. These may include[81,86,87]:

- More frequent ultrasound, to assess fetal growth and detect complications for women with a history of stillbirth
- Aneuploidy testing for women with a history of a perinatal loss due to congenital anomaly
- Cervical length screening between 16 and 24 weeks of pregnancy for women with a history of spontaneous preterm birth, in addition to a mid trimester fetal morphology scan.

Where the cause for the previous loss is known and modifiable, start appropriate treatment to minimise the risk of recurrence. Examples include[81,86,87]:

- Low-dose aspirin for women at risk for placental insufficiency
- Folic acid supplementation for women with a history of a perinatal loss due to neural tube defects
- Progesterone for women with a history of spontaneous preterm birth.[88]

Parents and their support people often experience intense worry and fear, and complex emotional responses during a subsequent pregnancy.[85] Provide care that is considerate and empathic, and let the parents and their support people know who they can contact if they have concerns. Encourage them to express their thoughts and to ask questions throughout the pregnancy. Should concerns emerge during the pregnancy, provide timely access to clinical care to allow prompt assessment and reassurance. If specialised support is needed, refer to appropriate clinical and psychosocial support services.

Where appropriate, clinicians should facilitate access to clinical and psychosocial care via telehealth, especially for parents who live in rural or remote areas and may have limited access to the care they require.

Discuss any relevant information with the parents using language that is in line with their health literacy, language, and cultural and spiritual needs. Enable access to an interpreter, Aboriginal and Torres Strait Islander health worker or liaison officer, cross-cultural health worker or other supports, in line with the parents' needs.

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

Offer Aboriginal and Torres Strait Islander women access to culturally safe maternity care models, in line with the woman's preferences.[5] These include models of care offered through ACCHOs or AMSs, or models that offer continuity of carer with the involvement of an Aboriginal and Torres Strait Islander health worker to support the woman's care.

Models that offer continuity of carer have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth[49], including Aboriginal and Torres Strait Islander women.[50]

For women from migrant and refugee backgrounds, facilitate access to cross-cultural health workers to support care, where appropriate and in line with the woman's preferences.

For healthcare services

Ensure that policies, procedures and systems are in place to prioritise access to maternity care models that allow continuity of carer for women with a history of a perinatal loss during a subsequent pregnancy, where this is in line with the woman's risks, needs and preferences.

Healthcare services providing care for women during, or planning for, a subsequent pregnancy should have systems in place to ensure that clinicians involved in their care consider information about the circumstances of the previous loss, including the findings of any investigations performed. Clinical records and communication should enable the woman's previous loss to be readily identifiable and discreetly communicated to clinicians providing care.

These systems should also ensure that clinicians recognise that certain procedures or aspects of care during a subsequent pregnancy after perinatal loss may cause apprehension for some women (for example, obstetric ultrasound). Where possible, provide opportunities for a support person to be present with the woman during antenatal visits, and when any investigations or procedures are being performed, in line with her needs and preferences. Ensure that systems are in place to enable clinicians' timely access to the results of any investigations performed.[81]

Ensure that policies, procedures and protocols are in place to recognise the risks associated with a subsequent pregnancy after a perinatal loss. These should provide the woman with access to an appropriate model of care that is respectful of her preferences, to support her psychological wellbeing and clinical management of risk. Ensure that information about antenatal care during a subsequent pregnancy following a perinatal loss is consistent with current evidence, and meets the woman's health literacy, language and cultural needs.

Healthcare services located in rural or remote locations should ensure that arrangements are in place to facilitate effective networks with larger centres, to enable women and their support people to access appropriate clinical and psychosocial expertise, including the use of appropriate communication technology such as telehealth services.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

Ensure that systems are in place to facilitate access to culturally safe maternity care models for Aboriginal and Torres Strait Islander women, including models of care offered through ACCHOs or AMSs, in line with the woman's needs and preferences.

These systems should ensure that, if access to these models of care is not possible, Aboriginal and Torres Strait Islander women are offered access to models of care that allow continuity of carer with support from an Aboriginal and Torres Strait Islander health worker or liaison officer. This includes midwifery continuity of carer models, which have been shown to contribute to positive pregnancy outcomes for women at higher risk of stillbirth[49], including Aboriginal and Torres Strait Islander women.[50]

Support clinicians to provide culturally safe care to women from migrant and refugee backgrounds, by facilitating access to cross-cultural health workers, where appropriate and in line with the woman's preferences. Provide regular education and training for clinicians in cultural safety.

Related resources

Several programs support culturally safe pregnancy care for Aboriginal and Torres Strait Islander women. Examples are **Birthing on Country** initiatives, the **Australian Nurse-Family Partnership Program** and services offered in different states and territories, such as:

- New South Wales – **Aboriginal and Maternal Infant Health Service**
- Victoria – **Koori Maternity Services**
- South Australia – **Aboriginal Family Birthing Program**.

A comprehensive list of ACCHOs across Australia is available from the **National Aboriginal Community Controlled Health Organisation**.

Appendix A:
General principles of care

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care. When implementing this clinical care standard, health services should ensure that quality improvement activities support these principles.

Person-centred care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.[8,89]

Clinical care standards support the key principles of person-centred care, namely:

- Treating patients with dignity and respect
- Encouraging patient participation in decision-making (see **Shared decision making**)
- Communicating with patients about their clinical condition and treatment options
- Providing patients with information in a format that they understand and encouraging them to participate in decision-making.

Woman-centred care

This clinical care standard supports the values and principles in *Woman-centred Care: Strategic directions for Australian maternity services*.[4] These aim to ensure that Australian maternity services provide care that is equitable, safe, woman-centred, informed and evidence based. Women are the decision-makers in their care, and maternity care should reflect their individual needs.[4]

This clinical care standard promotes the provision of individualised information and appropriate care based on current, high-quality evidence, including evidence on models of care. Models of care include midwifery continuity of care, obstetric-led care and general practitioner shared care.

In the maternity setting, 'woman-centred care' recognises the woman's baby, partner, family and community, and respects cultural and religious diversity as defined by the woman herself. It considers the woman's individual circumstances, and aims to meet her physical, emotional, psychosocial, spiritual and cultural needs. Care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. It respects the woman's ownership of her health information, rights and preferences, while protecting her dignity and empowering her choices.[90]

Shared decision making

Shared decision making involves discussion and collaboration between a consumer and their clinician. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, to reach the most appropriate healthcare decisions for that person.

Involving support people

The **Australian Charter of Healthcare Rights** (second edition) describes the rights that consumers, or someone they care for, can expect when receiving health care.[91]

Patients have the right to involve the people they want in planning and making decisions about their health care and treatment. This could be a partner, family member, carer, friend or consumer advocate such as a social worker. Many health services employ different types of liaison officers, such as Aboriginal and Torres Strait Islander liaison officers, who can provide patients with advocacy, information and support.

Quality statements that refer to clinicians' discussions with women about their care should be understood to include partners, other family members, carers or other support people if this is what the woman wishes, or a substitute decision-maker if she is unable to provide her consent.

Informed consent

Informed consent is a person's voluntary and informed decision about a healthcare treatment, procedure or intervention that is made with adequate knowledge and understanding of the benefits and risks to them, and the alternative options available. See the **Informed Consent in Health Care fact sheet**, developed by the Commission.

Action 2.04 in the National Safety and Quality Health Service (NSQHS) Standards requires healthcare services to ensure that informed consent processes comply with legislation and best practice.[8]

Cultural safety for Aboriginal and Torres Strait Islander people

Person-centred care includes care that is respectful of cultural diversity and individual needs.

The **Cultural Respect Framework 2016–2026** commits the Australian Government and all states and territories to embed cultural respect principles into their health systems.11 The framework should be used to develop, implement and evaluate cultural awareness and cultural competency strategies.

Systemic racism is a serious concern for Aboriginal and Torres Strait Islander peoples. Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health.[92]

Health consumers are safest when clinicians have considered power relations, cultural differences and patients' rights. Part of this process requires clinicians to review their own beliefs and attitudes.[93]

The NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health[93] describes six specific actions (**Table 3**) that aim to help health services improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander peoples.[8]

Table 3: The six actions in the NSQHS Standards that address meeting the needs of Aboriginal and Torres Strait Islander peoples

Standard	Action	
Clinical Governance Standard	1.2	The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
	1.21	The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
	1.33	The health service organisation demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people
	1.4	The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
Partnering with Consumers Standard	2.13	The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Comprehensive Care Standard	5.8	The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems

The National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards have similar criteria, and outline that the healthcare service identifies patient populations at greater risk of avoidable differences in health outcomes, including Aboriginal and Torres Strait Islander peoples.[9]

The National Registration and Accreditation Scheme aims to ensure consistency in the approach to cultural safety in health professions' codes of conduct nationally.[94]

It states that in order to ensure culturally safe and respectful practice, health practitioners must:

1. Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health
2. Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
3. Recognise the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual family and community
4. Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

Appendix B:
Indicators to support local monitoring

The Commission has developed a set of indicators to support clinicians and health services in monitoring how well they implement the care described in this clinical care standard. The indicators are a tool to support local quality improvement activities. No benchmarks are set for any indicator.

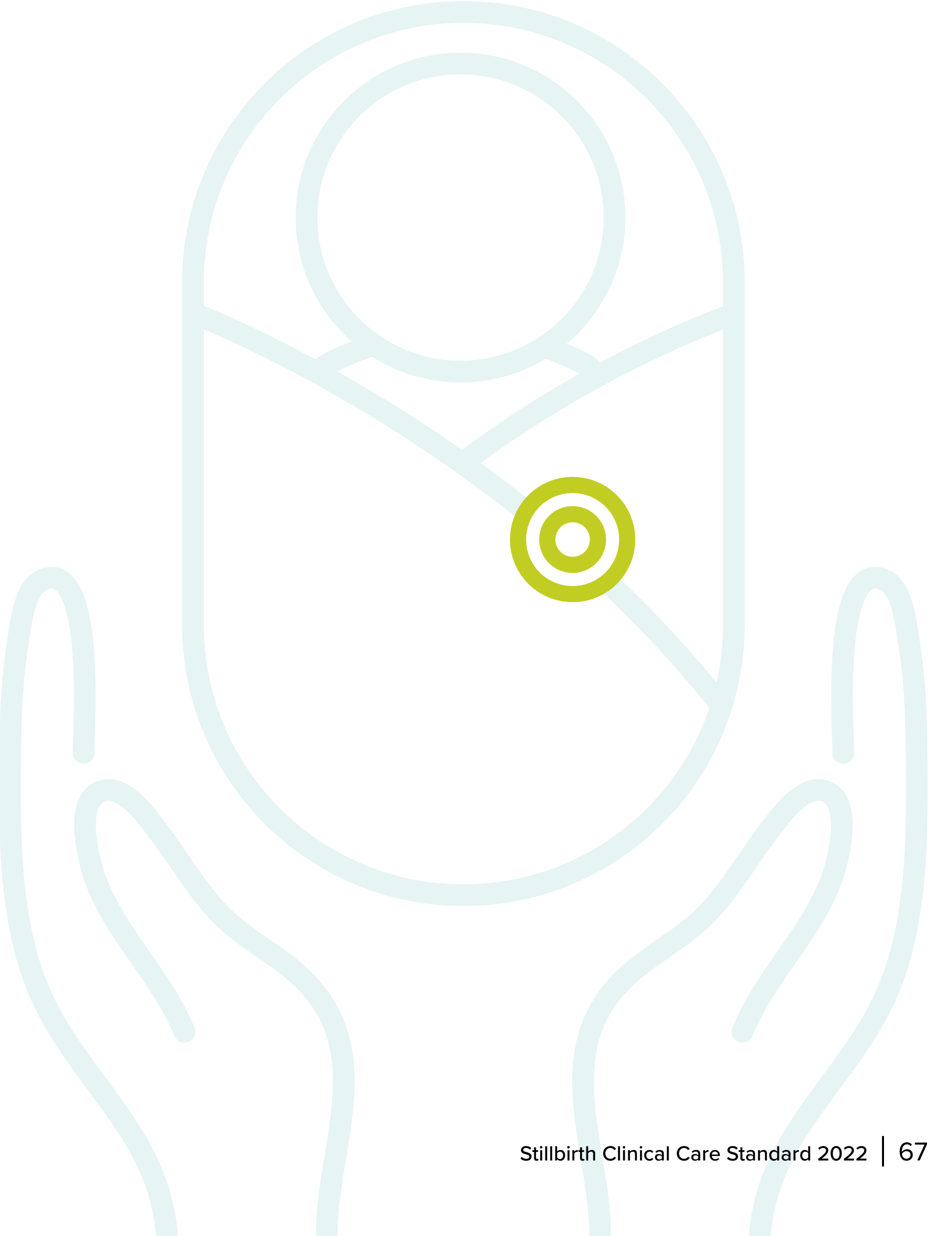
The process to develop the indicators specified in this document comprised:

- A review of existing Australian and international indicators
- Prioritisation, review and refinement of the indicators with the topic working group.

The data underlying these indicators are collected from local sources, through prospective data collection or retrospective chart audits, or review of policies and protocols.

In this document, the indicator titles and hyperlinks to the specifications are included with the relevant quality statement under the heading 'Indicator(s) for local monitoring'. Full specifications for the *Stillbirth Clinical Care Standard* indicators can be found in the Metadata Online Registry (METEOR) at **meteor.aihw.gov.au/content/766607**.

METEOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare, METEOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.



Appendix C:
Measuring and monitoring patient experiences

Systematic, routine monitoring of patients' experiences of, and outcomes from, health care is an important way to ensure that the patient's perspective drives service improvements and person-centred care. This is the case in all health services.

Patient experience measures

While this clinical care standard does not include indicators specific to measuring patient experiences, the Commission strongly encourages health services to use the Australian Hospital Patient Experience Question Set (AHPEQS). AHPEQS is a 12-question generic patient experience survey that has been validated in both day-only and admitted hospital patients across many clinical settings. The **instrument is available for download** to both private and public sector health services.

Patient-reported outcome measures

In Australia, patient-reported outcome measures (PROMs) are an emerging method of assessing the quality of health care. The Commission is leading a national work program to support the consistent and routine use of PROMs to drive quality improvement.

PROMs are standardised, validated questionnaires that patients complete, without any input from clinicians. They are often administered at least twice to an individual patient – at baseline and again after an intervention – or at regular intervals during a chronic illness. The information contributed by patients filling out PROM questionnaires can be used to support and monitor the movement of health systems towards person-centred, value-based health care.

PROMs are being used to evaluate healthcare effectiveness at different levels of the health system, from the individual level to service and system levels. There is growing interest across Australia and internationally in the routine interrogation of patient-reported outcome information for evaluation and decision-making activities at levels of the health system beyond the clinical consultation.

Appendix D:
Integration with national safety and quality standards

National Safety and Quality Health Service Standards

Monitoring the implementation of this clinical care standard will help healthcare services to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).[8]

The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

Within the NSQHS Standards, the Clinical Governance Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all healthcare services that applies to all other standards:

- The Clinical Governance Standard aims to ensure that systems are in place within healthcare services to maintain and improve the reliability, safety and quality of health care
- The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care, to the extent that they choose.

Actions 1.27b and 1.28

Under the Clinical Governance Standard, healthcare services are expected to support clinicians to use the best available evidence, including clinical care standards (see Action 1.27b), and to monitor and respond to unwarranted clinical variation (Action 1.28).

Healthcare services are expected to implement the NSQHS Standards in a way that suits the clinical services provided and their associated risks.

Information about the NSQHS Standards is available at the **NSQHS Standards website**.

National Safety and Quality Primary and Community Healthcare Standards

The National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards aim to protect the public from harm and improve the quality of health care delivered.[9]

The NSQPCH Standards are aligned to the NSQHS Standards. Both standards highlight the importance of clinical governance and consumer partnerships in effective, safe and high-quality health care, wherever health care is delivered.

Primary and community services can be subject to multiple sets of standards. It is intended that the NSQPCH Standards are used as the core safety and quality component of each set of standards, thus minimising the compliance burden across multiple sets of standards.

Glossary

Term	Definition
Aboriginal community controlled health organisations (ACCHOs)	Primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it, through a locally-elected Board of Management.
Aboriginal medical services (AMSs)	Healthcare services funded principally to provide services to Aboriginal and Torres Strait Islander people. These may or may not be community controlled. See **Aboriginal community controlled health organisations (ACCHOs)**.
antenatal	The period between conception and the onset of established labour.[95]
Ask, Advise, Help	A brief three-step intervention to support smoking cessation that can be provided by a wide range of clinicians in a variety of settings.[46]
assessment	A clinician's evaluation of a disease or condition, based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team.[8]
bereavement care	In this clinical care standard, refers to the care that should be provided to parents after perinatal loss to support their physical, emotional, psychological and spiritual wellbeing.
best-practice guidelines	A set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[8]
caesarean section	An operation in which a baby is born through an incision (cut) made through the mother's abdomen and uterus.[96]
carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[97]
clinical care standards	Nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.

Term	Definition
clinical practice guidelines	Statements that include recommendations intended to optimise patient care and are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.[98]
clinician	A trained health professional, including registered and non-registered practitioners, who provides direct clinical care to patients. Clinicians may provide care within a healthcare service as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health professionals, Aboriginal and Torres Strait Islander health workers and practitioners, and other clinicians who provide health care, and students who provide health care under supervision.
congenital anomaly	A structural, functional or metabolic abnormality that is present at birth, even if not diagnosed until months or years later.[99]
consultation	The seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It requires collaborative relationships and open communication with others in the multidisciplinary team.[90]
consumer	A person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[100]
continuity of carer	The practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period.[4]
early planned birth	When babies are born before 39 weeks of pregnancy by planned caesarean section (that is, without established labour) or induction of labour.[70]
first trimester screen	Testing for chromosomal anomalies (genetic conditions) during the first trimester of pregnancy, which includes[5]: ▪ Ultrasound measurement of fetal nuchal translucency thickness, completed between 11 weeks and 13 weeks 6 days of gestation ▪ Maternal plasma testing of pregnancy-associated placental protein-A (PAPP-A) and free beta-human chorionic gonadotrophin (β-hCG), completed between 9 weeks and 13 weeks 6 days of gestation.
healthcare record	A record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.[8]
healthcare service	A health organisation that is responsible for implementing clinical governance, administration and financial management of service unit(s) providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.[8]

Term	Definition
health literacy	The Australian Commission on Safety and Quality in Health Care separates health literacy into two components: individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, assess and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways consumers access, understand, assess and apply health-related information and services.[8]
hospital	A licensed facility providing healthcare services to patients for short periods of acute illness, injury or recovery.[8]
induction of labour	A procedure to artificially start the process of labour by way of medical, surgical, or medical and surgical means.[5]
informed consent	A process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient understands the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[101]
late-gestation stillbirth	Stillbirth occurring after 28 weeks of gestation, or in the third trimester of pregnancy.[2]
maternity care	Care provided during pregnancy and in the 12 months after giving birth.[95]
medical record	See **healthcare record**.
miscarriage	The spontaneous loss of a pregnancy before the unborn baby (fetus) can survive outside the womb, generally defined in humans as before 20 weeks.[5]
multidisciplinary team	A team comprising clinicians from multiple disciplines (branches of knowledge within the health system) who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[8]
neonatal death	The death of a live-born baby within 28 days of birth.[2]

Term	Definition
partnership	When patients and consumers are treated with dignity and respect, information is shared with them, and participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a healthcare service, including at the level of individual interactions; at the level of a service, department or program; and at the level of the service. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the healthcare service is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnerships will depend on the context of the healthcare service.[8]
patient	A person who is receiving care in a healthcare service.[8]
perinatal loss	In this clinical care standard, refers to any form of pregnancy loss[3], including miscarriage, stillbirth, ectopic pregnancy, termination of pregnancy or neonatal death.
perinatal period	The period covering pregnancy and the first year after pregnancy or birth.[5]
person-centred care	An approach to the planning, delivery and evaluation of health care that is founded on mutually helpful partnerships among clinicians and consumers. Person-centred care is respectful of, and responsive to, the preferences, needs and values of consumers. Key dimensions of person-centred care include: ▪ Respect ▪ Emotional support ▪ Physical comfort ▪ Information and communication ▪ Continuity and transition ▪ Care coordination ▪ Involvement of carers and family ▪ Access to care. Also known as patient-centred care or consumer-centred care.[8]
primary health care	The first point of contact for individuals, families and communities with health services. Primary health care is provided as close as possible to where people live and work, and comprises a large and essential part of the healthcare system.[102] It includes health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care.[103]
psychiatrist	A medical doctor who has completed specialised training in psychiatry and is registered with the Australian Health Practitioner Regulation Agency.
psychologist	A mental health professional who has completed at least six years of approved university study and supervised experience, and is registered with the Australian Health Practitioner Regulation Agency.
psychosocial	Social factors that have the potential to affect a woman's emotional wellbeing.[5]
qualified social worker	A graduate of an Australian Association of Social Workers (AASW)–accredited social work degree who is eligible for membership of the AASW.

Term	Definition
quality improvement	The combined efforts of the workforce and others – including consumers, patients and their families or carers, researchers, planners and educators – to make changes that will lead to better patient health outcomes, better system performance in care, and better professional development.[104] Quality improvement activities may be sequential, intermittent or continuous.[8]
risk assessment	Assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.[105]
risk factor	A characteristic, condition or behaviour that increases the possibility of disease, injury or loss of wellbeing.
scope of practice	The extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[106]
shared decision making	A consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances.[107]
spiritual care	Person-centred care that focuses on the spiritual dimensions of life, provided by practitioners to appropriately meet an individual's spiritual and emotional needs. It is most commonly offered in a one-to-one relationship, and may include presence, conversations, ritual, ceremonies, and the sharing of sacred texts and resources.[108]
stillbirth	A fetal death prior to the birth of a baby of 20 or more completed weeks of gestation or of 400 grams or more birthweight.[2] See also **late-gestation stillbirth**.
support people	In this clinical care standard, refers to individuals who the woman (or parents) receiving care choose to involve in their care. This may include family members, carers, friends, advocates, or people who can provide religious or spiritual support.
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: ▪ Brings together risk management, governance and operational processes and procedures, including education, training and orientation ▪ Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials ▪ Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures. The workforce is both a resource in the system and involved in all elements of system development, implementation, monitoring, improvement and evaluation.[8]
termination	Intentionally ending a pregnancy, either by medication or instrumentation, with the purpose being the death of the embryo or fetus.

Term	Definition
training	The development of knowledge and skills.[8]
ultrasound	The use of high-frequency sound waves to produce an image that shows the inside of the body.[109]
unwarranted clinical variation	Clinical variation that does not reflect a difference in patients' clinical needs or preferences, and may present an opportunity for improvement in healthcare system performance.
woman-centred care	Care that recognises a woman's baby or babies, partner, family and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet her physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences, while protecting her dignity and empowering her choices. Woman-centred care is the focus of midwifery practice in all settings.[90] See also **person-centred care**.

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The above artwork used throughout the document was designed by Ms Lani Balzan, a Wiradjuri artist from the south coast of New South Wales. The central symbol is the logo for the clinical care standards program which began at the Commission in 2013. The outer four circles of the artwork represent the four priority areas of patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide care that is informed, supported and organised to deliver safe and high-quality health care. The outer dots represent growth, healing, change and improvement.

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