Subject: Intrauterine Fetal Demise (IUFD)	
REVISION DATE: Jul 2015, 06/2012, 04/2007, 06/1999 REPLACES: L&D Intrauterine Fetal Demise	WRITTEN: March 1987 SUPERSEDES DATE: June 2012

This guideline is used to assist staff when caring for a patient with an intrauterine fetal demise. This applies to all medical and nursing personnel.

Purpose: The goal of care for a patient with an intrauterine fetal demise is to provide care and support with dignity and in a manner that considers the needs of the patient and family.

Summary of Changes: References/content updated to reflect most current standards of practice.

1. References:

1.1. American College of Obstetricians and Gynecologists (ACOG) (2009). Management of stillbirth. *ACOG Practice Bulletin, Clinical Management Guidelines for Obstetricians-Gynecologists (102).*

1.2. Lippincott, Williams, & Wilkins (2012). Fetal demise care. Retrieved from http://procedures.lww.com/lnp/view.do?pId=951191&s=p&fromSearch=true&searchQuery=fetal+demise.

2. Responsibilities:

2.1. Credentialed delivering provider.

2.1.1. Manage and assume responsibility for patient care administered.

2.1.2. Place appropriate medical orders in patient's electronic health record (EHR) based on comprehensive patient assessment.

2.1.3. If an autopsy is desired by parents, complete consent and make notification to pathologist upon delivery and before discharge.

2.1.4. Provide supportive care and allow for patient/family expression of grief.

2.2. Nurse.

2.2.1. Acknowledge all provider orders in the Electronic Health Record (EHR).

2.2.2. Monitor uterine activity before and during labor or labor induction.

2.2.2.1. Monitoring of uterine activity with a fetal demise is at the discretion of the provider. If no uterine activity monitoring is desired, the provider should annotate in a progress note.

2.2.3. Notify provider of abnormalities noted during patient assessments.

2.2.4. Provide supportive care and allow for patient/family expression of grief.

3. General

3.1. The most common risk factors associated with stillbirth are nulliparity, non-hispanic black race, obesity, and advanced maternal age (ACOG, 2009).

3.2. Dilation and evacuation can be offered in the second trimester. Labor induction is also appropriate at later gestational age, based on patient preference, or if the option for dilation and evacuation is unavailable. (ACOG, 2009).

3.3. Before 28 weeks gestation, misoprostol appears to be the most efficient method of induction. Typical dosage is 200-400 mcg vaginally every 4-12 hours (ACOG, 2009). (note: see 5.3.1.)

3.4. After 28 weeks gestation, induction of labor should be managed according to unit guidelines for labor induction (ACOG, 2009). (note: see 5.3.2.)

3.5. The most important tests in the evaluation of a stillbirth are fetal autopsy, examination of the placenta, cord, and membranes, and karyotype evaluation (ACOG, 2009)

3.6. **Birth certificates are required by state law for all fetuses born with any signs of life (breathing, heartbeat, pulsation of the umbilical cord, or definite movements of voluntary muscles), regardless of gestation. The provider must also complete a death certificate after death occurs**.

4. **Definitions**

4.1. Fetal death/Stillborn: "The delivery of a fetus showing no signs of life as indicated by the absence of breathing, heart beats, pulsation of the umbilical cord, or definite movements of voluntary muscles (ACOG, 2009)."

4.2. Spontaneous abortion: A pregnancy that ends before a fetus is viable, generally 20 weeks gestation (Lippincott, Williams, & Wilkins, 2012), (ACOG, 2009).

4.3. "Live Birth": The complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows evidence of life such as beating of the heart, pulsation of the umbilical cord, or

definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached (Section 18.50.950, Alaska Statutes).

4.4. Neonatal death: An infant born alive that dies after birth, before 7 days of life.

5. Standards of Practice/Guidelines for Care:

5.1. Upon mother's admission to the OB unit, ascertain her wishes regarding pastoral care. Notify clergy as appropriate.

5.2. Ensure all staff members are aware of patient's loss. Place picture card on patient's door.

5.2.1. After delivery of the fetus ensure the fetal demise symbol is present on the OB tracking board.

5.3. Draw specified labs (with IV start if possible) per provider's orders.

5.4. If patient presents to the unit for labor induction with misoprostol, assist provider with administration per guidelines.

5.4.1. Before 28 weeks gestation: misoprostol 200-400mcg vaginally every 4-12 hours or per provider's orders until an active labor pattern has been established (ACOG, 2009).

5.4.2. After 28 weeks gestation: misoprostol 100-200mcg vaginally every 4 hours or per provider's orders until an active labor pattern has been established. Misoprostol may also be given orally in doses of 100-200 mcg every 4 hours (ACOG, 2009).

5.4.3. Monitor and document uterine contractions and patient vital signs per misoprostol induction protocol, or per provider's orders.

5.5. If patient presents with SROM at pre-viable gestation and the fetus still has a heart rate, consider notifying the pediatrician and, potentially, the neonatologist at Providence to help the patient and her family understand comfort care.

5.6. If a baptism is requested/desired by the family, clergy will be notified. If there is a possibility that the baby will pass before clergy arrives, the infant should be baptized by a staff member. A certificate of baptism is typically provided for parents by the clergy member.

5.6.1. If the baby is stillborn, a blessing is used rather than a baptism.

5.6.1.1. Examples of blessings are as follows:

5.6.1.1.1. "Father in Heaven watch over this/these sleeping baby/babies in Your tender care as we treasure the memories of this/these little one/ones. Keep them by Your side and leave Your peace with the family at this sad time. Amen."

5.6.1.1.2. “Lord God, ever caring and gentle, we commit to Your love this/these little one/ones, quickened to life for so short a time. Enfold him/her/them in eternal life. We pray for his/her/their parents who are saddened by the loss of their child/children. Give them courage and help them in their pain and grief. May they all meet one day in the joy and peace of Your kingdom. We ask this through Christ our Lord. Amen.”

5.6.2. When performing a baptism, the wording is typically "_____ (baby's name), I baptize you in the name of the Father, and the Son, and the Holy Spirit. Amen”

5.6.1.1. When performing the baptism, pour water gently on the forehead of the baby once each when saying the name the Father, the Son, and the Holy Spirit.

5.7. Wrap infant in a blanket and offer mother/family the opportunity to hold the baby. Explain how the baby looks so that they know what to expect. If the baby has deformities, explore the baby for "normal" features and focus attention on these features.

5.8. If the mother/family are not ready to hold baby right away, make sure they know that they can see/hold the baby anytime they are ready. Allow the family time alone with the baby and as much time as they wish with the baby.

5.9. After verifying with the Nursing Supervisor that a bed is available, ask the mother if she wishes to stay on the Mother Baby unit or if she prefers to transfer to another unit.

5.10. OB Delivery: document admission and fetal demise record.

5.10.1. Regardless of gestational age, delivery information should be entered into the electronic health record under Delivery and Newborn Delivery bands. During the admission process of the baby, also known as “Bam Bam”, live birth must be annoted appropriately as “YES” or “NO” based on section 4.1.above.

5.10.2. If baby is born alive (at any gestation): admit baby and obtain a registration number and record delivery as a live birth. Upon death, the baby is then entered under the death column on the paper census sheet as:

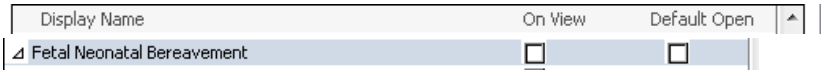
5.10.2.1 Stillbirth
5.10.2.2. Neonatal death

5.10.3. Any baby born, regardless of gestational age, requires admission and a medical record number.

5.10.4. Have provider complete a fetal death certificate,or birth and death certificate, as appropriate.

5.10.5. Within the interactive view (I-View) delivery band, Fetal Neonatal Bereavement must be opened. This is accomplished by opening the delivery band and then selecting

the customize view  (pencil image on the upper left corner of the I-View). Scroll down to the Fetal Neonatal Bereavement and select default open. This will allow documentation within the appropriate section of the electronic health record (EHR).



5.10.6. Complete the Perinatal Grief Checklist (Appendix 1) prior to discharge.

5.11. Weigh infant and record within the Newborn Delivery Data section.

5.12. Prior to transport off the unit, the infant will be identified with the following:

5.12.1. Three ID tags with mother's name, medical record number, infant's last name, sex, date, and time of birth.

5.12.1.1. Tie one tag around the infant's ankle.

5.12.1.2. Second tag will be attached to the outside of the blanket that the baby is wrapped in.

5.12.1.3. The third tag will attached to the outside of the transport container until the baby arrives in the morgue at which time it is placed on the outside of the drawer in which the baby is placed.

5.12.1.3.1. If the baby is taken to pathology instead of the morgue, the appropriate pathology labeling process will be followed. The third tag will accompany the baby on the outside of the transport container.

5.13. Notify Social Services of birth. Social Services will assist the family with funeral arrangements, transportation of infant, etc.

5.13.1. If Social Services is unavailable, and the family would benefit, Behavioral Urgent Response Team (BURT) may be contacted.

5.14. Notify *Now I Lay Me Down to Sleep* photography (1-877-834-5667) and determine if a photographer is available. If so, discuss photography options with the parent(s).

5.14.1. Obtain Photography Consent (See attachments).

5.14.2. Please call photographers only between the hours of 0800-2100 hours as they are volunteers.

5.15. Clean infant carefully due to extremely fragile skin and potential/probable sloughing of skin, allowing for family participation if desired.

5.16. Obtain a "memory box" for the family.. Footprints and/or handprints may be obtained (to be placed on one side of the memory box) and infant bereavement photographs may be offered (to be placed on the other side of the memory box)., Clip a lock of hair if possible(from the nape of the neck) as a memento for the family and place it within the memory box.

5.16.1 Additional items which may be included in the memory box are as follows:

5.16.1.1. Heart shaped pillow

5.16.1.2. Small gold ring

5.16.1.3. Teeny tears diaper

5.16.1.4. Infant gown

5.16.1.5. Tape measure

5.16.1.6. Infant hat

5.16.1.7. Any item that has been used on the baby following delivery or that the baby may have been wrapped which may be of significance to the family.

5.16.1.8. Sympathy card

5.16.1.9. Any photographs taken if desired by the family.

5.16.2. Allow family to participate in as many procedures with the baby as possible if desired.

5.17. Parental permission is required for photography, if parents do not wish pictures, honor their request. If requested, a photographer from *Now I Lay Me Down To Sleep* may be contacted to take bereavement photos with the family.

5.18. Provide emotional support to family, and allow them to begin their grieving process.

5.18.1 Emphasize the importance of not rushing the grieving process.

5.18.2. If the parents named the child, refer to the child by name whenever possible.

5.18.3. Verbalize words that offer encouragement, promote healing and give the family opportunity to express their thoughts and feelings (See Appendix 2, "Do's and Don'ts for Family, Friends, and Professionals").

6. Pathology

6.1. Physician will counsel family regarding genetic studies, autopsy, and organ donation.

6.2. If a **fetal chromosome** study is ordered:

6.2.1. Provider will place the order EHR as, "Chromosome Analysis," with comment as to why test is ordered.

6.2.2. Live infant or stillborn fetus > 20 weeks:

6.2.2.1. The Physician will collect all tissue specimens and communicate with pathology/laboratory to confirm appropriate specimen collection technique and transport medium.

6.2.3. If the specimen is from a spontaneous abortion or intrauterine fetal demise (<20 wks gestation):

6.2.3.1. Use sterile technique to separate out placental villi and place in transport medium.

6.2.3.2. Label the specimen with time, date, and type of tissue.

6.2.3.3. Complete the University of Washington Cytogenetics request including clinical indication for the test (e.g. congenital abnormalities, unusual appearance of the newborn or repeated spontaneous abortions in the mother).

6.2.3.4. Fill out the ANMC Tissue Examination Form noting source of the specimen and pertinent clinical history.

6.2.4. Provider must complete Physician Attestation of Informed Consent for Genetic Testing.

6.2.4.1. Deliver specimen with accompanying forms to ANMC Laboratory as soon as possible.

6.2.5. For fetal oral culture, provider will order Upper GI culture and use a charcoal swab to obtain the culture.

6.2.6. For placental evaluation, place the placenta in a white specimen bucket, and place a maternal label on both the bucket and the lid. Place the bucket in a biohazard bag and attach a completed tissue exam form to the outside of the bag with tape, then send the placenta to Pathology.

6.2.7. If the mother is Rh negative, draw fetal cord blood if able and send to lab for blood type and Rh sensitivity.

6.2.7.1. If the infant results are Rh positive, draw maternal blood sample and send to lab for RhoGAM work-up (see RhoGAM guidelines).

6.2.7.2. If unable to obtain fetal cord blood to determine fetal blood type and Rh status, the mother will need to be given RhoGam.

6.2.8. If **autopsy** is requested:

6.2.8.1. The physician will have the parent(s)_ sign the ANMC Autopsy Consent form.

6.2.8.2. The Physician will notify the pathologist of the need for autopsy upon newborn admission and maternal discharge. The RN will notify the House Supervisor who will note the autopsy request on the identification tag on the morgue drawer. The tissue exam slip will accompany the infant to the morgue.

7. Disposition of Body and Organ Donation

7.1. LifeCenter Northwest (1-888-543-3287) must be notified of all stillbirths and neonatal deaths regardless of gestational age. Do not approach the patient/family about organ donation. If LifeCenter Northwest determines that there is a viable option for organ donation, they will have a representative broach the subject with the patient/family. The Fetal Remains Release Form (located within the demise packet) must be filled out in the event of organ donation.

7.2. If infant is 20 weeks gestation or more, or less than 20 weeks with parental request for burial, infant may be transported to the morgue by the Nursing House Supervisor or security. Before the infant leaves the unit, confirm that the Fetal Neonatal Bereavement section within the Delivery band is completed. The infant is placed in the morgue drawer after parents have indicated their readiness to part with the infant.

7.2.1. Advise parents that they may request to see their baby any time before it is sent for autopsy or leaves the hospital. If the baby has been in the morgue, warn the parent(s) about what to expect regarding appearance and posture of baby as well as the fact that the baby will be cold.

7.2.2. If baby has already been examined by pathology, inform the parent(s) that the baby is wrapped in formalin-soaked gauze and can no longer be handled.

7.3. If infant is less than 20 weeks gestation and parents do not request burial, the infant is sent directly to pathology for disposal. The Fetal Remains Release Form must be completed and scanned into the newborn record. A copy may accompany the baby to pathology.

8. Birth and Death Certificate.

8.1 Under Alaska State Law, a death certificate must be filed with the local registrar for each fetal death ($\geq$ 20 weeks gestation) that occurs in the state.

8.2. If baby is born with signs of life (as defined in section 4.1.) at any gestation (including those less than 20 weeks), the provider will complete **a birth certificate worksheet and then, upon death of the newborn, will complete a death certificate**.

8.2.1. A fetal death certificate is used only for a death that occurs at a gestational age of $\geq$ 20 weeks. If < 20 weeks gestation and showing no evidence of life, State of Alaska regulations provide that a fetal death certificate may be prepared, filed, recorded, and registered at the **option of the parents or others concerned**.

8.21.2. If a baby is born with signs of life, RN documentation for the following must occur:

8.2.2.1. An Apgar score of at least 1 after delivery must be documented in the Newborn Delivery Data band with the newborns record.

8.2.2.2. Newborn heart rate and respirations are documented every 15-30 minutes within the newborn record until time of death.

8.2.2.3. Within the maternal record, the Fetal Neonatal Bereavement section of the Delivery band must be filled out and include the time of death as it is pronounced by the provider.

8.2.3. Give all Birth Certificates and Fetal Death Certificates to the birth certificate clerk for processing. Death certificates (non-fetal) should be left in the chart.

11. **Attachments:**

11.1. Attachment 1: Alaska Native Medical Center Perinatal Grief Checklist

11.2. Attachment 2: Do's and Don'ts for Family, Friends and Professionals Caring for Bereaved Parents

Attachment 1

ALASKA NATIVE MEDICAL CENTER
PERINATAL GRIEF CHECKLIST

Lifecenter Northwest Notified (1-888-543-3287) Yes_____ No_____

Clergy Services Offered Yes_____ No_____

Time to Hold/Visit with Baby Yes_____ No_____

Photographs Taken & Given Yes_____ No_____

Social Services Referral Made Yes_____ No_____

Patient Given Option to Stay on OB Unit or Transfer to another floor Yes_____ No_____

Father Given Opportunity of Spending the Night Yes_____ No_____

Autopsy Yes_____ No_____

Genetic Studies Yes_____ No_____

Correct Disposition of Remains-Form Yes_____ No_____

Room Marked Yes_____ No_____

List of Support Groups Given Yes_____ No_____

List of Suggested Reading Given Yes_____ No_____

(When Hello Means Goodbye)

Memory Packet Together To Parents___ On File___

- Lock of Hair
- Footprints/Handprints
- Crib Card
- Identification Band
- Baby Cap and/or Blanket

Birth Certificate Information Given if Live Birth Yes_____ No_____

RhoGAM Assessment Made Yes_____ No_____

Teaching Sheets Given Yes_____ No_____

Referral to CHN (what is CHN?) Yes_____ No_____

Certificate of Blessing/Baptism Yes_____ No_____

Attachment 2

Do's and Don'ts for Family, Friends and Professionals Caring for Bereaved Parents

DO'S

Do let your genuine concern and caring show.
Do be available to listen, to help with the other children, or whatever else seems needed at the time.
Do say you are sorry about what happened to their child and about their pain.
Do go to the visitation or funeral.
Do allow them to express as much grief as they are feeling at the moment and are willing to share.
Do encourage them to be patient with themselves, not to expect too much of themselves, and not to impose any "shoulds" on themselves.
Do recognize the importance of the baby in their lives.
Do allow them to talk about the child they've lost.
Do comfort them with touch as well as speech.
Do give special attention to the child's brothers and sisters - at the funeral and in the months to come. They too are hurt and confused and in need of attention which their parents may not be able to give them at this time.
Do realize that once they have experienced grief, they will never be the same again. It is normal.
Do reassure them that they did everything they could, that the medical care their child received was the best, or whatever else they need to know to be true and positive about the care given to their child.
Do treat the bereaved couple equally. Men need as much support as women.
Do reassure them that what they are feeling (anger, depression, shock, etc.) is normal.

DON'TS
Don't let your own sense of helplessness keep you from reaching out to the bereaved parent.
Don't avoid them because you are uncomfortable. Being avoided by friends adds pain to an already painful experience.
Don't ask how they are if you're not prepared to listen.
Don't say you know how they feel. Unless you've lost a child yourself, you probably don't know how they feel.
Don't say, "You ought to be feeling better by now" or anything else which implies judgment about their feelings.
Don't tell them what they should do or feel.
Don't change the subject when they mention their dead child.
Don't avoid mentioning the child's name out of fear of reminding them of their pain (they haven't forgotten it).
Don't encourage or rush them through their grief. Normal grieving takes 18-24 months and may extend beyond that time.
Don't rationalize a baby's death by saying:

"They are better off."
"You have an angel in heaven."
"It was a blessing."
"You're young, you can have another."
"You must be relieved it's over."
"The baby would have been abnormal anyway."
"It could have been worse."
"You have other children."